THURSDAY, MAY 4 **3:30 p.m. – 5:15 p.m.**

ELDER LAW AND DISABILITY PLANNING GROUP: OUR AGING CLIENTS - LOTS OF MONEY OR LACK THEREOF - THE QUESTIONS WE ALL RECEIVE

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ABA Section of Real Property, Probate and Trust Law Annual Symposium May 2006

"Our Aging Clients: Lots of Money or Lack Thereof: The Questions We ALL Receive"

OUTLINE OF PRESENTATION

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Postmortem Conception and Estate Planning

I. *Introduction*

A. Who is a postmortem conception (PMC) child?

Not *in utero* at genetic parent's death and born more than ten months after the genetic parent's death using frozen sperm or a frozen embryo.

B. Thousands of men are currently storing sperm for their own later use;[1] sperm has also been retrieved postmortem or while the man was in a persistent vegetative state.[2]

C. The number of PMC children is unknown, but court cases and newspaper articles have documented their existence. In 2003, the Social Security Administration confirmed eleven applications by PMC children for Social Security survivor benefits from their deceased fathers.[3]

[1]Both California Cryobank and Fairfax Cryobank encourage semen storage before testicular or prostate surgery; prior to a vasectomy; before various reproductive procedures such as IVF, GIFT or ZIFT; for men in high risk occupations such as men in the military, professional athletes, and men exposed to environmental toxins; cancer patients, and others.
Http://www.cryobank.com/spermbank.cfm;
Http://www.fairfaxcryobank.com/spstorage.aspx

[2]*See, e.g.*, Carson Strong, *Ethical and Legal Aspects of Sperm Retrieval After Death or Persistent Vegetative State*, 27 J.L. MED. & ETHICS 347, 347-58 (1999); Jamie Talan, *Posthumous Paternity: Exploring the Ethics of Sperm Retrieval for Surviving Spouses*, NEWSDAY, June 10, 2003, at A37.

[3]Kathleen Pender, *Brave New World of Inheriting,* S.F. CHRON., May 11, 2003, at 11. Benefits were awarded in four cases involving six children; in seven cases, benefits were denied.

II. *Cases involving PMC children*

A. To date all cases with PMC children have involved whether the child can receive Social Security survivors' benefits as the child of a deceased wage earner.

B. The PMC child will be presumed "dependent" on the deceased wage earner and thus eligible for benefits in two circumstances:

1. Where the child is treated as a legitimate child of the marriage even though born more than 300 days after the father's death.[4]

2. Where the PMC child is eligible to inherit under a state's intestacy laws.[5]

C. The next logical step: litigating the PMC child's right to inherit under a will or receive distributions from a trust.

II. *Statutes specifically addressing PMC children and inheritance*

A. States that may preclude a PMC child from inheriting from decedent:

1. Virginia: intestacy, will or trust.[6]

2. Georgia: intestacy only.[7]

B. States that allow a PMC child to inherit if specific conditions are met:

1. Louisiana: deceased father specifically authorized his spouse to use his sperm, and the child is born to the surviving spouse within 3 years of the father's death.[8]

[4]Gillett-Netting v. Barnhart, 371 F.2d 593, 598 (9th Cir. 2004).

[5]In re Estate of Kolacy, 753 A. 2d 1257 (N.J.Super. Ct. Ch. Div. 2000); Woodward v. Commissioner of Social Security, 760 N.E. 2d 257 (Mass. 2002). An earlier case, Hart v. Shalala, No. 94-3944 (E.D. La. 1994) found that a PMC child could not inherit in intestacy because Louisiana law required an heir to be alive at the decedent's death; that law has since been changed to allow a PMC child to inherit under certain conditions.

[6] VA. CODE ANN. SECTION 20-158(B) and Section 20-164.

[7]GA. CODE ANN. 53-2-1(A)(1).

[8]LA. REV. STAT. ANN. SECTION 9:391.1(A)(West Supp. 2005).

2. Texas, Colorado, Utah and Washington: require decedent's written consent to his wife using his gametic material after his death; no time limits on the child's birth.[9]

3. Delaware, North Dakota, Wyoming and California: decedent's written consent may authorize any person, not limited to spouse, to use his gametic material after his death.[10]

4. Florida: PMC child can inherit only if provided for in the decedent's will.[11]

III. *Other statutes that affect whether a PMC child can inherit*

A. Is the PMC child considered a child of the marriage even though not conceived before the decedent's death?

B. If the PMC child is not considered a child of the marriage, does the state allow a child to prove paternity after the father's death, or limit when the child can make a claim?

1. A PMC child will not benefit from a presumption of paternity.[12]
2. Some states require paternity to be established in the father's lifetime in order

[9]TEX. FAM. CODE ANN. SECTION 160.707 (Vernon 2002); COLO. REV. STAT. SECTION 19-4-106(8)(2003); UTAH CODE ANN. 78-45G-707(2005); WASH. REV. CODE ANN. SECTION 26.26.730 (West Supp. 2005).

[10]DEL. CODE ANN. TIT. 13, SECTION 8-707 (Supp. 2004); N.D. CENT. CODE 14-20-65 (2005); WYO. STAT. 14-2-907(2005); CAL. PROB. CODE SECTION 249.5 (West Supp. 2005). California further requires that the writing be signed by the decedent and at least one competent witness. In addition, the person designated by the decedent to use the genetic material for postmortem conception must give written notice within four months of the issuance of a death certificate that the material is available; and the child must be *in utero* within two years of the issuance of the death certificate.

[11]Fla. Stat. Ann. Section 742.17(4)(West 1997).

[12]*See* UNIF. PARENTAGE ACT SECTION 204(a)(2)(amended 2000), 9B U.L.A. 311 (Supp. 2004)("A man is presumed to be the father of a child if ... he and the mother of the child were married to each other and the child is born within 300 days after the marriage is terminated by death...").

to inherit,[13] or require some act of legitimation in the father's lifetime.[14]

3. Other states require the paternity action to be commenced within a short time of the father's death.[15]

4. States that don't allow a PMC child any meaningful opportunity to establish paternity may find their statutes subject to constitutional challenge.

a. *Lalli v. Lalli*[16] and *Labine v. Vincent*:[17] Still good law?

b. Compare *Handley* and *Dickson*.[18]

5. General statutes of limitations to bring a claim:

a. Is the PMC child a creditor and thus subject to a short claim statute?

I. Compare Tennessee[19] with Kentucky and Massachusetts.[20]

[13]Iowa Code Section 633.222 (1992 & Supp. 2004); Lawrence *ex rel.* Lawrence v. Shalala, No. 94-1812, 1995 U.S. App. LEXIS 3351, at *4 (4th Cir. Feb. 21, 1995); *In re* Paternity of N.L.B., 411 N.W. 2d 144 (Wis. Ct. App. 1987).

[14]ARK. CODE ANN. 28-9-209 (Michie 2004); CONN. GEN. STAT. ANN. 45a-438 (West 2004); KAN. STAT. ANN. 38-1114 (2005); OR. REV. STAT. 112.105 and 109.060-.070 (2003).

[15]S.V. v. Estate of Bellamy, 579 N.E. 2d 144 (Ind. Ct. App. 1991)(within five months of decedent's death); S.C. CODE ANN. 62-2-109 (Law. Co-op. Supp. 2004)(within eight months of decedent's death or six months of probate of the estate, whichever is later); MASS. GEN. LAWS ANN. CH. 190, section 7 (West 2004)(within one year of decedent's death); Estate of Mathis v. Mathis, 800 So. 2d 119, 121-122 (Miss. Ct. App. 2001)(within one year of death or within 90 days of first publication of notice to creditors, whichever is shorter).

[16]439 U.S. 259 (1978).

[17] 401 U.S. 532 (1971).

[18]Handley v. Schweiker, 697 F. 2d 999, 1001 (11th Cir. 1983); Dickson v. Simpson, 807 S.W.2d 726 (Tex. 1991).

[19]Andra J. Hedrick, *Decedents' Estates* – Bilbrey v. Smithers: *Limitations on Post-Death Paternity Claims for Purposes of Intestate Succession in Tennessee*, 27 U.MEM. L.REV. 517, 532-533 (1997).

[20]Ellis v. Ellis, 752 S.W. 2d 781, 782 (Ky. 1988); Woodward v. Comm'r of Soc. Sec.,

ii. Is the estate still open?[21]

III. *Will a PMC child be included if the will or trust uses a class term such as children, grandchildren, nieces and nephews, issue, or descendants?*

5 common scenarios:

A. Immediate gifts to a class

1. Specific sum to each member of the class.

2. Gifts of property to a class.

3. Gifts of income.

B. Postponed gifts to a class

4. Gifts of income.

5. Remainders.

IV. *Key questions for your client*

A. Has your client or a member of his/her family stored gametic material? Any indications of whether the material might be used after the owner's death?

B. Does your client wish to include all members of a class whenever born, even PMC issue?

C. Might a PMC child or grandchild have a claim as a pretermitted child?

D. What happens if no class members are alive at your client's death, but might be born long after his/her death?

760 N.E. 2d 257, 268 n. 21 (Mass. 2002).

[21]Wallace v. Collins, 988 S.W. 2d 258, 260 (Tex. App. 1998).

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POST-*SCHIAVO* LEGISLATIVE UPDATE

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Materials prepared January 2006

As anticipated, state legislatures across the country have been inspired by the Schiavo case to take another look at their version of health care directive statutes, and several have either passed legislation or are currently considering bills that amend the requirements for living wills. The changes, however, are not uniform, showing very different reactions to the Schiavo case. The following outline describes the recent state activity discovered by the author. Some of these changes were most likely under consideration before the Schiavo case and some are very clearly directly in response to the case. In addition to changes to states' health care directive legislation, the recent decision by the U. S. Supreme Court regarding Oregon's assisted suicide statute may also prompt state legislative activity, so the outline includes a summary of the case and speculation about state activity in that area. Finally, a new type of health care directive, the mental health care directive, has been making an appearance in state statutes, and the outline concludes with a general explanation and brief description of some state statutes on this subject.

Two caveats: there may be activity in other states that is not mentioned here, and the information in this outline may well go out of date very quickly, as legislative sessions proceed. Please note that these materials were prepared in January 2006.

My thanks to all the ACTEC Fellows who responded to my email requesting information from around the country.

I. POST-*SCHIAVO* LEGISLATIVE ACTIVITY ON HEALTH CARE DIRECTIVES

A. National Right to Life Committee Model Act. The National Right to Life Committee ("NRLC") has drafted and made available a model act, called the "Model Starvation and Dehydration of Persons with Disabilities Prevention Act." Essentially, the act provides that there is a presumption of nutrition and hydration, and "no guardian, surrogate, public or private agency, court, or any other person shall have the authority to make a decision on behalf of a person legally incapable of making health care decisions to withhold or withdraw hydration or nutrition from such a person except in the circumstances and under the conditions specifically provided for in Section 4 of this act." Section 4 provides that the presumption shall not apply if the nutrition or hydration would not sustain the person's life or provide comfort, or if the person executed a health care directive specifically authorizing the withholding or withdrawal of nutrition and/or hydration. Full text of the model act (revised as of January 2006) can be found at www.nrlc.org/euthanasia/modelstatelaw.html

B. New Jersey. In the 2005 legislative session, a bill was introduced, entitled "The Starvation and Dehydration of Persons with Disablilities Prevention Act." The bill did not pass. Although it shares the title of the NLRC model act, it differed from the current version in one very important respect. The presumption to continue nutrition and hydration would not apply if "there is clear and convincing evidence that the person, when legally capable of making health care decisions, gave express and informed consent to withdrawing or withholding nutrition or hydration in the applicable circumstances."

C. Georgia. In 2004, a bill was introduced, entitled "the Georgia Starvation and Dehydration of Persons with Disabilities Prevention Act." Similar to the New Jersey bill, it would not have applied the presumption in favor of nutrition and hydration if there was clear and convincing evidence that the person, when legally capable, gave consent to withholding. That bill did not pass. Senator Rogers, an author of the 2004 bill, had filed a similar bill to be considered in 2006 but pulled it from consideration in late December, because of concerns that the bill would create a presumption that a mentally disabled person would want to continue nutrition and hydration, a change from previous law. Rogers was quoted in the Atlanta Journal-Constitution as saying, "I decided that maybe it would be better to see if we could address the concerns of the disability community in a different way. Reflecting upon the bill, I don't think the way it was written was true with my intentions." Atlanta Journ.-Const. Dec. 30, 2005 at p. 3F. While the Journal-Constitution article was unclear, it may be that the concern was with persons who had never had capacity to make their wishes known. The text of the 2004 bill can be found at www.legis.ga.gov/legis/2003_04/search/hb1132.htm

D. Louisiana. Louisiana passed legislation last summer that retained the ability of a surrogate to decide to withhold or withdraw treatment but limited the role of a spouse in certain circumstances. Representative Gary Beard's original legislation would have created a presumption that a person would choose to continue hydration and nutrition unless the person had made a written or oral declaration to the contrary. That provision was removed and the existing law, which allowing the decision to be made by family members in order of priority, beginning with the spouse, in the absence of a declaration of intent from the patient, was retained. Beard's bill would have removed the spouse from the decisionmaking if the spouse had been living in "concubinage" or if the spouse was judicially separated from the incapacitated person or convicted of domestic violence that led to the spouse's condition. The concubinage provision was removed, because the legislators decided that term was no longer in use under state law, but was replaced by an exclusion of spouses if he or she "is cohabited with another person in the manner of married persons or who has been convicted of any crime of violence" against the spouse that resulted in the spouse's condition or if the spouse "has violated any domestic abuse protective order affecting the other spouse." La. R. S. 40:1299.58.2 (14); La. R. S. 40:1299.58.5. The 2005 legislation also added language to the statutory health care directive form

specifying whether artificial nutrition and hydration should be withheld or withdrawn if in a terminal or persistent vegetative state. La. R. S. 40:1299.58.3.C. (1).

E. Kansas. Kansas considered a bill that would make it impossible for a guardian to consent to withhold treatment unless the ward had signed a health care directive or durable power of attorney for health care stating such intent or if the guardian could prove beyond a reasonable doubt that the ward would want such treatment withheld. If the guardian had to rely on the last criteria, the ward would be given "full and complete due process including, but not limited to, the right to court appointed counsel, notice, hearing, subpoena power, discovery, payment of costs … and right to a jury trial." In such a proceeding, there would be a presumption against withholding treatment, and if the ward is unable to communicate, court appointed counsel shall make decisions for the ward. Kansas Senate Bill no. 92, which can be found at www.kslegislature.org/bills/2006/92.pdf The bill did not pass this legislative session but may be reintroduced.

F. Hawaii. The Hawaii legislature has a bill pending, SB 1809, entitled the "Starvation and Dehydration of Persons with Disabilities Prevention Act" which is essentially identical to the New Jersey legislation.

G. South Dakota In the 2005 session of the legislature, SB 204 was introduced that would have restricted the withholding of nutrition and hydration under the same circumstances as the New Jersey legislation. The bill failed, however, and there appears to be nothing pending in the 2006 session.

H. Minnesota. Pending SF 2008 contains essentially the same provisions as the New Jersey bill.

I. Pennsylvania. Pennsylvania has a bill pending that would update its living will statute and include durable powers of attorney for health care. This bill originated before the Schiavo controversy and appears to confirm a person's right to control end of life decisions. The bill can be found at: http://www2.legis.state.pa.us/WU01/LI/BI/BT/2005/0/SB0628P0693.pdf

J. Connecticut, Indiana and Colorado have committees considering legislation. Colorado is in the relatively early stages, but Connecticut should have a bill soon. According to news reports, the Indiana legislative study began meeting in August 2005.

K. Idaho. In 2005, Idaho combined its provisions for living wills and durable powers of attorney, and provided more options in its form for specifying one's intentions with regard to nutrition and hydration. Currently, in the Idaho form, you are given the choice of requesting providing or withholding of nutrition only, hydration only, or both. Idaho Code 39-4510.

L. Washington. Washington has a bill pending that would create a registry for health care directives. HB 2342. Montana had a bill last year to create a registry that did not pass, and there is some discussion in Idaho about introducing legislation to create a registry.

M. North Carolina. In late 2005, North Carolina added language to its health care power of attorney statute allowing the power of attorney to continue past death of the principal for purposes of disposing of remains, autopsy and anatomical gifts. HG 967. It is now considering adding language to the living will and health care directive statutes allowing the person to designate who has priority in making health care decisions.

N. Vermont. Vermont passed legislation in June 2005 that rewrote its laws on health care directives and health care powers of attorney. 18 V.S.A. 9700 et seq. Generally, the legislation reinforces, as stated in the introduction, "the fundamental right of an adult to determine the extent of health care the individual will receive, including treatment provided during periods of incapacity and at the end of life." One interesting provision allows the directive to include provisions specifically excluding "those persons whom the principal does not want to serve as his or her decision-maker, or those adults or minors with whom the agent shall or shall not consult or to whom the agent is or is not authorized to provide information regarding the principal's health care." Section 9702(9).

O. North Dakota. North Dakota amended various provisions of its health care directive legislation in its 2005 session. For example, it added the following language:

> In the absence of a direction to the contrary contained in a health care directive prepared under this chapter, nothing in this chapter requires a physician to withhold, withdraw, or administer nutrition or hydration, or both, from or to the principal. Nutrition or hydration, or both, must be withdrawn, withheld, or administered, if the principal for whom the administration of nutrition or hydration is considered, has directed in a health care directive the principal's desire that nutrition or hydration, or both, be withdrawn, withheld, or administered. If a health care directive prepared under this chapter does not indicate the principal's direction with respect to nutrition or hydration, nutrition or hydration, or both, may be withdrawn or withheld if the attending physician has determined that the administration of nutrition or hydration is inappropriate because the nutrition or hydration cannot be physically assimilated by the principal or would be physically harmful or would cause unreasonable physical pain to the principal.
>
> N.D. Cent. Code, § 23-06.5-09.

P. New Hampshire. New Hampshire has pending legislation making minor changes to its advance directives and DNR legislation. HB 656.

Q. Michigan. Michigan has two bills pending. HB 4752, introduced in May of 2005, with no other action taken since then, would disqualify a spouse with a "marital conflict of interest" from making decisions regarding withholding treatment, nourishment or hydration. A marital conflict of interest exists if the spouse has started divorce proceedings or is "engaged in a current, commonly known or openly acknowledged, adulterous relationship." The other bill, HB 5524, would create statutory authority for a health care directive, which apparently does not now exist under Michigan law, although Michigan does have provisions authorizing appointment of an attorney-in-fact for health care, or "patient advocate." See MCL § 700.496.

R. Alaska. Although this legislation does not appear to be in response to Schiavo, there is Alaska legislation, effective as of January 1, 2005, that revises the statutory forms for health care directive and power of attorney for health care. AS 13.52.010, .300, 13.26.332; see Steven O'Hara, Estate Planning Corner, 29 Alaska Bar Rag 10 (Winter 2005).

S. California. California has a bill pending (AB 1676) that would require the Secretary of State, Department of Health Services and the Attorney General's office to work together to develop and disseminate (via the web) information about end of life care, health care directives, and registration of health care directives (which is available in California). The registry, established in 2000, only held a little over 800 registrants as of April of 2005. The senate judiciary committee report on the bill states that a 2002 legislative study concluded that "the consistently low percentage of adults with formal directives reflects, in large measure, the extent to which advance care planning has been marginalized in clinical and legal practice and estate planning." The Senate Judiciary report further states that:

> The importance of advance health care directives is well-documented and tragically highlighted by the recent situation in Florida. Significantly increasing the number of persons with formal healthcare directives will enhance the quality of care at the end of life by making it more consistent with patents, values, goals and priorities. AB 1676 builds on the existing advance directives registry at the Secretary of State. This bill is an effort to education Californians about advance health care directives and to help individuals carry out their end-of-life choices.

The original version of the bill would have required the Dept. of Motor Vehicles to distribute information and registration materials.

Summary:

The state legislative reaction thus far has therefore been very varied, and the reactions have not been predictable on red state/blue state distinctions. One overriding concern is that states may follow the lead of the National Right to Life Committee and make withholding of artificial hydration and nutrition extremely difficult in the absence of a health care directive. There is a recent Pew Research Center survey on end of life treatment, taken Nov. 9-27, 2005, showing that the number of persons polled who actually have a living will has doubled since the last survey in 1990, but is still only 29%. The Pew survey also showed strong public support for the right to die, and 74% of those surveyed thought that close family members should be able to decide whether to continue medical treatment for a terminally ill loved one who is unable to communicate (which would seem contrary to the thrust of the state bills modeled after the NRL Committee bill). A copy of the full report can be found at http://people-press.org/reports/display.php3?ReportID=266

II. ASSISTED SUICIDE DEVELOPMENTS.

On January 16, 2006, the U.S. Supreme Court decided Gonzales v. Oregon, 2006 U.S. LEXIS 767, which held that the Controlled Substances Act did not allow the U.S. Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide. The Oregon Death with Dignity Act authorizes doctors to prescribe a lethal dose of drugs upon the request of a terminally ill patient if certain specific safeguards in the Act are followed. The U.S. Attorney General issued an Interpretive Rule under the CSA on November 9, 2001, which concluded that using controlled substances for physician assisted suicide is not a legitimate medical practice, and that prescribing them for such a purpose is a violation of the CSA. The CSA as well as a 1971 regulation issued by the Attorney General requires that every prescription for a controlled substance be issued for a legitimate medical purpose. 21 U.S.C. 812(b); 21 CFR 1306.04(a). The Court held that the 2001 Interpretive Rule exceeded the authority delegated to the Attorney General to interpret the CSA. Justice Scalia, joined by Chief Justice Roberts and Justice Thomas, wrote a dissent disagreeing with the majority's conclusion that the Attorney General exceeded its interpretive authority. Justice Thomas filed a separate dissenting opinion, arguing that the majority's opinion was inconsistent with the recent medical marijuana case, Gonzales v. Raich, 125 S. Ct. 2195(2005). The case was therefore decided on administrative law grounds, but it has cleared the cloud hanging over physician assisted suicide since the Interpretive Rule was issued and has renewed interest in states other than Oregon in enacting laws similar to Oregon's.

California has legislation pending, AB 651, the California Compassionate Choices Act, which is essentially identical to the Oregon Act. The bill had been introduced in 2005 but the Oregon case has renewed interest in the California bill. There is also legislation pending in Vermont, H. 168, which was introduced in February of 2005 and has not moved out of committee. A bill is pending in the Washington legislature that would authorize physician assisted suicide, SB 6843, and Booth Gardner, a former governor of Washington, has recently announced that he will head an

effort to get a citizen initiative on the Washington ballot authorizing physician assisted suicide.

III. MENTAL HEALTH ADVANCE DIRECTIVES.

Over twenty states now authorize by statute a specific type of health care directive that relates to mental health care. The statutes authorizing this type of directive have become more common in the past decade, and may be another source of future directive legislation in state legislatures. See Justine Dunlap, Mental Health Advance Directives: Having One's Say?, 89 Ky. L. J. 327 (2000); Robert Fleischner, Advance Directive Instruments For Mental Health Treatment: Advance Directives for Mental Health Care: An Analysis of State Statutes, 4 Psych. Pub. Pol. And L. 788 (1998). The most distinctive characteristic and purpose of a mental health advance directive (MHAD) is the ability to specify in the directive that it is irrevocable. Sometimes called a Ulysses contract, the reason for irrevocability is so that the signer can consent in advance, when competent, to treatment that the signer may be prone to refuse when incapacitated by their mental illness. The reference to Ulysses compares the situation to the direction Ulysses gave to his crew to tie him to the mast and leave him there as they sailed passed the Sirens, even though he would succumb to their calls and plead with his men to cut him loose. See Note, Ulysses in Minnesota: First Steps Toward a Self-binding Psychiatric Advance Directive Statute, 78 Cornell L. Rev. 1152(1993). For example, the Montana statute provides that "an individual may revoke a mental health advance directive provided that the mental health professional chosen by or provided for the individual determines in good faith that the individual has sufficient mental capacity to revoke the directive." MT Stat. 53-21-153. One concern about MHAD's is that they may interfere with a person's right to refuse medical treatment, if pressured to sign such a directive by concerned family members and unable to revoke and refuse treatment because the attending physician deems her lacking the sufficient capacity to revoke. See Comment, Dr. Jekyll's Waiver of Mr. Hyde's Right to Refuse Medical Treatment: Washington's New Law Authorizing Mental Health Care Advance Directives Needs Additional Protections, 78 Wash. L. Rev. 795 (2003).

IV. CONCLUSION

The *Schiavo* case brought national attention to the issue of end of life care, and states are responding in very different ways. Apart from *Schiavo,* many state legislatures were already reconsidering state statutes in this area. We can anticipate that the next few years will bring a large volume of activity, if not actual enactments, in this area.

ASSISTING THE AGING CLIENT WITH RESIDENTIAL ISSUES

I. What are the factors that affect the client's choice of residence?

a. Need for assistance with self-care

The need for assistance with self care can range from simple oversight, including medication reminders and assistance with meal preparation, to help with what are commonly known as the "Activities of Daily Living" including such items as bathing, dressing, grooming, cooking, eating, using the toilet and moving from bed to chair.

b. Mobility within the home

One of the problems with the standard split level residence is the difficulty a less mobile senior may have in moving from room to room. When a laundry room is only accessible by descending a flight of stairs, a trip to the laundry room with a basket of dirty laundry can present a risk of a fall and potential injury.

c. Mobility from the home

Losing the ability to drive presents numerous difficulties. Even removing the emotional issues regarding loss of autonomy, the practical reality of reaching this stage is that all travel from the residence requires planning. In suburban and rural areas, public transportation may not be available. In such instances, a senior may have to rely on what senior transportation may be available, if any.

d. Home maintenance concerns

Maintenance of a residence can be daunting task for younger individuals. For a senior, a residence with normal maintenance requirements can be problematic. Snow removal, gutter cleaning, exterior painting and the like can all be part of the responsibilities of home ownership.

e. Financial concerns

Home ownership involves financial obligations and bill paying. Even for a senior who does not have a mortgage obligation, utility bills, tax bills, home owner's insurance and the costs of maintenance can be a drain on a fixed income. Many seniors who live in the same residence in which they raised their families are "overhoused" as they are maintaining residences with living areas significantly larger than their current needs, and incurring the costs of being overhoused.

f. Access to medical services

As a residential location may have been chosen for the convenience of a young family or proximity to the workplace, it may not be close the senior's medical providers, requiring the senior to travel each time he or she needs to visit a physician or access other medical services.

II. What are the housing choices facing seniors

a. Continued residence of prior owned home

This is the preferred choice of most seniors. It is certainly possible to respect this choice in many situations, but not all. In a rural or suburban area, if the senior cannot drive, remaining in a certain residence may not be practical. Home care services ranging from light housekeeping to more personal care and medical care services can be arranged. A relatively new profession, geriatric care management can help individuals assess the level of services which a senior needs and help locate those services. The National Association of Geriatric Care Managers can provide helpful information and provide the names of professionals in a geographic area. www.caremanager.org The home made need to be modified to make it safer, including among other things, possibly adding grab bars along hallways and remodeling the bathroom (one of the most dangerous rooms in the residence for a frail senior).

b. Change in residence to single family home more suited to current needs

A change in residence to a property more suited to the needs of an aging resident, and in a location where services which might be needed in the future are more accessible may help the senior to remain living in the community even when their ability for self care may have declined.

c. Change in residence to senior housing

Independent living in an apartment or retirement community. No services provided, but likely such a community is located geographically near public transportation and medical services, and may be within walking distance of grocery stores and pharmacies.

Congregate living in separate apartments, in a complex in which assistance may be provided to residents, as needed. Services usually range from transportation and housekeeping to personal care and even some nursing care.

Assisted living including board and care homes

A relatively new term "Assisted Living" generally means a facility which provides meals and help with activities of daily living. Assisted living facilities vary on whether or not they provide high level assistance, including assistance with transferring from a bed to a chair. Note – assistance with transferring can be a significant factor in whether or not a particular facility will accept a resident. If an individual is large enough that two people are required to assist in the transfers, this limits the available facilities. Another factor which may limit the number of assisted living facilities willing to accept a resident is whether or not the individual is at risk for wandering away from the property.

Skilled nursing facility (nursing home)
Highest level of service provided, 24 hour skilled nursing care. Usually no one's choice of residence, and usually the last alternative. When this is the necessary alternative, consider the following resources:

1. A Guide for Families: Making the Transition to Nursing Facility Life – published by the American Healthcare Association. www.ahca.org
2. Nursing Homes getting good care there – published by The National Citizen's Coalition for Nursing Home Reform. www.nccnhr.org

Continuing care retirement community
Continuing Care Retirement Communities or CCRC's are an expensive alternative that can be a solution for some. The term "aging in place" means that the individual can reside within the community for the remainder of their live, moving from independent living to more supportive environments as needs increase. Because the contracts usually involve significant up front costs, considerable research is appropriate when considering a CCRC. Research includes among other things, the terms of the contract, the services provided by the community and the financial health of the organization (to ascertain whether the community is likely to remain operational for the duration of the senior's life). A CCRC can be an alternative that allows a couple who require different levels of care and who will reside in different environments to still live in close proximity to one another.

SELECTED TIPS AND INSIGHTS ON ENHANCING PATIENT EMPOWERMENT BY HELPING PATIENTS BUILD THEIR PERSONAL HEALTHCARE TOOLKITS

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SELECTED TIPS AND INSIGHTS ON ENHANCING PATIENT EMPOWERMENT BY HELPING PATIENTS BUILD THEIR PERSONAL HEALTHCARE TOOLKITS

At any given point of time, the likelihood that a person will become seriously ill or disabled generally far exceeds the likelihood that he will die during the same period. While American's increasingly are fearful about their ability to handle these challenges, Americans devote relatively little energy to planning or preparing to deal with their own or a family member's serious illness before they or a family member is diagnosed. What's more, the guidance provided to Americans that do attempt to engage in serious advance planning for a serious illness or disability often is limited. For instance, families often are counseled about the need for durable powers of attorneys and living will and even, in recent years, the possible desirability of executing an authorization to disclose protected health information that complies with the medical privacy standards of the Health Insurance Portability and Accountability of 1996. In some cases, they even are encouraged to read and/or keep handy their health and disability benefit information. Rarely, however, do Americans come away from such endeavors with anything but the most passing understanding about when and how to use these materials, much less an appreciation of the broader ranges of challenges that they are likely to confront when a serious illness or disability arises.

When confronted with a serious illness or disability, however, patients and their families readily become apparent and often overwhelming for patients and their families. When a client or his family member becomes seriously ill, patients and their families generally face the dual burden of coming to grips with the realities and necessities of coping with the care and treatment of the medical condition itself, while simultaneously deciphering and addressing the implications of the illness on the families' employment, insurance, and other financial affairs. Whether or not the illness in question is expected to be terminal, patients and family members inevitably struggle to come to grips with the physical, emotional and financial realities of a serious illness or injury. Where the illness physically or mentally impairs the patient, family and friends often struggle to negotiate the maze of rules and administrative procedures that impede their efforts to help the patient investigate and deal with patient care and other personal affairs. While negotiating these hurdles, patients and their families often also face overwhelming financial challenges. Whether or not the patient is covered by public or private insurance, negotiation of the requirements for maximizing coverage, evaluating and responding to coverage denials, and monitoring and paying for uncovered medical expenses frequently presents a Herculean challenge. Meanwhile, where the illness or injury requires that the patient or a family member take time away from work, a patient and his family often also must confront questions and concerns about the implications of the illness on the employment, income and benefit security of the patient and his family. The patient's entitlement to medical and health care and disability coverage and benefits, privacy, health care decision-making, financial accountability, and other rights increasingly depend upon a complex array of contracts supplemented by laws such as the newly

enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003: other Medicare, Medicaid and VA regulations: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA'): the Employee Retirement Income Security Act; disability and other employment laws, state insurance, health care, and guardianship laws: the Fair Credit Reporting Act and other credit collection laws; and a plethora of other statutes, regulations, and rules. Patients already emotionally and physically drained from the stress of coping with the medical realities of a patient's illness rarely are in a position to optimally organize themselves to handle the practical, legal and financial challenges that often go hand in hand with a serious illness and the circumstances rarely allow patients and their families the luxury of time to get up to speed. Consequently, Americans caring for ill and aging family members frequently are caught by surprise when they or a family member becomes seriously ill and are unprepared and lack the tools to handle these responsibilities at the time they are most needed.

Historically, patients in crisis have looked (or assumed that they could look) to employers, health care providers, community service agencies, neighbors and others to help them cope in these times of medical crisis. Until recently, and sometimes even today, they have assumed that medical and disability benefits provided by employment based or governmental programs will provide adequate protection for the patient and his family against the financial costs and income losses associated with the illness. They assume or hope that health care providers will look to these insurers, and not the patient or his family, to pay the costs of medically required care. They hope that health care providers or someone will explain to them how to find suitable home health care or nursing home providers, and a way to pay for those services. Unfortunately, changes in American society and in an age where employers, health plans, health care providers and government are placing increasing emphasis on "consumer driven health care" and "patient self-responsibility," these hopes and assumptions increasingly go unfulfilled. Instead, American families increasingly must rely upon their own ingenuity to develop the understanding and tools that they need to effectively cope with the practical, legal and financial demands of dealing with an illness while struggling to reorganize their lives to deal with the human realities of life with a serious illness. Therefore, while Americans generally recognize the inevitability of sickness, death and taxes, most are ill-equipped to meet the medical, financial, legal and other practicalities of coping with a serious illness in their family at the onset of the illness.

While the particular needs and circumstances vary based on the illness and other circumstances affecting any particular family, most American families share a need for certain core information and tools in order to prepare for and cope with the challenges that commonly arise when they or a family member suffers a serious illness. Whether and how quickly and effectively a seriously ill patient and his family are able to cope with many of the practical and financial challenges of dealing with the illness in their family often depends upon their ability to effectively access and utilize these tools of patient empowerment. The following paragraphs of this paper highlights selected knowledge and tools that may help ease certain burdens and challenges that patients and their families commonly encounter when attempting to cope with a serious illness.

- **Patients and Family Members Need Appreciation of Implications of HIPAA Privacy and Security Standards On Rights Of Patient and Family Members**

To alleviate the burden on a seriously ill or disabled patient, the patient and/or a friend of family member often may seek to have a friend or family member participate in or handle certain dealings with health care providers or health plans. In some instances, this participation may be sought with the full consent of the patient; in other circumstances, a well-intentioned friend or family member may seek to interject himself into these relationships without or in disregard of the preferences of the patient. In either circumstance, the Privacy and Security Standards of HIPAA[1]

The Privacy Standards of HIPAA generally seek to enhance the ability of patients to control the use and access of their protected health information. Under HIPAA, health care providers, health plans and health care clearinghouses ("Covered Entities") required to adhere to certain specific mandates in dealings with protected health information. For instance, Covered Entities are required to disclose protected health information to any individual or his personal representative, who requests access to, or an accounting of, his protected health information; and to HHS as part of a compliance investigation or review.[2] In addition, HIPAA prohibits Covered Entities from using or disclosing individually identifiable health care information about an individual without the prior written authorization except under certain narrowly defined circumstances.[3] Covered entities can only use and disclose such information without the individual's HIPAA-compliant authorization under certain other specifically enumerated circumstances. Under the final rules, a covered entity may use and disclose protected health information

[1]For a more detailed discussion of the relevant mandates of HIPAA's Privacy and Security Standards, see Stamer, "Chapter Thirty-Five-Medical Privacy," in ERISA LITIGATION (BNA 2005). Also note that under certain circumstances, applicable state law also may impose a myriad of restrictions on the ability of a health plan and/or health care provider to share or disclose personal medical or other information.

[2] 45 C.F.R. §164.502(a)(2)(i), (ii), (g)(1).

[3] "Protected health information" means "individually identifiable information:

(1) Except as provided in paragraph (2) of this definition, that is:
  (i) Transmitted by electronic media;
  (ii) Maintained in any electronic media; or
  (iii) Transmitted or maintained in any other form or medium.

(2) Protected health information excludes individually identifiable information in:
  (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. [§] 1232g;
  (ii) Records described in 20 U.S.C. [§] 1232g(a)(4)(B)(iv); and
  (iii) Employment records held by a covered entity in its role as employer.

In other words, the definition includes all protected health care information whether on paper, magnetic disk, or transmitted orally, electronically, by fax or telephone. Courts have rejected any attempt to confine protected health information to written information. South Carolina Med. Ass'n v. United States Dep't of Health & Human Servs., No. 3:01-2965-25 (D.S.C. Aug. 14, 2002); Association of Am. Physicians & Surgeons, Inc. v. United States Dep't of Health & Human Servs., 2002 WL 1917633 (S.D. Tex. July 17, 2002) (cited in Jack A. Rovner, Kathyrn A. Roe, Ralph L. Glover II, *Managing the Privacy Challenge: Compliance With the Amended HIPAA Privacy Rule*, 15 HEALTH LAW. 18 (Sept. 2002)).

without authorization for its own treatment,[4] payment,[5] and health care operations[6] as well as treatment and payment activities of providers who are not covered entities, and health care activities of another covered entity involving either quality or competency assurance or fraud and abuse detection and compliance, if both have or had a relationship with the individual and the protected health information relates to that relationship.[7] Finally, a covered entity that participates in an organized health care arrangement[8] may disclose protected information about the individual to another covered entity that participates in the organized health care arrangement for any health care operation activities of the organized health care arrangement.[9] In addition to adhering to these limitations, HIPAA also mandates that Covered Entities afford individuals that are the subject of protected health information certain other specified rights and protections. Covered Entities are required to notify individuals about these and other rights afforded under the HIPAA Privacy Standards by providing a Notice of Privacy Practices.

Although the protections of the Privacy Standards are intended to benefit patients by safeguarding their health information against indiscriminate use or access, patients and their families often find their efforts to address various treatment, payment or other concerns frustrated by the necessity of negotiating these regulations. Because Covered Entities face substantial civil and even criminal sanctions for violating the Privacy Standards,[10] covered entities often may resist sharing protected health information about a patient in the absence of a HIPAA-compliant written authorization from the patient or his personal representative unless the covered entity otherwise is satisfied that the disclosure otherwise is allowed pursuant as one of the permitted uses or discloses detailed under the Privacy Standards. Because HIPAA dictates detailed requirements[11] that must be met before a Covered Entity may treat a use or disclosure as authorized by the subject of protected health information, patients and family members desiring to rely upon the ability for an individual other than the patient to access protected health information from Covered Entities generally should arrange for the patient or his personal representative to sign a HIPAA-compliant authorization for that access.

[4]Treatment is the "provision, coordination, or management of health care and related services" to an individual by a health care provider, and referrals. 45 C.F.R. §164.501.

[5]Payment includes obtaining premiums, making eligibility and coverage determinations, obtaining reimbursements, coordinating benefits, subrogating claims, adjusting risk, billing, collecting, managing claims, processing health claims, obtaining payments under reinsurance such as stop loss insurance, authorizing reviews for medical necessity determinations, and authorizing utilization reviews. 45 C.F.R. §164.501.

[6]Health care operations includes case management, quality assurance activities, competency assurance activities, oversight activities (fraud, auditing, medical reviews, legal services), insurance activities (underwriting, premium rating), and business activities (business planning, management and administration). 45 C.F.R. §164.501.

[7]45 C.F.R. §164.506(c).

[8]An "organized health care arrangement" includes HMOs. 45 C.F.R. §160.103.

[9]45 C.F.R. §164.506(c)(5).

[10] HIPAA specifies that a covered entity violating HIPAA's Privacy or Security Standards may be fined not more than $50,000, imprisoned not more than 1 year, or both; or, if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; or if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, person gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

[11]45 C.F.R. §164.508 (c)(2)(iii).

- **Patients Need Help Getting and Keeping Relevant Information and Documents Organized**

One of the biggest challenges that patients and their families often confront is getting organized. During the course of an illness, patients and their families can be expected to share and receive a diverse array of information. Before the onset of a medical condition, few Americans appreciate the desirability of organizing the core documents and information that the patient and his family are likely to need to monitor and communicate effectively with health care providers about the condition and health history of the patient, to identify and utilize their health and other insurance coverages, to monitor and manage their medical and disability related finances, and to carry out certain other core tasks. Once a family member becomes ill, the failure or inability of patients and their family to organize and maintain this information often unnecessarily complicates the ability of the patient and his family to access efficiently the information needed to coordinate patient care, pursue medical, disability and other benefits, and address other patient needs. A well-organized personal health care management file or notebook containing necessary documents and other health care factual information can facilitate the ability of patients and their family members to respond promptly, accurately and effectively to anticipatable demands family members, health plans, and others may make for this information and to monitor and respond to relevant developments impacting on patient care or other responsibilities.

To facilitate the ability of the patient and family members to accurately communicate with health care providers about the medical history of the patient, for instance, it often is desirable to for patients and their families to maintain in a patient notebook or file up-to-date information about the patients' current and prior medical condition and care such as health history details, current medications and vitamins, names and contact information for current and former physicians and health care providers, patient and/or family member notes of meetings with health care providers, lists of new or unresolved symptoms, pending questions and concerns of the patient and his family, and the like. Organization of this information in a central location can help patients, health care providers and family members accurately share relevant information necessary to the proper care of the patient. The ability to care for a patient can also be enhanced by including names and contact information for the patient's family members, current and former physicians, holders of powers of attorney or others authorized to manage affairs, attorneys, accountants, and financial planners. Additional relevant information that should be maintained in this collection includes allergy and other relevant-medical information, medical records, medical expense and payment records, health coverage explanation of benefits letters, and any other information that might expedite the handling of personal and medical affairs during a period of illness.

Ideally, the patient's personal health care management file also should include copies of documents relevant to the care and benefit coverage of the patient. For instance, most patients will find it helpful to include in their file copies of health insurance cards, health insurance and disability policies and booklets, employer leave of absence and vacation

policies, and other information about procedures affecting the ability of the patient to qualify for and claim relevant benefits. Individuals should also consider including appropriate HIPAA compliant medical authorizations allowing health care providers and health plans to disclose medical information about the patient to family members and emergency contacts that the patient expects to assist in caring for the patient or handling other relevant responsibilities. This will reduce the risk that HIPAA's privacy rules will impede their ability to access important health information. Examples of other commonly helpful documentation includes durable medical powers of attorney, advance directives, custody and guardianship documents, wills, life insurance and annuity contracts, trusts, and beneficiary designations commonly prepared as part of an estate or financial planning process.

- **Patients Need A Better Understanding About Their Eligibility For Health Coverage**

Although employer provided coverage has declined across the past decade, employment based insurance remains the most common source of private medical coverage for most employed workers. Under the governing terms of the applicable employer or union sponsored health plans, medically-related or other absences as well as various other events may impact the eligibility or other rights of a patient or his family for enrollment in employer or sponsored health plan coverage. Patients and their family members who rely upon employment-based coverage need an appropriate understanding of the circumstances under which applicable health plan rule may result in a loss of coverage or allow the patient to be enrolled in coverage under an ERISA covered health plan.

Federal law traditionally has allowed employers broad freedom to decide the employees and dependents, if any, who are eligible for coverage under employer-sponsored health and welfare plans, subject to the plan sponsor's compliance with the generally applicable plan document and summary plan description requirements of ERISA and other applicable laws. Nevertheless, the courts have consistently ruled that employers may forfeit their ability to limit enrollment in their plans by failing to carefully craft the eligibility language contained in the plan documents and summary plan descriptions used in connection with those programs. Meanwhile, Congress has mounted an incremental assault on this freedom through a series of legislation such as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Family and Medical Leave Act of 1993 (FMLA), the Omnibus Budget Reconciliation Act of 1993 (OBRA' 93), the military leave mandates of USERRA, the portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and a host of other laws.

- **HIPAA Health Plan Eligibility Mandates**

Among some of the most potentially significant federal eligibility mandates for seriously ill patients and their families are the "Group Health Plan Portability, Access and Renewability Requirements" set forth in Title 7 of ERISA and Subtitle K, Chapter 100 of the Internal Revenue Code (the Code). In February, 2005, the Departments of Labor,

Treasury and Health and Human Services issued final regulations that supersede the jointly published interim regulations previously governing these provisions.

The portability requirements of HIPAA generally apply to all group health plans and health insurance issuers offering group coverage. However, certain arrangements are excepted. Its requirements regarding access, portability, and renewability do not apply to any group health plan (and group insurance offered under that plan) if the plan has less than two participants who are current employees on the first day of the plan year of the plan. Certain other exceptions also may apply if the requirements of HIPAA are satisfied and the group health plan provides only limited types of coverage. For purposes of these rules, "group health plan" generally includes any employee welfare benefit plan to the extent that it provides medical care to employees (including partners in a sponsoring partnership) or their dependents directly or through insurance, reimbursement or otherwise. "Health Insurance issuer" means an insurance company, insurance service, or insurance organization (including an HMO) which is licensed to engage in the business of insurance in a State and which is subject to State laws regulating insurance.

- **Prohibited Discrimination In Eligibility or Premiums**

HIPAA provides that, for plan years beginning on or after July 1, 1997, a group health plan or health insurance issuer may not establish rules regarding eligibility for health care coverage based on any of the following factors with respect to an individual or a dependent of an individual: health status; medical conditions (including both physical and mental conditions); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of domestic violence); or disability. Similarly, a plan may not establish premium contribution rules based on any of the above-listed factors.

- **HIPAA's Health Plan Special Enrollment Period Mandates**

HIPAA provides for special enrollment periods for persons who had previously declined enrollment in a group health plan because they had other coverage and subsequently lost that coverage. HIPAA requires that group health plans, and health insurance issuers offering group health insurance coverage, permit eligible employees or dependents to enroll under the terms of the plan if each of the following conditions is met: (1) the employee or dependent was already covered when the plan was previously offered; (2) if required by the plan sponsor or issuer, and provided that they gave notice to the employee, the employee stated in writing at such time that another source of coverage was the reason for declining enrollment; (3) the person was covered under COBRA's continuation coverage which was exhausted, or coverage was not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction of hours of employment) or termination of employer contributions toward such coverage; and (4) the person requested enrollment not later than 30 days after the loss of the other coverage.

HIPAA requires that, if a group health plan offers dependent coverage, it must offer a dependent special enrollment period for persons becoming a dependent through marriage, birth, or adoption or placement for adoption. The dependent special enrollment must last for at least 30 days. If the individual is eligible and is not already enrolled in the plan, he may enroll at such time as he enrolls the dependent.

The final rules add several examples clarifying what constitutes a loss of coverage for purposes of special enrollment. For example, a person who is covered by an HMO and moves outside the HMO coverage area and no other coverage is available has a loss of coverage triggering a special enrollment. A dependent that ceases to qualify as a dependent under the terms of the plan has a loss of coverage triggering a special enrollment. A person who exhausts the lifetime maximums under a health plan also suffers a loss of coverage which would entitle them to special enrollment rights on another plan for which they may be eligible.

- **Pre-Existing Condition Limitations**

Pursuant to these mandates, HIPAA provides portability of health care coverage for previously covered individuals by providing that such individuals may be covered by health insurance despite any preexisting conditions. HIPAA imposes three restrictions on the use of preexisting conditions in group health plans:

- A group health plan or health insurance insurer may not impose any preexisting condition exclusions relating to pregnancy.
- A group health plan or insurer may not impose any preexisting condition exclusion with respect to a newborn child, an adopted child who is under 18 years old, or a child who is placed for adoption who is under 18 years old, provided that such individual is covered under creditable coverage within 30 days of birth, or adoption or placement for adoption, respectively. However, a plan or insurer may exclude such newborn, adopted child or child placed for adoption if there is a break in coverage for more than 63 days.
- A group health plan or insurer cannot limit coverage for any preexisting conditions unless the following conditions are satisfied: (1) the definition of preexisting condition is limited to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date; (2) the permitted duration of any limitation or exclusion of coverage for a preexisting condition is limited to a period after the enrollment date equal to 12 months (or 18 months for a late enrollee); and (3) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

Under HIPAA, a participant is entitled to have the otherwise applicable preexisting condition limitation period reduced by any period of prior coverage under another health

plan, i.e. "creditable coverage." In order to allow a person to prove that they had creditable coverage under another plan, all health plans are required to issue certificates of creditable coverage to participants. The certificates must state the duration of the participants' coverage under the plan. Certificates must be issued automatically when coverage terminates and upon request. In many cases, the insurance company or TPA issues these certificates but, if not, it is the employer's responsibility to do so.

HIPAA provides that an individual establishes a period of "creditable coverage" through presentation of certification(s) describing such prior creditable coverage. Such creditable coverage is established by the individual's coverage under a group health plan (including a governmental plan), health insurance coverage (either group or individual insurance, including COBRA coverage periods), Medicare, Medicaid, military sponsored health care, or other programs outlined in HIPAA. Prior creditable coverage does not qualify as creditable coverage if there was longer than a 63-day break in an individual's health care coverage. However, any waiting periods prior to an individual's enrollment in an employer's health plan or a health maintenance organization ("HMO") will not count toward the 63-day period. Beginning July 1, 1997, HIPAA generally requires that the group health plan and health insurance issuer provide the certification describing the creditable coverage when the individual ceases to be covered under the plan or after a COBRA continuation period ceases. In addition, the group health plan and health insurance issuer may be required to provide such certification on the request of an individual within 24 months after the individual's coverage ceased. Plans may charge a fee to employers or insurers, but not to individuals, for preparing the certification.

The Final Regulations added a new requirement that all certificates of creditable coverage must contain an educational statement explaining HIPAA portability and the importance of the certificate. The final rules contain model certificates with the necessary educational statement as well as a host of other guidance about the application of these rules. The Final Regulations indicate that the updated model language will be the required language when the regulations take effect with the first plan year beginning on or after July 1, 2005.

The Final Regulations also address a wide range of other issues. Health plans are mandated by HIPAA and the new Final Regulations to provide specific notification to participants and beneficiaries of their rights under HIPAA. The final rules clarify that health plans must have written procedures that describe how a person can go about requesting a certificate. Employers who issue their own certificates will want to ensure their summary plan description, benefit communication materials, or handbook to which participants have access contains the necessary procedures. Also, dependents covered by a group health plan are entitled to their own certificate of creditable coverage. Under transitional rules, if it was not feasible for a health plan to provide a certificate in an individual dependent's name, the plan could issue the certificate in the name of the plan participant (i.e. the employee) and note that the coverage included dependent coverage. The final rules clarify that the transitional rule is no longer in effect; all dependents must now receive their own certificates in their own names. It is acceptable to provide a single

certificate that lists both the participant and his or her dependents as long as the type of coverage and coverage periods for the participant and dependents are identical and the dependents are listed by name.

Newly proposed rules issued at the same time as the final rules explain the interaction between HIPAA and the Family and Medical Leave Act (FMLA) and contain a model certificate of creditable coverage with FMLA language.

- **HIPAA's Health Plan Access and Renewability Requirements**

HIPAA imposes certain guaranteed renewability requirements that apply only to health insurance issuers. Every health insurance issuer offering coverage in the small group health care market must accept every small employer that applies for coverage, subject to certain capacity or financial limitations. For this purpose, a small employer is defined as one having an average of 2 to 50 employees on a business day during the preceding calendar year and who employed at least two employees on the first day of the plan year. HIPAA also requires that health insurance issuers offering coverage to small employers make "reasonable disclosure" in solicitation and sales materials of the availability of information concerning (1) the issuer's right to charge premium rates and factors that may affect changes in premium rates; (2) renewability of coverage provisions; (3) preexisting condition exclusions; and (4) the benefits and premiums available under all health insurance coverage for which the employer is qualified. A health insurance issuer offering coverage in any employer group market is generally required to renew or continue coverage at the option of the plan sponsor. Although HIPAA does not limit the ability of a health insurance issuer to adjust premiums for a group on renewal, state law may regulate such premium adjustments. HIPAA waives a health insurance issuer's obligation to comply with the renewability requirements under certain limited circumstances. Furthermore, HIPAA's group market reform rules do not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the group health plan has less than 2 participants who are current employees. Certain other specified arrangements also are exempt from these requirements.

- **Medicare Part D Regulations – Prescription Drug Coverage Employer Notification Requirements**

New Medicare Part D regulations require that any group health plan offering prescription drug coverage to Part D eligible individuals (including active and retired employees and beneficiaries) provide an initial annual notice whether the plan coverage is "creditable" or "non-creditable" to Part D eligible individuals and Centers for Medicare and Medicaid Services (CMS) by November 15, 2005.

Thereafter, notice of creditable status must be given to Part D eligible individuals at the following times: (1) prior to the Medicare Part D annual coordinated election period (November 15-December 31 each year); (2) prior to an individual's initial enrollment

period; (3) prior to the effective date of coverage for any Medicare eligible individual joining the plan; (4) whenever prescription drug coverage ends or changes so that it becomes (or is no longer) creditable; and (5) upon a beneficiary's request. "Prior to" means within 12 month before the event in question. Group health plans also provide the notice to CMS annually, or upon any change that affects whether the employer's prescription drug coverage is creditable.

CMS has published extensive although not yet comprehensive guidance about the required creditable coverage disclosure notices. This guidance currently includes two forms of model language that may be used when disclosing creditable coverage status to Part D eligible individuals - one is a creditable coverage disclosure notice, the other is a non-creditable coverage disclosure notice. Use of these model forms is optional. Group health plans that choose not to use the model forms must provide notices that meet specific standards described in this guidance. Employers may arrange for a third party to provide the notices. As for other delegated plan responsibilities, employers and group health plans that intend to outsource this notice should carefully evaluate the proposed vendor and any forms and procedures it uses, contract carefully with the vendor, and monitor the vendor's performance.

Employers will need to determine if their group health plan's coverage is "creditable or non-creditable". A group health plan can qualify as "creditable coverage" if it has a safe harbor plan design. An employer's prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D. The actuarial equivalence test measures whether the expected amount of paid claims under the employer's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D coverage. Attestation by a qualified actuary regarding creditable coverage status is not required for employers that do not elect to apply for the subsidy.

The existing Medicare Part D guidance outlines a plan design that would qualify for a simplified determination of creditable status. Specifically, a prescription drug plan's coverage is creditable if it (1) provides coverage for brand name and generic prescription; (2) provides reasonable access to retail providers and optionally for mail-order coverage; (3) is designed to pay on average at least 60% of participants' prescription drug expense; and (4) satisfies one of three standards relating to maximum annual benefits - maximum no less than $25,000 per year (or no maximum) and a lifetime maximum no less than $1,000,000.

Creditable coverage disclosure notices may be provided with other plan participant information materials, such as enrollment or renewal materials, if the disclosures are "prominent and conspicuous." The statements must be prominently referenced in at least 14-point type in a separate box, bolded or offset on the first page of the participant information. A single notice may be provided to a Medicare individual and Medicare eligible dependents covered under the same plan, but a separate notice is required if it is known that any spouse or dependent resides at a different address than the participant.

CMS also describes the standards that employers must meet if they wish to provide notices electronically.

- **Children Affected By Divorce or Medicaid**

Congress has increasingly become concerned about the availability of medical coverage under employer-sponsored group health plans for children affected by divorce or receiving Medicaid. OBRA '93 amended ERISA to require group health plans that provide coverage for dependent children to extend coverage to a child of an employee to the extent required by qualified medical child support orders (QMCSO). A QMCSO, similar to a Qualified Domestic Relations Order (QDRO), identifies an alternate recipient of health coverage who is required to be entitled to be covered by the health plan of the participant. OBRA'93 requires employers to adopt written plan provisions and procedures to comply with these new requirements.

- **Children Adopted or Placed For Adoption**

OBRA '93 amended ERISA to require that group health plans provide that children under 18 who are placed for adoption with a plan participant must be covered from the time of placement, even if the adoption is not yet final. Coverage is only required if coverage for other dependent children is provided by the plan. Health plans also may not restrict coverage of an adopted child based on a pre-existing condition at the time of the adoption or placement.

- **USERRA Health Plan Military Leave Mandates**

Health and welfare benefit plans also must comply with Federally mandated rules regarding the provision of health plan coverage to employees and their dependents during periods that the employee is absent from work due to service in the uniformed services ("military leave") and the reinstatement of coverage and benefits when a protected employee timely returns to employment following a military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

USERRA originally became law, and its anti-discrimination and anti-retaliation provisions took effect on October 13, 1994. Its protections have applied to members of the uniformed services seeking employment after December 11, 1994. Until recently, the agency charged with its interpretation and enforcement, the Veterans' Employment and Training Service (VETS) of the U.S. Department of Labor, had not published final regulations interpreting its provisions. On December 19, 2005, however, VETS published final regulations interpreting USERRA (the "Regulations"), as they apply to private and state and local governmental employers. Employers and employee benefit plans must comply with the Regulations no later than January 19, 2006

The Veterans Benefits Improvement Act, enacted by Congress and signed by President Bush on December 10, 2004, mandates that employers provide a notice to "all persons

entitled to rights and benefits under USERRA" of their rights, benefits and obligations. Employers may meet this obligation by posting the notice in a prominent place where employees customarily check for such information. On March 10, 2005, the Department of Labor published a notice in poster format explaining the rights of employees under USERRA for employers to use to communicate USERRA rights. The notice is available for download from the Department of Labor (DOL) Web site at www.dol.gov/vets/programs/userra/poster.pdf.

The protections of USERRA generally apply to any individual who is a member of, applies to be a member of, performs, has performed, applies to perform, or has an obligation to perform service in a uniformed service (a "veteran"). The Final USERRA Regulations provide substantial guidance about determining when an individual qualifies as a veteran protected by USERRA.

USERRA generally defines a health plan to include an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or arrangement under which the employee's health services are provided, or the expenses of those services are paid. USERRA covers group health plans, as defined in the Employee Retirement Income Security Act of 1974 (ERISA) at 29 U.S.C. 1191b(a). USERRA applies to group health plans that are subject to ERISA, and plans that are not subject to ERISA, such as those sponsored by State or local governments or religious organizations for their employees. USERRA also covers multiemployer plans, maintained pursuant to one or more collective bargaining agreements between employers and employee organizations, as they are defined in ERISA at 29 U.S.C. 1002(37). USERRA contains provisions that apply specifically to multiemployer plans in certain situations.

USERRA generally mandates that if the employee has coverage under a health plan in connection with his employment, the health plan must permit the employee to elect to continue the coverage for himself (and dependents, if the plan offers dependent coverage), under a health plan provided in connection with the employment.

The plan must allow the employee to elect to continue coverage for a period of time that is the lesser of the following:

- the 24-month period from date the employee's absence for the purpose of performing service begins; or
- the period beginning on the date on which the employee's absence for the purpose of performing service begins, and ending on the date on which he fails to return from service, or apply for a position of employment, as provided under the Regulations.

USERRA regulates the amount that a health plan can require an employee to pay to continue health plan coverage during a USERRA-protected absence. If the employee performs service in the uniformed service for fewer than 31 days, he cannot be required to pay more than the regular employee share, if any, for health plan coverage. If the employee performs service in the uniformed service for 31 or more days, he may be

required to pay no more than 102% of the full premium under the plan, which represents the employer's share plus the employee's share, plus 2% for administrative costs.

USERRA does not specify requirements for methods of paying for continued coverage. or expressly dictate the procedures that a health plan must use when administering elections to maintain or terminate USERRA mandated coverage. Rather, the Regulations specify that health plan administrators may develop reasonable procedures for governing these matters. However, the Final USERRA Regulations do provide detailed guidance about the allowable actions that a plan administrator may take, regarding the provision or cancellation of an employee's continuing coverage during a USERRA-protected leave for non-payment of required contributions.

USERRA generally guarantees an employee timely returning from a USERRA protected leave to reemployment in the job position that he would have attained, with reasonable certainty, if not for the absence due to uniformed service. The Final USERRA Regulations provide extensive guidance about the application of this requirement, including specific guidance about benefit entitlement and eligibility upon return to employment following a military leave.

According to this final guidance, when reemployed following a period of uniformed service, an employee is entitled to the seniority and seniority-based rights and benefits that he had on the date the uniformed service began, plus any seniority and seniority-based rights and benefits that the employee would have attained if he had remained continuously employed. In determining entitlement to seniority and seniority-based rights and benefits, the period of absence from employment, due to or necessitated by uniformed service, is not considered a break in employment.

In connection with these reinstatement rights, employees are entitled to immediate reinstatement of any health benefit or other coverage upon timely return to employment. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment, if an exclusion or waiting period would not have been imposed, had coverage not been terminated by reason of such service. However, USERRA permits a health plan to impose an exclusion or waiting period as to illnesses or injuries, determined by the Secretary of Veterans Affairs, to have been incurred in, or aggravated during, performance of service in the uniformed services. The determination that the employee's illness or injury was incurred in, or aggravated during, the performance of service may only be made by the Secretary of Veterans Affairs or his representative. Other coverage, for injuries or illnesses that are not service-related (or for the employee's dependents, if he has dependent coverage), must be reinstated, subject to the preceding paragraph.

- **Family And Medical Leave Act Of 1993**

The Family and Medical Leave Act of 1993 (FMLA) guarantees eligible employees of a covered employer who experience a qualifying family situation the right to take up to 12

weeks of unpaid leave of absence in each 12-month period from a covered employer. The FMLA also contains special rules concerning the right of covered employees to continue coverage during a qualifying family leave and to reinstatement of coverage after returning from a qualifying family leave. Many employers need to amend their welfare plans, practices, and polices to comply with these rules. The FMLA requirements apply to any plan an employer maintains or contributes to (including a self-insured plan) for providing health care (directly or otherwise) to the employer's employees, former employees, or their families. The continuation of coverage requirements extend to any medical benefits provided in an employer's health plan, including a supplement to a health plan, whether or not provided through a flexible spending account or other component of a cafeteria plan.

During a family leave, the FMLA requires that a covered employer allow an eligible employee to continue to receive coverage under the employer's group health plans as if the employee were not on leave. An employer may require an eligible employee to continue making employee contributions to continue group health plan coverage as if the employee were actively at work. The Department of Labor final regulations regarding the continuation of coverage during family leave state that the employer's obligation to maintain health coverage ceases if an employee's premium payment is more than 30 days late. The employer may recover the employee's share of any premium payments missed by the employee for any family leave period during which the employer maintained health coverage by paying the employee's share. However, the employer still must reinstate coverage to the employee upon return from family leave. When attempting to comply with this FMLA mandate, employers must consider other legal requirements affecting the funding arrangements of the health and other welfare plans, including the trust requirements of ERISA and, if applicable, the requirements applicable to cafeteria plans under Section 125 of the Code.

Except as required by COBRA, an ERISA-covered health plan's obligation to maintain health benefits under the FMLA ends when an employee informs the employer of his intent not to return from leave, when the employee fails to return from leave and thereby terminates employment, or when the employee exhausts his family leave entitlement. Published guidance about the relationship between the FMLA and COBRA states that the FMLA generally precludes a covered employer from applying the family leave continuation period to reduce the COBRA period. The FMLA provides, however, that a covered employer may require an employee to reimburse the employer for the portion of the premium that the employer paid to maintain the employee's medical coverage during an unpaid family leave if an employee fails to return to work at the end of his family leave, and the failure to return is not a result of a serious health condition that would entitle the employee to family leave or other circumstances beyond the control of the eligible employee. An employee who returns to work for at least 30 calendar days is considered returned to work under the regulations. The employer may recover its share of health premiums paid during the entire period of unpaid family leave taken by the employee. The amount that a self-insured employer may recover is limited to the employer's share of allowable premiums calculated in accordance with COBRA,

excluding the two percent fee for administrative costs. According to the Department of Labor regulations, an employer may either initiate legal action against the employee to recover its share of the premiums, or, unless otherwise prohibited by law, recover its share of health insurance premiums through deduction from any sums due the employee (e.g., unpaid wages, vacation pay, profit sharing, etc.). Attempts to recover health premiums through offset against other sums due the employee should not be undertaken without prior consultation with counsel to avoid incurring significant liability for unintentional violation of the FMLA, COBRA or other laws.

When the eligible employee returns to work after taking family leave guaranteed under the FMLA, the covered employer must restore any coverage under the health plan that the employee and his family enjoyed before he began his leave. The regulations state that an employee is entitled to be reinstated in medical coverage on the same terms as before his family leave without any qualifying period, physical examination, pre-existing condition exclusions, etc. According to the Department of Labor, an employee may choose to not retain health coverage during family leave without giving up his right to reinstatement of coverage following leave. Absent additional guidance, this regulatory position presents particular concerns where the medical coverage is provided through a medical spending account included in a cafeteria plan. An employee apparently remains eligible for this annually elected benefit amount and he can avoid making contributions for up to 12 weeks while he is on family leave.

- **COBRA Medical Coverage Eligibility Requirements**

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) also affords important protections to employees and dependents that otherwise would lose eligibility for employment based medical coverage under certain specified circumstances.

COBRA generally requires private employers[12] who normally employ 20 or more employees to offer their employees, and their immediate family members who are qualified beneficiaries, the opportunity to elect continued group health coverage after the occurrence of certain qualifying events. COBRA specifies what the qualifying events are, the length of time that the qualified beneficiary can maintain coverage under the health plan, minimum standards about notifications about COBRA rights, the election procedures and periods applicable to qualified beneficiaries, and the premium the employer can charge qualified beneficiaries for the group health coverage.

The qualifying events under COBRA include: (1) the employee's termination, other than for gross misconduct; (2) a reduction in hours that would cause the employee to cease to qualify for benefits; (3) the divorce or legal separation of a covered employee; (4) the death of the covered employee; (5) the covered employee's becoming entitled to Medicare; (6) a dependent child's ceasing to be a dependent child under the terms of the

12 Similar mandates also generally apply to health plans sponsored by public employers pursuant to COBRA provisions applicable to those programs.

plan; or (7) Chapter 11 bankruptcy of an employer from whose employ a covered retired employee retired at anytime.

Under COBRA, continuation coverage generally must be provided for 18 months after the date of the qualifying event when a covered employee is terminated or has a reduction in hours. The period for qualified beneficiaries who are disabled at the time of a termination of employment or reduction in hours may be extended to 29 months. For other qualifying events, continuation coverage must be provided for 36 months. If, during the 18-month period following a termination or reduction in hours, an additional qualifying event occurs, the period is extended to 36 months.

COBRA also requires specific notice and election procedures. COBRA mandates that the plan administrator provide initial notice of COBRA rights to covered persons when coverage begins. When a qualifying event occurs, COBRA mandates that the plan administrator send a specific notification to the qualified beneficiaries that contains detailed information about their COBRA rights and the applicable election procedures. The Department of Labor Regulations define specific content that must be included in each of these notifications, as well as provides rules regarding their delivery and other matters.

The May 26, 2004 Department of Labor Regulations interpret these mandates to require written notification as follows:

- **Initial Notice**

The plan administrator must provide an initial written notice to each covered employee and spouse of the covered employee (if any) of the right to continuation coverage provided under the plan not later than (1) the earlier of 90 days after the earlier of the date on which such individual's coverage under the plan commences, or, if later, the date the plan first becomes subject to the continuation coverage requirements; or (2) the first date on which the administrator is required, pursuant to § 2590.606–4(b), to furnish the covered employee, spouse, or dependent child of such notice of a qualified beneficiary's right to elect continuation coverage;

- **Notice of Qualifying Event By Employer**

No later than 30 days after the date that the qualified beneficiary will lose coverage on account of the qualifying event, the employer must notify the plan administrator of the occurrence of a qualifying event that is the employee's death, termination (other than on account of gross misconduct) or reduction in hours of employment, Medicare entitlement, or a proceeding under Title 11 of the Bankruptcy Code.

- **Notice of Qualifying Event By Employee or Qualified Beneficiary**

The qualified beneficiary or covered employee must notify the plan administrator of the occurrence of the divorce or legal separation of the employee from his spouse, a dependent ceasing to qualify as a dependent under the terms of the plan, or a second qualifying event while the qualified beneficiary is enrolled in COBRA coverage within 60 days of the later of the date of the qualifying event, the date of the loss of coverage or the date that the qualified beneficiary is informed of the responsibility to provide and procedures for providing the notification through delivery of the initial COBRA notice or the summary plan description.

- **Notice of Disability Status**

A qualified beneficiary (who is deemed a qualified beneficiary on account of a reduction in hours or termination of employment) who is seeking to qualify for an extension of his COBRA eligibility on account of disability must notify the plan administrator that he has received a determination from the Social Security Administration that he was disabled during the initial 60 days of COBRA coverage. This notification must occur within the 60 day period that ends on the later of (1) the date of the disability determination by the Social Security Administration, (2) the date on which a qualifying event occurs, (3) the date on which the qualified beneficiary loses or would lose coverage as a result of the qualifying event, or (4) the date that the qualified beneficiary is informed of his responsibility to provide the notification and the procedures for providing the required notification through the furnishing of the summary plan description or the initial COBRA notice. The plan may provide that such notification must be provided within the initial 18-month period of COBRA coverage.

- **Notice of Termination of Disability**

A qualified beneficiary on account of a reduction in hours or termination of employment whose eligibility for COBRA is extended on account of disability must notify the plan administrator of the determination by the Social Security Administrator that he is no longer disabled within 30 days of the later of the date the Social Security Administration determines he is no longer disabled or the date he is notified through the summary plan description or the initial COBRA notice of his responsibility, and the procedures to provide, that notification.

- **Notice of Qualifying Event**

The plan administrator must provide within 14 days of receipt of notification of the occurrence of a qualifying event written notice to each qualified beneficiary of the qualified beneficiary's rights to continuation coverage under the health plan. The notice must meet the requirements of the Department of Labor regulations.

- **Notice of Unavailability of COBRA**

If the plan administrator determines that a qualified beneficiary or other individual is not entitled to COBRA coverage after the plan administrator receives a notice from the qualified beneficiary of a qualifying event, second qualifying event or Social Security Administration disability determination, the plan administrator must provide written notification of the unavailability of COBRA coverage within 14 days of receipt of notification of the qualifying event, which explains the basis of the determination and explains the applicable appeals procedures.

- **Notice of Termination of COBRA**

The plan administrator must notify a qualified beneficiary enrolled in COBRA coverage of any termination of COBRA coverage that takes effect before the end of the maximum period applicable to that qualified beneficiary's qualifying event as soon as practicable after the determination of the plan administrator.

COBRA mandates that the election period during which a qualified beneficiary may decide whether to accept or reject COBRA coverage must last at least 60 days beginning on the date that the prospective employee receives notice of his or her continuation of coverage rights. The final Treasury Regulations state that if a qualifying event occurs at the end of a leave, the usual notice rules of COBRA generally apply. The employer generally must notify the plan administrator of the qualifying event within 30 days of the last day of the qualifying event. The final Treasury Regulations do not expressly address the effect of a COBRA Notice provided more than 30 days before the end of the leave. Amendments made under the Trade Act of 2002 mandate certain special enrollment rights for qualifying persons.

COBRA also regulates the amount that the health plan may charge a qualified beneficiary for COBRA coverage. A plan generally may require payment of a premium not to exceed 102% of the cost to the plan of providing coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred. For the additional 11 months available as a result of disability, the premium cannot exceed 150% of the cost to the plan of providing coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred.

The Trade Act of 2002 mandates that health plans covered by COBRA offer a second COBRA election period for workers who qualify for Trade Adjustment Assistance (TAA) because of trade-related unemployment. The Trade Act of 2002 also creates a tax credit for up to 65 percent of the premiums paid by TAA-eligible workers for medical coverage, including COBRA.

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Only TAA-certified workers who filed applications for certification on or after November 4, 2002, are entitled to a second opportunity to elect COBRA continuation coverage. Workers must apply for TAA certification through the Department of Labor or

designated state agencies before they can receive TAA benefits. They may be certified as part of a group of employees, or a single worker may apply for certification individually. The Trade Act requires that the employer or plan administrator make a second 60-day COBRA election period available to TAA-certified former employees.

An employee might qualify for this second chance to elect continuation benefits if he:

- has been certified to receive TAA benefits on or after November 4, 2002, and within six months of losing group health plan coverage;
- has lost health coverage because of a trade-related termination of employment, which resulted in being TAA-certified; and
- did not elect COBRA coverage when it was offered during the first election period following termination.

The Trade Act of 2002 does not provide continuation coverage to any persons who would not have been eligible for such coverage under existing COBRA rules. Only those former workers who were offered COBRA at the time of their termination and who failed to elect coverage during the first 60-day election period, are eligible to elect COBRA during the special second election period. The former employee may elect continuation coverage on behalf of eligible family members who do not have the independent right to elect COBRA coverage under the Act.

Where applicable, the special second COBRA election period begins on the first day of the month in which the individual is certified to be eligible for TAA benefits, so long as the election is made within six months after the initial loss of coverage. Assuming an election is made during the second special election period, coverage begins on the first day of the second election period. Because coverage is not made retroactive to the initial loss of coverage, the Trade Act of 2002 specifies that the period between the loss of health coverage and the beginning of the new special COBRA election period not be counted when calculating the 63-day break in coverage limitation under the HIPAA. (Under HIPAA, if a break in health insurance coverage is at least 63 days in duration, prior creditable coverage may be ignored.)

Recent HIPAA regulations jointly published by the IRS and the Department of Labor and the updated Department of Labor COBRA regulations provide limited guidance about the application of the Trade Act of 2002 on the COBRA and HIPAA rights of parties protected by its provisions. The final Department of Labor COBRA Regulation does not impose any specific disclosure requirement regarding rights and duties that may arise as a result of the Trade Act. However, the Department of Labor included an optional Trade Act paragraph in the model election notice to assist administrators who wish to notify potentially eligible individuals of their rights under the Trade Act as they relate to continuation coverage. The model election notice included in the COBRA regulations also has an optional paragraph describing the 65% health coverage tax credit (HCTC) created by the Trade Act of 2002 for an administrator to use if it believes employees might be eligible for trade adjustment assistance (TAA).

- **State Mandated Rules Generally Preempted Except State Insurance Regulation Eligibility Mandates Enforceable Against Insurers**

State law eligibility, benefit and other health benefit plan mandates are not directly enforceable against an employer-sponsored health plan or its sponsoring employer, although an employer or its health plan indirectly may become subject to these requirements if it purchases an insurance policy from an insurer or multiple employer welfare arrangement and the regulation or mandate falls within the ERISA section 514(b)(2) or (6) exemption allowing states to regulate the business of insurance. The fact that employers or their welfare benefit plan can't directly be compelled to comply with such mandates does not mean that state regulations don't impact these programs. Where the arrangement is insured, state mandates generally are enforceable against the issuing insurer. Consequently, unless the employer takes extraordinary steps, any relevant state mandates typically will be incorporated into the welfare plan by virtue of provisions in the contract of insurance.

The pre-emption provisions of ERISA generally operate to insulate health plans and their sponsors from the obligation to comply with most state laws including state insurance laws. Section 514 of ERISA provides that ERISA supersedes any state law that "relates to" a welfare benefit plan and is not specifically excluded from pre-emption under Section 514(b) of ERISA as a law that "regulates the business of insurance." The Supreme Court's findings in F*ort Halifax Packing Co., Inc. v. Coyne,* illustrates the court's construction of this preemptive scheme's operation. "ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit governed by only a single set of regulations." Thus, the courts have recognized that ERISA's preemption section was meant to protect employers from the burdens of multiple and perhaps inconsistent state regulations, and employees from losing benefits because of such inefficiencies. Importantly, however, the courts have noted that "Congress placed into ERISA an express disavowal of any intent to regulate insurers qua insurers." Thus, ERISA preserves the authority of states to regulate the business of insurance, provided that employee benefit plans and their sponsors are not deemed insurers subject to regulation pursuant to the "Savings Clauses" set forth in ERISA Sections 514(b)(2) and (6).

Recognizing these principles, the courts have broadly construed the preemptive reach of ERISA. Historically, the Supreme Court has interpreted the phrase "relates to" to sweep within ERISA's preemptive scope any state law which "has a connection with or reference to such a plan" other than those laws that affect employee benefit plans "too tenuously to be characterized fairly as relating to employee benefit plans." Furthermore, the courts have held that ERISA preempts the enforcement all such laws against an ERISA-covered employee benefit plan and its sponsor regardless of whether they conflict

with any specific provision of ERISA. Otherwise, the regulation of employee benefit plans would not be exclusively a federal concern. While the Courts always have recognized that some state laws affect employee benefit plans too tenuously to be characterized fairly as relating to employee benefit plans, the courts recognize that ERISA bars states from enforcing state law eligibility requirements which would compel an employer-sponsored health plan or its sponsoring employer to cover, or continue coverage for, certain employees or dependents or otherwise to regulate ERISA-covered health plans or their sponsors, even though those state insurance law mandates to that effect can be enforced against insurers issuing policies pursuant to which ERISA plans are maintained or insured. Thus, a state cannot compel an employer to cover a particular group or individual directly, but can indirectly affect the design of an insured employer-sponsored health plan by prohibiting an insurance company from selling a policy of insurance to an employer unless the policy complies with certain state mandated eligibility or other requirements. An employer or its health plan becomes potentially subject to these requirements only indirectly when the employer elects to purchase an insurance policy that contains mandated coverage or eligibility terms or otherwise incorporates these requirements voluntarily into its plan through the adoption of a written document containing these arrangements or making certain other oral or written representations regarding these terms that are binding under ERISA.

- **Section 125 Cafeteria Plan Rules**

Most health and welfare plan sponsors that offer health or group term life insurance as benefit options under a cafeteria plan arrangement will want to amend and restate their cafeteria plans to comply with Temporary Treasury Regulation Section 1.125-4T.

Code Section 125 regulates the circumstances under which an employer may allow employees to choose to elect to pay for certain health and other welfare benefit premiums on a pre-tax basis or choose welfare benefits from a menu of welfare benefit programs, cash or other taxable benefits, or some combination of both of these options. Arrangements that offer these options commonly are referred to as "cafeteria plans" or "flexible benefit plans." Unless the requirements of Code Section 125 are satisfied, the Code generally mandates that the employer treat each employee offered the election as having elected the taxable benefit for income and employment tax withholding and reporting purposes. This is generally the case even if the employee chose a benefit option that otherwise would not have generated taxable income for the electing employee absent the availability of the election. In contrast, if the requirements of Code Section 125 are met, the opportunity to elect cash or some other taxable benefit will not result in deemed taxable income to an employee who elects the nontaxable benefit. Therefore, employers offering employees the opportunity to elect between qualifying benefits and one or more taxable benefits must ensure that their arrangements meet the requirements of Code Section 125. Unless the requirements of Code Section 125 are met, the offering of a choice between nontaxable qualified benefits and taxable benefits will necessitate that the employer treat all employees offered the choice as having received the taxable benefits and report the applicable value of the taxable benefit as income to the employee. This is

the case regardless of whether, in the absence of a choice, the employee electing the nontaxable benefits otherwise could have excluded the nontaxable benefits from income. If the requirements of Code Section 125 are met, however, the employer only need report recipients as receiving taxable income to the extent that the benefits provided otherwise would have been taxable, or to the extent that the individual is a highly compensated employee receiving discriminatory benefits under a discriminatory cafeteria plan. Thus, in order to in fact be excluded from income, an otherwise nontaxable benefit must not be offered in accordance with Code Section 125, otherwise must qualify as a nontaxable benefit, and, in the case of a highly compensated employee, the benefit must not be discriminatory under Code Section125.

To qualify as a cafeteria plan, the election of an employee must be made pursuant to a properly executed written plan document that meets the requirements of Code Section 125. As most health plans contemplate that employees will contribute to the plan pursuant to pre-tax elections under Code Section 125, compliance with the election and other requirements of Code Section 125 generally also will be mandatory terms for a health plan. Similarly, cafeteria plan documents and related procedures governing health plan related elections must be drafted to permit the mid-year enrollment changes mandated by HIPAA and other applicable laws.

Code Section 125 also includes a number of non-discrimination requirements for cafeteria plans. A plan may not favor highly compensated employees as to eligibility. The plan cannot provide key employees with more than 25 percent of the total nontaxable benefits. Under the benefits test, plans may benefit a non-discriminatory classification, however, the facts and circumstances must demonstrate that what is offered, as well as the benefits actually selected, do not discriminate in favor of the highly compensated, and either: (1) employer contributions for each participant must be 100 percent of that of highly compensated, or (2) employer contributions for each participant are at least 75 percent of the cost of the most expensive coverage selected by a similarly situated participant. Also, plans which are part of a cafeteria plan must also satisfy their individual set of discrimination rules. As a penalty for discrimination, highly compensated or key employees are taxed on the highest aggregate value of all available benefits.

Special rules also apply under Code Section 125 to flexible spending account (FSA) arrangements. FSAs are arrangements that allow participants to convert taxable income into tax-free reimbursements of otherwise unreimbursed eligible expenses, such as medical, dental or vision care expenses or dependent care expenses. The participant elects, prior to the beginning of the plan year, how much money to contribute to each account for that plan year. Once money goes into an FSA account, it can only be used to reimburse eligible expenses. A cafeteria plan does not include any plan that defers the receipt of compensation or operates in a manner that enables participants to defer compensation by, for example, permitting participants to use contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year. This rule is

commonly referred to as the "use-it-or-lose-it" rule, requiring that unused contributions or benefits remaining at the end of the plan year be "forfeited."

IRS Notice 2005-42, published on May 18, 2005, modifies the "use-it-or-lose-it" requirement traditionally applicable to cafeteria plans under Code § 125. This modification creates a new 2-1/2 month grace period immediately after the close of the plan year during which participants can still incur expenses for qualified benefits. Under the modified rules, Code § 125 continues to prohibit cafeteria plans that allow participants to defer compensation beyond the close of the plan year. Under IRS Notice 2005-42, however, a cafeteria plan document now may, at the employer's option, be amended to provide for a grace period of up to 2-1/2 months immediately following the end of each plan year during which unused contributions or benefits remaining in an employee's dependent care, health flexible spending or other cafeteria plan account may be used. The effect of the grace period is that the participant may have as long as 14 months and 15 days (the 12 months in the current cafeteria plan year plus the grace period) to use the benefits or contributions for a plan year before those amounts are "forfeited" under the "use- it-or-lose-it" rule.

Employers are required to report dependent care benefits provided during a calendar year in Box 10 of the employees Form W-2. Since, in most cases, the W-2 will need to be provided prior to the close of the grace period, there was some confusion as to what number employers should report. Recently issued IRS Notice 2005-61 (September 7, 2005) clarified that employers may use the employee's dependent care spending account salary reductions for the year as a "reasonable estimate" of benefits provided.

- **Patients Need To Understand How To Determine What The Scope and Limits Of Their Health Coverage**

Patients and their families often fail to adequately understand the adequacy, scope and limits of their health and disability coverages and their role and responsibilities in maintaining and claiming benefits of that coverage.

As a starting point, many Americans lack any detailed understanding about the particulars of the coverage afforded to them under the medical benefit programs, if any, in which they participate. Misperceptions about the existence and adequacy of medical and disability coverage stem from a variety of sources. As a starting point, few Americans possess a realistic understanding about the true cost of medical services or medical coverage generally. As a result, Americans generally underestimate the cost of the medical services that a seriously ill family member is likely to need and the premium costs to secure coverage for that care. Meanwhile, Americans as a group tend to overestimate the coverage provided under their chosen health benefit program. For most American workers, cost considerations remain the primary consideration behind the medical and disability coverages, if any, in which an employee chooses to enroll himself and his family. Despite the delivery of summary plan descriptions and/or insurance certificates providing detailed descriptions of benefits, few American workers engage in

any detailed evaluation of the scope of coverage and benefits actually provided by the respective medical benefit programs, if any, in which they participate before the onset of a serious illness or injury. Prior to the onset of an illness or injury in their families, Americans generally operate on a presumption that except for co-payments and deductibles, their health benefit program generally will provide adequate coverage for any charges that a family member might be expected to incur for medically necessary care of a serious illness without making any significant effort to critically evaluate the specifics of their particular health benefit program. Even when seeking medical care, most Americans at the time they pursue care have not reviewed, and in fact are unaware of the potential need to review, the terms and conditions of the summary plan description, certificate of insurance, policies and plan documents and other documentation that governs their benefit entitlement, much less the identity and location of those documents. Rather, Americans seeking medical care commonly operate on a "no-news-is-good-news" mentality and presume that the required expense will be covered by their medical benefit program until their health plan denies coverage for a procedure, their health care provider bills them for the charges, or both. As a result, patients and their families often underestimate their true financial responsibility for payment of medical expenses incurred for treatment.

- **Patients Need Understanding Of Federal Prohibitions Against Discrimination In ERISA-Covered Health Plans**

Congress has enacted a number of Federal statutes that prohibit employment discrimination based on certain characteristics. These nondiscrimination mandates often provide important protections for patients and families seeking to claim the maximum available coverage under an ERISA-covered health or other benefit plans, as well as valuable employment rights. The following paragraphs highlight some of the more significant of these potentially applicable federal protections.

  - **ADA Disability Discrimination Prohibitions, Privacy Rules and Sanctions**

The disabilities discrimination prohibitions of the Americans With Disabilities Act of 1990 (ADA) prohibit an employer[13] and any of its agents from discriminating against any "qualified individual with a disability"[14] in any term, condition, or privilege of

[13]Under the ADA, Federal law extends the prohibition against discrimination in employment based on disability to private employers, private educational institutions, and private business and service providers. On July 26, 1992, the employment provisions included employers with 25 or more employees. On July 26, 1994, however, the reach of the employment provisions of the ADA was extended to employers with 15 or more employees.

[14]The ADA defines a "qualified individual with a disability" as an individual with a disability who meets the skill, experience, education and other job-related requirements of the position and who, with or without reasonable accommodation, can perform the essential functions of the job. The ADA broadly defines an individual with a disability as including any of the following persons: (1) a person who has a physical or mental impairment that substantially limits a major life activity; (2) a person having a record of such an impairment; (3) a person regarded as having an impairment; and (4) a person who associates with a person with a disability. Certain conditions that may have fit under the definition of a disability are specifically excluded by the ADA.