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Elder Law Attorney

A publication of the Elder Law Section
of the New York State Bar Association

Message from the Chair

As we greet 2004, I am pleased to announce the huge success of our January 27, 2004 Annual Meeting, thanks to Ron Fatoullah, our energetic Program Chair. Ron assembled speakers who shared valuable practice tips and telescoped statewide and national trends in elder law. We also continued our valued dialogue with attorneys representing the Departments of Social Services in various counties throughout the state. Many thanks to Lou Pierro, Valerie Bogart and Charlie Sabatino for their updates, to Ron Fatoullah, Vincent Russo, Ira Salzman, Allan Silver, Steve Stern, and Peter Strauss for their practice tips, and to Dan Fish, Peter Glase, Howard Krooks, Kate Madigan, Rick Marchese, René Reixach and Gary Samuels for their spirited panel exchange, moderated by Ron Fatoullah. The sold-out program retained its audience throughout the afternoon, notwithstanding a snowstorm raging outside. A true testimony to the important information expertly delivered! Many thanks to all participants.

Congratulations to the new slate of officers, elected unanimously in accordance with the report of the nominating committee, presented by Chair Cora A. Alsante. Howard S. Krooks ascended to Chair, with his term to start June 1, 2004. Daniel G. Fish is Chair-Elect, followed by Lawrence Davidow, Vice-Chair; Ellen Makofsky, Secretary; and Ami Longstreet, Treasurer.

In accordance with the guidelines established by the Awards Committee, two Section Awards were presented. One honored Judge Howard G. Munson, N.D.N.Y., for his decisions which have favored the practice of elder law. The Section also awarded a Special Award in Memory of Mitchell W. Rabbino with a plaque that reads: "Gracious Elder Law Practitioner, Tireless Advocate for Seniors, Respected Colleague, Valued Officer." Nomination forms for next year can be found on our Section's Web site at www.nysba.org/elderlaw and in future issues of the *Elder Law Attorney*. We encourage nominations in five different categories so that we may honor outstanding seniors, attorneys and judges.

The Executive Committee meeting preceded the program. Of chief concern to the Section is proposed legislation seeking to amend the Medicaid statute.

Inside this Issue

These proposals include imposing a penalty period for transfers of assets for Medicaid homecare and eliminating spousal refusal in community Medicaid situations. Other proposals presented to the legislature would require a waiver from the federal government. These include extending the look-back period to five years for all Medicaid applications, restricting the availability of spousal refusal in nursing home situations and beginning the penalty period at the date of application rather than at the date of transfer. These proposals, if enacted, would have a devastating effect on the frail elderly and persons with disabilities.

In order to educate the legislature as to the impact these proposals would have, I appointed a Special Committee on Medicaid Legislation, co-chaired by Howard S. Krooks and Vincent J. Russo. In addition to the Section officers, the other members of the Special Committee are Ron Fatoullah, Lou Pierro and René Reixach. Working on a tight deadline, the Special Committee issued a Report on Proposed Legislation which served as the basis of testimony presented by Lou Pierro before the state legislature. This Report can be found on our Section Web site. The Special Committee will reach out to the entire Section for its input and support in contacting legislators and educating the public as to these proposals.

Our Section will continue to be proactive when legislation or rules are proposed which affect our members and their clients. The Section's Long Term Care Reform Committee will revise its preliminary 2001 report, which examines the crisis in paying for long-term care and suggests some solutions. The committee will present this Report for Section approval at our spring Executive Committee meeting.

The spring will also bring our Mitch Rabbino Decision Making Day during the first week in May. We are working with the district delegates to identify locations and find speakers to present a "legal check-up" to the seniors in the area. Many thanks to Meg Z. Reed and Carol L. Scal and to our Section liaison from the State Bar, Lisa Bataille, for their hard work in implementing this important program.

Our Section continues to be a dynamic force interested in the rights and plights of the elderly and persons with a disability. I was gratified to see so many attendees at the committee meetings and invite all members to contact committee chairs, district delegates and officers with suggestions, thoughts and concerns. We particularly welcome the active participation of our members who practice in the public sector, as we hope to continue the dialogue that has become a highlight of our Annual Meeting.

Joan L. Robert

Editor's Message

The only constant in life is change. That idea may be even more true in the practice of elder law. With all of the new legislation, proposed legislation, and new proposed legislation, it certainly is a challenge to keep up. This issue is dedicated to both the new Medicare legislation and the proposed Medicaid legislation.

Originally, the Medicare theme of this issue was chosen long before the release of the Governor's Budget Bill and the proposed Medicaid legislation. However, through the hard work and dedication of our Section's Special Committee on Medicaid Legislation, we are able to include the timely response to the proposals. The Report was written by Howard Krooks, Vincent Russo, Cora Alsante, Dan Fish, René Reixach and Joan Robert, all of whom are members of the Special Committee on Medicaid Legislation, which is co-chaired by Howard Krooks and Vincent Russo. Lou Pierro presented this Report in support of testimony that he gave on February 3, 2004 before the state legislature.

U.S. Senator Larry Craig has written an article for this publication explaining some of the provisions of the new Medicare prescription drug legislation. As the Chairman of the Senate Special Committee on Aging, Senator Craig has been in the forefront of this issue, and will continue to be significantly involved in its implementation.

Greg Olsen, Executive Director of the New York State Alliance for Retired Americans, argues that the federal government lost the opportunity to provide a real, comprehensive and affordable prescription drug benefit to the Medicare program. This critical issue of prescription drug benefits under the Medicare program, which had been an important priority for years, Olsen explains, is a disappointment for retirees and advocacy organizations.

With all of the critical issues affecting seniors and their families that she is currently addressing, we are grateful to Joan Lensky Robert, Esq., Chair of our Section, for contributing her article regarding Medicare recovery. Joan examines the important cases rendered in 2003 which limit Medicare's right to recovery from a personal injury lawsuit.

Since this issue's focus is Medicare, it is appropriate to once again consider the information previously provided by Robert Grey, Esq., regarding mediation in a Medicare context. His article highlights how mediation can be the procedure of choice for handling some quality-of-care complaints.

Bernard Krooks, Esq., has written an article which is an excellent discussion of the basics of long-term care insurance, not only for the practitioner, but for our clients as well. This should serve as an informational article that can be distributed to all of our clients.

Taniella Harrison, Executive Director of Tri-County Home Nursing Services, explains the important factors to consider when referring a home care provider to facilitate your client's needs, and provides tips on how to work with the appropriate agency.

Stephen A. Linker, CPA, a Diplomate of the American Board of Forensic Accountants, has written an article which is useful in the area of practice management. As the director of Legal Support Services of The Resnick Group, LLC, Mr. Linker has experience in advising clients on how to avoid being victimized by crimes of confidence, such as embezzlement.

As always, this edition's NEWS section contains timely and useful articles by some of the most experienced practitioners in our Section. Thanks to all of them for their continued commitment.

Please enjoy this edition of *Elder Law Attorney*.

Steven Stern

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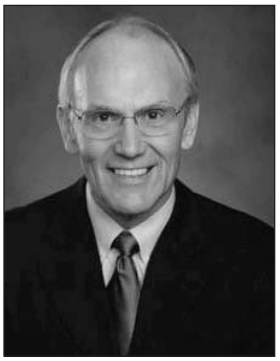
ELDER LAW NEWS

REGULAR COLUMNS

Understanding the New Medicare Legislation

By U.S. Sen. Larry Craig



As Chairman of the U.S. Senate Special Committee on Aging and a member of the Judiciary Committee, I appreciate the opportunity to share some insights into the new Medicare law with members of the New York State Bar Association.

This bill, which is hundreds of pages long, while not perfect, is an important step for America. With this bill the poorest among us will receive the greatest assistance—and that is as it should be.

Among its many provisions, this new Medicare bill includes three particularly important elements: a voluntary prescription drug benefit for seniors—*no one will be forced to enroll*; important changes for rural America made possible by raising support for beleaguered doctors and hospitals in rural states; and the introduction of health-care savings accounts—which will allow younger Americans to put their money in savings tax-advantaged Health Savings Accounts (HSAs) that can be used to pay for medical expenses for themselves or their families.

Immediate Prescription Drug Help for Seniors

The biggest change with the new Medicare bill, of course, is the prescription drug coverage. Starting in June 2004, seniors will have access to Medicare-approved drug discount cards which will be active until the full Medicare prescription drug benefit goes into effect January 1, 2006. The cards will cost $30 or less each year and are free if a senior's income is less than about $12,000 each year ($16,000 for married couples). For lower-income seniors who otherwise have no drug coverage, the cards will come "pre-loaded" with $600 to help pay for prescriptions immediately. If seniors don't use all the $600 in 2004, the remaining amount will be added to another $600 they will receive in 2005. This is a temporary program.

Long-Term Help for Older Americans

Starting in 2006, Medicare for the first time will offer coverage for prescription drugs administered through Medicare supervised health plans. The standard benefit (*lower income seniors will get more*) includes:

- A monthly premium of about $35
- A deductible of $250
- Prescription drug coverage is 75% up to $2,250 annually.
- Protection from high out-of-pocket costs. When total out-of-pocket spending reaches $3,600, co-pays will only cost $2 for generics and $5 for brand-name drugs.

"This [Medicare] bill . . . while not perfect, is an important step for America. With this bill the poorest among us will receive the greatest assistance—and that is as it should be."

This bill also offers significant financial incentives to encourage employers to continue to provide prescription drug coverage for their retirees. Even without this legislation, companies for several years now have been scaling back health coverage for those who have retired. The intent of the legislation is to stem that trend and encourage companies to continue to offer coverage.

Health Savings Accounts

For many attorneys in small practices and for those advising small businesses, the HSAs may become an attractive option to consider. HSAs are similar to medical savings accounts (MSAs). However, MSA eligibility has been restricted to employees of small businesses and the self-employed, while HSAs are open to everyone with a high-deductible health insurance plan. The only limitation on the health plan is that the annual deductible must be at least $1,000 for individual coverage and at least $2,000 for family coverage. The new HSAs are already available from a variety of insurance companies.

Contributions to the HSA by an employer are not included in the individual's taxable income. Contributions by an individual are tax-deductible. Individuals, their employers, or both can contribute tax-deductible funds each year up to the amount of the policy's annual deductible, subject to a cap of $2,600 for individuals and $5,150 for families. Individuals aged 55–64 can make additional contributions.

"It is no surprise for me . . . that in 2003, of the 21 members of the Special Committee on Aging, 16 voted for the bi-partisan, historic changes to Medicare—finally adding a much needed prescription drug benefit."

HSAs are portable, so an individual is not dependent on a particular employer to enjoy the advantages of having an HSA. Like an individual retirement account (IRA), the HSA is owned by the individual, not the employer. If the individual changes jobs, the HSA goes with the individual.

Keeping Our Eye on the Bill

The Special Committee on Aging was instrumental in the creation of the Medicare legislation in 1965. Since then the Committee has continually monitored the program and held regular oversight hearings about it. It is no surprise for me, then, that in 2003, of the 21 members of the Special Committee on Aging, 16 voted for the bi-partisan, historic changes to Medicare—finally adding a much needed prescription drug benefit. The Senate as a whole passed the measure 54-44.

All of us will keep our eye on the bill and monitor the new drug benefit's implementation. As the Chairman of the Special Committee on Aging, I know that our committee will be at the forefront of that review.

Larry Craig (R, I) is the senior U.S. Senator from Idaho.

The Other Side of the Medicare Prescription Drug Law

By Greg Olsen

The President and the United States Congress missed an important opportunity to provide a real, comprehensive and affordable prescription drug benefit to the Medicare program. Adding a prescription drug benefit to Medicare has been an important priority for retirees and advocacy organizations for over a decade, when the prices of prescriptions started to escalate. Over the past decade, the issue of prescription drug pricing has been at the forefront of local, state and national issues as the country has had to witness seniors taking bus trips to Canada to receive their prescriptions more affordably; at the same time, some states and some communities have introduced legislation or are passing plans to purchase their drugs more inexpensively.

"[T]his law was less to do about providing a prescription drug benefit to Medicare than it was about fundamentally altering the country's only successful universal health care program . . . "

The pharmaceutical companies have spent a great deal of time blocking any efforts to lower prices, claiming that they need exorbitant profits in order to fund research and development. Unfortunately, their claims continue to be untrue, they remain the most profitable industry in the country, prices continue to skyrocket and those who rely on prescriptions to maintain their health and independence continue to be priced out of the market or are forced to make difficult choices.

Medicare remains the most logical and appropriate place to try to help older Americans access affordable medications. Unfortunately, what was signed recently by the President will not make prescriptions more affordable, will cost over $540 billion ($140 billion more than was previously estimated) and will actually cost retirees more money to participate. The details below show that this law was less to do about providing a prescription drug benefit to Medicare than it was about fundamentally altering the country's only successful universal health care program and giving it away, along with massive subsidies, to the private sector while leaving older Americans at the whim of the private insurance industry that has historically shunned them.

The New York State Alliance for Retired Americans, representing almost 500,000 union and non-union retirees and individuals and almost 200 community groups statewide, opposed the Medicare Law for many reasons. All but a small handful of the nation's senior groups, labor groups, consumer groups, disability groups and individual advocacy organizations opposed the bill because they saw right through the rhetoric and looked at the provisions of the bill. It spells bad news to current retirees, future retirees, those on Medicaid, and those with current health benefits.

What Older Americans Should Know About the Medicare Law

Challenged Fact: The law protects traditional Medicare. This law really undermines the traditional Medicare program by forcing it to compete, beginning in 2010, with private insurance plans. Supporters tout this as "only a demonstration project," but it is the beginning of the privatization of Medicare. Private insurance companies will have the option to "cherry-pick" enrollees, that is they will accept healthier seniors, leaving sicker seniors in the traditional program. Unlike the traditional program, private insurers do not guarantee premiums, can drop patients and can change coverage. The law also establishes a "means test" for the Medicare program under which higher-income seniors will pay higher premiums for Part B, ranging from 40–220%.

Challenged Fact: All Medicare beneficiaries will have access to drug coverage. But in order to get such coverage you must either leave the traditional Medicare program and join a Medicare Advantage plan (this replaces the failing Medicare+Choice program that replaced the failed Medicare HMO program) or buy a stand-alone policy from a private "Plan Sponsor." The private "Plan Sponsor" is either an insurance company licensed in the state or a company that meets the solvency standards established by the Centers for Medicare and Medicaid Services (CMS). In addition, if a senior decides not to join the

new Medicare plan and joins later, they will be charged 1% of the cost of the premium for every month they do not join. So if an individual joins two years later (24 months), they will pay 24% above and beyond the premium.

Challenged Fact: The new drug benefit is voluntary. Seniors are forced to use private insurance companies for drug coverage (see above). In addition, Medigap policies that now provide prescription drug coverage must cease offering such benefits.

Challenged Fact: The law helps those who need it most. While the law does provide subsidies for low-income seniors, there are multiple levels of assistance depending on whether an individual is eligible for Medicaid and the extent of his or her income and assets. For example, it establishes a $6,000 ($9,000 for a couple) "assets test" for those under 135% of the established poverty level, which will disqualify 2.8 million very low-income seniors for assistance.

Challenged Fact: The law protects those with the highest drug costs. Yes and no. Medicare will cover 95% of a beneficiary's drug costs that exceed $5,100, but will pay nothing for drugs costing between $2,250 and $5,100. This huge gap in coverage—coupled with the higher premiums—will increase financial hardships for seniors with multiple health issues who live on fixed incomes. The gap in coverage will leave half of seniors without drug coverage for part of each year.

Challenged Fact: The law protects retiree coverage. Only partially. The law provides a subsidy to sponsors of qualifying private employer retiree health plans, but that amount is 28% of "allowable retiree costs" in excess of "cost threshold" up to the amount of the "cost limit." For 2006, the individual cost threshold is $250 and the cost limit is $5,000. Allowable retiree costs exclude administrative costs, net of rebates, chargebacks, discounts, etc. The law only requires the plan to provide drug coverage that is "at least actuarially equivalent to the standard prescription plan," which means many companies could, and probably will, reduce current coverage. *The Congressional Budget Office estimates that 2.7 million retirees who currently receive drug coverage through a former employer will lose those benefits.*

Challenged Fact: The law provides new preventive services. Several important diagnostic screenings for seniors are funded, as well a new "Welcome to Medicare" physical examination for new beneficiaries, but reimbursements to physicians who administer biotech medications and reimbursements for products such as home oxygen are reduced.

Challenged Fact: Discount card. This is misleading. There's no guarantee that the predicted 25% discounts will materialize. The percentage of discounts offered on the cards will depend on negotiations between the private providers of the cards and the pharmaceutical companies. Many of the drug companies will opt not to participate in the discount card program, and those that do participate are unlikely to provide discounts sufficient to make a real difference to seniors facing major prescription drug expenses. These "token" discount cards represent the only assistance seniors can expect until 2006 when the law is implemented.

These are just some of the many negative provisions that are in the bill.

The Medicare program was designed and built as a universal program that provides the same benefits at the same cost no matter where a senior lives. This bill takes a sharp turn away from that principle and instead carves up the country and allows the insurance companies to decide the costs that seniors will pay, what drugs will be covered, what their monthly premiums will be, etc. Here are some other problems with the law:

1. Private plans offering the prescription drug benefit will be employing formularies (lists of approved, covered drugs) to lower prices. However, if a senior joins a plan, they will not be allowed to see what drugs are on the formulary. If they are lucky enough to choose a plan that has their drug, they will be covered. If a drug is not on their formulary, the senior will have to pay 100% for the cost. If a drug is on the formulary when a senior joins and is then dropped off the formulary, the senior is locked into their plan, cannot leave for one entire year and will have to pay out-of-pocket if they want that drug.

2. Medicare is actually barred from negotiating lower prices. This is unconscionable. Every program in the U.S.—Medicaid, the VA, EPIC, nursing homes, government health facilities, managed care plans, etc.—negotiates discounts for their drugs. Language in the law actually barred Medicare from negotiating lower prices on behalf of its 40 million benefi-

ciaries. This was a lost opportunity to help seniors afford their medications and it shows that this bill was about rewarding the pharmaceutical companies that stand to gain $139 billion in profits from this bill. Furthermore, seniors will be responsible for paying whatever the annual cost that prescriptions rise each year—which is about 10–12% a year. These costs will be passed onto the retiree.

3. An arbitrary "paper crisis" was created, whereby should the amount of general funding spending on Medicare Part B and Part D exceed 45%, by law, steps would need to be taken to bring spending back under the 45% arbitrary threshold. This would be done by increasing seniors' costs, cutting benefits, cutting provider reimbursements or a combination of all three. The problems with this arbitrary cap is that it is only in place for Medicare. Nowhere else in government spending—such as tax cuts, defense or other program spending—does it apply. And this only applies to Part B (physician, out-patient) and Part D (the new prescription benefit). These two parts of the program will grow faster than the rest of the program. First, under Part B, medical advances have made it more routine to provide services on an out-patient basis. This trend will continue. Under Part D, Medicare was actually barred from negotiating lower prices and as the population gets older, these costs will continue to rise. In essence, Congress created a mechanism to weaken the program legislatively which will call for a variety of cuts to the program, further eroding the public's confidence and trust in Medicare.

4. For states like New York that have a state prescription drug plan, the EPIC program, these participants are placed at risk. The law allows the state to either coordinate with the new Medicare law or leave its program as a stand-alone. NYSARA and other state advocates want EPIC to remain as a stand-alone because the new Medicare law is inferior to EPIC. The Governor in his proposed Executive Budget maintains the EPIC program as a stand-alone but provides incentives for lower income retirees to use the new Medicare discount card before receiving benefits from EPIC.

   We applaud the Governor for leaving EPIC as a stand-alone. The EPIC program will cost over $700 million this year and, given the deficits that New York continues to face, the EPIC program could easily be targeted in years to come.

5. Provides billions of dollars in subsidies to private insurance companies to offer coverage to retirees. The General Accounting Office has shown over the years that Medicare-managed care plans actually are paid 3% more than what traditional Medicare pays for treating the same people. Under this law, these companies will receive billions worth of subsidies to continue to provide services. In fact, private insurance companies will be paid 26% more than traditional Medicare to treat the same people—this comes to $1,900 for each senior. Over the past several years, HMOs enrolled in Medicare dropped 2.7 million seniors nationwide.

   While health care costs continue to rise, this law pays the private sector more money to companies with track records of leaving seniors high and dry. Medicare spends only 2% on administrative costs while the best-managed companies spend 15%.

6. Begins to dismantle the program. The proposal is designed to diminish the number of people in the Medicare risk pool. It does this by paying private companies to encourage the healthiest retirees to go to managed care. It claims to be optional yet you'll be assessed a penalty for every month in which you do not participate. It expands tax-sheltered medical savings accounts, encouraging wealthier seniors to opt into tax-sheltered medical arrangements. It makes Medicare compete unfairly with private plans (who are subsidized to compete) by 2010. The traditional Medicare program, should all these provisions stay, will wind up with older and sicker seniors and the costs of the premiums and other out-of-pocket costs will go up by staggering amounts. This will undermine the program, make it appear unaffordable and the public will lose its support in a program that politicians will claim is an unaffordable dinosaur. Make no mistake, this is done by design.

We have been hearing constantly from New York seniors and those around the country that they are

very upset at this law and feel betrayed. They are accurate in how they feel. Congress and the President used the desire of seniors to get affordable medications as a way to change Medicare forever. For the worse, I might add.

"Medicare 'fix-it' bills will be gaining steam over the coming year and they should be strongly considered."

Since its passage, bills have been introduced in Congress that would change the worst parts of the bill. They include:

- Eliminating the doughnut hole,
- Allowing Medicare to negotiate prices on behalf of its beneficiaries,
- Eliminating the arbitrary 45% general fund spending cap,
- Eliminating the provisions making Medicare compete with private plans,
- Allowing prescriptions to be imported from Canada, etc.

Medicare "fix-it" bills will be gaining steam over the coming year and they should be strongly considered. After looking at the provisions of the bill, it is clear that this has little to do with helping seniors. Rather, this legislation is designed and structured in a way that, over the next decade, the public will lose faith in the program and its spending will accelerate, which will give those opposed to the concept of Medicare the ammunition they need to completely privatize it. That is clearly what this is all about and it is a shame. Medicare, while not perfect, has been very successful and provides quality services at a low cost to million of beneficiaries. No private plan will ever be able to match its cost and its universality. Before the Medicare program started in 1965, insurers would not cover seniors because they were too risky. This is why Medicare was passed. We have come full circle in 38 years. We are neglecting history and experience and are handing the keys to the Medicare car back to the private companies who, under this law, have been empowered with way too much decision-making power. The federal government is reducing its role as a provider and as a watchdog and this should be of great concern to us all.

NYSARA will continue to work at the national level to change this law and provide some reasonable and acceptable approach to providing prescription drug coverage under Medicare. We will also be working at the state level to introduce and support legislation to lower the costs of prescriptions in New York. This is the real issue, the cost of prescriptions.

For more information on what we are doing on the rx issue—please call (518) 783-6231 or visit our Web site: http://www.nysara.org.

Greg Olsen is the Legislative Director for Assemblyman Steve Englebright, Chair, Assembly Committee on Aging.

Advising Personal Injury Attorneys on Medicare Claims and Personal Injury Lawsuits: 2004 Update

By Joan Lensky Robert

A. Introduction

As the Elder Law attorney expands his/her practice to encompass advising the plaintiffs' bar on the interrelationship between personal injury recoveries and government entitlements, the Elder Law practitioner should be aware of 2003 cases which limit Medicare's right to recovery from a personal injury lawsuit. Medicare has long laid claim to lawsuit proceeds, seeking reimbursement for expenditures paid by Medicare due to the injuries caused by a tortfeasor. In 2003, however, three Circuit Court decisions rejected Medicare's claims for reimbursement from personal injury recoveries.[1] These cases found that when a tortfeasor, or his insurance, pays a plaintiff for injuries covered by the plaintiff's Medicare benefits, Medicare may not recoup its expenditures from the lawsuit proceeds. The Courts determined that the Medicare Secondary Payor program[2] is not triggered in non-mass torts.

In response to these cases, the Congress amended the Medicare Secondary Payor provisions of the Medicare Act[3] as part of the Medicare statute that President Bush signed into law on December 8, 2003. Do these "technical"[4] and "clarifying"[5] amendments alter or clarify the holding of these cases?

B. The Medicare Secondary Payor Program Prior to December 8, 2003

Medicare[6] is a Social Security health insurance program that provides coverage for hospitals and physicians. Individuals 65 years of age who are entitled to receive Social Security, widows or Railroad Retirement benefits are eligible for Medicare,[7] as are disabled individuals who have received Social Security Disability benefits for 25 months.[8] Those with end-stage renal disease who require dialysis or a kidney transplant also are eligible for Medicare, regardless of age.[9]

In 1980, the Congress enacted the Medicare Secondary Payor (MSP)[10] provisions in order to reduce Medicare Trust Fund disbursements by requiring Medicare beneficiaries to exhaust all available insurance coverage. The Medicare statute excludes certain items or services from coverage.[11] The statute also coordinates benefits between Medicare and group health plans.[12] When an active employee over the age of 65 is covered by group health insurance, this insurance is primary when the group consists of 20 or more employees.[13] The primary responsibility for payment of Medicare beneficiaries' medical bills is their own private health insurance plans', as Medicare may not make payment when the group health insurance which is primary to Medicare has paid or is reasonably expected to pay for a medical item or service.[14] Medicare was to be the Secondary Payor to make payment only if the Medicare recipient's own primary insurance did not have a contractual duty to pay.[15]

Medicare was also the secondary payer of claims for medical items and services payable under a federal or state workers' compensation plan, under an automobile or liability insurance policy or plan (including a self-insured plan), and under no-fault insurance expected to pay promptly. These insurance plans and policies are primary to Medicare.[16] When a Medicare recipient received payment from Medicare for medical services which should have or could have been paid by group health insurance of the Medicare recipient or by workers' compensation, an automobile or liability insurance policy or plan (including a self-insured plan) and under no-fault expected to pay promptly, Medicare was provided only conditionally.[17]

When Medicare is considered to have been conditionally provided, the Centers for Medicare & Medicaid Services (CMS) must initiate recovery as soon as it learns that payment has been made or could be made under any primary insurance plan.[18] CMS has a right of action to recover such conditional payments from any entity required to have made such payments, or from any entity holding funds condi-

tionally paid by Medicare.[19] Such entities may include defendants, plaintiffs, their attorneys, physicians or medical suppliers.[20] If CMS does not have to take legal action to recover, it receives the lesser of the amount of the Medicare primary payment or the amount of the third party payment. If it is necessary for CMS to take legal action to recover from the patient, CMS may recover twice that amount.[21] CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney or other entity entitled to payment by a third party payer for services for which Medicare paid.[22]

Since 1980, the Health Care Financing Administration (now known as CMS) has expanded the breadth of the Medicare Secondary Payor provisions by interpreting the statute to encompass defendants' automobile and liability insurance policies and self-insured defendants as primary plans obligated to pay for plaintiffs' medical costs, triggering conditional Medicare payments subject to reimbursement upon plaintiff's receipt of a lawsuit recovery. Once lawsuit proceeds were received, Medicare was to be repaid within 60 days. CMS may charge interest if payment is not made within 60 days. In the case of liability insurance settlements and no-fault insurance which should have known that Medicare should be reimbursed, the insurance company had to reimburse Medicare when the plaintiff did not, even though the insurance company had already reimbursed the beneficiary or other party.[23] CMS even sought recovery from the plaintiff's attorney if the Medicare claim was not paid.[24]

The issue addressed by the cases discussed below was whether a tortfeasor with liability insurance or who is self-insured constitutes a primary plan encompassed within the Medicare Secondary Payor statute such that Medicare's payments for injuries causally related to a lawsuit are provided only conditionally, to be reimbursed to Medicare from the plaintiff or from anyone holding the tortfeasor's funds. While the Fifth and Second Circuits found that, in general, tortfeasors' liability insurance or self-insurance was not a primary plan of medical coverage vis-à-vis a Medicare beneficiary, the amendments to the Medicare Act have eviscerated these holdings.

C. The Ninth Circuit *Zinman* Legacy

In 1995, the Ninth Circuit rendered a decision interpreting the Medicare Secondary Payor program. In *Zinman v. Shalala*,[25] the Circuit Court held that the Medicare Secondary Payor statute [26] permits Medicare to recover *in full* its expenditures when a Medicare beneficiary suffers an injury covered by a group health plan or liability, workers' compensation, automobile or no-fault insurance, and the Medicare beneficiary receives a settlement from that insurer. The Court held that Medicare will be "made whole" even if the plaintiff Medicare recipient has not been made whole by a settlement insufficient to cover in full all of the plaintiff's damages such as pain and suffering, medical injuries or lost wages.[27] The Court did not permit any allocation of the recovery to determine what portion of the recovery, if any, was intended to reimburse the plaintiff for medical costs paid by Medicare.[28] The Court held that CMS had a right to recover its full expenditures regardless of how amounts may be designated in a liability award or settlement, e.g., loss of consortium, special damages or pain and suffering. [29]

The issue before the *Zinman* Court was the amount of recovery to Medicare when Medicare has made conditional payments. The Court found that the subrogation right of Medicare does not confine the government's right of reimbursement to its right of subrogation, as the statute provides an independent right of recovery against any entity responsible for payment of services paid for by Medicare or that has received payment for Medicare-related items or services, including recovery from the plaintiff Medicare recipient.[30] The Court held that because the Medicare agency could pursue recovery to the full extent of its expenditures, the subrogation right did not limit its recovery from the plaintiff only to that portion of a lawsuit settlement intended to compensate the Medicare recipient-plaintiff for the medical expenditures paid by Medicare.[31]

The *Zinman* Court did not analyze whether or not the recovery received in a lawsuit triggered the Medicare Secondary Payor program, and whether the Medicare payments were, indeed, "conditionally provided" and subject to recovery. The Court discussed the general issue of subrogation of Medicare claims, but did *not* discuss directly the issue of whether Congress intended that the MSP "primary plan" provision encompass a defendant or his insurance in a tort action.

The *Zinman* holding that Medicare had a right to receive full payment from a tort settlement was the "rule" as applied by Medicare and as accepted by the tort bar. Thus was created the *Zinman* legacy, that plaintiffs' attorneys first satisfied in full the Medicare claim minus the allowed attorneys' fees for securing the Medicare reimbursement. The lawsuit recovery to

the Medicare beneficiary was diminished by the priority Medicare claim for reimbursement of medical services that had been paid conditionally by Medicare until reimbursed from the lawsuit proceeds.

D. The Fifth Circuit *Goetzmann* Decision

The routine payment of Medicare claims against lawsuit proceeds was rejected in *Thompson v. Goetzmann*.[32] In *Goetzmann*, the Fifth Circuit reviewed the statutory language of the Medicare Secondary Payor program. The Fifth Circuit rejected Medicare claims against a plaintiff, her attorney, and the defendant for recovery of Medicare's expenditures in a lawsuit settlement for a defective hip prosthesis. The *Goetzmann* Court noted that Medicare is a secondary payer only when the plaintiff Medicare recipient has sources of primary insurance coverage such as a group health plan or workers' compensation or liability insurance or no-fault.[33] The self-insured defendant was found not to be a primary plan of the plaintiff Medicare recipient established to pay medical costs of the plaintiff in a tort action.

In its initial December, 2002, decision,[34] the Court held that the defendant's self-insurance was not a primary insurer under the Medicare Secondary Payor program based on the regulation requiring that primary plans pay promptly, i.e., within 120 days of submission of a claim.[35] In July, 2003, the Fifth Circuit revised its initial decision but denied a rehearing. The Court excised that portion of the decision that found that primary insurance must be expected to pay promptly. The Court held that the Medicare Secondary Payor statute is triggered "if and only if a Medicare recipient has another source of medical coverage under a 'primary plan.'"[36] The Court held that a defendant's own insurance is not such a primary insurance plan based upon the ordinary meaning of the terms "plan" and "insurance."[37] The Court concluded that a primary plan of self-insurance, as used in the Medicare Secondary Payor statute, requires that the defendant estimate likely losses, create sufficient reserves to meet those losses and arrange for commercial insurance for losses in excess of a stated amount.[38] A defendant's negotiating a single settlement with an individual plaintiff "is not sufficient, *in and of itself*, for such entity to be deemed as having a 'self-insurance' plan."[39] "The failure of Congress to include in the MSP statute a right of action for reimbursement of medical expenditures against tortfeasors indicates that this statute 'plainly intends to allow recovery only from an insurer.'"[40]

The Court held that an alleged tortfeasor who settles with a plaintiff is not a group health plan, workers' compensation, liability insurance or self-insurer under the Medicare Secondary Payor Program. In *Goetzmann*, neither plaintiff nor plaintiff's attorney was required to reimburse the government because neither had received payment from an insurer covered by the statute. Defendant was not required to reimburse the government because the defendant was not an entity that should have paid for services covered by Medicare.

E. The Eleventh Circuit *Baxter* Decision

On September 15, 2003, the Eleventh Circuit decided *United States v. Baxter International, Inc.*[41] and held that the Medicare Secondary Payor program applied to a special fund established by the defendants to pay claims in a mass tort action. In *Baxter,* Medicare intervened in a products liability case in which the silicone breast implant manufacturers had established a $4.2 billion fund for the class plaintiffs. The Court found that this special fund was a self-insured plan of health insurance for plaintiffs who were Medicare beneficiaries, and that this special fund was primary to Medicare in paying for medical treatment caused by the breast implants. Medicare was thus found to have made conditional payments on behalf of the plaintiffs, and Medicare could recover costs from the special fund.[42]

In reaching its conclusion that defendants' special fund for a mass tort triggered the Medicare Secondary Payor statute and Medicare payments were only made conditionally pending the distribution of this fund to plaintiffs, the Eleventh Circuit applied the Medicare regulation[43] that defined "self-insurance."[44] The Court found that the defendants had established this special fund as self-insurance to cover plaintiffs' claims.[45] The Court also found that the special fund was a health insurance "plan"[46] which, pursuant to Medicare regulation,[47] is ". . . any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness."[48]

The Eleventh Circuit held that because the defendants had established the settlement funds to compensate the plaintiffs for their damages, the settlement funds were a "self-insured" "plan" to provide reimbursement for medical care. The Court also applied the Medicare regulation concerning primary insurance[49] and found that the settlement fund was a primary fund of insurance for plaintiffs who were

Medicare beneficiaries.[50] The Court rejected the defendants' argument that the failure to pay "promptly" within 120 days of receiving a claim removed the special fund from consideration as a primary plan of insurance for the plaintiffs.[51]

F. The Second Circuit *Mason* Decision

On October 2, 2003, the Second Circuit agreed with the holding of *Goetzmann*. *Mason v. The American Tobacco Company*,[52] is a Second Circuit case in which plaintiffs sought class certification to recover Medicare payments from tobacco companies for medical injuries caused by smoking. The plaintiffs were Medicare beneficiaries whose treatment for tobacco-related illnesses had been paid by Medicare. On October 2, 2003, the Second Circuit affirmed the District Court's dismissal of the plaintiffs' action.[53] The plaintiffs argued that the Medicare Secondary Payor program provided them with standing to sue the defendants to recover the cost of the Medicare expenditures as "private attorneys general" and to receive double damages upon successful recovery from the defendants' insurance companies.[54]

The plaintiffs claimed that the defendants' insurance should have been primary payers rather than Medicare, and they sought to recover these tobacco-related health expenditures for the government.[55] They alleged that the corporate defendants were a "self-insured plan as a matter of law, because the corporate structure through which each conducts its business has the purposes and legal effect, in part, to assume liability for injury."[56]

The Second Circuit rejected this argument. "The obvious problem with this approach is that it turns *every* corporation into an insurance company subject to suit under the MSP statute."[57] The Court noted that there was no statutory or regulatory authority for the proposition that any corporation that has decided not to buy insurance for its legal liabilities became a self-insured plan primary to Medicare in tort cases.[58] The primary plan's responsibility to pay rests on contract principles between itself and the Medicare beneficiary rather than upon tort liability.[59]

The Second Circuit followed the *Thompson v. Goetzmann*,[60] holding that the Medicare Secondary Payor program is not triggered in an individual tort action. It distinguished this case from *United States v. Baxter International, Inc.*,[61] as a segregated settlement fund had *not* been established explicitly to pay for medical costs of purported class members.[62] Indeed, the alleged tortfeasors had not assumed the medical costs of any identifiable group of individuals at all.[63] Based on *Mason*, then, in the Second Circuit prior to December 8, 2003, plaintiffs' attorneys should have rejected Medicare claims for reimbursement from lawsuit proceeds paid by the defendant in tort actions that are not mass torts.

G. December 8, 2003, Amendments to the Medicare Secondary Payor Provisions

The December 8, 2003, prescription drug amendments to the Medicare Act have received enormous publicity. Much less publicized were amendments to the Medicare Secondary Payor provisions of the Act intended to clarify when Medicare payments are considered conditional and trigger the Secondary Payor provisions. A technical amendment addresses the previous requirement that primary plans be those intended to make payments "promptly."[64] A clarifying amendment defines "entity" and "primary plan" in the context of conditional Medicare payments. What do these amendments say, and have they succeeded in overruling *Goetzmann* and *Mason* by encompassing all defendants or their insurers within the scope of the Medicare Secondary Payor statute?

1. "Prompt"

The Medicare statute prior to December 8, 2003, forbade Medicare from making payments for items for which payment could be expected to be made "*promptly (as determined in accordance with regulations)* under a workers' compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance."[65] The new statute eliminates the language "promptly (as determined in accordance with regulations),"[66] and now precludes Medicare payments for items or services that can be expected to be made from sources such as workers' compensation, auto insurance, liability insurance policies or plans, or no-fault.

Previously, Medicare payments made because automobile or liability insurance or no-fault expected to pay *promptly* had failed to do so were conditioned upon reimbursement to the Medicare program.[67] The amended statute includes a new subsection that authorizes conditional Medicare payments to be made for an item or service if a primary plan "has not made *or cannot reasonably be expected to make payment . . . promptly*."[68] The amended statute thus removes anticipated prompt payment by a primary insurer as

a trigger for conditional Medicare payments expecting reimbursement. It is, rather, the anticipated delayed payment by a primary insurer that now triggers conditional Medicare payments expecting reimbursement.

The Congress likely eliminated the requirement that the above insurance programs be considered a primary insurance plan only if they pay "promptly" in response to the December, 2002, *Goetzmann* holding. This initial *Goetzmann* holding was based in part on the reasoning that no defendants' insurance would pay a plaintiff promptly.[69] The Court thus found that defendants who paid for their own tort actions were not self-insured primary plans vis-à-vis the plaintiffs because they would not be anticipated to pay promptly, and hence did not trigger conditional Medicare payments subject to reimbursement by the government. The revised *Goetzmann* decision eliminated the prompt payment requirement as a basis of its renewed holding that tortfeasors, in general, were not primary insurance plans triggering conditional Medicare payments.[70]

2. "Self-insurance"

The new statute now adds that "[a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part."[71] This "clarifying amendment" likely was also made to supersede the *Goetzmann* decision,[72] which analyzed the ordinary meanings of "self-insurance" and "plan" to decide that a defendant does not become a self-insured plan merely by happenstance of not having purchased insurance.[73] The amended statute now defines any entity that does not have insurance as "self-insured," and calls the failure to obtain insurance a "plan."

3. "Primary"

The new statute also endeavors to define "primary" in the Medicare Secondary Payor context. As under the prior law, Medicare is a secondary payer for Medicare beneficiaries covered by group health plans with more than 20 employees.[74] These are primary plans, as are workers' compensation or an auto or liability insurance policy or plan or no-fault insurance.[75] Now, by the amended statute, when payment from these plans cannot be expected promptly, any Medicare payments made are conditioned upon reimbursement to Medicare when the plan does pay.[76]

Is the defendant's insurance a primary plan with regard to the plaintiff's Medicare benefits, triggering conditional Medicare payments? The new statute directs that

> [a] primary plan . . . shall reimburse [Medicare] . . . if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.[77]

This new language, then, states that liability insurance or a self-insured entity that has a responsibility to pay for a plaintiff's medical care due to legal proceedings becomes a primary plan vis-à-vis Medicare. Whether plaintiff settles or receives a judgment against the insurance carrier or against its insured, Medicare will be paid back for the medical expenditures causally related to the injury.

The amendments to the Medicare statute have codified the breadth of the Medicare Secondary Payor provisions struck down by the Second Circuit[78] and by the Fifth Circuit.[79] Under the amended Medicare Act, the defendant and his insurance will be primary.

4. "Action to Recover Payments"

The prior statute authorized the government to bring an action against *any entity responsible* to pay for medical services under a primary plan, or against any entity holding the funds or against medical providers that received payment from the primary insurance plan.[80] The amended statute authorizes the government to bring an action against "any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan . . .) to make payment with respect to the same item or service . . . under a primary plan."[81] The amended statute expands the entities against which recovery may be sought by

enumerating that it may now be the person responsible to make payment or the insurance of that person.

5. Effective Dates

The technical amendments, which eliminated the "prompt" payment requirement with the provision that payments which are *not* reasonably expected to be made promptly are conditionally paid,[82] are retroactive to 1984. The clarifying amendments, which declare a defendant's insurance primary to Medicare upon a lawsuit judgment or settlement, are retroactive to 1980.

H. Conclusion

In 2003, Circuit Court decisions limited Medicare's right to reimbursement from lawsuit proceeds for medical expenses. The Second Circuit and the Fifth Circuit determined that the defendant and/or his insurance was not routinely a primary plan that should pay in lieu of Medicare. With the enactment of sweeping changes in the Medicare prescription drug law came "technical" and "clarifying" amendments to the Secondary Payor provisions of the Medicare statute. The Congress has redefined a primary plan as one with responsibility to pay for a plaintiff's medical care as a result of legal process rather than pursuant to contract. The defendant's insurance becomes primary to Medicare when the defendant has a legal obligation to pay for care otherwise paid by Medicare.

The December 8, 2003, Medicare amendments have superseded *Mason* and *Goetzmann*.[83] The government still has retained the right to double damages when it must pursue collection of the funds. Despite *Goetzmann*, the government may seek recovery against the plaintiff, medical providers, the defendant or plaintiff's attorney for lawsuit proceeds payable to Medicare for treatment causally related to the lawsuit. Plaintiffs' attorneys should clarify, verify and satisfy Medicare claims before disbursing funds, as if *Goetzmann* and *Mason* had never been decided.

One avenue of challenge to claims that arose prior to December 8, 2003, does occur. The government's "technical" and "clarifying" amendments are an admission that prior to December 8, 2003, the law did not provide for Medicare claims against a plaintiff's lawsuit proceeds in torts other than mass torts. The Elder Law practitioner should assist the plaintiff's bar in challenging the retroactive application of these amendments to Medicare claims against lawsuit proceeds that arose prior to December 8, 2003.

Endnotes

1. *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003); *United States v. Baxter International, Inc.*, 345 F.3d 866 (11th Cir. 2003); *Mason v. The American Tobacco Company*, 346 F.3d 36 (2d Cir. 2003).
2. 42 U.S.C. § 1395y(b).
3. 42 U.S.C. § 1395y(b)(2)(1), (2).
4. 42 U.S.C. § 1395y(b)(2)(1), (2).
5. *Id.*
6. 42 U.S.C. § 1395.
7. 42 C.F.R. § 406.5.
8. 42 C.F.R. § 406.12.
9. 42 C.F.R. § 406.13.
10. 42 U.S.C. § 1395y(b).
11. 42 U.S.C. § 1395y(a). These exclusions include items not reasonable and necessary to treat illness, *id.* at (a)(1), and items and services for which the patient had no obligation to pay, and for which no other person, such as a prepaid health insurance plan, has an obligation to pay, *id.* at (a)(2).
12. 42 U.S.C. § 1395y(b)(1).
13. 42 U.S.C. § 1395y(b)(1)(A)(i). This provision does not apply to individuals with end stage renal disease, for whom Medicare is primary.
14. 42 U.S.C. § 1395y(b)(2)(A)(i).
15. *Id.*; *see* 42 U.S.C. § 1395y(b)(2)(B)(i), language eliminated by amended statute and redesignated as 42 U.S.C. § 1395y(b)(2)(B)(ii).
16. *Id.* 42 U.S.C. § 1395y(b)(2)(A)(ii), language eliminated by amended statute and redesignated as 42 U.S.C. § 1395y(b)(2)(B)(ii).
17. 42 U.S.C. § 1395y(b)(2)(B)(i).
18. 42 C.F.R. § 411.24.
19. 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. 411.24(g).
20. 42 C.F.R. § 411.24(g).
21. *Id.*
22. 42 C.F.R. § 411.25.
23. 42 C.F.R. § 411.24 (i)(1); (2).
24. *See, e.g., Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003).
25. 67 F.3d 841 (9th Cir. 1995).
26. 42 U.S.C. § 1395y(b)(2)(B)(i).
27. 67 F.3d at 844.
28. *Id.*
29. *Id.*
30. 42 U.S.C. § 1395y(b)(2)(B)(ii).
31. 67 F.3d 841, 845 (9th Cir. 1995).
32. 337 F.3d 489 (5th Cir. 2003).
33. 42 U.S.C. § 1395y(b)(2)(A).
34. 315 F.3d 457 (5th Cir. 2002).
35. 42 C.F.R. § 411.50(b).
36. 337 F.3d at 498.

37. "A 'plan' denotes 'a method for achieving an end . . .'"; "An insurer is the party to a contract of insurance who assumes the risk and undertakes to indemnify the insured, or pay a certain sum on the happening of a specified contingency." 337 F.3d. 497–498, omitting cites at FN 19 and 20.
38. 337 F.3d 498.
39. *Id.*
40. 337 F.3d. 499, citing *Health Ins. Ass'n v. Shalala*, 23 F.3d 412, 427 (D.C. Cir. 1994).
41. 345 F.3d 866 (11th Cir. 2003).
42. *Id.* at 886 (11th Cir. 2003).
43. "[A] self insured plan means a plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier." 42 C.F.R. § 411.50(b).
44. 345 F.3d 866, 896.
45. *Id.*
46. 345 F.3d 866, 894.
47. 42 C.F.R. § 411.21.
48. *Id.*
49. "'Secondary,' when used to characterized Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other insurance that is primary to Medicare." 42 C.F.R. § 411.21.
50. "We find the agency's interpretation to be in accord with the structure, history, and purpose of the MSP statute, all of which plainly indicate that Congress wanted Medicare's payment to be secondary and subject to recoupment in all situations where one of the statutorily enumerated sources of primary coverage could pay instead." 345 F.3d 866, 888. Emphasis in original.
51. "Here, we find that HHS—which was expressly delegated by Congress to formulate rules implementing the MSP statute—has consistently taken the position that Medicare payments are conditional and subject to recoupment regardless of whether another insurer can be expected to render a prompt primary payment." *Id.* at 887.
52. 346 F.3d 36 (2d Cir. 2003).
53. *Id.*
54. *Id.* at 38. See 42 U.S.C. 1395y(b)(3)(A) and (b)(2)(B)(ii).
55. *Id.* at 39.
56. *Id.* at 40.
57. *Id.* at 40. Emphasis in original.
58. *Id.* at 41.
59. *Id.* at 42.
60. 337 F.3d 489 (5th Cir. 2003).
61. 345 F.3d 866 (11th Cir. 2003).
62. 346 F.3d 36, 42 (2d Cir. 2003).
63. *Id.*
64. 42 U.S.C. § 1395y(b)(2)(A)(ii).
65. 42 U.S.C. § 1395y(b)(2)(A)(ii). Emphasis supplied.
66. The statute now reads that Medicare may not pay for an item or service if payment can be expected to be made under workers' compensation or automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance, without referencing the prompt 120 day payment requirement. *Id.*
67. "Any payment under this subchapter with respect to any item or service [for which payment can be expected to be made promptly under a workers' compensation, automobile or liability insurance policy or plan including a self-insured plan or no-fault] shall be conditioned on reimbursement to the appropriate Trust Fund . . ." 42 U.S.C. § 1395y(b)(2)(B)(i), redesignated as (b)(2)(ii) by the amended statute.
68. 42 U.S.C. § 1395y(b)(2)(B)(i), as redesignated by the amended statute.
69. 315 F.3d 457 (5th Cir. 2002), amended by 337 F.3d 489 (5th Cir. 2003).
70. 337 F.3d 489 (5th Cir. 2003).
71. 42 U.S.C. § 1395y(b)(2)(A)(ii), as amended.
72. 346 F.3d 36 (2d Cir. 2003).
73. 337 F.3d 489, 498 (5th Cir. 2003).
74. 42 U.S.C. § 1395y(b)(2).
75. 42 U.S.C. § 1395y(b)(2)(A)(ii).
76. 42 U.S.C. § 1395y(b)(2)(B)(i), as redesignated by the amended statute.
77. *Id.*
78. *Mason v. The American Tobacco Company*, 346 F.3d 36 (2d Cir. 2003).
79. *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003).
80. 42 U.S.C. § 1395y(b)(2)(B)(ii), redesignated as 42 U.S.C. § 1395y(b)(2)(B)(iii) by the amended statute.
81. 42 U.S.C. § 1395y(b)(2)(B)(iii).
82. 42 U.S.C. § 1395y(b)(2)(a)(ii).
83. *Mason v. The American Tobacco Company*, 346 F.3d 36 (2d Cir. 2003); *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003).

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Medicare Prescription Drug, Modernization and Improvement Act of 2003

By Robert M. Hayes

In this political season, debate over the new Medicare prescription drug benefit continues unabated. The Medicare Rights Center, the nation's largest independent source of health care information and assistance for people with Medicare, has answered a series of questions on the programs' logistical details—and, where necessary, has identified the devil in them.

To be sure, the new drug benefits may help a large number of Americans with Medicare. At the same time many experts recognize that the 2003 legislation may do people with Medicare more harm than good in the long run. Before turning to the benefit itself, here are several of the law's provisions that spark the most criticism.

The law permits drug prices to possibly soar unchecked by expressly forbidding government negotiation of lower drug prices. Bloated prices punish not only older and disabled Americans, who must pay in full for non-formulary drugs and all drugs in the vast Part D "donut hole," but also the federal budget, which will plunge deeper into deficits as Medicare pays premium prices for easily discountable drugs. Besides pandering to pharmaceutical companies at the expense of American taxpayers, the ban is inconsistent with other health care payment systems: the U.S. Veterans Administration and all other industrialized nations negotiate lower prices for drugs.

The law cuts off a key source of safe, affordable medications by banning reimportation of drugs from Canada. The very same pharmaceutical products sold in the United States can be found in Canada for substantially lower prices. By making it illegal for Americans to purchase and bring home these products, the new law effectively forces Americans to pay swollen prices for their drugs.

The law undermines enrollment for low-income benefits by imposing an asset test. While legislating a low-income program may score political points, the program will not help people unless they know how to and are able to enroll. Experience with low-income programs over the past four decades reveals that asset tests discourage enrollment: faced with a mountain of paperwork to prove their poverty, people give up on help that they need and deserve. Since assets generally affect income, the income test alone effectively ensures that the program is serving people in need, most economists say.

The law advances the privatization of Medicare by relying on private plans to administer the Part D drug benefit and by instituting the first-ever demonstrations of Medicare voucher programs. Americans of all ages disapprove of proposals to turn Medicare over to private insurance companies, concerned that a privatized system would restrict choice of doctors and access to care and hike health care costs. Original Medicare guarantees them access to almost any private doctor, private hospital and private therapists while also containing costs—including overheads and provider rates—through a public finance agency.

To learn about the new drug benefit and other changes under the Medicare Prescription Drug, Modernization and Improvement Act of 2003, see "The New Medicare Law: Drugs, Outpatient Therapy, New Wellness Benefits, and Changes to Your Costs" on p. 19. Numerous questions are being raised about the Medicare drug discount cards becoming available this spring and taking effect in June 2004. The Medicare Rights Center's "76 Things You Should Know About the New Medicare Drug Discount Cards" on p. 24 will give you the answers you need. You can also find these questions and answers online at http://www.medicarerights.org.

To stay abreast of news about the Medicare Part D drug benefit, discount drug cards, and other Medicare benefits, options and rights, subscribe to the Medicare Rights Center's free, weekly, e-newsletters at http://www.medicarerights.org/maincontentperiodicals.html.

The New Medicare Law: Drugs, Outpatient Therapy, New Wellness Benefits, and Changes to Your Costs

Frequently Asked Questions

While the recently passed Medicare bill offers some information about what the new drug benefit might look like, no one yet knows exactly how it will work, which drugs will be covered or how you will pay for coverage. The answers and more are left up to the federal agency that oversees Medicare (Centers for Medicare and Medicaid Services), which will write the regulations governing the benefit, and private companies as they create the plans that offer the drug benefit.

1. When will I be able to get drug coverage from Medicare?

The new drug benefit will begin on January 1, 2006, with the addition of a new part to Medicare: Part D. A Medicare drug discount card will go into effect in Spring 2004.

2. Will the new Medicare drug benefit help me?

The drug benefit may save you money if do not currently have drug coverage and your drug costs are over $810 a year (the break-even point given the currently estimated monthly premium of $35). However, whether you will save money will depend upon three factors:

1. Whether insurance companies in your area offer coverage at a reasonable premium;
2. Whether the drug benefit from an insurance company (or from the government if a private plan is not available in your area) will cover the drugs you need; and
3. Whether you can get your drugs cheaper through a discount drug plan or buying them from Canada.

3. What premium will I pay for drug coverage?

In addition to your Part B premium, you will have to pay a monthly premium for Part D coverage, which will be automatically taken out of your Social Security check. Some have estimated it will be about $35 a month ($420 a year) in 2006. You may also have to pay an additional premium to the private insurance company that offers the prescription drug plan in your area. No one yet knows what that monthly premium may be because no insurance company has ever offered a stand-alone drug plan before. Different companies will likely charge different premiums and cover different drugs. Premiums can rise a lot from one year to the next.

If your monthly income and assets are low you will have no monthly premium (see http://www.medicarerights.org/maincontentrxbillfaq.html).

4. Will I have full drug coverage?

No. Your drug coverage will be limited. You will have to pay a monthly premium, an annual deductible and varying amounts of co-insurance, depending on the total costs of the drugs you buy. After you have spent $3,600 out-of-pocket for covered drugs, your costs will go down significantly. But if you buy a drug that is not on your plan's formulary—list of covered drugs—or you buy it from another country, that cost will not count toward the $3,600 in out-of-pocket costs.

Here is the breakdown of the drug benefit as described in the new law. In 2006, on top of the monthly premium, you will pay:

- The first $250 of your drug costs each year (deductible);
- 25% of the cost of covered drugs between $251–$2,250;
- 100% of the cost of covered drugs between $2,251–$5,100; and
- 5% of the cost of covered drugs over $5,101 (or a co-payment of $2 for covered generics and $5 for covered brand-name drugs—whichever is greater).

Use the chart on page 20 to determine your out-of-pocket drug costs under the basic government plan in 2006 based on your current annual drug costs.

After 2006, your premiums, deductible and out-of-pocket costs will increase annually.

Your Annual Drug Costs	You Pay	Medicare Pays
Up to $250 (annual deductible)	**Monthly premium** **+ 100%** of drug costs	Nothing Nothing
$251–$2,250	**Monthly premium** **+ $250 deductible** **+ 25% co-insurance** for drug costs	Nothing Nothing 75%
$2,251–$5,100	**Monthly premium** **+ $750** ($250 deductible + $500 co-insurance for drugs $251–$2,250) **+ 100%** (for drugs $2,251–$5,100)	Nothing $1,500 Nothing
Over $5,101	**Monthly premium** **+ $3,600** ($250 deductible + $500 for drugs $251–$2,250 + $2,850 for drugs $2,251–$5,100) **+ $2 for generics and $5 for brand-name drugs, Or** **5% co-insurance** for any drug (whichever is greater)	Nothing $1,500 95%

You may only see a plan exactly like the one outlined above if no private company is offering a drug plan in your area and you get coverage directly through the government. Private companies can create their own set of criteria for coverage as long as the overall package is at least as good as the one outlined above. However, you must spend $3,600 out-of-pocket for covered drugs before your out-of-pocket costs are reduced substantially (catastrophic coverage).

5. Can I buy insurance to fill the gaps in Medicare drug coverage?

You may be able to. Private companies that offer a Medicare drug plan (the Part D benefit) can, if they choose, sell policies to pay some of your out-of-pocket costs. If offered at an affordable premium, these plans could help the majority of people with Medicare who have annual drug costs below $5,100. You can only buy such a policy from the same company from which you are getting your Medicare drug benefit. However, if your income is low you may qualify for supplemental insurance through your state's prescription drug assistance program.

If your annual drug costs are high (at least $5,100), no matter what Medicare drug plan you buy you will have to spend $3,600 out of pocket before you can get full Medicare drug coverage (catastrophic coverage). Once you have spent $3,600 out of pocket for covered drugs, you will only have to pay 5% co-insurance for each covered drug for the rest of the year.

States are the only entities that can choose to supplement the drug costs of their state prescription drug assistance program members so that they do not have to spend $3,600 out of pocket before "catastrophic coverage" begins. These programs are designed to help people with low incomes pay for their prescription drugs. Not all states offer these programs.

If you enroll in the Medicare drug benefit (Part D), you cannot also have a Medicare supplemental insurance policy (Medigap) that offers drug coverage. Medigap plans H, I and J, which currently offer limited drug coverage, will no longer be sold once the Medicare drug benefit begins. If you had one of these plans before January 1, 2006, you can only keep it if you choose not to enroll in the Medicare drug benefit. If later you want to drop the Medigap drug coverage and buy the Medicare drug benefit, you may have to pay a premium penalty. You are probably better off with the new Medicare prescription drug coverage than with the limited coverage offered by these plans.

6. Will I get extra help with drug coverage if my income is low?

Yes. If your annual income is below 150% of the Federal Poverty Level (FPL) and your assets are below specified limits (see chart on page 21 for details), you can apply for one of the programs below, which will offer less costly Medicare prescription drug coverage.

If You Have . . .	Your Assets	You Pay
Medicaid[1] ***and*** **income below 100% FPL** ($9,000[2] a year for singles and $12,000 a year for couples in 2003)	State Medicaid asset test applies	• No monthly premium • No deductible • $1/generic and $3/brand-name[3] (no co-pay after $3,600 in total annual drug costs)
Medicaid ***and*** **income above 100% FPL**[4]	State Medicaid asset test applies	• No monthly premium • No deductible • $2/generic and $5/brand-name[5] (no co-pay after $3,600 in total annual drug costs)
Income below 135% FPL and ***do not*** **have Medicaid** (below $12,000 a year for singles and $16,400 a year for couples in 2003)	Below $6,000 for individuals and $9,000 for couples	• No monthly premium • No deductible • $2/generic and $5/brand-name (no co-pay after $3,600 in total annual drug costs)
Income below 150% FPL and ***do not*** **have Medicaid** ($13,500 a year for singles $18,000 a year for couples in 2003)	Below $10,000 for individuals and $20,000 for couples	• Sliding scale monthly premium • $50 deductible • 15% co-insurance ($2/generic and $5/brand-name co-pay after $3,600 in total annual drug costs)

1. Institutionalized individuals with Medicaid, at all income levels, pay no co-pay, deductible or premium.
2. Numbers are rounded off. Federal poverty levels change every year.
3. Indexed to Consumer Price Index.
4. This includes "spend-down" or medically needy individuals, who spend a portion of their income to become eligible for Medicaid.
5. Indexed to the overall increase in drug costs.

7. How do I get the Medicare prescription drug benefit?

You will probably have to sign up for Part D at your local Social Security office during the initial enrollment period (six months starting November 15, 2005, during which you can enroll in Part D). The basic premium (estimated to be $35 a month) will be deducted from your Social Security check. Then there are three possible ways to get drug coverage:

1. You keep Original Medicare and sign up for a stand-alone Medicare drug plan offered by a private company (the company may charge you an additional monthly premium).
2. You keep Original Medicare and, if no stand-alone plan is available, you get drug coverage directly from the government.
3. You enroll in or remain in a Medicare private plan, like an HMO or PPO, which will offer the drug benefit as well as all your other Medicare-covered services (the company may charge you an additional monthly premium).

No matter which plan you choose, you can only change plans once a year.

8. Do I have to enroll in the Medicare prescription drug benefit?

No. Just like Medicare Part B, which pays for doctors and other medical services, the Medicare drug benefit is voluntary. However, if you do not enroll during the six-month open enrollment period when the benefit first becomes available, you may have to pay a premium penalty if you choose to enroll at a later date. The premium penalty will be at

least 1% for every month you delay enrollment (1% of the national average premium).

If you already have prescription drug coverage at least as good as Medicare's drug benefit, you will not be subject to a premium penalty. In order to avoid a premium penalty, you cannot have been without comparable drug coverage for more than 63 days.

9. What if I already have drug coverage through Medicaid?

If you have Medicaid, you will lose your Medicaid drug coverage and instead get drug coverage through Medicare. Medicaid will still help pay your other Medicare out-of-pocket costs, including the deductible and co-insurance, and you will not have to pay the drug plan premium. You will have to pay a co-payment for each prescription. The Medicare drug benefit may not be as good as the Medicaid coverage you had.

10. What if I already have drug coverage through a state prescription drug plan?

States can choose to offer coverage to supplement the Medicare drug coverage for individuals eligible for the state's drug plan.

11. What if I already have drug coverage through a former job?

If your former employer chooses to continue to offer prescription drug coverage you can choose:

- To keep it and not buy Medicare drug coverage (you will not have to pay a premium penalty if you later lose your retiree coverage and want to enroll in a Medicare drug plan if your coverage is at least as good as Medicare's drug coverage).
- To keep it and buy Medicare drug coverage (you will still have to spend $3,600 out-of-pocket for Medicare-covered drugs before the more substantial Medicare coverage begins).
- To drop it and buy Medicare drug coverage if it costs more and/or covers less.

12. Will the Medicare prescription drug benefit cover all drugs?

No. Each company that offers Medicare drug coverage will have its own formulary (list of covered drugs). They will likely provide incentives for you to use generic drugs. If a drug is not on the formulary or if you buy from another country, you will have to pay the full cost yourself. In addition, the cost of drugs not on your plan's formulary will not count towards your out-of-pockets costs to qualify for the drug benefit.

13. What is the Medicare discount drug card?

Between June 2004 and the end of 2005 (until the Medicare drug benefit begins), private companies will offer drug discount plans approved by Medicare. You will be able to buy a discount drug card that may save you some money on your prescription drugs. Each card will cost no more than $30 and will offer between 10–15% savings on some drugs. Each card will be different, so it will be very hard to choose which card, if any, to buy. You may be better off with the discount card you are currently using, getting your drugs from the Veterans Administration if you qualify, or buying them from Canada.

If your annual income is below $12,123 ($16,362 for a couple), the government will pay your fee for the discount card and 90–95% of the cost of covered drugs up to $600 a year. You will have to pay the other 5–10% and the full plan cost of any drugs above the $600. If you do not use the full $600 by the end of the year, you can carry over the remainder to 2005.

To learn more about the Medicare discount drug card, see http://www.medicarerights.org/maincontentrxcards_faq.html.

14. Will I be paying lower prices for drugs I buy through the Medicare drug plan?

No. Your co-insurance may be based on drug prices that are higher than you may be able to get in Canada. Each private company offering the drug benefit will negotiate individually prices for their members. If there are no private drug plans available in your area and you have Medicare drug coverage through the government, the price of the drugs you buy will probably be high because the new Medicare law specifically forbids the government from negotiating with pharmaceutical companies for lower-priced drugs.

15. Does the new Medicare law affect what Medicare pays for outpatient therapy caps?

Yes. The new law puts a two-year moratorium on the outpatient physical therapy cap that began on

September 1, 2003. The suspension began on December 8, 2003, the day the President signed the bill into law, and will extend until January 1, 2006.

People who received outpatient physical therapy during the two months the cap was in effect (September 1, 2003 to December 7, 2003) will still be responsible for any bills they incurred over the limit.

The therapy limits applied to outpatient therapy received at:

- therapists' or physicians' offices;
- outpatient rehabilitation facilities;
- skilled nursing facilities for outpatients or residents who do not have Medicare-covered stays; and
- home, through therapists connected with home health agencies, when not part of a Medicare-covered home health benefit.

The limits did not apply to outpatient therapy received at hospital outpatient facilities, unless given by the hospital's Medicare-certified skilled nursing facility.

Expect administrative errors. You should immediately appeal any denials for outpatient therapy services received after December 7, 2003.

16. Will other benefits be added to Medicare?

Yes, some wellness benefits will be added or expanded. As of January 1, 2005, Medicare will cover:

- One preventive physical examination in the first six months after a person enrolls in Part B (the exam will include measurement of height, weight and blood pressure, an electrocardiogram, education and counseling).
- Blood tests to screen for cardiovascular disease, including tests for cholesterol, lipids and triglyceride levels.
- Laboratory tests to screen high-risk individuals for diabetes.

17. Will the Medicare Part B deductible increase?

Yes. The Part B deductible, which has been $100 since 1991, will go up to $110 on January 1, 2005. Every year after that it will increase by the same percentage as the Part B premium increases.

18. Will I have to pay more for the Medicare Part B premium if my income is high?

Yes. Beginning January 1, 2007, the monthly Medicare Part B premium will be higher if your annual income is above $80,000 ($160,000 for couples). If so, the government will contribute less towards your Part B coverage. Currently, everyone pays 25% of the actual cost of Part B coverage; taxpayer money pays the other 75%. For example, in 2003 the actual cost of Part B coverage is $234.80 per month per person; people with Medicare pay $58.70 and the government pays $176.10.

In 2007, the Part B premium will be calculated according to the sliding scale described below:

Your Annual Income		Percentage of Actual Part B Coverage Cost You Will Pay	What Your Premium Would Have Been in 2003
Individuals	Couples		
Below $80,000	Below $160,000	25%	$58.70
$80,000–$100,000	$160,000–$200,000	35%	$82.18
$100,000–$150,000	$200,000–$300,000	50%	$117.40
$150,000–$200,000	$300,000–$400,000	65%	$152.62
Above $200,000	Above $400,000	80%	$187.84

76 Things You Should Know About the New Medicare Drug Discount Cards

What are the cards?

1. What is the Medicare drug discount card?

Between June 2004 and the end of 2005 (until the Medicare Part D drug benefit begins), private companies will offer discount drug cards approved by Medicare. You will be able to buy a card that may save you some money on your prescription drugs. Like other drug discount cards, the cards will offer discounts on certain drugs. Special assistance is available for people with low incomes, including up to $600 per year in 2004 and 2005 to help pay for drugs. Medicare-endorsed cards must meet certain guidelines, such as offering discounts on at least one drug in each therapeutic class. They are marked by Medicare's seal of approval.

2. Is the Medicare drug discount card actually drug coverage?

No. Showing the card at certain pharmacies may give you discounts on certain drugs.

3. Who offers the Medicare drug discount card?

Private companies, such as HMOs, PPOs, PFFSs, insurance companies, and pharmaceutical companies, can offer cards which will be certified by Medicare.

4. Is there one standard Medicare drug discount card?

No. You can only have one card, but you may have several to choose from. Different Medicare drug discount cards will offer different discounts for people on different drugs at different pharmacies in different locations. Some cards may offer better discounts for people with low incomes.

5. What is the difference between a Medicare drug discount card and other drug discount options already available?

Medicare drug discount cards may offer different discounts, and for different sets of drugs, than other discount options already available.

Medicare discount cards may offer better savings than some people can currently get on certain drugs. But, they are expected to offer as little as 10% savings on some drugs, which is far less than savings many people currently get through other discount cards and drug programs.

Who should get a card?

6. Can I get a Medicare drug discount card?

Anyone entitled to Medicare Part A and/or enrolled in Part B is eligible to buy a discount card unless they have Medicaid prescription drug coverage.

7. Must I get a Medicare drug discount card?

No, the card is voluntary. You probably have no need to get a card if you have prescription drug coverage or are already getting discounts of 10–25% on your medications.

8. Should I get a Medicare drug discount card?

If you are eligible for low-income benefits (see questions 33, 37), yes. If you are not eligible for low-income benefits, you must decide if a card is worth the fee and whether you can save more money on drugs in other ways.

9. Is the card worth the fee?

Stay tuned. It may be hard to tell, as it will depend on the drugs you use, the discounts a card offers on those drugs, and whether you can get deeper discounts elsewhere such as through Internet discount programs, the Veterans Administration or other discount cards.

How do I get a card?

10. When can I enroll?

Companies offering cards can begin enrolling members in May 2004, with cards becoming effective in June 2004.

11. How do I enroll?

First, determine which card, if any, meets your needs. Then, sign up with the company that offers that card. Card sponsors will have their own application packages, which may be available at your local pharmacy.

12. What will be in a company's application package?

Company application packages will give directions for applying and consist of two applications: one for the standard drug discount card, and one for the special low-income benefits.

13. Will each Medicare drug discount card be different?

Cards will vary, offering discounts for only certain drugs at certain pharmacies in certain locations. Some cards may offer different discounts for people with different incomes.

14. Where can I find a list of Medicare-endorsed cards?

A list of cards is expected to be made available at http://www.medicare.gov in April 2004.

15. How can I compare the cards?

The www.medicare.gov Web site will include a card comparison tool. The tool will show the estimated negotiated pharmacy prices offered by each card. Since each card could offer different discounts on different drugs, if you take several medications it may be hard to compare.

16. How can I compare the Medicare-endorsed drug discount cards with other discount opportunities?

Stay tuned. It may not be easy.

17. What if I don't have access to the Internet?

You can call 1-800-MEDICARE for assistance in comparing the Medicare-endorsed drug discount cards.

18. Can I have more than one Medicare-endorsed card?

No. You can only have one Medicare-endorsed drug discount card. However, you can have as many other cards (such as pharmaceutical company cards) as you would like, as long as they are not endorsed by Medicare.

19. What if I accidentally sign up for more than one card?

The sponsor of the second card you apply for will not be able to issue you the second card.

20. If I change my mind, can I ever switch to a different card?

Yes. You can switch cards between November 15 and December 31, 2004. You can cancel your card at any time.

21. If I like the card I have, will I need to reapply at the end of 2004?

No. As long as you pay your annual fee for 2005, you will be able to keep your card.

22. When will I know that I have been signed up for a card?

The card sponsor will notify you by mail.

23. How soon will I know?

Not right away, but you should know within a week.

24. What should I do if I get no reply?

Contact the card sponsor.

25. Can my application be rejected?

Your application can only be rejected if you already have Medicaid drug coverage or another Medicare drug discount card.

26. If my application is rejected and I have already sent payment for the card fee, can I get the fee refunded?

Yes. Contact the sponsor of the card which rejected your application.

What do cards cost?

27. How much does a card cost?

Cards will cost no more than $30 each year. If you qualify for low-income assistance (see questions 33, 37) that fee will be waived.

28. Whom do I pay?

You must pay the company sponsoring the card directly, unless you qualify for low-income assistance. The fee does not come out of your Social Security check.

29. How do I pay?

Card sponsors will indicate on their application how they wish to be paid.

30. Can I ever get a refund on the card fee?

No.

31. Can the fee increase in 2005?

Yes, but the highest the fee can be is $30.

How can I get additional help if my income is low?

32. Are there special low-income benefits (transitional assistance)?

Yes. The federal government will pay the fee for a Medicare-endorsed drug discount card, as well as

90–95% of your drug costs up to $600 a year in 2004 and 2005.

33. How will I know that I am eligible?

The government will conduct a general outreach campaign. Also, documentation from card sponsors should explain who is eligible and how eligible individuals can apply for the low-income benefits.

34. How low must my income be to be eligible for these benefits?

Individuals with incomes less than an estimated $12,569 in 2004 and couples with incomes less than an estimated $16,862 in 2004 will be eligible for the low-income benefits in 2004, as long as they do not have other drug coverage (excluding state pharmaceutical assistance).

35. Will the income limits increase in 2005?

Yes.

36. Do I need to prove my income?

No. You only need to state your income on the application for low-income benefits. The Centers for Medicare and Medicaid Services (CMS) may verify your income by reviewing any available data, such as tax returns and Social Security records.

37. Is there an asset test?

No. Eligibility for the low-income benefits is based only on income, family size and if you have any other prescription drug coverage.

38. What conditions can disqualify me from low-income benefits?

You cannot get the low-income benefits if you already have drug coverage from your current or former employer, Medicaid, the Federal Employee Health Benefits Program, Tricare or the Veterans Administration.

If you have coverage through a state pharmaceutical assistance program, you can still get low-income benefits.

39. Will I be automatically enrolled for the low-income benefit?

No. You must apply for low-income benefits when applying for a card.

40. What happens if the government already pays my Medicare premiums?

If you are enrolled in a Medicare Savings Program, your income is low enough to make you eligible for the low-income benefits. You will not be automatically enrolled, however, and will need to apply for the low-income benefits with a card sponsor.

41. How do I enroll?

First, you need to choose the card you want. Then, you need to complete and submit the company's application for people with low incomes.

42. Will all Medicare drug discount cards offer low-income benefits?

Yes.

43. Is there a different application for a Medicare drug discount card with low-income benefits?

Yes.

44. What information must I provide on the low-income application?

The application may ask you to report your family size, income and any other forms of prescription drug coverage you have.

45. How will family size figure into eligibility for low-income assistance?

Family size does not affect eligibility except to the extent that the income limit is higher if you are married.

46. Can I get help completing my application?

Drug card sponsors may have staff who can help you at participating pharmacies. Help may also be available at your local community center or State Health Insurance Assistance Program (SHIP).

47. How soon after I apply will I find out if I am enrolled?

You should know within one week. The drug card sponsor will know within three days of your application and then must notify you.

48. How will I find out that I am enrolled?

Your drug card sponsor must notify you by mail.

49. What do I do if my application is denied?

If you believe you are entitled to low-income benefits, you can appeal to Medicare.

50. If necessary, how will I know how to appeal?

Stay tuned. Appeal instructions should be provided on the notice informing you that you have not been enrolled

51. What if I become eligible for low-income benefits after I have already applied for a card?

You can apply for low-income benefits at any time. The amount of assistance you get may depend on when you apply. In 2004, you will get the full $600 no matter when you apply. In 2005, the amount of assistance will be based on when you apply. As long as you apply before April 1, 2005, you will get the full $600.

How do the cards work?

52. Are discounts limited to a certain set of drugs?

They can be. Each card will discount a separate list of drugs. No discounts will be available for drugs already covered by Medicare.

53. Can the list of drugs my card discounts change?

Yes. Both the drugs discounted and negotiated prices for discounted drugs can change as frequently as every week.

54. Will every card offer discounts on drugs in all therapeutic classes?

Yes. Every card is required to provide a discount for at least one drug in each therapeutic category of drugs commonly needed by people with Medicare.

55. Can discounts be limited to a certain geographic area?

Yes, discounts can be available in an area as small as your state. Some cards may make discounts available throughout the country.

56. Can I use my drug card at any pharmacy?

No. Each card will only work at certain pharmacies. In urban areas, 90% of card enrollees must live within two miles of a participating pharmacy. In suburban areas, 90% must live within five miles of a participating pharmacy. In rural areas, 70% must live within 15 miles of a participating pharmacy.

57. Will drug prices be the same at every pharmacy?

No.

58. Can card sponsors make available additional discounts to certain people based on income or other factors?

Yes.

59. Can I combine discounts from my Medicare drug discount card with another drug discount card to get a deeper discount?

No. You can only use one discount card for each purchase.

60. Can I carry over unused dollars of my $600 in low-income assistance from 2004 into 2005?

Yes.

61. Who will keep track of my $600 in low-income assistance?

Drug card sponsors will keep track of your $600 in assistance.

62. How can I find out how much of my $600 in assistance remains?

You can find out from your pharmacist or your card's Web site.

63. Is my $600 in assistance only applicable to a certain set of drugs?

You may apply your $600 to the costs of any drugs, excluding any drugs which would be covered by Part B, barbiturates, benzodiazepines, fertility drugs, vitamins not for prenatal care, weight-related drugs, cosmetic drugs, treatments for coughs and colds, and over-the-counter drugs.

64. Where can I find the list of drugs my card discounts?

Contact your discount card sponsor. The list will also be available online at www.medicare.gov.

65. Do I need to re-apply in 2005 in order to keep my low-income assistance?

No. You do not need to recertify or reapply to continue receiving low-income assistance. Once you are determined eligible for low-income assistance, you are considered eligible for the entire time you are enrolled in the Medicare drug discount card program.

66. What if I forget to re-enroll for my card in 2005?

If you sign up by April 1, 2005, you will get the full $600. If you enroll after this time, your benefits will be based on the date you enroll.

67. How do the drug discount cards and the low-income assistance coordinate with state pharmaceutical assistance programs?

States will have to determine how to coordinate the two programs. States may choose to pay the enrollment fee for a card, cover the co-insurance for the low-income benefits, or design another system for coordinating the benefits of the two programs.

68. What if my Medicare discount drug card does not discount a drug I need, but my state pharmaceutical assistance program does? Do I get to choose which program to use for each purchase?

Stay tuned.

69. If I qualify for low-income assistance, but I am happy with the discounts I get from my state pharmaceutical assistance program, can my state make me apply for low-income assistance available through the drug card?

Stay tuned.

70. Could a Medicare drug discount card disqualify me from drug assistance provided by certain pharmaceutical companies?

Stay tuned.

71. When will my card expire?

If you sign up for Medicare Part D benefits during the initial enrollment period (November 15 to May 15, 2006), your card will expire when your outpatient prescription drug coverage under Part D begins.

If you do not sign up for Part D during the initial enrollment period, your card will expire on May 15, 2006.

Do I have any protections?

72. What do I do if I lose my card?

Contact the card sponsor. There will probably not be a replacement fee.

73. What if I cannot remember the sponsor of my card?

The federal government is working to set up a system for you to find the name of your drug card sponsor.

74. If I buy a card, can the card sponsor sell my personal information to other companies or use it for other marketing activities?

No. Drug card sponsors are expressly forbidden from using your personal information for any marketing purposes and cannot even ask you for permission to use it.

75. What happens if I move; if I leave my Medicare private plan; if I join a different Medicare private plan; or if my card program terminates, and the discount card I purchased is no longer compatible with my situation?

In any of these cases, you will become eligible for a special enrollment period for a new card. You should first notify the sponsor of your current card that you want to discontinue it. You will then be able to buy a new card. You will have to pay the enrollment fee again and will not get a refund of your original fee. If you are enrolled in low-income assistance, it will move with you automatically and you will not need to pay the fee.

76. What protections are in place against telemarketing fraud and identify theft?

Stay tuned.

Robert M. Hayes, an attorney, is president and general counsel of the Medicare Rights Center (MRC). MRC is the nation's largest independent source of information and assistance for people with Medicare. Founded in 1989, MRC helps older adults and people with disabilities get good, affordable health care. Their Web site is www.medicarerights .org.

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Medicare Mediation

By Robert A. Grey

Welcome back to the new Elder Law Mediation News feature! We actively solicit your mediation questions, comments and experiences, positive or negative. Please send them to Robert A. Grey, Esq., 38 Stiles Drive, Melville, NY 11747-1016 or rgrey@justice.com.

Section 1154(a)(14) of the U.S. Social Security Act requires that all written complaints made by or on behalf of Medicare beneficiaries be reviewed by a Quality Improvement Organization (QIO).[1] Commencing in the fall of 2003, the Centers for Medicare & Medicaid Services (CMS, previously known as HCFA)[2] have rolled-out a new option nationwide for the handling of some quality-of-care Medicare complaints: mediation.

Under the Medicare Beneficiary Complaint Response Program, when a written complaint is received by the QIO, the QIO requests the medical records from the appropriate provider(s). A physician reviewer at the QIO reviews the medical records and sends notice of the review findings to the provider(s). The provider(s) have the right to appeal any adverse findings and have another physician reviewer conduct another medical record review. The second review findings are final. This is done without any complainant involvement or participation. The details of medical records review findings are considered confidential and consent is rarely given by provider(s) to release the detailed findings to the Medicare beneficiary. Typically, the complaining beneficiary receives only a letter without detailed findings, which merely states that the care received did or did not meet professionally recognized standards of care. Providers can submit comments which will be attached to the final response to the complainant, but this is also rarely seen in practice. There is little if any contact with the complainant from the time the complaint is filed to the time the complainant receives the final response. This time period can be as long as five months.

Under this mediation initiative, complaints received under the Medicare Beneficiary Complaint Response Program are still vetted by a physician reviewer at the QIO who reviews the medical records. Now, however, if the physician reviewer finds that the care provided does not rise to the level of malpractice and does not exhibit significant quality-of-care concerns, the complaint will be considered eligible for mediation. The QIO will then contact the complainant and offer mediation of the complaint. If mediation is agreed to by the complainant, the QIO will then offer mediation to the provider(s). If accepted by the provider(s), the QIO will schedule the mediation.

Many of the complaints within the parameters of the mediation program involve breakdowns in beneficiary-provider communication that lead the beneficiary to perceive an error or negligence has occurred.[3] For example, the beneficiary may have made the complaint because they felt rushed, ignored, treated unfairly due to age, disability, ethnicity, accent, language barriers or other factors, or that they received inadequate explanations or information regarding test results, discharge, etc. The complaints eligible for mediation will be those which the QIO has already determined did not involve error or negligence. Therefore, without mediation, the result of the complaint is going to be a letter from the QIO that the level of care met the proper standards. By electing mediation, complainants can get beyond the bureaucracy and air their perceptions, feelings, needs and desires directly to the provider(s) and hear the providers' perceptions, feelings, needs and desires. The parties have the opportunity to interact in a neutral setting and put some of the human touch back in the healthcare relationship. They may reach agreement on future provision of healthcare services that will enhance the satisfaction of all participants, and thereby improve the quality of Medicare services for that beneficiary, and potentially other beneficiaries as well. A single complainant has the power to reach an agreement that changes the system to the benefit of everyone—beneficiaries and providers alike.

Mediation is provided free of charge to all participants. Participation is voluntary; no one is forced to

agree to mediation. Agreeing or not agreeing to participate in mediation will have no bearing on a beneficiary's Medicare benefits. The mediators are outside contractors, not employees of CMS or the QIO. The mediators are compensated for their mediation services with federal funds. Participants at mediation sessions may include a volunteer "Mediation Advisor" who can provide support to the beneficiary or their representative, and a volunteer "Co-Mediator" with a healthcare background to assist in understanding medical terms.[4] Of course, participants can have their attorneys participate.

The QIO for all of New York State is IPRO. As such, IPRO administers the Medicare Beneficiary Complaint Response Program in New York and is responsible for the implementation of the mediation initiative throughout the state.[5] IPRO can be reached at 800-331-7767. They will assist callers in preparing written complaints and can provide the latest information on the nascent mediation option.

Conclusion

The goals of the Medicare Beneficiary Complaint Response Program mediation option include increasing Medicare beneficiary satisfaction, preserving and strengthening the beneficiary-provider relationship and improving the quality of care. Under the normal medical records review process the beneficiary remains essentially in the dark for weeks or months about the status and results of the investigation of their complaint. If it is found that the level of care provided met the proper standards, the beneficiary is told simply that. The beneficiary is rarely informed of the detailed investigative findings and never given the opportunity to address their concerns in person (or through a representative) directly to the provider.

The mediation program empowers Medicare recipients with the opportunity to discuss their complaint and concerns directly with the provider in a third-party neutral setting, and interactively hear the response directly from the provider.

As always with mediation, there is no record made of what was said (other than a written agreement if desired by the participants), the sessions are confidential and reaching agreement is entirely voluntary and at the discretion of the participants, not the mediator. Mediators have no power to decide anything. The worst-case post-mediation result leaves the parties in no worse position than if mediation had never occurred. Deciding not to utilize mediation deprives the Medicare beneficiary of the chance to participate in the system, improve the quality of care for themselves and possibly other beneficiaries, and to attain closure. You should endeavor to inform your clients of the existence of this new complaint resolution forum and encourage them to make use of it. It can increase their overall satisfaction with Medicare and with you. There is nothing to lose by trying it.

Also Noteworthy

On October 15, 2003, a bill was introduced in the U.S. House of Representatives to provide Medicare beneficiaries with access to prescription drugs at reduced prices negotiated by the Secretary of Health and Human Services, Secretary of Defense and Secretary of Veterans Affairs.[6] The bill would create a "dispute resolution mechanism . . . (such as an ombudsman) for the resolution of disputes between Medicare beneficiaries and prescription drug resellers and drug manufacturers in order to protect such beneficiaries" from artificially increased prices and price collusion. At the time of this writing the bill has been referred to the Committee on Ways and Means and the Committee on Energy and Commerce.

Endnotes

1. QIO's were formerly known as PRO's (Peer Review Organizations).
2. In 2001, HCFA (Health Care Financing Administration) was renamed CMS (Centers for Medicare & Medicaid Services). In 1977, HCFA was created under HEW (U.S. Dept. of Health, Education and Welfare). In 1980, HEW was divided into two separate departments: the Department of Education and the Department of Health and Human Services (HSS).
3. Four detailed examples from CMS of complaints amenable to mediation are available online at http://www.cmri-ca.org/QI/casereview/mediation/examples.html. CMRI is the QIO for California, but the examples are applicable in all 50 states.
4. Although the program designates this person as a "Co-Mediator," this person is actually a "medical reference" for the parties and will not function as a mediator. Some mediation models do utilize two mediators who co-mediate; this Medicare mediation program does not.
5. *See*, IPRO, *Healthy Seniors*, 2003 Summer/Fall, Page 2, available online at http://consumers2.ipro.org/dox/HS_SumFl_2003.pdf.
6. H.R. 3299, 108th Congress, 1st Session (2003). The bill is called the "Medicare Prescription Drug Price Negotiation Act" and was introduced by Rep. John B. Larson (D-Conn.).

Robert A. Grey, Esq. maintains a practice in Melville, Long Island, New York, with an emphasis on providing Alternative Dispute Resolution (ADR), particularly Mediation and Arbitration, in areas such as elder law, trusts and estates, probate, family, matrimonial, commercial, *e*-commerce, construction, labor, employment, disability and discrimination disputes. He is admitted to practice in New York, Washington, D.C., the Federal Eastern and Southern Districts of New York, and the United States Supreme Court. His practice serves the entire New York City metro area, including Long Island and the lower Hudson Valley.

Mr. Grey has experience as a guardian, court evaluator, guardian ad litem and attorney for AIPs in guardianship proceedings. He is the author of the chapter on "Mediation in Guardianship Practice" in the upcoming NYSBA *Guardianship Practice in New York State, 2nd Edition*, and has given presentations on mediation to various law school, bar association and community groups. He is a member of the NYSBA Elder Law Section, NYSBA ADR Committee, Suffolk County Bar Association Elder Law Committee, Queens County Bar Association Elderly and the Disabled Committee, and the National Association of Elder Law Attorneys (NAELA).

Robert A. Grey earned his J.D. degree from New York Law School in 1985, where he was a John Ben Snow Scholar, and his B.A. degree in Economics with an Adjunct in Business Management from the State University of New York (SUNY) at Binghamton in 1982, where he was a member of the International Economics Honor Society (calculation of GPAs and awarding of official honors were against University policy).

He is also a founding member and Deputy Managing Attorney of the NYPD Legal Bureau Civil Enforcement Unit. In 1995 this unit was a recipient of the Innovations in American Government Award of the Ford Foundation administered by the John F. Kennedy School of Government at Harvard University for its achievements in furtherance of the New York Police Department's (NYPD) Civil Enforcement Initiative. He is an 18-year veteran of the NYPD, having been sworn in as a Police Officer in 1986, promoted to Detective in 1991, and to his current rank of Sergeant in 1992.

Elder Law Section
Fall Meeting
Hudson Valley Resort and Spa • Kerhonkson, NY
November 5-7, 2003

(l-r) Michel Haggerty, Kate Madigan (speaker) and Lee Hoffman.

Fall Meeting Chair Ellen Makofsky.

(l-r) Leona Beane, Gayle Eagan and Liz Clark (speaker).

(l-r) Section Chair Joan Lensky Robert and Institute Co-Chair Ed Wilcenski.

(l-r) Kathy Loconti and Ron Spirn.

(l-r) Ellyn Kravitz and Institute Co-Chair Anthony Lamberti.

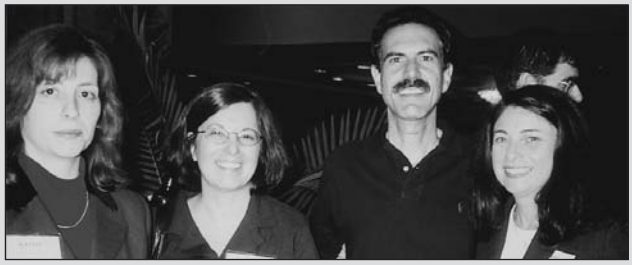
(l-r) Institute Speaker Albert Kukol and Jayme Coates.

(l-r) Heather Cornell and John Normile.

(l-r) Speakers Dan Fish, Vincent Russo and Jim Hayes.

(l-r) Speakers Steve Silverberg, Ellen Makofsky and Mike O'Connor.

(l-r) Steve Silverberg, Valerie Bogart, Bruce Birnbaum and Vincent Russo.



(l-r) Kathy Locenti, Linda Geraci, Ron Fatoullah and Mary Breheney.

New York Case News

By Judith B. Raskin

Medicaid Eligibility

This Article 78 proceeding was an appeal from a fair hearing decision denying an institutionalized Medicaid applicant's request to shorten her penalty period where her institutionalized spouse died and gifts made by both of them were attributed solely to her. Denied. *Woytisek v. Novello*, 2002-08531 (2d Dep't, Oct. 20, 2003).

Mr. and Mrs. Woytisek both entered a nursing home and then gifted over $100,000. The gift incurred a period of ineligibility for Medicaid benefits of 16 months. The couple assumed that Medicaid would allocate the gift between them and deem them each ineligible for Medicaid for eight months. Mr. Woytisek died in October 2000, prior to submitting his Medicaid application. When Mrs. Woytisek applied after the eight months had passed, she was denied because the agency applied the full 16-month period of ineligibility to her. After an unsuccessful fair hearing, Mrs. Woytisek brought this Article 78 proceeding. She argued that the Department of Health was arbitrary and capricious in applying the full penalty period to her.

The court upheld the fair hearing decision. The respondent's interpretation of the relevant statute (42 U.S.C. § 1396p(c)) and regulation (New York Comp. Codes R. & Regs. tit. 18, § 360-4.4(c)(2)(vii)) (N.Y.C.R.R.) was reasonable and therefore not arbitrary and capricious. A reasonable reading is that the penalty period will not be allocated to both spouses until they are both eligible for Medicaid. Mr. Woytisek was never eligible and never filed his application.

Medicaid Lien

An executor sought to vacate a Medicaid lien against the estate of a decedent who had received damages from the nursing home where he resided. Denied. *Estate of Barnes v. Lawrence Nursing Care Center, Inc.*, 23866 (Sup. Ct., Kings Co., Civil Term Part 13, Nov. 10, 2003).

In this action brought by the executor, the estate was awarded damages for the decedent's pain and suffering from the nursing home where the decedent resided. The Department of Social Services (DSS) then filed a lien against the award to be reimbursed for services rendered to the decedent. DSS reads Public Health Law § 2801-d subdivision 5 as saying that damages received from the nursing home should not be deemed available to a Medicaid recipient if the recipient is alive. The plaintiff argues that it applies to deceased recipients as well. DSS has asserted in ADM 02 OMM/ADM-3 that DSS does have a lien on the recipient's estate. The executor appealed the right of DSS to place the lien against the estate.

The Supreme Court, Kings County, Civil Term Part 13 held that section 2801-d of the Public Health Law does not bar DSS from filing a lien either during or after the life of the recipient where the recipient received a damage award from the nursing home. Legislative action and considerable case law clearly confirm that damages for pain and suffering are available to satisfy Medicaid liens both during life and after death. The ADM is incorrect in its assertion that Medicaid cannot recover from a damage award paid by a nursing facility during the life of the recipient nursing home resident.

Nursing Home Claim Under Debtor & Creditor Law

Defendant appealed from a decision denying her summary judgment motion where she was transferee of funds given to her by a nursing home resident and the nursing home sought payment of its bill. Reversed. *Grace Plaza of Great Neck, Inc. v. Heitzler,* N.Y.L.J., Jan. 7, 2004, p. 37, col. 2 (App. Div., 2d Dep't).

In January 1996, Mrs. Witt entered plaintiff's nursing home. About nine months later, Mrs. Witt received a medical malpractice settlement of $659,532. She then gifted a total of over $350,000 to her children (including her daughter, the defendant) and retained over $342,700. In November 1999, Mrs. Witt moved to a nursing home in Texas. Shortly thereafter, the plaintiff nursing home brought an action against Mrs. Witt's daughter for payment of $26,610.73 due for its services to Mrs. Witt. The plaintiff argued that the transfer of funds was a fraudulent

conveyance under Debtor & Creditor Law. The defendant moved for summary judgment. The Supreme Court, Queens County, denied the summary judgment motion, finding outstanding issues of fact as to Mrs. Witt's future insolvency and her intent to defraud when she made the transfers. The defendant appealed.

The Appellate Division reversed. The evidence showed that Mrs. Witt did not have outstanding debts when she transferred the funds. She retained sufficient funds combined with her income to pay her nursing home costs for three years until she was Medicaid-eligible. The court stated ". . . Mrs. Witt's decision to make gifts to her family while retaining assets reasonably calculated to cover the cost of her care until she became eligible to receive Medicaid assistance cannot be considered acts of intentional fraud against future creditors . . ."

Power of Attorney

A co-executor presented a power of attorney for filing with the Court Clerk naming her co-executor as her agent to carry out her responsibilities as co-executor. Filing denied. *Will of Jones*, 23700 (Surr. Ct., Broome Co., Oct. 1, 2003).

A co-executor was denied permission to file a power of attorney appointing her co-executor as her agent to act for her in her role as co-executor.

Provisions in Estates, Powers & Trusts Law § 13-2.3 (EPTL), 22 N.Y.C.R.R. § 207.48 and General Obligations Law § 5-1502G refer to handling estate matters through a power of attorney. However, only the beneficiary and not a fiduciary can appoint an agent in a power of attorney to act for her. A fiduciary may not delegate her duties but may petition the court to resign.

Article 81 Appointments

An Article 81 co-guardian and nephew of the incapacitated person appealed from that part of the decision in an Article 81 proceeding appointing a co-guardian to act with him. Appointment of co-guardian vacated. *In re Bertha W.*, 2003-02675 (2d Dep't, Nov. 24, 2003).

The Supreme Court, Kings County, appointed a nephew of the incapacitated person as Article 81 guardian and also appointed Steven T. Rondos, an attorney, as co-guardian. The nephew appealed the appointment of a co-guardian.

On appeal, the Second Department vacated the appointment of the co-guardian, Mr. Rondos. The court cited clear New York case law that strangers will not be appointed as guardians unless a qualified member of the family circle or a nominee is not available. Nothing in the record indicated that the nephew needed assistance.

Petitioner in an Article 81 proceeding appealed the appointment of a guardian for her son who was not her nominee. Granted. *In re Naquan S*, 2002-10388 (2d Dep't, Dec. 8, 2003).

The petitioner in an Article 81 proceeding for the appointment of a guardian for her son nominated her attorney, Steven T. Rondos, as a co-guardian. The Supreme Court, Kings County instead appointed Etta I. as co-guardian. The petitioner appealed.

The Second Department vacated the appointment of Etta I. and appointed Steven T. Rondos as co-guardian. It is firmly established that a stranger will not be appointed guardian "unless it is impossible to find within the family circle, or their nominees, one who is qualified to serve." The court cited *In re Dietz*, 247 App. Div. 366, 367; *In re Klein*, 145 A.D.2d 145, *In re Gustafson*, 308 A.D.2d 305; *In re Robinson*, 272 A.D.2d 176; *In re Chase*, 264 A.D. 330.

Article 81 Filing Fee

An Article 81 special guardian filed a motion to be discharged without filing a final account and did not pay the $45 filing fee. Fee required. *In re Ficalora*, 23873 (Sup. Ct., Queens Co., Dec. 1, 2003).

Pursuant to the decision of Justice Thomas in *In re Richter*, N.Y.L.J., Nov. 14, 2003 that the $45 fee for filing a motion be waived in similar circumstances, the clerk accepted a special guardian's motion without a filing fee. The motion was a request to discharge the special guardian without filing a final report.

The Supreme Court, Queens County, held that legislation clearly requires that the fee be paid and that there is no exception for a fiduciary in an Article 81 proceeding. The court suggests that where the incapacitated person has limited resources, the fiduciary may apply to have the incapacitated person deemed a "poor person" and have the fees waived. In a circumstance such as this, where the motion will result in the filing of two orders, only one $45 fee should be charged. Where the fiduciary makes the payment, she can request reimbursement.

Estate Recovery by Creditor

A creditor of an insolvent estate sought payment from a beneficiary of certain non-probate assets. Denied. *Proceeding by BCT Federal Credit Union*, 196 Misc. 2d 250 (Surr. Ct., Broome Co., June 4, 2003).

The petitioner creditor could not have its claims satisfied from an insolvent estate. The petitioner then claimed that the non-probate assets passing to decedent's son were available to pay its claims. The non-probate assets were a term insurance policy with $10,000 death benefit; a New York State Teacher's Retirement System pension naming decedent's son as beneficiary, valued at $461,510.83; and a 403(b) account under a school district program, invested in mutual funds and valued at $89,730.95.

The court held that these non-probate assets were unavailable to satisfy the creditor's claims. Anti-alienation provisions can be found in Insurance Law § 3212(b)(1). Insurance proceeds to a named beneficiary are protected against creditors' claims. While Education Law § 524 protects pensions against creditors' claims during the life of the owner, case law has held that a teacher's pension with the New York State Teacher's Retirement System is exempt from claims of creditors. The 403(b) annuity was part of a school district program and so not under the New York State Teacher's Retirement System or ERISA. (Pensions under ERISA are also protected against creditor claims but this law does not cover pensions from state and local governments.) The IRC considers 403(b) plans as annuities even when invested in mutual funds. EPTL § 13-3.2 states that annuities "shall not be impaired or defeated by any statute or rule of law governing the transfer of property by will, gift or intestacy." The Third Department relied on this in a recent case, *In re Clotworthy*, holding that an annuity is not subject to claims of a creditor.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of elder law, trusts and estates, and estate administration.

Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the New York State Bar Association, where she is a member of the Elder Law and Trusts and Estates Law Sections; and the Nassau County Bar Association, where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee.

Ms. Raskin shares her knowledge with community groups and professional organizations. She has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the New York State Bar Association as well as for numerous other professional and community groups. Ms. Raskin writes a regular column for the *Elder Law Attorney*, the newsletter of the Elder Law Section of the New York State Bar Association, and is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter. She is past president of Gerontology Professionals of Long Island, Nassau Chapter.

Mitchell W. Rabbino Decision Making Day

Decision Making Day is to be renamed Mitchell W. Rabbino Decision Making Day in honor of Mitchell W. Rabbino, Esq., who died on February 14, 2003. Decision Making Day is sponsored by the NYSBA Elder Law Section. On this day, Section members volunteer their time to provide information about advance directives across New York State.

The Elder Law Section chose to honor Mitchell Rabbino by renaming Decision Making Day because he was such a valuable resource and active member of the Section. Most importantly, he embodied the dedication, civility, professionalism and integrity which made elder law attorneys proud to be his colleague. He was a much-respected member of the Executive Committee of the Elder Law Section for several years, serving as Treasurer and then Secretary. At the 2003 NYSBA Annual Meeting in January, Mitchell W. Rabbino was elected Chair-Elect of the Elder Law Section.

Those wanting to make a contribution in honor of Mitchell W. Rabbino may send their contribution to the New York Bar Foundation where donations will be put into a special fund to support Mitchell W. Rabbino Decision Making Day.

Legislative News

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

Obviously, the important legislative news, perhaps the most important legislative news affecting the rights of seniors in New York in the past decade, is the proposed legislation which would have a profound impact on Medicaid eligibility. Here is the final version of the Section's response to the devastating proposals found in the Governor's Budget Bill. The Report was written by Howard Krooks, Vincent Russo, Cora Alsante, Dan Fish, René Reixach and Joan Robert, all of whom are members of the Special Committee on Medicaid Legislation, which is co-chaired by Howard Krooks and Vincent Russo. Lou Pierro presented this Report in support of testimony that he gave on February 3, 2004 before the state legislature.

Steven H. Stern

Please note that the opinions contained in the Report are those of the Elder Law Section, and not those of the New York State Bar Association.

Howard S. Krooks is a partner in the law firm of Littman Krooks LLP, with offices in New York City and White Plains. Mr. Krooks is certified as an elder law attorney by the National Elder Law Foundation and is Chair-Elect of the Elder Law Section of the New York State Bar Association. Mr. Krooks co-authored a chapter ("Creative Advocacy in Guardianship Settings: Medicaid and Estate Planning, including Transfer of Assets, Supplemental Needs Trusts and Protection of Disabled Family Members") included in *Guardianship Practice in New York State*, a book published by the New York State Bar Association. Mr. Krooks has lectured frequently on a variety of elder law topics for the National Academy of Elder Law Attorneys, the National Guardianship Association and the New York State Bar Association. In addition, Mr. Krooks has served as an instructor for the Certified Guardian & Court Evaluator Training: Article 81 of the Mental Hygiene Law Program sponsored by the Association of the Bar of the City of New York.

Steven H. Stern is a partner in the law firm of Davidow, Davidow, Siegel and Stern, LLP, with offices in Islandia and Melville, Long Island. Founded in 1913, the firm concentrates solely in the practice areas of elder law, business and estate planning. Mr. Stern is a member of the National Academy of Elder Law Attorneys and is the current Co-Chairman of the Suffolk County Bar Association's Elder Law Committee. He also serves as a member of the Suffolk County Elder Abuse Task Force's Consultation Team. With a strong commitment to educating the local senior community, he is a frequent speaker and published author and also hosts "Seniors Turn to Stern," a radio program on WLUX dedicated to the interests of seniors and their families.

New York State Bar Association

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NEW YORK STATE BAR ASSOCIATION
ELDER LAW SECTION
REPORT ON GOVERNOR'S BUDGET BILL: MEDICAID INITIATIVES

Dated: February 3, 2004

INTRODUCTION

The Elder Law Section of the New York State Bar recognizes the fiscal plight of the State and embraces the quest for affordable, accessible long term health care services for all New Yorkers. The Elder Law Section applauds the Governor's budget (in S. 6058 and A. 9558, referred to herein as the "Budget Bill") for its exploration of affordable long term care insurance for able-bodied New Yorkers. However, some of the budget proposals that seek to alter Social Security provisions of the federal Medicaid program eligibility rules ignore the plight of frail elderly New Yorkers facing the daunting task of paying for long term care.

OVERTURNING FEDERAL LEGISLATION BY ADMINISTRATIVE WAIVER

The Medicaid program is a joint federal-state health care program. Federal law establishes parameters that the states must follow if they are to be entitled to federal funding. If the states are dissatisfied with the federal requirements, they can seek to have the federal law amended. Rather than amending federal law, under the Budget Bill, New York State proposes to seek an administrative waiver. Those waivers were created to expand Medicaid services, not to restrict them. The proposed budgetary changes would take away federal rights without any amendment to the federal law. Therefore, it is unlikely that the proposed waivers will be granted.

EXCLUSION OF THE ELDERLY FROM THE DELIBERATIVE PROCESS

The process followed by the Governor in developing his recommendations is notable for the almost complete absence of any input from consumers or organizations other than those representing various health care providers or the insurance industry.

Opinions expressed herein are those of the Committee preparing this report and do not represent the opinions of the New York State Bar Association unless and until they have been adopted by its House of Delegates or Executive Committee.

LEGISLATIVE PROPOSALS

The following budget proposals will have devastating results on financially and medically needy seniors:

a. Increasing from 36 to 60 months the period of time during which financial transactions of a Medicaid recipient will be subject to review, and imposing this 60 month look-back period on non-institutionalized as well as institutionalized individuals;

b. Imposing ineligibility periods for community Medicaid services caused by the transfer of assets;

c. Eliminating spousal refusal in home care cases and limiting its use for spouses of institutionalized individuals; and

d. Commencing the penalty period for all Medicaid services on the date of application rather than on the date of a gift.

This Report was prepared by a Special Committee on Medicaid Legislation of the New York State Bar Association Elder Law Section. Detailed below are our specific thoughts regarding the ramifications of these four budget proposals, three of which are so radical that they require a waiver from the federal government before they can be implemented legally. They will also have the unintended effect of encouraging the use of institutional services rather than community services.

1. Medicaid: Look-back Period Extended to Five Years

Current Law (Consistent with Federal Law)

The look-back period for both institutional care and home care is 36 months, except for certain trust-related transfers, for which the look-back period is 60 months.

Proposed Change (Conflicts with Federal Law)

Under the Budget Bill, the look-back period would be changed to 60 months for both institutional care and home care, regardless of whether there have been trust-related transfers. The Budget Bill proposes that this change be made through an administrative waiver rather than as an amendment to the federal law which established the 36 month look-back rule.

Analysis and Issues

a. The proposal suggests that the elderly can predict their medical and financial circumstances five years into the future. It punishes unwitting elders who have helped their families with commonly made gifts and then experience medical events such as a stroke or Alzheimer's disease.

b. The proposal will create unacceptable new obstacles for vulnerable, frail elderly individuals and persons with disabilities to get care, because the proposal will require record keeping and documentation that is far beyond the ordinary practices of the elderly, especially poor and chronically ill elders. Therefore, low-income elders would be denied admission to a nursing home because of inadequate record keeping.

c. The harshest impact of this proposal will be on those applicants with dementia who will not be able to provide documentation or recollection of deposits and expenditures made up to 5 years previously.

d. The extension of the look-back period is arbitrary and without legal precedent. The Congress has determined that 3 years is a sufficient time period for the government to scrutinize a Medicaid applicant's finances prior to his/her application for benefits.

e. Any increase in the look-back period will have a significant impact on the government's administrative overhead, as caseworkers will be forced to examine 5 years of each applicant's financial records rather than the current 3 years. Increased labor costs will reduce any purported budgetary savings.

f. There is no reliable data to support the proposition that a longer look-back period will reduce the cost of the Medicaid program's share of nursing home care costs.

2. Medicaid: Penalty Rule Computation

Current Law (Consistent with Federal Law)

The penalty period commences on the first day of the month following the month in which the transfer was made. For example, a transfer of $52,170 by a New York City resident will result in a ½ year ineligibility period ($52,170 divided by $8,695)[1] for Medicaid institutionalized care, beginning the month after the transfer has been made. After the ½ year has passed, the transfer no longer would preclude Medicaid eligibility.

Proposed Change (Conflicts with Federal Law)

Under the Budget Bill, the penalty period would commence on the first day of the month during or after which a Medicaid application has been made, rather than on the date of the asset transfer. The Budget Bill proposes that this change be made through an administrative waiver rather than as an amendment to the federal law which established the penalty rule computation.

[1] $8,695 represents the average monthly cost of a nursing home in New York City in 2004 as determined by the New York State Department of Health.

Analysis and Issues

a. If implemented, this proposal will have severe consequences and will negatively impact numerous elderly citizens in nursing facilities and those waiting to be admitted to a nursing facility or in need of nursing home care in the future.

b. Under this proposal, seniors and people with disabilities denied Medicaid would, at the time of the denial, be impoverished, have physical and/or mental impairments so severe that they could no longer care for themselves, be in need of nursing home or home care, and have no other means (private insurance or Medicare) of paying for the needed care.

c. The denial of long term care will trigger adverse medical consequences. The absence of skilled nursing, physical, occupational and speech therapy and necessary assistance with medical care and activities of daily living will adversely affect seniors and people with disabilities who will be denied home care services and nursing home admission under this proposal. New York State allows facilities to deny admission when there is no payment source.

d. The harsh penalty that would be created by this proposal would be applied to all those who are unable to immediately recover the funds or the value of property transferred prior to the Medicaid application. Most transferees will have no legal obligation to refund the transfer. In other cases, transferees will be financially unable to make any refund or there will be no transferee from whom to recover. For example, a senior with Alzheimer's who made withdrawals totaling $10,000 from her savings account forty (40) months prior to the Medicaid application would be ineligible for Medicaid long term care benefits for two or more months following the month in which she applies. How will the frail elderly and/or disabled New Yorker obtain absolutely essential medical care? How will the nursing home be paid?

e. This proposal could discourage donations to charities, religious and political organizations and candidates for government office. Only those who can predict with absolute certainty that they will not need Medicaid for at least five years could safely make donations.

f. This proposal may harm families by inhibiting older members from providing financial assistance to younger members - with such things as down payments on homes and college tuition - out of fear that they may not qualify for Medicaid nursing home care if unforeseen events leave them unable to care for themselves.

g. In addition to the harm to seniors and those with disabilities, there would be considerable financial harm to health care providers. Hospitals and nursing homes are prohibited from discharging patients unless suitable alternative arrangements can be made, even if they must provide extended uncompensated care.

h. In cases where the nursing home admission has already occurred and the penalty is then applied, nursing homes will be required to provide uncompensated care for the duration of the penalty period or until hospitalization. Nursing homes would become financially strapped - impacting on staffing levels and the quality of care for all of its residents.

i. Those in hospitals at the time of the Medicaid denial would be unable to leave, as nursing homes and home care agencies will deny admission if there is no source of payment. Hospitals will become the default providers of care as access to nursing homes is barred during the penalty period.

j. This proposal will most likely not harm those who will divest themselves of assets far in advance of needing care. They are predictably the wealthier individuals who can retain sufficient assets to pay for themselves should they unexpectedly require care during the look-back period. Those of modest means, who may learn of the policy change only after they seek admission to a facility, are those likely to feel the greatest effect of the proposed changes. In fact, this proposal may encourage more and earlier transfers. Moreover, it is unclear how this proposal encourages those people to purchase long term care insurance.

k. These restrictions would come at a time when resources for community services are also being cut, and could leave many severely disabled seniors with unsafe and inadequate care in the community. Such a change would inevitably result in increased hospitalization for these frail seniors at additional cost to the system

l. If denied Medicaid, seniors would be forced to rely upon informal caregivers, (i.e., children). This proposal could have far reaching economic effects if a family member has to leave his or her job to try to take care of a severely incapacitated elder.

m. The current transfer of assets penalty provisions already exact a consequence for transfers made during the look-back period, requiring most seniors to spend down a significant amount of their assets before being able to access the Medicaid nursing home program.

3. Medicaid: Penalty Rule for Home Care

Current Law

There is no penalty period for community based home care caused by the transfer of assets under the Medicaid program. Medicaid recipients may have no more than $3,950 in assets and all income above $679 must be spent only on medical needs.

Proposed Change

The Budget Bill would impose a penalty period for uncompensated transfers of assets for purposes of community based home care, i.e., those in need of home health care, personal care services and assisted living program services. Medicaid recipients would continue to have only $679/month in income available to spend for rent, food, clothing and any other expenses other than medical costs.

Analysis and Issues

a. The proposal, if enacted, would seriously undermine the impact of the Supreme Court decision Olmstead v. L.C., which found it a violation of the Americans with Disabilities Act to institutionalize the qualified disabled rather than provide them with services in the community. Imposing a penalty period for home care services would restrict access to home care services in such a way as to diminish the effect of the Olmstead mandate.

b. Frail elderly have consistently voiced a preference for community-based care over institutional care whenever possible. Imposing a penalty period for home care services would be in contravention of well-known preferences of the elderly population requiring the care to remain in the community.

c. Medicaid recipients who already receive home care services under the current law may lose eligibility under the proposed law if they had made transfers within the past 5 years. The home health care agencies could abruptly terminate services, thereby placing the elderly individual at risk of serious harm and inadequate care in the community.

d. The caregiver spouse also will suffer detrimental effects. While in receipt of Medicaid home care services, the caregiver spouse in many instances is available to provide care to the ill spouse when the aide is not present. Upon the termination of needed services due to the new penalty period rules, the caregiver spouse may begin to deteriorate and require services him/herself as a result of the tremendous emotional and physical pressures that go along with becoming the sole caregiver.

e. This change also could have far-reaching economic effects if a family member has to leave his or her job to try to take care of a severely incapacitated elder. Frail elderly and disabled New Yorkers would find themselves uprooted from their homes and familiar surroundings to live with a caregiver family member. In addition to physical incapacities, many of these dislocated elders will have cognitive impairments which would be exacerbated by the trauma of a change in environment. Such a change would inevitably result in increased hospitalizations for these frail elders at additional cost to the system.

f. Applying a new penalty period to home care services may punish unknowing elders who have helped their families with commonly made gifts and then experience unforeseeable medical events such as stroke or Alzheimer's Disease.

g. Grandparent caregivers also will be affected by this proposal. Take, for example, a grandparent caregiver for her grandchild whose biological mother retains parental rights. Grandmother paid $30,000 for medical care and educational costs for her granddaughter. About 2 ½ years later she needed home care services. She would face no penalty under current law. Under proposals set forth in the Budget Bill, she may be denied coverage until after the penalty expires.

h. Frail elderly can currently place assets into a Supplemental Needs Trust managed by a not-for-profit agency, and these "pooled trust funds" can be used to supplement their necessary living expenses. If placing funds into a "pooled trust" will result in an ineligibility period for community based Medicaid services, they cannot afford to remain in their homes and apartments with no collateral source to supplement their needs.

4. Spousal Refusal

Current Law (Consistent with Federal Law)

a. An institutionalized Medicaid recipient may retain only $3,950 in available assets and $50/month in income. His/her spouse residing in the community may retain between $74,820 and $92,760 plus the family home and car, which are exempt assets in computing Medicaid eligibility. The community spouse may retain $2,319/month in income. For home care services such as personal care attendants, home health aides and certain day programs, the couple's income and resources are counted jointly, and a couple may not retain more than $5,700 in resources other than the family home and car, and only $970/month in income may be expended on items other than medical needs.

b. Federal law and New York State law authorize the community spouse to refuse to have his or her assets used in the computation of the Medicaid eligibility of the institutionalized spouse, so long as the institutionalized spouse assigns to the state the right of support from the spouse or, if the institutionalized spouse is unable to execute the assignment, the state has in place a law which automatically assigns this right. New York has in place such an assignment statute. This is the federal law in place since 1988, when Congress enacted legislation to prevent the impoverishment of spouses whose husbands and wives need nursing home care. New York State law authorizes "spousal refusal" for Medicaid home care benefits as well.

Proposed Changes

a. The Budget Bill would eliminate spousal refusal in nursing home care except for very limited exceptions (where undue hardship, as defined by the Commissioner of the Department of Health, is shown to exist) authorized under federal law. The Budget Bill proposes that this change be made through an administrative waiver rather than as an amendment to the federal law which established spousal refusal.

b. The Budget Bill would eliminate spousal refusal in home care services except in circumstances where one spouse is absent.

Analysis and Issues

a. The proposal is based upon the premise that spousal refusal is a "loophole". This is not correct. Spousal refusal was enacted after full congressional hearings which determined that forcing community/healthy spouses to impoverish themselves resulted in an increased drain on the public fisc. Spousal refusal is a right existing under explicit federal law. The vast majority of the elderly who do file for Medicaid under spousal refusal have provided extensive care for their spouse at home. It is as a last resort that the assistance is sought.

b. If spousal refusal were to be eliminated, the only avenue left to healthy spouses would be a return to divorce.

c. Spousal refusal is a humane policy which encourages the elderly to provide care at home for ill spouses and this policy slows down or eliminates more costly nursing home placement in a majority of cases.

d. The proposal distorts the facts by claiming that refusing spouses can get Medicaid benefits and not make their resources available. In fact, the federal and state statutes permit lawsuits against refusing spouses who hold unreasonable amounts of savings. The current law simply does not allow Medicaid to hold the ill spouse hostage because the healthy spouse refuses to pay for the care of the ill spouse.

e. The Budget Bill's proposal to eliminate spousal refusal in community Medicaid cases would simply force an increase in nursing home admissions and could run afoul of the United States Supreme Court Olmstead case which requires that care be provided in the "most integrated setting" possible.

f. Frail elderly will be forced into nursing homes at additional cost to the Medicaid system if married couples must spend down their assets to pay for home care until they are impoverished. There are no spousal allowances for Medicaid home care under current law. Thus, the ill spouse will be forced to seek more costly nursing home care once the married couple becomes impoverished.

g. Spousal refusal allows the healthy elderly spouse to maintain assets to generate income for his or her own living expenses and future long term care needs.

h. Without spousal refusal in home care cases, Medicaid home care services would be unavailable to couples with more than $5,700 in assets. The couple would be able to retain only $970/month in income to spend on food, clothing, rent, utilities, real estate taxes, transportation and any necessities other than medical needs. These proposals will hurt the frail elderly of modest means who may be unable to remain in the family home.

5. Apply for Federal Waivers to Implement Changes in the Medicaid State Plan

Current Law

Federal law governs the look-back period, which is 3 years, not 5 years, unless certain trust-related transfers have occurred. Federal law directs that the ineligibility period start the month during or after a transfer, not upon the application for benefits. Federal law prohibits a Medicaid denial of an institutionalized spouse if the community spouse refuses to make assets available for the support and maintenance of the applicant, so long as the applicant assigns to the state the right to pursue the support or the state has in place a statute that assigns this right in the event the applicant is unable to do so.

Proposed Changes

The Budget Bill seeks a federal waiver to alter the eligibility rules required by federal law. Specifically, the Budget Bill seeks new waivers to lengthen the look-back period, modify the nursing home spousal refusal provision and modify the penalty period calculation.

Analysis and Issues

a. Federal Medicaid law may only be avoided if there is an amendment to the law or if a waiver is granted, called an 1115 waiver (42 U.S.C. section 1396a). 1115 waivers are limited. They may alter only the Medicaid requirements found in section 1902 of the Social Security Act. The rules which the Budget Bill seeks to avoid by waiver (look-back period, penalty period and spousal refusal) are not in section 1902 and cannot be the subject of a waiver. The waiver envisioned would be beyond the authority of the federal Medicaid statute.

b. Any such waiver program sought by a state must demonstrate an expansion or improvement of services. Typically, the waiver would result in an overall cost savings by modifying the programs or eligibility to provide additional or more cost effective services that will save program costs elsewhere. It is hardly a demonstration project to prove that if eligibility is restricted fewer individuals will be eligible.

c. A similar waiver request by Minnesota was denied for this reason by HCFA (now CMS).

d. Obtaining such waivers from the federal government is a lengthy process. The proposals to restrict Medicaid eligibility set forth in the New York State 2004 budget are similar to waivers that the State of Connecticut applied for in February 2002. The Connecticut waiver proposal is still pending. Thus, whether and if any such waiver would be granted to the State of New York is speculative at best and calls into question the reality of any projected budgetary savings for the next several fiscal years. The purported savings are illusory and will not be realized given the reality of the federal waiver process. In the interim, if New York State imposes restrictions on Medicaid home care that it cannot impose on nursing home care without a federal waiver, the unintended consequence of the State's fiscal budget will be increased Medicaid nursing home costs.

CONCLUSION

Current Medicaid Eligibility Provisions Should Not Be Changed Until There Is a Comprehensive Long Term Care Program For Seniors

1. **No one yearns to be on a program like Medicaid**. Seniors engage in Medicaid planning mainly because they find themselves in a "lose-lose" corner. First, they lose their health and need long-term care and come face to face with nursing home costs averaging $100,000 per year in the New York metropolitan area. Second, they learn that they will have to lose virtually their entire estate to pay for long-term care paying 100% out-of-pocket until they reach Medicaid's definition of impoverishment. Congress created a partial remedy to this harsh result under Medicaid by allowing people to protect part of their estate if they are willing to pay the penalty of non-eligibility for a period of time.

2. **Research shows that transfers are of minimal amounts**. A 1993 GAO study[2] found that only 10 percent of the total cases it reviewed involved asset transfers, and that these transfers averaged $46,000, with one of every three transfers being an amount less than $10,000. If one were to apply the GAO findings to the total number of cases it reviewed, the average transfer per case was $4,600. This is an insignificant amount for Medicaid purposes. Whether the purpose is giving a legacy to family members, or helping loved ones meet expenses for housing, school, or other needs, these are reasonable family transactions affecting modest, middle class families.

   No reliable data exist assessing the actual effect of asset transfers on Medicaid expenditures. However, a few studies provide informative insight. In a 1995 study, Liu and Moon estimated that if every elder with a significant incentive to divest countable assets in order to become Medicaid eligible actually did divest him/herself of every penny, the amount transferred would equal about 4% of Medicaid nursing home expenditures.[3]

   As a practical matter, this estimate overstates the scope of disqualifying transfers, because the 1993 GAO study of practices in Massachusetts showed that about 90% of Medicaid planning involves permissible conversions of assets that trigger no penalty-- most typically setting aside money for burial arrangements, or making home repairs or purchasing an automobile. Moreover, that study also showed that most of the disqualifying transfers did, in fact, result in disqualification or withdrawal of application, resulting in no or little additional cost whatsoever to Medicaid.

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[2] U.S. General Accounting Office, *Medicaid Estate Planning* 2, GAO/HRD-93-29R (July 20, 1993).

[3] Korbin Liu and Marilyn Moon, "Recovering Hidden Assets: The Magic Bullet for Medicaid Savings?", The Urban Institute, *Policy Bites*, No. 23, September 1995.

3. **When people do become eligible for Medicaid, regardless of whether they have engaged in Medicaid planning, they must pay all but a small portion of their income each month for their care**. Medicaid then pays whatever the difference is between that amount and the Medicaid rate. Thus, costs to Medicaid are always mitigated by the individual's monthly income.

4. **The Proposed Medicaid Eligibility Changes in the Budget Bill are based on inaccurate premises**. It can be demonstrated that:

   - ❑ Many seniors and persons with disabilities are uninformed about the extremely complex laws which govern Medicaid eligibility. These individuals will be the most severely harmed by the proposed changes.

   - ❑ Most seniors and persons with disabilities do not have the capacity to predict accurately their medical needs and financial circumstances five years into the future.

   - ❑ Seniors of ample means are not willing to lose control of their assets and sacrifice access to a wide range of essential health care services and their right to select their health care providers in order to become eligible for Medicaid.

   - ❑ Long Term Care Insurance initiatives will not be available in 2004 to defray the cost of Medicaid expenditures for frail, elderly seniors.

   - ❑ If denied Medicaid coverage as a result of this proposal, seniors will not be protected from harm and will not be able to recover instantaneously funds, items or property and to convert these into the thousands of dollars per month needed to pay for their nursing home or home health care for the full duration of an imposed penalty period.

   - ❑ The termination of long term care services to disabled seniors will have adverse consequences on other state and federal spending or on health care providers.

   - ❑ The elderly do not fail to insure themselves against the risk of long term care expenses because of the availability of Medicaid. As long term care insurance is medically underwritten, it is not available now for those in need of long term care health services. Secondly, most senior citizens cannot afford long term care insurance. Insurance industry criteria provide that the premium for long term care insurance should not exceed 7% of an individual's annual gross income.[4] If the premium is $3,000/year/spouse, they should have retirement income of $42,000 per year for an individual, or $84,000 per year for a couple in order to maintain this insurance during retirement. Very few retired New Yorkers have such high retirement income.[5]

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[4] A Brookings Institution study estimated that at most just twenty percent of senior citizens both could afford and pass the medical underwriting for such insurance.

[5] According to the Social Security Administration, the average Social Security retirement benefit received by retired New Yorkers was $895 per month (or $10,740 per year) as of

- ❑ Medicaid planning is not a "loophole." It is authorized by federal law and is similar to tax planning authorized by the Internal Revenue Code.

5. **The State Medicaid Expenditures are Inextricably Linked to the High Cost of Health Care.** The private cost of a nursing home in the metropolitan New York area greatly outpaced inflation last year and is reflected in increased private and governmental expenditures. Seniors did not cause these rate hikes and should not be blamed for the high cost of their care.

6. **The proposed budget legislation discussed herein represents a dramatic shift from the long-standing policy of this State,** which was eloquently summarized by the New York State Court of Appeals in Matter of Shah as follows:

> [N]o agency of the government has any right to complain about the fact that middle class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential, medical treatment.

Cognizant of the financial burdens caused by long term care needs, the Elder Law Section of the New York State Bar Association is examining housing, insurance initiatives, home care and government entitlements in order to propose solutions to the problems facing our clients and our State. The Section welcomes the opportunity to share its findings and to explore solutions which protect the medically fragile individuals we represent.

Report Prepared by: New York State Bar Association Elder Law Section, Special Committee on Medicaid Legislation

Howard S. Krooks and Vincent J. Russo, Co-Chairs
Joan L. Robert, Chair, Elder Law Section
Cora A. Alsante, Daniel G. Fish, Rene H. Reixach

Testimony by: Louis W. Pierro

Special Thanks to the National Academy of Elder Law Attorneys (NAELA) and the Connecticut and Massachusetts Chapters of NAELA for their assistance.

December 2002. Social Security Administration web site (www.ssa.gov/policy/docs/quickfacts/state_stats/ny.html). In order to generate additional income to reach $42,000, a retiree would require more than $600,000 in savings assuming a 2% return on investment.

PRACTICE NEWS

Is It Good Practice to Hold on to Our Clients' Durable Powers of Attorney?

By Vincent J. Russo

Your client has executed Advance Directives: a Durable Power of Attorney, Health Care Proxy and a Living Will. The meeting is over. What do you do with the original(s)? This article will primarily focus on Durable Powers of Attorney; the same issues arise with Health Care Proxies and Living Wills.

Multiple Originals

Before you decide what to do with the originals, the first question to answer is, "How many originals is your client going to execute?" I would suggest that the attorney advise the client to execute two or more original Durable Powers of Attorney. This will be especially useful when a signed original has to be given to a broker, bank or other entity to complete a transaction. Even though New York law provides that a copy of an Advance Directive is a valid document, we know that third parties regularly insist on seeing the original document before accepting it.

If the last or only original Durable Power of Attorney is requested by a third party, the client can have the original document recorded at the County Clerk's office and certified copies can be obtained for the client's use. In our office, our rule of thumb is to have the client execute two originals of the Durable Power of Attorney, the second original for "just in case."

Revocation

One should be aware that when there are multiple originals, the issue of revocation becomes more complicated. Although the execution of multiple original Durable Powers of Attorney should be considered, the existence of several original documents and copies may give rise to a problem in the event the principal decides to revoke the power. It is correct that a later Durable Power of Attorney may contain language revoking prior Durable Powers of Attorney, but how will this revocation be implemented?

To accomplish a revocation, the client must locate all of the originals and copies of the Durable Powers of Attorney. The Elder Law attorney should therefore advise the client to keep a record of the banks and other institutions or individuals that have an original or copy of the Durable Power of Attorney. If a revocation of the document thereafter becomes necessary, there will be a record of those who must receive notice of revocation.

"In our office, our rule of thumb is to have the client execute two originals of the Durable Power of Attorney, the second original for 'just in case.'"

Storing the Originals

The Elder Law attorney may want to retain an executed original of the Advance Directives in his or her office. This will assure the availability of the Advance Directives in the event the client loses or misplaces his or her original. It would be prudent for the attorney to hold these original documents in a fireproof safe.

What would be the attorney's liability if the Advance Directives are lost or destroyed? Would the attorney be liable to the client? What if there is a delay in the attorney's providing the Advance Directives to the client which results in adverse financial or health care consequences? For example, the agent under a Durable Power of Attorney requests the original in order to sell stock which is selling at $20 per share, but the attorney takes a week to get the document to the client. The stock is later sold for $10 per share. Would the attorney be liable for the loss?

Release of the Originals

Retention of an executed Durable Power of Attorney can cause an ethical problem for the attorney, such as when the release of the Durable Power of Attorney being held by the attorney arises upon the principal's loss of capacity.

The request for the retained Advance Directive may come from a person other than the client, such as the attorney-in-fact. The dilemma for the attorney is whether or not to release the Durable Power of Attorney to someone other than the client. Who is the client—the principal, the agent, both? Can the attorney be held for the wrongdoings of an agent if the Durable Power of Attorney is released to the agent? The Elder Law attorney must be cognizant of these potential issues whenever a decision is made to retain an executed Power of Attorney.

"It is clear to me that holding on to original Durable Powers of Attorney can be dangerous for the attorney."

Glen A. Yale has written an excellent article on these issues entitled, "It's Right to Be Left, Holding the Power of Attorney," published in *Probate and Property*, January/February 2003. In his article, he makes the following points:

1. Before releasing a Durable Power of Attorney to an agent, diligence must be used by the attorney to verify that the principal wants the document released or lacks the ability to specify it.
2. A Springing Power of Attorney may offer an alternative solution. On the other hand, more issues may arise including proving that the Durable Power of Attorney has sprung and/or getting third parties to accept the document.
3. The attorney should receive written instructions from the principal at the time of the execution of the document as to when to release the Durable Power of Attorney.
4. The client can execute a Power of Attorney Escrow Letter which is a "Durable Special Power of Attorney" appointing the attorney to act for the limited purpose of holding the Durable Power of Attorney until releasing it as specifically instructed. Mr. Yale suggests that the use of this document will benefit both clients and their attorneys. Clients may be more willing to sign the document knowing that it will held by the attorney and will be released under specified circumstances. The attorney can be comfortable that the Durable Power of Attorney can be handled in a manner that complies with representing the client's interests in accordance with the rule of professional responsibility. Mr. Yale includes a form of Special Power of Attorney Escrow Letter with his article.

An Argument for "Not Holding On to Originals"

It is clear to me that holding on to original Durable Powers of Attorney can be dangerous for the attorney. Yes, in certain situations, the attorney can provide a service to a client who needs the attorney to protect the interests of the client—the principal of the Durable Power of Attorney.

Notwithstanding, in the vast majority of the cases, the attorney would be taking on a responsibility which contain significant risks of negligence and malpractice. If the attorney was to take on this responsibility, then I would suggest that the Escrow Letter as outlined by Glen Yale should be a necessary part of the execution of the Durable Power of Attorney. The attorney should charge the client for this added service. Should the charge be merely for the drafting of the document? How will the attorney be paid for the time expended in determining whether the Durable Power of Attorney should be released? If the attorney decides not to release the Durable Power of Attorney, who will pay for his time? Who will blame him for his failure to act?

I can think of numerous situations that can arise which will make this task daunting. Our current office policy is that we will *not* hold original Durable Powers of Attorney for our clients. Years ago, we did. We stopped when we encountered difficult situations, as mentioned above.

For example, we had the "race to the office." We drafted a Durable Power of Attorney which had co-agents, a son and daughter. The son called asking for the original and wanted to come over to our office later that day. An hour later the daughter called for the Durable Power of Attorney. She told us not to release it to her brother but only to her and told us we would be held liable if we released the Durable Power of Attorney to her brother. We then contacted their mother—the principal under the Durable Power of Attorney. She was in the hospital, having suffered a stroke. It appeared to us that she was not clear in her thinking when we asked her what to do. What would have happened if we released the Durable Power of Attorney to the son? How about to the daughter? Who would blame us for not releasing the document—the mother, the son, the daughter, all of them?

Recently a child called me asking for the original Durable Power of Attorney of his father, who—the son told me—was now mentally incapacitated. If I had the original, there would have been a number of steps for me to take (as outlined above). Didn't the father trust his son when he signed the Durable Power of Attorney? If not, he should not have signed the document. What does it mean? What should I do as the attorney? What a relief to say we did not have the originals and we have documentation that we gave them to his father (two originals in fact). I asked the son if his father gave him one of the originals or did his father communicate to him as to where the originals are (as we suggested at our Document Execution Meeting). The son was upset that we did not have the originals, then he calmed down as I explained our office policy and why. We offered to help him deal with his father's crisis and advised him that we would be happy to meet with him and his dad to determine the best course of action. We made it clear that we would need to meet with Dad (our client) before we could proceed. As a side note, our engagement agreements provide that we can discuss and share information and documents and implement planning on behalf of the client through designated persons, such as family members or agents under Advance Directives, if the client so desires.

The key for the Elder Law attorney is to explore these issues and make a policy decision as to how you want to handle the storing and releasing of original documents—if you take that responsibility on at all. My parting advice: BE CAREFUL!

Vincent J. Russo, J.D., LL.M., CELA, Managing Shareholder of the Long Island Law Firm of Vincent J. Russo & Associates, P.C. of Westbury, Islandia, Lido Beach and Smithtown, New York, has a Masters of Law in Taxation, and is admitted to the New York, Massachusetts and Florida state Bars. He is the Co-Author of *NEW YORK ELDER LAW PRACTICE*, published by West Publications, *When Someone Dies in New York* and *A Will Is Not Enough In New York*. Mr. Russo is a Founding Member and Past Chair of the Elder Law Section, New York State Bar Association and is currently Co-Chair of the Section's Special Committee on Medicaid Legislation. He is a Founding Member, Fellow and Past President of the National Academy of Elder Law Attorneys (NAELA) and Co-Founder of the Theresa Alessandra Russo Foundation which supports children with disabilities.

Fair Hearing News

By Ellice Fatoullah and René Reixach

We actively solicit receipt of your fair hearing decisions. Please share your experiences with the rest of the Elder Law Section and send your Fair Hearing decisions to either Ellice Fatoullah, Esq., at Fatoullah Associates, Two Park Avenue, New York, New York 10016 or René H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street, Rochester, New York 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.

In re the Appeal of G. L.

Ellice Fatoullah

Holding

Appellant's gifting of her home in suburban Buffalo to her two children without consideration was effective when the deed was executed in Florida and delivered to her daughter there in 1998, even though the deed was not recorded until 2002. Thus the denial of a Medicaid application in 2002 was incorrect since the transfer occurred outside the 36-month look-back period.

Facts

An application for Medical Assistance was filed on September 12, 2002 to cover the costs of the Appellant's care in a skilled nursing facility, where she had resided since April 15, 2002. The Appellant is 88 years of age.

While the Appellant was in Florida, she signed a Quit Claim Deed on January 17, 1998 conveying ownership of her home in suburban Buffalo to her two children for consideration of $1.00. The deed was witnessed by two individuals, one of whom notarized the Appellant's signature.

On September 10, 2002, the Appellant's daughter, one of the donees of the gifted home, recorded the deed in the Erie County Clerk's office.

By Notice dated November 27, 2002, the Agency determined to deny the application on the ground that the house valued at $59,900 had been transferred by the Appellant on September 10, 2002 for less than fair market value. The Agency determined to impose a penalty period of eleven months, during which the Appellant would be ineligible for Medicaid coverage for the cost of nursing facility services. The agency determined this by dividing the $59,900 uncompensated value of the transferred assets by $5,393, the applicable regional penalty rate.

On December 9, 2002, the Appellant requested a fair hearing to review the Agency's determination.

René H. Reixach

Applicable Law

Sections 360-4.1 and 360-4.8(b) of Title 18 of the New York Compilation of Codes, Rules and Regulations (N.Y.C.R.R., referred to herein as "the Regulations") provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated. A Medicaid applicant or recipient whose available non-exempt resources exceed the resource standard will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Section 366.5(d) of the Social Services Law and section 360-4.4(c)(2) of the Regulations govern transfers of assets made by an applicant or recipient (or his or her spouse) on or after August 11, 1993. Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, any transfer of assets for less than fair market value made by the person or his or her spouse within or after the "look-back period" will render the person ineligible for nursing facility services.

The "look-back period" is the 36-month period immediately preceding the date that a person receiving nursing facility services is both institutionalized and has applied for Medicaid. However, in the case of payments to or from a trust which may be deemed assets transferred by an applicant or recipient, the "look-back period" shall be a 60-month period instead of the 36-month period. A person is institutionalized if a patient in a nursing facility, or in a medical facility receiving the level of care in a nursing facility, or if the person is receiving waivered services.

A transfer for less than fair market value, unless it meets an exception not relevant here, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies or recertifies for Medicaid as an institutionalized person.

New York Real Property Law section 244 provides: "A grant takes effect, so as to vest the estate or interest intended to be conveyed, only from its delivery; and all the rules of law, now in force, in respect to the delivery of deeds, applies to the grants hereafter executed."

Discussion

The Agency's determination that the Appellant was not eligible for Medicaid because she transferred assets for less than fair market value was not correct.

The uncontroverted documentary evidence established that the Appellant executed a Quit Claim Deed on January 17, 1998, transferring her property interest in her home for less than fair market value to her two children. The Appellant's daughter actually recorded this deed in Erie County on September 10, 2002, two days before the Appellant's Medicaid application was filed. The Agency specifically determined that the date of transfer occurred on the date the deed was recorded, and evaluated eligibility accordingly.

The Appellant's daughter testified that she resides in Florida, and that the deed was executed when the Appellant was visiting in January 1998. She further testified that the deed was physically delivered to her in January 1998, but that she did not actually record the deed until the house was being put up for sale.

Under the New York Real Property Law, a grant takes effect from the date of delivery. The daughter's testimony as to the delivery date of the deed in January 1998 was plausible, since it is consistent with the date of execution. The testimony also was unimpeached at the hearing. The Agency must now take this information into account.

Accordingly, since the date of transfer occurred in January 1998, which was prior to the 36-month look-back period, the Agency's finding of ineligibility cannot be sustained.

Fair Hearing Decision

The Agency's determination to deny the Appellant's application for Medicaid benefits for nursing facility services because the Appellant is ineligible therefore, having transferred an asset for less than fair market value, is not correct and is reversed. The Agency is directed to reevaluate the Appellant's application for Medicaid taking into account that the transfer of the home occurred prior to the 36-month look-back period. The Agency is directed to provide Medicaid coverage to the Appellant in accordance with verified medical need in the event she is otherwise eligible for such benefits and to notify the Appellant and her representatives of its determination.

Editors' Comment

This decision correctly applies the provisions of the Real Property Law concerning gifts of real property taking effect on the date of delivery of the deed. This is a useful reminder of this rule, one which counsel for the Appellant advises that no other Decisions after Fair Hearing were located despite considerable discussion about this on an elder law listserve.

As a practical matter, this problem may be avoided by recording deeds promptly after they are executed and delivered. Even then, if the recording occurs in the month after execution and delivery, it is possible that a local agency will draw the same erroneous conclusion as did the local agency here, although the consequences will be much less severe if the delay only amounts to a month rather than over four years. While the Decision does not discuss at length the facts supporting the finding that the testimony about delivery of the deed was credible, one suspects that the fact that the daughter was out of state was critical.

The Appellant at this Fair Hearing was represented by **Joseph F. Gervase, Jr., Esq.**, of Diebold & Farmelo, P.C., in Buffalo, New York.

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, CT. She is Chair of the Litigation Committee of the New York State Bar Association's Elder Law Section, a Fellow of the National Academy of Elder Law Attorneys, on the Executive Committee of the Elder Law Section of the Connecticut Bar Association, and a Board Member of FRIA, a New York City advocacy group monitoring quality-of-care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimer's Association - NYC Chapter, and a member of its board for seven years. In addition, Ms. Fatoullah was appointed to serve on the New York State Task Force on Long-Term Care Financing, an advisory group created by Governor Pataki and the New York State legislature to study long-term care reform. She has taught Health Law at both Columbia and New York University Schools of Law, and litigation skills at Harvard Law School. She writes and lectures regularly on issues of concern to the elderly and the disabled. In 2002, the New York State Bar Association's Elder Law Section awarded her their first "Outstanding Practitioner Award". . ."in recognition of her dedication and achievements in the practice of Elder law."

René H. Reixach is an attorney in the law firm of Woods Oviatt Gilman LLP, where he is a member of the firm's Health Care Law practice group and responsible for handling all health care issues. He is Chair of the Committee on Insurance for the Elderly of the New York State Bar Association's Elder Law Section. Prior to joining Woods Oviatt, Mr. Reixach was the Executive Director of the Finger Lakes Health Systems Agency. Mr. Reixach authors a monthly health column in the *Rochester Business Journal* and has written for other professional, trade and business publications. He has lectured frequently on health care topics. Mr. Reixach has been an Adjunct Assistant Professor in the Department of Health Science at SUNY Brockport. He also appeared as an expert witness on Medicaid eligibility for the New York State Supreme Court. Mr. Reixach also has served on many advisory committees, including the New York State Department of Health Certificate of Need Reform Advisory Committee and the Community Coalition for Long Term Care. Among Mr. Reixach's civic and charitable involvements are serving as a Board Member and President of the Foundation of the Monroe County Bar, President of the Greater Upstate Law Project, and a Board Member of the Yale Alumni Corporation of Rochester.

Elder Care News

Never Too Young to Understand, Never Too Old to Ask Why: Alzheimer's Disease—A Family Matter

By Barbara Wolford

As the number of people afflicted with Alzheimer's disease (AD) increases, there will be an increase in the number of children who have family members that are caregivers for a family member or loved one that has been diagnosed with AD. Many children will have grandparents or relatives who live in close proximity or perhaps in the same home. Research and support services focus on the caregiver, but most do not address the impact of the disease on young children and teenagers. Often there are few noticeable physical symptoms and, in a child's eyes, the person appears the same. It can be a great loss to watch a grandparent whom you love forget who you are and become more helpless.

Alzheimer's disease affects the entire family, young and old. Children can be affected in both positive and negative ways. It is the natural tendency for caregivers to protect our children from unhappy and distressing events that our loved ones are encountering. No family is ever prepared for a life-threatening or chronic disease that begins to decimate the entire family structure. When someone in the family has AD, children and teens can receive less attention, experience ongoing changes to their routines and be asked to become involved in the caregiving needs of that loved one. Each family, each client and each set of circumstances are unique and individual to that family unit.

When I decided to research the topic of the impact of the disease on children, I knew I needed to start with my own children. I had cared for my dad until his death from AD in 2001. My children were very much involved and engaged in my caregiving efforts. I wanted to learn what their reactions, emotions and feelings were about their grandfather, his disease and the impact it had on their lives.

My 12-year-old son, when asked to tell me about his feelings for this article, queried if this was going to be on the front page—when I questioned him as to why that was important; he responded, "because everyone needs to know how bad this disease is and how we need to find a cure very soon."

"I knew grandpa was sick when he no longer knew my name, we couldn't do many things together and he couldn't remember things. Alzheimer's disease is about forgetting things, but much worse than forgetting to do your homework. Having grandpa at home was a good thing and a bad thing. It was nice that we could visit him whenever we wanted and if he got real sick we could just go to his house to take care of him. It was very bad at times because we didn't know what to do for him or how to help him when he got very mad or couldn't take care of himself.

"I knew grandpa was sick when he no longer knew my name. . . . Alzheimer's disease is about forgetting things, but much worse than forgetting to do your homework."

"Another good thing was that I was able to watch you take care of Poppa and I would want to take care of you the same way, but it would be very frustrating to spend so much time taking care of someone that forgot your name.

"Mom, you were always so stressed. I called you the 'human stressoid.' I know this is hard and may hurt your feelings, but you were not always very tolerant of my sister and me.

"If I knew Poppa was going to get AD, I would have spent more time with him. It makes me sad that he won't be around for my wedding. But, you know what, he really will be—because I'm getting married outside and he could be in the sky watching!"

Although my daughter is 12 years older than my son and had a very active role in assisting me with caregiving responsibilities, some of her thoughts, although more sophisticated were parallel to my son's.

"I can remember the day that it all sunk in for me. I knew that something was not right. I always

laughed when my grandfather called me by a name other than my own, or when he laughed one minute and the next minute yelled over nothing in particular. However, the day that I knew things were really wrong was the day I drove him to the dermatologist. I was running late and needed to get him to the doctor by 3:00. Class at the college ran over and I was dying to just get home. We went to the doctor, which took a mere five minutes. When we got back into the car I asked, "Is there anywhere else you need to go, Poppa, before we head back?" "No I am fine," he said. "But why are you in this lane? Get in the right hand lane," he demanded. "GRANDPA," I said in a firm voice; "I cannot get into that lane, there are several cars, I will hit them." He quieted down and seemed satisfied with my answer and I kept driving. Seconds later, he looked at me and then the steering wheel. He gazed into my eyes and then suddenly he grabbed the steering wheel. He pulled with all his might as I tried to pull back. The car jerked back and forth and, within seconds, we were in the right-hand lane. He stared out the window and did not say a word. The tears poured down my cheeks; I was so scared and nervous, I dropped him off and went right home. I wanted to call my mother so badly and cry, but I was scared. Scared that the family would turn against him. Scared that no one would trust him. Scared that I would not be able to be around him alone. More importantly, scared that everything he had would be taken away from him because of one simple mistake. I thought for a while and realized that my grandfather was not right, he was not the man that I loved so much or the man that I loved to be with, instead he was the man that I was now most fearful of.

"Within days, my grandfather was diagnosed with Alzheimer's and Parkinson's disease, end stages. What did this mean? What was going to happen to my family? What was going to happen to him? Days and weeks went by and my grandfather's health worsened. He could barely even make his own lunch. He called constantly, asking for something or what to do or how to make something. My family decided that bringing in a nurse would be the best option for him—he needed the help and so did we.

"As a grandchild dealing with a grandparent who had this disease, there were so many emotions running through my mind and body. Every day I felt a need, a want and an obligation to go to the house and see him. I felt a need to be there in the morning before school and classes in the afternoon. I felt this need not only as a loving, caring granddaughter giving back, but also as a loving, caring daughter trying to help her mother. My mom worked at least eight hours a day and even though there were full-time nurses at the house, she still always felt like she needed to be there. To try to relieve this stress I felt I needed to be there to help, because maybe if I was there she would go home and be with the family. As a fast-growing adult, I was obsessed with trying to alleviate this stress from my mother's hands. Whatever it was, I was going to do it just so that maybe she would not have to. My grandfather got worse and the time at the house became more and more. I felt like I was slowly losing my grandfather and quickly losing my mother.

"My obsession became greater and greater, to the point that I was spiraling out of control. But not once did I stop, because I owed it to my grandfather and my mother—they had done so much for me in my twenty years of life. As he got worse, I began to realize that there was no turning back. I began to realize that someday I would be doing this all over again with my mother and father. I fell into a deep depression. Every time I saw him lying in bed reaching for invisible objects in the air, I thought, "this is going to be my mother or father someday." I realized that I am going to lose them too!

"Being a grandchild of a grandparent that suffered from Alzheimer's is tough! I think one of the hardest things to deal with is watching someone you love deteriorate for so long and so slowly."

"Children, at some point, think about losing their parents someday. We never think why or how, just that someday they will no longer be with us. I was now scared of losing my grandfather and someday losing my parents. My reality sank in and I questioned my life, who I was and my relationships with my family. I often thought about running away and hating my family, just so that when they died it would not be so hard. I started to convince myself that I was crazy!!! Then I started talking to my younger brother and friends and realized that they had the same feelings when they experienced the death of their grandparents. The only way I got through these feelings and emotions was honesty. Honesty with my family and honesty within myself. If it was not for talking out how we felt, I am not sure any of us would have gotten through it.

"Being a grandchild of a grandparent that suffered from Alzheimer's is tough! I think one of the hardest things to deal with is watching someone you love deteriorate for so long and so slowly. To watch a family fall apart and then pull back together again is one of the factors of dealing with a family member with Alzheimer's. As a child, all I wanted was open

communication with my family. Moreover, my family gave us all open lines, to every fact of the disease. My mother told me the truth and let me in on all the doctor's thoughts and recommendations. My father listened to how I felt and helped my mother and me with how we felt. I was part of his every breathing moment and that, I think, was the key to dealing with the disease. If the lines of communication were shut or my family felt that I should not see him like that, I think I would never have understood. To be able to take care of him and just sit with him allowed me to appreciate the disease that much better."

After listening to my children's thoughts, feelings and experiences, I wondered how I could have better prepared them and helped then on this journey. I also thought that I could draw on our family experiences to help the clients that I deal with who may be facing some of the same challenges.

Researcher Dr. James McCrea believes that one of the most common mistakes families make is sheltering the youngest members of the family. "Young people can be extremely caring and resourceful, once they understand what is happening." Children will deal differently dependent on their age, stage of development and how important the person with dementia is in their lives and how often they interact with that person. At a time when they are trying to cope with their own growing up, they find they are trying to cope with an ill family member.

We need to realize that children also have a relationship with the loved one that is changing, and it may not be easy for them to express their feelings or even begin to have the ability to comprehend what is occurring within their family structure. It is hard enough to comprehend as an adult, to explain to oneself what the disease is doing to our loved one—let alone to be a child who is losing a loved one and having a parent at times overcome with the caregiving responsibilities for that loved one. The child is also dealing with a changing relationship with the parent that is caring for a loved one with a life-altering disease. The caregiver is spending more time with the grandparent and less time with them, they may feel that they are competing with their own grandparent for their parent's time and attention. In response to this situation, the child may take on more work around the house to alleviate their parent's workload, but this can also prove to have a positive outcome and allow them to feel more needed, valued and understanding of the needs of people with illnesses.

The Alzheimer's Association literature states that being a child of a loved one with AD, is difficult: relationships are being redefined, the person you love is becoming more dependent on others and you are losing that loved one more and more each day. A long grieving process has begun.

Educating ourselves and our children to normal aging is paramount. It is never too early to begin the education process. Alzheimer's disease and dementia is not a normal part of aging. We all forget people's names or the names of objects (my kids are growing accustomed to me calling items "things"). The difference between forgetfulness and memory loss is that we know what car keys are used for and the person with AD doesn't know what to do with the car keys.

How can we best help our children to understand what is happening with their loved one? How can we explain that grandpa no longer recognizes them, has forgotten their names and can no longer take care of himself? As a parent, it is crucial to keep the lines of communication open, to be honest and candid about the behavior changes that are transpiring. A line needs to be drawn between being honest, but not frightening or overwhelming them with scientific explanations or details that are not age-appropriate or that are more than they can handle. Honest explanations in language that they understand can reduce their fears. Listening and watching their reactions carefully is key to supporting and understanding their feelings. Often children will let you know how much they can handle and when they are open to listening. Perhaps one way to illustrate the disease to a young child is to have the child imagine that they have become separated from their classmates on a school trip and don't know where they are. Allow them to explore the feelings that they would be feeling and let them know that this could be how it feels to have Alzheimer's disease.

Helping teenagers understand the disease could be sharing the reality exercise below with them:

Teenager's reality	***Alzheimer's patient's reality***
Getting your driver's license	**Having to give up your driver's license**
Leaving home to go to college	**No longer being able to live independently**
Finding your lifelong companion	**Forgetting your spouse's name**
Studying and doing homework	**Not remembering the date and year**
Picking out new clothes	**Forgetting how to get dressed**

Children can react in a number of ways to the changes in the family environment. You may notice that your child is becoming withdrawn and doesn't want to interact with friends. Perhaps the opposite is occurring and your child never wants to be at home anymore. Like you, they may easily lose their patience or appear depressed. Children often don't talk about their feelings, but act them out instead. You may notice an increase of psychosomatic illnesses or not wanting to talk about what is bothering them. My children are still very concerned that I will acquire "Poppa's disease" and they will become my caregivers. I think one of the hardest things about being a caregiver is trying to preserve the integrity of the entire family by balancing everyone's needs, particularly the child's, in the midst of a busy and ever-changing household. As caregivers, we are constantly being told to "take care of ourselves," but we become overwhelmed with making sure our children are not getting lost in the process. I often felt that I needed to be the strong one, so that my family would not perceive me as weak. I didn't want them to see me lose my patience, admit to exhaustion or burden them with my caregiving responsibilities. It was important to me to try and keep some sort of normalcy to our family life, despite the turmoil that AD was creating. Trying to maintain family structure, as much as possible, will help to give your child a sense of security. You need to be willing to listen and to deal with family conflicts and problems when they occur, trying not to brush the problem "under the rug." There is not always the opportunity to wait until a more convenient time. Your attitude and way of explaining why your loved one is suffering will almost totally shape how a child reacts and behaves around an ill family member.

Some children need to be reminded that they did not do anything wrong, and that this disease is not contagious. They may appear embarrassed among their friends and no longer want to have friends visit.

There are many ways that children can engage in activities with their loved one that can enhance the time they spend together. Family members with AD often want to tell stories of long ago. What better way to preserve these memories than to record these stories for future generations? Many children are able to learn valuable life lessons and history from these stories. Music was an integral part of my dad's life. My children listened to music, pretending to be playing instruments and singing out loud. I will cherish these memories of their songfests. Early in the disease, activities that some may have thought to be childish engaged my dad for hours. My kids colored, played cards and helped him with word searches. Not only did these activities help to stimulate him, they created an opportunity for me to spend quality time with my dad and my kids. When dad was still able to walk, my son loved to take him for walks outside, around the yard and garden. I also knew there would be times when they didn't want to spend time with Poppa and respected their wishes.

It is also imperative to allow your children to express their feelings and to take time to listen to what they are saying. Remember to speak the words to your children about how much you care, because sometimes your actions don't speak loudly enough. Allow your children to help you improve the quality of life of their loved one affected by this disease. We need to keep them a part of our lives. You will find that both generations may be able to share enjoyable time together.

Ultimately, only you know what is right for you and your family, there is no right or wrong way to show your children how to be caregivers. Our role modeling is more important than finding the right answers to all our questions. Nowhere do actions speak louder than words than in a situation like this—weathering the Alzheimer's storm.

Some suggested reading for children:

- *Winifred Gordon McDonald Partridge* by Mem Fox
- *Grandpa Doesn't Know Me* by Miriam Aronson
- *The Terrible Thing That Happened at Our House* by Marge Blaine
- *When Meme Came to Live at Our House* by Mary Langdon
- *Through Tara's Eyes* by K. Bauman
- *The Memory Box* by Mary Bahe
- *Helping Children and Teens Understand Alzheimer's Disease*, published by the Alzheimer's Association

"People will forget what you said, people will forget what you did, but people will never forget how you made them feel." Author unknown

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GUARDIANSHIP NEWS

By Robert Kruger

Introduction

I am pleased, in this issue, to introduce one of the Vice-Chairs of the Committee on Guardianships and Fiduciaries, Anthony J. Enea, whose article below on Medicaid planning in the guardianship context is well worth reading.

Utilizing Article 81 for Medicaid and Estate Planning Purposes

In large part, as a result of the ingenuity and foresight of the legislature, the bar and the judiciary, Article 81 of the Mental Hygiene Law has, in my opinion, evolved into a highly effective Medicaid and estate planning tool. Whether it is the courts authorizing a Guardian to renounce an inheritance or authorizing a transfer of assets for purposes of facilitating Medicaid planning, Article 81 of the Mental Hygiene Law plays a critical role in planning for the incapacitated person and his or her dependents.

Article 81.21's Statutory Recognition of the Common Law Doctrine of Substituted Judgment

In order to give the reader a flavor of the statutory framework of Article 81, the following is a summary of its provisions which are of relevance to the authority given a Guardian to engage in Medicaid and estate planning. Article 81.21(a) of the Mental Hygiene Law (MHL) provides that the court may authorize the Guardian to exercise the powers necessary and sufficient to manage the property and financial affairs for the support and maintenance of the incapacitated person and those dependent upon the incapacitated person. The exercise of the powers must be consistent with the functional limitations of the incapacitated person, and his or her appreciation of the consequences and potential harm resulting from his or her inability to manage property and financial affairs. In exercising the powers the Guardian must give consideration to the wishes and preferences of the incapacitated person and the least restrictive form of intervention. Fashioning the powers of the Guardian in a manner that will insure the least restrictive intervention to the rights and liberties of the incapacitated person is given a high priority by the courts.

Article 81.21(a) of the MHL further provides that the transfers may be in any form that the incapacitated person could have employed if he or she had the requisite capacity, with the exception of the execution of a new Will or a Codicil for the incapacitated person.

Article 81.21(a) of the MHL further provides that the powers which may be granted include, but are not limited to, the power to:

1. Make gifts;
2. Provide support for persons dependent upon the incapacitated person for support, whether or not the incapacitated person is legally obligated to provide that support;
3. Convey or release contingent and expectant interests in property, including marital property rights and any right of survivorship incidental to joint tenancy or tenancy by the entirety;
4. Exercise or release powers held by the incapacitated person as trustee, personal representative, guardian for minor, guardian, or donee of a power of appointment;
5. Enter into contracts;
6. Create revocable or irrevocable trusts of property for the estate which may extend beyond the incapacity or life of the incapacitated person;
7. Exercise options of the incapacitated person to purchase securities or other property;
8. Exercise rights to elect options and change beneficiaries under insurance and annuity policies and to surrender the policies for their cash value;

9. Exercise any right to an elective share in the estate of the incapacitated person's deceased spouse;

10. Renounce or disclaim any interest by testate or intestate succession or by inter vivos transfer consistent with paragraph (c) of Section 2-1.11 of the Estates, Powers and Trusts Law of New York;

11. Authorize access to or release of confidential records; and

12. Apply for government and private benefits.

As is appropriately noted in the Law Revision Commission Comments to Section 81.21 of the MHL, the above-stated list of powers is intended to be illustrative rather than exclusive. But more importantly, the Commission correctly recognized that Section 81.21 gives statutory recognition to the common law doctrine of substituted judgment which is recognized by the courts in New York and other jurisdictions. An example of the utilization of this doctrine is the Court's decision in *In re Florence*, 140 Misc. 2d 393, 530 N.Y.S.2d 986. Simply stated, the Guardian, utilizing the power to engage in property management for the incapacitated person, including the power to transfer assets of the incapacitated person to another person, may be authorized to undertake the acts that the incapacitated person could have if he or she had the capacity to do so.

The courts in New York have been quick to employ the doctrine of substituted judgment, by granting Guardians the authority to transfer the assets of the incapacitated person in a varied set of circumstances. However, before the Guardian is permitted to transfer the assets of his or her Ward, there are several factors delineated in Section 81.21(b) which must be addressed in the Petition requesting the transfer of assets and which are considered by the court before ruling upon the requested transfer.

Factors Considered by the Court

Illustrative of the information that needs to be disclosed in the Petition pursuant to the provision of 81.21(b) of the MHL is:

> (a) Whether the disposition is consistent with any known testamentary plan or pattern of gifts. The Petitioner requesting the transfer of assets should articulate all of documentary proof whether it be contained in a Last Will, Revocable or Irrevocable Trust or any other writing in which the incapacitated has previously expressed an intention to transfer his or assets in a manner that is consistent with or similar to the transfers requested in the Petition;
>
> (b) Whether the incapacitated person expressed or manifested any intention that is inconsistent with the proposed disposition;
>
> (c) Whether the incapacitated person has engaged in making any significant gifts or pattern of gifts prior to his or her incapacity; and
>
> (d) Whether the incapacitated person has sufficient capacity to make the proposed disposition and if so his consent should be attached to the Petition.

In determining whether the court should approve the proposed transfer, the court pursuant to Section 81.21(d) of the MHL will consider among other things: (a) whether the incapacitated person has sufficient capacity to make the proposed disposition and if so, whether there has been consent; (b) whether the incapacitated person's disability will be of long or short duration; (c) whether the needs of the incapacitated person and his or her dependents or others depending upon him or her for support can be met from the assets remaining after the proposed transfer is made; (d) whether the proposed donees of the transfer are the natural objects of the incapacitated person's bounty; (e) whether the proposed transfers will produce tax savings which will benefit the Ward or his or her dependents; (f) whether the transfer is consistent with any known testamentary plan or pattern of gifts; and (g) any other factors that the court deems relevant.

Service of the Petition Upon Interested Persons

Section 81.21(a) of the MHL specifically delineates upon whom the Petition seeking the proposed transfer is to be served:

> (i) The persons entitled to notice in accordance with paragraph one of subdivision (d) of Section 81.07 of this Article. For example, spouse, if any, parents, if any, adult children, if any, etc.; and
>
> (ii) If known to the Petitioner or Guardian, the presumptive distribu-

tees of the incapacitated person as that term is defined in Section 103 of the Surrogate's Court Procedures Act, unless the court dispenses with such notice; and

(iii) If known to the Petitioner or Guardian, any person designated in the most recent Will or similar instrument of the incapacitated person as beneficiary whose sights or interests would be adversely affected by the relief requested in the Petition.

The incapacitated person's Last Will and any other documents of a testamentary nature executed should be carefully scrutinized to determine whom will be affected by the proposed transfer. It is not unusual to have one set of individuals who are interested parties for purposes of the Petition seeking the appointment of a Guardian, and a different group of individuals being interested parties for purposes of the Petition seeking the transfer of assets. Additionally, it is equally important that a determination be made whether any interested person is a person under a disability, which would require an appointment of a Guardian ad Litem to protect his or her interests with respect to the proposed transfer.

Required Findings to Be Made By Court to Grant the Petition

Section 81.21(e) of the Mental Hygiene Law specifies that prior to granting the Petition requesting a transfer of the incapacitated person's assets, the court must find by *clear and convincing evidence* and shall make a record of the following findings (emphasis added):

1. The incapacitated person lacks the requisite mental capacity to perform the act or acts for which approval has been sought and is not likely to regain such capacity within a reasonable period of time or, if the incapacitated person has the requisite capacity, that he or she consents to the proposed disposition;

2. A competent, reasonable individual in the position of the incapacitated person would be likely to perform the act or acts under the same circumstances; and

3. The incapacitated person has not manifested an intention inconsistent with the performance of the act or acts for which approval has been sought at some earlier time when he or she had the requisite capacity or, if such intention was manifested, what is the likelihood he or she would have changed such intention under the circumstances existing at the time of the filing of the Petition. Clearly, these are factual issues that will require an investigation by counsel for the Petitioner.

Clearly, the legislature's incorporation of the judicial doctrine of substituted judgment in Section 81.21(e)(2) of the MHL was imperative in allowing both the elder law practitioner and the judiciary to be as creative and pragmatic as possible with respect to the transfer of assets for Medicaid and estate planning purposes.

Before discussing some of the case law illustrative of the Medicaid and estate planning that has been permitted pursuant to Section 81.21 of the MHL, I direct your attention to Sections 81.16(b) and 81.22 of the MHL, which authorize the court to direct or ratify any transaction to establish protective arrangements including a trust (revocable or irrevocable) which may even extend beyond the life of the incapacitated person. These sections are often neglected provisions of Article 81, which the attorney can look to when confronted with Medicaid or estate planning issues for an incapacitated person, and where a Supplemental Needs Trust may be appropriate.

Relevant Case Law Regarding Transfer of Assets Requests by Guardians Under Article 81

Commencing in 1994, the genesis of the judiciary's willingness to expansively interpret Article 81 began to take form. The following cases are merely illustrative of the scope and breadth of the judiciary's recognition of the doctrine of substituted judgment.

A. *In re Klapper*, N.Y.L.J., Aug. 9, 1994, p. 26, col. 1 (Sup. Ct., Kings Co.)

The son/Guardian of a nursing home resident (his mother) sought permission to transfer the majority of mother's assets (approximately $340,000) to his family. The Court held that use of such Medicaid planning is legally permissible and the transfer for purpose of Medicaid planning would not violate public policy. In reaching its decision, the Court found that the mother had an extensive history of consistently providing financial support to her son

and his family. The Court noted that the annual expenses of the son and his family were approximately $62,400 per year; however, the annual income was approximately $43,000, a shortfall of $19,000, per year or $1,500 per month.

The Court determined that there is no question that the use of such Medicaid planning by competent persons is legally permissible and that proper planning benefits their estates. The Court opined that transfers for the purpose of Medicaid planning do not violate public policy. Rather, it appears to be the intention of Article 81 to permit such a transfer. The Court opined that the fundamental policy underlying Article 81 is to assist the incapacitated person to compensate for his or her limitations and to provide the least restrictive alternative. In order to effectuate this policy, an incapacitated person should be permitted to have the same options available relevant to transfers of property that are similarly available to competent individuals.

B. *In re Cooper (Daniels)*, 162 Misc. 2d 840, 618 N.Y.S.2d 499 (Suffolk Co. 1994)

The sister/Guardian of an incapacitated person sought authority to (a) renounce her Ward's share in his deceased wife's estate, (b) transfer the assets of a bank account to the Ward's two children, ages 20 and 23, and (c) transfer the Ward's real property to her 20-year-old child. The Court held that a competent, reasonable individual . . . would prefer that his property pass to his child rather than serve as payment for Medicaid and nursing home care bills where a choice is available. The Court further found that denying an incompetent person, through her Guardian, the same rights to conduct Medicaid planning that are available to any competent person in the state of New York would achieve a result in direct contravention of the expressed intention of Article 81.

The Court allowed the requested renunciation and transfer of assets, while requiring retention of sufficient funds in the guardianship to pay for the nursing home care during the Medicaid penalty period. The Court further allowed the transfer of real property to the 20-year-old child, relying on Social Services Law § 366 (5)(d)(3)(I)(B) which permits the transfer of a home to a child under the age of 21 without negatively affecting Medicaid eligibility.

C. *In re Parnes*, N.Y.L.J., Nov. 2, 1994, p. 32, col. 2 (Sup. Ct., Kings Co.)

The Petitioner requested permission to transfer $150,000 in liquid assets of an incapacitated nursing home resident to her husband (who had liquid assets totaling $345,000) as well as the transfer of the incapacitated person's share of a jointly owned house ($110,000). The Court held that the transfer would aid the husband in meeting his own household and medical expenses and in providing to his incapacitated spouse services and items not covered by Medicaid. The Court granted the application, even in the absence of any evidence that the Ward had ever contributed to her husband's support and in the absence of any evidence of pattern of gift giving. The Court also noted that a husband's exercise of spousal refusal would not violate public policy.

D. *In re DaRonco*, 167 Misc. 2d 140, 638 N.Y.S.2d 275 (1995)

The Conservator/wife of an incapacitated spouse sought to convert the conservatorship to a guardianship and to authorize the transfer of the entire incapacitated spouse's estate to herself, and to subsequently exercise a spousal refusal when applying for Medicaid. The Court granted the petition converting the conservatorship to a guardianship, and authorized the requested transfers. The Court determined that the cost of nursing home care for the Ward exceeded the Ward's monthly income and would eventually result in depletion of his entire estate in less than seven years. The Court further held that the spend-down of the incapacitated person's estate would eventually leave his wife/Guardian and minor son destitute. The Court also noted that, because the proposed transfers would be to a spouse, gift taxes would be avoided and no Medicaid penalty period would be incurred due to the spouse/Guardian's invocation of her spousal refusal rights pursuant to Social Services Law § 366(3)(a).

E. *In re Baird*, 167 Misc. 2d 526, 634 N.Y.S.2d 971 (1995)

The proposed Guardian sought to renounce part of the incapacitated person's interest in the estate of a deceased friend for Medicaid planning purposes. The Court held that the New York State Department of Social Services (DSS) was not a necessary party in the Article 81 proceeding. The Court cited MHL § 81.07(d)(1)(viii) for authority that the local DSS, and not the state DSS, is a party entitled to notice of the proceeding.

The Court held that the Guardian under Article 81 has the power to renounce part of the incapacitated person's interest in the estate of a deceased friend in order to provide funds to pay for nursing home costs during the Medicaid penalty period, while allowing the remaining funds to pass to her children and not be used for her nursing home expenses. The Court opined that a competent reasonable person would make the renunciation and that a person

involved in an Article 81 proceeding should have the same options available as a competent individual who has assets. Again, a clear invocation of the doctrine of substituted judgment.

F. *In re Shah*, 95 N.Y.2d 148, 711 N.Y.S.2d 824 (2000)

The Court of Appeals affirmed the decision of the Appellate Division, Second Department, which authorized the Guardian/spouse to transfer to herself the entire assets of her incapacitated spouse for the purpose of allowing her to then exercise a spousal refusal and make her spouse eligible for Medicaid, and to further be able to refuse to use those assets for support of her spouse.

G. *In re Banks*, N.Y.L.J., June 27, 2000 (Sup. Ct., N.Y. Co. 2000)

The Court allowed the Guardian of an incapacitated nursing home resident who had a large accumulated debt to be able to transfer one-half of $164,000 of her belatedly discovered assets to a pooled trust pursuant to Social Services Law § 366.2(b)(2)(iii)(B).

Section 366.2 of the Social Services Law permits the establishment of a pooled trust for an incapacitated person that is funded by one-half of the person's assets. The other one-half is spent down and then the person is eligible for Medicaid.

H. *In re John XX*, 226 A.D.2d 79, 652 N.Y.S.2d 329 (1996)

The Appellate Division affirmed the trial court's Order granting the Petition of an Article 81 Guardian to distribute certain assets of the incapacitated person to his adult daughters. The Court held that, subject to the provisions of Section 81.21 of the MHL, Guardians have the authority to effect transfers of assets for the purpose of rendering incapacitated persons Medicaid eligible.

The Court opined that a contrary conclusion would have the effect of depriving incapacitated persons of the range of options available to competent individuals. The Court further opined that the proposed transfer did not constitute a fraud on the Department of Social Services as a future creditor.

Conclusion

As the baby boomers come of age, and begin to face all of the medical and physical problems associated with aging, I am certain that reliance upon Article 81 and its body of case law will increase with greater frequency. The continued creativity of the elder law bar partnered with the willingness of the judiciary to broadly interpret Article 81 and the doctrine of substituted judgment will help insure that the rights of the incapacitated are not in any way compromised.

Anthony J. Enea

Once again, I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007; phone number: (212) 732-5556, fax: (212) 608-3785 and e-mail address: ***RobertKruger@aol.com.***

Robert Kruger

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1. The National Elder Law Foundation is not affiliated with any governmental authority. Certification is not a requirement for the practice of law in the state of New York and does not necessarily indicate greater competence than other attorneys experienced in this field of law.

Robert Kruger is the Chair of the Committee on Guardianships and Fiduciaries, Elder Law Section of the New York State Bar Association. He is also Chair of the Subcommittee on Financial Abuse of the Elderly, Trusts and Estates Section, New York State Bar Association. Mr. Kruger is an author of the chapter on guardianship judgments in *Guardianship Practice in New York State* (NYSBA 1997) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of the Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

National Case News

By Steven M. Ratner

This column addresses recent cases in jurisdictions other than New York. Questions or comments regarding this column can be sent to the author at smr_law@yahoo.com.

In re John M. Power, Supreme Court, Appellate Division of New York, December 9, 2003

This case involved an attorney who was publicly censured in both New York and New Jersey after running a misleading newspaper advertisement offering a seminar on living trusts for prospective clients.

The facts of this case were straightforward. John M. Power was admitted to the practice of law in the states of New York, New Jersey, and Florida. During this proceeding, Mr. Power maintained a law office in both New York and New Jersey. In April 2002, the Supreme Court of New Jersey reprimanded Power based upon his violation of Rule 7.1(a)(1) of the New Jersey Rules of Professional Conduct and Opinion 25 of the New Jersey Committee on Attorney Advertising.

New Jersey Rule of Professional Conduct 7.1 provides in relevant part: "A lawyer shall not make false or misleading communications about the lawyer, the lawyer's services, or any matter in which the lawyer has or seeks a professional involvement." The New Jersey Supreme Court found that the contents of Power's advertisements contained misstatements related to:

1. The costs, expenses, and time associated with the probate of a will;
2. The impact of having a living trust in the event of incapacitation;
3. The avoidance of probate by creation of a living trust;
4. Tax consequences relating to a living trust; and
5. The inadequacy of a will without a living trust in order to protect assets.

After the New Jersey Discipline Review Board concluded that Power's advertisement contained potentially misleading statements to future clients in violation of Rule 7.1, and that he should be required to take a course in Trusts and Estates, the New Jersey Supreme Court issued an order reprimanding Power and ordering him to obtain pre-approval of all proposed advertisements, solicitations, flyers and related communications for two years.

Since Power also maintained an office in New York, the First Department Disciplinary Committee started a proceeding seeking reciprocal discipline pursuant to 22 N.Y.C.R.R. § 603.3.

The Appellate Division took into account that sanctions for misleading advertising in the state of New York have ranged from censure to suspension, but ultimately imposed the same discipline that was imposed by New Jersey.

Ronald E. Hines v. Kentucky Bar Association, Supreme Court of Kentucky, December 30, 2003

In *Hines*, the Kentucky Supreme Court recently disciplined an attorney who violated the Kentucky Rules of Professional Conduct by commingling his client's property with his own.

This case involved an attorney, Ronald E. Hines, who represented James Howard Bell, an incapacitated person, in a guardianship proceeding. Bell took part in some fraudulent activity including writing a bad check for $38,000 in order to purchase a truck. After the check bounced, the dealership made Bell convey his 150-acre farm in exchange for the truck. When the guardian became aware of this exchange, she contacted Hines. Hines negotiated the return of the farm in exchange for the truck and approximately $11,000 cash. Rather than having the farm returned to Bell, the farm was deeded directly to Hines.

The Kentucky Rules of Professional Conduct SCR 3.130-1.15(a) provide in part that "a lawyer shall hold property of clients or third persons that is in the lawyer's possession in connection with a representation *separate* from the lawyer's own property."

By acquiring an interest in Bell's real estate, Hines clearly failed to keep his own property separate from Bell's property and was in violation of the Kentucky Rules of Professional Conduct.

One year after the transfer, Bell died and the court ordered Hines to transfer the farm to the Bell Estate. After appealing the district court's decision, Hines transferred the property back to the Bell Estate and further acknowledged that taking title to property in his name was a violation of duties owed to his client under the Kentucky Rules of Professional Conduct. Hines was publicly reprimanded and ordered to pay costs.

Margaret Gagliardo v. Paulette Caffrey, Illinois Appellate Court, November 7, 2003

In *Gagliardo*, an attorney was recently disqualified from a case because he violated the Illinois Rules of Professional Conduct by representing a client whose interests were adverse to those of a former client.

This case involved an attorney, Christopher Matern, who represented an estate for a limited time. By representing the estate, Matern owed a fiduciary duty to the estate and its sole beneficiary, the decedent's widow, Margaret. After representing the estate, Matern's firm was then hired by the decedent's sister, Paulette, for the purpose of helping her purchase interests in various family businesses from the estate.

Margaret filed a motion to disqualify Matern and his law firm from representing Paulette individually based upon Rules 1.7 and 1.9 of the Illinois Rules of Professional Conduct, which prohibit an attorney who has formerly represented a client in a matter from later representing another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client, unless the former client consents after disclosure.

The court ultimately found that Matern and his law firm must be disqualified from the case because he was in violation of the Illinois Rules of Professional Conduct. The court reasoned that in the limited time that he represented the estate, he was involved with matters crucial to the estate. Matern's involvement with the estate concerned estate finances. The court found a substantial relationship between Matern's former representation of the estate and his representation of Paulette. Therefore Margaret's motion to have Matern disqualified was granted.

Steven M. Ratner is the founder of the Law Office of Steven M. Ratner, P.C., a firm committed to serving the needs of the elderly, with offices in Manhattan and White Plains. Mr. Ratner is a frequent lecturer and author on issues within his practice areas and is the author of the Elder Law Chapter in the *New York Lawyer's Deskbook*.

Steven M. Ratner graduated from the University of Oregon School of Law where he was first in his class, a member of the Order of the Coif, and an Associate Editor of the *Oregon Law Review*. Mr. Ratner received an LL.M. in Taxation from New York University where he was a Student Editor of the *Tax Law Review* and the recipient of the Harry J. Rudnick Memorial Award.

Mr. Ratner's work experience includes a one-year clerkship with the Honorable Herbert Y.C. Choy of the United States Court of Appeals for the Ninth Circuit in Honolulu, Hawaii.

Snowbird News

Will Florida's Use of Escrow Agreements Work for New York Clients?

By Scott M. Solkoff

Three years ago, I introduced the use of escrow agreements to a conference of the Florida Bar's Elder Law Section. The escrow agreements have since proven a successful tool throughout the state of Florida and may work for your New York clients as well.

An escrow agreement is very similar to a trust agreement in that a fiduciary holds assets for the benefit of another. However, because escrow agreements are not trusts, the Medicaid trust rules should not apply. HCFA Transmittal No. 64 along with interpretive rules of the fifty states, are now relied upon to determine the treatment of trusts for Medicaid eligibility purposes, but these rules do not define a trust as the same as an escrow agreement. For this reason, escrow agreements may be used as a trust substitute without some of the negative consequences imposed by the Medicaid eligibility rules.

If monies are transferred to an escrow agreement and are available to the individual, any assets held in escrow would be "countable" to the extent of that availability. If, however, the escrowed funds are not available to the applicant or the applicant's spouse, they cannot properly be counted towards the Medicaid asset caps.

To the extent funds are transferred to an escrow agreement and anything less than fair market value is received in exchange for the transfer, the transfer would incur a period of ineligibility. If, however, assets are transferred into escrow and fair market value is received in exchange, there should be no period of Medicaid ineligibility.

In this way, the Medicaid transfer and asset rules apply the same to an escrow agreement as to trusts. If the money is available, it is counted to the extent of the availability. If the money is rendered unavailable, it is not counted as an asset but a transfer penalty is assessed unless fair market value is received in exchange for the transfer.

The main difference between an escrow agreement and a trust may be form over substance, but so are the Medicaid rules. Because an escrow agreement is not a trust, we have been successful in having a 36-month look-back instead of a 60-month look-back. Even more significantly, we have been able to lift the escrow agreement out of the trust policies. For the eligibility specialists with the Florida Department of Children and Families, the trust policies and rules are very complex. It again being form over substance, because the arrangement is an "escrow" arrangement and not a "trust" arrangement, the eligibility specialists have avoided reference to the trust rules. This is as much an issue of the psychology of eligibility determination as it is a legal one. We know that the case workers welcome a reason not to have to look at those pesky trust rules.

"The main difference between an escrow agreement and a trust may be form over substance, but so are the Medicaid rules."

We apply the escrow tool in a variety of contexts. In my office, we have used the escrow agreement as a condiment to a personal service contract. Other of my colleagues have used the same concept to accompany gifting strategies.

With a personal service contract, the elder normally pays a caregiver, often a child, a lump-sum payment in exchange for the caregiver's promise to take care of the elder for the remainder of the elder's life. The lump-sum payment is determined by taking into account the elder's life expectancy. This payment can often be a hefty six figures. When merged with an escrow concept, the elder pays a third-party escrow agent instead of the caregiver. An escrow agreement details the use of the funds, directing that the agent cannot use any of the funds for the elder. The agent would be given the authority to pay the caregiver, over scheduled payments, the escrowed funds. If the agent becomes unable to carry out the contracted-for services, the payments are made to an alternate caregiver.

There are a number of advantages to an escrow agreement when used with a personal service contract. For one thing, the caregiver's income tax liability may be greatly abated. Because the payments can be paid out over time, we maximize the deferral opportunity on the payment of income taxes and can use more than one tax year. Another cause for celebration is that of the guardianship court. If a personal service contract is done within a guardianship or conservatorship proceeding, the courts are often reluctant to authorize a lump-sum transfer to a child or other caregiver. With the escrow agreement, the court knows that the funds cannot be accessed other than on the agreed schedule of payments from the escrow agent to the caregiver. This allows for a much higher level of security, whether coming from the perspective of a judge or otherwise. Escrow agreements can also be used in conjunction with a gifting program. Gifts can be held "in escrow" until certain occurrences are met. This allows for enforced trust among siblings.

Escrow agreements can be used for a variety of reasons and, properly drafted, should not be counted as available assets for Medicaid eligibility purposes.

Scott M. Solkoff is Chair-Elect of the Florida Bar's Elder Law Section and a principal with Solkoff & Zellen, P.A., a law firm exclusively representing the interests of the elderly and disabled throughout Florida.

Request for Articles

If you have written an article, or have an idea for one, please contact *Elder Law Attorney* Editor

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Articles should be submitted on a 3-1/2" floppy disk, preferably in Microsoft Word or WordPerfect, along with a printed original and biographical information.

Bonus News 1

Nuts and Bolts of Long-Term Care Insurance

By Bernard A. Krooks

With annual long-term care costs ranging from $100,000 to $150,000 and more in the New York metropolitan area, a long-term chronic illness can have a devastating effect on a family's finances. Unfortunately, our country has no health insurance system for long-term care. In deciding who receives government-financed health care, we discriminate based on the type of illness a person has. If you have an acute illness such as heart disease or cancer, then you are covered under our system. However, if you have a chronic long-term illness such as Alzheimer's disease, Parkinson's or multiple sclerosis, then we provide little or no coverage.

Essentially, there are four ways to finance long-term care: 1) private pay, which can become extremely costly, 2) Medicare, which covers primarily hospital and physician care and provides extremely limited coverage for long-term care, 3) Medicaid, which is means-tested and has strict income and asset limitations, and 4) long-term care insurance (LTCI).

Many clients consider purchasing LTCI as a way to help defray the costs of a catastrophic illness. Therefore, attorneys should become familiar with the various types of LTCI policies available. Although LTCI has been around for more than a decade, the policies continue to evolve and lack standardization. As a result, because you may be comparing apples to oranges, it can be extremely difficult to analyze policies, each of which will have its own definitions and benefits. To help, set forth below are a few general principles and some of the terms that frequently appear in LTCI contracts.

Although a 65-year-old has a 43 percent chance of entering a nursing home, LTCI is not necessarily solely for your older clients. In fact, LTCI should be considered by all those with the financial means to purchase it. Sadly, about 40 percent of all patients receiving long-term care are under the age of 65. However, purchasing a policy at a young age is not without risk. Although the premiums will be lower, risks include:

- The possibility of significant changes in long-term care delivery systems;
- Policies may not be based on today's definitions of care;
- Policies may contain outdated and inflexible definitions for places of care;
- Premiums can be raised if the company increases rates for a class of beneficiaries;
- The claims-paying performance of the insurance company may change; or
- The financial condition of the insurance company may change.

Nevertheless, a couple of points seem pretty clear: The cost of long-term care is likely to rise substantially and the federal and state governments will continue tightening Medicaid eligibility rules.

Before purchasing a LTCI policy, in addition to reviewing the specific terms of coverage, you should check to see that the insurer being considered is highly rated by one or more of the agencies that rate insurance companies. The insurance company financial stability should be a critical factor in your choice. You can obtain the ratings of insurance companies from several sources, including A.M. Best Company, Moody's or Standard & Poor's insurance rating services.

When considering LTCI policies, the following contract terms (listed here in alphabetical order) should be examined:

ACTIVITIES OF DAILY LIVING (ADL)—These include bathing, eating, dressing, using the toilet ("toileting"), moving about ("transferring") and continence. Someone with a physical illness or disability often needs help with ADLs. Individuals with cognitive impairments, such as Alzheimer's disease, typically need supervision and reminders to do ADLs. Care required as a result of a cognitive impairment is generally covered by LTCI.

ALTERNATE PLAN OF CARE—This benefit pays for care not specifically covered in a policy by allowing an alternative plan of care to be submitted for approval by the insurance company. It is an extremely important benefit as there is no way of knowing what care alternatives might be available at some point in the future.

BED-RESERVATION BENEFIT—This benefit helps to pay for the cost of a bed in a nursing home when the insured is temporarily absent, either due to a required hospital stay or simply to a visit to family members. Some plans pay only for a reserved bed if the insured goes to a hospital, while others pay regardless of the reason the insured is absent from the nursing home.

BENEFIT AMOUNTS—This is basically how much the policy will pay. Each policy has a daily benefit and a benefit period. Policies will generally cover anywhere from two to ten years or provide lifetime benefits. For married couples, some policies will provide shared benefits. This will allow spouses to share the overall benefits. For example, if one spouse uses two years of a five-year policy, the other spouse would be permitted to utilize the remaining three years, if necessary.

Typically, policies will cover the cost of custodial care, or assistance with at least two of six ADLs. However, some policies may be more restrictive in determining how benefits are triggered. In addition, the policy should provide care to those who suffer from a cognitive impairment, such as dementia or senility, or Alzheimer's disease. Make sure the policy has a separate benefit trigger for cognitive impairment; otherwise, it is possible that the insured could be denied benefits if he can still do most ADLs on his own. It is important to understand what it means not to be able to perform a particular ADL. Some policies will pay if the insured only needs supervision and not active help with an ADL due to a cognitive impairment. Policies that require hands-on assistance, as opposed to standby assistance, make it harder to qualify for benefits.

CARE ADVISORY SERVICES—Many LTCI policies will pay for the cost of a personal care advisor or geriatric care manager. This is especially important to assist an insured and his family in designing the best care plan to meet their needs and desires, and to help locate and contract with service providers in the community. Some policies will even offer incentives such as higher benefits or shorter waiting periods when a company-provided personal care advisor is used.

ELIMINATION PERIOD—Similar to the deductible in a car or home insurance policy, the elimination period in a LTCI policy is the period of time during which the insured is required to pay out-of-pocket before he is eligible to receive benefits under the policy. LTCI policies typically specify elimination periods ranging from 20 to 180 days. It is important to review how the policy treats repeat stays in a nursing home. Some companies require another elimination period for a second stay; whereas other companies allow you to add on the second stay to the first stay without applying another elimination period.

EQUIPMENT AND HOME MODIFICATION—Many LTCI policies will pay for modifications to an insured's residence, such as the widening of doorways or the installation of wheelchair ramps, grab bars or other equipment.

EXPENSE REIMBURSEMENT V. INDEMNITY PLANS—Among the leading companies, the primary model for LTCI is an expense reimbursement whereby the insured individual or a designated long-term care provider is reimbursed for the costs of care, up to stipulated limits in the policy. An indemnity policy is one that will pay a predetermined amount for the cost of care each day, regardless of the expenses incurred. For example, if you have an indemnity plan that pays $300 of benefits each day, but the charges for your care total only $250, you will still receive the full $300 for that day.

One advantage to an indemnity plan is that any excess payment could be used to offset expenses that might not otherwise be covered under the policy. Thus, you are likely to recover the cost of premiums paid much faster with an indemnity plan, since all of the benefits are paid in full each day. In addition, an indemnity plan will generally allow you to pay family members or friends to care for you. Conversely, many policies require the home health care agency or caregiver be licensed.

An expense-reimbursement plan pays actual long-term care expenses covered under the policy, up to the daily benefit amount. Many expense-reimbursement plans utilize a "pool of money" concept whereby the insured is reimbursed for covered expenses incurred until the aggregate sum of policy benefits is exhausted. Thus, if daily expenses fluctuate, the insured would be able to offset an expensive day of care against an inexpensive day later that week or month.

GUARANTEED RENEWABILITY—This means that, as long as premiums are paid on time, the insurance company cannot cancel the policy. Although the companies do have the right to increase premiums by class in the state, they can't revoke them because of a change in health. In addition, some plans are now offering limited-payment options. This means that some companies offer the option to have the policy paid up in 10 or 20 years. This is helpful for people who want to finish paying premiums during their prime earning years. The premiums for these plans are higher than other plans, but, for some, this is an excellent way to plan to have the policy paid off in a limited time. Many of these policies include a rider that returns a portion of the premiums paid to the insured's beneficiaries upon death.

INFLATION RIDER—An inflation rider will help the policy benefits keep pace with inflation. Without an inflation rider, an insured may end up with a policy that seems to provide adequate coverage at the time of purchase but is actually insufficient at the time the coverage is needed due to increasing costs of health care. There are several different inflation-rider options including compound inflation, simple inflation, and cost-of-living adjustments. A compound inflation rider may significantly increase the cost of the policy, depending on the age of the insured. However, for

younger purchasers of LTCI, it is essential to consider a compound inflation rider.

INTERNATIONAL CARE—Many LTCI policies will only cover care delivered in the United States. For clients who have homes or relatives abroad, perhaps with the intention of retiring there one day, it might make sense to consider a policy that pays for care delivered in a foreign country.

NON-FORFEITURE BENEFITS—A non-forfeiture clause allows the insured to receive some amount of coverage for premiums already paid, even if the insured stops paying the premiums. Usually, the policy must be in force for a certain number of years. Some companies offer cash benefits payable upon death.

PARTNERSHIP POLICIES—New York is one of four states that offer Partnership Policies. The other three states are Connecticut, California and Indiana. New York's plan, unlike the other three, offers 100 percent asset protection when the insured exhausts the policy benefits and qualifies for Medicaid.

The New York program is a public/private partnership funded, in part, by the Robert Wood Johnson Foundation. Essentially, if someone uses their policy benefits for the required minimum benefit period, they are eligible to apply for Medicaid without regard to the amount of assets they have. There is no limit to the amount of assets an individual may retain and still receive Medicaid. However, all income above Medicaid-allowable amounts must be contributed towards the cost of care. It should be noted that the Medicaid benefits are payable only for care delivered in New York State.

RESTORATION OF BENEFITS—Some LTCI policies offer a feature known as restoration of benefits. This benefit is used to restore some or all policy benefits when policy benefits are not paid for a predetermined period of time such as 180 days.

SPOUSAL DISCOUNTS—Many LTCI policies provide a discount for married individuals. These discounts are sometimes provided even if one spouse doesn't have a policy, but may be higher if both do. Some policies also provide a lifetime waiver of premium for the surviving spouse when the other spouse dies. This benefit is usually triggered after the policy has been in force for several years, depending upon the company.

TAX QUALIFICATION—If a LTCI policy is tax-qualified then a portion of the premiums may be deductible for Federal income tax purposes. In order to be considered tax-qualified, LTCI policies must contain certain provisions as specified in the Internal Revenue Code.

If these criteria are met, the deductibility of LTCI premiums is subject to the 7.5 percent floor for medical expenses and is then further limited depending on the age of the taxpayer. Pursuant to IRC § 213(d)(10), the annual limitations are as follows: $250 for individuals who are 40 years of age or less; $470 for those who are 41 to 50; $940 for those who are 51 to 60; $2,510 for those who are 61 to 70; and $3,130 for those who are over 70. The foregoing amounts are adjusted annually for inflation.

The Long-Term Care and Retirement Security Act of 2003, introduced in both the House of Representatives (H.R.2096) and the Senate (S.1335) would greatly expand the deductibility of LTCI premiums. These bills, if enacted, would provide for an above-the-line deduction for qualified LTCI premiums. By allowing for an above-the-line deduction, all taxpayers will be able to deduct the cost of LTCI premiums.

For New York State tax purposes, an individual is entitled to a credit equal to 10 percent of the premiums paid on approved policies. This results in a dollar-for-dollar reduction in the amount of tax owed. Any unused credit may be carried forward to future years.

WAIVER OF PREMIUM—Most LTCI policies waive premiums once the insured starts receiving benefits. This benefit varies widely from company to company with some companies waiving the premium upon the receipt of covered care and others upon receipt of covered benefits.

Conclusion

LTCI can be an excellent way of defraying some health care costs. But as with other types of insurance, it defrays only some of the risk. Attorneys can provide a value-added benefit to their clients by offering an independent assessment of the different policies available.

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BONUS NEWS 2

Embezzlement: What? Who? Why? How? Detection!! Prevention!!

By Stephen A. Linker, CPA, DABFA

The Fraud Triangle

The research on fraud has identified three key factors that determine whether a person will commit fraud. The three factors, which comprise the so-called "fraud triangle," are: perceived pressure facing the person, perceived opportunity to commit fraud, and the person's rationalization, or integrity.

All three factors are usually necessary for fraud to result. For example, an unethical person facing financial pressure will have to identify an opportunity to commit fraud to be able to commit it. Similarly, a person facing financial pressure and in a job position that presents an opportunity to commit fraud will not do so if his personal integrity outweighs the other two factors. On the other hand, even the second person might commit the fraud if he rationalizes it, for example, by convincing himself that he is only "borrowing" the money and will pay it back.

So understanding the three elements of the fraud triangle will provide the fraud investigator with more angles from which to investigate. For example, an investigator might determine that several employees in a department had the opportunity to commit fraud there. Investigation of the employees' personal lives might reveal that only one of them also faced pressures that would motivate committing fraud. However, while it is beneficial to consider pressures and opportunities, rationalizations normally are not a focus of the investigation because they are difficult to identify.

Here is some detail about the three factors.

Factor 1— Perceived pressure facing the person
- a. Financial
- b. Personal habits
- c. Work-related feelings

Pressures that might motivate a person to commit fraud may be financial in nature, relate to a personal habit, or stem from work-related feelings. Financial pressures include factors such as debt arising from high medical bills, overuse of credit cards, divorce, investment losses, or sheer greed. Personal habits such as alcohol, drug, or gambling addiction or an expensive extramarital affair, may result in financial pressures to commit fraud in order to obtain funds to support the habit or pay debts resulting from it. Work-related factors include feelings of resentment—because of being overworked, underpaid, or not promoted—that may prompt a person to "get even" with the employer by committing fraud against the employer. Family or peer-group expectations also may motivate a person to commit fraud.

For example, Mrs. T., the bookkeeper, was getting a divorce and needed to amass legal fees for the divorce and the related child-custody battle. She also had a gambling habit.

Factor 2— Perceived opportunity to commit fraud
- a. Level of trust is reached
- b. Internal controls are weak or nonexistent

Opportunities to commit fraud can arise when an employee or manager reaches a level of trust in an organization or when internal controls are weak or nonexistent. Then the employee or manager will perceive that there is an opportunity to commit fraud, conceal it, and attempt to avoid detection and punishment. While opportunities to commit fraud in an organization may appear limitless, for any one person fraud opportunities are limited to the means available to him. For example, a shipping dockworker would not have the opportunity to manipulate accounts receivable in order to steal cash receipts, but might have the opportunity to steal inventory.

Good controls are an important means of limiting the opportunity for embezzlement, but even when controls exist, a person in a high-enough level of trust or authority may be able to override the controls in order to commit the embezzlement. For instance, a high-level and trusted manager might be able to direct a lower-level employee to forgo a control procedure usually performed.

Here are some examples of conditions that can provide an environment for embezzlement in an organization.

a. Inadequate segregation of duties

b. Failure to inform employees about company rules and about the consequences of violating them

c. Rapid turnover of employees

d. Constantly operating under crisis conditions

e. Absence of mandatory vacations

f. Failure to uniformly and consistently enforce standards and policies or to punish perpetrators

Here are some examples of conditions that can provide an opportunity for embezzlement by management.

a. Existence of related party transactions

b. Use of many banks

c. Inadequate or inexperienced staffing in the accounting department

d. Weak subordinate personnel

e. Frequent change of auditors or legal counsel

For example, Mrs. T. was the company's bookkeeper *and* office manager. No one followed up on her activities. There was no segregation of duties. She performed all of the billing, collecting, disbursing, banking, and recording of all transactions. She was always under a lot of pressure and, like a good soldier, never took a vacation. She explained to her boss that she "didn't need a vacation because there was nowhere to go," and she said she "loved her work."

Factor 3— The person's rationalization or integrity

a. Management honesty versus dishonesty

Personal integrity might very well be the most important factor in keeping a person from committing embezzlement. There are many cases in which individuals with severe financial or personal pressures and the opportunity to misappropriate assets do not do so because of strong personal moral codes. In a recent survey, auditors ranked "attitude" factors (such as management honesty) as more important than situational factors as indicators of the possibility of embezzlement. Some investigators believe that a strong moral code can prevent individuals from using rationalizations to justify illicit behavior. Some typical rationalizations for misappropriation of assets and management fraud include:

a. I'm only borrowing the money and will pay it back.

b. Nobody will get hurt.

c. The company treats me unfairly and owes me.

d. It's for a good purpose.

e. It's only temporary, until my financial position improves.

f. Everybody's doing it.

g. I'm not part of a team; I'm just an employee, a peon.

Characteristics of Embezzlers

1. Demographics are similar (sex, age, religion, and education level).

2. Personalities are usually *not* antisocial.

3. There is not necessarily a past criminal record.

4. There is usually not a deficient family environment.

5. There is not necessarily a sporadic job history.

Research into the characteristics of embezzlers shows that they share more demographic characteristics (such as gender, age, religion, and education level) with the general population than with other criminals. White-collar criminals do not usually have antisocial personalities, past criminal records, deficient family environments, or sporadic job histories.

Rather, they are usually older than other criminals (past thirty years of age), are married with stable family situations, and have above-average educations. Seventy percent of embezzlers are male. The age and gender may be due to the fact that, as one study found, almost one-half of all embezzlements are committed by professional and managerial employees. Senior officers and owners commit ten percent of all embezzlements. Until recently, it was the older male who had attained that level of trust and authority that provides an opportunity for embezzling. However, the study found that clerical and other employees commit thirty percent of embezzlements. Moreover, as the percentage of females in positions of authority and responsibility over assets increases, it is believed by law enforcement authorities that the percentage of female embezzlers will increase proportionately.

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BONUS NEWS 3

Referring the Right Home Care Provider to Your Clients Is Important . . . Here's How

By Taniella Jo Harrison

Your client can become extraordinarily stressed when met head-on with the challenge of coordinating the right care for themselves or a family member when someone is disabled or sick. When faced with such a situation, it's often wise to consider recruiting a professional home care provider. In New York State, there are over 900 home care agencies that employ and train over 250,000 home care professionals and paraprofessionals. These agencies offer a wide range of services designed not only to help the sick and infirm, but also to ease the family's responsibilities. Home care agencies can provide nursing, personal care, homemaking and companion services. Many can help patients maintain their highest level of health while they continue to live at home in comfort as long as possible and function at their personal best, avoiding expensive hospital bills and nursing homes. As you already know, being a main referral source to families in times of stress, pointing them to the right care professional is crucial to accommodating your clients' needs. Make certain the providers you interview offer the services your client needs.

When referring a home care provider that will facilitate your client's needs, several factors should be taken into consideration, including how long the provider has been in business, how they select and train their employees and whether the agency is licensed, bonded and insured. More specifically, here are some issues to address:

- **Determine what type of help is really needed.** Home health care aides typically oversee patients' modest medical needs, help with personal hygiene, prepare meals, provide an escort to outside appointments and leisure activities, perform light housekeeping, run errands and provide companionship. Will a registered nurse be necessary, or does the patient need more of a companion or a housekeeper? Not all home care providers offer similar services. Also, did you know that according to New York State regulations, all medical home care services must be authorized by a patient's physician?
- **Make sure the agency is up-to-date with the New York State Department of Health (NYSDOH)**. The NYSDOH regulates, and surveys on an ongoing basis, several different types of home care agencies with either a license or a certification as follows:
  - **Licensed Home Care Services Agency.** Provides a full range of skilled and paraprofessional nursing care mostly through contracts with local social services or other service agencies—Medicaid coverage is arranged this way. Also, these agencies sub-contract with other home care providers, especially when they specialize in servicing a specific population. These agencies usually accept a wide range of payment, including private-pay and third-party insurance.
  - **Certified Home Health Agency.** Provides short-term home care services usually through the Medicare and Medicaid program.
  - **Long-Term Home Health Care Program.** A special federal Medicaid waiver program called "Nursing Homes Without Walls" allows a person who is eligible for a nursing home to stay at home.
  - **Hospice.** Provides home care, inpatient and palliative services to the terminally ill in their homes.

Agencies with these designations have met specific and high standards of operation set by NYSDOH. Additional information can be obtained at the New York State Association of Health Care Providers. For a listing of home care agencies that service your area, go to www.nyshcp.org

- **Find out your client's source of payment for home care services.** There are many ways a person can pay for home care services, including Medicare, Medicaid, special New York State programs administered through the Office of Mental Health, Office of Mental

Retardation and Developmental Disabilities, and Department of Aging, third-party insurance (including long-term care insurance) and private pay. Each home care agency may accept different payment methods. Home care coverage, benefits and eligibility requirements for each payment source varies.

- **Forge a relationship.** Get to know key staff at several home care agencies; develop a personalized relationship; understand their management structure; and speak directly to others who have worked with the home care agency and have experienced the company and its employees first-hand. Know the size of the agency and how long they've been serving the community. Determine their promptness and quick response to your client's needs. This allows you to have full confidence in the quality of services you refer.
- **Determine scope and geographic coverage capacity.** Knowing a home care agency's geographic coverage areas is crucial. Make sure the home care provider can service your client with ease. Does the agency provide their staff with transportation assistance so they can get to patients living in hard-to-reach areas? Find out if they have access to regular and replacement staff that will readily cover the area your client lives in. Also, will your client have a different person each week? Make sure the agency can deliver what your client needs.
- **Be certain that the home care provider appropriately screens, insures, and trains home care workers.** Make sure the agency thoroughly checks the background of all home care staff. Does the agency conduct criminal background checks and drug screens? Be sure employees are covered by the agency's insurance policies for theft and injuries to themselves or the patient. Is the agency bonded? Find out if the home care staff assigned to your client will have the specific and necessary specialized skills to provide the right care. Where and how have the home care workers been trained?
- **Ascertain the agency's plan to establish and monitor quality care.** Insist on the family being able to participate in the development of the home care plan. Family members are often able to provide valuable insight into the patient and the family situation, so that the home care provider can better address their needs and requirements. Determine whether or not supervisors are assigned to each patient to ensure the quality of the care they are receiving. Find out the type of emergency procedures that are in place. It is important to know what back-up procedures the home care provider has in case of an emergency. Are all caregivers available 24 hours a day, seven days a week? Who is to be contacted during an emergency?
- **Be certain that the home care provider ensures patient confidentiality**. Recently passed legislation ensures patient confidentiality and details the regulations home health agency employers must follow. Be informed of the agency's procedures.

Taniella Jo Harrison is the Executive Director of Tri-County Home Nursing Services, Inc. (TCHNS), a fully licensed, bonded, and insured home health agency dedicated to providing homebound clients with excellent care, while maintaining the highest level of health and comfort. Taniella holds a B.S. degree in Business Administration from Tuskegee University and an MBA from Nova Southeastern University. In January 2003, she was honored as one of *The Network Journals'* Top "40 Under 40." She was also profiled in the magazine's June issue. Her e-mail address is THarrison@tchns.com

Tri-County Home Nursing Services, Inc. (TCHNS) was founded in 1981 by Ella Ferguson, a Registered Nurse, and is headquartered in Westbury, New York. TCHNS provides compassionate, sensitive, and reliable health care to people who cannot fully care for themselves, whether they are elderly, disabled, or chronically ill. TCHNS is ranked No. 18 in *Long Island Business News'* Minority-Owned Companies list and was featured in a Growth Strategies article in that magazine in November 2003. For more information about selecting the best home care agency for your client, contact TCHNS. Their phone number is (516) 997-1208, and their Web site address is http://www.tchns.com.

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