

The Polner Abrahams Report

The Source For Intelligent Estate and Elder Law Planning

Courtesy of The Law Office of Beth Polner Abrahams

Volume 1 Issue 1

Focus On...

Medicare and The Drug Plan Update

Forewarned is forearmed. While designed to provide assistance with drug costs and save money, the new Medicare law only partly accomplishes its goal. In truth, it is confusing even to experts, and poses administrative hurdles that could be difficult to overcome.

What are the options? Beginning January 2006, Medicare beneficiaries—seniors over age 62 and disabled persons—are required to select and enroll in a drug plan if they do not have **comparable coverage**. The penalty for not complying is 1% of the monthly premium when you do enroll. The Federal government will offer Medicare Part D (similar to a drug HMO) or beneficiaries may enroll in a private plan that has contracted with the Federal agency, CMS. The new law permits private plans to set their monthly premiums (with partial subsidies by Medicare) and choose which drugs to include in their plan. The government estimates an initial monthly premium of \$10–\$67 for plans with annual premium increases. You will not be penalized if you enroll by May 2006.

Which drugs will be covered? This is confusing and is expected to be contentious among providers, seniors and advocates. Covered drugs will vary from plan to plan, and each plan will be allowed to develop a list of covered drugs called a **formulary**. Medicare will develop a model for **therapeutic classes** of drugs and private plans will be required to cover two drugs in each therapeutic class. However, plans may change their list of covered drugs during a year even if it

means a drug is dropped from a plan. Plan enrollees—except Medicaid recipients—may only change their plans once per year during the enrollment period. It is hoped, but not yet confirmed, that Medicare recipients will be given prior written notice of changes to drug lists.

How much will drugs cost? The new law is also controversial in that it does not permit the Federal government to

use its clout to negotiate drug prices with manufacturers, as the Veterans Administration already does. Instead, each private plan must negotiate for manufacturers' discounts and with pharmacies for additional reductions.

What will the Medicare beneficiary pay for drugs? While designed to provide drug coverage for all seniors and the disabled, the law differentiates between low and higher income persons, and between those with minimal and higher drug expenses. There are additional differences for Medicaid/Medicare recipients who are called **dual eligibles**. Medicare beneficiaries will pay an annual deductible of \$250. In addition, each year, for drug

Welcome to the debut issue of my quarterly newsletter.

Each edition will address concerns of the elderly and disabled, their families and guardians. Please email your comments and topic suggestions to Info@bpaElderLaw.com.



For over 23 years, I have provided quality legal representation to seniors and the disabled, plus customized estate planning to meet the personal needs of families, their children and other loved ones. My broad legal background includes federal and state litigation and appeals in the New York State Appellate Division and Court of Appeals, advocacy for equal housing opportunity under federal and New York State law and banking law.

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costs of \$251–\$2,250, the Medicare beneficiary will pay 25% with the balance paid by Medicare; for drug costs of \$2,251–\$5,100, there is no drug coverage (called the **donut hole**), so the Medicare beneficiary pays 100%. Some plans may permit the purchase of listed drugs at a discount for the donut hole in coverage. When drug costs exceed \$5,100, coverage begins; the senior or disabled person will pay either 5% of the drug cost, or \$2 for generic drugs and \$5 for brand-name drugs.

What about dual eligibles? Medicaid recipients—including home care, persons in nursing homes and in waiver programs—will also be required to enroll in a Medicare drug plan. If incapacitated, their legal guardian or representative will bear the responsibility for enrollment. As of January 1, 2006, Medicaid will no longer provide drug coverage. There will not be a donut hole for drug coverage from \$2,251–\$5,100 of drug costs. Enrollment for Medicaid recipients is expected to begin mid-November 2005 and must be completed before January 1 to avoid any gap in drug coverage. For Medicaid recipients or their representatives who do not choose a plan, Medicaid will automatically enroll the recipient in a randomly selected plan beginning March 15, 2006. This does not ensure proper drug coverage for needed prescriptions and leaves a potential lack of coverage for several months. Enrollment is therefore critical for dual eligibles.

Low income seniors and the disabled who are **not** Medicaid recipients will also be able to receive premium subsidies, and cost sharing for drugs will be greatly reduced or eliminated. Because EPIC is considered **comparable coverage**, enrollees are not required to enroll in a drug plan or Medicare Part D. Subsidies are also available, and low-income seniors and the disabled who have not received an application for a drug discount subsidy should contact the Social Security Administration.

What happens to other insurance coverage for drug plans? Many seniors and disabled persons are currently covered by employer/retiree plans and private health insurance plans with drug coverage called **medigap** plans. At present, it appears that employer-sponsored plans will be permitted to continue drug benefits as **credibly equivalent plans**, but seniors may still be required to enroll in a Medicare drug plan if these do not meet the criteria. For private health insurance such as Medicare gap or supplemental plans, it is preferable to enroll in a Medicare Part D plan to avoid the premium penalty, just in case gap coverage is not sufficient in the future or coverage is not legally comparable.

What if the senior/disabled does not enroll by January 1, 2006? Failure to enroll will result in higher Medicare drug premiums. A penalty will be charged for each month the person has not enrolled. The penalty is expected to be 1% per month of annual premiums nationally. For example, if a senior fails to enroll in the basic Medicare Part D plan for 36 months and then needs drug coverage, the premium will be 36% more than the annual premium for new enrollees.

How can a plan be selected? The Federal Medicare agency, CMS, has established a website at <http://www.medicare.gov> for information and comparison. At least one nonprofit has created a section on its website to assist seniors and the disabled at: <http://www.medicarerights.org>. What is clear, unfortunately, is that seniors and the disabled will have to sift through a large quantity of information in order to make informed decisions about enrollment. Low-income seniors and the disabled without access to the Internet will require additional assistance to make informed choices. Since enrollment will begin in November 2005, gathering this information should not be left to the last minute.

Update on Health Care Decision-Making

The **Health Care Decisions Act** became effective in New York State in March 2003, allowing 17-A Surrogate Court guardians of mentally retarded persons to make end-of-life decisions for their wards. The Act does not include guardians for developmentally disabled adults. Many parents have loved ones with aspects of both diagnoses.

Then, on June 13, 2005, the New York Appellate Division reached a decision barring the retroactive application of the Health Care Decisions Act to guardians who received their appointments before March 2003. The decision held that there is no legislative basis for retroactively permitting guardians for mentally retarded persons to make end-of-life decisions despite the safeguards and procedures in the law.

A new medical certification form for physicians and psychologists for 17-A proceedings can be found at www.courts.state.ny.us/forms/surrogates. The form certifies that the mentally retarded person (or other classification) is not (or is) capable of understanding and appreciating the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and is unable to reach an informed decision to promote his or her own wellbeing. Guardians appointed for a mentally retarded loved one will have an additional statement on their letters of guardianship which permits them to make all health care decisions including end-of-life decisions under **Surrogate Court Procedures Act 1750-b**.

Still unanswered is whether **Amended Letters of Guardianship** for a mentally retarded person will be treated as 'new' letters post-March 2003. Amended Letters of Guardianship usually occur if a standby guardian is certified following the

death or resignation of a guardian. Also unanswered is whether it will be possible to obtain Amended Letters upon the presentation of an updated medical form with a request for Amended Letters. Many Surrogates are in the process of developing new policies to address this issue.

In response to these judicial decisions, the N.Y.S. Legislature introduced legislation to address end-of-life decision-making for developmentally disabled persons under **Assembly Bill No. 8274**. The bill passed the Assembly on June 15, 2005 and was referred to the Senate as **Bill No. S5323** on the same day. The bill was delivered to Governor Pataki on October 6.

Additionally, legislation has been proposed to add a new section to the Public Health Law called the **Family Health Care Decisions Act**. The legislation will create a process for empowering an individual to make health care decisions for persons who lack capacity and who have not signed a health care proxy nor left clear and convincing evidence of their health care treatment wishes. The **Senate Bill No. 4296** was submitted to the Committee on Health on April 13, 2005. The text of the proposed legislation can be found at <http://www.senate.state.ny.us>.

Questions and concerns may be addressed to this office by your organization.

The Law Office of Beth Polner Abrahams concentrates in the areas of:

- Elder Law
- Estate and Tax Planning
- Guardianship and Supplemental Needs Trusts
- Probate and Administration of Estates

Supplemental Needs Trusts

What are Supplemental Needs Trusts?

Supplemental Needs Trusts (SNTs) provide an important estate planning tool and lifetime maintenance option for families with loved ones who are disabled. The two kinds of inter vivos (living) SNTs for the disabled are often referred to as **Third Party Trusts** and **Pay Back Trusts**. There are also SNTs typically are found in Wills. With an SNT, the funds in the Trust will not be depleted by the high cost of medical care generally needed by a disabled person.

What are Third Party Trusts? Third Party Trusts are created with funds which belong to, or come from, someone other than the disabled person, his or her spouse, or a legally responsible relative such as a parent or minor child. Usually, no court supervision is required. It is preferable to have the Trust provide that it will be used to supplement, not replace, government assistance such as Medicaid and SSI. The remainder beneficiary of the Trust, at the disabled person's death, must be specified and can be family members and/or a charitable organization.

What are Pay Back Trusts? Pay Back Trusts are usually funded with monies received by the disabled

person from an inheritance, personal injury, malpractice award or settlement. The Trust may also be funded with monthly income such as Social Security disability or annuity/retirement payments. The Trust may be created by a parent or grandparent, or if none, then by a court or court-appointed guardian. Medicaid must be the remainder beneficiary of the Trust to pay back medical assistance provided by that agency during the disabled person's lifetime.

What are Trusts in Wills? Trusts in Wills provide for a lifetime of care for the disabled loved one without disrupting government benefits such as Medicaid and SSI. The Trust must be carefully drafted in Wills and supplements, but does not replace government benefits. The SNT remainder beneficiary, at the disabled person's death, must be specified and can be family members or a charitable organization.

At no charge, Ms. Polner Abrahams will gladly address nonprofits, support groups and professional associations on the subjects of Elder Law, Estate Planning and Disability Planning.

Please contact her office for details.

Law Office of Beth Polner Abrahams

Dedicated to providing quality, caring and personalized legal representation.

Handling all aspects of estate and tax planning, elder law and representation of incapacitated and disabled adults in guardianship proceedings.

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