

Helping Seniors Who Cannot Manage Monies— Coordinating the Efforts of Courts and SSA's Representative Payment Program

Daniel L. Skoler

As we enter the new millennium, society's machinery for helping America's decisionally-impaired elderly population cope with the dollar side of getting along is faced with some difficult and fascinating challenges. This machinery consists of two major institutional systems—one as old as the common law,¹ the other a “new kid on the block” whose exponential growth has given it a “market share” more than ten times larger than the other.

These two systems differ in number of defining characteristics. One is state government driven.² The other is a creature of the federal government—the United States' pre-eminent social insurance program that oversees, administers, and dispenses money benefits exceeding in dollar volume the total government budgets of all but a few nations in the world.³

One system relies on the state court apparatus and formal procedural, adjudication, and evidentiary development techniques for decisionmaking on issues such as need, suitability, oversight, and appropriate surrogates to control the resources of citizens in need of money management help. The other system, since inception, has featured more informal processes of investigation and decisionmaking, i.e., paper applications rather than court petitions, interviews rather than hearings, and thousands of staff decisionmakers guided by strict internal protocols rather than a small cadre of carefully selected probate judges to deal with vital issues of “who,” “what,” and “under what terms.”

At the same time, there are important similarities. Both of these institutional systems administer guardianship programs that place full financial power in surrogates required to take on comprehensive “fiduciary” responsibilities on behalf of incapacitated persons. And both systems have, in the final decade of the 20th century, and despite generally conscientious performance of responsibilities, been exposed to considerable public attention, criticism, and pressures for reform. This reform includes efforts to minimize performance lapses, prevent fraud and overreaching by surrogates, promote accountability, and recognize important new trends in advocacy, protection, and autonomy for citizens with impaired

capacities who simply cannot meet the demands and pressures of personal financial management.

What are these two systems? The first is the nation's probate/guardianship court structure, operating in all 50 states as a component of each state's overall court system; adjudicating some 100,000 to 200,000 petitions for guardianship appointments each year; overseeing approximately 600,000 active guardianships; and involving some 1,500 judge decisionmakers (many with jurisdiction extending beyond initiation of guardianship petitions, review of status changes, and approval of terminations).⁴ This is the basic mechanism by which our society, under the rule of law, can entertain and determine claims that an individual's power to make decisions on his or her own behalf is so impaired as to require the appointment of another party (relative, friend, agency, professional surrogate, etc.) to make decisions for that individual. The power may extend to personal affairs or financial decisions and, when granted, is usually plenary in scope despite a recent trend toward limitation, whenever possible, to maximize the impaired person's autonomy.⁵

Second, there is the 60-year-old federal representative payment system of the Social Security Administration (SSA) (about as old as the Social Security Act itself).⁶ The SSA handles some 1.3 million representative payee (RP) appointments a year and oversees a “limited guardianship program” in which more than 1 out of every 10 of the 50 million Americans entitled to some form of Social Security benefit

Continued on page 2

In This Issue

- 3** End-of-Life Care Legislative Highlights
- 5** Reinventing Insurance Regulation
- 12** Center for Elder Rights Opens in Virginia
- 13** Internet Tips for the Elderly

Helping Seniors Who Cannot Manage Monies

Continued from page 2

check (nearly 7 million persons in all)⁷ need to receive that benefit through a representative payee. This is required because the beneficiary has been determined to be unable to manage his or her benefits in their “own best interest.” It is a “limited guardianship” because the “guardian” has authority over only one kind of asset—the beneficiary’s Social Security income.⁸ In addition, the guardian has fiduciary responsibilities to expend those monies only for the well being and personal care of the beneficiary, whether involving food, shelter, clothing, education, medical/dental, recreational, or personal convenience outlays.⁹

Do these programs need to be “coordinated”? Do they overlap or intersect in significant ways as regards older and disabled Americans? The answer is clearly “Yes”—not totally, but quite significantly. First, many individuals under representative payment may require guardianship of all of their assets and, thus, the same individuals can and should be subject to both representative payment and court guardianship. Indeed, the establishment of incapacity requiring a

court-appointed guardian will routinely trigger and justify appointment of a representative payee by SSA if that person is entitled to and receiving Social Security benefits as a retired or disabled worker, a dependent, a survivor, or an adult or child with a disability warranting the receipt of means-tested SSI benefits.¹⁰ It is also possible that an individual with sufficient mental or emotional incapacity to warrant appointment of a guardian may not need that comprehensive level of financial control if the individual’s sole or predominant income comes from Social Security funds which can readily be handled through less formal, less expensive, and more flexible SSA representative payment arrangements. Moreover, functioning representative payees may be ideal candidates for full guardianship appointment if they have been effectively overseeing benefit management as a representative payee or may have valuable information based on their RP experience about the nature and extent of a person’s incapacity in the event of initiation of full guardianship proceedings.

It was exactly this intersection that led the American Bar Association, supported by grant funds from the Social Security Administration and the State Justice Institute,¹¹ to launch a project in 1998 to examine how coordination, communication, and mutual education about the two systems might enhance the operations of each. The project also sought to suggest how that coordination could advance broader goals of maximizing beneficiary/ward autonomy and providing needed money management help with the fewest possible personal restrictions. This effort contemplated the development of two work products that would advance the foregoing goals: (i) a set of “best practices” for courts and the SSA to advance productive coordination and interaction, and (ii) curriculum models for training formats that would enable state court judges and their staffs to better understand, work with, and take advantage of the Social Security representative payment system in administering their state guardianship systems.

The project has run its course and the ABA is now completing its planned work products, including the development of reports, articles, and training packages. This article focuses upon and provides a summary of the “best practice” findings and recommendations of the project. More complete details on the program can be found in the project’s final report and curriculum models (to be available in Spring 2001). The “best practice” principles are set forth below in abbreviated form¹² and will be briefly explained in the concluding text of the article. It should be noted that the project contemplated an examination not only of guardianship court practices and systems, but also juvenile and family court operations as they relate to children with representative pay-

Continued on page 9

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End-of-Life Care Legislation: Year 2000 Highlights

Charles P. Sabatino**

Surrogate Decisionmaking

*2000 **Fla.** Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890)
2000 **Haw.** Sess. Laws 42 (H.B. 1836)
*2000 **Ill.** Legis. Serv. PA 91-714 (H.B. 2574)
2000 **Md.** Laws 553 (S.B. 684)
2000 **Va.** Acts 1034 (S.B. 734)
2000 **Va.** Acts 598 (S.B. 677)
2000 **W. Va.** Acts H.B. 4144

Organ Donation

2000 **Colo.** Legis. Serv. 175 (S.B. 00-54)
2000 **Ky.** Acts 4 (H.B. 255)
2000 **Ky.** Acts 88 (H.B. 208)
2000 **R.I.** Pub. Laws 00-261 (H. 7393)
2000 **V.I.** Sess. Laws 6354 (B. 23-0191)

Drivers' License Designations

2000 **Haw.** Sess. Laws 295 (S.B. 2863)
2000 **Okla.** Sess. Law Serv. 153 (H.B. 2660)

Do-Not-Resuscitate Orders

2000 **Del.** Laws 360 (H.B. 181)
*2000 **Fla.** Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890)
*2000 **Md.** Laws 152 (H.B. 770)
2000 **Mich.** Legis. Serv. PA 59 (H.B. 5489)

Palliative Care

2000 **Del.** Laws 475 (S.B. 296)
*2000 **Fla.** Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890)
2000 **Haw.** Sess. Laws 228 (S.B. 862)
*2000 **Ill.** Legis. Serv. PA 91-714 (H.B. 2574)
2000 **N.H.** Laws 268 (S.B. 424)
2000 **N.J.** Sess. Law Serv. 62 (A. 316)
2000 **N.J.** Sess. Law Serv. 63 (A. 317)

Assisted Suicide

2000 **Md.** Laws 106 (H.B. 154)

Studies & Commissions

*2000 **Fla.** Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890)
2000 **Iowa** Legis. Serv. HF 2385 (West)
2000 **Ky.** Acts 394 (H.C.R. 44)
*2000 **Md.** Laws 152 (H.B. 770)
2000 **N.J.** Sess. Law Serv. 64 (A. 318)

* Legislation listed in multiple categories

Surrogate Decisionmaking

- u Florida** - 2000 Fla. Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890), approved June 15, and effective immediately, enacts a variety of amendments, including deleting the requirement in the default decisionmaker authorization (§765.401) that the patient have a terminal condition, end-stage condition, or be in persistent vegetative state before a “proxy” (i.e., default decisionmaker) can exercise decisionmaking authority (but the statute retains the language that the decision must be supported by “clear and convincing evidence”). See complete description of the enactment below under “Palliative Care,” p. 14.
- u Hawaii** - 2000 Haw. Sess. Laws 42 (H.B.1836), approved and effective April 26, amends the state’s Uniform Health-Care Decisions Act to eliminate the exclusion of pregnant women from coverage of the Act.
- u Illinois** - 2000 Ill. Legis. Serv. PA 91-714 (H.B. 2574) (West), approved June 9, and effective January 1, 2001, adds 20 Il. Comp. Stat. §2310-600 to the Civil Administrative Code, requiring the Department of Public Health to publish the summary of Illinois laws concerning advance directives (required by federal Patient Self-Determination Act). Requires the Department to publish in Spanish the summary and various statutory advance directive forms. Permits publication to be limited to the World Wide Web and permits the Department to contract for the preparation and publication of the materials.
- u Maryland** - 2000 Md. Laws 553 (S.B. 684), approved May 18 and effective October 1, addresses the process for documenting an oral advance directive under Md. Code Ann., Health-Gen. §5-602, clarifying that the “substance” of the directive must be documented in the medical record and not just the “fact” of the directive. It also clarifies that if an advance directive is revoked, under §5-604, by an oral statement to a health care provider, the practitioner and a witness must document the substance of the revocation in the medical record.
- u Virginia** - 2000 Va. Acts 1034 (S.B. 734), enacted without the governor’s signature April 19, makes a somewhat restrictive change in the authority of an agent under a health care advance directive in Va. Code Ann. §54.1-2982—specifically, that an agent has authority to make decisions about “visitation,” provided the advance direc-

Continued on page 4

End-of-Life Care Legislative Highlights

Continued from page 3

tive makes express provisions for visitation and subject to physician orders and policies of the institution”

- u **Virginia** - 2000 Va. Acts 598 (S.B. 677), approved April 7, amends Va. Code Ann. §§54.1-2987 to -2992 to amplify and clarify the procedures that health care providers must follow if they have a conscious objection to complying with an advance directive or “durable do-not-resuscitate” order.
- u **West Virginia** - 2000 W. Va. Acts H.B. 4144, approved April 4, repeals the state’s three separate health decisions acts and adopts a variation of the Uniform Health Care Decisions Act. The Act significantly combines and simplifies separate state laws. Provisions in the Act that vary from the Uniform Act include: (1) a requirement that the directive be both witnessed (by two witnesses) and notarized; (2) the use of two distinct documents (the living will and the medical power of attorney), rather than one combined advance directive; (3) a conscious objection provision that places the burden of arranging the transfer of the patient to another facility on the shoulders of the surrogate decisionmaker, rather than the health care provider; and (4) a mandate that health care facilities advise new admissions of the availability of advance directives (analogous to the federal Patient Self-Determination Act) and give the person assistance in completing the forms if the person desires.

Organ Donation

- u **Colorado** - 2000 Colo. Legis. Serv. 175 (S.B. 00-54) (West), approved May 23, amends Colo. Rev. Stats. §§12-34-101.5, -103, -105, -107, -110; §§13-22-103, -104; §§42-2-107, -108, -118, -121; and §24-72-204 to create an electronic central registry of donors of organs and tissue to facilitate timely and successful organ and tissue procurement.
- u **Kentucky** - 2000 Ky. Acts 4 (H.B. 255), approved February 9, concerns the processes for distributing donated organs. It adds a new section to Ky. Rev. Stat Ann. §311 to require that if an organ donee is not specified by the donor, that an organ shall be donated to the organ procurement organization (OPO) for the county in which the gift is made. Requires the OPO to use best efforts to locate recipient within its counties of jurisdiction, and permits the state to enter into reciprocal agreements with other states after obtaining approval of the Organ Procurement and Transplantation Network designated by the federal DHHS. Also prohibits an OPO from being mandated to transfer an organ for transplantation

to another state’s OPO or transplant center if a suitable recipient can be found within the Kentucky OPO’s service area.

- u **Kentucky** - 2000 Ky. Acts 88 (H.B. 208), approved March 8, adds a new section to Ky. Rev. Stat. Ann. §311, seeking to strengthen compliance with anatomical gift instructions made on drivers’ licenses or in living wills by prohibiting family members and health care surrogates from modifying the decedent’s wishes or denying an anatomical gift from being made. It also denies them legal standing to seek modification or denial of the donor’s gift.
- u **Rhode Island** - 2000 R.I. Pub. Laws 00-261 (H. 7393), approved and effective July 13, amends the statutory durable power of attorney for health care form (R.I. Gen. Laws §23-4.10-2) to authorize the agent’s authority to continue after the death of the principal merely for the purpose of informing the family or next of kin of the principal’s desire, if any, to be an organ and tissue donor.
- u **Virgin Islands** - 2000 V.I. Sess. Laws 6354 (B. 23-0191), approved June 30 and effective 30 days thereafter, replaces the territory’s 1984 version of the Uniform Anatomical Gift Act with an updated version, codified at V.I. Code Ann. tit. 19, §401-415.

Drivers’ License Designations

- u **Hawaii** - 2000 Haw. Sess. Laws 295 (S.B. 2863), approved July 3, and effective January 1, 2001, establishes a procedure to allow individuals to designate on their driver’s license or civil identification the existence of an advance health-care directive.
- u **Oklahoma** - 2000 Okla. Sess. Law Serv. 153 (H.B. 2660) (West), approved April 28, and effective November 1, amends the motor vehicle law, Okla. Stat. Ann. tit. 47, §6-111, to require the Department of Public Safety to promulgate rules for provision of a small decal for attachment to licenses, identifying the licensee as having executed an Advance Directive for Health Care and/or a Do-Not-Resuscitate order.

Do-Not-Resuscitate Orders

- u **Delaware** - 2000 Del. Laws 360 (H.B. 181), approved June 30, and effective immediately, establishes a “pre-hospital advanced medical directives” (i.e., an EMS-DNR order) at Del. Code Ann. tit. L6, §9706, and gives the Director of Public Health authority to promulgate rules. The Act extends immunity from criminal and civil liability to EMS personnel for compliance with such regulations. The regulations are to be consistent with the

Continued on page 14

Reinventing Insurance Regulation for the Benefit of Consumers— A Time for Change

Robert Hunter

The financial services marketplace is experiencing rapid change. Adding to this change is Congress' recent enactment of the Gramm-Leach-Bliley Act, which eliminates depression-era barriers to the cross-ownership of banks, insurance companies, and securities firms. Unfortunately, consumer laws have not kept pace with these changes, especially in the area of insurance.

“One-stop shopping” for financial services (e.g., banks selling investment and insurance), new product designs, faster ways of accessing money from more sources, and e-commerce all hold great potential for consumers. But they also expose consumers to the risk of losing their hard-earned dollars, especially when consumers lack information or are misled about products. While state-based insurance regulation has been adequate in some areas such as solvency, it has failed frequently to protect consumers from many market abuses, discrimination, and dislocations. Dramatic improvements in insurance regulation are needed to better promote beneficial competition and to protect insurance consumers.

In response to the passage of Gramm-Leach-Bliley, the associated threat of a federal takeover of insurance regulation, and cries from the industry for deregulation, the National Association of Insurance Commissioners (NAIC) has pledged to “modernize” insurance regulation. The blueprint for the NAIC modernization effort is its “Statement of Intent: The Future of Insurance Regulation,” issued in March 2000. The NAIC declared that its “primary goal is to protect insurance consumers, which [it] must do proactively and aggressively.”

The NAIC reinvention process presents a perfect opportunity to update consumer laws, to raise the bar of consumer protection standards, and to give consumers a stronger voice in the historically industry-dominated regulatory process. Based on their proposals, however, it is evident that the NAIC is poised to squander this opportunity, electing instead to acquiesce to the demands of the industry.

The Need for Improving Insurance Regulation to Benefit Consumers

Insurance regulation has traditionally been focused on insolvency protection—making sure that companies do not go out of business and have the financial capacity to pay claims. Although insolvencies plagued the industry in the 1980s, changes in insurance regulation and a strong securities market led to a healthier industry in the 1990s.

Continued on page 6

Changes in Insurance Regulation Bring Risks For Older Consumers

Elder law practitioners and advocates for the aging may find the field of insurance regulation arcane and distant from their immediate concerns. Many may have only peripheral awareness of the recent movement toward “financial services modernization” and the enactment of the Gramm-Leach-Bliley Act in November 1999. The Act dismantles barriers between the insurance, banking, and securities industries and is turning the world of insurance regulation inside-out. In its wake, the National Association of Insurance Commissioners (NAIC) has pledged to “modernize” and “reinvent” insurance regulation and has created nine new committees to address the new regulatory landscape. The committees are producing proposals at a dizzying pace.

The law and aging community should take heed. Advocates fear that this is all happening too fast, that the turmoil offers the insurance industry an opportunity to push for deregulation, and that the proposals being put forth may not be good for consumers. The “white paper” following, written by Robert Hunter, Director of Insurance for the Consumer Federation of America (CFA), gives a consumer perspective on the NAIC proposals and sets out an “Insurance Consumer Bill of Rights” to guide regulatory change. Mr. Hunter serves as a Funded Consumer Representative at the NAIC meetings and has played a leadership role in bringing consumer views to the attention of the NAIC committees.

Where do the elderly stand in this regulatory “reinvention” whirlwind? Potentially on the brink of great risk. Older consumers already may find the world of insurance confusing. They may be more vulnerable to fraud and misinformation, less able to voice complaints, and

Continued on page 6

Insurance Risks

Continued from page 5

more in need of help with difficult policy language. Under the new proposals, they may lose important protections. For example:

- u A proposal for the “national treatment of companies” would rely on designated states to regulate insurance companies nationwide. An elderly consumer who buys a long-term care policy from a company regulated under the laws of another state may find redress difficult if she is later denied home health coverage based on the other state’s laws.
- u Another proposal would set up a voluntary organization that would be responsible for setting standards for insurance contract language, reviewing rates, examining advertising, and approving policies for the marketplace. Thus, if a health insurance policy or a rate change for auto insurance is approved for use in a state, advocates and consumers will have little opportunity for input or objections.
- u If an older consumer has a complaint about the denial of a claim or misleading information, state insurance department “market conduct” programs are there to police the marketplace. However, proposals under consideration would allow companies to “self-certify” for compliance with market conduct standards.

Mr. Hunter’s white paper, reprinted with permission of the Consumer Federation of America, is a clarion call to consumer advocates, including those in the aging network. For a more detailed version of the paper, contact CFA at www.consumerfed.org. For more information about the Funded Consumer Representative program of the National Association of Insurance Commissioners, visit their web site at www.naic.org.

—Erica Wood
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Insurance Regulation—A Time for Change

Continued from page 5

An equally important goal of insurance regulation is preventing unfair and deceptive practices and policing market conduct. While regulators have fared well in insolvency protection, their track record in market conduct regulation is quite poor. Unfortunately, there are irresponsible insurers and agents in the market. Even responsible insurers can get caught up in bad practices. Insurance regulators have too often been slow to identify and address market problems, often acting only after media reports or lawsuits have been initiated. A few recent examples include:

- u Despite being banned as a factor for use in pricing life insurance for decades, recent media accounts report some large companies, e.g., American General, continued to use race-based pricing in life insurance.
- u Regulators announced an investigation of State Farm practices after cases alleging bogus medical reasons to deny claims were reported on the investigative television program *Dateline*.
- u As a result of efforts by fair housing groups and the U.S. Department of Housing and Urban Development, Nationwide Insurance Company settled allegations of unfair discrimination against minorities in homeowners insurance by agreeing to stop certain discriminatory practices.
- u After numerous and widespread cases of fraudulent and deceptive sales of life insurance made their way through the courts, state regulators began an investigation, resulting in nationwide settlements by companies such as Met Life and Prudential.
- u According to recent testimony by the General Accounting Office (GAO) regarding a scandal in which a banned securities broker allegedly embezzled more than \$200 million in insurance company assets over an 8-year period, the GAO found “regulatory weaknesses in multiple states over several years during key phases of insurance regulatory oversight.”

In addition to lagging behind in responding to market abuses, with some exceptions, state legislators and regulators have failed to enact measures that would bring true competition to the marketplace and address bad practices. The insurance industry, a \$750 billion business and a powerful and dominant force in state legislatures and the NAIC, has thwarted many efforts to enact consumer safeguards, such as better disclosure to facilitate comparison shopping and more fair pricing structures for certain insurance, e.g., consumer credit insurance. The NAIC members now have an opportunity to stand up for consumers and resist industry pressure. But will they?

The NAIC’s Work and Its Impact on Consumers

Improvements in the speed, efficiency, and consistency of regulatory processes are needed—and in that regard, some aspects of the NAIC proposals are positive. But rather than focusing on raising the consumer

protection bar, the work of the NAIC appears, rather, directed at holding off federal intrusion and satisfying the industry by creating a state-based “national” model and implementing changes for insurers to get their products to consumers faster. The following describes some of NAIC’s priority work and why it poses a threat to consumers.

National Treatment of Companies

The 50-state system has come under attack for lacking uniformity and coordination and being slow to respond to changes in the market. With the enactment of the Gramm-Leach-Bliley Act in which federally-regulated financial services firms will be under the same corporate roof as state-regulated insurance companies, many believe it is time for federal regulation of the insurance industry. In response, the NAIC is proposing a state-based “national” regulatory model that relies on a state or handful of states to regulate a company on a nationwide basis. The NAIC would develop national standards for the companies and assign a task force to confer national status on companies that choose to be regulated on a national basis. The task force would also determine which states can serve as national regulators. Reliance on a state or a few states to regulate nationwide could lead to consumers buying insurance from essentially unregulated companies. This approach has several problems, including:

- u There is no evidence that the standards the NAIC enacts will adequately protect consumers.
- u If reliance is based on one state, a state that has weak regulation could attract more insurers. A regulatory scheme should strive for higher, not lower, standards.
- u Because of the powerful influence of insurers in the state legislative and regulatory arena, the state of domicile is often under the greatest political pressure not to act to end a bad practice.
- u The resources of states vary widely. Studies show that most states do not have the resources they need to regulate under the current system. Consumers can expect more deceptive and fraudulent practices as state resources are drained regulating insurance companies on a countrywide basis.
- u Residents of one state cannot be adequately represented by the legislature/executive of another. A consumer who buys a policy from a company regulated under the laws of another state has little chance of recourse when she, for example, is denied long-term care coverage based on the other state’s laws.
- u Regulated insurance companies should not be allowed to choose which regulator governs their practices. If several flock to one state that has lower consumer protection standards, not only will the state’s resources be

overwhelmed, but also other states may lower their standards to attract more insurers.

An effective national approach to insurance regulation can only be accomplished through a federal bill that builds in the minimum consumer protections (*see p. 8*) necessary to qualify a state and insurer for such treatment. We commend the NAIC, a nonprofit entity, for recognizing that it requires federal authorization to fully implement a national treatment approach. We hope the NAIC members will promote their stated goal of protecting consumers “proactively and aggressively” by advocating for strong measures in any federal legislation. If a national system is adopted, a national funded consumer advocate’s office must be created to ensure that consumers are represented in legislative and regulatory matters.

A Speedier, One-Stop Approval Process for New Policies

While we recognize that a more efficient, consistent, and consumer-oriented review of new insurance policies is needed, we are not convinced that a one-stop approval process deserves the priority status given it by the NAIC. Consumers—some of whom have been victims of life insurance policies that promised rates of return they could not give), consumer credit insurance policies that pay pennies in claims per dollar in premium, and race-based pricing—are in no hurry for such policies. Urgently needed, however, are standards to ensure fair pricing, adequate disclosure, and a more honest marketplace.

CARFRA, a voluntary organization, is dangerous for consumers

The NAIC’s proposed voluntary organization Coordinated Advertising, Rate and Form Review Authority (CARFRA) would be responsible for setting standards for insurance contract language, reviewing rates charged for policies, and examining advertising material. This organization would then review and approve or disapprove policies for entry into the market. The individual states, which traditionally had this authority, could reject the decision of CARFRA only for “good cause.” “Volunteers” from various insurance departments would be assigned to review and approve policies and the industry would fund the organization.

The major problems with this proposal are that CARFRA lacks direct accountability to the relevant public and there is no assurance that standards for product approval will benefit consumers. For example, if a panel made up of Montana members approves a rate or policy for use in California, it would be difficult for California consumers to

Continued on page 8

Insurance Regulation—A Time for Change

Continued from page 7

object. The industry-supported organization could agree to approve confusing and deceptive contract language that could mislead thousands of consumers about the type of insurance coverage they are purchasing, such as whether a homeowners policy covers the full replacement value or only the market value of the damaged property. CARFRA must be an independent, legally authorized entity with democratic processes such as on-the-record voting, notice and comment rulemaking, conflict of interest standards, prohibitions on ex-parte communications, etc. CARFRA cannot rely on the industry it regulates to provide its funding.

Looming Deregulation Poses Huge Threat to Consumers

In a bow to industry pressure, the NAIC is considering “deregulation.” This means doing away with approving policies and rates before the policies are sold and relying on market conduct regulation to identify and address abuses. We believe the entire premise behind deregulation (less front-end regulation) coupled with more back-end regulation (market conduct) is deeply flawed. From an efficiency and consumer protection perspective, it makes no sense to lessen efforts to prevent the introduction of unfair and inappropriate policies in the marketplace. It takes far less effort to prevent an inappropriate insurance policy or market practice from being introduced than to examine the practice, stop a company from doing it, and provide proper restitution to consumers after the fact.

In the absence of rate regulation, consumers could face, for example, huge and immediate price increases in their auto insurance and have little or no choice, especially if the large insurers all move to increase rates. Based on the regulators poor track record of market conduct regulation, it is clear that consumers need better and smarter regulation, not less regulation.

More Coordinated and Uniform Approach to Market Conduct

Insurance departments need to better police the marketplace, especially in light of all the changes in technology and mergers among companies. Use of a minimum standards-type approach to market conduct will only benefit consumers if the standards are high and based on best practices around the nation. Most important, insurers that violate the law must be held accountable to consumers for losses suffered. For example, if it was not disclosed to a consumer that she would have to pay penalties when she cancelled her life insurance policy (and she would not have cancelled had she known),

the insurer should pay the consumer the amount lost and any other damages she suffered.

Proposal for Companies to “Self-certify” for Compliance with Market Conduct Standards Spells Disaster for Consumers

Despite the well-documented level of bad practices by many large insurance companies, particularly life insurance companies, over the past few years, the NAIC is considering “self-certification” proposals. History demonstrates that this industry is not in a position of public trust, so self-policing proposals are not acceptable to consumers. Further, some proposals would allow certification information to be confidential and non-discoverable, and waive penalties for violations if the company corrected the practice on its own. How does it benefit consumers if health insurance companies routinely deny claims for certain treatments but later agree to pay—and all this is kept confidential by the insurance regulators?

The NAIC’s “Statement of Intent” and subsequent actions reveal a plan of reinvention that heeds the call of the industry for less regulation and envisions a system that relies on the insurance company’s home state to regulate it on a national basis. We agree that better coordination and more consistent regulatory standards are desirable and necessary—as long as these standards are the highest—and not the lowest—common denominator.

Raising the Bar—Consumer Principles for Insurance Regulation

For the states to succeed in their stated primary goal of protecting insurance consumers, they must use this opportunity to raise the bar of consumer protection, especially in the areas of consumer disclosure, policing market conduct, and preventing unfair discrimination. The following are consumer principles by which the NAIC and states can be assessed to determine whether they are serious about achieving their stated goal:

- 1. Timely and Meaningful Disclosure.** Consumers should have access to timely and meaningful information of the actual costs, terms, risks, and benefits of insurance policies. Consumers should know how much they are being charged in commissions and other fees.
- 2. User-friendly Design of Policies.** Insurance policies should be designed to promote competition, facilitate comparison-shopping, and provide meaningful and needed protection against loss. Policies should be standardized so consumers could compare “apples to apples.”
- 3. Access to Adequate Coverage.** All consumers should have access to adequate coverage and not be subject to

Insurance Regulation—A Time for Change

Continued from page 8

unfair discrimination. Insurance companies should not be able to refuse to sell certain insurance policies in certain neighborhoods based on their perceptions about customers in those areas.

- 4. Non-discriminatory Marketplace.** All consumers should reap the benefits of technological changes in the marketplace that decrease prices and promote efficiency and convenience. Wealthy consumers should not be given all the good deals. Companies should be required to give the best price for which the consumer qualifies. To assess whether insurers are acting fairly, data about the premiums, losses, and location of policies sold must be available to the public.
- 5. Privacy Protection.** Consumers should have control over whether their personal financial and health information is shared with affiliates or third parties.
- 6. Meaningful Right of Redress.** Consumers must be able to hold companies that violate the law accountable for losses they suffer, e.g., if a long-term care policy does

not cover the costs of care in a certain facility that the consumer was told would be covered.

- 7. Competent Regulatory Structure.** Consumers should enjoy a regulatory structure that is accountable to the public, promotes competition, remedies market failures and abusive practices, preserves the financial soundness of the industry and protects policyholders' funds, and is responsive to the needs of consumers.
- 8. Representation.** Consumers should be adequately represented in the regulatory process, including through an independent public counsel whose sole responsibility is to represent consumers before the legislature and regulators.

These principles can help the states and the NAIC achieve their stated goal of protecting consumers “proactively and aggressively.” While the NAIC is being pushed to adopt the approach of less regulation, we think smarter, more efficient regulation benefits consumers and insurers and leads to more beneficial competition in the market. The reinvention process presents the perfect opportunity for state regulators to raise the consumer protection bar and incorporate these principles into insurance regulation. We must see concrete actions that raise the bar for insurance consumers if consumers are to continue to support state regulation.

Helping Seniors Who Cannot Manage Monies

Continued from page 2

ees in receipt of Social Security or SSI benefits. This analysis for *BIFOCAL*, however, will focus on the representative payment system as it impacts on older Americans.¹³

The following “best practices” relate to action that might be undertaken or explored both by guardianship courts and by the SSA. They were developed initially with the aid of a select advisory board of professionals and academics reflecting considerable experience in the systems and fields under examination, and then introduced in a series of national and state continuing education conferences (some augmented with brief questionnaire probes of participants)¹⁴ conducted for judges, court staff officials, and allied professionals. Most of these are largely self-explanatory and several have already been implemented in varying degrees in a number of states.¹⁵ Two states, for example, have actually enacted legislation mandating the substance of the practice no. 4, listed below.¹⁶

Best Practices for Courts

- 1. Investigation of Guardianship Petitions.** Court staff should check with the SSA in prehearing investigations

to confirm the Social Security benefit and representative payment status of proposed wards.

- 2. RP Interviews.** Where the proposed ward receives Social Security or SSI benefits and has a functioning representative payee (RP), court staff should interview that individual for information on finances, functional capacity, and living circumstances of the ward.
- 3. RP Testimony.** In guardianship hearings, whether involving guardianship of property or person, testimony of RPs concerning the ward's functional capacities should generally be sought.
- 4. RP Management as Screening Criterion.** As a matter of explicit policy, courts should view the existence or initiation of RP management as a viable alternative to court guardianship in appropriate cases and articulate this in relevant guidelines and policy directives.
- 5. Access to Monitoring Reports and Case Files.** In assessing guardianship appointments or complaints of neglect or irregularities by guardians, courts should seek and have access to the SSA's RP files and data banks for individuals with RP histories, consistent with applicable privacy and confidentiality strictures, exemptions and waivers.

Continued on page 10

Helping Seniors Who Cannot Manage Monies

Continued from page 9

6. **Use by Courts of Monitoring Reports.** In given circumstances, state courts should be allowed to supplement annual guardianship accounts and reports with prescribed SSA monitoring reports for wards in receipt of RP administered benefits.
7. **RP Curriculum Units in State CLE Programs.** State judicial education officials and SSA regional training staffs should develop and present course units for judicial personnel and staffs on the RP system and how it impacts guardianship operations.¹⁷
8. **Model RP Provisions in Guardianship Decrees.** When judges frame limited guardianship orders and decrees, they should have available model RP clauses for guidance in formulating guardianship regimes that involve a ward's receipt of Social Security benefits.
9. **Identifiers for Documents Supplied to SSA.** When courts send orders or actions to SSA on wards under RP management, these should always show the ward's Social Security number to enable SSA to readily locate case files and attend to necessary data insertion.
10. **Court Leadership in Planning for Future Needs.** Courts should assume leadership, alone or with responsible state executive branch agencies, in assessing total state needs for guardianship-like protection of incapacitated citizens as well as factoring in RP management and other surrogate decisionmaking devices as less restrictive alternatives to help government meet those needs.¹⁸

Best Practices for the Social Security Administration

1. **SSA Court Liaison Specialists.** SSA district offices should designate one or more employees as court liaison individuals to facilitate ready contact and furnish reliable data about the Social Security and RP status of wards.
2. **National Source for RP Data and Verification.** SSA should establish a national "1-800" telephone line enabling state court officials to ascertain the RP status of any adult or child involved in court guardianship or protective service proceedings.¹⁹
3. **Continuing Orientation on RP System for Courts.** SSA field offices should regularly offer and provide briefings for probate and family/juvenile court judges on the RP program, problems of mutual interest or concern, and recent developments and new program initiatives
4. **Continuing Notice to Courts of RP Status Changes.** When a beneficiary under RP management has a court

guardian, SSA should assure that the court is advised of any significant changes in RP status initiated or learned about by SSA.

5. **Exchange of Data on Organizational Service Providers.** SSA should provide state court systems with regularly updated lists and information on "qualified" RP service organizations that might also serve well in guardianship roles or, in the alternative, have experienced difficulties in fiduciary management.

A review of the foregoing concepts suggests a number of beneficial steps that could be served by their widespread implementation. *The first relates to the critical issue of whether a guardianship is needed or appropriate in a given case.* When a petition is filed for an individual who has previously received Social Security benefits under the supervision of an RP appointed by SSA, that RP could provide valuable information on the nature of the ward's mental and functional capacities, not only for handling money but also concerning general capacities for self care and independent living—and this can be done through interviews in pretrial investigation of a case or actual court testimony at the guardianship hearing.

Next, there is the question of a suitable person to serve as guardian. Often, the proposed guardian may have been an RP for a ward in receipt of SSA benefits and his or her record as such will provide valuable guidance in a court's assessment of whether the person can take on broader duties of financial management than merely dispensing a benefit check for the ward. Moreover, SSA's special RP data banks (now in advanced stages of development) can indicate the existence of any questionable practices, possible improprieties, or unsuccessful experience with a particular RP on earlier appointments of this kind. (Indeed, a highly effective RP can be a preferred candidate when a different guardian is named in a petition and the evidence raises some question as to that individual's suitability).

Third, in the framing of a guardianship decree, the presence of an existing RP arrangement may well dictate special action. This could include (i) a limitation of the powers of a proposed guardian to exclude management of Social Security benefits and generally integrate that function with the broader financial and personal decisionmaking to be handled by the guardian (e.g., management of real estate, life insurance, living arrangements, and investment needs), or (ii) an analysis and determination that no guardianship of the ward's property is really necessary and RP management can serve as an alternative to formal guardianship (e.g., where the ward's only or predominant source of income is his or her Social Security benefit payments).²⁰

Fourth, the increasingly important area of court monitoring of guardianship activity and performance could be

strengthened by enhanced SSA contact and lines of communication. For example, SSA might be able to identify instances in particular cases involving guardians also serving as RPs of substandard performance, impropriety, or even outright fraud (which have dogged both guardianship courts and the RP system in recent years, especially among organizations which provide fiduciary services to large numbers of individuals). Such situations, fortunately, have been infrequent but where they do arise, have proved horribly damaging to the well being of victimized beneficiaries in both systems and have tended to seriously erode public confidence in those systems.²¹

Finally, a better exchange of information, liaison, and continuing education opportunities between state guardianship and SSA representative payment systems can offer significant benefits. This can provide an increased understanding of the authorities, procedures, and legal obligations of each system and the always welcome cooperation that eases the job of hard-pressed government programs where good and responsive personal relations, knowledge of needs, free exchange of information on common clients, and ways to resolve small working bottlenecks that unintentionally produce delays, misunderstandings, and frayed tempers have been worked out. For example, it may be quite clear that when a family situation dictates the need to establish guardianship, a new court-appointed guardian should be substituted for an existing RP. Nevertheless, as a matter of law, that change from the "old RP" to a court-preferred "new RP" is the prerogative of SSA and not the court. It cannot be mandated by a state court order, is subject to SSA's own established application procedures and appointment priorities, and is best approached by clearly conveying the court's perspectives, preferences, and supporting factual data so that SSA can understand the situation and make the appropriate decision. Some courts have not fully appreciated this and the result has often been misunderstanding, impatience, and even ill-advised and unproductive litigation.²²

Court guardianship and SSA representative payment practices affect too many needy Americans and impact on too many of the same individuals not to make the maximum effort at coordination, cooperation, and exchange of information in operation of those programs. The outcome cannot help but

The final report of the ABA State Court/Representative Payment Coordination Project (Award #SJI-98-N-138) will be available for distribution in late March. Single copies (with best practice and curriculum guides incorporated) will be provided without charge to individuals and organizations working in areas related to the project's subject matter. Written requests should be directed to the ABA Commission on Legal Problems of the Elderly, 740 15th St., N.W., Washington, DC 20005-1022. Questions? Phone (202) 662-8690.

produce better services to the clients served and less problems for the systems themselves. "Best Practices" of the kind explored in this article are, as the saying goes, "hardly rocket science." However, all indications suggest that they have an important role to play and merit serious attention for those at work in, affected by, and vested with a serious public interest in these programs and their contributions to American society.

Notes

1. S.B. Hurme, *Steps to Enhance Guardianship Monitoring* at 5 (ABA 1991); S.J. Brakel, J. Parry & B.P. Weiner, *The Mentally Disabled and the Law* at 369 (3d ed., 1985).
2. Each state has a separate code concerning guardianship (typically part of its general probate code governing wills and estates) and despite many basic similarities and the influence of longstanding Uniform Code models, these exhibit a number of differences in terminology, procedures, and substance. Hurme, *Current Trends in Guardianship Reform*, 7 Md. Journal of Contemp. Legal Issues 143-144 (1995-96).
3. SSA, *Annual Statistical Supplement 1999*, Soc. Sec. Bulletin, at 13, [total OASDI and SSI benefit outlays at \$779 billion annually, an amount greater than the current national budget expenditures of all nations in the world except Germany (\$1.04 trillion) and Japan (\$804 billion)]. For national income and expenditure estimates, see N.Y. Times 2001 Almanac, p. 514 *et seq.*, individual profiles in "Nations of the World" under "Economy" sub-headings (Penguin Reference Series, 2000).
4. See, generally, Andrews, *Elderly in Guardianship Crisis of Constitutional Proportions*, Elder Law Journal (Spring 1977).
5. L.A. Frolik & R.L. Kaplan, *Elder Law* 244-246 (West "In a Nutshell" Series, 1995); D. Hermann, *Mental Health and Disability Law* 223-225 (West "In a Nutshell" Series, 1997).
6. About 2.8 million of these payees serve adults, mostly elderly and disabled individuals. The remaining 60 percent serve minor children (all of whom are presumed legally "incapable," with very few exceptions, and must therefore have appointed RPs). SSA, *SSA's Representative Payment Program* (monograph, June 1999).
7. For statutory and regulatory provisions governing the representative payment system, see 42 U.S.C. §405(j) *et seq.* (OASDI) and §1383(a) *et seq.* (SSI); 20 C.F.R., pt. 404, subpt. U (OASDI) and pt. 416, subpt. F (SSI). The U.S. Veterans Benefits Adm'n also administers a legislatively authorized representative payment program (called its "Fiduciary Program") for veterans and beneficiaries deemed incapable of managing VA monetary benefits being paid to them. See 38 U.S.C §5502 & 38 C.F.R. ch. 17. That program (not discussed in this article) has both similarities and dissimilarities to the Social Security RP program but is much smaller in size and scope, i.e., involves less than 1percent of the SSA/SSI dollar volume and number of participants.
8. Social Security benefit income averages roughly \$8,000 to \$10,000 per year for OASDI beneficiaries (less for eligible dependents) and \$4,000 to \$6,000 for SSI recipients. SSA, *Annual Statistical Supplement 1999* at 19, 293 (extrapolation).
9. RP duties also include filing annual financial reports [required by 42 U.S.C. §205(j)(3)(A)], informing SSA of changes that may affect beneficiary status, and saving any monies not needed for current and reasonably foreseeable needs. SSA, *A Guide for Representative Payees* at 3 & 11 (Pub. No. 05-10076, April 1998).

Continued on page 12

Helping Seniors Who Cannot Manage Monies

Continued from page 11

10. See 20 C.F.R. §416.621 (a legal guardian is the preferred payee for adult beneficiaries along with custodial relatives) and SSA Program Operations Manual §GN00502.010 (policy prohibiting direct payment of funds to a beneficiary on receipt of a court order appointing a legal guardian for that individual that is based upon a clear finding that the beneficiary is legally incompetent under state law standards).
11. SJI Grant No. A-97-004, "Enhancing Coordination of State Courts with the Federal Representative Payment Program."
12. The full formulations (incorporated in the State Court/RP System project's final report) involve more comprehensive presentations of each practice along with explanatory comments and cautions whose inclusion in this article would exceed size limits.
13. Although most "best practice" findings for adults have validity in both the probate and family/juvenile court arenas, sufficient differences are operative for children with RP management, particularly those under foster care or other state agency oversight, to warrant specialized formulations for juvenile and family courts.
14. There were eight of these CLE conferences, running from Nov. 1999 to Oct. 2000 and consisting of both state and national meetings (four for probate judges, three for juvenile and family court judges and staffs, and one for a mixed court staff/practitioner audience). A total of approximately 350 judges and other professionals attended these pilot sessions.
15. A questionnaire survey at last year's annual conference of the Texas College of Probate Judges (Aug. 2000) showed that more than 40 percent of the responding judges and key court staff were engaged in implementation of one or more of a half dozen of the "best practices" enumerated in this article.
16. See Va Code Ann. §37.1-134-14 and W. Va. Code §44A-2-12.
17. In a recent questionnaire survey of a national sample of judges attending a conference of the National College of Probate Judges, a majority of the respondents perceived "a real need" for RP system training in their courts, even though many did not believe that the RP system's presence presented a significant problem in carrying out their guardianship jurisdiction (NCPJ Spring Conference, April 2000).
18. The State of Texas has generated a valuable and probably unique model of this kind of initiative for other states to examine. See Guardianship Alliance of Texas, *Report to Gov. & 75th Legislature on Guardianship Issues* (Nov. 1998 and 1999 Annual Update).
19. Implementation of this recommendation (as well as no. 5. of the "Best Practices for Courts" listing, p. 9) may raise Federal Privacy Act issues and possibly the need for a legislative exemption as has been provided to a number of agencies and units of government (both state and federal) with legitimate needs to access certain information in SSA data banks. See 20 C.F.R. subpt. C, §401.100 *et seq.*
20. See n. 11, *supra*. In addition, some state instructional manuals and courses specify that Social Security benefits are not considered part of the ward's estate and, thus, not a sufficient basis standing alone for guardianship. See State Bar of Texas, *Advanced Estate Planning and Probate Course* at V. Miscellaneous (June 2000).
21. Last year, two ongoing "mass frauds" on the part of state-appointed guardians and SSA RPs came to a head. Both involved organizations serving as fiduciaries for many persons (more than 140 SSA/SSI beneficiaries in Martinsburg, W. Va., and 300 wards under court guardianship in Riverside, Calif.) with major misappropriation of funds and victimization of older, often mentally disabled individuals. Each scandal received widespread publicity and in one case, provoked Congressional Hearings to investigate and consider preventive legislation. See C. Maness, *Guardian Angels*, Cal. Lawyer 35 (Jan. 2000); ABC Television 20-20 Series, *When Nobody's Looking* (TV broadcast feature story, Jan. 20, 2000); Hearings, House Committee on Ways & Means, 106th Cong., *Statement of Dept. Comm'r Susan Daniels* (May 4, 2000)(focus on remedial measures to tighten oversight and deter fraud).
22. For example, in *In re P.M. v. J.M.* (SSA Appeals Council, 1999), a guardianship court in New Hampshire actually attempted (illegally and without success) to direct that a certain relative be named not only guardian but also RP for 3 children. For other examples of incorrect state court assumptions of authority and jurisdiction relating to RP's and benefits managed by them, see D.L. Skoler & A.L. Allbright, *Judicial Oversight of the Nation's Largest Guardianship System: Caselaw on SSA Representative Payee Issues*, 24 Mental Disability Reporter 1 (Jan/Feb, 2000).

Center for Elder Rights Opens in Virginia

The Center for Elder Rights has been established within the Virginia Department for the Aging to provide legal, consumer, aging, and long-term care information and assistance to older Virginians and their families.

Accessible from anywhere in the United States through a toll-free hotline (1-800-552-3402), family members responsible for the care of an older Virginian may call to get services or information. Center staff also will provide a variety of services to clients who call or walk in. As the Elder Rights Center evolves, it will include:

- u Counseling for people with concerns about Medicare, Medicaid, and other health insurance;
- u Counseling on pensions and retirement benefits;
- u A public guardianship program for indigent and incapacitated people who have no other person to serve as a guardian;
- u A National Resource Center to develop strategies for educating rural and geographically isolated older citizens and their families about fraud, waste, and abuse in the Medicare and Medicaid programs;
- u An ombudsman program (contractual) to resolve problems encountered in long-term care facilities and community-based programs serving older Virginians;
- u An attorney who prepares public and professional information, education, and training materials, and overseas legal services provided by Virginia's Area Agencies on Aging;
- u A registry of more than 100 attorneys from across Virginia who can provide legal services to indigent and low-income older Virginians;
- u Staff who can provide information, guidance, and counseling on a variety of aging and long-term care issues.

Contact Information: Center for Elder Rights, 1600 Forest Avenue, Suite 100, Richmond, VA 23229. Nationwide Toll-Free: 1-800-552-3402 (Voice/TTY).

Great Catches and Fishhooks: Internet Tips for the Elderly

Hon. John N. Kirkendall, Judge of Probate, Ann Arbor, Mich.

The Internet has spawned a rich harvest of resources for elders. It is also a fertile sea for the unscrupulous. The National Consumers League has created a web site to alert consumers to prevalent schemes designed to enrich the unprincipled at the expense of others. Last year, consumers lost \$3.2 million through Internet fraud. In 1999, figures show 20 percent of those fleeced were age 50 and over. Whether this reflects appropriately the number of elders who succumbed to unlawful wiles is not known precisely. Elders may be more reluctant than their younger counterparts to report. Even so, 20 percent is a significant number.

The mechanism most attractive for would-be cheats is the on-line auction. Some 87 percent of all Internet fraud takes place at these sites. The rest, in order, were sales of general merchandise, Internet access services, computer equipment and software, and work-at-home plans.

The League has developed a list of tips for Internet users that is posted at its site. It is probably over simplistic to sum them up, however, the adage still applies: If a deal looks too good to be true, it probably is.

- u Do business with companies you know and trust.
- u Understand the offer.
- u Check out the company's track record.
- u Be careful to whom you give financial or other personal information.
- u Take your time to decide.
- u Be aware there are differences between private sales and sales business.
- u You may be better off paying by credit card than with a check, cash, or money order, as long as you know with whom you're doing business.

It was particularly revealing to learn that a miniscule amount of fraudulent transactions takes place where consumers use credit cards. The overwhelming amount of fraudulent cases involve cash and money orders.

Because web sites can be quickly set up, can look solid and impressive, and may involve persons with whom we are unacquainted, special care must be taken when conducting business through them. By the time the check has cleared, the site may be in the ether. Common sense is ones best ally. See <http://www.fraud.org>

Once one is aware of the fishhooks and how to avoid them, it is time to go after the great catches available. The

older person may be interested in exploring government services, useful products, and sites that improve the quality of daily life.

An excellent compilation of government services is available at www.firstgov.gov. Legal services, Social Security information, veteran's services, Medicare and Medicaid information, food assistance program, private pension and health benefits, child support enforcement, disabilities benefits, federal retiree benefits information, and home energy assistance for low-income families are a sampling of the useful information available.

Products of interest to elders are also present in abundance. For example, a device selling for less than \$150 is available that will allow users to check who is at the front door by turning to a special channel on the television set. I found it at www.x10.com.

My favorite sites for older persons are those people can use each day to enrich their lives. The creation of a family home page allowing family members from all around the country to post and look at pictures of children and grandchildren is particularly appealing. Software such as Microsoft *FrontPage* makes this easy to do. And, if you do not mind a little advertising on your web page, the server holding the site can be available to you free of charge through sites such as www.tripod.com. Developing your own personal page using www.my.yahoo.com is easy. You can configure it to receive e-mail free. You can also configure it to give you the weather, specialized stock quotes, currency exchange rates for countries you select, and the times specific movies are showing at theatres near you.

Just for fun you can play *Jeopardy* at www.station.sony.com; send an electronic card through www.bluemountain.com; get a map to your destination through www.mapsonus.com; play sports games at www.ibm.com/sports/games.html; or track that plane your grandchildren are on at www.thetrip.com.

Did you know it is against the law to tie your alligator to a fire hydrant in Detroit; for a driver to operate a motor vehicle while blindfolded in Alabama; to push a live moose out of a moving plane in Alaska; or to allow a gorilla in the back-seat of the car in Massachusetts? These and other dumb laws are found (where else?) at www.dumblaws.com.

There is an ocean of opportunity out there for older persons. A working knowledge of the Internet will beat the "blahs" better than any elixir I know.

End-of-Life Care Legislative Highlights

Continued from page 4

state's Death with Dignity Act (i.e., advance directive law), and shall specify the allowable content of pre-hospital directives; options for both advanced life support and basic life support; methods of identification including an official form and the optional use of a Medic Alert identifier; methods of revocation; and assurance of reciprocity with neighboring states.

- u Florida** - 2000 Fla. Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890), approved June 15, and effective immediately, enacts a variety of amendments, including a clarification to certain do-not-resuscitate provisions. Specifically, it clarifies in §395.1041 that all hospital personnel, not just emergency services personnel, may comply with a pre-hospital DNR order and be given immunity from criminal or civil liability or professional discipline; clarifying in several provisions that the absence of a DNR order does not preclude a physician from withholding or withdrawing CPR as otherwise permitted by law; and clarifying in §401.45 what constitutes a valid order not to resuscitate for purposes of compliance by EMTs and paramedics. See complete description of the enactment under "Palliative Care," below.
- u Maryland** - 2000 Md. Laws 152 (H.B. 770), approved April 25 and effective October 1, expands the scope of persons who are protected (under the Md. Code Ann., Health-Gen. §5-608) for complying with EMS-DNR orders to include any "health care provider." Also requires a study by the Attorney General, described below under the "Studies" heading, p. 15.

Palliative Care

- u Delaware** - 2000 Del. Laws 475 (S.B. 296), approved July 26, adds a new subsection to Department of Corrections statute, tit. 11, §6536, mandating the state's Department of Corrections to provide on-site hospice services to terminally ill inmates. Prior to this Act, there was no requirement that hospice services be offered by the Department.
- u Florida** - 2000 Florida Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890), approved June 15, and effective immediately, enacts a variety of amendments. Highlights include the following:
 - a) Clarifies certain do-not-resuscitate provisions, specifically—clarifying in §395.1041 that all hospital personnel, not just emergency services personnel, may comply with a DNR order and be

given immunity from criminal or civil liability or professional discipline; clarifying in several provisions that the absence of an DNR order executed pursuant to §401.45 does not preclude a physician from withholding or withdrawing CPR as otherwise permitted by law; and clarifying in §401.45 what constitutes a valid order not to resuscitate for purposes of compliance by EMTs and paramedics.

- b) Revises the continuing education requirements for license renewal for certain health care professionals (§455.597) to provide that courses in end-of-life care and palliative care may be substituted for approved courses on domestic violence, if the professional has taken a course on domestic violence within the previous 2-year licensure period.
- c) Revises the statement of legislative findings and intent of the Health Care Advance Directives Act (§765.102) to encourage professional regulatory boards to adopt standards and guidelines regarding end-of-life care and pain management, and to encourage educational institutions to promote training. It further requires the certain state agencies to create a joint campaign on end-of-life care for purposes of educating the public.
- d) Creates new §765.1103 in the Health Care Advance Directives chapter to require physicians to disclose to patients information concerning pain management and palliative care in the course of diagnosis and treatment discussions. Further requires that health care facilities and their providers comply with requests for pain management or palliative care.
- e) Makes minor revisions to the sample form for designation of a health care surrogate and the living will form (§765.203 and §765.303).
- f) Deletes the requirement in §765.401 that the patient have a terminal condition, end-stage condition, or be in persistent vegetative state before a "proxy" (i.e., default decisionmaker) can exercise decisionmaking authority (but retains the language that the decision must be supported by "clear and convincing evidence.")
- g) Establishes an End-of-Life Care Workgroup, to be staffed by the Department of Elderly Affairs, to examine end-of-life care reimbursement methodologies and care standards and to develop a report with recommendations for the legislature by December 31, 2000.

- u **Hawaii** - 2000 Haw. Sess. Laws 228 (S.B. 862), approved and effective June 14, creates a new provision §329-A to –H, allowing for the acquisition, possession, cultivation, distribution, transportation, administration, and use of marijuana for medical purposes. (Eight other jurisdictions have legalized, by voter initiatives, medical use of marijuana.)
- u **Illinois** - 2000 Ill. Legis. Serv. PA 91-714 (H.B. 2574)(West), approved and effective June 2, eliminates the requirement to use official triplicate prescription forms for Schedule II controlled substances. Permits facsimile transmission of prescriptions for Schedule II controlled substances administered to patients by parenteral, intravenous, intramuscular, subcutaneous, or intraspinal transfusion to a patient in a private residence, long-term care facility, or hospice. Provides that the facsimile serves as the original written prescription and shall be maintained in the same manner as the original written prescription. If a patient resides in a hospice, the prescription must note that the patient is a hospice patient. Finally, the bill changes the Schedule of certain controlled substances and eliminates some from the Schedules.
- u **New Hampshire** - 2000 N.H. Laws 268 (S.B. 424), approved June 12 and effective August 11, amends the states Controlled Substances Act (N.H. Rev. Stat. Ann. §318-B) by adding a new paragraph that clarifies the professional use of controlled substances for pain management. The provision permits a physician to administer a high dosage of controlled drugs for pain management purposes if, in the physician’s judgment, the benefit of the relief expected outweighs the risk of the high dosage, even if it may increase the risk of death, so long as it is not furnished for the purpose of causing death and so long as it falls within rules of the board of medicine.
- u **New Jersey** - 2000 N.J. Sess. Law Serv. 62 (A. 316) (West), approved and effective July 13, amends N.J. Stat. Ann. §26:2H-5 to require facilities to monitor pain as a fifth vital sign in patients. Specifically, facilities must (1) routinely inquire whether a patient is in pain; (2) maintain policies and procedures as prescribed by the commissioner for asking patients to rate their degree of pain for a specified period of time and to record their responses; and (3) routinely record levels of pain intensity on patient charts. The Act further mandates the Commissioner of Health and Senior Services to adopt rules to implement the Act.
- u **New Jersey** - 2000 N.J. Sess. Law Serv. 63 (A. 317) (West), approved and effective July 13, adds to the state’s Cancer Research Act (N.J. Stat. Ann. §52:9U) a mandate that the State Commission on Cancer

Research take steps to encourage the development of research projects on pain management and palliative care for persons diagnosed with cancer.

Assisted Suicide

- u **Maryland** - 2000 Md. Laws 106 (H.B. 154), approved and effective April 25, amends its assisted suicide law—Md. Ann. Code art. 27, §416—to include emergency medical service providers in immunity protection from criminal liability where they perform specified activities related to pain management or related interventions

Studies & Commissions

- u **Florida** - 2000 Fla. Sess. Law Serv. 00-295 (C.S./C.S./S.B. 1890), approved June 15, and effective immediately, enacts a variety of amendments, including establishing an End-of-Life Care Workgroup, to be staffed by the Department of Elderly Affairs, to examine end-of-life care reimbursement methodologies and care standards and to develop a report with recommendations for the legislature by December 31, 2000. See complete description of the enactment under “Palliative Care,” p. 14.
- u **Iowa** - 2000 Iowa Legis. Serv. HF 2385 (West), approved April 5, adds §142C.15 to Iowa Statutes, directing the Department of Public Health to investigate the feasibility of establishing an organ donor registry in Iowa, authorizing a feasibility study if sufficient funds are available, and authorizing the department to contract for the establishment of such a registry.
- u **Kentucky** - 2000 Ky. Acts 394 (H.C.R. 44), approved April 7, directs the Legislative Research Commission to establish a 20-member task force to (1) complete a study to identify the barriers to quality end-of-life care and pain management; (2) identify strategies to improve access to quality end-of-life care that is based upon patients’ and families’ desires; (3) identify ways to strengthen accountability to determine whether quality care is being delivered; and (4) identify payment methods for delivering a seamless system of care. It clarifies that the task force is not to study or support health care provider assisted suicide or euthanasia, provides for selection of task force members, and requires a final report by September 1, 2001.
- u **Maryland** - 2000 Md. Laws 152 (H.B. 770), approved April 25 and effective October 1, requires a study by the Attorney General, in consultation with others, of the advisability of (1) simplifying the state’s EMD-DNR form; (2) expanding the scope of persons who may comply with an EMS-DNR order to include non-health personnel who are authorized to operate automated external

Continued on page 16

End-of-Life Care Legislative Highlights

Continued from page 15

defibrillators; and (3) adopting a procedure and form for “Physician Orders for Life Sustaining Treatment” (POLST) similar to that developed in Oregon. The study report is due December 31, 2001. Also addresses EMS-DNR orders as described above under the “Do-Not-Resuscitate” heading, p. 4.

- u **New Jersey** - 2000 N.J. Sess. Law Serv. 64 (A. 318) (West), approved and effective July 13, establishes the New Jersey Pain Management Policy Advisory Council as a follow-up entity to the Legislative Commission for the Study of Pain Management Policy that expired upon issues of its report in March 1999. The 21-member Council is to provide advice and recommendations to state agencies with respect to pain management policy, including: acute and chronic pain management treatment practices; state statutes and regulations relating to pain management therapies; the use of alternative therapies; acute and chronic pain management education provided by medical schools; acute and chronic pain management needs of both adults and children; and other issues.

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