

Elder Law Update, April 2009

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1 HEALTH CARE REFORM

This is the year that significant changes in our health care financing system will likely be enacted by Congress. The challenge before Congress and President Obama is to provide better access to health insurance for the 50 million Americans without coverage, while improving quality and lowering the cost of care.

Health care reform is likely to focus on two fundamental concerns - 1) coverage of the uninsured and 2) controlling health care costs. In terms of coverage, most of the 50 million people without health insurance are working families who are without employer coverage and who just cannot afford the cost of insurance.

Most of these families have income that is less than two times the federal poverty level—that is, less than about \$40,000 for a family of four. The average cost of health insurance premiums for such a family is roughly \$13,000 per year. Obviously, a family with low income cannot afford expensive health insurance. The result is that many Americans have no health coverage.

Many of the uninsured go without preventative health care and then develop serious illnesses. The uninsured are then hospitalized for problems that could have been avoided. The unpaid cost of these treatments is then passed on to the private or government health care system in the form of increased premiums and costs of care for the insured. Therefore, one aspect of health care reform will be to expand insurance coverage to pick up these uninsured families.

The second focus of reform will be on reducing the cost of health care in the United States where we expend much more per capita than any other country in the World. Our disproportionately high costs are due to a variety of factors. One factor is the high administrative costs. One of the big goals of the Obama Administration is to reduce administrative costs by making all health care records standardized and electronic. The inefficient storing of medical records makes it difficult to coordinate care, measure quality and leads to medical errors. Although it would be expensive and challenging to implement, most experts agree that the anticipated savings in the delivery of health care could be substantial.

Another factor may be our tort law system, which critics would argue creates a highly expensive defensive medicine practice.

President Obama has proposed a set aside of \$634 billion in a reserve fund for health care reform. The White House has been short on details regarding the elements of health care reform, preferring to rely on Congress to develop the plan.

Nevertheless, there is a good chance that health care reform will involve the creation of a new federal insurance plan. It would be available to anyone at any age. Employers would be required to help pay for the plan. This public health insurance plan would be an alternative to the private insurance system.

This federal insurance program represents a big threat to the private insurance industry. Critics of President Obama's plan suggest that such a federal insurance plan would drive private insurers from the market. The government's buying power will essentially create a below market cost for medical goods and services. Without the need to create a profit, government insurance can always trump a private insurer from a cost standpoint. And if enough consumers are attracted to the federal insurance program, the pool of privately insured will decrease, driving up premiums and rendering private insurance significantly less attractive.

Medical providers are also concerned that a new government program would essentially behave like Medicare. Medicare has long been known to underpay for services - close to 71% of private rates for hospital services and 83% for doctors services. In response to the President's proposal, the American Medical Society issued a cautious statement asking to evaluate the details of the plan before they pledged support, noting the history of under-funding to the current public programs.

Advocates and critics of health care reform are carefully watching the developments in the Massachusetts health care plan. This state-version of a universal health care plan was launched in 2006. The program required all state residents to join and businesses to pay into the program. Due in part to massive early enrollment of the previously uninsured, the state's overall costs of the health care program jumped a staggering 42% since 2006. The Massachusetts government recognizes that the plan will not be sustainable over the next 5-10 years if they do not take steps to curb the growth of health care spending. Thus, the state is taking steps to investigate the introduction of cost controls. This is the great fear that **keeps** many stakeholders such as doctors, hospitals, insurers and consumer groups wary of the federal universal health care plan.

President Obama has proposed some cost cutting efforts to help pay for the health care reform:

- He would increase prescription drug coverage premiums for Medicare beneficiaries who have higher income. ;

- He would save an estimated \$176 billion dollars over 10 years by cutting Medicare payments to Medicare Advantage plans. These plans are a private alternative to traditional Medicare. They provide additional services such as vision, hearing and dental care. Such benefits cost the government an average of 12-14% more than a traditional Medicare benefit.

- He would also engage in bundling of payments to hospitals. This plan would pay hospitals under the Medicare program for services that arise not only in the hospital, but also in the month after the patient left the hospital and received care in a nursing home or home health agency.

Both the President and the Democratic leaders concede that the cost of the health care reform will exceed \$1 trillion dollars. And critics of the plan fear that the costs could skyrocket much like the situation in Massachusetts. Actual savings in such a plan may not be seen quickly and may not be seen absent cost controls. For the most part, the discussion of health care reform has not even addressed the separate but related issue of the cost of long term care.

Details of health care reform will emerge over the next few months. Both the House and Senate have agreed in principal to fund the health care plan. The recent defection of Arlen Specter to the Democrats is likely to give them a filibuster proof majority in the Senate. It therefore seems likely that health care reform will be enacted by the end of the year.

2. STATE BUDGET & BAILOUT FUNDS

The downturn in the economy has hit all state budgets hard. Pennsylvania is no exception. At the end of the first quarter in 2009, Pennsylvania posted a budget deficit of \$1.6 billion. Pennsylvania did receive some of the so called "bailout" funds, including an increase in the Federal Medicaid Percentage of 6.2 % through December 2010. Therefore, Pennsylvania will share a smaller percentage of Medicaid funding with the Federal government.

While the governor's current state budget proposal includes increases to the Medicaid program, the State Senate Budget Bill includes significant cuts. Some of the cuts reportedly take into account funds received by the Federal Government. But on their face, they appear to slash otherwise popular programs, like funding for Autism - by over 25%.

The Governor's budget also includes proposed changes to the Medicaid Estate Recovery Program...

3. EXPANSION OF ESTATE RECOVERY PROPOSED

Currently, The Estate Recovery Program seeks to recover assets of an individual over age 55 who received Medicaid for long term care services in a facility or the community. Under this Program, The Department of Public Welfare has a statutory lien on probate assets up to the amount of Medicaid paid to the deceased. The probate estate includes assets that are solely titled in the name of the individual upon his or her death. Probate is the court controlled process by which these assets are distributed to beneficiaries, typically through a will. The Medicaid lien has priority over interests of the beneficiaries of the probate estate.

With few exceptions, the Department of Public Welfare has not pursued non-probate disposition of assets, such as joint accounts with the right of survivorship, life estates, living trusts, and life insurance policies. Non-probate assets pass to beneficiaries pursuant to separate contract, outside of the terms of a will and consequently without the need for probate.

The Department's limitations on recovering non-probate assets may soon change. On April 28th legislation was introduced that would expand the reach of Medicaid Estate Recovery. The legislation would grant the Department the ability to recover against property passing through accounts or real estate held as Joint Tenancy With the Right of Survivorship, Tenancy by the Entireties and Life Estates.

As drafted, such legislation (Section 1412 of House Bill 1351) would not honor the creation of assets made joint well beyond the 5 year look back period. More information on the proposed expansion of Estate Recovery is available on website of the [Pennsylvania Association of Elder Law Attorneys](#).

4. FAMILY CAREGIVER SUPPORT ACT

Other potential changes in state law include an amendment to the Family Caregiver Support Act. As you may be aware, this Program helps families caring for a loved one at home who is over 60 and needs assistance with the activities of daily living.

New legislation would increase the amount available to qualified primary caregivers from \$200 per month to \$500 per month. The amount of one-time grants for home modification devices - such as stair climb or modifications to a bathroom - would increase from \$2,000 to \$6,000. These would be the first increases in the program since 1990.

This is the 5th attempt at passing legislation to amend the Family Caregiver Support Act. As in previous legislative sessions, the State House has acted quickly to pass its bill. The bill is currently in the Senate Aging and Youth Committee; and will then likely proceed to the Senate Appropriations Committee, where it unfortunately stalled last year.

5. ASSISTED LIVING REGULATIONS

As you may recall, our state enacted legislation in 2007 that created a new class of assisted living providers. These facilities are intended to serve those individuals with higher care needs than those currently in our personal care residences. These new residences would be entitled to Medicaid benefits through the state's Department of Aging Waiver Program.

Assisted living regulations were proposed by the Department on August 9, 2008. Comments to the regulations were submitted by many concerned parties, including industry and consumer advocacy groups. Many of the issues focused on how much space should be required in the assisted living units and training of the staff. These needs are being weighed against the cost of their implementation.

The Elder Law Section of the Pennsylvania Bar Association also recently submitted its comments on the proposed regulations. The Bar pointed out several areas of concern.

One specific area is the lack of an initial pre-admission assessment that would identify whether a consumer can be adequately served in the assisted living facility. As proposed, the regulations put consumers in the position of having to move into a facility without knowing for certain if they will be able to remain there.

Another concern is the lack of an appeals process for a resident who is being discharged. If a facility determines that it can no longer meet the needs of a resident, the proposed regulations offer the resident no process to object to or appeal the facility's decision.

The Department of Public Welfare has been in the process of reviewing and addressing the comments. Officials from the Department are hopeful that revised Assisted Living Regulations will be completed by Summer and that the Regulations can be published by Fall. Once the Regulations are in place, the Department will move to request that Medicaid Waiver benefits be made available to select residents of these facilities.

6. AGING WAIVER APPROVED

In conjunction with the creation of assisted living regulations, one of the state's primary long term care goals is to shift residents out of nursing homes and into the community. Most of our clients would prefer to receive care in their homes rather than a nursing home. In-home care can be less expensive than institutional care. Payment for in-home care is available through several sources, including Medicaid funding via the Department of Aging's Waiver Program.

The Department of Aging Waiver Program is for those persons 60 years of age and older who are medically eligible for nursing home care and meet the financial criteria. Currently, there is an income limit for those who wish to qualify. In 2009, that income limit is \$2022 per month.

Every five (5) years, Pennsylvania must re-apply to the Federal government for the right to use the Department of Aging Waiver services. The recent Federal approval of the Aging Waiver program included several directives from the Federal authorities. They included a required clarification of the medical standard for eligibility under the Waiver program.

In order to be considered clinically eligible for either Medicaid nursing facility services or the Aging Waiver Program, an individual must be assessed and determined to need the level of care provided in a nursing facility. The Department of Aging conducts the Level Of Care assessments which the Department of Public Welfare uses to authorize Medicaid eligibility.

During its re-application for the Aging Waiver eligibility, the Federal government instructed the Department of Public Welfare to take measures to assure that Level Of Care assessments are conducted consistently throughout the Commonwealth. If you were unaware, consumers and their advocates had been expressing concerns about perceived inconsistencies in level of care assessments.

In order to address this concern, the Department issued updated guidance to the Area Agencies on Aging for use in conducting level of care assessments for Medicaid Nursing Facility and Waiver Services. One significant clarification specified that the consumer may be considered clinically eligible even though the consumer does not require Medicare skilled nursing services. An individual who needs intermediate care standard would meet the level of care criteria.

Other changes to the Waiver Program include:

- Consideration of policies that would allow for payment to spouses who are providing services to an eligible individual,

- Standardization of rates that may be charged by providers. Currently rates are set on the local level by the Area Agencies on Aging.

Previously managed by the Department of Aging, the PDA Waiver Program is now overseen by the Office of Long Term Living with the level of care assessments conducted by the Department of Aging.

7. MERGER OF DEPT OF AGING & OFFICE OF LONG TERM LIVING

The man over-seeing the Waiver re-application and the assisted living regulations is John Michael Hall, head of the Pennsylvania Office of Long Term Living - the Department that coordinates the work of the Department of Public Welfare and Aging. Mr. Hall's role was expanded greatly last year when Nora Dowd Eisenhower resigned as head of the Department of Aging. Mr. Hall then became acting head of the Department.

In his 2009 Budget, Governor Rendell has proposed to consolidate the Department of Aging with the Department of Public Welfare into a new Department of Aging and Long Term Living. The House Aging Committee recently held a public hearing on the proposed merger, where stakeholders from all sides of the issue were given the opportunity to give testimony. Many stakeholders expressed general support for the plan. However, some expressed concern about the details of the consolidation. They wanted assurances that current services would not be negatively impacted.

The consolidation is intended to improve coordination of services. The Department of Aging is essentially the gatekeeper to aging and disability programs for the elderly, while the Department of Public Welfare controls much of the funding eligibility. The Governor states that a single state department will be able to better coordinate and operate budgeting, policymaking and information technology, while creating a more efficient single point of contact for consumers and providers.

In the recent past there has been some tension between the Department of Public Welfare and the Department of Aging. It will be interesting to see if there are objections raised to this consolidation during the legislative process. Some of the Governor's goals would seem to imply a reduction in staffing, which may lead to considerable debate.

8. ANNUITY CASES

The Department of Public Welfare lost two Medicaid annuity cases in the last year. The cases of [James v. Richman](#) and [Weatherbee v. Richman](#), were both Federal court cases decided adversely to the Department.

In the Medicaid qualification field, immediate, irrevocable annuities serve to convert otherwise available resources to an unavailable monthly income stream. Available resources are those that are limited in amount when one wishes to qualify for Medicaid. Most of the liquid assets - bank accounts, stocks, bonds and so on are considered available to pay for one's care. If you have too many of these available resources, you cannot qualify for Medicaid. One way to reduce these resources is to buy an irrevocable, immediate annuity for the spouse of a Medicaid applicant for long term care services. These annuities convert a lump sum premium into monthly payments for a term of years.

These annuities work because the Medicaid Act defines monthly payments from an annuity as income. Income of the community spouse cannot be considered available to the Medicaid applicant. Therefore, the annuity payments from an immediate annuity, payable to the community spouse, are not available to the Medicaid applicant in the qualification process.

After the passage of the Deficit Reduction Act, the Department of Public Welfare issued detailed regulations surrounding the use of these annuities. One of the requirements is that you name the Department of Public Welfare as the primary beneficiary of the annuity up to the amount of Medicaid paid to the applicant.

One of the contentious issues between practitioners and the Department is the extent to which the Department can consider the income derived from an annuity a resource. The Department contends that so called "factor" companies (like JG Wentworth) will buy the annuity or its stream of payments for a lump sum (much like they buy lottery or personal injury annuities). Therefore, the annuity remains a resource up the amount that the factor company will pay for an annuity. This theory is not found in Federal law and has been the subject of some litigation.

One of Marshall, Parker & Associates clients purchased such an annuity in 2005. In that case, Mrs. James applied for Medicaid on behalf of her husband after buying the annuity. She received a Medicaid denial on the grounds that the annuity or the payments therefrom could be sold to a factor company for a lump sum. Therefore, the Department contended the amount of the lump sum represented an available resource, disqualifying Mr. James for Medicaid.

Mrs. James sued the Department of Public Welfare and the case was litigated all the way to the United States Third Circuit Court of Appeals. The Court issued its decision last November in Mr. James favor. The Court stated that 1) in accordance with Social Security regulations, the contractual provisions of the annuity prevented Mrs. James from selling the annuity or the payments therefrom, and 2) The Department's theory would contravene the well

held rule that income to the community spouse cannot be considered available to the institutionalized spouse in the application for Medicaid. The Department was consequently ordered to provide Mr. James Medicaid.

In January of 2009, a second case was decided against the Department on the same grounds. In the case of Weatherbee v. Richman, the same type of community spouse annuity was purchased as in the James case. The Department issued the same basis for the denial. That is, the Department believed that the annuity or the payments therefrom could be sold for a lump sum. The difference in this case was that this annuity was purchased after the enactment of the Deficit Reduction Act in 2005. The Department contended that provisions of the Deficit Reduction Act permitted a state via legislation or policy to consider the annuity as an available resource.

The Weatherbee Court rejected the Department's reasoning with reference to the James Third Circuit decision and further contended that the Deficit Reduction Act did not support the Department's theory. The Court concluded that the state's position was in conflict with Federal law permitting the creation of these annuities and consequently any such legislation or policy was not enforceable. The Weatherbee case has been appealed to the Third Circuit Court of Appeals.

9. JOINT ACCOUNT CASES: NOVOSIELSKI & PIET

A major decision out of our state Supreme Court is likely to be decided this year. The case involving the Estate of Novosielski, 937 A.2d 449 (Pa.Super 2007) has tremendous implications for those of you who are engaged in estate planning, financial planning or a practice that is exposed to the creation of joint accounts.

The case revolves around the how the intent expressed in the creation of a will affects the disposition of assets in later created joint accounts. Prior to her death, Alice Novosielski suffered from various psychotic disorders along with dementia. She had signed a power of attorney giving Thomas Proch authority to handle her financial affairs. Mr. Proch proceeding to consolidate Alice's substantial assets - about \$500,000 into one account - a treasury bill with the Federal Reserve Bank. Mr. Proch created the account jointly with Alice. The court record suggests that due to her illness, there is some doubt as to whether Alice understood the nature of the investment, let alone the impact of the joint ownership.

In Pennsylvania, joint accounts are controlled by the Multiple Parties Account Act, which provides that any sum remaining in a joint account at the death of a party belongs to the surviving party and not the estate of the decedent unless there is clear and convincing evidence of a different intent at the time the account is created. In this case, Alice had a will, drafted prior to the creation of the joint account wherein Alice left her estate to her surviving siblings and only \$5,000 to Mr. Proch.

Needless to say, the will was challenged by the surviving siblings when they realized that Mr. Proch had named himself as the joint owner on the Treasury Bill and was claiming the rightful heir of \$500,000. The case proceeded to the Superior Court in 2007 where the Superior Court developed some very unusual reasoning to rule against Mr. Proch. The Court concluded that the disposition set forth in a validly executed will can have the effect of

altering a later created joint account. That is, a will can represent clear and convincing evidence that the creator of a joint account does not intend the funds in the joint account to pass to the surviving owner.

This ruling baffled most estate planners. A will has the effect of disposing of solely owned assets at the time of your death. Assets held pursuant to a contract, such as joint accounts, life insurance, annuities, trusts or other such arrangements pass pursuant to that contract. The law has always been that a will only expresses one's intent with regard to solely owned assets, not those held in a joint account with the right of survivorship. After the decision in Novosielski, estate planners in Pennsylvania had to take steps to ensure that a will did not undermine other estate planning that employed joint accounts. Clients often want to leave a child's name on a bank account or certificate of deposit with the intent that a specific child receive those funds. But pursuant to Novosielski, those transactions would be undone by a previously executed will that had a different disposition.

The Supreme Court agreed to hear the Novosielski case, a sign that they may think the Superior Court erred at least on the basis for their conclusions. There are other ways to rule against Mr. Proch, if it is the Court's intent to bring some justice to the Novosielski family. This case has resulted in several other similar court decisions, including the Superior Court case - In the Estate of Piet. The sooner the Supreme Court clarifies the rules regarding the effect a will can have on the disposition of the joint account, the easier it will be for estate and financial planners to advise their clients.

10. FEDERAL ESTATE TAX

One of the hot topics facing the President and Congress is the status of the Federal Estate Tax system. Under legislation enacted in 2001, the so called Federal "death tax" is scheduled to expire in the year 2010. Currently, the exemption amount of individuals in 2009 is \$3.5 million. With proper planning, married couples can exempt up to \$7 million. The tax rates above the exemption start at 45%

This tax system is regularly the subject of political debate. It tends to affect the very wealthy and movements to eliminate the tax altogether have resulted in heated disagreements on party lines. The tax has a history of adversely affecting family farms and businesses where there does not exist sufficient cash available to pay the enormous tax obligation. An attempt to phase out the tax system during the last administration resulted in a compromise plan. Since 2001, the tax exemption has been steadily increasing to its current amounts. In 2010, it is scheduled to "sunset" or expire. Beginning in 2011, the exemption is scheduled to return to 2001 figures - that is, a \$1 million dollar exemption and 55% tax rates.

Don't count on that happening. It is highly unlikely that Congress would permit the tax system from expiring altogether. Studies have shown that repeal of the estate tax could cost the government \$1.3 trillion over the decade from 2012 to 2021. Under the current system in 2009, less than 1% of all estates will be subject to Federal estate taxes. On the campaign trail, President Obama stated that he supported capping the exemption at the current \$3.5 million exemption amount. The Congressional budget resolution reflects the President's cap at \$3.5 million with a tax rate of 45% beyond the cap. It is still possible that the staggering deficit and

proposed spending on health care reform could have an impact on the final version of the Estate Tax law.

11. ELDER JUSTICE ACT

With one party in control in Washington, new legislation may be passed that has previously been stalled. One such piece of legislation has bipartisan support and may be passed in the near future. Re-introduced by Senator Orrin Hatch and Blanche Lincoln, the Elder Justice Act is a bill that would seek to protect the elderly from abuse and exploitation.

Consistently introduced since the 107th Congress and unanimously supported by the Senate Finance Committee, the bill might finally become law. The Elder Justice Act would

- Establish the Elder Justice Coordinating Council to advise and coordinate responses by federal, state and local governments related to elder abuse;
 - Direct the federal government to collect data on elder abuse to increase understanding of the scope of the problem;
 - Implement penalties and prosecution for failure to report abuse and other crimes in long-term care facilities;
 - Ensure adequate resources and infrastructure are in place to better prevent and tackle abuse, treat the victims and prosecute offenders.
- To date our federal government has had a disjointed response to elder abuse and has dedicated few resources to combat the problem. For example, the government spends \$6.7 billion per year on child abuse. In contrast, the federal government spending on elder abuse totals \$153 million annually, a relatively small amount when considering that more than 76 million “Baby Boomers” will reach retirement age over the next three decades.

12. LONG TERM CARE INSURANCE

Hard times hit the long term care insurance industry in 2008 and 2009. All three of the big long term care insurers, Met Life, Genworth and John Hancock raised rates on their policy-holders. Met Life's rates were raised 18% for policy holders who purchased policies from 1998 through 2005. That is a big jump, considering the annual premiums are often \$3,000 per person. John Hancock's policies were raised 14 % on policies issued before 2000. Genworth, which had a reputation for not raising premiums, also raised them 8 to 12% on pre 1997 policies.

The increases are due to a variety of factors. Most agree that pricing is based upon assumptions, including the rate of policy lapses, interest rates and the number of claims to be filed. Long term care insurance is proving to be a challenging insurance product for companies as very few of these policies are lapsing and the number of claims are larger than anticipated. Add the woeful interest rates to the equation and you have the inevitable response of increased premiums.

Two already troubled long term care insurers exited the marketplace. Consec transferred about 140,000 of its long term care policies to a state supervised trust. As many of you are aware, Consec has for years struggled to make payments on the claims under these policies. The trust will pay the claims from a pool of \$175 million in capital transferred to the trust. But the trust may need to raise rates or reduce benefits to make those claims as it has no other source of additional capital.

The story is not much better for Penn Treaty which was placed into court ordered financial rehabilitation, a process by which the struggling insurance company's assets will be restructured to meet the company's obligations. If rehabilitation is unsuccessful, the company will have to be liquidated

For long term care policyholders, their policies are guaranteed renewable. Therefore, they will not be cancelled provided the policyholder continues to pay the premium. Even if Consec's Trust becomes insolvent or Penn Treaty is liquidated, there are state funds that guarantee a long term care policy up to a maximum of \$300,000 per policyholder. Unfortunately, when an insurance company enters receivership, a frequent consequence is a significant increase in premiums.