NYSBA WINTER 2005 | VOL. 15 | NO. 1

# Elder Law Attorney

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

## Message from the Chair

I have only recently returned from the Elder Law Section's Fall Meeting held in Rochester, New York, on October 21–23. I would like to take this opportunity to highlight two aspects of the Fall Meeting, each of great importance to the Section. The first and the more sobering aspect of the two matters concerns new federal interpretations of long-standing Medicaid eligibility provisions. When the Section opposed many of the proposed restrictive eligibility provisions contained in Governor Pataki's budget bill, our position was based in large part on the inability of the state of New York to obtain a Section 1115 waiver for such changes (only the proposal to extend a penalty period to community Medicaid would not have required such a waiver). We based our conclusions on the fact that 1115 waivers could only be granted by the Department of Health and Human Services for provisions found in Section 1902(c) of the Social Security Act. The transfer of asset rules (i.e., the lookback period and commencement date of the penalty period) are contained in Section 1917(c) of the Act. Furthermore, the proposals did not further the objectives of the Medicaid program, but rather imposed additional restrictions on eligibility. Finally, the waiver proposals were not budget-neutral, as is required by federal law.

The Centers for Medicare and Medicaid Services ("CMS") takes a different view of Section 1115 waivers. Under the CMS interpretation, a state could request a waiver to effectuate a change in the transfer of asset rules. Although Connecticut, Minnesota and Massachusetts currently have waivers pending before CMS, which have not been acted upon since February 2002 in the case of Connecticut's waiver request, CMS could take action on these waivers at any time. If any of these waivers are granted, two things are sure to happen. There will be extensive litigation surrounding the constitutionality of the granting of such a waiver, and Governor Pataki will likely find it easier to propose many of the same provisions as he did last year in his 2005–2006 budget bill, due in January 2005.

Other new interpretations that were discussed at the Fall Meeting pertain to annuities and post-eligibility transfers. In the case of annuities, the emergence of a secondary market for annuities in CMS's view means that an irrevocable annuity that is actuarially sound may have a market value and be counted as a resource for Medicaid eligibility purposes. All that is required is a sale of the annuity income stream in the secondary market for whatever price the mar-

## Inside this Issue

ket will bear. In fact, the North Dakota Supreme Court recently ruled that an annuity is a countable resource for Medicaid eligibility purposes because the income stream was said to be marketable in the secondary "factors" market. See: http://www.court.state.nd.us/court/opinions/20040071.htm (N.D., No. 20040071, Oct. 12, 2004). Another CMS interpretation would permit states to *not* count an annuity as an available resource provided that it meets certain guidelines. One such guideline would be to allow the state to require that the named beneficiary be the county Department of Social Services up to the amount of Medicaid benefits paid. It would seem that a state could easily adopt the secondary market approach to treating annuities as available resources, although a change in the state Medicaid plan would be required for the latter approach of requiring the county DSS to be named as a beneficiary.

With respect to post-eligibility transfers by a community spouse, it has long been CMS policy (and that of its predecessor, the Health Care Financing Administration, or "HCFA") that once eligibility has been established for an institutionalized spouse, assets of the community spouse are no longer available to the institutionalized spouse. Therefore, the community spouse could transfer such assets with no resulting impact on the continued eligibility of the institutionalized spouse.[1] Upon a re-examination of this issue, CMS now believes that there is another interpretation that can be supported. Under the new interpretation, although the "assets" of a community spouse cannot be deemed available to the institutionalized spouse, a "transfers of assets" by a community spouse can result in a penalty period for the institutionalized spouse. Under the new CMS interpretation, each state has the option of deciding which of the two alternatives the state wishes to adopt. This should sound familiar to most of you who will recall the *Wisconsin v. Blumer* Supreme Court decision, wherein the Supreme Court determined that federal law permits states to decide whether to use the resources-first or income-first approach to allocating income of the institutionalized spouse to the community spouse. In fact, CMS got the "idea" to create a second interpretation with respect to post-eligibility transfers from the *Blumer* case, which is premised on CMS being permitted to leave to the states to decide amongst two policy interpretations where federal law is ambiguous. With states and the federal government struggling to address rising Medicaid costs and other budget shortfalls, containment of those costs appears to have a greater impact on policy. Now, the federal statute that supported only one policy from CMS for many years is somehow ambiguous and subject to two equally supportable interpretations. Not surprisingly, this new interpretation is more restrictive than the long-standing post-eligibility rule previously espoused by CMS.

Of great concern to me is the apparent shift regarding the interpretation of the federal Medicaid Act and that a new direction in the formation of federal policy will have a devastating impact on the elderly and disabled people the law was intended to help. We all agree that there are serious concerns with the Medicaid program and the current status of the way in which we deliver health care to our state's most vulnerable citizens. But we think there is a better way to address these issues. Making long-term care insurance more accessible, as the legislature did in enacting the 2004–2005 budget, is a good start. Another focus should be to keep more people at home, where they prefer to be and where the costs of delivering services tend to be less expensive. I will, of course, keep the Section apprised of any future developments in this area.

The second aspect of the Fall Meeting, and the more uplifting of the two, is the high quality of the programming. René Reixach, Program Chair, put together a program that received rave reviews from its attendees, and for good reason. I wish to congratulate René for doing such an exceptional job in chairing this program. I also want to thank Kathy Heider, Meetings Director at NYSBA, who did such a wonderful job planning this event. Attendees particularly enjoyed the Friday evening dinner reception held at the George Eastman House, the world's preeminent museum of photography and former home to George Eastman, founder of the Eastman Kodak Company.

We were fortunate to have A. Vincent Buzard, President-Elect of the New York State Bar Association, meet with the officers of the Section and join us at our Executive Committee Meeting on October 21. Mr. Buzard returned on October 22 to address all conference attendees, having just driven to Rochester from Albany in order to be with our Section for the second time in two days. Our attendees learned of the various issues confronting the Bar Association for the upcoming year, including tort reform, issues affecting same-sex couples, diversity of membership, improving the quality of life of lawyers, improving public understanding of the legal system, and strengthening our legislative advocacy efforts. Harold Iselin of Greenberg Traurig also joined us at the Officer's Meeting and Executive Committee Meeting. Mr. Iselin served ably as the lobbyist for the Association in its efforts to oppose the restrictive Medicaid eligibility provisions contained in Governor Pataki's 2004–2005 budget bill. As we know, none of these provisions were included in the final budget signed by the Governor on August 11, 2004.

*(Continued on page 4)*

# Editor to Editor

**Steven H. Stern**
**Outgoing Editor**

When I first assumed the position of Editor of *Elder Law Attorney*, my goal was to expand the areas covered to provide our Section with articles and information that would not normally be covered in our educational programs throughout the year. I invited elected officials, both local and federal, responsible for health care policy to contribute their thoughts. I asked other professionals such as financial advisors, accountants, and geriatric care managers, to contribute articles that would assist elder law attorneys in expanding their knowledge of related issues. My desire was to paint a picture of what elder law is really all about; not just a few issues, but a wide range of topics important to ourselves as practitioners, and to those we represent.

After three wonderful terms, this is my last issue as Editor-in-Chief of the *Elder Law Attorney* newsletter. Steven Ratner of Manhattan and White Plains is set to take over as your new Editor-in-Chief, and we are all confident that he will do a superb job. I wish him well.

I would like to take this opportunity to say thank you to our colleagues who continue to provide outstanding articles as regular contributors to this publication:

| | |
|---|---|
| Judith B. Raskin: | New York Case News |
| Steven H. Stern and Howard S. Krooks: | Legislative News |
| Vincent J. Russo: | Practice News |
| Ellice Fatoullah and René Reixach: | Fair Hearing News |
| Daniel G. Fish: | Publication News |
| Scott Solkoff: | Snowbird News |
| Valerie Bogart: | Public Elder Law Attorney News |
| Ellen Makofsky: | Advanced Directive News |
| Ronald Fatoullah: | Public Policy News |
| Robert Kruger: | Guardianship News |
| Michael L. Pfeifer: | Capacity News |
| Steven M. Ratner: | National Case News |
| Robert Grey: | Mediation News |
| Natalie Kaplan: | Quotes to Remember |
| Barbara Wolford: | Elder Care News |

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**Steven M. Ratner**
**Incoming Editor**

It is a great honor to have been chosen as the next Editor of the *Elder Law Attorney*. The *Elder Law Attorney* is one of the finest publications in our field and I believe we owe a tremendous debt to the leadership and hard work contributed by our two previous Editors, Steven Stern and Lawrence Davidow.

My involvement with the newsletter began approximately two years ago when I responded to a notice requesting an author for the National Case News column. Over the past two years, I have enjoyed reporting to the Section on some of the most important cases affecting our practice area, including *Oregon v. Ashcroft* and *Wisconsin v. Blumer*.

After writing this column for two years, I threw my name into the hat when the leadership began looking for a new Editor. I believe that my experience shows that the *Elder Law Attorney* is open to all Section members. I certainly will welcome new authors as well as ideas for new columns.

I am currently in the process of selecting a three-member Board of Editors to provide guidance over the coming years. A notice was recently circulated over the listserve requesting that attorneys interested in serving on the board contact me.

The Board of Editors will assist me in choosing themes for our upcoming issues, locating appropriate authors, as well as editing the articles prior to submission to the Bar. In addition, it is our hope that the next Editor will be chosen from the Board of Editors.

In conclusion, I would like to repeat that I am honored that I have been chosen as the next Editor. It is my hope that I can continue in the fine tradition of both Lawrence Davidow and Steven Stern.

**Steven Ratner**

## Chair's Message *(Continued from page 1)*

Another positive note is that our forum for this event was Rochester, and more than half of the 135 attendees were from an upstate venue (we won't debate here what constitutes "upstate," but I will say that I have excluded Westchester County from this analysis). The Section leadership has attempted to reach out to all of its members by holding programs throughout the state. The Fall Meeting has been designated as the program to achieve this objective and I was delighted to see so many upstaters at this event. Next year's Fall Program is scheduled to be held in Saratoga Springs.

The Fall Meeting itself consisted of two days of presentations followed by the Section's Advanced Institute, a roundtable forum held on October 23 allowing Section members to address practice management and substantive legal issues with an expert in each of nine areas (Discharge Planning and Nursing Home Admission Agreements, Estate Planning and Tax Issues, Fair Hearings, Guardianship, Medicaid, Practice Management Issues, Real Estate, Retirement Plans, Spousal Issues and Supplemental Needs Trusts). Many thanks to T. David Stapleton, Jr. and Richard A. Weinblatt, who served as co-chairs of the Advanced Institute, and to our "experts," who devoted significant time preparing material and leading discussions throughout the day. On the programming side, we were treated to excellent presentations from speakers with diverse backgrounds. Of particular note were presentations by the Honorable Richard C. Wesley, Judge, United States Court of Appeals for the Second Circuit; Section member Aytan Y. Bellin, who spoke about the use of pooled trusts; Joseph F. Hurley, Founder and CEO of Savingforcollege.com, who spoke about the use of Section 529 Plans; Richard A. Marchese, Jr., Senior Deputy County Attorney for Monroe County; the Honorable George D. Maziarz, New York State Senator from Lockport, who sponsored the recently enacted Assisted Living Bill; Gail Holubinka of MedAmerica Insurance Company of New York, who spoke about the current status of long-term care insurance as a tool to address long-term care needs; David Leven, Executive Director of Compassion in Dying of New York, who spoke about issues encountered in the treatment of pain in New York; and Barbara J. Collins, Centers for Medicare and Medicaid Services, who spoke about a variety of federal policy interpretations related to Medicaid financial eligibility issues.

I will keep the Section posted on any future developments in these areas, and certainly expect to be able to provide an update at the Section's Annual Meeting (Valerie Bogart, Chair), which will be held on Tuesday, January 25, 2005 at the Marriott Marquis in New York City. Also, we will be holding our Spring Advanced Institute at the Radisson Hotel at JFK Airport on April 28, 2005. The Advanced Institute is being co-chaired by Stephen J. Silverberg and Elizabeth Clark.

I look forward to seeing many of you at the Annual Meeting. I wish you all the best.

**Howard S. Krooks**

### Endnote

1. See Letter dated November 22, 1994 from A.W. Schnellbacher, Chief of the Medicaid Operations Branch of the Division of Medicaid, Region VIII; see also Letter dated February 17, 1995 from Gary Wilks, Associate Regional Administrator, Division of Medicaid, for HCFA Region VIII; see also Letter dated April 5, 2000 from Ronald Preston, Associate Regional Administrator, Division of Medicaid and State Operations, Region 1.

## Outgoing Editor's Message

*(Continued from page 3)*

As I have said previously, they are truly some of the most experienced practitioners in our Section, and we are all grateful to them for their continued commitment.

Thank you to Wendy Pike, Lyn Curtis and Lisa Bataille of the NYSBA for all of your assistance and support through the years, and ensuring a top-quality publication for our Section.

I would also like to thank past Chairs Cora Alsante and Joan Robert and Chair Howard Krooks for allowing me the privilege to serve and to grow with the Elder Law Section.

Finally, thanks to Lawrence Davidow, my partner and dear friend, for setting the standard for this publication and his guidance in continuing the vision. And a very special thank you to Joan Fichtner, one of our MVPs at Davidow, Davidow, Siegel and Stern, for her five years of outstanding efforts in helping to make *Elder Law Attorney* one of the New York State Bar Association's preeminent publications.

Farewell, and please enjoy this edition of *Elder Law Attorney.*

**Steven Stern**

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# ELDER LAW NEWS

## REGULAR COLUMNS

# Prescription Drugs and Medicare: What the Medicare Act of 2003 Provides for Your Clients

By Vicki Gottlich and Patricia Nemore

## I. Introduction

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[1] Although this legislation includes sweeping changes to the Medicare program, the focus of discussion has been on the creation of a new Medicare Part D which offers Medicare beneficiaries a limited prescription drug benefit effective January 1, 2006. The new drug benefit will be operated through private insurance plans that offer only prescription drug coverage (PDPs), or through Medicare HMOs or preferred provider organizations (PPOs) that participate in the Medicare Advantage program.

Perhaps the most significant positive aspect of the Act's prescription drug benefit is the low-income subsidy for beneficiaries with incomes up to 150 percent of the federal poverty level and with limited resources. The salutary effects of this subsidy, however, are mitigated by the fact that beginning January 1, 2006, the Act also eliminates all Medicaid drug coverage for the more than 6 million individuals who are dually eligible for both Medicare and Medicaid.[2] Moreover, it requires states to pay back to the federal government—through a mechanism popularly referred to as "the clawback"—much of the savings they would otherwise realize from their reduced Medicaid obligation to those individuals.

This article will provide attorneys with basic information about the prescription drug benefit provided in the Medicare Act of 2003 and proposed implementing regulations, so that they can assist their clients in evaluating their options.

## II. The Basic Drug Benefit and the Exceptions Process

Much of the debate about the Medicare Act centered on the adequacy of the 2006 drug benefit itself. However, the discussion failed to mention that the Act gives the private prescription drug plan sponsors a great deal of flexibility to design their own benefit structure, and thus decreases the likelihood that many plans will even offer the statutory "standard" benefit. The flexibility accorded plan sponsors will make it more difficult for beneficiaries to compare plans, if more than one drug plan is available to them, thereby undermining the concept of "choice" that purports to be a cornerstone of the Medicare drug program.

*"Perhaps the most significant positive aspect of the Act's prescription drug benefit is the low-income subsidy for beneficiaries with incomes up to 150 percent of the federal poverty level and with limited resources."*

The statute sets forth the following standard prescription drug coverage: In 2006, after meeting a $250 deductible, the beneficiary pays 25 percent of the cost of a covered Part D prescription drug[3] up to the initial coverage limit of $2,250. Once the initial coverage limit is reached, the beneficiary enters the "doughnut hole" in which she pays the full cost of her medicine. When her total out-of-pocket expenses for the year, including the deductible and initial coinsurance, reach $3,600, she pays $2 for a generic or preferred drug and $5 for other drugs, or 5 percent coinsurance, whichever is greater.[4] Because the deductible, initial coverage limit and annual out-of-pocket threshold will increase each year by the increase in expenditures for Part D drugs, after 2006 it is likely that the increase in a beneficiary's out-of-pocket costs will exceed the increase in her social security benefit.

Despite media descriptions of a $35 premium for the drug benefit, the Medicare Act does not include a set premium amount. Premiums will be determined by a bidding process and will vary from plan to plan and from region to region. Premium amounts will be especially critical for individuals with low incomes, as they will only receive full assistance for plans with premiums that are at or below a benchmark amount determined by the bidding process.[5] A beneficiary who does not enroll in a drug plan when she first becomes eligible will be assessed a penalty for late

enrollment, unless she had "creditable coverage" from another source, such as a retiree health plan.[6]

Drug plan sponsors are not required to offer the standard benefit, but can offer actuarially equivalent benefit packages or alternative benefit packages.[7] An actuarially equivalent plan is one in which the cost-sharing varies through the use of such mechanisms as tiered co-payments, i.e., higher co-payments for brand name and/or non-preferred drugs. An alternative benefit package might also include changes to the deductible and the initial coverage limit, though the deductible cannot be an amount higher than the $250 set in the statute. Plans can also offer enhanced alternative benefit packages which offer better coverage than the standard drug benefit at a higher premium.[8]

Medicare will establish nonbinding model formulary guidelines, but each plan will determine its own formulary and the drugs that it will cover. Another critical and often overlooked factor is that only the cost of Part D covered drugs that are included on a plan's formulary counts toward the deductible and out-of-pocket limits.[9] As a result, a beneficiary whose only drug expense in January 2006 is $300 for a one month's supply of a Part D drug that is not on her plan's formulary will not meet her deductible through the purchase of that drug. Even though she will incur $3,600 in out-of-pocket expenses for the year, those expenses are not taken into consideration in determining whether she is eligible for the reduced cost-sharing for high out-of-pocket costs.[10] Thus, not only is the beneficiary responsible for paying the full costs of non-formulary prescriptions, she gets no credit toward the out-of-pocket limit for the expenses she incurs. Even a dually eligible individual will be responsible for the full cost of a non-formulary drug, including a drug previously paid for by Medicaid, because Medicaid will no longer pay for any drug that could be covered under Part D.

### Exceptions Process

All drug plan sponsors must establish an exceptions process whereby individuals enrolled in a drug plan can seek coverage for a non-formulary drug, or to have a covered drug assigned to a lower tier to reduce their cost-sharing.[11] The prescribing doctor must show that all of the drugs on any tier of the plan's formulary for treatment of the same condition would not be as effective or would have adverse consequences, or both, for the individual requesting the exception. If the plan approves the exception request, the drug will be treated as other drugs on the formulary, so that the beneficiary's cost sharing counts toward the deductible and the annual out-of-pocket limit.[12]

Despite the importance of the exceptions process for individuals, the process created in the proposed regulations appears both burdensome and lengthy. Each plan may establish its own standards for determining whether an enrollee requires a non-formulary drug, including requiring a high standard of medical and scientific evidence that may not be readily available. A beneficiary who pursues the multi-layered exceptions and appeals process through all levels of review in order to get a face-to-face hearing may not get a decision on the request for close to a year, if all the steps proceed as quickly as required under the statute and the proposed regulations.[13] The time period is problematic for numerous reasons, including the fact that there is no method for giving a beneficiary a limited supply of a needed drug pending an exception request.

Further, it is unclear what notice, if any, beneficiaries will receive that a drug is not on the plan's formulary and that an exception may be requested. Neither the statute nor the proposed regulations assign responsibility for providing notice to a beneficiary who presents a prescription for a non-formulary drug at the pharmacy. Nor is there a description of what such notice should include. The Medicare Act only requires drug plans to make information about formulary changes available on the Internet.[14] The proposed regulations say that notice must be provided 30 days in advance of the change, and do not mention the form the notice must take.[15]

## III. Low-Income Protections

Medicare beneficiaries with incomes up to 150 percent of the federal poverty level for a family of the size involved should be eligible for subsidies to assist with drug benefit costs. Subsidies vary according to income, Medicaid status and institutional status. So-called full subsidy eligible individuals are those with full Medicaid status (full-benefit dual eligibles) or incomes below 135 percent of the federal poverty level and countable resources of not more than $6,000 for an individual and $9,000 for a couple.[16] Partial subsidy individuals can have incomes up to 150 percent of the federal poverty level and resources of not more than $10,000 per individual and $20,000 per couple.

All full subsidy individuals are entitled to 100 percent subsidy for the "low-income benchmark premium," elimination of the deductible, continuation of coverage through the doughnut hole, and elimination of all cost-sharing after they meet the annual out-of-pocket maximum.[17] Full-benefit dual eligibles who are institutionalized, including those in nursing homes but not those living in the community under a Section 1115 waiver program, have no cost-sharing at all. Full-benefit dual eligibles with incomes up to 100 percent of the federal poverty level initially pay no more than $1 for generic or preferred brand or $3 for non-preferred brand, with co-payments after 2006 indexed annually to the Consumer Price Index. All other full subsidy individuals initially pay co-payments of no more than $2 for generic or preferred brands or $5 for non-preferred brands, with co-payments indexed annually to the cost of Part D drugs.

Partial subsidy individuals pay a sliding scale premium, a $50 deductible, co-insurance of 15 percent instead of the full 25 percent, including continued coverage through the doughnut hole, and a co-payment of no more than $2 for generic or preferred brand or $5 for non-preferred brand for all drugs after the out-of-pocket threshold is met.

## IV. Dual Eligibles

Among the most dramatic aspects of the Medicare Act is its complete elimination of Medicaid prescription drug coverage for all individuals who are dually eligible for both Medicare and Medicaid.[18] Beginning January 1, 2006, any individual eligible to enroll in a Part D plan who is receiving full Medicaid services cannot receive prescription drug coverage through Medicaid. This is true regardless of whether the individual has actually enrolled in a Part D plan and regardless of whether the plan covers the specific drug needed. Thus, Medicaid will not pay for the limited co-insurance amounts or, more importantly, for a non-formulary drug. Because of the design of the Medicare drug benefit, many dual eligibles will find themselves with less prescription drug coverage than they had under Medicaid and potentially less protection during appeals processes to challenge denials or other barriers to coverage.

Presumably because of the loss of Medicaid drug coverage, the Medicare Act requires that dual eligibles who have not enrolled in a Part D plan be automatically enrolled in one.[19] However, the law does not specify how, when or by whom this should be done, other than to direct that dual eligibles be enrolled randomly if more than one prescription drug plan in their area is available for the fully subsidized premium amount. The proposed regulations are similarly vague, except that they place the timing for auto-enrollment at the end of the initial enrollment period for drug plans, which is May 15, 2006.[20] Thus, the regulations create a five-month coverage gap that would exist from January, when Medicaid drug coverage ends, through May, when auto enrollment would begin. The proposed regulations also require states to notify all full-benefit dual eligibles of their eligibility for the full low-income subsidy and of the fact that they will be auto-enrolled in a drug plan if they don't enroll, but timing of such notice is not specified.[21]

## V. Conclusion

Although the Part D benefit does not begin until January 2006, activity related to implementation has begun and will continue in 2005. Attorneys may want to engage their state legislatures and Medicaid agencies concerning the state's enrollment process for the low-income subsidies and the state's notice to dual eligibles about loss of Medicaid prescription drug coverage. The states must begin enrolling individuals in low-income subsidies by July 1, 2005. Regardless, initial enrollment in a Part D drug plan for all beneficiaries begins November 15, 2005.[22]

Most importantly, attorneys will want to keep abreast of developments so that they can assist their eligible clients to enroll in a low-income subsidy. They will also want to be aware of the drug plans that become available in their community so that they can enroll clients for whom they serve as guardian and otherwise assist all clients with the difficult choices they will have to make.

## Endnotes

1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, § 101, adding § 1860D-1 *et seq.* to the Social Security Act of 1935, 42 U.S.C.A. § 1395w-101 *et seq.* (West 2004 Supp.).
2. Dual eligibles include Medicare beneficiaries with full Medicaid benefits, regardless of whether they got coverage through a "spend down" or as being categorically needy, as well as those with full coverage under a Section 1115 research and demonstration waiver.
3. Covered Part D drugs generally include prescription drugs covered under Medicaid, with some exceptions. 42 U.S.C.A. § 1395w-102(e) (West Supp. 2004).

4. *Id.* § 1395w-102(b).
5. *Id.* §§ 1395w-113(a), 1395w-114 (a), (b).
6. *Id.* § 1395w-113(b).
7. *Id.* § 1395w-102(b)(2)(A)(ii), (B), (c).
8. 69 Fed. Reg. 46632, 46815-8 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. §§ 423.100, 423.104(e)(2)(i)(B), 423.104(e)(5)(ii), 423.104(f)), 423.104(g)).
9. 42 U.S.C.A. § 1395w-104(b) (West Supp. 2004).
10. Payments made by employer-sponsored retiree health plans also do not count toward the out-of-pocket limit, thus only increasing the amount the beneficiary must spend before the reduced cost-sharing for high drug expenses begins. *Id.* § 1395w-102(b)(4)(C)(ii), 69 Fed. Reg. 46632, 46815 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. § 423.100).
11. 42 U.S.C.A. § 1395w-104(g), (h) (West Supp. 2004).
12. *Id.* § 1395w-104(h).
13. 69 Fed. Reg. 46632, 46843, 46845-6, 46846, 46846-7 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. §§ 423.572, 423.590, 423.600, 423.610).
14. 42 U.S.C.A. § 1395w-104(a)(3)(B).
15. 69 Fed. Reg. 46632, 46819 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. § 423.120(b)(5)).
16. 42 U.S.C.A. § 1395w-114 (West Supp. 2004).
17. *Id.* § 1395w-114(a)(1)(A), (b). The low-income benchmark is the weighted average of plan premiums for the basic benefit package in the region in which the individual lives.
18. *Id.* § 1396u-5(d)(1).
19. *Id.* § 1395w-101(b)(1)(C).
20. 69 Fed. Reg. 46632, 46811 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. § 423.34(d)).
21. *Id.* at 46632, 46854, 46862 (to be codified at 42 C.F.R. §§ 423.773, 423.904(c)(3)); 69 Fed. Reg. 46751 (preamble).
22. The initial enrollment period extends through May 15, 2006. 42 U.S.C.A. § 1395w-101(b)(2) (West 2004 Supp.).

**Vicki Gottlich is an attorney in the Washington, D.C., office of the Center for Medicare Advocacy, Inc., where she provides legal assistance, training, research, consultation and litigation support regarding Medicare and employer-sponsored health benefits. Her recent work focuses on issues surrounding the Medicare Act of 2003. Ms. Gottlich has written articles on Medicare for *Bifocal* and the *NAELA News*, and has served as a trainer at the National Aging and the Law Conference, and at NAELA Symposia and Institutes. Ms. Gottlich received a J.D. from New York University School of Law and an L.L.M. degree from the National Law Center, George Washington University.**

**Patricia Nemore is an attorney in the Washington, D.C., office of the Center for Medicare Advocacy, Inc. For more than 20 years her legal career has concentrated on Medicaid and Medicare for older people and people with disabilities, and nursing home residents' issues. Recent work focuses on issues affecting low-income Medicare beneficiaries and the Medicare Act of 2003 and on ongoing issues of state implementation of Medicare Savings Programs. Ms. Nemore has served as a trainer at the National Aging and the Law Conference, NAELA Symposia and Institutes. Ms. Nemore is a graduate of the Catholic University School of Law.**

## REQUEST FOR ARTICLES

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

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*Articles should be submitted on a 3½" floppy disk, preferably in Microsoft Word or WordPerfect, along with a printed original and biographical information.*

# Medicare's New Drug Benefit

By Dee Mahan and Marc Steinberg

In January 2006, Medicare will add a voluntary prescription drug benefit, called Medicare Part D. However, because many in Medicare will continue to incur high drug costs even with the benefit, adding this new drug coverage will not end the need for Medicare beneficiaries to consider their drug expenditures in their financial planning. Making decisions about the new benefit will be a complicated process for many beneficiaries:

- The program is very confusing, even for health policy experts.
- Medicare beneficiaries will confront several choices, including whether to sign up, how to pick a plan, and how to sign up.
- Once coverage starts, many will need help navigating administrative hurdles to get access to the drugs they need.
- Dual eligibles—those beneficiaries who are eligible for both Medicaid and Medicare–will have to receive their drug coverage through Medicare. As a result, they will lose many of the protections they had under the Medicaid program.

To help you work with your clients as they try to evaluate the new benefit, this article outlines some basics of the new drug benefit, discusses special issues for low-income beneficiaries, and suggests approaches for helping your clients with their planning. At the time of writing, the final rules for the program had not been published, and the proposed rules left many issues unresolved.[1] We have noted instances where our comments are based on assumptions that might change when the final rules are published.

## Medicare Drug Benefit Basics

### Program Structure

**Voluntary Program, but Late Enrollment Penalties.** The drug benefit is voluntary and requires most beneficiaries to affirmatively sign up for the program. (The exception is automatic enrollment for dual Medicare-Medicaid eligibles, which is discussed in the section "Special Issues for Low Income Benefits," below). The sign-up process is scheduled to begin on November 15, 2005 and continue through an open enrollment period that ends on May 15, 2006. After the initial enrollment period, there will be annual open enrollment periods from November 15 to December 31 when beneficiaries can switch plans or enroll if they have not already done so.[2] Individuals who become eligible for Medicare between enrollment periods can enroll in Part D when they become eligible for Part A or Part B benefits.

Those who wait until after open enrollment to sign up may be subject to a late-enrollment penalty equal to 1 percent of the national average plan premium *per month* that enrollment is delayed.[3] Late-enrollment penalties will not apply if someone maintains what is referred to as "creditable coverage"—other drug coverage certified as being equal to Medicare's basic drug benefit. This includes VA coverage, FEHBP retiree coverage, currently available Medigap drug coverage, and most employer- or union-sponsored retiree plans.[4] Beneficiaries with drug coverage should confirm with their insurance company or plan administrator that the coverage is "creditable." If a beneficiary's existing drug coverage ends or changes so that it no longer qualifies as "creditable," he or she has up to 63 days to enroll in a Medicare drug plan before late-enrollment penalties start to accrue.[5] There are requirements that plans notify enrollees if their coverage status changes, but those requirements have not been finalized.[6]

**How the Benefit Will Be Delivered.** Medicare's drug benefit will be offered through private plans that contract with CMS; these plans will be at financial risk for a portion of enrollees' drug costs, meaning that they will have incentives to limit expenditure.[7] Individuals who wish to enroll in the program will have to select among the plans in their region—there should be at least two plan options for each region.[8] Plans will be either stand-alone drug plans (referred to as Prescription Drug Plans, or PDPs) or Medicare Advantage plans (the new name for Medicare managed care). Medicare Advantage Plans will be required to offer a drug benefit if they wish to participate in the Medicare program. Plans will bid to serve one or more geographic regions, but these regions have not yet been determined.

**Signing Up: How Different Will Plans Be?** Plans will be allowed to vary in several important aspects. The law gives plans latitude to set rates, make some modifications in benefit design, and limit the drugs covered. This can make plan-to-plan comparisons difficult in areas where there are multiple plans to choose from.

- **Different premiums.** Plans will set their own monthly premiums; most beneficiaries will have to pay 25.5 percent of the premium, with the rest subsidized by Medicare.[9] At this time, we do not know how much premiums will be or how much they will vary across plans. The government estimates that premium costs to beneficiaries will average $35 a month, or $420 a year, in 2006. Your clients should expect their premiums to go up annually.
- **Benefits can be different.** All plans will have to offer a benefit *comparable* to Medicare's "basic drug benefit," described below. However, plans can alter that benefit design as long as they offer something certified as "actuarially equivalent." For example, the basic benefit specifies just one level of cost-sharing—25 percent of drug costs. It is widely assumed that plans will have different cost-sharing levels for generics, preferred brands, and non-preferred brands.[10] Plans can offer additional benefit options that are richer than the basic plan; these will likely have higher premiums.
- **Drug prices will be different.** Drug prices will remain extremely important to beneficiaries: The basic benefit sets beneficiaries' cost-sharing at a percent of the drug price, and coverage stops once annual costs reach a certain level. Each plan will negotiate with manufacturers for drug price discounts and with pharmacies for reductions in dispensing fees. Plans are required to pass a portion of those discounts on to beneficiaries.[11] However, because each plan will be negotiating on its own, prices will vary from plan to plan and possibly even between pharmacies in the same plan. A plan can change drug prices at any time during the year.
- **Drugs covered will vary**. All participating plans will be allowed to develop a formulary—a list of covered drugs. Participating plans will have to cover only the drugs on their formulary. The law requires that two drugs in each "therapeutic class" be included in every plan's formulary. While Medicare is developing a "model" list of therapeutic classes, the model is only a suggestion that plans will not be required to follow.[12] Plans can change their formulary during the year, although there will likely be a requirement to provide notice of such changes, at least to the enrollees who are taking a drug that will have a change in formulary status.[13]

### The Basic Drug Benefit

Every plan that participates in the program will have to offer what is referred to as the "basic drug benefit" or a benefit certified as being of equal value to the basic benefit. The basic benefit for 2006 as defined in the law[14] has the following features:

- An annual deductible, which is $250 in 2006.
- 25 percent cost-sharing on all prescriptions between $251 and $2,250 in drug costs for 2006 (this is referred to as "initial coverage").
- No coverage after $2,250 in drug costs until the beneficiary has met the annual "true-out-of-pocket maximum." This gap in coverage is what is euphemistically called the "doughnut hole." In 2006, the annual true-out-of-pocket maximum is reached once a beneficiary has spent $3,600 of his or her own money on prescription drugs (including the $250 deductible and the 25 percent cost-sharing for initial coverage). Someone with no other drug coverage would reach the out-of-pocket maximum once total 2006 drug expenses reached $5,100. During this gap in coverage, beneficiaries will be able to purchase formulary drugs at the plan's discounted price. However, even during the gap in

coverage when the beneficiary is paying all prescription costs, *only spending on drugs on the plan formulary will count toward total out-of-pocket payments*.

- After an individual meets the annual true-out-of-pocket maximum, what is referred to as "catastrophic coverage" begins and continues until the end of the year. With catastrophic coverage, the beneficiary must pay either 5 percent of the cost of each prescription or $2 for generics and $5 for brand-name drugs.

Every year, beneficiaries will start over with a new deductible and new cost-sharing. The deductible, the point where initial coverage ends, and the point where catastrophic coverage begins will all increase annually by the same percent as any increase in Medicare's drug spending—projected to be about 10 percent annually for the first seven years of the program.[15] The Congressional Budget Offices projects that the out-of-pocket drug spending (not including premium costs, which are separate) that will be required to qualify for catastrophic coverage in 2013 will be $6,400.[16] This underscores the need for those in Medicare to continue factoring drug expenses into their financial plans.

## Special Issues for Low-Income Beneficiaries

The law provides additional help for low-income beneficiaries in the form of premium subsidies and significantly reduced cost-sharing. This added help, however, comes with some complexities and program changes that may, at the least, create a great deal of confusion for many and, at the worst, result in gaps in coverage or inadequate access to necessary medications.

Individuals eligible for low-income assistance include those who are eligible for both full Medicaid and Medicare benefits ("full dual eligibles"); those enrolled in one of three Medicare Savings Programs (MSPs); and others in Medicare with family incomes under 150 percent of poverty who also meet the law's asset tests. (The three Medicare Savings Programs are the Qualified Medicare Beneficiary, or QMB, program; the Specified Low-Income Medicare Beneficiary, or SLMB, program; and the Qualifying Individual 1, or QI-1, program.)

### The Benefit and Issues for Dual Eligibles and MSPs

**Premium Subsidies and Help with Cost-Sharing.** There are more than 6.1 million low-income Medicare beneficiaries nationwide—over 537,000 in New York—who are full dual eligibles. Currently, Medicaid covers their outpatient prescription drugs, as well as long-term nursing home care. Starting on January 1, 2006, their Medicaid drug coverage will end, and they will instead have to obtain their outpatient prescription drugs through a new Medicare Part D plan.

An additional 1.1 million Medicare beneficiaries nationwide—about 68,000 in New York—are enrolled in one of three MSPs that help pay for their Medicare premiums and cost-sharing. These beneficiaries do not have outpatient drug coverage through Medicaid, although they may have coverage through state pharmacy assistance programs, like New York's EPIC program.

Both of these groups will be automatically eligible for premium subsidies equal to the average premium in their region. They will also have continuous drug coverage (no "doughnut hole"), and their cost-sharing will be greatly reduced. The amount that cost-sharing will be reduced will depend on a beneficiary's income and on whether or not he or she resides in an institution. Full dual eligibles residing in institutions will have no premiums or copayments. Other dual eligibles, including those enrolled in MSPs, will have copayments ranging from $1 to $5 (depending on their income and use of generics), as well as the same premium subsidy.[17] Copayments will increase with inflation after 2006.

**Enrollment and Plan Selection**. Enrolling in the low-income subsidy will be a separate process from enrolling in a Part D drug plan. Under the proposed regulations, both partial and full dual eligibles will be automatically eligible for the subsidy, although the proposed regulations do not specify whether beneficiaries will have to take any affirmative steps to enroll.[18] State Medicaid agencies are expected to begin determining which dual eligibles to automatically enroll in the subsidy and issuing notices to those beneficiaries during the summer of 2005. Dual eligibles can start signing up for a plan on November 15, 2005, like others in Medicare.

There are some special issues for full dual eligibles who will be losing their Medicaid drug coverage. It is critical that they enroll in a plan during the six weeks between November 15, 2005 and January 1, 2006 (when their current Medicaid drug coverage will stop). There are two reasons for this: 1) to avoid a gap in drug coverage and 2) to ensure that the plan's list of covered drugs is appropriate for their needs.

- **Avoiding a gap in coverage.** Full dual eligible beneficiaries who do not choose a plan will be automatically enrolled in a plan, which will be selected at random from among the plans available in the region with premiums equal to or less than the subsidy amount. However, the proposed regulations do not provide for automatic enrollment until the end of the initial open enrollment period, which is May 15, 2006.[19] This means that beneficiaries could experience a four-and-a-half month gap in coverage if they do not choose a plan.

  CMS has acknowledged the need to change the automatic enrollment procedure in the final regulations to ensure that there is no gap in coverage. However, important details, including what agencies will perform the automatic enrollment and when the enrollment will take place, remain unknown at this time.

- **Selecting an appropriate plan.** Ensuring that full dual eligibles enroll in an appropriate drug plan will be one of the major challenges of the coming year. Although dual eligibles will be able to change plans at any time, their limited financial means and their inability to pay for drugs out-of-pocket make it especially important that they choose a plan with a formulary that covers the drugs they need and that participates with their local pharmacy. Dual eligibles' choices of plans will be constrained by the premium subsidy to those with premiums that are equal to or less than their subsidy amount. Many beneficiaries will need extensive counseling during this time to work through all these details. For those who are in institutions or who have physical or cognitive impairments, family members and guardians will also need to be involved.

### Other Low-Income Beneficiaries

Other Medicare beneficiaries whose incomes are below 150 percent of the federal poverty level and who meet the law's assets test will also be eligible for some level of low-income subsidy. The level of subsidy will vary depending on the beneficiary's income and assets. The lowest-income, non-dual eligible beneficiaries who meet the assets test will have copayments of $2 for generics and $5 for brand-name drugs. Those with higher incomes and assets will have higher copayments and some degree of deductibles and coinsurance.

Under the law, beneficiaries will be able to enroll in the subsidy by applying through either the Social Security Administration (SSA) or their state's Medicaid agencies.[20] SSA will be issuing its own proposed regulations regarding enrollment procedures later this year. The duration of the eligibility periods and process for renewing eligibility will be left to the discretion of state Medicaid agencies and SSA,[21] creating the potential for differing eligibility periods for beneficiaries depending on which agency determines the beneficiary's eligibility.

## Assisting Beneficiaries

### Evaluating Options

The complexity of the benefit, coupled with the possibility of many plan options, make it a certainty that Medicare beneficiaries will need assistance when deciding whether to sign up and when picking a plan. The following suggestions are intended to help you navigate key decisions that most beneficiaries will need to make at the program's outset.

**Whether to sign up**. The decision about whether to sign up or not should be based on several factors: the beneficiary's eligibility for low-income assistance; other coverage options they may have; and their current drug costs. All full dual eligibles should sign up for the benefit. Others who are eligible for low-income assistance should be strongly encouraged to sign up even if they are at the assistance level that requires higher premium payments: Failing to sign up will mean that late-enrollment penalties will begin to add up and that the benefit will become increasingly unaffordable.

For those not eligible for the added low-income help, the decision can be more difficult.

- Individuals who have comprehensive employment-related retiree coverage will generally be better off keeping that coverage, assuming it remains available.[22] They will still need to carefully compare their retiree drug coverage, including premiums, with Medicare's drug benefit. In most cases, though, coverage through a former employer will be better.

- Those with no other coverage and very high drug costs should probably enroll in the drug benefit. Although not comprehensive, the drug coverage will offer some financial relief.

- For individuals with no drug coverage but very low drug costs, the decision will be harder. In

2006, the financial "break-even" point for the benefit will be $810 in drug expenses. So, it is possible that someone with low drug expenses could spend more with the benefit than without. Still, not signing up is a gamble because of late-enrollment penalties and limited enrollment times. The cost of late penalties and, if a beneficiary's health status changes, the risk of going without needed coverage for several months, should be weighed against the cost of paying more now.

**Picking a plan**. Selecting a plan will require comparing premiums; reviewing the list of covered drugs, participating pharmacies, and drug prices; and obtaining any information available on plan performance and/or quality. Information on premiums and covered drugs will be available at the start of the program. Information on plan performance will not be available at the start of the program. It is unclear how much drug price information will be readily available once the program begins.[23]

CMS has indicated that it will provide a Web-based plan comparison tool at www.medicare.gov. If you are assisting clients with plan selection, you should familiarize yourself with that site—it may prove valuable when comparing options. Unfortunately, even with careful plan selection, covered drugs, drug prices, and participating pharmacies may change, so the chosen plan, though best at the time of selection, may, in the end, be inadequate.

### Coordinating Coverage

Medicare drug plans are required to coordinate benefits with state pharmacy assistance programs (SPAPs) like New York's EPIC program, with Medicare always the primary payer. This gives SPAPs an opportunity to fill in the gaps in Medicare's drug benefit, which could be especially helpful to lower-income beneficiaries.[24] Since SPAP coverage counts toward an individual's annual out-of-pocket maximum, Medicare's catastrophic coverage essentially limits SPAP liability. However, SPAP coverage of drugs not on a plan formulary will not count toward an individual's annual out-of-pocket maximum. In addition, under the statute, SPAPs may not discriminate among Part D plans,[25] which will make it difficult for New York to automatically enroll all EPIC members in the same Part D plan, and which will create numerous administrative challenges.

Other plans can provide "wrap-around" coverage—coverage that fills in Medicare's gaps. These plans include employment-related retiree plans, FEHBP, plans related to military service, and coverage through a Medicaid waiver.[26] However, none of the costs covered by these plans will count toward an individual's annual out-of-pocket maximum.

### When Things Go Wrong: A Quick Look at Grievances and Appeals

Plans will be required to have a process in place that beneficiaries can use to appeal coverage decisions, including coverage for a non-formulary drug or cost-sharing requirements (if a drug's cost-sharing changes).

Appeals can be requested directly with the drug plan by a beneficiary or by his or her authorized representative or physician.[27] The proposed standard turnaround time for an appeal decision is 14 days. Expedited requests can be made, and the time frame for expedited determinations is 72 hours. These time frames are, unfortunately, longer than those currently required by Medicaid.[28] There will also be opportunities, although somewhat limited, for appeals with CMS and judicial review.

## Conclusion

The new Medicare drug benefit will bring with it many challenges for those who work with seniors and others in Medicare: the benefit is confusing; plan selection will be extremely important, yet comparing plans may well be difficult; and many beneficiaries will still have high drug costs. Low-income beneficiaries will have a richer benefit but, for many—particularly those in Medicaid who are accustomed to having their prescriptions paid through that program—signing up will be a difficult and complicated process. Much about the program is still not known because the regulations governing the program's operation are not final. But it is certain that beneficiaries will need significant counseling to fully evaluate their options.

## Endnotes

1. Proposed rules were published at 69 Fed. Reg. 46,632 (2004) (to be codified at 42 C.F.R. pts. 403, 411, 417, and 423) (proposed August 3, 2004).
2. The law calls for at least a six-month long initial enrollment period starting on November 15, 2004. The dates for enrollment and annual election periods are set out in the Proposed Rules. In addition, there will be special enrollment periods available to those who involuntarily lose coverage during the year. Proposed 42 C.F.R. § 423.36.
3. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (here-

inafter MMA), § 101, creating § 1860D-13(b) of the Social Security Act.

4. MMA § 104, amending 42 U.S.C. § 1395ss. Individuals enrolled in Medigap plans as of January 1, 2006 will be able to keep those plans. However, current Medigap plans H, I, or J, which offer drug coverage, will not be permitted to sign up new subscribers after the Medicare drug benefit begins. The law directs the National Association of Insurance Commissioners to develop new Medicare supplemental policies.
5. Proposed 42 C.F.R. § 423.36(c).
6. Proposed 42 C.F.R. § 423.884(c) requires employment-sponsored plans to notify enrolled Medicare beneficiaries regarding whether or not the plan's coverage is considered "creditable." Comments on the proposed rules submitted October 4, 2004 by Families USA through the Medicare Consumers Working Group suggest additional notice requirements. These comments are available online at: http://www.familiesusa.org/site/DocServer?docID=5141.
7. The exception is the so-called "fallback" plans. Because it is unclear whether there will be plans bidding in each region, to help ensure at least some access for all beneficiaries, the law provides for government-sponsored fallback plans. In areas with fewer than two plans bidding, CMS will contract with a plan to provider services in that area (such plans will not bear financial risk for drug costs). MMA §101, creating § 1860D-11(g).
8. MMA § 101, creating § 1860D-3(a)(1).
9. MMA § 101, creating § 1860D-13(a)(3). Individuals who qualify for low-income assistance may have their premiums waived or reduced. See the section on "Special Issues for Low-Income Beneficiaries" in this article.
10. Proposed 42 C.F.R. § 423.104(e)(2)(i) outlines the option for varying cost-sharing under the basic benefit.
11. While plans are required to make their negotiated prices available to enrollees, the percentage of any discount that must be passed along to beneficiaries is not specified. Negotiated prices that are made available need only "take into account" subsidies, rebates, and other price concessions. Proposed 42 C.F.R. § 423.100.
12. The law directs the U.S. Pharmacopeia (USP) to develop a list of therapeutic classes that will serve as a model for formulary development. MMA § 101, creating § 1860D-11(e)(2)(D)(ii).
13. Proposed 42 C.F.R. §§ 423.120(b)(5) and (b)(6). The proposed rules require plans to notify CMS, affected enrollees, authorized prescribers, and pharmacies 30 days prior to either removing a drug from the plans' formulary or changing its cost-sharing tier. No formulary changes can be made during the start of and 30 days after the end of the annual enrollment period.
14. MMA § 101, creating § 1860D-2(b).
15. Letter from Douglas Holtz-Eakin, Director, Congressional Budget Office, to Senator Don Nickles (November 20, 2003) (on file with Families USA).
16. *Id*.
17. Marc Steinberg, *Is Your State Ready for 2006? An Introduction to What the New Medicare Part D Prescription Drug Benefit Means for Medicaid* (Washington: Families USA, September 2004).
18. Proposed 42 C.F.R. § 423.773(c).
19. Proposed 42 C.F.R. § 423.34(c).
20. MMA § 101, creating § 1860D-14(a)(3)(B)(i).
21. Proposed 42 C.F.R. § 423.774(c).
22. The government projects that 2.7 million in Medicare who currently have retiree drug coverage will lose that coverage as a direct result of the new law and that even more beneficiaries will see coverage reduced. *Approximately Half of Americans in Medicare at Risk of Losing Coverage When the New Law is Implemented* (Washington: Families USA, October 20, 2004).
23. Under the proposed rules, plans are required to make information available so that beneficiaries can make an informed selection. Proposed 42 C.F.R. § 423.48.
24. MMA § 101, creating § 1860D-23; proposed 42 C.F.R. § 423.464(e).
25. MMA § 101, creating § 1860D-23(b)(2).
26. Proposed § 42 C.F.R. 423.464 (f).
27. Proposed § 42 C.F.R. 423.566 (c).
28. Proposed § 42 C.F.R. 423.570(c)(3) specifies that the turnaround time for an expedited appeal in an emergency situation must be "prompt" under the new law. In contrast, Medicaid law at 42 U.S.C. § 1396r-8 requires a 24-hour turnaround and requires that a 72-hour drug supply be provided in an emergency situation if a determination cannot be made immediately.

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# The Medicare Prescription Drug Card: Impact on Low-Income Beneficiaries Who Have EPIC or Medicaid

By Valerie Bogart and Diane Archer

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The Medicare Act of 2003[1] creates a new Medicare Prescription Drug Program that provides limited assistance paying for prescription drugs. Detailed federal regulations were proposed on August 3, 2004, with comments due on October 4, 2004.[2] Many consumer advocacy groups submitted comments.[3] The Medicare Act of 2003 provides for prescription drug assistance in two phases. First, since May 2004 and continuing through December 2005, people with Medicare who are not enrolled in full Medicaid may enroll in a Medicare-approved prescription drug discount card. Second, beginning November 15, 2005, with coverage effective January 1, 2006, Medicare beneficiaries may enroll in the new Part D Medicare benefit, and obtain partial drug coverage either through a stand-alone prescription drug plan (PDP) or through a Medicare Advantage plan (MA-PD) (formerly known as Medicare + Choice—essentially, a Medicare HMO).

This article will explain the first phase of this implementation now in effect, the prescription drug cards, and the impact on low-income Medicare beneficiaries who are eligible for either Medicaid or the EPIC program in New York State. The second phase, the Part D program, for which enrollment will begin in November 2005, will be discussed in a later article.

## 1. Who Is Eligible for a Prescription Drug Card

Since May 1, 2004, people with Medicare have been able to enroll in a discount drug card approved by the federal Centers for Medicare and Medicaid Services (CMS), effective June 1, 2004. To be eligible, the individual must be enrolled under Medicare Part A or B (or be entitled to Part A). They may not enroll if they have full Medicaid drug coverage (i.e., Medicaid with no spend-down). If they are enrolled in a Medicare Advantage (Medicare managed care) plan that offers an exclusive drug discount card, they can only choose to enroll in that card. Those who qualify for Medicaid only with a spend-down may enroll and use the card during the time their spend-down is not met.

The drug card sponsor negotiates discounts for drugs on its formulary, which are savings passed on to the drug card enrollee, who uses the card at pharmacies included in the card's network. Discounts range from 10–25 percent. The drug cards may charge an annual enrollment fee not to exceed $30. One may be enrolled in only one card at a time.

Information on choosing one of the 39 approved national cards, or various New York State-specific cards, is available at the official Medicare site, http://www.medicare.gov or at 1-800 MEDICARE. Information is also available at non-profit advocacy cites such as http://www.benefitscheckup.org. In New York, for people over 65 with incomes under $35,000 (singles), and $50,000 (couples), EPIC continues to be their best option. EPIC enrolls its lowest income enrollees in a free Medicare drug card that coordinates with EPIC and waives EPIC fees, which is described below. New Yorkers under 65, or those over 65 whose income is above the EPIC limits, are likely to be better off with other drug discount options, such as those offered by the pharmaceutical companies and through the Internet.[4] People who buy their drugs from Canada tend to get the best savings. While technically not legal, the federal government has said it would not prosecute any individual who buys drugs from Canada for individual use.

## 2. Limitations of Drug Cards

In addition to the very limited discount they offer, there are important limitations to these cards:

### A. Limited Formulary

The card gives discounts only on prescription drugs on its formulary, which should be published on the CMS website or should be available upon request

from the drug card sponsor. The plan must provide a discount on at least one drug in 209 therapeutic classes, with at least one generic drug in 115 of these 209 classes. Examples of the 209 therapeutic classes are anti-anxiety drugs, calcium blockers, cholesterol reducers, and antidepressants. There is no requirement that the card include any particular drug in these classes, so many popular brand-name drugs are not covered.

- The cards *may* offer discounts on *non*-prescription drugs.
- The cards *may not* be used for weight-loss or weight-gain drugs, drugs to promote hair growth, drugs for relief of colds or coughs, or most prescription vitamins.
- Insulin, syringes, and medical supplies for insulin injections, including needles, alcohol, and gauze, are also discounted, but not test strips and lancets.

### B. Lock-in

From November 15–December 31, 2004, enrollees were permitted to change cards, with the effective date of the change being January 1, 2005. However, after January 1, 2005, once enrolled, cardholders may not change the card except in exceptional circumstances. The exception applies if they move outside the card's area, enter or leave a long-term care facility, join or leave a Medicare managed care plan, or if the sponsor stops offering the discount card. Someone who voluntarily disenrolls from a card after December 31, 2004 may not enroll in a different card. However, a drug card holder may enroll in or use other drug discounts, such as EPIC or discounts available from pharmaceutical companies.

### C. Change in Formulary

While cardholders are locked in, the drug card may change its formulary and prices for its drugs as often as *once a week*. The sponsor need not inform its cardholders of these changes; the cardholder must call the program or check its website to stay current. An individual who chooses a card specifically because it covers a certain drug may find that, in the next week or the next month, the card no longer covers that drug. Yet the individual is locked in and may not switch to a different card in that year.

- Note that a change in the card's formulary, or a new diagnosis necessitating a new prescription, do not constitute exceptional circumstances that would permit the beneficiary to change cards mid-year.

### D. Change in Pharmacies

Pharmacies may add or drop cards in which they participate during the year, and the cards may change covered pharmacies during the year. Prices may vary between participating pharmacies even using the same card.

## 3. How to Enroll

A. CMS has issued a standard enrollment form for all drug card programs.[5] Enrollment is effective in the month after the enrollment form is received by the card program, unless received late in the month. The card sponsor sends the enrollment form to CMS for approval, which should be given within 48 hours. Once an enrollment form is approved by CMS, the plan is supposed to send a discount card within five workdays.[6] Enrollment may also be done by phone.

B. There is open continuous enrollment for these cards—any eligible beneficiary may enroll in a card for the first time at any time until December 31, 2005, with no penalty for late enrollment. However, be forewarned that when the prescription drug benefit begins effective January 1, 2006, there will be a financial penalty for late enrollment.

## 4. Medicare Drug Discount for People with Low Income, Including Those on EPIC and Medicaid—In General

The Medicare Act of 2003 provides for additional "transitional assistance" for individuals whose income is under 135 percent of the federal poverty line (FPL) (see chart on page 22 with income levels). This is (a) a $600 credit per year, for 2004 and 2005, toward the purchase of prescription drugs with a drug discount card, and (b) waiver of the annual $30 drug card enrollment fee. "Income" is defined as adjusted gross income under IRS rules, except that it includes Social Security. There is no asset test.

To qualify for this credit of up to $1,200, plus waiver of the card fee, individuals may not have drug coverage under a group health plan, military or federal employee coverage, or full Medicaid. However, those who have EPIC, VA drug benefits, drug coverage from a Medigap policy or Medicare Advantage

(managed care plan), or Medicaid with a spend-down may still qualify for this additional subsidy, as explained below.

The $600 credit does not affect eligibility for other federal public benefits, including Food Stamps.[7] The $600 credit may be applied toward the Medicaid spend-down as an incurred expense.[8]

The $600 credit is paid by the government in the form of partial payment for drugs purchased with the drug discount card. The amount of the government payment is either 90 or 95% of the cost of the drug, depending on the enrollee's income. In other words, the enrollee pays a copayment of five or ten percent of the cost of the drug, until the government's payments for the balance of the cost reach $600 for the year. The chart on page 22 shows the income limits for the different levels of copayment. The chart also compares the income limits for EPIC and copayment and deductible costs. More on EPIC below.

**Enrollment:** Every New Yorker over age 65 who is eligible for the transitional assistance $600 credit should enroll in EPIC, and receive the $600 credit through EPIC, as discussed in part 5 below. Those who are under age 65, unfortunately, may not enroll in EPIC. They must separately enroll with a drug card and the additional $600 assistance, discussed in part 7 below.

### 5. Relationship of Drug Card, the $600 Credit, and EPIC

We are fortunate that New York State is one of over 30 states with a State Pharmacy Assistance Program, though New York's is limited to people age 65 and over, excluding younger people with disabilities who have Medicare. Like other states, New York's EPIC program is more generous than the Medicare drug card. Its discount is substantially greater. According to the state Department of Health website, EPIC saves, on average, 80% after fees and deductibles, compared to 10-25% savings on the Medicare discount cards. As shown in the chart below, EPIC income levels are significantly higher than 135% of the Federal Poverty Line—the eligibility limit for the $600 annual drug credit. Also, many people whose income is under 135% of the FPL are eligible for full Medicaid, so are not eligible for and do not need the $600 annual drug credit. Here are the rules for people who have EPIC at different income levels.[9] All may keep their EPIC coverage.

A. EPIC enrollees whose incomes are *above* 135% FPL (see chart on p.22) do not qualify for the $600 credit.

These individuals may keep EPIC and also *may* enroll in a Medicare drug discount card, although in most instances there would be no reason for them to do so. They will have to pay as much as a $30 annual fee for the drug card, in addition to their EPIC fees or deductible. The Medicare drug discount card may *not* be used with the EPIC card for the same drug purchase. The Medicare drug discount card might be used for drugs not covered by EPIC, including some of the non-prescription drugs of medical supplies listed above.

Those with higher incomes, for whom the EPIC fee or deductible is high, have to choose whether to enroll in EPIC, in a drug discount card, or both. They may never use both cards at the same time for the same drug purchases. In almost all cases, EPIC is the better choice unless people's drug costs are very low, and they are prepared to gamble that they will not need costly prescription drugs. Factors that should be considered in this decision are:

- Their drug costs—if these costs are lower than the EPIC fee or deductible, then they may prefer to disenroll from EPIC. If they do so, they will need to compare all their drug discount options. They should realize that the Medicare drug card discount will be limited to the card's formulary, and to non-drug items the card may cover. Moreover, should they need high-cost drugs, they will be worse off if they do not have EPIC.
- How soon they will meet the EPIC deductible for the year. Note that under the EPIC deductible plan, even if the individual has not met the deductible, the pharmacy is limited to charging the price set by EPIC (average wholesale price less 20%), which may be better than the Medicare drug card.

Drugs purchased with the discount card *may not* be applied to the EPIC deductible; only drugs purchased with the EPIC card may be applied to the EPIC deductible.

B. EPIC enrollees whose incomes are *below* 135% of the FPL, but who are not eligible for full Medicaid with no spend-down, are eligible for the $600 "transitional assistance" credit, and waiver of the drug card enrollment fee, as follows:

i. New York State passed legislation allowing EPIC to automatically enroll EPIC recipients at this income level who qualify for the $600 credit into one Medicare drug discount plan.[10] This plan is First Health. EPIC sent letters in late May 2004 to 123,000 EPIC recipients eligible for the $600 credit, based on their 2003 income, informing them of automatic enrollment in the First Health drug card, with opportunity to decline enrollment by June 1, 2004.

- Individuals who did not qualify based on 2003 income, but who may qualify using 2004 income, should call EPIC and request a transitional assistance application. The toll-free hotline is 1-800-332-3742 or write EPIC, P.O. Box 15022, Albany, NY 12212-5022.
- Those on the Medicare Savings Program QI-1 program (pays Medicare Part B premium for incomes 120%–135% FPL) may not have been sent letters and should call or write to EPIC for an enrollment form.

ii. CMS approved the $600 subsidy and enrollment into First Health's drug card program for 99,000 EPIC recipients. 16,000 were rejected and 8,000 were being reviewed as of July 2004.

iii. THE CARD IS FREE —The $30 annual fee for the First Health card is waived.

iv. EPIC FEES WAIVED—Those eligible for the $600 credit will have their EPIC fees waived, but *only* if they enroll in First Health *or* belong to a Medicare Advantage plan's exclusive card program. See cards listed in endnote 3. See chart for range of annual EPIC fees, and http://www.health.state.ny.us/nysdoh/epic/faq.htm for complete fee schedule. Those who have already paid fees, which are billed quarterly, will receive reimbursement retroactive to enrollment in the Medicare drug discount card program.

TIP: Since the drug discount card sponsors advertise their cards, many EPIC recipients may be tempted to enroll in a card. If they enroll in any card other than First Health, even if their income is below 135% FPL, the drug discount card fee and EPIC fees will not be waived.

v. EPIC PAYS PART OF THE 5% or 10% COPAYMENT. The enrollee should present both the First Health and EPIC card at the pharmacy, and ask the pharmacy to bill First Health first for all prescriptions until the $600 credit is used up. EPIC will pay part of the 5% or 10% copayment that applies to the Medicare drug discount card for low-income people (see chart). The client's share of the copayment will in most cases be *less* than the copayment would have been if the client only had EPIC, and not the First Health card.

EXAMPLE: Sally has EPIC and qualifies for the 10% copayment (her income is $1045 per month). She buys a drug that costs $300. The pharmacist bills First Health, which pays 90% of the cost ($270). This amount is deducted from the $600 credit, leaving $330 credit left. Sally should ask the pharmacy to submit the 10% copayment ($30) to EPIC. EPIC will charge Sally seven dollars ($7.00), which is the applicable EPIC copayment for medications that cost between $15.01 and $35 (see chart). EPIC will pay the balance of $23.

vi. The $600 CREDIT FOR 2004 and 2005:

- If client applies for this credit in 2004, she or he will receive $600 credit in 2004 and another $600 in 2005 without having to re-apply in 2005.

- Any unused portion of $600 from 2004 will roll over to 2005 in most cases.
- If client applies for this credit in 2005, client only receives a prorated amount of the $600 credit based on the quarter of enrollment in 2005, i.e., if clients enroll in April, they will get $450 credit.
- When the $600 credit is used up for the year, client will still have EPIC coverage—and will stop using the First Health card, except for any medications not covered by EPIC.
- Credit toward the $600 is given for purchase of any drug not excluded under the Medicare Act of 2003 (e.g., not weight loss drugs), even if not on the formulary of First Health or other drug card.

### 6. EPIC and Medicaid

Individuals may be on EPIC and on the Medicaid spend-down program.

- The full cost of drugs while on EPIC, including the subsidy paid by EPIC as well as the copayment, may be used toward the Medicaid spend-down.[11]
- If they receive the $600 credit while on EPIC, the $600 subsidy may be applied toward the Medicaid spend-down.[12]

EPIC Recertification—EPIC recipients should indicate they do not have any other drug coverage if they are on the Medicaid spend-down program.

### 7. The $600 Credit for People Who Are Not on EPIC

Two types of low-income people may have Medicare but not EPIC: (1) those who are under age 65 are not eligible for EPIC, and (2) people age 65 and over, who are financially eligible for EPIC, but have never applied for EPIC, mostly because they don't know about it. There are many people in these two groups whose incomes are under the 135% Federal poverty level, so are eligible for the additional drug card benefit worth up to $1,200. However, only a small fraction of people have signed up for a card on their own. The majority of people with low incomes who have a card have been automatically enrolled either by their Medicare HMO or by their State Prescription Drug Assistance Program (EPIC in New York State).

To help ensure that as many people as possible with low incomes are enrolled in a drug card with transitional assistance, the Centers for Medicare and Medicaid Services (CMS) launched an initiative to send letters to all people enrolled in a Medicare Savings Program[13] who were not signed up for one of the national Medicare discount drug cards. The letters will assign them to a randomly selected card, and give them the opportunity to enroll, by calling an 800 number. Since this program serves people under as well as over age 65, it is an opportunity to enroll younger people with disabilities.

Those who do call will then be asked whether they have other insurance that would make them ineligible for the $600 transitional assistance, and whether they have enrolled in another discount card. They will also be asked to verify their income so CMS knows whether they have a 5 or 10% copayment. Individuals who do not call to activate their cards *will not* be enrolled and *will not* receive the $600 credit toward the cost of their drugs. The card and the $600 credit was effective beginning November 2004. People *may* call the 800 number and ask to be switched to a different card.

While this outreach effort by CMS is helpful for people *under* age 65, who do not qualify for EPIC, it is less helpful for New Yorkers with low incomes over age 65, who qualify for but are not enrolled in EPIC. Unfortunately, the card they receive through this auto-assignment will be randomly selected, so will not be the First Health card that coordinates with EPIC. Nor will they be told about EPIC if they call to activate their card. While they will receive the $600 credit per year, they will not receive the special extra benefits of those in EPIC—EPIC's subsidy of part of the 5 to 10% copayment, and the huge discounts afforded by EPIC after the $600 credit is exhausted.

TIP:

- *Those 65 and over* whose incomes are below the 135% Federal Poverty Level should enroll in EPIC, and receive their $600 credit automatically through EPIC, because of the enhanced benefits available only through the EPIC/First Health card. If they receive the automatic assignment from CMS, they should decline enrollment and instead apply for EPIC.

- *Those under 65*, who are not eligible for EPIC based on their age, should enroll in a card and apply for the $600 discount. This requires either responding to the letter from CMS, if they receive one, or filling out the combination Standard Enrollment Form for the Medicare-Approved Drug Discount Card and Additional Assistance in Paying for Your Prescription Drugs (CMS-20016-B).[14] This allows self-attestation of income eligibility. The signed and completed form should be mailed directly to the card sponsor the client chooses. (See No. 3 above.) Enroll early in 2005, to avoid a prorated reduction of the $600 credit for 2005.

## 8. Drug Discount Card and Medigap Policyholders

For those whose income is over 135% FPL, so lack the $600 annual credit, using the discount card will delay meeting the annual $250 Medigap deductible if they are enrolled in Plans H, I or J.

For those whose income is below 135% FPL, so have the $600 annual credit—they must use the drug discount card to purchase drugs before they meet their annual deductible. Only the 5% or 10% copayment will count toward the deductible. This will delay meeting the deductible.

## Endnotes

1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003; Pub. L. 108-73, signed into law December 8, 2003.
2. 69 Fed. Reg. 46632 (August 3, 2004). Interim federal regulations were published earlier, on December 15, 2003, 68 Fed. Reg. 69840.
3. *See, e.g.*, comments of the Medicare Consumers Working Group posted at http://www.medicareadvocacy.org/Reform_ActWGCommentsRaiseConcerns.htm. The Working Group includes dozens of organizations including the Medicare Rights Center, Center for Medicare Advocacy, Families USA, National Council on Aging, AFL-CIO, Brookdale Center on Aging at Hunter College, and others.
4. *See* http://www.medicarerights.org/rxframeset.html.
5. *Available at* http://www.medicare.gov/medicarereform/formsandinstructions.asp.
6. Information from Samuel Sadin Law Institute/Brookdale Center on Aging of Hunter College/CUNY, which sites the CMS Training Module.
7. *See* USDA policy guidance issued June 18, 2004 *at* http://www.fns.usda.gov/fsp/rules/Memo/04/061804.htm.
8. *See* Dear State Medicaid Director letter from CMS, July 19, 2004 *at* http://www.cms.hhs.gov/states/letters/smd071904.pdf.
9. http://www.cms.hhs.gov/states/letters/smd071904a.pdf. Some of this information is from State Dep't of Health website *at* http://www.health.state.ny.us/nysdoh/epic/medicare_drug_card.htm.
10. http://www.cms.hhs.gov/states/letters/smd071904a.pdf. N. Y. Executive Law § 547-b, amended L. 2004, ch. 49, § 2 (Part A), eff. May 3, 2004.
11. 18 N.Y.C.R.R. § 360-4.8(c)(1)., 91 ADM-11.
12. *See* Dear State Medicaid Director letter from CMS, July 19, 2004 *at* http://www.cms.hhs.gov/states/letters/smd071904a.pdf.
13. The Medicare Savings Program is a program administered by Medicaid that pays the Medicare Part B, and sometimes Part A premiums, and sometimes the Medicare copayments and deductibles, for people whose income is under 135% of the Federal Poverty Level. This is the same income limit that applies to the $600 credit. One applies for the Medicare Savings Program at a regular Medicaid office. *See* http://www.health.state.ny.us/nysdoh/mancare/omm/savingsprogram/medicaresavingsprogram.htm.
14. Form *at* http://www.medicare.gov/medicarereform/formsandinstructions.asp.

**Valerie Bogart is Director of Selfhelp Community Services, Inc., Evelyn Frank Legal Resources Program.**

**Diane Archer is Founder and Special Counsel, Medicare Rights Center.**

## Medicare Transitional Assistance $600 Credit for Low-Income People Compared with EPIC and Medicaid

| | | 2004 monthly income limit | 2004 annual income limit | Co-payment | Annual fee or deductible |
|---|---|---|---|---|---|
| **Medicaid** (for comparison) | Single | $679[1] | $ 8,148 | $2 brand name, $.50 generics, up to annual $100 cap[2] | Spend-down if over income limit |
| | Couple | $970 | $11,640 | | |
| **Medicare Prescription Drug Card—Transitional Assistance Benefit of $600 credit/year** | | | | | |
| < 100% Federal Poverty Level (FPL) | Single | $776/mo. | $ 9,310 | 5% for first $600 in meds, then 100% | $30 fee is waived for these income levels. If on EPIC, fee waived only if enrolled in First Health card |
| | Couple | $1041/mo | $12,490 | | |
| 100% - 135% FPL | Single | $1047/mo | $12,569/yr | 10% for first $600 in meds, then 100% | |
| | Couple | $1405/mo. | $16,862/yr | | |
| **EPIC** | | | | | |
| EPIC Fee Plan (lowest income) | Single | | < $20,000 | co-pay depends on cost of prescription: $3 for Rx up to $15 $7 for Rx $15.01 - $35 $15 for Rx $35.01 - $55 $20 for Rx over $55 | Annual fee up to $230, paid quarterly, amount depending on income |
| | Couple | | < $26,000 | | Annual fee up to $300, depending on income |
| EPIC Deductible Plan (higher income) | Single | | $20,001 - $35,000 | | No fee - deductible between $530 - $1230 depending on income |
| | Couple | | $26,001 - $50,000 | | No fee - deductible between $650 - $1715 depending on income |

For complete EPIC fee schedule, applications and other information see http://www.health.state.ny.us/nysdoh/epic/faq.htm

### Endnotes

1. Includes $20 disregard for persons over age 65, blind, or disabled.
2. Psychotropics, birth control, and TB medications are exempt from copays, as are all copays for pregnant women.

# New York Case News

By Judith B. Raskin

## Power of Attorney

**Defendant appealed from an order requiring him to return gifts he made to himself as attorney in fact where the power of attorney did not specifically authorize gifting. Appeal denied. *Marszal v. Anderson*, No. 95073 (App. Div., 3d Dep't, May 26, 2004).**

Mother's will named her son and daughter as equal beneficiaries. In 1995, mother appointed son as her agent under a durable power of attorney but the document did not include specific gifting authority. In 1996, mother moved in with son for eight months after which time she entered a nursing home. Son then gifted all of mother's assets to himself. Daughter brought an action to require her brother to return her half of mother's assets. Daughter claimed breach of fiduciary duty and unjust enrichment. She did not argue the validity of the document but rather that it was not her mother's intention that her brother gift all of mother's assets to himself. The defendant introduced testimony that his mother had intended he get all of the assets. The Supreme Court ordered the son to return one-half of the assets to the plaintiff.

Defendant appealed, *inter alia*, from that order. The appellate division affirmed. The presumption of impropriety can only be overcome by "the clearest" showing that the principal intended to make the gift. The court found the testimony insufficient to meet this test.

## Medicaid

**Petitioner executor appealed from a decision that the deceased Medicaid applicant's funds were excess resources, not loans from her children. Appeal denied. *Faber v. Merrifield*, TP 04-00425 (App. Div., 4th Dep't, October 1, 2004).**

In this appeal of an article 78 proceeding, petitioner, as executor, sought reversal of a Supreme Court decision affirming denial of the decedent's Medicaid application for excess resources. The petitioner argued that sufficient evidence was presented to show that the excess resources were in fact loans made to decedent by her children.

The Appellate Division confirmed the lower court decision, holding that the lower court had based its decision on substantial evidence. The Appellate Division may not substitute its judgment on that evidence for the judgment of the lower court.

**Petitioner appealed from a decision in an article 78 proceeding that a 1986 trigger trust that did not exclude the grantor as a remainder beneficiary was an available resource. *Ferrugia v. New York State Dep't of Health*, CA 03-01169 (App. Div., 4th Dep't, March 19, 2004).**

The Supreme Court held that a 1986 "trigger trust" was an available resource where the grantor Medicaid applicant had the right to change the remainder beneficiaries but did not exclude the grantor from the list of potential beneficiaries.

On appeal, the Fourth Department confirmed the lower court decision. However, two of the justices strongly dissented. Their reasoning is set forth in a memorandum. Their main arguments are: 1) legislation prohibiting trigger trusts was not in effect in 1986; 2) the trust provision giving the grantor the right to change the remainder beneficiaries does not hold open the possibility, as the lower court held, that she had the ability to return trust property to herself; 3) the grantor did not have the possibility of a reversionary interest and the grantor cannot be a remainderman; and 4) the trust terminated by its terms upon the grantor's entry into the nursing home and so she had no resources of the trust under her control when she made the Medicaid application.

**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.**

# Legislative News

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

Continuing Care Retirement Communities (CCRCs) continue to grow in popularity as seniors consider their housing options at retirement and beyond. CCRCs offer a range of services and levels of care, from independent living, to assisted living, and if necessary, nursing care. The great benefit of CCRCs is that all of the various levels of care are offered within the same community, allowing seniors to "age in place."

An ever-increasing number of seniors are choosing to spend their retirement years in CCRCs. However, residents of these communities have mostly been seniors with substantial assets, as the costs can be significant. On September 28, 2004, Governor Pataki signed new legislation in an effort to make continuing care retirement communities more available and affordable for New Yorkers. The legislation becomes effective January 1, 2005.

According to the Bill Summary, the current structure of continuing care retirement communities pursuant to Article 46 of the Public Health Law makes an entity's entry into the market difficult. Moreover, the reality of the application of Article 46 is that continuing care retirement communities are cost-prohibitive for many of New York's seniors. To that end, this legislation establishes a new continuing care retirement community model in New York, which would foster the growth of these communities and reduce the cost to its residents.

In general, CCRCs must amass large financial reserves in order to spread the risk, which in turn excludes seniors of moderate means. In an effort to contain costs, most new communities being developed are of a type where residents pay only for the services they receive under the fee-for-service model. The new law, Article 46-a of the New York Public Health Law, provides for a "fee-for-service continuing care retirement community" demonstration program, in order to provide a comprehensive, cohesive living arrangement for aging New Yorkers oriented to the enhancement of their quality of life on a fee-for-service basis. The Bill Summary explains that the fee schedule for fee-for-service CCRCs is graduated across the continuum of care, which allows for maximum affordability in independent living, where 80% of residents reside.

Steven H. Stern

These facilities would cater to middle-income seniors, which should mean that the median income of the residents at a facility should track with the median income of the counties in which the facility is located. Such residents would need to agree to privately pay, either directly or through long-term care insurance, for all services ranging from independent living units to skilled nursing beds. Only after the individual has spent down, based on their financial standing upon entrance into the community, would the individual be eligible for Medicaid.

Provisions included in the bill provide for the following:

The authorization of up to eight fee-for-service continuing care retirement communities to encourage affordable care options for middle-income seniors.

The communities shall have access to up to 350 of the nursing facility beds set aside in subdivision (5) of section forty-six hundred four of article 46 of the Public Health Law.

Conditions which must be met by a fee-for-service continuing care retirement community prior to receiving an operating certificate include:

- The applicant plans to provide services to at least one thousand citizens over the age of 62.
- The facility provides access to on-site geriatric services, including, but not limited to nursing facility services, assistance with activities of daily living, home health services, and independent living units on a fee-for-service cost schedule.
- The community will establish a benevolent care fund to make funds available to qualifying subscribers who are unable to pay certain fees.
- The applicant has experience providing quality continuing care services to senior citizens.
- No more than two communities may be awarded to for-profit operators.

The requirements of the fee-for-service continuing care contract include, but are not limited to: a description of all services which are to be furnished by the operator; fees charged; terms and conditions under which a contract may be canceled by the operator or by a resident; and a statement requiring a resident either: exhaust available resources, including funds from a refundable entrance fee prior to applying for Medicaid Assistance or any other income-qualified state subsidy for long-term care; or purchase or maintain long-term care insurance, which would provide requisite coverage for all levels of services offered at such continuing care retirement community. For residents who have long-term care insurance prior to signing a fee-for-service continuing care contract, the applicant/operator shall assist the resident in determining which services the resident's existing long-term care insurance policy may not cover.

Although considered a "demonstration project," the hope is that this legislation will serve as an important step forward in fostering the growth of CCRCs in New York.

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# Practice News

## When Annuities Can Make Sense in a Long-Term Care Plan

By Vincent J. Russo and Marvin Rachlin

Annuities can be a useful tool for the elder law attorney when recommending long-term care planning.[1] The attorney must also advise the client of the tax implications of any Medicaid plan which is being considered. To date, there has been limited use of annuities in New York.

**Marvin Rachlin (l) and Vincent J. Russo**

### What Is an Annuity?

An annuity is an investment vehicle whereby an individual (the "annuitant") establishes a right to receive fixed periodic payments, either for life or a term of years. To the extent to which the anticipated return is commensurate with the money invested, the purchase of an annuity shall be considered a compensated transfer of assets; to the extent that the anticipated return is less than the amount invested, it shall be considered to be a trust-related transfer for less than fair market value.

For tax purposes, the typical annuity contract will involve a transfer of funds in return for specified annual payments based on the annuitant's reasonable life expectancy.[2] The amount of the annual payment is calculated by spreading the amount paid for the annuity over the annuitant's life expectancy, factoring in a prescribed rate of return on the unpaid funds, and also taking into account the possibility that the person may outlive his or her life expectancy.[3] If the present value of the projected annuity payments, based on the annuitant's life expectancy, is equal to the price paid for it, then the purchase of the annuity contract is a transfer for fair consideration and may be referred to as "actuarially sound."

Since the basic annuity contract provides that payments will cease on the annuitant's death, an early death of the annuitant can result in a significant loss to an individual or his family. Consequently, many contracts are written with the provision that payments will be made for life, but in no event for less than a specified term of years, called a "term certain." As a general rule, if the term certain exceeds the individual's reasonable life expectancy, then the purchase of the annuity will not be a transfer for fair consideration (as it will not be considered "actuarially sound").

In other words, if the annuity contract has a term certain but does not guarantee payments for the life of the annuitant, then the term certain must not exceed the annuitant's life expectancy in order for it to be actuarially sound. If the term exceeds life expectancy it will be considered a transfer for less than full consideration because part of the benefit passes to a third party.

One should also note that an annuity may be disqualified if the purchaser has a greater than 50/50 chance that he or she will die within a twelve-month period.[4] The local Medicaid agency may take this position using this IRS rule.

### Types of Annuities

There are basically two types of annuities which can be considered:

(i) A commercial annuity (i.e., through an insurance company); and

(ii) A private annuity ("PAN"), which is an agreement between individuals such as family members.

Typically, the private annuity will be between members of a family, but that is not a requirement. As with a commercial annuity, a PAN can be for the life of the purchaser or for the joint lives of the purchaser and another (such as husband and wife), or any other customary form that an annuity may take.[5]

The typical PAN, however, will *not* have a term certain, so that payments will cease on the annuitant's death and the contract performance will be completed; therefore, no part of the transferred property is included in the annuitant's estate for estate tax purposes.[6]

### Term Certain Versus Life Annuity

A term certain will guarantee a specific amount which will be paid out to the annuitant or his or her

estate. A life annuity may pay more or less that the specific amount under a "term certain" depending upon whether the annuitant outlives the life expectancy or not.

For many seniors, the "term certain" is preferred because the senior's estate will not absorb a loss if the annuitant dies earlier than his or her life expectancy.

## The Benefit of a Private Annuity Versus a Commercial Annuity

The private annuity can be arranged with the consideration being assets other than cash, such as a home or other real estate. This is very helpful if the assets are appreciated in value or illiquid.

For example, a commercial annuity would be purchased for cash, while a private annuity could be purchased in exchange for real estate.

## Application of Medicaid Transfer Penalty Rules Related to Annuities

Under the Medicaid eligibility rules, if a transfer is made for less than full consideration by an individual, then he or she will be subject to a period of ineligibility ("transfer penalty period") for Medicaid nursing home care based upon the value of the uncompensated transfer.

### 1. Transfer for Consideration

An annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years. To the extent to which the anticipated return is commensurate with the money invested, the purchase of an annuity shall be considered a compensated transfer of assets; to the extent that the anticipated return is less than the amount invested, it shall be considered to be a trust-related transfer for less than fair market value.[7] For Medicaid purposes annuities are treated like trusts and will be subject to the Medicaid transfer penalty rules and the sixty-month look-back rule.

### 2. HCFA Transmittal No. 64

Health Care Financing Administration, State Medicaid Manual Transmittal No. 64 (November 1994), HCFA Pub. 45-3 (HCFA Transmittal No. 64) provides a description as to how annuities are treated under the trust/transfer provisions. This transmittal provides some explanation and a set of life expectancy tables, but does not offer much more about annuities:

"When an individual purchases an annuity, he or she generally pays to the entity issuing the annuity (e.g., a bank or insurance company) a lump sum of money, in return for which he or she is promised regular payments of income in certain amounts. These payments may continue for a fixed period of time (for example, 10 years) or for as long as the individual (or another designated beneficiary) lives, thus creating an ongoing income stream. The annuity may or may not include a remainder clause under which if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.

"Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value) must be made. If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.

"To make this determination, use the following life expectancy tables,[8] compiled from information published by the Office of the Actuary of the Social Security Administration. The average number of years of expected life remaining for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty. The penalty is assessed based on a transfer of assets for less than fair market value that is considered to have occurred at the time the annuity was purchased."

"For example, if a male at age 65 purchases a $10,000 annuity to be paid over the course of 10 years, his life expectancy according to the table is 14.96 years. Thus, the annuity is actuarially sound. However, if a male at age 80 purchases the same annuity for $10,000 to be paid over the course of 10 years, his life expectancy is only 6.98 years. Thus, a payout of the annuity for approximately 3 years is considered a transfer of assets for less than fair market value and that amount is subject to penalty."

Note: The life expectancy tables are compiled from information published by the Office of the Actu-

ary of the Social Security Administration. The IRS life expectancy tables are not applicable in calculating a Medicaid transfer penalty period.

## Medicaid Considerations of Private Annuities

For Medicaid purposes, the transfer of property in return for a PAN is treated the same as for a commercial annuity. That is, the projected value of payments must be actuarially sound based on the annuitant's life expectancy and the applicable interest rates. The rate that should be used is 120 percent of the Federal Midterm Rate for the month the annuity contract is consummated.[9]

Note that there may be situations where the life expectancy tables may *not* be used. If the annuitant's state of health is such that, according to the diagnosis of a physician, there is a greater than 50/50 chance he or she will die within a twelve-month period, then the tables may not be used.[10] Further, if tables are used in such a situation, it is likely that a disqualifying transfer would result, and in addition, some or all of the transferred assets would be included in the deceased annuitant's gross estate.[11]

### Example

Father, age 70, exchanges his house worth $100,000 for a private annuity (PAN), from his child. The monthly payout is $833.33 for a term of ten years. Father's life expectancy is 11.92 years. This example assumes that the regional monthly rate for private pay nursing home care is $5,000 for the purpose of calculating the Medicaid transfer penalty period.

**Analysis #1:** Since his life expectancy is 11.92, there is full consideration for the transfer. The total payment of $100,000 is equal to the amount transferred. Hence, there is no Medicaid transfer penalty period. This could be challenged by the local Medicaid agency because it may not be considered actuarially sound based on the federal midterm rate. See analysis #2 below.

**Analysis #2:** If the current federal midterm rate is 8%, then the total payout over 10 years should be $145,594. If the total payout is only $100,000, then there was a transfer of $45,594 ($145,594 less $100,000), resulting in a penalty period of 9.1188 months ($45,594 ÷ $5,000 per month).

In order to achieve full consideration, the monthly payout should have been $1,213.28 per month for a total of $145,594 ($1,213.28 x 120 months).

It is not clear if the local Medicaid agency will apply only the life expectancy table versus the life expectancy table and the appropriate rate of return as applied under federal tax law.

## Medicaid Estate Recovery

Health Care Financing Administration (HCFA) ruled in a letter dated January 24, 2000 to the California Medicaid agency that the state may recover Medicaid expenditures for an annuity policyholder against the surviving beneficiary of the policy. However, some questions remained regarding the treatment of annuities in Medicaid estate recovery programs. In a letter to Herbert Semmel of the National Senior Citizens Law Center, Linda Minamoto, Associate Regional Administrator of HCFA's Region IX, further clarified the treatment of annuities. Minamoto's letter stated that: 1) there can be no estate recovery as long as there is a surviving spouse or dependent child, even if the remainder-person on the annuity is not a person in either of these categories; 2) the value of the interest in the annuity is the remainder balance that was owned by the beneficiary at the time of death. (Minamoto adds: "The remainder balance can diminish over time with annuity payments being made to statutory protected survivors, until such time as an 'estate recovery' can actually be made"); and 3) the January 24 letter on annuities does not apply to life insurance.

In New York State, since Medicaid recoveries are limited to the probate estate, there is no claim against remaining annuity assets. Federal law permits New York State to expand their definition of an estate if they choose to.

## Medicaid Planning for Single Individual

Annuities can be structured so that there is full consideration for the annuity. In such cases, there will be no transfer penalty. An individual can become Medicaid-eligible in exchange for conceding the monthly payments as part of the Medicaid income budget. This approach would be more valuable in a nursing home situation than a community-based home care case due to the high cost of nursing home care and because under current law there is no transfer penalty rule for Medicaid community based home care.

## Spousal Medicaid Planning

Another area where the purchase of an annuity can be beneficial is when the community spouse has assets in excess of the community spouse resource allowance and desires to protect the excess resources.

For example, if Steven and Jane have combined liquid assets of $170,000 and Steven needs immediate nursing home care, one option is for Steven and Jane to spend down their excess resources (the amount above the community spouse resource allowance).

As an alternative, the assets could be shifted to Jane and then Jane could file a "spousal refusal" with Steven's Medicaid application. Steven would be approved for Medicaid and the local Medicaid agency would have the right to sue Jane (the "refusing spouse").

Prior to the filing of the Medicaid application, Jane could purchase an immediate pay annuity for a period which is less than her life expectancy with $100,000 of her $170,000. For Medicaid eligibility purposes, when Steven applies, he would have no assets and Jane has $70,000 (which is below the community resource allowance). Hence, she will not be subject to a lawsuit from the local Medicaid agency seeking a contribution of her assets.[12]

On the other hand, she now has an additional income stream. The local Medicaid agency may sue the community spouse based on her ability to support her husband if her income is in excess of the allowable community spouse income allowance (in 2004, $2,319 per month).

One should note that there may be other options available to Jane which would allow her to protect her excess assets. For example, she could seek an enhanced community spouse resource allowance as to the excess assets (approx. $100,000).[13]

In addition, there may be a number of other factors to consider before implementing this plan, such as the effect of this plan on Jane if she requires long-term care during the annuity payout period.

## Conclusion

This article provides a brief overview of how annuities may fit in long-term care planning. For a more complete understanding of the long-term care planning options available, we refer you to *New York Elder Law Practice—2004* (Russo & Rachlin, West Group (1-800-328-4880)).

## Endnotes

1. *See* Alexander A. Bove, Esq., Boston, Massachusetts, "Making Resources Disappear: The Magic of Annuities and Self-Canceling Notes," presented at the NAELA 1996 Symposium.
2. Treas. Reg. § 1.72-2(b)(2).
3. Treas. Reg. § 20.2031-7(d)(2)(iv).
4. IRS Rev. Rul. 80-80, and Treas. Reg. § 1.7520-3(b)(3).
5. IRS General Counsel Memorandum (GCM) 39503, May 1986.
6. GCM 39503.
7. N.Y.S. Department of Social Services, Administrative Directive, Transmittal: 96 ADM-8, page 8.
8. *See* the life expectancy tables for males and females published by the Office of the Actuary of the Social Security Administration; *see also* N.Y.S. Department of Social Services, Administrative Directive, Transmittal: 96 ADM-8.
9. I.R.C. § 7520(a)(2) and Treas. Reg. § 25.7520-1.
10. IRS Rev. Rul. 80-80, and Treas. Reg. § 1.7520-3(b)(3).
11. I.R.C. § 2001(b)(1)(B).
12. *Mertz v. Houstoun* (E.D. Pa., No. 01-2627, July 30, 2001). The Federal District Court held that an actuarially sound annuity purchased for fair market value and for the sole benefit of a community spouse may not be counted in determining the institutionalized spouse's Medicaid eligibility.

    *Delaware Dep't of Health and Social Services v. Dean*, Del., No. 9, 2001, May 15, 2001. The Delaware Superior Court held an actuarially sound annuity purchased by a spouse of a Medicaid applicant does not trigger a penalty period and is not a countable asset.
13. For a further discussion of this issue and other Medicaid planning issues, see Vincent J. Russo & Marvin Rachlin, New York Elder Law Practice 2001 Edition (West Group (1-800-328-4880)).

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# 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 R. M.*

### Holding

Ellice Fatoullah

The Agency should have computed the value of a transfer of a remainder interest in real property by the Appellant for which the remainderman had paid $10,000 by deducting that amount from the fair market value of the remainder interest rather than by deducting that amount from the fair market value of the property prior to determining the value of the transferred remainder interest.

### Facts

The Appellant was age 78 and applied for Medicaid on August 3, 2003. On August 28, 2003 the Appellant entered a nursing home, and the Appellant was permanently absent from her home effective September 1, 2003. On October 21, 2003, the Appellant transferred a remainder interest in her home; she retained a life estate in the home. At the time she transferred the interest in her home, the fair market value of the home was $49,090.91. The remainderman paid the Appellant $10,000 for the remainder interest in the home.

By notice dated May 21, 2004, the Agency determined that the Appellant was not eligible for Medicaid for nursing facility services for a period of 3.42 months, beginning November 1, 2003, because the Appellant had transferred assets for less than fair market value. In making that determination, the Agency first deducted the $10,000 payment for the remainder interest from the $49,090.91 fair market value, and applied the proportional value of the remainder interest for an individual age 78, which is 52.951%, against the $39,090.91 uncompensated fair market value of the entire property, resulting in a 3.42-month penalty period of ineligibility.

On June 25, 2004, the Appellant requested a Fair Hearing to review the Agency's determination.

### Applicable Law

Section 366.5(d) of the Social Services Law and section 360-4.4(c)(2) of Title 18 of the New York Compilation of Codes, Rules and Regulations (N.Y.C.R.R., referred to herein as "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, either as an in-patient in a nursing facility or as an in-patient in a medical facility at a level of care such as is provided in a nursing facility, any transfer of assets made 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.

René H. Reixach

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. A person is institutionalized if a patient is in a nursing facility or in a medical facility receiving the level of care provided 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 provided by the Regulations, 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. The period of ineligibility begins with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other period of ineligibility under section 360-4.4(c) of the Regulations for any other prohibited transfer.

The Department issued Administrative Directive 96 ADM-8, dated March 29, 1996, to inform local social

services districts of changes in the treatment of transfers and trusts in the Medicaid program as a result of the Omnibus Budget Reconciliation Act of 1993. This Administrative Directive offered extensive instructions concerning the treatment of asset transfers and the computation of the penalty period.

### Discussion

The parties agreed on fair market value of the Appellant's transferred home, on her age at the time of transfer, and on the use of the table of actuarial coefficients found in Administrative Directive 96 ADM-8. The Appellant is correct that the Agency's computation was in error.

The Agency erred in its computation by subtracting the $10,000 from the fair market value before applying the remainderman's coefficient. The correct computation of the fair market value of the remainderman's interest is as follows:

| | |
|---|---|
| $49,090.91 | fair market value of the real estate |
| x .52951 | coefficient for conversion |
| $25,994.13 | (rounded up) fair market value of the remainderman's interest |
| –$10,000.00 | paid by the remainderman for that interest |
| $15,994.13 | uncompensated value |

A proper determination of the penalty period would be $15,994.13 uncompensated transfer divided by $6,058, the regional nursing home rate, equals 2.64 months. Accordingly, the Agency should have opened the Appellant's Medicaid case effective January 1, 2004, with a sum of $3,878.13 in excess resources to be applied to the cost of the Appellant's nursing home care, which represents the remaining uncompensated value of the remainderman's interest as of January 1, 2004.

### Fair Hearing Decision

The Agency's determination that the Appellant was not eligible under Medicaid for nursing facility services for a period of 3.42 months, beginning November 1, 2003, because the Appellant transferred assets for less than fair market value, was not correct and is reversed. The Agency is directed to pen the Appellant's Medicaid case effective January 1, 2004, with a sum of $3,878.13 in excess resources to be applied to the cost of the Appellant's nursing home care, which represents the remaining uncompensated value of the remainderman's interest as of January 1, 2004.

### Editors' Comment

The Decision addresses an issue not previously addressed to the knowledge of the Appellant's counsel and the Editors. It is clearly correct. The value of the transferred remainder interest was the total value of the home times the remainder coefficient. The Appellant received $10,000 for that remainder interest. Therefore, the uncompensated value of the transfer was the value of the transferred remainder interest, $25,994.13, less the $10,000 compensation paid for it, totaling $15,994.13. The Agency overstated the value of the uncompensated transfer by applying the $10,000 payment against the total value of the property rather than against the value of the interest that was transferred.

A witness at the hearing was a certified public accountant, who testified pro bono to help establish the Appellant's case. This points out the importance of treating a Fair Hearing as a matter of substance. Testimony by such a financial expert could have been persuasive to the Administrative Law Judge that the Agency's computation was incorrect.

The Appellant at this Fair Hearing was represented by **George R. Pfann, Jr., Esq**., of Ithaca, 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 served 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 In 2002, the New York State Bar Association's Elder Law Section awarded her, along with René Reixach, the 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.**

# Elder Care News

## Anxiety in the Older Adult

By Barbara Wolford

Anxiety disorder in the older adult is the most common mental illness (other than cognitive disability) in the United States, more prevalent than depression. Approximately six out of every 100 people age 65 and older are coping with at least one anxiety disorder. Recent statistics report that 19.1 million adults suffer from some form of anxiety. Adults with anxiety disorders are three to five times more likely to see their primary care physicians for symptoms or complaints stemming from anxiety, but which are presented to the health care professional as physical in nature. These individuals also present six times more frequently in hospital emergency rooms for generalized complaints and require hospital admission for work-ups to determine the etiology of their symptoms. Adult women are more likely to be diagnosed with anxiety disorders than adult males. Race or ethnicity are not considered factors. A National Comorbidity Study (NCS 2994) shows that the odds of having anxiety disorder are directly related to individuals with low income and inadequate education.

When community-based adults 65 years and older were asked to discuss their anxiety, they indicated feelings such as:

> "My heart starts to race, and I can't catch my breath. I think that I am having a heart attack."
>
> "I can't sleep at night. My brain won't shut off."
>
> "I am afraid something bad is going to happen to me, my spouse, my child . . ."

Anxiety is defined as a state of tension, apprehension and a negative view of the world. It can be an ordinary response to danger or a threatening situation. Anxiety can be a normal part of life, an emotion or state any of us can experience or identify with—when asked to speak publicly, before taking a test, or during a life event with a family member. Anxiety becomes a disorder when the frequency and intensity become overwhelming, it interferes with psychosocial functioning or occurs when there is no real threat to the individual. Geriatric anxiety is defined as "excess anxiety that occurs repeatedly and leads to distress and disability." Older adults worry about health, family, finances and their own mortality. Anxiety may also be solely in terms of somatic symptoms that have no medical cause. Older adults may complain of headaches, chest pains, fatigue or stomach pains.

Research has suggested that inasmuch as your gene makeup causes predisposition to medical conditions, individuals may be susceptible to anxiety disorders. If you have a parent that has had an anxiety disorder, you may have an increased chance that you may also acquire this disorder. However, some researchers discount this theory and believe not in "gene predisposition" but in behavior that has merely been modeled by parent behavior. . . ."We are what we have learned."

Signs and symptoms of anxiety disorders may be acute or chronic in nature.

Biological symptoms can be:

- excessive perspiration
- heart palpitations
- fainting/dizziness
- dysapnea (difficulty breathing)
- nausea
- muscle tension
- shakiness
- flushing
- gastro-intestinal disturbances
- insomnia

Cognitive symptoms can be:

- worry
- apprehension
- anticipation of danger
- "going crazy" syndrome

- fear of dying
- being on edge
- irritability
- being terrified
- nervousness

Behavioral symptoms can be:

- jumpiness
- tremors
- pacing
- social avoidance
- hypervigilance

Co-morbidity factors—anxiety disorder with substance abuse, anxiety with depression or anxiety with medical conditions—can make detection of anxiety disorder difficult to determine, as many of the manifestations mirror medical conditions. Some medical conditions produce anxiety (i.e., hypoglycemia, CHF, COPD). Abuse of alcohol, cocaine, caffeine, nicotine and other substances can precipitate anxiety. Another barrier to obtaining an accurate diagnosis is due to the fact that many elderly individuals do not seek medical care.

Another barrier to valid diagnosis of anxiety disorder is that often the medical professional diagnoses the individual with a depressive disorder, since many of the symptoms overlap. According to Dr. Zvi Gellis, Director, Center for Aging Research at the State University of Albany, "Anxiety disorder is usually the disorder that occurs first and because of that illness, depression follows and the depressive illness and symptoms are what the primary care physician observes and treats." Clients question why they feel so depressed if they have any anxiety disorder. Dr. Gellis reports that studies suggest approximately 10% to 40% of people with anxiety disorders will also be diagnosed with a depressive disorder. There are three reasons for this:

- Many individuals coping with anxiety disorders feel helpless, hopeless and pessimistic about the future due to the negative impact of their symptoms.
- Anxiety can lower self-esteem and confidence, leading to further disappointment and frustration.
- Negative thoughts and feelings increase the risk of a person feeling depressed.

There are several types of anxiety disorders:

- Panic disorder: characterized by unexpected panic attacks—periods of heightened emotions that are frightening and uncomfortable, and anticipatory anxiety about their recurrence.
- Agoraphobia: fear and avoidance of a place or situation where there is no perceived way of getting help.
- Obsessive-compulsive disorder: a disabling condition that intrudes on thinking and behavior. Obsessions are persistent, irrational, impulses or images, usually of an unpleasant nature, that take over the consciousness of a person with the disorder.
- Post-traumatic stress disorder: an anxiety reaction to an event that threatens the life or bodily integrity of the person or someone with whom one is closely associated. Persons may experience the trauma directly, witness it or hear about it.
- Acute stress disorder: differs from PTSD in that the duration is only between two and 30 days.
- Generalized anxiety disorder: pervasive, chronic condition rather that one that occurs in spurts.

Researchers have noted that most older adults suffer from generalized anxiety disorder (GAD), which is defined as excessive anxiety and worry that occurs for at least six months. It also has been termed "tension disorder." Diagnostic criteria of two or more of the following symptoms would classify GAD: feeling on edge, easily fatigued, difficulty concentrating, irritability, muscle tension, sleep disturbances and impaired attention. These symptoms of anxiety or worry cause clinically significant distress or impairment in social and other areas of functioning.

Screening tools are used to help identify anxiety disorders. Information is gathered about life stressors, circumstances and coping mechanisms of the individual. Four initial queries can be made:

- Have you felt keyed up, on edge?
- Have you been worrying a lot?
- Have you been irritable?
- Have you had difficulty relaxing?

If the client responds positively to these questions, then proceed with additional questions such as:

- Have you been sleeping poorly?
- Have you had headaches, neck aches?
- Have you had trembling, tingling, dizziness, sweating?
- Have you been worried about your health?
- Have you had difficulty falling asleep?

Positive responses to these questions would indicate that a referral should be made to an allied health professional for further diagnostic work-up.

The following ten steps to making a referral for anxiety disorder can be helpful to the professionals in the elder care community:

1. Help the older adult to identify the problem as they view it.
2. Be respectful of the client's opinions and preferences.
3. Try to determine all the agencies/support services that the client is presently utilizing.
4. Encourage family support and assistance.
5. If possible, engage client in decision-making process and advise of the referral process.
6. Help to facilitate the referral by anticipating possible barriers.
7. *Assume* that the client is ambivalent about the referral—they most likely are fearful and are exhibiting increased anxiety and stress.
8. Help the client to view the referral as empowering.
9. If necessary, attempt to establish the contact for the client and family.
10. Do follow up with client/family to verify if the client has gone through with the referral.

It is important to remember that anxiety in older adults is real if the symptoms are excessive, uncontrollable, create distress and interfere with daily living.

**Barbara Wolford is the Director of Elder Care Services for the elder law and estate planning firm of Davidow, Davidow, Siegel & Stern. She has been associated with the firm since 1996. Ms. Wolford is a Licensed Practical Nurse who concentrates in assisting families with the complex Medicaid process as well as the assessment procedure necessary for evaluating families' needs. Her background as a former Nursing Home Admissions Director lends itself well to her current position. In addition, she is very active in senior organizations and advocacy by serving as the co-director of the Council for the Suffolk Senior Umbrella Network, a board member of the New York State Coalition for the Aging, a member of the Long Island Coalition for the Aging, a member of the American Association on Aging, Nassau and Suffolk Geriatric Professionals of Long Island and Case Management Society of America.**



# Advance Directive News

## A Sad Saga

By Ellen G. Makofsky

The removal of life support is an emotional decision complicated by legal issues and personal, religious and moral beliefs. The importance of advance directives is illustrated by the sad story of Terri Schiavo.

Terri Schiavo was 26 years old when she suffered a heart attack as a result of a potassium imbalance. The heart attack and ensuing loss of oxygen resulted in brain damage so severe that she has never regained consciousness and is unable to care for herself. Among other things, she is unable to eat or swallow and is kept alive by means of a feeding tube. She has lived in various nursing homes requiring constant care since 1990. Like most young people, Terri probably gave little thought to the fragility of life and consequently did not execute an advance directive. Unable to make decisions on her own behalf she left no one with the ability to make them for her. The absence of an advance directive has led her family into an abyss of litigation.

Initially Michael Schiavo, Terri's husband, and Terri's parents had an amicable relationship but as the years went by the relationship soured. In May of 1998, eight years after the initial incident, Michael Schiavo petitioned the guardianship court in Florida to authorize the discontinuance of artificial life support. Terri's parents opposed the withdrawal of the artificial nutrition and hydration and a torrent of litigation ensued. Following the trial the guardianship court authorized the discontinuance of artificial life support. The order was affirmed on appeal and review was denied.

In affirming the trial court's order, the court concluded:

> In the final analysis, the difficult question that faced the trial court was whether Theresa Marie Schindler Schiavo, not after a few weeks in a coma, but after ten years in a persistent vegetative state that has robbed her of most of her cerebrum and all but the most instinctive of neurological functions with no hope of a medical cure but with sufficient money and strength of body to live indefinitely, would choose to continue the constant nursing care and the supporting tubes in hopes that a miracle would somehow recreate her missing brain tissue, or whether she would wish to permit a natural death process to take its course and for her family members and loved ones to be free to continue their lives. After due consideration, we conclude that the trial judge had clear and convincing evidence to answer this question as he did.[1]

*"The removal of life support is an emotional decision complicated by legal issues and personal, religious and moral beliefs."*

It seemed that Terri's husband had proven to the court, by clear and convincing evidence, that Terri would not have wanted to be kept alive in the condition she now found herself. That said, Terri's parents continued to litigate on other fronts until the fall of 2003 when the Supreme Court of Florida put an end to their efforts by again denying review. As a consequence, on October 15, 2003, Terri's nutrition and hydration tube was removed.

So what happened next? An end run by the Florida legislature which on October 21, 2003 tried to overcome the court's decision by enacting a bill to permit the Governor to issue a stay in cases like Terri's and restore the feeding tube. Governor Jeb Bush signed the bill into law and subsequently issued a stay. The nutrition and hydration tube was reinserted pursuant to the Governor's executive order.

The issue of who has the right to make medical decisions for Terri wound up right back in court, where the lower court and then the Supreme Court of Florida decided that the newly enacted law violated the fundamental constitutional tenet of separation of powers and was unconstitutional.

One would think the matter was finished, and yet it is still not over. As of this writing, Terri's parents have returned to court with a new cause of action which contends that their daughter would not willingly violate the rules of the Catholic Church. Terri's parents are now arguing that even if in the past Terri made statements indicating she would not want to be kept alive with no hope of recovery she would have changed her mind if she had known of the Church's recently articulated position on the matter. Terri's parents are pointing to the recent statement of Pope John Paul II that people in Terri's condition should always be provided nourishment.

I do not know where will it end and when will it end. I can surmise that both Michael Schiavo and Terri's parent's love her enormously and are experiencing unimaginable heartache. Each side believes they are right in their own knowledge of what Terri would have wanted, but no one really knows because Terri left no advance directive. No matter what the final outcome is, there can be no winner, not Terri, not Michael and not Terri's parents.

## Endnote

1. *In re Guardianship of Schiavo*, 780 So. 2d 176, 180 (Fla. 2d DCA 2001).

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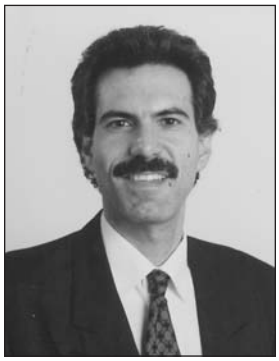
**Ms. Makofsky currently serves as co-chair of the Long Island Alzheimer's Foundation (LIAF) Legal Advisory Board and is the immediate past president of the Gerontology Professionals of Long Island, Nassau Chapter. She is the former co-chair of the Senior Umbrella Network of Nassau. She serves on the Board of Directors of Landmark on Main Street.**

# Public Policy News

## Shifting the Focus Away from Medicaid Eligibility "Reform": Creative Budget Crisis Solutions

By Ronald A. Fatoullah



The New York State legislature (the "legislature") finally passed the long awaited budget, and thankfully much of the dreaded provisions restricting Medicaid were not enacted. Nevertheless, with regard to the so-called "reforms" put forth by Governor Pataki, it is likely that we have merely dodged a bullet, not escaped the war. The Governor had proposed to extend the look-back period from three to five years for all transfers, to establish a penalty period for home care and community-based applications, to partially eliminate spousal refusals and to start the look-back period from the date of the Medicaid application rather than the date of transfer. Had these provisions been enacted, Medicaid eligibility and the ensuing benefits for the elderly and disabled would have been seriously curtailed.

In its budget, the legislature recognized that the cost of long-term health care remains a huge financial burden on the state. However, rather than restricting Medicaid eligibility, the legislature has taken the high road by making long-term care insurance more attractive, providing for new Continuing Care Retirement Communities ("CCRC") and passing the Assisted Living Reform Act.

In New York, under the old law, a person who had purchased a "Partnership" policy (i.e., a New York State Partnership for Long Term Care insurance policy), would be eligible for Medicaid only after entering a nursing home and receiving Partnership policy benefits for three years in a nursing home or six years of home care (or any combination of two home care days to one nursing home day). After such three to six-year period, Medicaid eligibility would be available and any resources of the applicant in excess of $3,950 would be disregarded. If one did not use the policy for the full amount of time, there would be no Medicaid benefit.

According to the new law, a three-year stay in a nursing home will no longer be required. For any individual who resides in a nursing home for more than one year but less than three years, a dollar-for-dollar protection will be available. For example, if the Partnership policy expends $150,000 in benefits, then such person may retain $150,000 in assets when he or she applies for Medicaid and is therefore protected from a total Medicaid spend-down.

In addition, this legislation authorized New York State to enter into reciprocal agreements with other states that have Partnership policies. If a New York State resident moves to another state and resides in a nursing home for three years with Partnership policy benefits, he will now be eligible for Medicaid in that state provided that state has a Partnership policy and has entered into a reciprocal agreement with New York.

Further, the New York State tax credit for premiums paid for long-term care policies has been increased from ten percent to twenty percent. Also, seniors will now be able to designate a third party to receive notice if premium payments are due. This will minimize the chance of the policy lapsing just when it may be needed the most. Finally, the legislation directs the Health Department, Insurance Department and Office on Aging to explore alternative methods of financing the cost of long-term care and the payment of premiums.

Though these are positive steps in a much-needed direction, long-term care insurance is no panacea. Many young and relatively healthy individuals are deterred from purchasing long-term care insurance policies because of high premiums. Conversely, older adults might not realize the need for long-term care insurance until illness strikes, at which time the pre-existing condition prevents him/her from qualifying.

In a further effort to expand long-term care options, Governor Pataki has recently signed into law legislation expanding residential housing options for seniors in New York State. The law enhances long-term care opportunities for seniors with moderate incomes by creating new, fee-for-service Continuing Care Retirement Communities (CCRCs) in New York State. CCRCs combine an apartment-like setting with access to long-term care services in the continuum of care, including nursing home beds.

This legislation allows for the establishment of up to eight fee-for-service CCRCs in New York State as part of a statewide demonstration project. Currently, CCRCs operating in New York are obligated to set their entrance fees at a high enough level to guarantee payment for nursing home care and related long-term care services for the resident if the need should arise. However, the new law allows seniors to contract for CCRC health care services on a "pay-as-you-go" basis.

Governor Pataki has also signed the new Assisted Living Reform Act (the "Act"). This legislation can reduce long-term care costs by making seniors and their families more comfortable with assisted living facilities.

Some of the key points of the Assisted Living Reform Act (the "Act") include the provision of a clear definition of an "Assisted Living Facility" ("ALF"). This definition will hopefully mitigate the confusion of potential residents who currently find it difficult to compare residences and the services they offer.

ALFs are differentiated from Adult Homes, Hospice programs, Senior Housing buildings, hospitals, public housing projects and NORCs (Naturally Occurring Retirement Communities). The Act defines an ALF as one which provides the following services for five (5) or more adults: housing, on-site 24-hour monitoring, personal care/home care services in a home-like setting, daily food service, case management and the development of Individualized Service Plans for each resident.

The Act also allows an operator to apply for an "Enhanced Assisted Living" certificate. This differs from the regular assisted living certificate in that an enhanced ALF offers "aging in place" (known as AIP). AIP means that the facility will maintain residents who wish to remain in the facility but who require assistance and have greater medical needs. However, even with this provision, the resident will not be allowed to age in place unless the facility's operator, the resident's Primary Medical Doctor and possibly the existing home care agency (already servicing the resident), agree that the resident's needs can be "safely and appropriately" met at the facility.

If a facility advertises itself as serving individuals with needs such as dementia, cognitive impairments, or other special conditions, the facility must submit a special plan to the New York State Department of Health ("NYSDOH"), explaining in detail how the facility will meet these needs. This plan must include a description of proposed staff training and staffing levels and needed environmental modifications. Until NYSDOH has approves the plan and issues a "Special Needs Assisted Living Certificate," the facility may not market itself as such.

Presently, many facilities proclaim that they provide assisted living services, but are not actually licensed to do so. These facilities are known as "look-alikes." Prior to the Act, only facilities licensed under the New York State Assisted Living Program ("ALP"), were officially permitted to arrange for home health services to be provided through a Certified Home Health Agency ("CHHA"), a Licensed Home Care Services Agency ("LHCSA"), or a Lombardi ("Long-Term Home Health Care") program. The Act however, requires "look-alikes" to become licensed or face criminal penalties (class A misdemeanor plus civil penalties) and provides incentives if these facilities apply quickly for licensure.

The Act also requires written residency agreements in plain language and 12-point type, which must cover at least 16 separate items of information, including a description of the services to be provided and fees to be charged. The entire agreement must be furnished to the resident any time there is a change in the fee schedule.

Other Act provisions include the creation of an enforcement fund, full disclosure of facility ownership to consumers, the right of residents to choose their health care providers, a 16-point resident bill of rights, the formation of an ongoing assisted living task force, and much-needed protection against involuntary resident discharge.

The recent drive to curtail Medicaid eligibility appears to turn a blind eye toward another promising avenue: ***Medicaid waivers that benefit seniors and the disabled***. Such waivers are meant to expand the Medicaid program, not curtail its benefits. A Medicaid waiver is permission granted by the federal government to a state, allowing that state to operate a specific kind of program by waiving certain federal requirements. There are three (3) main categories of waivers: program waivers, research and demonstration waivers and Health Insurance Flexibility and Accountability (HIFA) waivers.

New York State has a program waiver known as the New York Non-Emergency Transportation Program. This program was approved in 1996 and allows the counties of New York State to design and administer their own medical transportation program under the auspices of the State Medicaid Agency. At present, 12 of New York's 62 counties (largely located upstate) participate in this program; the City of New York, Nassau and Suffolk excluded. Under this program, each county is considered a district, and each district is then given the authority to arrange for all available modes of transportation, authorize pay-

ments for transports as deemed necessary, and contract with transportation providers.

While the Access-A-Ride and Able-Ride programs provide non-medical transportation in New York City and Nassau County, currently, only those with Medicaid coverage are able to utilize ambulette transportation for all of their medical appointments (Medicare does not cover this service). Rather than looking to cut Medicaid, downstate seniors would benefit from this waivered service and would help them live in their own homes for a longer period of time, were we to follow the lead of our upstate counties.

In addition, the Home and Community-Based Waiver Program, or 1915(c) waiver, recognizes that people can be cared for in their own homes and communities without need for institutionalization, thereby allowing them to maintain their communal and familial ties at a cost equal to that of institutional care.

The Texas STAR+PLUS program resembles a managed Medicaid plan, such as that offered by VNS-CHOICE, in that the plan member may continue to be treated by his or her Medicare provider of choice, while agreeing to accept Medicaid services from an in-plan provider panel. New York should encourage these programs so that the Medicaid needs of seniors that could not be realistically met within managed-care capitated rates, could still be met under the traditional Medicaid program.

And then we have the "infamous" 1115 Research and Demonstration waiver. This waiver allows states to fund experimental and pilot programs and can be used to demonstrate something that has not been tried on a widespread basis and can provide for services that are not available elsewhere. These demonstrations cannot cost the federal government more than the same service would have cost without the waiver. These waivers were meant to expand services, *not* to curtail Medicaid eligibility. New York State has one such waiver, known as "The Partnership Plan," which was designed to move approximately 2.1 million Medicaid beneficiaries from fee-for-service systems to a mandatory managed care setting. The project also expands health insurance coverage to former State Safety Net recipients. On June 29, 2001, Family Health Plus was added to the project, to offer health coverage to more low-income, uninsured adults.

The last variety of waiver is known as a Health Insurance Flexibility and Accountability ("HIFA") Demonstration Initiative. The goal of this initiative is to encourage states to try methods of increasing the number of people with health care coverage within present Medicaid and State Children's Health Insurance Program ("SCHIP") resources. There are currently no HIFA waiver initiatives in New York State, yet another example of the need to urge legislators to take advantage of initiatives which could shift the focus away from unnecessary Medicaid cuts though creative use of alternate funding streams.

A distinction must be made between true Medicaid reform and merely slashing eligibility for those in need. Without Medicaid, many of our seniors would truly be bereft of any health care. To make eligibility rules more restrictive would be ill-advised, especially as we see the magnified and rapid increase in the numbers of older adults. At the same time, Medicaid *does* strain our budget, and it is hoped that the options described, and other creative alternatives, will attract the interest of our legislators, leaving Medicaid accessible for those truly in need.

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# National Case News

## *Bush v. Schiavo*

By Steven M. Ratner

### Introduction

In *Bush v. Schiavo*,[1] the husband and legal guardian of a woman in a persistent vegetative state challenged Florida Governor Jeb Bush and the Florida state legislature over the constitutional validity of an Act permitting the Governor to issue a one-time stay to prevent the withholding of nutrition and hydration of a patient. Finding the Act was in contravention of the fundamental constitutional tenet of separation of powers, the Florida Supreme Court held the Act unconstitutionally encroached on the powers of the judicial branch, unlawfully delegated legislative authority to the executive, and was therefore unconstitutionally invalid facially and as applied.

### Background

Theresa "Terri" Marie Schindler was born in 1963, and lived with her parents until she married Michael Schiavo in 1984. Michael and Theresa moved to Florida in 1986 where for all accounts they enjoyed a happy marriage and successful employment. On February 25, 1990, at age 26, Theresa suffered a cardiac arrest as a result of a potassium imbalance. Michael responded by calling 911 and Theresa was rushed to a hospital. Her brain, starved of oxygen, was irreparably damaged as a result of her cardiac arrest. By 1996, CAT scans showed a severely abnormal brain structure where massive portions of her cerebral cortex were no longer present, having been destroyed from oxygen deprivation. Theresa never regained consciousness, and since 1990, has lived in nursing homes, totally dependent on care provided by nursing staff.

Theresa's condition is described as a persistent vegetative state; she is not in a coma. Whereas an individual in a coma possesses some cognitive function and awareness, an individual in a persistent vegetative state is totally unaware of her surroundings. She remains unconscious, but manifests certain reflexive, non-cognitive behaviors. Theresa has normal breathing and heart rhythms, and has defined cycles of sleep and wakefulness. Her dependence on life support is limited to feeding and hydration through a tube, but under Florida law,[2] this is considered an "artificial life prolonging measure" which may be discontinued if the wishes of the patient can be ascertained.

Theresa's condition is permanent and cannot be cured. Although severe, there is no consensus among physicians regarding the extent of Theresa's brain damage. Some doctors maintain she has a small amount of isolated living tissue in her cerebral cortex, and may respond to intensive rehabilitation. Others believe she has no living cerebral tissue whatsoever, and any reaction to stimulus is reflexive and therefore non-cognitive. Regardless, absent a miracle, Theresa will remain in her current condition, permanently unconscious, reflexive, and dependent on others for her most intrinsic personal needs.

In 1992, a series of medical malpractice lawsuits netted Theresa Schiavo over $1,300,000 and Michael $600,000 for loss of consortium. A year later, Michael, acting as guardian, refused rehabilitative treatment for Theresa Schiavo. This developed into a bitter dispute between Michael and Theresa's parents, Robert and Mary Schindler. Michael continued to refuse rehabilitative treatment for Theresa while her parents sought to remove Michael as guardian and act on her physician's recommendations to enroll Theresa in a rehabilitation program.

Soon after, Michael attempted to block the Schindlers' access to Theresa Schiavo's medical records, and placed a "do not resuscitate" order on her chart. After he ordered nursing home staff to withhold treatment of an infection, the Schindlers brought action against Michael in 1993 to remove him as Theresa Schiavo's sole legal guardian. The action was dismissed that same year. In 1996, the Schindlers successfully obtained a court order from Pinellas County Circuit Court requiring Michael Schiavo to grant Robert and Mary Schindler access to Theresa's medical records and reports.

In 1998, eight years after Theresa lost consciousness, Michael petitioned the guardianship court to authorize the termination of life-prolonging procedures. Florida law permits a guardian to allow the court to act as the ward's surrogate and determine what course of action the ward would want to pursue. Michael maintained Theresa would not want to live indefinitely in her non-cognitive, dependent state, and that it was against her wishes to remain on artificial life support. The Schindlers opposed the

petition, arguing that because some physicians recommended rehabilitative treatment, some degree of recovery was possible, and therefore Theresa would want to live.

At trial, both sides offered evidence of Theresa's wishes regarding long-term artificial life support, as well as expert testimony regarding the extent of Theresa's brain damage. The court found by clear and convincing evidence that Theresa Schiavo was in a persistent vegetative state, and that Theresa would elect to cease life-prolonging procedures if she were competent to make her own decision.

The Second District court affirmed the order on direct appeal, and the Florida Supreme Court denied review. Subsequently, the guardianship court issued a final order authorizing the termination of artificial life-continuing procedures. However, litigation on the matter continued. The Schindlers immediately began an attack on the final order on grounds that they could establish new circumstances which make it no longer equitable to enforce the earlier order. The Second District Court permitted a limited evidentiary hearing, but ultimately denied the motion on the grounds that the evidence was insufficient to show that any new medical treatments offered sufficient promise of improving Theresa Schiavo's cognitive function. Theresa's nutrition and hydration tube was removed on October 15, 2003, thirteen years after she lost consciousness.

National public interest, fueled by media reports of Theresa's condition and video clips circulating on the Internet, compelled citizens nationwide to pressure Florida lawmakers to intervene on Theresa Schiavo's behalf. Republican state representatives responded. Lawmakers initially sought to impose a six-month moratorium on the disconnection of artificial life-sustaining measures, but the proposition was met with opposition from legislators who had drafted Florida's "right to die" legislation. Florida Senate President Jim King, who initially opposed intervention, offered a novel theory: because the Governor had the authority to stay an execution, he could therefore be given authority to stay the termination of artificial life-sustaining measures in order to protect the due process rights of individuals in a position similar to Theresa Schiavo. Acting on the theory, King, along with House Speaker Johnnie Byrd, crafted a narrowly tailored bill that gave the Governor authority to stay the termination of artificial life-sustaining measures. The bill was presented six days after Theresa Schiavo's feeding tube was removed. Both houses passed the bill without committee hearings or legal analysis of the constitutional implications.

As a result, the Florida legislature enacted chapter 2003-418 (the Act), which Governor Jeb Bush signed into law the same day. Pursuant to the authority purportedly granted in the Act, Governor Bush issued executive order No. 03-201 to stay the continued withholding of nutrition and hydration of Theresa. Theresa's feeding and hydration tube was reinserted in compliance with the order. That same day, Michael Schiavo brought action for declaratory judgment in the Second District Court. The District Court entered a final summary judgment in May 2004 in favor of Michael Schiavo, finding the Act violated the separation of powers requirement in the Florida Constitution and violated Theresa's vested right to privacy. Governor Bush appealed, and the Second District Court of Appeal certified the case as one of great public importance, requiring immediate resolution by the Florida Supreme Court.

At issue before the Florida Supreme Court was the constitutionality of the Act, specifically, whether the Act violated the separation of powers and non-delegation doctrines codified by the Florida Constitution, and whether the Act violated Theresa Schiavo's vested right to privacy. The court found the separation of powers and non-delegation issues to be dispositive, and did not render a decision regarding Theresa Schiavo's privacy rights. The court held, in a unanimous decision, that the Act violated both the separation of powers and non-delegation doctrines of the Florida Constitution, in that the legislature unlawfully encroached onto the authority of the judiciary, and that the legislature unlawfully delegated its constitutionally granted powers to the executive.

Relying on *Chiles v. Children A, B, C, D, E, & F*,[3] the court reasoned that the separation of powers doctrine encompasses two fundamental prohibitions: that no branch may encroach upon the powers of another; and that no branch may delegate to another branch its constitutionally assigned powers. Quoting *Chiles,* the Supreme Court wrote: "the judiciary is a coequal branch of the Florida government vested with the sole authority to exercise the judicial power. [T]he legislature cannot . . . reallocate the balance of power expressly delineated in the constitution among the three coequal branches."

The court held that the Act, which was specifically tailored to affect only Theresa Schiavo, was an attempt on the part of the legislature to unlawfully review or otherwise overturn a purely judicial decision; namely, Michael Schiavo's final judgment permitting termination of artificial life-sustaining measures on Theresa. The court held that since Michael Schiavo petitioned the court to act as surrogate regarding continued life support, the resulting deci-

sion was purely judicial, and therefore non-reviewable by the executive. "When a final judgment is issued . . . it is without question an invasion of the authority of the judicial branch for the Legislature to pass a law that allows the executive branch to interfere with the final judicial determination in the case." Because the Act specifically bestowed upon the Governor the right to modify a final judgment of the court in a purely judicial matter, it was an unlawful intrusion into the powers of the judiciary.

The Florida Supreme Court also held that the legislature's actions were an impermissible delegation of legislative authority to the executive, and therefore unconstitutional on its face. The court stated that in order to permissibly delegate legislative authority to the executive, the statute must clearly announce adequate standards to guide in the execution of the powers delegated, and these guides must be so clearly defined that the executive is precluded from exercising significant discretion. Relying on the language of the Act, the court found there was no language that would serve to "limit the Governor from exercising completely unrestricted discretion in applying the law." The legislature failed to provide any standards indicating under what circumstances the Governor should issue or subsequently lift the stay. Furthermore, because the Act provides no guidelines for the application of the powers, the use of those powers becomes discretionary and unreviewable.

## Conclusion

In sum, the court found the Act unconstitutional as applied to Theresa Schiavo because the Act unlawfully permitted the executive to intrude onto a power solely reserved for the judiciary. The court also found the Act unconstitutional on its face as an impermissible delegation of authority from the legislature to the executive. The Florida Supreme court recognized the gravity of the issue before the court and sought to strike a balance between the constitutional limitations on each of the coequal branches of government, and legislators' duties to the public. While the legislature has the unquestionable authority to enact laws to protect those citizens who are otherwise incapable of protecting their own interests, those laws must be in conformity with the Constitution. Furthermore, the court expressed justifiable concern over the dangerous precedent that could result if it had upheld the Act: that no judgment would ever be final, that the democratic process could conceivably strip an individual's vested rights, based solely on public opinion.

## Endnotes

1. Florida Supreme Court, September 23, 2004.
2. *See Florida Statutes* § 765.102(3, 10).
3. 589 So. 2d 260 (Fla. 1991).

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**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.**

**Matthew Trask, a third-year student at Pace Law School, assisted in writing this article.**

# Snowbird News

## New "Mortgage" Rule for Florida Medicaid

By Scott M. Solkoff

The Florida Department of Children and Families (DCF), the agency responsible for Florida Medicaid financial eligibility determinations, has issued a new rule regarding the countability of mortgages. Effective October 1, 2004, mortgages are deemed an available resource to a Medicaid applicant.

When it became clear that DCF was seeking to combat Medicaid planning through rule changes, the Elder Law Section of The Florida Bar and the Academy of Florida Elder Law Attorneys responded with a plan, a lobbyist and a paid attorney. The groups have been successful in stopping all other changes that had been proposed but, after studying the mortgage issue, believed that DCF had a legal right to seek the change. Though the two elder law groups worked with the government in an attempt to achieve greater clarity, the rule itself was not contested.

At SSI, the Program Operations Manual (POMs) assumes that all mortgages are liquid and therefore countable toward the SSI asset cap. SI 01110.305 states that all mortgages and promissory notes are liquid absent contrary evidence. Since a state's Medicaid plan can be as restrictive as the SSI rules (but not more restrictive), our Public Policy Task Force determined that the state had the right to move forward on this rule.

This new rule, assuming that all mortgages are liquid and therefore countable, changes the longstanding policy in Florida that many mortgages are illiquid by their terms. Clients might have loaned a child some money to purchase or refinance a home and might have taken back a mortgage in exchange. Since the transaction itself was a fair-market-value transaction, there was no period of ineligibility imposed. Moreover, if the mortgage and underlying note were not assignable and not otherwise convertible back to cash, the mortgage itself was illiquid, unavailable and therefore not counted toward the applicant's Medicaid eligibility.

Some clients had mortgages prior to seeing an elder law attorney. Other clients did these transactions for the real purpose of qualifying for Medicaid. In some states, including Florida and New York, if an applicant makes an uncompensated transfer of assets for the purpose of Medicaid qualification, a period of ineligibility is imposed. In the past, however, so long as the mortgage was a fair exchange for the cash, the government never gets to the question of whether the transaction was done to get Medicaid. Prior to October 1, therefore, the client might have done such a transaction for the purpose of Medicaid qualification and been able to qualify for Medicaid right away.

There will likely be attacks on this new mortgage rule. As I write this still in the first month of the rule's implementation, there has been little activity but some believe the state has gone too far.

While the SSI rules do assume the liquidity of all mortgages, the rules also, in the same breath, allow for evidence to the contrary. The fact is that some mortgages should be and are considered liquid. Mortgages that can be called in early should be countable because the mortgage holder can convert the mortgage to cash. Mortgages that are assignable should sometimes be countable because the mortgage holder might be able to sell the mortgage to an assignee.

For mortgages that are not assignable and that must be paid back on a valid schedule, the evidence could well show that the mortgage is not a liquid asset. DCF's interpretation of the new rule seems to take the position that even with such evidence of illiquidity, the mortgage will still be deemed liquid and countable. It will likely be argued that this position would run counter to the SSI rules and would make Florida law illegally more restrictive than the SSI rules.

For now, practitioners should be aware that all mortgages created after October 1, 2004, will be deemed disqualifying liquid assets by DCF. Mortgages created prior to that date will be treated under the old policy where not assignable meant nonliquid.

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# Mediation News

By Robert A. Grey

*Welcome back to Elder Law Mediation! 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.*

## Dutchess County Leads the Way

On August 13, 2004, the *New York Law Journal* published a decision[1] by Supreme Court Justice James D. Pagones (Dutchess County) as a Decision of Interest under the headline "At Bifurcated Guardianship Hearing Court Finds that Brain-Damaged Woman Is Incapacitated."[2] Both the Decision of Interest abstract and the decision itself prominently mention mediation.

> *". . . I am an avid proponent of the use of mediation in Article 81 cases. Justice Pagones' bifurcated hearing/ voluntary mediation procedure appears to be a logical and efficient way to implement mediation."*

I interviewed Principal Court Attorney Kenneth M. Bernstein about the use of mediation in guardianship cases in Dutchess County. Mr. Bernstein informed me that when Justice Pagones sat in Family Court the Justice found that mediation often produced favorable results. Justice Pagones believes that mediation can also be beneficial in Article 81 matters.

Article 81 hearings in Dutchess County are bifurcated in that Justice Pagones first holds a hearing on the issue of the capacity of the AIP. If the AIP is found by the court to be incapacitated the court directs that there will be a second hearing. The purpose of the second hearing is to determine what property management and personal care powers, if any, constitute the least restrictive form of intervention, and who shall serve as guardian (as well as any other issues specific to the case). However, in his decision finding the AIP incapacitated, Justice Pagones takes the additional step of informing the parties of the availability of mediation as an alternative to further litigation. The case will only proceed to mediation if the parties and the Court Evaluator unanimously consent. If so, the mediation is conducted by an outside mediator under a sliding-scale fee structure. Justice Pagones has offered mediation in this manner in a number of Article 81 cases since 2002. Each time that mediation was agreed to the mediation significantly contributed to the resolution of the case. In the case published by the *Law Journal* the parties did avail themselves of mediation. The case was subsequently resolved without the need for the second hearing.[3]

As any reader of this Mediation News feature knows, I am an avid proponent of the use of mediation in Article 81 cases. Justice Pagones' bifurcated hearing/voluntary mediation procedure appears to be a logical and efficient way to implement mediation. The publication of his decision as a Decision of Interest by the *New York Law Journal* is an excellent step in getting the word out to bench and bar that mediation can have a significant positive effect on the outcome of Article 81 matters.

## The Medicare Prescription Drug Price Negotiation Act—Status Update

In the Winter 2003 edition of this publication I wrote that 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.[4] At that time the bill had been referred to the Committee on Ways and Means and the Committee on Energy and Commerce. Presently, the bill is in the Subcommittee on Health of the House Energy and Commerce Committee.

The bill includes a provision that would provide an Alternative Dispute Resolution mechanism for the resolution of disputes between Medicare beneficiaries and prescription drug resellers and drug manufacturers in order to protect such beneficiaries and to ensure that: (1) prescription drug resellers are not artificially increasing prices charged to Medicare beneficiaries (above those negotiated under the Act) in places such as rural areas where there is less competition; and (2) such resellers are not colluding on prices in areas with more potential significant competition.[5]

The bill was introduced by Representative John B. Larson (D-Conn.). There are 19 co-sponsors of the bill. The New York co-sponsors are Representative Maurice D. Hinchey (D-22nd Congressional District) and Representative Jerrold Nadler (D-8th Congressional District).

## NYSBA Publishes 2004 Supplement to Guardianship Practice in New York State

The 2004 Supplement to the NYSBA *Guardianship Practice in New York State* treatise has been published. In addition to updated statutory and case law, it includes four new chapters, one of which is entitled "Mediation in Guardianship Practice."[6]

## Endnotes

1. *In re Weinlein [Milewski]*, 1719/04, Supreme Court, Justice Pagones (Dutchess County).
2. The NYLJ categorized the decision under "Trusts and Estates."
3. The record has been sealed.
4. H.R. 3299, 108th Congress, 1st Session (2003). The bill is called the "Medicare Prescription Drug Price Negotiation Act."
5. From the Bill Summary at www.thomas.loc.gov.
6. In the interest of full disclosure, the author of the new chapter on mediation in guardianship practice is the author of this Mediation News feature.

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**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).**

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# November 2004 Seniors' Housing Alert

By Wayne Kaplan

## State of the Industry

Just back from the NIC (National Investment Center for the Seniors Housing & Care Industries) conference in Chicago. The general atmosphere among the 1,400 attendees was very upbeat. With regard to the development and financing of seniors' housing properties, the industry seems to be very positive right now. And for a change, there are more buyers than sellers. Robert Reich, former U.S. Secretary of Labor, was the keynote speaker. He emphasized that in the short term, the economy will get better, but slowly. He also said that capital for seniors' housing is and will continue to come from all over the world, not just the U.S.

## Assisted Living Occupancy Climbs Slowly

NIC's Key Financial Indicators for the first quarter of 2004 report that assisted living occupancy is continuing to show signs of improvement. The median occupancy rate for stabilized ALFs open 24 months or more increased to 86% during the first quarter of 2004, which is better than 85% in Q4 2003 and 83% in Q1 2003. Anthony Mullen of NIC said that average net "move-in rates" for the quarter remained below three per month for assisted living. He also said that assisted living capitalization rates held steady during the first quarter, with the average coming down from 11 to 10.9%. One transaction at 8.75% illustrated that there is both interest and competition among investors for the very best assisted living properties, which is driving down capitalization rates for the best properties in the sector.

## Assisted Living Quarterly Update

According to Houlihan Lokey Howard & Zukin's 1st Quarter 2004 Healthcare Quarterly Update, first-quarter 2004 merger and acquisition activity appears to have slowed relative to 2003 levels, attributable to a decrease in the number of stabilized facilities on the market and to the markets taking a breather after a busy 2003. Mortgage refinancing also slowed, attributable to heavy activity last year given owner interest in locking in low rates. Loan volume placed in Q4 2003 decreased year-over-year, and delinquencies increased. However, industry leaders predict that traditional lenders will become more active and the industry will see an increase in loan volume as appetite for higher yields in health care and seniors' housing grows.

## Seniors' Housing Facilities Are Maturing

The median age for all seniors' housing property types in the top 30 metropolitan areas is 19 years. According to NIC, the specifics are:

| Property Type | Median Age |
|---|---|
| Nursing Facilities (freestanding) | 29 years |
| CCRCs | 24 years |
| Independent Living (freestanding) | 16 years |
| Assisted Living (freestanding) | 11 years |
| Assisted Living (with dementia care) | 7 years |
| Dementia Care (freestanding) | 6 years |

*"With regard to the development and financing of seniors' housing properties, the industry seems to be very positive right now. And for a change, there are more buyers than sellers."*

## Congregate Care/Independent Living Sector Thrives

The congregate care/independent living sector is the healthiest sector in the seniors' housing industry and will be the first to benefit as baby boomers age, according to Integra Realty Resources' Viewpoint 2004. Data compiled by ASHA indicates an 89% average occupancy nationally, the highest of the three seniors' housing sectors. New construction continues to be slow as demand grows. Rental rate increases have been strong and should continue. Independent living operators are also facing rising liability insurance costs, but not to the degree experienced by other forms of seniors' housing.

## Carlyle Advances in NY

The Carlyle Group, a global private equity firm with more than $16.2 billion under management, recently purchased a Queens, NY, ALF called The Savoy at Little Neck (formerly Deepdale Hospital). The facility has 120 assisted living units and a 15-unit dementia wing. The purchase price was reported to

be $25.5 million, or $188,900 per unit, and the cap rate was 10.2%. Carlyle also purchased the Huntington Terrace ALF on Long Island about a year ago and word has it that Carlyle is looking to acquire more properties in the New York Metro area.

### Aging Demographics

Aging American demographics will benefit the assisted living industry. As the population ages and develops more chronically debilitating conditions, the customer base for ALFs will continue to expand because people are living longer (the average life expectancy was 83 years in 2000), there are more senior citizens (35.1 million persons age 65 or older in 2000 and 40.2 million by 2010), and the number of people with disabilities is growing.

### Most & Least Expensive ALF Rates

According to the MetLife Mature Market Institute 2003, the cities, regions and states with the 10 most and least expensive average per-month rates for assisted living facilities in 2003 were:

**2003's 10 Least Expensive:**

| Rank | Locality | Monthly Charge |
|---|---|---|
| 1 | Jackson, MS | $1,020 |
| 2 | Columbia, SC | $1,281 |
| 3 | Detroit, MI | $1,297 |
| 4 | Grand Rapids, MI | $1,381 |
| 5 | Scranton, PA | $1,444 |
| 6 | Phoenix, AZ | $1,536 |
| 7 | Dell Rapids, SD | $1,557 |
| 8 | Denver, CO | $1,564 |
| 9 | Little Rock, AR | $1,587 |
| 10 | Kansas City, MO | $1,608 |

**2003's 10 Most Expensive:**

| Rank | Locality | Monthly Charge |
|---|---|---|
| 1 | Washington, DC | $4,429 |
| 2 | Stamford, CT | $4,073 |
| 3 | Statewide, AK | $4,036 |
| 4 | Bridgewater, NJ | $3,886 |
| 5 | New York, NY | $3,830 |
| 6 | Highland Park, IL | $3,775 |
| 7 | Chicago, IL | $3,659 |
| 8 | Wilmington, DE | $3,383 |
| 9 | Brunswick, ME | $3,297 |
| 10 | Madison, WI | $3,210 |

### What the Experts Are Saying

*"Medicare funding is a current crisis . . . Social Security is a crisis waiting to happen."*

—Robert Reich,
former U.S. Secretary of Labor

*"Consolidation continues, but the focus has shifted to major regionals gobbling up assets rather than the very large national firms swapping and merging."*

—Gary Lucas,
SVP & Managing Director of the Seniors' Housing Group
at Marcus & Millichap Real Estate Investment Brokerage Co.

*". . . (T)he explosive demand for housing by an increasingly aging-but-living-longer population won't surface much before 2020. By then, the entire country will look, demographically, like Florida looks today."*

—David Schless,
President of The American Seniors Housing Association

*"We feel that on a long-term basis, seniors' housing is a very promising business, with demographics driving demand that will continue to outstrip supply."*

—Phillip Anderson,
EVP & COO
of CNL Retirement Corp.

*"Right now, the parents of baby boomers are moving into assisted living facilities. We expect the numbers to pick up again in a decade or so when the baby boomers themselves are ready for these places."*

—Tom Isles,
Dir. of Suffolk County (NY) Planning Dep't

**Mr. Kaplan is a partner at Ruskin Moscou Faltischek, where he is chairman of the Seniors' Housing Group and practices in the Health Law, Corporate Law and Real Estate Departments.**

**Mr. Kaplan has over 20 years of extensive experience in regulatory health law, transactional health law, real estate, general corporate, financial matters and construction law. He has spent most of that time as General Counsel and Senior Executive Vice President of Kapson Senior Quarters Corp., an assisted living and seniors' housing provider, which went from being a small privately held business to a public company subsequently bought out by a Wall Street investment bank and then taken private again. Mr. Kaplan headed up all of this company's legal operations, was one of its three senior executives, and was one of the two people who participated in the company's roadshow in anticipation of its initial public offering.**

**Mr. Kaplan was appointed by the Governor of New York to the New York State Life Care (Continuing Care Retirement) Community Council, and sits on the Board of Directors (Emeritus) and is Chairman of the Legal Committee of the Empire State Association of Adult Homes and Assisted Living Facilities. Mr. Kaplan also sits on the Board of Directors of Friends Assisting Nassau Seniors (FANS), and sat on the Board of Directors of the American Seniors Housing Association (ASHA), the Assisted Living Federation of America (ALFA), and was a founding Board Member of the Connecticut Assisted Living Association (CALA) and the New Jersey Assisted Living Association (NJALA). Mr. Kaplan was also appointed to the New York State 1995 Governor's Conference on Aging by the New York State Office for the Aging to develop New York State's platform for the 1995 White House Conference on Aging.**

**Mr. Kaplan has also been appointed as a receiver by the New York State Supreme Court for an unaffiliated third party's assisted living facility in a mortgage foreclosure action, and has been a featured speaker at international, national, regional and local senior housing forums, including the United Nations-International Conference on Urban Senior Housing, The New York State Bar Association, the Assisted Living Federation of America, the National Association of Senior Living Industries, the Connecticut Assisted Living Association, the City Club of New York, the International Association of Corporate Real Estate Executives (NACORE), and on the WLIE Talk Radio show "Seniors on the Move." In addition, Mr. Kaplan has been featured in and written articles for numerous publications, including *The New York Times*, *Newsday*, the *New York Law Journal*-Long Island edition, the *New York Real Estate Journal*, *Provider Magazine*, *Assisted Living Today*, *Spectrum Magazine*, *Continuum*, and *Multi-Housing News*. Mr. Kaplan has also been a volunteer Judge/Arbitrator in the Suffolk County, N.Y., District Court system since 1990.**

# Quotes to Remember

By Natalie J. Kaplan

The Health Insurance Portability and Accountability Act (HIPAA) regulations indirectly provide access to medical records by a health care agent.[1]

Three supporting provisions state: 1) an individual may be given access to his or her own health records;[2] 2) a personal representative must have the same access as the individual; and 3) one with health care decision-making powers must be treated as a personal representative. *Ergo*, a health care agent (with health care decision-making powers) has the same right of access as the principal.[3]

Below are the quotes to remember:

1. "A covered entity is permitted to use or disclose protected health information as follows: (i) to the individual." 45 C.F.R. § 164.502(a)(1)(i).
2. "[A] covered entity must treat a personal representative as the individual." 45 C.F.R. § 164.502(g)(1).
3. "If a person has authority to act on behalf of an individual . . . in making decisions related to health care, a covered entity must treat such person as a personal representative." 45 C.F.R. § 164.502(g)(2).

## Endnotes

1. *See also Mouggiannis v. North Shore-Long Island Jewish Health System, Inc.*, N.Y.L.J., May 19, 2004, p. 19, col. 3 (Nassau Co. S. Ct.).
2. Denial of access of an individual to his or her own records is permitted when access is not in the best interest of the individual. Similar denial of access to a personal representative is also permissible. 45 C.F.R. § 164.502(g)(5).
3. Discretionary disclosure may be granted to family members and others. 45 C.F.R. § 164.510(b)(i).

**Natalie J. Kaplan is a longtime New York City and Westchester County elder law attorney whose practice includes in-house counseling by Elder Law on Wheels.®**

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