Locked Units: Ins and Outs

By K.T. Whitehead, CELA

The doctor’s report said that Mrs. Smith, the proposed ward, was totally incapacitated. Yet, when the ad Litem visited her in a locked Alzheimer’s unit, for what she thought would be a perfunctory, routine few minutes, she found Mrs. Smith sitting and working the most recent New York Times Sunday crossword puzzle in ink. Mrs. Smith gave a very precise and accurate medical history, including dates of care, hospitalization, treatments and physicians over the past several years. While she was 92, she was clearly not “totally incapacitated.” Mrs. Smith was angry. She wanted to return to her home and to know why she was “locked up in jail.”

Upon questioning the physician, it became apparent that the physician relied on the daughter’s statements about her mother’s mental health when completing the guardianship affidavit. The doctor did not go back and check his own records. Mrs. Smith had no history of dementia.

After the ad Litem’s initial visit, many long discussions with the daughter’s attorney, and an independent medical exam, Mrs. Smith was moved to an assisted living facility and later back to her own home.

How does someone become a resident in a locked Alzheimer’s unit? When does the individual decide if they are going to move into a locked Alzheimer’s unit? When does a third party decide? What is the procedure for coming out of a locked Alzheimer’s unit? Why do we have almost no legal process for admitting or discharging people to or from locked Alzheimer’s units?

A locked unit is the same for mental health and Alzheimer’s care. It is an area in a hospital, nursing home or assisted living facility that can only be entered or exited with a pass code or special keying devices. These codes and keys are controlled by those who run the units. Once someone is placed into a locked unit, she...
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Dear NAELA Members:

As you know, Congress is currently considering changing the Medicaid penalty period start date to the date of application and increasing the lookback period from three to five years. These changes would severely hurt our clients - the elderly and individuals with disabilities across the nation. As a member of NAELA, I would want my leadership to let me know what steps NAELA is taking in response to this proposed legislation. Therefore, the purpose of this letter today is to update you on NAELA’s public policy and public relations activities in response to this threat and to ask you to take action now.

If you haven’t yet done so, please take the time to contact your Members of Congress about these punitive Medicaid changes that Congress may soon act upon.

There is urgency in this call to action. While it is true that House and Senate budget reconciliation action, which will include Medicaid cuts and program changes, has been delayed due to Hurricanes Katrina and Rita, the fact is that there is now more pressure from some in Congress to find budget cuts to offset the costs associated with the natural disasters.

Please write to your representative and senators TODAY using the sample letter found at NAELA.org under Government Affairs. Since Congress is back in session, fax or e-mail your letters to their Capitol Hill offices as soon as possible. Consider asking your clients to call or write as well.

Following is a summary of NAELA’s actions and activities related to the current Medicaid policy crisis. Please add your efforts to this list!

Thank you for helping NAELA with this critical issue.

Sincerely,

Lawrence E. Davidow, CELA
NAELA President

Medicaid 2005:
Public Policy and
Public Relations Joint Campaign Summary

The NAELA Board of Directors approved and funded an expanded public policy advocacy campaign in May, and an expanded public relations campaign in July. The goal of the joint campaign is to defeat the proposals to change the penalty period start date and the lookback period in order to protect seniors and individuals with disabilities. NAELA is fulfilling this goal by strongly opposing these changes and by pro-actively communicating better solutions for Medicaid reform. This strategy has helped secure a role for NAELA as an expert and valued resource for Members of Congress and congressional staff.

Susan McMahon, NAELA’s Associate Director, coordinates the public relations efforts, led by Kellen Communications, with NAELA’s public policy work in Washington, DC. Stan Samples and Ann Krause direct our public relations activities. Charlie Sabatino chairs our Public Policy Committee; Vincent J. Russo chairs the Medicaid Strategies Task Force; and Brian Lindberg, NAELA’s Public Policy Consultant, directs our advocacy and lobbying efforts in DC. At the board’s direction, Brian hired two seasoned lobbyists to assist in the Medicaid fight: Howard Cohen and Chris Jennings. They have proven to be assets to our efforts.

This group of dedicated and hardworking NAELA members and staff have developed strategies for countering these punitive proposals by the Bush Administration, the National Governors Association, and the newly minted Medicaid Commission. They have created workable solutions to address the budget mandate to find savings in the Medicaid program while ad-

(continued on page 4)
President's Message  
(continued from page 3)

dressing the myths around Medicaid planning. We have been able to promote greater understanding and respect for elder law attorneys and NAELA itself among congressional leaders, Hill staff, and the public.

Public Policy Activities

Medicaid Section of NAELA.org:  
The NAELA website is the central resource for Medicaid advocacy materials, including the Grassroots Advocacy Kit. This kit was developed for use by NAELA members. It contains sample letters, talking points, background information, Capitol phone numbers, leave-behind materials, etc. The site also houses NAELA's position papers, documents regarding the current transfer of asset proposals, the House and Senate budget reconciliation, NAELA’s proposed Medicaid solutions (presented as replacements for current legislation), Myths and Realities About Medicaid Planning, NAELA Members as Resources: Issue List; and a NAELA Fact Sheet. Go to http://www.naela.org/private/OurGov/medicaid.html.

New Personnel:  One of our first objectives was to bring on to the NAELA advocacy team perspectives from outside the organization that represented both Republicans and Democrats. Howard Cohen and Chris Jennings were hired and bring years of experience and contacts to our public policy efforts. Howard served as a counsel and senior staff member on the House Energy and Commerce Committee, which is currently drafting the Medicaid bill. Chris worked on health and aging issues on the Senate Special Committee on Aging for almost 10 years and as President Clinton’s chief health policy advisor. Both Howard and Chris have extensive knowledge of Medicaid and have played integral roles in all aspects of this campaign.

Coalitions:  For more than 10 years, NAELA has been working with coalitions in Washington, DC. Represented by Brian Lindberg and Charlie Sabatino, NAELA has been a good team player and has taken on leadership roles for these organizations. Brian currently chairs the Long-Term Care Task Force of the Leadership Council of Aging Organizations (LCAO), which includes 53 aging groups in DC. In addition, NAELA is a member of the Medicaid Coalition, which has more than 200 member organizations representing a diverse group of consumer and provider interests. These relationships are critical in our fights to protect Medicaid beneficiaries.

These coalitions are in constant communication with each other, congressional staff, and the media and are able to mobilize their many members to work on behalf of protecting Medicaid.

Recent coalition and individual organization actions related to the asset transfer effort include:

- Briefings for the LCAO and Medicaid Coalition on asset transfer issues conducted by Charlie Sabatino, Trish Nemore and Vincent Russo.
- AARP ran full-page ads on two occasions in the Washington Post, Washington Times, Roll Call, and the Congressional Quarterly specifically opposing the change to the penalty period start date and the lookback period.
- The LCAO wrote a letter to all Members of Congress, including members of the committees with jurisdiction over Medicaid, opposing the transfer of asset changes. The LCAO includes AARP, National Committee to Preserve Social Security and Medicare, Alzheimer’s Association, National Council on Aging, B’nai B’rith, AFL-CIO, and many other prominent organizations.
- NAELA has worked with the national trade organizations of the nursing home industry to oppose the change in the start date for the penalty period. The American Health Care Association has testified before the Finance Committee in opposition to the change and has lobbied Congress on the issue. The American Association of Homes and Services for the Aging has also lobbied against the date change.

Hearings/Briefings/Debate:  
NAELA has taken a very public approach to opposing the changes in the Medicaid transfer rules. By appearing before House and Senate committees, conducting briefings for staff, and publicly debating our harshest critic, we have positioned NAELA as a voice of authority, professionalism, and reason. We owe a debt of gratitude to our members who have helped make this effort possible – those on the Medicaid Strategies Task Force and those who have represented us. They have served us with distinction and class.

- NAELA Past President Bernie Krooks testified on April 27, 2005, before the House Energy and Commerce Committee.
- Vincent Russo, also a NAELA Past President, testified before the Senate Special Committee on Aging on July 20, 2005.
- Brian Lindberg, Trish Nemore, 

(continued on page 6)
NAELA Executive Director’s Column

By Laury Adsit Gelardi

I am sure this will be one of the last Executive Director’s columns I will write for NAELA. After 17 years, I will miss this...and interacting with NAELA members on a daily basis. It has been a long, but very wonderful journey.

Each of you deal with retirement issues with your clients all day long. But, have you ever really sat down to think of your own retirement: what it means, when it will happen or what you will do? Most of you tell me you haven’t. In fact, many of you have confessed to me over the years that you haven’t even done your own wills. I always thought you were too busy. Now I am fairly certain that it is a case of the “cobbler’s children having no shoes.” Or could it be “the avoidance theory” — if I don’t do it, nothing will happen and I will put off the inevitable. As Dr. Phil would say...how has that worked for your clients?

At the Joint Meeting being held in Tucson December 9 – 11, I will be a small part of a panel of NAELA members who will be talking about “the real issues of retirement.” Each one of the panelists is coming at it from a different tract – being forced to retire due to health reasons, wanting to cut back on work time to avoid going stark-raving mad, wanting to devote more time to family issues or just deciding that the “time has come” to do something else in life. The one common theme is that it takes a lot of soul (and sole) searching. Quitting work, losing an identity that has taken years to achieve, changing roles, and no longer “being the one in charge” are not easy changes to make...and most of us won’t do it on the spur of the moment, although some of us will wait until we are forced into it by our own health issues. Retirement is a decision that takes planning — way beyond the wills and the trusts and the powers of attorney — way beyond the distribution of wealth and your own end of life issues — way beyond the paper trail that we leave when we are ultimately gone.

I hope that sharing my journey will encourage some of you to think about it. None of us is getting any younger and the years aren’t getting any easier to endure. While most of us view the age of 65 as the “time to begin” thinking about retirement, the reality is different. There is enough research out there, that each of us needs to look realistically at the good ole’ family tree and see what our “genetic future” has to bring? It was a wake-up call when I realized that my Mom, being 67 when she died, represented a milestone in our family. She actually lived longer than any other female on the maternal side of the family. While my father’s mother was 88 when she died, my Father was only 62. I remember being angry when they died....not because of my loss, but because I felt they were cheated out of their time to enjoy their hard earned, yet never achieved, retirement years. Now, approaching 50 and being the youngest of five girls – now all in their 50’s – 62 and 67 don’t seem so far way.

If you believe that you work to live.... not live to work, then “what the future might bring” is very important. If you admit that life is finite and uncertain, how do you assure that you will accomplish what is really important to you? Planners encourage people to go through the “what if I had one year to live scenario.” Most of us shrug-off those efforts as hokey. I never liked role-

(continued on page 7)
and Vincent Russo briefed the Democratic staff of the House Energy and Commerce Committee and the Senate Finance Committee staff on Medicaid eligibility rules, including spousal impoverishment, transfer rules, and how the current proposals would hurt older and disabled individuals.

- NAELA organized similar briefings on the issues of reverse mortgages, long-term care insurance, and the Long-Term Care Partnership Program for the Energy and Commerce Committee staff.

- Republican staff turned down offers for similar briefings, but we continue to provide information to them on an individual basis.

- On September 7, 2005, Vincent Russo debated Stephen Moses at the Cato Institute, in Washington, DC. More than 125 individuals attended – many of them key players in the health care policy world. Stephen Moses runs the Center for Long-Term Care Financing. For years, Mr. Moses has accused elder law attorneys of being one of the primary reasons that our long-term care system does not serve Americans well. Vincent Russo demonstrated his knowledge, expertise, and compassion for our clients with his reasoned and thoughtful delivery at the debate.

Congressional Budget Office/ Government Accountability Office/ Congressional Research Service: NAELA and its members have successfully initiated a dialogue with CBO, GAO, and CRS to provide data, insights, and observations about whom we serve and how the Medicaid program works. These influential entities have responded positively and have requested our assistance as they develop their work products for Congress.

SR-PAC: Brian Lindberg and our lobbyists have attended more than 20 fundraisers since July 15th and have discussed the Medicaid transfer of asset changes with key congressional members. Examples include: Finance Committee Chairman Grassley and Ranking Democrat, Senator Baucus; numerous House Energy and Commerce Committee members including Representatives Dingell, Wilson, and Waxman, and key Medicaid supporters such as Senators Gordon Smith and Jeff Bingaman of the Smith-Bingaman amendment, which reduced Medicaid cuts in the Senate. The opportunities that the Senior Rights PAC affords NAELA have been invaluable during this critical fight to save Medicaid.

Proactive Reform Proposals: NAELA’s Medicaid Strategies Task Force, the Public Policy Committee, and the Board of Directors approved a list of six changes to the Medicaid program eligibility rules that our advocacy team could use (as necessary) in working with Congress to stop the change in the penalty period start date and lookback period. These proposals have shown NAELA to be forthcoming about certain areas of Medicaid law, shown our willingness to help find savings in the program, and have helped provide opportunities for us to discuss why other proposals would severely hurt our clients. The proposals can be found in Vincent’s testimony on the NAELA website under Government Affairs.

Public Relations Activities

NAELA’s public relations staff has played a key role in successfully positioning NAELA in the public spotlight. The PR team has worked side-by-side with the public policy team to ensure that NAELA’s message has been delivered properly and promptly to Congress, the media, and the NAELA membership.

Communicating on Key Events: Ann Krause and Stan Samples have made it their business to ensure that the media is informed of each of the key developments that help to make our case against the punitive transfer of assets changes and in favor of more reasoned approaches.

Letters: One example of this has been their work to ensure that letters to Congress from organizations and coalitions supporting NAELA’s position on transfer of assets are provided to and understood by the media. Ann and Stan have worked hard to make sure everyone is aware of the significance of the
President's Message
(continued from page 6)

letters from the LCAO and AARP. In addition, the PR team faxed NAELA’s own letter on the same topic to all of the congressional offices.

Hearings: The PR staff prepared press releases, pitches for radio, TV, and print media, and communicated with local DC media when Vincent Russo testified before the Senate Special Committee on Aging.

Debate: When Vincent debated Stephen Moses of the Center for Long-Term Care Reform, the PR staff wrote pre- and post-debate press releases, “packaged” debate transcripts, and pitched the debate to the media. At the debate and afterwards, Stan Samples met with several DC-based media contacts. The PR staff helped prepare Vincent for the debate with specific message platforms, edited for sound bite use with the media, and on-location media training, including videotape auditing.

Letters to the Editor: The PR team distributed “letters to the editor” to daily newspapers in areas home to members of the Senate Finance Committee and the House Energy and Commerce Committee. The letters stated NAELA’s position opposing the changes to Medicaid and went out under local NAELA member signatures. We also sent similar letters to the editor, but using a national perspective, to national media. These letters were signed by Lawrence Davidow, NAELA President.

News Bureau: One of the most important functions of the NAELA PR team is to staff the news bureau. Ann and Stan answer questions from the media, develop news releases and other content, pitch and place stories with the media, facilitate interviews, and provide pre-interview media coaching. In addition, they spend many hours working to connect the appropriate NAELA member with an interested media contact in order to get the right story about NAELA, our members, and our clients in the public eye. They also provide a critical function by monitoring Medicaid hits in the media and by monitoring Medicaid activity by various groups, including the Medicaid Commission and the National Governors Association.

NAELA Executive Director’s Column
(continued from page 5)

you may be too! I love what I do, but have often said: “if I could only do less of it, I could get a life!” After years of saying that, I have come to the realization that I can’t do anything “part way.” I’m an “all or nothing kind-of-gal.” So, I have given my all to this first chapter of my life. NAELA has been a tremendous source of pride, a great source of growth and strength and a precious source of love and support to me for 17 years.

Now is the time for me to give back in other ways and to have time to take care of myself. I am blessed to have a wonderful husband who came to me late in life (yes, he’s my second husband, after NAELA) and with whom I want to spend more time. I want the time to tend to sick friends, to go on spur-of-the-moment lunches, to decorate for the holidays or to send cards to those who mean the most to me. It has become impossible to find the time to decorate for the holidays or to send cards to those who mean the most to me. It has become a hassle to schedule time off or to enjoy it when I do have it. It has become a real life-barrier to spend 180 days per year in hotels and away from home. It has become common place to feel exhausted all the time, but to always feel under the gun.

As a baby boomer, business owner, association executive, and youngest in the family, I tend to be an over-achiever and a workaholic. I don’t say that to make anyone feel sorry for me….I say that to make some of you recognize that

Schedule of Events

DECEMBER 8 - 11, 2005
NAELA Institute
A Joint Conference with the National Association of Professional Geriatric Care Managers. Rescheduled from the Sheraton, New Orleans to the JW Marriott Starr Pass in Tucson, Arizona.

JANUARY 20 - 22, 2006
2006 NAELA UnProgram, Embassy Suites Outdoor World, Grapevine, TX

APRIL 19, 2006
Fundamentals of Elder Law, Hyatt Regency at Capitol Hill, Washington DC

APRIL 20-23, 2006
2006 NAELA Symposium, Hyatt Regency at Capitol Hill, Washington DC

NOVEMBER 2006
2006 NAELA Institute - location to be determined.

MAY 2-6, 2007
2006 NAELA Symposium, Renaissance Cleveland Hotel, Cleveland, OH

FALL, 2007
2007 NAELA Institute, Atlanta, GA

SPRING, 2008
2008 NAELA Symposium, NAELA’s 20 Year Anniversary, Hawaii

NAELA Executive Director’s Column
(continued from page 5)

playing, but when I sat down and asked myself “what I wanted to do if I only had 10-15 years left?”….I realized that while I love my work, it captivates me to the point that I exclude a lot of important things from my life. In the hustle and bustle of getting things done, it has become a hassle to schedule time off or to enjoy it when I do have it. It has become impossible to find the time to decorate for the holidays or to send cards to those who mean the most to me. It has become a real life-barrier to spend 180 days per year in hotels and away from home. It has become common place to feel exhausted all the time, but to always feel under the gun.

As a baby boomer, business owner, association executive, and youngest in the family, I tend to be an over-achiever and a workaholic. I don’t say that to make anyone feel sorry for me….I say that to make some of you recognize that
Guardianship/ Capacity SIG
(continued from page 1)

cannot leave without permission.

The legal system has developed a very specific and elaborate process to ensure that when services are imposed for mental illness, one’s 14th Amendment rights are not violated. “No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty or property, without due process of law...” U.S. Const. Amend. XIV. Exact procedures and substantive evidentiary standards must be followed before placing a person with mental illness into a locked unit. The constitutional mandate is the underpinning of all legal precedent for confining people in locked mental health units. An exploration of the constitutional case law surrounding commitment can give us insight into the protections that should be in place, but are not for people who may be placed in a locked Alzheimer’s unit.

One Supreme Court case outlining the minimum due process needed for commitment was O’Connor vs. Donaldson, 422 U.S. 563, 95 S.Ct. 2486 (1975). In this case, Donaldson sued his physician, the hospital superintendent and other staff members for wrongfully confining him to the Florida State Hospital. Donaldson was found by his physician to be suffering from “paranoid schizophrenia” and was committed to “care and maintenance.” Donaldson was confined for fifteen years. His treatment plan was to have “milieu therapy.” “Milieu therapy” was a euphemism for confinement in a mental hospital and mingling with other patients.

The law in Florida at the time gave the hospital staff and the physician the power to release or not release the patient. The sole and simple reason for Donaldson’s confinement was the physician’s opinion. There was no third party process to review a commitment. The Supreme Court found that “a State cannot constitutionally confine without more [sic] a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.” Id., at 491.

Mrs. Smith’s case parallels Donal-
Guardianship Capacity SIG
(continued from page 8)

sions or participate in the decision process. It is difficult for physicians to
gauge the needs of an older adult during this devastating process, let alone
for family members to figure out when someone with dementia or Alzheimer’s
is capable of making decisions and consenting to treatment.

While being placed into an Alzheimer’s unit which is locked may be
in a patient’s best interest, problems arise for those few patients for whom
the placement is inappropriate. Additionally, there are many persons who
simply do not need a locked unit even if they have a dementia or Alzheimer’s
diagnosis. When someone has a diagnosis of Alzheimer’s or dementia,
should they automatically be placed into a locked unit? What duty do we have
to safeguard these people from themselves, while also allowing them their
own freedoms and personal rights? There is a clash between the practical
side of the day-to-day care for a person with Alzheimer’s or dementia, and with
the patient’s constitutional rights.

A delicate balance between the
rights of the individual versus the need
to protect the individual exists when
placing someone in a locked unit. There
is a need for an inexpensive and efficient
process to protect the older person, while
enabling family members to obtain appro-
priate care for the older person.

When an older person is suffering
from dementia or Alzheimer’s, the family
is often suffering and having a difficult
time coping with the loss of the
older person’s mental acuity. Good in-
tentions abound, but the first question
should be: what does the older person
want? Then, when do the wishes of the
older person need to be overruled, be-
cause she has lost capacity and her de-
cisions are not sound? If her wishes are
to be overruled, what is the process
needed to guarantee the rights of the
older person?

There are huge consequences when
decisions to place into a locked
Alzheimer’s unit are made in haste with-
out process or substance. We must
make sure our client’s constitutional
rights are protected; that they are in the
least restrictive environment; and that
they are appropriately placed.

Stetson College of Law
Builds First Model
Courtroom for Seniors and
People with Disabilities

National advocates for the rights of seniors and people with disabilities
gathered at Stetson University College of Law on Sept. 16 for the dedication
of the nation’s first “elder-friendly” courtroom.

“We can only hope that this courtroom inspires the creation of others,”
said AARP CEO Bill Novelli. “You have created a place of law and justice
that is accessible to anyone and everyone.”

The courtroom has touch screens, electronic gates that open automati-
cally, hearing amplification devices, flat-panel monitors, refreshable Braille
displays, a multi-lingual software speech synthesizer and translator and other
features specially designed for people with reduced vision, limited hearing
or other physical disabilities.

As U.S. Attorney General, Dick Thornburgh shepherded the American
with Disabilities Act. He reminded the courtroom audience of landmark Su-
preme Court case Lane V. Tennessee, in which a gentleman with disabilities
was forced to climb out of his wheelchair and crawl up the steps of a court-
house to attend a judicial proceeding. “The Eleazer courtroom doesn’t sim-
ply accommodate wheelchair access, though that is monumental in its own
right. It goes so much further. Its technology will enable people with various
sensory impairments to participate fully in our judicial process,” Thornburgh
said.

Lawrence Davidow, President of the National Academy for Elder Law
Attorneys said construction of the new courtroom is the beginning of a move-
ment to increase access, dignity, respect and involvement of all people with
disabilities, regardless of age, in every courtroom in the United States. “This
courtroom is all about enhancing the lives of people with disabilities and
people as they age. We intimately know what this courtroom means to them;
access to justice with dignity, enhancing their ability to be a part of a pro-
cess that directly impacts their lives, without barriers, seamlessly allowing
their disabilities to be a non-issue,” Davidow said.

Stetson professors Rebecca Morgan and Roberta Flowers spearheaded
courtroom construction. “This innovative courtroom combines cutting-edge
technology while recognizing that our system of justice will always be about
people,” said Flowers.

The courtroom will be used initially for Consumer Protection Program
activities that educate the elder community about various types of consumer
fraud. In the spring, elder law and advocacy students will use the new facil-
ity, and Morgan and Flowers are working to make the courtroom available
for actual court proceedings in the near future. Stetson dedicated the court-
room in honor of Distinguished Professor of Law Emeritus William R.
Eleazer.

To view images of the courtroom and the dedication event, please visit
http://www.law.stetson.edu/Communications/news.asp?id=206

Stetson University College of Law is Florida’s first law school. It has
educated lawyers for more than a century and offers continuing legal educa-
tion programs for regional, national and international audiences. Stetson is
tied for first in advocacy and third for legal research and writing by the 2006
U.S. News & World Report national rankings and is the headquarters for the
National Conference of Law Reviews.
Health Care SIG
Talking With Your Clients About The New Medicare Prescription Drug Benefit

By Vicki Gottlich, Esq.

In recent weeks President Bush, Secretary of Health and Human Services (HSS) Leavitt, Centers for Medicare & Medicaid Services (CMS) Administrator McClellan, former senator and presidential candidate Bob Dole, and others have begun a publicity campaign around the country to discuss the new Medicare Part D, which adds an optional prescription drug benefit to the Medicare program effective January 1, 2006. If these people are talking about Part D six months before the benefit will pay for covered drugs costs, is it time for elder law attorneys to start discussing Part D as well? The answer is yes.

That answer may be surprising, given that we really do not know much detail about the practical operation of the Part D program. We do know that the prescription drug benefit will be offered through private insurance plans known as Prescription Drug Plans or PDPs. We will not know how many of these plans will be available in each of the prescription drug regions established by CMS until CMS enters into final contracts with the plans sometime in September. Based on public announcements, we know that 10 companies, including AARP in conjunction with United Health Group, have applied to CMS to offer national plans that serve all of the regions. CMS has said that beneficiaries in some regions will have many more than 10 plans from which to choose while beneficiaries in other regions, such as the Maine- New Hampshire region, may be limited to the 10 national plans. In addition, Medicare HMOs, PPOs, and some private fee-for-service plans (known collectively as Medicare Advantage plans with prescription drug coverage, or MA-PDs) will also be offering prescription drug benefits, increasing the choices for beneficiaries who live in areas where these options are available.

We also do not know how much the prescription drug plans will cost. Press accounts mention an average premium of $37 per month, but that figure is only an estimate. The PDPs submitted their premium bids to CMS on June 6; these bids are currently being analyzed. It is likely that some plans will have a premium that is much greater than the estimate. The amount of the premium will be significant to all beneficiaries, especially given the large increase that is anticipated in the Medicare Part B premium for 2006. The premium amounts will be particularly relevant to beneficiaries with low-incomes who seek additional assistance in paying their Part D costs since the assistance with premiums will be capped. In addition, premium amounts are expected to rise each year.

Each plan’s benefit structure also is unknown. The statute defines the following standard benefit: There is a $250 deductible for drugs on a plan’s formulary. After the deductible is met, the beneficiary pays 25% of the cost of formulary drugs and the drug plan pays 75%, up to $2250 in total formulary drug costs. Then the beneficiary enters the proverbial “doughnut hole” where s/he is responsible for the full cost of prescriptions while continuing to pay the monthly premium. Once the beneficiary’s total out-of-pocket costs for formulary drugs, including the deductible but not the premium, equal $3600, the beneficiary is responsible for 5% of drug costs and the drug plan pays the remaining 95% of costs. Generally, the beneficiary and the drug plan will have expended $5100 on formulary drugs before the catastrophic coverage level is reached. The $3600, which will be indexed yearly, represents annual out-of-pocket expenditures; a beneficiary begins again at $0 each January 1.

Drug plans are not required to offer the standard benefit, however, as long as the value of the drug benefit they offer is actuarially equivalent to the value of the standard benefit. In fact, it is anticipated that many drug plans will not offer the standard drug benefit. Instead, plans may follow the model used by private insurance and vary beneficiary cost-sharing to promote use of less costly drugs. For example, a plan may have different tiers of cost-sharing: the lowest tier for generic drugs, a higher tier for preferred brand name drugs, and the highest cost-sharing tier for non-preferred brand name drugs. Plans may also require a very high amount of cost-sharing for very expensive and rare drugs. The regulations even allow plans to have a tier under which the beneficiary pays the full cost of the drug. A beneficiary’s costs may also depend on the pharmacy s/he uses. Plans may charge more if beneficiaries use pharmacies that are not in the drug plan’s pharmacy network or charge more for non-preferred network pharmacies.

We also do not know precisely what drugs will be paid for under Part D. The statute establishing the Medicare drug benefit specifically excludes from payment certain classes of drugs, including barbiturates, benzodiazepines (such as Xanax and Valium), weight loss/weight gain drugs, and over-the-counter drugs that are frequently used by older people, particularly those in nursing homes. Some PDPs and MA-PDs may offer to cover these drugs as an optional benefit for an extra premium. All PDPs and MA-PDs can determine which drugs covered by Part D to include in

(continued on page 11)
their formulary, or list of covered drugs, as long as they include at least two drugs in each category or class of drugs. CMS has recently announced that drug plans must cover all or substantially all drugs in six categories: anti-cancer, anticonvulsants, antidepressives, antipsychotics, immunsuppressants, and HIV/AIDS drugs. If a drug is not on a drug plan’s formulary, then the beneficiary will get no assistance in paying for the drug, and out-of-pocket costs for the drug do not count towards the deductible or towards reaching the out-of-pocket spending limit and catastrophic coverage.

In addition to determining whether to include a drug on its formulary, each drug plan can determine the cost-sharing tier on which to place the drug. Drug plans may also require that a beneficiary get prior approval or prior authorization from the plan before paying for the drug, and may deny coverage if such approval is not obtained. They may also require the beneficiary to try a less costly drug first before they will pay for the more costly drug in order to determine whether the less costly drug will be effective. Thus, it will not be enough for beneficiaries to determine whether the medications they take are included on a particular plan’s formulary. They will have to know the cost-sharing tier and whether a plan employs utilization management tools to discourage the use of certain drugs.

Again, information about drug plan formularies will not be made available until October when the drug plans begin marketing and CMS sends information about Medicare Part D to all beneficiaries. Formulary information will not be mailed directly to all beneficiaries, however. Beneficiaries, their families and their advocates who use the Internet will be able to obtain formulary information through the CMS website, www.medicare.gov. Others will have to call all of the drug plans available in their region. The drug plans may give them information specific to them or an abridged formulary; the plans will not be required to give beneficiaries the complete drug formulary unless they request a copy.

Medicare Part D is voluntary; some beneficiaries may choose not to enroll during the initial enrollment period, which will run from November 15, 2005-May 15, 2006. However, individuals who delay enrolling in a Part D plan until after their initial enrollment period will have to pay a late penalty on their premium, similar to the way a penalty is imposed for delayed enrollment in Medicare Part B. Under Part D, the late penalty will be 1% of the premium for each month of delayed enrollment for as long as a beneficiary remains in a Part D plan. A beneficiary who delays enrolling in Part D for 5 years will therefore pay an additional 60% on her premium; the actual dollar amount will fluctuate as the premium changes each year. Individuals who have drug coverage through a retiree health

(continued on page 12)
People who are currently enrolled in one of the Medicare Savings Programs (MSP), namely, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individual (QI), that pay the Part B deductible and sometimes Medicare co-payments, as well as people who get SSI but who do not automatically get Medicaid, are deemed eligible for the Part D low-income subsidy and do not have to apply. The deeming of MSP recipients may prove significant for some clients.

Others with incomes up to 150% of FPL and with resources of up to $10,000 for an individual or $20,000 for a couple also may be eligible. The amount of assistance varies with income and resource levels. CMS estimates that 8.2 million Medicare beneficiaries may qualify for the subsidy by filing an application with the Social Security Administration (SSA) or with the local Medicaid office. SSA has begun sending applications to beneficiaries who potentially may be eligible, and will continue mailing applications through mid-August. SSA and Medicaid offices will begin processing applications on July 1. Also on July 1 people can apply by filling out an application on the SSA web site, www.ssa.gov. Anyone who is found eligible for the subsidy, either by applying or by being deemed eligible, will automatically be enrolled in a Part D plan in May 2006 if they have not chosen a plan on their own.

Here’s where elder law attorneys come in. First, attorneys can discuss with their clients the need to apply for the low-income subsidy, if not now, then possibly when their income and assets are diminished during a spend-down period before Medicaid eligibility. For many people the subsidy will mean the difference between being able to afford prescription drug coverage and not being able to purchase the coverage. Individuals whose income and/or resources appear slightly too high should be encouraged to apply because of various exclusions and disqualifications. Beneficiaries who live in states whose income and asset eligibility criteria for the Medicare Savings Programs are more liberal than the criteria for the Part D low-income subsidy should be encouraged to apply for MSP. Again, once an individual is found eligible for an MSP program s/he is automatically eligible for the low-income subsidy, even if s/he does not meet the subsidy income and/or assets eligibility criteria. Attorneys should familiarize themselves with MSP eligibility criteria in their states in order to determine whether any of their clients are more likely to receive assistance with Part D costs by applying for MSP assistance.

Second, attorneys need to evaluate the role they can play in assisting clients choose and enroll in a Part D plan. Although dual eligibles will automatically be enrolled in a plan, they, unlike other Medicare beneficiaries, do not change plans at any time. Thus, an elder law attorney can assist a dual eligible client or the client’s family in determining the plan that is best for the client. Other clients may also need assistance, especially those who currently have other drug coverage through an employer or Medigap plan and who need to determine whether they should retain their current coverage or enroll in a Part D plan.

Third, attorneys need to incorporate Medicare Part D into their health care planning. Remember, the low-income subsidy for dual eligibles and others with limited income and resources pays the Medicare Part D premium only up to the benchmark or average premium amount. A beneficiary who wants to enroll in a more costly Part D plan with perhaps a more generous formulary will have to pay the difference.
between the benchmark and higher premiums. Can these payments be made from a trust already established on behalf of the beneficiary? Can an existing trust be used to pay the beneficiary’s other cost-sharing expenses, including the deductible and costs in the doughnut hole, if the beneficiary does not receive a subsidy, or the co-payments and costs for non-formulary drugs? Does your state Medicaid program recognize the incurred medical expense deduction? Will dual eligible clients in nursing homes be able to deduct the extra premium amount and the cost of non-formulary drugs from their share of cost paid to the nursing home?

Attorneys who draft financial and health care powers of attorney documents on behalf of clients need to consider which agent will have authority to choose a Part D plan or to change Part D plans if the client becomes incapacitated. Which agent will have authority to pursue an exception on behalf of the client to get a non-formulary drug covered by the plan or to get a formulary drug moved to a lower cost-sharing tier? There is some concern among national advocates that nursing homes will file for guardianships on behalf of residents who lack family or others to assist them in choosing a plan or in seeking a formulary exception. What role can an elder law attorney play in that regard, especially to ensure that guardianships are limited?

Finally, what opportunities will the next few months bring to promote information about elder law generally and as it relates to Part D? Representatives from CMS and SSA will be visiting senior centers and lunch sites throughout the country to encourage enrollment in the low-income subsidy and Part D. How can an elder law attorney participate in such events? Can an attorney follow-up on such events through Op Ed pieces or other media exposure?

As advocates for older people and people with disabilities, we need to ensure that our clients get all of the benefits to which they are entitled. We need to ensure that the information provided to them is clear and accurate. Talk with your clients about Medicare Part D, and in doing so promote the role that elder law attorneys can play with all of their health care and planning needs.

NAELA Announces Availability of Two Symposium Tuition Scholarships


The scholarship was established through the NAELA Memorial Fund in memory of Vivian Cohn Smith. It is a needs-based scholarship, covering tuition and room at the 2006 Symposium. The annual scholarship is available to elder law attorneys who are unable to afford the costs associated with attending the NAELA Symposium, and who would use the training to assist and advocate on behalf of the disabled and incapacitated.

The Vivian Cohn Smith Scholarship for Patient Advocacy was made possible through the generous donations made in Vivian’s name to the NAELA Memorial Fund by Vivian’s family and friends; Needham, Mitnick & Pollack, plc; and other individuals and law firms. Vivian, the sister of NAELA Fellow Helen Cohn Needham, CELA, passed away in November 1997 after a 10-year fight against breast cancer. She learned the value of patient advocacy from her own experience—Vivian was a disability worker for the state of North Carolina and saw her role as using what she had learned as a patient to advocate on behalf of others.

Application Process

The applicant must send a statement to NAELA (no more than one page long) that explains the following:

- Applicant’s current job/position and involvement in elder law.
- Why the applicant needs the scholarship.
- How the applicant would apply the training received at the Symposium to her/his advocacy on behalf of patients.

Selection Process

The family of Vivian Cohn Smith will review all applications and determine to whom to grant the scholarships.

Deadline for Application

All applications must be submitted no later than February 15, 2006. Applications must be sent to Bridget Jurich, NAELA, 1604 N Country Club Rd., Tucson, AZ 85716-3102.
Drafting Living Wills After Schiavo

By Thomas J. Murphy, Esq.

For estate planning practitioners, the Teri Schiavo controversy has created a “good new, bad news” situation. The good news is that the Schiavo case heightened interest in the general public regarding the need to have a living will, also known as an advance medical directive. The bad news is that Schiavo poses a tougher challenge for practitioners by highlighting the need to draft living wills addressing the problematic issues that arise when family members cannot agree on treatment for a seriously ill person. The purpose of this article is to suggest new provisions for practitioners to include in the living wills they are drafting for their clients.

The Schiavo case first came into the public limelight in the spring of 2004 when the Florida legislature passed a statute that precluded Ms. Schiavo’s husband and guardian from withdrawing life support procedures. Since that time, I have reviewed hundreds of living will forms and have discussed the matter with many health-care providers and administrators, as well as other attorneys.

There are three deficiencies that I commonly see in the living wills (including my own) that I have reviewed. First, they only apply to a patient who has been diagnosed as terminally ill. However, many patients, to include Teri Schiavo, may be gravely ill and in an irreversible condition but are not considered to be terminal.

Second, virtually all living wills are premised on the fact that all family members know what the patient would want to have done and are all in agreement on this. But when a dispute erupts, living wills are silent on how to address and resolve this.

Third, living wills typically offer very little practical or precise guidance to the decisionmakers beyond some general platitudes about undertaking no heroic measures. With many state legislatures proposing tighter standards for ascertaining the patient’s intentions, providing some guidance will take on added importance.

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(continued on page 15)
Drafting Living Wills After Schiavo
(continued from page 14)

Given these concerns, I have some suggestions in drafting more effective living wills.

Terminal and Non-Terminal Conditions as the Triggering Event

Most living wills specifically apply to a terminally ill patient. But often the term “terminally ill” is not defined, which can create problems for healthcare providers. The most workable option is to use the Medicare definition of “terminally ill,” defined as “death occurring within six months of the diagnosis if the condition runs its normal course.”

But this does not solve all the problems. Several gerontologists have emphasized to me that patients with advanced Alzheimer’s or who have suffered a serious stroke are never considered to be terminal. It would also not include those patients in an irreversible coma or persistent vegetative state, nor those patients who may be conscious but enduring an unacceptable quality of life due to the injury or illness.

As a result, I have revised my living will to address three categories of conditions that will allow the agent or agents to make the decision regarding end-of-life care:

a) an incapacitated person who is terminally ill,

b) irreversible coma, brain death or persistent vegetative state, and

c) a greatly diminished and, hence, unacceptable quality of life.

The first category is for the incapacitated and terminally ill patient. I use the common probate code definition of “incapacity,” i.e., the inability to make or communicate responsible decisions about the person.

The second category of a patient’s condition is for an irreversible coma, brain death or persistent vegetative state (“PVS”). Teri Schiavo would have come within this category. Because of the media coverage of Ms Schiavo, I have already had several clients question the appropriateness of using PVS as a standard because much of the media raised questions about what a PVS diagnosis meant and even if such a condition actually exists.

Unfortunately, much of this discussion was very inaccurate and misinformed. Since the early 1990s, PVS has come to be a well-defined and recognized condition. The leading authority is the Multi-Society Task Force on PVS that issued a two-part article in 1994, in the New England Journal of Medicine that set forth the definition and clinical aspects of PVS. A diagnosis of PVS requires no awareness of self or the environment and an inability to respond to any visual, auditory, tactile or noxious stimuli. The distinguishing feature is intermittent sleep-wake cycles, where the patient opens his or her eyes with some reflexive response to external stimuli. But the response is only reflexive. There is no sustained visual tracking of an object or any fixation on a visual target. Likewise, other reflective actions such as gagging, coughing, chewing, blinking, smiling, grimacing or sighing may occur. Most PVS patients have fairly normal breathing and gastrointestinal functions and maintain a normal body temperature but are unable to experience pain, thirst or hunger.

There seem to be two main points to emphasize to a client who may have some reservations about appointing an agent if the client should ever lapse into PVS. One point is that the diagnosis can only be made if the patient lacks all awareness. The second point is that at least one month must elapse since the onset of the condition before a diagnosis of PVS can be made. In other words, a doctor cannot make this diagnosis within hours or days of admission to a hospital. This has been a frequent concern of my clients since Schiavo.

The third category of a patient’s condition that will authorize an agent to act is if the non-terminal patient is incapacitated and suffering an unacceptable quality of life. The patient may be conscious and somewhat alert, but the illness or injury has caused the patient’s condition to deteriorate to the point where life may no longer be worth living. This category would include the advanced Alzheimer’s patient or the patient who has suffered serious and irreparable injury from a stroke.

Guidance to the Agent/Decisionmaker

It is difficult for many of my clients to define or describe exactly when it becomes fruitless to continue treatment and accept a death occurring sooner than it otherwise might. It is also impossible to plan for every medical treatment or possibility.

This is where estate planning practitioners will need to get creative and even seek assistance from the medical community in drafting living wills. Most living wills are couched in terms of treatments, or what the medical community calls “interventions.” The typical living will will have the client check off yes/no boxes dealing with specific interventions like CPR, dialysis, transfusions or chemotherapy. But this is just a tiny portion of all possible interventions. What of the other thousands of interventions or future interventions not yet invented or widely used?

The doctors that I have spoken with strongly discourage this approach. Instead, they recommend a broad, goal-oriented approach. It focuses on the result the patient wants to achieve and not on how to reach that result. My new, revised living will lists the following criteria for the agent to consider when making a decision:

- Inability to walk without the assistance of others or a wheel chair
- Experiencing pain most of the time
- Experiencing discomfort (such as nausea, diarrhea or weakness) most of the time
- Inability to control my bladder and bowels
- Having a feeding tube inserted into my stomach and/or being unable to be fed by a spoon
- Use of a ventilator that is required to keep me alive
- Inability to recognize family or close friends
- Incurring costs for the provision of medical care that will create a financial hardship for me, my family or other loved ones

The idea is to provide some objective guidance to the decisionmaker. The living will should indicate that any one or more of these criteria tend to support the decision to withhold or terminate...
Drafting Living Wills After Schiavo
(continued from page 15)

terminate life support. In other words, the decisionmaker is not compelled to withhold life support if one or more of the criteria exist. Rather, they are simply factors for the agent to weigh when exercising his or her discretion.

When I began to use this approach, I was surprised with my clients’ reaction. Some wanted to include some of these criteria but not all. Different clients removed different criteria. As a result, I have the client initial which ones they agree with. I am also considering having a blank space next to each criterion and having the client use a scale of 1 to 5 to rank them in order of importance.

This is far preferable to the approach often taken by practitioners that simply authorize the withdrawal of life support treatment if the burdens of treatment outweigh the benefits. Such an imprecise test is an invitation to litigate if a dispute within the family erupts. It will also create problems in those states where legislation may be enacted to impose higher standards in proving the patient’s intentions.

Schiavo emphasizes the need to provide the decisionmaker with some delineated and objective criteria to consider when making the decision. This is not an easy task for the estate planning practitioner who is discussing this with a young and healthy client who has never given much thought to any of this. A goal-oriented approach has worked well for me.

Disputes Regarding the Withdrawal of Life Support

Another difficult issue in the Schiavo case was the dispute that erupted regarding decisions made by Ms Schiavo’s husband/guardian. Virtually every doctor or hospital administrator that I have spoken with have candidly admitted that it is the family member who complains the loudest who will, at least initially, control the decision regarding termination of life support treatment. In other words, a hospital ethics committee will not authorize the withdrawal of life support if there is a family member who is threatening to hire a lawyer or complain to a local television reporter. While estate planning practitioners can argue over whether a hospital can lawfully exercise such authority, it is a foreseeable situation that must be addressed when drafting a living will.

I have made three revisions to my living wills to address disputes. First, I have included a new paragraph, captioned “Resolution of Disputes,” that names a particular person to make the final and binding decision in the event of a disagreement.

Second, in that same paragraph, there is a provision that states who is excluded from the decisionmaking process, such as a troublesome child or in-law. This is to avoid what one colleague of mine has characterized as “the black hat on the white horse,” such as the child who has not been in contact with the family for many years but who suddenly appears and wants to control the decision. This provision should prevent this messy situation from impacting the decision.

Third, I have added a paragraph that specifically allows the agent to initiate litigation against the hospital, healthcare provider or family member who fails to promptly implement the agent/decisionmaker’s directives. This is already authorized under the Patient Self Determination Act, but it is always a good practice to include this language since this could be the tipping point in having the hospital honor the agent’s decision.

Likewise, a provision should be added that the patient or the patient’s estate will not be responsible for the payment of medical bills for services provided that are inconsistent with the patient’s desires. While this provision may or may not be enforceable, it may cause doctors and family members to think twice when the decision is made. Or a provision may state that any family member will forfeit their inheritance if they contest, interfere with or delay the patient’s expressed desires.

Other suggestions

Several other points should be kept in mind when drafting living wills. First, all practitioners should reacquaint themselves with the seminal United States Supreme Court decision in Cruzan v. Director, Missouri Dept of Health, 497 US 261 (1990) that held that there is a constitutionally protected right to refuse any and all health care treatment, to include the provision of nutrition and hydration. A state is permitted to require a surrogate decisionmaker to produce clear and convincing evidence of what the patient’s desires would have been, but it cannot otherwise infringe on that right. The federal Patient Self Determination Act (PSDA), which largely codified the Cruzan case, requires that all healthcare facilities must follow a living will or other advance medical directive. Cruzan and the PSDA should remind practitioners that they should not be constrained by restrictive state laws. Examples are where a state requires the use of a statutorily-created form, limits the decisionmaking authority to only certain irreversible or terminal conditions or to a certain period of time, or requires a doctor’s certification where the cessation of nutrition and hydration is prohibited.

Another point to consider concerns the termination of the provision of hydration and nutrition. The media in Schiavo repeatedly referred to “starving her to death” and of the pain that would result to Ms. Schiavo. This is not so. Patients do not starve to death.

(continued on page 17)
Drafting Living Wills After Schiavo
(continued from page 16)

in these situations. It is the lack of hydration that results in death. Withholding hydration causes death much faster than withholding nutrition. The lack of hydration creates renal (kidney) failure that causes a fairly painless death, usually within days and always within a month of the withholding. It also overlooks that food or fluids can be very distressing to a dying patient by making it harder for the patient to breathe and increasing the need for suctioning. It can also increase pressure on tumors, thereby increasing pain. Food and fluids can also induce nausea, diarrhea or swelling.

It should also be kept in mind that most of the justices in Cruzan stated that artificially-administered hydration and nutrition is a medical treatment. It requires consent by the patient or agent and a skilled clinician to implant and remove the feeding tube. There is nothing natural or non-invasive about it.

Encouraging clients to have “the talk”

No written document can take the place of a thorough discussion among family members about end-of-life issues. The silver lining of Schiavo is that, hopefully, more of these discussions have and will take place. Practitioners drafting living wills are simply trying to memorialize that discussion. The objective is to allow the agent/decisionmaker to make the best decision they can with the least amount of guilt. The agent should be able to say “That’s what Dad would have wanted us to do”. If so, the drafting attorney has done an exemplary job.

Thomas J. Murphy, Esq., is an estate planning, probate and elder law attorney in Phoenix. He can be reached at 480-838-4838 or by visiting his website at www.murphylawaz.com.

Endnotes
i. 42 CFR 418.3
vi. 42 USC 1395cc(a)

Call for Nominations
Annual Theresa Award

The Theresa Award is an annual community service award presented by the Theresa Alessandra Russo Foundation to a NAELA member in recognition of his or her advocacy and support of individuals with disabilities. Through the efforts of this NAELA member, individuals with disabilities are able to achieve a better quality of life, protect their rights and preserve their dignity.

There are many NAELA members who are worthy of this community service award. It is a wonderful opportunity for a NAELA member to nominate a colleague who is “making a difference” in the lives of those in need. Please let us know who you would like us to consider. We need to hear from you!

The recipient of the award will be announced at the NAELA Symposium and honored at the Theresa Foundation’s Annual Awards Dinner, held in the Spring.

The Theresa Foundation will also contribute a cash grant of $2,500 to an organization named by the recipient of the award, that assists and supports children with special needs.

Nominations can be made by contacting NAELA Executive Director, Laury Adsit Gelardi at 1604 N. Country Club Road, Tucson, AZ 85716-3102; they can be faxed to her at (520) 325-7925. Nominations are accepted throughout the year.

For more information, call Laury Adsit Gelardi at (770) 850-0015, ext. 113 or Vincent Russo at (516) 683-171, ext. 2131. Nominations will be considered by an awards committee comprised of past recipients of the Theresa Award as well as Vincent J. Russo and Laury Adsit Gelardi, who are board members of the Theresa Foundation.

Additional Sources
It helps to have clients elaborate on their thoughts and goals for end-of-life issues by reviewing and completing a values questionnaire. There are a number of good questionnaires on the Web. Two of the best are the Values History Form published by the Institute for Ethics of the University of New Mexico Health Sciences Center, available at http://hsc.unm.edu/ethics/advdir/vform_eng.shtml and the Caring Conversations questionnaire published by the Center for Practical Bioethics in Kansas City, available at www.practicalbioethics.org/mbc-cc.htm.

Two useful sources for drafting living wills are the popular Five Wishes booklet that can be purchased for $5 from www.agingwithdignity.org and the Lawyer’s Tool Kit for Health Care Advance Planning published by theABA’s Commission on Legal Problems of the Elderly, available at www.abanet.org/elderly.

FAQs about NAELA’s Senior Rights Political Action Committee

Q Why do we have a Senior Rights PAC?
- To assist congressional candidates who support our goals and objectives
- To increase NAELA’s access to Members of Congress
- To educate Congress about the needs of the elderly and individuals with disabilities
- To promote understanding of the work of elder law attorneys

Q To whom does the SR-PAC give money?
- Republicans, Democrats, Independents, Senators, and Representatives who are running for office or are up for re-election
- Candidates who are committed to our goals and the interests of our clients, such as those who supported the Elder Justice Act and improvements to Medicare
- Candidates who have been sympathetic to our concerns about Medicaid cuts and punitive changes to asset transfer rules
- Candidates who have shown an interest in working with NAELA on issues of mutual concern and interest to our clients, such as the Older Americans Act
- Candidates who need to hear more about our clients’ needs

Q How do we raise money for the SR-PAC contributions?
- Regularly scheduled Happy Hours at NAELA Institutes and Symposia, held in conjunction with the Public Policy Committee
- Fundraisers like Comedy Night at the 2005 Symposium and the UnFundraiser at the 2005 UnProgram
- Deputization: NAELA members are being deputized to raise money on behalf of the SR-PAC
- Contribution forms are available in membership packets and online contributions will soon be possible via the Government Affairs section of www.naela.org

Q Who are our strongest supporters?
Our strongest supporters are NAELA members who have a steadfast commitment to protecting the rights of elders and the rights of elder law attorneys to advise them. Contributors include the NAELA Board of Directors, Past Presidents, Fellows, Chapter Presidents, and YOU! Thanks for making a difference!

Q How much have we raised so far?
More than $128,000!

Q How much money have we given away?
In 2004, the first year of the SR-PAC’s existence, $28,000 was given to candidates.
To date, in 2005, $49,000 has been contributed to candidates, with another $35,000 pledged to candidates for 2005.

Q How do SR-PAC contributions translate into access to Members of Congress?
Political Action Committees are a major presence in the political process. NAELA’s SR-PAC enables PAC Director, Brian Lindberg, and NAELA members to attend fundraisers for congressional members and candidates. Fundraisers offer us an opportunity to meet with the Member of Congress and to discuss the critical issues of the day as they relate to elder law and our clients. On occasion, NAELA members have attended fundraisers in the home states of their own senators and representatives and in DC.
Which Members of Congress has the SR-PAC contributed to this year?

**Democrat**
- Sen. Max Baucus (MT) Finance
- Sen. Jeff Bingaman (NM) Finance; HELP
- Sen. Hillary Clinton (NY) Aging, HELP
- Sen. Kent Conrad (ND) Budget; Finance
- Sen. Blanche Lincoln (AR) Aging, Finance
- Sen. Jack Reed (RI) HELP
- Sen. Harry Reid (NV) Leadership
- Sen. Charles Schumer (NY) Finance; Judiciary
- Sen. Ron Wyden (OR) Finance; Aging
- Rep. Anna Eshoo (CA-14th) Energy & Commerce
- Rep. Nancy Pelosi (CA-8th)

**Republican**
- Sen. Norm Coleman (MN)
- Sen. Susan Collins (ME) Aging
- Sen. Mike DeWine (OH) HELP; Judiciary; Approp.
- Sen. Mike Enzi (WY) Budget; Aging; HELP
- Sen. Bill Frist (TN) Leadership
- Sen. Chuck Grassley (IA) Finance
- Sen. Jon Kyl (AZ) Finance; Judiciary
- Sen. Gordon Smith (OR) Finance; Aging
- Sen. Olympia Snowe (ME) Finance
- Sen. Arlen Specter (PA) Judiciary
- Rep. Dennis Hastert (IL-14th) Leadership

**Senate/House Committee Key**

- Aging = Senate Special Committee on Aging
- Appropriations = Senate Appropriations Committee
- Budget = Senate Budget Committee
- Energy & Commerce = House Energy & Commerce Committee
- Finance = Senate Finance Committee
- HELP = Senate Health, Education, Labor and Pensions Committee
- Judiciary = Senate Judiciary Committee
- Leadership = Senate or House Leadership Officer
- Ways & Means = House Ways & Means Committee

The purpose of the SR-PAC is to help elect candidates who will support the goals and objectives of NAELA. SR-PAC funds are used to make contributions to candidates for public office. The contribution amounts listed are only suggestions; more or less may be contributed (subject to a limit of $5,000 per donor per calendar year). The amount given, or the refusal to give, will not benefit or disadvantage a NAELA member. You may refuse to contribute without reprisal. Only members of NAELA may be solicited to contribute. We may not accept contributions from corporations, foreign nationals, federal government contractors, or by one person in the name of another person, nor may we accept contributions of more than $5,000 per calendar year from any one contributor. Contributions are not tax deductible. Federal law requires us to obtain and report the name, address, occupation, and employer of each contributor who gives more than $200 in any calendar year.
Letter to the Editor  
*By Michael F. Loring*

I attended the “Debate” sponsored by the CATO Institute between Attorney Vincent Russo, Past President of NAELA, and Mr. Stephen Moses, President of the Center for Long Term Care Reform. The debate was structured similar to a Presidential Debate with opening statements and questions from the speakers to one another. The positions of the speakers were, as expected, pro Medicaid (Attorney Russo) and anti Medicaid (Mr. Moses). The audience was comprised of various groups representing the elderly, legislative staff persons from House and Senate Committees, and approximately 20 - 25 members of NAELA from various states.

As an observer of the debate, I felt that each speaker made their points, but that Attorney Russo (biased as I am) clearly and succinctly provided to the audience the realization that the proposed Medicaid changes filtering their way through Congress would cause more injurious hardships to the elderly and people with disabilities then presently exist today.

Attorney Russo dispelled many of the propositions advanced by Mr. Moses and one in particular, that Elder Law Attorneys (whom Mr. Moses says should be disbarred) are not money hungry predators of the Elderly, but rather advocates for the Elderly. Attorney Russo stated unequivocally, “I am proud to be an Elder Law Attorney.” As NAELA Members, we are also proud to be Elder Law Attorneys and to wear that label with pride.

NAELA Members owe a huge THANK YOU to Vincent Russo who accepted the challenge to participate in the debate and spent countless hours preparing his position paper and his remarks for the debate. Additionally, a thank you should also be given to Brian Lindberg and the staff of Kellen Company who assisted Attorney Russo in preparation for this debate, but most of all, to Vincent Russo who made us all proud to be NAELA Members.
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A Changing Supreme Court: The Stakes for Older Americans

By the National Senior Citizen's Law Center (NSCLC)

President Bush, announcing his July 19 nomination of John J. Roberts as Associate Justice of the Supreme Court, aptly said, “The decisions of the Supreme Court affect the life of every American.” Older Americans are no exception to this truth. They have much riding on the changes that Roberts, now confirmed as Chief Justice, and Harriet Miers, just named to replace Justice Sandra Day O’Connor, could bring to the law.

Most Americans know well the basic guarantees this nation has committed to assure for our seniors: equal opportunity on the job while they remain in the workforce; income security after they retire; and access to quality, affordable health care. For decades, seniors have taken these protections for granted. That assurance has been provided by laws like Social Security, the Age Discrimination in Employment Act, the Americans with Disabilities Act, Medicare, and Medicaid. Now, many seniors are aware that those laws have come under fire on Capitol Hill.

Less widely understood is the stealth threat from the courts. In fact, the forces now lobbying Congress to repeal entitlements in Social Security, Medicaid, and other long-standing federal statutes have a Plan B. That “other plan” targets the judiciary. Their hope for the 21st century is that a new generation of activist federal judges will quietly, out of the public eye, strike down or undermine enforcement of the network of protections enacted through national dialogue during the 20th century.

Before confirming the President’s nominees to life-tenured seats on the Supreme Court, the Senate needs to examine whether they will use that power to advance this activist and undemocratic agenda for the judiciary, an agenda frequently packaged as judicial philosophies such as “federalism,” “property rights,” “originalism,” or the “constitution-in-exile.”

Already, under the present Court, opinions have been written that disparate the legitimacy of vital senior protections, opinions which future judges could invoke as precedents to threaten the viability of those protections.

Consider these examples:

- In 1993, Florida State University reneged on an agreement to implement a market-based salary plan that would have particularly benefited senior faculty members and other employees. In response, Professor Daniel J. Kimel and a number of his colleagues sued, alleging that Florida State had violated the federal Age Discrimination in Employment Act (ADEA). Professor Kimel’s complaint typifies challenges that confront aging Americans. As workers become more seasoned and experienced, they—perversely—face more job risk and less security. Congress enacted the ADEA precisely to give older workers a shield against this pervasive workplace hazard.

- In January 2000 a narrow 5-4 Supreme Court majority threw Professor Kimel and his colleagues out of court. Kimel’s age discrimination claim was not important enough to subject the state of Florida to liability, even if it had violated the law. The reason, the five justices asserted, is that, “older persons, unlike those who suffer discrimination on the basis of race or gender, have not been subjected to a history of purposeful unequal treatment.”

- In 2001 the same type of Alice-in-Wonderland logic was invoked by the same 5-4 majority to bar the courthouse door to Patricia Garrett. She had lost her Director of Nursing job at the University of Alabama in Birmingham Hospital after taking medical leave for breast cancer treatment. Once again, the justices—dismissed disability-based discrimination as less sympathetic than race or sex discrimination. Few older Americans are immune from fear of the double whammy that hit Patricia Garrett—a temporary encounter with disability that then leads to long-term economic catastrophe.

In numerous other cases involving vital senior safeguards, the current Supreme Court has similarly been split down the middle. Chief Justice Roberts and Miers, if confirmed, will decisively affect future resolution of the issues at stake in these cases. For example:

- whether beneficiaries of entitlement programs such as Medicaid can enforce their federal rights to treatment in court—in many instances the only effective tool for ensuring that states spend federal funds in accordance with federal guarantees to patients;
- whether government social programs—such as nursing home safety standards—should be immobilized by courts, by requiring governments to compensate regulated facilities for the costs of complying with regulatory requirements;
- whether employers are immune from liability under the Age Discrimination in Employment Act unless plaintiffs can prove actual intent to discriminate on the basis of age—an interpretation that would render most age discrimination claims nearly impossible to prove;
- whether states are barred from guaranteeing independent medical review of HMO denials of coverage under health insurance plans.

In the latter case, a 5-4 decision in which retiring Justice Sandra Day O’Connor’s vote was necessary to preserve patients’ opportunity for independent review of HMO coverage denials, Roberts as a private lawyer argued the contrary view on behalf of an HMO client of his law firm. That fact does not demonstrate what his position would be as a judge. But it does underscore how great a difference could be made by his replacement of Chief Justice Rehnquist and Miers’ replacement of Justice O’Connor.
Book Review

By Tonya Gabbard, Esq.

Planning for the Future: Providing a Meaningful Life for a Child with a Disability after Your Death

By L. Mark Russell, Attorney, and Arnold E. Grant, Attorney

NAELA member, L. Mark Russell, Esq., and co-author, Arnold E. Grant, have recently written a new book that will be an excellent resource for parents who have a child with a disability, and also for the attorneys who advise them. The book contains an excellent summary of planning devices that are familiar to most NAELA members, such as special needs trusts, OBRA trusts, guardianship, basic Medicaid planning, powers of attorney, and estate and income tax planning. In addition, the book contains detailed discussions about a number of planning issues that are unfamiliar to many NAELA members, yet are vitally important to parents who have a son or daughter with a disability, including:

- Methods of dealing with the excess resource problem when parents or others have mistakenly transferred property to a child with a disability. Interestingly, the answer differs depending on the age of the child, the nature and severity of the disability, and the manner in which the property is held (whether in the name of the child, in a joint account with a parent, in an UTMA account, or in an improperly prepared trust);

- An extensive discussion of relevant government benefit programs, including special rules designed to permit people with disabilities to work while still qualifying for SSI, SSDI and Medicaid, such as the Ticket To Work Program, the Student Earned Income Exclusion, the Plan For Achieving Self-Support, the Trial Work Period, the Unsuccessful Work Attempt, Impairment Related Work Expenses, Subsidy and Special Work Conditions, and various types of Extended Periods of Eligibility;

- The importance of the Mental Health Power of Attorney for families that have a member with mental illness;

- Life planning issues relating to residential alternatives, educational opportunities, employment options, and social/recreational activities. (Although not strictly legal advice, parents have major concerns regarding these issues and are very appreciative of advice in these areas);

- Forms for preparing the Letter of Intent, which parents can use to convey vital information about their child to future caregivers;

- Financial charts for computing the amounts required to be placed in the special needs trust. The amount varies depending on anticipated expenses, the life expectancy of the child, and assumptions relating to inflation and rate of return;

- Methods of reconciling the needs of elderly parents with the needs of a child with a disability when engaging in Medicaid planning for the entire family;

- Planning for personal injury and workers compensation settlements, and methods for reducing the impact of Medicare and Medicaid liens, and maximizing future benefits.

This is actually the fifth edition of this critically useful book. Attorneys Russell and Grant first wrote the book in 1993, and it was out of print for some time. The 2005 edition is now completely revised and over 600 pages in length.

Attorney L. Mark Russell is a NAELA member and has a family member with a disability. For fifteen years he has concentrated his law practice on estate planning for families who have a child with a disability. Attorney Arnold Grant, former adjunct professor of tax at Chicago-Kent College of Law, is a partner in the law firm of McGuire Woods, LLP and is nationally recognized for his work on issues relating to tax and estate planning.

The book is available online at www.specialneedslegalplanning.com, or by phone at 1-800-247-6553. The introduction and table of contents are available on the website at no charge.

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A CALL FOR NAELA BOARD OF DIRECTORS NOMINATIONS

NOMINATIONS MUST BE RECEIVED NO LATER THAN January 15, 2005.

Are you tired of sitting on the sidelines? Are you ready to share your experience and expertise? Here’s your chance to help lead the association dedicated to furthering the profession of elder law.

NAELA is currently seeking members to serve in the following leadership positions on its board of directors: President-Elect, Vice President, Treasurer, Secretary, and seven directors. The officer positions are one-year positions, and the director positions are for two-year terms.

You can make a difference! With change occurring at fast speed this opportunity to serve on the NAELA Board of Directors will put you in the driver’s seat.

THE BENEFIT PACKAGE
● A role in advancing your profession.
● Exposure to a wealth of personal and professional contacts.
● Access to up-to-date information about the challenges facing your practice in the future.
● The chance to exchange ideas and perspectives with other volunteer leaders.

QUALIFICATIONS
● Demonstrated commitment to NAELA and the profession of elder law.
● Strong background in committee and volunteer work on a local and/or national level.
● A proven track record on affecting change.
● Ability and commitment to dedicate the time to attend three in-person board meetings per year.
● A proven team player.

WE WANT TO HEAR FROM YOU
If you are interested in serving or know of potential candidates, please send a letter of interest and a resume to: Susan McMahon, NAELA Associate Director, at NAELA, 1604 N. Country Club Rd., Tucson, Arizona 85716; Fax (520) 325-7925 or by e-mail at: smcmahon@naela.com.