



CONNECTICUT ELDER LAW RESOURCES

Wills & Trusts

**Long Term
Care**

**Consumer
Fraud**

Housing

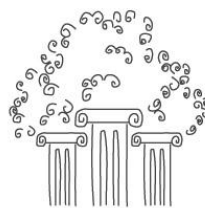


CONNECTICUT ELDER LAW RESOURCES

The Senior Citizens' Law Day program – for which these materials were originally prepared – was sponsored by:



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DISCLAIMER

For those attending this Senior Citizens' Law Program or subsequently reviewing the materials in this packet, we ask you to be aware of the following information.

We tried to ensure that the materials included in this packet were accurate and up-to-date on the day of the program in November 2008. The legal rules discussed in the materials are subject to change, however, and readers should be aware of the need to check to see if a rule may have changed, before relying in the future on the description of the rules that is included in this packet.

In a similar vein, the enclosed materials are intended to provide program participants with general information on key aspects of the legal issues addressed. The manner in which these rules may operate in any particular individual's life circumstances can vary.

For both of these reasons, individuals should consult with an attorney if making decisions about legal issues addressed in these materials. An attorney can give advice appropriately tailored to an individual's unique circumstances, and will check to ensure use of the most up-to-date versions of applicable legal rules.

BIOGRAPHIES – CONTRIBUTORS

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Edward D. Abdelnour is an associate in the West Hartford Private Clients Group of Cummings & Lockwood. Edward practices in the areas of estate planning and estate and trust administration. Edward received his B.A. from the University of Michigan in 1996. He received his J.D., with honors, from the University of Connecticut School of Law in 2000, where he served as an Executive Editor of the Connecticut Journal of International Law. Since completing law school, Edward has co-authored several articles dealing with trust and estate issues, including one featured in the Connecticut Law Tribune. Edward is admitted to practice in both Connecticut and New York.

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Richard S. Fisher

Richard S. Fisher is a partner in the Stamford law firm of Cacace, Tusch & Santagata practicing in the area of taxes, estate planning, elder law and business law. He received a B.S. degree with a major in accounting from Penn State University, a J.D. degree from Cornell Law School and a Masters of Law in Taxation degree from George Washington University National Law Center.

Fisher was a founding member of the Connecticut Bar Association Elder Law Section and continues to serve on its Executive Committee. He is currently a member of the National Academy of Elder Law Attorneys. He has been active in the American Bar Association Tax Section and the Connecticut Bar Association Tax Section, having served as Chair of the latter. Fisher also has been the President of the Estate Planning Council of Lower Fairfield County and is currently on the Executive Committee of the CBA Estates & Probate Section. He was co-chair of the Section's committee that proposed revisions of the Connecticut living will statute and the conservatorship law.

He was on the board of directors of The Jewish Home for the Elderly of Fairfield County, having served as vice chair and secretary. Dick was a founding member of the Fairfield County Chapter, Alzheimer's Association, and has served as president. As a result of mergers there is now a state-wide chapter of the Alzheimer's Association and Dick is presently Vice Chair of the Connecticut chapter.

A frequent speaker, Fisher has been a presenter to such groups as the Connecticut Bar Association, the Connecticut Probate Assembly, the International Association of Financial Planners, the Southwestern Connecticut Area Agency on Aging, and Regions I and II of the Alzheimer's Association.

Judith Hoberman

Judith Hoberman is a member of the Hamden, Connecticut law firm Shedd and Hoberman, L.L.C., and has practiced in the areas of Elder Law, Medicaid and other public benefits for thirty years. Ms. Hoberman received her B.A. degree *cum laude* from Yale University in 1974, and her J.D. with honors from the University of Connecticut School of Law in 1977. She is the Chair of the Connecticut Bar Association Elder Law Section. Ms. Hoberman has

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Kate McEvoy

Kate McEvoy is the Deputy Director of the Agency on Aging of South Central Connecticut, Inc. (AASCC). She is also the legislative liaison for the Connecticut Association of Area Agencies on Aging (C4A), and represents C4A on the Steering Committee of the Connecticut Elder Action Network (CEAN) and the Connecticut Long-Term Care Advisory Council. In these capacities, she is a frequent lecturer on advance health care directives, Medicare, home and community-based services, entitlements and policy issues.

Kate is the author of the treatise *Connecticut Elder Law* (2008, Thomson/Reuters West). Additionally, among other articles, she is the author of "Should We Focus More on the Individual? A Discussion of Advance Care Planning Law in Connecticut" for Connecticut Medicine and "Recent Developments in Connecticut Conservatorship Law" for the Connecticut Bar Journal. Her work on advance directives has in past years focused on drafting proposed changes to Connecticut's statutes that were passed in the 2006 session. In recognition of this work, she received an ADACC Advocacy Award from the Connecticut Americans with Disabilities Act Coalition and the 2006 Excellence in Achievement Award for Public Service from the Connecticut Coalition for End-of-Life Care.

In 2006, Kate was a recipient of a "20 Noteworthy Women" award from the *New Haven Business Times*. She was also selected, in 2005, to participate in the William Caspar Graustein Foundation Community Leadership Program.

Kate served as the Chair of the Executive Committee of the Elder Law Section of the Connecticut Bar Association from 2006-2008, and in 2004 and 2008 was an adjunct faculty member at Quinnipiac University School of Law, at which she taught an elder law course. She is currently a member of the Board of Directors of the United Way of Greater New Haven, and serves as the Chair of its Community Impact Cabinet. She is also a member of the Boards of Directors of the Connecticut Legal Rights Project and the Clifford Beers Clinic. In 2005, Connecticut Speaker of the House James Amann appointed Kate to the Task Force on Re-Establishment of the Department on Aging.

Kate is a graduate of Oberlin College with a B.A. in Economics and English and received her law degree from the University of Connecticut School of Law. She is admitted to practice in Connecticut.

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Sarah Poriss

Sarah Poriss has a solo practice in West Hartford focusing solely on consumer protection issues. She graduated from the University of Connecticut School of Law in 2002 and spent four years as an associate at Consumer Law Group in Rocky Hill working on all types of consumer cases: home improvement fraud, identity theft, debt collection harassment and credit reporting errors, lemon law and auto fraud. When she started her own practice, she saw that few attorneys were representing consumers being sued on old, unpaid debt (which cases make up over 85% of cases in the small claims court) or representing homeowners in foreclosure. Those cases make up a large portion of her practice. Because of her experience representing consumers, she was asked to be on the Judicial branch's Bench-Bar Foreclosure and Small Claims committees, where attorneys and judges work together to make the court system more accessible to the

unrepresented person. She is a member of the National Association of Consumer Advocates (www.naca.net), the Connecticut Bar Association and the Better Business Bureau.

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Heather is admitted to practice in Connecticut and is a member of the American, Connecticut and Hartford County Bar Associations. She is also a member of the Executive Committee of the Estates and Probate Section of the Connecticut Bar Association is co-chair of the continuing legal education subcommittee of this Section. Heather is a member of the UCONN Foundation Planned Giving Professional Advisory Council. In addition, Heather is a Director of the Estate and Business Planning Council of Hartford.

Heather is a frequent speaker on estate and tax planning issues and has authored a number of articles focusing on various estate planning subjects. She most recently spoke to the Connecticut Society for Certified Public Accountants regarding changing domicile.

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Lea Nordlicht Shedd practices Elder Law as a member of the law firm Shedd and Hoberman, L.L.C. in Hamden, Connecticut. She is a past Chair of the Connecticut Bar Association Elder Law Section, and serves on that Section's Steering Committee.

Ms. Shedd is a frequent speaker on legal issues affecting older persons, and has written extensively in this field, including articles on housing alternatives

for older persons, ethical issues confronting the elder law attorney, Medicaid, and a history of the CBA Elder Law Section.

From 1980 to 1986 Ms. Shedd was Chair of the Legal Studies Department of Quinnipiac College (now Quinnipiac University), Hamden, Connecticut, where she developed and taught the undergraduate course Legal Problems of the Elderly. She has continued to teach Elder Law at Quinnipiac as an adjunct faculty member in the College of Arts and Sciences and, more recently, in the School of Law.

Ms. Shedd received her B.A. degree cum laude from New York University (University Heights), where she was elected to Phi Beta Kappa, and her J.D. from the University of Connecticut School of Law.

FREQUENTLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES & HEALTH CARE PLANNING

** Adapted from materials originally prepared by Connecticut Legal Services*

ADVANCED DIRECTIVES

What are advance health care directives?

Advance health care directives, or advance directives, are:

- ❑ Documents that provide instructions concerning health care wishes; and
- ❑ Documents that appoint someone (a “proxy”) to speak for an individual who is unable to speak for him or herself.

What types of advance directives are currently used in Connecticut?

Connecticut law recognizes the following advance directives:

- ❑ A living will, which is a document that expresses your wishes concerning life support (CPR, ventilation, artificial means of providing nutrition and hydration) and other health care preferences (for example: dialysis, chemotherapy, blood transfusion, antibiotics)
- ❑ An appointment of health care representative, which authorizes another person, in situations in which you are unable to speak for yourself, to accept or refuse any treatment, service or procedure used to diagnose or treat a physical or mental condition, including withholding or withdrawing life support systems
- ❑ An advance designation of conservator, through which you can indicate whom you would wish to have serve as conservator if an appointment were ever to become necessary
- ❑ A document of anatomical gift, which authorizes donation of all or part of your body upon or after death

- ❑ A designation of disposition of remains, through which you can indicate wishes concerning custody of your body, and wishes concerning burial, cremation and interment

I completed advance directives some time ago. Are these still valid?

Once advance directives are completed, signed and witnessed, they are valid and do not become “stale” or too old to be legally valid. If you used forms to appoint a “health care agent” or completed a durable power of attorney for health care decisions, these are still valid although since October 1, 2006, Connecticut no longer uses these forms.

What is the difference between a living will and a Do-Not-Resuscitate Order?

A living will is a document that you complete that expresses your wishes concerning life support (CPR, ventilation, artificial means of providing nutrition and hydration) and other health care preferences (for example: dialysis, chemotherapy, blood transfusion, antibiotics).

A Do-Not-Resuscitate (DNR) Order is an order written by your physician instructing those who give you medical treatment not to perform cardio-pulmonary resuscitation (CPR) (including chest compressions, defibrillation, or breathing or ventilation by any assistive or mechanical means) on you.

What is a conservator of the person?

A probate court can appoint a “conservator of the person” to make personal decisions for you if and only if you ask the court to do so (this is called voluntary conservatorship) or if:

- ❑ You are incapable of caring for yourself; and
- ❑ It does not appear that you are being adequately cared for without a conservator; and
- ❑ Appointment of a conservator is the least restrictive available means of helping you (this is called involuntary conservatorship).

A conservator of the person makes personal decisions including decisions about where you live, what benefits you receive, and, unless you already

have advance directives, health care decisions. By contrast, a “conservator of the estate” makes financial decisions.

Am I required to complete advance directives?

No. Connecticut law states that medical care cannot be conditioned on whether or not an individual has completed advance directives. A federal law called the Patient Self-Determination Act requires that hospitals and nursing facilities ask you at the time that you are admitted whether you have advance directives, but you do not have to complete advance directives to receive care.

Why complete advance directives?

- ❑ To increase the likelihood that your end-of-life care wishes will be followed
- ❑ To give guidance to your physician
- ❑ So that a legal proxy can speak for you if you cannot
- ❑ To avoid disputes among family members
- ❑ To ensure that these private, intimate decisions do not end up being reviewed by a probate court
- ❑ Because the United States Supreme Court has held that you have a constitutionally protected right to refuse unwanted medical treatment
- ❑ Because many of the situations in which life support must be considered occur unexpectedly
- ❑ To express your religious convictions
- ❑ To illustrate what you think of as a “good death”
- ❑ Because it is an act of love for your family and friends

What should I do before completing advance directives?

- ❑ Talk to people whom you trust (your spouse or life partner, family, friends, physician, clergy person and/or lawyer) about what you want
- ❑ Consider reviewing resources that explain how to decide what you want, how to choose a proxy, and how to communicate your decisions to your loved ones (for example: the American Bar Association)

Commission on Law on Aging Consumers Toolkit for Health Care Advance Planning, which is available at:
<http://www.abanet.org/aging/toolkit/home.html>)

- ❑ Obtain and review the forms for the advance directive(s) that you want to complete

What are the requirements for completing a living will?

A living will is a document that expresses your wishes concerning life support (CPR, ventilation, artificial means of providing nutrition and hydration) and other health care preferences (for example: dialysis, chemotherapy, blood transfusion, antibiotics).

To complete a living will, you must:

- ❑ Be eighteen (18) years old or older
- ❑ Be “capable”, which means that you are able to understand what is authorized by the form
- ❑ Complete the form with your wishes
- ❑ Sign the form and have the form signed by two witnesses

What are the requirements for completing an appointment of health care representative?

An appointment of health care representative authorizes another person, in situations in which you are unable to speak for yourself, to accept or refuse any treatment, service or procedure used to diagnose or treat a physical or mental condition, including withholding or withdrawing life support systems.

To complete an appointment of health care representative, you must:

- ❑ Be eighteen (18) years old or older
- ❑ Be “capable”, which means that you are able to understand what is authorized by the form
- ❑ Complete the form with your wishes
- ❑ Sign the form and have the form signed by two witnesses

What are the requirements for completing an advance designation of conservator?

Through an advance designation of conservator, you can indicate whom you would wish to have serve as conservator if an appointment were ever to become necessary.

To complete an advance designation of conservator, you must:

- ❑ Be eighteen (18) years old or older
- ❑ Be “of sound mind”, which means that you are able to understand what is authorized by the form
- ❑ Complete the form with your wishes
- ❑ Sign the form and have the form signed by two witnesses

What are the requirements for a document of anatomical gift?

A document of anatomical gift authorizes donation of all or part of your body upon or after death.

To make an anatomical gift, you must be at least 18 years old and can make the gift by any of the following means:

- ❑ By document of gift that you have signed (if you cannot sign, the document must be signed by another person and two witnesses at your direction and in your presence)
- ❑ By imprint on your driver’s license
- ❑ By will

What are the requirements for completing an advance designation of remains?

Through a designation of disposition of remains, you can indicate your wishes concerning custody of your body, and wishes concerning burial, cremation and interment.

To complete a designation of disposition of remains, you must:

- ❑ Be eighteen (18) years old or older
- ❑ Be “of sound mind”, which means that you are able to understand what is authorized by the form
- ❑ Complete the form with your wishes
- ❑ Sign the form and have the form signed by two witnesses

What advance directives forms should I use?

Although Connecticut law does not require you to use the exact language of the state forms, it may be advisable to do so because Connecticut health care providers are most familiar with those forms and this may make it less likely that there will be a dispute over interpreting your health care wishes.

The state forms, as well as instructions on how to complete them, can be downloaded free of charge from the web site of the Connecticut Office of the Attorney General:

<http://www.ct.gov/ag/site/default.asp>

These forms give you a choice about whether to use a form that combines all of the advance directives in one document or separate advance directives forms.

If you use the combined form, you do not have to complete all of the advance directives that are included. Simply choose those that you want to complete, and leave the other sections blank.

Are advance directives that were completed in other states or foreign countries valid in Connecticut?

Connecticut law recognizes advance directives that were validly executed in other states and foreign countries, as long as they are not contrary to Connecticut public policy (for example: Connecticut law does not permit physician-assisted suicide).

Will my Connecticut advance directives be valid in other states or foreign countries?

Not all states and foreign countries recognize Connecticut advance directives as valid. Another state may have different laws, forms and procedures. It is therefore a good idea to consult an attorney and/or to prepare a new living will if you move from Connecticut to another state.

You can also download forms and instructions free of charge for each of the fifty states from a web site sponsored by the National Hospice and Palliative Care Organization:

www.caringinfo.org

When should I update my advance directives?

Once they are completed, signed, and witnessed, advance directives are valid and do not go "stale" or become too old to be legally valid. Although Connecticut law concerning advance directives changed on October 1, 2006, advance directives completed before that date remain valid.

Older advance directives may not, however, be as flexible as the current forms. Further, it may be a good idea to review and update your advance directives as follows:

- ❑ if your health status changes significantly
- ❑ if your marital status changes
- ❑ if the person whom you have identified as your proxy is ill, is no longer capable of acting as your proxy, or passes away

What if I change my mind? Can I revoke my advance directives?

Yes. Advance directives can be revoked as follows:

- ❑ A living will can be revoked at any time and in any manner, no matter what your mental or physical condition
- ❑ An appointment of health care representative must be revoked in writing signed by you and by two witnesses

Please note: if you appoint your spouse as your health care representative, the appointment is revoked by your divorce, legal separation, annulment, or dissolution unless you indicated otherwise in your form

- ❑ A document of anatomical gift must be revoked in writing
- ❑ An advance designation of conservator must be revoked in writing signed by you and by two witnesses
- ❑ A designation of disposition of remains can be revoked by completing a new form

When do my advance directives become operative?

A living will becomes operative only when:

- ❑ You have a “terminal condition” (“the final stage of an incurable or irreversible medical condition which, without the administration of life support, will result in death within a relatively short period of time”) or are “permanently unconscious” (“includes permanent coma and persistent vegetative state in which the individual is at no time aware of himself or the environment and shows no behavioral response to the environment”)

And

- ❑ A physician finds that you are unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment
- ❑ An appointment of health care representative becomes operative when the form is handed to your doctor and he or she finds that you are unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment
- ❑ An anatomical gift becomes effective upon your death

- ❑ An advance designation of conservator becomes operative only if and when a probate court finds that you are legally incapable of caring for yourself
- ❑ A designation of disposition of remains becomes effective upon your death

Under what circumstances could a physician withhold or withdraw life support from me?

A physician can withhold or withdraw life support (for example: CPR, ventilation, artificial means of nutrition and hydration) from you only after:

- ❑ Determining that it is merited by using his or her best medical judgment;
- ❑ Confirming either that you have a “terminal condition” or are “permanently unconscious” (this must be done in consultation with a doctor with neurological training); and
- ❑ Considering your wishes.

In considering your wishes, Connecticut law states that physicians should first consider the instructions in your living will, if you have one. If you haven’t completed a living will, physicians can consider past conversations with you about your preferences, and/or can speak with your health care representative, next-of-kin, legal guardian or conservator.

How will my health care decisions be made if a probate court appoints a conservator for me?

If a probate court has appointed a conservator of the person for you, that conservator must:

- ❑ With limited exceptions, comply with your previously executed advance directives; and
- ❑ If you have previously appointed a health care representative, allow him or her to continue to make health care decisions for you.

How does Connecticut law protect my rights and preferences?

- ❑ Hospitals and nursing facilities must provide you with comfort care and relief of pain
- ❑ Health care facilities cannot require you to complete advance directives in order to receive care
- ❑ A health care facility that is unable to comply with your advance directive must arrange to promptly transfer you to a facility that can do so

if there is a dispute about the terms of your advance directives, the probate court can help resolve the dispute.

Consumer Issues

CONSUMER FRAUD OVERVIEW

Introduction to Consumer Fraud

What is Consumer Fraud?

Fraud is a crime commonly committed against the elderly. Simply put, it involves deceit, dishonesty, and swindling. According to the National Fraud Information Center, 60% of the calls to its national information hotline come from senior citizens or retired persons. Con artists believe that the elderly crave contact with other people, and the clever con can exploit this need.

Why are the Elderly a popular target of con artists and swindlers?

Several reasons can be cited for the targeting of seniors:

- ❑ Seniors tend to be more trusting.
- ❑ Seniors often have special needs and concerns that the con artist can exploit.
- ❑ Con artists feel they can more easily intimidate seniors.
- ❑ Con artists believe seniors will not report the crime because of the fear of reprisal, embarrassment, and losing their independence if family members learn of the scam.
- ❑ Seniors are home during the day, making them easier targets.
- ❑ Seniors tend to be more isolated and more willing to talk to strangers.
- ❑ Seniors have money (home equity, savings accounts, pension income).

How can one avoid being "scammed"?

Generally speaking, here are some useful tips for avoiding being victimized by a scam artist:

- ❑ Never make a buying decision based upon emotion (such as "do it for your kids or your grandkids").
- ❑ Don't let yourself be pressured into a quick decision.
- ❑ Check out the company or individual with the Better Business Bureau or law enforcement agencies.
- ❑ Be wary of "something-for-nothing" or "get-rich-quick" schemes.
- ❑ Remember that when someone tries to sell you something, you are in control. You can cut the conversation when you want.
- ❑ Never make a purchase at the time it is presented to you. Give yourself time to verify the company or product offered.
- ❑ Never send cash through the mail. Send a check or money order or use a credit card. (Certain protections are available to the consumer using a credit card---see Section III entitled Credit Card Consumer Protections).
- ❑ Beware of any door-to-door salesmen (such as contractors).
- ❑ Beware of any salesperson who insists you send him or her money immediately. Beware of high-pressure sales tactics.
- ❑ Never give your credit card number for identification purposes. (Some merchants may request to see your card for identification purposes, but the merchant, by law, may not write down the identification number.)
- ❑ Never give anyone your credit card or checking account number over the phone--unless you are familiar with the company and you initiated the call.
- ❑ Never give the expiration date or the 3-digit code on the back of the card near the signature area of your credit card to unfamiliar or unsolicited callers.
- ❑ Keep in mind that written authorization is not required to withdraw funds electronically from a checking account on a one-time only basis.
- ❑ If a service is offered, ask for references and contact them.
- ❑ Contact a family member to get another opinion prior to signing a contract or purchasing a product.
- ❑ When seeking to purchase a product or service, comparison shop.

How have senior citizens been victimized or "scammed"?

Advance fee schemes

Newspaper ads and emails offering loans that use money available from "foreign investors." If the "foreign investor" lender asks for an advance fee, chances are the lender intends to take the fee without ever providing a loan. The "processing" fee can typically range from \$200 to \$500.

Phony Mortgage Notices

If you receive a notice stating that a new company has taken over the loan servicing or purchased your mortgage, be sure to check with the loan company with whom you were doing business. Usually the con artists give a post office box as the address for sending payments. (Note: If you are concerned about payments being correctly credited to your account, many banks allow payments to be processed by their local branches, making it easier to make your payment in person.)

Unscrupulous Loan Brokers

Carefully compare loans, interest rates, points and fees. Deal only with licensed brokers but be warned that even licensed brokers are not subject to usury laws. While an institutional lender usually charges from zero to three points for a loan, private lenders can charge as much as 20 points. (A point is 1% of the loan; if your loan is \$100,000, one point is \$1,000.)

Be sure to check the license of your realtor and mortgage broker. What is the license number? Who issued it? Does it match the individual's driver's license? (It is illegal for an individual to work under another person's license.)

Foreclosure sharks

These sharks will scan the newspaper foreclosure notices for easy marks. They will offer to save one's home, clear bad credit and arrange refinancing.

Often the fine print in these contracts includes a provision transferring the house title to the foreclosure shark. In addition, the sharks may include a provision for a balloon payment at the end of the "consolidation" contract.

Home Improvement Financing

Sharks con seniors into purchasing home improvements secured by a mortgage on the home. Most consumer advocates discourage the use of one's home as collateral for repairs. Be advised: anytime you are getting involved in a real estate transaction to refinance your home, get legal advice.

As with the mortgage broker, check the home improvement contractor's professional license, note the number, and make sure it matches the individual's driver's license. Check with a knowledgeable friend, family member, and/or attorney.

Home Repair

The con artist will often offer to oil a shingled roof or repair a driveway for a low fee if they can do the work immediately. Once the work is done, the fee turns out to be much higher. Older people are especially vulnerable since they are usually unable to check the work (such as going up on the roof). It is not uncommon for the con artist to do work at a low fee for one resident to create a referral in the neighborhood.

Many of these home repair scams allow the con artist access to the house and the valuables stored in the home. There is one large group of home repair scam artists known as "The Travelers," who work the entire United States.

Tips To Avoid This Scam:

- ❑ Beware of someone who comes to your door unannounced and claims to have a load of whatever he says your property needs: asphalt, shingles, paint, etc.
- ❑ Get three estimates for the work to be done.
- ❑ Get references.
- ❑ Check the references on previous work done by these contractors.
- ❑ Check with the CT Department of Consumer Protection to see if the contractor is licensed in Connecticut. Consumers have more protection under the law if the contractor is licensed.
- ❑ Never advance more than 25% of the cost up front.

- ❑ Be sure that all the work to be done is detailed in writing.
- ❑ Never sign a certificate of completion before the work is completed.
- ❑ Never sign an estimate without first reading it carefully. What you think is an estimate could in fact be a contract that is secured by your home. Never sign a contract or estimate that gives your home as a security.
- ❑ Offer to review the estimate and return it to the contractor at a later time so you can check with an attorney, family, or friends.

Selling Property Without a Broker

A home owner might be approached by a prospective buyer who will offer to pay the full asking price, with 1% to 5% down and the remainder in a few months. The con artist will rent the property and the seller never sees the money.

False Charitable Solicitation

Beware of calls or visits from individuals claiming to represent a charity. Often the con artists will use a false group name containing the word "United" which can easily be confused with the United Way.

Tips To Avoid This Scam:

- ❑ Never commit to a donation at that time.
- ❑ Ask the individual to leave the information at your door or mail it.
- ❑ Beware if the caller refuses to send you information on the charity.
- ❑ Beware if somebody offers to send someone to pick up the money, asks you to use immediate delivery service (such as Federal Express), or wants it sent to a P.O. Box. Bypassing the normal mail service shields the con artist from prosecution for mail fraud.
- ❑ Hang up. Call the organization that is supposedly asking for donations. Confirm that it is involved in a fund drive and what percentage of the money it is receiving. (Professional fund-raising groups may be receiving over 50 percent of the proceeds.)

- ❑ Check with the Connecticut Department of Consumer Protection to see if the contractor is licensed in Connecticut. You have better protections under the law if the contractor is licensed.

Bogus Sweepstakes

A legitimate sweepstakes is an advertising or promotional device by which items of value (prizes) are awarded to participating consumers by chance, with no purchase or "entry fee" required to win. By law, you should have an equal chance of winning whether or not you order.

Some individuals may believe their chances to win will be increased if they make a purchase and confuse separate "yes" and "no" envelopes as requiring a purchase. Nevertheless, the chance of winning a large prize is generally quite small.

Bogus operators often request a fee to process your entry or to process your "winning entry." Be warned: never send money to receive a prize. If you've won something, why should you pay?

According to a 1992 Louis Harris survey 92 percent of all adult Americans have received phony prize notifications and nearly a third took the bait.

Tips To Avoid This Scam:

- ❑ Beware of any mail featuring "Congratulations, You've Won."
- ❑ Beware if a "you've won" notice comes by phone on a weekend when most business offices are closed. This prevents a supposed winner from verifying the story with the real company.
- ❑ Beware if you are urged to act now.
- ❑ Beware if you hear "legitimate-sounding" group names (American, Clearinghouse, Digest, Publisher's, Family).

Auto-repair Rip-off

Typically, the dishonest shop will take advantage of the fact that most people know little about their car. One of the most common scams is the "metal filings in the transmission oil pan" scam. A certain amount of metal is normal and the metal is kept separate from the rest of the transmission by

a transmission-oil filter. Nevertheless, customers have been scammed into ordering an expensive overhaul of the transmission.

Tips To Avoid This Scam:

- ❑ Check with friends or family about shops that have given them good service.
- ❑ Contact your local Better Business Bureau to check whether any complaints have been filed against a shop you are considering using.
- ❑ Are the shop's mechanics "ASE certified"? (The National Institute for Automotive Service Excellence is a non-profit organization that tests and certifies mechanics' competence. Certified shops display the white and blue ASE logo.)
- ❑ Is the mechanic working on your vehicle certified to do the work required?
- ❑ Are the employees and the shop relatively clean and tidy? A clean operation may suggest that you and your car will be treated with the proper consideration.
- ❑ Be sure to get a written estimate before authorizing any repair work.
- ❑ Ask the shop to keep all of the old parts for you. Fear of the customer's inspection of the old parts may cause the shop to think twice about ripping you off.
- ❑ Have the mechanic show you the new component on your car.
- ❑ Contact your local AAA office if they offer a low-cost diagnostic service (approx. \$40), which does not rely on repairing vehicles for its income.
- ❑ Beware of shops that advertise a hard-to-believe low price for a basic service like a front-end alignment. This may be a lure to scam customers to have expensive and unnecessary work done (such as ball-joint replacement).

So-called Government Agency

An organization claiming to be associated with the Social Security Administration will offer a service such as card replacement for a fee. All services from the Social Security Administration are free.

Investment Fraud

A company may claim to be offering a "retirement-oriented" investment which is "IRS approved." In addition, the retirement investment opportunity will supposedly yield a much higher return than a bank or legitimate IRAs (as much as 200% or 300%).

Churning is a scheme in which a stockbroker sells some of the shares from a customer's portfolio to purchase new shares. By doing so, the stockbroker makes a commission on the new sale which the customer had not authorized.

Tips To Avoid This Scam:

- ❑ Keep track of existing investments.
- ❑ Exercise extra caution during the tax season.
- ❑ Take the time to evaluate the opportunity and consult a competent tax advisor.
- ❑ Avoid any investment touted as "IRS approved." The IRS does not endorse specific tax deals.
- ❑ Don't buy an investment on the basis of a television infomercial or radio ad. The ad has not been "cleared" by some federal or state agency or the broadcaster.
- ❑ Beware of promises of no-risk, sky-high returns. Basic Rule: A higher return means a higher risk.
- ❑ Remember, a promise of 200% or 300% profit may be a reflection of someone who has no intention of delivering on the promise and will say anything to make the sale.
- ❑ Never transfer or roll-over your IRA or other retirement funds directly to an investment promoter. Your fund should go directly to a pension fund administrator (bank, trust department, or mutual fund) to be recognized as an IRA.
- ❑ Beware of investing in a "general partnership" or "limited company." Con artists use such schemes to evade the consumer protection requirements of securities laws (such as disclosure of previous violations, personal bankruptcies, and actual marketing costs).

- ❑ Don't be swayed by the fact that a bank or trust department is serving as an IRA custodian. The custodian is not obligated to check out the investment and not liable if the investment turns out to be bogus.
- ❑ Keep in mind that a "hot" industry does not necessarily translate into a "hot" company.
- ❑ Always check out an investment and promoter before you turn over your money. Even if the opportunity is not a "security," check with your state securities division.
- ❑ Educate yourself about IRAs and retirement planning.

Pigeon Drop

An old scheme which is still quite common. The con artists claim to have found a large sum of money and offer to share it with you. You are asked to withdraw "good faith" money and are given a phony address where you are to collect your share of the found money. You never see them again.

Bank Examiner

A phony bank examiner contacts you and asks for your help in catching a dishonest bank employee. The "examiner" asks you to withdraw a specified amount of cash from your account so that he or she may check the serial numbers. After turning over your money to the "examiner," you never hear from him or her again.

Medical frauds

Fake laboratory tests, miracle cures and mail-order clinics are other methods criminals dream up to defraud you. Legitimate doctors and hospitals do not advertise through the mail.

Telemarketing Recovery Schemes

Fraudulent telemarketers will sell lists of people they have swindled to other fraudulent telemarketers. The second group will contact the people and offer to recover their money for a fee.

Skimming Scam

The "skimmer" offers to buy your house for your asking price, but then says he or she will close the deal sooner if he or she doesn't have to get financing through a bank. He or she convinces you to sign a contract containing a "subject to rehabilitation loan" clause enabling him or her to go to a lender to borrow money using the home as collateral.

He may borrow thousands of dollars and even rent out the home. Eventually, he will default on the loan without ever making payments to you. As a result, you end up taking back the house which now has a huge mortgage on it. The skimmer has since disappeared.

Insurance Fraud

Churning is a scheme in which policy holders are persuaded to buy variable-life or whole-life policies without paying any money out of pocket. The agent tells the customer that the new, more valuable policy will be paid with the cash value from their prior policy. However, the value of the new policy exceeds the value of the old policy. So to keep the premiums current, the customer unknowingly is borrowing money from the company.

Twisting is similar, but occurs when company A's agent persuades company B's customer to pledge his or her current life insurance policy to purchase company A's policy.

Credit Repair Services

It is not unusual for a company to offer to repair a bad credit report. For a fee, the company offers to erase a bad credit history. However, no one can remove any accurate information from your credit report. You can have any incorrect information removed from your credit report by contacting the credit bureau yourself and supplying proof of the error, or you can supplement your credit report by filing information that contradicts existing information.

The Fair Credit Reporting Act, as amended by the Fair and Accurate Credit Transactions Act, provides for one free credit report in a 12 month period from each of the 3 national credit reporting agencies. Free credit reports can be obtained by visiting www.annualcreditreport.com or by calling 1-877-322-8228.

Credit Card Consumer Protections

The Fair Credit Billing Act protects consumers using credit cards to make purchases for goods and services. The protections are as follows:

- ❑ **Billing errors appearing on your statement:** Charges which you did not make or cannot identify; a charge listed with the wrong amount; a charge for goods you did not accept or which went to the wrong address; and/or incorrect credits for items returned.

Contact your credit card issuer in writing as soon as possible. Don't ignore the error. You do not have to pay the disputed amount until the problem is resolved and your nonpayment will not be reported to the credit bureau.

- ❑ **Defective goods and services:** If you have unsuccessfully tried to solve the problem with the merchant, you may withhold payment (if you used a store-issued card). Otherwise, you are covered only if the sale was for more than \$50 and took place in your home state or within 100 miles of your home address.

When requesting a credit from the merchant rather than the card issuer, ask for a copy of the credit to be mailed immediately. If you do not receive it, dispute the claim in writing to the credit card issuer.

- ❑ **Fraud:** If your card is lost or stolen, report it immediately. If no charges have been made by the time you notify the credit card issuer, you are not responsible for any subsequent ones. Under any circumstances, you are liable only for a maximum of \$50 of unauthorized charges.

If you think that the Fair Credit Billing Act has not been followed, be sure to contact the compliance officer in writing at the credit card issuer's address. After your phone conversations with the merchants or card issuers, write follow-up letters that repeat what you discussed. In addition, if the card issuer is unresponsive, you can write to:

The Division of Consumer and Community Affairs
Board of Governors of the Federal Reserve System

20th Street and Constitution Avenue., N.W.
Washington, D.C. 20551

Tips:

- ❑ Sign your credit card as soon as you receive it. Otherwise, a thief can sign your name in his or her writing.
- ❑ Keep credit card statements and receipts from credit purchases for a year.
- ❑ In the event of a dispute, keep copies of all related correspondence, receipts, and telephone records so you can prove you followed proper procedures.
- ❑ Check your credit report for errors. It should contain: name, social security number, birth date, current and previous address, payment history with credit cards, department store charge accounts, loan payments, credit inquiries, whether or not you were granted credit, and public record information (bankruptcies, foreclosures, or tax liens).

Common Consumer Myths

Myth # 1: *You have a three-day right to cancel any purchase.*

Generally, it applies to credit or cash transactions of \$25 or more initiated through face-to-face contact (door-to-door sales) away from the seller's regular place of business. This provision does not cover vehicle purchases.

Myth # 2: *A store must give you a refund if you request one.*

Each business has the right to set its own return/refund policy. However, each business (merchant) must conspicuously post its policy. If no policy is posted, the business must accept returns for 20 days from the date of purchase. Options include offering customers cash, store credit, exchanges, or no adjustment at all.

Before purchasing anything, check the store's return policy.

Myth # 3: *All the money you contribute to a charity goes for its intended charitable purpose.*

Charitable organizations are not obligated to spend a certain percentage of their contributions on their stated charitable purposes. Ask the telephone solicitor whether they are being paid or volunteering their services. Inquire about the percentage of the proceeds being used for the organization's primary programs.

A common rule of thumb: at least 65 to 70 percent of the donations solicited by a charity should go towards charitable purposes.

Auditing Your Medical Bills

- ❑ Insist on a completely itemized bill. You have a right to examine the bill, whatever the source of payment.
- ❑ Is the personal information correct? (Name and address)
- ❑ Is the insurance policy information correct?
- ❑ Check the company name, group number, and your policy number for any errors.
- ❑ Were you billed for the hospital room you requested? Is the rate and length of stay correct?
- ❑ Were you charged twice for the same item?
- ❑ Were you charged for any procedure which was not done or which you did not authorize?
- ❑ Does the price of the same procedure vary on your bill from one day to another? If so, ask for an explanation.
- ❑ If you have questions, contact your doctor/business office.

Contact Numbers:

- ❑ The Consumer Law Project for Elders: 1-800-296-1467
- ❑ National Fraud Information Center (National Consumer League Project)
- ❑ 1-800-876-7060; www.fraud.org
- ❑ Connecticut Attorney General: (860) 808-5318;
www.cslib.org/attygenl
- ❑ CT Department of Consumer Protection: (860) 713-6300;
www.ct.gov/dcp

- ❑ Connecticut Department of Banking: 1-800-831-7225
- ❑ Better Business Bureau: (203) 269-2700; www.connecticut.bbb.org
- ❑ BBB Wise Giving Alliance: (703) 276-0100; www.give.org
- ❑ National Do Not Call Registry: 1-888-382-1222; www.donotcall.gov
- ❑ Equifax (national credit reporting agency): 1-800-685-1111
- ❑ Experian (national credit reporting agency): 1-888-397-3742
- ❑ Trans Union (national credit reporting agency): 1-800-888-4213
- ❑ Official phone number and website for free annual credit report: 1-877-322-8228; www.annualcreditreport.com

TELEPHONE SCAMS

If you're an "older" consumer, age 60 or more, be careful about buying things by telephone. You may be a special target of those selling bogus products and services.

It's easy enough to fall prey. Telemarketing fraud is a multibillion dollar business in the United States. Every year, thousands of consumers lose anywhere from a few dollars to their life savings to telephone con artists. To protect yourself when you get a sales offer by phone, follow these simple rules:

1. Don't buy over the phone from unfamiliar companies.
2. Always take your time making a decision.

Legitimate businesses that sell by phone understand this. Remember that most people who lose money in telemarketing scams never see a penny of it again.

How Older People Become Victims of Telemarketing Fraud

Fraudulent telemarketers try to take advantage of older people who may be more trusting and polite toward strangers. Older women living alone are special targets of these phone calls.

Here are some of the reasons people become victims of telemarketing fraud:

1. Often, it's hard to know whether a sales call is legitimate. Telephone con artists are skilled at sounding believable - when they're really telling lies.
2. Sometimes telephone con artists reach you when you're feeling lonely. They may call day after day - until you feel it's a friend, not a stranger, trying to sell you something.
3. You may find it hard to get salespeople off the phone - even if they are selling something you're not interested in. You don't want to be rude.
4. You may be promised free gifts, prizes, or vacations - or the "investment of a lifetime" - but only if you act "right away." It may sound like a really good deal.

In fact, telephone con artists are only after your money. Don't give it to them.

Common Telephone Scams

Con artists are always developing new scams. Here are some common ones:

- ❑ **Prize Offers:** You usually have to do something to get your "free" prize - attend a sales presentation, buy something, or give out a credit card number. The prizes are generally worthless or overpriced.
- ❑ **Travel Packages:** "Free" or "low-cost" vacations can end up costing a lot with all their hidden costs. Or, they may never happen. You may pay a high price for some part of the package - like hotel or airfare. The total cost may run two to three times more than what you'd expect to pay or what you were led to believe.
- ❑ **Vitamins and Other Health Products:** The sales pitch also may include a prize offer. This is to entice you to pay hundreds of dollars for products that are worth very little.
- ❑ **Investments:** People lose millions of dollars each year in "get rich quick" schemes that promise high returns with little or no risk. These can include gemstones, rare coins, oil and gas leases, precious metals, art, and other "investment opportunities." These turn out to be worthless or worth much less than what you paid.

- ❑ **Charities:** Con artists often label phony charities with names that sound like better-known, reputable organizations. They won't send you written information or wait for you to check them out with watchdog groups like those listed later under "For More Information."
- ❑ **Recovery Scams:** If you buy into any of the above scams, you're likely to be called again by someone promising to get your money back. Be careful not to lose more money in this common practice. Even law enforcement officials can't guarantee to recover your money.

Tip-Offs to Fraud

Telephone con artists spend a lot of time polishing their "lines" to get you to buy. Here are some of them:

- ❑ You have to "act now" - or the offer won't be good.
- ❑ You've won a "free" gift, vacation, or prize - and you pay "only" for "postage and handling" or other charges.
- ❑ You must send money, give a credit card or bank account number, or have a check picked up by courier - before you've had a chance to carefully consider the offer.
- ❑ You don't need to check out their company with anyone - including your family, lawyer, accountant, local Better Business Bureau, or consumer protection agency.
- ❑ You don't need any written information about their company or their references.
- ❑ You can't afford to miss this "high-profit, no-risk" offer.

If you hear these - or similar - "lines" from a telephone salesperson, just hang up the phone.



What You Can Do To Protect Yourself

It's very difficult to get your money back if you get cheated over the phone. So, before you buy anything by telephone, remember:

1. **Don't buy from unfamiliar companies.** Legitimate businesses understand when you want information about their offer or company.

- ❑ Always ask for and wait until you receive written material about any offer or charity. If you get brochures about expensive investments, ask someone whose financial advice you trust to review them.
 - ❑ Always check out unfamiliar companies with your local consumer protection agency, Better Business Bureau, State Attorney General, the National Fraud Information Center, or other groups listed later under "For More Help." Unfortunately, not all bad businesses can be identified through these organizations.
2. **Always take your time making a decision.** Legitimate companies won't pressure you to make a fast decision.
- ❑ It's never rude to wait and think about an offer. Be sure to talk over big investments offered by telephone salespeople with a trusted friend, family member, or financial advisor.
 - ❑ Never respond to an offer you don't thoroughly understand.
3. **Never send money or give out your credit card or bank account number to unfamiliar companies.** Be aware that any personal or financial information you provide may be sold to other companies.

For More Help

Before you buy from an unfamiliar organization, check it out first with some of these groups. Your local phone directory has phone numbers and addresses.

- ❑ National Fraud Information Center (National Consumer League Project) 1-800-876-7060; www.fraud.org
- ❑ Connecticut Attorney General: (860) 808-5318; www.cslib.org/attygenl
- ❑ Connecticut Department of Consumer Protection: (860) 713-6300; www.ct.gov/dcp
- ❑ Better Business Bureau: (203) 269-2700; www.connecticut.bbb.org

Check national charities with this group:

BBB Wise Giving Alliance
4200 Wilson Boulevard, Suite 800
Arlington, VA 22203-1804
(703) 276-0100; www.give.org

To avoid unwanted telephone sales calls from marketers, you can place your name on the National Do Not Call Registry.

National Do Not Call Registry: 1-888-382-1222; www.donotcall.gov

To avoid junk mail offers of credit, call the "Opt in/Opt out" registry of the major credit bureaus: 1-888-5-OPTOUT (1-888-567-8688)

Indiscriminate Sales or Survey Calls

When used correctly, proper selection of prospects or respondents and careful choice of the time to call, selling and surveying by phone provide useful services for companies and their customers. In addition, these services give employment to people who cannot work at other jobs, such as some disabled persons.

People usually get annoyed when firms sponsoring the calls don't use selectivity in choosing names or times.



What You Can Do

Remember, a telephone call is just as personal as a face-to-face conversation. Don't feel obligated to answer questions just because the questioner sounds "official." Don't answer questions on the phone you wouldn't answer if they were asked by a stranger on the street.

Always find out who is calling; ask for the name of the person and the company he or she represents.

If the caller is a sales person and you're not interested, say so. One response is to ask the caller to send you all the information in a letter so you can consider it at your leisure.

If you don't recognize the name of the company conducting a survey, offer to call back or ask the caller to call you again after you've had time to check the firm with the Better Business Bureau.

It's your phone service and your time. If you're not interested, say so. If the caller is rude enough not to let you go graciously, hang up.

Harassing, Abusive Or Obscene Calls

Surprisingly, experience has shown that nuisance calls don't come just from strangers. They also come from acquaintances, neighbors or business associates. Generally, such calls are made at random. If you get such a call and give the caller no satisfaction, the person will usually give up after one or two attempts. If you get anonymous calls or calls that try to get information you don't want to give, here are some suggestions for dealing with them.



What You Can Do

Always use the telephone on your terms, not those of the caller. Don't talk to anyone unless you want to.

Ask the caller to identify himself or herself. If the caller asks, "Who is this?" don't give your name. Instead ask, "What number did you call?" or "Whom do you want?" If the call isn't legitimate, that very likely will end it.

Instruct your children and the baby-sitter never to talk on the phone to someone they don't positively recognize. Teach them to ask for the number so someone can call back later.

If the caller remains silent after you answer, hang up. Some want to listen, just to see what you'll do, particularly to see if you'll get angry.

If the caller makes an obscene or improper remark, hang up immediately.

Harassing Phone Calls For Debt Collection

Improper use of the telephone for debt collection purposes is also a concern. This includes calls from collection agencies who make annoying or

threatening phone calls to obtain money which may be owed to them. Calls in this category could include:

- ❑ Calls received outside normal business hours. (Generally 8:00 am to 9:00 pm are considered normal business hours).
- ❑ Repeated calls-more than two calls per week to discuss the matter with the debtor involved.
- ❑ Calls to third parties during which the details of a debtor's account are discussed.
- ❑ Calls threatening bodily harm or property damage.
- ❑ Calls asserting that your credit rating will be hurt or that legal action will be taken if this is not true.

Debt collection calls made in a manner intended to frighten, abuse, or harass the debtor are in violation of both the Connecticut Creditors Collection Practices Act and the federal Fair Debt Collection Practices Act.

Complaints regarding debt collection should be referred to:

Connecticut Department of Banking
Government Relations and Consumer Affairs
260 Constitution Plaza
Hartford, CT 06103-1800
1-800-831-7225

The Consumer Law Project for Elders (a project of Connecticut Legal Services, Inc.): Provides free legal advice and assistance to people 60 and over who have consumer questions or problems. 1-800-296-1467

Threatening Calls

Calls in this category include the extreme cases--bomb threats, threats to life and property, threats of kidnapping, robbery, or bodily injury to members of your family. Sometimes, these calls are repeated over an extended period of time to harass and frighten a family. If you are unfortunate enough to be a victim of such a campaign, the techniques in this material aren't enough. Call the police and the telephone company immediately. They will work together toward eliminating the problem.

UNDERSTANDING IDENTITY THEFT

What is identity theft?

There are two kinds of fraud commonly referred to as identity theft.

1. *Account Takeover:* The first kind of 'identity theft' is really the taking over of your accounts by someone not authorized to use or access your accounts. For example, if you lose your wallet or it is stolen, the thief may take over your credit card or bank accounts before you realize it and you are able to report the fraud to your creditors and bank (who will then freeze or close the accounts). Another aspect of account takeover can be accomplished when the fraudster obtains 'convenience checks' that can be cashed and then charged to your credit cards.

When you discover that an account has been taken over, take immediate action to contact your bank or credit card companies and be sure to examine your next account statements and properly dispute any charges made by the fraudster.

2. *Theft of your identity:* The other major kind of identity theft happens when someone obtains your personal information (name, address and Social Security number) and opens new accounts in your name without your knowledge or permission. Often the fraudster will apply for credit using your name and SSN, but will request that bills be sent to a "mailing address". When this occurs, you will not know when the accounts are opened or used. You should be able to detect this kind of fraud by reviewing your credit report, which is why it is a good idea to obtain credit reports on an annual basis from the three major credit reporting agencies.

How do I protect myself from identity theft or account takeover?

- Don't give out your personal information to anyone unless you initiated the transaction and trust the company or individual you are dealing with. You should not have to give out your SSN to anyone unless you are making an application for credit that you initiated. You do not have to provide your SSN on job applications until you are offered the

job, and you do not have to give a car dealer your SSN until you are ready to apply for credit at the dealership (such as if you pay cash for your vehicle or obtain financing through your own bank).

- ❑ Do not carry your SSN card in your wallet
- ❑ Do not carry more credit cards or checkbooks on you than you need that day or that week.
- ❑ CARRY CASH only. It may seem backward- but if your wallet is stolen, all you lose is your cash, not your identity!
- ❑ Safeguard your SSN and account information in your home. Service providers, contractors and others who have access to your home are common perpetrators of identity fraud.
- ❑ If you suspect you have been victimized, you can contact the credit bureaus and add a fraud alert to your reports. The initial report is temporary, and you can make it long-term by providing the credit bureaus a police report or a report from the Social Security Administration, Postmaster or Department of Motor Vehicles (if your driver's license is stolen)
- ❑ If you start receiving letters or phone calls seeking to collect on a debt that is not yours —or are served with a small claim or other lawsuit— this may be a sign your identity has been stolen. Do not ignore these communications and seek help as soon as possible.

What about all the news stories about data breaches—how can I protect myself?

The news is filled with reports of companies who have not safeguarded their customers' personal and account information. The truth is, you cannot do anything to guarantee that your information will not be in a batch of lost or stolen data.

You can check your credit reports at least once per year for any unfamiliar entries. If you are notified that your information was lost or stolen, you will likely be given the opportunity to enroll in a credit watch program. Once you believe you may be at risk, you should always keep a close eye on your credit (check it at least two times per year).

However, your information may be circulated or resold years after the data breach, so you should continue to be vigilant in the years after being notified your information was lost or stolen. Be careful not to fall prey to companies that are now profiting from our fear of identity theft. Even the credit bureaus offer identity watch packages -- for a fee.

FORECLOSURE

The most common type of foreclosure is foreclosure of a mortgage. There are new protections in place to assist homeowners who find themselves behind on their mortgages or who are in foreclosure:

- **EMAP:** The Connecticut Housing Finance Authority (CHFA) administers a program called the Emergency Mortgage Assistance Program ("EMAP"). Certain homeowners who have experienced a significant decrease in household income and/or who have experienced a mortgage interest rate adjustment that makes it suddenly difficult to make the monthly payment may qualify for EMAP.

If you think you may qualify, contact the CHFA at 1877-571-CHFA as soon as you become late on your mortgage. They will send an application and you will need to submit your personal financial information (such as tax returns and bank statements) as part of the application process. Be sure to start gathering and organizing this information to facilitate the application process.

- *Foreclosure Mediation:* As of July 1, 2008 and running through 2010, a homeowner in foreclosure (of a residential real estate mortgage) may apply for mediation through the court with the foreclosing bank.

An application for mediation will be served on the homeowner along with the foreclosure summons and lawsuit. The mediation is an opportunity for a homeowner (with or without an attorney) to sit down with a representative of the bank and a mediator to determine whether the loan can be modified to suit the homeowner's financial needs. You will have to provide tax returns and bank statements before the mediation occurs.

Other foreclosure situations

- *Foreclosure of judgment liens:* it is not uncommon these days to be sued for collection of an old unpaid credit card debt. If you lose the case, a judgment enters against you and you are ordered to pay a nominal amount, usually \$35 per week, toward the judgment. Once a creditor obtains a judgment, it may place a lien on any of your real estate. If you fail to make payments on the judgment- and sometimes even if you do make the ordered payments—the creditor may foreclose on the lien. The lien amount may be as little as \$5,000, but the creditor may commence a foreclosure.

Usually, this is an extremely effective scare tactic: it causes the homeowner to find a way to pay off the judgment to avoid foreclosure. But if you do not pay attention to the foreclosure, and there is equity in your property, you may suddenly get notice that your property will be auctioned off to pay the debt! If you are served with ANY lawsuit, big or small, seek assistance immediately.

- *Mechanic's liens:* If you hire a contractor to perform repairs or other work to your property, and you do not pay the contractor in full, you may be served with a mechanic's lien.

The lien can only be served within 90 days of the last day the contractor performed any work. The homeowner may have good defenses to the lien—such as the contractor was not licensed to perform home improvements or the homeowner was never provided a copy of the home improvement contract.

If you find you have been served with such a lien, seek assistance immediately. Most liens can be resolved with a simple mediation of the dispute with the contractor, or through assistance of the Department of Consumer Protection or the Better Business Bureau. The homeowner does have legal rights, so the advice of an attorney should be sought.

HOUSING OPTIONS FOR SENIORS IN CONNECTICUT

The question of availability for elderly housing is not always a quick answer. Trying to make it easier for seniors and their families, the Elderly Services Division prepares Elderly Housing Directories on a yearly basis. These directories give the most up-to-date listings of Elderly Housing available in Connecticut and are available on the Publications page of the Connecticut Elderly Services web site, <http://www.ctelderlyservices.state.ct.us>.

Along with a listing, this page provides definitions for the different types of housing options available for seniors. There are some distinct differences regarding services that may be required of the living environment and some services that are prohibited. In addition to providing different types of services, housing communities can offer varying degrees of the same service. Different housing options can also vary in terms of the following:

1. The residents they serve;
2. Whether they are required to be licensed to operate;
3. Their conditions for requiring when residents must move to another level of care; and
4. Costs.

ASSISTED LIVING

An assisted living designation in this housing directory is reserved for managed residential communities that provide their residents with support services through an entity that is licensed by the Connecticut Department of Public Health as an Assisted Living Services Agency (ALSA). Each managed residential community may be the licensee or it may provide services through a contract with a licensed, assisted-living provider. The ALSA provides residents with assistance with activities of daily living, including nursing services and medication supervision; it does not typically provide skilled-medical services. Staff members typically oversee and monitor

residents and are available twenty-four hours a day to meet residents' unscheduled needs. They develop individualized service plans tailored to the needs of each resident. A nurse is on call twenty-four hours a day. Residents may be independent upon admission or they may have chronic and stable conditions as determined by a physician or health-care practitioner. These conditions may be physical or medical; they may also include chronic and stable mental-health and cognitive conditions. Residents are usually able to stay in assisted-living facilities until twenty-four hour skilled care becomes necessary. Residents typically have private, apartment-like living units and pay monthly fees.

Along with employing a service coordinator, residential communities must provide core services that include meals, laundry, transportation, housekeeping, maintenance and recreational activities. Among other services they must provide are twenty-four-hour security, emergency call systems, on-site washers and dryers and sufficient common space to accommodate fifty percent of each community's resident population. ALSAs are responsible for providing assisted-living services and ensuring that the required core services are provided by the managed residential communities. It is important to note that the ALSA license pertains to the provision of *services* as provided in a managed residential community; it does not pertain to the community itself (Section 19-13-D105 of the Regulation of Connecticut State Agencies). To be listed as an assisted-living community in this directory, the community must have on-site, assisted-living services provided by a licensed ALSA or expect to have such services in the near future.

CONDOMINIUM

Residents who live in condominiums generally own specific living units within their condominium complexes. Unit owners usually jointly own the land on which the housing structures are located and the common areas. Common areas typically include: exterior walls, parking areas, walkways, halls and stairways, elevators, outside grounds, basements, and in some cases, recreational areas such as swimming pools and tennis courts. Living units can be free-standing homes, townhouses, garden apartments or apartments in high-rise buildings.

Residents are responsible for paying the mortgages and property taxes on their units. Each condominium community governs itself by a unit owner's association. The main function of the association is to pay for repairs, maintenance and taxes of common areas. The association elects a governing body, typically a board of directors, to manage the community's property. Residents usually pay monthly fees to the association, in addition to their mortgages, for the upkeep of common areas.

CONGREGATE

Congregate housing gives residents the opportunity to obtain some support services while living in a residential environment. These services help residents live semi-independently. Congregate communities help individuals who have temporary or periodic difficulties with one or more activities of daily living. Congregate housing is not designed for individuals who need extensive services or need assistance or supervision throughout the day or at night.

These communities, in addition to providing one meal per day in a communal setting, housekeeping and twenty-four-hour security, may help residents access community-based services that provide personal care. Additional meals, transportation and recreational activities may also be provided. Some of these services may require additional fees. A service coordinator may be available in some facilities to help residents arrange other community services.

Congregate communities are not licensed and do not provide rehabilitation or nursing services, nor do they dispense or monitor the self-administration of medications. Residents usually live in private apartments and pay rent monthly.

CONGREGATE HOUSING FOR THE ELDERLY

Some congregare communities in Connecticut are publicly sponsored and are associated with the State's Congregate Housing For The Elderly program. These communities generally meet the description of congregare housing as it is described above; there are, however, certain requirements associated with this program.

Connecticut regulations require that these communities provide residents with individual apartments that have private kitchens and baths. These communities provide one main meal per day in the facilities' main dining areas, housekeeping services and twenty-four-hour security. Communities may also assist residents in accessing personal-care services.

Residents must comply with age and income requirements and have temporary or periodic difficulties with one or more essential activities of daily living. Residents pay rent and a congregate services fee; they may receive subsidies for either or both of these charges.

CONTINUING-CARE RETIREMENT COMMUNITY (CCRC)

Continuing-care retirement communities (CCRCs) are also sometimes referred to as life-care communities. Through contractual agreements, continuing-care communities provide residents living accommodations and a wide variety of services, including long-term health and nursing services. Various levels of care, such as independent living, assistance with daily activities and nursing-home care, are usually provided on the communities' campuses.

Residents may move from one level of care to another as their needs change. Each resident must enter into a continuing-care contract with a CCRC in order to obtain residency; the resident must be independent upon admission. Every resident is required to pay a substantial, lump-sum entrance fee and monthly fees in exchange for lifetime housing and health-related services. These fees vary depending upon the community, the type of living unit chosen and whether an individual or couple is the occupant. Continuing-care communities have different policies regarding the availability and terms of entrance-fee refunds.

Housing units can be apartments in high-rise or low-rise buildings, townhouses, garden apartments, cottages or free-standing homes. Units can range in size from studios to three bedrooms. Residents are not generally entitled to have equity in their units; instead, they are entitled to lifetime *use* of their units. CCRCs are not licensed in Connecticut, but they must adhere to certain statutory requirements (Chapter 319hh of the Connecticut General Statutes, Management of Continuing-Care Facilities). Various components of their health-care packages, however, are licensed by the State of Connecticut.

COOPERATIVE

Cooperatives are associations that own and operate housing communities for the benefit of their occupants. The associations may be incorporated and may be for profit or non-profit. Each resident owns shares in the cooperative corporation that in turn owns all the living units and common spaces associated with the community. Shareholders are required to cooperate in ownership and management. Residents lease apartments from the cooperative corporation; only individuals who own shares in the cooperative are allowed to lease apartments. These leases grant residents the right to occupy units, but they do not stipulate rent. Instead, residents are required to pay maintenance charges that are set annually by a board of directors. Shareholders usually also pay one-time membership fees.

Residents do not carry mortgages and, as shareholders, are responsible for the debts of the cooperative. Cooperatives may decide with whom they wish to share ownership as long as they do not violate existing laws prohibiting discrimination. Residents who wish to move must sell their shares in the cooperative to buyers who must acquire approval from the board of directors. Similar approvals are also required for subleasing units.

INDEPENDENT LIVING

Facilities designated as independent living in this directory are rental housing communities that are restricted to elderly individuals. In some communities, younger persons with disabilities may also be allowed admission. Residents are generally permitted to occupy living units by entering into rental contracts for fixed periods of time. Living units are usually apartments that can vary in size.

These communities are not licensed, but they must comply with building and safety codes regarding the design, construction and safety features of their buildings. They can be either publicly or privately sponsored, and they may have rent subsidies available to their residents. Although residents are typically independent, some of them may use support services to help maintain their independence.

Facilities may employ resident service coordinators who help residents live independently by helping them access community-based services. Some

communities may be congregate-meal sites where, usually on weekdays, one afternoon meal in a central dining area is available to each resident. Some facilities may also provide or arrange recreational activities and/or transportation services. Communities vary in terms of the amount and types of services they provide.

MANUFACTURED/MOBILE HOME

Manufactured homes can refer to mobile homes or prefabricated houses that are manufactured off site. Prefabricated houses can be transported as one unit or in separate sections. Houses are either set down or erected and finished on site. After being placed on lots, some mobile homes are configured with peaked roofs and "skirts" to give them a permanent appearance.

Manufactured homes are usually less expensive per square foot than housing that is built completely on site. Standards for the construction of manufactured homes have been regulated by the federal government since 1976. Homes manufactured after this time have metal plates on them showing that they comply with these standards. Federal standards specify how strong, durable, fire and wind resistant and energy efficient a home should be. Notwithstanding these requirements, the cost of casualty insurance is often higher for manufactured homes than for homes built on site. Local zoning ordinances may restrict or prohibit manufactured homes from residential districts. Consequently, many residents who live in such homes typically live in mobile home parks.

Residents usually own their homes and site them on spaces they rent from owners of these parks. Once sited, most homes are not moved. As a result, individuals interested in manufactured homes have a choice of buying new homes or already-sited, used homes. Residents are responsible for maintaining their homes. The parks typically provide common facilities such as laundry and recreation areas, private roads within the parks, maintenance of the grounds, property taxes on lots and utilities.

In Connecticut, mobile home parks are licensed by the Department of Consumer Protection. They must conform with requirements of the State Building and Fire Safety Codes and local ordinances and zoning regulations. Every park must have a caretaker in charge at all times to keep the park and

its facilities and equipment clean, orderly and in sanitary condition. Each resident must receive a written rental agreement from the owner of the park before a home or lot can be offered. Park owners are not allowed to charge residents entrance fees. Only parks that are restricted to elderly residents are listed in this directory; most of these communities are comprised of mobile homes.

NURSING FACILITIES

Two types of nursing facilities that are licensed by the Connecticut Department of Public Health are rest homes with nursing supervision and chronic and convalescent nursing homes.

Nursing homes can elect to be licensed in one or both of these categories. Before entering nursing homes, prospective residents or their guardians must sign admission agreements. Nursing homes provide their residents with rooms, meals, recreational activities, help with daily living and protective supervision. Residents live in private or semi-private rooms. They usually have physical or mental impairments that keep them from living independently.

Unlike some other facilities, nursing homes employ medical personnel to provide health care to residents. Some facilities provide sub-acute care, which is medically more sophisticated than traditional nursing home care. These facilities can usually provide this care at a lower cost than hospitals.

The costs of staying in a nursing home vary by facility. Residents' options for paying for these costs may include: private pay, long-term-care insurance, Medicare or Medicaid. Many nursing homes accept Medicare and/or Medicaid as payment; some do not. Along with meeting stringent standards, Medicare-approved facilities agree to participate in the Medicare program and limit the rates they charge Medicare-reimbursed residents. Any nursing home can elect to qualify all its beds for Medicare reimbursement or allocate only some beds for this purpose. Non-Medicare beds can be charged rates above the Medicare limit.

Long-Term-Care Ombudsmen help protect the health, safety, welfare and rights of individuals living in nursing homes. Ombudsmen receive, investigate and resolve complaints made by or on behalf of residents against

nursing homes. Residents wishing to make complaints or receive clarification on residents' rights, should contact the regional Ombudsman office in their area. Ombudsmen and their support staff respect the privacy and confidentiality of individuals who make complaints or request information.

Rest Homes With Nursing Supervision

Rest homes with nursing supervision are for individuals with chronic conditions who are unable to live independently but do not need constant skilled care. These individuals typically have controlled and/or stable chronic conditions that require minimal skilled-nursing services, nursing supervision or assistance with personal care on a daily basis. Residents are normally not confined to a bed and usually have a greater degree of mobility than those individuals who reside in chronic and convalescent nursing homes. Nursing supervision under medical direction is provided twenty-four hours a day. A full range of medical, social, recreational and support services are provided.

Chronic And Convalescent Nursing Home

Chronic and convalescent nursing homes are designed for individuals who need continuous skilled-nursing services and/or nursing supervision; these individuals have uncontrolled and/or unstable and/or chronic conditions. Individuals can also have chronic conditions that require substantial daily assistance with personal care. Skilled-nursing care is provided under medical supervision and direction to carry out non-surgical treatment and dietary procedures for chronic diseases or convalescent stages of acute diseases or injuries. Residents need nursing care but do not require hospitalization.

RESIDENTIAL-CARE HOME

Residential-care homes in Connecticut are licensed by the Department of Public Health. These homes can also be referred to as homes for the aged, rest homes, personal-care homes or board and care homes. In Connecticut, a board and care home usually provides fewer services than a facility that is generally considered a residential-care home; it is also not licensed by the State.

Residents of residential-care homes may have some health, social and personal-care needs, but they do not require the extensive medical care a nursing home provides. Most require some assistance with activities of daily living, supervision of medications and/or protective oversight. Although residents may use devices, they are ambulatory and have some degree of independence, but they are not able to live on their own. Residents should be able to evacuate their homes unassisted in case of an emergency.

Residential-care homes provide residents with a communal living environment. Residents typically live in a private or semi-private room; lavatories and bathing areas can be either private or shared among residents. The cost of living in these homes depends upon the home and type of room chosen; private rooms are generally more expensive than semi-private rooms. Some residents use government assistance to help them pay for their care. Many of the smaller homes are large, single-family homes that have been renovated.

The owners of these homes often provide services to residents with the assistance of other staff. Close relationships may develop among residents and between residents and staff that contribute to a home-like atmosphere and family environment.

Residential-care homes are required to provide three meals per day, housekeeping and laundry services, personal care, recreational activities, twenty-four-hour supervision and emergency call systems. Menus for meals must meet requirements set by the Department of Public Health. The personal-care services that these homes provide do not require the training or skills of a licensed nurse. Staff is not required to provide nursing services. Some homes, however, have a nurse on staff. Staff members can supervise medications that residents *self-administer* and may help residents schedule their doctors' appointments.

Retirement Community

Retirement communities are typically designed for independent older people who are in reasonably good health. Some communities offer rental units, while others require residents to purchase their units. Units can exist in any form in which housing is created, for example, single-family homes, condominiums, townhouses, apartments, cooperatives or mobile homes.

Retirement communities vary in terms of the kinds of services they provide and the fees they charge. Some communities feature extensive recreational and leisure activities. Some may offer services such as meals, housekeeping, transportation or twenty-four-hour security. Other communities provide a more comprehensive service package that offers residents a spectrum of health care and support services. There are also some retirement communities that are strictly independent living; they do not provide residents with assistance in obtaining support services. Residents in these communities must arrange and pay for their own services.

Some retirement communities, in which residents own their units, provide common areas where recreation or other types of services are offered. Developers, management companies or unit associations may own these areas. Homeowners are often assessed for the management of these areas. The fees can remain relatively stable or increase when it is deemed necessary.

Retirement communities are commonly moderate to high priced depending upon the services and amenities they provide. Retirement communities in this directory must be age-restricted communities. They can be comprised of any particular housing or combination of housing types. They can also provide any amount of services.

OPTIONS FOR PAYING FOR LONG-TERM CARE¹

GENERAL QUESTIONS

What is Long-Term Care?

Long-Term Care refers to the kind of care or help you might need for conditions related to the natural course of aging, or to an accident, disability, chronic illness, or cognitive impairment, like Alzheimers disease. It is the type of care you need when you are not able to care for yourself, and it includes institutional, home and community-based care services.

When is Long-Term Care most likely to be needed?

Long-Term Care is not just for the elderly. More than half of the people needing Long-Term Care today are 65 years old or older, but surprisingly, people between the ages of 18 and 64 make up 40% of the people needing Long-Term Care services. Generally speaking, the need for Long-Term Care services can be experienced at any age. Anyone can be incapacitated by a motor vehicle accident, a stroke, heart disease, or chronic illness. These facts argue for individuals to plan for this possibility sooner rather than later.

What does Long-Term Care cost?

In Connecticut, the average cost of care is \$7,905 per month. Rates usually go up 6% per year and currently most nursing homes seem to be charging \$290 to \$350 per day or more. This level of expenses can clearly wreak havoc with most family=s resources. The costs of care at home can vary. If a person needs 24-hour care, that may require two shifts, anywhere from \$150 to \$250 per day or more.

¹ Parts I and II, and some of Part III, of these materials were originally developed by Albany Law School and have been modified to reflect the rules applicable in Connecticut. All materials are simplified, introductory in nature and selective in their presentation and should not be relied upon without further discussion with an expert in the field.

Can I pay for my long-term needs myself?

The reality is that many of us are living to much older ages. Depending on a spouse or relative to provide Long-Term Care may not be a practical solution. At the time you require care, your spouse or other family member may not be able to give you the help you need. These persons are probably juggling a job or other family responsibilities, making it difficult or impossible to carry the extra burden of caring for a family member. Frequently, family members no longer live in close proximity to the person who needs the help.

Who pays for Long-Term Care?

Contrary to common belief, Medicare, group medical plans, HMOs, or other health insurance policies generally provide little or no coverage for long-term care expenses. Major medical plans (group or individual) or other health insurance plans are designed to pay for medically necessary services and items, such as hospitalization, doctors' services, and prescriptions. Coverage for Long-Term Care, if any, is very limited. Supplemental insurance policies will meet the copays and deductibles for the 100 days that Medicare covers, but rarely more.

Does Medicare Ever Pay For Long-Term Care?

Medicare was also never designed to pay for long-term care. Medicare was designed to address acute, short-term care. It does provide very minimal coverage for custodial care, accounting for only about 2% of long-term care costs nationally.

Medicare coverage for nursing home confinement:

- ❑ Begins only after a prior hospitalization of at least 3 days,
- ❑ Requires a *skilled level of care*,
- ❑ Requires that the facility be Medicare certified, and
- ❑ Lasts a maximum of 100 days.

Medicare coverage is also subject to copayments and deductibles: after the first 20 days, the patient pays \$119/day unless Medicare supplemental

insurance is available. Note: a nursing home resident can buy this coverage even when in the nursing home already!

Medicare coverage is also available for care at home if the following criteria are met:

1. The beneficiary must be "homebound" - confined to his or her home;
2. The beneficiary's doctor must have established a care plan;
3. The beneficiary must need intermittent skilled nursing care, physical or speech therapy, or occupational therapy
4. The services must be provided by a Medicare-certified home health care agency.

LONG-TERM CARE INSURANCE

In Connecticut, there are two categories of long-term care insurance policies:

1. Policies that are state-approved under the Connecticut Partnership for Long-Term Care, and
2. All other long-term care policies also approved by the Connecticut Insurance Department.

Who is eligible for coverage by long-term care insurance?

Generally, if you are in reasonably good health and can take care of yourself, you can buy long-term care insurance, although as you get older, long-term care insurance becomes more costly and may become unavailable

What do long-term care insurance policies cover?

Generally, long-term care insurance policies cover skilled, intermediate and custodial care in nursing homes. They may also cover home health care provided by home health agencies. Some policies may cover adult day care. Increasingly, policies cover care in assisted living facilities provided the requirements for coverage are met.

What may not be covered under a long-term insurance policy?

All policies contain limitations and exclusions. It is therefore important to review each policy carefully.

Insurance companies generally require that a period of six months pass before the policy pays for care related to a health problem you had when you applied for insurance. Such health problems are called preexisting conditions.

Alzheimer's disease and other organic cognitive disabilities developed after people successfully purchased long-term care insurance are generally covered under long-term care policies, but other non-organic mental and nervous disorders are often not covered.

What do long-term care insurance policies cost?

The cost (premium) for a long-term care insurance policy is dependent on such factors as your age when you become insured and the amount of coverage or benefits selected in the policy. The actual premium will depend on purchase age, health status, level of benefits purchased, and other factors. Policies cost more the older you are when you purchase and if certain benefits, like non-forfeiture, are selected. Employer-sponsored plans may cost much less for younger persons.

What is the Connecticut Partnership for Long-Term Care?

"Partnership" plans were originally created with help from grants by the Robert Wood Johnson Foundation to plan and implement an alternate way to finance long-term care. Connecticut's Partnership program links private long-term care insurance with Connecticut's Medicaid program. A person who buys such a policy may qualify for Medicaid while still owning assets equivalent to the amounts the policy has paid out. For example, if a policy provides for and has paid out \$80,000 in long-term care benefits, \$80,000 of the person's assets will be excluded in determining Medicaid eligibility. When the person dies, the State will make no claim to the \$80,000.

PUBLIC PAY: MEDICAID PAYMENT FOR LONG-TERM CARE¹

Medicaid is a joint federal-state program. There are a number of Medicaid programs. These materials discuss Medicaid payment in Connecticut for long-term care in a nursing home, at home, or in the community.

Medicaid does not supply any direct services. Services are rendered by qualified providers who then bill Medicaid for reimbursement of the services provided to the individual client. The reimbursement rates to these providers are established by the state. In general, the state pays facilities less than the private pay rate.

Medicaid is the payer of "last resort." Medicaid pays only after private pay, medical insurance, and/or Medicare benefits have been applied.

What is Medicaid?

Medicaid provides payment for institutional and community-based care for eligible persons who are treated by participating institutions and practitioners. Medicaid covers nursing home care and all other medical care including home care, acute hospital care, physicians, and pharmacy. Medicaid is a means-tested, needs-based program with limitations on income and resources.

What are the Income and Asset Limits?

The gross income limit for the Medicaid portion of the Connecticut Home Care Program for Elders (CHCPE), which pays for home and community based services, is \$1,809 per month. For Medicaid coverage in a nursing home, a person's gross monthly income only has to be less than the facility's monthly private pay facility cost to meet the income requirements. *(Note: Medicaid does not pay for "residential care homes," which provide somewhat less care than nursing homes but may seem quite similar. Residential care homes are paid for by the State Supplement program, which has an \$1,809 monthly income limit and different eligibility rules.)*

The asset limit (sometimes referred to as the resource limit) for an individual seeking Medicaid is \$1,600. Where a husband and wife are both seeking Medicaid for long-term care, the asset limit is \$3,200. Where one spouse is

seeking Medicaid long-term care coverage in a nursing home or under the CHCPE, and the other spouse lives in the community, as a general rule the spouse in the community is allowed to keep one-half of the couple's assets (counted as of when long-term care begins), but no less than \$19,908 and no more than \$99,540, plus certain exempt assets (explained below). There may be situations where the spouse in the community could retain more assets.

(The income and asset limits used here are for 2006, and change each year.)

Note: *The Connecticut Home Care Program for Elders also includes programs that are funded exclusively by the state; for these non-Medicaid programs, there is no income limit (although copayments may apply for those with income over \$1,596/month) and asset limits are higher: \$19,908 for a single person, \$29,862 for a couple.*

What resources are not counted when determining Medicaid eligibility?

Examples of resources that are exempt from inclusion in the Medicaid eligibility resource limit are your family residence (of any value where there is a spouse or minor or disabled child in the house, and up to \$500,000 in value in certain other instances); irrevocable pre-paid burial expenses (the limit for Connecticut contracts is \$5,400), plus a revocable contract for "burial space items" (like a casket); personal and household property; one automobile; life insurance policies that have cash surrender value where the total face value is \$1,500 or less. Certain trusts are also not counted as assets in determining Medicaid eligibility.

The family residence must be the primary residence of the applicant, and/or his or her spouse or minor or disabled child. It may be a one, two, or three family house, and may also include any attached property. If an individual with no spouse and/or no minor or disabled child enters a nursing home and is not medically expected to return home within six months, the home is no longer exempt, and must be put on the market.

What are Connecticut Department of Social Services' (DSS) requirements to determine Medicaid eligibility for long-term care?

In order to qualify for Medicaid for long-term care in Connecticut, the following must apply:

1. The applicant must be a resident of (actually present in) Connecticut;
2. The applicant must meet the required income and/or asset limits; and
3. The applicant must meet criteria that shows (s)he needs long-term care.

What is Spending Down?

If the value of the applicant's assets are over the allowed amount, that person would be expected to use his or her assets to pay for his or her own expenses (including but not limited to long-term care expenses), or "spend down" until his or her assets were depleted to the applicable asset limit. In other words, the person is spending down his or her assets to meet the eligibility asset requirement.

What are Medicaid transfer of asset rules?

Any asset transferred *for the purpose of qualifying for Medicaid* is considered an impermissible transfer of assets for which a penalty is imposed. Any transfer of assets for which the transferor does not receive "fair market value" is considered a transfer for the purpose of qualifying for Medicaid unless it can be proven that the transfer was made only for another purpose.

No penalty period will be imposed for any transfer or sale of an asset for which the applicant receives the fair market value.

What is the "Look Back Period"?

The DSS must determine whether an applicant for benefits has disposed of assets for less than fair market value at any time during the thirty-six (36) months prior to application. Federal Medicaid law underwent significant change as of February 8, 2006, however, and for any transfers that occurred on or after that date, the DSS must look back sixty (60) months prior to application for transfers. These time periods are commonly referred to as the "look back" period.

What is the "Penalty Period"?

Transfers for less than fair market value that occurred during the applicable look back period are reviewed and, unless the transfer falls within an exception, a period of ineligibility for benefits, or a "penalty period," is calculated. *(Note that a check for \$10,000 to buy a car that was worth \$10,000, would not result in a transfer penalty since fair market value was received, as long as the car was for the applicant, his or spouse or minor or disabled child.)*

The length of the penalty period is determined by dividing the uncompensated value of the transferred asset by the average monthly cost of nursing home care for a private patient in the state. For transfers made prior to February 8, 2006, the penalty period begins on the first day of the month in which the transfer occurs. Whether the transfer affects Medicaid eligibility when needed depends on the uncompensated value of the transfer and the date on which the transfer was made. For transfers made on or after February 8, 2006, however, the penalty period begins on the first day of the month in which the transfer is made, or in which the person applies for Medicaid and is otherwise eligible for benefits, *whichever is later*.

What Transfers are Exempt?

Even if a large gift was made during the applicable "look back" period, the gift will have no effect on eligibility if it was exempt. This also means that an exempt gift can be made at any time, even at the eleventh hour, without any effect on benefits. Some examples of exempt transfers are:

- ❑ **Transfers between spouses.** All transfers between spouses are entirely exempt.
- ❑ **Certain gifts of the home.** Transfer of home property to the following individuals are exempt transfers: to the spouse, to a child under twenty-one (21) or child who is blind or disabled, to a sibling who has an equity interest in the home and has lived there for one year immediately prior to the applicant's need for long-term care, or to an adult child who has lived in the home for two (2) years before the applicant entered a facility or applied for the CHCPE as long as the care avoided nursing home admission or CHCPE application during that time.

- ❑ **Gifts to or for the sole benefit of blind or disabled child.**
Transfers of assets to a blind or disabled child will not be subjected to a penalty period, nor will transfers to certain special trusts for the sole benefit of a blind or disabled child.

What Is Transferee Liability?

In Connecticut, the state may recover assets transferred for less than fair market value from the recipient, if the transfer was made during the applicable look back period (36 or 60 months) and if there is a penalty period. There is some question as to whether this law is legally enforceable.

How Can the Spouse at Home be Protected?

The spouse at home can retain a certain amount of the couple's assets, subject to limitations. The spouse at home is also deemed to need a certain amount of monthly income to meet his or her monthly expenses (referred to in Connecticut as the Minimum Monthly Needs Allowance or MMNA). If the income of the spouse at home is insufficient to meet the MMNA, then a portion of the income of the spouse receiving long-term care services may be retained to make up this MMNA shortfall. There may be other means by which a spouse at home can keep additional assets or additional income. Couples should consult with an attorney to determine the best approach for these difficult issues.

Note: These materials provide a short summary of a very complicated area of law. Many topics are not covered. For example, whether and to what extent the State can seek reimbursement for Medicaid benefits paid is not discussed, nor is the effect of an annuity on eligibility or the receipt of an inheritance on continued eligibility. Individual situations should be carefully analyzed with proper counsel to determine best approaches and outcomes.

ESTATE PLANNING

GENERAL INFORMATION ABOUT ESTATE PLANNING

Surprisingly, many people would be unsure or inaccurate in their answer if asked what would happen to their assets if they were gone tomorrow. This should be an easy question to answer. It certainly is an important one. We work all of our lives to accumulate assets, and we should have control over where those assets go after we are no longer here to enjoy them. However, due to various rules of law, moving assets to younger generations is often neither simple nor without pitfalls. For example:

- ❑ Wills do NOT control the distribution of all assets. Many assets are distributed outside of the will, so the plan of distribution in a will does not describe the total plan. Property passing under a will does NOT avoid probate.
- ❑ Making lifetime gifts to children can have serious income tax consequences for both parents and children, particularly if the gifted property has appreciated in value since the parents acquired it, or if the parents' personal residence is gifted.
- ❑ If you could no longer manage assets due to incompetency, a court proceeding would be required in order to take over management of your solely owned assets even if your spouse was available to manage assets.
- ❑ If minor children or grandchildren inherit property and provisions for management of that property are not specified in a will or trust, the child will receive the entire inheritance at the age of eighteen in Connecticut.

Wills, trusts, and other estate planning documents can be very important in preserving our property and in distributing property during our lifetimes or at our deaths. Without a will or trust, a person's assets are disposed of according to state law at that person's death. Specific state laws known as the intestacy laws (which provide for the distribution of the assets of an individual who dies without a will) may or may not match the deceased

person's desires regarding who should get the property or how the property should be handled.

Without a will or trust, a person has no opportunity to:

- ❑ Personally select guardians for minor children;
- ❑ Name the person who should manage the children's assets until they are distributed to the children at a particular age; or
- ❑ Select the person who should handle the details of distributing the estate.

Without estate planning, these important decisions are left to a judge who can only apply state law to determine what would be reasonable under the circumstances. Most people would prefer to set their own guidelines for distribution and management of assets.

If no special provisions are made, minor children receive their share of the estate immediately upon reaching the age of majority, which is 18 years of age in Connecticut. Through trust provisions, parents can give directions and restrictions on how and when assets should be distributed.

Clearly written wills and trusts can minimize the cost of administering an estate. If a will is used and probate is required, the will tells the probate court what the deceased's wishes were so the court can quickly and inexpensively approve procedures to carry out those wishes.

A trust may be used to avoid the probate process, allowing for transfer of assets to beneficiaries with no court intervention. Provisions may be added to your estate planning documents to prevent unnecessary bureaucracy.

For example, the document may provide that if a beneficiary does not survive by at least 90 days, that beneficiary will be deemed not to have survived. This provision could save the cost and delay of probating assets through the estate of the deceased beneficiary to get them to the ultimate recipient. This provision can also be used in some cases to avoid application of the generation-skipping transfer tax.

A survivorship clause also prevents an unintended distribution of property. Suppose Frank and Joan are a married couple with no children, and have no

will or trust. Under the law of intestacy, the distribution of property is determined according to the order of death. If an accident occurs and only one spouse survives, the surviving spouse inherits all property. If the surviving spouse lives for only a week due to injuries incurred in the accident, all assets are inherited by the relatives of the second spouse to die, since the predeceased spouse's relatives are not considered heirs of the spouse who survived one week. Since the spouse who survived legally owned all assets, only that spouse's heirs receive an inheritance. A survivorship clause in a will or trust allows you to establish the amount of time a beneficiary must survive in order to inherit.

It is very important that wills and trusts are drafted according to statutory requirements, are clearly written, and cover all details of the estate plan. If ambiguities arise after a death, the person whose document is being implemented is not available to answer questions. It is therefore important that documents are drafted without ambiguities.

Thinking about death, accident, or illness is never pleasant. However, when the inevitable does occur, it is never an ideal time for family members to be forced into making decisions or to be burdened with excessive administrative details. Planning ahead is far more favorable than burdening a family during a period of grief.

Probate Avoidance

Most people, if asked, would prefer to avoid some of the expense and time delay of having their estate probated. According to a national survey, sixteen months is the average length of time involved between a person's death and completion of all paperwork required to conclude the probate process. Some of these delays occur in order to analyze various tax savings opportunities and to gather information on current assets and outstanding liabilities.

These delays may occur whether probate is required or whether non-probate techniques are used to transfer assets after death. Other delays occur due to notices and mandatory waiting periods required under probate statute and can be avoided through estate planning. Therefore, although the benefits of avoiding probate are often overstated, it is often desirable to attempt to avoid probate to the extent possible.

Probate refers to the process by which assets of a deceased individual are passed to a beneficiary under the supervision and jurisdiction of a court (the "Probate Court"). Various forms of ownership and kinds of assets are not subject to probate, such as assets owned "jointly with right of survivorship" or assets such as life insurance and retirement assets that pass by contract.

Various methods of avoiding probate exist.

- ❑ **Ownership in joint tenancy with right of survivorship.** Upon the death of one joint tenant, the surviving joint tenants remain the legal owner(s), and probate is not required. Probate will be required upon the death of the last surviving joint tenant, since no other owner will survive.
- ❑ **Life insurance, Individual Retirement Account (IRA) or Annuity with a named beneficiary.** Upon the death of the insured or the account owner, the surviving beneficiary is the legal owner of the proceeds and probate is avoided. However, probate is NOT avoided if the insured's estate is listed as beneficiary or if the beneficiary is deceased.

Therefore, it is very important to have a primary and a contingent beneficiary listed, so the proceeds are paid to the contingent beneficiary if the primary beneficiary is not available. However, if an asset is transferred to a child outside the will or trust through titling or beneficiary designation on an account, life insurance policy, or other asset, the child will receive the asset at the age of majority, even though the will or trust provides that children will not receive assets until a later age. So, in these situations one may wish to name a trust for the benefit of the child as the beneficiary instead.

WILLS

What is a Will?

A will is a written, legal document that sets forth how a person (the testator) wants his or her property distributed at the time of his or her death. A will is signed (executed) by the testator with formalities required by state law. A will may be changed or revoked during the lifetime of the testator.

The average will:

- ❑ Directs payment of funeral and administrative expenses;
- ❑ Directs payment of the testator's debts;
- ❑ Directs the manner and allocation of estate taxes if estate taxes will be due;
- ❑ Names an executor; and
- ❑ Directs how the testator's assets are to be distributed at his/her death.
- ❑ Special circumstances can cause a wide variance in the contents of wills. A will may also:
 - ❑ Names a guardian for minor children and set up a trust for assets that might pass to those children;
 - ❑ Provides for disabled children;
 - ❑ Provides for gifts to charity; and
 - ❑ Sets up trusts for the benefit of children, grandchildren and more remote descendants.

What are the legal requirements for writing and signing a will in Connecticut?

To execute a will, the testator must be eighteen years of age or over and of sound mind and memory. (C.G.S. § 45a-250) Generally, the testator must sign the will in the presence of two witnesses who know that the document being signed is a will. (C.G.S. § 45a-251) The witnesses should be disinterested, that is, they do not inherit any assets from the estate of the testator.

Do different laws in other states mean that a will made in Connecticut would not be accepted in another state? Can a will made in another state be accepted in Connecticut?

Generally, a will that is valid in the state in which it was executed is valid in another state. Connecticut recognizes wills that were validly executed in another state.

Why is it desirable to have a will? What happens if a person does not have a will?

If you write a will, you have control over how your assets will be distributed, and you can appoint the person who will handle your affairs after your death. If you die without a will and have assets that do not pass automatically to another at the time of your death, state law will dictate how those assets will be distributed. This law is referred to as the Law of Intestacy. That is, when a person dies intestate, or without a will, often the way state law and the courts direct distribution of a deceased's estate is not what that individual would have wanted.

What assets pass automatically without needing a will?

Assets in joint names with another individual, in trust for another individual, payable on death to another individual or by beneficiary designation (i.e., life insurance, IRAs and other retirement assets) pass to the named individual and do not pass by the terms of your will. They are considered to pass "outside the will."

If all my assets are owned jointly or set up to pass outside my will, do I still need a will?

It is advisable to have a will for any assets you may have forgotten to put in joint names or have not made other provisions for. If you have no will and have assets that would be distributed under the will, the laws of intestacy will apply to those assets.

How can a will be changed? What should NOT be done to change a will?

Wills can be changed by:

- ❑ Executing a new will that revokes all prior wills, or
- ❑ Executing a codicil, which is an amendment to a will, that changes only certain parts.

Wills cannot be changed by writing the changes on the existing will or by crossing out items on the existing will.

How can a will be revoked?

A will can be revoked by physically destroying the document or by executing a new will which revokes prior wills.

Where should a will be kept? Where should a will NOT be kept?

Your original will should be kept in a safe place with other important papers. It can be kept in your attorney's vault. Your named executor should know how to locate your will.

A will should not be kept in the testator's safe deposit box, because there may be delays in opening the safe deposit box.

What is the interaction between wills and trusts?

Trusts may be established by a will (i.e., the terms of the trust are contained within the will itself). This type of trust is a testamentary trust. A testamentary trust may be established for the purposes of: providing for a spouse, child, or other beneficiary; for tax planning; and/or for the use by a beneficiary during his/her lifetime with the remainder to go to a charity.

Wills may also be used to fund trusts. This type of will is a pour-over will. A pour-over will directs that estate assets be added to an existing trust (a living trust that was established during the lifetime of the testator) for further distribution in accordance with the terms of the trust.

What is the function of an executor/executrix of a will? Who can be an executor?

An executor is appointed within a will to make sure that the provisions of the will are carried out. An executor can be a family member, trusted friend or advisor, or institution. A will generally appoints an alternate to serve if your executor predeceases you or is otherwise unable to serve.

An executor may have to post a surety bond to insure his or her faithful performance unless the Testator's will directs otherwise.

What if there is no executor or alternate who can act?

If the alternate is also unable to act, the Court appoints an administrator who is chosen according to statute but who acts according to the terms of the will.

What is probate and how does it work?

To probate a will means to go through a probate court proceeding to prove to the Court that the will is valid. If there are no objections and the will appears in good form, there is rarely a problem with probate. A will is generally probated before the probate court where the decedent lived at the time of his or her death.

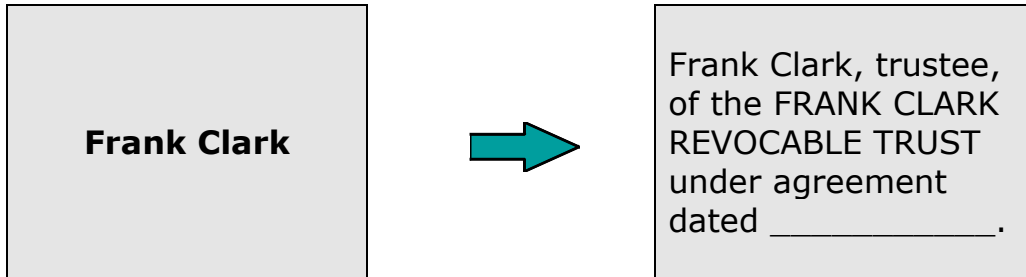
TRUSTS

The Living Trust: Avoid Probate While Maintaining Total Management And Control Of Assets

A revocable living trust has the benefit, among others, of avoiding the probate process. If assets are owned by a trust, no court is involved in the transfer of trust assets upon death. It is still necessary to determine what assets exist to pay creditors, file required tax returns, and to distribute assets to beneficiaries. However, avoiding court proceedings and requirements simplifies and expedites the process. With that said, all probate will be avoided only if all assets of a decedent are titled in the name of the trust prior to the death of the individual, which is unusual.

Probate only arises when the legal owner of property dies, leaving no joint owner or named beneficiary. A living trust avoids probate because the owner of the assets is the trustee of your living trust.

Instead of owning property as Frank, the name on the deed, account, security or other asset is changed to the name of the trust (i.e., "Frank Clark as trustee of THE FRANK CLARK REVOCABLE TRUST under agreement dated _____").



The trustee of the trust owns the property. Frank, as trustee of the trust, has control over all property (as provided in the terms of the trust agreement). Typically, Frank could spend money, mortgage, sell or give away assets. If Frank should ever lose the ability to manage his financial affairs, the named successor trustee takes over as trustee and manages the trust assets on Frank's behalf. Married couples who have revocable trusts often designate each other as successor trustee and name at least one additional successor trustee in case the spouse is also unable to serve effectively as trustee.

When Frank dies, no probate is required since the trust is still the legal owner of the property. According to the provisions of the trust agreement, the party named as successor trustee will have the power to distribute property according to the terms provided in the trust. The successor trustee is typically the same person or institution who would be named as executor in a will. This should be someone who is capable of completing paperwork, responsible with money, and who can get along with the named beneficiaries. The successor trustee can be the surviving spouse, a family friend, one of the named beneficiaries or a bank or trust department.

Living trusts work well for both married and single people. In the case of a married couple, each spouse has his or her own living trust. If the spouses want to leave everything to each other, then each spouse's living trust would designate the other spouse to receive the trust's assets. Each trust would also designate backup beneficiaries in case the spouse had predeceased.

Joint living trusts holding the assets of both spouses are common in a few mostly Western states which have what are known as "community property"

laws governing married couples' ownership of assets. Joint living trusts can work well for married couples who live in these states. In Connecticut, as in the majority of states that do not have community property laws, joint living trusts can actually cause serious legal problems. For that reason, they are generally best avoided here.

Case Study

For purposes of illustration, assume that, at this time, Joyce Clark had only one asset: an apartment building worth \$200,000. She owned this property in her sole name. Joyce has a will which leaves everything to her son, Frank.

Upon Joyce's death, Frank takes the will to his attorney. Frank's attorney explains that various papers must be filed with the probate court so the court can authorize Frank to manage the property during the pendency of the probate proceeding. After a waiting period passes, required tax returns must be filed and taxes paid, and an accounting of all activity which occurred since the date of death must be completed. Administrative fees for this process must be paid even though there may be no cash available in the estate.

Frank leaves the attorney's office and does nothing. One year later, Frank receives an offer from a buyer who wants to purchase the building. The offer is for \$300,000, but is contingent upon a quick sale since the buyer needs to complete the purchase rapidly for tax planning purposes.

Frank is tired of managing the building, could use the cash, and knows that several repairs will be needed soon. Much to Frank's dismay, he discovers that he cannot sell the property. The deed to the building is still in Joyce's name and because she is deceased, she cannot sign a deed transferring the property to the buyer.

Frank returns to the attorney and asks how to clear title so that sale can be consummated.

The answer: Probate must be initiated to get Frank nominated as executor with authority to transfer the property. Initiation of probate procedures and issuance of a document authorizing Frank to act as the estate representative may be expedited in order to clear title prior to

the buyer's deadline.

However, Frank's failure to get tax releases may constitute a cloud on title which could take time to clear. In the meantime, Frank's buyer may be lost. If the sale doesn't go through and Frank keeps the property, the same title problem will arise if he ever wants to mortgage it. In order to clear title the probate process must be commenced. Substantial additional costs will now be included since tax returns and accounting of all expenses and income must incorporate the entire period of time since the date of Joyce's death.

Tax penalties and interest may apply. Income tax rates applicable to income earned may be higher than would have been required if returns were filed promptly and planning was done. Time delays will increase administrative costs.

The moral to this story: Probate cannot be avoided unless planning is done in advance. If Joyce decided during her lifetime, that she wanted to avoid probate on the apartment building, she could use various techniques.

First, she could transfer the property to Frank during her lifetime. If she did this, Joyce would no longer have a legal right to income from the building. Even if Frank gave her the income from the building, the income would be taxable on Frank's income tax return, form 1040, and at Frank's income tax rate. Frank's creditors could reach the building, and, if Frank got a divorce, the building could affect the divorce settlement. Additionally, a great income tax advantage (i.e. a step-up in cost basis upon death) would be lost by gifting the property to Frank during Joyce's lifetime rather than letting him inherit it. Possible gift tax ramifications must also be considered. In addition to other considerations, Joyce must keep in mind that if Frank predeceases her, the building will be probated through his estate if it had been put into his name.

A **second** technique which Joyce could use to avoid probate of the building would be to transfer the building to Frank and herself as joint tenants with right of survivorship. This form of ownership would eliminate probate of the property as long as either Frank or Joyce survived. However, the concerns outlined earlier regarding putting

property in someone else's name such as tax, creditor, and management problems would apply to Frank's one-half ownership in the property. Whether Joyce changes the name on the deed to Frank's name solely or to Frank and Joyce as joint tenants, Joyce will need Frank's permission in order to mortgage or sell the building.

A **third** option to avoid probate of the apartment building would be the execution of a living trust. In order to make the trust effective, Joyce must sign a revocable living trust agreement, and then she must execute a deed which transfers the apartment building from Joyce Clark to "Joyce Clark, trustee of the JOYCE CLARK REVOCABLE TRUST under agreement dated _____."

Frank is named as successor trustee of the trust. Pursuant to the trust agreement, if Joyce becomes incapacitated, Frank would step in and manage the trust assets, in this case the apartment building, for Joyce's benefit. This would eliminate the requirement of going into court to prove that Joyce is incompetent to manage her affairs.

Upon Joyce's death, the legal owner of the property is the trust, so probate is not required. The deed shows the trustee of the trust as owner of the apartment building. The trust agreement appoints Frank as successor trustee so that upon Joyce's death, Frank becomes the trustee of the trust and has legal authority to transfer the property to the beneficiaries named in the trust agreement.

In this case, Frank is the beneficiary, so he issues a deed which transfers the property from "Frank Clark, as successor trustee of the Joyce Clark Revocable Trust under agreement dated _____," to Frank Clark.

Tax returns must be filed, but no probate, statutory waiting periods, or notice requirements apply. Time requirements and costs of administration are reduced.

If probate avoidance is desired but Joyce does not want to name Frank as successor trustee, a family friend or other individual or a bank, trust department or other professional could be appointed as successor trustee.

As with all estate planning, each person's individual situation and wishes must be analyzed before a decision is made as to the most effective planning technique. In considering living trusts or other probate avoidance and estate planning techniques, it is very important that a professional knowledgeable about living trusts be consulted.

ANSWERS TO COMMONLY ASKED QUESTIONS ABOUT LIVING TRUSTS

What is a Living Trust?

A Living Trust is a method of avoiding the probate process if properly funded. If assets are owned by a trust, no court is involved in the transfer of assets upon death. Therefore, no public notices are required, no records become public, and generally there is no probate court oversight. It is still necessary to determine what assets exist, to pay creditors, to file required tax returns, and to distribute assets to beneficiaries. However, avoiding court proceedings and requirements simplifies and expedites the process.

A trust is a legal entity created and funded during the lifetime of the creator for the benefit of designated beneficiaries under the laws of the state and a valid trust document.

- ❑ The grantor (or settlor) is the creator of the trust;
- ❑ The trustee holds legal title to the property and has the responsibility to manage the trust's principal assets and income for the economic benefit of all the beneficiaries; and
- ❑ The beneficiaries can be either current beneficiaries who receive income and/or principal during their lifetimes from the trust, or remainder beneficiaries who receive the balance of the trust principal and/or income when the trust is terminated.

What if I change my mind? Can a Living Trust agreement be changed or revoked?

A Revocable Living Trust allows you to amend any provision of the trust or to totally revoke the trust.

What are the advantages of creating a Revocable Living Trust?

- ❑ Using the trust to plan for future incapacity (an alternative to a Court-appointed conservator of the estate) by ensuring continuity of management of your assets if you are no longer able to take care of your own financial affairs;
- ❑ Is acceptable in all states and avoids probate of out-of-state property as well as property located in the state of residency (i.e., would avoid the need for a secondary (“ancillary”) probate in each out-of-state state in which property is held);
- ❑ Avoidance of probate so no court is involved;
- ❑ Potentially, earlier distribution of your assets after death;
- ❑ Keeps your plan of distribution private;
- ❑ Eliminates the requirement of public notices in a newspaper;
- ❑ Allows for optimum tax planning using federal and state income, gift, and estate tax law, yet requires no extra tax returns or filings; and
- ❑ Allows you to remain in control and manage your own property and does not require management fees to be paid to anyone unless you wish to appoint an outside manager.

What are the disadvantages of a Revocable Living Trust?

- ❑ Higher attorneys’ fees to draft a revocable living trust and pour-over will;
- ❑ Costs of funding the trust (that is, transferring ownership of assets to the trust and reviewing all beneficiary designations);
- ❑ The cost of a third-party trustee to manage your trust (trustees commonly receive a yearly commission based on the assets of the trust, unless otherwise provided for in the trust document);
- ❑ The loss of control when a third-party trustee manages your property during your lifetime; however, a creator of a Revocable Living Trust can serve as his or her own trustee as long as he or she has the capacity to do so;
- ❑ The cost of preparing the trust income tax returns if the creator of the trust is not the trustee;

- ❑ Foregoing the assistance of the Probate Court in monitoring the stages of estate administration; and
- ❑ What a Revocable Living Trust will NOT accomplish:
- ❑ A Revocable Lifetime Trust does not shelter your assets from state and federal estate and income taxes. Retaining the right to revoke or amend the trust is considered, under federal and Connecticut tax law, sufficient control of the property to include it in your taxable estate.
- ❑ What must be done to fund a Revocable Living Trust?
- ❑ Again, it is essential that a Revocable Living Trust be funded properly. In order to fund the trust:
 - ❑ Bank accounts must be transferred into the name of the trust;
 - ❑ The trustee of the trust must be made the registered owner of stocks and bonds;
 - ❑ Real estate must be deeded over to the trustee of the trust;
 - ❑ If every asset owned individually by the person has not been transferred to the trust prior to death or does not have a beneficiary designation, such asset must go through probate or other proceeding in the Probate Court before the asset can be distributed to beneficiaries.

How are assets managed with a Revocable Living Trust?

Assets transferred to the Revocable Living Trust must be managed by the trustee. The trustee is usually given direction in the trust agreement with respect to investments and distribution of the trust income and principal.

If I have a living trust, do I still need a will?

If all assets are held in the name of the living trust, a will is not used at the time of death. However, a will must be signed in conjunction with a living trust in case an asset is inadvertently left out of the trust. The will simply states that any property not already in the living trust should be transferred to the trust. This document is called a pour-over will since it pours assets over into the trust.

Does having a living trust mean that I still have to file income tax returns?

As long as the person who put the assets into the trust is the trustee of the trust, the individual will continue to file and pay income taxes in exactly the same way as before the trust was created. Income generated by trust assets is simply treated as income of the individual, so no extra tax returns are required.

Although administration of a living trust is generally less costly than probate, a trust will not eliminate all fees of administration since, even with a trust, titling must be verified, values determined, tax returns filed, expenses paid, and distributions made. The trust does eliminate most court involvement, maintains more privacy than probate, eliminates notice requirements and waivers from beneficiaries, and, in many cases, simplifies implementation of tax planning techniques.

The benefit of a living trust also depends upon the personal desires and goals of each individual. In some cases, regardless of whether dollars can be saved in the long run, an individual may not want to spend time or money completing estate planning during lifetime.

The right estate planning tool for you depends upon your personal goals. In some cases, the desire to keep affairs private and to allow for transfer of assets without waiting periods required in probate may make use of a living trust beneficial regardless of the level of cost savings.

The primary goal of any estate plan must be to achieve the individual's desired objective. No minimum estate value is required in order to benefit from a living trust. The type of assets involved and overall goals should be assessed to determine whether a living trust would be beneficial.

What is the cost to set up a living trust?

Costs of a living trust will vary substantially from attorney to attorney and from state to state, and costs will vary depending upon your particular estate planning needs. An initial consultation will allow you to meet an attorney and discuss your individual situation. At the conclusion of that meeting, a cost estimate should be made available to enable you to balance costs versus benefit.

Will a living trust protect my assets from potential nursing home costs?

Revocable living trusts, which allow you to continue to manage your own assets and which can be revised or revoked at any time, have been discussed in this commentary. Revocable living trusts will not shield assets from nursing home costs. Assets held in a revocable living trust will be considered to be your assets for purposes of Medicaid eligibility. Medicaid is the government program which covers costs of nursing home care for those eligible. Eligibility is available only to those whose income and assets are under allowable levels. If you can manage and control the assets, the assets are considered yours for purposes of Medicaid eligibility.

What are other types of trusts?

- ❑ Trusts may be either revocable or irrevocable:
- ❑ Revocable trusts which may be amended or terminated during the lifetime of the trust creator; and
- ❑ Irrevocable trusts which generally may not be amended or terminated during the lifetime of the trust creator.
- ❑ Trusts may be divided into two further categories:
- ❑ Lifetime trusts, or inter vivos trusts, which are established during the lifetime of the individual creating the trust; and
- ❑ Testamentary trusts which are established at the death of the individual creating the trust in the creator's will.
- ❑ Lifetime trusts may be revocable or irrevocable.
- ❑ Trusts may be established for purposes such as:
 - ✓ Providing for the creator of the trust or the spouse, child, or other beneficiary;
 - ✓ Tax planning;
 - ✓ The use by a beneficiary during his/her lifetime with the remainder to go to a charity; or
 - ✓ Avoiding probate; i.e. to opt out of court-supervised administration of an estate.

Why would a person want to set up an Irrevocable Lifetime Trust?

1. An Irrevocable Lifetime Trust is not the same as a Revocable Lifetime Trust.
2. An Irrevocable Lifetime Trust is used to address different estate planning objectives, such as:
 - To provide asset management for a beneficiary who needs financial assistance now but who is immature, financially irresponsible, or incapacitated (a Supplemental Needs Trust);
 - For Medicaid planning;
 - ✓ To provide payments during the lifetime of the initial beneficiary(ies) with a charity receiving the trust balance at the death of the initial beneficiary(ies);
 - ✓ To remove assets from a person's taxable estate. Some of these trust arrangements trigger the payment of gift taxes and the filing of gift returns.
 - ✓ Life insurance trusts – to remove the proceeds of life insurance from the estate of a decedent;
 - ✓ Minors' trusts – to provide management of the assets and to pay income and principal for the support, maintenance, and education of a minor.

MEDICARE PRESCRIPTION DRUG COVERAGE

From the Center for Medicare Advocacy, Inc
www.medicareadvocacy.org

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Stein and Chiplin, 2008 Medicare Handbook,
"Prescription Drug Coverage," © 2008.

INTRODUCTION

Effective January 2006, Medicare beneficiaries have limited assistance paying for prescription drugs through a new Medicare Part D. The drug benefit, added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),² is not part of the traditional Medicare program, but rather is offered through private insurance plans.

The Part D benefit is premised on the notion that individual Medicare beneficiaries should have a choice of private drug plans in order to select a drug benefit that best meets their needs. The statute creates three categories of drug plans: stand-alone plans that offer only prescription drug coverage, Medicare Advantage (MA) plans with a drug benefit, and fallback plans. The categories of drug plans are discussed below.

Most significantly, the MMA establishes a low-income subsidy for beneficiaries with incomes up to 150 percent of the federal poverty level and with limited resources. The Act also eliminated, beginning January 1, 2006, all Medicaid drug coverage for the more than 6 million individuals who are dually eligible for both Medicare and Medicaid (dual eligibles). Moreover, it requires states to pay back to the federal government much of the savings they would otherwise realize from their reduced Medicaid obligation to those individuals, and it includes other provisions that will affect state budgets.

² Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-73 (Dec. 8, 2003); 42 U.S.C. §§1395w-101 *et seq.* (2004 Supp.); 42 C.F.R. §423.506.

In the first two years of the program, favorable reimbursement rates induced private companies to offer Part D plans throughout the country.³ It remains to be seen whether they will be as greatly available in the future.

ELIGIBILITY FOR PART D COVERAGE

Prescription drug coverage under Part D is voluntary. A beneficiary may purchase Part D coverage if she has Part A or Part B. Beneficiaries do not have to have both Part A and Part B coverage to choose prescription drug coverage, unless they choose to enroll in an MA plan, in which case they must be in both Parts A and B.⁴ The beneficiary must enroll in a Part D plan that serves the geographic region in which she resides.⁵ Beneficiaries who are incarcerated are not eligible to participate in Part D.⁶

CHOICE OF DRUG PLANS

Prescription Drug Plans

The majority of Medicare beneficiaries who remain in the traditional Medicare program will be able to purchase drug coverage through prescription drug plans (PDPs) that offer only prescription drug coverage. PDPs are offered by sponsoring organizations pursuant to a one-year contract with the Centers for Medicare & Medicaid Services (CMS).⁷

Medicare Advantage Plans

Individuals who are enrolled in a Medicare Advantage plan established under Medicare Part C must receive their prescription drug coverage through their MA plan, known as an MA-PD. They may not purchase a separate PDP. However, individuals who are enrolled in a Medicare Advantage private fee-for-service (PFFS) plan that does not include a prescription drug option may

³ Information about prescription drug plans for 2008 is available at <www.medicare.gov>. In addition, rules may change as CMS issues additional program guidance to clarify how the Part D program will operate.

⁴ 42 C.F.R. §423.30.

⁵ 42 U.S.C. §§1395w-101(a)(3)(A).

⁶ 42 C.F.R. §§423.4, 423.30(a).

⁷ 42 U.S.C. §§1395w-101(a)(1)(A), 1395w-112(b)(1), 1395w-151(a)(14).

purchase a PDP for their Part D coverage. Individuals who want to join an MA-PD for the first time must have both Medicare Part A and Part B.⁸

Fallback Plans

Under the MMA, each beneficiary must have a choice of enrollment in at least two plans.⁹ One of the plans must be a PDP, and the two plans cannot be sponsored by the same organization. In regions¹⁰ where two drug plans meeting the above requirements are not available, the MMA authorizes creation of a fallback prescription drug plan. Fallback drug plans are more limited in the scope of benefits they can offer; they can only offer the statutory standard benefit.¹¹ However, in 2006 and 2007 there were substantially more than two drug plans in each prescription drug plan region, so that CMS did not need to contract with fallback plans. CMS anticipates that sufficient drug plans will be available in 2008 as well.

THE PART D DRUG BENEFIT

Covered Part D Drugs

The MMA defines the drugs that are covered under Part D, and therefore the drugs for which payment will be made under Part D, in relationship to their coverage under Medicaid and under other parts of Medicare. A Part D drug is a drug that is approved by the Food and Drug Administration, for which a prescription is required, and for which payment is required under Medicaid.¹² Biological products, including insulin and insulin supplies, and smoking cessation drugs are also covered under Part D.¹³

⁸ 42 U.S.C. §1395w-101(a)(1)(B). Note that individuals enrolled in a Medicare Part C Medical Savings Account (MSA) may also purchase a PDP to obtain drug coverage.

⁹ 42 U.S.C. §1395w-103(a).

¹⁰ CMS has established 34 PDP regions, several of which include more than one state. A map is available at <<http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PDPRegions.pdf>>. Each PDP must offer coverage to all beneficiaries in the region that it serves. A PDP may also offer a plan that serves more than one region or that is national in scope. 42 U.S.C. §1395w-111(a).

¹¹ *Id.*; §1395w-111(g)(4).

¹² 42 U.S.C. §§1395w-102(e)(1), 1396r-8(d), (k).

¹³ 42 U.S.C. §§1395w-102(e)(1)(B), (2)(A).

The MMA excludes from coverage those categories of drugs for which Medicaid payment is optional.¹⁴ Of particular significance to Medicare beneficiaries is the exclusion of drugs for weight gain (e.g., those used in connection with treating weight loss due to cancer or HIV/AIDS), barbiturates (e.g., those used to treat seizures in older people), benzodiazepines (e.g., those used to treat acute anxiety, panic attacks, seizure disorders, and muscle spasms in those with cerebral palsy), and over-the-counter medications. Many of the excluded medications are used by nursing home residents.¹⁵ Note, however, that some of these drugs may be covered if prescribed for a purpose other than those prohibited by MMA.¹⁶ MMA also excludes from Part D coverage those drugs for which payment could be made under Medicare Part A or Part B. CMS has determined that such drugs are excluded from Part D coverage even if the beneficiary does not have coverage under the part of Medicare (either Part A or Part B) that would generally pay for the drug.¹⁷

Part D plans are not required to pay for all covered Part D drugs. They may establish their own formularies, or list of covered drugs for which they will make payment, as long as the formulary and benefit structure are not found by CMS to discourage enrollment by certain Medicare beneficiaries.¹⁸ Part D plans that follow the formulary classes and categories established by the United States Pharmacopoeia will pass the first discrimination test. However, CMS indicates it will still review formularies to determine whether the placement of specific drugs in each category or class, as well as other benefit design issues, discriminates against particular individuals. Plans also have the flexibility to change the drugs on their formulary during the course of the year.¹⁹

¹⁴ Congress added an exclusion for drugs used to treat sexual or erectile dysfunction unless prescribed for a different use approved by the Food and Drug Administration. Pub. L. No. 109-91, §103(a)(1), (a)(2); 42 U.S.C. §§1395w-102(e)(2)(A), 1396r-8(d)(2).

¹⁵ Richard G. Stefanacci, "The Cost of Being Excluded: Impact of Excluded Medications Under Medicare Part D on Dually Eligible Nursing Home Residents," University of the Sciences in Philadelphia (Feb. 16, 2005). Available at <<http://www.ascp.com/medicarerx/upload/ASCPPaperExcludedMeds.pdf>>.

¹⁶ 70 Fed. Reg. 4193, 4230 (Jan. 28, 2005).

¹⁷ 42 C.F.R. §423.100.

¹⁸ 42 C.F.R. §§423.120(b), 423.272(b).

¹⁹ 42 C.F.R. §423.120(b).

Structure of the Drug Benefit

Introduction

Much of the debate about the MMA centered on the adequacy of the drug benefit itself. However, the discussion did not mention that prescription drug plans are given a great deal of flexibility to design their own benefit structure.²⁰ Thus, the majority of plans have chosen not to offer the statutory “standard” benefit and instead offer an alternative benefit structure.²¹ Variations in plan benefit structure, along with the substantial number of plans available, have adversely affected the ability of Medicare beneficiaries to compare and choose the plan that best meets their needs.

The Standard Drug Benefit

The MMA establishes a standard drug benefit that Part D plans may offer. The standard benefit is defined in terms of the financial structure of the cost sharing and not in terms of the drugs that must be covered. In 2008, this standard benefit requires payment of a \$275 deductible. The beneficiary then pays 25 percent of the cost of a covered Part D prescription drug up to the initial coverage limit of \$2,510.²² The initial coverage limit is calculated based on the total cost of the drugs used by the beneficiary. Once the initial coverage limit is reached, the beneficiary enters a second deductible period known as the “doughnut hole” in which she pays the full cost of her medicine.²³ When her total out-of-pocket expenses for the year, including the deductible and initial coinsurance, reach \$4,050, she pays \$2.25 for a generic or preferred drug and \$5.60 for other drugs, or 5 percent coinsurance, whichever is greater.²⁴ Note that the \$4,050 amount is calculated on a calendar year basis; a beneficiary who amasses \$4,050 in

²⁰ All prescription drug plans, regardless of their benefit design, are supposed to provide beneficiaries with access to negotiated prices for the covered Part D drugs they include in their formulary, even if the beneficiary is required to pay the full cost of the prescription. 42 C.F.R. §423.104(g)(1).

²¹ Jack Hoadley, Elizabeth Hargrave, Katie Merrell, Juliette Cubanski, and Tricia Neuman, “Benefit Design and Formularies of Medicare Drug Plans: A Comparison of 2006 and 2007 Offerings,” Kaiser Family Foundation (Nov. 2006). Available at <<http://www.kff.org/medicare/upload/7589.pdf>>.

²² The beneficiary’s share of cost is \$558.75, or 25 percent of the difference between \$2,510 and \$275. When added to the deductible, the beneficiary’s total cost sharing for formulary drugs up to the initial coverage limit is \$833.75.

²³ Once a beneficiary reaches the doughnut hole, she must spend an additional \$3,216.25 on formulary drugs to reach the catastrophic limit. At that point, the beneficiary and the drug plan will have paid a combined total of \$5,726.25 in costs for formulary drugs.

²⁴ 42 U.S.C. §1395w-102(b)

out-of-pocket costs on December 31 will have to start all over again on January 1. The deductible, initial coverage limit, and annual out-of-pocket threshold increase each year by the increase in expenditures for Part D drugs.²⁵

MMA does not mandate a set premium amount. Premiums are determined by a bidding process and vary from plan to plan and from region to region. Private insurance companies that want to continue participating in the Part D drug benefit must submit new bids each year. Thus, the premiums they charge are likely to change on a yearly basis. Premium amounts will be especially critical for individuals with low incomes, as they will only receive full assistance for plans that offer the standard benefit and that charge the lowest premiums.

Alternative Coverage and Enhanced Alternative Coverage

Part D drug plans are not required to offer the standard benefit, but they can offer alternative prescription drug coverage. Alternative coverage must be "actuarially equivalent" to the standard benefit. In other words, the value of the benefit package must be equal to or greater than the value of the standard benefit package.²⁶ In an actuarially equivalent plan, the cost sharing varies through the use of such mechanisms as tiered copayments. For example, a beneficiary's share of cost may be less for a generic or preferred brand name drug than for a non-preferred brand name drug. However, a plan that offers an alternative benefit package cannot impose a higher deductible (\$275 in 2008) or require a higher out-of-pocket limit (\$4,050 in 2008) than required by the standard benefit.

Plans can offer enhanced alternative coverage that might also include changes to the deductible and the initial coverage limit, though the deductible cannot be higher than the amount set in the statute (\$275 in 2008). Enhanced alternative coverage might also include coverage of drugs that are excluded under Part D or coverage of some drugs in the coverage gap or doughnut hole. A PDP that wants to offer a drug plan with enhanced

²⁵ 42 C.F.R. §§423.104(d)(1)(ii), (3)(ii). See Medicare Part D Benefit Parameters for Standard Benefit: Annual Adjustments for 2007. Available at

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/2007_Part_D_Parameter_Update.pdf>.

²⁶ 42 C.F.R. §§423.4, 423.100, 423.104(e).

alternative coverage in a region must also offer a PDP with the basic benefit package in that region.²⁷

Calculating Beneficiary Expenses

As indicated above, only the costs of Part D covered drugs that are included on a plan's formulary count toward the deductible and out-of-pocket limits.²⁸ For example, a beneficiary whose only drug expense in January 2008 is \$400 for a Part D drug that is not on her plan's formulary will not meet her deductible, and the \$4,800 in out-of-pocket expenses she will incur for the year for the non-formulary drug do not qualify her for the reduced cost sharing for high out-of-pocket costs.

Payments that count toward the yearly out-of-pocket limit are referred to as true out-of-pocket expenses, or TrOOP. Only out-of-pocket costs for formulary drugs that are paid for by the beneficiary, by a family member or other person acting on her behalf, or by a state pharmacy assistance program are considered TrOOP and are counted toward the out-of-pocket limit.²⁹ Payments made by other insurance, including employer-sponsored plans and AIDS Drug Assistance Programs (ADAPs), do not count toward the limit. Such uncounted payments increase the amount the beneficiary must spend before the reduced cost sharing for high drug expenses begins. In sum, the beneficiary is responsible for paying premiums and the full costs of non-formulary prescriptions and gets no credit for these payments toward the out-of-pocket limit.

Access to Pharmacies

A drug plan may establish a network of retail pharmacies with which it enters into contracts in its service area as long as the pharmacies are conveniently located for all enrollees in the drug plan. The network must include access to long-term care pharmacies that serve residents of nursing facilities.³⁰ A plan that does not offer the standard benefit can offer reduced

²⁷ 42 C.F.R. §423.104(f).

²⁸ The regulations discuss beneficiary cost sharing in terms of "covered Part D drugs." 42 C.F.R. §423.104. CMS uses the term to describe Part D drugs that are on a plan's formulary. 70 Fed. Reg. 4228 (Jan. 28, 2005).

²⁹ 42 U.S.C.A. §1395w-102(b)(4)(C)(ii); 42 C.F.R. §423.100.

³⁰ CMS, Prescription Drug Benefit Manual (PDBM), Ch. 5, §50.5—Long-Term Care (LTC) Pharmacy Access. Available at http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDMChap5BeneProtections_03.09.07.pdf.

copayments to enrollees who use its preferred pharmacies. A plan may also offer access to formulary drugs through a mail-order pharmacy.³¹

A Part D plan must provide coverage for formulary drugs purchased at an out-of-network pharmacy if a beneficiary cannot reasonably be expected to obtain the drugs through a network pharmacy. A beneficiary may not use an out-of-network pharmacy on a routine basis. A beneficiary may also have to pay a larger copayment or coinsurance for using an out-of-network pharmacy.³² Plans may establish policies and procedures, including contracting with pharmacies that are outside of their service areas, to accommodate seasonal residents, often known as “snowbirds” and travelers.³³

ENROLLING IN A PART D PLAN

Introduction

Enrollment in Medicare Part D differs dramatically from enrollment in Medicare Part B, which is also voluntary. A beneficiary who becomes entitled to Part A is automatically enrolled in Part B unless she takes steps to notify the Social Security Administration that she does not want Part B coverage. Enrollment in Part D requires the beneficiary to take affirmative steps to enroll and get Part D coverage. She must first choose a drug plan from the options available in her area. Then, she must enroll through the plan she chooses. If she may be eligible for the low-income subsidy, she must file a separate application for the subsidy either with her state Medicaid agency or with Social Security.

Enrollment Periods

Initial Enrollment Period

Individuals who had Medicare Part A and/or Part B when Part D became effective had an initial enrollment period that ran from November 15, 2005, through May 15, 2006. The initial enrollment period for individuals who are first eligible to enroll in Part D on or after March 2006 corresponds to the initial enrollment period for Part B, i.e., the seven-month period running

³¹ 42 C.F.R. §423.120(a).

³² 42 C.F.R. §423.124.

³³ 70 Fed. Reg. 4193, 4249 (Jan. 28, 2005).

from three months before the month the individual first becomes eligible and ending three months after the first month of eligibility.³⁴

Annual Coordinated Enrollment Period

Starting in 2007 the annual coordinated enrollment period corresponds to the annual coordinated enrollment period for Part C and runs from November 15 through December 31.³⁵

Special Enrollment Periods

- Individuals may be eligible for a special enrollment period³⁶ if:
- They did not enroll in Part D during their initial enrollment because they had other prescription drug coverage deemed to be “creditable coverage,” and they lose the creditable coverage;
- They were given incorrect information concerning the status of their other prescription drug coverage as creditable coverage;
- They were given incorrect information about enrollment by a federal employee;
- They have Medicare and full Medicaid coverage or a Medicare Savings Program (MSP);
- They move out of a plan’s service area;
- Their PDP’s contract with Medicare is terminated;
- They enrolled in an MA-PD during the first year of eligibility and want to return to traditional Medicare and a PDP;
- They move into, reside in, or move out of a nursing home.

Effective Date of Enrollment

Part D coverage becomes effective:³⁷

- The same month that Part A and/or Part B coverage becomes effective for individuals who enroll before their month of entitlement to Part A or enrollment in Part B;

³⁴ 42 C.F.R. §§423.38, 407.14.

³⁵ 42 C.F.R. §423.38(b).

³⁶ 42 C.F.R. §423.38(c).

³⁷ 42 C.F.R. §423.40.

- The first day of the next calendar month after enrollment for individuals who enroll after the first month of entitlement for Part A or enrollment in Part B;
- The following January 1 for individuals who enroll during the annual coordinated enrollment period; and
- At the time specified by CMS for individuals who enroll during a special enrollment period.

Involuntary Disenrollment

An individual may be involuntarily disenrolled from a drug plan for reasons similar to the grounds for disenrollment from a Medicare Advantage plan.³⁸ These include no longer living in the plan's service area, loss of eligibility for Part D, death of the individual, termination of the PDP, failure to pay premiums on a timely basis, engaging in disruptive behavior that substantially impairs the ability of the plan to arrange for or provide services.³⁹

Ability to Change Plan Mid-Year

Changes During the Annual Coordinated Enrollment Period

All beneficiaries may switch plans once during the annual coordinated enrollment period, which runs from November 15 to December 31 each year.⁴⁰ Enrollment becomes effective on January 1 of the next year.

Changes During Open Enrollment Periods

Individuals enrolled in a Medicare Advantage (MA) plan also may change plans once during the open enrollment period, which is the first three months of each year. An enrollee in an MA-PD may use the open enrollment period (January through March) to change to another MA-PD or to disenroll from the MA-PD and return to traditional Medicare and a PDP. Someone who enrolls in an MA plan that does not offer prescription drug coverage may not change to an MA-PD or to original Medicare and a PDP during the open

³⁸ See discussion on enrollment and disenrollment in Stein and Chiplin, *2008 Medicare Handbook*, Chapter 7, Aspen Publishers, 2008.

³⁹ 42 C.F.R. §423.44.

⁴⁰ 42 C.F.R. §423.32(a).

enrollment period. The beneficiary must wait to change plans until the next annual election period.⁴¹

In each year, individuals who enroll in a PDP are “locked in” to their plan for the remainder of the calendar year, even though the plan in which they enroll may change the formulary or cost-sharing arrangements during the year. Enrollees in PDPs must wait until the next annual coordinated enrollment period to switch plans, with enrollment in the new plan becoming effective on January 1 of the following year.⁴²

Special Enrollment Periods

Beneficiaries may also be eligible to change plans mid-year if they qualify for a special enrollment period described above.

Enrollment Process for Individuals Who Are Eligible for Medicare and Medicaid

The MMA established an enrollment process that provides for automatic assignment into drug plans for individuals who are dually eligible for Medicare and Medicaid (dual eligibles) and who do not choose their own PDP or MA-PD during their initial enrollment period. In addition, dual eligibles are automatically eligible for a continuous special enrollment period and therefore are not ever locked in to a prescription drug plan.⁴³

Failure to Enroll on a Timely Basis

Late Penalty

A beneficiary who does not enroll in a Part D plan within 63 days of her initial enrollment period and has no other “creditable” prescription drug coverage must pay a late penalty if she subsequently enrolls in a Part D plan. The penalty is assessed at one percent of the national average premium for each month of delayed enrollment, for the remainder of the

⁴¹ 42 C.F.R. §§422.62(a)(3), (4), (5).

⁴² In December 2006, Congress created a limited enrollment period for all of 2007 and 2008 to allow enrollees in traditional Medicare to enroll in a Medicare Advantage plan without drug coverage. Pub. L. No. 109-432 §206(a) (Dec. 20, 2006) adding 42 U.S.C. §1395w-21(e)(2)(E). Congress ended the limited open enrollment period effective July 31, 2007. Pub. Law. 110-48 §2 (July 18, 2007).

⁴³ 42 U.S.C. §1395w-101(b)(3)(D); 42 C.F.R. §423.38(c)(4).

time in which the beneficiary is enrolled in a Part D plan.⁴⁴ Thus, a beneficiary who becomes eligible for Part D at age 65 but who delays enrolling until age 70 may be assessed a 60 percent penalty on her premium (5 years × 12 months × 1%). Since the penalty is based on a percentage of the average premium each year, the dollar value of the penalty changes as the national average premium changes.

A beneficiary who becomes eligible for Medicare based on disability has a new initial enrollment period for Part D upon turning age 65. As a result, any late enrollment penalty assessed against such a beneficiary ends with the new initial enrollment penalty.

Creditable Coverage

Someone who delays enrollment because she has creditable coverage, i.e., coverage through another insurance plan deemed comparable to Part D coverage, will not be assessed a penalty for late enrollment if she later decides to enroll in Part D. A determination of whether coverage is creditable involves an actuarial assessment of whether the other insurance provides coverage of the costs of prescription drugs that equals or exceeds the actuarial value of the prescription drug benefit.⁴⁵

Coverage offered through an employer or union-sponsored health plan, the federal employee health benefits program (FEHBP), Medicaid, a state pharmaceutical assistance program, programs for veterans, and TRICARE may constitute creditable coverage. The entity sponsoring the coverage must inform beneficiaries whether or not the coverage provided meets the definition of creditable coverage.⁴⁶

Coverage offered through some prestandardized Medicare Supplemental (Medigap) policies may qualify as creditable, as may coverage through some policies sold in Michigan, Minnesota, and Wisconsin, which are not required to sell the standard policies. The standard Medigap policies H, I, and J that offered drug coverage to beneficiaries who purchased them before January 1, 2006, do not meet the definition of creditable coverage. Insurers that offer Medigap policies were required to notify their insureds concerning the

⁴⁴ 42 C.F.R. §§423.46, 423.286(d)(3).

⁴⁵ 42 U.S.C. §1395w-113(b)(5).

⁴⁶ 42 U.S.C. §1395w-113(b)(4), 42 C.F.R. §423.56.

status of their policies. Beneficiaries are advised to check with their insurers about the status of their policies.

Choosing a Part D Plan

CMS is supposed to provide information to all Medicare beneficiaries to help them choose a Part D prescription drug plan. Information is made available through the Medicare & You handbook, through the Medicare toll-free number, and through the Medicare Web site, www.medicare.gov. In addition, Part D plan sponsors are required to make available to all individuals eligible to enroll in Part D information about all beneficiary cost sharing, their formulary and cost control mechanisms, their pharmacy network, and their exceptions and appeals process.⁴⁷ Beneficiaries who want this information have to check with each drug plan.

Beneficiaries who have retiree health coverage also must contact their former employers or unions to determine the effect of enrollment in a Part D plan on their retiree health benefits. Some employers and unions will terminate all retiree health coverage, and not just the drug benefit, for retirees and their dependents if the retiree enrolls in a Part D plan. Dual eligible beneficiaries who are automatically enrolled in a Part D plan and who will lose their retiree health benefits because of their auto-enrollment may need to decline Part D affirmatively if they want the retiree health coverage to continue for themselves and/or their dependents.

PREMIUM AND COST-SHARING SUBSIDIES FOR PART D PRESCRIPTION DRUGS FOR LOW-INCOME INDIVIDUALS

Introduction

For the first time in program history, Medicare has a low-income benefit for people with limited incomes and resources. While the Medicaid program has also played a role in paying Medicare's cost sharing for beneficiaries dually eligible for both programs, Medicare has never provided direct low-income subsidies. In its design of the benefit, Congress adopted aspects of the federal Supplemental Security Income program (SSI) and of Medicaid's Medicare Savings Programs (MSPs). Similarly, to administer the benefit,

⁴⁷ 42 C.F.R. §423.128.

Congress looks to the Social Security Administration and to state Medicaid agencies.

The Subsidies

Some form of low-income subsidy (LIS) to help pay costs of Medicare Part D is available to Medicare beneficiaries with incomes up to 150 percent of the federal poverty level (FPL) for a family of the size involved.⁴⁸ Subsidies vary according to income, Medicaid status, and institutional status. So-called full subsidy eligible individuals are those with full Medicaid status (full-benefit dual eligibles), those with Supplemental Security Income (SSI) but no Medicaid, those enrolled in one of three MSPs, and individuals with incomes below 135 percent of FPL and countable resources in 2007 of not more than \$7,620 for an individual and \$12,190 for a couple. Partial subsidy individuals can have incomes up to 150 percent of FPL and resources in 2007 of not more than \$11,710 per individual and \$23,410 per couple. Resource levels will increase each year based on increases in the consumer price index. Income and resource levels are generally announced in January of each year.

Full Subsidy Eligible Individuals

All full subsidy individuals are entitled to a 100 percent subsidy for the “low-income benchmark premium” (the weighted average of plan premiums for the basic benefit package in the region in which the individual lives), for a plan offering the standard Part D benefit, elimination of the deductible, continuation of coverage through the doughnut hole, and elimination of all cost sharing after they meet the annual out-of-pocket maximum. In addition, their cost sharing is reduced as follows:

- ❑ Full-benefit dual eligibles who are institutionalized have no cost sharing at all.
- ❑ Full-benefit dual eligibles with incomes up to 100 percent of FPL initially pay no more than \$1.05/generic or preferred brand or \$3.10/non-preferred brand, in 2008.
- ❑ All other full subsidy individuals initially pay copayments of no more than \$2.25/generic or preferred brand or \$5.60/non-

⁴⁸ 42 U.S.C. §1395w-114.

preferred brand, with copayments indexed annually to the cost of Part D drugs in 2008.⁴⁹

Partial Subsidy Eligible Individuals

In 2008, partial subsidy individuals pay a sliding scale premium, a \$56 deductible, coinsurance of 15 percent instead of the full 25 percent, including continued coverage through the doughnut hole, and a copayment of no more than \$2.25/generic or preferred brand or \$5.60/non-preferred brand for all drugs after the out-of-pocket threshold is met.⁵⁰

Deemed Subsidy Eligible Individuals

Certain individuals are treated as full subsidy eligible individuals regardless of their actual income and resources. These are full-benefit dual eligibles, recipients of SSI benefits, and beneficiaries of the three MSPs: QMB, SLMB, and QI.⁵¹

An initial determination that someone qualifies for the low-income subsidy remains in effect for a full year. As the program becomes more established, however, eligibility determinations may be subject to more frequent review, depending on an assessment of the likelihood of a change in the beneficiary's financial status.⁵²

Eligibility Determinations

Where to Apply

Beneficiaries who are not "deemed eligible" have the choice of filing an application for the low-income subsidy (LIS) either at their state Medicaid office or through the Social Security Administration (SSA).⁵³ Because of strong encouragement by SSA and CMS, the overwhelming majority of beneficiaries apply through SSA.⁵⁴ However, though some beneficiaries may

⁴⁹ 42 C.F.R. §423.773(b).

⁵⁰ 42 C.F.R. §423.773(d).

⁵¹ 42 C.F.R. §423.773(c).

⁵² Final rules were issued on Dec. 30, 2005. 70 Fed. Reg. 77,664 (Dec. 30, 2005) and codified at 20 C.F.R. §§418.3600 *et seq.*

⁵³ 42 C.F.R. §423.774(a).

⁵⁴ In 2005, to assist with enrollment in the low-income subsidy, SSA sent notices to a large number of Medicare

prefer SSA offices over state welfare offices, applying at SSA may not always be in a particular individual's best interest, since Medicaid offices screen for other benefits as well⁵⁵ and may have speedier determination time frames and more user-friendly appeals systems.⁵⁶ Unlike the Medicaid regulations, the Social Security regulations impose no time restrictions by which SSA must act on applications and appeals.⁵⁷

In some states, the choice of location for filing the LIS application may determine whether a beneficiary is found eligible for the LIS. State Medicaid offices must screen for eligibility for all Medicaid benefits, including MSP, when an LIS application is filed. In a state with more generous income and/or resource limits for its MSP program, or in a state that does not count support and maintenance provided by others (known as in-kind support and maintenance), someone found ineligible for LIS might still qualify for MSP benefits. By qualifying for MSP benefits, that individual is deemed eligible for the low-income subsidy. If the same individual had applied for LIS through SSA, she would have been found ineligible for LIS without a determination being made about her eligibility for MSP.

Eligibility Criteria

In determining eligibility for the LIS, income is to be determined according to MSP rules, which in turn refer to SSI rules. One improvement over both SSI and MSP rules is the definition of "family size," which requires using a standard that reflects the actual number of dependents in an applicant's household. Dependent is defined as one who relies on the applicant or spouse for at least one-half of her support. Resources are defined as liquid resources, "such as checking and savings accounts, stocks, bonds, and other resources that can be readily converted to cash within 20 days," and real estate that is neither the primary residence of the applicant nor the land on which the residence is located.⁵⁸

beneficiaries telling them that they may be eligible for the LIS to assist with their drug costs.

⁵⁵ 42 U.S.C. §1396a(a)(10); 42 C.F.R. §435.902.

⁵⁶ Eligibility regulations proposed by SSA do not include time frames for making eligibility determinations and include a very limited appeals process. 70 Fed. Reg. 10,558 (Mar. 4, 2005) (to be codified at 20 C.F.R. §§418.3600 *et seq.*).

⁵⁷ 20 C.F.R. §§418.3110, 418.3220, 418.3230.

⁵⁸ 42 C.F.R. §423.772.

Appeals Process

The appeals process for someone who is denied the low-income subsidy depends on where the application is filed. When the Medicaid agency makes the decision, any appeal must follow the procedures used for Medicaid appeals. SSA will use its redeterminations and appeals procedures for the determinations it makes.⁵⁹ SSA regulations provide for a telephone hearing or a case review. The preamble indicates that the hearings will not be conducted by Administrative Law Judges who hear other Social Security appeals.⁶⁰

Effect of Eligibility Determination for Low-Income Subsidy

Individuals, other than full-benefit dual eligibles,⁶¹ who are found eligible for the low-income subsidy, must still separately enroll in the Part D plan of their choice.⁶² CMS facilitated the enrollment of those found eligible for the LIS in a Part D plan and who had not chosen a Part D plan.

DUAL ELIGIBLES

Introduction

Among the most dramatic aspects of the Medicare drug benefit legislation is its complete elimination of Medicaid prescription drug coverage for all individuals who are dually eligible for both Medicare and Medicaid. Beginning January 1, 2006, any individual eligible to enroll in a Part D plan who is receiving full Medicaid services cannot receive prescription drug coverage through Medicaid.⁶³ This is true regardless of whether the individual has actually enrolled in a Part D plan and regardless of whether the plan covers the specific drug needed. Concomitantly, the state cannot receive federal matching payments for such services.

⁵⁹ 42 C.F.R. §423.774(c).

⁶⁰ 70 Fed. Reg. 77,664, 77,674 (Dec. 30, 2005).

⁶¹ Note that receipt of the low-income Part D subsidy may affect eligibility and/or benefit amounts in other assistance programs that consider medical expenses in making eligibility and subsidy determinations.

⁶² Dual eligible beneficiaries must also apply to a PDP or MA-PD if they do not want to be auto-enrolled in a drug plan or if they want to change the drug plan to which they were assigned.

⁶³ 42 U.S.C. §1396u-5(d)(1).

Definition of Dual Eligibles

Dual eligibles are defined as individuals who have coverage under a Part D plan and who are eligible for full Medicaid benefits under any category of a state Medicaid plan. Those with full coverage under a so-called §1115 research and demonstration waiver fall within the definition; individuals receiving prescription drug coverage under a §1115 Pharmacy Plus waiver do not.⁶⁴

Assignment of Dual Eligibles to Drug Plans

Presumably because of dual eligibles' loss of Medicaid drug coverage, Congress requires the automatic enrollment in a prescription drug plan of any dual eligible who has not voluntarily enrolled.⁶⁵ Dual eligible beneficiaries are randomly assigned to Part D plans with premiums at or below the average premium for their region. Under CMS guidance the effective date of auto-enrollment into a Part D plan for individuals with Medicare who become eligible for Medicaid will be the same as the effective date of Medicaid eligibility. The effective date of auto-enrollment for individuals who become eligible for Medicare and Medicaid in the same month will also be the date of Medicaid eligibility. New dual eligible individuals who have Medicaid first will be auto-enrolled retroactively to the date of their Medicare eligibility. In all situations, retroactive enrollment raises the possibility that dual eligibles may be required to pay for their drugs out of their own pockets and then be reimbursed.⁶⁶

The Inspector General of the Department of Health and Human Services determined that, in 2006, nearly one-third of dually eligible beneficiaries were assigned to drug plans that included less than 85 percent of the 178 most commonly used Part D drugs. Some of the drugs excluded from a substantial number of plan formularies (lists of covered drugs) are drugs for high blood pressure, high cholesterol, and pain relief. Only 18 percent of beneficiaries were assigned to plans that covered all 178 drugs, though this did not guarantee that these plans covered all drugs needed by each beneficiary.⁶⁷

⁶⁴ 42 C.F.R. §423.772.

⁶⁵ 42 U.S.C. §1396u-5(c)(6).

⁶⁶ Updated Guidance—Changes to the Effective Date and PDP Notice Requirements for Auto-Enrollment and Facilitated Enrollment—March 17, 2006.

<<http://www.cms.hhs.gov/States/Downloads/UpdatedGuidance4MANCostPlanonAEnFE.pdf>>.

⁶⁷ <<http://oig.hhs.gov/oei/reports/oei-05-06-00090.pdf>>.

Unlike other Medicare beneficiaries, however, dual eligible beneficiaries retain the right to switch plans at any time.⁶⁸ Thus, individuals assigned to a plan whose formulary does not include the prescriptions they use may switch to a more appropriate plan. Note, however, in 2006 and continuing on into 2007, CMS computer systems could not process changes from one Part D plan to another quickly enough to ensure that coverage under the new plan would become effective on the first day of the month following the change. In addition, some beneficiaries were enrolled in more than one plan, causing some dual eligible beneficiaries to be assessed a premium by the second plan. CMS instituted an enrollment reconciliation process to address multiple plan enrollments and/or discrepancies in CMS records of enrollment.⁶⁹

Medicaid Wrap-Around

The elimination of coverage for an otherwise covered Medicaid service represents a substantial departure from the historic Medicare-Medicaid relationship for dual eligibles, under which Medicaid has paid Medicare's cost sharing and provided "wrap-around coverage" for services where, as with home health, Medicare coverage is more limited than Medicaid's or where, as with prescription drugs and long-term care, Medicare coverage is nearly non-existent.⁷⁰ The significance of this situation cannot be overstated. Because of the design of the Medicare drug benefit, many dual eligibles have less prescription drug coverage than they had under Medicaid and potentially less protection during appeals processes to challenge denials or other barriers to coverage. Further, they have to make copayments for their prescriptions, with the copayment amounts increasing yearly.

Medicaid can continue to cover for dual eligibles, using both federal and state funding, those drugs that it is permitted but not required by law to cover for any Medicaid beneficiary and that are not, by definition, Part D covered drugs. Such drugs include benzodiazepines, barbiturates, prescription vitamins, cough and cold relief drugs, and non-prescription drugs, among others. States also have the option of paying copayments for dual eligibles and/or for drugs that are not on a plan's formulary. However, they will receive no federal matching payments and must use only state

⁶⁸ 42 C.F.R. §423.38(c).

⁶⁹ <http://www.cms.hhs.gov/MMAHelp/downloads/Enrollment_recon_Process_Final2.pdf>.

⁷⁰ For a full discussion of dual eligibility, see Stein and Chiplin, *2008 Medicare Handbook*, Chapter 10, Aspen Publishers, 2008.

funds if they assist dual eligibles with these costs. Many states continue to cover at least some of the excluded Part D drugs.⁷¹

Nursing Facility Residents

In addition to the problems that may be experienced by other dually eligible individuals, those who reside in nursing and other long-term care facilities experience problems that arise because of the setting in which they live. For example, there is no assurance that a dually eligible resident who does not choose a plan for herself will be automatically assigned to a plan that includes the pharmacy used by her nursing facility, although all plans are required to include long-term care pharmacies in their networks. Drug plans are not required to provide covered medications in the packaging utilized by nursing facilities or formats utilized by residents; access to medically necessary drugs and drug formats may be provided through the exceptions and appeals processes.⁷² Thus, a beneficiary may need to file an appeal in order to get the prescription ordered by the treating physician.

Dually eligible individuals who reside in a nursing facility pay no copayment for their medications. This benefit is not extended to residents of assisted living facilities and others who are receiving home and community-based services pursuant to a Section 1115 waiver. Those individuals must pay the copayments described above for dual eligible beneficiaries.⁷³

Transitioning into a Part D Plan

When Medicare beneficiaries move from another source of payment for their prescriptions to a Part D plan, they may encounter difficulties caused by changes in formularies and other utilization management tools used by Part D plans to contain costs. The transition may be particularly difficult for nursing home residents and other dual eligibles, and for beneficiaries with chronic conditions who are stabilized on their current treatments.⁷⁴

All Part D plans are required to establish a transition process for new enrollees who are prescribed Medicare-covered drugs that are not on the

⁷¹ <<http://www.cms.hhs.gov/States/EDC/list.asp#TopofPage>>.

⁷² CMS, PDBM, Ch. 5, §50.5, *supra*.

⁷³ 42 C.F.R. §§423.772, 423.782(a)(2)(ii). CMS, PDBM, Ch. 6, §30.4—Transition. Available at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf>.

⁷⁴ CMS, PDBM, Ch. 6, §30.4, *supra*.

plan's formulary.⁷⁵ Each plan has the flexibility to design its own process as long as the process is consistent with sub-regulatory guidance issued by CMS. Because many drug plans failed to provide the 30-day transition fill, suggested in CMS's initial guidance, CMS issued stronger guidance that established a minimum set of standards for the transition process. Another CMS memorandum encouraged plans to continue to cover drugs after they are removed from their formularies for enrollees who are taking the medications.⁷⁶

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS

States may choose to provide cost sharing and wrap-around drug coverage for dual eligibles and other low-income residents through a State Pharmaceutical Assistance Program (SPAP).⁷⁷ Any payments made by the SPAP on behalf of a Part D enrollee will count toward the enrollee's true out-of-pocket costs. In other words, SPAP payments for cost sharing and for a plan's covered drugs while the beneficiary is in the "doughnut hole" count toward meeting the \$4,050 out-of-pocket limit (in 2008) which, in turn, leads to reduced or eliminated enrollee cost sharing. State Medicaid programs, including Pharmacy Plus waivers under Section 1115 of the Social Security Act, ADAPs, and any other programs where the majority of the funding is from federal sources, cannot be SPAPs.⁷⁸

SPAPs must not discriminate among drug plans with respect to their supplemental coverage;⁷⁹ this requirement prevents an SPAP from automatically enrolling subsidy-eligible individuals into one particular drug plan. Plans must coordinate with SPAPs concerning certain basic elements of the drug benefit they offer.

⁷⁵ 42 C.F.R. §423.120(b)(3).

⁷⁶ CMS, PDBM, Ch. 6, §30.4, *supra*.

⁷⁷ 42 C.F.R. §§423.454, 423.464(e)(1).

⁷⁸ 42 C.F.R. §423.464(e)(1)(iv).

⁷⁹ 42 C.F.R. §§423.464(e)(1)(ii), 423.464(e)(1)(ii).

GRIEVANCE, APPEALS, AND EXCEPTIONS PROCESSES

Grievance Procedures

All drug plans must establish processes for hearing and resolving grievances similar to the process utilized by Medicare Advantage plans under Medicare Part C.⁸⁰ Grievances are separate and distinct from appeals and from quality of service complaints filed with a quality improvement organization. Grievances may be filed with the drug plan orally or in writing within 60 days after the incident; plans generally must resolve grievances within 30 days. However, plans must resolve within 24 hours a grievance arising from the plan's decision not to expedite a coverage determination or redetermination under the appeals process.⁸¹

Coverage Determinations and Appeals

The Coverage and Appeals Process

As directed by Congress, the coverage determination and appeals process for Part D also mirrors closely the process utilized by Medicare Advantage plans.⁸² The process begins when the drug plan issues a coverage determination.⁸³ The beneficiary may request a redetermination, performed by the drug plans, of an unfavorable coverage determination. Individuals who remain dissatisfied after the redetermination can request a further review known as reconsideration; the reconsideration will be performed by the independent review entity (IRE). Following an IRE review, the enrollee may appeal to an administrative law judge (ALJ), then to the Medicare Appeals Council (MAC), and finally to federal court. An expedited review is available if the standards set out in Medicare Part C are met.⁸⁴

Plans must notify enrollees of initial coverage determinations as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request. They have seven days in which to notify enrollees of a redetermination decision. Plans must act on requests for

⁸⁰ 42 U.S.C. §1395w-104(f). See Stein and Chiplin, *2008 Medicare Handbook*, §7.04[F], Aspen Publishers, 2008.

⁸¹ 42 C.F.R. §423.564.

⁸² 42 U.S.C. §§1395w-104(g)–(h), 1395w-104(g)–(h).

⁸³ See discussion about notice, *infra*.

⁸⁴ 42 C.F.R. §§423.560–423.638.

expedited coverage determination no later than 24 hours after receiving the request, and on expedited redeterminations within 72 hours.⁸⁵ Note that beneficiaries who file an appeal after paying out of pocket for a needed prescription are not eligible for expedited consideration.

Unlike under Medicare Part C, unfavorable redeterminations on Part D claims are not automatically forwarded to the IRE. The beneficiary must file a request for reconsideration with the drug plan within 60 days of the redetermination decision.⁸⁶ However, the plan must forward the beneficiary's request to the IRE within 24 hours if it does not act in a timely manner on a redetermination request. The IRE must issue its reconsideration decision within the same time frames noted above for issuing a redetermination.

A beneficiary may file a written request for an ALJ hearing with the entity specified in the IRE reconsideration notice within 60 days of receiving an unfavorable reconsideration determination, provided the amount remaining in controversy meets the threshold requirement.⁸⁷ In determining whether the jurisdictional amount is met in a claim involving the refusal to provide a covered drug, CMS projects the costs of the drug based on the number of refills prescribed for the disputed drug during the calendar year. The ALJ hearing is conducted pursuant to the procedures for hearings of Part A and B appeals.⁸⁸

A beneficiary may appeal further to the MAC and then to federal court, following procedures for Medicare Advantage plans.⁸⁹

What Constitutes a Coverage Determination

Coverage determinations that trigger appeal rights include a drug plan's decision not to pay for or provide a medication because the drug is not on the plan's formulary, is not considered medically necessary, is furnished by an out-of-network pharmacy, or is not a drug for which Medicare will pay under Part D. An individual may also appeal when a coverage determination is not provided in a timely manner and delay would adversely affect the health of the beneficiary; a request for an exception is rejected; and the

⁸⁵ 42 C.F.R. §§423.568, 423.572, 423.582, 423.590.

⁸⁶ 42 C.F.R. §423.600.

⁸⁷ The amount in controversy (in 2008, \$120 of the ALJ level and \$1,180 for judicial review) may increase yearly based on increases in health costs.

⁸⁸ 42 C.F.R. §§423.610, 423.612.

⁸⁹ 42 C.F.R. §§423.620, 423.630.

individual is dissatisfied with a decision regarding the copayment required for a drug. A coverage determination may be requested by the beneficiary, her appointed representative, or the prescribing physician.⁹⁰

The Exceptions Process

Part D plans that use formularies to manage drug utilization must also have an exceptions process whereby plan enrollees can seek coverage for a non-formulary drug or request that a formulary drug be provided at a lower tier for cost sharing (thereby reducing the copayment or coinsurance).⁹¹ As noted above, denial of an exception request constitutes an unfavorable coverage determination from which appeal rights flow. The importance of the exceptions process cannot be overstated; CMS guidance indicates that the exceptions process will provide all beneficiaries with access to the medically necessary drugs prescribed for them.⁹²

In order to get an exception to require the plan to cover a non-formulary drug, the prescribing doctor must show that all of the drugs on any tier of the plan's formulary for treatment of the same condition would not be as effective or would have adverse consequences, or both, for the individual requesting the exception. For this purpose formulary includes the application of cost-savings tools, such as dose restrictions, quantity limits, prior authorization, step therapy, and therapeutic substitution requirements, all of which would result in non-coverage for an otherwise coverable Part D drug.

If the plan approves the exception request, the drug will be treated as other drugs on the formulary, so that the beneficiary's cost sharing counts toward the deductible and the annual out-of-pocket limit. A beneficiary will not have to file a new exception request each time the prescription is refilled. If the beneficiary renews her membership in the plan after the plan year, the plan has the option of continuing coverage of the medicine.⁹³ If the plan does not adopt this option, the beneficiary would have to reapply for an exception the next year.

Plan enrollees may also use the exceptions process to ask that a drug they require be assigned to a lower tier to reduce their cost sharing for the drug

⁹⁰ 42 C.F.R. §423.566.

⁹¹ 42 U.S.C. §1395w-104(g), (h); 42 C.F.R. §423.578.

⁹² Medicare Modernization Act Final Guidelines—Formularies, *supra*.

⁹³ 42 C.F.R. §423.578(c)(4).

when the preferred drug would not be as effective or would have adverse consequences. The exceptions process must address situations where a formulary's tiered copayment structure changes during the year and an enrollee is using a drug affected by the change. However, a plan does not have to cover nonpreferred drugs at the lower, generic drug co-pay level if the plan maintains a separate tier dedicated to generic drugs. Further, if the plan maintains a formulary co-pay tier in which it places very high cost and unique items, such as genomic and biotech products, it may exclude these very high costs or unique drugs from its exceptions process.⁹⁴

Because exceptions requests are coverage determinations and are governed by the rules for coverage determinations, the plan must act within the time frames for standard coverage determinations (72 hours) or expedited coverage determinations (24 hours), depending on which standards are met. A beneficiary may appeal the denial of an exception request through the appeals process.

Despite its importance, the exceptions process has proven to be both burdensome and lengthy to use. Drug plans may require a doctor's certificate explaining why the plan enrollee needs the non-formulary drug. Each plan has its own criteria for what should be included in the certificate; many plans have different forms a doctor must use depending on the drug in question. CMS has approved a standard exceptions request form developed by the American Medical Association, the Center for Medicare Advocacy, and other groups but has not required that plans honor the standard form. Each plan determines how it will evaluate the doctor's determination that the enrollee requires a non-formulary drug, including establishing a process to compare the medical and scientific evidence about the safety and effectiveness of the non-formulary and formulary drugs. Most plans require extensive documentation, sometimes asking for both the beneficiary's own medical records and medical journals. Because the Part D appeals process follows the appeals process for Medicare Advantage plans, it involves the exhaustion of multiple layers in order to get a face-to-face hearing.

Notice and Other Due Process Issues

The prescription drug plan has the responsibility for giving its plan enrollees notice of a change in the formulary or notice that coverage for a requested drug has been denied. The plan must provide written notice of a formulary change, including a change in tiered cost sharing, 60 days in advance of the

⁹⁴ 42 C.F.R. §§423.578(a)(6), (7).

change to those enrollees who use the prescription, as well as to CMS, prescribing physicians, and pharmacies. The notice must include the change, other available drugs, and a description of the exceptions process. Alternatively, a plan can choose to give an enrollee the 60 days' notice and a 60-day supply of the drug when a refill request is presented to the plan.⁹⁵ On April 26, 2006, CMS issued a Memorandum that encourages plans to continue coverage for drugs they take off formulary for enrollees who have been taking the medications.

It is unclear, however, how enrollees will learn of their rights when coverage of or payment for a prescription is denied at the pharmacy. The regulations place the burden on the plan to provide notice of appeal rights for coverage determinations. CMS states that the pharmacy is not required to provide notice of the reasons for the denial or of the appeals process.⁹⁶ Instead, each drug plan must arrange with its network pharmacies to either post at the pharmacy or distribute a generic notice that tells enrollees to contact the plan if they disagree with the information provided by the pharmacist.⁹⁷ This approach does not consider the extra burden placed on the enrollee, who must make a special effort to get and then act on the notice, or the practicalities of providing notice when an enrollee uses a non-network pharmacy.

The appeals process also does not provide adequate protection to someone who must appeal to continue receiving coverage of a drug she has been using. Unlike under Medicaid, the MMA does not provide for continued access to the medication if an appeal is filed on a timely basis. Thus, dually eligible individuals whose prescription drug coverage will be paid for under Medicare instead of Medicaid may lose an important protection. CMS has indicated in sub-regulatory guidance that Part D plans must provide a continued supply of a medicine to nursing home residents through the exceptions process.

CONCLUSION

The Medicare Part D prescription drug program continues to evolve. Advocates should monitor whether plans decide to remain in the program in future years, and whether those that do change their formularies and/or cost-sharing structures. Low-income subsidy eligible individuals may need to

⁹⁵ 42 C.F.R. §423.120(b)(5).

⁹⁶ 70 Fed. Reg. 4194, 4349-40 (Jan. 28, 2005).

⁹⁷ 42 C.F.R. §423.562(a)(3).

enroll in a different plan if their plan no longer qualifies for a subsidy to pay the entire premium. All enrollees may need to change plans or pursue exceptions if the plan they chose eliminates drugs from its formulary or adds utilization management tools.