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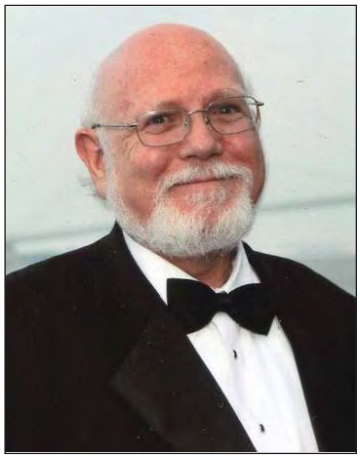
Message from the Chair



David Goldfarb

We have completed our Section's Lobby Day in Albany, and we were successful in eliminating all items of concern in the final New York State budget bill. We had a number of meetings with members of the Assembly, the State Senate, their staff and representatives of the Executive. We concentrated on three issues in the governor's proposed budget bills: elimination of Medicaid spousal refusal for community based care, requiring a nursing home level of care for participation in MLTC home care, and a proposal to allow banks to freeze accounts where there is suspected abuse.

I would like to thank the three teams from our Section consisting of **Jeff Asher, Tara Anne Pleat, Richard Weinblatt, Rene Reixach, Matt Nolfo, Tammy Lawlor, Deep Mukerji, JulieAnn Calareso, Marty Hersh, Judie Grimaldi** and **Britt Burner**. I would also like to thank our team leaders **Kevin Kerwin** from the State Bar and **Jane Preston** and **Josh Oppenheimer** from Greenberg Traurig. **Ron Kennedy** from the State Bar also joined us when we discussed with legislators the NYSBA Power of Attorney proposal which is now a State Bar priority. In other legislative matters **Ira Salzman, Patty Bave** and **Fern Finkel** continue to work on responses to the proposed legislation that would prohibit medical facilities from bringing guardianship proceedings in order to facilitate collections.

Our CLE program and reception at the Annual Meeting in January was a great success thanks to co-chairs **Sal DiCostanzo** and **James Barnes**. A special thank you to our speakers **Richard Marchese, Fern Finkel**, and **David Okrent** who did the 2017 Updates; **Richard Weinblatt, Bruce Birnbaum** and **David DePinto** who spoke on Annuities; and **Amy Guss** who spoke on IRAs, Beneficiary Designations and Planning Considerations. And a special thanks to **CaringKind** and **RDM Financial Group** who sponsored our reception at the Warwick Hotel. Our Section award recipient this year was Jeffrey A. Asher for his actions in furtherance of the rights of the elderly and persons with disabilities, and the recipient of the **Joel K. Asarch** Scholarship was law student **Jessica M. Klersy**.

With the potential changes in health care coverage both at the federal and state level these can be stressful and trying times for our clients. I look forward to working with our Section committees and Section members to protect the rights of our clients.

David Goldfarb

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Message from the Co-Editors-in-Chief

Judith Nolfo McKenna

Some things are worth the wait. This edition of the *Journal* was delayed, in part to a wonderful article titled "Say What? The Affordable Care Act, Medicare and Hearing Aids." We waited (with many of you) for the future of the Affordable Care Act under the new administration. On May 4th, the House narrowly approved their version of a replacement plan, but it is widely viewed as unacceptable in the Senate. So, the ACA remains alive, and we made the decision to forge ahead. Professor Mary Helen McNeal's article gives us an excellent overview of age-related hearing loss, and a detailed study of hearing aids under the ACA and other insurance coverage. As the majority of our clients age, hearing loss is an inevitable fact, and we thank Professor McNeal for this wonderful and timely submission.

This edition of the *Journal* contains the report of the Nominating Committee provided by Immediate Past Chair JulieAnn Calareso, advising the Section of the honorees of our awards as well as the Slate of Officers and District Delegates who were elected at the Annual Meeting in January. The Annual Meeting was co-chaired by James Barnes and Sal Di Costanzo and they have provided us with an excellent summary of the events and educational offerings of the day.

The co-chairs of our legislation committee, Jeff Asher and Deep Mukerji, provide a glimpse into the issues addressed as part of this year's budget process as well as other items of interest. James Sarlis contributed a unique perspective on addressing medication errors impacting the senior population. For those newer to the practice of law, Regina Kiperman and Naomi Levin provide a primer of the process courts use when a distributee of a probate estate is under a legal disability.

Tara Anne Pleat

This *Journal* is rounded out by Deidre M. Baker's article on securing "Immediate Need" Medicaid, and Bob Mascali's article addressing the impact that ABLE accounts might have on Special Needs Trust practice. Both articles address recent changes in the law and the corresponding influence on our practices.

On another front, this edition marks the final edition under our current Chair, David Goldfarb. We are so grateful for his leadership and his wisdom. It has been a wonderful year, and we wish David some well-deserved peace and quiet from the constant demands the Chair faces each day.

The Summer edition of the *Journal* will welcome Marty Hersh as the incoming chair, and under his leadership we will look forward to another exciting year. We hope all of you will join Marty at his first official Section meeting this summer in Lake Placid. For those of you who have never been, Tara and I can attest to the pristine beauty and peace of the area. You can visit the Olympic Village, and feast on some of the unique and delicious culinary offerings (and craft beers) that Lake Placid has to offer.

In this edition, we are spotlighting Bob Kurre as our Senior Member together with his Committee, the Practice Management Committee. Scott Silverberg is the subject of our New Member Spotlight.

As is our rallying cry, we are in need of submissions for the Fall *Journal*, we are fortunate to say that the Summer *Journal* is spoken for! Fall articles will be due by August 1st for submission to the Fall *Journal*. Please keep them coming!

Tara and Judy

We invite you to participate in our private online professional Community for the Elder Law and Special Needs Section. We want all of you to share your experiences and your knowledge while also being free to ask questions of others in the Section and participating in the intellectual discussion we hope to generate. You can find our Community at www.nysba.org/eldercommunity.

An Honor to Honor Two Distinguished Persons

By Nominating Committee Chair JulieAnn Calareso

Our Section's Nominating Committee, of which I was lucky enough to serve as Chair, was hard at work in the months leading up to the Section's Annual Meeting. Britt Burner, Esq., Laurie Menzies, Esq., Neil T. Rimsky, Esq., Patricia Shevy, Esq., Richard A. Weinblatt, Esq. and I were tasked with nominating persons for Section awards, and also had the distinct honor of presenting a slate of Officers and District Delegates to the membership. Another esteemed group of individuals were tasked with awarding this year's Elder Law and Special Needs Section's Hon. Joel K. Asarch Scholarship.

The Elder Law and Special Needs Section has a tradition of bestowing upon deserving persons awards in grateful acknowledgment of their contributions to our Section. This year, the Section's Nominating Committee was proud to honor Jeffrey A. Asher, of the Law Offices of Jeffrey A. Asher, PLLC. Our Section recognized Jeff, with gratitude, for his actions in furtherance of the rights of the elderly and persons with disabilities. Jeff, a member of our Section for over two decades, has served in a variety of roles, both formal and informal, and has always been, and remains, willing to take on a task or work with a group to advance the interests of the elderly or disabled.

This past year, in particular, Jeff has represented our Section on two very important task force efforts. First, Jeff led our Section's work group on the reformation of the Power of Attorney. He was instrumental in collaborating with the Bar Association and advancing proposed reforms to the Power of Attorney statute. Jeff's collaboration with others has led to the Bar Association making Power of Attorney reform one of its legislative priorities this year. Jeff provided valuable input and insight into how and why reformation of the statute was so imperative to the elderly and those with disabilities, and he eloquently and strategically presented all of the opinions and positions advanced by our Section. His work on this important issue was invaluable to our Section members and those we serve.

After tackling the Power of Attorney issue from the Elder Law and Special Needs attorney's perspective, Jeff then stepped up and offered to be our Section's liaison with the Trusts and Estates Law Section as it presses for the adoption of the Uniform Trust Code. Jeff articulated our Section's position on some of the proposals put forth, and was able to advocate for modifications that would benefit the elderly and those with disabilities who sought to use trusts in their planning. Jeff's diplomacy and advocacy has positioned our Section to be able to support the anticipated proposal of a UTC adoption, and we will be comfortable in knowing our client's and our own interests are protected.

The Elder Law and Special Needs Section was proud to present this award to Jeffrey A. Asher, in grateful recognition of actions in furtherance of the rights of the elderly and persons with disabilities.

In addition to the "fun" part of the Nominating Committee's work, our Committee also served an important role in presenting a slate of Officers to the Members of the Section for ratification. The Members elected Officers for terms beginning June 1, 2017:

Chair:	Marty Hersh, Esq.
Chair-Elect:	Judith Grimaldi, Esq.
Vice Chair:	Tara A. Pleat, Esq.
Secretary:	Matthew J. Nolfo, Esq.
Treasurer:	Deepankar Mukerji, Esq.

In addition, we nominated persons to fill district delegate positions for terms beginning June 1, 2017:

For the 4th Judicial District: Katherine Carpenter, Esq. (initial term)

For the 6th Judicial District: Karen Jean McMullen, Esq. (second term)

For the 9th Judicial District: Sara Meyers, Esq. (second term)

For the 11th Judicial District: David I. Kronenberg, Esq. (second term)

Fortunately, the Members voted unanimously to ratify the nominations presented by the Nominating Committee.

As the Nominating Committee was completing its work, the Asarch Scholarship Committee had a job to do—select an award recipient. Our Section was fortunate this year to be able to carry on our annual tradition of bestowing one deserving second- or third-year law student with the Hon. Joel K. Asarch Elder Law and Special Needs Section Scholarship. The New York Bar Foundation awards this scholarship, established by The Foundation through a gift from the Elder Law and Special Needs Section of the New York State Bar Association. The $2,500 scholarship is awarded to a second year or third-year law student who is enrolled in a law school in the State of New York and is actively participating in an Elder Law Clinic at the school during the academic year, or performs other substantial efforts which demonstrate interest in the legal rights of the elderly or the practice of elder law. A preference is given to a student who demonstrates a present and permanent physical or mental disability that substantially limits one or more of the major life activities of the individual, and to a student who demonstrates financial need.

This year, our recipient was Jessica Klersy. Ms. Klersy is a third year law student at Touro Law and has excelled

in her studies. She herself has a hearing disability and truly embodies the qualities of an Asarch scholarship recipient. She has interned at an elder law firm, participated in an elder law clinic in law school, and is a pro bono scholar who will be working in the public interest this spring semester at Nassau Suffolk Law Services.

The award was established in memory of the late Joel K. Asarch, a Nassau County Supreme Court Justice who spent a large portion of his time on the bench adjudicating guardianship cases and advocating for those who could not help themselves. Judge Asarch was a frequent lecturer at our Section meetings, and his premature death was a loss to New York jurisprudence. Our Section and his family were pleased to be able to establish this award in his honor with the assistance of the New York State Bar Foundation. If you know of a deserving law student, keep your eyes open for the 2017-2018 award application that will come out this fall!

This year, our Section was proud to have our Section Award recipient, Jeffrey A. Asher, and our Asarch recipient, Jessica Klesey, accept their awards at our Annual Meeting on Tuesday, January 24, 2017, during the Association's Annual Meeting in New York City.

Committee Spotlight: Practice Management Committee

The Practice Management Committee focuses on helping members of the Elder Law and Special Needs Section run their law practices efficiently. Members have conference calls about best practices, challenges being faced, and technological advancements among other related practices.

By sharing information in this manner, members of the committee are able to benefit from the experiences of other practitioners, avoid common pitfalls, educate themselves about ethical issues related to running a law practice, and learn about the most effective technologies.

ARTICLE

SAY WHAT? THE AFFORDABLE CARE ACT, MEDICARE, AND HEARING AIDS

MARY HELEN MCNEAL*

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* Professor of Law and Director, Elder Law Clinic, Syracuse University College of Law. This project was supported by a research grant from the Syracuse University College of Law, for which I am grateful. Many thanks to Christine Demetros, J.D. and M.L.S., Barclay Law Library, Assistant Director of Student Learning, Brian Frederick, SUCOL '15, and Colleen Gibbons, Ph.D. and SUCOL '17, for their outstanding research assistance. An earlier version of this Article was presented at the Clinical Law Review Writer's Workshop in the fall of 2014, and I am thankful for participants in the small group for their insights and helpful comments. Thanks also to the Syracuse University College of Law faculty who shared their thoughts at a works-in-progress session before this project took shape. Additional thanks go to Amy Campbell, Karen Doherty, David Gayle, and Diane Hoffman for comments on an earlier draft of this Article.

One of the most common consequences of aging is hearing loss, representing the third most prevalent chronic medical condition among seniors. Empirical evidence links hearing loss to a variety of other medical conditions, including depression, falls, and cognitive problems. Additionally, there is a demonstrated relationship between hearing loss and dementia. And yet, most insurance programs do not cover the cost of hearing aids. Even Medicare, the federal insurance program for those aged sixty-five and over, statutorily excludes coverage of hearing aids, which cost between $2,000 and $7,000 a pair.

The Affordable Care Act ("ACA"), reflecting a radical departure from the goals embodied in the 1965 Medicare law, presents a lens for examining this issue anew. Numerous statutory provisions and the philosophy embodied in the ACA are useful catalysts for reform of the Medicare law. This Article elaborates on one specific provision of the ACA that could be utilized to authorize insurance coverage under the Medicare program. It also addresses other provisions in the ACA, including required preventive screenings and selected "Essential Health Benefits," that, absent the Medicare exclusion, arguably would provide for such coverage. Acknowledging the tension between the ACA and Medicare law, this Article argues that the ACA is a useful tool for amending the Medicare law and eliminating this antiquated coverage exclusion. Finally, it suggests strategies for effectuating that result.

"If we are lucky, we will all grow old. But how frightening to grow old and not be able to see clearly, hear distinctly . . . because we cannot afford the necessary medical appliances to aid our failing faculties."[1]

I. Introduction

Age-related hearing loss is the third most prevalent chronic medical condition among older adults.[2] And yet, most insurance programs do not

[1] H.R. Rep. No. 78-385, at VI (1976).

[2] Patricia A. Tun et al., *Aging, Hearing Acuity, and the Attentional Costs of Effortful Listening*, 24(3) Psychol. & Aging 761, 761–66 (2009). Hearing loss affects approximately forty-nine percent of those aged seventy and over, Derrick Lopez et al., *Falls, Injuries from Falls, Health Related Quality of Life and Mortality in Older Adults With Vision and Hearing Impairment—Is There a Gender Difference?*, 69(4) Maturitas 359, 359 (2011), and twenty-five to fifty percent of those sixty-five and older, *Quick Statistics About Hearing*, Nat'l Inst.

cover the cost of hearing aids. The devices are expensive, costing, in 2014, from $2,200 to more than $7,000 per pair, depending on the features and quality of the devices.[3] Unfortunately, Medicare, which provides health insurance to 46.3 million people ages sixty-five and over,[4] does not cover hearing aids because hearing aids, eyeglasses, and other similar devices were statutorily excluded in 1965 when the Medicare law was enacted.[5] Yet many Medicare beneficiaries cannot afford to pay for hearing aids out of pocket.[6] An increasingly small percentage of seniors have additional coverage through employer-sponsored retiree health plans, which occasionally offer limited coverage for hearing aids. Coverage in the Medicaid program, a joint federal-state partnership providing medical insurance for people with low incomes, also is quite limited and varies from state to state.

The failure of Medicare to provide any coverage for the costs of hearing aids, as well as the limited coverage provided in other insurance plans, is striking given the negative consequences of age-related hearing loss. Recent research demonstrates a relationship between hearing loss and dementia.[7] Hearing loss often results in increased isolation[8] and depression,[9] which frequently contribute to additional medical problems. There are demonstrated correlations between hearing loss and declines in "health related quality of life,"[10] increased incidents of falling,[11] accelerated cognitive decline,[12] and exacerbated age-related memory deficits.[13] Given the relationship between hearing loss and other medical problems, it is critical to develop advocacy

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ON DEAFNESS & OTHER COMMC'N DISORDERS, http://www.nidcd.nih.gov/health/statistics/Pages/quick.aspx [https://perma.cc/KT94-BJ7C] (last updated April 20, 2015).

[3] Ian Cropp, *Why Do Hearing Aids Costs So Much?*, AARP (Oct. 3, 2014), http://www.aarp.org/health/conditions-treatments/info-05-2011/hearing-aids-cost.html [https://perma.cc/R98L-SKZJ]. Over seventy-five percent of patients are fitted for two hearing aids. FREDERICK N. MARTIN & JOHN GREER CLARK, INTRODUCTION TO AUDIOLOGY 371 (12th ed. 2015). The average costs of mid-level hearing aids range from $4,400 to $4,500 a pair. Cropp, *supra* note 3.

[4] Juliette Cubanski et al., *A Primer on Medicare: Key Facts about the Medicare Program and the People it Covers*, KAISER FAM. FOUND. (Mar. 20, 2015), http://kff.org/medicare/report/ a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/ [https://perma.cc/C9GT-ZWE4].

[5] *See* S. REP. NO. 89-404, at 1989 (1965).

[6] Half of all people on Medicare in 2013 had incomes below $23,500 per year. *See* Cubanski et al., *supra* note 4.

[7] *See* Frank R. Lin et al., *Hearing Loss and Incident Dementia*, 68(2) ARCHIVES OF NEUROLOGY 214, 214–20 (2011).

[8] *See* Frank R. Lin et al., *Hearing Loss and Cognition in the Baltimore Longitudinal Study of Aging*, 25(6) NEUROPSYCHOLOGY 763, 768 (2011) ("Communication impairments caused by hearing loss can lead to social isolation and loneliness in older adults.").

[9] *See* Bamini Gopinath et al., *Hearing Handicap, Rather than Measured Hearing Impairment, Predicts Poorer Quality of Life Over 10 Years in Older Adults*, 72 MATURITAS 146, 146 (2012).

[10] *See* Lopez et al., *supra* note 2, at 359.

[11] *See id.*; *see also* Wade Chien & Frank R. Lin, *Prevalence of Hearing Aid Use Among Older Adults in the United States*, 172(3) JAMA INTERNAL MED. 292, 292 (2012).

[12] *See* Frank R. Lin et al., *Hearing Loss and Cognitive Decline Among Older Adults*, 173(4) JAMA INTERNAL MED. 293, 293 (2013).

[13] *See generally* Tun et al., *supra* note 2.

strategies to assist seniors forced either to pay for hearing aids out of pocket or to simply go without.[14]

The passage of the Affordable Care Act ("ACA")[15] offers an exciting opportunity for such hearing aid advocacy. The ACA does not alter basic Medicare coverage policies nor eliminate the statutory exclusion of coverage of hearing aids.[16] However, if one examines the ACA in the absence of current Medicare law, numerous provisions could otherwise be interpreted to mandate insurance coverage of hearing screenings and hearing aids. One provision in the ACA authorizes the Secretary of Health and Human Services to test innovative service delivery models that could be utilized to provide coverage for hearing aids.[17] Other relevant provisions include those requiring general preventive screenings, the "Welcome to Medicare" visit, annual preventive visits, and the "Essential Health Benefit" provisions requiring depression screenings and rehabilitative and habilitative services. Thus, the ACA provides an opportunity to deliver coverage under the Medicare program on an experimental basis and a platform from which to advocate amending the Medicare statute, thereby promoting consistency with both the preventive care philosophy and provisions of the ACA. This Article will expound on these arguments for insurance coverage of hearing aids, focusing primarily on Medicare, the largest provider of health insurance for seniors,[18] and will suggest strategies for effectuating that result.

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[14] While insurance coverage for hearing aids is one way to improve hearing health, other proposals have been generated. Most notably, the President's Council of Advisors on Science and Technology ("PCAST"), acknowledging the high cost of hearing aids, the absence of adequate insurance coverage, and the failure of costs to decline as other technologies become less expensive, made numerous recommendations to increase the availability of hearing devices. *See generally* Letter from PCAST to Barack Obama, President of the United States (Oct. 2015), https://www.whitehouse.gov/sites/default/files/microsites/ostp/PCAST/pcast_hearing_tech_letterreport_final3.pdf [https://perma.cc/3243-7EJF]. PCAST's recommendations include the following: (1) Permit the sale of hearing aids over the counter; (2) Reduce regulatory controls; (3) Modify Federal Trade Commission regulations to encourage competition among manufacturers and dispensers; and (4) Permit the sale of Personal Sound Amplification Products ("PSAPs") for the use of hearing assistance. One particular recommendation included the withdrawal of the Federal Drug Administration's November 7, 2013 draft guidance on PSAPs. *Id.* at 8. This guidance has already been withdrawn, and a request for comments on the guidance has been issued. *See generally* Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products, 83 Fed. Reg. 786 (Jan. 7, 2016).

[15] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

[16] *See* 42 U.S.C.A. § 1395y(a)(7) (West 2015); *see also* Michael J. DeBoer, *Medicare Coverage Policy and Decision Making, Preventive Services, and Comparative Effectiveness Research Before and After the Affordable Care Act*, 7 J. HEALTH & BIOMEDICAL L. 493, 495 (2012).

[17] 42 U.S.C.A. § 1315a (a)(1) (West 2015) ("The purpose of the CMI [Center for Medicare and Medicaid Innovation] is to test innovative payment and service delivery models to reduce program expenditures under the applicable subchapters while preserving or enhancing the quality of care furnished to individuals under such subchapters. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).").

[18] Cubanski et al., *supra* note 4.

Part II provides an overview of those affected by age-related hearing loss, a description of sensorineural hearing loss, and a summary of corrective devices and their usage. Part III outlines the costs of hearing aids, summarizes health insurance options for seniors, and offers a glimpse of life for seniors living in poverty. Part IV addresses the relationship between untreated hearing loss and other medical problems among the elderly. Part V argues that the ACA provision authorizing innovative projects to improve quality and reduce costs can and should be used to expand coverage of hearing aids. It also identifies several other sections of the ACA that are useful catalysts for advocating amendment of the Medicare law to provide this coverage. Additionally, it addresses coverage under the Medicaid program and private insurance policies in light of the ACA. Finally, Part VI recommends specific strategies to effectuate this result. Given an estimated twenty-three million older adults with untreated hearing loss,[19] providing insurance coverage for hearing devices is imperative.[20]

II. Overview of Age-Related Hearing Loss

A. Wide-Spread Prevalence of Presbycusis

Age-related hearing loss, known as presbycusis,[21] affects an estimated twenty-five to forty percent of the U.S. population sixty-five and older.[22] Its prevalence rises with age, with an estimated forty-nine percent of those seventy and older experiencing hearing loss,[23] and an estimated eighty percent of those eighty and older experiencing it.[24] In the United States, the preva-

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[19] Chien & Lin, *supra* note 11, at 293.

[20] This article addresses presbycusis, age-related hearing loss, and not the concerns of those who are born into a deaf community. *See, e.g.*, Megan A. Jones, *Deafness as Culture: A Psychological Perspective*, 22(2) Disability Stud. Q., 51–60 (2002). Those who become deaf later in life may be characterized as "physically deaf" and those who are born into a deaf community as "culturally Deaf." Many people who become deaf later in life are culturally hearing; their culture includes spoken language, with their thoughts, speech and opinions centered around the world they inhabited prior to becoming deaf. *Id.* For some but not all of those who are culturally Deaf, their native language is signed, not spoken. *Id.* These communities have varying perspectives and concerns; however, the concerns of the culturally Deaf community regarding hearing devices and insurance are beyond the scope of this article.

[21] *See generally* George A. Gates & John H. Mills, *Presbycusis*, 366 Lancet 1111 (2005).

[22] *Quick Statistics About Hearing*, *supra* note 2.

[23] Lopez et al., *supra* note 2, at 359; *see also* Heather E. Whitson & Frank R. Lin, *Hearing and Vision Care for Older Adults: Sensing a Need to Update Medicare Policies*, 321(17) JAMA 1739, 1739 (2014) (stating that "[t]he prevalence of hearing loss doubles with every age decade").

[24] Roger Chou et al., *Screening Adults Aged 50 Years or Older for Hearing Loss: A Review of the Evidence for the U.S. Preventive Services Task Force*, 154(5) Annals Internal Med. 347, 347 (2011). Different studies report different statistics, with variations likely attributable to varying definitions of hearing impairment and age, and different methods of assessment, including some subjective testing. *See id.* at 354. Some currently fear we face an impending epidemic of hearing impairments. *See, e.g.*, *Untreated Hearing Loss in Adults—A*

lence of hearing loss has been found to be higher among men.[25] A study of participants with an average age of seventy-eight found the incidence of hearing loss was approximately thirty percent among males and thirteen percent among females.[26] Hearing loss prevalence was higher among study participants with hypertension, diabetes, and heavy tobacco use.[27]

Despite the high rate of presbycusis, fewer than one in three U.S. adults aged seventy and older who could benefit from hearing aids have ever used them.[28] Hearing aids are expensive, with prices of fitted models ranging from approximately $2,200 to over $7,000 per pair.[29] Other impediments to obtaining a hearing device include stigma, negative associations with age and disability, and cosmetic concerns.[30] Many people deny their hearing loss, particularly because age-related hearing loss happens so gradually.[31] The average time between initial diagnosis and treatment is over ten years.[32] Hearing loss statistics are similar in other western countries.[33] World- wide, there is a noticeable correlation between hearing aid use and level of

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Growing National Epidemic, AM. SPEECH-LANGUAGE-HEARING ASS'N, http://www.asha.org/aud/articles/untreated-hearing-loss-in-adults/ [https://perma.cc/9RDL-2FCR].

[25] Yuri Agrawal et al., *Prevalence of Hearing Loss and Differences by Demographic Characteristics Among U.S. Adults*, 168(14) JAMA INTERNAL MED. 1522, 1525 (2008).

[26] Lopez et al., *supra* note 2, at 361. Males are affected more at high sound frequencies, STANLEY A. GELFAND, ESSENTIALS OF AUDIOLOGY 193 (3rd ed. 2009), with women showing greater hearing loss in the low frequencies, DEBRA BUSACCO, AUDIOLOGIC INTERPRETATION ACROSS THE LIFESPAN 135 (2010).

[27] Agrawal et al., *supra* note 25, at 1525.

[28] *Quick Statistics About Hearing*, *supra* note 2. According to the Hearing Loss Association of America ("HLAA"), eighty percent of those who could benefit from hearing aids do not get them. *Hearing Health Care and Insurance*, HEARING LOSS ASS'N AMERICA, http://www.hearingloss.org/content/hearing-health-care-and-insurance [https://perma.cc/9FCC-JEN5]. Of those between ages twenty to sixty-five who could benefit from hearing aids, only sixteen percent have ever used them. *Quick Statistics About Hearing*, *supra* note 2.

[29] Cropp, *supra* note 3.

[30] Mark Ross, *Why People Won't Wear Hearing Aids*, REHABILITATION ENGINEERING RES. CTR. ON HEARING ENHANCEMENT, http://www.hearingresearch.org/ross/hearing_aids/why_people_wont_wear_hearing_aids.php [https://perma.cc/J3SX-K969] (last updated July 1, 2013) (explaining that those with hearing loss often choose not to obtain or wear hearing aids due to societal and public attitudes around them; such attitudes may include age- or disability-related stigma, the perception that hearing aids are not worth the hefty price tag, or the belief that hearing aids simply will not be effective).

[31] *See, e.g.*, Susan Seliger, *Why Won't They Get Hearing Aids?*, N.Y. TIMES: NEW OLD AGE (Apr. 5, 2012, 11:53 AM), http://newoldage.blogs.nytimes.com/2012/04/05/why-wont-they-get-hearing-aids/?_php=true&_type=blogs&_r=2 [https://perma.cc/QH6J-CVJR]; Samuel Trychin, *Why Don't People Who Need Them Get Hearing Aids*, U. FLORIDA (2003), http://users.clas.ufl.edu/mcolburn/Web-links/Nursing%20Lecture/Why%20Don't%20People%20Who%20Need%20Them%20Get%20Hearing%20Aids.htm [https://perma.cc/X6U3-DSZL].

[32] *Untreated Hearing Loss in Adults—A Growing National Epidemic*, *supra* note 24.

[33] *See, e.g.*, *Seniors*, SPEECH-LANGUAGE & AUDIOLOGY CAN., http://sac-oac.ca/public/seniors [https://perma.cc/KJ87-6JWS]; Francesco Cacciatore et al., *Quality of Life Determinants and Hearing Function in an Elderly Population: Osservatorio Geriatrico Campano Study Group*, 45(6) GERONTOLOGY 323, 323 (1999) (noting the very high prevalence of hearing impairment among the elderly in Italy). It is difficult to compare presbycusis rates around the world due to incomplete data, varying thresholds for defining hearing impairment, and the use of variable age groups. *See* Colin Mathers et al., *Global Burden of Hearing Loss in the Year 2000* 2–6 (World Health Org., Geneva, GBD 2000 Working Paper, 2003), http://www.who.int/

government assistance.[34] For example, in Australia, which has a high subsidy rate, nearly forty percent of the hearing-impaired population uses hearing aids.[35] In Europe, the highest rates of hearing aid use are in Denmark, Norway, the United Kingdom, the Netherlands, and Sweden—all countries with high subsidy rates.[36] Use has been found to correlate not only with standard of living, but also with "accessibility to hearing health care, subsidy levels, and general historical factors."[37] Evidence that the level of subsidy increases hearing aid use in other Western countries offers useful lessons for the United States as it explores the ramifications of untreated presbycusis.

B. Hearing Loss Basics

Presbycusis is a sensorineural hearing loss caused by cochlear[38] and/or neural damage.[39] It is the result of various kinds of physiological degeneration caused by the normal aging process plus the accumulated effects of noise exposure, chemicals (particularly from medications), medical disorders and their treatment, and genetics.[40] Both cochlear and neural damage are permanent; neither medicine nor surgery can replace missing or damaged

healthinfo/statistics/bod_hearingloss.pdf [https://perma.cc/C2KL-C3WU]. Consequently, it is also difficult to compare hearing aid use. *See, e.g.*, Nikolai Bisgaard, *An International Perspective*, *in* INST. OF MED. & NAT'L RESEARCH COUNCIL, HEARING LOSS & HEALTHY AGING: WORKSHOP SUMMARY 39, 39–42 (2014), http://www.nap.edu/read/18735/chapter/1#v [https://perma.cc/44UE-96PW].

[34] *See* Bisgaard, *An International Perspective*, *supra* note 33, at 40–41; *see also* Nikolai Bisgaard, *Hearing Industry Perspectives for EU Funded Hearing Research*, HEARCOM (2009), http://www.hearcom.info/lenya/hearcom/authoring/about/DisseminationandExploitation/Workshop/5_Nikolai_Bisgaard_Industry-perspectives.pdf [https://perma.cc/GQC7-X3HJ] (presentation from the Workshop on Hearing Screening and New Technologies).

[35] Bisgaard, *Hearing Industry Perspectives for EU Funded Hearing Research*, *supra* note 34, at 9.

[36] *See id.* at 11; *see also* Christine Cassel et al., *Policy Solutions for Better Hearing*, 315(6) JAMA 553, 553 (2016) (noting that hearing devices are included in basic health coverage in the United Kingdom, Denmark, and Switzerland).

[37] Bisgaard, *An International Perspective*, *supra* note 33, at 40. In developing countries, the usage rate is less than one percent. Mathers et al., *supra* note 33, at 14. As one industry expert stated, "If you live in a developing country and get some money, hearing aids are not the first thing you think about." Bisgaard, *An International Perspective*, *supra* note 33, at 40.

[38] The cochlea is the part of the inner ear that translates noise vibrations into nerve im- pulses, which are then sent to the brain. *Cochlea*, FREE MED. DICTIONARY, http://medical-dictionary.thefreedictionary.com/cochlea [https://perma.cc/C4M3-NHYQ].

[39] GELFAND, *supra* note 26, at 159; *see also* BUSACCO, *supra* note 26, at 3.

[40] GELFAND, *supra* note 26, at 186, 193. Hearing loss from chemicals is known as ototoxicity. *See* BUSACCO, *supra* note 26, at 131 ("Elderly adults tend to take numerous medications for chronic health conditions, which can result in ototoxicity."). Audiologists have identified various types of presbycusis, with some seniors having more than one type. For a full discussion of the various types, see GELFAND, *supra* note 26, at 194–96.

hair cells, and neurons do not regenerate.[41] The degree of hearing loss ranges from mild to profound[42] and may be unilateral or bilateral.[43]

Sensorineural hearing losses due to presbycusis typically result in hearing loss in the higher frequencies. High frequency acoustic cues in speech are necessary for understanding most consonant sounds and higher octaves; with high frequency hearing loss, certain sounds are rendered barely audible or inaudible.[44] Therefore, the most common complaint of those with presbycusis is that they can hear speech, but that it is unclear or hard to understand. Speech is even harder to decipher when noise or competing sounds are present.[45]

Seniors also may experience mixed hearing loss, a combination of a sensorineural loss and conductive loss in the same ear. "Conductive" hearing loss impairs the transmission of sounds from the environment to the cochlea, resulting in a weaker signal and therefore diminished volume.[46] Although the conductive portion of the hearing loss can often be treated with medical and/or surgical intervention or amplification devices,[47] the sensorineural loss will remain.[48]

C. Treatments for Age-Related Hearing Loss

The first step in evaluating potential presbycusis is a hearing screening during a routine physical. If a senior fails the screening, the physician typically refers the patient to an audiologist or otologist, who conducts a diag-

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[41] Gelfand, *supra* note 26, at 159; *see also* Busacco, *supra* note 26, at 3 ("For this type of hearing loss, there is usually no medical or surgical intervention to restore hearing sensitivity to within normal limits.").

[42] Busacco, *supra* note 26, at 3. For further discussion of how hearing loss is measured, see *Hearing and Hearing Loss*, Am. Acad. Audiology, www.howsyourhearing.org/hearing-loss.html [https://perma.cc/3ZSD-YHTU] (indicating that hearing loss is measured in decibels: the higher the decibel number, the greater the degree of hearing loss).

[43] Busacco, *supra* note 26, at 2, 135.

[44] Gelfand, *supra* note 26, at 159. For a discussion of high frequency hearing loss, see, for example, Debbie Clason, *Understanding high-frequency hearing loss*, Healthy Hearing (May 12, 2015), http://www.healthyhearing.com/report/52448-Understanding-high-frequency-hearing-loss [https://perma.cc/8FKW-L7MM]; Ryan Crawford, *What Is High Frequency Hearing Loss*, Hearing Rehab Ctr. (Oct. 29, 2012), http://www.hearingrehabcenter.com/ what-is-high-frequency-hearing-loss/ [https://perma.cc/3AWM-ZMJD].

[45] Gelfand, *supra* note 26, at 193; *see also* Busacco, *supra* note 26, at 135 ("Older adults typically report difficulty understanding speech in a variety of communication environments especially in the presence of background noise, reverberation, and listening at a distance"). For people with cochlear disorders many sounds are too soft to hear adequately or too loud to hear comfortably, Gelfand, *supra* note 26, at 159, resulting in hearing impaired people asking you to "speak up" and then asking you to "stop shouting" when you do, *id.* at 159–60. Those with severe-to-profound degrees of sensorineural loss will not be able to hear speech, including their own speech, without amplification. The inability to monitor one's own speech can lead to aberrations in vocal pitch and loudness, as well as articulation errors. *Id.*

[46] Busacco, *supra* note 26, at 3; Gelfand, *supra* note 26, at 161.

[47] Busacco, *supra* note 26, at 3; Gelfand, *supra* note 26, at 161.

[48] Busacco, *supra* note 26, at 3–4.

nostic hearing test to determine the appropriate treatment.[49] If the tests are ordered by a physician "for the purpose of obtaining information necessary for the physician's diagnostic medical evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem," Medicare will cover the costs of the testing.[50] The assessment includes a test to determine hearing thresholds at different frequencies, or pitches, measured in hertz, and the loudness of the sound, measured in decibels.[51] It also includes an analysis of both the particular situations in which the patient is unable to hear and the patient's communication requirements,[52] as well as social, emotional, occupational, and health issues.[53] Other considerations in measuring a hearing handicap are how the hearing loss restricts participation in day-to-day activities and otherwise affects health-related quality of life.[54] Treatment possibilities include a hearing aid, cochlear implant, bone-anchored hearing device, and modified communication strategies. The treatment is customized for the patient. If a device is implemented, the patient will require annual evaluations to maintain maximum device effectiveness.

The initial goal for a person who has presbycusis is to increase the intensities of sounds so that they become audible, maximizing the audibility of conversational speech without making the amplified signal uncomfortably loud.[55] Hearing aids offer one mechanism to do this. Today, most hearing

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[49] For discussion of the tensions among various treating professionals, see *infra* text accompanying notes 324–333.

[50] CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE BENEFIT POLICY MANUAL, CHAPTER 15 100 (Rev. 212, Nov. 6, 2015), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf [https://perma.cc/U6YP-MJR2]; *see also* DEP'T OF HEALTH & HUMAN SERVS. & CTRS. FOR MEDICARE & MEDICAID SERVS., CMS MANUAL SYSTEM, TRANSMITTAL 132, CHANGE REQUEST 6447, PUB 100-02 MEDICARE 9 (Sept. 3, 2010), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R132BP.pdf [https://perma.cc/9SWV-LW82]; *infra* text accompanying notes 331–336 (discussing the legislative proposal to eliminate the physician-referral requirement). For a discussion of the types of testing that should be conducted, see, for example, Theresa Hnath Chisolm, *The Spectrum of Hearing Impairment and Interventions*, *in* INST. OF MED. & NAT'L RESEARCH COUNCIL, HEARING LOSS & HEALTHY AGING: WORKSHOP SUMMARY 31, 31–36 (2014), http://www.nap.edu/read/18735/chapter/5 [https://perma.cc/GM7Z-GY88].

[51] *See, e.g.*, *The Audiogram*, AM. SPEECH-LANGUAGE HEARING ASS'N, http://www.asha.org/public/hearing/Audiogram/ [https://perma.cc/7WXJ-U82Z]. The record of these test results is called an Audiogram. *Id.* Human ears show differing sensitivities to different frequencies. A human ear is most sensitive to frequencies in the 1000 to 4000 Hz range, with men's fundamental vocal frequency averaging about 85–150 Hz and women's about 175–250 Hz. MARTIN & CLARK, *supra* note 3, at 41, 48.

[52] GELFAND, *supra* note 26, at 445.

[53] *Id*.

[54] *Id*. (citing Michael Valente et al., *Guidelines for the Audiologic Management of Adult Hearing Impairment*, AM. ACAD. AUDIOLOGY (2006), http://audiology-web.s3.amazonaws.com/migrated/haguidelines.pdf_53994876e92e42.70908344.pdf [https://perma.cc/3L9S-XCJH]; Carole Johnson & Jeffrey Danhauer, *Health-Related Quality of Life Benefits of Amplification in Adults*, 18(5) AUDIOLOGY TODAY 28, 28–31 (2006)). Amplification is said to improve health-related quality of life by mitigating the social and psychological impact of hearing impairment for older adults. GELFAND, *supra* note 26, at 445.

[55] GELFAND, *supra* note 26, at 426, 450.

aids dispensed in the United States are digital, offering many adaptive functions, including sophisticated compression schemes, feedback cancellation, noise reduction, switching between directional and omnidirectional modes, and programs with different amplification strategies (e.g., quiet room, noisy environment, with music, etc.), to name a few.[56] Most hearing aids are battery powered and programs can be adjusted with a switch on the instrument or a remote control device.[57] Some hearing aids contain a telecoil, which links it to other assistive technology, connecting the listener directly to the source of the sound while eliminating most background noise.[58]

Typically, hearing aids are worn either behind or in the ear.[59] Behind-the-ear ("BTE") instruments now represent over seventy percent of the hearing aids dispensed in the United States,[60] although in-the-ear ("ITE") hearing aids may offer both cosmetic and acoustic benefits for some patients.[61]

Other assisted devices, including cochlear implants and bone-anchored hearing aids ("BAHA"), are surgically implanted. Cochlear implants are recommended only if the loss is so severe that the patient cannot benefit from traditional hearing aids.[62] These implants include internal components that are surgically inserted and external components, such as a microphone, which are worn outside of the body.[63] An external speech processor picks up sounds, which are transmitted to a receiver that converts them to electrical impulses eventually sent to the brain.[64] A cochlear implant is programmed for the individual patient.[65] Candidates for a cochlear implant must have working auditory fibers and an absence of medical problems that could com-

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[56] *Id*. at 431.

[57] *Id*. at 426, 431.

[58] For an explanation of telecoils, see, for example, Hearing Loss Ass'n of Am., The Telecoil 2, http://www.hearingloss.org/sites/default/files/docs/HLAA_Telecoil_Brochure.pdf [https://perma.cc//5UBM-E5V5]. Often the telecoil is used with a "hearing loop" which enables sound to be picked up electromagnetically and transmitted to the telecoil. *See id*. The telecoil is activated by a t-switch on the hearing aid or cochlear implant which allows the user to switch between the telecoil and the microphone, or use both simultaneously. Gelfand, *supra* note 26, at 428.

[59] Gelfand, *supra* note 26, at 428. There are also body-level devices, used for the most severe hearing losses. *Id*. Today's ear-level hearing devices are able to incorporate many of the advantages of the body-level devices and avoid the cosmetic and other problems presented by the body-level devices. *Id*. (citing Karl E. Strom, *The Hearing Care Market at the Turn of the 21st Century*, 7(3) Hearing Rev. 8 (2000)).

[60] *See* Martin & Clark, *supra* note 3, at 372.

[61] Gelfand, *supra* note 26, at 430.

[62] *See* Martin & Clark, *supra* note 3, at 378; *see also* JoNel Aleccia, *Older Ears Hear Again with Cochlear Implants*, NBCNews (Oct. 2, 2008, 8:30 AM), http://www.nbcnews.com/id/26980383/ns/health-aging/t/older-ears-hear-again-cochlear-implants/#.VMq2lmjF82s [https://perma.cc/5XZL-7W82] (reporting a growing use of cochlear implants among seniors).

[63] Gelfand, *supra* note 26, at 453.

[64] *See, e.g.*, *Cochlear Implants*, Nat'l Inst. on Deafness & Other Commc'n Disorders, http://www.nidcd.nih.gov/health/hearing/pages/coch.aspx [https://perma.cc/3A47-K2YR]. For a more technically precise explanation, see Martin & Clark, *supra* note 3, at 379.

[65] Gelfand, *supra* note 26, at 453–55.

plicate surgery.[66] Those with dementia are not candidates for cochlear implants, given that the dementia interferes with the individual's ability to learn to use the device.[67] While cochlear implants may be effective for addressing severe hearing loss, they raise myriad other issues, leading some advocates in the disability community to oppose their use.[68]

The BAHA is anchored in the skull with a titanium screw,[69] allowing sound to be conducted through the bone instead of the middle ear.[70] A BAHA typically is used to treat conductive and mixed hearing losses, and therefore is not used to treat presbycusis alone.[71]

Despite the recommendations of hearing health professionals for individual assessments and customization of devices, personal sound amplification products ("PSAPs") are proliferating and may assist some with hearing loss. The U.S. Food and Drug Administration ("FDA") currently considers PSAPs to be devices for use by those without hearing loss, and therefore, at the present time, the FDA does not regulate PSAPs as hearing aids.[72] How-

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[66] *Id*. at 455.

[67] *See, e.g.*, Saundra Young, *Hope for Hearing*, CNN (Dec. 18, 2012, 12:12 PM), http://www.cnn.com/2012/12/28/health/cochlear-implants/ [https://perma.cc/MHE7-ZT9F] (noting that age is not a factor in determining eligibility, providing the candidate is healthy enough to undergo the surgery and does not have dementia, which would interfere with the use of the device). Despite these requirements, an increasing number of seniors are obtaining cochlear implants and experiencing cognitive benefits in addition to enhanced hearing. *See, e.g.*, Isabelle Mosnier et al., *Improvement of Cognitive Function After Cochlear Implantation in Elderly Patients*, 141(5) JAMA Otolaryngology—Head & Neck Surgery 442–50 (2015); Aleccia, *supra* note 62 (reporting a growing use of cochlear implants among seniors).

[68] *See, e.g.*, Allegra Ringo, *Understanding Deafness: Not Everyone Wants to be 'Fixed'*, Atlantic (Aug. 9, 2013), http://www.theatlantic.com/health/archive/2013/08/understanding-deafness-not-everyone-wants-to-be-fixed/278527 [https://perma.cc/4H9A-JPP9] (explaining that those who consider themselves members of the Deaf community view American Sign Language as their primary method of communication, and do not perceive deafness as a deficit to be fixed via surgical insertion of a medical device such as a cochlear implant).

[69] *See* Maryanne Tate Maltby & Pamela Knight, Audiology: An Introduction for Teachers and Other Professionals 48, 50 (2000).

[70] *See Bone Anchored Devices*, U. Md. Med. Ctr., http://umm.edu/programs/hearing/services/bone-anchored-devices#what [https://perma.cc/D33C-SK42].

[71] *See Bone Anchored Devices*, *supra* note 70. The BAHA is relevant for this discussion largely due to proposed regulations that would have eliminated Medicare coverage. The proposed regulations were ultimately rejected. Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 79 Fed. Reg. 66,120, 66,241–427 (Nov. 6, 2014) (codified at 42 C.F.R. § 411.15(d)(2)); *see also* Susan Thomas, *CMS rules to continue Medicare coverage of Osseointegrated Implants*, Am. Cochlear Implant Alliance (Nov. 3, 2014), http://www.acialliance.org/news/200864/CMS-rules-to-continue-Medicare-coverage-of-Osseointegrated-Implants.htm [https://perma.cc/J256-F9TD].

[72] *See Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products—Draft Guidance for Industry and Food and Drug Administration Staff*, FDA (Nov. 7, 2013), http://www.fda.gov/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm373461.htm [https://perma.cc/5BGR-R4P6] (explaining that the FDA "regulates electronic products that emit sonic vibrations, such as sound amplification equipment"). However, the FDA recently reopened the comment period for these guidelines to address the "accessibility, affordability, and use of hearing aids and PSAPs." Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products; Draft Guidance for Industry and Food and Drug Administration Staff; Reopening of the Comment Period, 81 Fed. Reg.

ever, the PSAPs are marketed to those with hearing loss, reportedly are helpful in amplifying sound,[73] and are recommended by some as a less expensive alternative for those with mild-to-moderate age-related hearing loss.[74] Recent technological developments enable them to be used with Bluetooth and smart phone technology.[75] Hearing health professionals are concerned, however, that more serious health problems are overlooked in the absence of a hearing assessment, that the devices merely amplify sound and are inadequate to meet hearing needs, and that they do not address potential underlying causes of hearing difficulties.[76]

Those with presbycusis also may be assisted with nontechnical interventions, such as enhanced communication strategies, problem-solving approaches, relaxation techniques, and techniques for families and partners to utilize when communicating with seniors with hearing loss.[77] Group-based audiological rehabilitation programs have proven particularly effective, and these trainings may be useful both to those with sophisticated tools such as cochlear implants and to those without assistive listening devices.[78]

786, 787 (Jan. 7, 2016); *see also* Eric A. Mann, *Current FDA Standards*, *in* INST. OF MED. & NAT'L RES. COUNCIL, HEARING LOSS & HEALTHY AGING: WORKSHOP SUMMARY 48, 51 (2014), http://www.nap.edu/read/18735/chapter/6 [https://perma.cc/XA9K-F9HL] (noting the "gap between a PSAP and a hearing aid is essentially narrowing to nothing . . . it is how you market it and how you label it").

[73] *See, e.g.*, Mark Ross, *Personal Sound Amplification Products (PSAPs) Versus Hearing Aids*, REHABILITATION ENGINEERING RES. CTR. ON HEARING ENHANCEMENT, http://www.hearingresearch.org/ross/hearing_aids/psaps_vs_hearing_aids.php [https://perma.cc/Q5NG-GXV9] (last updated July 1, 2013).

[74] *See, e.g.*, Letter from PCAST, *supra* note 14, at 7 (noting that "the distinction between a PSAP and a hearing aid . . . is not clear, and there are many people with mild hearing impairment who can benefit from amplification by headphones and other devices, including PSAPs").

[75] *See* Cathy Gandel, *Not Ready for a Hearing Aid but Need a Little Help?*, AARP (May 27, 2015), http://www.aarp.org/health/conditions-treatments/info-2015/hearing-amplifiers-psaps.html [https://perma.cc/997F-EZM8].

[76] *See* Debbie Clason, *The case against personal sound amplification devices*, HEALTHY HEARING (Mar. 28, 2014), http://www.healthyhearing.com/report/51934-The-case-against-personal-sound-amplification-devices [https://perma.cc/58g6-JF97]. Physician and researcher Frank Lin is increasingly supportive of PSAPs, and notes that the gap between these devices and hearing aids is narrowing and asks how these devices can be more accessible to consumers. *See* Mann, *supra* note 72, at 51. Examples of other evolving uses of technology in the hearing field include smart phones functioning as hearing aids, computerized phone-based auditory testing and training, and the use of "teleaudiology" to answer patient questions and even fine-tune a hearing aid. *See* Gabrielle Saunders, *Teleaudiology*, *in* INST. OF MED. & NAT'L RESEARCH COUNCIL, HEARING LOSS & HEALTHY AGING: WORKSHOP SUMMARY 61, 61 (2014), http://www.nap.edu/read/18735/chapter/7#61 [https://perma.cc/9JNT-46YT] (defining teleaudiology as "the delivery of audiology services and information via telecommunications technologies").

[77] *See, e.g.*, Chisolm, *supra* note 50, at 34–35.

[78] *See id.* For an example of a communication strategy training program for those with cochlear implants, see generally SUSAN BINZER, COCHLEAR AMS., IMPROVING UNDERSTANDINGS WITH COMMUNICATION STRATEGIES, http://hope.cochlearamericas.com/sites/default/files/resources/FUN2041%20Adult%20Communication%20Strategies%20TP.pdf [https://perma.cc/DFU3-QB9M]. *See generally* Whitson & Lin, *supra* note 23 (supporting CMS reimbursement for unbundled hearing services such as therapeutic rehabilitation).

III. Impediments to Hearing Aid Use Among Seniors

A. Costs

Seniors in need of hearing devices fail to use them for numerous reasons.[79] One common explanation is cost. Hearing devices are expensive. In 2014, a pair of fitted hearing aids ranged from approximately $2,200 to over $7,000, with the average costs of mid-level hearing aids falling between $4,400 and $4,500 a pair.[80] High costs typically are attributed to materials, research expenses, and marketing.[81] If purchased from a hearing clinic, costs tend to be two and a half times higher than wholesale prices due to the need for expensive equipment, salaries, overhead, licenses, insurance, and staff time spent on adjustments and fittings, all of which are typically included.[82] A *Consumer Reports* study indicated that the average mark-up was 117% in those cases where the wholesale price could be determined.[83] Some argue that this system of "bundled" pricing, which include the costs of fitting and

[79] *See supra* notes 33–39 and accompanying text.

[80] Cropp, *supra* note 3. Over seventy-five percent of patients are fitted for two hearing aids. Martin & Clark, *supra* note 3, at 371; *see also* Paul Dybala, *Hearing aid prices*, Healthy Hearing (Oct. 16, 2015), http://www.healthyhearing.com/help/hearing-aids/prices [https://perma.cc/Y3AS-BPLQ] (indicating that costs range from $1,600–$8,000 a pair and that the average cost is $4,800 per pair); Amy M. Donahue et al., *NIDCD Research Working Group on Accessible and Affordable Hearing Health Care, in* Inst. of Med. & Nat'l Research Council, Hearing Loss & Healthy Aging: Workshop Summary 77, 78–79 (2014), http://www.nap.edu/read/18735/chapter/8 [https://perma.cc/W2JD-7FC5] ("[A]mong nonadopters [of hearing aids], cost is cited as the primary reason for not getting a hearing aid. Two-thirds of these people said that they would get a hearing aid if insurance or other programs provided 100 percent coverage . . . ."). Requests for information about costs and affordability are the most frequent inquiries to the HLAA office, and their most frequently visited website page is the financial aid fact sheet for hearing technologies. *Hearing Health Care and Insurance*, *supra* note 28.

[81] Cropp, *supra* note 3.

[82] *See id.* A breakdown of the actual costs of hearing aids shows materials costing only a small percentage of the total price, with research constituting about one-third. *Id.* Some question the value of offering hearing aids as a "bundled" service that includes ongoing fittings and adjustments, arguing that bundling results in devices that cost more and users paying for services they may not need or want. *See, e.g.*, Margaret Wallhagen, *The Current U.S. Hearing Health Care Model*, *in* Inst. of Med. & Nat'l Research Council, Hearing Loss & Healthy Aging: Workshop Summary 36, 38 (2014), http://www.nap.edu/read/18735/chapter/5#36 [https://perma.cc/MW5P-VJY4] ("Many audiologists are arguing that costs should be unbundled because the cost of a hearing aid is not really the cost of the hearing aid by itself but the cost of the hearing aid plus that of surrounding services.").

[83] *Hearing aid buying guide*, Consumer Reports (Sept. 2015), http://www.consumerreports.org/cro/hearing-aids/buying-guide.htm [https://perma.cc/8TRM-P7A5]. Another hearing aid buying guide is available from the Better Hearing Institute. Sergei Kochkin, *Guide to Buying Hearing Aids*, Better Hearing Inst., http://www.betterhearing.org/hearingpedia/hearing-aids/guide-buying-hearing-aids [https://perma.cc/Q5K4-X8WD]. For the story of one consumer's adventure replacing her hearing aid, see Tricia Romano, *The Hunt For an Affordable Hearing Aid*, N.Y. Times: Well (Oct. 22, 2012, 4:53 PM), http://well.blogs.nytimes.com/2012/10/22/the-hunt-for-an-affordable-hearing-aid/?_r=0 [https://perma.cc/SY3P-53Q2].

follow-up, is "of uncertain benefit and prevents patients from distinguishing between sources of expense."[84]

Costco Wholesale,[85] Audicus, and "hi HealthInnovations"[86] have now entered the hearing aid market, providing lower cost devices;[87] however, these devices do not include services such as "assessment, repair, earwax removal, counseling, and aural rehabilitation," services typically included when devices are purchased through a clinic.[88] Some question these merchants' ability to provide devices tailored to an individual senior's needs,[89] and critics are concerned that such devices fail to maximize patients' full hearing potential and that their purchase may result in related medical problems going undetected.[90] Others, such as the President's Council of Advisors on Science and Technology ("PCAST"), see the current requirement of a medical evaluation (or patient waiver) prior to obtaining a hearing device as an unnecessary barrier to hearing assistance.[91]

B. Insurance Coverage of Hearing Devices

Despite the high costs of hearing aids, an overview of the health insurance landscape for seniors reveals that little coverage is available and further explains why these lower cost options are attractive to seniors. Medicare, the

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[84] Whitson & Lin, *supra* note 23, at 1740; *see also* Letter from PCAST, *supra* note 14, at 3 (recommending a number of reforms to make hearing devices more accessible and affordable, including the unbundling of services).

[85] For a list of the products available at Costco Wholesale, see *Hearing Aid Styles*, Costco Wholesale, http://www.costco.com/hearing-aid-styles.html [https://perma.cc/6Q2W-EBL2].

[86] "hi HealthInnovations" is a subsidiary of United Healthcare. For a list of the products available from "hi HealthInnovations," see *Products*, hi HealthInnovations, https://www.hihealthinnovations.com/page/productlanding [https://perma.cc/FJ6U-W55A].

[87] For a discussion of hearing aid costs, see Ed Belcher, *Why Does a Hearing Aid Cost Six Times the Price of an IPad?*, Audicus (Oct. 16, 2014), https://audicus.com/why-does-a-hearing-aid-cost-six-times-more-than-an-ipad [https://perma.cc/33AY-YNGF]. In this blog posted on the provider Audicus' website—which advertises "the best hearing aids with the lowest markups"—Belcher concludes that the average markup of hearing aids sold by dispensing businesses is 300% and that the production costs of a hearing aid are typically only 8% of the total costs, with the remaining costs going to dispensing fees, administrative salaries, and markup. *Id.* A different analysis concludes that a hearing aid that would have sold for $230 in 1952 would sell in today's dollars for $2,000, much less than the current average price. *See* Ashlee Vance, *Why do Hearing Aids Cost More than Laptops?*, Bloomberg Businessweek (June 6, 2013, 6:26 PM), http://www.businessweek.com/articles/2013-06-06/why-do-hearing-aids-cost-more-than-laptops [https://perma.cc/8D2J-8J8B].

[88] Robert Burkard, *The Changing Health Care System*, *in* Inst. of Med. & Nat'l Research Council, Hearing Loss & Healthy Aging: Workshop Summary 75, 75 (2014), http://www.nap.edu/read/18735/chapter/8#75 [https://perma.cc/TH8J-B5WB] (noting there is no mechanism to provide these services elsewhere for those who purchase hearing aids directly from retailers).

[89] *See* Gyl A. Kasewurm, *An Independent Practice's Guide to Battling Big Box Retail and Commoditization in Hearing Healthcare*, Hearing Rev. (June 20, 2014), http://www.hearingreview.com/2014/06/independent-practices-guide-battling-big-box-retail-commoditization-hearing-healthcare [https://perma.cc/F9E9-8UE7].

[90] Martin & Clark, *supra* note 3, at 489.

[91] Letter from PCAST, *supra* note 14, at 4–5.

primary insurer for most seniors, provides health insurance to 46.3 million people ages sixty-five and older.[92] In 2013, Medicare expenditures constituted more than twenty percent of total health expenditures in the United States and in 2014, fourteen percent of the federal budget.[93]

The Medicare program is comprised of several "Parts." Most people age sixty-five and older are entitled to Medicare Part A, which primarily covers hospital benefits, but also covers some short nursing home stays, hospice benefits, and limited home health care.[94] Seniors also may enroll in Medicare Part B, which covers physician services, outpatient services, preventive services, and limited home health care.[95] As an alternative to Medicare Part B, seniors may elect to enroll in a Medicare Advantage Plan, also known as Medicare Part C. Such plans provide all of the services covered by "traditional" Medicare Parts A and B.[96] In 2015, thirty-one percent of Medicare beneficiaries were enrolled in Medicare Advantage Plans.[97]

Given that Medicare has high deductibles and covers only some of the health care expenses seniors face,[98] seniors often choose one of several routes to supplement Medicare. One option is to purchase supplemental coverage in the form of a "Medigap" policy.[99] Twenty-three percent of Medicare beneficiaries have Medigap policies.[100] However, such policies are expensive, averaging $183 per month in 2010.[101] Another option, but one available to fewer and fewer seniors, is an employer-sponsored retiree health

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[92] Cubanski et al., *supra* note 4. An additional nine million people with disabilities under age sixty-five also have Medicare coverage. *Id.* Before the enactment of Medicare in 1965, approximately half of all seniors had no medical insurance at all. *Id.*

[93] *Id.*

[94] *Medicare at a Glance*, KAISER FAM. FOUND. (Sept. 2, 2014), http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet [https://perma.cc/C5HH-KEBY].

[95] *Id.*

[96] *Id.* Medicare Advantage Plans, available through private insurers, follow either a health maintenance organization model ("HMO") or provide services through a preferred provider organization ("PPO"). *Id.* For a discussion of the challenges of understanding enrollment in and coverage through Medicare Part B, see generally STACY SANDERS, MEDICARE RIGHTS CTR., MEDICARE PART B ENROLLMENT: PITFALLS, PROBLEMS AND PENALTIES (Nov. 2014), http://www.medicarerights.org/pdf/PartB-Enrollment-Pitfalls-Problems-and-Penalites.pdf [https://perma.cc/4M6L-ASL5].

[97] *Medicare at a Glance*, *supra* note 94. The number of Medicare Advantage Plan enrollees has increased fifty percent since the passage of the ACA. Patricia Neuman et al., *Medicare Advantage and Traditional Medicare: Is the Balance Tipping?*, KAISER FAM. FOUND. (Oct. 20, 2015), http://kff.org/report-section/medicare-advantage-and-traditional-medicare-is-the-balance-tipping-issue-brief [https://perma.cc/C377-Q5LK]. Seniors who elect not to enroll in any Medicare-related physician coverage plan and later choose to do so are subject to a penalty that can have long-lasting effects. *See* Bob Rosenblatt, *Don't Mess Up Your Medicare Part B*, HELPWITHAGING.COM, http://helpwithaging.com/health-insurance/dont-mess-up-your-medicare-part-b [https://perma.cc/ZA5X-NBCW].

[98] *See Medicare at a Glance*, *supra* note 94.

[99] *See id.*

[100] Gretchen Jacobson et al., *Medigap Reform: Setting the Context for Understanding Recent Proposals*, KAISER FAM. FOUND. (Jan. 13, 2014), http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context [https://perma.cc/WV63-5FNX].

[101] *Id.*

plan.[102] The percentage of large employers offering such plans dropped from sixty-eight percent in 1988 to twenty-eight percent in 2013.[103] Today, fewer than one in five American workers have employer-sponsored, retiree health insurance.[104]

Finally, seniors with very low incomes and modest assets may be eligible for assistance under the Medicaid program. Medicaid covers the costs of Medicare premiums, some cost sharing, and long-term care.[105] However, only 4.6 million seniors are eligible for Medicaid,[106] a small percentage of the 46.3 million seniors enrolled in the Medicare program.[107] Under the ACA, states have the option of expanding their Medicaid programs to cover all persons with incomes less than 138% of the federal poverty level.[108] In those states that provide expansion, which currently number thirty-one, se-

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[102] Such plans are subject to the Medicare coordination of benefits rules that determine whether Medicare or the private plan is the primary insurer. *See, e.g.*, SANDERS, *supra* note 96, at 5. "Coordination of benefits" is defined as "a sharing of costs and coverage by two or more health plans. When a Medicare beneficiary has a second form of insurance, Medicare will act as either a primary or a secondary payer. Primary insurance always pays first, and secondary insurance pays after the primary insurance, typically covering cost sharing and services not covered by the primary insurer, depending on the rules of the policy." *Id.* For Medicare recipients with an employer-sponsored retiree health plan, the employer-sponsored plan is secondary to Medicare. *Id.*

[103] Frank McArdle et al., *Retiree Health Benefits at the Crossroads*, KAISER FAM. FOUND. (Apr. 14, 2014), http://kff.org/report-section/retiree-health-benefits-at-the-crossroads-overview-of-health-benefits-for-pre-65-and-medicare-eligible-retirees [https://perma.cc/RSF7-7WWK]. "If this trend continues, fewer future Medicare beneficiaries will have retiree health benefits and more will be responsible for paying Medicare premiums and out-of-pocket costs." Gretchen Jacobson et al., *Wide Disparities in the Income and Assets of People on Medicare by Race and Ethnicity: Now and in the Future*, KAISER FAM. FOUND. (Sept. 20, 2013), http://kff.org/medicare/report/wide-disparities-in-the-income-and-assets-of-people-on-medicare-by-race-and-ethnicity-now-and-in-the-future [https://perma.cc/ZRD4-SDE8].

[104] McArdle et al., *supra* note 103. Retiree health insurance historically has been more common among large employers, state and local governments, and certain industries. *Id.* Those employers that do offer coverage are increasingly exploring ways to reduce costs. *Id.*

[105] *See Seniors & Medicare and Medicaid Enrollees*, MEDICAID.GOV, https://www.medicaid.gov/medicaid-chip-program-information/by-population/medicare-medicaid-enrollees-dual-eligibles/seniors-and-medicare-and-medicaid-enrollees.html [https://perma.cc/283Q-MFUY].

[106] *Id.*

[107] Cubanski et al., *supra* note 4.

[108] 42 U.S.C. § 1396d(y)(1) (2012), as limited by Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (holding that Medicaid expansion under the ACA could not be compulsory for the states). For information regarding state Medicaid expansion, see, for example, *Medicaid Expansion & What It Means for You*, HEALTHCARE.GOV, https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/ [https://perma.cc/8UWS-ZKP2]. For an analysis of the extent of Medicaid expansion and of the coverage gap resulting from the *Sebelius* decision, see Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid—An Update*, KAISER FAM. FOUND. (Jan. 21, 2016), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update [https://perma.cc/RW5U-H2QP]. Of those unable to secure coverage due to states' decisions to opt out of Medicaid expansion, "over half are middle-aged (age 35 to 54) or near elderly (age 55 to 64). Adults of these ages are likely to have increasing health needs, and research has demonstrated that uninsured people in this age range may leave health needs untreated until they become eligible for Medicare at age 65." *Id.*

niors between the ages of sixty and sixty-five may have additional insurance coverage under Medicaid.[109]

This glance at the health insurance landscape for seniors reveals the critical need for Medicare to cover the costs of hearing aids. Currently, the vast majority of seniors have no insurance coverage for hearing aids at all. Those with Medicare Advantage Plans may have a modicum of coverage.[110] The small percentage of seniors fortunate enough to have employer-sponsored retiree health insurance also have limited coverage.[111] For the nineteen percent of Medicare beneficiaries eligible for Medicaid, coverage is very limited and varies by state.[112] Only twenty-nine states cover any portion of the costs of hearing aids through Medicaid.[113] Medigap policies typically do not cover hearing aids.[114]

In contrast with hearing aids, cochlear implants, which cost over $40,000 per implant,[115] are typically covered through Medicare, Medicaid, and private insurance plans.[116] The BAHA device is similarly covered, under the rationale that it is a prosthesis that replaces, rather than augments, hearing.[117] PSAPs are sold directly to consumers, are not considered medical devices, and are therefore not covered by insurance.[118]

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[109] Julia Paradise, *Medicaid Moving Forward*, KAISER FAM. FOUND. (Mar. 9, 2015), http://kff.org/health-reform/issue-brief/medicaid-moving-forward [https://perma.cc/M5HC-7XKM].

[110] *See, e.g.*, *Medicare and Hearing Aids*, EHEALTHMEDICARE.COM, http://www.ehealthmedicare.com/about-medicare/hearing-aids [https://perma.cc/RY6N-MVUT].

[111] *See id.*

[112] *See Medicaid Regulations*, HEARING LOSS ASS'N AMERICA (Jan. 2015), http://www.hearingloss.org/content/medicaid-regulations [https://perma.cc/FF9S-UVDS].

[113] *See id.* The problem of limited coverage is exacerbated by the challenge of identifying a medical provider willing to accept Medicaid. For a general description of this problem, see Elizabeth Renter, *You've Got Medicaid—Why Can't You See the Doctor?*, U.S. NEWS & WORLD REP. (May 26, 2015, 9:00 AM), http://health.usnews.com/health-news/health-insurance/articles/2015/05/26/youve-got-medicaid-why-cant-you-see-the-doctor [https://perma.cc/N66Q-ZWZG].

[114] *Medicare and Hearing Aids*, *supra* note 110.

[115] *See, e.g.*, *Cochlear Implants Frequently Asked Questions*, AM. SPEECH-LANGUAGE-HEARING ASS'N, www.asha.org/public/hearing/Cochlear-Implant-Frequently-Asked-Questions [https://perma.cc/L7H5-MPQ4]. This cost includes the device, surgery, and rehabilitation. *See id.*

[116] *See id.*

[117] *See generally* Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 79 Fed. Reg. 66,120, 66,241–427 (Nov. 6, 2014), codified at 42 C.F.R. § 411.15(d)(2) (2015) (discussing CMS's final decision that BAHAs remain covered by Medicare, despite earlier proposal to eliminate coverage).

[118] The FDA, seeking "to better understand how we can overcome the barriers to access and spur the development of devices that compensate for impaired hearing," has reopened its comment period on a draft guidance that "clarifies the difference in regulatory requirements between hearing aids and PSAPs." Press Release, FDA, The FDA Engages Stakeholders on Opportunities to Improve Hearing Aid Usage and Innovation (Jan. 6, 2016), http://www.fda.gov/newsevents/newsroom/pressannouncements/ucm480239.htm [https://perma.cc/JX8G-CW9C]; Mann, *supra* note 72, at 49; *Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products—Draft Guidance for Industry and Food and Drug Administration Staff*, FDA (Nov. 7, 2013), http://www.fda.gov/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm373461.htm [https://perma.cc/4BS4-YRNU] (ex-

C. Poverty Among Seniors

Compounding the problem of inadequate insurance coverage for hearing aids is the high rate of poverty among seniors.[119] In 2013, 9.5% of those aged sixty-five and over lived in poverty,[120] with the percentage increasing with age.[121] Thirty-four percent of seniors have incomes below two hundred percent of the official measure of poverty.[122] The causes of increased poverty are multifaceted, and include reductions in income due to a decreasing percentage of seniors with pensions,[123] an absence of wage increases in the final years of employment,[124] and caregiving duties for the seniors' own parents that may result in seniors retiring earlier than planned.[125] Additionally, until recently, a depressed housing market resulted in seniors with less equity in

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plaining that the FDA "regulates electronic products that emit sonic vibrations, such as sound amplification equipment"). *See generally* Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products; Draft Guidance for Industry and Food and Drug Administration Staff; Reopening of the Comment Period, 81 Fed. Reg. 786 (Jan. 7, 2016).

[119] *See, e.g.*, Mary Borrowman, *Understanding Elderly Poverty in the U.S.: Alternative Measures of Elderly Deprivation* 3 (Schwartz Ctr. for Econ. Policy Analysis, Working Paper No. 2012-3, 2012), http://www.economicpolicyresearch.org/images/docs/research/inequality_poverty/WP%202012-3%20Mary%20Borrowman.pdf [https://perma.cc/3YDB-MDCL]; Juliette Cubanski et al., *Poverty Among Seniors: An Updated Analysis of National and State Level Poverty Rates Under the Official and Supplemental Poverty Measures*, Kaiser Fam. Found. (June 10, 2015), http://kff.org/medicare/issue-brief/poverty-among-seniors-an-updated-analysis-of-national-and-state-level-poverty-rates-under-the-official-and-supplemental-poverty-measures [https://perma.cc/7S6T-G9A6].

[120] U.S. Census Bureau, Rep. No. P60-249, Income and Poverty in the U.S.: 2013, at 12 (2014), https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf [https://perma.cc/B9A2-6WLQ].

[121] Cubanski et al., *supra* note 119. The 2013 poverty level for one person was $11,173. U.S. Census Bureau, *supra* note 120, at 43. In 2011, the Census Bureau developed a supplemental measure of poverty, which deducts the costs of health expenses. Cubanski et al., *supra* note 119. Under the supplemental measure, fifteen percent of those aged 65 and over lived in poverty in 2013. *Id.*

[122] *Income Security and the Elderly: Securing Gains Made in the War on Poverty: Hearing Before the S. Special Comm. on Aging*, 113th Cong. (2014) (statement of Patricia Neuman, Sc.D., Director, Program on Medicare Policy and Senior Vice President, Kaiser Family Foundation), http://www.aging.senate.gov/imo/media/doc/Neuman_3_5_14.pdf [https://perma.cc/2NGP-8K4A]; *see also Visualizing Income and Assets Among Medicare Beneficiaries: Now and In the Future*, Kaiser Fam. Found. (June 2014), http://kff.org/interactive/visualizing-income-and-assets-among-medicare-beneficiaries-now-and-in-the-future [https://perma.cc/H8VW-XARH] (noting that, in 2013, fifty-three percent of all Medicare beneficiaries had "less than $25,000 in income on a per person basis").

[123] *See, e.g.*, Travis Waldron, *Why the Decline in Pensions Will Mean an Increase in Poverty for America's Retirees*, ThinkProgress (Aug. 8, 2012, 2:30 PM), http://thinkprogress.org/economy/2012/08/08/656681/pension-decline-poverty-increase [https://perma.cc/UEB8-JNUE]; Alicia H. Munnell et al., Ctr. for Ret. Research at Boston Coll., NRRI Update Shows Half Still Falling Short 5 (Dec. 2014), http://crr.bc.edu/wp-content/uploads/2014/12/IB_14-20-508.pdf [https://perma.cc/3KUJ-CVS4].

[124] *See, e.g.*, Pamela Yip, *Middle Class Struggles to Preserve Retirement Security*, New Am. Media (Nov. 19, 2014), http://newamericamedia.org/2014/11/middle-class-struggles-to-preserve-retirement-security.php [https://perma.cc/8MVF-U3A8].

[125] *See id.*

their homes and fewer overall assets.[126] Many experts project that poverty rates among seniors will continue to rise in the foreseeable future, with one source anticipating a 180% increase in the number of seniors living in poverty by the year 2050.[127]

Additionally, the costs of medical care have skyrocketed in the last fifty years.[128] When originally enacted, Medicare was designed to cover hospital costs and limited physician and other health services. While there was a concern at that time that individual seniors were unable to pay their hospital bills, overall health costs were not a concern.[129] It was only later that health care costs began their rapid ascent.[130] By 2009, health care costs had increased from one percent of the Gross Domestic Product ("GDP") in 1960 to more than seven percent.[131]

Another cause of senior poverty is the increased health care spending that accompanies aging.[132] Health care expenses account for fifteen percent of a Medicare household budget,[133] an amount three times greater than non-Medicare households spend on health care.[134] While Medicare spending per

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[126] *See, e.g.*, *id.* (quoting Eric Kingson, co-director of Social Security Works and professor at Syracuse University's Aging Studies Institute).

[127] Teresa Ghilarducci, *By 2050, There Could Be as Many as 25 Million Poor Elderly Americans*, ATLANTIC (Dec. 30, 2015), http://www.theatlantic.com/business/archive/2015/12/elderly-poverty-america/422235 [https://perma.cc/FK86-ADTQ]. While a large part of this increase is due to the growing number of seniors, approximately one-third relates to a weakening retirement security system. *Id.*; *see also* Gretchen Jacobson et al., *Income and Assets of Medicare Beneficiaries, 2014–2030*, KAISER FAM. FOUND. (Sept. 10, 2015), http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030 [https://perma.cc/26EV-2UXJ].

[128] *See, e.g.*, *Health Costs: A Primer*, KAISER FAM. FOUND. (May 1, 2012), http://kff.org/report-section/health-care-costs-a-primer-2012-report [https://perma.cc/NPF3-W3JQ] (noting that health care costs have increased from an average of $356 per person in 1970 to $8,402 per person in 2010). Health care spending increased over the last fifty years by 1.1–3.0% more than the rest of the economy, although that trend has slowed somewhat in the last decade. *Id.*

[129] *See infra* text accompanying notes 220–225.

[130] *See, e.g.*, *Health Costs: A Primer*, *supra* note 128.

[131] Christopher Chantrill, *U.S. Health Care Spending History from 1900*, USGOVERNMENTSPENDING.COM, http://www.usgovernmentspending.com/healthcare_spending [https://perma.cc/3K54-B2WW] (noting this trend, which showed health care spending as a portion of the Gross Domestic Product rising from 1% in 1960, to 2% in 1970, 3% in 1980, 5.3% in 1995, and 7% in 2009); *see also* Dana P. Goldman & Abby E. Alpert, *Costs and Insurance*, *in* DANA P. GOLDMAN & ELIZABETH A. MCGLYNN, U.S. HEALTH CARE: FACTS ABOUT COSTS, ACCESS AND QUALITY 1, 3 (2005), http://www.rand.org/content/dam/rand/pubs/corporate_pubs/2005/RAND_CP484.1.pdf [https://perma.cc/W4FG-68CT] (noting an increase in real health care spending in the United States from five percent of the GDP in 1960 to fifteen percent in 2002).

[132] *See, e.g.*, Juliette Cubanski et al., *Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households*, KAISER FAM. FOUND. (Jan. 9, 2014), http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households [https://perma.cc/CAF9-RSZE].

[133] KAREN DAVIS ET AL., THE COMMONWEALTH FUND, MEDICARE: 50 YEARS OF ENSURING COVERAGE AND CARE 7 (Apr. 2015), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/apr/1812_davis_medicare_50_years_coverage_care.pdf [https://perma.cc/2YQY-UZLU].

[134] *See id.*

beneficiary is expected to continue to rise, there is reason to believe that the growth rate may be slowing.[135]

Although a disproportionate number of people relying on Medicare are low-income, many are not poor enough to qualify for Medicaid. In 2014, half of all Medicare beneficiaries had incomes below $24,150, with one quarter having incomes below $14,350.[136] In 2010, eighteen percent of Medicare beneficiaries had no supplemental coverage to compensate for Medicare's limited coverage options.[137] This group included a disproportionate share of those with incomes between $10,000 and $20,000, those living in rural communities, and African American beneficiaries.[138] Substantial disparities in income, savings, and home equity exist among Medicare beneficiaries depending on race and ethnicity.[139] In 2012, the median income, savings, and amount of home equity were substantially lower for black and Hispanic Medicare beneficiaries than white beneficiaries.[140] Twenty percent of black and Hispanic beneficiaries had no savings or were in debt.[141] Today, the cost of a hearing aid is beyond the reach of many seniors, and this burden of inadequate insurance coverage falls disproportionately on people of color.

Given the limited insurance coverage and the poverty facing seniors, an out-of-pocket expenditure of $2,000 to $7,000 is simply not feasible. A small number of options other than insurance exist for seniors with presbycusis. For example, eligible veterans may obtain hearing devices for free.[142] And there are a limited number of programs that provide financial assistance for the general public.[143] However, those options neither meet the need for nor compensate for the shortage of available insurance coverage.

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[135] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 4 (Mar. 14, 2014), http://medpac.gov/documents/reports/mar14_entirereport.pdf [https://perma.cc/MC3C-CFVV] ("Medicare spending per beneficiary over the next 10 years is projected to grow at a slower rate than in the past 10 years (3.3 percent annually compared with 6.1 percent annually).").

[136] Jacobson et al., *supra* note 127.

[137] *Medicare at a Glance*, *supra* note 94.

[138] *Id.*

[139] *See* Jacobson et al., *supra* note 103.

[140] *See id.*

[141] *Id.*

[142] For a list of those categories of veterans eligible for hearing aids, see *Federal Benefits for Veterans, Dependents and Survivors, Chapter 1 Healthcare Benefits*, U.S. DEP'T VETERANS AFF., http://www.va.gov/opa/publications/benefits_book/benefits_chap01.asp [https://perma.cc/CH2X-EWDP]. If eligible, the veteran receives the services and hearing aid free of charge. *Id.*

[143] *See, e.g.*, *Financial Assistance: Programs & Foundations*, HEARING LOSS ASS'N AMERICA, http://hearingloss.org/content/financial-assistance-programs-foundations [https://perma.cc/T5XW-ELRV]. For those who use PSAPs as an alternative, they spend on average $250–$350 for a device. Gandel, *supra* note 75.

IV. The Relationship Between Presbycusis and Other Medical Conditions

The scientific literature is replete with evidence of the relationship between age-related hearing loss and other medical conditions. For example, recent research indicates a link between hearing loss and dementia, with a leading study concluding that hearing loss is independently associated with dementia.[144] The study consisted of participants between the ages of thirty-six and ninety who had audiometric testing done and also were dementia free.[145] The participants were followed for a median of 11.9 years, and the risk of dementia was found to increase with the severity of the baseline hearing loss.[146] Other studies have reached similar results, concluding that participants with Alzheimer's-type dementia had a higher degree of hearing loss than those in the control group.[147] This study also concluded that greater hearing loss is associated with higher adjusted relative odds of having dementia.[148]

Although the precise cause of this connection between dementia and hearing is unclear, two hypotheses exist. The "effortful hypothesis" posits that those with hearing loss must contribute extra cognitive resources to hearing, and therefore have fewer resources available for other cognitive functions.[149] The second hypothesis suggests that the other consequences of hearing loss—such as reduced social engagement, isolation, and depression—diminish an individual's ability to participate in the very type of activities likely to decrease the risk of dementia.[150] The only real doubt, according to one leading researcher in the field, Johns Hopkins School of Medicine

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[144] Lin et al., *supra* note 7, at 217–18; *see also* Stig Arlinger, *Negative Consequences of Uncorrected Hearing Loss—A Review*, 42 Int'l J. Audiology 2S17, 2S17 (2003) (noting that hearing loss "is clearly related to depression and dementia").

[145] Lin et al., *supra* note 7, at 214.

[146] *Id.*

[147] Richard F. Uhlmann et al., *Relationship of Hearing Impairment to Dementia and Cognitive Dysfunction in Older Adults*, 261 JAMA 1916, 1916–19 (1989).

[148] *Id.*; *see* Arlinger, *supra* note 144, at 2S20. For a contrary conclusion from a dated study, see Virginia Gennis et al., *Hearing and Cognition in the Elderly: New Findings and a Review of the Literature*, 151 Archives Internal Med. 2259, 2259–64 (1991) (concluding that there is no meaningful association between hearing loss and later cognitive function).

[149] Lin et al., *supra* note 8, at 770; *see also* Luigi Ferrucci, *Functional Reserves and Hearing*, *in* Inst. of Med. & Nat'l Research Council, Hearing Loss & Healthy Aging: Workshop Summary 21, 21 (2014), http://www.nap.edu/read/18735/chapter/4#21 [https://perma.cc/5CL2-KPKK] (noting that when people have trouble hearing, they have to expend more resources trying to hear; dual tasks create a competition for brain resources; and seniors often have fewer functional reserves to draw upon to assist with a sensory loss such as hearing loss). *See generally* Jonathan E. Peele et al., *Hearing Loss in Older Adults Affects Neural Systems Supporting Speech Comprehension*, 31(35) J. Neuroscience 12,638 (2011) (illustrating that observed behavior in neural activity suggests that sensory changes have cascading consequences for other neural processes). This view is consistent with seniors' subjective reports that the constant effort to understand speech when their hearing is diminished results in mental fatigue. *See, e.g.*, Tun et al., *supra* note 2, at 765.

[150] *See* Lin et al., *supra* note 7, at 218.

Professor Frank Lin, is the precise mechanism that causes the link between dementia and hearing loss.[151] Additional research confirming these results could have substantial implications for the treatment of individuals with hearing loss and public health issues more broadly.[152]

Early intervention and effective treatment can reduce the impact of hearing loss and thus reduce the prevalence of hearing loss-related diseases.[153] These diseases, such as dementia, have enormous social and economic costs.[154] For example, it is estimated that dementia affects approximately 5.3 million people in the United States,[155] with the direct cost of care in 2010 at $157–215 billion annually.[156] Costs are estimated to rise to over $1.1 trillion by 2050.[157] Given this dynamic, insurance coverage for screenings and hearing aids for the elderly may help prevent or delay the onset of dementia and lower its social and economic costs.

Dementia is only one such medical problem related to untreated presbycusis. Presbycusis also may result in poorer cognitive functioning more generally.[158] For example, empirical research has demonstrated a link between recall and hearing loss.[159] In one study, seniors experiencing relatively minor hearing loss were found to have a reduced ability to recall words than those without hearing loss.[160] A subsequent study demonstrated that older adults with greater hearing loss performed worse on tests measuring memory and

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[151] *Id.*

[152] *Id.* at 219.

[153] *Id.* at 220.

[154] *See, e.g.*, *2015 Alzheimer's Disease Facts and Figures*, Alzheimer's Ass'n, https://www.alz.org/alzheimers_disease_facts_and_figures.asp#prevalence [https://perma.cc/ZQN4-YKFE]; *see also* Michael D. Hurd et al., *Monetary Costs of Dementia in the United States*, 368(14) New Eng. J. Med. 1326, 1326 (2013).

[155] *See Alzheimer's Disease Facts and Figures*, *supra* note 154.

[156] *See* Hurd et. al., *supra* note 154, at 1326.

[157] *See Alzheimer's Disease Facts and Figures*, *supra* note 154.

[158] *See* Lin et al., *supra* note 12, at 294; Tun et al., *supra* note 2, at 764–65; *see also* Sushmit Mishra et al., *Cognitive Spare Capacity in Older Adults with Hearing Loss*, 6(96) Frontiers Aging Neuroscience 1, 11 (2014), http://journal.frontiersin.org/article/10.3389/fnagi.2014.00096/abstract [https://perma.cc/URU6-ASYU] (concluding that "[o]lder adults with hearing loss have lower CSC (cognitive spare capacity) than young adults without hearing loss, probably because they have poorer cognitive skills and deploy them differently"); Jerker Ro¨nnberg et al., *Hearing Loss Is Negatively Related to Episodic and Semantic Long-Term Memory but Not to Short-Term Memory*, 54 J. Speech, Language, & Hearing Res. 705–26 (2011) (finding "hearing loss was selectively and negatively related to episodic and semantic long-term memory"); Rachel V. Wayne & Ingrid S. Johnsrude, *A Review of Causal Mechanisms Underlying the Link Between Age-Related Hearing Loss and Cognitive Decline*, 23 Ageing Res. Revs. 154, 154–166 (2015) (concluding that as the elderly experience hearing loss, speech perception makes greater demands on cognition, with increased demands unmasking potential cognitive decline).

[159] Tun et al., *supra* note 2, at 761–66.

[160] *Id.* at 765–66. This finding supports the theory that a sensory deprivation such as hearing loss requires extra effort, which results in attentional resources being diverted from other cognitive tasks. *Id*.

executive function.[161] Again, although the precise link between hearing loss and decreased cognitive functioning is unclear,[162] any finding that hearing loss and cognitive decline are related renders it imperative to treat the hearing loss.

Untreated hearing loss can result in a lower quality of life.[163] In a test measuring functional health and well-being, those with a self-reported hearing handicap and severe hearing loss reported lower scores on several domains.[164] Additional negative consequences included activity limitations, increasing reliance on family and other social supports, and negative well-being.[165] Hearing loss also causes isolation, as those who cannot hear well tend to avoid social situations where they cannot hear or may need to hear.[166] This isolation in turn leads to increased loneliness and depression.[167]

Additionally, hearing loss may result in an increased risk of falling,[168] which creates a potential cascade of other medical problems. People experiencing untreated hearing loss spend more days hospitalized than those without hearing loss.[169] One study indicated that those with moderate to severe hearing impairments had significantly poorer driving records when faced with auditory distractions, and those with hearing loss were more likely to have ceased driving, resulting in a loss of independence.[170]

While the precise impact of adequate treatment for presbycusis deserves extensive additional research,[171] hearing aid interventions can alleviate depressive symptoms, reduce social isolation, and improve quality of life

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[161] Lin et al., *supra* note 8, at 763–64. In contrast, elderly patients who received cochlear implants were found to have improved cognitive abilities and enhanced quality of life. Mosnier et al., *supra* note 67, at 442–50.

[162] Arlinger, *supra* note 144, at 2S20; Lin et al., *supra* note 7, at 217–20; Lin et al., *supra* note 8, at 763–70.

[163] *See, e.g.*, Gopinath et al., *supra* note 9, at 150; Lopez et al., *supra* note 2, at 363.

[164] Barbara E. Weinstein, *Psychosocial Impacts*, *in* Inst. of Med. & Nat'l Research Council, Hearing Loss & Healthy Aging: Workshop Summary 25, 27 (2014), http://www.nap.edu/read/18735/chapter/4#27 [https://perma.cc/8TP2-BRHH] (citing Dayna S. Dalton et al., *The Impact of Hearing Loss on Quality of Life in Older Adults*, 43(5) Gerontologist 661, 661–68 (2003)). The severity and type of hearing loss affected self-reported measures of well-being. Weinstein, *supra* note 164, at 27.

[165] Gopinath et al., *supra* note 9, at 146.

[166] Arlinger, *supra* note 144, at 2S17–2S18.

[167] *Id.*

[168] Lopez et al., *supra* note 2, at 359; *see also* Anne Viljanen et al., *Hearing as a Predictor of Falls and Postural Balance in Older Female Twins*, 64A J. Gerontology Series A: Biological Med. Sci. 312, 312 (2009).

[169] Dane J. Genther et al., *Association of Hearing Loss with Hospitalization and Burden of Disease in Older Adults*, 309(22) JAMA 2322, 2323 (2013).

[170] Alan M. Jette, *The Impact of Hearing Loss on Physical Functioning*, *in* Inst. of Med. & Nat'l Research Council, Hearing Loss & Healthy Aging: Workshop Summary 19, 20 (2014), http://www.nap.edu/read/18735/chapter/4#18 [https://perma.cc/3AGC-HWCF].

[171] *See* Lin et al., *supra* note 7, at 219 (stating that whether hearing devices and rehabilitation strategies could have an effect on cognitive decline and dementia is unknown and requires further research).

for seniors with hearing loss.[172] Hearing aid users show significant improvement in both mental[173] and physical domain[174] tests, and show a smaller decline in vitality than those who do not use hearing aids.[175] Researchers hypothesize that the use of hearing aids promotes "feelings of being competent, confident, and inclined (or motivated) to exploit life's possibilities . . . and could thus improve overall well-being."[176] Addressing hearing loss, through both "preventive strategies focusing on timely identification of persons with hearing handicap, as well as . . . referral to hearing services could both counteract the poor use of prescribed hearing aids and preserve [quality of life] in older hearing-impaired adults."[177]

These connections between hearing loss and various medical and social conditions form a sufficient basis for providing insurance coverage for all screenings—even for those who are asymptomatic[178]—and for hearing aids. While more research on these issues would be helpful, the quality of life for many seniors hangs in the balance. Additional insurance coverage cannot wait until these connections are thoroughly explained.

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[172] Gopinath et al., *supra* note 9, at 146–51. These findings come from a study of approximately 850 participants with hearing loss who were evaluated over a fifteen-year period. *Id.* at 147. Participants responded to the "36-Item Short-Form Survey (SF-36)" which measures the following characteristics: "'physical functioning', 'role limitations due to physical problems', 'bodily pain', 'general health perceptions', 'vitality', 'social functioning', 'role limitations due to emotional problems', and 'mental health'." *Id.* Those who used hearing aids demonstrated higher scores in the "mental composite" score and in the "mental health" domain compared to non-hearing aid users. *Id*. at 148. Additionally, those with self-perceived hearing loss experienced a larger negative impact on quality of life than those with measured but uncorrected hearing loss. *Id.*; *see also* Arlinger, *supra* note 144, at 2S19 (citing Francesco Cacciatore et al., *Quality of Life Determinants and Hearing Function in an Elderly Population: Osservatorio Geriatrico Campano Study Group*, 45 GERONTOLOGY 323 (1999)); Chisolm, *supra* note 50, at 33–34 (citing Cynthia D. Mulrow et al., *Association Between Hearing Impairment and the Quality of Life of Elderly Individuals*, 38(1) J. AM. GERIATRICS SOC'Y 45 (1990)); Adrian Davis et al., *Acceptability, Benefits, and Costs of Early Screening for Hearing Disability: A Study of Potential Screening Tests and Models*, 11(42) HEALTH TECH. ASSESSMENT 1, 1 (2007); Chuan-Fen Liu et al., *Long-term Cost-effectiveness of Screening Strategies for Hearing Loss*, 48 J. REHABILITATION RES. & DEV. 235, 235 (2011); Cynthia D. Mulrow et al., *Quality-of-life Changes and Hearing Impairment*, 113 ANNALS OF INTERNAL MED. 188, 188 (1990). *But cf*. Cynthia D. Mulrow et al., *Sustained Benefits of Hearing Aids*, 35 J. OF SPEECH, LANGUAGE, & HEARING RES. 1402, 1402 (1992) (finding cognitive changes reverted back to baseline after twelve months).

[173] Gopinath et al., *supra* note 9, at 146–51.

[174] Weinstein, *supra* note 164, at 27 (citing E. M. Chia et al., *Hearing Impairment and Health-Related Quality of Life: The Blue Mountains Hearing Study*, 28(2) EAR & HEARING 187, 187–95 (2007)).

[175] Gopinath et al., *supra* note 9, at 148. Experts agree that more research is needed as to the efficacy of hearing aids and other communication strategies in improving health. *See, e.g.*, Weinstein, *supra* note 164, at 28.

[176] Gopinath et al., *supra* note 9, at 150.

[177] *Id.*

[178] For a discussion of the United States Prevention Services Task Force ("USPSTF") and its withdrawal of its earlier recommendation for asymptomatic screening, see *infra* notes 246–252 and accompanying text.

V. Legal Arguments for Enhanced Insurance Coverage of Hearing Aids

The ACA represents a dramatic shift from the perspective of the 1965 Medicare statute, which was designed to cover the increasing health care costs that accompany old age and, in particular, the costs of a severe illness.[179] In contrast, the ACA reflects a largely preventive focus, transforming "the U.S.'s public and private health care financing systems into vehicles for promoting public health."[180] The ACA includes opportunities and funding for innovations to enhance quality of care and reduce costs within the Medicare and Medicaid programs, provisions requiring a plethora of preventive services, all mandated at no cost, and the more well-known provisions requiring health insurance for all Americans. While the ACA does not override Medicare's statutory exclusion of hearing aid coverage, it does build on a gradual transformation of Medicare from a program providing coverage largely for expensive medical care to one promoting health and broad coverage of routine but necessary medical services.[181] One author describes the ACA's expansion of Medicare coverage to preventive care and care management as "manifest[ing] a recognition that the traditional Medicare benefits and coverage package . . . [does] not permit the Medicare program to cover the range of health-related services that are warranted based upon the needs of Medicare beneficiaries, sound medical practices, and information developed by medical and other sciences."[182] The changes in the Medicare law since its enactment as well as the ultimate passage of the ACA conflict with Medicare's 1965 statutory exclusion of hearing aids. They also highlight a philosophical divide between the two major health care initiatives of the last sixty years. The ACA reflects contemporary thinking on the role of health insurance, and it can be utilized to amend the Medicare law and ultimately mandate insurance coverage of hearing devices.

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[179] *See, e.g.*, *History of SSA During the Johnson Administration 1963-1968*, Soc. Security Admin., https://www.ssa.gov/history/ssa/lbjmedicare1.html [https://perma.cc/R6PS-7QUC] (noting that, in 1965, slightly over half of all seniors had any insurance coverage for hospitalization and even those with substantial savings "faced the threat of being wiped out financially by a severe illness"). One history of Medicare states that when John F. Kennedy and Richard Nixon discussed health care coverage, "Health insurance . . . was synonymous with hospital insurance." William A. Pearman & Philip Starr, Medicare: A Handbook on the History and Issues of Health Care Services for the Elderly 7 (1988).

[180] John Aloysius Cogan, Jr., *The Affordable Care Act's Preventive Services Mandate: Breaking Down the Barriers to Nationwide Access to Preventive Services*, 39 J.L. Med. & Ethics 355, 355 (2011). For further discussion of a public health perspective on hearing services, see Burkard, *supra* note 88, at 76–77.

[181] For a discussion of the gradual evolution within Medicare, see generally DeBoer, *supra* note 16; Eleanor D. Kinney, *The Affordable Care Act and the Medicare Program*, 13 Yale J. Health Pol'y, L. & Ethics 253, 258 (2013) (describing the ACA reforms with respect to Medicare as "simply steps in the implementation of reforms already in place").

[182] DeBoer, *supra* note 16, at 495–96.

This Part will begin by outlining the preventive care focus of the ACA. It will then describe Medicare, given its role as the primary insurer of seniors, providing a summary of the history and purpose of the legislation, particularly as it relates to hearing aids. This Part recommends avenues for enhancing coverage of these devices for Medicare beneficiaries in light of the ACA. These avenues include recommending that the Secretary, as permitted under the ACA, authorize pilot projects providing insurance coverage of hearing devices in the Medicare program. This Part also highlights specific ACA provisions that, but for the Medicare statutory exclusion, could be construed to provide insurance coverage of hearing devices, and demonstrate that these provisions justify amending Medicare to provide such coverage. In its final section, this Part proposes methods of expanding coverage of hearing aids under the Medicaid program and private insurance plans.

A. Preventive Care Focus of the ACA

The ACA reflects a focus on and is replete with preventive care coverage requirements. The statute provides for two sets of specific covered preventive services. First, the ACA requires a wide range of preventive services for all insured people, including alcohol counseling, vaccinations, and screenings for depression, HIV, Type 2 diabetes, obesity, and tobacco use.[183] Secondly, the ACA requires specific screenings for select populations,[184] and mandates preventive screening and other services for the elderly through the Medicare program.[185] Specific preventive services for seniors include bone mass measurements, cardiovascular disease screening, medical nutrition therapy, prostate cancer screening, glaucoma tests, and flu shots, among others.[186] Under the ACA, Medicare recipients receive these services in the ACA-mandated initial "Welcome to Medicare" visit, annual "wellness visits," and personalized prevention plans.[187] Additionally, the Secretary of the

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[183] *See* 42 U.S.C. § 300gg-13 (a) (1) (2012); *Preventive Services Covered Under the Affordable Care Act*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Sept. 23, 2010), http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html [https://perma.cc/BB8B-3GEH].

[184] *See What Free Screenings Does the ACA Require?*, AM. MED. NEWS (Aug. 2013), http://m.amednews.com/article/20130812/government/130809971&template=mobileart [https://perma.cc/XYU9-MLP6].

[185] *The Affordable Care Act and Older Americans*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Mar. 19, 2015), http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-and-older-americans/index.html [https://perma.cc/XBK6-433A]. For a list of all preventive services available to Medicare recipients, see *Preventive Services*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PreventiveServicesPoster.pdf [https://perma.cc/FZQ8-F3MJ].

[186] *The Affordable Care Act and Older Americans*, *supra* note 185. For further discussion of the expansive nature of these preventive services for seniors, see DeBoer, *supra* note 16, at 537–40.

[187] DeBoer, *supra* note 16, at 537 (citing Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 4103(b), 124 Stat. 119, 553–55 (2010) (codified as amended at

Department of Health and Human Services ("HHS") is authorized to modify the list of "no-cost" preventive services if the modification is consistent with United States Preventive Services Task Force ("USPSTF") recommendations and with services required in the initial prevention visit.[188] These mandated preventive services must be provided at no cost to the patient, including no copays and no deductibles.[189] A radical departure from prior law and policy, this "no-cost" requirement applies to Medicare recipients[190] and to all private health plans, including individual, small group, large group, and self-insured plans, except those plans "grandfathered" under the ACA.[191]

The ACA also requires health insurance plans to include "Essential Health Benefits" ("EHB"), a term defined to include services in ten broad statutory categories.[192] All plans offered in the individual and small group market (as well as Medicaid[193]) are required to provide an EHB package.[194]

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42 U.S.C.A. § 1395x(hhh)(4)(G) (West 2015))). Significantly, the ACA specifically provides that its preventive services mandate does not alter coverage of diagnostic or treatment services as outlined in the Medicare program statute. DeBoer, *supra* note 16, at 540 (citing Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 4105(b), 124 Stat. 119, 559 (2010) ("Nothing in the amendment . . . shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.")).

[188] 42 U.S.C.A. § 1395m(n) (West 2015).

[189] 42 U.S.C. § 300gg-13(a)(1) (2012). For further discussion of specific issues arising in the preventive care coverage context, see *Preventive Services Covered by Private Health Plans under the Affordable Care Act*, Kaiser Fam. Found. (Aug. 4, 2015), http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/ [https://perma.cc/8M9S-QRZN].

[190] For a list of Medicare Part B preventive services covered, see *Preventive & Screening Services*, Ctrs. for Medicare & Medicaid Servs. (Mar. 5, 2012), http://www.medicare.gov/coverage/preventive-and-screening-services.html [https://perma.cc/LB83-CZ8V]. For information on who is covered by Medicare Part B, see Cubanski et al., *supra* note 4 (citing *March 2015 Medicare Baseline*, Cong. Budget Off. (Mar. 2015), http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf [https://perma.cc/9TTP-XDJU]). Although regulations governing Medicare Advantage Plans (Part C) are slightly different, those plans, too, are required to provide preventive services at no costs. *Your Medicare Coverage Choices*, Ctrs. for Medicare & Medicaid Servs., https://www.medicare.gov/sign-up- change-plans/decide-how-to-get-medicare/your-medicare-coverage-choices.html [https://perma.cc/WWF7-D9Q9]. A 2012 report from CMS indicates that all Medicare Advantage insurers provided all of the preventive services to their enrollees without cost. *See* Ctrs. for Medicare & Medicaid Servs., The Affordable Care Act: A Stronger Medicare Program 8 (Feb. 2013), https://www.cms.gov/apps/files/medicarereport2012.pdf [https://perma.cc/2S7G-99EK].

[191] For a list of Medicare Part B preventive services covered, see *Preventive & Screening Services*, *supra* note 190. For facts on who is covered by Medicare Part B, see Cubanski et al., *supra* note 4 (citing *March 2015 Medicare Baseline*, Cong. Budget Off. (Mar. 2015), http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf [https://perma.cc/9TTP-XDJU]).

[192] *Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage*, Ctrs. for Medicare & Medicaid Servs. (Feb. 2, 2013), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html [https://perma.cc/W9LM-BCRX].

[193] Plans provided in the Medicaid programs, which are required to offer the same benefits as those contained in an EHB package, are referred to as Alternative Benefit Plans. *Alternative Benefit Plan Coverage*, Medicaid, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/alternative-benefit-plans.html [https://perma.cc/YH59-24PY]; *Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage*, *supra* note 192.

EHB includes, for example, services related to mental health and substance abuse, maternity and newborn care, emergency services, pediatric services, laboratory services, and rehabilitative and habilitative services.[195] Plans must provide a predetermined level of coverage and require no deductibles, copays, or co-insurance.[196] Although this mandate currently does not apply to large employer plans,[197] large employers are required to limit cost sharing for essential benefits that would otherwise be included in an EHB package.[198]

This shift to a prevention model is evident throughout the ACA. For example, the statute required the establishment of a National Prevention, Health Promotion and Public Health Council ("Council") within the HHS to "coordinate and lead the federal effort in prevention, wellness, and health promotion practices, the public health system, and integrative health care."[199] The Act also requires the President to establish an Advisory Group on Prevention, Health Promotion and Integrative and Public Health to advise the Council on "lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion."[200]

Other prevention-oriented initiatives in the ACA include the creation of both a health education and public outreach campaign and a media campaign focused on health promotion and disease prevention, as well as the develop-

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For specifics on the application of the EHB requirement to the Medicaid context, see, for example, Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., to State Medicaid Dirs. (Nov. 20, 2012), https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf [https://perma.cc/9ZAP-28PP].

[194] *Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage, supra* note 192.

[195] *Id.*

[196] *Preventive Services Covered by Private Health Plans under the Affordable Care Act*, *supra* note 189; *see also Summary of the Affordable Care Act*, KAISER FAM. FOUND. (Apr. 25, 2013), http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/ [https://perma.cc/AJ4A-3Q38].

[197] This was based on the assumption that most large group plans already included these benefits. For further discussion of these issues, see, for example, Christopher Condeluci, *How the ACA Insurance Market Reforms Could Affect Large Employers*, FORBES (Oct. 24, 2014, 5:53 PM), http://www.forbes.com/sites/realspin/2014/10/24/how-aca-insurance-market-reforms-could-affect-large-employers/ [https://perma.cc/SQD2-JVE6].

[198] *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS. FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN, https://www.cms.gov/cciio/resources/files/downloads/ehb-faq-508.pdf [https://perma.cc/V6YS-9Y89]; Condeluci, *supra* note 197.

[199] DeBoer, *supra* note 16, at 535 (citing Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 4001(a), (d)(1), 124 Stat.119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended at 26 U.S.C. § 4001 (repealed 2014))).

[200] *Id.* at 534 (citing Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 4001(f)(1), (3), 124 Stat. 119). This entity is composed of non-federal licensed health professionals. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 4001(f)(2), 124 Stat. 119, 539–40 (codified as amended at 42 U.S.C.A. § 300u-10 (West 2014)).

ment of a website to provide personalized prevention plan tools.[201] The ACA also created a Prevention and Public Health Fund to promote wellness, prevention, and public health activities.[202] It requires the Center for Disease Control and Prevention's Community Prevention Services Task Force to coordinate with the USPSTF to review evidence related to "effectiveness, appropriateness, and cost effectiveness of community prevention interventions."[203] Further, the ACA provides grants for community-based preventive health programs and interventions for seniors.[204] One final example is the establishment of the Patient-Centered Outcomes Research Institute ("PCORI"), an independent body dedicated to evaluating and disseminating information about clinical effectiveness research.[205]

A particularly important provision within the ACA signifies the United States' shifting perspective on health care and health care financing. The ACA created the Center for Medicare and Medicaid Innovation ("Innovation Center") within the Centers for Medicare and Medicaid ("CMS") to test new models for the provision of, and payment for, health care within the Medicare and Medicaid programs.[206] The "twin goals" of these innovations are "enhancing the quality of health and health care while reducing costs through improvement of health outcomes."[207] Significantly, the Secretary is permitted, "solely for the purposes of testing innovative service delivery and payment models, to waive requirements in the Medicare program statute 'as may be necessary.'" [208] This provision paves the way to test the viability of Medicare coverage of hearing aids and would override the statutory hearing aid exclusion.

B. The ACA and Medicare Coverage of Hearing Aids

1. Medicare's Statutory Exclusion

The Medicare statute explicitly excludes coverage of "routine physical checkups, eyeglasses . . . [and] hearing aids or examina-

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[201] *Id.* (citing Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 4004(a), (c), (e), (f), 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. §§ 300u-12(a), (c), (e), (f) (2012))).

[202] Cogan, *supra* note 180, at 356 (citing 42 U.S.C. § 300u-11 (2012)).

[203] *Id.* (citing 42 U.S.C. § 280(g)-10 (2012)). For recommendations of this Community Prevention Services Task Force, see *All Findings of the Community Preventive Services Task Force*, The Community Guide (Dec. 23, 2015), http://www.thecommunityguide.org/about/conclusionreport.html [https://perma.cc/38PT-6PCG]. Interestingly, none of the Task Force's recommendations relate to hearing health. *Id.* For additional information on the USPSTF, see *infra* notes 245–248.

[204] Cogan, *supra* note 180, at 356 (citing 42 U.S.C. §§ 300u-13–14 (2012)).

[205] 42 U.S.C. § 1320e(b)(1) (2012).

[206] *Center for Medicare and Medicaid Innovation*, Ctrs. for Medicare & Medicaid Servs. (Feb. 5, 2016), https://www.cms.gov/about-cms/agency-information/cmsleadership/office_cmmi.html [https://perma.cc/D582-E5BD].

[207] DeBoer, *supra* note 16, at 546.

[208] *Id.* at 549; *see also* 42 U.S.C.A. § 1315a(d)(1) (West 2015).

tions."[209] While Medicare Part B covers a diagnostic hearing exam if ordered by a physician to determine if medical treatment is necessary, it does not cover routine hearing exams, hearing devices, or exams for the purpose of prescribing, fitting, or changing hearing aids.[210]

Although Medicare's statutory exclusion of hearing aids conflicts with current health care policy, it was arguably consistent with the goals of the Social Security Act when enacted. Medicare was intended to provide protection against the high costs of hospitalization and medical care[211] and sought to "provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act."[212] One goal of the program was to help make "economic security in old age more realistic."[213] Although originally drafted to cover only hospital stays,[214] the legislation was later expanded to cover physician services.[215] After the implementation of the Social Security and Medicare programs, the economic status of elderly Americans improved dramatically.[216] In 1966 seniors paid fifty-six percent of their med-

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[209] 42 U.S.C.A. § 1395y(a)(7) (West 2015); *see also* Zells v. U.S. Sec'y of Health & Human Servs., 44 F. App'x 917, 917 (9th Cir. 2011), *cert. denied*, 132 S. Ct. 852 (2011). Zells argued that Medicare should cover a hearing aid necessary to compensate for hearing loss due to Medicare-covered treatment for cancer, arguing, inter alia, that this was not routine coverage. *Zells*, 44 F. App'x at 917.

[210] *See Your Medicare Coverage*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.medicare.gov/coverage/hearing-and-balance-exam-and-hearing-aids.html [https://perma.cc/32QY-A7ZJ]; CMS PUB. 14 § 15903, HEARING AID EXCLUSION, 2013 WL 3303025. The exclusions in the Medicare statute are implemented through "National Coverage Decisions" ("NCD"), 42 C.F.R. 405.1060 et seq. *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html [https://perma.cc/UG3R-SJK4] (describing specific items, services or treatments covered by Medicare). With respect to hearing aids, there have been no coverage decisions, presumably because of the statutory coverage exclusion. The only applicable decision concerns coverage for cochlear implants, which Medicare characterizes as a device "implanted surgically to stimulate auditory nerve fibers." CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL, CHAPTER 1, at 89–90 (Rev. 187, Dec. 10, 2015), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf [https://perma.cc/CDY7-8ARJ]. Coverage is provided for cochlear implants provided the patient qualifies under the standards in the NCD. *Id.* If CMS does not address a given coverage issue through an NCD, a fiscal intermediary or carrier may make a "Local Coverage Decision" ("LCD") as to whether or not coverage is reasonable and necessary for a particular service or item. *See Medicare Coverage Database*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?list_type=ncd [https://perma.cc/C7VU-XAHF]. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PROGRAM INTEGRITY MANUAL, CHAPTER 13 (Rev. 608, Aug. 14, 2015), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c13.pdf [https://perma.cc/8G8K-AZV6].

[211] Wilbur J. Cohen & Robert M. Ball, *Social Security Amendments of 1965: Summary and Legislative History*, SOC. SECURITY BULL. 3, 3 (1965).

[212] S. REP. NO. 89-404, at 1943 (1965).

[213] *Id.* at 1964.

[214] *See* Jacqueline Fox, *Medicare Should, but Cannot, Consider Cost: Legal Impediments to a Sound Policy*, 53 BUFF. L. REV. 577, 588 (2005).

[215] *Id.* at 589.

[216] *See, e.g.*, KAREN DAVIS ET AL., MEDICARE: 50 YEARS OF ENSURING COVERAGE AND CARE 10 (2015).

ical expenses out of pocket, while today seniors pay only thirteen percent of their medical expenses out of pocket.[217]

While an earlier, more progressive plan proposed during the Truman administration included coverage for hearing aids and eyeglasses,[218] the original Medicare bill did not cover routine hearing-related services, nor did it cover vision or dental services—including eyeglasses, eye tests, and dental procedures and supplies such as cleanings, fillings, tooth extractions, dentures, and dental plates—or related vision or dental preventive care.[219] Payment was provided for medical services if the patient had a specific complaint, but not "for routine annual or semiannual checkup[s]."[220] There is a dearth of legislative history on these particular statutory exclusions, and the exact reasons for these omissions are lost in history.[221] The exclusions were included despite the legislative goal of making "the best of modern medicine more readily available to the aged."[222]

One obvious explanation for the exclusion of hearing aids, vision services, and dental care was cost.[223] In analyzing the role of cost in formulating Medicare policy in 1965, Jacqueline Fox writes, "There was no provision made for coverage of preventive care and the premise of Part B, as with Part A, was to be there for cases of emergency and high costs."[224] Robert M. Ball, Commissioner of Social Security at the time, has explained that the decision not to include coverage for routine care relating to hearing loss and hearing aids was made under the assumption that once seniors gained insurance coverage for the "major costs of hospital and physicians' services most older people [would] be better able to budget for the costs of routine care . . . ."[225] Ball also has commented that the population likely to benefit

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[217] *Id.*

[218] John D. Morris, *Truman's Health Plan Compared with British*, N.Y. Times, May 1, 1949, at E7.

[219] Social Security Act of 1965, Sec. 1862(a)(7), codified at 42 U.S.C. § 1395y(a)(7) (2012); *Dental Services*, Ctrs. for Medicare & Medicaid Servs., https://www.medicare.gov/coverage/dental-services.html [https://perma.cc/8725-GSEC]; *see* Cohen & Ball, *supra* note 211, at 3.

[220] S. Rep. No. 89-404, at 1990 (1965).

[221] *See* Lise Hamlin, *Hearing Aid Coverage Under Medicare*, Hearing Loss Magazine, at 28, 28 (July 1, 2014), http://www.nxtbook.com/ygsreprints/HLAA/g42663_hlaa_julaug2014/#/28 [https://perma.cc/PS2F-YFDL].

[222] S. Rep. No. 89-404, at 1965.

[223] Most scholars assume the exclusion was due to costs. *See, e.g.*, Cassel, *supra* note 36, at 553 (writing that "[t]he justification used in 1965 to exclude hearing aids from Medicare coverage was that hearing technologies were routine and low cost and therefore should be paid for by consumers"); Whitson & Lin, *supra* note 23, at 1740 ("The rationale for noncoverage of sensory aids initially hinged on the notion that consumers should pay for common and affordable items, especially those of limited health benefit.").

[224] Fox, *supra* note 214, at 589.

[225] *Hearing Loss, Hearing Aids, and the Elderly: Hearing before the Subcomm. on Consumer Interests of the Elderly of the Special Comm. on Aging*, 90th Cong. 309–10 (1968) (statement of Robert M. Ball, Comm'r on Soc. Sec.).

from hearing services was not a "large enough, or strong enough, or savvy enough contingent to be at the table when the bill was drafted."[226]

Subsequent legislation has attempted to eliminate Medicare's statutory exclusion of hearing aid coverage. When Medicare expansion was considered in 1968, hearing aid coverage was deemed unlikely because of concerns that new coverage would also have to include eye tests, eyeglasses, and other preventive care.[227] At congressional hearings conducted in 1973, Senator Frank Church described the absence of hearing aid insurance coverage as an issue with "great economic and emotional impact upon the elderly."[228] He noted that "few disabilities have more harsh impact upon the elderly," particularly given that hearing loss leads to "emotional isolation."[229] In 1976, then-Congressman Claude Pepper, Chairman of the Subcommittee on Health and Long Term Care, issued a report that recommended Medicare cover the costs of hearing aids, along with eyeglasses and dentures.[230] As one witness testified, "the use of hearing aids ends the 'isolation, degradation and loneliness' of many older people who might otherwise mistakenly be 'thought to be practically senile.'" [231] Despite this powerful testimony, these efforts failed, as have subsequent attempts to provide such coverage.[232] However, the ACA changes the landscape and evolving medical research alters the dynamic, making this an opportune time to once again advocate for Medicare coverage of hearing aids.[233] Such an amendment would enhance the health of many seniors currently unable to afford hearing aids and is

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[226] Hamlin, *supra* note 221, at 28.

[227] *Hearing Loss, Hearing Aids, and the Elderly: Hearing before the Subcomm. on Consumer Interests of the Elderly of the Special Comm. on Aging*, 90th Cong. 309–10 (1968) (statement of Robert M. Ball, Comm'r on Soc. Sec.).

[228] *Hearing Aid and the Older American: Hearings before the Subcomm. on Consumer Interests of the Elderly of the Special Comm. on Aging*, 93rd Cong. 1 (1973) (statement of Sen. Frank Church, Chairman, Special Comm. on Aging).

[229] *Id.* Senator Church noted that even the former Secretary of Health, Education and Welfare, Wilbur Cohen, who opposed Medicare coverage of hearing aids in 1965, believed by 1973 that providing coverage, with a small deductible, was feasible. *See id*; *see also* Interdepartmental Task Force, Dep'ts of Health, Education, & Welfare, New Perspectives in Health Care for Older Americans 52 (1976), https://ia601700.us.archive.org/7/items/netivesi00unit/netivesi00unit.pdf [https://perma.cc/SE3X-PFRY] (recommending that Medicare Part B cover hearing aids, eyeglasses and dentures).

[230] *See generally* H.R. Subcomm. on Health and Long-Term Care of the Select Comm. on Aging, 94th Cong., Medical Devices and the Elderly: Unmet Needs and Excessive Costs for Eyeglasses, Hearing Aids, Dentures and Other Devices (1976). After noting the expense of hearing devices, the Report also pointed out conflicts of interest in the hearing aid industry, inadequate training of hearing aid dealers, an absence of educational requirements for hearing aid dealers in some states, lack of industry oversight, and overpricing and excessive costs. *See id.* Additional issues within the hearing aid industry, while potentially still relevant today, are beyond the scope of this paper.

[231] *Id.* (citing the testimony of Dr. Blue Carstenson).

[232] *See, e.g.*, Medicare Hearing Enhancement and Auditory Rehabilitation (HEAR) Act of 2007, H.R. 1912, 110th Cong. (2007); Medicare Hearing Enhancement and Auditory Rehabilitation (HEAR) Act of 2009, S. 1837, 111th Cong. (2009). See *infra* notes 262–281 and accompanying text for discussion of legislation currently pending.

[233] For arguments in support of altering Medicare policies, see, for example, Whitson & Lin, *supra* note 23, at 1739 ("Given present-day understanding of the health effects of sensory

consistent with the ACA's dual goals of enhancing the quality of care while reducing costs.[234]

2. The ACA and Insurance Coverage of Hearing Aids for Medicare Beneficiaries

The philosophy embodied in the ACA provides opportunities to expand insurance coverage of hearing aids. The Secretary could, and should, use her authority under the ACA to implement model projects requiring insurance coverage of hearing devices, even for Medicare beneficiaries. Additionally, the statutory requirements of a wide range of preventive services at no cost, some of which arguably should include hearing aids, justifies amending the Medicare statute to provide such coverage. The recent and mounting empirical evidence of additional medical problems caused by, and related to, untreated hearing loss warrants these changes.

a. Implement Pilot Projects Authorizing Coverage of Hearing Devices

The Act authorizes the Secretary to test innovative service delivery and payment models that "focus on the twin goals of improving health care quality and reducing spending."[235] The previously-mentioned Center for Medicare and Medicaid Innovation ("Innovation Center"), an entity within CMS, is the repository for pilot projects, and currently prioritizes "[t]esting new payment and service delivery models, [e]valuating results and advancing best practices," and "[e]ngaging a broad range of stakeholders to develop additional models for testing."[236] All projects are carefully evaluated, examining quality of care, including patient outcomes, and the models' impact on spending.[237] Participating entities are provided feedback throughout the demonstration, and the Innovation Center promotes "broad and rapid dissemination of evidence and best practices that have the potential to deliver higher

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loss and advances in technology, Medicare policy for coverage of hearing and vision rehabilitative services, established a half century ago, may need reconsideration.").

[234] Determining the actual costs of providing hearing devices through Medicare is beyond the scope of this article. However, Medicare coverage of hearing aids would potentially minimize the expense of health care costs for medical conditions caused or exacerbated by untreated hearing loss. For a general discussion of this principle, see, for example, Scott Solkoff, *Report on the Patient Protection and Affordable Care Act: Its Impact on the Special Needs and Elder Law Practice*, 11 NAELA J. 1, 18 (2015) (noting that "[b]y emphasizing more proactive health care, it is believed that the overall need for and cost of health care will decrease because the need for treatment will decrease").

[235] DeBoer, *supra* note 16, at 549 (citing 42 U.S.C.A. § 1315a(a)(1) (West 2015)).

[236] *About the CMS Innovation Center*, Ctrs. for Medicare & Medicaid Servs., https://innovation.cms.gov/about/index.html [https://perma.cc/L2KY-8A83] (last updated Oct. 21, 2015). For a more specific list of "Model Design Factors," see *Model Design Factors*, Ctrs. for Medicare & Medicaid Servs., https://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf [https://perma.cc/VN3N-MF22].

[237] *About the CMS Innovation Center*, *supra* note 236.

quality and lower cost care."[238] Projects must address the needs of Medicare beneficiaries, Medicaid beneficiaries, or those individuals who participate in both programs.[239] Pilot projects currently underway include an "Oncology Care Model," a "Medicaid Emergency Psychiatric Demonstration" model, and an "Independence at Home" model for Medicare beneficiaries with multiple chronic conditions.[240]

Pilot projects providing coverage of hearing aids in the Medicare program would satisfy the ACA's goals and CMS's priorities as well as offer numerous benefits. First, the pilots would enable CMS to evaluate the impact of this coverage on health care quality and patient improvement. Second, they would provide CMS with the data necessary to evaluate the relative costs of providing hearing aid coverage within the Medicare program compared with the costs of addressing the medical, social, and other consequences of untreated presbycusis. Finally, and most importantly, such projects would bypass the current Medicare statutory exclusion of hearing aids on an interim basis, providing insurance coverage of hearing aids for the many seniors who need them both to prevent the attendant health consequences of untreated hearing loss and to maintain their quality of life. Such a project, ideally suited for the Innovation Center, would generate invaluable data and insights to broadly inform insurance coverage policies regarding the treatment of presbycusis.

b. Utilize the Preventive Focus of the ACA to Advocate Amending the Medicare Statute to Cover Hearing Aids

The abundant variety of preventive services mandated under the ACA and the links between untreated presbycusis and other medical conditions would, but for Medicare's statutory exclusion, warrant Medicare coverage of hearing aids. First, hearing aids themselves are preventive services. Second, the screening for and treatment of presbycusis should be included in the depression screening that the ACA mandates. Given that the ACA, standing alone, would provide for insurance coverage for hearing aids, the Medicare

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[238] *Id.* According to a summary of the ACA from Health Policy Alternatives dated April 2010, "The Secretary must select models for testing where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures." HEALTH POLICY ALTERNATIVES, SUMMARY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT 86 (Apr. 20, 2010), http://www.acscan.org/pdf/healthcare/implementation/PPACA-HPA-summary.pdf [https://perma.cc/Q5WP-G5N2].

[239] *See* HEALTH POLICY ALTERNATIVES, *supra* note 238, at 22–23. Those beneficiaries who participate in both Medicare and Medicaid are known as "dual eligibles." *See, e.g.*, *Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 2016), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf [https://perma.cc/6ZNB-BEBY].

[240] *Innovation Models*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/#views=models [https://perma.cc/WZ65-KBM7].

statute should be amended to be consistent with the ACA's philosophy and provisions.

i. Hearing Aids as Preventive Services

The negative medical consequences of untreated hearing loss among the elderly are well documented.[241] These adverse medical conditions may be prevented, or at a minimum mitigated, by insurance coverage of regular hearing screenings and the provision of hearing aids when indicated. Therefore, both the screenings and the hearing aids can and should be considered preventive services under the ACA. This argument is particularly persuasive given the relatively new evidence of a link between hearing loss and dementia[242] and the uncontroverted evidence that hearing devices enhance quality of life.[243] The Secretary's authority under the ACA permits her to modify the list of preventive services,[244] and such coverage is consistent with the ACA as written. Such a change would further enhance arguments for eliminating Medicare's current statutory exclusion.

The path to include hearing aids as a preventive service is through the USPSTF, which recommends to CMS the preventive services that should be mandatory.[245] To formulate its recommendations, the USPSTF relies on the work of the Evidence-based Practice Center ("EPC"),[246] which reviews and evaluates existing scientific, evidence-based literature. After analyzing the evidence, the USPSTF "grades" the preventive services, and those receiving an "A" or "B" grade are included in the list of mandatory preventive ser-

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[241] *See supra* Part II.

[242] *See* Lin et al., *supra* note 7, at 214.

[243] *See supra* Part II.

[244] 42 U.S.C.A. § 1315a(d)(3) (West 2015).

[245] The original role of the USPSTF was to recommend the standard medical care that primary care physicians should provide and to whom. Paul Bernstein, *Prevention of Illness*, 12 Marq. Elder's Advisor 157, 162 (2010) (providing a history and summary of the role of the USPSTF). Today, policy makers, public and private insurers, research organizations, and professional associations rely on the USPSTF's recommendations. Janell Guirguis-Blake et al., *Current Processes of the U.S. Preventive Services Task Force: Refining Evidence-Based Recommendation Development*, 147(2) Annals Internal Med. 117, 117 (2007). The USPSTF, composed of private sector experts in prevention and primary care, examines the scientific evidence supporting a particular medical service, makes recommendations, and develops a future research agenda. Bernstein, *supra*, at 162. While some consider the USPSTF "unbiased, independent and meticulous" and "the 'gold standard' of preventive health services," *id.*, others have accused it of becoming politicized, particularly in the context of the health care reform debate, *see, e.g.*, Editorial, *Senate Health Care Follies*, N.Y. Times (Dec. 6, 2009), http://www.nytimes.com/2009/12/06/opinion/06sun1.html [https://perma.cc/G9FJ-QK4D]. For a response to those critics, see Joseph W. Stubbs, *Statement on the Politicization of Evidence-based Clinical Research*, Am. Coll. Physicians (Nov. 24, 2009), http://www.eurekalert.org/pub_releases/2009-11/acop-sot112409.php [https://perma.cc/KY4J-KZER].

[246] Bernstein, *supra* note 245, at 162–63.

vices.[247] Significantly, the Task Force's recommendations do not take cost considerations into account.[248]

USPSTF's 1996 recommendation on hearing stated that "[s]creening older adults for hearing impairment . . . and making referrals for abnormalities when appropriate, is recommended."[249] The most recent USPSTF statement regarding hearing loss and older adults was issued in 2012 and is a departure from its 1996 statement. The 2012 recommendation, addressing asymptomatic screenings, was based on evidence available through 2010. The recommendation included an "I" statement, a finding of insufficient evidence to make a decision.[250] In 2012, the USPSTF concluded that "the current evidence is insufficient to assess the balance of benefits and harms of screening for hearing loss in asymptomatic adults aged 50 years or older."[251] However, the 2012 statement also noted the underreporting of hearing loss due to stigma, the public's reluctance to utilize hearing devices, the subtle and gradual onset of hearing loss among the elderly, and the effect of other diseases and impairments on self-reported hearing loss.[252] At least one study suggests that testing with a tone-emitting otoscope is inexpensive and efficient,[253] and the USPSTF acknowledged that hearing tests cause no harm.[254]

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[247] *Grade Definitions*, U.S. Preventive Servs. Task Force (Oct. 2014), http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm [https://perma.cc/G8YP-TAF4]. An "A" grade is assigned if "there is high certainty that the net benefit is substantial." *Id*. A "B" grade is assigned if there is "high certainty that the net benefit is moderate" or "moderate certainty that the net benefit is moderate to substantial." *Id.* The USPSTF may also conclude that a preventive service is not worthy of a recommendation for or against (a "C" grade), or that the evidence is insufficient to make a determination (an "I" grade). *Id.*

[248] Bernstein, *supra* note 245, at 163.

[249] U.S. Preventive Servs. Task Force, Screening for Hearing Impairment, *in* Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force (2d ed. 1996), http://www.ncbi.nlm.nih.gov/books/NBK15501/ [https://perma.cc/ 9FCU-6LBU].

[250] *Grade Definitions*, *supra* note 247.

[251] *Hearing Loss in Older Adults: Screening*, U.S. Preventive Servs. Task Force (July 2015), http://www.uspreventiveservicestaskforce.org/uspstf11/adulthearing/adulthearrs.htm [https://perma.cc/ANW8-9E6J]; *see also* Virginia A. Moyer, *Screening for Hearing Loss in Older Adults: U.S. Preventive Services Task Force Recommendation Statement*, 157(9) Annals Internal Med. 655, 660 (2012). The 2012 recommendation may also reflect changes in the USPSTF method of evidence review and assessment as well as in the recommendation statement itself, changes developed between 2001 and 2007. *See* Mary B. Barton et al., *How to Read the New Recommendation Statement: Methods Update from the U.S. Preventive Services Task Force*, 147 Annals Internal Med. 123, 123–27 (2007).

[252] *See Final Recommendation Statement: Hearing Loss in Older Adults: Screening*, U.S. Preventive Servs. Task Force (Dec. 2014), http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hearing-loss-in-older-adults-screening [https://perma.cc/RXP5-DUWS]. In its recommendation, the USPSTF also cited a study on the positive impact of hearing aids, noting "quality-of-life improvements, including social, affective, cognitive and physical domains." *Id*. (citing Cynthia D. Mulrow et al., *Quality-of-life Changes and Hearing Impairment. A Randomized Trial*, 113 Annals Internal Med. 188, 188 (1990)); Moyer, *supra* note 251, at 658.

[253] *See* Liu et al., *supra* note 172, at 240 (reporting on a study among veterans 50 years of age or older screened through one of three mechanisms, with the effectiveness measure being hearing aid use one year later). *See generally* C.W. Watson et al., *Telephone Screening Tests for Functionally Impaired Hearing: Current Use in Seven Countries and Development of a US*

Finally, the USPSTF statement acknowledged that "the cost of a hearing aid is a barrier to use for many older adults because it is not covered by Medicare and many private insurance companies."[255]

At the time of the USPSTF's 2012 recommendation regarding asymptomatic screening, many of the evidence-based research findings on the link between hearing loss among the elderly and other medical problems, including dementia, were not yet available. The USPSTF should reexamine its standard in light of this powerful new evidence and conclude, given current medical research and the other factors noted in its 2012 recommendation on screening, that an "A" or "B" recommendation is indicated. Such a recommendation would result in the addition of hearing screenings and devices to the list of mandated preventive services.

ii. Incorporate the Screening and Treatment of Presbycusis into Mandatory Depression Screenings

The mandatory "Welcome to Medicare" visit requires a depression screening for all seniors,[256] as do the required annual prevention visits.[257] "Essential Health Benefits," required for individual and small group plans as well as for Medicaid, also require depression screening as a preventive service for all adults.[258] It is well documented that untreated presbycusis causes isolation, which often leads to depression.[259] Research indicates that "[u]ncorrected hearing loss gives rise to a poorer quality of life, related to isolation, reduced social activity, a feeling of being excluded, and increased symptoms of depression."[260] A depression screening that does not also include, at a minimum, screening for and treatment of those medical conditions that can cause depression has limited utility. It would be unthinkable to conduct a screening for another serious condition such as heart disease, but then not provide insurance coverage for the patient's high blood pressure that contributes to the heart disease. Given the link between hearing loss and depression, failure to include hearing screening and treatment as part of a

Version, 23(10) J. AM. ACAD. OF AUDIOLOGY 757 (2012) (describing a national telephone hearing test modeled on one used in seven other countries that can be taken at www.nationalhearingtest.org).

[254] *See* Moyer, *supra* note 251, at 656 ("Adequate evidence shows that the harms of treatment of hearing loss in older adults are small to none.").

[255] *Final Recommendation Statement: Hearing Loss in Older Adults: Screening*, *supra* note 252.

[256] *See Your "Welcome to Medicare" Preventive Visit*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.medicare.gov/people-like-me/new-to-medicare/welcome-to-medicare-visit.html [https://perma.cc/NQK6-NYC4].

[257] *See Depression Screenings*, MEDICARE, https://www.medicare.gov/coverage/depression-screenings.html [https://perma.cc/H5YL-KACF].

[258] *See Preventive Care Benefits for Adults*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.healthcare.gov/preventive-care-adults/ [https://perma.cc/SV7Z-8YJK].

[259] *See* Arlinger, *supra* note 144, at 2S17.

[260] *Id.* at 2S20; *see also* Gates & Mills, *supra* note 21, at 1116 ("People with depression and cognitive dysfunction should be assessed to exclude occult hearing loss as a contributing factor.").

depression screening is contrary to the preventive care philosophy embodied in the statute.[261] Because recommending a hearing device for those with hearing loss would assist in alleviating depression, insurance coverage of both the screening and treatment should be required under these provisions, creating more impetus for repeal of Medicare's statutory hearing aid exclusion.

C. Amending the Medicare Statute in Light of the ACA

Today's climate of preventive care creates an opportunity to bring the two major health reform initiatives of the last sixty years into sync with one another. As indicated, the ACA's mandated prevention services provide the foundation for repeal of Medicare's statutory hearing aid exclusion. Three bills pending as of the date of this Article address this issue. The most straightforward proposal is the "Seniors Have Eyes, Ears, and Teeth Act," H.R. 3308, introduced by Representative Alan Grayson in July 2015.[262] This legislation proposes to expand Medicare coverage by removing the explicit statutory language excluding coverage for hearing aids, eyeglasses, and dental expenses.[263] Although the legislation has 116 sponsors as of March 2016, it is not expected to pass.[264]

The second proposal, the "Help Extend Auditory Relief (HEAR) Act of 2015," adds "aural rehabilitation" to the definition of covered "medical and other services."[265] It also adds hearing aids to the list of covered durable medical equipment.[266] The legislation further defines "hearing rehabilitation" to include services provided by a physician or audiologist, services including aural rehabilitation, audiologic assessments, and "a threshold test to determine audio acuity."[267] The HEAR Act defines a hearing aid as "any wearable instrument or device for, offered for the purpose of, or represented as aiding individuals with, or compensating for hearing loss."[268] Another bill, the "Medicare Hearing Aid Coverage Act of 2015," would delete the hearing aid coverage exclusion and require a study reviewing program pro-

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[261] Gates & Mills, *supra* note 21, at 1116.

[262] Seniors Have Eyes, Ears, and Teeth Act, H.R. 3308, 114th Cong. (2015).

[263] *Id.*

[264] *See, e.g., H.R. 3308: Seniors Have Eyes, Ears, and Teeth Act*, GovTrack, https://www.govtrack.us/congress/bills/114/hr3308 [https://perma.cc/E8EQ-VX8Q] (giving H.R. 3308 a 0% chance of passage, in part because all of the co-sponsors are members of the minority party).

[265] Help Extend Auditory Relief (HEAR) Act of 2015, H.R. 2748, 114th Cong. § 2(a)(3)(GG) (2015).

[266] *Id.*

[267] *Id.* at § 2(c).

[268] *Id.* at § 2. This definition eliminates current distinctions between hearing aids, said to enhance hearing, and cochlear implants and BAHA devices, which replace hearing. The HEAR Act provides that a hearing aid is available every three years for individuals who meet other statutory requirements. *Id.*

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NYSBA

2017 Elder Law and Special Needs Section Annual Meeting Recap

By James R. Barnes and Salvatore M. Di Costanzo

On Tuesday, January 24, 2017, members of the Elder Law and Special Needs Section gathered in New York City for the New York State Bar Association's 2017 Annual Meeting. A standing-room only crowd packed the New York Hilton Midtown for the Section's annual business meeting, awards presentation, and MCLE program. Section Chair, **David Goldfarb**, Esq., presided over the meeting.

The first order of business was a presentation by the Nominating Committee for the 2017-2018 slate of officers, including:

- Chair: **Marty Hersh**, Esq.
- Chair-Elect: **Judith Grimaldi**, Esq.
- Vice Chair: **Tara A. Pleat**, Esq.
- Secretary: **Matthew J. Nolfo**, Esq.
- Treasurer: **Deepanker Mukerji**, Esq.

The entire slate was unanimously elected by the members in attendance. After the election, the agenda turned to the presentation of Section awards. This year's recipient of the Section's most prestigious award was **Jeffrey A. Asher**, Esq., of the Law Offices of Jeffrey A. Asher, PLLC. The Section recognized him for his actions in furtherance of the rights of the elderly and persons with disabilities. Jeff led two major initiatives in the past year on behalf of the Section, namely the work group focused on the reformation of the Power of Attorney and serving as liaison to the Trusts and Estates Law Section as it presses for the adoption of the Uniform Trust Code. The next presentation was the Honorable Joel K. Asarch Elder Law and Special Needs Section Scholarship, which is awarded through The New York Bar Foundation. This scholarship is awarded annually to a law student who demonstrates an interest in the legal rights of the elderly or those with disabilities. The 2017 recipient was **Jessica Klersy**, a third year law student at Touro Law Center.

Last October, the Section lost one of its cherished members with the passing of **Sharon Kovacs Gruer**, Esq. A moving memorial celebrating the life and many accomplishments of Sharon was given by **Beth Abrahams**, Esq., and **Ellen Makofsky**, Esq. Sharon was a past Chair of the Section, a tireless advocate of the elderly and disabled, and a dear friend to so many members of the Section. She will be truly missed.

The MCLE program, offering attendees 4.0 CLE credits, was co-chaired by **Salvatore M. Di Costanzo**, Esq., and **James R. Barnes**, Esq. The program commenced with a three-part "Update" including, a Medicaid Update by **Richard A. Marchese**, Esq., a Guardianship Update by **Fern J. Finkel**, Esq., and a Tax Update by **David R. Okrent**, Esq. The Annual Meeting Update is typically one of the most anticipated parts of the program, as attendees are looking for guidance in the form of recent case law, new regulations, legislative updates, and the anticipated climate for the new year. After a brief break, the late afternoon program sought to focus on many of the details and nuances inherent in investments, especially relative to planning and Medicaid eligibility. The meeting continued with a panel presentation entitled "Annuities: Medicaid Treatment, Tax Considerations, and Appropriateness as an Investment." This panel was moderated by **Richard A. Weinblatt**, Esq., and included **Bruce L. Birnbaum**, JD, LLM, CLTC, and **David J. DePinto**, Esq. The final speaker of the day was **Amy J. Guss**, Esq., and her topic was "IRAs, Beneficiary Designations, Medicaid Planning Considerations with Focus on SNTs."

The program concluded a little before 6 p.m., and many of the attendees walked across the street from the Hilton to a cocktail reception at the Warwick New York Hotel. This reception was generously sponsored by CaringKind and RDM Financial Group. Attendees were able to relax and enjoy conversation in a warm setting with colleagues following a full day of Section meetings, activities, and educational programs. As the 2017 Annual Meeting concluded, members returned home with a renewed energy for the Section's work ahead this calendar year.

James R. Barnes and Salvatore M. Di Costanzo

NYSBA 2017 Annual Meeting
Elder Law and Special Needs Section Meeting

Fern J. Finkel, Esq.
Finkel & Fernandez LLP

Richard A. Marchese, Esq.
Woods Oviatt Gilman LLP

Fern J. Finkel, Esq., Finkel & Fernandez LLP and David R. Okrent, Esq., The Law Offices of David R. Okrent

NYSBA Elder Law and Special Needs Section Legislation Committee Spring 2017 Update

By Co-Chairs Deepankar Mukerji and Jeffrey Asher

On February 7, 2017, twelve members of the Elder Law and Special Needs Section traveled to Albany, and with the help of the NYSBA's lobbyists and staff, lobbied our state legislators to oppose certain provisions of Governor **Andrew M. Cuomo**'s proposed 2017-2018 Executive Budget ("Budget Bill"). At the Section's Executive Committee meeting in January, the Legislation Committee presented these items of concern to that Committee, which authorized the Section representatives to voice the Section's concerns regarding the legislative items. In particular, the provisions of the Budget Bill we lobbied against were as follows:

- S2007/A2007, Part E, Section 1, which seeks to require a nursing home level of care as a condition of managed long-term care eligibility,
- S2007/A2007, Part E, Section 5, which seeks to eliminate Medicaid "spousal refusal," and
- S2008/A3008, Part AA, which seeks to amend the New York State Banking Law to add a new section 4-d allowing financial institutions to put transaction holds on accounts if the financial institution suspects certain financial abuses.

Additionally, the members of the Elder Law and Special Needs Section lobbied against the following proposed bill:

- A1350, which seeks to amend Article 81 to, among other things, prohibit health care facilities from bringing Article 81 guardianship proceedings when the primary purpose of the proceeding is bill collection or resolving a bill collection dispute, as well as to prohibit creditors, health care providers, daycare providers, educational providers, or residential services providers of an incapacitated person to serve as their guardian.

Lastly, the members of the Elder Law and Special Needs Section lobbied for the swift passage of an amendment to Social Services Law § 366(2)(b)(2)(iii) to conform with the recent passage of federal Public Law 114-255—entitled the "21st Century Cures Act"—allowing disabled individuals to create their own special needs trust. This conforming legislation was not included in the Governor's Budget Bill and will have to be introduced by the legislature. The Section and NY-NAELA continue to work on passage of this milestone law.

The Section's memoranda outlining its positions on the above issues may be found in the Library page of the Section's online Community page.

The Section members made a strong case in opposition to these issues and, although none of our proposed changes were incorporated into the Governor's revised Budget Bill, the Section, with the assistance of the NYSBA's lobbyists and staff, will continue to work with our state legislators to include our positions in the Senate's and Assembly's version(s) of the Budget Bill.

The Section's Legislation Committee will keep you up to date as things progress.

Tammy R. Lawlor, Rene H. Reixach, Deepankar Mukerji and Matt Nolfo

Britt N. Burner and Judy D. Grimaldi

Tammy R. Lawlor, Rene H. Reixach, Deepankar Mukerji and Matt Nolfo

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visions providing coverage of hearing aids, with recommendations for potential changes.[269]

Other, less ambitious efforts to address the expense of hearing aids also are pending. Bills have been introduced in both the Senate and in the House of Representatives that would provide a tax deduction up to $500 for the cost of a qualified hearing aid.[270] Taking an alternative approach, the "Audiology Patient Choice Act of 2015" would enable patients to obtain care from an audiologist without being under the care of a physician, thus reducing patient costs.[271] This legislation as well as the tax credit proposals would reduce the costs of securing hearing aids, but they would not provide sufficient coverage for many Medicare recipients.

Another bill, the Medicare Audiology Services Enhancement Act of 2015, amends the Medicare statute to include "audiology services."[272] Audiology services are defined as the following services provided by an audiologist, pursuant to a physician's order or referral: hearing and balance assessment services; auditory treatment services, including auditory processing and auditory rehabilitation treatment; vestibular treatment services; and "intraoperative neurophysiologic monitoring services."[273] This legislation expands audiologists' role beyond diagnosis to include treatment, while retaining the physician referral requirement.[274]

The ACA's philosophy and mandated provisions support the elimination of Medicare's statutory exclusion of hearing aid coverage. Undoubtedly, one reason for the previous lack of success in eliminating this statutory exclusion is the cost of providing hearing aids to the many people who need them. These costs were explicitly acknowledged as recently as the fall of 2015 when the PCAST noted that this factor has prevented Congressional support for amending the Medicare law.[275] PCAST suggested that reforms in the marketing and bundling of hearing aids could reduce costs, and consequently "the analysis and potential for Congressional action would change."[276]

Arguments for the elimination of the hearing aid exclusion are augmented by the demonstrated relationship between age-related hearing loss

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[269] *See* Medicare Hearing Aid Coverage Act of 2015, H.R. 1653, 114th Cong. (2015).

[270] *See* Hearing Aid Assistance Tax Credit Act, S. 315, 114th Cong. (2015); Hearing Aid Assistance Tax Credit Act of 2015, H.R. 1882, 114th Cong. (2015).

[271] Audiology Patient Choice Act of 2015, H.R. 2519, 114th Cong. (2015); *see also* Medicare Telehealth Parity Act of 2015, H.R. 2948, 114th Cong. (2015) (expanding the telehealth program geographically, and expanding the definition of services to include audiology services, replacing "physician and practitioner" with "physician and professional," and then defining "professional" to include "audiologist").

[272] *See* Medicare Audiology Services Enhancement Act of 2015, H.R. 1116, 114th Cong. (2015).

[273] *Id*. For an analysis of this legislation, see *Know the Facts: H.R. 1116*, Am. Speech-Language Hearing Ass'n, http://www.asha.org/Advocacy/Know-the-Facts-About-HR-1116 [https://perma.cc/7XFB-K9S5].

[274] *See Know the Facts: H.R. 1116*, *supra* note 273.

[275] Letter from PCAST, *supra* note 14, at 2.

[276] *Id*.

and dementia as well as the uncontroverted evidence that hearing loss causes isolation, depression, cognitive changes, and increased falls.[277] Although providing coverage of hearing devices would likely result in additional costs,[278] treating each condition impacted by hearing loss is also expensive. Appropriately treating the underlying condition, the hearing loss itself, could well result in substantial savings from a reduced need to treat the related conditions and is an issue that, at a minimum, should be explored in evidence-based research.[279] Acknowledging the importance of cost concerns, medical researchers are now concluding that "equal consideration must be given to the societal and health care costs incurred by not enabling access to assistive devices that may prevent or delay the expensive consequences of sensory impairments."[280] Given the high percentage of seniors affected by presbycusis and the other health conditions to which it contributes, providing Medicare coverage for hearing aids may well save money and will undoubtedly improve the quality of life for many.[281]

D. The ACA and Medicaid Coverage of Hearing Aids

1. Preventive Services Argument

The Medicaid program, the federal-state partnership program that provides health insurance for people who have low incomes, provides limited coverage for hearing aids. In its current form, it could potentially assist those receiving Medicare and Medicaid, as well as those "young" seniors not yet eligible for Medicare[282] and those enrolling in Medicaid through the ACA's Medicaid expansion provision (in those states opting to participate).[283]

However, twenty-one states and the District of Columbia provide no Medicaid coverage at all for hearing devices for adults.[284] In those states

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[277] *See supra* Part II.

[278] Determining the actual costs of providing hearing devices through Medicare is beyond the scope of this article. The pending legislative proposals that would provide for Medicare coverage of hearing devices do not, as of the date of publication, contain fiscal notes estimating the costs of implementation.

[279] Further discussion on the impact of providing preventive services on the cost of medical care is worthy of substantial discussion, but beyond the scope of this article.

[280] Whitson & Lin, *supra* note 23, at 1739.

[281] Expanding Medicare law in this fashion has the potential to affect both the Medicaid and private insurance market, even in the absence of statutory or regulatory changes to those programs. *See, e.g.*, Kinney, *supra* note 181, at 256 ("State Medicaid programs and private payers are greatly influenced by the policy developments in the Medicare program and often follow Medicare policy.").

[282] *See Seniors & Medicare and Medicaid Enrollees*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html [https://perma.cc/283Q-MFUY].

[283] *See supra* notes 107–108.

[284] *See Medicaid Regulations*, *supra* note 112. For a list of coverage by state, see *Medicaid Benefits: Hearing Aids*, KAISER FAM. FOUND., http://kff.org/medicaid/state-indicator/hearing-aids/ [https://perma.cc/26YU-MBRE].

offering some Medicaid coverage, the coverage amount often is capped and the plans frequently exclude coverage for fittings or repairs after the warranty has expired, for servicing of hearing aids, and for certain types of hearing devices.[285] The result is devices and services that remain unaffordable for many.

The ACA offers some assistance. The arguments outlined above for coverage via the preventive services provisions of the ACA apply to some Medicaid recipients needing hearing devices. The ACA requires Medicaid programs to provide the preventive services recommended by the USPSTF to newly eligible, adult Medicaid recipients.[286] Additionally, the ACA provides a financial incentive to states to include preventive services at no cost to all recipients.[287] For those eligible before the enactment of the ACA and those in the states that elect to receive the financial incentive, the preventive services arguments raised with respect to Medicare apply to Medicaid with equal or greater force. Because Medicaid has no statutory exclusion of hearing aids, arguments for coverage under Medicaid, read in conjunction with the ACA, are even stronger than those made in the Medicare context.

2. Rehabilitative and Habilitative Services Argument

The ACA requires most insurance plans to include EHB and those offered under Medicaid to include "Alternative Benefit Plans" that essentially mirror the requirements for EHB.[288] While the ACA defines the categories of EHB that plans must provide, the specifics are defined at the state level.[289] The Act states that each state may designate a "benchmark plan,"[290] with individual plans following its requirements.[291] If the state's identified benchmark plan does not include the required categories of benefits, HHS may supplement it.[292] If the selected plan fails to include rehabilitative and habilitative services, the state may determine which services should be pro-

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[285] *Medicaid Regulations*, *supra* note 112.

[286] *See* Alexandra Gates et al., *Coverage of Preventive Services for Adults in Medicaid*, KAISER FAM. FOUND. (Nov. 13, 2014), http://kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid/ [https://perma.cc/C22F-VTND].

[287] *See generally id.*

[288] *See* VICKI WACHINO, CTRS. FOR MEDICARE & MEDICAID SERVS., CMCS INFORMATIONAL BULLETIN: ALTERNATIVE BENEFIT PLAN CONFORMING CHANGES (Jan. 28, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-28-16.pdf [https://perma.cc/4GT9-RHVL]; *see also* Mann, *supra* note 193 (describing the relationship between EHB and Alternative Benefit Plans within Medicaid).

[289] *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/cciio/resources/data-resources/ehb.html [https://perma.cc/VFF2-RC46] [hereinafter *EHB Benchmark Plans*].

[290] 45 C.F.R. § 156.100 (2016).

[291] SABRINA CORLETTE ET AL., COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL 2 (Mar. 2013), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Mar/1677_Corlette_implementing_ACA_choosing_essential_hlt_benefits_reform_brief.pdf [https://perma.cc/RNE4-96LC].

[292] 45 C.F.R. § 156.110(c) (2016).

vided in that category.[293] Finally, the regulations state that if the state plan does not include habilitative services as required, health plans still must provide such services.[294]

Among the EHB the ACA mandates for individual and small group plans and for Medicaid recipients—albeit under a different name—are rehabilitative and habilitative services and devices.[295] Those terms have been defined in a uniform glossary of definitions that health plans for individuals, plans in the exchange, and group plans must provide in a standard statement of benefits and coverage.[296] Final regulations have been promulgated regarding some of the relevant definitional provisions.[297] The glossary itself, developed with the assistance of the National Association of Insurance Commissions ("NAIC"), was finalized on August 17, 2015.[298] It defines "rehabilitation services" as:

> Health care services that help a person *keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.* These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.[299]

"Habilitation services" are defined as:

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[293] *Id.* at § 156.110(f); *see also EHB Benchmark Plans*, *supra* note 289.

[294] 45 C.F.R. § 156.115(a)(5) (2016). Plans are required to provide services "in a manner that meets one of the following: (i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings; (ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and (iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices." *See also EHB Benchmark Plans*, *supra* note 289.

[295] *EHB Benchmark Plans*, *supra* note 289. EHB "include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care." *Id.* For similar requirements in the Medicaid program, see WACHINO, *supra* note 288.

[296] *Summary of Benefits & Coverage & Uniform Glossary*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html [https://perma.cc/8KB3-D2BW].

[297] Summary of Coverage and Benefits and Uniform Glossary, 80 Fed. Reg. 34,292 (June 16, 2015) (to be codified at 26 C.F.R. 54.9815-2715(c)(2)(i), 29 C.F.R. 2590.715-2715(c)(2)(i), and 45 C.F.R. 147.200(c)(2)(i)).

[298] *Glossary of Health Coverage and Medical Terms*, U.S. DEP'T OF LABOR, http://www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf [https://perma.cc/3B8N-8SUQ]; Summary of Coverage and Benefits and Uniform Glossary, 80 Fed. Reg. 34,292 (June 16, 2015) (to be codified at 45 C.F.R. 147).

[299] *Glossary of Health Coverage and Medical Terms*, *supra* note 298 (emphasis added).

> Health care services that help a person *keep, learn or improve skills and functioning for daily living.* Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.[300]

Although the mandate to provide these services is clear, what the terminology actually means is less clear. The Habilitation Benefits Coalition ("HBC"), formed to advocate for habilitation coverage in the EHB package, offers one of the most useful discussions of these provisions.[301] Advocating for definitions that provide the full range of services and devices for those with disabilities, the HBC relies on congressional testimony to interpret the provisions. It notes the floor statement of Congressman George Miller, who described rehabilitative and habilitative services as including "items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning."[302] Congressman Bill Pascrell, Jr. offered a similar description of this provision, adding that the goal is to "maintain or prevent deterioration of functioning as a result of an illness, injury, disorder or other health condition."[303]

Commentators acknowledge the challenge of determining the meaning of rehabilitative and habilitative services under the ACA. Some argue that "insurers will likely continue developing their own definitions of coverage for items such as habilitative services, which have not been traditionally covered by insurers."[304] Consequently, internal appeals and external reviews may focus on the meaning of this terminology.[305]

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[300] *Id.* (emphasis added).

[301] *See generally Habilitation Benefits Coalition*, HAB: HABILITATION BENEFITS COALITION, https://habcoalition.wordpress.com/ [https://perma.cc/CVZ2-FH34]. The thirty-four-member coalition includes the American Speech-Language-Hearing Association and the Hearing Loss Association of America. *See* AM. ASS'N ON HEALTH & DISABILITY, Defining 'Rehabilitative and Habilitative Services and Devices' in the Essential Health Benefits Package Pursuant to Congressional Intent Under the Affordable Care Act 10 (Oct. 20, 2011), http://www.aahd.us/wp-content/uploads/2012/03/HabilitationBenefitsCoalition101911.pdf [https://perma.cc/K3W4-6ETS].

[302] AM. ASS'N ON HEALTH & DISABILITY, *supra* note 301, at 4 (citing 156 CONG. REC. H1882 (Mar. 21, 2010)).

[303] *Id.* (citing 156 CONG. REC. E462 (Mar. 23, 2010)).

[304] Joseph Friedman et al., *A Crystal Ball: Managed Care Litigation in Light of the Patient Protection and Affordable Care Act*, 27 HEALTH L. 1, 6 (Dec. 2014); *see also* Wendy K. Mariner, *The Picture Begins to Assert Itself: Rules of Construction for Essential Health Benefits in Health Insurance Plans Subject to the Affordable Care Act*, 24 ANNALS HEALTH L. 437, 439 (2015) (regarding EHB, writing that "both the statute and the regulations speak in broad categorical terms, leaving considerable discretion to insurers to decide what to cover in particular health plans and in individual cases," and then discussing the appropriate application of statutory rules of construction to both the insurance policies and the statutory and regulatory provisions).

[305] Friedman et al., *supra* note 304, at 6.

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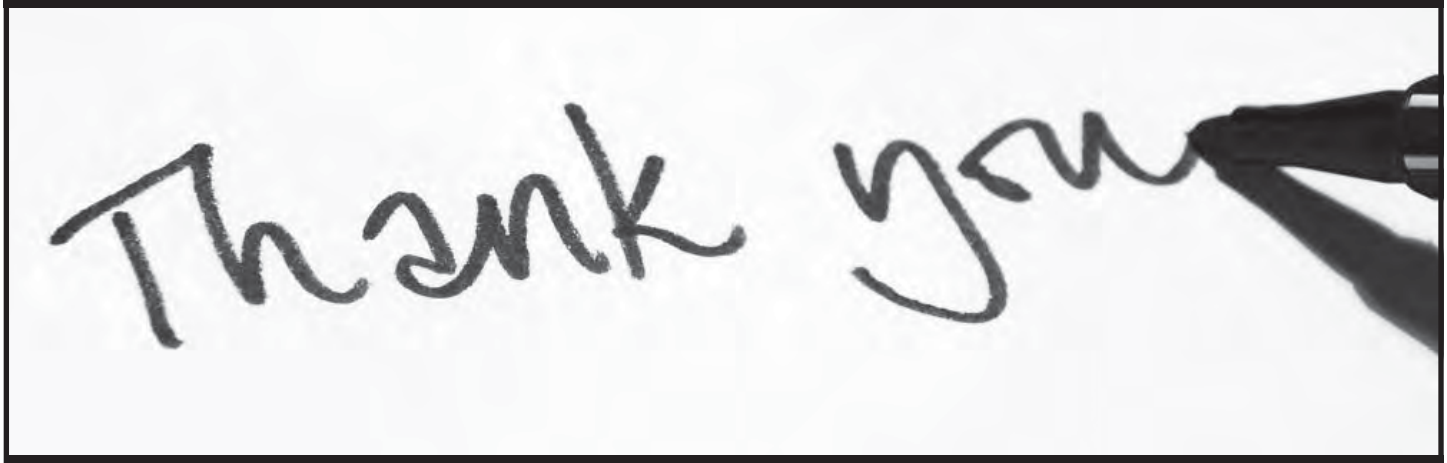

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Although none of the limited interpretations of this particular mandatory EHB mention hearing aids, providing coverage of hearing aids is consistent with the sparse definition offered in the law.[306] Hearing aids restore hearing, assist seniors in maintaining their function in a variety of contexts, and help prevent further deterioration, in particular for those documented medical conditions that may be caused or exacerbated by untreated presbycusis. Therefore, hearing aids should be covered under the rehabilitative and habilitative provisions of the ACA for those enrolled in Medicaid.

As she does in provisions regarding preventive services, the Secretary of HHS has the authority to modify the EHB currently required.[307] Adding hearing devices to those benefits is consistent with the Secretary's authority and the goals of the ACA.

3. Implement a Pilot Project

As discussed above with respect to Medicare, the Secretary could implement a pilot project testing the viability of providing mandatory hearing aid coverage in the Medicaid program. As with a Medicare pilot, the data from that project could be utilized to evaluate potential enhanced quality of care and the impact on costs.

In light of these arguments, expanding Medicaid coverage could be approached on several levels: (1) adding hearing aids to the list of preventive services; (2) explicitly stating that hearing devices are included in the rehabilitative and habilitative services section of the EHB provisions; (3) advocating for individual Medicaid recipients seeking coverage of hearing devices, including appealing denials of coverage; and (4) urging Congress to mandate that all Medicaid plans provide additional coverage for the costs of hearing devices.[308] Finally, absent a congressional mandate, individual states

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[306] It is also consistent with the definitions recommended by the Habilitation Benefits Consortium, *supra* note 301. *See also* 80 Fed. Reg. 75,517 (proposed Dec. 2, 2015) (addressing coverage of non-EHB in benchmark plans, stating that plans may not include "routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or nonmedically necessary orthodontia as EHB.") Notably, hearing aids have not been included on this list. *Id.*

[307] 42 U.S.C.A. § 1395m(n)(1) (West 2015). For further discussion of the Secretary's role regarding EHB, see DeBoer, *supra* note 16, at 535–40.

[308] Because Medicaid is a joint federal-state program, Congress sets the minimum required services that states must cover. Jean Hearne & Julie Topoleski, *An Overview of the Medicaid Program*, Cong. Budget Off. (Sept. 18, 2013), https://www.cbo.gov/publication/44588 [https://perma.cc/8QAM-Y3CS]; *see also Benefits*, Ctrs. for Medicare & Medicaid Servs., http://medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html [https://perma.cc/8N4N-5MM3]. For example, in the Medicaid program for Children, Early and Periodic Screening Diagnostic and Treatment ("EPSDT"), the federal government mandates the coverage of hearing screenings and treatment. *See, e.g.*, *Early and Periodic Screening, Diagnostic, and Treatment*, Ctrs. for Medicare & Medicaid Servs., http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html [https://perma.cc/CMV3-MK25]

should expand their Medicaid coverage to be consistent with the ACA's preventive care provisions.[309]

E. The ACA and Private Insurance Coverage of Hearing Aids

The arguments above regarding coverage of hearing devices under the rehabilitative and habilitative categories of EHB apply to policies in the private sector as well. If these arguments prove unsuccessful, the passage of the ACA renders strategies for greater mandated private insurance coverage of hearing devices at the state level a harder sell, ironically.[310] As indicated, each state must have a "benchmark plan" applicable to individual and small group markets,[311] with each plan providing the defined EHB.[312] If states decide to expand the list of EHB, states are obligated to pay either the enrollee or the insurer for the costs of those additional health benefits.[313] Although the insured are responsible for cost sharing, including deductibles, copays, and co-insurance, those costs are limited and annual and lifetime limits cannot be applied to EHB,[314] resulting in greater costs to the states if they expand the list of EHB. A state-by-state examination of the approved benchmark plans demonstrates that only Hawaii, which offers coverage of

("Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.").

[309] This interpretation of the ACA and explicit expansion of the ACA, even if successful, would leave the many low- and moderate- income seniors not quite "poor enough" for Medicaid to fend for themselves.

[310] Independently of the ACA, some states have legislated coverage of hearing aids. *See, e.g.*, *State Hearing Health Insurance Mandates*, HEARING LOSS ASS'N AMERICA (Jan. 2014), http://hearingloss.org/content/state-hearing-health-insurance-mandates [https://perma.cc/9XKK-MXHC]. However, most of this coverage is for those under the age of 18, and when adults are covered, the amount is generally quite limited. *Id.*

[311] *EHB Benchmark Plans*, *supra* note 289. If states refuse to identify a benchmark plan, a default plan applies. 42 C.F.R. § 156.100 (2015).

[312] An exception to this are plans that are grandfathered, which include job-based plans that have not significantly reduced benefits or increased costs since March 2010 and individual plans for people that were enrolled prior to March 2010. *See Grandfathered Health Insurance Plans*, HEALTHCARE.GOV, https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/ [https://perma.cc/E49M-SFU9].

[313] 42 U.S.C. § 18031(d)(3) (2012); *see also Quick Take: Essential Health Benefits: What Have States Decided for Their Benchmark?*, KAISER FAM. FOUND. (Dec. 7, 2012), http://kff.org/health-reform/fact-sheet/quick-take-essential-health-benefits-what-have-states-decided-for-their-benchmark/ [https://perma.cc/J7FP-KQT5] ("The ACA specifies that if states require plans to cover services beyond those defined as EHBs by the law, for example certain state-mandated benefits, states must defray the costs of those benefits."). Health benefits required by states prior to December 31, 2011 are defined by regulation as not "additional EHB" and therefore states are not required to reimburse enrollees or insurers for them. *EHB Benchmark Plans*, *supra* note 289.

[314] 45 CFR § 147.126. Individuals are, however, responsible for premiums and out-of-pocket expenses. 42 U.S.C.A. § 18022(c)(3)(A) (West 2014). The cap on cost-sharing does not include premiums or spending on non-covered services. *Id.* at § 18022(c)(3)(B).

hearing aids up to every sixty months,[315] has added hearing aids to its list of expanded EHB coverage.[316]

One incentive private employers may have to incorporate hearing aid coverage into their plans is the growing number of seniors remaining in the workforce.[317] Private, employee-based insurance represents the largest sector of the health insurance market.[318] An increasing number of seniors are postponing retirement and continuing in the workforce, largely due to financial insecurity.[319] Some of those over fifty, and certainly many over sixty-five, will experience age-related hearing loss.[320] Mandating insurance coverage for assistive hearing devices, including hearing aids where appropriate, will enable older employees to remain in the work force longer and encourage employers to retain experienced employees able to work at maximum productivity.[321]

VI. Recommendations

The philosophy embodied in the ACA affirms the necessity of insurance coverage of hearing aids for seniors. Specific provisions in the Act and its underlying philosophy are useful catalysts for amending the Medicare law to eliminate the statutory exclusion and provide coverage for hearing screenings and devices. Although past efforts to do so were stymied, the ACA and empirical evidence demonstrating the relationship between presbycusis and other medical conditions alter the dynamic. Now is the time, as the health care and insurance industries continue adapting to comply with the

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[315] Haw. Dep't of Commerce & Consumer Affairs, PPACA Essential Health Benefits – Benchmark Benefits Package 5, http://files.hawaii.gov/dcca/ins/Benchmark%20Benefit%20Package%20Grid_Final%20for%20DCCA%20Site.pdf [https://perma.cc/P9V4-R2K2].

[316] *EHB Benchmark Plans*, *supra* note 289. In some states, coverage that existed prior to the ACA is maintained on the list of required benefits.

[317] Philip Moeller, *Challenges of an Aging American Workforce*, U.S. News & World Rep. (June 19, 2013, 11:50 AM), http://money.usnews.com/money/blogs/the-best-life/2013/06/19/challenges-of-an-aging-american-workforce [https://perma.cc/8WR2-V4VQ].

[318] Cogan, *supra* note 180, at 361.

[319] *See, e.g.*, Don Lee, *More Older Workers Making Up Labor Force*, L.A. Times (Sept. 4, 2012), http://articles.latimes.com/2012/sep/04/business/la-fi-labor-seniors-20120903 [https://perma.cc/4LKK-BL6M].

[320] *Basic Facts About Hearing Loss*, Hearing Loss Ass'n America, http://www.hearingloss.org/content/basic-facts-about-hearing-loss [https://perma.cc/9UR4-TQKU] (noting that approximately twenty percent of adults in the United States report some degree of loss, and at age 65, one out of three individuals has a hearing loss).

[321] A senior with presbycusis and still in the workforce may well have an ADA argument if an employer fails to accommodate her hearing loss. *See* Equal Emp't Opportunity Comm'n v. Branch Banking & Tr. Co., 571 F. Supp. 2d 682, 685 (E.D.N.C. 2008) (finding material issue of fact as to whether employer failed to reasonably accommodate for disabled employee's hearing loss); *see also* Jeffries v. Verizon, No. CV 10–2686, 2012 WL 4344197, at *17 (E.D.N.Y. Aug. 31, 2012) (recommending summary judgment be denied to employer in regards to defendant employer's failure to accommodate claim due to his hearing loss). The role of the ADA in requiring employers to provide hearing devices is beyond the scope of this article.

ACA, to develop the robust coalitions necessary to make this statutory change a reality.

Absent that statutory change, the ACA presents very specific opportunities to argue for hearing aid coverage for Medicare and Medicaid recipients and those with private insurance. Advocating the implementation of pilot projects providing this coverage to Medicare and Medicaid recipients is one strategy. Other strategies include lobbying the Secretary to add hearing devices to the list of preventive services and EHB, and arguing for coverage under existing preventive services and EHB provisions. These strategies should be pursued on behalf of individual beneficiaries and also in a broader, systemic fashion. Making these arguments forcefully will require motivated advocates and willing clients, and hearing aid providers comfortable with testing these theories.

Additionally, it is critical to lobby and coordinate with regulators, particularly at CMS, to adopt regulations and coverage decisions allowing for these interpretations of the ACA. CMS's recent position reversal following a proposal to further limit Medicare coverage of hearing devices illustrates the powerful role of effective regulatory advocacy. Historically, Medicare has covered certain devices including cochlear implants, and brainstem implants,[322] as well as osseointegrated implants,[323] which include the BAHA.

In 2014, CMS proposed revising its definition of hearing devices eligible for Medicare coverage,[324] and specifically proposed excluding the BAHA, which previously had been covered, from Medicare coverage.[325] Responding to comments opposing this change, CMS reversed its position in the Final Rule[326] and continued existing CMS policy treating BAHAs like

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[322] Ctrs. for Medicare & Medicaid Servs., Medicare Benefit Policy Manual: General Exclusions from Coverage, Chapter 15, at 27–28 (Rev. 198, Nov. 6, 2014), http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf [https://perma.cc/7HCW-WQ59] [hereinafter General Exclusions from Coverage]. Such devices are used when "hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss or surgery." *Id.* These devices are defined as "devices that replace the function of cochlear structures or auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays." *Id.*

[323] *Id.* Osseointegrated implants are defined as "devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer." *Id.*

[324] Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 79 Fed. Reg. 40,207, 40,213–14 (proposed July 11, 2014).

[325] *See* General Exclusions from Coverage, *supra* note 322; *see also* Ctrs. for Medicare & Medicaid Servs., Medicare National Coverage Determinations Manual, Chapter 1, at 89–90 (Rev. 187, Dec. 10, 2015), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf [https://perma.cc/G2VN-DPCN].

[326] Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 79 Fed. Reg. 66,120, 66,241–427 (Nov. 6, 2015) (to be codified at 42 C.F.R. § 411.15(d)(2)). CMS articulated three arguments for its reversal of position: (1) AOIs, like cochlear implants, are in fact implants and therefore considered prosthetic devices covered under other Medicare categories; (2) These devices replace rather than restore or amplify hearing, as do more tradi-

cochlear implants, covering both under Medicare.[327] This revised Final Rule demonstrates the power of effective administrative advocacy and the need for vigilant monitoring of regulatory changes in this arena.[328]

Advocates should lobby the USPSTF to reexamine its position on hearing testing and devices in light of substantial new evidence linking hearing loss to numerous medical conditions, all of which are expensive to treat. The essential preventive services the USPSTF identifies are incorporated into the ACA regulations, and therefore the USPSTF plays a critical role in this process.

To better implement these reforms, advocates for those with presbycusis must develop a common strategy. It is in the interests of consumers with hearing loss as well as professional organizations to support pending initiatives providing Medicare coverage of hearing aids. However, dynamics among the various hearing professional organizations complicate and contribute to the failure of reform efforts. Some organizations promote a particular professional perspective,[329] while others promote the interests of those with hearing loss.[330] Others combine these missions.[331] Exemplifying these

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tional hearing aids; and (3) Because AOIs utilize technologies that did not exist when Medicare was enacted in 1965, Congress could not have intended to exclude them from Medicare coverage. *Id.* Followed to its logical conclusion, this last argument would require that most of the devices used today, which rely on technologies that did not exist in 1965, also be covered.

[327] GENERAL EXCLUSIONS FROM COVERAGE, *supra* note 322.

[328] Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 79 Fed. Reg. 66,120, 66,241–427 (Nov. 6, 2015) (to be codified at 42 C.F.R. § 411.15(d)(2)).

[329] *See, e.g.*, *About Us*, AM. ACAD. AUDIOLOGY, http://www.audiology.org/about-us [https://perma.cc/4F5R-DT9E] ("The American Academy of Audiology is the world's largest professional organization of, by, and for audiologists . . . [and] is dedicated to providing quality hearing care services through professional development, education, research, and increased public awareness of hearing and balance disorders."); AM. SPEECH-LANGUAGE-HEARING ASS'N, http://www.asha.org/ [https://perma.cc/T3HQ-M7QR] ("The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 182,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech language pathology support personnel; and students."). The American Academy of Otolaryngology-Head and Neck Surgery ("AAO-HNS") represents head and neck surgeons who treat the ear, *About Us*, AM. ACAD. OTOLARYNGOLOGY–HEAD & NECK SURGERY, http://www.entnet.org/content/ about-us [https://perma.cc/J93X-REVZ], while the Academy of Doctors of Audiology's ("ADA") mission is to offer "programming and support to those audiologists and students who are or who desire to be autonomous practitioners in whatever setting they choose to practice." *Academy of Doctors of Audiology*, ACAD. DOCTORS AUDIOLOGY, http://www.audiologist.org/about [https://perma.cc/74V5-UM88]. The ADA's mission emphasizes practice ownership. *Id.*

[330] *See, e.g.*, *Who We Are*, HEARING LOSS ASS'N AMERICA, http://www.hearingloss.org/content/who-we-are [https://perma.cc/B4LJ-E9PU] (describing its mission as providing "assistance and resources for people with hearing loss and their families . . . and rais[ing] public awareness about the need for prevention, treatment, and regular hearing screenings throughout life"); *see also Message to Audiologists, Hearing Aid Specialists, Hearing Aid Manufacturers*, HEARING LOSS ASS'N AMERICA (Apr. 2, 2012), http://www.hearingloss.org/content/message-audiologists-hearing-aid-specialists-hearing-aid-manufacturers [https://perma.cc/U8NQ-HC6T] (responding to debate over United Health Care's "hiHealth Innovations" effort to provide consumers with hearing aids via phone and other technology). For more information on hi

tensions is the current debate over pending legislation, the Audiology Patient Choice Act, which would permit audiologists to provide hearing services without physician referral or oversight.[332] Naturally, the American Academy of Audiology ("AAA") supports this legislation,[333] as does the Academy of Doctors of Audiology ("ADA").[334] The American Academy of Otolaryngology–Head and Neck Surgery ("AAO-HNS") opposes the legislation because it grants audiologists direct access to Medicare patients, bypassing physician examination or referral.[335] The AAO-HNS supports alternative legislation, the Medicare Audiology Services Enhancement Act of 2015, which the American Speech-Language-Hearing Association ("ASHA") also supports.[336] The AAA opposes this bill due to the level of physician oversight it requires.[337]

Tensions such as these, particularly those addressing "direct access," interfere with the development of a coordinated strategy that benefits seniors and others with hearing loss.[338] Advocates for seniors must coordinate with

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Health Innovations, see HiHealthInnovations, https://www.hihealthinnovations.com [https://perma.cc/EQ38-PFWY].

[331] *See, e.g., About Us*, Coalition for Global Hearing Health, http://coalitionforglobalhearinghealth.org/about-us/ [https://perma.cc/J3C9-8EWN] (describing its goals "to advocate for effective hearing health services and policies, to equip and empower hearing healthcare professionals, families, educators, communities and those with hearing loss, and to encourage and perpetuate best practices"). It has a special focus on promoting hearing health services in low-resource communities. *Id.*; *see also Meet the Members*, Hearing Indus. Ass'n, http://www.hearing.org/Content.aspx?id=50 [https://perma.cc/F94H-XKSC] (describing itself as an "association of manufacturers of hearing aids, assistive listening devices, component parts, and power sources").

[332] H.R. 2519, 114th Cong. (2015).

[333] *Academy Endorses Audiology Patient Choice Act*, Am. Acad. Audiology (May 22, 2015), http://www.audiology.org/advocacy/academy-endorses-audiology-patient-choice-act [https://perma.cc/PV57-GMGQ].

[334] Stephanie Czuhajewski, *Representative Jenkins and Cartwright Reintroduce the Audiology Patient Choice Act*, H.R. 2519, Acad. Doctors Audiology (May 22, 2015), http://www.audiologist.org/latest-news-archive/1420-rep-jenkins-and-cartwright-reintroduce-apca [https://perma.cc/PY2P-ZNGU]. The ADA states that the legislation will "improve access to qualified, licensed Medicare providers, by allowing seniors with a suspected hearing or balance disorder to seek evaluation and rehabilitation directly from audiologists, eliminating archaic medical doctor order requirements." *Know the Facts About the Audiology Patient Choice Act*, Acad. Doctors Audiology (May 2015), http://audiologist.org/_resources/documents/18x18/HR2519IssueBrief.pdf [https://perma.cc/62EM-82UR].

[335] Letter from James C. Denneny III, Exec. Vice President and CEO, Am. Acad. of Otolaryngology—Head and Neck Surgery, to Speaker John Boehner & Rep. Nancy Pelosi (June 2, 2015), http://www.entnet.org/sites/default/files/uploads/scope_6-2-15_aaohns.pdf [https://perma.cc/C5H9-X66U]. It further states that "it is 'not a turf issue,' but a patient safety issue." *Id.*

[336] *AAO-HNS Supports ASHA Legislation*, Am. Acad. Otolaryngology, http://www.entnet.org/content/audiology-scope-practice-issues [https://perma.cc/3EEA-FKNN]; *see also Support Medicare Coverage of Audiology Services Legislation*, Am. Speech-Language-Hearing Ass'n, http://cqrcengage.com/asha/app/write-a-letter?2&engagementId=81432 [https://perma.cc/V2GF-WJAD].

[337] *Ask Your Representative to Oppose the Medicare Audiology Services Enhancement Act*, Am. Acad. Audiology, http://capwiz.com/audiology/issues/alert/?alertid=64237626 [https://perma.cc/6J8S-2RCY].

[338] *See* Veterans' Access to Hearing Health Act of 2015, H.R. 353, 114th Cong. (2015) (outlining the ongoing debate about Veterans Administration services for veterans with hearing

these and other relevant organizations to collaboratively develop, evaluate, and promote legislative and regulatory policies.[339] Absent a consensus among hearing professionals and advocacy organizations, opponents will exploit internal conflicts to defeat legislative reforms.

VII. Conclusion

Presbycusis is one of the most common conditions of aging, and affects all aspects of an individual's life, including his or her medical condition, mental health, social networks, and overall quality of life. One is hard-pressed to imagine other consequences of aging that affect so many people and have such far-reaching effects. The failure to mandate adequate insurance coverage of hearing devices—primarily through Medicare but also via Medicaid and private insurance—particularly in this climate of preventive care and mandated services, is short-sighted and antiquated. Advocates have ample opportunities and arguments to change this.

loss and who can provide those services); *AVAA opposes S 564 and HR 353*, Ass'n of VA Audiologists (Sept. 10, 2015), http://myavaa.org/2015/09/10/avaa-opposes-s-564-and-hr-353/ [https://perma.cc/4QKX-BL9Z] (highlighting opposition to services provided by hearing aid specialists as opposed to audiologists); *see also Audiologists Must Continue Advocacy Efforts Against H.R. 353*, Am. Speech-Language-Hearing Ass'n, (July 27, 2015), http://www.asha.org/News/2015/Audiologists-Must-Continue-Advocacy-Efforts-Against-HR-353/ [https://perma.cc/DN5T-W3XB] (lobbying against the proposed bill and voicing concern about a lack of training by "hearing aid dispensers"). A past issue raising similar tensions was United Health Care's "hiHealth Innovations," an initiative that offered online hearing tests. The debate among professional organizations with respect to this issue resulted in a Cease and Desist Order from the Food and Drug Administration (FDA) ordering hiHealth Innovations to cease marketing the test. *See, e.g.*, Therese Walden, *The Audiologists Are Coming!*, Am. Acad. Audiology, http://www.audiology.org/about-us/academy-leadership/board-directors/let-me-hear-you-34 [https://perma.cc/89CA-72QQ]; Letter from Steven D. Silverman, Dir., Office of Compliance, Ctr. for Devices & Radiological Health, Dep't of Health & Human Servs., to Lisa Tseng, CEO, hi HealthInnovations (Mar. 28, 2012), http://www.audiology.org/sites/default/files/documents/20120418_hihealthLetter.pdf [https://perma.cc/6BKN-XN5X].

[339] A coordinated strategy, such as that implemented in securing other significant reforms in health care and social welfare policy, must include advocacy at the state and federal level, and the use of social media, personal stories, health research and economic data. For an example of a recent success in effectuating systemic change, see, for example, *Roadmap to Victory*, Freedom to Marry, http://www.freedomtomarry.org/pages/roadmap-to-victory [https://perma.cc/Q3VS-JC6C].

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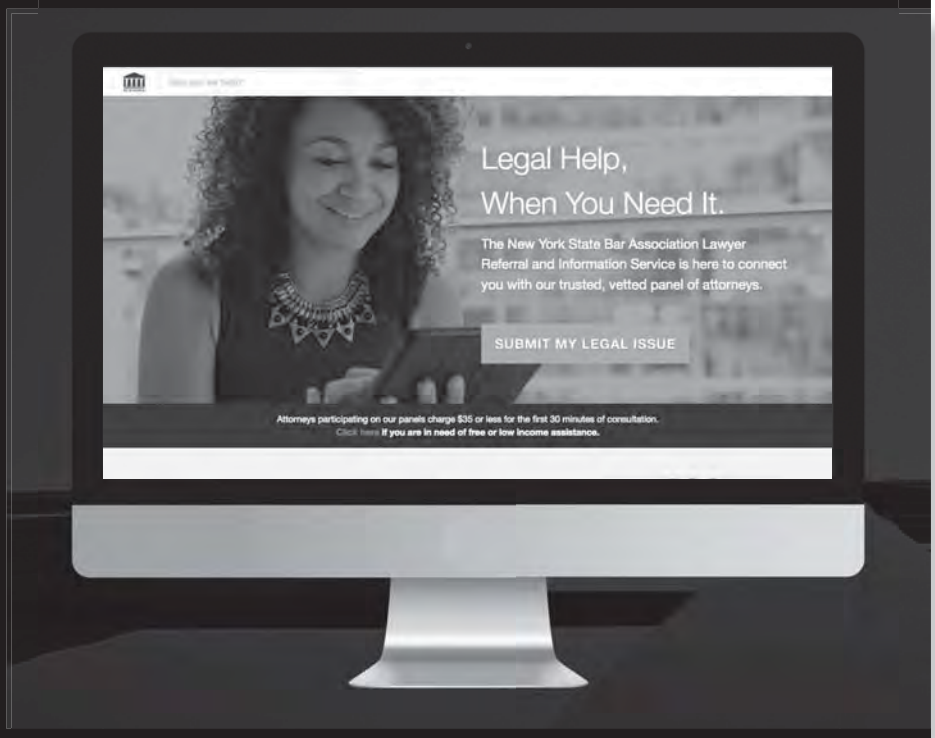

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Prescription for Disaster: Addressing the Problem of Medication Error in the Elder Population

By Jim D. Sarlis

Gadget girl. That's what one esteemed periodical called her. In its "Genius" issue, no less. The 15-year-old, Lilianna Zyszkowski, invented PillMinder, a system that uses a regular drugstore pill dispenser, teched up to communicate with a Twitter account, to track medication intake. She was inspired to create PillMinder after her grandfather accidentally overdosed on his blood thinners and wound up in the hospital.[1]

Defining the Problem

Every year, medication-related problems cause over a hundred thousand deaths and cost the health care system billions of dollars.[2] In fact, if medication-related problems were a category ranked along with diseases, it would be the fifth leading cause of death in the United States.[3]

Elders use medications on a regular basis more often than any other population group.[4] While in developing countries 85% to 90% of elders are on at least one medication daily,[5] in developed countries it is common for elders to be on three or more daily medications, a practice known as polypharmacy.[6]

Significantly, elders have been shown to process medications differently from other age groups, including in the way the medications are absorbed, their availability and distribution throughout the body, and their clearance out of the body.[7] Studies have shown, for example, that the rate of clearance of drugs metabolized by the liver typically decreases 30% to 40% in the elderly.[8] This can lead to lower effectiveness or increased risk of adverse reactions.[9] This combination of multiple medications and age-related differences in processing them leads to unique problems when particular drugs are prescribed to the elderly, increasing the risk of adverse drug interactions, dangerous side effects, and even death.

The problem of medication error in the elder population actually has a number of separate but related components. According to the FDA definition, adopted from the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP), a medication error is

> any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.[10]

Jim D. Sarlis

When all is said and done, of course, it all boils down to making sure that elders are prescribed appropriate medications in the first place, taking into account side effects, adverse interactions, and available alternatives,[11] and then making sure they take their medications correctly, at the right times, and in appropriate dosages.

This article examines the problem of medication error in this vulnerable segment of the population, and recommends steps that might help.

Standards for Analyzing Medication Use

Standards known as "consensus criteria" are used to analyze safe medication use in patients. Among the most widely used sets of consensus criteria for medication use in older adults are the Beers Criteria.

Developed in 1991, and updated in 1997, 2002, 2012, and 2015, the Beers Criteria (or, as it is commonly known, the Beers List) is a system of identifying and categorizing drugs that should be avoided, or used only with extreme caution, in the elderly population.[12] Based on evaluation by nationally recognized experts in geriatric care, clinical pharmacology, and psychopharmacology to reach consensus, the Beers Criteria have been used to survey clinical medication use, analyze computerized administrative data, and evaluate intervention studies to decrease medication problems in older adults. The Beers Criteria were also adopted by the Centers for Medicare and Medicaid Services (CMS) in July 1999 for nursing home regulation.[13]

Originally, the Beers Criteria as established in 1991 consisted of a list of drugs to be avoided in nursing home residents regardless of diagnoses, dose, and frequency of medication use.[14] The 1997 updates evaluated new drugs that were developed during the intervening six years and broadened application of the criteria to elders outside

the nursing home setting.[15] The 2002 updates introduced two categories: (1) medications or medication classes that should generally be avoided in persons 65 years or older because they are either ineffective or pose an unnecessarily high risk for older persons when a safer alternative is available, and (2) medications that should not be used in older persons known to have specific medical conditions. Many of the drugs were considered to have adverse outcomes of high severity.[16]

The latest version is intended for use by clinicians in outpatient as well as inpatient settings to improve the care of patients age 65 years and older. Entries range from drugs as serious as barbiturates ("High rate of physical dependence; overdose a concern") to such everyday products as Benadryl (i.e., Diphenhydramine) ("A first generation H1 antagonist with anticholinergic properties, which may increase sedation and lead to confusion or falls").[17]

The Beers Criteria address three categories of drug use or selection that are inappropriate for elderly patients:

- Inappropriate drug choice, i.e., medications generally to be avoided in the elderly population. Examples include diazepam (better known by its brand name, Valium), which has a long half-life and can lead to accumulation of the drug, leading to excessive sedation and an increase in the risk of falls and fractures.
- Excess dosage. Examples include Long-term use of stimulant laxatives such as bisacodyl (brand name Dulcolax), which may exacerbate bowel dysfunction.
- Drug-disease interaction. Examples include patients with cognitive impairment taking barbiturates, anticholinergics and muscle relaxants, which can worsen cognitive performance.[18]

The Criteria have been widely used for many years to study prescription patterns within populations, educate health care providers, and evaluate data regarding use, cost, and health outcomes. Significantly, studies have shown the Beers Criteria, and the derivative lists they begat,[19] to be useful in decreasing problems in elders.[20]

Recent Studies Find Medication Errors Are Common

Studies have concluded that the prevalence of medication errors among elders is alarmingly high, particularly in those outside the nursing home setting.[21] Rates in those studies range from 11.5% to 62.5%, with the mean being about 25%,[22] and the percentage of hospital admissions attributable to medication errors hovering around 30%.[23] Even when appropriate medications are prescribed, they can still cause problems if they are not taken properly. While this is a problem in the nursing home setting, there are—theoretically, anyway—checks and balances in place because drugs are administered by the medical and nursing staff, and nowadays all prescriptions and procedures are routinely logged onto centralized computer records. The greater problem is: How can we protect elders who are living at home, particularly if they are on their own?

Modern Technology to the Rescue

There is no shortage of apps to track medication intake. Virtually all of them can be run for just a few dollars a month on the average smartphone (though, as always, good luck finding one to run on a BlackBerry). They go by names like MedsLog, MotionPHR Health Record Manager, Medsy, and Dosecast. But the shortcoming of virtually all of these apps is that they require the patients themselves, or someone on their behalf, to manually enter the data.

Some, however, are interactive to varying degrees. One system, the Philips Medication Dispensing Service, reminds users to take their pills and, if ignored, the service alerts a designated caregiver. The pill dispenser gives patients audio reminders when it is time to take their pills. At the push of a button, their medication is dispensed to them at the proper times.

Another, called PillDrill, consists of a small hub that looks somewhat like an alarm clock, a pill container that looks like the ones found in the average drug store, scanning tags, and an interesting device called the Mood Cube. The hub connects via Wi-Fi to give audio-visual notifications when it is time to take the medication. The patient has the option of either affixing a scannable tag to the pill bottle or putting individual doses into the system's pods. After the pill is taken, the patient simply waves the tagged bottle or the pod over the hub and it will record that the medicine was taken. The PillDrill app then keeps track. After the hub is connected with the app, it will send out updates to inform whoever is listed (the patient, the patient's kids, the caregivers) if and when the pills have been taken. The Mood Cube is intended to monitor the patient's reactions to the medication. It has five faces: great, good, okay, bad, and awful. Keeping track of these reactions is supposed to help determine whether the dosage or medication need to be changed.

Which brings us back to PillMinder and its ilk, representing one of the most intriguing and comprehensive models for tracking drug usage. Still in the development stage, it started off as a school science project. The prototype was a simple device: a drugstore pill dispenser strip of the kind labeled for the days of the week, rigged with wires and inexpensive sensors to send a message to a Twitter account as the patient's fingers touch the sensors, causing Twitter to send a notice to any number of smartphones (of the patient, the patient's children, a geriatric care manager), creating a record of medication usage. PillMinder went on to win the 2015 White House Science

Fair and got picked up by a California-based company, Gate Keeper Innovation.

The key difference between PillMinder and most other medication trackers is that PillMinder is more than just an app or device or gadget—it is a comprehensive system that is self-executing. It self-tracks drug usage and self-records the data as the patients go about their day. It keeps track of all relevant information—type of medication, whether or not taken, dosage, timing—automatically and based on actual real-time events, without the need for manual data entry (or the risks of fibbing, flubbing, or forgetting that manual entry represents). Expanding upon this concept, as these types of systems become more and more sophisticated—and more and more self-sufficient, keeping track of themselves, by themselves, without the need for human input—they become more and more foolproof.

Mandatory e-Prescriptions

The technology available today and in the foreseeable future has the potential to help solve these problems. But not without a comprehensive database that is updated regularly, and a compliance mandate based on the demands of law or some kind of regulatory body.

Just as prescriptions for certain controlled substances can now only be made online rather than by paper prescriptions,[24] prescriptions for patients over a certain age could be done the same way, via a central databank, thus providing an opportunity for medications on the Beers List to be flagged, possible adverse interactions to be noticed, and contraindications to be caught, while a complete history is recorded, all in a central place with comprehensive data available at all times to everyone who should be able to access it.

The same technology that allows us to stay connected with family and friends around the world, that guides us to the nearest Starbuck's no matter where we are, that is now being used to stem the abuse of controlled substances, can be used to monitor the medications prescribed to elders.

Recommendations

There are several ways to reduce medication error in the elder population:

- The expansion and dissemination of lists identifying specific medications as inappropriate under all circumstances, or inappropriate for certain conditions, is the most important and basic first step. Such lists should be comprehensive, of course, but more than that they should be as specific, thorough and detailed as possible to be of maximum utility. Not only should they be made widely available, they should be part of a publicly accessible database.
- Inclusion of literature with medications: directions, brochures, leaflets. Simple print literature in large, clear fonts would be the best way to inform elders.
- Enhanced education and training of personnel who are involved with the sale, distribution, and administration of medications to elders would go a long way towards reducing the problem. This population would include not only doctors and nurses, but also pharmaceutical reps, pharmacists, geriatric care managers, and arguably could include other staff of institutions like hospitals, nursing homes, assisted living facilities, senior centers, and other institutions.
- The creation and updating of a national database, as well as the hardware and software to self-execute the monitoring and tracking of medication usage in conjunction with it, are key. The widespread implementation of appropriate prescription criteria and computerized decision-making, prescription-checking, and cross-checking systems would improve the appropriateness and safety of drug administration to the elderly.
- And, finally, legislation requiring mandatory e-prescriptions linked to this database.

Conclusion

The problem of medication error in the elder population is already a major health issue. Ever-increasing life expectancies mean that it is likely to become an even bigger problem unless immediate steps are taken. Implementation of these recommendations can help reverse the trend.

Disclaimers

Nothing in this article is to be considered medical advice, and no steps or refraining from steps should be taken based on this article, which presents only general information. If you suspect that you or your loved one has been exposed to medication error, or have any questions related to same, go to an emergency room or consult your doctor immediately.

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Neither the New York State Bar Association nor this periodical has adopted any position on the issues discussed in this article; nor do they take any position on any of the proposed legislation discussed. The views expressed in this article are those of the author only.

Endnotes

1. Pressler, J., "Gadget Girl," *America's Best and Brightest*, Smithsonian, December 2015, pp.58-61.

2. Some have estimated that medication-related problems cause 106,000 deaths annually at a cost of $85 billion, while others have calculated the cost of medication-related problems to be $76.6 billion to ambulatory care, $20 billion to hospitals, and $4 billion to nursing home facilities. Bootman, J.L., Harrison, D.L., Cox, E, *The health care cost of drug-related morbidity and mortality in nursing facilities*, Arch. Intern. Med. 1997; 1572089- 2096; Perry, D.P., *When medicine hurts instead of helps*, Consultant Pharmacist, 1999; 141326- 1330; Bates, D.W., Spell, N., Cullen, D.J., et al., *The Adverse Drug Events Prevention Study Group, The costs of adverse drug events in hospitalized patients*, JAMA. 1997;277307-311; Johnson, J.A., Bootman, J.L., *Drug-related morbidity and mortality: a cost-of-illness model*, Arch. Intern. Med. 1995; 1551949-1956.

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5. *See, e.g.,* Bertoldi, A.D., Barros, A.J.D., Hallal, P.C., Lima, R.C., *Drug utilization in adults: prevalence and individuals determinants*, Rev. Saúde Pública 2004, 38(2):228-38; Mosegui, G.B., Rozenfeld, S., Veras, R.P., Vianna, C.M., *Quality assessment of drug use in the elderly*, Rev. Saúde Pública 1999, 33(5):437-44.

6. *See, e.g.,* Barat, I., Andreasen, F., Damsgaard, E.M.S., *The consumption of drugs by 75-year-old individuals living in their own homes*, Eur. J. Clin. Pharmacol. 2000, 56(6-7):501-9; Kaufman, D.W., Kelly, J.P., Rosenberg, L., Anderson, T.E., Mitchell, A.A., *Recent patterns of medication use in the ambulatory adult population of the United States: the Slone survey*, JAMA 2002, 287(3):337-44.

7. This is known as "alterations in pharmacokinetic processes" and include absorption, first-pass metabolism, bioavailability, distribution, protein building, renal and hepatic clearance.

8. *See* FDA website report on Medication Errors Related to Drugs, 07/08/2016, available at http://www.fda.gov/Drugs/DrugSafety/MedicationErrors/.

9. Kim, J., Cooper, A., *Geriatric Therapy* in Applied Therapeutics: The Clinical Use of Drugs, 8th edition, edited by Koda-Kimble MA, Young LY, Kradjian WA, Guglielmo BJ. Philadelphia: Lippicott Williams & Wilkins; 2005:1-19.

10. *See* FDA website report on Medication Errors Related to Drugs, 07/08/2016, available at http://www.fda.gov/Drugs/DrugSafety/MedicationErrors/.

11. I.e., avoiding what is known by the term of art "Inappropriate Medication Usage" or "IMU."

12. http://archinte.jamanetwork.com/article.aspx?articleid=615518. See notes 14-17, *infra*.

13. *See, e.g.,* Zachary, A., Marcum, PharmD, MS, Hanlon, J.T., PharmD, MS, *Commentary on the New American Geriatric Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults,* Am. J. Geriatr. Pharmacother., 2012 Apr; 10(2): 151–159 doi:10.1016/j.amjopharm.2012.03.002; Hanlon, J.T., Shimp, L.A., Semla, T.P., *Recent advances in geriatrics: drug-related problems in the elderly*, Ann Pharmacother. 2000; 34:360–65.

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17. The 2015 version, *see* American Geriatrics Society 2015 Beers Criteria Update Expert Panel (2015), *American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*, J. Am. Geriatr. Soc. 63 (11): 2227–46. doi:10.1111/jgs.13702. PMID 26446832, updated the 2012 version, *see* The American Geriatrics Society 2012 Beers Criteria Update Expert Panel, *American Geriatrics Society updated Beers criteria for potentially inappropriate medication use in older adults*, J. Am. Geriatr. Soc. 2012; 60:616-31.

18. Patient Safety Authority Advisory, State of Pennsylvania, *The Beers Criteria: Screening for Potentially Inappropriate Medications in the Elderly* (PA PSRS Patient Saf Advis 2005 Dec);2(4):11-5, available at http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2005/dec2(4)/Pages/11.aspx .

19. Two other oft-used criteria are the Zhan and the McLeod. In 2001, the Zhan researchers classified 1997 Beers Criteria drugs into 3 categories: "always avoid," "rarely appropriate," and "some indications." In 2003, an expert panel classified the 2003 Beers Criteria drugs into the same three categories, but only the categories "always avoid" and "rarely appropriate" were included in the criteria. The McLeod method was developed by a Canadian panel of experts. Like the original 1991 Beers Criteria, the McLeod Criteria list 18 inappropriate medications for all elderly regardless of diagnoses or conditions, and like the later Beers Criteria updates, it lists 16 inappropriate drug-disease interactions, and 4 inappropriate drug-drug interactions.

20. Golden, A.G., Preston, R.A., Barnett, S.D., Liorente, M., Hamdan, K., Silverman, M.A., *Inappropriate medication prescribing in homebound older adults*, J. Am. Geriatr. Soc. 1999;47948- 953; Mort, J.R., Aparasu, R.R., *Prescribing potentially inappropriate psychotropic medications to the ambulatory elderly,* Arch. Intern. Med. 2000;1602825- 2831; Smalley, W.E., Griffin, M.R., *The risks and costs of upper gastrointestinal disease attributable to NSAIDs*, Gastroenterol. Clin. North Am. 1996;25373-396; Thapa, P.B., Gideon, P., Cost T.W., Milam, A.B., Ray, W.A., *Antidepressants and the risk of falls among nursing home residents*, N. Engl. J. Med. 1998; 339875-882; see also note 21, *infra*.

21. *See, e.g.,* Guaraldo, L., Cano, F., Damasceno, F., Rozenfeld, S., *Inappropriate medication use among the elderly: a systematic review of administrative databases*, BMC Geriatrics 2011, 11:79.

22. *Id.*

23. Doucet, J., Chassagne, P., Trivalle, C., et al., *Drug-drug interactions related to hospital admissions in older adults: a prospective study of 1000 patients,* J. Am. Geriatr. Soc. 1996; 44944-948.

24. The New York State Internet System for Tracking Over-Prescribing (I-STOP) Act (Senate Bill 7637/Assembly Bill 10623) which the New York State legislature unanimously passed in June 11, 2012 and Governor Andrew Cuomo signed into law two months later, established a real-time database which tracks controlled substance prescriptions issued by every doctor in the state of New York (with certain limited exceptions). *See* N.Y. Public Health Law § 281. On September 30, 2016 Governor Cuomo signed as Chapter 350 of the Laws of 2016 legislation (A.9335/S.6778) changing e-prescribing exception regulations to allow a prescriber to make a notation in the patient's medical record indicating that they have issued a paper prescription and noting one of the three statutory exceptions as the reason why an e-prescription was not possible.

Senior Member Spotlight: Robert J. Kurre

Interview by Katy Carpenter

Q Where are you from?

A I was born in Brooklyn, New York. My family lived in Ridgewood, Queens at the time. When I was three years old, my family moved to Long Island. I have lived on Long Island ever since.

Robert J. Kurre

Q Where is your favorite place you've traveled to?

A A tie between Italy, the Hawaiian islands, and Disneyworld.

Q How many kids do you have (family)?

A I have two daughters, Amanda, age 7, and Sophia, age 5. I am married to Deborah, who holds a master's degree in social work but has become the chief executive officer of our home.

Q What's your favorite part about your job?

A I like relating to my clients and making a difference in their lives. I also enjoy the intellectual challenge of practicing elder law and trusts and estates law. I also like the camaraderie of the Elder Law and Special Needs Section. I have made many friends and always feel re-energized whenever I attend Section meetings.

Q Tell me about a project or accomplishment that you consider to be the most significant in your career.

A In 2004, I served as the Vice Chair of the Elder Law Section's Long Term Care Reform Committee whose January 2005 report served as the framework for innovative solutions to long-term health care issues in New York.

Q Have you had any turning points in your life?

A In 2000 after practicing commercial litigation, bankruptcy, and insurance law for almost ten years, I decided to switch to elder law and trusts and estates law. I obtained a position as an associate at a leading elder law firm where I gained significant experience. I have never looked back at the switch because it has been very rewarding.

Q Where do you see yourself in five years?

A Pretty much where I am now except with more gray hair! I feel my practice is going well and it is where I want it to be. My daughters will be approaching their teenage years so I will brace myself for the impact that will have on my wife and I.

Q What did you want to be when you were 13?

A I wanted to be a professional baseball player. I played on my high school baseball team but didn't make it beyond that because I couldn't hit the curveball.

Q Are there hobbies you look forward to on the weekends?

A I am an avid reader and enjoy spending time with my daughters and wife. I especially enjoy going on hikes, golfing, the beach, and traveling. I also hold a black belt in Chinese Kenpo karate.

Q Have you ever been given advice that you remember?

A One piece of advice that comes to mind is being a person of integrity means acting the same way whether or not someone is watching you. When it comes to marketing a law practice, I received advice that the best form of marketing is doing good work and treating people fairly.

Q Do you have any words used to describe yourself?

A I am family-oriented. My wife and daughters come first. I think I'm also good natured and try to see the good in people and situations. I am inquisitive and enjoy learning not only about the law but many things in life.

Q What advice do you have for attorneys starting to practice in the areas of elder law and special needs?

A It's a great area to practice if you enjoy helping people. Get involved in the Elder Law and Special Needs Section. Attend the meetings and continuing legal education classes, participate in the Communities, study the law and ask a lot of questions. Take advantage of the resources available to you. When I first transitioned into elder law, I signed up for just about every course or seminar I could find related to the area. I also shortened the learning curve by listening in my car to many hours of recordings from continuing legal education courses.

Q Is there anything else you want people to know about you?

A I have made practice management a focus. I realized early on that I needed to work smarter and not harder. This has made a huge impact on my practice and also allowed me to have a much better quality personal life. I encourage everyone to put an emphasis on practice management to run their practices efficiently.

The Legal Intersection of Inheritance and Disability: A Primer

By Regina Kiperman and Naomi Levin

Picture John. John has had a difficult life and, now that he is dead, will have a difficult estate to settle, due mostly to the composition of his family. John is survived by four siblings. One of John's siblings is missing, the other in jail, the third (the nominated executor) was involved in a tragic accident and now has a court-appointed guardian of the person and property, and the fourth—the baby, if you will—happens to be 13. In short, John's estate is a recipe for disability disaster.

Commencement of Proceeding

The first issue is who can commence this proceeding? Although the nominated executor is incapacitated, the nominated executor's court-appointed guardian may commence the probate petition.[1] (Incidentally, the court-appointed guardian would also be able to commence an administration proceeding if John had died intestate.[2])

When an estate proceeding is commenced, the Surrogate's Court must (i) acquire jurisdiction over all interested parties; and (ii) ensure that the rights of all interested parties are adequately protected. When an interested party is under a disability, the court takes certain precautions. A person under a disability is defined in New York Surrogate's Court SCPA 103(40), and includes five groups of people: (a) an infant, (b) an incompetent, (c) an incapacitated person, (d) unknown or whose whereabouts are unknown, or (e) confined as a prisoner who fails to appear under circumstances which the court finds are due to confinement in a penal institution.

Jurisdiction

The second issue is how the court can acquire jurisdiction over interested parties, including those under a disability. The court obtains personal jurisdiction over all of the parties by ensuring they are either served with process, sign a Waiver of Process and Consent to Probate, or make an appearance.[3]

Service of Process

In Surrogate's Court, process is typically made by distribution of a Citation to the interested parties[4] in the manner authorized by the court.[5] With few exceptions, a person under a disability should still personally receive process. If the disabled person has a guardian, then the Citation is issued to both the disabled person and the guardian, or person concerned with the disabled person's welfare.[6] In our case at hand, John's incarcerated brother would be served personally; the warden of the prison would also be served.

Regina Kiperman

Naomi Levin

Exceptions to personally serving the person under a disability are where the person cannot be found. In this case the court typically requires an affidavit of due diligence and may then authorize an alternative method of service, including, but not limited to, service of citation by publication.[7] The fiduciary of John's estate will need to prepare an affidavit, explaining the efforts taken to find John's missing brother.[8] Another exception is where the disabled person is an infant under the age of 14 and residing with the petitioner, in which case no service is required upon the infant.[9] John's 13-year-old brother, therefore, may not need to be served if he is residing with the Petitioner (who, in this case, would be John's executor).

Waiver and Consent

Typically, and depending on the type of disability, a person under a disability cannot sign a waiver and consent. However, if a person under a disability was, during a period of capacity, able to nominate an attorney-in-fact under a Power of Attorney, then the agent under the Power of Attorney could execute the Waiver of Process and Consent to Probate on behalf of the disabled person so long as the agent was given the specific authority to execute such a document in the Power of Attorney document and provided that the Power of Attorney is recorded with the court.[10] If the person under a disability has a guardian, then the guardian can also execute a Waiver and Consent provided that the guardian submits an affidavit to assure the court that, in essence, the guardian does not have a conflict.[11]

Appearance

A person under a disability may make an appearance. An infant or an incapacitated person may appear by their guardian.[12] Hence, if a disabled individual is to receive an inheritance, one of the options is to petition the court for the appointment of a guardian for that person and for that person's property (SCPA Article 17 (for infants), SCPA 17A (for developmentally or intellectually disabled)

Regina Kiperman is a Partner and Naomi Levin is an Associate with Grimaldi & Yeung, LLP. Regina focuses on Probate and Estate Administration, Estate Litigation, Elder Law (including Guardianship and Medicaid planning), and Estate Planning. Naomi focuses on Elder Law, Estate Planning, and Guardianship.

or Mental Hygiene Law Article 81 (for incapacitated individuals)). The theoretical benefit to the appointment of a guardian would be the familiarity of the person serving as the guardian (rather than a completely independent court appointed Guardian ad Litem ("GAL"). Once a guardian is appointed, that guardian would then have standing to make an appearance on behalf of the disabled individual and protect the disabled individual's interests. Although a parent is a natural guardian of an infant, a parent may not always be able to appear on behalf of the infant child because of possible conflicts of interest. (For example, if John's parents were alive, it could be conceivable that the parents would not be able to speak for the minor child, even if appointed his guardian, if the parents were planning to contest the validity of a will, which would then put the infant child's share in jeopardy).

Guardian ad Litem to Protect the Disabled Person's Interests

Where the disabled person does not have a guardian, the appearance shall be made by the GAL.[13]Although a GAL may be nominated and appointed by an infant who is over the age of 14,[14] the court may deny the nomination where there is a conflict of interest.[15] A GAL may also be appointed by the court.[16] A GAL shall be an attorney admitted to practice in the state of New York.[17]

There are circumstances where the court does not need to appoint a GAL. These are set forth in SCPA 403. Generally, a GAL is not as necessary where the disabled beneficiary would receive the same or greater than he would receive in intestacy. For example, if John bequeathed his 13-year-old sibling a quarter of the estate, a GAL would probably not be appointed. However, if John bequeathed his 13-year-old sibling 1/10 of the estate, a GAL may be appointed to determine whether to contest the bequest. A GAL is also not appointed where the assets of the estate are less than $50,000 and the sole beneficiary is the surviving spouse.[18]

The GAL serves as the fiduciary for the disabled person for this proceeding and is therefore empowered to submit moving papers and request additional information from the parties. Typically, the GAL will review the court file, confirm that jurisdiction is complete, speak to the relevant parties, investigate the circumstances, and submit a report to the court. The GAL may file objections to a will, or engage in pre-objection discovery (routinely known as 1404 depositions and discovery). The GAL may also assert the surviving spouse's right of election.[19] If the failure to exercise the right of election would impact the surviving spouse's eligibility for Medicaid benefits, then the GAL has a duty to seek approval to elect.[20] If a Guardian ad Litem appears, the disabled person can still be heard. A GAL cannot enter a settlement over the objections of the disabled person.[21]

Once the GAL writes the report and a decree is entered, the GAL is discharged. The court will direct the payment of the GAL's fees—be they from the estate, from the petitioner—or from any other party.[22]

Even though a GAL is appointed to represent the person under a disability, this appointment is temporary. If the disability persists beyond the proceeding, then the appropriate party will need to petition for either a limited or permanent guardian under SCPA Article 17, Article 17A, or Mental Hygiene Law Article 81. In John's case, a GAL is virtually unavoidable for the missing beneficiary/distributee. The GAL for the 13-year-old can be avoided if the 13-year-old resides with the nominated executor, who, in this case, is himself represented by this Article 81 Guardian. The prisoner could expedite matters by appointing somebody to act as his GAL, or, better yet, getting out of prison.

Endnotes

1. New York Surrogate's Court Procedures Act ("SCPA") 1402(1)(a).
2. SCPA 1001(4).
3. SCPA 203.
4. SCPA 306.
5. *See generally* SCPA 307.
6. SCPA 311.
7. SCPA 307(3).
8. *See* 22 NYCRR 207.16 for list of methods to be employed to meet the due diligence requirement.
9. SCPA § 307(4).
10. New York Estates Powers and Trusts Law ("EPTL") 13-2.3. If the POA is going to be recorded, then 22 NYCRR 207.48 requires that the person attempting to record the POA also include an affidavit explaining the circumstances that gave rise to the furnishing of the POA. The POA and the affidavit pursuant to 207.48 are typically filed in the miscellaneous department. There is a cost for filing. *See* SCPA 2402.
11. SCPA 402(1).
12. SCPA 402(1).
13. SCPA 402(2).
14. SCPA 403(1).
15. SCPA 403(1)(c).
16. SCPA 403(2).
17. SCPA 404(1).
18. SCPA 403(3)(d).
19. EPTL 5-1.1-A(c)(3)(D); *In re Furrer*, N.Y.L.J., May 14, 1996, at 32 (Sur. Ct., Suffolk County).
20. *In re* Mattei, 169 Misc. 2d 989, 647 N.Y.S.2d 415 (Sup. Ct., Nassau County 1996).
21. *In re Estate of Bernice B.*, 176 Misc. 2d 550 (Sur. Ct., NY County 1998)
22. SCPA 405.

Securing Medicaid Benefits for Those With an Immediate Need

By Deidre M. Baker

Remaining safely in the community for as long as possible is a goal for most, if not all, seniors. In order to achieve this goal, many seniors and their families look to Medicaid to provide home health aides to assist the senior with his or her activities of daily living. These home care services are often called personal care services (PCS). Personal care services are defined as assistance of a personal care aide with nutritional, environmental support, and personal care functions. "Such services must be essential to the maintenance of the patient's health and safety in his or her own home" ordered by the attending physician, based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness" of services.[1]

Deidre M. Baker

While the Medicaid program and its services allow many individuals to stay in the community, the program has its drawbacks. People who apply for Medicaid in order to finance home care services often face delays in the application process, as well as facilitating services once the application is approved. The application and approval process was further complicated with the introduction of Managed Long Term Care (MLTC), which now requires the applicant be evaluated through the Conflict Free Evaluation and Enrollment Center (CFEEC), run by New York Medicaid Choice, before a referral can be made to a MLTC.

The time between submitting an application seeking long-term care services and the start of the services can drag on for several months. This delay is problematic for Medicaid applicants in the community as services are not administered until the application has been approved, and an assessment to determine if the applicant is in need of home care has been conducted. This is in contrast to Medicaid applicants in a nursing home since skilled nursing facilities routinely provide services while the applicant is "Medicaid pending." Unfortunately, many families lack the financial resources to privately pay for home care while the Medicaid application is pending.

"Immediate Need" Procedures Address Medicaid Delays

Consumer advocates have long been concerned about the delay in receiving home care services through the Medicaid program. As a result, a lawsuit was filed in 2007 regarding the delay in receiving personal care services, and is still pending today.[2] The suit asserts that when there is an "immediate need" for home care services, Medicaid services must be authorized while a Medicaid application is pending. The lawsuit focuses on Medicaid personal care services, and was brought before the transition to Managed Long Term Care. Since the lawsuit was filed, the legislature has repeatedly amended the state law upon which the lawsuit is based, most recently in April 2015.[3]

On April 1, 2015 New York enacted a law that addressed the long delays in the home care Medicaid context. The law requires the State Medicaid agency to set up procedures for Medicaid applications to be processed and approved in seven calendar days if there is an "immediate need" for PCS or services through the Consumer Directed Personal Assistance Program (CDPAP).[4] After requesting and fielding comments from the public, it took the State over a year to set up and implement these new procedures. In July, 2016, the New York State Department of Health issued an Administrative Directive setting forth the requirements and procedures for expedited Medicaid eligibility determinations for New York Medicaid applicants/recipients who have an "immediate need" for PCS or services through CDPAP.[5]

CDPAP is a Medicaid program in New York State that provides an alternative way of receiving home care services, where the consumer has more control over who provides the care and how it is provided. The consumer can hire almost anyone, including any family members, except his or her spouse. A special benefit of CDPAP is that CDPAP aides may perform "skilled" care that otherwise may only be performed by a nurse; these services cannot be performed by a typical home health aide under the Medicaid program.

How to Apply for Medicaid if There Is an Immediate Need for Personal Care or Consumer-Directed Services

Before the local Department of Social Services will determine if an individual has an immediate need for home care services, the applicant must meet the following conditions: (1) have an immediate need for Personal Care or Consumer Directed Personal Assistance Services;

(2) have no informal caregivers who are able or willing to provide personal care services; (3) have no home care agency providing needed assistance; (4) does not have third party insurance or Medicare benefits available to pay for needed assistance; and (5) does not have adaptive or specialized equipment or supplies in use to meet the need for assistance, or has adaptive or specialized equipment or supplies that cannot meet the need for assistance.[6]

An applicant must indicate that he or she meets these conditions by completing the OHIP-0103, "Immediate Need for Personal Care Service/Consumer Directed Personal Care Services: Informational Notice and Attestation Form." In addition, the Human Resources Administration developed a transmittal form that was intended to facilitate the requests for immediate need by consumers. The transmittal form must be accompanied by the other required documentation, which varies depending on whether the consumer is already a Medicaid recipient, needs to upgrade his or her Medicaid benefits to include long term care services, or is a first time applicant. The varying requirements are documented on the transmittal form.[7]

In addition to the Attestation of Immediate Need, all applicants must submit either a Medical Request for Home Care[8] or a physician's order outlining the need for home care, as well as an Authorization for Release of Health Information Pursuant to HIPAAA[9]. The authorization is needed so individuals other than the consumer can contact Medicaid regarding the application. As a practice tip, a detailed cover letter should also be submitted, including an explanation of the immediate need and a list of all documents submitted.

If the consumer is already a Medicaid recipient, but he or she is now seeking community based long term care, a completed Access NY Supplement A[10] detailing the consumer's resources must be submitted. Consumers without active Medicaid benefits must submit a completed Access NY Insurance Application in addition to the Access NY Supplement A. It is recommended that all documents submitted to the local Medicaid office be done via certified mail in order to receive proof of receipt.

Procedures Once the Medicaid Application Has Been Submitted

The Immediate Need Request packages are time stamped in order to establish the date received by the Local Department of Social Services (LDSS); the expedited processing begins the first calendar day after receipt of all the necessary documents; this is referred to as day one.[11] Within four calendar days after receipt of the package, the Home Care Services Program (HCSP) will review the documents to determine if the application is complete. If the review determines that the package is incomplete, a written notice will be sent to the applicant outlining what documentation is missing and provide a due date for submission.

Within seven days of receiving a complete Medicaid application, the local Medicaid office must reach a determination as to eligibility for Medicaid benefits. Within twelve days of receiving a complete Medicaid application and determining that the applicant is eligible for Medicaid, the local Medicaid office must conduct a social and nursing assessment of the client, determine if the applicant is eligible for personal care or consumer directed services, authorize the services, and notify the applicant the services authorized.[12]

Once the services have been authorized, the Medicaid office must assign the case to either a Medicaid agency or a CDPAP fiscal intermediary and arrange for the services to be provided "as expeditiously as possible."[13] After the home care services have been in place for 120 days, the consumer will receive a notice from New York Medicaid Choice detailing the requirements for enrolling in a MLTC.

Endnotes

1. 18 NYCRR 505.14(a
2. *Konstantinov v. Daines*, 2014 NY SlipOp 30657.
3. NY Soc. Serv. L. § 366-a(12).
4. *Id.*
5. 16 OHIP/ADM-02—Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services.
6. *Id.*
7. Human Resources Administration, Department of Social Services, HCSP-3052(E), *Immediate Need Transmittal to the Home Care Services Program.*
8. HCSP-M11q.
9. OCA-960.
10. DOH-4495A.
11. MICSA Medicaid Alert: *Immediate Need for Personal Care or Consumer Directed Personal Assistance Services* (October 19, 2016).
12. *Id.*
13. 16 OHIP/ADM-02.

New Member Spotlight: Scott B. Silverberg

Interview by Katy Carpenter

Q Where are you from?

A Long Island, more specifically East Williston—North Nassau County. Happily born and raised.

Q What do you like about the area and community you serve?

A It's home to me. It's where I grew up—I work about two miles away from my childhood home. I like that there are kind people and a diverse neighborhood with normal, hard-working people.

Scott B. Silverberg

Q Where is your favorite place you've traveled to?

A I've traveled all over the country but little internationally: San Francisco, San Diego, Seattle, Florida, Detroit, D.C., Philly, Boston, Israel, England, Amsterdam and the Caribbean. I would say my two favorites are San Francisco and D.C.—I love the food, they're different, cool cities!

Q Why did you choose to practice in the areas of law: Estate Planning, Elder Law & Special Needs Planning?

A Simple answer: it's what my dad does and I work for him. Now that I've been practicing, I can't imagine working in any other area. I enjoy what I do and I'm happy every day. Clients are from my area and I enjoy getting to be there for friends and family through difficult times in their lives or helping to plan for their future.

Q How is it working with your dad?

A It has its ups and downs but it's always interesting. I work with clients and want to prepare for those above and below them and we work with families from generation to generation so it's a great feeling to be doing the same with my dad.

Q What's your favorite part about your job?

A I'd say the client interaction. Whether it's finalizing and signing their wills or getting someone approved for Medicaid, I enjoy seeing their relief. It's as if you see and feel the weight coming off their shoulders.

Q Tell me about an accomplishment that you consider to be the most significant in your career thus far.

A I'm on the edge of finishing a long-term care matter for a family whose estate plan I completed. Now both mom and dad are placed in a nursing facility and I've helped mom's Medicaid application be approved and now I'm working on dad's application. I've been with the family from the estate planning to the long-term care stage.

Q Have you had any turning points in your life?

A It's more of a long-arching turning point: one of my closest friend's dad, who had a great influence on me growing up, was diagnosed with cancer two years ago. I was able to meet with them in the hospital to set up a will and put an estate plan in place to protect his assets. He passed away a few weeks later and I assisted with the estate administration. This was so personal to me and for a family that had an influence on my earlier life, so I know I'm in the right area of law.

Q Where do you see yourself in five years?

A Definitely continuing to do this work. Both politically and professionally, I don't know what it will bring or what we'll be able to do or what Federal laws may change, but I know the landscape of what we do will evolve.

Q What did you want to be when you were 13?

A President or General Manager for the New York Jets. There's a joke amongst my family and friends that there comes a day in every young, Jewish boy's life that they learn they have a better chance to run a team rather than play for one!

Q Are there hobbies you look forward to on the weekends?

A My biggest hobby is sports. I am a huge Jets and Mets fan, and I love both going to games and watching on TV. I go to all of the Jets home games, and when they're on the road I always have friends over to watch the day's games. I also love cooking, which tends to work its way into my sports hobby as well.

I have a wide range of hobbies. I enjoy going to the movies or going to musicals, plays and concerts. I also enjoy going to museums in the City or hanging out in the park. I enjoy cooking but I do that as much during the week as I do on weekends. I like to enjoy whatever the City has to offer with friends.

Q Have you ever been given advice that you remember?

A Not directly, but my grandmother has always shown me the importance of being honest and doing what's right. She will fight for when she is wronged, but she will also tell the waitress if something was left off the check when we go out to eat. She has always been an example of doing what is right, whether it's good for you or not. Her example is the best advice I've ever gotten.

Q Do you have any words used to describe yourself?

A Joyful and caring.

Q Is there anything else you want people to know about you?

A I believe it's important to find a time to laugh and enjoy things given the morbidity of what we do for work.

New York NAELA Niche: Are We Now ABLE to Forget About Special Needs Trusts?

By Robert P. Mascali

Introduction

NO!...but the decision whether to fund an account under the ABLE Act[1] and/or to utilize a special needs trust now requires an in-depth analysis of many factors when planning is being considered for a person with a disability. In addition, the recent enactment of the Special Needs Fairness Act[2] now expands considerably the ability for competent disabled beneficiaries to establish their own special needs trusts.

Robert P. Mascali

In December 2014, the Achieving a Better Life Experience (ABLE) Act was signed into law by President Obama and authorizes the states to adopt individual ABLE programs. The ABLE Act allows contributions to be made to tax-advantaged ABLE Act 529A accounts to pay for qualified expenses for individuals who are disabled. Many states are working toward implementation as the Internal Revenue Service has encouraged states to quickly establish their ABLE programs. As of the writing of this article there are 17 states that have implemented ABLE programs and most of them allow deposits from out-of-state residents. For an updated list and comparison of the various programs you can go to www.ablenrc.org.

1. The Basics of the ABLE Account

In general, ABLE accounts are similar to the tuition accounts allowed under the IRS Code Section 529 except that they are limited to individuals with a disability that manifested itself before the age of 26. Take note that the account does not need to be set up before age 26, only that the disability began before that age. There can only be one ABLE account for a beneficiary and under current law the maximum amount that can be deposited into such an account during any year is $14,000, and the maximum amount is the ABLE account state's cap for the traditional 529 Plan. The funds accrue income-tax-free and can be used for a range of expenses related to the disability of the beneficiary such as transportation, housing, education, assistive technology and basic living expenses. For a beneficiary receiving Supplemental Security Income (SSI), if the account exceeds $100,000, there will be a suspension of their SSI. However, there is no effect on benefits under the Medicaid program, even if a beneficiary is also on SSI that is suspended because the account exceeds the $100,000 limit. Upon the death of the beneficiary or termination of the account, there is a payback required for benefits received under the Medicaid program, regardless of whether the funds were deposited by the beneficiary or came from a third party.[3] Furthermore, the money in ABLE accounts does not count against the person's eligibility for Supplemental Security Income (SSI), Medicaid, Supplemental Nutrition Assistance Program (SNAP or "food stamps,") Section 8 housing, and other means-tested public assistance programs.

2. The Basics of Special Needs Trusts

Pooled Special Needs Trusts

There are two different types of pooled trusts: The first party pooled trust permitted under federal law [42 U.S.C. 1396p (d)4(C)] and funded with assets—usually cash—belonging to the individual with a disability, and the third party pooled trust, which has no predicate in federal law but essentially has the same characteristics but which is funded with assets belonging to someone other than the beneficiary, usually a family member or close friend. Other than the source of funds which then dictates the disposition of the funds that remain upon termination, both the first and third party pooled trusts are for the benefit of a person with a disability and otherwise share similar characteristics, briefly summarized as follows:

1. The funds are administered by a non-profit organization according to the terms of a Master Trust, with the assistance of a financial institution for the management and investment of the funds;
2. The funds are pooled together for investment and efficiency but each beneficiary has a separate sub-account;
3. The funds are disbursed by the administrator for the benefit of the beneficiary, almost always to third party vendors and service providers;
4. The administrator fulfills reporting requirements to public agencies that provide benefits to the beneficiaries;
5. The administrator provides periodic accountings to the beneficiaries.
6. The administrator distributes the funds remaining upon termination in an appropriate fashion:
   (a) In the first party pooled trust the remaining funds are either retained by the nonprofit for the benefit of other disabled individuals or

to the extent that they are not so retained the remaining funds are used to satisfy any pay back required by the state Medicaid program or programs if the beneficiary received services from different states. (NOTE: While New York currently permits all of the remaining funds to be retained by the nonprofit, other states have different rules and requirements as to a possible payback for Medicaid from the pooled trust remainder funds.)

(b) In the third party pooled trust, since there is no requirement for a payback for Medicaid because the funds came from a third party, the remaining funds are disbursed according to the terms agreed upon by the nonprofit and the grantor at the time the trust was established.

For a list of the various pooled trusts you can visit www.specialalliance.org.

First Party Special Needs Trust

This type of trust is authorized by federal law found at 42 U.S.C 1396p(d)(4)(A) for a person with a disability as defined by the Social Security Law[4] who is less than 65 years of age. Unlike the pooled trust under (d)(4)(C), which contains no age restriction and which is governed by the terms of a Master Trust, this type of trust requires the assistance of counsel in preparing the trust document, which must contain the required elements of the federal statute, the most important of which being that the funds must be used solely for the benefit of the disabled beneficiary and that the trust must contain a provision requiring that any funds remaining upon termination of the trust must first be used to satisfy any Medicaid payback. While practitioners are free to include many other provisions in the trust, care must always be taken to ensure that the trust will not run afoul of the requirements for Medicaid and, if applicable, the Social Security Administration for those beneficiaries who are receiving SSI. For this reason, some practitioners prefer to utilize the trust contained in *Matter of Morales*[5] with some modifications to comport with the current provisions of the NYS Estates, Powers and Trusts Law, 7-1.12 and applicable regulations. Until recently this type of special needs trust could only be established by the parent, grandparent or guardian of the individual with a disability or through a court proceeding, but as a result of the enactment of the Special Needs Fairness Act[6], the trust may now also be established by the individual provided he or she possess the requisite capacity.

Third Party Special Needs Trust

This type of trust has no corresponding federal statute mandating the required terms of the trust; in New York State the concept of a third party special needs trust has existed since 1978 when Bronx Surrogate Gelfand, over the objections of the New York Attorney General, approved a testamentary trust established by a parent for a child who was then a 77-year-old resident of Rockland State Psychiatric Hospital (see *In re Escher Trust* at 94 Misc.2d 952) The trust that was approved provided for totally discretionary distributions for the benefit of that child during life with the remaining funds being distributed to other beneficiaries. This case and others gave rise to the New York statute, EPTL 7-1.12, which originally dealt with only the third party trust but is also now applicable to first party trusts.[7] Other than the general terms of the statute, there are no specific requirements for this type of trust and care must again be taken to ensure that the terms of the trust will not impair the beneficiary's ability to receive public benefits. The third party trust is either created *inter vivos* by the third party, although funding may be immediate or delayed to a future date, or the special needs trust can be testamentary and funded though the testator's probate estate. In either event, since the funds that are deposited into the trust are not funds to which the beneficiary is otherwise entitled, there is no requirement for a payback to Medicaid and the grantor/testator is free to direct the remainder to beneficiaries of his/her choosing.

3. Considerations When Deciding Whether to Use an ABLE Account or a Special Needs Trust…or Both

Age

Clearly the determinative factor is going to be the age of onset of the disability of the prospective beneficiary as ABLE accounts are limited to those individuals who became/become disabled prior to age 26. It is important to reiterate that the age consideration is NOT how old the individual is at the time of the establishment of the ABLE account—rather it is the age when the disability presented itself. As for the different types of third party special needs trusts and the pooled first party special needs trust, there are no age restrictions but the first party special needs trust cannot be established for a beneficiary over the age of 64.[8]

Disability

For ABLE accounts, the law requires that the person for whom the account is set up must either be receiving certain public benefits because of blindness or disability, or the person will need to be able to provide a written signed documentation from a licensed physician certifying blindness or a "physical or mental impairment which results in severe functional limitations" or other specified conditions.[9]

The federal statute that permits a special needs trust under either (d)(4)(A) or (d)(4)(c) requires that the beneficiary of the trust must be disabled according to the definition contained in the Social Security Act.[10]

The requirement for a disability under either a pooled or non-pooled third party trust is not quite as definitive.

Often these third party trusts are utilized for an individual who is, or may be, receiving benefits now or possibly in the future, someone who is borderline disabled, or an individual who might transition on and off public benefits based upon their physical or mental condition at the time. If the qualitative tests for "disability" cannot be satisfied for an ABLE account or a first party pooled or individually established special needs trust, then the only option may be a third party special needs trust.

Who Can Establish and Fund the Account or Trust?

An ABLE Account can be established by the beneficiary of the account or by a beneficiary's parent, legal guardian or agent acting pursuant to a power of attorney. The funds can come from either the account beneficiary or any third person (including an individual, trust, estate, partnership or corporation) but the annual limit is a total of $14,000 from whatever source.

A third party special needs trust or pooled special needs trust can be established by any person other than the intended beneficiary and it can be funded by any third party with no monetary limitation. However, in New York a special needs trust cannot be funded directly or indirectly by a person with a legal obligation of support to the beneficiary or by someone with a financial obligation to the beneficiary at the time the beneficiary is receiving or applying to receive public assistance.[11]

As a result of the recent enactment of the Special Needs Fairness Act, either the pooled or non-pooled first party special needs trust can now be established by the beneficiary, a parent, grandparent, legal guardian or a court, also with no monetary limitation. As mentioned above, there is still a distinction between the pooled and non-pooled in that there is no age limitation on the beneficiary for a (d)(4)(C) but under (d)(4)(A) the special needs trust beneficiary cannot be age 65 or older.

What Types of Expenses Can Be Paid?

The ABLE Act lists certain "qualified disability expenses" that can be paid, and while the list is not exhaustive the expenses must be related to the disability of the beneficiary. To the extent that expenses are paid that are found to be "non-qualified" they will be subject to federal income tax and a 10% penalty.

Both the third party and first party special needs trusts and pooled trusts offer some more flexibility as to permissible expenses since there is no specific requirement that the expenses be "related" to the disability of the beneficiary. That being said, disbursements are for goods and services that will enhance the quality of life of the beneficiary while protecting public benefits. In all first party trusts the expenses must be for the sole benefit of the beneficiary.

What Happens to the Funds in the Account or Trust Upon Termination?

As mentioned at the outset of this article, one of the most significant, if not the most significant, aspect of the ABLE account is that upon the termination of the account there is a required payback for Medicaid received by the beneficiary, but the payback is limited to the time the account was established. Additionally, there is no distinction made as to the source of funds and unlike the third party trusts, the payback is from all funds remaining regardless of the source.

In the third party special needs trust and pooled trusts there is no Medicaid payback and the grantor is able to designate the remainder beneficiaries. Some of the third party pooled trusts have provisions providing for the retention of some portion of the remaining funds and inquiry of the pooled trust administrator as to the policy on remainder funds is always recommended.

In the first party special needs trust there must be a provision requiring a payback to Medicaid for benefits received by the beneficiary during lifetime—not merely from the time the trust is established.[12] As for the first party pooled special needs trust, the remainder funds can be retained by the nonprofit administrator of the pooled trust for the benefit of other disabled individuals, but the policies differ among the various states and once again inquiry is always recommended.

4. Some Practical Advice

A major benefit afforded to individuals with disabilities under the ABLE Act is the treatment it affords disbursements for shelter expenses, including rental payments. Under the SSI program when payments for rent and other shelter expenses are paid by a third party, the SSI recipient's monthly SSI payment is reduced by an amount up to one third of the monthly amount. However, payments for rent and other shelter expenses from an ABLE account are considered payments by the individual regardless of the source of the funds that went into the ABLE account. In other words, if a parent paid the rent for a child on SSI, the monthly SSI benefit would be reduced. However, if the parent deposits the same funds into the ABLE account and the child or other permitted signatory on the ABLE accounts uses those funds in that same month to pay rent there is no reduction of SSI or income tax implication. Similarly, if the payments into the ABLE account come from a trust there would be no reduction. Therefore, coordination between a special needs trust and an ABLE account can be a very helpful planning device and all attorneys should consider including provisions in their trust documents that permit disbursements into an ABLE account. (Although not germane to the topic of this article, practitioners should also consider similar language allowing transfers to ABLE accounts when drafting powers of attorneys and other documents

for parents or loved ones who are planning for an individual with a disability.)

Similarly, using an ABLE account in marital support matters so that payments are made to the ABLE account by the parent/spouse can also afford the beneficiary the same level of monetary protection against a SSI reduction in the monthly amount.

Some practical concerns when considering an ABLE Account in lieu of a special needs trust:

- The requirement for a Medicaid payback even where the funds come from a third party;
- There can be only one account per beneficiary and there are annual and lifetime limits;
- The potential for over funding of the account by generous but uninformed family members and friends leading to income tax issues for the beneficiary;
- Ensuring that distributions from the ABLE account are for Qualified Disability Expenses and that all distributions are properly documented;
- Depending upon the particular individual there may be the possibility of fraud, undue influence and exploitation.

Conclusion

As can be seen from the above discussion, the availability of ABLE accounts has drastically changed the special needs planning landscape for individuals with disabilities and provides many new opportunities and challenges. However, it is also clear that there continues to be a need for special needs trusts—individually established and as part of pooled trusts—and practitioners should be alert to the differences and cognizant of the interaction of all of these planning devices to insure the best overall and coordinated plan for their clients and loved ones.

Endnotes

1. 26 U.S.C 529A; Public law 113-295.
2. Public Law 114-255; 42 U.S.C. 1396p(d)(4)(A).
3. POMS SI 01130.740.
4. 42 U.S.C. 1382c(a)(3).
5. *In re Morales*, N.Y.L.J, 7/28/1995, page 25.
6. *Supra* note 2.
7. NYS Social Services Law Section 366.
8. Note that a number of states do assess a penalty for transfers to a pooled trust by an individual over the age of 65.
9. *Supra* note 3.
10. *Supra* note 4.
11. EPTL 7-1.12.
12. *In re Abraham* XX 11 N.Y. 3rd 429.

Robert Mascali is a senior consultant with the Center for Special Needs Trust Administration, Inc., which is a national nonprofit organization that administers special needs and pooled trusts and is of counsel to the firm of Pierro, Connor and Associates with offices in New York City and Latham, NY. Mr. Mascali has been an attorney for over 40 years working in the private, government and non profit sectors. Mr. Mascali is the immediate Past President of the New York Chapter of the National Academy of Elder Law Attorneys He also serves on the Executive Committee and is Co-Vice Chair of the Special Needs Planning and the Legislation Committees of the Elder Law and Special Needs Section of the NYS Bar Association. He is also a member of Massachusetts NAELA and the Academy of Special Needs Planners. He is a frequent author and speaker on issues dealing with special needs planning.

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	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Who is eligible? Are there age restrictions?	To qualify, an individual must have a disability that occurred before age 26 and: (a) Be able to provide if requested, written, signed documentation from a licensed physician certifying blindness, "physical or mental impairment which results in severe functional limitations" or a condition listed on the Social Security Administration's list of compassionate allowances conditions. or (b Receiving or eligible to receive SSI or SSDI (See POMS SI 01130.740.) Designated beneficiaries can open an ABLE account by certifying, under penalties of perjury, that they meet the necessary requirements. (See IRS Guidance, Tax Benefit for Individuals With Disabilities: IRC Section 529A January 29, 2016.)	Generally used for persons who are disabled but may be used for a beneficiary who is borderline disabled or is modestly employed and not eligible for SSI or SSDI but may need other needs based benefits such as Medicaid, SNAP or Housing Subsidy. Some pooled trusts require that the beneficiary has a disability that meets the SSA definition of disability. (See Social Security Administration's Disability Starter Kits.) There is no age restriction for the beneficiary.	The beneficiary has a disability that meets the SSA definition of disability. (See Social Security Administration's Disability Starter Kits.) For an individual age 64 or younger: A first party pooled trust can be established for an individual with a disability age 64 or younger. For an individual age 65 or older: Further research is recommended on a state by state basis. (See CMS Bulletin, May 12, 2008.)	While most third party special needs trusts are established for persons who are disabled, the beneficiary does not need to have a specific disability. Families who suspect that a family member may need governmental benefits in the future can set aside that family member's inheritance in a third party special needs trust	Self-settled special needs trust requires a person be disabled per SSA regulations but the trustee of a (d)(4)(A) trust can be a family member, friend, professional or corporate trust. Further research is recommended on a state by state basis.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Who can set up and fund the account?	The beneficiary or designated beneficiary's parent, legal guardian, or agent acting under power of attorney can set up the ABLE account. Any person can contribute to the beneficiary's ABLE account, including the designated beneficiary. "Person" is defined by the IRS to include an individual, trust, estate, partnership, association, company or corporation. (See POMS SI 01130.740; 26 U.S.C. S7701(a)(1).)	The grantor can be anyone, except the beneficiary. Multiple third-parties can contribute to the trust.	The grantor can be the beneficiary, parent, grandparent, court or legal guardian. The trust is funded with the beneficiary's own money usually as a result of a personal injury or workers' compensation settlement, direct inheritance, Social Security back payment, or an award of marital property or spousal support.	Same as third party pooled special needs trust.	The grantor can be a parent, grandparent, court or legal guardian. The trust is funded with funds which belong to the beneficiary as in the first party pooled special needs trust.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Does the beneficiary have to reside in the state where the program or trust is located?	Some state ABLE programs are open for nationwide enrollment while others require in-state residency. (See ABLE National Resource Center.)	Many pooled trusts organizations are state-centric, but there are a number of national pooled trust organizations that serve clients throughout the United States. The Academy of Special Needs Planners provides a list of national, regional and state pooled trusts organizations. (See ASNP Directory of Pooled Trusts.)	Same as the third party pooled special needs trust.	There are no restrictions on a third party special needs trust.	Same as third party special needs trust.
Can the beneficiary have more than one account or type of trust?	A beneficiary can have only one ABLE account. (See POMS SI 01130.740.)	A beneficiary can have more than one trust account. For example, a beneficiary can have both a third-party and first-party trust.	Same as third party pooled special needs trust.	Same as third party pooled special needs trusts.	Same as third party pooled special needs trust.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Are there any restrictions on contributions?	A limit of $14,000 per year or that amount equal to the annual federal gift tax exclusion can be contributed. (See POMS SI 01130.740.) Federal law stipulates that a state's ABLE plan set a limit on aggregate contributions on behalf of a designated beneficiary, based on limits set for a state's 529 college-savings plan. (See 26 USC 529A: Qualified ABLE programs, (b)(6).)	There are no limits on contributions per year but no contributions can be made by the beneficiary or with funds the beneficiary has a legal right to.	There are no limits on contributions per year but contributions can only be made by the beneficiary or with funds the beneficiary has a legal right to.	Same as third party pooled special needs trust.	Same as first party pooled special needs trusts.
Are Medicaid benefits protected?	A beneficiary can retain *Medicaid* as long the disbursements are for qualified expenses and the account does not exceed the state's ABLE plan aggregate contribution limit that is adopted from the state's 529 college-savings plan. (See Pub. L. 113-295, div. B, title I, §103, Dec. 19, 2014, 128 Stat. 4063 (b)(2); 26 USC 529A: Qualified ABLE programs, (b)(6).)	A beneficiary can retain *Medicaid* as long as all distributions are made to vendors or third parties and cash not distributed directly to the beneficiary.	Same as third party pooled special needs trust.	Same as third party pooled SNT.	Same as third party pooled special needs trust.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Are SSI benefits protected?	A beneficiary can retain *SSI* as long the disbursements are for qualified expenses and the ABLE account remains below $100,000. If the account balance goes above $100,000, then the individual's SSI benefits will be suspended but not terminated until it falls below $100,000. (See POMS SI 01130.740.) Note that funds from an ABLE Account can be used to pay for shelter expenses such as mortgage or rent, homeowner's insurance, taxes, heat, electricity, water, sewer and garbage pick-up without resulting in a one-third loss of SSI.	The trust is set up to protect *SSI* benefits. There are no restrictions on the account balance in order to maintain eligibility. Distributions toward shelter expenses may be deemed as in kind support and result in a one-third loss of SSI. There is discretion to transfer up to $14,000 per year to an ABLE Account to be used for Qualified Housing Expenses which may avoid a reduction in SSI.	Same as third party pooled special needs trust.	Same as third party pooled special needs trust.	Same as third party pooled special needs trust.
Is there oversight to ensure the funds are used for the individual with a disability in accordance with the rules?	The eligible beneficiary or person with signing authority (designated beneficiary's parent, legal guardian, or agent acting under power of attorney) will be responsible for retaining documentation about disbursements and will need to categorize	A pooled special needs trust is helpful when a parent or other person wants to leave money for a disabled individual but fears the individual cannot prudently handle funds on his or her own or in the case where a family member needs	Same as third party pooled special needs trust.	While SSI, DMH/DDS/DHS and Medicaid agencies can demand an accounting of how funds in a third party special needs trust are managed, there is less oversight than with pooled first and third party special needs trusts.	Same as third party special needs trust.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Is there oversight to ensure the funds are used for the individual with a disability in accordance with the rules? (cont.)	distributions to determine federal income tax obligations. (See IRS Notice 2015-81.) State reporting requirements will vary.	to remain eligible for needs based benefits. Those who want to leave money for the benefit of a person with special needs may not want to burden family members with trust administration or may not have friends or family members able and/or willing to manage a special needs trust. In both cases, the individual can benefit from the services of a pooled trust administrator, regardless of Medicaid and SSI benefit preservation. The third party pooled special needs trust offers an experienced choice to families when selecting a trust administrator to manage funds left for the benefit of a disabled individual. For clients receiving SSI and Medicaid benefits, the pooled trust administrator provides oversight so as to not jeopardize these benefits.		With an individual trustee or Corporate trustee who is not familiar with distribution rules, there is a greater risk of naive error which may result in a loss or diminution of benefits.	

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Is there oversight to ensure the funds are used for the individual with a disability in accordance with the rules?		Additionally, the trust administrator fulfills reporting requirements from the state's Medicaid office and/or SSA for SSI recipients.			
What type of assets are accepted?	Cash assets fund an ABLE account. Real estate or other non-cash assets are not accepted. (See 26 USC 529A: Qualified ABLE programs.)	Cash assets are accepted to fund the trust. The funds are pooled together for investment purposes and each beneficiary has his or her own sub account. Some pooled trust organizations may accept real estate or non-cash assets.	Same as third party pooled special needs trust. Note: Assets that belong to the beneficiary or which he or she has a legal right to cannot be commingled with either a third party pooled or non-pooled special needs trust.	Unless a corporate or other professional trustee has specific rules regarding what assets can be held in a trust, there are no limitations as to what type of assets are acceptable.	Restrictions will vary depending on the trustee's rules or practices. An individual trustee may be more willing to hold real estate in the trust than a professional trustee. Note: Assets that belong to the beneficiary or which he or she has a legal right to cannot be commingled with either a third party pooled or non-pooled special needs trust.
What are the set up and ongoing costs?	Fees vary with each state's ABLE program. Set up and ongoing costs are nominal and are typically less than those associated with setting up a special needs trust.	Enrollment and administration fees are likely higher than those associated with ABLE accounts but are often lower than for-profit businesses that offer trust services.	Same as third party pooled special needs trust.	Administration fees will vary depending on who is serving as trustee. If an individual family member, he or she may not charge. There are administrative costs involved	Same as third party pooled special needs trust.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
What are the set up and ongoing costs? (cont.)		Management fees for a pooled special needs trust can be less than one percent on an annual basis. A fee schedule should be available.		with filing taxes and filing accountings.	
What expenses can be paid?	Qualified Disability Expenses (QDE) must be related to the beneficiary's disability and include but are not limited to: education; housing*, transportation, employment training and support, assistive technology and related services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for ABLE account oversight and monitoring, funeral and burial; and, basic living expenses. *To avoid any impact to a beneficiary's SSI benefits, funds from the ABLE account used to pay for housing must be spent within the same calendar month that funds are withdrawn from the account. (See POMS SI 01130.740.)	Disbursements can pay for goods and services that will enrich the quality of life of the beneficiary while protecting benefits of SSI and Medicaid recipients. There is greater flexibility in what the pooled trust can pay for compared to the ABLE account since expenses do not have to be related to the beneficiary's disability. The following are some examples: education, transportation, health care, cable, phone, internet, employment training and support, assistive technology, care provider, prevention and wellness, home renovations, legal fees, hobby, leisure, and recreation activities, gifts for others that are given	Disbursements are for the sole benefit of the beneficiary and can pay for goods and services that will enrich the quality of life of the beneficiary while protecting benefits of SSI and Medicaid recipients. There is greater flexibility in what the pooled trust can pay for compared to the ABLE account since expenses do not have to be related to the beneficiary's disability. The following are some examples: education, transportation, health care, cable, phone, internet, employment training and support, assistive technology, care provider, prevention and wellness, home renovations, legal fees, recreation,	Same as third party pooled special needs trust.	Same as first party pooled special needs trust.
	As stated above, distributions from an ABLE account avoids the loss of one-third reduction in SSI due to in kind expense rule. ,	on behalf of the beneficiary, paying for a family member companion on vacations or travel or for family and/or friends to visit the beneficiary and all funeral expenses.	hobby and leisure activities. Purchasing a prepaid funeral is allowed but funeral expenses are disallowed following the death of the beneficiary.		
How are funds disbursed from the account?	The designated beneficiary or the person with signature authority (designated beneficiary's parent legal guardian, or agent acting under power of attorney) has account access to make disbursements by check and/or credit card. (See POMS SI 01130.740.)	Named by the grantor, an advocate is responsible for making disbursement requests on behalf of beneficiary. The advocate has access to financial statements and can be the beneficiary, guardian, conservator, power of attorney, family member, case manager, and/or someone named who is familiar with the needs of the beneficiary. The PSNT organization makes payments from a beneficiary's sub account for approved disbursements.	Same as third party pooled special needs trust.	The trustee has sole discretion regarding all distributions from an SNT. The trustee may consult with the beneficiary, his or her representative or an advocate to determine goals, prioritization of needs, wants and what is affordable given the amount and type of assets held in the trust.	Same as third party special needs trust.
Are contributions tax-deductible?	Contributions are not deductible for federal tax purposes. States may offer tax incentives for in-state eligible beneficiaries. (See POMS SI 01130.740.)	Contributions are not tax-deductible (federal or state).	Same as third party pooled special needs trust.	Same as third party pooled special needs trust.	Same as third party pooled special needs trust.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
Is the account revocable?	Once the account is set up, the funds in the ABLE account are irrevocable. Funds in an ABLE account can be transferred to another qualifying beneficiary who must be a sibling, whether by blood or by adoption (brother, sister, step-brother, step-sister, half-brother, and half-sister). (See POMS SI 01130.740)	The trust can be revocable until funded.	The trust is irrevocable.	Same as third party pooled special needs trust.	The trust is irrevocable.
How are funds invested?	The investment options vary with each state's program. The eligible beneficiary or person with signing authority can change the way funds are invested no more than twice a year. Financial records should be made available that document all activity in the account. (See 26 USC 529A: Qualified ABLE programs.)	Trust funds are pooled, or grouped together, for investment purposes and an accounting is maintained in each beneficiary's sub account. Pooling funds can provide for greater investment opportunities and lower administrative fees. All earnings based on a beneficiary's share of the principal are allocated to each beneficiary's sub account. Account statements should be made available to authorized individuals by mail or via online access.	Same as third party pooled special needs trust.	The investment options are within the discretion of the trustee. General trust rules require that they conform to reasonable prudent person rules regarding investments.	Same as third party special needs trust.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
What happens to remaining funds upon the death of the beneficiary?	For a beneficiary who received Medicaid, an ABLE account is subject to Medicaid payback for medical benefits received from the time since the ABLE account was established. The claim is limited to the total amount of assistance paid by the Medicaid, less premiums paid by, or on behalf of, the beneficiary to a Medicaid Buy-In program and after all outstanding Qualified Disability Expenses have been paid. (See 26 USC 529A: Qualified ABLE programs.) Note: Funds remaining in the ABLE account can be used for funeral expenses prior to Medicaid payback.	For the third-party special needs trust, there is no Medicaid payback requirement. What happens to remaining funds in the trust upon the death of the beneficiary varies greatly among pooled trust organizations. Some do not retain any of the remainder funds and any remaining funds will go to the successor beneficiary(ies) named in the Joinder Agreement. Others retain all or a portion of the remaining funds. Given this disparity, it is important to ask what the remainder policy is when researching pooled trust organizations.	Federal law authorizes pooled trust organizations to pay back the state(s) for medical claims paid by Medicaid on behalf of the beneficiary during the beneficiary's lifetime or the funds can go to a nonprofit organization. (See 42 U.S.C. §1396p(d)(4)(C).) Each nonprofit pooled trust organization has its own remainder policy. Some do not retain any of the remainder funds while others retain all or a portion of the funds. Given this disparity, it is important to ask what the remainder policy is when researching pooled trust organizations. Note: Paying for funeral prior to Medicaid payback is not allowed.	There is no pay-back requirement for third party special needs trusts. The grantor can designate a remainder man or can leave the beneficiary a limited power of appointment to designate a remainder man among a class of individuals or charities.	Same as first party pooled special needs trust. Note: Paying for funeral prior to Medicaid payback is not allowed.

	ABLE account	Third party pooled special needs trust	First party (d)(4)(C) pooled special needs trust	Third party (non-pooled) special needs trust	First party (d)(4)(A) (non-pooled) special needs trust
What happens if nonqualified expenses are paid?	Account earnings from the ABLE account used for *non-qualified disability expenses* will be subject to federal income tax and an additional 10 percent federal tax penalty. Penalties will also apply for failure to report (See 26 USC 529A: Qualified ABLE programs.)	Distributions are not limited to certain qualifying expenses only but wrongful distributions may adversely affect benefits. For a beneficiary receiving Medicaid and/or SSI, the individual's benefits could be reduced or he or she may lose eligibility for a period of time.	Same as third party pooled special needs trust.	Same as third party pooled special needs trust.	Same as for first party pooled special needs trust. However, in some cases, if a wrongful distribution is made, it may sabotage an otherwise well written trust and cause the trust to be deemed as an available asset. As a result, a beneficiary may lose SSI or Medicaid.

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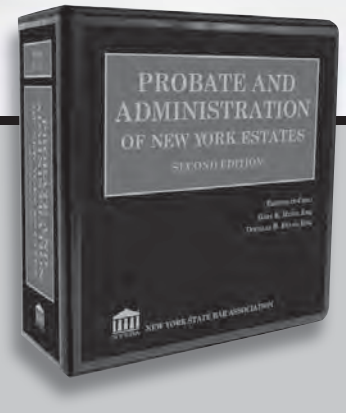

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Section Committees and Chairs

Client and Consumer Issues
Melinda Bellus
Legal Services of the Hudson Valley
30 South Broadway, 6th Floor
Yonkers, NY 10701
mbellus@lshv.org

Diversity
Veronica Escobar
The Law Offices of Veronica Escobar
118-35 Queens Boulevard
Suite 1220
Forest Hills, NY 11375
vescobar@veronicaescobarlaw.com

Elizabeth Valentin
Littman Krooks LLP
399 Knollwood Road, Suite 115
White Plains, NY 10603-1900
evalentin@littmankrooks.com

Elder Abuse
Deborah S. Ball
Law Offices of Deborah S. Ball
880 Third Avenue, 13th Floor
New York, NY 10022
dball@ballnyelderlaw.com

Julie Stoil Fernandez
Finkel & Fernandez LLP
16 Court Street, Suite 1007
Brooklyn, NY 11241-1010
jstoilfernandez@ffelderlaw.com

Estates, Trusts and Tax Issues
Patricia J. Shevy
The Shevy Law Firm, LLC
7 Executive Centre Drive
Albany, NY 12203
patriciashevy@shevylaw.com

Judith Nolfo McKenna
Law Office of Judith Nolfo McKenna
1659 Central Avenue, Suite 104
Albany, NY 12205-4039
judy@mckennalawny.com

Ethics
Natalie J. Kaplan
Elder Law on Wheels
477 Madison Avenue, Suite 530
New York, NY 10022
nkaplan@elderlawoffices.com

Phillip M. Tribble
Tribble Law
3 Tallow Wood Drive; Suite H-1
PO Box 1411
Clifton Park, NY 12065
ptribble@ptribblelaw.com

Financial Planning and Investments
Ronald A. Fatoullah
Ronald Fatoullah & Associates
60 Cutter Mill Road, Suite 507
Great Neck, NY 11021
rfatoullah@fatoullahlaw.com

William D. Pfeiffer
The Pfeiffer Law Firm PLLC
20 Corporate Woods Blvd
Albany, NY 12211
wpfeiffer@albanyelderlaw.com

Guardianship
Patricia A. Bave
Kommer Bave & Ollman LLP
145 Huguenot Street, Suite 402
New Rochelle, NY 10801
pbave@kboattorneys.com

Fern J. Finkel
Finkel & Fernandez LLP
16 Court Street, Suite 1007
Brooklyn, NY 11241
ffinkel@aol.com

Health Care Issues
Tammy Rose Lawlor
Miller & Milone, P.C.
100 Quentin Roosevelt Boulevard,
Suite 205
Garden City, NY 11530
TLawlor@millermilone.com

Legal Education
JulieAnn Calareso
Burke & Casserly, P.C.
255 Washington Avenue Extension,
Suite 104
Albany, NY 12205
jcalareso@burkecasserly.com

Richard A. Weinblatt
Haley Weinblatt & Calcagni, LLP
One Suffolk Square
1601 Veterans Memorial Hwy
Suite 425
Islandia, NY 11749
raw@hwclaw.com

Legislation
Deepankar Mukerji
Keane & Beane, PC
445 Hamilton Ave., 15th Floor
White Plains, NY 10601
dmukerji@kblaw.com

Jeffrey A. Asher
Law Offices of Jeffrey A. Asher, PLLC
43 West 43rd Street, Suite 72
New York, NY 10036
jasher@asherlawfirm.com

Liaison to Law Schools
Margaret M. Flint
John Jay Legal Services
Pace Law School
80 North Broadway
White Plains, NY 10603-3711
gflint@law.pace.edu

Peter J. Strauss
Drinker Biddle & Reath LLP
1177 Avenue of the Americas
New York, NY 10036
advocator66@gmail.com

Marianne Artusio
Touro College Jacob D. Fuchsberg
Law Center
225 Eastview Drive
Central Islip, NY 11722
MarianneA@tourolaw.edu

Mediation
Beth Polner Abrahams
Polner Abrahams Law Firm
350 Old Country Road, Suite 101
Garden City, NY 11530
Beth@bpabrahamslaw.com

Antonia J. Martinez
Antonia J. Martinez, LLC
P.O. Box 883
Croton on Hudson, NY 10520
elderlawtimes@yahoo.com

Medicaid
Valerie J. Bogart
New York Legal Assistance Group
Evelyn Frank Legal Resources Program
7 Hanover Square, 18th Floor
New York, NY 10004
vbogart@nylag.org

Rene H. Reixach Jr.
Woods Oviatt Gilman LLP
2 State Street, Suite 700
Rochester, NY 14614
rreixach@woodsoviatt.com

Membership Services
Salvatore M. Di Costanzo
Maker, Fragale & Di Costanzo, LLP
350 Theodore Fremd Avenue
Rye, NY 10580
smd@mfd-law.com

Pauline Yeung-Ha
Grimaldi & Yeung LLP
9201 Fourth Avenue, 6th Floor
Brooklyn, NY 11209
pyeung@gylawny.com

Mental Health Law
Suanne L. Chiacchiaro
45 Wintercress Lane
East Northport, NY 11731
slc4law@optonline.net

Martin Petroff
Martin Petroff & Assoc. Attorneys at Law
1725 York Avenue
New York, NY 10128
mbpetroff@petroffelderlaw.com

Mentoring
Anne E. Dello-Iacono
The Dello-Iacono Law Group, P.C.
105 Maxess Road, Suite 205
Melville, NY 11747
anne@dellolaw.com

Practice Management
Miles P. Zatkowsky
Dutcher & Zatkowsky
1399 Monroe Avenue
Rochester, NY 14618
miles@dutcher-zatkowsky.com

Publications
Judith Nolfo McKenna
Law Office of Judith Nolfo McKenna
1659 Central Avenue, Suite 104
Albany, NY 12205-4039
judy@mckennalawny.com

Tara Anne Pleat
Wilcenski & Pleat PLLC
5 Emma Lane
Clifton Park, NY 12065
TPleat@WPLawNY.com

Real Estate and Housing
Jeffrey G. Abrandt
Goldfarb Abrandt Salzman & Kutzin LLP
350 5th Avenue, Suite 4310
New York, NY 10118-1190
abrandt@seniorlaw.com

Special Education
Adrienne J. Arkontaky
The Cuddy Law Firm
50 Main Street, Suite 1280
White Plains, NY 10606
aarkontaky@cuddylawfirm.com

Special Needs Planning
Lisa K. Friedman
Law Office of Lisa K. Friedman
880 Third Avenue, Thirteenth Floor
New York, NY 10022
lf@lisafriedmanlaw.com

Sponsorship
Elizabeth Briand
Bleakley Platt & Schmidt LLP
One North Lexington Avenue
White Plains, NY 10601
ebriand@bpslaw.com

Technology
Moira Schneider Laidlaw
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55 Smith Avenue
Mount Kisco, NY 10549-2813
mlaidlaw@smhal.com

Monica P. Ruela
Capell Barnett Matalon & Schoenfeld LLP
100 Jericho Quadrangle, Suite 233
Jericho, NY 11753
monica@makofskylaw.com

Veteran's Benefits
Edward F. Cunningham
Law Offices of Edward F. Cunningham
62 Cambridge Avenue
Garden City, NY 11530
ed@edcunninghamlaw.com

Sarah Amy Steckler
Keane & Beane, PC
445 Hamilton Ave., 15th Fl.
White Plains, NY 10601
ssteckler@kblaw.com

Section Officers

Chair
David Goldfarb
Goldfarb Abrandt Salzman & Kutzin, LLP
350 Fifth Avenue, Suite 4310
New York, NY 10118
goldfarb@seniorlaw.com

Chair-Elect
Martin Hersh
Law Offices of Martin Hersh, Esq.
PO Box 567
Liberty, NY 12754
elder.law@verizon.net

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Grimaldi & Yeung, LLP
9201 Fourth Avenue, 6th Floor
Brooklyn, NY 11209
jgrimaldi@gylawny.com

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Wilcenski & Pleat PLLC
5 Emma Lane
Clifton Park, NY 12065
tpleat@wplawny.com

Treasurer
Matthew J. Nolfo
Matthew J. Nolfo & Associates
275 Madison Avenue, Suite 1714
New York, NY 10016
mnolfo@estateandelderlaw.net

Financial Officer
Martin S. Finn
Lavelle & Finn, LLP
29 British American Boulevard
Latham, NY 12110-1405
marty@lavelleandfinn.com

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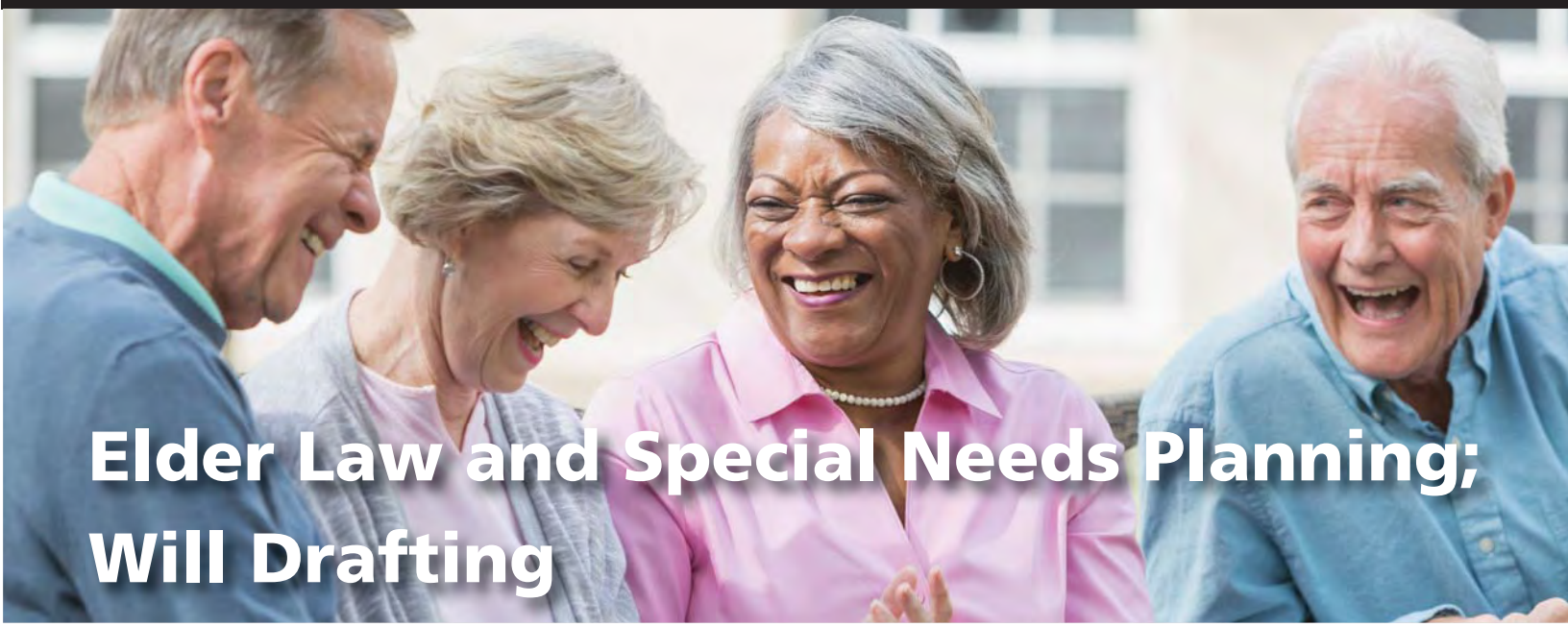

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Authors

Elder Law and Special Needs Planning
Bernard A. Krooks, Esq.
Littman Krooks LLP, New York, NY

Will Drafting
Jessica R. Amelar, Esq.
New York County Surrogate's Court, New York, NY

This practice guide is currently divided into two parts.

Part One, written by Bernard A. Krooks, Esq., examines the scope and practice of elder law in New York State, covering areas such as Medicaid, long-term care insurance, powers of attorney and health care proxies. Elder law cuts across many distinct fields including benefits law, trusts and estates, personal injury, family law, real estate, taxation, guardianship law, insurance law and constitutional law.

Part Two, written by Jessica R. Amelar, Esq., gives the attorney a step-by-step overview of the drafting of a will, from the initial client interview to the will execution. This section provides a sample will, sample representation letters and numerous checklists, forms and exhibits.

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