LEGAL ISSUES OF THE AGING: MEDICARE, HOSPICE CARE, HEALTH CARE POWERS OF ATTORNEY AND ADVANCED DIRECTIVES FOR END-OF-LIFE ISSUES

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I. LEGAL ISSUES OF THE ELDERLY

A. Introduction

1. This presentation is a summary of a Wisconsin Bar Association presentation on September 22, 2017.

2. For a fuller discussion of the issues, the seminar materials are available.

B. A Medicare Primer

1. Medicare consists of four alphabet soup coverages.

(a) Part A – Hospital inpatient insurance (paid for while working through payroll deductions).

(b) Part B – Outpatient medical insurance (typically paid for by monthly deductions from social security checks).

(c) Part C – Advantage plans (optional privatized Medicare coverage for deductibles and co-pays); usually available free of separate premiums, although some Advantage plans are beginning to charge small monthly premiums.

(d) Part D – Drug coverage (paid for by an additional deduction from social security monthly benefit checks).

(e) Medicare supplement insurance (optional private insurance paid monthly out-of-pocket) to cover deductibles and co-pays required by Medicare.

2. A choice each Medicare recipient must make is whether to (i) participate in an Advantage plan (Medicare HMO/PPO - free or nominal cost), (ii) buy a Medicare supplement, or (iii) self-insure Medicare co-pays and deductibles.

3. General advice is that Medicare supplements provide more choices and options, but charge a monthly premium; with a Medicare supplement, there should be very few out-of-pocket expenses for medical care in retirement (long-term care of more than 100 days excepted).

(a) Advantage programs are a PPO/HMO where the patient can only see providers who participate in that program; participation varies from community to community.

(b) There are many Advantage programs; the government pays the Advantage program a fixed fee to provide insurance coverage; the provider must manage costs to make a profit.

(c) Programs were intended to contain Medicare costs (they have not done so, but might actually do so at some point).

(d) If a health care provider does not participate in the Advantage program (think Mayo Clinic, Cleveland Clinic), the patient cannot go there; there are also requirements to be met before a patient can see a specialist.

(e) There have been Advantage plan horror stories (Stage 4 lung cancer patient told he had allergies and a referral to a pulmonologist was withheld), but there are many patients who are completely satisfied with Advantage plan coverage.

(f) Once on the Advantage plan, there is medical underwriting to switch to a Medicare supplement; there is no such restriction going from a Medicare supplement to an Advantage plan.

(g) Coverage may be a problem for the Advantage participant who splits the year between north and south; not all Advantage plans operate in both places.

(h) If a client cannot afford the Medicare supplement premiums (say, $150 to $200/month, double for a married couple), the Advantage plan is a Godsend.

(i) If a client can afford the supplement, the client will have more options, more choices.

(j) Advantage plan has co-pays and deductibles for almost everything, but it would be hard for those deductibles and co-pays to exceed the cost of a Medicare supplement; the Advantage plan will almost always be cheaper.

(k) As mentioned, one can easily go from Medicare supplement to Advantage plan but not the other way.

II. HOSPICE CARE UNDER MEDICARE

A. Focus of Hospice Care

1. Rather than trying to cure a disease or other condition, hospice care centers on comfort, symptom control, pain relief and palliative care. Hospice care became a Medicare benefit in 1983.

2. It is end-of-life care or palliative care.

3. To be eligible, a physician must certify a terminal illness (death is believed to be within six months, but this can be renewed without limit). The simple truth is that nobody knows for sure when someone will die, so the time period is a rolling six months and is quite flexible; there are no penalties for being wrong about the six-month period.
Note: about 7% of patients electing hospice leave the program because they recover.

4. The hospice patient must accept that the care will be palliative, focused on comfort rather than curing the illness. Medicare providers will not pursue treatment which seeks to slow the progress of a disease (often the patient is sick and tired of the treatment to cure the disease).

5. The patient must sign a statement affirmatively electing hospice benefits; thus, the care is neither automatic nor mandatory.

6. Benefits are paid under Part A hospital coverage, although the care need not occur in a hospital.

7. Benefit periods are:

(a) 90 days, with a

(b) 90 days renewal, and then

(c) 60 days with unlimited renewals

8. The physician must recertify terminal illness at the start of each new benefit period, but again, this is a guess.

B. Selection of Hospice Care Provider

1. There are many hospice care providers:

(a) Some are part of a large health care system—Humana, Aurora, Vitas, Ascension, etc.

(b) Some are independent nonprivate – Horizon Health Care, Season's Hospice Care

(c) Some are for-profit

(d) An estate planner, through word of mouth or conversations with social workers or trusted medical professionals, should have a list of the better hospice providers to suggest; typically, providers will often be geographically focused, serving specific areas.

2. It is critical that the hospice provider be Medicare approved; this information can be obtained from the Medicare website, or by asking the provider.

3. In seeking a hospice provider there are questions that should be asked:

(a) What are options for inpatient or respite care? Does the hospice provider maintain their own in-patient facility?

(b) How fast is crisis response?

(c) Are there limits on service?

(d) Are doctors and RNs certified in palliative care?

(e) What bereavement services are offered?

C. What will Medicare cover through hospice benefits?

1. Doctor or nursing care (at home or in hospital or skilled care facility)

2. Medical equipment (e.g., hospital bed in home)

3. Medical supplies

4. Rx for pain or symptom control

5. Hospice aids

6. Some PT and OT for movement stiffness, retain range of motion, massage

7. Dietary counseling

8. Social workers

9. Grief and loss counseling for family

10. Short-term inpatient stays in a hospital or other facility for pain management

11. Respite care (5 days maximum at a time). This can be very useful, e.g., every other weekend patient goes to an inpatient facility, giving caretakers a needed regeneration break.

12. 24-hour integrated monitoring of symptoms, pain and psychological challenges by a team of professionals experienced and specifically trained for the care needed by the patient's changing situation

D. What will Medicare hospice NOT cover?

1. Treatment to cure the illness

(a) Aricept to delay progress of Alzheimer's

(b) Cholesterol medicine to reduce the buildup of harmful plaque over time

(c) Radiation, chemotherapy for cancer treatment unless needed for pain relief

(d) ER or ambulance service unless needed for an unrelated condition (e.g., fall and broken arm) unless it is part of the hospice care.

(e) Services from a provider not approved by the hospice team

(f) Assistance with a Medicaid application (welfare)

(g) Room and board (this is a surprise for most). Hospice care is home-based or, if in-patient, then must private pay for the facility.

(h) To avoid billing surprises for non-covered services, care should be coordinated through the hospice network.

2. If home hospice care is not possible (could purchase some private, less than fulltime services), then consider Medicaid where appropriate; Medicaid will pay for a residential facility and then the hospice care can be provided there. Medicaid poverty and income levels would need to be met.

E. Level of Care

1. The level of hospice care is driven by what the patient needs; less at the beginning, more at the end.

2. Services typically begin with routine home care and visits by hospice personnel to check on changing needs.

3. During period of crisis, home care can be continuous in 8-hour shifts.

(a) Services needed to keep patient at home

(b) Mostly care by RN or LPN

4. There is inpatient respite care for relief of family caregivers.

(a) Up to 5 days in inpatient facility

(b) "Occasional basis" (not specifically defined, which is helpful)

(c) Cannot be back-to-back stays

(d) E.g., every other month or may be even every other weekend.

5. Occasional general inpatient stays for hospital care when needed for pain or symptom control.

(a) At a hospital, skilled nursing facility

(b) For needs which cannot be met in another setting

(c) Needs medication adjustments, overnight, stabilizing conditions

F. Out-of-Pocket Costs Under Hospice

1. 5% coinsurance up to maximum of $5 per drug

2. 5% coinsurance on short-term inpatient respite care

G. Ceasing Hospice Benefits

1. Hospice election is not irrevocable.

2. If person does not like hospice care, he or she can stop it at any time and resume whatever other care or treatment the patient was receiving before hospice was elected; this should make electing hospice a little less threatening.

3. The opt-out must be made in writing.

4. A hospice provider cannot revoke a person's hospice election.

5. Hospice care could end if a doctor will not recertify the six-month life expectancy, but Medicare seems to grant latitude here.

6. If stopped, discharge planning needs to occur.

H. Should Other Insurance Coverage Be Dropped During Hospice?

1. Since hospice benefits are covered under Part A (coverage already paid for by payroll deductions while working), should Medicare Parts B, D, and Medicare supplement (if patient chose this insurance) be dropped? Recall there are charges for these coverages. Note: Medicare Part B must be paid even if the patient chose Advantage plan coverage.

2. Generally such coverage should be continued if patient can afford it.

(a) Coverage may be needed for conditions completely unrelated to the terminal condition.

(b) UTI, broken arm, pinkeye, etc.

3. Recall: to get back into Medicare supplement insurance there may be preexisting condition issues and open enrollment periods delaying the reentry into the insurance program.

I. Hospice Drug Disposal

1. A new bill authorizes a hospice worker to give drugs to a disposal program after the patient has passed away.

2. Requires family permission.

3. Some drugs are controlled substances – opioids, etc.; flushing drugs down the toilet harms the municipal water supply and opioids are probably something clients don't want around the house.

III. HOSPICE CARE: PUTTING IT ALL TOGETHER

A. When to Consider Hospice Care

1. When a Health Care Power of Attorney is activated, it is a good time to do some general thinking about hospice care.

2. Whether to choose hospice can be evaluated by answering the four questions:

(a) Is patient older than age 80?

(b) Does the person's array of health issues involve one or more of the top four leading causes of death, i.e., heart disease, cancer, chronic lower respiratory disease (lungs), stroke (cerebral vascular disease)?

(c) Within the past few months have there been three or more visits to the hospital, ER or intensive care unit (health care frequent flyer hospital status)?

(d) Within the past six months has there been a fundamental decline in the ability to carry out one or more of the activities of daily living (ADLs), e.g., bathing, eating, dressing, toileting, transferring from bed to chair, etc.?

(e) If the answer to these four questions is yes, hospice care may be appropriate.

3. Social workers or hospice staff can also perform a hospice assessment, avoiding the "H" word; it may better be called a "needs" assessment.

4. It is a mistake to "save" hospice care for last seven days of life.

5. My anecdotal experiences with clients' comments as to hospice care have been universally positive.

6. Is it better to have a free-standing hospice provider not attached to a health care system? Is it harder to break free from the "curative" current of such a system? Statistics show shorter hospice utilization (hence underutilization) in large health care organization environments.

B. Choosing a Hospice Care Physician

1. Hospice treatment requires the naming of a physician to oversee hospice care.

2. This can be an existing, long-term physician from whom the patient has been receiving care, but not all doctors will agree to be the attending hospice physician.

3. Hospice care requires a different attitude or perspective.

(a) A doctor's mindset is typically to save life at all costs; death is considered a failure.

(b) Today's medical schools teach palliative care, but some physicians do not get the memo; in fairness, family members and perhaps the patient, too, push the doctor for a cure, when perhaps a cure is not in the cards (at least within a reasonable probability); statistics indicate end-of-life medical care is expensive for Medicare, hence profitable for hospitals.

(c) Certainly, every physician has vivid and extensive experience in death and dying issues and must at some point consider abandoning care, but some adopt a fighting retreat approach.

4. Every hospice provider has a staff physician who oversees hospice care (a medical director).

(a) The physician will advise the hospice team even if the hospice physician is not the attending physician.

(b) The hospice medical director can also be the designated hospice treatment physician if no other physician is available or appropriate.

C. Why Not Hospice?

1. The hospice care decision is fraught with enormous challenges.

2. We are giving up on Mom? Doesn't she deserve a chance to get better?

(a) At some point, where no improvement is possible, care intended to make someone better is elder abuse.

(b) The patient resists such care (physical therapy or nutrition) because he or she either chooses not to do it or simply cannot do it.

(c) Food should be offered but if a patient chooses not to eat or cannot eat, then the children's harangue about needing to eat to get better, or physical exercise to maintain or improve mobility, is not helpful.

(d) At times, the body is making decisions that the mind cannot change.

(e) Hospice is often a relief to patient whose life is torture due to other family members' inability to accept the inevitability of a loved family member's death.

(f) Still, there are some who choose to "not go gently into that good night" as Dylan Thomas would write, but I am not sure there is a higher place in heaven for those who choose to suffer longer, though my religion has, I think, taught me that for years.

3. Hospice is not a bad deal.

(a) 24-hour on-call service from a team skilled in all the issues of illnesses and their effects

(b) Full coverage under Medicare

(c) Full coverage for drugs; co-pays are insignificant

(d) Integrated social workers

(e) Weekly (daily if needed) medical supervision

(f) Home health care, linens and laundry

(g) Respite care for caregivers (every other weekend)

(h) Clergy for spiritual needs, if desired

(i) Safety evaluations and supervision

(j) Patient can elect to end hospice care at any time and return to prior treatment

4. Hospice care is better care for end-of-life people; ironically, people receiving hospice care actually live 28 days longer than patients who do not receive such care, presumably in greater comfort and with better care and conditions.

D. Our End-of-Life Conundrum

1. The success of our medical system is one of the causes of our current health care problems.

(a) Medical science has been largely successful in eliminating sudden cataclysmic deaths; how we die has been fundamentally changed.

(b) We now typically die from chronic, slow, debilitating medical conditions; our issues are bits and pieces over a long period of time.

(c) Some argue that we have created a good deal of suffering in these areas: (i) financial (end-of-life medical care is expensive and often produces little if any benefit; (ii) spiritual – we have more time to focus on and agonize over our demise; (iii) social issues – long periods of disability.

2. Ironically, this gives us more time to ponder issues related to death or dying.

3. From a scientific point of view, this will doubtless continue, prolonging our lives, but will be of little benefit if our quality of lives is not commensurate.

IV. HEALTH CARE POWER OF ATTORNEY AND ADVANCED DIRECTIVE

A. The Three Stages of Life

1. Many commentators suggest that instead of having just one "conversation" about end-of-life issues, there should be three.

2. Commentators suggest that these conversations should correlate to the three stages of life.

3. The first stage is where we all are now:

(a) Healthy, living independently, maybe a few nicks or scratches as to health care issues, but no serious dents or collisions; what we think about end-of-life decisions is largely academic and platitudinal; our boilerplate language on end-of-life is just fine.

(b) We encourage clients to have these discussions with their children or other health care agents, and I suspect some do. I suspect many do not or that if they occur they are awkward and largely ineffective and that is probably just fine.

4. The second stage is when a client receives a serious diagnosis that may directly affect his or her mortality; this discussion would typically involve the trajectory of a specific disease and related issues that may arise.

5. The third stage is the final 12 months of life when what should be happening is a conference with a patient, the attending physician and a health care agent.

(a) At this juncture the decision process and challenges are well defined.

(b) The patient can make specific choices based on the inevitable course of his or her specific illness.

(c) These choices should be recorded as orders in the patient's chart and will determine treatment choices.

(d) This process is set forth in a program known as PULSE, which is a passion for some estate planner.

6. These issues are covered in a video entitled "Consider the Conversation" available through Amazon for $29.00

B. <u>Attorney Involvement with Health Care Powers of Attorneys Are End-of-Life Directives</u>

1. I suppose a typical client meeting for estate planning goes something like this.

(a) The initial call results in sending out of an estate planning questionnaire.

(b) There is an initial 1-1/2 hour meeting where there is a discussion of (i) the estate tax exposure (more extensive if client is subject to the tax); (ii) any special needs for children; (iii) GST-type trusts to provide divorce, creditor and state (if not federal) estate tax protection; (iv) whom to appoint for health care and financial powers of attorney; (v) probate avoidance; (vi) charitable gifts (though I tend to hold these for subsequent revisions of documents because it slows down the estate planning process to a crawl; (vii) possibly alerting client to long-term care insurance alternatives for defensive reasons.

(c) A second meeting occurs to sign documents, discuss beneficiary updates, funding trust to avoid probate, the need to review if there is a change in tax laws, the family's assets or change in the client's family circumstances.

2. All of this typically is in the context of a fee-conscious client whose first question is almost always "How much is this all going to cost," and their statement that "I just want something simple."

3. My discussion of end-of-life provisions in the health care power of attorney might take several minutes.

(a) If you are terminally ill (no chance of recovery), then there is no need to prolong the dying process with heroic efforts.

(b) If you are irreversibly comatose, there is no need to keep you alive with food and hydration through tubes.

(c) If you are in pain, you will receive plentiful pain relief drugs; not to worry about addiction or hastening time of death.

(d) Do you have any religious beliefs that are inconsistent with this approach? (Possibly conservative Catholics, Jehovah's Witnesses as to transfusions, and the occasional doctor who wants all possible treatment.)

4. Possibly this is sufficient for people in the first stage of life, but it hardly does justice to the issues if someone is in stage two (a serious life-threatening diagnosis) or stage three (the final 12 months of life).

5. In some cases, elder care attorneys will suggest a mediated advance directive meeting outside the lawyer's office with a trusted, specifically trained, facilitator.

(a) These trained experts are available through hospice providers, social service agencies, and final wish programs such as Honoring Choices.

(b) Law firms may wish to develop a relationship with such organization to have an "embedded" conversation facilitator to whom they could refer clients.

(c) Note this would result in the health care power of attorney being produced from that process and not the lawyer's form.

(d) Query whether the lawyer should use the "typical" form on the theory that something is better than nothing if the client does not follow through with the more extensive "consultation." The most basic health care power of attorney is so extraordinarily better than a guardianship that having any health care power of attorney should be a priority.

(e) The question becomes what should be the lawyer's role in health care power and advanced directive be? I would suggest that the role should be different

depending on the client's stage of life. When the client is in stage 2 or 3, expert outside help may be desirable.

6. Possibly the standard power of attorney is fine if there is a stage 3 PULSE conference with the doctor, the patient and the health care power of attorney for the last 12 months of life.

7. I have never been a fan of detailed health care powers of attorney that give directions based on specific medical test scores.

C. Conclusion

1. I have referred to the Welsh poet Dylan Thomas's famous poem about fighting death. "Do not go gentle into that good night." Thomas is a 20th century poet who had his own problems – mental illness, alcoholism, and he wrote this poem as he was attending to his dying father. Thomas advises, and I quote:

> Do not go gentle into that good night,
> Old age should burn and rave at close of day;
> Rage, rage against the dying of the light.

2. The message here is that we should all leave the world kicking and screaming, and that we all have to die.

3. There is, I suppose, an affirmation of the value of life and value of perseverance, to live life to the fullest, but apropos in our hope today, a comment on the inevitability of death.

4. As a counterpoint to Dylan Thomas, I have also attached a copy of Robert Browning's "Rabbi Ben Ezra," my favorite poem on aging, which stresses that age is where the best of life is realized. It is a longer, more contemplative poem. The speaker is Rabbi Ben Ezra, a 12th century scholar. Browning, of course, is a Victorian, a little more preachy, a little more religious, a little more confident and content than we 21st century dwellers may feel, but he extols the value of aging. In his poem he invites us and I quote, to "Grow old along with me; the best is yet to come; the last of life, for which the first was made." He continues and I quote, "Youth shows but half," suggesting that youth will fade and what replaces it is that wisdom and insight of age. This sounds pretty good to a lawyer on the threshold of age. And this one positive note, I will end and ask if there are any questions.