ELDRS Update

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Recent News for the Elder Practitioner

May – July 2011

By Christopher W. Smith

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Alzheimer's/Dementia

- Physical inactivity, smoking, depression, low education, hypertension, obesity and diabetes are responsible for roughly half of all Alzheimer's cases according to a University of California-San Francisco study. Pam Belluck, Grasping For Any Way To Prevent Alzheimer's, N.Y. Times, July 25, 2011.

- Two antidepressants commonly given to Alzheimer's patients, Zoloft and Remeron, were found ineffective to treat Alzheimer's/dementia according to a British study published in The Lancet. Tan Ee Lyn, Two Antidepressants Ineffective For Dementia, Reuters, July 19, 2011.

- A government audit found that one in seven elderly nursing home residents receive powerful antipsychotic drugs even though the medicines increase the risk of death and are not approved for the resident's treatments. CMS even accused nursing homes of using the drugs to garner kickbacks from the drug makers. Gardiner Harris, Antipsychotic Drugs Called Hazardous For The Elderly, N.Y. Times, May 9, 2011.

By The Numbers

- The Medicare population is not affluent:
    - Half of Medicare beneficiaries had incomes below $22,000 in 2010; less than one percent had incomes over $250,000.
    - Half of all Medicare beneficiaries have less than $2,100 in retirement account savings (such as IRAs) and half have less than $31,000 in other financial assets (such as savings accounts); 5% have combined savings of $1 million or more.
    - Half of all Medicare beneficiaries had less than $60,000 in home equity in 2010.

  Source: Kaiser Family Foundation, Projecting Income and Assets: What Might The Future Hold For The Next Generation Of Medicare Beneficiaries, June 2011.

- An AARP study estimated the value of U.S. family caregiving at $450 billion annually. Jennifer Ludden, AARP Finds Toll On Family Caregivers Is 'Huge,' NPR, July 18, 2011. A Met Life study found that one quarter of adult children provide personal care and/or financial assistance to a parent, a threefold increase over the past 15 years. The study estimated that the average caregiver loses $303,880 in lifetime lost wages and other benefits. The MetLife Study Of Caregiving Costs To Working Caregivers, MetLife Mature Market Institute, 2011.

- About 5% of the population accounts for almost half of all health care spending in the United States, according to the National Institute for Health Care Management Foundation. Althea Fung, Report: 5 Percent Of People Account For Half Of U.S. Health Care Spending, June 27, 2011.
- Americans gave an estimated $290.89 billion to charities in 2011, a 2.1% increase over 2010. While this was the first increase since 2007, total giving still fell short of the $326.57 billion given in 2007. Stephanie Strom, Charitable Giving Rose Last Year For First Time Since 2007, N.Y. Times, June 19, 2011.

- According to the U.S. Department of Agriculture, it costs, on average, $226,920 to raise a child. Families earning more than $99,730 spend closer to $377,040. Tom Henderson, New Sticker Price on Raising a Child: $226,920, ParentDish, June 10, 2011.

- According to the World Health Organization, more than 1 billion people in the world are living with some sort of disability; that's 15% of the world's population or nearly 1 in 7 people. Joanne Silberner, Nearly 1 in 7 People On Earth Is Disabled, Survey Finds, NPR: Shots Blog, June 9, 2011. Also, according to a study in the journal *Pediatrics*, more than 15% of U.S. kids (up from 12.8% in 1997-98) have a developmental disability of some sort. Liz Szabo, One In Six Children Have A Developmental Disability, USA Today, May 22, 2011.

- According to the Milliman Medical Index, the total health care cost for a typical family of four covered by a PPO is $19,393, an increase of $1,319 or 7.3% over 2010. Lorraine Mayne, et al., 2011 Milliman Medical Index, May 11, 2011.

- Medicaid serves more Americans (47.4 million or 16% of the population) than Medicare (37.6 million or 12% of the population). In Michigan, the numbers are roughly equal: Medicaid serves 1.4 million and Medicare serves 1.3 million (about 14% of the population for each). The Kaiser Family Foundation, statehealthfacts.org.

- The world's population is expected to reach 10.1 billion by 2100 according to the United Nations. The world is expected to reach 7 billion people in October of this year. Justin Gillis and Celia W. Dugger, U.N. Forecasts 10.1 Billion People By Century's End, N.Y. Times, May 3, 2011.

Elder Abuse

- A recent AARP survey examined the demographics of the types of people most likely to fall victim to certain exploitation tactics. The AARP Foundation National Fraud Victim Study, May 2011.

- Relying on newspaper articles, Met Life updated its past study on elder financial abuse. MetLife Mature Market Institute, The MetLife Study of Elder Financial Abuse, 2011.

- The Center for Elders and the Courts created an excellent three-part curriculum available free online to train judicial educators (or anyone else) about elder abuse. It can be found at http://www.eldersandcourts.org/curriculum/index.html.

Financial and Estate Planning

- Lucky fan Christian Lopez "gave" the $250,000 baseball he caught from Derek Jeter's 3,000th hit back to Jeter. But he will most likely not face any gift tax implications. A 1998 IRS statement (issued during the homerun chase between Sammy Sosa and Mark

McGwire) said that fans would not be subject to gift tax laws for catching and immediately returning a historic baseball. Gerry Beyer, Will Yankees Fan Be Subject To Gift Tax For Returning Jeter's Ball?, Wills, Trusts & Estates Prof Blog, July 12, 2011.

- The number of large companies that automatically enroll new employees in their 401(k) plans grew from 24% in 2006 to about 57% today. But while over 85% of employees participate in 401(k) plans when auto-enrolled (compared to 67% of those in companies that do not auto-enroll), the amounts actually being saved decreased because the auto-enroll plans typically set default contribution rates at a low 3% (vs. 5-10% when individuals enroll themselves). Anne Tergesen, Automatic 401(k) Enrollment Depresses Overall Savings Rate, Smart Money: Encore Blog, July 8, 2011.

- The Government Accountability Office issued a report encouraging middle-income households (worth about $350,000) without pensions to purchase an inflation-adjusted immediate annuity. The government is concerned about the decline in defined benefit plans and studies suggesting that about half of those reaching retirement will run out of money. Margaret Collins, Delay Taking Social Security, Add Annuity To Survive Retirement, GAO Says, Bloomberg, July 1, 2011.

- Effective January 1, 2013, Ohio's "estate tax" will be repealed. Chris Kick, Ohio Repeals Estate Tax, Farmers See Relief in Sight, Farm and Dairy, July 1, 2011.

- According to a Harris Interactive survey, only 55% of 401(k) participants are satisfied with their retirement benefits versus a 64% satisfaction rate among those with traditional pensions. Less than half of workers are satisfied with their health insurance (48%), vision insurance (46%), dental insurance (43%), and stock options (43%). Emily Brandon, Workers Unhappy With 401(k) Plans, U.S. News: Planning To Retire Blog, June 17, 2011.

- The two largest providers of reverse mortgages (accounting for 43% of the market), Wells Fargo and Bank of America, are no longer offering them. Tara Siegel Bernard, 2 Big Banks Exit Reverse Mortgage Business, N.Y. Times, June 17, 2011.

- The IRS automatically revoked the tax-exemptions for approximately 275,000 charities for failing to file annual tax forms. A list of the charities that had their exemption revoked can be found at http://www.irs.gov/charities/article/0,,id=240099,00.html. These charities can reapply for the tax exemption at a reduced fee of $100. Stephanie Strom, I.R.S. Ends Exemptions For 275,000 Nonprofits, N.Y. Times, June 8, 2011.

Health Insurance

- New rules by the Department of Health and Human Services would give $3.8 billion in low-interest loans to consumer-controlled health plans. HHS hopes that these consumer run plans (or "co-ops") would concentrate on improving care and would bring needed competition to established insurers. Christopher Weaver, HHS Sets Rules For Consumer-Controlled Health Plans, Kaiser Health News, July 18, 2011.

- Starting in March 2012, all insurers and employers will have to provide information about their health plans in standardized "coverage facts labels," making it easier for consumers to understand and compare health plans. Susan Jaffe, Consumers Add Their 2 Cents to Health Law's Plan Labels, Kaiser Health News, June 30, 2011.

- The Department of Health and Human Services weakened its proposed rules regarding a patient's right to externally appeal health insurance decisions. Consumers will still have a right in all states to externally appeal a denial based on "medical judgment," but not for other reasons such as a mistaken diagnosis coding or a denied request to see a specialist outside the insurer's network. Also, patients will only have two months to appeal (versus four), insurers will have the option to hire their own consultants to handle the appeals (rather than an outside board), and these rules will not be effective until January 1, 2012. Amy Goldstein, Obama Administration Narrows Rules For Patient Health-care Appeals, The Washington Post, June 22, 2011.

- The Affordable Care Act provided funds to states to assist consumers with health insurance problems. Each state's Consumer Assistance Program can be found at http://www.healthcare.gov/law/provisions/cap. In Michigan, the Michigan Health Insurance Consumer Assistance Program is run by the Office of Financial and Insurance Regulation and can be reached at (877) 999-6442.

Long-Term Care

- The Centers for Medicare & Medicaid Services has enhanced its nursing home comparison website by using 21 new quality-of-care measures, as well as listing any enforcement actions against a particular home. http://www.medicare.gov/nhcompare/home.asp.

- Half of Medicare-certified hospices are now for-profits, and Medicare's hospices costs have increased from $2.9 billion in 2000 to $12 billion in 2010. Although hospice is intended for patients who have no more than six months to live, 19% now receive hospice services for longer than six months. Longer stays are more profitable because

Medicare pays a flat daily rate, and the greatest expense is incurred at the beginning and end of a stay. Long-stay patients are more likely to be found at for-profit hospices. A recent Harvard study found that patients stay an average of 98 days at for-profit hospices versus 68 days at non-profit hospices. Jordan Rau, Kaiser Health News, Growing Hospice Care Costs Bring Concerns About Misuse, June 27, 2011; Peter Waldman, Preparing Americans For Death Lets Hospices Neglect End Of Life, Bloomberg, July 22, 2011.

- Sales of hybrid life/long-term care insurance policies—life insurance policies that can be converted into long-term care benefits—are up, while sales of standard long-term care insurance dropped 23% over the past five years. Insurance companies reported increased sales of these hybrid insurance products between 62% and 124% in 2010. Elizabeth Ody, Insurers Pair Long-Term Care With Life To Entice Older Buyers, Bloomberg Businessweek, May 19, 2011.

- 71% of long-term care nursing assistants and 49% of long-term care nurses turnover each year. Long-term Care Struggling To Hold Onto Employees, Expert Explains, McKnight's Long-Term Care News, May 12, 2011.

- If someone purchases long-term care insurance, is she or he more likely to end up in the nursing home? Not necessarily, according to a study co-authored by Gail Jensen of the Institute of Gerontology at Wayne State University. For the very disabled, insurance did increase the probability that a person would have a long nursing stay. But for the moderately disabled, insurance enabled more seniors to avoid or delay the nursing home. There is also no evidence that long-term care insurance deterred informal caregiving. Young Li and Gail A. Jensen, The Impact Of Private Long-Term Care Insurance On The Use Of Long-Term Care, Inquiry, Spring 2011.

- Genworth and John Hancock released their annual studies on the cost of long-term care.

  According to Genworth Financial, the average cost for:
  - A semi-private nursing home room is $193/day (an increase of 5.7%);
  - An assisted living facility is $3,261/month (an increase of 2.4%);
  - A licensed home health aide service is $19/hour (flat from last year); and
  - Adult day health care is $60/day (flat from last year).

    Assisted Living And SNF Costs Are Up, Home Care Costs Stay Flat, Study Reports, McKnights Long-Term Care News, May 12, 2011.

  According to John Hancock Financial, the average cost for:
  - A private nursing home bed is $235/day (avg. annual increase of 3.5% over time);

- A semi-private nursing home room is $207/day (avg. annual increase of 3.2% over time);
- An assisted living facility is $3,270/month (avg. annual increase of 3.4% over time); and
- A licensed home health aide service is $20/hour (avg. annual increase of 1.3% over time).

  John Hancock Announces Results of 2011 National Long-Term Care Cost Study, John Hancock.

Medicaid

- Medicaid does indeed help the poor. The National Bureau of Economic Research compared the health results of 6,000 people in Oregon receiving Medicaid and 6,000 who did not. Those on Medicaid saw regular doctors, felt better, were less depressed, and had better financial stability. While the findings seem obvious, many had previously argued that other safety nets (e.g., emergency rooms, charities) would create equal results. Gina Kolata, First Study Of Its Kind Shows Benefits Of Providing Medical Insurance To Poor, The New York Times, July 7, 2011.

- 32 states offer an online, publicly-accessible application for Medicaid and/or CHIP that can be electronically submitted, and 18 states allow individuals to renew coverage online. (Note: Michigan has an online children's Medicaid and CHIP application, which now accounts for 71% of these applications.) Online Applications for Medicaid And/Or CHIP: An Overview of Current Capabilities And Opportunities For Improvement, The Kaiser Commission On Medicaid And The Uninsured, June 23, 2011.

- A loophole in the Affordable Care Act would allow as many as 3 million early retirees to qualify for Medicaid because Social Security would not be considered income. The Obama administration has acknowledged the loophole and will look for a fix. Richard Alonso-Zaldivar, Medicaid For The Middle Class?, AP, June 21, 2011.

- Enhanced federal Medicaid matching funds, provided by the American Recovery and Reinvestment Act of 2009, ended on June 30, 2011. The average federal share of Medicaid expenditures is reduced to 57%, down from a high of 67%. Enhanced Medicaid Match Rates Expire In June 2011, The Kaiser Commission On Medicaid And The Uninsured, June 22, 2011; Robert Pear, As Number Of Medicaid Patients Goes Up, Their Benefits Are About To Drop, N.Y. Times, June 15, 2011.

- The Centers for Medicare & Medicaid Services confirmed that states can offer the same Medicaid protections to same-sex couples as heterosexual couples. Sam Baker, CMS

Outlines Medicaid Protections For Same-Sex Couples, The Hill: Healthwatch Blog, June 10, 2011.

- Medicaid will join Medicare and will not reimburse hospitals for about two dozen various hospital errors such as operating on wrong body parts and certain surgical-site infections. Phil Galewitz, Kaiser Health News, Medicaid To Stop Paying For Hospital Mistakes, June 1, 2011.

Medicare

- For information regarding Blue Cross Blue Shield's Michigan Legacy Medigap plan, please see the Michigan section.

- Congress continues to consider bills to remove Social Security numbers from Medicare cards. Matt Richtel, Bill Aims to Limit Identity Theft Using Medicare Cards, N.Y. Times: Bits Blog, July 19, 2011.

- Doctors are not flocking away from Medicare patients. While the number of doctors accepting new Medicare patients declined 2.6% from 2008 to 2005 (92.9% vs. 95.5%), only about 90% are accepting patients with traditional health insurance, down around 7%. Only two-thirds of doctors were accepting new Medicaid patients. Paula Span, Found: Doctors Who Take Medicare, N.Y. Times: The New Old Age Blog, July 6, 2011.

- The Centers for Medicare & Medicaid services said it would pay for Provenge (for prostate cancer) despite a cost of $93,000 and trials showing that it extends life by only four months. CMS will also pay for Avastin (breast cancer) despite a cost of $88,000 a year and an FDA recommendation that Avastin should not be used for breast cancer because it has not been shown to extend life and may have undesirable side effects. *See, e.g.*, Editorial, Extremely Expensive Cancer Drugs, N.Y. Times, July 6, 2011.

- Medicare will begin tracking "Medicare spending per beneficiary" as a new measure of hospital performance, including the costs that a patient incurs 90 days after leaving a hospital. The Obama administration believes that such measures will encourage hospitals to coordinate care with other providers. Robert Pear, Medicare Plan For Payments Irks Hospitals, N.Y. Times, May 30, 2011.

- Medicare's trustees reported that the hospital insurance trust fund would be exhausted in 2024 (five years earlier than previously predicted). Robert Pear, Slow Recovery Worsens Financial State Of Medicare, N.Y. Times, May 13, 2011.

- Reader's Digest will begin offering co-branded Medicare products from Humana. Steve Ivey, Humana Joins Reader's Digest On New Medicare Products, Business First, May 10, 2011.

Medicine

- Seven of the top twenty best-selling prescription drugs are scheduled to go "off patent," making generics available soon: Zyprexa (10/11), Lipitor (11/11), Lexapro (3/12), Seroquel (3/12), Plavix (5/12), Actos (8/12), and Singulair (8/12). David W. Freeman, Prescription Drug Prices Set To Fall As Patents Expire, CBS News, July 25, 2011.

- Patients at teaching hospitals receive poorer care in July (called the "July Effect"). The primary cause: more experienced residents are replaced by newbies. Ryan Jaslow, 'July Effect' In Teaching Hospitals Increases Odds Patients Will Die, CBS News, July 12, 2011.

- More medical schools are requiring students to take the M.M.I., a test consisting of nine brief interviews designed to gauge an applicant's bedside manner and ability to work in groups, when applying to medical school. Gardiner Harris, New For Aspiring Doctors, The People Skills Test, N.Y. Times, July 10, 2011.

- New rules by the American Medical Association limit first-year residents to 16-hour shifts and second- and third-year residents to 28-hour shifts. Jenny Gold, New Rules Provide Relief For Sleep-Deprived Medical Residents, Kaiser Health News, July 1, 2011.

- What patients pay for the same medical procedures (e.g., MRI's or CT scans) can vary dramatically in the same region depending on what doctor he or she chooses. Interestingly, the Midwest showed the least variations. change:healthcare, Q2 2011 Healthcare Transparency Index.

- The U.S. Supreme Court released two decisions regarding pharmaceuticals.

    - In *Pliva v. Mensing*, the Court found that generic drug makers could not be sued for failing to warn patients about dangerous side effects even though brand-name manufacturers could be sued for not providing the same warning. The majority cited a federal law requiring generic manufacturers to provide the exact same label information as the drugs they imitate.

    - In *Sorrell v. IMS Health*, the Court found that states could not forbid the sale of prescription records from pharmacies for marketing purposes. Pharmaceutical companies use these prescription records to target doctors. The Court stated

that restricting the use of these records would violate the First Amendment. *See, e.g.*, Robert Barnes, Supreme Court Protects Generic-Drug Makers From Being Sued For Lack Of Warning, The Washington Post, June 23, 2011.

- 4.4 million hospital stays are the result of potentially preventable readmissions adding $30 billion a year to the nation's health care tab or $1 out of every $10 spent on hospital care. A government funded pilot program called Project RED (Re-Engineered Discharge) prepares patients for being discharged the moment a patient is admitted to the hospital. Early pilot studies suggest the program may reduce hospital readmissions by up to 30%. Laura Landro, Don't Come Back, Hospitals Say, The Wall Street Journal, June 7, 2011.

- Similar to a credit report, the Department of Health and Human Services proposed the creation of an "access report" showing the name of any individual who accessed a person's electronic health records and what he or she did with them. Bob Sullivan, Is Someone Snooping Your Health Records? New Rule Will Tell You Who, MSNBC: The Redtape Chronicles Blog, May 31, 2011.

- Autopsies are only performed 5% of the time, down from roughly 50% in the 1960's, causing concerns about understanding the effectiveness of treatments. Michelle Andrews, Decline in Autopsies May Obscure Understanding Of Disease, Kaiser Health News, May 17, 2011.

- For those over 65 diagnosed with early, lower-risk prostate cancers, having the prostrate removed early does not increase the likelihood of survival. Scott Hensley, Surgery No Better Than Waiting For Most Men With Prostate Cancer, NPR: Shots Health Blog, May 17, 2011; Ken Covinsky, Watchful Waiting Or Surgery For Prostate Cancer?, GeriPal Blog, May 17, 2011.

- By measuring the length of telemores in our chromosomes (which get shorter as we age), a new blood test may be able to tell your "biological" age as opposed to your "chronological" age. The test may be available in Britain later this year. Kim Carollo, Can A Blood Test Determine How Long People Will Live?, ABC News, May 16, 2011.

- Uninsured Americans leaves hospitals with up to $49 billion in unpaid bills. Kelly Kennedy, Up To $49 Billion Unpaid By Uninsured For Hospitalizations, USA Today, May 13, 2011.

- A new website will use a number of geriatric scales to help physicians determine a patient's life expectancy. The creators hope that the website will help doctors to make

better treatment decisions. Paula Span, Figuring The Odds, N.Y. Times: The New Old Age Blog, May 2, 2011.

Michigan

- Premiums for Michigan's popular Blue Cross/Blue Shield "Legacy" Medigap plans will increase by 12%, effective August 1, 2011. Plan C will now cost $121/month. However, once a person leaves Michigan, his or her Medigap plan will not be subsidized and will cost $194/month. Furthermore, despite misleading language in the settlement suggesting that the issue had been tabled, Blue Cross/Blue Shield will deny eligibility to retirees who receive partial or full financial assistance to pay premiums from employers. Still, Legacy is a good value for many, if not most, Michigan seniors. *See, e.g.*, Patricia Anstett, Seniors' Medigap Premiums To Rise By 9%, Detroit Free Press, June 29, 2011.

- Detroit's Human Services Department spent more than $210,000 meant for the city's poor on furniture (such as a $3,000 mahogany-finished conference table and $315 trash cans). Steve Neavling and Jim Schaefer, High-end Items For Detroit Office Bought With Money For Poor People, Detroit Free Press, July 20, 2011.

- The new Center for Gerontology at Western Michigan University is reviving the school's gerontology program that was eliminated in 2004. Mark Schwerin, New Center for Gerontology to Serve Aging Population, WMU News, June 13, 2011.

- The Department of Health & Human services rated Michigan as "Average" compared to other states for Overall Health Care quality, a slight decline from the baseline year. Notably, Michigan was ranked as "Strong" and "Very Strong" on home health and hospital care measures but "Weak" on nursing home care measures. U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, State Snapshots.

Social Security

- The Social Security Administration announced that it is reducing its office hours by half an hour and will now close at 3:30 p.m. instead of 4 p.m.

- Inflation adjustments to Social Security may decrease if Congress decides that a "chained CPI" should be used. Instead of looking at price changes for a single good, a "chained CPI" assumes that a person will buy a substitute item if the cost of a good increases too much (e.g., a person will buy chicken when the price of beef increases significantly). This would lower inflation adjustments. Scott Patterson, Social Security Payments Would Fall With New Inflation Gauge, USA Today, July 24, 2011.

- The AARP released a new Social Security calculator to help individuals decide the optimal age to start collecting Social Security benefits. While useful to many (or most), the calculator does not take into account outside assets, survivor or disability benefits, or taxes. Tara Siegel Bernard, AARP's New Social Security Calculator, NY Times: Bucks Blog, July 12, 2011.

- Unlike Medicare, the economic outlook for the Social Security trust fund remained stable. While projections show that the Social Security trust fund will be exhausted in 2036, tax revenues could continue to support three-fourths of benefits through 2085. Robert Pear, Slow Recovery Worsens Financial State Of Medicare, N.Y. Times, May 13, 2011.

Useful Resources

- The Substance Abuse and Mental Health Services Administration offers a free publication on *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities*. It can either be shipped to you (for free) or downloaded online at http://store.samhsa.gov/product/SMA10-4515.

- The National Resource Center on LGBT Aging offers a number of legal resources for the LGBT community and can be found at http://www.lgbtagingcenter.org/resources/index.cfm.

- The Bureau of Engraving and Printing released a free iPhone/iPad app for the blind and visually impaired to read U.S. paper currency. It can be found in Apple's iTunes store. http://www.eyenote.gov/

Rules of the Pool: BEM Changes Affecting Pooled Trusts

By Michele P. Fuller, Michigan Law Center PLLC, ELDRS Council Member

Effective April 1, 2011, there was a significant change to the State Medicaid policy contained in the Bridges Eligibility Manual (BEM) which was not much of a surprise to those of us who administer or regularly use pooled special needs trusts. The rules are all easily accessible on-line at http://www.mfia.state.mi.us/olmweb/ex/bem/bem.pdf.

Historically, the State of Michigan and the Department of Human Services (DHS) and its predecessors had always treated the creation and funding of a pooled special needs trust, or pooled account trust (PAT), as an exempt asset and without penalty regardless of age or amount of funding. This was a boon to our clients who needed access to government

benefits, particularly long-term care Medicaid Assistance, yet needed access to funds to support their continued quality of life.

Approximately three years ago, DHS's interpretation of the policy changed. Even though the trust was treated as an exempt asset, when funded by an individual over age 65, the transfer of assets into the trust was treated as a divestment for less than fair market value, resulting in a penalty. In the vast majority of cases, counsel for the claimant successfully overturned the imposition of a penalty through the appeal process. However, perhaps as intended, the department policy change had a distinct chilling effect on the willingness of elder law practitioners to recommend this planning tool to their clients since they were likely to have to deal with an appeal in an already complex and stressful situation.

Then, effective April 1, 2011, the department changed the Bridges Eligibility Manual to reflect the formerly unofficial policy which affects the ability of disabled individuals over age 65 to fund a pooled trust. The new policy is outlined in BEM 401 as follows:

> The trust contains the resources of a person who is disabled (not blind), and under age 65 per BEM 260. See Transfers to an Exception B trust in this item.
>
> Accounts in the trust are established by courts or by disabled persons':
> •• Parents.
> •• Grandparents.
> •• Legal guardians/conservators
>
> Treat assets and income transferred into an Exception B, Pooled Trust as part of the trust for the entire month of transfer. Transfers to an Exception B, Pooled Trust by a person age 65 or older is a divestment. Do a complete divestment determination if the person is in a Penalty Situation per BEM 405.

There are several problems with the new policy. First, the state policy is supposed to follow and implement the federal policy in 42 USC § 1396(p)(d)(4)(C), and, for the most part, the language is virtually identical. Significantly, unlike the requirements outlined for (d)(4)(A) trusts, correlating to Exception A trusts under the BEM's, it does not reference an age limit for individuals funding a pooled trust. Importantly, BEM 260 defines disability and does not contain a reference to age. Further, the federal statute allows an individual to execute and fund a pooled trust agreement. However, BEM 401 does not list the individual/claimant as a proper party to establish the PAT for him or herself.

In response, the Elder Law and Disability Rights Section (ELDRS) of the State Bar is working with legislators to develop a statute to allow funding into a pooled trust without penalty. Meanwhile members of the council are working with policy makers, lobbyists and families in an attempt to remedy this policy in a grassroots effort to stop the imposition of

penalties. The ELDRS section is fresh from a victory regarding enforcement of PEME (pre-eligibility medical expenses) eligibility policy and may take up this issue next.

Other states are facing the same issue. The State of Maryland will implement its pooled trust act, which will be effective October 1, of this year. The bill is straightforward and allows execution and funding of a pooled trust regardless of age. This issue was also successfully litigated in Wisconsin. Hopefully litigation will not be the catalyst for change in Michigan.

http://www.law-business.com/media/DHS-Representation%20Memo.pdf

Garnishment Issues

By Brad Vauter, Elder Law of Michigan, ELDRS Council Member

It is a misnomer to say many of the elderly or disabled are "judgment-proof." A more careful statement might be that many of the elderly or disabled are "collection-proof." This is so because most government benefit or retirement checks are exempt from garnishment and have been for decades.

Until recently, though, this protection was not self-executing, and the very poor sometimes saw their meager checking account disappear (by way of garnishment, bank charges, bounced check fees, overdraft fees, etc.) because they didn't know how to respond to a proposed garnishment, or they didn't file objections within the 14 days allowed after getting a proposed garnishment notice. And if calls to the Legal Hotline for Michigan Seniors are any indication, many supposedly "untouchable" funds or accounts were still drained. This was a great detriment to the poor senior or disabled individual.

It is troubling, too, as Michigan Court Rule 3.101(I)(6) was amended and made effective September 1, 2009, putting financial institutions on alert. When a garnishment request came in for a customer who had only Social Security income, for instance, the financial institution should have told the plaintiff's attorney to fish elsewhere.

But the court rule only seemed to be honored in the breach, according to callers to Elder Law of Michigan. Almost always, the financial institutions "froze" the accounts. And perhaps not coincidentally, the poor then faced extra charges and fees imposed by the same institution that didn't follow court rules in the first place.

But the times or tide may be changing. Besides the Michigan Court Rule changes from 2009, the Feds have gotten in on the act and created new rules that are more protective of such funds in

financial institutions. See the rules and analysis at the following website: http://www.federalregister.gov/articles/2010/04/19/2010-8899/garnishment-of-accounts-containing-federal-benefit-payments

These new rules took effect May 1, 2011, so benefits like Social Security (retirement and disability), Supplemental Security Income (SSI), Veterans and other federal benefits are much safer in financial institutions from the reach of most creditors. Thus, the elderly and disabled who need these funds for day-to-day living may have more protection.

Also, the past practices of various financial institutions in Michigan allowing garnishments from accounts with "co-mingled" funds should be gone as well. The new rule provides stronger safeguards for the customers, who have income from protected funds, or elsewhere, when the amount in their account totals no more than two months' worth of government benefits. The new federal regulations require all financial institutions to determine if an account contains exempt funds. If that is the case, then the institution is required to protect two months' worth of benefit payments from garnishment. If there is more than two months' worth of funds—and the funds are government benefits—then the recipient may have to file an objection in court. Let's say a depositor receives a Social Security monthly payment of $850. Under the new rule, $1,700 in the account is automatically protected in the event a creditor serves the bank with a garnishment. And, that amount is protected even if all of the funds are not from a government benefit. (It is worth noting that this newer regulation and protection applies only to government benefits which are directly deposited into the recipient's account and does not apply to deposits of paper checks.)

Other items of note from the federal regulations:

The federal government will now insert an electronic "tag" on all direct deposits of exempt payments.

- When a financial institution receives a garnishment order from a court, it must review the debtor's account within two business days and determine which (if any) federal payments are exempt under the new regulation. These payments cannot be frozen or garnished.
- Financial institutions are required to exempt all tagged deposits made during the two months prior to the receipt of any garnishment order and protect those deposits from garnishment. No longer will consumers be required to identify or segregate payments that are exempt from garnishment.
- Within three business days of receiving the garnishment order, a financial institution must provide the debtor with the name of the creditor, the date of the garnishment and the amount of both the protected and non-protected assets in the account.
- As in the past, amounts owed for federal obligations and for most back child support and spousal support orders won't be given any real protection from garnishment, even if they come from otherwise exempted federal sources; federal benefits might still be garnished for these obligations.

Elder Law of Michigan has helped callers send letters of complaint to any financial institution violating the existing garnishment court rules, demanding return of the money, fees and costs involved, and is prepared to help do the same under the new federal regulations. We have also advised callers to make sure a copy of the complaint letter gets to the federal or state oversight agency involved, depending on the type of financial institution involved. It might be prudent for everyone to do the same, so that these regulations and rules are no longer honored in the breach.

http://www.federalregister.gov/articles/2010/04/19/2010-8899/garnishment-of-accounts-containing-federal-benefit-payments
Michigan Court Rule 3.101(I)(6)

And In This Corner . . .

By John B. Payne, Garrison Lawhouse PC, ELDRS Council Member

A recent change in policy at Department of Human Services requires the local office to request representation by an assistant attorney general (AAG) at any hearing when the claimant is represented by an attorney. Rebekah Visconti, Department of Human Services Office of Legal Services Memo (April 19, 2011) http://www.law-business.com/media/DHS-Representation%20Memo.pdf. This new policy, which is not found in any Bridges Manual, is a real game-changer. It will change the way Elder Law attorneys approach Medicaid cases from initial application through circuit court appeals.

Attorneys who have perceived administrative hearings as informal proceedings must discard that notion. An administrative hearing is a trial. It is the only opportunity for the claimant to get in his or her evidence. The local offices have been lax in their own preparation, so mistakes by claimants' attorneys have often turned out to be minor errors that did not kill their cases. That will change in this more adversarial milieu, so it is vital to review some of the problems attorneys will have to overcome before and during the hearing.

(1) Agency Intransigence

The DHS local office is directed to attempt to resolve issues before the hearing. The Bridges Administrative Manual (BAM) reads, in part, as follows:

> Resolve disagreements and misunderstandings quickly at the lowest possible level to avoid unnecessary hearings.

> Upon receipt of a hearing request, attempt to schedule a prehearing conference with the client or authorized hearing representative and conduct a supervisory review.
>
> The client or authorized hearing representative is not required to phone or meet with any Department staff in order to have a hearing. Any notice of prehearing conference must explain this. BAM Item 600(11) (July 1, 2011). http://www.mfia.state.mi.us/olmweb/ex/bam/600.pdf.
>
> The department must assure that clients receive the services and assistance to which they are entitled. Concerns expressed in the hearing request should be resolved whenever possible through a conference with the client or authorized hearing representative rather than through a hearing.
>
> The spokesperson for the local office at the prehearing conference may be anyone from the county director to a first line supervisor. Whoever is assigned this function, however, acts on behalf of the county director.
>
> A prehearing conference must be offered to the client or authorized hearing representative upon receipt of a hearing request . . . BAM Item 600(11) (July 1, 2011).

But Wayne County and other DHS offices make little effort to resolve matters before the hearing. They do not afford supervisory conferences, even when they are explicitly demanded in the hearing request. If the local office does not provide the opportunity for a pre-hearing conference, mention that to the AAG and the ALJ. It might not change the result of the hearing, but it may persuade the AAG to be less confrontational during the hearing and the ALJ to grant more latitude in the presentation of the claimant's case.

(2) Patching Documentary Problems

Local offices often refuse to accept additional documents between denial and hearing, even when a denial is based on insufficient verification. This position may be adopted by the ALJ, who will state that only documents presented to the specialist before the denial will be considered as part of the hearing record.

The refusal to accept additional verification may be contested by arguing that the specialist did not comply with the notice and opportunity requirements found in BAM Item 130(5) (July 1, 2011). The specialist is directed to specify what is requested, using the Verification Checklist, Form DHS-3503, and to allow the claimant 10 days to provide requested documents. The

specialist must extend the deadline on request at least once and may extend it up to three times. Furthermore, the manual states, "If neither the client nor you can obtain verification despite a reasonable effort, use the best available information. If no evidence is available, use your best judgment." BAM Item 130(3). http://www.mfia.state.mi.us/olmweb/ex/bam/130.pdf.

It is at least arguable that an ALJ who refuses to accept new evidence of eligibility at the hearing is denying the claimant a fair hearing. Claimants in Social Security disability hearings are permitted to introduce new documentation. 20 CFR § 404.946. This right is not spelled out in the Michigan Social Services Act, but it should be inferred because DHS must "provide [an] adequate procedure for a fair hearing of appeals and complaints" according to the Administrative Procedures Act (APA). MCLA 400.9. The APA requires hearings to be "conducted in an impartial manner." MCLA 24.278. Furthermore, the decision of the ALJ becomes the "final decision of the agency." MCLA 24.281(3). The ALJ, not the specialist, makes the "final decision of the agency," and, therefore, should hear the Claimant's objection to the DHS local office decision de novo. To review the specialist's decision for abuse of discretion, or even error, does not meet the requirement of a "fair hearing" that is "conducted in an impartial manner."

(3) Withholding the Record

The request for a hearing should demand a complete copy of the case file. The claimant has a right to it, but many local offices ignore the request. The Bridges Administrative Manual includes this directive:

> Clients and AHRs have the right to review the case record and obtain copies of needed documents and materials relevant to the hearing.
>
> Send a copy of the DHS-3050 and all documents and records to be used by the department at the hearing to the client and AHR. DHS-4772, Hearing Summary Letter, may be used for this purpose. BAM Item 600(24) (July 1, 2011).

Medicaid policy prohibits denial of access to the case records, apart from a hearing request. The BAM provides, in part, as follows:

> Case materials not separately restricted by law or court order must be available to the client upon request.
>
> Telephone requests are not sufficient. You may send the client a DHS-63 for completion or return. Correspondence that clearly identifies the client is also acceptable. Before providing any materials requested by mail, contact the client to verify that s/he made the request.

> Within five workdays after receiving the completed DHS-63 or letter, send one copy of any unrestricted materials requested. BAM Item 310(7) (April 1, 2009).

If the local office does not comply with this policy, request a recess for the specialist to make the copies and for you to review them.

The local office sometimes receives instruction from Lansing regarding specific cases or circumstances. Even if the instruction is in writing, it is unlikely that it will be provided to the claimant or the claimant's counsel. This should be a topic of inquiry during the hearing. If the specialist or "Family Independence Manager" (supervisor) admits that Lansing provided instruction, cite as error the failure to provide a copy or request that the staff member in Lansing be called for testimony and cross-examination.

The new policy memorandum directs the local office to request an AAG for any hearing at which the claimant is represented by counsel. If the claimant has an attorney and an AAG is not present, the local office is directed to request an adjournment. Unless the local office did not request an AAG, the ALJ is likely to grant the adjournment. To minimize the likelihood of such an adjournment, make it clear in the hearing request that you will be representing the claimant. If you are stepping in after the claimant filed the hearing request without an attorney, notify the local office immediately that you will be representing the claimant at the hearing.

Familiarity with the Bridges Administrative Manual is vital in Medicaid hearings. Read BAM Items 130 and 600 carefully. There are important due process guarantees in those manual items. You will find issues to raise on your claimant's behalf if the local office is not fulfilling its responsibilities. The local office may have an AAG to represent the Department at the hearing, but the case is still in the hands of the specialist until the ALJ opens the record. The specialists often pay little attention to the BAM. Knowing the important BAM provisions will give you an advantage in the hearing.

Legislative Update

(As of July 12, 2011)
By Todd Tennis, Capitol Services, Inc.

The Legislature is in recess for July and August, but, although state policymakers completed the 2011-2012 budget before they left Lansing, there are a number of issues regarding implementation of the budget they will be considering when they return in the fall. Some that relate to the Elder Law and Disability Rights Section include legislation altering Michigan's Medicaid Estate Recovery Program, as well as debate over the creation of a Managed Care Provider Tax to help support Medicaid funding.

On the Estate Recovery front, the federal government recently approved Michigan's Estate Recovery program, originally signed into law back in 2007. The state began implementation of it on July 1. It will apply to anyone age 55 or older who began receiving Medicaid long-term care benefits after September 30, 2007. Although the current law was only recently implemented, part of the 2011-2012 budget executive proposal was to increase state revenues by expanding the current Estate Recovery program.

Senate Bills 404-406, sponsored by Senator Roger Kahn (R-Saginaw Twp.), make a number of changes to the current Estate Recovery statute, with the goal of increasing the amount of funds the state may collect from long-term care Medicaid recipients upon their death. The bill does this primarily by removing some statutory hardship exemptions contained in the original law.

The main relief in the current Estate Recovery program comes from exempting an amount up to 50% of the average price of a homestead in the county in which the homestead is located from the amount that may be recovered. The other hardship exemption is for the portion of the estate that is the primary income producing asset of survivors. Removal of this exemption would be particularly harmful to recipients and their families who own family farms and small businesses.

The new legislation also removes the provision stating that Michigan's estate recovery program does not apply to persons who began to receive Medicaid long term care before September 30, 2007; removal of this language will cause confusion. Furthermore, the new legislation removes the requirement for DCH to provide written materials explaining the waiver process. Finally, the proposed legislation unfairly impinges upon the property rights of co-owners, who would typically take clear ownership as survivors upon the death of Medicaid recipients.

Members of the ELDRS Council have met with Senator Kahn to express the Section's concerns with the new Estate Recovery legislation. The Section was (and remains) skeptical that Estate Recovery will do more good than harm, and the concerns regarding potential impact on housing stock and low-income families remain. The legislation will see more attention when the Legislature returns in the fall.

Health Care Claims Assessment

The other main issue tied to the Department of Community Health budget is colloquially known as the "Provider Tax." For the past several years, the state has assessed a Use Tax on Medicaid Health Maintenance Organizations (HMO's) and Prepaid Inpatient Health Plans (PIHP's). The federal government has been examining this process, and Governor Snyder's administration believes that new rules may soon be issued that ban this technique.

Therefore, the Governor's proposed Department of Community Health budget for 2011-2012 (which was passed by the Legislature and signed into law) assumes an end to the HMO/PIHP Provider Tax. It also proposed replacing those funds with a 1% tax on eligible paid health claims. Unlike the previous system, the new tax would not only be paid by those who benefit from the increase in federal Medicaid dollars brought into the state but also by a broad base of health care insurers. According to the Senate Fiscal Agency, the proposed new tax would generally apply to "…claims paid by group and individual health insurance companies, with the exception of those providing Medicare Advantage, Medicare Part D, and Federal employee coverage…"

Opponents of the legislation argue that it is premature to amend state Medicaid policy before the federal government specifically states that the current framework is no longer acceptable. A number of business advocates have lobbied against the change, arguing that it amounts to a new tax. However, the legislation's supporters contended that not enacting the legislation would result in a 20% reduction in provider reimbursement, with serious negative consequences for Medicaid recipients throughout the state. After a great deal of contention, SB 348 (Senator Roger Kahn, R-Saginaw) passed the Senate on June 30. It will be taken up by the House when it returns from summer recess.

Health Exchange Work Groups Report Progress

Part of the Affordable Care Act calls for states to create Health Exchanges to serve individuals and small businesses as an alternative to current health insurance options. States were given the option to craft their own exchanges, with the alternative that the exchange would be implemented by the federal government. Michigan's state government recruited a stakeholder work group to help design the exchange that included representatives from business, consumer advocates, health plans, health professionals, local government and universities. On July 13, the groups made an initial report to a joint hearing of the Senate Insurance and Health Policy Committees.

The recommendations of the work group covered areas of governance, business operations, finance, technology and regulatory action. Key recommendations include:

- Michigan should establish a single, state-specific Exchange that acts as an independent public authority with the option to seek non-profit status at a later date;

- The Exchange would be run by a 13-member board appointed by the Governor and be subject to FOIA and the Open Meetings Act;

- The Exchange should serve as a market organizer/distribution channel with some flexibility to impose limits on the number of plans offered;

- Carriers should be charged a fee for participation in the Exchange at startup and to fund ongoing operations;

- The Exchange should have an annual audit and information on the overall financial dealings of the Exchange should be publicly available;

- The Exchange should be subject to oversight by the Office of Financial and Insurance Regulation.

Additionally, the presenters on behalf of the work group cautioned that steps should be taken to ensure that the Exchange does not turn into a de facto high risk pool for low-income individuals. Bills to create the Exchange will likely be introduced soon (and may already be introduced by the time this goes to press), and the Legislature will have further hearings on the issue in the fall.

Don't Miss the ELDRS Fall Conference

For all of the latest information and updates on what is happening in the elder law field, be sure to attend the ELDRS fall conference, Sept. 21-23, at the Crystal Mountain Resort in Thompsonville, Michigan. For more information, visit the Section's online Calendar of Events at www.michbar.org/elderlaw/calendar.cfm.

Upcoming Events Section of the ELDRS Newsletter (Rev. 07/30/2011)

DATE	ORGANIZATION	TITLE	LOCATION	WEBSITE
August 11, 2011	NAELA	Virtual Meeting: Estate Planning for Members of the Military – What our Heroes are not told	Webinar	www.naela.org
August 19 – 20, 2011	NAELA	2011 NAELA CAP-Only Conference	Chicago, Ill	www.NAELA.org
August 31, 2011	SBM Probate Section / ICLE	Handling Guardian ad Litem Appointments (Seminar)	Webcast	www.icle.org
September 15 – 18, 2011	National Association of Professional Geriatric Care Managers	2011 NAPGCM Advanced Practice Retreat	San Diego, CA	www.caremanager.org/calendar.cfm
September 16, 2011	Michigan Parkinson's Foundation	Michigan Parkinson Initiative Symposium: 2011	Lansing, MI	www.parkinsonsmi.org/
September 21, 2011	National Association of Professional Geriatric Care Managers	NAPGCM Business Webinar - Starting, Maintaining and Growing a Solo Geriatric Care Management Practice	Webinar	www.caremanager.org/calendar.cfm
September 21-23, 2011	SBM ELDRS Section	Changes & Choices Fall Conference	Thompsonville, MI	www.michbar.org/elderlaw/calendar.cfm
September 27, 2011	SBM Probate Section / ICLE	Post-Death Tax Planning and Preparing Fiduciary, Estate & Gift Tax Returns (Seminar)	Plymouth, MI	www.icle.org
October 4, 2011	SBM Probate Section / ICLE	Drafting an Estate Plan for an Estate Under $5 Million (Seminar)	Plymouth, MI	www.icle.org
October 13 – 16, 2011	National Association of Professional Geriatric Care Managers	2011 National Gerontological Nursing Association Annual Convention	Louisville, KY	www.caremanager.org/calendar.cfm
October 19, 2011	National Association of Professional Geriatric Care Managers	NAPGCM Business Webinar - From Relationship Builder to Challenger: Techniques to Grow Your Business (Steve Barlman, MSW)	Webinar	www.caremanager.org/calendar.cfm
October 20, 2011	SBM Probate Section / ICLE	Fundamentals of Estate Planning (Seminar)	Plymouth, MI	www.icle.org
October 21 – 23, 2011	Midwest Geriatric Care Managers Association	NAPGCM Midwest Chapter Annual Conference	Branson, MO	www.midwestgcm.org/

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October 25, 2011	National Association of Professional Geriatric Care Managers	2011 New York Chapter Annual Conference "All Things Aging...A Symposium on Care Management"	New York, NY	www.caremanager.org/calendar.cfm
November 3, 2011	Michigan Society of Gerontology	2011 Michigan Society of Gerontology (MSG) Fall Forum: "The Impact of Health Care Reform on Older Michiganians,"	East Lansing, MI	www.msginfo.org/
November 3 – 5, 2011	National Association of Professional Geriatric Care Managers	2011 Western Region Chapter Conference	Las Vegas, NV	www.caremanager.org/calendar.cfm
November 4-6, 2011	National Association of Professional Geriatric Care Managers	2011 Southeast Chapter Annual Fall Conference	Nashville, TN	www.caremanager.org/calendar.cfm
November 6 – 8, 2011	National Association of Professional Geriatric Care Managers	2011 Mid-Atlantic Chapter Conference	Philadelphia, PA	www.caremanager.org/calendar.cfm
November 8 – 12, 2011	NAELA	2011 NAELA Advanced Elder Law Review/CELA Prep Course	Boston, MA	www.NAELA.org
November 10-12, 2011	National Association of Professional Geriatric Care Managers	2011 South Central Chapter Conference "Mastering Your Practice While Avoiding the Sand Traps"	Grapevine, TX	www.caremanager.org/calendar.cfm
November 10 – 12, 2011	NAELA	2011 NAELA Advanced Fall Institute	Boston, MA	www.NAELA.org
December 8, 2011	NAELA	Virtual Meeting: Working Virtually: Three offices, Sick Kids and Keeping my Sanity: Implementing System	Webinar	www.naela.org
January 19-20, 2012	NELF	2012 “WOW” Program	Grapevine, TX	www.naela.org
January 20-22, 2012	NAELA	2012 UnProgram	Grapevine, TX	www.naela.org
March 6, 2012	SBM Probate Section / ICLE	Drafting an Estate Plan for an Estate Under $5 Million (Seminar)	Plymouth, MI	www.icle.org
April 25, 2012	NAELA	2012 Basics Workshop	Seattle, WA	www.naela.org
April 26-28, 2012	NAELA	2012 Annual National Conference	Seattle, WA	www.naela.org
June 26, 2012	SBM Probate Section / ICLE	Drafting an Estate Plan for an Estate Under $5 Million (Seminar)	Plymouth, MI	www.icle.org