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Elder Law Attorney

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Message from the Chair

Safe Return™

Many of us have raised small children and experienced the terror of being in a shopping mall, turning around for a moment, then turning back and realizing that the child is missing. Words alone cannot describe the total panic of such an event. Now imagine that it is not a small child, but the missing person is your mother or father or aunt or uncle. They may have walked out of their own home in the middle of the night, thinking that it was the middle of the day. They may have wandered out in the middle of the winter without any warm clothing. They may have gotten onto the wrong train or bus and could be in another city without any way to explain who they are or how they got there. It is very difficult to express the anxiety that family members experience when an Alzheimer's patient wanders and becomes lost. Wandering is a common behavior with this illness and it is a potentially life-threatening event.

This column is usually reserved for inspirational articles or updates on news of immediate interest to the membership of the Elder Law Section. I would like to take this opportunity however, to make a break from tradition and make you aware of a simple step that each Section member could take to possibly save the life of an Alzheimer's patient. It is an elegantly simple step to help find Alzheimer's patients who have wandered away and are at risk. That step is called Safe Return.™

The most effective solution is for patients to have a bracelet or necklace that immediately identifies them as an Alzheimer's patient. The first step is to register the patient with the Safe Return™ program. The program gets information that would help identify the patient (such as name, address, date of birth, height and weight). As an option, a photograph of the patient can also be provided. The program also gathers information about the caregiver (such as name, address, and telephone numbers). The reverse side of the jewelry alerts anyone who reads it that the patient is memory impaired. This is crucial to be sure that law enforcement or health care individuals are made aware of the true condition and are able to distinguish the behavior from other causes, such as substance abuse, for example. The reverse side of the jewelry also contains the name of the Alzheimer's

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Association and has an 800 telephone number engraved on it.

Some patients are uncomfortable with a bracelet that identifies them as suffering from memory loss and are reluctant to wear the jewelry. To help overcome this reluctance, the jewelry comes in different designs, one that has the name of the Alzheimer's Association on it, one that simply says Safe Return,™ and one that simply has the logo of the Alzheimer's Association. If the patient simply will not wear the identifying jewelry there are iron-on clothing labels with identifying information, which are also available.

In the event that the patient is lost, the Safe Return™ program can fax identifying information and the photograph to law enforcement officials. When a patient is located, the bracelet allows a police officer or hospital admitting staff member or ordinary citizen to quickly contact the Safe Return™ program through the 800 number. That number is active 24 hours a day, 365 days a year and can link the patient and the caregiver.

In New York City alone, there are more than 200,000 people with Alzheimer's disease. Six out of ten of them will become disoriented, even in their own neighborhood and unable to find their way back to the safety of home. That means that there are 120,000 people in New York City whose safety is directly at risk.

Each Elder Law Section member can take the constructive step of making information about the Safe Return™ program available in their office. Brochures to help clients register for the program can be made available in each of our waiting rooms.

Although this danger is not a strictly legal problem, it is something that elder law attorneys are in a unique position to address. We commonly advise our clients about homecare programs, daycare programs, assisted living facilities and nursing homes. We discuss documents such as powers of attorney, living wills, health care proxies and trust agreements that can be drafted to help avoid harm to our elderly clients. A part of our routine counseling should also include information about protecting our elderly clients from the common risk of getting lost as a result of this illness. Since we come in contact with so many families of Alzheimer's patients, we can make them all aware of the Safe Return™ program and have a direct impact on the safety of our clients.

Daniel G. Fish

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.

Editor's Message

Our theme for this issue is Social Security and Medicare. Our first theme piece is authored by Vincent J. Russo and Marvin Rachlin and gives an overview of the Nuts and Bolts of the SSI program. This piece is followed by an article from Steven P. Lerner entitled, "Ten Frequently Asked Questions about Social Security Disability Benefits."

Brian Andrew Tully has authored a lengthy piece on Medicare Parts A, B and C, and Valerie J. Bogart has submitted her training outline for advocates addressing the new Medicare Drug Program.

Finally, Joan Lensky Robert has authored a piece on SSI with a focus on its relationship with Supplemental Needs Trusts.

Our usual columns then follow. Many thanks to Judith B. Raskin, Ellen G. Makofsky, Robert Kruger, Robert A. Grey, James H. Cahill, Jr., Scott M. Solkoff, and Matthew J. Nolfo for their tireless efforts on the part of the Section.

Our issue concludes with five bonus news pieces that we hope you will find of interest.

Steven M. Ratner

Supplemental Security Income: The Nuts and Bolts

By Vincent J. Russo and Marvin Rachlin

As an Elder Law attorney, it is critical to have an understanding of all the government benefits that are available to our clients, young and old. Supplemental Security Income (SSI) is a government benefit that provides a cash stipend to help an eligible individual with his or her monthly living expenses and care.

Marvin Rachlin (l) and Vincent J. Russo

Overview

The Supplemental Security Income program is a Federal Welfare Program that pays cash benefits to eligible beneficiaries who are either over 65, blind or disabled. It is a means-tested program with income and resource limitations. SSI has been with us since 1973, and in New York State it replaced the former state program of Assistance to the Aged Blind and Disabled (AABD), which was partially federally funded.

To assure that former AABD clients did not receive less from SSI, than they had from the state program, states were required to supplement the federal amount, with state funds to equal the former AABD payment. The federal SSI check is a combination of federal and state funds, and therefore varies from state to state. The monthly payment is adjusted annually.

The current allowance is $666 for a single and $973 for a couple. Lower amounts are paid to those living in another person's home.

Those living in a non-medical congregate care facility such as an adult home received $1,014 per month in 2005. All SSI payments are exempt for Medicaid eligibility purposes.

Medicaid Eligibility

By virtue of a contract between New York State and the federal government, a federal determination of eligibility for SSI is treated as an eligibility determination for Medicaid as well.[1] By virtue of a computer program Medicaid is automatically notified of an individual's entry into the SSI system. Medicaid then opens the Medicaid case, without any further application or contact from the individual. In addition to being enrolled in New York State's Medicaid program automatically, there is no ongoing necessity for re-certification as long as the individual remains eligible for SSI.

Medicaid Eligibility When SSI Is Discontinued

Not only is Medicaid notified when an individual is enrolled in SSI, they are also notified if SSI is discontinued. Although there is an automatic Medicaid approval when an individual goes on SSI, there is no automatic removal from Medicaid when SSI is discontinued. The federal law prohibits the state from automatically dropping Medicaid when SSI is discontinued.[2]

Upon discontinuance of SSI, Medicaid must make an independent determination of Medicaid eligibility. The individual must now meet all Medicaid eligibility requirements, like any new Medicaid applicant. The individual will be entitled to notification of acceptance or denial, and will also be entitled to a fair hearing review of the Medicaid eligibility decision.

SSI Income Standard

SSI breaks income into four categories.

1. **Earned income:**

   Consists of wages, self-employment, payment for goods sold or services rendered.

2. **Unearned income:**

   Social Security, pensions, public assistance benefits, except food stamp benefits which are not counted. Interest and dividends are no longer counted as income by SSI.[3]

3. **In kind income:**

   This is a non-cash benefit such as payment of rent and/or utilities. Providing of meals is also counted as in kind income. Gifts of or the provision of clothing is no longer considered in kind income by SSI. In kind income for room and board can result in a 1/3 reduction of the SSI grant. This reduction can be partially offset if the SSI recipient pays something toward room and board or if he/she provides their own food and meals.[4]

4. **Deemed income:**

   If an applicant or recipient of SSI lives with a spouse, or a child under the age of 18 lives with a parent, then the income and assets of the non-applying spouse or parent are deemed available to the applicant, which often creates ineligibility.

SSI Resource Standards

SSI limits non-exempt resources to $2,000. This includes cash, bank accounts, CDs, stocks, bonds and virtually all liquid assets.

Exempt Resources

1. **Homestead:**

   SSI exempts an individuals home which can be a one-, two- or three-family home and the land upon which it stands.[5] Although a two- or three-family homestead is exempt, the rent received from the apartments is not exempt and will affect the individual's eligibility.

2. **Household goods and personal effects:**

   SSI no longer considers household goods and personal effects as countable resources. Such items no longer have to be inventoried or evaluated.

3. **Life insurance and burial funds:**

   SSI exempts life insurance with a face value of $1,500 or less. If the face value exceeds $1,500 the cash value will count towards the $2,000 resource limit, unless the cash value is $1,500 or less. In the absence of life insurance, or if the insurance is less than $1,500 the applicant can maintain a separate burial fund bank account. The account when added to any insurance cannot exceed $1,500. Any interest earned on the burial fund account is exempt even if such interest brings the account over $1,500.

4. **Burial space:**

   In addition to the $1,500 burial fund, an applicant can purchase or own burial space including a cemetery plot, a casket, a mausoleum, a headstone, or any other repository. It is possible to reduce excess resources by purchasing burial space items before applying for SSI.

Exempt Income

$20 per month from any income source is exempt, without regard to any other income exemptions.

Earned income:

The first $65 per month is excluded, plus 50% of the balance of earned income. This is in addition to the basic exemption of $20. Earned income is most likely to be a factor for individuals over the age of 65, rather than those who are disabled, since the ability to earn income could affect the disability status.

Exempt Unearned Income

The basic $20 monthly exclusion is the only exemption for unearned income. There are several categories of income that are excluded by SSI in their entirety:

a.) Food stamp benefits

b.) German and Austrian reparation payments; such payments should be kept separate and apart from any non-reparation funds

c.) Restitution payments to Japanese-Americans

d.) Agent Orange settlement payments

e.) Crime victims' compensation benefits

f.) Interest earned on a burial allowance

g.) Proceeds of a bona fide loan, including student loans and reverse mortgages

h.) Compensatory damages from a lawsuit; punitive damages are not exempt

Asset Transfer Penalties

The SSI asset transfer rules work mechanically like Medicaid's transfer rules. The big difference is the divisor. For SSI, the divisor is the monthly SSI grant. Since the monthly SSI grant for a single individual living alone is $666, a transfer of $20,000 would make the SSI recipient ineligible for 30 months ($20,000 ÷ 666). There is a cap of 36 months on all SSI penalty periods.[6]

Return of Transferred Assets

It is possible to reduce or eliminate an SSI transfer penalty by returning all or part of the transferred assets. There will be no penalty if the entire transferred asset is returned in the same month it was transferred. After that even if everything is returned, eligibility will not exist prior to the first day of the month following the month of return. A partial return of transferred assets will reduce the SSI penalty period proportionally; but the partial return will not be credited until the first day of the month following the partial return. Returned assets will of course affect the eligibility of the individual.

Planning with SSI

Since SSI can be essential for an individual who is blind, disabled or over age 65, Elder Law attorneys are in a position to counsel individuals and their families on how to access SSI. In many instances, planning for eligibility is necessary in order to qualify for the benefits. Elder Law attorneys are experienced in counseling clients who are disabled or with limited means on how to pay for living expenses and care. In order to provide the maximum benefit to our clients, elder law attorneys must be familiar with SSI so that they can advise their clients in the appropriate situations on how to plan for SSI qualification.

Note: This article has not discussed the various "work programs" for disabled SSI recipients, nor have we discussed the appeal rights of the program.

Endnotes

1. 42 U.S.C.A. § 1383c.
2. 42 C.F.R. § 435.916k.
3. Pub. Law 108-203.
4. 20 C.F.R. § 416.1102.
5. 20 C.F.R. § 416.1210.
6. 42 U.S.C.A. § 1382b(C)(1)(A)(IV)(II).

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For a more complete understanding of SSI and other government benefits, we refer you to *New York Elder Law Practice*, Russo & Rachlin. Thomson West.

Ten Frequently Asked Questions About Social Security Disability Benefits

By Steven P. Lerner

Introduction

Elder Law Practitioners most often represent clients that are over the age of 65. However, the practitioner may come in contact with a younger individual who alleges that he/she is disabled. Clients may be eligible for Social Security benefits through the programs under the Social Security Act[1] and accompanying Regulations.[2] The Social Security Act provides many benefit programs, which include the Disability Insurance Program,[3] the Supplemental Security Income Program,[4] Childhood Insurance Disability Program,[5] Survivor's Benefits[6] and Retirement Benefits.[7] This article will focus upon Social Security Disability benefits under the Disability Insurance Program.

I. What Benefits Does Social Security Disability Provide and Who Is Eligible?

While the Social Security Act provides for benefits for retired workers, it also provides for payments in the form of Disability Insurance Benefits[8] to former workers who are now disabled and unable to work. It provides monthly income during a period of disability while the individual is unable to perform substantial gainful activity[9] so long as he/she is currently under insured status.[10] After two years, one receives Medicare.[11] Unlike Medicaid, one's assets and income do not affect a person's eligibility for Social Security Disability benefits. Assets and income of a spouse are also not countable in determining a person's eligibility for Social Security Disability benefits.

II. How Does One Qualify for Disability and Disability Insurance Benefits?

The disabled wage earner must have paid into the Social Security system, i.e., Federal Insurance Contributions Act (FICA),[12] which is federal withholding paid to the Social Security system.

In order for an individual to be eligible for a period of disability and Disability Insurance Benefits, one must be "currently insured."[13] One is currently insured if one has sufficient quarters of coverage. Each year is divided into four quarters of possible employment and taxation. The parameters for eligibility state, in general, that the individual must have paid taxes into (FICA) for a period of twenty (20) quarters out of the last forty (40) quarters, or, translated, five (5) years out of the last ten (10) years prior to the application for Social Security Disability Benefits.[14] Those under the age of thirty-one (31) require fewer quarters of coverage, but never fewer than six (6) quarters.[15]

III. What Are the Medical Criteria for Eligibilty for Disability Insurance Benefits?

The Social Security program of Disability Insurance Benefits provides monthly payments to a wage earner who is totally and permanently disabled. The Social Security Administration has issued a Listing of Impairments[16] and Medical Vocational Guidelines,[17] which are used to establish that one is disabled. If an individual presents medical evidence that there is a medically diagnosed impairment with the symptoms, signs, and test results that meet those identified in the listings, then a finding of a period of disability is indicated.[18] If an individual does not specifically meet a listed impairment, that individual can still qualify for Social Security Disability benefits if the severity of the person's impairments rise to the level of a listed impairment, taking into account the functional limitations created by the impairments.

IV. What Is Meant by Total and Permanent Disability?

One must be totally and permanently disabled in order to receive Social Security benefits.[19] One is permanently disabled if one is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months;[20] or in the case of an individual who has attained the age of 55 and is blind, inability by reason of such blindness to engage substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.[21] One is

totally disabled if his/her physical or mental impairment or impairments are of such severity that he/she is not only unable to do previous work but cannot, after considering the individual's age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy.[22]

The Social Security Administration must also consider the combined effects of all of the individual's impairments without regard to whether or not any such impairment, if considered separately, would be of such severity as to rise to a level that would impair the individual's ability to perform substantial gainful activity.[23] The statute defines a physical or mental impairment as "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."[24]

V. What Does Substantial Gainful Activity Really Mean?

The courts have uniformly ruled that substantial gainful activity is work of a functional nature that the disabled individual can realistically perform in a competitive work environment.[25] The distinction between a competitive work environment and a non-competitive work environment is generally seen with younger individuals who perform work services in a sheltered environment.[26] Those who may require a job coach to assist him/her with day-to-day work activities and requires and receives oversight, supervision, coaching and assistance in performing the work, would not be considered performing substantial gainful activity in a competitive work environment.

VI. How Does One Apply for Disability Insurance Benefits?

One applies for disability insurance benefits through the Social Security Administration.[27] The application requests information concerning the individual's personal data, as well as the disabling condition, the date that the applicant last worked, the income earned by the applicant in the form of wages for the three years prior to the application, and information regarding the applicant's children who are under the age of 18. As part of the application process, the applicant will also complete a Disability Report and a Work History Report in order to establish the individual's capacity to perform his/her past work. After reviewing the application, the Social Security Administration will issue a Notice of Approved Claim or a Notice of Disapproved Claim.[28]

VII. How Does One Appeal a Denial of Disability?

If the application is denied, the applicant must file a Request for a Hearing before an Administrative Law Judge of the Office of Hearings and Appeals of the Social Security Administration within sixty (60) days of the Notice.[29]

An Administrative Law Judge conducts the disability hearing.[30] At the Administrative Hearing, the Administrative Law Judge acts as an independent fact-finder to render his/her own determination on the claimant's application for benefits. The Administrative Law Judge will review all of the documents in the evidentiary record, hear sworn testimony and then render a decision. The Administrative Law Judge is not bound by any of the prior determinations made by the Social Security Administration and as there is no one present at the Administrative Hearing from the Social Security Administration to cross-examine the claimant, the Rules of Evidence are dispensed with.

The Social Security Administration utilizes a five-step sequence to evaluate disability claims.[31] The Second Circuit has summarized the procedure as follows:

> First, the Commissioner considers whether the claimant is currently engaged in substantial gainful activity. If he is not, the Commissioner next considers whether the claimant has a "severe impairment" which significantly limits his physical or mental ability to do basic work activities. If the claimant suffers such an impairment, the third inquiry is whether, based solely on medical evidence, the claimant has an impairment which is listed in Appendix 1 of the regulations. If the claimant has such an impairment, the Commissioner will consider him disabled without considering vocational factors such as age, education, and work experience; the Commissioner

> presumes that a claimant who is afflicted with a "listed" impairment is unable to perform substantial gainful activity. Assuming the claimant does not have a listed impairment, the fourth inquiry is whether, despite the claimant's impairment, he has the residual functional capacity to perform his past work. Finally, if the claimant is unable to perform his past work, the Commissioner then determines whether there is other work which the claimant could perform.[32]

If the decision is unfavorable, an appeal may be filed through the Appeals Council of the Office of Hearings and Appeals of the Social Security Administration.[33]

Once the Appeals Council makes its determination, the individual may appeal an unfavorable decision in the United States District Court, naming the Commissioner of the Social Security Administration as a defendant.[34]

VIII. Does Eligibility for Private Disability Insurance Automatically Establish Eligibility for Social Security Disability?

Private disability policies often provide for coverage if one is unable to perform one's prior work, or if one is temporarily unable to work, or if one is partially disabled. These standards differ from those used by the Social Security Administration's Disability Insurance Benefit Program, which requires a total and permanent disability from all competitive employment.[35] Coverage by private disability insurance does not mean an automatic finding of disability for Social Security.

IX. If One Returns to Work and Is No Longer Receiving Social Security Disability, Must One Reapply if One Cannot Work in the Future?

As some individuals who return to work are not able to continue their return to competitive employment, the law provides for a trial work period.[36] A trial work period is defined as an attempt to perform substantial gainful activity, where the individual may test his/her ability to work and still be considered disabled.[37] If the individual is not able to continue working within the nine-month period, then one may return to the disability rolls without any interruption in coverage.[38] If the individual is able to continue working, then his/her benefits will cease. However, if one becomes disabled again within three years from returning to competitive employment, one can receive disability benefits without proving disability again.[39] This is a wonderful tool to allow individuals to make attempts at working, without risking their benefits.

X. How Is the Attorney Paid in This Type of Practice?

An applicant may retain an attorney to act as his/her representative before the Social Security Administration.[40] An attorney is entitled to charge a fee of 25% of past-due retroactive benefits or $5,300, whichever is less.[41] Unless directed otherwise, the Social Security Administration will automatically withhold 25% from the retroactive benefits that are being paid to the disabled individual.[42]

Conclusion

Although an application for Social Security Disability benefits may be denied initially, once successful, the individual who is totally and permanently disabled will receive a monthly disability income to sustain him/her in difficult times.

Endnotes

1. 42 U.S.C. §§ 401 *et seq.*
2. 20 C.F.R. §§ 404.1 *et seq.*
3. 42 U.S.C. § 423.
4. 42 U.S.C. §§ 1381 *et seq.*
5. 42 U.S.C. § 402(d).
6. 42 U.S.C. § 402(e), (f).
7. 42 U.S.C. § 402(a).
8. 42 U.S.C. § 423.
9. 42 U.S.C. § 423(d), (e). Substantial gainful activity means work that involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit. 20 C.F.R. § 404.1510. *See also* 20 C.F.R. §§ 404.1571 *et seq.*
10. 42 U.S.C. § 423(c); 20 C.F.R. §§ 404.101 *et seq.*
11. 42 C.F.R. § 406.12.
12. 42 U.S.C. § 409.
13. 42 U.S.C. § 423(c)(1); 20 C.F.R. § 404.120.
14. 42 U.S.C. § 423(c)(1)(B)(i); 20 C.F.R. § 404.130.
15. 20 C.F.R. § 404.130(c).

16. 20 C.F.R. § 404, Subpart P, Appendix 1, Part A.
17. 20 C.F.R. § 404, Subpart P, Appendix 2.
18. 20 C.F.R. § 404, Subpart P, Appendix 1, Part A.
19. 42 U.S.C. §§ 423(d)(1)(A), 416(i)(1).
20. 42 U.S.C. §§ 423(d)(1)(A), 416(i)(1).
21. 42 U.S.C. §§ 423(d)(1)(B), 416(i)(1).
22. 42 U.S.C. § 423(d)(2)(A).
23. 42 U.S.C. § 423(d), (e). Substantial gainful activity means work that involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit. 20 C.F.R. § 404.1510. *See also* 20 C.F.R. §§ 404.1571 *et seq.*
24. 42 U.S.C. § 423(d)(3), 20 C.F.R. § 404.1508.
25. *City of New York v. Heckler*, 578 F. Supp. 1109 (D.C.N.Y., 1984), *aff'd*, 742 F.2d 729 (2d Cir., 1985), *aff'd*, 106 S.Ct. 2022, 476 U.S. 467, 90 L.Ed. 2d 462 (1987).
26. 20 C.F.R. § 404.1573(c).
27. 42 U.S.C. § 423(a)(1)(c); 20 C.F.R. § 404.611. Online, one can apply at www.ssa.gov.
28. 20 C.F.R. § 404.900 (a)(1).
29. 42 U.S.C. § 423(b)(1); 20 C.F.R. § 404.900(a)(3). In the past, the applicant that was denied benefits would have to request a reconsideration determination before the hearing process, but that phase has been eliminated for disability cases, however, the reconsideration phase is still part of the administrative review process in other Social Security matters. (*see* 20 C.F.R. § 900(a)(2)).
30. 20 C.F.R. §§ 404.914, 404.915 and 404.916.
31. 20 C.F.R. §§ 404.1520 *et seq. See Bluvband v. Heckler*, 730 F.2d 886, 891 (2d Cir. 1984).
32. *Bluvband v. Heckler*, 730 F.2d 886, 891 (2d Cir. 1984).
33. 20 C.F.R. §§ 404.900(a)(4), 404.967 *et seq.* There is one Appeals Council, located in Falls Church, Virginia, and it handles all of the cases under review.
34. 20 C.F.R. § 404.900 (a)(5).
35. 42 U.S.C. § 423(d)(2)(A).
36. 42 U.S.C. § 422(c).
37. 20 C.F.R. § 1592(a).
38. 20 C.F.R. § 1592.
39. 20 C.F.R. § 1592a.
40. 20 C.F.R. § 404.1705(a).
41. 42 U.S.C. § 406(a)(2)(A); 20 C.F.R. §§ 404.1720, 404.1730.
42. 20 C.F.R. § 404.1720(b)(4).

Steven P. Lerner, a member of the firm of Kassoff, Robert, & Lerner, LLP, is a member of the National Organization of Social Security Claimants' Representatives and the National Academy of Elder Law Attorneys. A graduate of Syracuse University School of Law, Mr. Lerner's special areas of expertise are Social Security Disability, Social Security Retirement, Social Security Overpayment, Elder Law, Estates and Real Estate. He is listed in *Who's Who in American Law*. Mr. Lerner has lectured extensively on Social Security matters and Elder Law issues. He has written numerous articles on various legal matters ranging from Elder Law to Social Security. Mr. Lerner is a member of the Elder Law Section of the New York State Bar Association, and also the Nassau County Bar and American Bar Associations.

Medicare Parts A, B and C: Eligibility, Enrollment, Costs and Coverage

By Brian Andrew Tully

I. Overview

Medicare is the insurer for virtually all elderly people in the United States since Title XVIII was added to the Social Security Act in July 1965. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA). The program operates under legislation passed by Congress,[1] and under regulations adopted by the Health Care Financing Agency.[2]

Medicare has four separate parts: Medicare Part A, which is hospital insurance; Medicare Part B, which is medical insurance; Medicare Part C, which is Medicare Advantage; and Medicare Part D for prescription drugs.

Medicare redistributes contributions to pay costs of non-workers (Part A) and is subsidized from general funds (Part B). Part A is financed through mandatory payroll taxes under the Federal Insurance Contributions Act (FICA) and the Self Employment Contributions Act (SECA). Part B is financed partly by monthly Medicare Part B insurance premiums paid by Medicare Part B enrollees, with the balance paid from the Federal Treasury. Part C services, provided by various health care providers, such as Health Maintenance Organizations ("HMOs") are funded by the enrollee paying his or her Part B premium, the private premium charged by the insurance company, and the Federal Treasury paying a flat monthly per capita amount for each enrollee.

II. Medicare Part A

A. Eligibility

Individuals are eligible for Medicare Part A hospital coverage provided they are:

1. People who are eligible for Social Security or Railroad Retirement benefits; those over age sixty-five, who have paid FICA or SECA taxes through employment for at least 40 quarters; or,
2. People who are not eligible for Social Security or Railroad Retirement benefits but who were employees of the federal government, and are over age sixty-five and have worked at least 40 quarters; or,
3. Disabled, as determined under the Social Security Act, for at least 24 months (regardless of age); or,
4. People with end-stage renal disease (ESRD) who require dialysis treatment or kidney transplant or ALS (Lou Gehrig's Disease) (regardless of age); or
5. People who are over sixty-five but ineligible for Social Security benefits because of not having worked the requisite number of quarters, but who elect to purchase Part A at a monthly premium.

B. Enrollment

1. Enrollment for Covered Individuals Receiving Social Security or Railroad Retirement Benefits

For fully covered individuals age sixty-five and over who receive Social Security or Railroad Retirement benefits monthly, enrollment in Part A benefits is automatic. That individual will receive Medicare Part A coverage and a Medicare card effective on the first day of the month of his or her sixty-fifth birthday.

2. Enrollment for Covered Individuals NOT Eligible for Social Security or Railroad Retirement Benefits

Fully covered individuals such as federal government employees who were not eligible for Social Security but paid Medicare taxes will not receive Social Security or Railroad Retirement benefits upon retirement at age sixty-five or older. Therefore, they will not be automatically enrolled into the Medicare Part A system, even though they are fully covered. To obtain Medicare Part A benefits, such individuals must apply for them by enrolling in Medicare Part A through their local Social Security office.

A covered individual who is required to enroll and who wants to obtain Medicare Part A coverage begin-

ning at age sixty-five, may do so prior to becoming sixty-five. Such an individual's eligibility will only start on the first day of the month in which he or she becomes sixty-five. For example, a person who will be sixty-five on June 31 is eligible for Medicare Part A on June 1 and can enroll in May.

A covered individual can also enroll in Medicare Part A after he or she reaches the age of sixty-five because Medicare Part A is retroactive for covered individuals for six months. Medicare Part A coverage will begin at sixty-five if the individual enrolled within six months following his or her sixty-fifth birthday. If a covered individual fails to enroll for more than six months following his or her sixty-fifth birthday, there may be a loss of benefits since coverage will be retroactive for only six months.

3. Enrollment for Covered Individuals Who Do Not Retire at Sixty-Five

A covered individual who continues working after becoming sixty-five, and thus begins receiving Social Security or Railroad Retirement benefits, will be automatically enrolled in Medicare. These individuals are eligible for Medicare Part A benefits even though they are not retired.

4. Enrollment for Uncovered Individuals

Enrollment procedures for uncovered individuals with a work history of less than 40 quarters who have to pay a monthly premium for Medicare Part A coverage are different. They cannot wait up to six months following their sixty-fifth birthday to enroll and be covered retroactively. Instead, they have a seven-month window to apply that begins with the third month prior to becoming sixty-five and ending four months after becoming sixty-five. If they fail to enroll during the seven-month window, the penalty for late enrollment is a ten percent increase in the monthly Part A premium for each year that the individual could have enrolled but did not.

5. Enrollment for Disabled Persons Under the Age of Sixty-Five and Those with ESRD

The enrollment period for disabled persons under the age of sixty-five and for those with end-stage renal disease (ESRD) begins three months prior to the month of eligibility and ends twelve months after the month of eligibility.[3] For those with ESRD, disability begins when the need for dialysis begins. There is no penalty for enrolling after the twelve-month period, but eligibility will only be retroactive for twelve months.

C. Costs and Coverage[4]

Most people do not have to pay a monthly payment, called a premium, for Part A. If an individual does not get premium-free Part A (i.e., the individual, or his or her spouse, did not work enough quarters or an individual is disabled but no longer gets free Part A because he or she returned to work), he or she may be able to buy it for $393 per month in 2006.

Although Medicare Part A is described as hospital insurance, it covers a lot more. Medicare Part A helps cover medically necessary:[5]

- ***Hospital Stays:*** Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes the in-patient care one gets in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in the room. It also doesn't include a private room, unless medically necessary. In-patient mental health care in a psychiatric facility is limited to 190 days in a lifetime.
- ***Skilled Nursing Facility Care:*** Skilled nursing facility care is designed to provide care only for short-term stays for an acute condition. Medicare does not provide any coverage for custodial care, which is the majority of nursing home care. Care that can be provided by a non-medical professional is custodial. Medicare will provide limited coverage of a nursing home stay only if: (1) the patient was hospitalized for at least three consecutive days excluding the day of discharge; (2) admission to the nursing home is within thirty days of the hospital discharge, unless such care is medically inappropriate within that time; (3) the patient requires skilled nursing or skilled rehabilitation services or both, on a daily basis and such services can be provided only in a skilled nursing facility on an in-patient basis; (4) the services provided are for a condition that was treated while the patient was hospitalized; and (5) the patient's stay is approved by the facility's utilization review committee and the peer review organization.
- ***Home Health Care:*** Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language services that are ordered by one's doctor and provided by a Medicare-certified home health agency. Also includes medical

social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

- ***Hospice Care:*** For people with a terminal illness and who are not expected to live more than six months, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare (like grief counseling). Hospice care is usually given in one's home (which may include a nursing facility if this is the individual's home). However, Medicare covers some short-term hospital and in-patient respite care (care given to a hospice patient so that the usual caregiver can rest). The patient must elect hospice care in lieu of all other Medicare benefits for the terminal illness.
- ***Blood:*** Pints of blood one gets at a hospital or skilled nursing facility during a covered stay.

III. Medicare Part B

A. Eligibility

Individuals are eligible for Part B coverage provided they are:

1. All persons eligible for Medicare Part A; or,
2. United States residents or lawful resident aliens who have resided continuously in the United States for five years or longer and are over age sixty-five[6] (regardless of employment history); or,
3. Disabled persons eligible for Part A; or
4. Persons with ESRD or ALS who are eligible for Part A.

B. Enrollment

All individuals eligible for Medicare Part A benefits will automatically be enrolled for Medicare Part B benefits, unless such coverage is declined by the individual.[7] Once enrolled in Medicare Part B, a covered person may disenroll at any time. Thereafter, he or she may only re-enroll during the annual enrollment period, January 1 through March 31 each year, with Medicare Part B benefits not available until July 1 of that year. If an individual fails to enroll, or disenrolls and fails to re-enroll within 12 months, there will be a penalty of ten percent of the monthly premium for each year the person could have been enrolled.[8]

Voluntary purchasers of Medicare Part A are not automatically enrolled in Medicare Part B and must enroll to obtain Medicare Part B coverage. A voluntary purchaser of Medicare Part A must enroll in Medicare Part B within the three-month period prior to becoming sixty-five, in order to have Medicare Part B coverage during the month the person becomes sixty-five. If he or she does not enroll during the preceding three-month period, the voluntary purchaser must enroll within four months after becoming sixty-five. An enrollment for Medicare Part B coverage by a voluntary purchaser, beyond the enrollment period, will result in a penalty of ten percent of the monthly premium.[9]

C. Costs and Coverage[10]

The most common form of payment among covered individuals is having their Medicare Part B monthly premiums deducted automatically from their Social Security, Railroad Retirement or civil service annuity benefits. However, since voluntary purchasers do not receive a monthly benefit check from Social Security, Railroad Retirement or civil service annuity, automatic deduction is not possible and quarterly bills are sent to all voluntary purchasers.[11] Employers, unions, or other organizations may have a group payment plan for Medicare Part B coverage for people over the age of sixty-five who are still employed.[12]

The annual deductible for benefits paid under Part B is $124 for 2006. Home health care services, flu shots, and pneumonia vaccines under certain circumstances are exempted from the deductible.[13] Additionally, there is a co-insurance liability imposed on all Medicare Part B enrollees. Medicare will only pay 80 percent of the approved charge for any covered Medicare Part B service, and the patient is responsible for paying 20 percent.[14] Home health care services (when provided under Medicare Part B), used durable medical equipment that is purchased at a cost at least 25 percent less than the reasonable charge for new equipment, flu shots and pneumonia vaccines under specified conditions are not subject to any co-insurance payment by the patient.

Medicare Part B helps cover the following medical necessities:[15]

- ***Medical and Other Services:*** Doctors' services (not routine physical exams except for a "Welcome to Medicare" one-time physical exam within the first six months the individual has Part B), outpatient medical and surgical services

and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). It also covers a second, and sometimes a third, surgical opinion for surgery that isn't an emergency (in some cases), outpatient mental health care, and outpatient occupational and physical therapy, including speech-language services. (These services are also covered for long-term nursing home residents.)

- ***Clinical Laboratory Services:*** Blood tests, urinalysis, some screening tests, and more.
- ***Home Health Care:*** Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language therapy that are ordered by your doctor and provided by a Medicare-certified home health agency. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
- ***Outpatient Hospital Services:*** Hospital services and supplies received as an outpatient as part of a doctor's care.
- ***Blood:*** Pints of blood one gets as an outpatient or as part of a Part B-covered service.

IV. Medicare Covered Items and Services

A. Medicare Also Covers the Following Items and Services:[16]

These items and services are covered no matter what kind of Medicare plan the individual has. However, the amount Medicare pays for these items and services depends on the type of plan.[17]

- ***Ambulance Services***—when it's medically necessary for an individual to be transported to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger his or her health.
- ***Chiropractic Services***—manipulation of the spine to correct a subluxation.
- ***Clinical Trials***—routine costs if one takes part in a qualifying clinical trial (doesn't cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial).
- ***Diabetic Self-Management Training***—for certain people with Medicare at risk for complications from diabetes. The individual's doctor or other health care provider must request this service.
- ***Diabetic Supplies***—glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases).
- ***Durable Medical Equipment***—items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home.
- ***Emergency Room Services***
- ***Eyeglasses***—one pair of eyeglasses with standard frames after cataract surgery that includes implanting an intraocular lens.
- ***Foot Exams and Treatment***—if the individual has diabetes-related nerve damage and meets certain conditions.
- ***Hearing and Balance Exams***—if the individual's doctor orders him or her to see if medical treatment is needed (hearing aids and exams for fitting hearing aids aren't covered).
- ***Kidney Dialysis Services***—kidney dialysis, and services and supplies, either in a facility or at home.
- ***Long-Term Care***—only skilled care given in a certified skilled nursing facility or in the individual's home (not custodial care).
- ***Medical Nutrition Therapy Services***—for people who have diabetes, or for people who have kidney disease (unless on dialysis) with a doctor's referral for three years after a kidney transplant.
- ***Mental Health Care***—inpatient or outpatient; certain limits and conditions apply.
- ***Practitioner Services***—such as those provided by clinical social workers, physician assistants, and nurse practitioners.
- ***Prescription Drugs***—Medicare Part B covers limited prescription drugs, like certain injectable cancer drugs.
- ***Prosthetic/Orthotic Items***—arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); prosthetic devices needed to

replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy).

- ***Second Surgical Opinions***—covered in some cases.
- ***Smoking Cessation Counseling***—inpatient or outpatient services, up to eight face-to-face visits during a 12-month period if the individual is diagnosed with a smoking-related illness.
- ***Surgical Dressings***—if required for treatment of a surgical or surgically treated wound.
- ***Telemedicine***—services in some rural areas.
- ***Tests***—X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests if medically necessary.
- ***Transplant Services***—heart, lung, kidney, pancreas, intestine, and liver transplants (under certain conditions and in a Medicare-certified facility only), and bone marrow and cornea transplants (under certain conditions); immunosuppressive drugs if the transplant was paid for by Medicare, or paid by an employer group health plan that was required to pay before Medicare. (The individual must have been entitled to Part A at the time of the transplant and entitled to Part B at the time he or she gets immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility.)
- ***Travel (Outside the United States)***—services provided in Canada when one travels between Alaska and another state. (The "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and for services received while on board a ship, the territorial waters adjoining the land areas of the United States.)
- ***Urgently Needed Care***—care one needs for a sudden illness or injury that isn't a medical emergency.

B. Items and Services that Medicare Part A and Medicare Part B Do Not Cover:[18]

- ***Acupuncture***
- ***Deductibles, Co-insurance, or Co-payments*** when an individual gets health care services
- ***Dental Care and Dentures*** (with only a few exceptions)
- ***Cosmetic Surgery***
- ***Custodial Care*** (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home
- ***Eye Refractions***
- ***Health Care You Get While Traveling Outside of the United States*** (except as listed above)
- ***Hearing Aids and Hearing Exams*** for the purpose of fitting a hearing aid
- ***Hearing Tests*** (other than for fitting a hearing aid) that haven't been ordered by the individual's doctor
- ***Long-Term Care***, such as custodial care in a nursing home
- ***Orthopedic Shoes*** (with only a few exceptions)
- ***Prescription Drugs***, most prescription drugs aren't covered
- ***Routine Foot Care*** such as cutting of corns or calluses (with only a few exceptions)
- ***Routine Eye Care and Most Eyeglasses***
- ***Routine or Yearly Physical Exams*** (Medicare will cover a one-time physical exam within the first six months the individual has Part B.)
- ***Screening Tests and Screening Laboratory Tests***, with some exceptions
- ***Shots (Vaccinations)***, with some exceptions
- ***Some Diabetic Supplies***

V. Medicare Coverage Options

A. The Original Medicare Plan

1. Overview

The Original Medicare Plan, comprised of Parts A and B, is one of the health plan choices that are part of the Medicare Program. An individual will stay in the Original Medicare Plan unless he or she chooses to join a Medicare Advantage Plan or other Medicare Health Plan.

The Original Medicare Plan is a fee-for-service plan that is managed by the federal government. The

rules[19] for how the Original Medicare Plan works are below.

- If the individual has Medicare Part A, he or she gets all the Part A-covered services listed in Section II, Subsection C of this article.
- If the individual has Medicare Part B, he or she gets all the Part B-covered services listed in Section III, Subsection C of this article.
- The individual can go to any doctor or supplier that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility.
- The individual pays a set amount for his or her health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and the individual pays his or her share (co-insurance or co-payment) for covered services and supplies (unless the individual has a Medigap policy).
- After you get a health care service, each month the individual gets a Medicare Summary Notice (MSN) in the mail. These notices are sent by companies that handle bills for Medicare. The notice lists the details of the services received and the amount the individual may be billed.

2. Costs and Coverage

What an individual pays out-of-pocket with the Original Medicare Plan depends on the following:[20]

- whether an individual has Part A and/or Part B (most people have both)
- whether an individual's doctor or supplier accepts "assignment"
- how often an individual needs health care
- what type of health care an individual needs
- whether an individual chooses to get services or supplies not covered by Medicare. In this case, he or she would pay all the costs for these services
- whether an individual has other health insurance coverage that works with Medicare

If an individual has Medicare Part A and/or Part B, he or she will have to pay a part of the services he or she gets. The individual's Original Medicare Plan costs in 2006 are:[21]

- $124 Medicare Part B deductible
- $88.50 Medicare Part B premium
- $952 for a hospital stay of 1–60 days each benefit period
- $238 per day for days 61–90 of a hospital stay each benefit period
- $476 per day for days 91–150 of a hospital stay each benefit period
- All costs for each day of a hospital stay over 150 days
- $0 for the first 20 days of a skilled nursing facility stay each benefit period
- $119 per day for days 21–100 of a skilled nursing facility stay each benefit period
- All costs for each day of a skilled nursing facility stay after day 100 in the benefit period
- 20 percent of the Medicare-approved amount for most doctor services, outpatient therapy, preventive services, and durable medical equipment
- $0 for Medicare-approved home health services
- $0 for Medicare-approved clinical laboratory services
- 50 percent for most outpatient mental health services
- All costs for the first three pints of blood you get as part of an inpatient hospital stay (unless you or someone else donates blood to replace what you use)
- All costs for the first three pints of blood an individual gets as an outpatient, then 20 percent of the Medicare-approved amount for additional pints of blood (unless the individual or someone else donates blood to replace what he or she has used)
- Co-payments and co-insurance amounts for other services
- Note: In 2006, there may be limits on physical therapy, occupational therapy, and speech-language services.

3. Medigap: Medicare Supplemental Insurance

The Original Medicare Plan pays for many health care services and supplies, but it does not pay all of the individual's health care costs or cover prescription drugs. To help cover extra costs, one might want to get a Medigap policy. Starting January 1, 2006, individuals will not be able to buy new Medigap policies covering prescription drugs because private companies approved by Medicare will offer this coverage.

A Medigap policy is a health insurance policy sold by private insurance companies. They must follow federal and state laws which protect the purchasers. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."

Costs that individuals must pay, like co-insurance, co-payments, and deductibles, are called "gaps" in Original Medicare Plan coverage. An individual might want to consider buying a Medigap policy to cover these gaps in Original Medicare coverage. Some Medigap policies also cover benefits that the Original Medicare Plan doesn't cover, like emergency health care while traveling outside the United States. A Medigap policy may help individuals save on out-of-pocket costs. If an individual buys a Medigap policy, he or she will pay a monthly premium to the private insurance company that sells him or her the policy.

In all states except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of 12 standardized policies (Plans A–L), so they can be compared easily. Each plan has a different set of benefits. Plans K and L are new policies that help limit high out-of-pocket costs for doctor's services and hospital care. They may already be available in some states. They will likely have a lower premium than other Medigap policies. However, unlike Plans A–J, an individual will pay more of Medicare's co-insurance and deductibles before the policy pays its share of these costs.

Two of the standardized policies (Plans F and J) may have a high deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT policies usually cost less because the individual must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, the individual may use any doctor or hospital.

The Original Medicare Plan works with a Medigap policy as follows:[22]

- The individual may go to any doctor, specialist, or hospital (unless he or she buys a Medicare SELECT policy). Medicare pays its share, and then the individual's Medigap policy pays its share. What the individual's Medigap policy covers depends on which plan (Plan A-L) he or she buys. However, Medigap policies generally cover Medicare's co-insurance, co-payments, and deductibles.
- The individual pays his or her monthly Medicare Part B premium, and pays the insurance company a monthly premium for his or her Medigap policy.
- After the individual gets a health care service, in most cases each month he or she will get a Medicare Summary Notice in the mail and the Medigap insurance company will send information on what it paid on the individual's behalf.

VI. Medicare Part C: Medicare Advantage Plans

A. Overview

The Balanced Budget Act of 1997 created a new part C of Medicare, called "Medicare + Choice," commonly known as the "Medicare Advantage Program."

If an individual joins a Medicare Advantage Plan or other Medicare Health Plan, he or she is still in the Medicare Program, still has Medicare rights and protections, and still can get all of his or her regular Medicare-covered services. What the individual pays out-of-pocket in addition to the Part B premium depends on the plan's monthly premium amount. Medicare Advantage Plans and other health plans will have one premium that includes coverage for Part A and Part B benefits, prescription drug coverage (if offered), and any extra benefits (if offered). The individual will have to pay other costs (such as co-payments or co-insurance) for the services he or she gets. Generally, the out-of-pocket expenses in these plans are lower than in the Original Medicare Plan.

B. Medicare Advantage Plans

Medicare Advantage Plans are health plan options that are part of the Medicare Program. If an individual joins one of these plans, he or she generally gets all his or her Medicare-covered health care through that plan. This coverage can include prescription drug coverage. Medicare pays a set amount of money for the individual's care every month to these private health plans whether or not the individual uses services. In most of

these plans, generally there are extra benefits and lower co-payments than in the Original Medicare Plan. However, an individual may have to see doctors that belong to the plan or go to certain hospitals to get services.

Some Medicare Advantage Plans may pay all or part of the individual's Medicare Part B premium. If the individual joins a plan that offers this benefit, it may save him or her money and he or she would still get all Medicare Part A- and Part B-covered services.

Medicare Advantage Plans include Medicare HMOs, Medicare PPOs, Medicare Special Needs Plans, and Medicare Private Fee-for-Service Plans. They are explained below:[23]

- ***Medicare Health Maintenance Organization (HMOs) Plans***—Individuals generally must get their care from primary care doctors, specialists, or hospitals on the plan's list (network) except in an emergency.
- ***Medicare Preferred Provider Organization (PPOs) Plans***—In most of these plans, the individual pays less if he or she uses primary care doctors, specialists, and hospitals on the plan's list (network). The individual can go to any doctor, specialist, or hospital not on the plan's list, but it will usually cost extra.
- ***Medicare Special Needs Plans***—These plans provide health care coverage designed for specific groups of people. These plans may limit all or most of their membership to people in certain long-term care facilities (like a nursing home), people eligible for both Medicare and Medicaid, or people with certain chronic or disabling conditions.
- ***Medicare Private Fee-for-Service (PFFS) Plans***—If an individual joins one of these plans, he or she can go to any primary care doctor, specialist, or hospital that accepts the terms of the plan's payment. The private company, rather than the Medicare Program, decides how much it will pay and how much the individual pays for the services he or she gets.

C. Other Medicare Health Plans

There are some types of Medicare Health Plans that are not part of Medicare Advantage. However, they are still part of the Medicare Program. In some of these plans, the individual generally gets all his or her Medicare-covered health care from that plan. This coverage can include prescription drug coverage. Medicare pays a set amount of money for the individual's care every month to these private health plans.

These other types of Medicare Health Plans include Medicare Cost Plans, Demonstrations, and PACE (Programs of All-inclusive Care for the Elderly).

Endnotes

1. 42 U.S.C.A. § 1395 & ccc.
2. 42 C.F.R. Pts. 405–424.
3. 42 C.F.R. § 406.13; 42 C.F.R. § 408.24(a)(8).
4. *See* Section III: "Medicare Coverage Options: The Original Medicare Plan" *for a more detailed itemization of the costs.*
5. Centers for Medicare & Medicaid Services.
6. 42 U.S.C.A. § 1395o; 42 C.F.R. § 407.10.
7. 42 U.S.C.A. § 1395p(f); 42 C.F.R. § 407.17.
8. 42 C.F.R. § 408.22.
9. 42 C.F.R. § 408.40–53.
10. *See* Section III: "Medicare Coverage Options: The Original Medicare Plan" *for a more detailed itemization of the costs.*
11. 42 C.F.R. § 408.60.
12. 42 C.F.R. § 408.80–90.
13. 42 C.F.R. § 410.160(b).
14. 42 U.S.C.A. § 13951(a); 42 C.F.R. § 410.152.
15. Centers for Medicare & Medicaid Services.
16. Centers for Medicare & Medicaid Services.
17. *See* Section III, Subsection A: "The Original Medicare Plan;" Section IV, Subsection B: "Medicare Advantage Plans*; and* Section IV, Subsection C: "Other Medicare Health Plans."
18. Centers for Medicare & Medicaid Services.
19. *Id.*
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*

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Medicare Drug Program (Part D) Training Outline for Advocates

By Valerie J. Bogart

PART I

The Basics

I. What is Medicare Part D?—Introduction

A. Medicare Part D is a *prescription drug benefit* available to anyone with Medicare Part A or B.[1] Part D is different than Parts A and B in an important way. For Medicare benefits provided under Part A or Part B, the beneficiary can get services simply by having a Medicare card. Drug coverage under Part D is available ONLY if one ENROLLS in a Prescription Drug Plan (PDP).

B. The drug benefit is offered through private companies as Prescription Drug Plans (PDPs) or through Medicare Advantage plans (MA-PDs).

1. Stand-Alone Plans—(PDPs)—21 different companies will have different packages of plans, for a total of 46 plans in NYS. More info on these below.

2. Medicare Advantage Plans (MA-PDs) are HMOs or PPOs (Preferred Provider Organizations) that provide Medicare services in a managed care model, limiting the member's choice of providers.

a. Examples in NYS are Elderplan, HIP VIP, and Blue Choice Senior Plan. Twenty-five different organizations will offer 165 different plans in NYS, some covering only certain counties.

b. Individuals who are enrolled in a Medicare Advantage plan established under Medicare Part C *must* receive their drug coverage through their Medicare Advantage prescription drug plan, known as an MA-PD. They *may not* purchase a separate PDP. If they do, they will be disenrolled from their Medicare Advantage plan entirely.

- There is one type of Medicare Advantage plan—a private fee-for-service (PFFS) plan—that may not include a prescription drug option. Enrollees may purchase a PDP for their Part D coverage. (In New York, American Progressive is the only PFFS available upstate.)[2]

3. Medigap policies that include drug coverage (H, I, and J) are NOT Prescription Drug Plans (PDPs), and are not "creditable coverage" (as good as or better than Part D). These policies will no longer be sold, though people who already have them may keep them. If they keep them, and also join a PDP, then the drug coverage under the Medigap plan will be eliminated. The Medigap premium will be reduced to reflect this change. (See http://hiicap.state.ny.us/mgap/mgap03.htm.)

- Someone with a Medigap H, I, or J policy who keeps it and delays enrollment into Part D will face a late enrollment penalty because the Medigap is not "creditable coverage."

C. Huge change for the drug coverage of "dual-eligibles" on January 1, 2006

1. "Dual-eligibles" are people who receive both Medicare and Medicaid benefits. There are about 560,000 dual-eligibles in New York State. (See endnote 2) (GLOSSARY at the end of this outline).

2. Under the current system, their drugs are provided by Medicaid.

3. Starting January 1, 2006, *most (not all)* of their drugs will be provided by the new Medicare drug plan.

4. People who receive SSI may be dual-eligibles:
   a. Some receive both SSI and Social Security—so get Medicare.
   b. Some receive ONLY SSI, but have been enrolled in Medicare by New York State to save the state money.[3] Don't assume that just because your client receives only SSI, and not Social Security, she does not have Medicare. Ask the client if he or she has a Medicare card.
5. People who have MEDICAID ONLY, with no Medicare, will NOT be affected. Medicaid will continue paying for their drugs.

D. **Costs in General**—The basic benefit requires Medicare beneficiaries to pay large out-of-pocket costs—$3,600 out of the first $5,100 in drug costs each year plus a monthly premium. For dual-eligibles (Medicaid recipients) and other low-income people, a low-income subsidy (LIS) known as "extra help" is available that will reduce these out-of-pocket costs. This will be discussed in detail below.

E. **Important: Most people may need to enroll in TWO programs.**

1. Enrollment in a Medicare prescription drug plan (PDP)

> Dual-eligibles and Medicare Savings Program (MSP) will be automatically enrolled in a plan (PDP)—Medicaid recipients effective January 1, 2006, and MSP effective June 1, 2006. Everyone else must enroll directly.
>
> Because the automatic assignment of Medicaid and MSP recipients to plans will be random, the plans may not be the best ones for them. It is vitally important that we help them choose the best plan and switch at the right time. More on this in VII.E below.

2. Enrollment in the Low-Income Subsidy (LIS), which offers "extra help" in paying for prescriptions because of the many gaps in coverage under the basic Medicare drug plan.

> Dual-eligibles and Medicare Savings Program enrollees will be automatically enrolled in "extra help." Everyone else must APPLY.

> **TIP—**Keep in mind that enrolling in either a drug plan or "extra help" isn't enough. The Low-Income Subsidy is useless if one isn't enrolled in a drug plan (PDP). A PDP is useless if one can't pay the huge out-of-pocket costs, but has not enrolled in "extra help."

II. What Is the Medicare Drug Benefit?

A. **Basic Drug Benefit**—What costs must the Medicare beneficiary pay (if they have NO low-income subsidy)?

		OUT-OF-POCKET Per Year
$250 **deductible** per year		$250
25% **co-payment** between $251 and $2,250	+	$500
100% of costs between $2,251 and $5,100 (This is the "**doughnut hole**") (see IV.B.6)	+	$2,850
	=	**$3,600**
Estimated $32 per mo. premium	+	$ 384
Total out-of-pocket costs plus premium (this is for the first $5100/ per year costs.)	=	**$3,984**
5% of costs after reaching $5,100 **"catastrophic threshold"** by paying $3,600 in out-of-pocket ("OOP") costs (see II.E. below)		$ varies

Available at http://medicareadvocacy.org/FAQ_PrescDrugs.htm (scroll down for graphic).

> **TIP**—Basic benefit is best for those with total annual costs under $2,250 (they don't reach the "doughnut hole") OR more than $7,000. Not until does the plan pay at least half the total annual drug costs.(See http://cmwf.org/usr_doc/moon_medicarerxdrug_ib_730.pdf p. 3.)

1. The "basic plan" is a suggested format, but plans may vary the different components, as long as the total average annual out-of-pocket expenses are the same. This is why it will be difficult to compare plans.
   a. For example, a plan may eliminate the $250 deductible, but may charge higher co-payments.
   b. Or a plan may provide coverage during the "doughnut hole," but charge a higher premium or co-payments, or may not cover as many drugs on its formulary.
2. The basic plan is a minimum. Plans may also offer an enhanced benefit and charge more, but must offer at least one "basic" plan.[4] Enhanced plans may include drugs that are not required in "basic" plans." (See below about formularies.)

B. **Variations of Plans in NYS**

1. In NYS, 46 stand-alone plans will be offered by 21 different companies,[5] plus 2 other national companies may offer plans. In addition, 25 different Medicare Advantage plans will offer 165 different HMO and Preferred Provider Organization (PPO) packages.[6] When clients are deluged with marketing materials, we need to make sure they enroll only in plans they can afford and that meet their needs.
2. STAND ALONE PLANS (See endnote 5)

   Out of 46 plans in NYS:

   4 plans have premiums below $20/month; the lowest is $4.10

   14 plans have premiums between $20.01-$29.99/month

   22 plans have premiums between $30-$49.99

   5 plans have premiums over $50 per month; the highest is $85.02

   a. 25 plans have ZERO deductibles, 5 have reduced deductibles, only 16 plans have the standard $250 deductible.
   b. 40 out of 46 plans have tiered co-payments. TIERS of co-pays may charge differently for generic than brand name, and separate brand name into different tiers. More expensive brand names might have a higher co-payment than others.
   c. 6 of the 46 plans will offer some coverage during the "doughnut hole." Of these 1 will cover brand as well as generic drugs in the "doughnut hole." The other 5 will cover only generic.
   d. All but 3 offer mail order.
   e. Most plans (42 of 46) will have over 81% of the top 100 drugs on their formularies; 17 will offer over 90% of the top 100 drugs.
      - Not all plans are available for free to Medicaid recipients (dual-eligibles). (See more on "extra help" below.)
      - A cheap plan—with no premium or deductible—is not necessarily the best plan. These plans may have limited formularies and other barriers. See Enrollment section below.
3. **Medicare Advantage Plans**—Medicare Advantage is the new name for Medicare Plus Choice or Medicare HMO. Under this plan, you can only use your Medicare card for hospitals, physicians, home care, and all other services by using providers in your HMO plan's network and sometimes only with the "prior approval" of the plan or your primary care physician.
   a. The number of companies offering Medicare Advantage plans has grown to 25 in NYS, offering 165 different plans! Many of these are "Preferred Provider Organizations" or PPOs, which are somewhat less strict than HMOs. In a PPO, you might not need permission to go to a specialist, as in an HMO, but the specialist must be on a "preferred" list of your PPO.
   b. Unlike the stand-alone PDPs, many of the Medicare Advantage plans are available only in certain counties.

c. Members of a Medicare Advantage plan are given the option of joining the drug plan that is part of the Medicare Advantage plan, or leaving the plan altogether. If they stay in the MA plan for medical coverage, they must use that plan's drug benefit. If they want to join a different Part D plan, they must disenroll altogether.

d. ELDERPLAN—A Medicare HMO in NYC—will offer drug coverage. Though it is not a Part D plan, the coverage is "creditable." Members do not have to join a Part D plan. If they do, they will be disenrolled from Elderplan altogether.

e. LOW COSTS—Unlike the stand-alone plans, 14 of 25 companies offering Medicare Advantage plans in NYS are offering at least one drug plan with **NO** monthly premium.

Twenty-three out of the 25 companies are offering at least 1 Medicare Advantage Plan with **NO deductible**.

Three of the 25 companies offer plans with coverage during the "doughnut hole" for generic drugs.

f. What's the DOWNSIDE?

- **LOCK IN**—With costs lower in these plans, it will be tempting for our clients to join. The catch is that beginning January 1, 2006, Medicare Advantage enrollees are LOCKED IN to a plan and will have very limited rights to disenroll. This is discussed further below with enrollment.
- Also, plans may have restrictive formularies and other barriers to accessing vital drugs.

C. **What Drugs Does the Medicare Drug Benefit Include?**

1. Each PDP will have a "formulary." This is a drug list.
2. The Center for Medicare & Medicaid Services (CMS) requires each formulary to include at least 2 drugs in each "therapeutic class," for example, anti-inflammatories, blood pressure, or cholesterol drugs.[7] Plans must also include insulin and medical supplies used to inject insulin.

a. You or your physician may request an "exception," also called a "coverage determination," to ask the plan to cover a drug not on its formulary. This procedure and other appeals are described in Point VIII below.

b. Plans may require members to obtain "prior approval" in order to get certain drugs, or to go through "step therapy," in which they first try less expensive drugs and only receive costlier alternatives if the first ones aren't effective.

3. Formularies must also include "all or substantially all" drugs in six classes: anti-depressants, anti-psychotics, anti-convulsants, anti-cancer, immunosuppressant, and HIV/AIDS drugs.[8] These must include generic drugs and older brand name drugs.

a. CMS made this requirement out of concern that beneficiaries could be harmed if forced to change or stop long-time drug regimens, even briefly. Also, CMS wanted to prevent drug plans from "cherry-picking"—enrolling only members who do NOT need these drugs.

b. There are some exceptions—some drugs in these 6 classes do NOT have to be included.[9]

c. With the exception of most HIV/AIDS drugs, patients NEWLY prescribed one of the drugs in these 6 classes MAY be subject to utilization management techniques—prior approval, step therapy, generic substitution. For patients already on any of these drugs, the plan must "demonstrate extraordinary circumstances" to use such techniques.

- Plans may not have any way of knowing that an enrollee is not a new user of these meds. Patients, their doctors and advocates will

need to bring this to the drug plan's attention.

4. LIST of Top 100 Drugs—CMS has compiled a list of the 100 most prescribed drugs, based on experience in the temporary prescription drug card program that is ending December 31, 2005. In its charts listing the drug plans available in each state or region, CMS indicates the number of the top 100 drugs on each plan's formulary. For the 46 stand-alone plans in NYS, the lowest is 73 drugs and the highest is 99.
5. PLANS MAY CHANGE FORMULARIES ANY TIME—The plan must provide members taking the affected drug, their prescribing physicians, pharmacists, and CMS with a 60-day notice of formulary change.[10] The notice must state other available drugs and explain how to request an exception.
   a. If the plan does not provide advance notice, they must provide a 60-day supply of the drug and notice at the time of the refill.
   b. Most members are locked into a drug plan for a whole year (except those on Medicaid & Medicare Savings Programs, which may change monthly). Because of the "lock-in," the 60-day notice only gives most members a chance to request an "exception" or talk to their doctor about switching drugs. Medicaid recipients & MSP enrollees may change plans monthly. More on this later.
   c. In addition to removing drugs from the formulary, the 60-day notice must also be given if the plan changes the "cost-sharing tier" for a drug.

D. **What Drugs Will Medicare Part D *Not* Cover?**

1. Certain drugs are not covered by the Medicare drug benefit. These include benzodiazepines, such as Valium, Ativan, and Xanax, barbiturates, drugs for weight loss or weight gain, and over-the-counter drugs and vitamins.[11] A list of excluded drugs is available at http://www.wnylc.net/pb/docs/NYFAHC_Fact_Sheet.pdf.
2. The excluded drugs may not be included in the "basic" drug benefit. However, a plan may offer coverage with a higher premium that includes these drugs.[12]
3. Medicaid and EPIC will still cover these drugs, to the extent they were covered before. This is one reason why anyone eligible should enroll in EPIC even if they have the "better" Low-Income Subsidy. They will use BOTH benefits. The chart at the link above shows whether EPIC or Medicaid covers these drugs.

E. **Which Out-of-Pocket Costs Count Toward the $3,600 Needed to Meet the "Catastrophic Coverage" Threshold** (when the enrollee's out-of-pocket costs are reduced to 5% co-payments)?

1. The basic benefit requires those without the Low-Income Subsidy to pay a certain amount from their own pockets in one year before receiving assistance at the catastrophic level. This out-of-pocket (OOP) amount is $3,600 for 2006. When they have paid that amount, the beneficiary's costs go down to a 5% co-payment for the rest of the year.
   a. This $3,600 total is made up of the $250 annual deductible, the 25% co-payment up to $2,250 in total drug costs, then 100% of drug costs in the "doughnut hole." It does not include the monthly premium. (See II.A. above)
   b. Even people who have a Low-Income Subsidy reach a catastrophic limit where their co-payments are reduced.
2. Only certain drug costs count toward the $3,600 threshold for catastrophic coverage. Only *allowable* drug costs, not every drug the client buys, counts. Drug costs that count toward the out-of-pocket limit are called "True Out-of-Pocket" costs (TrOOP), or TrOOP-eligible costs.
3. About 25% of all Medicare beneficiaries will hit the $3,600 catastrophic coverage limit. For the rest, with lower drug costs, it will not matter which expenses count toward the $3,600 and which don't.

TrOOP-eligible	Not TrOOP-eligible
• Annual deductible and co-insurance and cost of drugs during coverage gap ("doughnut hole"), but only for drugs that are on your plan's formulary or that were approved in exception process • Because EPIC is a State Pharmaceutical Assistance Program (SPAP), the entire payment made by EPIC counts towards TrOOP costs, not just the portion paid by the client. *But this is only for drugs on the PDP formulary*. • Contributions from family, friends • Cash assistance (not actual drugs) provided by drug manufacturer-patient assistance programs[13]	• Monthly premiums • Drugs not on formulary, no exception granted or appeal won • Drugs excluded from the Medicare drug plan, such as Valium, Ativan, and Tylenol. (See http://www.wnylc.net/pb/docs/NYFAHC_Fact_Sheet.pdf) • Payments for over-the-counter drugs, vitamins • Payments by insurance that is not "creditable"—workers' compensation, auto insurance • Payments by government programs such as VA, TRICARE, or Black Lung, even though they are creditable • Payments by state programs that receive federal funding such as ADAP (AIDS Drug Assistance Program)

Table 1. TrOOP chart—Adapted from Andrew Koski, Home Care Association

4. The chart above shows which costs are "TrOOP-eligible" and which are not. Those that are "TrOOP-eligible" count toward the out-of-pocket $3,600 threshold. (See Table 1. TrOOP chart.)

F. **What Plan You Choose Will Affect When You Will Meet the $3,600 Out-of-Pocket Threshold for Catastrophic Coverage.** Catastrophic coverage is not triggered until the beneficiary pays $3,600 out-of-pocket, not counting monthly premiums. A "better" plan will reduce out-of-pocket costs—it may charge a lower co-payment, or it may cover drugs in the "doughnut hole." Because of this, you may not spend $3,600 until later in the year, if at all, so it may delay catastrophic coverage.

Example: Some people may pay a higher premium for a more generous drug plan. For example, Sam pays a higher premium for a plan that eliminates the "doughnut hole." Sam pays 25% of total drug costs not only up to $2,250 in drug costs, like the basic benefit, but until Sam reaches the catastrophic threshold. Because the drug plan continues paying 75% of drug costs during the "doughnut hole," Sam will not incur $3,600 in out-of-pocket expenses until well past the $5,100 mark in total allowable drug costs.

Sam's example—Fewer Out-of-Pocket Costs Delays Catastrophic Coverage

$250 deductible	—he pays out-of-pocket
$3,600–$250 = $3,350	—out-of-pocket costs Sam must pay before catastrophic coverage is reached
$3,350 is 25% of $13,400	—Sam must incur $13,400 in actual drug costs, of which plan pays 75%, before he is out-of-pocket $3,350 and reaches the catastrophic coverage threshold
$250 deductible + $13,400 in additional costs equals $13,650 in actual drug costs to reach $3,600	—Sam will not receive catastrophic coverage (5%) until his total drug costs reach **$13,650**

(Example by Andrew Koski, Home Care Association)

G. **Which Pharmacies Will the Drug Plan Use?**

1. In **urban** areas, a Part D plan must contract with enough pharmacies so that at least 90% of Medicare beneficiaries, on average, are within 2 miles of a network pharmacy.[14]
   a. In **suburban** areas 90% of beneficiaries must live within 5 miles of a network pharmacy.
   b. In **rural** areas, 70% of beneficiaries must live within 15 miles of a network pharmacy.
2. Plans may use **mail order pharmacies** as well. They may not require members to use mail order, but may provide cost incentives—cheaper co-payments, for example.
3. **Residents of nursing homes:** Drug plans are required to contract with any pharmacy willing to participate in the plan's long-term care network if it meets minimum performance and service criteria. Plans must demonstrate to CMS that they have a network of pharmacies that provide convenient access for nursing home residents enrolled in the plan.[15]

PART II

The Low-Income Subsidy or "Extra Help"

III. "EXTRA HELP" (Low-Income Subsidy)—What Is It and Why Is It Good?

A. **"Extra help"** is the government's new name for the Low-Income Subsidy. Without it, Medicaid recipients who have Medicare (dual-eligibles) and other low-income Medicare beneficiaries would have VERY high out-of-pocket costs with Medicare drug coverage—monthly premiums, annual $250 deductible, high co-payments, and the "doughnut hole."

B. **There are TWO types of extra help.**

1. **"Better extra help" or "Level 1"**—is for the lowest income people:
   a. Medicaid recipients, including people who have a spend-down if they incur their spend-down[16]
   b. People in a Medicare Savings Program—QMB, SLIMBY, or QI-1 enrollees.
   c. Others with incomes under 135% of the Federal Poverty Line (FPL).[17] In 2005 this is:

$12,919.50 a year ($1,076.63 a month)—single
$17,320.50 a year ($1,443.38 a month)—couple
Assets must be less than $6,000 for one person or $9,000 for a couple.

2. **"Some extra help" or "Level 2"**—is for people whose income is between 135% and 150% of the FPL.[18] In 2005 this is:

For an individual: Between $12,919.50 and $14,355 a year (between $1,076 and $1,196.25 a month)
For a couple: Between $17,320.50 and $19,245 a year (between $1,196.25 and $1,603.75 a month)
Assets must be less than $10,000 for one person or $20,000 for a couple

C. **What costs does extra help pay?**

1. PREMIUM—Monthly PREMIUM IS FREE for those with the "better" extra help. It is paid for by a subsidy. However, the full subsidy is ONLY for "basic" plans. Of the 46 stand-alone plans in NYS, at least 10 and maybe more are "basic."[19]
   a. If an extra help beneficiary opts for a better benefits plan, he or she must pay the difference between the better plan premium and the premium subsidy amount.[20]
   b. The "Medicare & You Handbook 2006" mailed in October to 43 million Medicare beneficiaries has an error in the version tailored to each region. Starting on page 97-A, you'll see a series of charts listing the Medicare Prescription Drug Plans. The last column of the charts is called "If I Qualify for Extra Help Will My Full Premium Be Covered?" *Due to an error, this column lists "Yes" for every plan.* This error does not impact the charts listing Medicare Advantage plans. The national version of the hand-

book, without the charts, is posted at http://www.medicare.gov/publications/pubs/pdf/10050.pdf.

CMS is refusing to send out a corrected handbook. Instead, they tell people to check their website at http://www.medicare.gov for the corrected version or, after October 17, 2005, to use the Medicare Prescription Drug Plan Finder, or to phone 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-4028.

2. Deductible—Basic plan has $250 deductible
   a. "Better" extra help has NO deductible.
   b. "Bad" extra help has a $50 deductible.
3. Co-payments—Basic plan has 25% co-payment up to $2250 in costs.
   a. "Better" extra help has co-pays up to $5 per drug. (See Table 4 below) NOTE—In Medicaid, if client tells pharmacist she cannot pay the co-payment, pharmacist must give the drug anyway. THAT IS NOT TRUE in Part D! Pharmacists *may* waive the co-payment, but are not required to.
   b. "Bad" extra help has 15% co-pays.
   c. Medicaid recipients pay NO co-pay in a nursing home.
4. "Doughnut hole"—basic plan—client must pay FULL cost of the next $2,850 in drugs
   a. In both types of extra help, there is no "doughnut hole." You continue paying the same co-pays as in # 3 above.
5. Catastrophic coverage—basic plan—co-pay reduced to 5%
   a. "Better" extra help—NO co-payments once reach $5,100 limit
   b. "Bad" extra help—co-pays reduced to $5 and under.

Comparing the Standard Drug Benefit to Benefits with Extra Help			
	Standard Benefit	**Level 1 Extra Help** Has **Medicaid** or **MSP** or income less than 135% of FPL	**Level 2 Extra Help** **No Medicaid**—Income between 135% and 150% of FPL
Premium	$32/month (average) ($384 a year)	None[21]	Income-based premium—see chart below
Deductible	$250/year	None[22]	$50 deductible[23]
Co-payment	25% of drug expenses up to $2,250, after meeting the deductible	Between $1 and $5 (See Table 3 below); NO CO-PAY in NURSING HOME	15% of drug expenses after the deductible[24]
Doughnut hole	After $2,250 in drug expenses, coverage stops and the "doughnut hole" begins. No drug coverage for expenses between $2,250 and $5,100, at which time out-of-pocket spending has reached $3,600	No doughnut hole— Continue same co-payments as before (See Table 4 below)	
Catastrophic coverage	The greater of: $2/generics, $5/brands OR 5% of the drug cost	Drugs are FREE—no co-pay—once total drug expenses reach $5,100—including costs paid by Medicare plan.[25]	Co-payment reduced to $2/generics, $5/brands after out-of-pocket spending has reached $808—that's when you incurred $5,100 in drug expenses, including those paid by drug plan.[26]

Table 2. Standard Benefit vs. Benefits with Extra Help

Level 2—THE SLIDING SCALE PREMIUM—2006[27] When Income Is Between 135% and 150% of FPL[28] NOTE: Assumes $32/mo. premium				
Federal Poverty Level	**Income—Annual**	**Percentage of Subsidy**	**Annual Premium**	**Monthly Premium**
Below 135%	Up to $12,919 for an individual Up to $17,320 for a couple	100%	$ 0 per person	$ 0 per person
Above 135% but below 140%	$12,920 to $13,398 for an individual $17,321 to $17,962 for a couple	75%	$111 per person	$8 per person
Above 140% but below 145%	$13,399 to $13,876 for an individual $17,962 to $18,603 for a couple	50%	$222 per person	$16 per person
Above 145% but below 150%	$13,877 to $14,355 for an individual $18,604 to $19,245 for a couple	25%	$333 per person	$24 per person

Table 3. Sliding Scale Premium for Level 2 Beneficiaries

CO-PAYMENTS FOR "EXTRA HELP"[29]		
	Brand name drugs	**Generic drugs**
LEVEL 1—> 135% FPL—Co-payments charged until total drug costs reach $5,100 (including costs paid by drug plan), then NO CO-PAY for the rest of the year		
Medicaid recipients with income < 100% FPL	$3	$1
Medicaid recipients with income between 100%–135% FPL	$5	$2
Non-Medicaid recipients with income under 135% FPL[30]	$5	$2
Medicaid recipient in a **nursing home**, even a brief stay	NO CO-PAY	NO CO-PAY
LEVEL 2—135%-150% FPL	15% after $50 deductible. Reduced to $5 brand name and $2 generic after total drug expenses, including amount paid by Medicare drug plan, reach $5,100 (actual out-of-pocket is $808).	

Table 4. Co-payments for Extra Help Beneficiaries

IV. How Does One Enroll in the Low-Income Subsidy or Extra Help?

A. **Two groups are "deemed" eligible for extra help.** They will be *automatically enrolled in extra help*.[31] They do not need to file an extra help application.[32] So far, 559,000 New Yorkers in these 2 groups should have received a letter during the summer of 2005 from CMS saying that they are "deemed" eligible and do not have to apply for the subsidy.[33] They should KEEP THESE LETTERS (copy posted at http://www.cms.hhs.gov/medicarereform/11132DualLetter.pdf and http://www.cms.hhs.gov/medicarereform/11133MSPLetter.pdf). If you are not sure whether you have "extra help" you can call 1-800-MEDICARE to find out. (They are behind in listing people recently enrolled.)

1. DUAL-ELIGIBLES—those enrolled in Medicare and Medicaid.[34]

   a. This may include people receiving only SSI and no Social Security.[35] The state enrolled about 100,000 SSI recipients in Medicare to save the state money. (See Endnote 2) Ask SSI-only clients if they have a Medicare card. If so, they too will lose Medicaid drug coverage on January 1, 2006.

   b. Spend-down—This includes Medicaid recipients with a spend-down. As long as they "meet" the spend-down in any month from July to December 2005, they will be enrolled in extra help for all of 2006. This is true even

if they get cut off from Medicaid later in 2005 or 2006.

- Anyone in the NYC Home Attendant meets the spend-down because they are billed for the spend-down each month, even if they don't pay the bill.
- Anyone who receives Medicaid certified home health agency (CHHA) services meets the spend-down as long as the CHHA bill is submitted to Medicaid that shows they meet the spend-down.
- Anyone in the PAY-IN program meets the spend-down.
- Anyone who documents to Medicaid that they meet the spend-down with any other bills in any month from July to December 2005.
- **TIP—**If they do not meet the spend-down with current medical bills, see if client can meet the spend-down with past or current medical bills. She only needs to meet the spend-down for ONE MONTH in the rest of 2005. (See chart below)

b. Client can ELIMINATE the spend-down by enrolling in a Supplemental Needs Trust, and depositing her spend-down each month into the trust. See "*How to Get Medicaid Despite Having 'Excess Income'—Using the NYSARC Supplemental Needs Trust to Eliminate the Spend-down for Persons Who Are Elderly (65+), Blind or Disabled*."[36]

General Rules on Using Medical Expenses to Meet the Spend-down

* Bills may be for the applicant, his/her spouse and children under 21.
* Bills do not have to be PAID to meet the spend-down. They only must be INCURRED, which means the service was rendered and billed for. Medicaid may not require proof of payment.
* **OLD *UNPAID*** medical bills may be applied to meet the spend-down. If the amount of the bills is more than enough to meet one month's spend-down, the excess can be carried forward *indefinitely*. The bills can even be six years old.
* **RECENT *PAID*** medical bills for services provided and paid for within the three months before the month of application, and during the month of application, may be used to meet the spend-down in the month of application. If the bills are not used up to meet the first month spend-down, they can be used to meet the spend-down for SIX months. The six months begins either with the month of application, or up to three months before the month of application if client wants retroactive Medicaid. Excess paid bills may not be carried forward any further.
  - **Bills paid by EPIC or ADAP** in the three months before the month of application, and in the month of application, may be used to meet the spend-down. This is the actual amount paid by EPIC or ADAP, not just the client's co-payment. (See "Using ADAP, EPIC and Other Bills Paid by a New York State or Local Funded Program to Meet the Medicaid Spend-Down," posted at http://www.wnylc.net/pb/docs/UpdateEPICSpend down1.pdf.)

(See Self help Medicaid spend-down outline for more info.) **http://www.wnylc.net/pb/docs/SpendownOUTLINE.pdf**

2. **Those enrolled in a Medicare Savings Program (MSP)**[37]
   a. In these programs, the Medicare Part B premium ($78.20 in 2005, going up to $88.50 in 2006), and for QMB and SLIMB, some of the Medicare Part B deductibles and co-pays, is paid for by Medicaid, but you do not need Medicaid to be eligible for any of these programs
   b. There are three MSP programs: (See http://www.health.state.ny.us/nysdoh/mancare/omm/savingsprogram/medicaresavingsprogram.htm)
      - QMBs—Qualified Medicare Beneficiaries—under 100% FPL and assets $4000 single/$6000 couple
      - SLIMBs—Specified Low-Income Medicare Beneficiaries—under 120% FPL. Assets $4000 single/$6000 couple
      - QIs—Qualified Individuals—under 135% FPL and NO ASSET LIMIT
   c. Where do you apply for an MSP program?
      - QMB requires a full Medicaid application and requires clients to go to the Medicaid office.
      - SLIMB and QI-1 use the one-page short application (http://www.health.state.ny.us/nysdoh/mancare/omm/savingsprogram/msapp.pdf).
      - The Medicare Rights Center and other agencies, including Self-help, have staff who are "deputized" to accept applications, and forward them to the Medicare Rights Center for quicker processing, without the client having to go to the Medicaid office. Lists of deputized agents: call 800-333-4114.

B. **Who Must *Actually* Apply for Extra Help?**
   1. Medicare beneficiaries who are *not* enrolled in Medicaid and *not* in any of the MSPs *must* apply, if they meet the income and asset guidelines. These are described in detail below.

QUIZ—	Which of these people are automatically enrolled in Extra Help and which must apply? ANSWER IN ENDNOTE 38 • Kate is a 68-year-old widow and has Medicare and Medicaid with a spend-down of $300. She gets 20 hours/week of Medicaid home attendant services. • Henry is a 72-year-old widower and is enrolled in QMB. • Natalie and Jack are both 69 years old. Neither has Medicaid nor is enrolled in an MSP program. Their income is $33,750 a year.

V. **The Application for Extra Help and Income and Asset Limits and Step-by-Step Guide to Completing Application**
   A. **The extra help application** for a Low-Income Subsidy application is available beginning July 2005.
      1. In July 2005, SSA began sending 19 million extra help applications with letters to Medicare beneficiaries who have Social Security income under 150% of the FPL.
         a. A copy of the application is at http://www.wnylc.net/pb/docs/ExtraHelpApplicationSSA405.pdf.
         b. Many people who receive the letter will NOT be eligible for extra help, because they have additional income other than Social Security, or because they have too much in assets.
      2. This application is also available at Social Security offices and by calling 1-800-MEDICARE.
      3. The application can be completed online.[39] When one files online, there is first an online "qualifier" that screens out people clearly not eligible. If one is not screened out, one can continue to complete and file the application.
         a. NOTE: Glitches have been observed in online applications filed so far. For

example, you cannot go back and correct an error once you are at the end of the form.

4. The application can also be completed by telephone through the SSA attestation program.
   a. This program permits an application to be filed by telephone without the need of a "wet" signature.
   b. Call 1-800-772-1213 to fill out an application.
5. **NO documentation of income or assets needs to be submitted with the application.** However, SSA can verify information with the IRS or SSA when processing the application, and can request documentation later.
6. **Must use the original application**—not a photocopy, and not a downloaded copy. This is because the application is scanned.
7. **USE BLACK INK or a No. 2 pencil.** This is for the scanner.
8. **Fill in boxes that don't ask for numbers with an "X,"** not a checkmark

B. Who **Is Applying? Questions 1 and 2**

1. Question 1: Applicant's Name
   a. If both spouses are applying, pick one spouse's name.
   b. The application requires the applicant's *own* Social Security number. For example, an applicant who receives widow's benefits may be using the spouse's Social Security number for other programs. Verify that the Social Security number is correct.
   c. Match the name with the name on Social Security's records. Some people may be using a nickname or dropped a suffix.
2. Question 2:
   a. If applicant is single, divorced, widowed, or does not live with spouse, he or she skips to Question 3.
   b. If the spouse is in a long-term care facility the general rule is:
      - If the spouse's absence has been longer than 6 months, the applicant does not "live with" the spouse.
      - If the spouse's absence has been less than 6 months, the spouse has been "living with" the spouse.
   c. If applicant lives with spouse, indicate in Question 2 whether only the applicant is applying, or whether both the applicant and the spouse are applying. If so, check the 2nd box in Question 2—they can apply on the same form.
   d. Even if only one spouse is applying, the other spouse's name and Social Security number are required in Question 2, and his or her signature is required if they live together. Also, the other spouse's income and assets must be disclosed.

C. **Assets (Resources)[40]—Questions 3-8**

1. Question 3: Asks if savings, investments and real estate other than your home are worth more than $11,500 for singles and $23,000 for couples. Answer must be YES, NO or NOT SURE.
   a. If answer is YES, they tell you not to complete the rest of the application. (See below for tips if resources are too high.)
   b. If answer is NO or NOT SURE, go on to No. 4-7.
   c. This question is tricky because of funds intended for burial, which raise the asset limit. (See below, Question 6: savings intended for burial.)
2. **Liquid Assets—Questions 4-6**
   a. Question 4: Liquid resources are resources that can be converted into cash within 20 days. They include:

- Cash
- Stocks
- Bonds
- Retirement accounts—Individual Retirement Accounts (IRAs, 401(k), KEOGH, 403(b)). (**NOTE**: This is different than Medicaid, which does NOT count these investments if distributions are being made.)
- Financial institution accounts—checking, savings, certificates of deposit

b. Joint Accounts—The whole account is presumed to be owned by the applicant, not just half the account.

- As in SSI, this presumption is "rebuttable." You would need to document the source of the money. (For example, your daughter and you have a joint account that contains her savings because her husband gambles. You must show it is her money and was not a gift to you.)
- Since you cannot attach documentation to a mailed application, you should bring the application with documentation to the Social Security office. Or, simply transfer the money out of your name and wait until the next month after the transfer to apply.

c. Transfer of assets—Just like community Medicaid and the Medicare Savings Program, there is no penalty for transferring assets to bring them down to the allowable levels.

d. Question 5: Life insurance policies

- Whole life insurance policies with a total face value of $1,500 or less do NOT count. Must add both spouses' policies together to see if total is more than $1,500.
- Term life insurance usually has no cash surrender value so is not counted. (BUT if the total face value exceeds $1,500, the cash surrender value of all policies is countable. Call the company to find out its cash value.)

e. Question 6: Savings intended for burial

- If some savings listed in Question 4 (liquid assets) or Question 5 (life insurance) are expected to pay for burial expenses for the individual and/or spouse, answer "yes."
- By answering YES, individual or couple may have an additional $1500 each in savings and assets and receive extra help.
- **NOTE:** Unlike Medicaid and SSI, the "burial funds" do not have to be set aside in a separate burial fund. They may be part of regular savings. But client must state that some of the savings is expected to pay for burial to increase the asset limits as follows:

ASSET LIMITS—EXTRA HELP		
	Level 1—Better Extra Help	**Level 2—Some Extra Help**
Savings Limit if NO funds intended for burial	$6,000 for one person and $9,000 for a couple	$10,000 for one person and $20,000 for a couple
Savings Limit if funds ARE intended for burial	$7,500 for one person and $12,000 for a couple	$11,500 for one person and $23,000 for a couple

D. **Real Estate—Question 7**

1. DO NOT count the value of the primary residence
2. DO COUNT any other real property owned.
   - The question does not ask for the value of property owned.
   - The local Social Security office will call to get details.
3. Resources (other than those discussed above) that are NOT COUNTED:[41]

a. Home

b. Household goods/personal effects

c. Automobiles

d. Non-cash business property

e. Property essential to self-support

f. Non-business property essential to self-support

g. Burial spaces including burial plots, crypts, urns, headstones

h. Pre-paid irrevocable funeral agreements

i. Retained retroactive SSI or Social Security benefits for nine months after the month they are received

j. Refunds for federal income taxes

k. Victim's compensation payments for the first nine months

l. Holocaust reparations

m. Funds received from a government or non-governmental agency, program or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical and/or social services.

E. **Living Situation—Question 8**

1. If the applicant provides at least one-half financial support to relatives living with him or her, indicate that number. Unlike SSI or Medicaid, these relatives increase the household size and the income limits.
   - This may make people eligible who would not otherwise be eligible for the Medicare Savings Program or LIS.
2. Relatives include anyone related to the applicant by blood, marriage or adoption.
3. Since dependent's income is not countable, the higher income limit could make the applicant eligible for more help.

F. **Income[43]—Questions 9-16**

1. Income is anything the applicant and/or spouse receives in cash or in-kind that can be used to meet their needs for food and shelter.
2. It is always the GROSS income that is counted.
3. Whose income counts?

   a. The gross income of the applicant and the spouse, if they live together.

   b. The spouse's income is counted regardless of whether the spouse is also an applicant.
      - BUT not the income of dependent family members.

INCOME LIMITS FOR LOW-INCOME SUBSIDY (FEDERAL POVERTY LEVEL)[42]					
Household Size	100%	135%	140%	145%	150%
1	$9,570.00	$12,919.50	$13,398.00	$13,876.50	$14,355.00
2	12,830.00	17,320.50	17,962.00	18,603.50	19,245.00
3	16,090.00	21,721.50	22,526.00	23,330.50	24,135.00
4	19,350.00	26,122.50	27,090.00	28,057.50	29,025.00
5	22,610.00	30,523.50	31,654.00	32,784.50	33,915.00

Table 5. Household Size Income Guidelines

- However, dependent family members will be considered in Question 8 for family size.

4. **Questions 9-10**

   a. **Unearned monthly income from various sources**

      - Social Security—this amount will be determined from the SSA's own records
      - Railroad Retirement
      - Veterans benefits
      - Pensions and annuities (But do not include dividends, interest or income received from savings, investments, or retirement accounts)
      - Other countable income (need to write in source):
        - Alimony and support payments
        - Rental income (net after expenses)
        - Workers' compensation
        - Death benefits
        - Royalties and honoraria
        - TANF—"Family Assistance" in NYS (public assistance for families with children)

   b. Question 10 asks if these amounts have decreased in the last two years.

      - They ask for changes because they are comparing information on the application with information in their database, which may be a few years old.
      - If their database shows much higher income, they might suspect that you are hiding something and deny the application. By explaining that your income has recently decreased, you explain the disparity and your application has a better chance of being accepted.

   c. Unearned income that is *not* counted:

      - Federal income tax refund
      - SSI benefits, including state supplement (The SSI recipient would be auto-enrolled in extra help anyway, so does not have to apply. But if his or her spouse is not on SSI, and applies for extra help, that spouse does not have to report the SSI on the application.)
      - Food stamps
      - Public assistance based on financial need wholly funded by a state—excludes Safety Net Assistance in NYS, but TANF (Family Assistance in NYS) for families with children is COUNTED
      - Holocaust reparations
      - Home energy assistance
      - The first $20 of unearned income in a month
      - Federal subsidized housing assistance[44]

5. **Question 11—In-kind support and maintenance**

   a. In-kind support and maintenance is any food and shelter that is given to the applicant/spouse or received because someone else pays for it.

   b. The rule follows the SSI rule, NOT the New York Medicaid rule, which does NOT count this in-kind support.

      - As in SSI, in-kind payments by non-profit organizations for rent or other assistance do NOT count as income.

   c. In-kind support includes payments for:

      - rent
      - mortgage payments
      - property taxes
      - heating fuel or gas
      - electricity
      - water
      - sewage & garbage collection services

   d. The maximum amount of in-kind support countable as income is either (1) one third of the monthly SSI benefit rate for an individual or a couple OR (2) the current market value of the support, whichever is LOWER.

- The monthly SSI benefit rate is $579/month for an individual and $869/month for a couple.
- Therefore, the maximum amount of income countable for in-kind support is $193/month for an individual and $290/month for a couple. This amount, or the actual market value of support, if lower, must be written in Line 11, rounded to the nearest dollar.

6. **Earned Income—Questions 12-16**
   a. SKIP if single applicant or either spouse in a couple has not worked in the last 2 years.
   b. Otherwise: Question 12—expected wages for 2005
      - For applicant and spouse
      - Include the expected gross wages, before taxes, for both the applicant and the spouse.
      - **NOTE:** Though you must report gross income, SSA uses SSI budgeting rules for earned income. They will not count more than half of gross income—the first $65 of monthly income plus half of the remainder is NOT counted.
   c. Question 13—if self-employed, expected net earnings or loss for 2005 for both the applicant and the spouse.
      - If the applicant expects a loss, do not put a minus (-) sign before the number. Rather, put an "X" in the appropriate box and then fill in the amount.
   d. Question 14—net loss. If the applicant's or spouse's wages or self-employment earnings have decreased in the last 2 years, answer "yes."
   e. Question 15—indicate if applicant or either spouse recently stopped working or plans to stop working in 2006.
   f. Question 16—ONLY for people UNDER age 65 who have impairment-related work expenses.
      - The presumed amount for work related expenses is 16.3%.

G. Finishing **the Application**
   1. Even if the spouse is not applying, their signature is required.
   2. If there has been a change of address, please put an "X" in the box.
      a. Sometimes, a beneficiary may have moved but never changed their mailing address.
      b. If they receive direct deposit they may not be aware that SSA does not have their current address.
   3. **Do NOT include cover letters, documentation or other materials if you mail the application.** If there are circumstances that an applicant wants to explain, go to the local SSA office and fill out the application with a staff member.
   4. See below for strategies on where to apply.
   5. Once the application is submitted, the applicant will get a confirmation receipt that the application has been received.
   6. If SSA needs more information before they deny the application, they will send you a letter giving you 20 days to submit the documentation.
   7. If no documentation is needed, SSA should send the applicant a decision two weeks after receipt of the application.

VI. Strategies on Applying for Extra Help and Using Medicaid, MSP and EPIC

A. **Where to Apply**—Client should have choice of where to apply—at the Social Security office, online, or through Medicaid
   1. Even though Medicaid offices are supposed to accept extra help applications, and help people file them, as of June 21, 2005, NYS Department of Health has instructed local Medicaid programs NOT to accept these applications.[45] This is against federal law. Until this policy changes, the only reason to apply at Medicaid is for the Medicare Savings Program (MSP) or Medicaid. **Both of these are "back doors" to the Low-Income Subsidy. Because of different**

rules, you may be eligible for Medicaid or the MSP but not for extra help.

2. **MSP**—Medicare Savings Program
   a. The QI-1 program has NO asset limit.
   b. QMB, SLIMB—The other MSP programs have an asset limit, but one may transfer assets and be eligible the next month.
   c. Contact a Medicare Savings Program "deputy" at Selfhelp. Outside Selfhelp, call the Medicare Rights Center—800-333-4114.
3. **Medicaid**—You may be eligible even if your income or assets are high because of special rules.
   a. SPEND-DOWN—Even though someone has a high income, even over the 150% limit, they may be eligible for Medicaid with a spend-down. If they meet the spend-down in ANY month in 2005, they will be auto-enrolled in the BETTER Low-Income Subsidy.
      - They might meet the spend-down with old, unpaid medical bills, or and bills you paid or that EPIC or ADAP paid in the last three months to meet your current spend-down.
      - Or they might eliminate the spend-down by joining a pooled Supplemental Needs Trust such as NYSARC.
   b. There is no penalty for transferring assets for community Medicaid.
   c. Some rules are better for the Low-Income Subsidy than for Medicaid.
      - If the applicant supports a relative who lives with him that is not his spouse—an adult child or parent, for example, under the Low-Income Subsidy Rules the income level is INCREASED for a larger household size.
   d. Some rules are better for Medicaid than for the Low-Income Subsidy:
      - Medicaid does not count in-kind income, such as rent paid by a relative. This counts for extra help.
      - Medicaid has "spousal refusal." For extra help, a spouse's income and resources must be counted.
      - IRAs and other retirement accounts count for the Low-Income Subsidy, but don't for Medicaid if they are owned by a spouse, or if they are in payment status.
   e. Some rules are the same for all three programs; you can transfer assets in one month and qualify for the program the next month (community Medicaid only, not for nursing home).
4. **Strategy Tip—File Both Applications at the Same Time.** The problem with applying for Medicaid or an MSP is that the applications can take months. Applications filed now might be accepted by the end of 2005, but those filed in the fall are likely not to be.
   a. Therefore anyone who is eligible for either Low-Income Subsidy should ALSO apply at Social Security (if eligible), even if they are applying for Medicaid or the MSP at the same time.
   b. Social Security promises that they will turn around applications in two weeks but the reality is that applications have taken much longer. Still, it may be faster than Medicaid.
   c. Even if your assets are within the extra help limits, so you file an extra help application at Social Security, you should apply for the Medicare Savings Program too—to save $78.20 each month. BUT apply for BOTH at the same time. The extra help application will be processed quickly. The MSP application might take months.

B. **What Happens to Medicaid?**

1. Medicaid will continue to pay for drugs that are "excluded" from the Medicare basic drug benefit. (See http://www.wnylc.net/pb/docs/NYFAHC_Fact_Sheet.pdf) AND for all other medical services as before.)
2. Medicaid will continue to pay for ALL drugs for recipients who do not have Medicare. This includes people under age 65 who are in the first 2 years of receiving Social Security disability.
3. The NYS Medicaid program has said that it will "wrap-around" the Medicare drug benefit to cover drugs denied by a drug plan because it is not on their formulary. In theory, this means that if Mary's physician has prescribed a drug that is not on her plan's formulary, Medicaid will pay for it. BUT it is not yet decided HOW this will work.
   a. Medicaid may require recipients or their physicians to request an "exception" first and wait 24-72 hours for a response from the plan before Medicaid covers the drug. (See Exception process in Point VIII below.)
   b. However it works, clients will need to bring two drug cards to the pharmacy—their Medicare drug card and their Medicaid card.
4. Transition—CMS will allow state Medicaid programs to provide "early refills" of prescriptions in December 2005, and give 90 days of drug supply instead of the usual 30, to help people through a tough transition. NYS has not yet said it will do this.

C. **What Happens to EPIC?**

1. EPIC will continue and anyone eligible for it will continue to be eligible (Age 65+, under $35,000 income for singles or $50,000 for couples). (See EPIC income chart at http://www.health.state.ny.us/nysdoh/epic/faq.htm.)
2. EPIC will not require any of its enrollees to join a Medicare drug plan. However, they will be strongly encouraged to join. EPIC cannot choose a plan or steer its members to a particular plan.
   a. One way EPIC will encourage people to join is to WAIVE its own annual fee for people in a Medicare drug plan who have the "better" extra help/low-income subsidy (Level 1). These people also pay no annual deductible and no monthly premium for their Medicare drug plan.
      - The EPIC fee in the "some" extra help (Level 2) will NOT be waived. These people must also pay a sliding scale premium for their Medicare drug plan and a $50 annual deductible.
   b. People with both EPIC and a Medicare drug plan with the "better" low-income subsidy will have the best help.
      - For drugs covered by the Medicare drug plan, the co-payments are $2 for generics and $5 for brand name, which are lower than the EPIC co-payments:

Rx Costs:	EPIC Co-pay:	Extra Help Co-pay
up to $15	$ 3	$2—generic $5—brand name (if drug on formulary)
$15-$35	$ 7	
$36-$55	$15	
Over $55	$20	

Table 6. EPIC Co-payment Chart

      - For drugs not covered by the Medicare drug plan—whether because they are "excluded" or not on the plan's formulary, or because the pharmacy is not in the drug plan's network. EPIC will cover them with its usual co-payments (Table 6 above).
3. Added benefits of EPIC
   a. EPIC plans are "creditable coverage" (announced October 7, 2005) This means that it is as good as or better than the Medicare drug plan. This means EPIC members can choose NOT to enroll in a Part D plan as long as they are on EPIC. If they enroll within 63 days of losing EPIC,

they will not have to pay a penalty. (See Enrollment section below)

b. EPIC is a "State Pharmaceutical Assistance Program" or SPAP. This means that costs paid by EPIC, not just the client's own co-payments, will count toward the "TrOOP"—True Out-Of-Pocket expenses (See Point II.E above). This will help them reach the "catastrophic coverage" limit sooner. At this point, for those with:

- Better Low-Income Subsidy have NO co-payments for the rest of the year.
- Worse Low-Income Subsidy will have $2/$5 co-payments instead of the higher EPIC co-payments.
- No Low-Income Subsidy will pay the lower of the EPIC co-payments or 5 percent of the drug cost.

(a) Because of this benefit, people who have very high drug costs—over $5,100 per year—might consider enrolling in Part D and EPIC even if they are not eligible for extra help.

PART III

Enrolling in and Using a Drug Plan

VII. Enrollment in a Prescription Drug Plan (PDP)

Remember that there are *two* types of enrollment: enrollment in a *drug plan*, and enrollment in the Low-Income Subsidy (LIS or "extra help"). This section is just about enrolling in a *drug plan*.

A. First year enrollment

On October 15, 2005, Medicare will send all Medicare beneficiaries information on PDPs in their areas and how to enroll.[46] This will be part of the "Medicare and You" booklet they receive each year. Many people probably just throw this away. TELL CLIENTS TO KEEP IT!

Clients cannot begin enrolling until November 15, 2005. Use the month from October 15-November 15 to review client's medications and drug plan choices and select a plan. (See form for listing meds, alternatives.)

Initial enrollment period is November 15, 2005 to May 15, 2006, for people who are on Medicare now or whose Medicare starts before March 1, 2006.[47]

c. TO HAVE COVERAGE *on* JANUARY 1, 2006, THEY MUST enroll before December 31, 2005. It is advisable to enroll well before then. For those who enroll after January 1, 2006, coverage will begin the first day of the month following enrollment.[48]

4. After May 15, 2006, no one who was already on Medicare before March 1, 2006, may enroll in a drug plan until the annual enrollment period which is from November 15-December 31, 2006.

a. They will have to pay a penalty when they do enroll, unless an exception applies. (See below)

b. Those who did enroll in the initial enrollment period will be locked in to the plan they enrolled in, unless an exception applies. (See below)

5. **EXCEPTIONS—Who may enroll for the first time after May 15, 2006, and before November 15, 2006.**

a. **NEW Medicare beneficiaries**—Those who first become eligible for Medicare Part A or B in March 2006 or later have a "Special Enrollment Period." They have a 7-month period to enroll in a drug plan. The period begins 3 months before and ends 3 months after the month of either (a) their 65th birthday, or (b) the month they begin to receive Medicare based on disability.[49]

b. **People who involuntarily lose creditable coverage** may enroll in a "Special Enrollment Period." They have 60 days to enroll in a Part D plan before incurring a late penalty.

c. **Medicaid and MSP** recipients may switch plans every month. Presumably new Medicaid recipients will be

able to enroll when they first get Medicaid.

B. From 2007 on, the annual enrollment period will be limited to November 15 to December 31.[50] Most people will be locked in for a full year.

C. **LOCK-IN—Who may change plans and when?**

1. ONE-TIME change each year

a. First year (2006)—Anyone enrolled before May 15, 2006, may change plans ONCE between January 1, 2006, and May 15, 2006.

- Those in Medicare Advantage may make one more change to certain types of Part D plans from January 1, 2006-June 30, 2006 (Open Enrollment Period).

b. Later years (2007 and after)—one-time switch allowed to another Part D plan every year from January 1-March 31 after the November 15-December 31 election period the previous year. This is for all Part D plans and for Medicare Advantage.

2. Other than this one-time change, with some exceptions, most people are locked into a plan for one year, and may only change plans at the "Annual Election Period" from November 15 to December 31 every year, with the change effective January 1 of the next year.

a. This lock-in makes it especially important for our clients to carefully choose a plan that meets their needs

3. Medicare Advantage—Their members are not only locked in for DRUG coverage, but for ALL hospital and physician's care under Medicare Parts A & B. This is a huge change from the way it has been through December 31, 2005, when anyone who was unhappy with their Medicare HMO could disenroll anytime. Reasons for this might be that their physician left the network, they were denied access to a specialist, they were denied home health care or rehab care, etc.

Beginning January 1, 2006, Medicare Advantage members will be locked in to their plans the same way everyone else is locked into a Part D drug plan. They will be able to change plans, or disenroll from a Medicare Advantage plan and switch back to original Medicare only once after the "annual election period."

4. EXCEPTIONS: WHO MAY change plans more than once a year. "Special enrollment period"—Certain people have a **"Special enrollment period"** in which they are allowed to enroll in or change Part D plans and also Medicare Advantage plans after the "initial enrollment period" or outside of the short annual election period.[51]

a. WHO MAY CHANGE PLANS ONCE A MONTH

- Dual-eligibles (on both Medicare and Medicaid)
- Medicare Savings Program—People in QMB-only, SLIMB-only, and QI. (This is a new policy announced by CMS on August 25, 2005.[52] Before, MSP enrollees could change only once outside of the general annual enrollment period.)

b. If you move to geographic area not covered by your plan.

c. If you reside in, move into or out of a nursing home—may change plans any time until 2 months following discharge from the facility.

D. **Automatic Enrollment for Dual Eligibles**

1. In late October 2005, CMS notified dual-eligibles by mail of a plan into which they will be auto-enrolled if they do not choose their own plan. The form notice is posted at http://www.cms.hhs.gov/medicarereform/states/autoenrollnotice.pdf. *WARN CLIENTS TO EXPECT THIS* so they do not throw the new drug card and information away.

a. This automatic assignment is RANDOM, with *no regard* to their actual needs—whether the plan covers their medications or includes their local pharmacies.

b. The only beneficiaries not assigned randomly are those already enrolled in Medicare Advantage (MA) (formerly Medicare + Choice) or a Medicare HMO. They will be assigned to the Medicare Advantage plan's PDP (MA-PD), if any.

c. In NYS, there will be 10-15 plans accepting auto-enrollment of Medicaid recipients. There may be more. (See Endnote 4 and text) Only plans with a premium below the state's "benchmark" of $29.83 will accept Medicaid recipients with a free premium. (On the list at link at endnote 6, 15 plans are below that benchmark.)

2. If the plan they were auto-enrolled in is not the best for them, dual-eligibles will be able to enroll in a different plan between November 15 and December 31, 2005, like everyone else. When they enroll in a different plan, it will cancel the automatic random assignment.

3. If they do not choose a plan, they will be automatically covered under the plan they were auto-enrolled in on January 1, 2006.[53]

4. Dual-eligibles MUST be in SOME drug plan by January 1. Otherwise, they will have no drug coverage at all.

a. CMS is permitting states to make enrollment in Medicare Parts A, B **and D** a condition of eligibility for Medicaid.

b. This means Medicaid could be **terminated** if a recipient refused enrollment in a Medicare drug plan. People who have full Medicaid with no spend-down, or who also have QMB, should be the only ones subject to termination because Medicaid pays all their Medicare premiums and co-insurance. Medicaid recipients who do not have QMB should not be vulnerable to termination if they decline Part D coverage. This is a gray area.

c. However, if an individual has enrolled in Part D, states may not terminate Medicaid coverage in its entirety for failure to *use* the Medicare drug plan. But the state may refuse to provide any Medicaid drug coverage if the client refused to use the Medicare drug plan first.[54]

E. **"Facilitated Enrollment"**—This is delayed automatic enrollment for people enrolled in "extra help" who are *not* on Medicaid.[55]

1. What is facilitated enrollment?

a. In April 2006, CMS will automatically assign these beneficiaries to a plan, to be effective June 1, 2006. This assignment will be *random*. The only beneficiaries not assigned randomly are those already enrolled in Medicare Advantage (formerly Medicare + Choice) or a Medicare HMO, who will be assigned to the drug plan of their Medicare Advantage plan (MA-PD).

b. If they do not choose a plan of their own by May 15, 2006, the beneficiary will be "facilitated enrolled" into the randomly assigned plan, effective June 1, 2006.

c. Facilitated enrollment is like delayed automatic enrollment into a prescription drug plan effective June 1, 2006. (Note that even though they are auto-enrolled into "extra help" as of January 1, 2006, they will have no drug coverage until June 1, 2006, unless they affirmatively enroll in a plan before May 15, 2006.)

2. Who gets facilitated enrollment?

a. Medicare Savings Program (MSP) participants

b. Anyone else determined eligible for extra help by either the SSA or Medicaid

3. Changing plans—Those enrolled in an MSP, like those in Medicaid, will be able to change plans monthly. This is called a "Special Enrollment Period." Others in extra help have a different "special enrollment period"—they may change only once between June 1, 2006,[56] and the annual enrollment period (November 15 to December 31).

SUMMARY—AUTOMATIC VS. FACILITATED ENROLLMENT		
	Automatic enrollment	**Facilitated enrollment**
Who?	Full benefit **dual-eligibles**	Others eligible for "extra help" and **MSP** enrollees
When will CMS notify beneficiary of the plan they will be randomly assigned to?	Late October 2005	April 2006
Deadline to choose an alternate plan before auto-enrollment takes effect	**By December 31, 2005** (but earlier is better—as a practical matter at least 2 weeks before).	**By May 15, 2006**
When is auto-enrollment effective if beneficiary doesn't pick another plan?	**January 1, 2006**—Since Medicaid drug coverage will end on December 31, 2005—automatic enrollment guarantees that this group will have continuous drug coverage.	**June 1, 2006**—Since this group is not losing Medicaid drug coverage, they have more time to choose a plan that meets their needs.
How often can the beneficiary change plans?	Can change monthly. Called a Special Enrollment Period.	MSP enrollees may change monthly. Others in LIS may change plans just once in a special enrollment period some time after June 1, 2006 (details unknown). After that, must wait until November 15, 2006, for the annual enrollment period.

Table 7. Automatic vs. Facilitated Enrollment

F. **Penalty for Late Enrollment and "Creditable Coverage"**

1. Late enrollment will be penalized by a higher monthly premium unless certain circumstances apply.
2. **Creditable coverage**. There is NO penalty for delay as long as you have "creditable coverage" that is "actuarially equivalent" to Medicare basic drug coverage.[57] This is drug coverage that is *as good as or better* than the standard basic Part D benefit.
   - Once you lose "creditable coverage," you have 63 days to sign up for Part D.[58] If you do this, there will be no penalty when you do join.
3. Which coverage is "creditable"?
   a. VA coverage and Tricare (military) coverage is creditable. Employee, retiree or union health insurance may or may not be creditable, depending on its scope of coverage.
   b. Employers, unions, and other health insurers must send notices to their members before November 14, 2005, as to whether or not their coverage is considered "creditable" by Medicare.[59] This is just one day before drug plan enrollment begins!
   c. **EPIC** coverage is creditable (announced October 7, 2005). This means that people may join EPIC alone and not join a Medicare drug plan. If they decide down the road to join a Medicare drug plan, there will be no penalty.
      - If an EPIC member moves outside of New York, or has an increase in income and loses EPIC, she must enroll in a Part D

plan within 63 days of losing EPIC to avoid a penalty.

d. **ADAP**, unfortunately, does not count as "creditable" coverage. Neither do **Medigap** policies H, I, and J that include some limited drug coverage.

e. **Example of creditable coverage:** Betty is retired and has prescription drug coverage from her former employer. In November 2005, her health insurance company informs her that her drug coverage is "creditable," i.e., at least as generous as Part D. If she loses her retirement coverage in 2 years and then applies for Part D in 63 days, she will not be penalized.

f. **Example of non-creditable coverage:** Mike is retired and has prescription drug coverage from his union. On November 14, his insurance company informs him that his drug coverage is *not* creditable. If he does not sign up for Part D during the initial enrollment period between November 15, 2005, and May 15, 2006, he will be penalized with a higher premium.

4. **Warning about retiree benefits:** Retirees who receive notice that their retiree coverage is creditable do not have to join a Part D plan to avoid a penalty. But what if they join one anyway—perhaps they are confused, or fell prey to aggressive marketing?

   - They risk losing their *entire* retirement health package, not just their drug coverage. This is because employers receive HUGE subsidies to continue their drug coverage under the Medicare drug law. Their insured members are not allowed to "double dip." Clients should NOT sign up for Part D in addition to "creditable" retiree coverage without talking to a lawyer. (For Selfhelp clients, staff should contact the Legal Resources Program.)

5. **How much is the penalty?**

   a. Your monthly premium is increased by 1% of the base premium *per month* of delay.[60]

   b. The premium is expected to increase about 10% every year from the expected $37 premium in 2005.[61]

   c. Someone who has extra help/the Low-Income Subsidy but delays enrolling in a drug plan must pay 20% of the enrollment penalty for the first 60 months of their enrollment.[62] After that, there is no more penalty. (See Example Two below)

   d. Why would someone delay in signing up?

      - Bob is healthy and does not have high drug costs now. In 3 years he develops a chronic illness and wants to join. He will pay a 36% increase in the premium as a penalty for his delay (1% for each month).

TIP—Anyone eligible for the Low-Income Subsidy should sign up now and enroll in a drug plan by May 15, 2006, even if they have no drug costs now. These have no premium (or a reduced premium) and will avoid a penalty later.

TIP—Since **EPIC** is "creditable" coverage, everyone over age 65 should enroll in EPIC before May 15, 2006, even if they do not use many drugs. This will avoid a penalty later. Also costs paid by EPIC (not just client's co-payments) will count toward the catastrophic coverage threshold.

PENALTY EXAMPLE ONE

If Joe waits 11 months past his eligibility period to sign up, his premium will increase by 11% or .11.

This adds up to $4.07 a month) ($37 x .11) and $48.84 a year ($444 x .11). (2006 premium is $37 or $444/year).

Penalty premium is **$41.07** a month and $492.84 a year.

If Joe doesn't turn 65 until 2007, the same 11-month delay would result in a higher penalty because in 2007 the base premium will increase by 10%. It will be $40.70 a month/$488.40 a year.

The 11% increase would add $4.48 a month to the premium and $53.76 for the year.

Penalty premium is **$45.18** a month and $542.16 a year.

PENALTY EXAMPLE TWO—
Penalty with Extra Help

Florence is enrolled in an MSP. She has retiree prescription drug coverage, but on August 1, 2005, she receives a letter stating that the drug plan is not considered creditable coverage. She doesn't take any drugs so she decides not to enroll in a Medicare drug plan before the enrollment period ends on May 15, 2006. In June 2007, she begins to take an expensive arthritis drug and decides to enroll in a drug plan, but she cannot do so until November 15, when the annual enrollment period begins.

Since she is in the MSP, she is deemed eligible for extra help.

She has waited 18 months to enroll. Her penalty is 18% of the premium. The base premium for 2007 is $42.00; 18% of $42 is $7.56.

Since Florence qualifies for extra help Medicare pays her entire premium. However, she must pay 20% of the $7.56 penalty or $1.51 per month. She must pay this for 60 months. When the premium rises every year, the penalty will rise because it is based on a percentage of the premium.

VIII. Choosing a Plan

With so many plans, it will be hard to compare them. On October 17, 2005, CMS will post a Plan Finder tool to compare drugs on http://www.medicare.gov. A cost estimator is available, but this will not compare formularies, etc. http://www.medicare.gov/medicarereform/MPDP_Cost_Estimator.asp. They are telling beneficiaries to call 1-800-MEDICARE, but new information is that this hotline will only be able to look up information on a particular plan—whether it covers member's drugs or pharmacies. It does NOT compare different plans for the caller. So the Internet will be the only realistic way.

1. What to look at in a plan"

   Cost of premium and deductible—just because there is no premium or deductible, or they are low cost, the plan may not meet member's needs. Check out the other factors below.

   Formulary—Does the plan formulary cover all or a majority of client's drugs at same dosages and strengths?

   Pharmacy—Does plan contract with client's usual pharmacy or another in the neighborhood?

   Quantity limits—Does plan limit number of prescriptions a beneficiary may get in a month, or the number of pills available in a single prescription?

   Is permission needed to get prescriptions? Plans may require members to obtain "prior approval" before getting certain drugs. To get this approval, the plan might require the member to show that she tried generic drugs or cheaper brand name drugs first and that they were not effective, This is called "step therapy."

IF client *not* on Medicaid or in "extra help"

a. How much is deductible—less than $250?
b. What are the **co-payment tiers** for generic and brand name drugs?
c. Will client have to pay more to use non-preferred pharmacies, or if they don't use mail order?

2. Other factors if client *IS* on Medicaid or "extra help"
   - Make sure plan they select is one that will have a FREE premium. Premium must be under "benchmark" which is $29.83 in NYS. (See link at endnote 6.) Otherwise, member must pay a supplement to the premium.
3. Transition process—Will plan provide drugs that are not on its formulary on a temporary basis for new members to give them a chance to change their medications or request an "exception"? CMS does not require this.
4. Exceptions process—What is the plan's process for a member to request a drug that is not on its formulary? Will they accept oral requests? How much documentation is needed? What medical standard will they use? Will they provide a temporary supply of a drug while the exception is being processed?

IX. Exceptions and Appeals Process—Asking a drug plan to cover medically necessary drugs not on their formulary

A. **Exceptions/Coverage Determinations**

1. Exception requested when:
   a. A non-formulary drug is prescribed and medically necessary[63]
   b. An enrollee is using a drug that has been removed from their plan's formulary mid-year[64]
   c. Plan uses various cost utilization tools
      - "step therapy" (trying a low cost drug first before getting a more expensive one) NOTE that plan may require use of over-the-counter drug first which is NOT covered by plan; must pay out of pocket.
      - restricts dosage form or amount (e.g., pill not liquid)
      - "therapeutic substitution"; substitutes a lower cost or generic drug for the one prescribed
   d. Enrollee wants to reduce cost-sharing for a formulary drug
      - but no exceptions allowed from generic co-pay rate if plan has separate co-pay tier for generics
      - if plan has separate tier for high-cost or unique drugs, those drugs are not eligible for tiering exception.[65]
2. Exceptions may be requested beginning January 1, 2006. CMS rejected request by advocates and the AMA to allow exception requests to be made earlier.
3. What must be shown to get an exception:
   a. To reduce cost-sharing, physician must assert that lower-tiered drug is less effective or would have adverse effects.
   b. To get drug not on the formulary or that is being dropped from the formulary
      - Physician must determine that ALL formulary drugs on ANY tier would not be as effective as non-formulary drug; would have adverse effects, or both.
      - Plans can establish their own standard of proof—medical or scientific evidence that the drug is not safe!!! Clinical trials!
4. Who can request exception—enrollee, appointed representative, or prescribing physician?[66]
   - Gray area about whether health care proxies, powers of attorney, guardians have authority if not specifically listed in their powers. If no guardian appointed, and enrollee lacks mental capacity to sign a power of attorney, who will have authority to request an exception?
5. How is exception request made?
   a. Enrollee goes to pharmacy, which tells her that her plan won't pay for the drug because it's not on her formulary, or because she must try a cheaper drug first (step therapy), etc.
   b. At that point, client receives no written notice. This is NOT a "coverage determination." Pharmacy should

give her plan's phone number for her or her physician to REQUEST a coverage determination.

6. Time for plan to respond; must issue coverage determination as expeditiously as enrollee's health requires, but no later than:
   a. 72 hours is standard request.[67]
   b. 24 hours for expedited or emergency requests made by physician who states that standard time frame would jeopardize the life or health of the beneficiary or ability to regain maximum function.[68]
      - Expedited determination required if physician indicates that applying the standard time frame may "seriously jeopardize the life or health of enrollee or enrollee's ability to regain maximum function."[69]
      - CANNOT get expedited review if enrollee (or anyone else) PAID for drug while requesting exception!!
      - Can request that decision be made FASTER than 24 hours if real emergency. e.g., need antibiotic in liquid form not pill form.
7. Transition process—Drug plans must have a transition process that will help new enrollees who are stabilized on a particular drug regimen transition to a formulary that may not have all of their drugs.[70]
   a. CMS recommends (*but does not require*) drug plans to give a one-time, temporary 30-day supply while enrollees apply for exceptions (See V below), or ask their doctor for a substitute drug.
   b. CMS also suggests that plans *may* (not must) contact new enrollees before coverage begins to review changes in their drug regimens or explain how to request exceptions.
   c. NURSING HOME RESIDENTS—Drug plans MUST cover a temporary 90-180-day supply of drugs that are not on the formulary of the resident's drug plan, while an "exception" to the formulary is being processed. (An exception MUST be requested in order to get this temporary supply.) CMS strengthened its requirement from a polite request in March 2005, to a firm requirement later. ". . . We believe that all part D plans must cover a temporary supply of non-formulary part D drugs while an exception is being adjudicated."[71] This protection is unique to nursing home residents.
8. MEDICAID and MEDICARE SAVINGS PROGRAM recipients may SWITCH plans once a month. They may want to do this if they are denied coverage for a drug. But it won't be effective until the first of the next month, so they may still need to navigate the exception process.
   a. MEDICAID may WRAP AROUND the drug plan coverage, and cover drugs the plans do not cover. But as of now they say they will require enrollees to REQUEST an exception first, before Medicaid will cover.

B. **Appeal Process**—if drug plan denies request for exception
   1. Redetermination by the drug plan
      a. Must be requested in writing within 60 days of coverage determination[72]—plans *may* accept oral request
      b. Plan must make standard redetermination within 7 calendar days[73]
         - 72 hours for expedited redeterminations[74]—expedited decision must be requested by physician
   2. Reconsideration by an Independent Review Entity (IRE)
      a. Must be requested in writing within 60 days of a redetermination.[75]
         - NOTE—more burdensome process than Medicare Advantage appeals, which are automatically referred for outside review if denied by plan. Here, enrollee must take action to request the outside review.

b. IRE must make decision within 7 calendar days for standard reconsideration.[76]
   - 72 hours for expedited reconsiderations[77]

c. IRE must solicit view of prescribing doctor

3. Hearing by an administrative law judge—must request in 60 days
   a. Under new process for all Medicare ALJ hearings, there are now videotelephone hearings with a Medicare ALJ in Ohio! (For NYS)
   b. Must meet minimum amount of $100 (2005) value of drug based on number of refills prescribed in a plan year; can aggregate several different drugs in an appeal
4. Medicare Appeals Council—must request in 60 days
5. Federal district court[78]—must request in 60 days
   - Drugs under appeal must be worth $1,050 (2005)—will go up every year

C. **Grievance Procedures**

1. Enrollees must file grievance within 60 days of event or incident[79]
2. Plans must make decision within 30 days[80]
3. 24 hours if complaint involves a refusal by the plan to grant a request for an expedited coverage determination or expedited redetermination[81]

IX. Timeline

A. **For 2006 Coverage**

July 2005

(1) Social Security begins processing applications for extra help subsidy. Call 1-800-772-1213 or visit http://www.ssa.gov for help.

(2) DUAL-ELIGIBLES—CMS begins sending letters to Medicaid and Medicare Savings Program enrollees stating that they are "deemed" eligible for extra help and do not have to apply.

August 2005

Social Security begins sending letters informing those who applied for extra help whether they qualify.

September 2005

Medigap (supplemental) insurance companies send notices to policyholders with drug coverage (usually plans H, I, and J) informing them of their options.

October 2005

Medicare & You 2006 Handbook is mailed to all Medicare households, listing plans available in local area. In NYS there will be 35 plans.

Comparative information about Medicare prescription drug plans will be available at http://www.medicare.gov or 1-800-MEDICARE.

Employers/unions who provide prescription drug coverage to their retirees and employees with Medicare will directly notify them about their new prescription drug coverage choices.

DUAL-ELIGIBLES—CMS will mail a letter to all people with both Medicare and Medicaid telling them which drug plan they will be automatically enrolled in as of January 1, 2006, if they do not pick a different plan before that date.

November 14, 2005

Deadline for union, retiree, employer, Medigap, EPIC (and other state Pharmaceutical Assistance Programs) and all other health plans to notify their enrollees whether their coverage is "creditable." If it is creditable, enrollees will pay NO penalty if they do not enroll in Part D, as long as they keep that coverage. If it is not creditable, enrollees pay a late fee penalty if they do not enroll in a Medicare drug plan.

November 15, 2005

Enrollment for the Medicare prescription drug plans begins. People must call the company offering the plan, 1-800-MEDICARE or enroll online at http://www.medicare.gov.

DUAL-ELIGIBLES—Medicaid recipients may select and enroll in a plan other than the one they were automatically assigned to in October, to be effective January 1, 2006.

December 31, 2005

Deadline to enroll in a Medicare prescription drug plan that will be effective January 1, 2006. If one enrolls after January 1, coverage won't be effective until the first of the following month.

DUAL-ELIGIBLES—DEADLINE for Medicaid recipients to select and enroll in a plan other than the one they were auto-assigned to in October.

January 1, 2006

Medicare prescription drug coverage begins for those who enrolled in a plan by December 31, 2005.

DUAL-ELIGIBLES—Medicaid coverage for most drugs ENDS; replaced by Medicare drug coverage from the drug plan enrollee was auto-assigned to in October 2005, unless enrollee selected and enrolled in a different plan before December 31, 2005.

April 2006

Medicare will send a reminder to those who have not enrolled in a Medicare prescription drug plan that they must enroll before May 15, 2006, to avoid a late enrollment penalty.

MEDICARE SAVINGS PROGRAM ENROLLEES and others with LOW-INCOME SUBSIDY/EXTRA HELP (except those on Medicaid)—CMS will send them letters randomly assigning them to a drug plan that will be effective June 1, 2006, if they do not select one before May 15, 2006.

May 15, 2006

Last day to enroll in a Medicare prescription drug plan until November 15, 2006 (except for people who first become eligible for Medicare in the meantime, or those permitted to change plans because they are on Medicaid, in a Medicare Savings Program, move out of their plan's geographic area, enter or leave a nursing home, etc.).

MEDICARE SAVINGS PROGRAM ENROLLEES and others with LOW-INCOME SUBSIDY/ EXTRA HELP (except those on Medicaid)—Last day to select a plan different than the one they were randomly assigned to in April 2006, to be effective June 1st. This is called "facilitated enrollment."

Jan. 1-June 30, 2006

One-time switch period when you may switch drug plans one time without penalty.

July-Oct. 2006?

One-time switch allowed for individuals with extra help who were auto-enrolled into a plan effective 6/1/06 because they did not pick a plan on their own. Exact switch period not yet known. (Persons with Medicaid or QMB/SLIMB/QI-1 may switch plans at any time.)

B. For 2007 COVERAGE (same schedule for 2008 and after)

Nov. 15-Dec. 31, 2006

Open enrollment in Medicare Part D to be effective January 1, 2007. Initial enrollments are allowed (premium penalty applies if you were eligible earlier but did not enroll).

You may not enroll for the first time in a Part D plan from January 1, 2007-November 15, 2007, unless you are new to Medicare, first enroll in Medicaid, enter or leave a nursing home, or within 63 days of losing "creditable" coverage from another insurer.

Jan 1.-Mar. 31, 2007

Annual one-time drug plan switch period. Otherwise, may only switch plans if you are a Medicaid recipient, in the Medicare Savings Program, or if you move out of the geographic area covered by your plan, move into or out of a nursing home.

GLOSSARY

ADAP. AIDS Drug Assistance Program. Does not qualify as an "SPAP"—State Pharmaceutical Assistance Program.

Automatic enrollment. "Dual-eligibles" (receive Medicaid and Medicare) will be automatically assigned, at random, to a drug plan effective January 1, 2006, unless they choose a plan of their own. On that day Medicaid drug coverage ends except for drugs excluded from the Medicare drug program. Dual-eligibles may change their prescription drug plan at any time.

Basic benefit. The basic Medicare drug benefit with no low-income subsidy/extra help. The basic benefit has the lowest premium available (expected to be $37/month in 2006).

CMS. Centers for Medicare and Medicaid Services. This is the federal agency that runs Medicare and Medicaid.

Catastrophic coverage. A name for the step of Part D in which the plan pays nearly all of a beneficiary's drug expenses until the end of the year. In this step in the basic plan, the beneficiary pays about 5% of his drug expenses. With extra help, catastrophic coverage eliminates any co-payments (Level 1) or reduces the co-payments (Level 2).

Coverage gap. Also known as the "doughnut hole."

Creditable coverage. Prescription drug insurance/ coverage that is better than or as good as the basic Medicare Part D drug benefit. If you lose creditable coverage you have to sign up within 63 days or be penalized with a higher premium.

Deductible. In an insurance plan, this is the amount the beneficiary pays before the plan starts to pay.

Deemed eligible. Deemed eligible beneficiaries are automatically eligible for the "better" extra help (Level 1) to help pay for the cost of the prescription drug plan. In New York, there are two categories of deemed eligibles: (1) dual-eligibles and (2) those enrolled in an MSP.

"Doughnut hole." In basic benefit, overage gap between $2,251 and $5,100 in total *allowable* drug costs where the client must pay for 100% of drug costs. There is no "doughnut hole" for people with extra help (low-income subsidy).

Dual-eligible. These are beneficiaries who have both Medicare and Medicaid, including many SSI recipients who have Medicare even though they don't receive Social Security.

EPIC. Elderly Pharmaceutical Insurance Coverage program; New York State SPAP (See below) that helps low-income seniors age 65+ pay for their prescription drugs. EPIC payments will probably be counted as out-of-pocket costs; we will hear in the next few months whether they will qualify. Can have both EPIC and a Medicare Drug Plan and the Low-Income Subsidy (extra help).

Excluded drugs. Drugs that are not included in a basic Medicare drug plan, such as benzodiazepines (Ativan, Valium).

Extra help. Extra help is a new name for the Low-Income Subsidy that helps low-income beneficiaries pay the high out-of-pocket cost of a Medicare prescription drug plan. Extra help pays all or part of the cost of premiums, deductibles, co-payments, and the "doughnut hole." The extent of the help depends on whether person has Level 1, which is better than Level 2.

Facilitated enrollment. Facilitated enrollment applies to "MSP" enrollees and others determined eligible for extra help (low-income subsidy), who do not receive Medicaid. This group must pick a prescription drug plan of their own by May 15, 2006, or else they will be randomly assigned to a prescription drug plan. MSP enrollees may then change plans monthly. Others with extra help who are not in an MSP and not on Medicaid may only change their drug plan once before the annual enrollment period from November 15 until December 31, 2006.

Formulary. Entire list of drugs covered by a prescription drug plan.

FPL. Federal Poverty Line. The federal government determines the federal poverty line. For 2005, 100% of poverty is $9,570/year for one person; $12,830/year for a couple.

LIS. Low-Income Subsidy. Re-named "extra help" by the federal government, the subsidy helps beneficiaries pay for the cost of a prescription drug plan. There are two Levels of the LIS. (See "extra help" definition.)

MA. Medicare Advantage plan. Plans that provide Medicare services in a managed care model, either an HMO or PPO (Preferred Provider Organization). Effective January 1, 2006, most of these plans will offer a Medicare Part D benefit.

MA-PD. Medicare Advantage-Prescription Drug plan. The prescription drug package offered by a Medicare Advantage plan.

MSP. Medicare Savings Program. Government programs that help low-income beneficiaries pay for Medicare Part B costs. These are QMB (QUIMBY), SLIMB (SLIMBY), and QI-1. All pay the Part B premium. QMB and SLIMB pay some of the other deductibles and coinsurance.

OOP. Out-of-Pocket; a concept used in "TrOOP."

PDP. Prescription Drug Plan. Private plan that offers the Medicare drug benefit.

Premium. The money a beneficiary pays to have an insurance plan. In Part D, this is a monthly fee.

QI-1. Qualified Individual-1 Program. This is one of the three Medicare Savings Programs for the highest income people (135% FPL). There is an income limit but no asset test required for this program.

QMB. Qualified Medicare Beneficiary Program. This is one of the three Medicare Savings Programs. It pays for an enrollee's Medicare premiums, deductibles and coinsurance. There is an income and asset limit for this program (100% FPL).

SLIMB. Specified Low-Income Medicare Beneficiary Program. This is one of the three Medicare Savings Programs. It pays for an enrollee's Medicare Part B premium. There is an income and asset limit for this program (120% FPL).

SPAP. State Pharmaceutical Assistance Program. State-based prescription drug programs that help people pay for their drugs, such as New York's EPIC program. SPAP enrollees may have special benefits under Medicare drug plans, if EPIC is determined to be "creditable coverage." If so, costs paid by EPIC count toward "TrOOP"(See below). A Medicare beneficiary will not face a late enrollment penalty if they

later join a Part D PDP, as long as they were enrolled in EPIC.

TrOOP. TRue Out-Of-Pocket expenses. These are drug expenses and drug costs (mostly paid by the beneficiary) *allowable* under the Medicare drug law and countable towards cost-sharing and out-of-pocket expenses when approaching the catastrophic coverage threshold. Some costs NOT paid by the beneficiary may count as "TrOOP expenses." These may include costs paid by family or friends, and EPIC (maybe—to be determined). It is *very important* for beneficiaries to be aware of what costs count towards TrOOP when they are in the "doughnut hole."

Endnotes

1. 42 C.F.R. § 423.30(a)(1)(i) and (ii).
2. 42 U.S.C. 1395w-101(a)(1)(B).
3. Beginning June 2004, NYS began enrolling SSI-only Medicaid recipients in Medicare Part A and B by enrolling them in the Medicare Savings Program for both A & B. Usually people just join the MSP for Part B. Enrollment of SSI-only recipients into Medicare has increased from only 1,272 statewide in January 2002 to 104,861 in December 2004. (NYS DOH Dual Eligible Statistics, Robert Borrelli, on file with Selfhelp).
4. 42 C.F.R. § 423.104(f).
5. CMS, list of all the "stand-alone" plans as of Sept. 30, 2005, *available at* http://www.cms.hhs.gov/map/charts/chart4NY.pdf.
6. http://www.cms.hhs.gov/map/charts/chart5NY.pdf. List of Medicare Advantage plans as of Sept. 25, 2005. Also see national spreadsheet of Medicare Advantage plans, sortable by state, county, and sponsoring organization, *available at* http://www.cms.hhs.gov/map/charts/MedicareHealthPlans.zip.
7. 42 C.F.R. § 423.120 (b)(2)(i).
8. CMS, Q & A to Drug Plan Sponsors, "Clarification—Formulary Review," updated June 16, 2005, *available at* http://www.cms.hhs.gov/pdps/formularyqafinalmmrevised.pdf. CMS expects that plans will not use prior authorization or step therapy for patients already stabilized on these drugs, unless the plan can prove extraordinary circumstances. Plans may use management techniques (prior authorization, step therapy) for members who first begin treatment with drugs in all these categories except for HIV/AIDS drugs. This Q & A partially revises earlier "Guideline for Reviewing Prescription Drug Plan Formularies and Procedures," *available at* http://www.cms.hhs.gov/pdps/FormularyGuidance.pdf (2005, exact date unknown).
9. *Id.* Exceptions—drugs that plans do not have to include are Iressa (lung cancer) and Fosphenytoin (anticonvulsant used by injection to control seizures, usually used for a short time when other seizure meds can't be taken orally, such as during surgery). Plans may omit *either* but not both escitalopram (Lexapro) or citalopram (Celexa) (both are anti-depressants). Fuzeon (HIV drug also called T-20 or Pentafuside, enfurvitide) must be included but may require prior authorization for *new* users. Multi-source brands of the identical molecular structure may be omitted. Plans are not required to include extended release products or all dosages.
10. 42 C.F.R. § 423.120(b)(5).
11. 42 C.F.R. § 423.100; SSA 1860-2(e)(2), 1927(d)(2).
12. 42 C.F.R. § 423.104(f)(1)(ii)(A).
13. Draft CMS proposal July 2005, no citation available.
14. 42 C.F.R. § 423.120.
15. CMS Long-Term Care Guidance, dated Mar. 16, 2005, *available at* http://www.cms.hhs.gov/pdps/LTC_guidance.pdf.
16. 42 C.F.R. § 423.772(d).
17. 42 C.F.R. § 423.773(b).
18. 42 C.F.R. § 423.773(d).
19. List of stand-alone drug plans eligible for auto-enrollment of dual eligibles as of Sept. 18, 2005, *available at* http://www.cms.hhs.gov/map/charts/chart3NY.pdf.
20. Federal Register, Vol. 70, No. 18, pgs. 4384-4385.
21. 42 C.F.R. §§ 423.780(a), 423.780(e)(1).
22. 42 C.F.R. § 423.780(a)(1).
23. 42 C.F.R. § 423.782(b)(1) (defined as 80% of the annual deductible).
24. 42 C.F.R. § 423.782(b)(2).
25. 42 C.F.R. § 423.782(a)(3).
26. 42 C.F.R. § 423.782(b)(3).
27. 42 C.F.R. § 423.780(e)(2)-(4).
28. Adapted from Federal Register, Vol. 70, No. 18, pg. 4388.
29. 42 C.F.R. § 423.782(a)(2)(iii)(A), (B).
30. 42 C.F.R. § 423.782(a)(2)(iii)(B).
31. 42 C.F.R. § 423.773(c).
32. 42 C.F.R. § 423.773(c)(2).
33. 42 C.F.R. § 423.773(c)(2); *available at* http://www.cms.hhs.gov/medicarereform/states/lis_deemed_notices.pdf.
34. 42 C.F.R. § 423.773(c)(1).
35. 42 C.F.R. § 423.773(c)(1)(ii).
36. Posted at http://www.wnylc.net/pb/docs/Fact_Sheet_on_Enrolling_into_a_Supplemental_Needs_Trust_to_Eliminate_the_Medicaid_Spend_Down.pdf. Also see outline on Supplemental Needs Trusts and other materials *available at* http://www.wnylc.net/pb/docs/SNT_Materials.htm and http://www.wnylc.net/pb/docs/SNTOutline.pdf. All state and local directives and NYSARC forms are also posted here.
37. 42 C.F.R. § 423.773(c)(1)(iii).
38. (1) Kate is a dual-eligible. She is auto-enrolled in the "better" extra help. It does not matter how much her spend-down is, since she meets it with home care. (2) Henry is in the Medicare Savings Program so is deemed eligible for the "better" extra help and does not have to apply. (3) Natalie and Jack. Since their income is well over 150% FPL for a couple, they will not qualify for extra help.
39. http://ssa.gov/, click on the link on the lefthand column for "Apply Here for Help with Prescription Drug Costs." Or go directly to https://s044a90.ssa.gov/apps6a/i1020/main.html.

40. CMS Guidance to States on the Low-Income Subsidy (State Guidance), May 25, 2005, 30.8.
41. CMS Guidance to States on the Low-Income Subsidy (State Guidance), May 25, 2005, 30.8.2.
42. POMS HI 03001.010 Eligibility for a Prescription Drug Subsidy; *available at* http://policy.ssa.gov/poms.nsf/lnx/0603001010.
43. CMS Guidance to States on the Low-Income Subsidy (State Guidance), May 25, 2005, 30.9.1; *available at* http://www.cms.hhs.gov/medicarereform/guidance5-25-05.pdf.
44. The United States Housing Act of 1937, The National Housing Act, Section 101 of the Housing and Urban Development Act of 1965, Title V of the Housing Act of 1949, Section 202(h) of the Housing Act of 1959.
45. GIS directive 05 MA-024; *available at* http://www.wnylc.net/pb/docs/05MA024.pdf (June 21, 2005).
46. http://www.cms.hhs.gov/medicarereform/newcovprescdrug.pdf.
47. 42 C.F.R. § 423.38(a).
48. 42 C.F.R. § 423.40(a).
49. 42 C.F.R. §§ 423.38(a)(3)(i), 407.14.
50. 42 C.F.R. § 423.38(b)(2).
51. 42 C.F.R. § 423.38(c).
52. E-mail from MMA_STATES@LIST.NIH.GOV to State Medicaid programs, re "MSP and Special Enrollment Period," dated Aug. 25, 2005.
53. 42 C.F.R. § 423.34(d).
54. CMS Q &A, "Medicare Enrollment as a Condition of Medicaid Eligibility," July 11, 2005 (not yet posted as of July 20, 2005, on http://www.cms.hhs.gov/medicarereform/states/default.asp).
55. 42 C.F.R. § 423.38(b).
56. CMS Chart, Apr. 5, 2005, *available at* http://www.cms.hhs.gov/medicarereform/states/auto_vs_facilitated.pdf.
57. 42 C.F.R. §§ 423.46(a), 423.56(a).
58. 42 C.F.R. § 423.46.
59. 42 C.F.R. § 423.56(c), (d), and (f)(3). CMS Model notice of creditable and non-creditable coverage *available at* http://www.cms.hhs.gov/medicarereform/CCguidances.asp.
60. 42 C.F.R. §§ 423.286(d)(3), 423.780(e).
61. 42 C.F.R. § 423.104(d)(5)(iv) (Mandated annual increase equal to the annual percentage increase in per capita spending on Part D drugs.).
62. 42 C.F.R. § 423.780(e).
63. 42 C.F.R. § 423.578(b).
64. 42 C.F.R. § 423.578(b)(1)(i).
65. This rule is not in the statute; it is only in the final regulation.
66. 42 C.F.R. § 423.578(b)(4).
67. 42 C.F.R. § 423.568(a).
68. 42 C.F.R. § 423.572(a).
69. 42 C.F.R. § 423.570(c)(3)(ii).
70. 42 C.F.R. § 423.120(b)(3); CMS "Transition Process Guidance," Mar. 16, 2005, *available at* http://www.cms.hhs.gov/pdps/transition_process.pdf.
71. CMS Q & A "What is CMS' Policy Regarding Emergency Supply of Medications for Long Term Care Residents?" undated (after Mar. 16, 2005), *available at* http://www.cms.hhs.gov/pdps/qafirstfillforltcresidents-final.pdf.
72. 42 C.F.R. § 423.582(b).
73. 42 C.F.R. § 423.590(a).
74. 42 C.F.R. § 423.590(d)(1).
75. 42 C.F.R. § 423.600(a).
76. 42 C.F.R. § 423.600(d).
77. *Id.*
78. 42 C.F.R. §§ 423.610, 423.612, 423.620, 423.630.
79. 42 C.F.R. § 423.564(d)(2).
80. 42 C.F.R. § 423.564(e)(1).
81. 42 C.F.R. § 423.564(f).

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SSI—The Basics of Eligibility: Income, Resource and Transfer Rules and Use With Supplemental Needs Trusts

By Joan Lensky Robert

I. Introduction

The Supplemental Security Income (SSI) program[1] provides an important safety net to the aged, blind and persons with disabilities. It is crucial that the Elder Law attorney understand the basics of the SSI program, for its rules impact planning for the young disabled and for impoverished seniors. The definition of "disability" used in Supplemental Needs Trusts is that used in the SSI program,[2] and Medicaid rules may not be more restrictive than the SSI rules.[3] Moreover, SSI recipients automatically receive Medicaid in the State of New York.[4] The following is an overview of the eligibility rules for the SSI program, as well as a discussion of the use of Supplemental Needs Trusts for SSI recipients.

II. SSI Eligibility

A. Overview

The Supplemental Security Income (SSI) program[5] was signed into law in 1972 by President Nixon in order that the "worthy poor" receive a standard monthly income paid by the federal government and administered by the Social Security Administration. The statute addressed gaps in federal benefit coverage for the aged, blind, and disabled who had not been able to work sufficiently to be currently insured under the Social Security Act and who are poor.[6] Prior to the enactment of the SSI program, only state welfare programs were available to provide cash income to this population.

The SSI program is a needs-based program. The federal program provides a monthly cash stipend to aged, blind and disabled individuals whose available resources and income do not exceed the maximum income and resource standards of the program. An aged person is over 65.[7] A blind person designation is based on the Social Security standard of central visual acuity of less than 20/200 in the better eye with the use of correcting lens.[8] A disabled person is a person who has an inability to perform substantial gainful employment that is expected to last for 12 months.[9]

In the initial years, the aged, blind, and disabled individuals who previously had received state benefits were grandfathered into the federal program, with each state providing a Mandatory State Supplement in order that its aged, blind, and disabled citizens not receive fewer benefits in the new federal program.[10] With annual cost of living increases of the federal payment amounts, the Mandatory State Supplements have been phased out. However, each state may provide an Optional State Supplement which is added to the basic federal payment amount which was based on the national poverty level. New York state continues to provide an Optional State Supplement, but that amount has not been indexed to provide a yearly cost of living adjustment.[11]

B. SSI Resource Rules

In order to be eligible for SSI, an aged, blind or disabled individual may have $2,000 in available resources and a couple may have $3,000.[12] Each individual is allowed a separate burial fund in the amount of $1,500.[13] A homestead is an exempt resource.[14] There is no value limitation on an exempt homestead.[15]

Not all resources are countable resources for SSI purposes. Liquid resources are countable resources. Liquid resources "are cash or other property which can be converted to cash within 20 days, excluding non work days."[16] "If the individual has the right, authority, or power to liquidate the property or his or her share of the property, it is considered a resource."[17]

C. SSI Income Rules

1. Overview

For 2005, the SSI stipend is $666/month for an individual living alone. SSI is usually paid to those who have not worked and who have not paid into

the Social Security system. However, it may also supplement other benefit programs, including Social Security Disability and Old Age and Survivors benefits, for those who have worked but who receive a lower monthly stipend than SSI provides. When computing the monthly SSI payment, the Social Security Administration considers other income received by the SSI recipient. The Social Security Administration distinguishes between earned and unearned income, and between cash income and income received in-kind. Income is anything that one receives in cash or in kind that can be used to meet the SSI recipient's needs for food and shelter.[18]

2. Earned Income

The SSI program encourages SSI recipients to work. When an SSI recipient works, he or she retains the earned income. An SSI recipient who earns income will have this income deducted from the SSI monthly check pursuant to a formula set out in the regulations.[19] To determine how the salary will reduce the SSI benefit, one disregards the first $65 of the earned income plus an additional $20 income disregard, plus one-half of the remaining earned income. The remaining one-half of the earned income is then deducted from the SSI payment. If, for example, the SSI recipient earns $1,000/month, $85 is disregarded, = $915, and one-half of that amount, or $457.50 is deducted from the SSI amount of $666, leaving $208.50 as the monthly SSI amount. The SSI recipient keeps the $1,000 salary plus the $208.50.

3. Unearned Income

Unearned income paid in cash to the SSI recipient reduces the SSI monthly benefit dollar for dollar. Other Social Security benefits or annuities paid to the SSI recipient or cash disbursements from a trust are examples of unearned income that will be deducted from the SSI stipend.[20] The first $20 paid is not deducted from the SSI payment. For example, if the SSI recipient also had a Social Security benefit of $286 per month, the monthly SSI payment amount would be reduced to $400 per month ($286-$20=$266; $666-266=$400).[21]

4. Income That Does Not Affect the SSI Benefit

a. In-Kind Income for Items Other Than Food and Shelter

Certain items received by the SSI recipient are not countable income. For example, bills paid directly to the supplier of goods and services other than for food and shelter will not result in a reduction of the SSI benefit.[22] This is non-countable income provided *in-kind* to the SSI recipient.

b. Loans

If an SSI recipient receives a *loan* for which there is an intent to repay, the loan is not considered income.[23] This is an important regulatory standard because of the necessity of loans during the often lengthy SSI application or appeal process.

5. In-Kind Income That Does Affect the SSI Benefit: Food and Shelter

a. Food

Bills paid directly to the supplier of food will result in a reduction of SSI benefits.[24]

b. Shelter

The rules for shelter are less straightforward. "Shelter includes room rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage and garbage collection services."[25] The SSI benefit differs depending upon whether or not one resides in one's own fiscal household or whether or not one resides with others. This designation, in turn, differs depending upon the Circuit in which the SSI recipient resides, as case law and regulation apply different standards to the in-kind subsidy of shelter.

(1.) Household Living Arrangements

The SSI program pays a higher amount to those who live in their own household. An SSI recipient is in his/her own fiscal household if he or she pays rent[26] or has an ownership interest or a life estate interest in the home.[27] If the SSI recipient is residing in the household of another, then the SSI recipient is presumed to be using a pro-rata share of the household expenses.[28]

The pro rata share standard results in a reduction in SSI benefits if the other SSI recipients are not living below the poverty level. For example, if there are four members of the household and the household monthly expenses are $3,200, the pro rata share of each member of the household is $800 per month. If the SSI recipient, who receives a maximum monthly payment amount of $666 per month, does not pay his or her pro rata share, the federal SSI benefits will be reduced by one-third.

(2.) In-Kind Payment of Shelter and Household Living Arrangements

Whether or not assistance with paying for shelter expenses will reduce SSI benefits depends upon the Circuit in which the SSI recipient resides. By regulation applied in 47 states, one is not receiving in-kind support and maintenance for shelter if the SSI recipient has a business arrangement with the landlord and pays the fair market rent.[29]

In most states, of course, with a $666/month maximum SSI payment, the fair market value of rent will likely be more than the SSI benefit itself. In three states, Illinois, Indiana and Wisconsin, a federal regulation[30] based upon the Seventh Circuit decision *Jackson v. Schweiker*[31] directs that only if the rent required is less than EITHER the fair market value OR a presumed value of rent will there be an SSI reduction based upon the recipient's residing in the household of another. The presumed value of rent is one-third of the SSI federal amount. When the SSI recipient must pay rent that is *more than one-third of the federal SSI benefit level,* then, by regulation in Illinois, Indiana and Wisconsin, there is no reduction in benefits, as there is no actual economic benefit to the SSI recipient.

The Second Circuit, in 1989, applied the *Jackson v. Schweiker* standard in *Ruppert v. Bowen*.[32] Although the federal regulation was never changed, in the Second Circuit, when the actual rent is more than one-third of the federal SSI benefit level (approximately $200), bills paid directly for housing will not result in an actual economic benefit for the SSI recipient and thus should not result in a reduction of the monthly stipend, so long as the person making the payment is not legally responsible for the SSI recipient and does not reside in his or her household.

D. Income and Resource Rules for Children Under 18

The financial eligibility of the disabled child for SSI depends upon the economic situation of the parents. The parents' assets and income are deemed available to the child when computing eligibility for SSI for the disabled child. The larger the size of the household, the larger the size of the income that may be earned without eliminating SSI. If a single parent has one disabled child, that parent's earned income over approximately $1,300/month will disqualify the disabled child from SSI**.** Unearned income of a parent, however, reduces SSI benefits dollar for dollar.[33]

If a court order authorizes a stipend to a parent for caring for the child, the court should characterize this stipend as earned rather than unearned income in order to continue eligibility of the child for SSI and automatic eligibility for Medicaid.

III. Transfer of Resources

From July 1, 1988, until December 14, 1999, if an SSI applicant/recipient received resources and then transferred these resources to another, there was no ineligibility period for SSI benefits.[34] However, as of January 1, 2000, with the enactment of the Foster Care Independence Act of 1999, if an SSI recipient transfers resources, there may be a wait for SSI benefits. These new rules mirror Medicaid eligibility rules.

A. Uncompensated Transfers: In general, the uncompensated transfer of resources will result in a period of ineligibility for SSI. The wait is calculated by dividing the resources transferred by the monthly SSI benefit. There is a 36-month look-back, and the ineligibility period is capped at 36 months, no matter how great the transfer.[35]

B. Exempt Transfers: The home may be transferred to a spouse, a minor child or a disabled child, to a caregiving child, or to a sibling with an equity interest in the home without a wait for benefits.[36] All resources may be transferred to a spouse, to a disabled child, to a trust for the benefit of a disabled child, or to a trust for the sole benefit of a disabled individual under the age of 65 without the transferor's incurring a wait for SSI benefits.[37]

C. Transfers into a Supplemental Needs Trust: No ineligibility period will be assessed for an SSI recipient or applicant under the age of 65 who transfers resources into a trust which provides a payback to the state for the lifetime of Medicaid provided pursuant to 42 U.S.C. § 1396p(d)(4)(A) or to a pooled income trust pursuant to 42 U.S.C. § 1396p(d)(4)(C).[38] The SSI recipient over the age of 65 may transfer assets into a pooled trust, but the maximum 3-year ineligibility for SSI benefits caused by the transfer will apply. After the ineligibility period has ended, the assets in a pooled trust will not be considered an available resource to the SSI recipient. There is no payback for SSI benefits.

IV. Use of Supplemental Needs Trusts (SNTs) for SSI Recipients

A. Overview

SSI recipients or applicants under the age of 65 with resources from lawsuits, inheritances, or savings may transfer the resources into SNTs without incurring any wait for SSI benefits. The Trustee may pay the bills of the SSI recipient. Other than the Trustee providing food and shelter, the ordinary bills of a disabled person paid by the Trustee of the SNT will not result in a decrease of the SSI monthly benefits. If the SSI recipient pays for his or her own food and shelter from the SSI payment, then there is no in-kind income reduction. Even if the trust pays for shelter that reduces the SSI benefit, the reduction in the SSI payment may still improve the beneficiary's quality of life.

Elder Law attorneys are presented with advocacy opportunities to see that SNTs[39] accomplish the goals of improving the standard of living and independence of beneficiaries with disabilities. SNTs are extraordinary examples of a public/private partnership to provide for the needs of the disabled. With SNTs to supplement rather than supplant government entitlements, the disabled have the financial means to reside in the community rather than in institutions. SNTs funded with the disabled individual's own assets have been in the legal arsenal of most Elder Law attorneys since 1993[40] as a means of preserving the Medicaid[41] benefits of the disabled under the age of 65. The interrelationship between these trusts and SSI,[42] however, was not set by statute until 1999.[43]

B. *Olmstead v. L.C.*: The Statutory Right Not to Be Institutionalized

In 1999, the Supreme Court declared[44] that under the Americans with Disabilities Act[45] states are required to place persons with mental disabilities in community settings rather than in institutions when appropriate.[46] Finding that the states' reluctance to place or retain individuals in the community rather than in institutional settings constitutes discrimination based upon disability, [47] the Court upheld the application of regulations issued by the Executive Branch to implement Title II of the Americans with Disabilities Act.[48] These regulations require that qualified individuals not be excluded from the community by reason of disability, and that the public entity make reasonable modifications in policies or procedures when necessary to avoid discrimination[49] on the basis of disability.

C. *Chevron U.S.A. Inc. v. Natural Resources Defense Council*,[50] *Christensen v. Harris County*,[51] the Administrative Procedure Act and the "Law"

The Supreme Court has delineated under what circumstances the courts will defer to an Executive Branch's interpretation of a statute. In *Chevron U.S.A. v. Natural Resources Defense Council*,[52] the Supreme Court held that a court must give effect to an agency's regulation containing a reasonable interpretation of an ambiguous statute.[53] The Court distinguished this holding, however, in *Christensen v. Harris County*,[54] in stating that an Executive Branch Agency's opinion letter interpreting duly promulgated regulations is not entitled to deference in interpreting a statute.[55] "Interpretations such as those in opinion letters—like interpretations contained in policy statements, *agency manuals*, and enforcement guidelines, all of which lack the force of law—do not warrant *Chevron*-style deference."[56]

Over the past three decades, the SSA bureaucracy has cobbled together volumes of eligibility standards which have all too often been used by a hostile bureaucracy to reduce or deny SSI benefits. Thousands of SSA claim representatives in all 50 states have applied the SSA's Program Operations Manual (the POMS) as the "law" when rendering income and resource eligibility decisions. To the extent that the POMS incorporates provisions not in the statutes or regulations, the use of POMS violates the Supreme Court holding of *Christensen*, as no deference to the Agency's opinion letters is warranted when a regulation is clear on its face. "To defer to the agency's position would be to permit the agency, under the guise of interpreting a regulation, to create de facto a new regulation."[57]

Under *Christensen*, SSA claim workers should render eligibility decisions based on the duly promulgated regulations and *not* on the POMS. Thus, the SSA commissioner should comply with the *Olmstead* Executive Order by re-evaluating old policies and developing new policies based on duly promulgated regulations. Under *Christensen*, duly promulgated regulations should implement the enabling SSI statute. Under *Olmstead*, these regulations should promote the statutory right of those with disabilities to reside in the community.

D. *Olmstead* Executive Order 13217

On June 18, 2001, President George W. Bush issued *Olmstead* Executive Order 13217[58] in order to implement the holding of *Olmstead v. L.C.*[59] This Executive Order mandates that each state implement a plan to provide services for the qualified disabled in an integrated setting. As the State of Georgia originally argued in its losing *Olmstead* position that finances and not discrimination prevented the reentry of the plaintiffs into a community setting,[60] the use of SNTs to supplement government entitlements will provide a financial safety net to allow the vulnerable disabled individual to remain in the community. In many instances, however, SSI claim representatives use outdated Program Operation Manuals, in contravention of *Christensen*, to reduce SSI payments to those with SNTs.

E. OBRA 1993 and the SSI Trust Statutes: Still No Regulations

Over 12 years have passed since the October 1, 1993, effective date of OBRA 1993, with its authorization of "payback" SNTs.[61] Because the Secretary of HHS never promulgated "Medicaid Trust" regulations, the SSA staff relied upon the use of the POMS when reviewing "Medicaid Trusts" in which SSI recipients are beneficiaries. Five years have passed since the January 1, 2000, effective date of the transfer provisions of the SSI statute. Because the SSA commissioners never promulgated "SSI Trust" regulations, the SSA staff has likewise relied upon the use of the POMS when reviewing "SSI Trusts" to determine whether the trust corpus is an exempt resource and whether income disbursements reduce or eliminate SSI payments. Many applicable POMS have not been revised since the 1999 enactment of the SSI statute exempting transfers into protected trusts.[62]

Although there are no specific federal regulations implementing OBRA 1993 or the SSI trust provisions, regulations have been promulgated which implement the SSI statute as to the availability of resources.[63] POMS Trust standards used by the SSA staff may be accessed at http://www.SSA.gov. The SSA Commissioners' adjudicators of fact now apply POMS SI 01120.201 as the "law" that determines whether a trust conforms with the SSI statute. In particular, the following POMS serve to reduce SSI benefits for disabled beneficiaries of SNTs:

1. The Available Resource Regulation

When a disabled individual applies for SSI, he or she may have no more than $2,000 in available resources.[64] Only available resources, however, are counted. Available resources are liquid assets, i.e., cash or items that can be converted to cash within 20 days to be used for the support and maintenance of the SSI recipient, as well as real property or personal property that an individual could convert to cash to be used for his support and maintenance.[65] If the individual does not have the right, authority or power to liquidate the property, it is not a resource of the SSI recipient.[66]

As an SNT for a mentally incapacitated person often is established through court order, must he or she await a court decision, which may take months to obtain, in order to qualify for SSI? Must the trust be funded prior to eligibility, or are the funds subject to a court's jurisdiction "not liquid" and hence "not available" during the pendency of a proceeding which seeks a court order to establish the trust?

The Social Security Administration does not apply the SSI resources regulation,[67] with its 20-day liquidity test, to resources under the jurisdiction of state courts that are in the process of being transferred into SNTs. Presently, the SSA presumes the availability of the resources under the jurisdiction of state court judges as being "actually available" until they are deposited into the SNT. If SSA claim representatives apply the resource regulation with its "20-day liquidity" test, then resources under the jurisdiction of state court judges will not be considered "actually available" during the pendency of the application in state court.

2. Nonacquiescence and the SSI Income Regulation

As per the discussion concerning the household living arrangements and SSI benefits, *supra*, the federal SSI statute is applied disparately to residents of the various Circuits. This occurs due to the nonacquiescence policy of HHS. Pursuant to nonacquiescence, the administrative agency will be bound only by Circuit Court decisions and will apply those decisions only in the Circuits in which they were issued. Hence the federal regulation is applicable only to the Seventh Circuit,[68] and a Second Circuit case with the same holding is applicable only in New York, Con-

necticut and Vermont.[69] Only Supreme Court cases will have general validity nationwide in defining the "law" for the disabled. By not appealing losing cases to the Supreme Court, the government avoids nationwide standards.

When the trustee of an SNT subsidizes the rent of the disabled beneficiary by making payments directly to the landlord, SSA has applied the POMS,[70] rather than the regulation[71] in effect in the Seventh Circuit or the court decision in effect in the Second Circuit in reducing the monthly SSI payment. Based on policy as interpreted in the POMS, the monthly SSI payment is reduced by one-third if the Trustee provides a private rent subsidy for an SSI recipient who cannot afford to pay market rent.[72] The POMS does not distinguish between payments made from a third-party SNT or from a trust funded with the disabled person's own assets when discussing the use of income.

Pursuant to *Olmstead*'s statutory right for qualified disabled individuals not to be institutionalized and pursuant to the *Christensen* mandate that unambiguous regulations be followed, SSA should eliminate its present nonacquiescence policy which limits applicability of the *Jackson* regulation and of the *Ruppert* decision and apply them in all 50 states. This unambiguous regulation should eliminate any reduction of SSI benefits by reason of rental subsidies paid by SNT Trustees. Application of this regulation would make it fiscally easier for the disabled to remain in the community.

3. Household Living Arrangements

The SSI program pays a higher amount to those who live in their own households. The SSI regulation[73] provides that an SSI recipient resides in his or her own household, if he or she "ha[s] [an] ownership interest or a life estate interest in the home."[74] Frequently, the SSI recipient resides with a relative who is a caregiver for the disabled individual who may be unable to reside in the community without the relative's assistance. By application of an interpretation of the regulations, the monthly SSI benefits can be reduced if SSA determines that the SSI recipient is residing "in another's household"[75] because others residing in the same house as the SSI recipient also pay for household expenses. Social Security applies this standard even if the SSI recipient owns the home.

Rather than applying the unambiguous regulation to find that the SSI recipient resides in his or her own household, the Social Security Administration has issued a POMS[76] that provides that a person is residing in another person's household if they share household expenses. Application of this POMS rather than of the regulation,[77] results in a reduction of SSI benefits for the disabled individual, in contravention of the mandate of the *Olmstead* Executive Order.

4. SNT Ownership of a Home with a Mortgage

The SSI income regulation applied only in the Seventh Circuit states[78] provides that if the fair market value of rent is more than one-third of the SSI payment amount, then the in-kind payment of the rent does not result in an actual economic benefit to reduce the SSI monthly payment. However, if the SSI recipient outside of the Seventh Circuit owns a home in which the SNT Trustee pays a mortgage, the POMS provides that the SSI be reduced due to a rental subsidy.[79] Applying the POMS rather than the *Jackson* Seventh Circuit regulation[80] in all Circuits results in a reduction of SSI benefits when the mortgage is greater than one-third of the monthly SSI payment amount.

5. The Earned Income of the Disabled Child's Parent

Some court-ordered trusts provide that the Trustee pay a stipend to the legally responsible relative as a caretaker. This is based on the court's recognition that a parent cannot secure employment if he or she must oversee and provide care to a severely disabled child who would otherwise be institutionalized. Earned income results in less of a deduction from the SSI benefit than does unearned income. The Elder Law attorney must be careful to calibrate the stipend to a "break even" amount of income that can be earned so that the SSI benefits of the disabled child will not be eliminated by application of earned income disregards.[81]

Presently, SSA claims representatives denominate a stipend *not* as "earned" income but as "unearned" income. This classification of the monthly stipend may result in the elimination of the child's SSI.[82] In *Calef v. Barnett*,[83] the claims representative reduced the child's SSI benefits because the Trustee paid a court-ordered stipend to the mother/guardian of a minor child. On appeal, after reviewing the state court order and the testimony of the mother enumerating the daily tasks for which the stipend was paid, the ALJ reversed the decision and found that the stipend was earned income. However, the Regional Commissioner appealed, notwithstanding the ALJ's

Finding of Fact, and the Appeals Council affirmed the decision.

V. Conclusion

In a time when the government looks to reduce its expenditures and increase the privatization of entitlement programs, a governmental policy that applies the SSI rules uniformly and which encourages Supplemental Needs Trusts as a means of increasing the independence of those with disabilities will improve the quality of life of our vulnerable citizens without greatly increasing public expenditures. The Elder Law practitioner should be cognizant of the SSI rules and vigilant that the government complies with the law as enacted and promulgated, not as interpreted by bureaucrats eager to protect their budgets. The SSI program remains as important a safety net today as in 1972 for the "worthy poor."

Endnotes

1. 42 U.S.C. §§ 1381 *et seq*.
2. *See* 42 U.S.C. § 1396p(d)(4)(A).
3. *Comacho v. Sullivan*, 786 F.2d 32 (2d Cir. 1986).
4. N.Y. Soc. Serv. L. § 366(1)(a)(2).
5. 42 U.S.C. §§ 1381 *et seq*.
6. *Id*.
7. 20 C.F.R. § 416.801.
8. 20 C.F.R. § 416.981.
9. 20 C.F.R. § 416.905.
10. 20 C.F.R. § 416.2050.
11. 20 C.F.R. § 416.2035.
12. 20 C.F.R. § 416.1205.
13. 20 C.F.R. § 416.1210(1).
14. 20 C.F.R. § 416.1212(a).
15. 20 C.F.R. § 416.1212(b).
16. 20 C.F.R. § 416.1201(b).
17. 20 C.F.R. § 416.1201(a)(1).
18. 20 C.F.R. § 416.1012.
19. 20 C.F.R. § 416.1112.
20. 20 C.F.R. § 416.1123.
21. 20 C.F.R. § 416.1124(c)(12).
22. 20 C.F.R. § 416.1103(g).
23. *Id.*
24. 20 C.F.R § 416.1130(g). "In-kind support and maintenance means any food . . . that is given to you or that you receive because someone else pays for it." 20 C.F.R. § 416.1130(b).
25. 20 C.F.R. § 416.1130(b).
26. 20 C.F.R. § 416.1132(c)(2).
27. 20 C.F.R. § 416.1132(c)(1).
28. 20 C.F.R. § 416.1133.
29. 20 C.F.R. § 416.1130(b).
30. Exception cited in 20 C.F.R. § 416.1130(b).
31. 683 F.2d 1083 (7th Cir. 1982).
32. *See Ruppert v. Bowen*, 871 F.2d 1172 (2d Cir. 1989); *see* 20 C.F.R. §§ 416.1132, 1133, 1140, 1141.
33. 20 C.F.R. § 416.1160.
34. 20 C.F.R. § 416.1246(f).
35. 42 U.S.C. § 1382b(c)(1)(A).
36. 42 U.S.C. § 1382b(c)(1)(C)(i).
37. 42 U.S.C. § 1382b(c)(1)(C)(ii).
38. 42 U.S.C. § 1382b(e)(5).
39. SNTs may be funded either with the disabled individual's own assets or with a third-party's assets. The discussion concerning payback trusts pertains to those funded with the disabled individual's assets. The discussion concerning the use of the trust's income applies to self-settled or third-party trusts.
40. The Omnibus Budget Reconciliation Act of 1993 authorized disabled individuals under the age of 65 to place their own funds into a trust established by a parent, grandparent, legal guardian or through court order without any ineligibility period for the Medicaid program so long as upon the death of the Medicaid recipient remaining assets would be paid back to the State for an amount up to the total Medicaid services provided. 42 U.S.C. § 1396p(d)(4)(A); 42 U.S.C. § 1396p(c)(2)(B0(iv). For these trusts, there is no prohibition against the use of principal. *Cf.* 42 U.S.C. § 1396a(k), the "Medicaid Qualifying Trust statute," repealed by OBRA 1993, which counted as available resources assets in a self-settled trust which the trustee had discretion to utilize for the grantor/beneficiary/Medicaid recipient; *cf also* 42 U.S.C. § 1396p(c), the statute that governs Medicaid and trusts for those not under the age of 65.
41. 42 U.S.C. §§ 1396 *et seq.*
42. 42 U.S.C. §§ 1381 *et seq*.
43. 42 U.S.C. § 1382b(e), as part of the Family Care Independence Act of 1999, Pub. L. No. 106-169, § 205; 113 Stat 1822, signed into law December 14, 1999.
44. *Olmstead v. L.C.*, 527 U.S. 581 (1999).
45. 42 U.S.C. § 12132.
46. *Olmstead v. L.C.*, 527 U.S. 581 (1999).
47. *Id*.
48. 28 C.F.R. § 35.130(d) states, "A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." *Id.*
49. 28 C.F.R. § 35.130(b)(7).
50. 467 U.S. 837 (1984).
51. 120 S. Ct. 1655 (2000).
52. 467 U.S. 837 (1984).

53. *Id*. at 842-844.
54. 120 S. Ct. 1655 (2000).
55. *Id.*
56. *Id.* Emphasis supplied.
57. *Id* at 1662.
58. 66 F.R. 33155-33156 (June 18, 2001).
59. 527 U.S. 581 (1999).
60. *Id.,* referencing App. To Pet for Cert, at 37a.
61. 42 U.S.C. § 1396p(d)(4)(A).
62. *See, e.g.,* POMS SI00835.110, Home Ownership as LA Basis 12/17/91; SI00835.380—Rental Subsidies 3/24/94.
63. *See, e.g*., 20 C.F.R. § 416.1201.
64. 42 U.S.C. § 1382(a).
65. 20 C.F.R. § 416.1201(a), (b).
66. 20 C.F.R. § 416.1201(a)(1).
67. 20 C.F.R. 416.1201.
68. Exception cited in 20 C.F.R. § 416.1130(b).
69. *Ruppert v. Bowen*, 871 F.2d 1172 (2d Cir. 1989).
70. SI 01120.201.
71. 20 C.F.R. § 416.11130(b).
72. SI 01120.201. "Food, clothing, or shelter received as a result of disbursements from a trust by the Trustee to a third party is income in the form of in-kind support and maintenance and is valued under the presumed maximum values (PMV) rule. (See SI 00835.300 for instructions pertaining to the PMV rule. See SI 01120.200F. for rules pertaining to income.)" *Id.*
73. 20 C.F.R. 416.1132(C)(1).
74. *Id.*
75. SI 00825.100 Living in Households, SI 00835.00 Living Arrangements and In-kind Support and maintenance, SI 00835.160 Sharing.
76. SI 00825.100 Living in Households, SI 00835.00 Living Arrangements and In-kind Support and Maintenance, SI 00835.160 Sharing, SI 00835.310 Distinguishing Between In-kind Support and Maintenance and Other Unearned In-kind Income, SI 00835.110 Home Ownership as L.A. Basis.
77. 20 C.F.R. § 416.1132(C)(1).
78. 20 C.F.R. § 416.1130(b).
79. "Each of the subsequent monthly mortgage payments would result in the receipt of income in the form of ISM [in-kind support and maintenance] to the beneficiary living in the house, each valued at no more than PMV [presumed market value] (*See* SI 01120.200 E.1.b.)."
80. 20 C.F.R. § 416.1130(b).
81. *See* SI 00810.350 Income Break-Even Points.
82. *Compare* 20 C.F.R. § 416.1110, *What is earned income*, to 20 C.F.R. § 416.1120, *What is unearned income*.
83. Cv 00-5943 (E.D.N.Y.).

Joan Lensky Robert served as Chair of the Elder Law Section of the New York State Bar Association from 2003-2004. She currently is its Chair of the Committee of Persons under a Disability and of the By-Laws Committee. She also serves as the Associate Dean of the Nassau Academy of Law and is a member of the Board of Directors of the Nassau County Bar Association. Ms. Robert also is a member of the Editorial Board of the *Bill of Particulars*, the journal of the New York State Trial Lawyers Association and of the *Elder Law Attorney*. She has been honored for service by the Long Island Alzheimer's Foundation, Project Real and the Multiple Sclerosis Society, Long Island Chapter. She and husband Charles enjoy being "empty nesters."

ELDER LAW NEWS

REGULAR COLUMNS

New York Case News

By Judith B. Raskin

Article 81

An Article 81 guardian sought the authority to exercise the incapacitated person's right of election. Denied. *In re Rivera*, 8 Misc.3d 746, 799 N.Y.S.2d 391, May 18, 2005 (Sup. Ct., New York County).

When Helen Oringer's husband died, her Article 81 guardian attempted to exercise Mrs. Oringer's right to her elective share of her husband's estate. But the Supreme Court would not accept the filing of a notice of election without an order of the Supreme Court authorizing the guardian to exercise the right of election. The guardian then moved by order to show cause for this authority but Mrs. Oringer died the day before the court signed the order.

The Supreme Court held that the right to file a notice of election is personal. As the guardian's powers did not include the right to exercise a right of election, an order granting that authority had to be signed during Mrs. Oringer's lifetime.

An Article 81 guardian sought an order deeming transfer of assets for a Medicaid applicant as of the date of admission to facility. Denied. *In re Watson as Guardian*, 800 N.Y.S.2d 338, 2005 N.Y. Misc. LEXIS 1745, August 16, 2005 (Sup. Ct., Monroe County).

The incapacitated person entered a Medicaid facility in December 2004. In June 2005, the guardian requested gifting authority. Because the guardian wished to have the penalty period for the transfers begin as soon as possible, and because the transfers were not yet made, he requested that the court deem the transfers made as of the date of entry to the facility and not the actual transfer dates.

The court denied the request. The guardian was not entitled to relief that would not be granted to a competent person. The court would not set a transfer date prior to the application to the court to permit the transfers or prior to the actual transfers.

Plaintiffs who were denied SSI benefits under federal law because of their immigration status moved, inter alia, by summary judgment for an order requiring New York State to provide them with those benefits. Granted. *Khrapunskiy v. Doar,* 2005 NY Misc. Lexis 1970.

The plaintiffs, all legal aliens, did not become citizens within the time frame mandated in 1996 under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in order to retain their SSI benefits. Based on that failure, they were denied SSI benefits. They argued that SSL section 209 requires that New York State provide them with the SSI benefits regardless of the federal law.

The decision set out the history of section 209, the SSI program and the 1996 changes in the SSI eligibility requirements for legal aliens under PRWORA. The court concluded that New York State continues to have a duty to those blind and disabled persons no longer eligible under federal law for SSI based on their immigration status. "The State may not stop paying benefits at the level that it provided in SSL Sec. 209(2) merely because the Federal government no longer pays."

Judith B. Raskin is a member of the law firm of Raskin & Makofsky. She is a Certified Elder Law Attorney (CELA); and maintains memberships in the National Academy of Elder Law Attorneys, Inc., the Estate Planning Council of Nassau County, Inc., and NYS and Nassau County Bar Associations. She is the current chair of the Legal Advisory Committee of the Alzheimer's Association, Long Island Chapter.

Advance Directive News

What It Means to Be a Health Care Agent

By Ellen G. Makofsky

When clients come to my office seeking counsel, I eventually get around to a discussion of health care proxies and advance directives. Once the health care proxy is explained and the client determines that he or she wants to execute a proxy, I ask the client who should be appointed as the health care agent. Often the answer pops out quickly: my spouse, the child who lives closest, my daughter, the oldest son. Having recently served as a health care agent I came to realize that proximity, sex and birth order are not always the best indicators of who should be chosen. The client should be thinking about choosing a person who will be able to commit the time necessary to do the job, who will not substitute their own beliefs or wishes for those of the principal and who has the emotional strength to make difficult decisions.

Often a health care agent is selected without thought to the possibility that the job might involve constant and active day-to-day decision-making. The agent instead is selected with the idea that the agent will make that final "pull the plug decision" only. This is a false premise. The health care proxy law provides that the health care agent has the power to act when the principal lacks the capacity to make a decision regarding prospective treatment.[1] The reasoning behind this provision is that physicians need to have someone authorized to make treatment decisions when the patient is unable to make his or her own decision.

When a patient is frail and elderly, lack of capacity can suddenly become an issue. Even a mentally alert patient may lose capacity as a result of ongoing treatment or a surgical procedure. A variety of medications prescribed to reduce or control pain or provide other restorative benefits can reduce capacity. Patients may enter into a delirium which will affect capacity for a period of time or for the remainder of an individual's life. As a consequence of the loss of capacity, the health care agent will be called upon to make all sorts of major and minor medical decisions for the patient. An agent must have conversations with the physician and staff members to try and determine the real risks and potential benefits of any proposed treatment. The health care agent needs to have an overall understanding of the patient's likely prognosis in order to make good decisions. A health care agent must be willing to take on the real time commitment that the job may entail. If the selected agent is unable to devote sufficient time to evaluating the information he or she elicits from the physicians and staff, that person is not a suitable agent.

> *"The job of health care agent is not for the faint of heart. . . . [M]edicine can be more art than science, and treatment can be a slippery slope."*

The health care proxy law requires that the agent act according to the principal's wishes. Where the wishes are unknown a best interest standard is used except where the decision relates to artificial nutrition and hydration.[2] If decisions are to be made regarding tube feeding, those decisions must be made within the framework of what the principal would have wanted. In choosing a suitable agent, thought must be given to selecting a person who respects the principal's wishes and who is capable of separating his or her own personal convictions from the wishes of the principal.

The job of health care agent is not for the faint of heart. Most of us, if asked what kind of medical decision-making we would like for ourselves, would respond that we would want continued treatment if there was a reasonable chance of recovery. The agent is often left to respond to that wish. However, medicine can be more art than science, and treatment can be a slippery slope. When a patient is seriously ill, physicians will often seek permission for one treatment after another in an attempt to cure the illness. Some treatments may be innocuous, others very invasive and sometimes painful. When is enough, enough? A course of treatment can have ups and downs. A prognosis can be uncertain. Even the best efforts of the physician and staff can result in a poor

outcome: a patient who eventually requires a ventilator or who cannot be weaned from a feeding tube. Months of care and treatment can result in the agent having to make the awful determination that treatment is no longer appropriate or that a ventilator or feeding tube must be removed. These are decisions that take an emotional strength not present in every individual.

As attorneys we need to guide our clients in choosing the most suitable agent. The mantle of health care agent is a difficult one to wear, but for some that mantle is the right fit. It is our job to help our clients make the selection.

Endnotes

1. N.Y. Public Health Law § 2981(4).
2. N.Y. Public Health Law § 2982(2).

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Guardianship News

By Robert Kruger

Guardianship and Risks from Unexpected Directions

The idea for this article came from my involvement in a matter where I was Property Management Guardian. I was, in essence, sued. Having experienced that scintillating frisson of fear and panic, I waited to write this article until I collected other anecdotes in a similar vein . . . similar in the sense that exposure came from unexpected quarters.

An attorney accepting an appointment as Property Management Guardian or Trustee of a Supplemental Needs Trust should know that the fiduciary must adhere to a standard of undivided loyalty, must not engage in self-dealing, must invest prudently and the like. These obligations are self-evident. This article does not address such matters.

Rather, this article addresses the curveballs . . . attacks from unexpected directions. The first of these arose on my watch and involved an elderly nursing home resident (Esther) and the nursing home's difficulties with her Medicaid application. The problems I encountered are not singular to guardianship; an attorney assisting a family applying for institutional Medicaid could face a similar problem here.

In preparation for the submission of Esther's Medicaid application, I supplied whatever personal and financial documentation was required. The application was prepared and submitted by the nursing home and, eventually, a notice of non-acceptance was received. The nursing home asked me to execute a limited power of attorney to authorize the nursing home to request a fair hearing and it asked me to send the home additional documentation as well.

My assistant faxed the package, including the limited power, to the staff of the home's attorneys in timely fashion. We were told that we would be contacted in a few days if anything further was required. We were not contacted.

After the 60-day time to request a fair hearing elapsed, the home's counsel submitted a Proof of Claim against my surety. When contacted, counsel for the home denied receiving the limited power. Instead of requesting the document, or advising me to request the fair hearing, or requesting the fair hearing itself (in the expectation that the absence of the limited power could be excused as an oversight), the 60-day deadline for requesting a fair hearing came and went and no appeal was taken.

My final accounting as guardian having been filed a few months earlier, and anticipating smooth sailing, I awoke to a Proof of Claim submitted months later, requesting a surcharge against the surety in a sum approaching ***$180,000***.

The surety, equally asleep, failed to answer. Rather than defend a belated claim which the surety might assert against me, I contested the claim and submitted a brief in opposition thereto. It is here that I believe the matter has application to the elder law bar as a whole.

The brief argued that I owed the nursing home a duty of cooperation only. The home carried the laboring ore and, so long as I cooperated with the home and supplied them with such documentation as I could, the surety (and by extension, me) could not be held liable. I argued further that the home had a duty to notify me if a document was missing or lost or misplaced and that the home had breached that duty and should be equitably estopped from claiming over against the surety (and by extension, me) for its loss.

When we appeared before the judge, he urged us to see whether Medicaid could reinstate the application *nunc pro tunc*, a seemingly futile exercise except for one salient fact that I had not hitherto known.

The attorney appearing for the home (not the same one who had been on the case initially) told the Court that it was firm practice to file a protective request for a fair hearing, limited power of attorney or not, whenever a notice of non-acceptance was received.

It took months to reinvigorate the matter with Medicaid but the notice of fair hearing did in fact keep the matter alive and the application was eventually approved.

There are several disconnects here: the nursing home filed a claim based upon a default in requesting a fair hearing that it apparently had filed; one attorney representing the home knew that the request was filed and another did not. Also, I should have requested a fair hearing and not relied upon the home to do so.

Those of us who have practiced guardianship and conservatorship for many years would notice another disconnect. Particularly in the Second Judicial Department (where this proceeding is venued) the judges who sat in this part would have known that the nursing home dropped the ball. It is hard to imagine Judges Rossetti, Kassoff, Leone or Scholnick seriously entertaining this claim.

Those judges, experienced judges, no longer sit in the part. We have newer and for the most part, far less experienced judges, who do not necessarily know how things work in this arena. After my initial shock over the claim, and before the disclosure that a fair hearing had been requested, the most disturbing aspect of this matter was the apparent lack of understanding of the judge presiding. A claim that I thought was frivolous became a serious matter before this judge.

* * *

The second curveball was related to me by a colleague, an experienced attorney, who was the subject/victim of the incident in his capacity as Co-Guardian of the Property (with the mother) of a minor child.

The guardianship bank accounts were in the name of both co-guardians in their fiduciary, not individual, capacity. A very large financial institution . . . a major commercial bank . . . allowed the mother to withdraw over ***$150,000*** in guardianship funds on her signature alone. The mother took the money, and her child, to Florida, leaving her co-guardian to face attempted surcharge by the court examiner and the surety.

He was, indeed, defendant in a lawsuit. Of course, he cross-claimed against the bank and in due course, after an expenditure of countless hours and untold aggravation, the matter was resolved, favorably to the child and favorably to my colleague. The funds were restored to the child by the bank, who in turn recovered a substantial portion of the funds from the mother.

That may sound inevitable. What is omitted is the fact that my colleague had not been particularly diligent checking on the bank statements. This defalcation, so to speak, did not occur overnight. It occurred over a period of 3-4 months and my colleague caught on rather late in the day. His neglect did not cause the loss but his diligence could have minimized it. The price he paid was in aggravation, not dollars.

If you are a Property Management Guardian, review the bank statements shortly after they arrive, not months later. Pay attention.

* * *

The third curveball involved a claim asserted by an administrator of the estate against co-guardians and caregivers as a result of the accidental death of an incapacitated person (IP), a 93-year-old Alzheimer's victim, a wanderer, who fell to her death from a third floor window, at night, despite the presence of her companion/aide sleeping at the foot of her bed.

The co-guardians, one of whom was also a care provider and the other of whom was an attorney, were charged with breach of fiduciary duty along with the aide on duty that night. There were many causes of action in the case entitled, *Nancy Cummings*, *Appellant v. Guardianship Services of Seattle, et al.*, Respondents, decided April 18, 2005, before the Court of Appeals, Division 1, State of Washington. The claim that caught my attention was not neglect, but breach of fiduciary duty based upon the neglect of others.

As a guardian in several matters, I put myself in the position of the attorney-guardian in *Cummings* and ask what his neglect could have been. The opinion did not discuss the facts beyond what I have described and this case arose on motions for summary judgment. The cause of action against the fiduciaries based upon the alleged neglect of the caregiver survived the motion for summary judgment.

If I were guardian for a cognitively impaired individual residing in the community, should I consider nursing home placement if the IP is a wanderer or agitated and physically capable of harming herself? Why place a person in a nursing home who appears to be safely cared for at home but who may act unpredictably? Can I ensure safety beyond hiring a geriatric care manager and staffing the case through the case manager? Or, perhaps, the caregiver had a long history of substance abuse and was hired despite that history.

The issuance of neglect was not adjudicated and more significantly, the facts were not set forth beyond the short recitation of the manner in which the accident occurred, but I find it mystifying how that cause of action survived the motion. We are guardians, not guarantors, against every vicissitude of life.

Once again, I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007, ***RobertKruger@aol.com.***

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

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@nysbar.com.

Quotations provide an excellent method to prepare yourself or your client. They can help maintain or regain perspective, and they can encourage outside-the-box thinking and problem-solving. I hope you will find these as useful and enlightening as I do.

> Vanity asks, is it popular? Politics asks, will it work? But conscience and morality ask, is it right?
>
> —*Martin Luther King, Jr.*

> It is the province of knowledge to speak and it is the privilege of wisdom to listen.
>
> —*Oliver Wendell Holmes, Sr.*
> (U.S. Author and Physician 1809-1894)

> Tomorrow's fate, though thou be wise,
> Thou canst not tell nor yet surmise;
> Pass, therefore, not today in vain,
> For it will never come again.
>
> —*Omar Khayyam*, "Living Life"

> A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.
>
> —*Sir Winston Churchill*

> It has been my experience that folks who have no vices have very few virtues.
>
> —*Abraham Lincoln*

> Under certain circumstances, profanity provides a relief denied even to prayer.
>
> —*Mark Twain*

> Only two things are infinite, the universe and human stupidity, and I'm not sure about the former.
>
> —*Albert Einstein*

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

Mr. Grey has experience as a guardian, court evaluator, guardian *ad litem* and attorney for AIPs in guardianship proceedings. He is the author of the chapter on "Mediation in Guardianship Practice" in NYSBA's *Guardianship Practice in New York State, 2004 Supplement*, 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 Academy of Elder Law Attorneys ("NAELA").

Ethics News

By James H. Cahill, Jr.

The past few years have brought drastic changes to the fiduciary appointment process. Amongst the changes is an attempt to increase the diversity of appointees with a cap of the permissible amount of compensation to an appointee. While the "compensation cap" has seemingly increased the diversity of appointees, there is an anecdotal groundswell of reports concerning appointees who are at best unqualified and at worst inept. This author's firm has encountered appointees who did not realize they need to attend the hearing, requested that the Court conduct "secret testimony" excluding the person who is adversely affected by the testimony and other appointees who, after receiving an appointment, do not qualify as guardian, court evaluator or otherwise decline the appointment after months have transpired.

This article examines the liability of a court appointee, such as a court evaluator, in view of the judicial function of such an appointment. A court evaluator in an Article 81 judicial proceeding is a position filled by appointment by the judge presiding over the case. The court evaluator must perform statutorily defined investigative and reporting tasks (Mental Hygiene Law § 81.09) and, in addition, a court evaluator must attend all court proceedings and conferences and be available as a witness at the hearing itself (Mental Hygiene Law § 81.09[c][9]; § 81.12[b]). In the simplest of terms, the court evaluator serves as "the eyes and ears of the court" in performing an investigation. In this regard, Courts have determined that an absolute privilege extends to an utterance or writing directed at a court evaluator. However, the reader should note that the same "immunity" which appears to apply to a "court evaluator" does not appear to extend to appointees who act as guardian or counsel.

A. Immunity as a Concept

Absolute judicial immunity is often "essential to safeguarding the integrity of the judicial process," and often "extends to those performing functions closely associated with that process, *Hill v. City of New York,* 45 F.3d 653, 660 (2d Cir. 1995)." "Quasi-judicial" absolute immunity may at times protect various persons who are not judges from any and all lawsuits arising out of their actions, if (1) such persons are themselves "integral parts of the judicial process," *Briscoe v. LaHue*, 460 U.S. 325, 335 (1983), or (2) their actions are taken pursuant to a direct judicial order. *See Richman v. Sheahan,* 270 F.3d 430, 435 (7th Cir. 2001) (citing cases from First, Fifth, and Ninth Circuits); *see also Respass v. New York City Police Dep't*, 852 F. Supp. 173, 177 (E.D.N.Y. 1994) (citing *Roland v. Phillips,* 19 F.3d 552 (11th Cir. 1994) (*see also Bluntt v. O'Connor*, 291 A.D.2d 106; 737 N.Y.S.2d 471 (4th Dep't, 2002)).

B. Immunity of Statements in Judicial Proceedings

The testimony of a court evaluator remains protected both as a quasi-judicial act and by the general rule that a statement made in the course of legal proceedings is absolutely privileged if it is at all pertinent to the litigation (*55th Mgmt. Corp. v. Goldman*, 1 Misc. 3d 239, 768 N.Y.S.2d 747 (2003); *Mosesson v. Jacob D. Fuchsberg Law Firm*, 257 A.D.2d 381, 382 (N.Y. App. Div. 1999); *Youmans v. Smith*, 153 N.Y. 214, 219). "Nothing that is said in the court room may be the subject of an action for defamation unless, this court has declared, it is 'so obviously impertinent as not to admit of discussion, and so needlessly defamatory as to warrant the inference of express malice'" (*Martirano v. Frost*, 25 N.Y.2d 505, 508, *quoting Youmans v. Smith*, *supra*, at 220). All that is required for a statement to be privileged is a minimal possibility of pertinence or the simplest rationality (*Seltzer v. Fields*, 20 A.D.2d 60, 62, *aff'd,* 14 N.Y. 2d 624). Any doubt is to be resolved in favor of relevancy and pertinence (*supra*, at 63). The absolute privilege rule is broad and liberal in order to protect counsel, witnesses and the parties to a judicial action (*Chapman v. Dick*, 197 App. Div. 551). The rule rests on the policy that counsel and witnesses should be able to speak with a free and open mind which the administration of justice demands without the constant fear of libel suits (*Youmans v. Smith*, *supra*, at 223). The privilege is broad enough to extend to all matters which would be libelous if not for their introduction into an action and which might become pertinent at any time during the proceedings (*Chapman v. Dick*, *supra*, at 559). Pertinency is a question of law for the court to decide (*People ex rel. Bensky v. Warden*, 258 N.Y. 55, 60).

C. Prosecutorial Immunity

The immunity afforded a court evaluator seems to be analogous to that regularly afforded prosecuto-

rial action. It is well established that "a state prosecuting attorney who acted within the scope of his duties in initiating and pursuing a criminal prosecution (*Imbler v. Pachtman*, 424 U.S. 409, 430 (1976)) "is immune from a civil suit for damages under § 1983" (*id.* at 431); *see, e.g.*, *Kalina v. Fletcher,* 522 U.S. 118, 124 (1997) (such a prosecutor "[i]s not amenable to suit [for damages] under § 1983"); *Buckley v. Fitzsimmons*, 509 U.S. 259, 273 (1993) ("acts undertaken by a prosecutor in preparing for the initiation of judicial proceedings or for trial, and which occur in the course of his role as an advocate for the State, are entitled to the protections of absolute immunity"); *see also Imbler,* 424 U.S. at 420 ("The Courts of Appeals . . . are virtually unanimous that a prosecutor enjoys absolute immunity from § 1983 suits for damages when he acts within the scope of his prosecutorial duties."). The rationale for conferring absolute immunity in such circumstances is that "[t]he public trust of the prosecutor's office would suffer if he were constrained in making every decision by the consequences in terms of his own potential liability in a suit for damages." *Id.* at 424-25. It appears this same degree of trust is required for court evaluators to exercise their investigative and reporting role to the court.

D. Scope of the Prosecutor's Immunity

Because the immunity attaches to the official prosecutorial function (*see, e.g., Imbler*, 424 U.S. at 430) and because the initiation and pursuit of a criminal prosecution are quintessential prosecutorial functions, see *id.*, a prosecutor has absolute immunity for the initiation and conduct of a prosecution "unless [he] proceeds in the clear absence of all jurisdiction," *Barr v. Abrams*, 810 F.2d 358, 361 (2d Cir. 1987) ("Barr"). A prosecutor engaging in "prosecutorial activities intimately associated with the judicial phase of the criminal process" loses "the absolute immunity he would otherwise enjoy" only if he "acts without any colorable claim of authority." *Id.* The scope of a prosecutor's jurisdiction is determined by law. In considering whether a given prosecution was clearly beyond the scope of that jurisdiction, or whether instead there was at least a colorable claim of authority, *see, e.g., id.* ("at least a semblance of jurisdiction"), Courts inquire whether the pertinent statutes may have authorized prosecution for the charged conduct, (*see, e.g.*, *id.* at 361-62; *Bernard*, 356 F.3d at 504; *Schloss v. Bouse*, 876 F.2d 287, 291 (2d Cir. 1989)).

Once a court determines that the challenged prosecution was not clearly beyond the prosecutor's jurisdiction, the prosecutor is shielded from damages liability for commencing and pursuing the prosecution, regardless of any allegations that his actions were undertaken with an improper state of mind or improper motive (*see, e.g., Bernard*, 356 F.3d at 503; *id*. at 502 ("a defendant's motivation in performing such advocative functions [as deciding to prosecute] is irrelevant to the applicability of absolute immunity")). While the discretion afforded a court evaluator is not as comprehensive as that of a prosecutor, it appears that the court evaluator's decision concerning whether to obtain medical records, financial records, and interview neighbors and associates of the "AIP" remain discretionary acts that are protected by "immunity." Similarly, a court evaluator has the right to make motions that fall squarely within his or her discretion.

E. Quasi-Judicial Immunity as Shield for Court Evaluators

Courts have recognized that it is imperative to the nature of the judicial function that judges be free to make decisions without fear of retribution through accusations of malicious wrongdoing (*Tarter v. State of New York*, 68 N.Y.2d 511, 518, 503 N.E.2d 84, 510 N.Y.S.2d 528 (1986); *see also Antoine v. Byers & Anderson*, 508 U.S. 429, 435, 124 L. Ed. 2d 391, 113 S. Ct. 2167 (1993)). Judicial immunity discourages inappropriate collateral attacks on court rulings and fosters judicial independence by protecting courts and judges from vexatious litigation. Indeed, "most judicial mistakes or wrongs are open to correction through ordinary mechanisms of review, which are largely free of the harmful side-effects inevitably associated with exposing judges to personal liability" (*Forrester v. White*, 484 U.S. 219, 227, 98 L. Ed. 2d 555, 108 S. Ct. 538 (1988)). Allowing members of the judiciary to exercise independent judgment, without the threat of legal reprisal, is "critical to our judicial system" (*Tarter*, 68 N.Y.2d at 518).

Recognizing the distinct nature of the judicial process, "judicial immunity . . . protects Judges only in the performance of their judicial functions" (*id.*). The court in *Mosher-Simons v. County of Allegany* (99 N.Y.2d 214, 783 N.E.2d 509 (2002)) determined that a logical extension of this premise is that "other neutrally positioned government officials, regardless of title, who are delegated judicial or quasi-judicial functions should also not be shackled with the fear of civil retribution for their acts" (*id.*). The common law provides absolute immunity from subsequent damages liability for all persons—governmental or otherwise—who are integral parts of the judicial process (*Briscoe v. LaHue*, 460 U.S. 325, 335, 75 L. Ed. 2d 96, 103 S. Ct. 1108 (1983); *see also Prosser and Keeton*, Torts § 132, at 1058 (5th ed.) ["judicial immunity has been

extended to . . . adjuncts of the judicial process"]). Notably, this extension of judicial immunity to those whose actions are an integral part of the judicial process is limited. It is circumscribed to claims arising from the performance of the specific judicially delegated function.

In *Mosser*, the Court of Appeals found that the Family Court was immune from a claim of negligent placement; and, the placement was undeniably the execution of a judicial function. The Court therefore found that the associated antecedent fact-gathering process necessary for the Court to reach this placement decision also must be cloaked with judicial immunity. The Court-ordered DSS home study was an integral part of the judicial decision-making process. The caseworker gathered and reported pertinent information to assist the Court in determining an appropriate place for the child to live. The information necessary for the placement decision was available only by way of evaluations that would be impracticable for the Court to perform itself. The Court noted that Social Services Law recognizes the important role played by caseworkers in gathering information on behalf of the Family Court (*see* Social Services Law § 424 ["Each child protective service shall . . . assist the Family Court or Criminal Court during all stages of the Court proceeding in accordance with the purposes of this title and the Family Court act"]). Thus, the caseworker functioned as an extension of the Court and was acting within the scope of the Court's order when he completed the study. Given the Court's language that appears to almost duplicate the function fulfilled by the Court evaluator, it appears that the court evaluator's acts similarly enjoy immunity so long as the actions are within the scope of their duties.

Conclusion

Whether acting as a court evaluator or alternatively suffering under the burden of a misguided appointee, it is important to understand that a court evaluator enjoys quasi-judicial immunity from claims such as malpractice, discrimination and similarly framed claims.

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Snowbird News

Directed Passion: Welcome to the New Long-Term Care Reality

By Scott M. Solkoff

(In error, only the first few paragraphs of the following article were published in the last issue of the Elder Law Attorney *(Fall 2005, Vol. 15, No. 4). The complete article appears below.)*

I am not afraid and neither should you be. The times, they are a changin' and never has the practice of Elder Law been confronted with as great a challenge but as jubilant an opportunity as now. The very concept of long-term care is being debated. Our lawmakers have made reform of the Medicaid program a most urgent effort. Task forces have been created. Public hearings are being held. The question no longer is whether change will come or even when change will come. The question is what the long-term care system will look like tomorrow and how we, as Elder Law Attorneys in Florida and New York, will be able to help our clients.

> *"People are fantastically 'unfinished' at birth. We are given a set of abilities, looks and resources but it is left to us to develop and direct our passion."*

While serving as Chair of the Florida Bar's Elder Law Section this past year, I learned that leaders of the state and national organizations are receiving e-mails and telephone calls from Elder Law Attorneys across the country, most expressing fear and uncertainty in the face of coming change. Almost all are negative calls, not negative in words but negative in spirit. It appears that the first thing some Elder Law Attorneys think of when they hear the Medicaid system is being reformed is whether they will be able to make as much money under a new system. I tell each of these callers that they can make as much or more money as they are making now and that I can tell them how to do it with two words. It is at this point that I can almost hear the disbelief and the mind closing through the speaker of my phone. "Directed Passion."

Whenever I say this—"*Directed Passion*"—it sounds like I am saying "Plastics." The new paradigm. The answer to the coming years. But it's true. The answer to the coming change to the long-term care system is *directed passion.*

If you love what you do and you do what you love, you will make money if that is part of your objective. Many attorneys have forgotten why they do what they do and some never knew. Most are so busy that they get up in the morning without much time for thought . . . get in the car . . . turn on the radio or get on the phone . . . get out of the car . . . walk into the office . . . day goes by in a blur . . . no time for a real lunch or any time for oneself . . . get back in car . . . tired now . . . back home . . . dinner . . . some down time . . . sleep . . . repeat from the beginning five to six days per week for the majority of one's life. Employees carry on their work. There is no director, just actors playing out a script that someone else wrote.

There are some who have made it a point to reflect, who have decided that they would take the time (and you must "take" it, it is never freely given) to map out their own personal passion. What is my purpose in life? What is the goal of my profession? Am I to spend my life acting out someone else's script or am I going to figure myself out and become a director? If I become a director, what shall I direct? My passion! I shall direct my passion!

And so it is that I am not afraid of the coming changes. The changes are coming whether I like it or not. I am only afraid that I will be somehow unworthy of my task as director but this is within my control.

People are fantastically "unfinished" at birth. We are given a set of abilities, looks and resources but it is left to us to develop and direct our passion. If we do not adequately develop or direct our passion, there is a default set of behaviors that kick in. It is the instinct of an "ant" developing its anthill. We start to work and we continue to work and we begin to thrive on routine in a script that someone else wrote. Depending upon your beliefs, you may attribute this

script to God or to some natural instinct but it is only meant as a default. It is far preferable to decide upon one's own passion and to then fight for and fuel that passion. The act of self-direction is what completes us.

When I tell these attorneys that they will not only survive but thrive if they have "directed passion," I am pretty certain that some of them think I am avoiding the real issues. Others have not only thanked me for the talk but have written flowing letters of gratitude. Those who cannot accept a simple answer—*directed passion*—are only interested in the nitty-gritty of what is going on with pending legislation and how we can stop or delay change. To them I say that the actual legislation and rules are very important and I am not avoiding those very real issues. I have indeed personally put much time, thought, energy and travel into the "nitty gritty" but I know that some change is inevitable. I hope my contribution to the legislative and broader public policy process continues to help in some way. I have already had small victories and hope I can do more but, for me personally, little of that will matter if I do not have a directed passion. For all of us, in every part of our lives, it is the product of directed passion that ultimately leads to success.

Some people think well in abstractions but concrete answers help also. What is the directed passion of the Elder Law Attorney if not to better the quality of life for the elderly and/or disabled? While your own professional passion may differ, I have some evidence to support my belief that most Elder Law Attorneys have a similar passion. In New York and in Florida, our respective Elder Law bars were recently tested about passion. We had to make decisions about supporting legislative change that would seemingly help the elderly and disabled while decreasing our relevance in certain practice areas. While there was some debate about our purpose, there was overwhelming support for the principle that we stand for bettering the lives of our clients rather than preserving a broken system from which we happen to profit.

Both in Florida and in New York, Elder Law Attorneys pursued good public policy not because it would profit us but because we stood on the principle that our clients come first. It is this principle, very closely akin to "passion," that will guide and inform the debate from this point forward. While the "nitty-gritty" of the public policy work seems never ending and is all very important, it is this guiding principle that will carry the day and determine our failures and our successes. So too is it with passion. We will always be relevant to our clients if we know more than they do about how to access a higher quality of life. We will fail to remain relevant if we keep acting out someone else's script.

If we have a directed passion, we will overcome the gravity of pointless habit and we shall be successful, not only in dollars but in spirit. The universal force of inertia is very strong and very psychologically addictive. It is so much easier not to think and not to challenge oneself. It is so much easier to read the lines than to write them. Defining one's passion is no easy task. It takes the right mind-frame and sometimes even the right setting. One might even prod the creative process by engaging in some catalytic activity before facing the question. For some, this catalytic activity is hiking or being in nature. For some it is listening to certain music. It might be going to a museum or art gallery. Each of us has our own triggers. If you do not yet know what yours are, find them.

Once the passion is determined, sleep on it and live with it for some period of time until it becomes accepted as truth for you. Then it just takes some planning. This is literal pen to paper planning where you map out how you will realize your passion. If your passion is to better the quality of life for the elderly and disabled, then you might write down some of the methods you could use to make this happen. Forget the old paradigm of what has become a "traditional" Elder Law practice. Forget all about what your colleagues are doing and forget, for the most part, what you hear at the seminars. What can you do to realize your passion? If you do this and actually leave the old paradigm behind, you will personally realize success. If many of us bust out of the old paradigm and start thinking fresh thoughts on how to direct our passion, we will experience a great collective Renaissance. That is what is needed so that we are directing the new reality by realizing our passions. If we continue moving bricks from one side of the office to the other, we will not only be ignorant of our own potential but we will end up being enslaved by someone else's ideas.

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Pearls and Gems

Penalty Period Issues: Return of Gifted Assets

By Matthew J. Nolfo

As most elder law attorneys have experienced from time to time, a client will consult with you and share that he or she transferred assets based upon the advice of the client's accountant, financial planner, bridge partner, neighbor or, when there needs to be someone to blame, the client's son-in-law.

A recommendation for an elderly person with the onset of some type of illness to transfers assets out of his or her name is not uncommon. Yet the haste with which some clients rush to make these transfers often causes problems that an elder law attorney is employed to remedy.

As is well understood, a client considering the prospect of admission to a nursing home must be well-advised of the look back and penalty periods that are imposed based upon a transfer of non-exempt assets (and/or income) within the scope of those time periods.

With some exceptions, a transfer of assets or of income to another individual creates a thirty-six (36)-month look back period wherein all gifts must be reported or disclosed to Medicaid at the time that eligibility is sought. A transfer of assets or income to or from a trust invokes a five (5)-year look back period.

As we all know, the look back period is really just a disclosure period and the more important period to consider is the period of ineligibility caused by a transfer of assets (or income) that was made within the respective look back period. It is the amount of the gift that most often dictates the length of time that the applicant must wait until he or she can be eligible for nursing home Medicaid. The value of the transfer, divided by the average monthly cost of nursing home care in the county or region where the applicant resides, determines this penalty period.

As such, we are sometimes confronted with a client who advises us that transfers had already been recommended and made, regardless of whether the applicant or applicant's spouse becomes in need of nursing home placement sooner than expected (i.e., within the penalty period created by the transfer of assets or income).

Moreover, no plan was advised for an adequate amount of liquid assets or income to be set aside to pay the nursing home during the penalty period so that eventually the penalty period would expire and the assets retained by the applicant or applicant's spouse would be exhausted down to the allowable resource level at the time of projected Medicaid eligibility.

In this instance, a primary consideration is made to attempt to lessen the value of the gift so that the penalty period caused by the gift would be less and so the client may be eligible for nursing home Medicaid sooner.

It seems that most practitioners are very comfortable espousing the principle that a partial return of the gifted assets can be made back to the client or for the benefit of the client who made the gift initially in order to achieve a smaller penalty period so that nursing home Medicaid eligibility may be accelerated.

However, a review of the pertinent rules suggests differently.

How Much to Return?

96 ADM 8 holds on page 23, paragraph 5, that one of the exceptions to the imposition of a penalty period for an uncompensated transfer is "If all transferred assets are returned to the individual prior to the MA (Medicaid) eligibility determination, no transfer penalty is imposed." The next sentence then goes on to provide that, "If a portion of the transferred assets is returned prior to the MA (Medicaid) eligibility determination, the uncompensated value of the transfer is reduced by the amount of assets returned."

The next paragraph on page 23 under paragraph 5 provides for the same return of either all assets or a portion of the assets transferred after Medicaid eligibility is determined as well. In the event of a partial return of the gifted assets, the penalty period imposed by the initial gift is to be recalculated and the penalty period reduced.

This rather liberal interpretation of the pertinent regulations has often been embraced by many practitioners—including myself—with success. It has only been recently when one county has started to challenge these partial returns of gifts and has insisted that either the entire gift be returned or Medicaid eligibility is to be denied if the penalty period created by the initial gift is still running.

A review of the statutory authority seems to confirm this county's assertion. Social Services Law 366.5(d)(3), in setting forth which type of circumstances will preclude the imposition of a penalty period when a non-exempt transfer of assets has been made, at paragraph (iii) requires that "a satisfactory showing that *all assets* transferred for less than fair market value have been returned to the individual."

Moreover, the Medicaid Reference Guide ("MARG"), updated as of February 2005, at page 356, similarly holds that, "a transfer penalty is not imposed against an A/R (Medicaid applicant) when a satisfactory showing is made that . . . *all of the assets* transferred for less than fair market value have been returned to the individual."

SSL § 366(d)(3) and the MARG allow no flexibility on the amount of the gift that is to be returned, mandating that the whole gift must be returned to the individual who made the gift in order for the penalty period initially created by the gift not to interfere with the individual's own nursing home Medicaid eligibility. This would be seemingly unfair since the penalty period is dictated only by the value of the gift and that the Department of Health provides a monthly, incremental amount by which to determine such penalties.

But clearly, there is a conflict on whether a return on part of the gift is permissible to allow someone to secure nursing home Medicaid eligibility if the gift has already been made and the penalty period created by the gift has not expired, even though some of the months of the penalty period may have already passed.

As such, clearly anyone who suggests that a gift be made and projects a penalty period based upon the gift must confirm that liquid assets shall be available to pay a nursing home for the duration of the penalty period, if necessary. Relying on the return or partial return of part of the gift should obviously not be a primary component of the asset protection plan for that client.

To Whom to Return the Gift and/or for What Purpose

SSL § 366.5(d)(3) and the MARG at page 356 provide that the asset that was gifted is what has to be returned to the individual who gifted the asset to create the penalty in the first place. There is no qualification under either of these authorities on this issue.

96 ADM 8, at page 23 at the bottom paragraph, provides that, "For the purposes of these rules, transferred assets shall be considered to be returned if the person to whom they were transferred: uses them to pay for nursing facility services for the MA (Medicaid) applicant/recipient; or provides the MA (Medicaid) applicant/recipient with an equivalent amount of cash or other liquid assets."

In this event, 96 ADM 8 allows the return of the gift to be made either to the individual that gifted the asset or for payment to be made for "nursing facility services" for the MA. 96 ADM 8 at page 7 defines "nursing facility services" as nursing care and health-related services provided in a nursing facility; a level of care provided in a hospital which is equivalent to the level of care provided in a nursing facility; and waivered services under section 1915(c) and (d) of the Social Security Act. The same definition of "nursing facility services" is provided under SSL § 366.5(d)(1)(x).

96 ADM 8 also suggests that the very asset gifted by the individual does not itself have to be returned to the donor of the gift or for nursing facility services provided on his or her behalf but that the return of the gift could also be made with "an equivalent amount of cash or other liquid assets."

First, section 366.5(d)(3) does not allow for anything other than the asset gifted to be returned to only the donor of the gift.

Second, even if the local DSS office processing the application follows 96 ADM 8's more flexible interpretation of how the return of the gift reduces the penalty period initially imposed by the gift, payments made by the transferee on behalf of the donor of the gift for such services as home care, assisted living, medical supplies and bills as well as rent and other basic living expenses, would not be considered a "return" of the gift even under the liberal view set forth under 96 ADM 8.

Consequently, no practitioner can be casual about his or her advice against "overgifting" of assets and/or income in counseling a client to preserve and

gift assets or income against the costs of long-term care. If a client seeks assistance on a transfer of assets or income already made and sufficient assets or income do not exist to pay a nursing home through the penalty period if the client were to enter a facility prematurely, the pertinent legal authorities are ambiguous as to how this extended penalty period might be remedied. While this type of client situation is not a common occurrence, these clients surface enough so that the differences in the legal authorities set forth above should be well understood.

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An adjunct professor at New York University's School of Continuing Education and Professional Studies, Mr. Nolfo teaches courses in Estate Planning and Asset Protection Planning. He has also been quoted by the *Wall Street Journal*, the *Daily News* and *New York Newsday* and has appeared on NBC News, CBS News and ABC/Business Week News to discuss Estate Planning and Elder Law issues.

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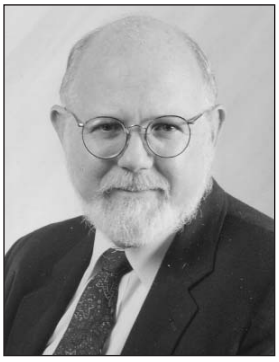
Bonus News 1

Medicaid Income Exemptions: Different Rules for Eligibility and Chronic Care Budgeting

By David Goldfarb



Although it rarely becomes an issue, the laws on income exemptions for determining Medicaid eligibility and for post eligibility budgeting are actually different. It is almost never relevant, but it has come up with a couple of recent issues, where New York State was not allowing certain income deductions for chronic care budgeting. This article discusses where some of the income deductions originate; which ones New York State is not allowing for chronic care budgeting; and why in some instances the state may be wrong.

For purposes of Medicaid eligibility determinations, New York provides for some specific income disregards and exemptions. N.Y. Soc. Serv. Law § 366 subd. 2(a). New York also provides specific disregards and exemptions for other public assistance programs that do not apply to persons who are receiving SSI or categorically related to SSI. N.Y. Soc. Serv. Law §§ 131-a(12)(c), 131-n(1). These exemptions apply to persons categorically related to other New York public assistance programs. N.Y. Soc. Serv. Law § 366 subd. 2(a)(5).

New York law specifically provides that SSI income exemptions apply for SSI-related applicants and recipients (disabled, blind, aged). N.Y. Soc. Serv. Law § 366(2)(a)(5). Federal law requires this. 42 U.S.C.S. § 1396a(a)(10)(C)(i)(III) provides in part that, ''the methodology to be employed in determining . . . eligibility, . . . shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals. . . .'' 42 U.S.C.S. § 1396a(r)(2)(A) provides that, ''[t]he methodology to be employed in determining income and resource eligibility for individuals . . . may be less restrictive, and shall be no more restrictive, than the methodology—(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI. . . .''

However, these deductions apply to eligibility determinations and community-based budgeting, but not all of them apply to chronic care (institutional) post-eligibility budgeting. Institutional care post-eligibility budgeting is controlled by specific federal laws and regulations. 42 U.S.C. § 1396a(r)(1)(A); 42 C.F.R. § 435.832.

A good example of applying the SSI rules to Medicaid eligibility is the fairly new law on exempting interest on exempt funds. Beginning July 1, 2004, the income earned on certain exempt resources will be treated as exempt income. This exemption comes from 42 U.S.C.S. § 1382a(b)(23) as amended by P.L. 108-203 (2004) which provided an exclusion for ''interest or dividend income from resources—(A) not excluded under section 1613(a) (42 U.S.C.S. § 1382b(a)), or (B) excluded pursuant to Federal law other than section 1613(a) (42 U.S.C.S. § 1382b(a)).'' This, for example, would exclude income and dividends earned on exempt reparations. The exclusion is discussed in the SSI POMS at SI 00830.500 (08/17/2004). The state implemented the exclusion in GIS 04 MA/027 (11/8/04). However, the GIS indicates the exemption does not apply to chronic care (nursing home) budgeting. As noted in this article, pursuant to 42 C.F.R. § 435.832(c), only specific enumerated deductions apply to post eligibility institutional care budgeting and ''[i]ncome that was disregarded in determining eligibility must be considered in this process.''

The state also takes the position that income diverted to an SNT will not be disregarded for purposes of chronic care budgeting (nursing home care), even where the beneficiary is under 65 and there would be no transfer penalty. 05 OMM/INF-1 at page 4 states, "It should be noted that this disregard does not apply under chronic care budgeting." Again, this is apparently based on 42 C.F.R. § 435.832(c). *See also* 42 U.S.C. § 1396a(r)(1)(A).

There are two arguments why this last position by New York State is wrong. The first regards income which is directly assigned to an SNT. If the income is irrevocably assigned to the trust it is no longer income which comes under the disregard rules. The

10th Circuit U.S. Court of Appeals upheld Oklahoma's distinction between eligibility and post eligibility budgeting with regard to Social Security Disability payments, *which could not be assigned* but were received and then placed into a Supplemental Needs Trust. *Reames v. Oklahoma ex rel. Okla. Health Care Auth.*, 411 F.3d 1164, 2005 U.S. App. LEXIS 11157 (10th Cir., 2005).

Secondly, the chronic care budgeting rules are apparently inconsistent with the later laws providing for exempt trusts. In *In re Kennedy*, 3 Misc. 3d 907, 779 N.Y.S.2d 346 (Sur. Ct., Nassau Co. 2004), the Surrogate's Court, Nassau County, approved the establishment of a Supplemental Needs Trust funded solely with social security disability payments. The Court held that although the spend-down requirement of N.Y. Soc. Serv. Law § 366(2)(a)(7) appeared to be inconsistent with the supplemental needs trust provisions of N.Y. Soc. Serv. Law § 366(2)(b)(2)(iii), they should nevertheless be construed together and the court therefore considered the SNT as an exception to the general Medicaid rules including the spend-down rules. Even though *Kennedy* was dealing with community-based care, the rationale for dealing with inconsistent provisions of the law is the same. Also, the CMS State Medicaid Manual points out, the laws regarding placing income into an SNT must be read so that they are not a nullity. CMS State Medicaid Manual § 3259.7.

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Bonus News 2

Proposed Changes to the Statutory "Short" Form Power of Attorney

By George A. Sirignano, Jr.

As practicing attorneys, many of us have prepared powers of attorney for our clients, frequently using the Statutory Short Form Power of Attorney codified in Article 5 of the General Obligations Law (GOL). The current statutory form is, as the name implies, short. It can be modified, if desired, to expressly include additional language which eliminates or supplements one or more of the powers or to include language which makes one or more additional provisions which are not inconsistent with the statutory provisions (*See* GOL § 5-1503).

Last year I had the opportunity to try a Turnover Proceeding before then Surrogate Alfred Weiner in the Rockland County Surrogate's Court which concerned the validity and effect of a Short Form Statutory Power of Attorney which had been modified to expressly provide that the Attorney-in-Fact, whom I represented, was authorized to make unlimited gifts of the Principal's assets to himself (*Salvation Army v. Ferrara*, 3 Misc. 3d 944).

In that Proceeding, the Salvation Army contended that the Attorney-in-Fact had engaged in self-dealing and that such self-dealing created a presumption of invalidity that had to be rebutted by the Attorney-in-Fact. Given the applicable evidentiary rules, e.g., the Dead Man's Statute (CPLR § 4519), such a presumption can often be difficult to overcome. The provisions of the General Obligations Law concerning the gifting power in a power of attorney, and the permitted modification thereof, were, therefore, critical to the Attorney-in-Fact's contention that the presumption did not apply.

After hearing the evidence and reviewing the applicable law, Surrogate Weiner found that the Power of Attorney was properly executed by the Principal. He also found, by reason of the 1997 amendment of Section 5-1501 of the GOL to permit gifting, and the enactment of Sections 5-1502M and 5-1503 of said Law construing gift transactions and permitting modifications of the statutory short form power of attorney, that the presumption of impropriety did not apply, and that the Attorney-in-Fact was not required to establish the validity of the Power of Attorney (*Salvation Army v. Ferrara, supra*, at pp. 945-946).

Surrogate Weiner dismissed the Proceeding against the Attorney-in-Fact, but he noted that Section 5-1502M of the GOL provides that gifting thereunder is "only for the purposes which the agent reasonably deems to be in the best interest of the principal. . . ." He suggested that the GOL be amended "to provide for the same limitation when there is express language in the power of attorney for gifts to an agent in excess of $10,000.00 per year."(*Salvation Army v. Ferrara, supra*, at p. 947).

Apparently, the Law Revision Commission heard Surrogate Weiner's message and, although not in the form suggested by Surrogate Weiner, has proposed significant amendments to the Statutory Short Form Power of Attorney provisions of the GOL. The intent of the Bill (S 5151) (Appendix A) is to provide greater and more understandable information to both the principal and the agent to avoid the potential for financial exploitation of the principal. The effect is to make the Statutory Short Form Power of Attorney anything but short, and to impose additional language, execution and accounting requirements.

The proposed legislation would repeal current Section 5-1501 of the GOL and replace it with five (5) new Sections, to wit: 5-1501, 5-1501A, 5-1501B, 5-1501C and 5-1501D. The Bill also proposes the repeal of current Sections 5-1505 and 5-5106 and the enactment of new Sections 5-1505, 5-1506, 5-1507, 5-1508, 5-1509, 5-1510 and 5-1511, as well as amendments to Sections 5-1502A though 5-1502K, 5-1502M, 1-1502O and 5-1503.

Proposed Section 5-1501 contains seventeen (17) definitions of terms including, *inter alia*, terms not previously used in connection with the Statutory Short Form Power, such as "best interest," "capacity," "compensation," "incapacitated," "third party" and "vulnerable adult." Proposed Sections 5-1501A, 5-1501B and 5-1501C contain the Nondurable, Durable and Springing Statutory Short Form Powers of Attorney. A copy of the proposed Short Form Durable Power of Attorney appears at the end of this Article for the reader's review.

The significant proposed changes can be divided into three (3) areas: the principal, the agent, and third parties.

With respect to the principal, there is a proposed new Section 5-1501D which is titled "Explanation for Principals." It provides that this Explanation consists of the "Caution to the Principal" and the "Instructions" which appear in paragraph D of said Section. The Caution must be set forth in the power of attorney in language similar to that currently used. The proposed legislation adds notice of the principal's right to revoke the power so long as the principal is of sound mind, and references provisions on Termination set forth in said Section and in proposed Section 5-1509 which provides the manner of, and the form for, revocation of the power of attorney. The Caution also refers the principal to the "Notice to the Agent" which appears on the proposed Statutory Short Form Power of Attorney. The "Instructions," among other things, give notice that the principal

may designate a person to monitor the agent (*see also* proposed § 5-1503(4)) and may provide for the compensation of the agent (*see also* proposed § 5-1506). The proposed amendment to Section 5-1502K will permit the agent to obtain access to the principal's medical records, without a Health Care Proxy, to pay the principal's medical bills.

In the event that the principal wishes to grant the agent authority to make gifts, the proposed amendment to Section 5-1502M will increase the statutory provision to the amount of the annual Federal Gift Tax exclusion permitted under Section 2503(b) of the Internal Revenue Code, which is presently $11,000. The proposed amendment will also permit gift splitting of the assets of the principal and/or the principal's spouse to their issue and parents. Notably, if the principal desires to grant the agent authority to make gifts in excess of the foregoing amounts, whether to the agent (as in *Salvation Army v. Ferrara, supra*), or to others, such gifts are classified as "major gifts" and the principal will be required to execute a new provision, incorporated into the proposed Statutory Short Form Power of Attorney, which expressly provides the agent with the desired authority. This new provision will have to be separately signed by the principal and witnessed by two (2) witnesses in the same manner as a Will.

There are also numerous changes proposed with respect to the agent. First, the agent, or agents if two or more are designated to act together, will be required to sign and duly acknowledge the Statutory Short Form Durable Power of Attorney, which would be ineffective without same. The Bill specifically provides that the agent's signature does not, however, have to be affixed to the power at the same time as the principal's, and that the signature of a successor agent is not required until all preceding agents are unable or unwilling to serve (§ 5-1501B). Second, the agent is given a "Notice to the Agent" in the power of attorney, and a statutory "Standard of Care" is codified in Section 5-1505. Included in this Notice, which must be set forth in the proposed Statutory Short Form Durable Power of Attorney, is the requirement that the agent keep a record of all transactions and make same available as provided in Section 5-1505, and, if the agent is unable or unwilling to act, that the agent must give notice to successor agents. The agent is also given notice that a power of attorney does not permit the agent to "contract for the principal's marriage or divorce, exercise the principal's governmental voting privileges, or make health care decisions for the principal." Interestingly, the Notice also advises the agent that the power of attorney does not permit the agent to practice law without a license. Third, pursuant to proposed Section 5-1507, whenever the handwritten signature of the agent is required, the agent must disclose the principal and agent relationship and must attest that the act is within the scope of authority under a valid power of attorney.

Noticeably absent from the "Notice to the Agent" is the provision of the Bill which requires that, if no successor agent has been appointed in a Durable Power of Attorney, an agent may not resign without Court approval. Proposed new Section 5-1508 provides for a civil special proceeding to, *inter alia*, approve an agent's resignation, and for many other purposes including, *inter alia*, to compel the agent to turn over records, to remove an agent, and to compel a third party to honor a power of attorney.

The term "third party" is defined in proposed Section 5-1501 as "a financial institution or person." Said Section also broadens the definition of "financial institution" to include a security broker, firm, and dealer, and an insurance company. Under proposed Section 5-1504, no third party shall refuse to honor a properly executed Statutory Short Form Power of Attorney without reasonable cause, which does not include the third party's preference for its own form. The third party may require, however, that a power of attorney be accompanied by an affidavit of the agent made in accordance with the Section. The requirements thereof would appear to be satisfied by the customary affidavit presently used. No third party acting in reliance thereon would have liability for doing so unless the third party had actual knowledge that the power was no longer valid.

Sections 5-1510 and 5-1511 as proposed by the Bill give validity and effect to all powers of attorney validly executed in another state or jurisdiction, whether or not the principal was a domiciliary of New York when the power was executed, and to all validly executed powers under prior law.

The proposed changes appear to be helpful with respect to the protection of the principal, especially the elderly, through the additional information provided to the principal and agent, and by requiring the acceptance of powers of attorney by a broader group of third parties. On the other hand, the proposed changes add complexity to the "short" form power of attorney and will require increased legal counseling of persons who are about to become, or who are acting as, agents.

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Appendix A

S. 5151 14 1 **short form power of attorney in accordance with the provisions of this** 2 **title:** 3 **"DURABLE POWER OF ATTORNEY** 4 **NEW YORK STATUTORY SHORT FORM** 5 **THE POWERS YOU GRANT BELOW CONTINUE TO BE EFFECTIVE** 6 **IF YOU BECOME INCAPACITATED** 7 **CAUTION TO THE PRINCIPAL: This is an important document. As the "princi-** 8 **pal," you are giving the person whom you choose (called the "agent")** 9 **broad powers during your lifetime to sell or otherwise dispose of your** 10 **property and spend your money.** 11 **You have the right to revoke or terminate this Durable Power of Attorney** 12 **at any time as long as you are of sound mind.** 13 **This Durable Power of Attorney does not authorize anyone to make medical** 14 **or other health care decisions for you. You may execute a "Health Care** 15 **Proxy" to do this.** 16 **This form is explained more fully in the accompanying Explanation for** 17 **Principals.** 18 **This document constitutes a DURABLE POWER OF ATTORNEY pursuant to Arti-** 19 **cle 5, Title 15 of the New York General Obligations Law. It will contin-** 20 **ue to be effective if you become incapacitated.** 21 **1. DESIGNATION OF AGENT(S):** 22 **I, _____, 23 (insert your full name and address), hereby appoint the following** 24 **individual(s) as my agent(s)** 25 **TO ACT for me:**
26 _____
27 _____
28 _____
29 **(Insert above the full name and address of the person appointed, or of** 30 **each person appointed if you want to designate more than one.)** 31 **2. DESIGNATION OF SUCCESSOR AGENT(S):** 32 **If every agent named above is unable or unwilling to serve, I** 33 **appoint as my agent(s) TO ACT for me** 34
_____
35 _____
36 **(Insert above the full name and address of the person appointed, or of** 37 **each person appointed if you want to designate more than one successor.)** 38 **3. DIRECTIONS IF YOU CHOOSE MORE THAN ONE AGENT:** 39 **(If you do not initial the space below, then your agents must act** 40 **TOGETHER. If your agents must act TOGETHER, but any agent is incapaci-** 41 **tated, not living, or otherwise unable to act, the other(s) may act** 42 **without him or her. If you have named only one person as agent and only** 43 **one person at a time as successor, then this section does not apply.)** 44 **(___) My agents may act SEPARATELY.** 45 **4. This DURABLE POWER OF ATTORNEY becomes effective when I sign it, and** 46 **shall not be affected by my subsequent incapacity.** 47 **5. GRANT OF POWERS** 48 **I grant power to my agent(s) with respect to the following subjects as** 49 **defined in sections 5-1502A through 5-1502O of the New York General** 50 **Obligations Law:** 51 **(See Explanation for instructions on how to grant powers.)** 52 **(__) (A) real estate transactions;** 53 **(__) (B) chattel and goods transactions;** 54 **(__) (C) bond, share, and commodity transactions;** 55 **(__) (D) banking transactions;** 56 **(__) (E) business operating transactions;**

S. 5151 15 1 **(__) (F) insurance transactions;** 2 **(__) (G) estate transactions;** 3 **(__) (H) claims and litigation;** 4 **(__) (I) personal relationships and affairs;** 5 **(__) (J) benefits from military service;** 6 **(__) (K) health care billing and payment matters; records, reports, and** 7 **statements;** 8 **(__) (L) retirement benefit transactions;** 9 **(__) (M) making gifts to my spouse, children and more remote descend-** 10 **ants, and parents, not to exceed, for each donee, the annual** 11 **federal gift tax exclusion amount pursuant to the Internal** 12 **Revenue Code. For gifts to my children and more remote descend-** 13 **ants, and parents, the maximum amount of the gift to each donee** 14 **shall not exceed twice the gift tax exclusion amount, if my** 15 **spouse agrees to split gift treatment pursuant to the Internal** 16 **Revenue Code; (For all other gifts, use section 12, "Authori-** 17 **zation to Make Major Gifts");** 18 **(__) (N) tax matters;** 19 **(__) (O) all other matters;** 20 **(__) (P) full and unqualified authority to my attorney(s)-in-fact to** 21 **delegate any or all of the foregoing powers to any person or** 22 **persons whom my attorney(s)-in-fact shall select;** 23 **(__) (Q) EACH of the matters identified by the following letters:** 24 **_____. You need not** 25 **initial any other lines if you initial line (Q).** 26 **6. SPECIAL INSTRUCTIONS:** 27 **(On the following lines you may give special instructions. See the** 28 **Explanation for information.)** 29

_____
30
_____
31
_____
32
_____
33
_____
34
_____

35 **7. DESIGNATION OF MONITOR** 36 **I wish to designate _____, whose address(es) is (are)** 37 **_____, as monitor(s).** 38 **Upon the request of the monitor(s), my agent(s) must provide the** 39 **monitor(s) with a complete record of all transactions entered into on my** 40 **behalf. Third parties holding records of transactions entered into on my** 41 **behalf may provide such records to the monitor(s).** 42 **8. COMPENSATION OF AGENT(S):** 43 **(If you do not initial below, your agent(s) will NOT be entitled to** 44 **compensation.)** 45 **(___) My agent(s) shall receive reasonable compensation for services** 46 **rendered.** 47 **9. ACCEPTANCE BY THIRD PARTIES: If this Durable Power of Attorney is** 48 **properly executed, any third party who receives a copy of it may rely** 49 **upon its validity. I agree to indemnify the third party for any claims** 50 **that may arise against the third party because of reliance on this Dura-** 51 **ble Power of Attorney. I understand that my revocation of this Durable** 52 **Power of Attorney is not effective as to a third party until the third** 53 **party has actual notice or knowledge of the revocation.** 54 **10. TERMINATION: This Durable Power of Attorney continues until I have** 55 **revoked it or it is terminated by my death.**

S. 5151 16 1 **11. SIGNATURE AND ACKNOWLEDGMENT** 2 **In Witness Whereof I have hereunto signed my name this _____ day of** 3 **_____, 20___. il 0 PRINCIPAL signs here: ==>** 4 **_____** 5 **State of New York** 6 **County of _____ ss.:** 7 **On the ____ day of _____, in the year 20___, before me, the under-** 8 **signed, personally appeared _____, personally known to me** 9 **or proved to me on the basis of satisfactory evidence to be the individ-** 10 **ual whose name is subscribed to the within instrument and acknowledged** 11 **to me that he/she executed the same in his/her capacity, and that by** 12 **his/her signature on the instrument, the individual, or the person upon** 13 **behalf of which the individual acted, executed the instrument.** 14 **[~~Seal~~]** 15 **_____** 16 **Signature and Office of individual taking** 17 **acknowledgment** 18 **12. (OPTIONAL) AUTHORIZATION TO MAKE MAJOR GIFTS and OTHER TRANSFERS** 19 **CAUTION TO THE PRINCIPAL: This section allows you to authorize your** 20 **agent to make major gifts and other transfers of your money or other** 21 **property during your lifetime.** 22 **If you do NOT wish to allow your agent to make major gifts or other** 23 **transfers, leave Section 12 blank, or delete or cross off everything** 24 **between the two rows of asterisks (* * *).** 25 *** *** 26 **A. GRANT OF POWERS TO MAKE MAJOR GIFTS OR OTHER TRANSFERS** 27 **I grant power to my agent(s) to make major gifts or other transfers from** 28 **my assets, as specified below, as further defined or limited by the New** 29 **York General Obligations Law:** 30 **(Provide the additional information required for each power you are** 31 **granting, and initial the blank space to the left of each such power.)** 32 **(__) (1) Making gifts to my spouse, children and more remote descendants** 33 **in larger amounts than the annual federal gift tax exclusion pursuant to** 34 **the Internal Revenue Code (state limit or unlimited)_____** 35 **_____** 36 **(__) (2) Making gifts in amounts up to the federal gift tax exclusion** 37 **pursuant to the Internal Revenue Code to a person or persons other than** 38 **my spouse, children and more remote descendants, and parents (identify** 39 **or describe the person or persons)_____** 40 **_____** 41 **_____;** 42 **(__) (3) Making gifts in amounts larger than the annual federal gift tax** 43 **exclusion pursuant to the Internal Revenue Code exclusion to a person or** 44 **persons other than my spouse, children and more remote descendants, and** 45 **parents (identify or describe the person or persons and state limit or** 46 **unlimited)** 47 **_____** 48

_____; 49 (__)
(4) Making transfers for educational expenses or medical expenses 50 pursuant to section 2503(e) of the Internal Revenue Code (identify 51 person or
persons)_____ 52
_____
53
_____;
54 (__) (5) Changing or designating the beneficiary of my life insurance 55 within these limitations and guidelines:_____

S. 5151 17 1 _____
_ 2
_____
; 3 (__) (6) Changing the ownership of my life insurance within these limi- 4 tations and guidelines:
_____ 5
_____ 6
_____; 7
(__) (7) Changing or designating the beneficiary of my retirement plans 8 within these limitations and guidelines:_____ 9
_____
10 _____
; 11 (__) (8) Creating or changing any joint ownership within these limita- 12 tions and guidelines:
_____ 13
_____
14 _____
; 15 (__) (9) Creating or changing any other survivorship interest including 16 a "payable on death" account or a totten trust within these limitations 17 and guidelines:
_____ 18
_____
19
_____
; 20 B. GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE MAJOR GIFTS TO 21 HIMSELF OR HERSELF: 22 I grant specific authority for the following agent(s) to make the 23 following major gifts or other transfers to himself or herself: 24 (Provide the name of each agent whom you authorize to make major gifts 25 or other transfers to himself or herself, and any limitations or guide- 26 lines, then initial the blank to the left of the agent's name.) 27 (__) _____
(name of agent(s), within the 28 following limitations and guidelines)_____ 29
_____; 30 C.
SPECIAL INSTRUCTIONS: 31 In this section, you may specify any additional major gifting powers, 32 guidelines, and limitations. _____ 33
_____
34 _____
35 D. ACCEPTANCE BY THIRD PARTIES: If this Authorization to Make Major 36 Gifts is properly exe- cuted, any third party who receives a copy of it 37 may rely upon its validity. I agree to indemnify the third party for any 38 claims that may arise against the third party because of reliance on 39 this Authorization to Make Major Gifts. 40 E. SIGNATURE OF PRINCIPAL: 41 In Witness Whereof I have hereunto signed my name this ____ day of 42 _____, 20__. 43
_____ 44 (Your signature) 45 F. SIGNATURES OF WITNESS- ES 46 By signing as a witness, I acknowledge that the principal signed the 47 Authorization to Make Major Gifts in my presence and the presence of the 48 other witness. I also acknowledge that the principal has stated that 49 this Authorization to Make Major Gifts reflects his or her wishes and 50 that he or she has signed it voluntarily. I am not named herein as a 51 permissible recipient of major gifts. 52 _____ _____ 53 (Signature of witness 1) (Signature of witness 2) 54 _____
_____ 55 (Date) (Date) 56
_____ _____

S. 5151 18 1 **(Print name) (Print name)** 2 _____
_____ 3 **(Address) (Address)** 4
_____ _____ 5
(City, State, Zip code) (City, State, Zip code) 6 * 7 **13. NOTICE TO THE AGENT:** 8 **This Durable Power of Attorney is valid only if the principal is of** 9 **sound mind when the principal signs it. As the "agent," you are given** 10 **specific powers to engage in financial or property transactions or both** 11 **on the principal's behalf during the principal's lifetime in accordance** 12 **with the terms of this document. As the agent, you are entitled to** 13 **receive reimbursement for reasonable expenses actually incurred in** 14 **connection with the performance of your duties.** 15 **As the agent, you are not entitled to use the principal's money or prop-** 16 **erty for your own benefit or to make gifts or any other transfers to** 17 **yourself or anyone else unless this document specifically gives you the** 18 **authority to do so. None of the authority granted to you under this** 19 **document allows you to create the principal's Last Will and Testament,** 20 **contract for the principal's marriage or divorce, exercise the princi-** 21 **pal's governmental voting privileges, or make health care decisions for** 22 **the principal. A power of attorney does not entitle you to practice law** 23 **without a license.** 24 **As the agent, you have a duty (called a "fiduciary duty") to the princi-** 25 **pal. Your fiduciary duty requires that you:** 26 **1. act solely in the best interest of the principal and avoid** 27 **conflicts of interest between the principal and you or any other person;** 28 **2. keep the principal's property separate and distinct from any prop-** 29 **erty you own or otherwise control;** 30 **3. keep a complete record of all receipts, disbursements, and trans-** 31 **actions entered into by you as agent, or your authorized delegate, on** 32 **behalf of the principal and make such record available in accordance** 33 **with Article 5, Title 15, Section 5-1505 of the New York General Obli-** 34 **gations Law; and** 35 **4. provide written notice to the successor agents in the order of** 36 **their appointment if you are unwilling or unable to act.** 37 **Your fiduciary duty is explained more fully in the New York General** 38 **Obligations Law, Article 5, Title 15, Section 5-1505. If you violate** 39 **your fiduciary duty, you may be liable for damages and you may be** 40 **subject to criminal prosecution.** 41 **Signature requirement: In any transaction where you are acting as the** 42 **agent under the authority of this document and where the hand-written** 43 **signature of the agent OR principal is required, you shall disclose your** 44 **relationship as agent to the principal by writing the name of the prin-** 45 **cipal and signing your own name as "agent," in accordance with the New** 46 **York General Obligations Law, Article 5, Title 15, Section 5-1505.** 47 **If you are unwilling or unable to serve as agent under this Durable** 48 **Power of Attorney, you must provide written notice to the successor** 49 **agents in the order of their appointment.** 50 **The law governing Powers of Attorney is found at the New York General** 51 **Obligations Law, Article 5, Title 15. If there is anything about this** 52 **document or your duties under it that you do not understand, you should** 53 **ask a lawyer to explain it to you.** 54 **14. ACKNOWLEDGMENT OF APPOINTMENT:** 55 **I/we, _____ (print your name),** 56 **have read the foregoing Durable Power of Attorney. I am/we are the**
S. 5151 19 1 **person(s) identified therein as agent(s) for the principal named there-** 2 **in.** 3 **I/we acknowledge my/our fiduciary duty and acknowledge and accept the** 4 **provisions of any special instructions contained herein.** 5 **Agent(s) sign(s) here: ==>** 6
_____ 7
_____ 8 **State of New York** 9 **County of _____ ss.:** 10 **On the ____ day of _____, in the year 20____, before me,** 11 **the undersigned, personally appeared _____** 12 **_____, personally known to me or proved** 13 **to me on the basis of satisfactory** 14 **evidence to be** 15 **the individual(s) whose name(s) is (are) subscribed to the within** 16 **instrument and acknowledged to me that he/she/they executed the** 17 **same in his/her/their capacity(ies), and that by his/her/their** 18 **signature(s) on the instrument, the individual(s), or the person** 19 **upon behalf of which the individual(s) acted, executed the** 20 **instrument.** 21 **[~~Seal~~]** 22 _____ 23 **Signature and Office of individual taking acknowledgment** 24 **§ 5-1501C.**

Bonus News 3

Assisted Signatures in the Elder Law Practice: What Constitutes Execution of a Document When the Client Needs Help Holding the Pen

By Jim Sarlis and Lori Somekh

Jim Sarlis

We who deal with older clients are often faced with situations where it is a challenge for our client to actually hold a pen and sign his or her name to a document. This can lead to uncertainty regarding how to best handle this situation. This article is intended to help clarify the situation and offer some guidance.

Assume the following facts: An elderly seller, mentally sound but physically feeble, executes a deed; his hand is guided as he places his name on the deed and the person who guides his hand writes out the seller's name in a manner that bears no resemblance to the seller's customary "signature" from long ago. There is no issue as to the client's mental capacity: based upon the view of the witnesses present, it is seller's intention to sign. The signature is notarized. The instrument in question is signed in New York and, by its terms, New York law governs. Is the execution of the deed under these circumstances valid? Would the execution withstand an objectant's allegations of forgery or other wrongdoing?

The execution of a deed (i.e., a writing conveying real property) is universally required in all United States jurisdictions.[1] In New York, the governing law is Real Property Law § 243 which requires that a deed conveying real property must be signed by the grantor.[2] The issue is: What constitutes a "signature"? The statutory definition of "signature" is found in New York General Construction[3] Law § 46, which states:

> The term signature includes any memorandum, mark or sign, written, printed, stamped, photographed, engraved or otherwise placed upon any instrument or writing with intent to execute or authenticate such instrument or writing.

Case law applying this statute, and the treatises discussing this subject, make it clear that any mark is an acceptable form of signature[4] and that the key element of a "signature" for New York law is *not* the appearance or form of the writing or characters written or affixed, but rather the signer's *intent* to sign.[5]

A case on point with the situation we have here is *Koo v. Robert Koo Wine & Liquor, Inc.*[6] It involved the execution of a deed and the statute Real Property Law § 243. There, one brother signed the name of another brother on a deed; a litigation followed where the objectant to the deed alleged that the signing of the absent brother's name was a forgery, particularly in the absence of a written authorization to sign as agent. However, the Court held that since the brother had the authorization and consent of his brother, the signing of the absent brother's name was not a forgery, was the signature of said absent brother, and constituted a valid signature for purposes of making a binding, lawful deed.

Lori Somekh

The background, policy, and legal analysis regarding "signatures" are extensively discussed in Corpus Juris Secundum. It emphasizes that the writing of one's name by one's self is not necessary for a valid signature and that any character, symbol or figure may be adopted as one's signature. Of particular significance herein is Volume 80, *Signatures*, Section 6, addressing signatures "by the hand of another":

> Generally, a signature may be made by the hand of another, acting in the presence of such person, and at his direction, or request, or with his acquiescence. . . . A signature so made becomes the signature of the person for whom it is made, and has the same validity as though written by him. . . . Where a signature is made in this manner the person writing the name is regarded as a mere instrumentality, by which the person whose signature is written exercises his own discretion and acts for himself, and not through an agent. So a mark made for a person [by another person] at his direction may be regarded as his signature.
>
> The writing of a name or the making of a mark by one other than the person whose signature the name or mark purports to be may constitute a sufficient signature of such person, where he touches the pen or pencil used in the

process while the purported signature is being made, but the touching of the pen or pencil is not essential to the validity of the signature.

The policy that a "signature" includes any mark or symbol is also evident in the statutes governing execution of negotiable instruments and Wills. Uniform Commercial Code § 3-401(2) parallels this policy, as does New York Estates, Powers and Trusts Law § 3-2.1, which extensively regulates the question of signature and applies to other areas of law, which provides for guidance of testator's hand: Valid signature may be by personally subscribing his name, or having a third person subscribe it for him at his request, or by having a third person guide his hand on writing. A testator's signature is sufficient and complies with law if, being physically unable to sign his name, he calls upon another to assist him even to the extent of holding and guiding his hand so long as it is his wish that his signature be thus made and he acquiesces in or adopts it.

All of the foregoing are in keeping with the policy that a "signature" includes any mark, symbol, or the assisted writing, made by the signer, or with his authorization, or at his direction or request, or with his consent.

This is contrary to the legal elements of forgery, which in New York is governed by statute: Penal Law Article 170. All the forgery statutes state that a requisite element is the "*intent* to defraud, deceive, or injure" (emphasis added). No such intent or conduct is evident in the situation which is the subject of this article.

Further supporting this point of view is the Notary Public Advisory Board, New York State Department of State, Division of Licensing Services, which, when consulted for its opinion on such a situation, also opined that, under the circumstances involved, the notarization of signer's signature was proper. It was signer's intent to sign and the making of a mark that constituted the signature, and the notarization was proper and valid.

As a final point, it is significant to note that under such circumstances, the legal presumption is that the signature was valid and the burden is on any objectant to prove that execution was not valid.

Conclusion

Based upon all of the foregoing, it follows that the deed at issue in our example was duly signed by the grantor in that a mark or signature was affixed to the deed by the grantor or by such act that constituted the act of the grantor as a matter of law. Specifically, the grantor's affixing an ink mark which, with the aid or assistance of another's hand, wrote out grantor's name, while grantor held or touched the pen or writing instrument and the person's hand steadied, guided, or assisted him, at grantor's request and/or with his consent, constituted the signature of grantor and was lawful, valid and binding. The signature and execution of the deed were valid, lawful, and binding, and conveyed the real property pursuant to said deed. Furthermore, the act does not constitute forgery—nor any other wrongdoing—particularly in the absence of a showing of fraudulent deceptive intent. Any objectant to the deed would bear the heavy burden of proving that the signature was not valid, and in light of the opinion of the eyewitnesses, all present at the time of execution, as to the validity of the execution, such objectant would certainly fail to convince a trier of fact by the preponderance of the evidence; instead, the presumption of due execution would prevail. Similarily, the notarization of the signature would also be proper, lawful, and valid.

Endnotes

1. Friedman, *Contracts and Conveyances of Real Property*, 4th Edition (1984 as amended); 26 Corpus Juris Secundum § *Deeds* § 4(a).
2. New York Real Property Law § 243; *See also* Powell, The Law of Real Property, §§ 889-890.
3. The meaning of the word "Construction" here is how words are to be "construed" or interpreted. This Volume of the statutes contains meanings, interpretations, applications, and constructions of the statuatory language.
4. *In re Mark's Will*, 21 A.D.2d 205, 250 N.Y.S.2d 177 (1964).
5. *People v. Mercado*, 123 Misc. 2d 775, 474 N.Y.S.2d 950 (1984); *People v. Lo Pinto*, 27 A.D.2d 63, 275 N.Y.S.2d 969 (1966).
6. 170 A.D.2d 360, 566 N.Y.S.2d 63 (1991) (signatory to writing transferring real property can, with requisite intent, adopt any mark or sign as his own signature, without resort to or need for written agency agreement). *See* Annotations to McKinney's Consolidated Laws of New York Annotated (1989 as amended).

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Lori R. Somekh is a graduate of St. John's University School of Law and Pennsylvania State University. Ms. Somekh is a member of the New York State Bar Association Elder Law and Real Property Law Sections, Queens County Bar Association Elderly and Disabled Committee and Steering Committee on Fiduciary Appointments, Nassau County Bar Association, National Academy of Elder Law Attorneys, Yashar Attorneys and Judges Chapter of Hadassah and Women's Bar Association of the State of New York.

Bonus News 4

Parents Can Designate School and Medical Powers

By Gerard Wallace

At the end of last June, Governor Pataki signed a bill into law which created a "Designation of Person in Parental Relation" in Article 5 of the General Obligations Law, by adding a new Title 15-A, with sections 5-1551–5-1555. *See* Chapter Number 119 (S.3216; A.6307). The new law repealed last year's "Caregiver Consent" Act, which contained a suggested form (Title 18). That consent bill was signed by the governor under the condition that it would be repealed and replaced by the designation power. The previous consent bill was similar to bills that the governor had vetoed twice before.

The designation law, effective 90 days after signing, creates a limited parental power of attorney by legalizing the common practice of parents writing short notes to schools or to medical providers in order to permit other persons to assume responsibility for children. The law has a simplified note for up to thirty days of care, and also a more formal note for longer periods of care. The new law does not have a suggested form.

The new law describes how to designate, who can be designated, and what parental powers can be designated.

The Note (Writing)

The new law provides that parents can designate a caregiver via a writing that contains certain information. For periods of time that are less than one month, the writing must contain:

- parent's name
- designee's name
- children's names
- parent's signature with date

If the time period is not stated, it's assumed to be thirty days. The note can also describe the extent of the powers.

For periods of time between thirty days and six months, the note must also contain:

- address and telephone number of the parent
- address and telephone number of the designee
- date of birth of each child
- date of commencement or event that causes the designation to be active
- written consent of the designee
- statement that no court order bars the parent from designating
- notarization

If any of the extra elements necessary for the six-month writing are missing, the note is still good for thirty days so long as it contains the core elements.

It is unclear if the parent and the designee must both have their signatures notarized. The previous bill mandated notarization only by the parent or parents. It may be that this writing can be signed (without notarization) by the designee. But, when possible, designees should get their signature notarized in order to eliminate a potential issue.

Designees

Any adult can be designated. The person does not have to be a relative.

Person in Parental Relation

Designations confer the powers and responsibility of a "person in parental relation." This phrase is a legal term, which is defined in both the Public Health Law and the Education Law. The designation states that a "person designated by a parent pursuant to this title shall possess all the powers and duties of a person in parental relation pursuant to sections twenty-one hundred sixty-four and twenty-five hundred four of the public health law and sections two and thirty-two hundred twelve of the education law, unless otherwise specified in the designation." Such a person can perform all the actions listed in numerous statutes that refer to a "person in parental relation." *See* section 5-1555(1).

"Person[s] in parental relation" can enroll a child in school, be responsible for most schooling activities, like getting birth certificates for enrollment, receiving report cards, consenting to class trips. They do not get all the powers of a parent, just those listed in the

twenty or so statutes in the education law that empower a "person in parental relation."

The law amends the Public Health Law by adding designees to the definition of a "person in parental relation." A "person in parental relation" can consent (or refuse) immunization and routine medical care, including prescription medications, dental work, and mental health therapies. The law does not permit designees to consent to certain medical procedures, including major medical treatment as described in section 80.03 of the Mental Hygiene Law, electroconvulsive therapy, and the withdrawal of life sustaining medical care. In sum, a designee cannot consent to elective major medical procedures, which require the consent of the parent(s) or legal guardian.

School Enrollment

One limitation on the use of these writings concerns proof of school enrollment. Free tuition at a public school requires that the student reside in the school district. Residence must be proven to the school authorities. The new law specifically states that these writings cannot be used as proof of children's residency. The new law does permit designated caregivers to enroll children in school, but they must prove residency by other means.

In some school districts, authorities demand legal custody or legal guardianship to prove residency. Since persons who are designees should be able to enroll children in school, legal custody and guardianship are clearly not the only proofs of residency.

Proving residency requires sufficient evidence to overcome the presumption that children reside with their parents. Some school districts accept sworn statements by parents and caregivers as sufficient proof. Since this law implies that out-of-court writings should enable caregivers to assume educational responsibilities, it follows that sworn affidavits attesting to the residency of children, when accompanied by a proper designation, should be sufficient to prove residency.

Other Provisions

The new law limits the effect of a designation to a period of six months. Since the new law does not prohibit renewals, subsequent designations can repeatedly designate the same caregiver.

The designation is not "durable," the powers of a designee cease when a parent becomes incapacitated.

If there's a court order indicating that the parents are joint custodians, then both must sign the designation.

The law can be revoked at will by one parent, either orally or in writing. Notice can be to the designee or to the school or medical provider.

The law also covers "incapacitated persons" which refers to adult children who are unable to make decisions for themselves. For such persons, other statutes stipulate that a parent must become the legal guardian. This part of the new law will probably be disregarded and eventually deleted.

With this law a major change has been made to the Public Health Law. For the first time someone other than a parent or legal guardian can consent to "medical, dental, health and hospital services" for a child.

Gerard Wallace is a consultant to AARP NY and to the National Committee of Grandparents for Children's Rights on the legal issues facing non-parents raising children. From 2001 to 2003 he wrote a column on these issues for the *Elder Law Attorney* and he will once again be writing on these issues. See www.grandparentsrightslaw.com.

Bonus News 5

Changes Affecting Trust & Estate Law

2004 New York State Legislative Session

By Joshua S. Rubenstein

The 2004 legislative session saw significant activity affecting estate and trust planning and administration in New York. Important areas addressed include the unification of professional privileges, the termination of uneconomical trusts, the procedural and substantive requirements for guardianship proceedings, the appointment of attorney-executors, and the calculation of the New York State estate tax. The following provides a summary of each of these enactments, and their status as of press time.

Estates, Powers & Trusts Law (EPTL)

The EPTL has been amended by adding a new section, 7-1.19. This section allows any trustee or beneficiary of a lifetime or testamentary express trust, other than a wholly charitable trust, to apply to the surrogate's court for early termination, provided the court finds that (1) continuation of the trust is economically impractical, (2) the trust's early termination is not prohibited by the express terms of the disposing instrument, and (3) such termination would not defeat the specified trust purposes and would be in the best interests of its beneficiaries. Distribution shall be made among the current and presumptive remainder beneficiaries in such manner as the court determines. This change is effective immediately and applies to trusts whenever created.[1]

EPTL 10-10.1 has been amended to ensure that the language of the statute does not inadvertently create estate tax liability by limiting the permissible ascertainable standards that would override this savings statute (generally preventing trustees who are beneficiaries from exercising discretion in their own favor) to those enumerated in §§ 2041 and 2514 of the Internal Revenue Code.

The change is a result of the Governor's concern, after the 2003 amendment to EPTL 10-10.1, that the portion of the statute permitting other ascertainable standards might conflict with the federal tax law and inadvertently create a general power of appointment, to the detriment of a donee or trustee. This change is effective immediately.[2]

Insurance Law

Subsection (a) of Insurance Law § 1110 has been amended to authorize charities to issue gift annuities for cash and other property. Formerly, New York limited the assets charities were allowed to receive in exchange for a charitable gift annuity to cash and marketable securities. This change is effective immediately.[3]

Mental Hygiene Law

Section 81.03 of the Mental Hygiene Law (MHL) has been amended by adding "health care proxies" to the definition of "available resources" in subdivision (e), and by adding definitions of "life-sustaining treatment," "facility" and "mental hygiene facility" as new subdivisions (j), (k) and (l). This change is effective as of December 13, 2004 (90 days after enactment).[4]

Section 81.04 of the MHL has been amended to clarify that the jurisdiction of the surrogate's court over an Article 81 proceeding extends not just to persons who are residents of, or physically present in a county in which the proceeding is pending, but also to persons who have property in the county. This change is effective as of December 13, 2004 (90 days after enactment).[5]

MHL § 81.05 has been amended to clarify the location of venue when the alleged incapacitated person is in a facility. This change is effective as of December 13, 2004 (90 days after enactment).[6]

Section 81.06 of the MHL has been amended to allow institutions flexibility in identifying the person who acts on their behalf in commencing guardianship proceedings, by allowing the chief executive officer (CEO) to designate someone to assume this responsibility. Formerly, only the CEO could act in this capacity. This change is effective as of December 13, 2004 (90 days after enactment).[7]

Section 81.07 of the MHL has been amended to make substantial changes to the manner in which notice of a proceeding is to be given. This change is effective as of December 13, 2004 (90 days after enactment).[8]

Subsection (a)(2) of MHL § 81.08 has been amended to require that a petition identify the persons the petitioner intends to serve with notice of the

proceeding in order to facilitate the court evaluator's investigation. This change is effective as of December 13, 2004 (90 days after enactment).[9]

Subsection (a)(5) of MHL § 81.08 has been amended to require the petition to include any of the information required by § 81.21(b) when powers are sought to transfer a part of the alleged incapacitated person's property or assets to or for the benefit of another person. This change is effective as of December 13, 2004 (90 days after enactment).[10]

Section 81.09 of the MHL, dealing with the duties of the court evaluator, has been amended by assigning the evaluator additional duties. These include determining whether the alleged incapacitated person understands English or only another language, thus requiring an interpreter. It also provides the court with authority to appoint as court evaluator "any person including, but not limited to, the mental hygiene legal service in the judicial department where the person resides, a not-for-profit corporation, an attorney, physician, psychologist, accountant, social worker, or nurse, with knowledge of property management, personal care skills, the problems associated with disabilities, and the private and public resources available for the type of limitations the person is alleged to have." This change is effective as of December 13, 2004 (90 days after enactment).[11]

MHL § 81.10 has been amended to clarify that persons seeking relief under the article have the right to be represented by legal counsel of their choice. This change is effective as of December 13, 2004 (90 days after enactment).[12]

Subsection (f) of MHL § 81.11 has been amended to allow only an incapacitated person or such person's counsel the right to request a jury trial. This change is effective as of December 13, 2004 (90 days after enactment).[13]

Section 81.13 of the MHL has been amended to reduce the time for the court to issue its decision to within seven days of the hearing. This change is effective as of December 13, 2004 (90 days after enactment).[14]

MHL § 81.15 is amended to give the court the power to decide whether an incapacitated person should receive copies of the initial and annual reports. This change is effective as of December 13, 2004 (90 days after enactment).[15]

Section 81.16 of the MHL has been amended to provide that the order and judgment be entered and served within 10 days of its signing, and that the court evaluator, guardian or counsel for a person subject to a proceeding, explain an order or judgment in a manner that the person could reasonably be expected to understand. This change is effective as of December 13, 2004 (90 days after enactment).[16]

Subsection (a) of MHL § 81.21 has been amended to provide additional powers to a guardian to help enable the guardian to manage the person's estate, both during life and after death. This change is effective as of December 13, 2004 (90 days after enactment).[17]

Section 81.25 of the MHL has been amended to allow the court—in cases where the value of the estate is so great or for other sufficient reason for which the court determines it is inexpedient to require security in the full amount prescribed by law—to restrict some or all of the assets of an estate without further court order, and to require a bond in reduced amount. The statute accomplishes this by adding language almost identical to that of Surrogate's Court Procedure Act 803 (SCPA). This change is effective as of December 13, 2004 (90 days after enactment).[18]

Section 81.28 of the MHL has been amended to eliminate language referring to SCPA 2309, to clarify that the courts are not bound by the SCPA scheme in devising compensation for the guardian. This change is effective as of December 13, 2004 (90 days after enactment).[19]

Subsection (d) of MHL § 81.29 has been amended to provide the court with power to revoke durable powers of attorney in situations where the attorney-in-fact has breached his or her fiduciary duty. This change is effective as of December 13, 2004 (90 days after enactment).[20]

MHL § 81.30 has been amended to expand the requirements of the guardian's initial report. This change is effective as of December 13, 2004 (90 days after enactment).[21]

Section 81.31 of the MHL has been amended to permit the Mental Hygiene Legal Service to monitor the cases in which it has acted as counsel or court evaluator. This change is effective as of December 13, 2004 (90 days after enactment).[22]

Subsection (c) of MHL § 81.36 has been amended to permit the court to dispense with a hearing on an application for an order of modification increasing the powers of the guardian. This change is effective as of December 13, 2004.[23]

Not-For-Profit Corporation Law

Paragraph (b) of § 1401 of the Not-For-Profit Corporation Law has been amended to require owners of

private cemeteries, prior to removal of interred bodies, to provide notice not only to the next of kin but also to the county clerk and county historian and, in the case of buried veterans, the New York State Division of Veterans' Affairs. In the absence of next of kin, the amendment further authorizes, but does not require, cemetery owners to act as a guardian to ensure proper reburial. This change is effective immediately.[24]

Public Health Law

Section 18 of the Public Health Law has been amended to add a patient's distributees, if no personal representative has been appointed, and the attorney for a qualified person or the patient's estate, if he or she has a power of attorney, as a qualified person to have access to a patient's medical records. This change is effective immediately.[25]

Surrogate's Court Procedure Act

Subdivision 1 of SCPA 1105 has been amended to provide that public administrators of the counties comprising the city of New York shall receive at least two-thirds of the amount paid to the judges of the surrogate's court of such counties. This change is effective as of February 27, 2005 (30 days after enactment).[26]

Subdivisions 2 and 3 of SCPA 2307-a have been amended to provide that a testator's written acknowledgment of disclosure relating to attorney-executors' fees and commissions must be separate from the will, but may be annexed to it. In addition, the acknowledgment form has also been amended to include a statement providing that absent the disclosure acknowledgment, an attorney serving as executor is entitled only to one-half the commission he or she would otherwise be entitled to receive. This change is effective immediately.[27]

Tax Law

Article 10 of the Tax Law, dealing with transfer, inheritance, and estate taxes of residents dying prior to September 1, 1930, has been repealed. Article 10-A, dealing with such taxes of nonresidents dying prior to September 1, 1930, and Articles 10-B and 10-C, dealing with such taxes of residents and nonresidents dying after August 31, 1930, and prior to April 1, 1963, appear not to have been repealed. This change is effective immediately but does not affect any refund applications.[28]

Subsection (b) of Tax Law § 952 has been amended to change the calculation of the estate tax for estates with property located both in New York and in another state. Specifically under this section, if a resident's estate includes real or tangible personal property having an actual situs outside of New York, the tax imposed shall be reduced only by "an amount determined by multiplying the maximum amount of the federal credit for state death taxes by a fraction, the numerator of which is the decedent's federal gross estate reduced by his or her New York gross estate and denominator of which is his or her federal gross estate," and no longer by however much is claimed by other states, if that is less. This change is effective immediately for estates of decedents dying on or after January 1, 2002.[29]

Subsection (b) of § 960 of the Tax Law has been amended to extend to nonresidents the same relief afforded to residents under Tax Law § 952(b), as amended. This change is effective immediately for estates of decedents dying on or after January 1, 2002.[30]

Subsection (b) of Tax Law § 976 has been amended by changing the date on which interest begins to run for late estate tax payments. Interest for late estate tax payments will now begin to run from the original due date for filing the estate tax return and not from the date of the decedent's death. This change is effective immediately for the estates of decedents dying on or after February 1, 2000.[31]

Endnotes

1. 2004 N.Y. Laws ch. 359, A10967, S5166 (signed on August 10, 2004).
2. 2004 N.Y. Laws ch. 82, A10962, S6308 (signed on May 18, 2004).
3. 2004 N.Y. Laws ch. 199, A10286, S5987A (signed on July 20, 2004).
4. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
5. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
6. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
7. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
8. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
9. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
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21. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
22. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
23. 2004 N.Y. Laws ch. 438, A8838A, S6830A (signed on September 14, 2004).
24. 2004 N.Y. Laws ch. 675, A3163A, S1465A (signed on November 3, 2004).
25. 2004 N.Y. Laws ch. 634, A8602-B, S4964A (signed on October 26, 2004).
26. 2004 N.Y. Laws ch. 751, A6619, S147-A (signed on January 28, 2005).
27. 2004 N.Y. Laws ch. 709, A11127, S6986 (signed on November 16, 2004).
28. 2004 N.Y. Laws ch. 60, A9560-B, S06060 (signed on August 20, 2004).
29. 2004 N.Y. Laws ch. 60, pt. I, § 5, A9560-B, S06060 (signed on August 20, 2004).
30. *Id.*
31. 2004 N.Y. Laws ch. 60, pt. I, § 2, A9560-B, S06060 (signed on August 20, 2004).

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