ELDRS Update

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2012 Medicare Update

By Jill Goodell, C. Jill Smith-Goodell PLLC

The Affordable Care Act mandates changes in Medicare for several years in the near future. Here are changes for 2012 that will affect our clients:

- For the 2012 policy year, Medicare Part D (prescription drug plans) open enrollment began on October 15 and ends on December 7 (previous open enrollment dates were November 15 through December 31.) This change allows for enrollment processing prior to the January 1 effective date. Don't let your clients miss this change. Note: Re-enrollment is important every year because the plans change their premiums and the drugs they include in their formulary. Every beneficiary should look at plan options on the Medicare website to be sure they will be getting what they need.

- Medicare drug plans and Advantage plans will begin to benefit from high quality scores from their enrollees. The plans with the highest score ("Five-Star") will receive financial incentives and be allowed to enroll beneficiaries throughout the year instead of just during open enrollment.

- Open enrollment is also the time Medicare beneficiaries can move out of an Advantage plan and back into original Medicare. (For some beneficiaries original Medicare with a supplemental plan or "Medigap" plan is a more cost-effective option than an Advantage plan.) Note: Beneficiaries who qualify for Medicare and Medicaid ("dual eligibles" or "duals") can make changes at other times of the year.

- Medicare Advantage plan premiums will, on average, be 4 percent lower in 2012 than in 2011. Enrollment in Advantage plans is anticipated to increase by 10% for 2012.

- One percent of Medicare beneficiaries were enrolled in plans for 2011 that will not be available in 2012. Those beneficiaries should have received a mailing telling them to look for an alternative plan that would meet their needs. Beneficiaries in Advantage plans that are discontinued will be automatically enrolled in original Medicare if they do not choose a new Advantage plan. Beneficiaries in a Part D plan that is being discontinued will need to enroll in another plan in order to keep their prescription drug coverage. A gap in prescription drug coverage can result in a 10 percent premium penalty for the rest of the beneficiary's life.

- The Medicare program has added a benefit that does not require a co-pay for beneficiaries, known as the Annual Wellness Visit. This visit to the physician's office is not what we normally think of as an annual check-up and has caused some confusion. Beneficiaries need to specifically ask for the Annual Medicare Wellness Visit when they make their appointment. This includes a medical history and a blood pressure check. An appointment for a check-up will result in a bill for the beneficiary. Other free services from Medicare include mammograms, cervical cancer screening, cholesterol screening, colorectal cancer screening, and prostate cancer screening.

The coverage gap (the infamous "doughnut hole") in Medicare Part D drug plans will close a little further for 2012. Beneficiaries who use sufficient drug benefits and have sufficient co-pays ($2,930) to get into the doughnut hole will be able to purchase generic drugs at 50 percent of their cost but the full price of the drug will apply toward the total needed to get beneficiaries out of the doughnut hole ($4,700). They will also be able to purchase brand names drugs covered by their plan at 86 percent coverage (compared to 93 percent last year) and have the full price of the drug apply toward the total needed to get them out of the doughnut hole. The doughnut hole is on schedule to be eliminated in 2020.

To help your client find a plan that suits him or her or for additional information and regular updates go to www.medicare.gov or www.hhs.gov.

How Klooster and Recent Medicaid Changes Impact Deed Planning

By Robert C. Anderson, Elder Law Firm of Anderson Associates, PC

It just got a lot tougher for aging clients to plan for their real estate. In March 2011, the Michigan Supreme Court decided *Klooster v City of Charlevoix*. In April 2011, Michigan changed its Medicaid rules to make jointly-owned, non-homestead property countable. In July 2011, Michigan implemented Medicaid Estate Recovery against homes which pass through probate. If

these three changes impact a client, the recommended strategy for homes, cottages, and recreational property is some form of joint tenancy with full rights of survivorship.

The Klooster decision approved the use of joint ownership with survivorship to prevent uncapping of the taxable assessment after the death of the original owner. Other probate-avoidance methods, such as life estates, enhanced life estates with powers of sale (lady bird deeds), and deeds in trust result in an uncapping event after death of the original owner.

On April 1, 2011, Michigan's Medicaid Agency changed its regulation on joint interests in non-homestead properties. Under the new regulation, a person's fractional interest in non-homestead, jointly-owned property is countable for Medicaid purposes—even if the owner owned the interest longer than Medicaid's 60-month look-back period and the other owners refuse to sell. This can create problems for jointly-owned cottages and recreational land. This rule does not affect the homestead because the fractional joint interest of a home is exempt.

This problem can be solved by reducing the retained share of the aging client to 1% and increasing the non-countable share owned by a child or other loved one to 99%, provided that Medicaid will not be needed within 60 months. The Court of Appeals in *In Re: Estate of Ledwidge*, 136 Mich App 603 (1984), approved the use of non-equal joint interests. The author has never had a problem recording an unequal joint tenancy deed. Also, a joint tenancy deed starts the 60-month Medicaid look-back, whereas deeds into revocable trusts and lady bird deeds do not.

The next Medicaid bombshell came on July 1, 2011, when Michigan implemented probate-only Estate Recovery. The primary purpose of Estate Recovery is to allow Michigan to recover its Medicaid costs of nursing home care from the provisionally exempt homestead if it later passes through a probate estate.

While any probate avoidance tool would appear to work to avoid Estate Recovery, joint ownership may be the best method. A living trust cannot be used because a home in a trust loses its exempt status under Michigan Medicaid and results in property tax uncapping when the original landowner/sole trust beneficiary dies. A life estate deed, including lady bird deeds, cannot be used if the goal is to cap the freeze on the taxable assessment. Joint ownership is potentially the best solution.

Adding a loved one as a joint owner on the deed creates a vested interest, which can affect the title by the named party's "four Ds": divorce, debts, disability, or disharmony situation. To minimize these problems: (1) have the named loved ones sign over a limited financial durable

power of attorney to the original owner(s), (2) reduce the number of named parties to one or two who then sign a sharing agreement to include other beneficiaries, and (3) have the spouse of a named party sign a waiver of marital rights agreement. To increase client understanding, we refer to this strategy as a Lion Cub Deed. The original owner client is the "lion", and the named loved one on the deed is the "cub."

This article was first published in the October 2011 issue of the State Bar of Michigan's Real Property Law Section.

Legislative Update

By Todd Tennis and Ellen Hoekstra, Capitol Services, Inc.

Estate Recovery Update

In late spring, a package of legislation (Senate Bills 404-406) enhancing Michigan's Medicaid Estate Recovery program was introduced by Senator Roger Kahn (R-Saginaw Twp.). Although the legislation was purportedly part of the "budget implementation" bills due to be run by October 1, we have yet to see the Senate Appropriations Committee schedule it for a hearing. Lobbyists for ELDRS, as well as ELDRS members, have been meeting extensively with members of the Senate Appropriations Committee and relaying the section's concerns with SB 404.

The main concern the section has is the removal of the hardship exemptions that exist under Michigan's current law. While the section was never a proponent of Michigan's original Estate Recovery statute passed in 2007, the inclusion of hardship exemptions at least made it less onerous. In addition, SB 404 would also remove requirements for informational materials to be provided to potential Medicaid enrollees, as well as requirements that the Department of Community Health promulgate rules that govern the Estate Recovery program.

Senator Kahn has said that he is working on a new draft of the legislation. We are hopeful that the new draft will address the Section's concerns. However, since the state began implementation of our existing Estate Recovery program on July 1, 2011, the Council maintains that it is probably too early to tinker with it regardless of the content of the new draft. It is still timely to contact your state senator about these bills.

Elder Abuse Bills Moving in the Senate

A package of bills aimed at reducing occurrences of elder abuse in Michigan has been moving out of the Senate Families, Seniors and Human Services Committee. The bills were the result of a work group that included, among others, the Prosecuting Attorneys Association, Elder Law of Michigan, the Michigan Office of Services to the Aging, and the Attorney General's Office. The Council has discussed these bills and has taken a position of support for SB 455-459, 461-2; 464-468, and 709.

The bills are as follows:

- SB 454 (Nofs) – Allow vulnerable adult to present videotaped testimony - Passed out of committee and recommended to the Committee of the Whole with Sub S-1.
- SB 455 (Rocca) – Revises sentencing guidelines to reflect increased penalties for fraud against vulnerable adults - Passed out of committee and recommended to the Committee of the Whole with Sub S-2.
- SB 459 (Emmons) – Increase penalties for financial abuse of vulnerable adults - Passed out of committee and recommended to the Committee of the Whole.
- SB 464 (Schuitmaker) – Require the development of investigative protocols for crimes relating to the abuse and neglect of vulnerable adults - Passed out of committee, and recommended to the Committee of the Whole with Sub S-2.
- SB 465 (Hildenbrand) – Revise sentencing guidelines to reflect increased penalties for financial abuse of vulnerable adults - Passed out of committee and recommended to the Committee of the Whole with Sub S-2.
- SB 466 (Schuitmaker) – Creates a Senior Medical Alert program (similar to an "Amber Alert") - Passed out of committee and recommended to the Committee of the Whole with Sub S-1.
- SB 468 (Hansen) – Prohibits a magistrate from refusing to accept a criminal complaint for an alleged crime against a vulnerable adult that was signed by someone other than the victim - Passed out of committee and recommended to the Committee of the Whole.
- SB 456 and SB 460 (Young) – Require banks and credit unions to issue a written disclosure of rights of account holders for joint accounts - SB 456 and SB 460 are still in committee.
- SB 457 (Colbeck) – Allows county medical examiners to establish an elder death review team - Passed out of committee and recommended to the Committee of the Whole with Sub S-1.
- SB 458 (Jones) – Amends the definition of "security" in the Uniform Securities Act to include variable annuity contracts - still in committee.
- SB 461 (Schuitmaker) – Makes several amendments to the Estates and Protected Individuals Code, including the requirement that guardian ad litem reports include an estimate of the amount of assets readily convertible into cash in an individual's estate. The bill also enumerates the rights of an individual for whom a guardian has been appointed - Passed out of committee and recommended to the Committee of the Whole with Sub S-2.
- SB 462 (Bieda) – Requires nursing home employees to report instances of abuse and neglect directly to the Department of Community Health (currently they are required to

report such to the nursing home director) - Passed out of committee and recommended to the Committee of the Whole with Sub S-2.

- SB 463 (Young) – Requires financial institutions to train employees to spot possible financial abuse of vulnerable adults. Also requires financial institutions to report suspected cases of financial abuse to a county department of human services. This bill is still in committee.
- SB 467 (Jones) – Provides for the regulation of annuity sales. This bill is still in committee.
- SB 706 (Gregory)—Governs the use of senior specific certification and professional designation by insurance producers. This bill is still in committee.

Dual Eligibles' Input Sought

Comments regarding the development of a plan to integrate the financing and delivery of services for people enrolled in both Medicare and Medicaid were accepted until early October. Public Sector Consultants gathered input through forums and email.

Following the RFI process, workgroups will be convened in the fall to consider the views from the forums held in the summer and from comments submitted. Once it is available, Information regarding the workgroups can be found at http://janus.pscinc.com/dualeligibles. Additionally, the legislature has scheduled public hearings on this issue.

Bills Limit Access to Name Brand Drugs

HB 4733 (Rep. Dave Agema, R-Grandville) and HB 4757 (Rep. Matt Lori, R-Constantine) would eliminate epilepsy/seizure disorder and mental illness recipients' access to name brand medications. These recipients are currently eligible, along with those for HIV/AIDS and cancer and organ transplant recipients, the latter of whom are unaffected by this legislation. Contained in HB 4733 is a grandfather clause for current recipients, but future recipients with epilepsy/seizure disorder or mental illness will be excluded. The DCH has projected savings of around $6 million a year by moving recipients to less expensive medications. Also, Angela Minicuci, the DCH spokesperson, stated that drug manufacturers would be more apt to offer states rebates if these recipients to take more generic medication. Opponents are concerned that disruption of a patient's medication regimen can lead to illness and even death. Generics are allowed a margin of error from 80%-120% for the active ingredient. Not only is the amount of active ingredient in question but the amount of inactive ingredients can produce a "buffer" that alters the absorption rate of the medication. Due to these factors, it is impossible to tell how a patient will react to the medication.

These bills were introduced in June and remain in the House Appropriations Committee.

Snyder Signs Claims Tax Bills

Governor Snyder has signed the claims tax bills into law. This legislation eliminates the existing 6 percent use tax on Medicaid managed care organizations and replaces it with a broad based 1 percent claims assessment. Without the legislation, there was a risk of losing nearly $800 million in federal Medicaid reimbursement from the federal government. The Council had supported this legislation.

POLST Progress Report

By Robert C. Anderson, Elder Law Firm of Anderson Associates PC

We have seen a good deal of progress with POLST since our Council took on the project more than two years ago. When the Council formed the POLST Committee, there were three pockets of POLST use in Michigan: Jackson's Allegiance Hospital, Traverse City's Munson Hospital, and Escanaba's St. Frances Hospital, and a separate statewide task force of clinicians led by Sam Watson of the Michigan Health Association (Michigan hospitals). Each of the POLST communities in Michigan used a different form. Our goal has been to create a single POLST form for statewide use.

A first step was to combine both the legal effort with the clinical effort, and the two groups began having monthly conference calls together. A second major step was to decide that we did not want to obtain legislative approval for POLST but rather statewide administrative approval.

The biggest legal issues we face are in how to design a statewide form which is consistent with *In re Martin* and the key health care statutes, which are archaic and poorly written, including the Do-Not-Resuscitate Procedures (DNR Act), Patient Advocate Designation Act, Dignified Death Act, and guardianship laws.

The four Council representatives on the statewide Task Force, including Josh Ard, Caroline Dellenbusch, James Steward, and Robert Anderson, proposed a simplified form that eliminates (1) the formalistic witnessing and other requirements of the DNR Act, and (2) the need to have the patient or the patient's legal representative sign the form. It will then be the task of the physician who signs POLST and the clinician facilitator who assists to correctly determine patient preferences on POLST with clear and convincing evidence.

We have not received full support from the Task Force's clinicians on the proposal, and attorneys need assurances that the instructional guide for POLST implements the patient's informed consent according to a clear and convincing evidence standard.

To decide these issues, our next call will bring in Charles Sabatino and another representative of National POLST, whose support is mandatory in order to have a statewide endorsed form. It is hoped that once we develop POLST on a statewide basis, it can be adopted through legislation, along with improvements to our guardianship and other health care laws. Stay tuned.

Recent News for the Elder Practitioner

By Christopher W. Smith, Smith Elder Law

Topics

By The Numbers

- Tithing at mainline Protestant churches (e.g., Lutheran, Presbyterian, and Episcopalian) declined to its lowest level in at least four decades to an average of 2.38% in 2009. Tithing at 40-Year Low in Mainline Churches, Study Finds, The Chronicle on Philanthropy, October 14, 2011.
- The U.S. birthrate declined to 64.7 births per thousand women in 2010, which is down from 69.6 births per thousand women in 2007 (the beginning of the recession), according to the Pew Research Center. Sabrina Tavernise, Dip in Birth Rates Reflects Recession, Report Suggest, N.Y. Times, October 12, 2011.

- 48.5% of the population lives in a household that received some type of government benefit in the first quarter of 2010, according to Census data. Further, 34.2% lived in households where someone received benefits such as food stamps or Medicaid, 14.5% lived in homes where someone was on Medicare, and 16% lived in households where someone received Social Security. Sara Murray, Nearly Half of U.S. Lives in Household Receiving Government Benefit, Wall Street Journal: Economics Blog, October 5, 2011.
- In geographical areas with high end-of-life medical costs, advance directives reduced medical expenses by 14% in the last six months of life, according to a study published in the *Journal of the American Medical Association*. But advance directives had no significant effect on medical costs in low-or middle-spending markets. The belief is that the care in these markets is already better aligned with patient goals and preferences. Christian Torres, Living Wills Help Curb Costs Only in High-Spending Areas, Study Finds, Kaiser Health News: Capsules Blog, October 4, 2011.
- The federal government paid $268 billion in pension and health benefits to former federal and military employees last year. In total, the federal government has an unfunded liability to retired workers of $5.7 trillion, compared to a $6.5 trillion unfunded Social Security liability. Dennis Cauchon, Federal Retirement Plans Almost As Costly As Social Security, USA Today, September 29, 2011.
- Elder women have higher out-of-pocket medical spending than men at any age and out-of-pocket medical spending increases 29% upon widowhood (largely due to increased spending on long-term care). Gopi Shah Goda, et al., Does Widowhood Explain Gender Differences in Out-Of-Pocket Medical Spending Among The Elderly?, The National Bureau of Economic Research, September 2011.
- 19.3% of American adults smoked in 2010, a slight decline from 20.9% in 2005 according to the Centers for Disease Control. 78.2% of smokers smoke every day. Maggie Fox, Smoking Drops a Little in 2010: CDC, National Journal, September 7, 2011.
- 33% of internet users 65 or older use social networking sites, an increase from 26% last year, according to the Pew Research Center. Mary Madden and Kathryn Zickuhr, 65% of Online Adults Use Social Networking Sites, Pew Internet & American Life Project, August 26, 2011.
- Medicare and Medicaid spending rose 10% in the second quarter of this year and is on track in 2011 to break the $1 trillion mark for the first time ever. Dennis Cauchon, Medicare, Medicaid Tab Keeps Growing, USA Today, August 3, 2011.
- At the current rate, the U.S. government will pay for nearly half of all health care costs by 2020, according to the Centers for Medicare and Medicaid Services (CMS). Total health care spending is expected to nearly double to $4.6 trillion in 2020, up from $2.6 trillion in 2010. In 2020, health care expenditures are forecasted to be paid as follows: 31% by the federal government, 18% by state and local government, 26% by

households, 18% by private business, and 7% by other private revenues. Parija Kavilanz, U.S. Will Pay for Half of All Health Care Costs by 2020, CNN Money, July 28, 2011; Looking To Uncle Sam, The Economist, July 30, 2011.

- 16.4% of Americans lack health insurance. Michigan falls just below the average at 16.1%. Texas had the highest percentage of uninsured residents at 27.8% and Massachusetts had the lowest at 4.7%. Elizabeth Mendes, Texans Most Likely to Be Uninsured, Mass. Residents Least, Gallup Poll, March 11, 2011. (Note: The U.S. Census Bureau reports the uninsured rate at 16.3%.)
- "Economic insecurity among senior households increased by one-third between 2004 and 2008, from 27% to 36%. . . . About half of all senior households of color and senior single women households are economically insecure." Tatjana Meschede, From Bad to Worse: Senior Economic Insecurity on the Rise, Demos and the Institute on Assets & Social Policy (grantees of Atlantic Philanthropies), July 28, 2011.

Alzheimer's/Dementia

- 19% "of Medicare nursing home patients with advanced Alzheimer's or other dementias were sent to hospitals or other nursing homes for questionable reasons in their final months," according to a study published in the *New England Journal of Medicine*. Some believe the high rate of hospitalizations is intended to shift costs to Medicare, which pays much more than Medicaid for nursing home stays after hospitalizations. Marilynn Marchinone, Dementia Patients Suffer Dubious Hospitalizations, AP, September 28, 2011.
- Despite advanced scanning technology, a simple memory test proved to be more effective in predicting whether a person with "mild cognitive impairment will go on to develop Alzheimer's" according to a study published in the *Archives of General Psychiatry*. Nancy Shute, Memory Quizzes Still Best for Alzheimer's Diagnosis, NPR: Shots Blog, September 6, 2011.
- Older women (average study age 82) with sleep apnea had an 85% higher risk of developing mild cognitive impairment or dementia. Elderly Women with Sleep Apnea Are at a Great Risk for Dementia, Study Finds, McKnight's Long-Term Care News, August 11, 2011, reporting on Kristine Yaffe et al., Sleep Disordered Breathing, Hypoxia, and Risk of Mild Cognitive Impairment and Dementia in Older Women, The Journal of the American Medical Association, 2011.

Elder Abuse and Exploitation

- More than 2 million elder adults share a Social Security number with their adult children, according to a study by ID Analystics. The study suggests a high number of adult children are using their parents' Social Security numbers to obtain credit. Bob

Sullivan, Stealing Elderly Parents' Identities a Hidden, Common Crime, MSNBC: Redtape Chronicles, October 4, 2011.

- Marie Therese Connolly won a "genius grant" from the McArthur Foundation for her efforts in combating elder abuse. Genius Grant Will Help Advocate Fight Elder Abuse, NPR: Morning Edition, September 23, 2011.
- The Government Accountability Office (GAO) issued a report about the oversight of court-appointed guardians administering Social Security and veteran benefits on behalf of incapacitated adults. The report criticizes how state courts are screening new and monitoring existing guardians. The report recommended that the Administration on Aging (AoA) pilot projects that would improve court monitoring of guardians. The report also encouraged the Social Security Administration (SSA) to take measures to allow it to disclose more information to state courts and to encourage more information sharing between SSA and Veterans Affairs (VA). Incapacitated Adults: Oversight of Federal Fiduciaries and Court-Appointed Guardians Needs Improvement, Government Accountability Office, July 22, 2011.
- The ABA compiled a report on five different court-focused initiatives designed to improve the criminal justice response to elder abuse. Lori A. Stiegel and Pamela B. Teaster, A Multi-State Assessment of Five Court-Focused Elder Abuse Initiatives, American Bar Association Commission on Law and Aging, June 30, 2010.

Insurance

- Employers are spending 9% more on health care coverage this year than they did in 2010. Family plans cost $15,073 on average while individual plans cost $5,429. Workers paid an average of $921 for individual coverage and $4,129 for family coverage. Julie Appleby, Costs of Employer Insurance Plans Surge in 2011, Kaiser Health News, September 27, 2011.
- Most insurers will soon be required to cover birth control without co-payments under new standards issued by Health and Human Services. Insurance will also be required to cover domestic violence screening, HIV screening, breast-feeding counseling and equipment, gestational diabetes in pregnant women, DNA testing for HPV, and certain annual preventative care visits. Robert Pear, Insurance Coverage for Contraception Is Required, N.Y. Times, August 1, 2011.
- 19% of individual insurance applicants are denied coverage, but the actual rate may vary widely depending on location. Denial rates for individual plans are available by searching for insurance plans at http://www.healthcare.gov. Phil Galewitz, Health Insurers Deny Coverage to Many Who Apply for Individual Policies, Kaiser Health News, September 11, 2011.

Long-Term Care

- The CLASS Act (Community Living Assistance Services and Support) is officially dead – or at least on life support after the Obama administration decided to stop implementing the program. The voluntary, long-term care insurance program would have allowed individuals to receive a $50 a day long-term care benefit in exchange for at least five years of premiums paid into the program. The decision was made after government actuaries could not devise a sustainable funding scenario, which was a requirement for the program. One scenario had individuals paying $235 to $391 a month for a $50 a day benefit. The Obama administration refused to support repealing the CLASS Act and the political debate will continue. Without the CLASS Act, the Affordable Care Act loses $86 billion (or 40% of the projected savings that the act was supposed to create) because of the premiums that the CLASS program would have collected before it paid out benefits. Sam Baker, Obama's HHS Ends Controversial Program in Health Reform Law, The Hill: Healthcare Blog, October 14, 2011; Julie Appleby and Mary Agnes Carey, CLASS Dismissed: Obama Administration Pulls Plug on Long-Term Care Program, Kaiser Health News, October 14, 2011.
- Michigan ranked 31st in long-term care services and supports according to a scorecard put out by the AARP, The Commonwealth Fund, and The Scan Foundation. Michigan ranks 15th in Choice of Setting & Provider, 21st in Quality of Life & Quality of Care, 33rd in Support for Family Caregivers, and 37th in Affordability & Access. Overall, Minnesota was the highest performing state and Mississippi the worst. Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People With Physical Disabilities, and Family Caregivers, September 2011 available at http://www.longtermscorecard.org/.
- The Department of Human Service's Agency for Healthcare Research and Quality released its Nursing Home Survey on Patient Safety Culture report. The report measures the culture of resident safety from the perspective of nursing home staff. Overall, smaller nursing homes and nonprofit/government nursing homes had more positive responses. Nursing Home Survey on Patient Safety Culture: 2011 User Comparative Database Report, Agency for Healthcare Research and Quality (Part of DHHS), August 2011.
- Sales of traditional long-term care insurance declined from 303,000 policies in 2007 to 235,000 in 2010. However, sales of policies that combine long-term care insurance with life insurance grew modestly from 15,000 in 2007 to 26,000 in 2010. Anne Tergesen, "Combined" Insurance Policies Grow, The Wall Street Journal, July 31, 2011 (citing a report done by Limra, a nonprofit insurance research organization).

- Occupancy rates at both nursing facilities and assisted living remained basically constant at 88.4% and 88.5%, respectively, according to the National Investment Center for the Seniors Housing & Care Industry. Occupancy Rates Remain Stable in Eldercare Facilities, McKnight's Long-Term Care News, July 28, 2011.

Medicaid

- The requirements to qualify for Michigan's Medicaid Home Help Services have changed. An individual now needs certain assistance with Activities of Daily Living (eating, toileting, bathing, grooming, dressing, transferring, and mobility) before he or she will be eligible for financial assistance for help with Instrumental Activities of Daily Living, such as taking medication, meal preparation/cleanup, shopping for food, and other necessities of daily living. Michigan Department of Community Health, Bulletin Number MSA 11-38, September 1, 2011.
- 32% of pre-retirees and 43% of retirees think Medicare will pay the majority of their costs for three months in a nursing home, while only 10% of pre-retirees and 7% of retirees think Medicaid will pay. Of course, Medicare has only a limited skilled nursing facility benefit. The poll also posed other questions such as financial ability to live comfortably in retirement, expected retirement age, and health in retirement. The poll was conducted by NPR, the Robert Wood Johnson Foundation, and the Harvard School of Public Health. Jennifer Ludden, Retirement: Reality Not As Rosy As Expectations, NPR: Morning Edition, September 27, 2011.

Medicare

- Reminder: Medicare's annual open enrollment period ends on December 7 this year. All Medicare beneficiaries need to review their Part D prescription drug plans or their Medicare Advantage plans on or before December 7.
- Part B Medicare premiums for most beneficiaries (including those who have enrolled in the last two years and are paying higher amounts) will be $99.90 in 2012. The Part A inpatient hospital deductible will increase to $1,156.00 (from $1,132.00). The Part B deductible will decrease $22 to $140 (from $162).
- Only nine Medicare Advantage plans (none in Michigan), out of 569 plans, received a five-star rating from Medicare. Five-star plans will get a huge competitive advantage, the ability to enroll new customers at any time instead of just during the open enrollment period. Plans with three stars or better will also get financial bonuses. Overall, the average rating for next year increased to 3.44, up from 3.18 stars this year. Christopher Weaver, Chasing the Stars, Insurers Improve Quality – and Revenue, Kaiser Health News, October 12, 2011.

- Aetna is teaming up with CVS to sell a Medicare Part D prescription drug plan that will cost about $26 a month. The plan is similar to the WalMart – Humana partnership that currently sells for $15.10 a month. Pat Wechsler, Aetna Teams with CVS To Sell Medicare Prescription Drug Plan, Bloomberg, October 3, 2011.
- 46% of Medicare beneficiaries have never shopped for better Medicare coverage according to a survey by the National Council on Aging and UnitedHealthCare. Of those in the study, 41% assumed they could not save any money, 35% said they are confused by Medicare, and 16% said they simply do not understand Medicare at all. According to PlanPrescriber.com, a subsidiary of eHealth, Inc., less than 7% of their customers were in the lowest-cost prescription drug plan and only 10% in the lowest-cost Medicare Advantage plan for prescriptions based on data collected from its website. Glenn Ruffenach, 4 Best Sites for Medicare Information, Smart Money: Encore Blog, September 26, 2011; 2012 Medicare Choices Come Early: How Not to Overpay, Reuters, September 27, 2011.
- On average, Medicare Advantage premiums will be 4% lower in 2012 than in 2011, and Medicare Advantage enrollment is expected to increase 10%. Department of Health and Human Services, 2012 Medicare Advantage Premiums Fall and Projected Enrollment Rises, Press Release, September 15, 2011.
- In 2009, 19% of Medicare Part D enrollees (who did not receive a low-income subsidy) reached the coverage gap or "doughnut hole." Only 3% of these individuals reached the catastrophic coverage level. When in the "doughnut hole," beneficiaries filled, on average, 11% fewer medications. Jack Hoadley et al., Understanding the Effects of the Medicare Coverage Gap in 2008 and 2009, Kaiser Family Foundation, September 2011.
- Medicaid pays less for prescription drugs than Medicare. On average, drug manufactures provided rebates that reduced the cost of Medicaid prescriptions by 45%, but only reduced the cost of Medicare prescriptions by 19%. Federal law requires the minimum Medicaid rebate to be 23%, and drug companies must pay more if a drug's price increases faster than inflation. In contrast, Medicare relies on private insurer negotiations. Robert Pear, Medicaid Pays Less Than Medicare for Many Prescription Drugs, U.S. Report Finds, N.Y. Times, August 15, 2011.
- The average Part D prescription drug plan premium will be about $30 a month – down very slightly from $30.76 in 2011. Noam N. Levey, Cost of Medicare's Part D Drug Plan Is Dropping, L.A. Times, August 5, 2011.
- The Centers for Medicare and Medicaid Services (CMS) will cut Medicare payments to nursing homes by 11% ($3.8 billion) in 2012. CMS says the cuts are necessary to recapture unexpected payments it made under a new classification it implemented. Rehabilitation facilities will see a 2% increase and hospices will receive a 3% increase in

2012. Sam Baker, Medicare Cuts Payments to Nursing Homes, The Hill: Healthwatch Blog, July 29, 2011.

- According to the Government Accountability Office and the Department of Health and Human Services, Medicare made $48 billion in improper payments in 2010, estimated to be the largest source of improper payments of any government program. Medicare Advantage had a higher error rate (14.1%) than traditional fee-for-service Medicare (10.5%). Kay L. Daly and Kathleen M. King, Improper Payments: Reported Medicare Estimates and Key Remediation Strategies, Testimony from the Government Accountability Office (GAO), July 28, 2011.
- Interested in opinion polls related to Medicare? The New England Journal of Medicine summarized 21 different opinion polls. Example findings: 68% "of Americans believe that Medicare's benefits are worth the cost of the program for taxpayers." (CBS, June 2011.) 51% of seniors "rate their health insurance as excellent" versus 32% of those under 65. (KFF, August 2009.) Robert J. Blendon and John M. Benson, The Public's Views about Medicare and the Budget Deficit, The New England Journal of Medicine, July 28, 2011.
- Does Medicare's prescription drug program (Part D) decrease hospital and nursing home spending? Yes, according to a study published in the Journal of the American Medical Association. Non-drug spending fell by $1,200 (about 11%) for individuals who did not have coverage before the Part D program began in 2006. Alex Wayne, Medicare Drug Benefit Trims Spending on Hospitals, Study Finds, Bloomberg, July 26, 2011.

Medicine and Hospitals

- About 11% of the U.S. population takes antidepressants, according to the Centers for Disease Control. One in five women ages 40-59 take antidepressants, the highest rate of any demographic group. Scott Hensley, Look Around: 1 In 10 Americans Takes Antidepressants, NPR: Shots Blog, October 20, 2011.
- Emergency room visits increased about 10% in 2010, "the largest increase ever, according to preliminary data from the Centers for Disease Control and Prevention." Jessica Marcy, ER Docs Focus on Medical Liability Reforms, Kaiser Health News, October 18, 2011.
- The United States Preventative Services Task Force made a controversial recommendation that men should no longer take PSA blood tests to screen for prostate cancer. The recommendation found that because prostate cancer is slow growing and prevalent in many healthy men, the preventative actions taken because of early detection are causing more harm to men than waiting for additional symptoms. Gardiner Harris, U.S. Panel Says No to Prostate Screening For Healthy Men, N.Y. Times, October 6, 2011.

- About 40% of cancer screenings paid for by Medicare are medically unnecessary because they are "given more frequently than medically recommended or at times when they cannot gain any proven medical benefit," according to a study by *iWatch News* out of the Center for Public Integrity. Rochelle Sharpe and Elizabeth Lucas, Forty-Percent of Medicare Spending on Common Cancer Screenings Unnecessary, Probe Suggests, The Huffington Post, October 7, 2011.
- Nearly one out of three Medicare beneficiaries had surgery in the last year of life, one in five had surgery in the last month of life, and one in ten had surgery in the last week of life, according to a study published in the Lancet using 2008 Medicare data. Gina Kolata, Surgery Rate Late In Life Surprises Researchers, N.Y. Times, October 5, 2011.
- Women 65 and older who have a hip fracture are twice as likely to die within a year as those who do not according to a study in *Archives of Internal Medicine*. Women 65 to 69 have a five-fold increase in the risk of death within a year after a hip fracture. In contrast, women 80 and older had no increase in the risk of death within one year, although there is a three-fold increase in death for *healthy* women over 80 before the hip fracture. Nancy Walsh, Mortality High in Year after Hip Fracture, MedPage Today, September 26, 2011.
- 16.7% of Michigan hospital patients were readmitted within 30 days in 2009, the seventh worst rate in the country, up from 16.2% in 2004. The overall average readmission rate for the United State is 16.1%. Within Michigan, Southeast Michigan had the worst readmission rates. (Pontiac and Royal Oak had the highest readmission rates at 18.9% and 18.8%.) St. Joseph had the lowest readmission rate at 13.8%. Among states, Utah had the best readmission rate at 13.1% and West Virginia had the worst at 17.3%. You can customize many more factors at http://www.dartmouthatlas.org. The Dartmouth Atlas of Health Care, Percent of Patients Readmitted Within 30 Days of Discharge Following a Medical Admission, September 2011.
- The number of medical codes for billing is about to increase from around 18,000 to around 140,000 when the U.S. adopts a coding system largely based on one developed by the World Health Organization. Anna Wilde Matthews, Walked into a Lampost? Hurt While Crocheting? Help Is on the Way, The Wall Street Journal, September 13, 2011.
- The latest issue of *Health Affairs* is dedicated to the causes of rising health care costs. Who or what is driving the costs? (*See, e.g.*, Jordan Rau, Studies: Doctors, Hospitals Profit As Health Costs Rise, Kaiser Health News: Capsules Blog, September 8, 2011.)
    - One study blames U.S. doctors. The government pays primary physicians 27% more and private insurers pay 70% more in fees than physicians' counterparts in other countries. The government paid 70% more and private payers paid 120% more for hip replacements compared to the equivalent in foreign countries. Miriam J. Laugesen and Sherry A. Glied, Higher Fees Paid to US Physicians Drive Higher

Spending for Physician Services Compared to Other Countries, Health Affairs, September 2011.

  - Another study blames a high number of insurers. The study found that in markets that have a lower number of insurers, prices are about 12% lower compared to markets where there are a high number of insurers. Glenn A. Melnick, et al., The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices, Health Affairs, September 2011.
  - Three-fourths of health care cost increases are driven by higher costs for each medical case. Only one-fourth of spending increases are from an increase in the total number of medical cases. Charles S. Roehrig and David M. Rousseau, The Growth in Cost Per Case Explains Far More of US Health Spending Increases Than Rising Disease Prevalence, Health Affairs, September 2011.

- Only 1.5% of money spent on medical research goes to "outcomes research," and even less money is spent comparing the effectiveness of various treatments (i.e., what treatment works best). Funding from both the 2009 economic stimulus package and the Affordable Care Act is aimed at increasing comparative effectiveness research. David Brown, "Comparative Effectiveness Research" Tackles Medicine's Unanswered Questions, Washington Post, August 15, 2011.
- Increasingly, hospitals hire "hospitalists," doctors "whose sole job is to oversee the care of hospitalized patients." A study in the Annals of Internal Medicine found that while patients cared for by hospitalists have shorter hospital stays, these patients are also more likely to be readmitted to a hospital or to visit an emergency room within 30 days versus patients who were cared for by their regular primary care doctors. Patients seen by a hospitalist were also more likely to be discharged to a nursing home or rehabilitation facility than to their homes. Julie Rovner, Do Hospitalists Cost More Than They Save?, NPR: Shots Health Blog, August 3, 2011 referencing study by Yon-Fan Kuo and James S. Goodwin, Association of Hospitalist Care with Medical Utilization after Discharge: Evidence of Cost Shift from A Cohort Study, Annals of Internal Medicine, August 2, 2011.

Social Security

- The Social Security Administration announced that monthly Social Security and Supplemental Security Income (SSI) benefits will receive a cost-of-living adjustment of 3.6% for 2012. The maximum amount of earnings subject to Social Security tax will increase from $106,800 to $110,100. For more information, please go to: http://www.socialsecurity.gov/cola/.
- Social Security added 13 new compassionate allowances for certain immune system and neurological disorders. The compassionate allowance program fast tracks disability

determinations for certain conditions. The new allowances are for Malignant Multiple Sclerosis, Paraneoplastic, Pemphigus, Multicentric Castleman Disease, Pulmonary Kaposi Sarcoma, Primary Central Nervous System Lymphoma, Primary Effusion Lymphoma, Angelman Syndrome, Lewy Body Dementia, Lowe Syndrome, Corticobasal Degeneration, Multiple System Atrophy, Progressive Supranuclear Palsy, and the ALS/Parkinsonism Dementia Complex. Social Security Expands Compassionate Allowances Conditions, Social Security Administration, October 13, 2011.

Special Needs

- A new blood test can determine if a fetus has Down syndrome as early as the 10th week of pregnancy. The new blood test eliminates the high risks associated with amniocentesis. However, many advocates fear the new test will increase abortions. Andrew Pollack, The Quandary Posed by a New Down Syndrome Test, N.Y. Times: Prescriptions Blog, October 18, 2011.
- Parents with an autistic child have an 18.7% chance of having a second child with autism. Previously, researchers thought the reoccurrence was between 3% and 10%. Sally Ozonoff, et al., Recurrence Risk for Autism Spectrum Disorders: A Baby Siblings Research Consortium Study, Pediatrics, August 15, 2011.
- A study of autism in twins found that the rate of autism in both fraternal twins was higher than expected. This suggests that environmental factors play a role in causing autism in addition to genetic factors. Perri Klass, "Environment" Poses A Knotty Challenge in Autism, N.Y. Times, August 8, 2011.

Tools for Your Practice

- Need to help your patient decide which hospital to go to? Medicare just released its Hospital Compare website (similar to the existing Nursing Home Compare) to assess hospitals based on a number of detailed reported quality measures from friendliness to infections and surgical complications to the cost Medicare pays for a certain procedure. Worth checking out at http://www.hospitalcompare.hhs.gov/.
- Is a client or family member about to see the doctor? Help relatives ask the right questions from a Department of Health & Human Services website. You can either use the standard list of 10 questions, or you can build your own list at http://www.ahrq.gov/questions/.
- When is the best time for a couple to take Social Security? A number of calculators can help. AARP has a new calculator. Another one is http://www.socialsecuritytiming.com, which has a free calculator and one made for financial advisers. There are also two calculators designed by Laurence J. Kotlikoff (at a cost):

http://www.maximizemysocialsecurity.com or the more comprehensive software http://www.esplanner.com. Tara Siegel Bernard, When You Want to Collect Social Security vs. When You Should, NY Times: Bucks Blog, July 27, 2011; Steve Vernon, A Great New Tool for Deciding When to Take Social Security, CBS Money Watch, October 4, 2011.

Just For Fun

Helping a client with advance funeral planning? Consider these options:

- Have you seen QR codes, those seemingly purposeless squares on advertisements that look like bar codes? By scanning a QR code with a smart phone, you can find out more information about the product. Now some companies are putting QR codes on gravestones to allow people to instantly learn more information about that individual's life. Susan Gilmore, "Living Headstones" Use Technology to Honor the Dead, Seattle Times, July 31, 2011.
- Why settle for a boring porcelain urn? Instead, create an urn to look like your image from Cremation Solutions. Gerry W. Beyer, Personal Cremation Urns, Wills, Trusts & Estate Prof Blog, September 8, 2011.
- Want to have the last word? Go to Dead Man's Switch and write last e-mails to loved (or not so loved) ones. It will check-in with you every so often. and if you do not respond, the last e-mails will be sent. Gerry W. Beyer, Sending E-mails from the Grave, Wills, Trusts, & Estates Prof Blog, August 20, 2011.

Calendar		
Probate Section - SBAM	Council Meetings	10:15 a.m., Dec. 17, 2011, Jan. 21, 2012, Feb. 18, 2012, University Club of MSU, Lansing, MI
NAELA	2012 UnProgram	January 19-20, Grapevine, TX
	Elder & Special Needs Law Annual Conference	April 26-28, Seattle, WA
ELDRS - SBAM	Spring Conference	March 16, 2012, Plymouth, MI