SENIOR LAWYER NEWS

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Medicare Part D – Prescription Drug Coverage

Bob Spicknall

If you are one of the 42 million Americans who receive their health care from Medicare you probably have been receiving and will continue to receive information on Medicare Part D. Medicare is introducing a new Prescription Drug Program called Medicare Part D on January 1, 2006. Medicare Part D will be funded by the federal government, but it will be administered by private government-approved Prescription Drug Plans (PDPs).

Basics of Medicare

- Part A — hospital insurance.
- Part B — medical insurance. The premium for Part B will increase from $78.20 in 2005 to $88.50 in 2006. The Part B deductible will be $124.
- Part C — combines Parts A & B under a private plan, often referred to as Medicare Advantage. Few people in Virginia have this.
- Part D — prescription drug coverage, new January 1, 2006.

How Part D Works

You purchase a prescription drug plan and pay a monthly premium. The prescription drug plan will work as follows: some plans will provide additional coverage (deductible, coinsurance) beyond the minimum prescription drug benefits stated below:

1. The Medicare Part D beneficiary or retiree pays the initial deductible of $250.
2. Between $251 and $2,250 in drug costs, Medicare will pay 75% (or $1,500) and the retiree will pay 25% (or $500) of the costs.
3. Between $2,251 and $5,100 of prescription drug expenses, the retiree will pay 100% of the costs. Sometimes this is referred to as the “doughnut hole” or “coverage gap.”
4. After the retiree has spent a total of $3,600 annually in true out-of-pocket costs, which is the amount the retiree pays using his own money, Medicare will begin paying approximately 95% of the prescription drug costs.

Part D Initial Enrollment Period

There will be an initial six-month enrollment period from November 15, 2005 until May 15, 2006 for prescription drug benefits in 2006. A penalty may apply to those who do not enroll during this time and choose to enroll later.

If You Currently Have Prescription Drug Coverage

If you have a Medicare Supplement with built-in drug benefits (Plans H, I or J) you will have the following options:

1. Keep your current plan, and do not enroll in Part D.
2. Keep your current plan and request that the drug benefits be removed. Your premiums will be lowered and you can sign up for Part D. Please note private insurers will no longer be able to sell Medicare supplement plans with drug coverage effective January 1, 2006, so you will not be able to switch back to your previous drug coverage.
3. You may choose another Medicare supplemental policy without drug benefits (e.g. Plan F) without having to answer medical questions, and sign up for Part D during this initial enrollment period.

Penalty

There may be a penalty for those who are eligible for Part D and decide to enroll after the initial enrollment period. The late penalty is 1% of the national average monthly premium and will accumulate monthly. Thus a 24 month delay will result in a 24% increase in Part D premium and will be assessed for as long as they are enrolled in Medicare Part D.

Some insureds with employer group health plans may have “creditable coverage” and will not be penalized for enrolling at a later date. However, those with individual Medicare supplement plans with drug coverage (plans H, I or J) will not be considered having “creditable coverage” by Medicare. Therefore, a penalty will be assessed to those individuals enrolling in Part D after May 15, 2006.

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Message from the Chair

William T. Wilson

At the December meeting of the Senior Lawyers Conference (SLC) Board of Governors, we were privileged to hear from Senator Emmett W. Hanger Jr. of Augusta County, who chairs the Senate Committee on Rehabilitation and Social Services. His committee oversees legislation that affects nursing homes and assisted living facilities. I reported in the October 2005 *Virginia Lawyer* that I was trying to contact the chairs of key committees in the House of Delegates and the Senate to ask about some of the problems that face nursing homes and assisted living facilities, in an effort to see how the SLC could help. Senator Hanger was kind enough to spend almost two hours explaining to the board of governors the legislature's concerns about these facilities and what the SLC could do. As we get older, all of us face the possibility of living in one of these institutions, and we certainly want the care provided to us, our friends and our families to be of high quality.

Not long ago, the *Washington Post* ran a series of articles that included horror stories arising from the operation of some assisted living facilities. The same sort of thing happens in nursing homes. Too frequently, these institutions are understaffed, at times with people who are under qualified, leading to patient neglect and abuse.

I was recently involved in a case in which an elderly woman, while in a nursing home recovering from surgery for a broken hip, was allowed to fall, breaking her other hip. The nursing home neglected to call the family's doctor. The staff put the patient back to bed, and she spent the night in agony. Because she had Alzheimer's disease, she was unable to describe her discomfort. The next morning, the staff dressed her while she cried out in pain and then took her to the local hospital for a postsurgical. When she repeatedly cried out, the orthopedic surgeon suspected something was wrong and ordered x-rays. It was then that the second broken hip was discovered. A lawsuit was filed and a large verdict was returned against the nursing home. When collection efforts began, we discovered that the nursing home not only was mortgaged to the hilt, but it also was one of a network of nursing homes which was insured by one liability insurance policy with total coverage for all homes and all claims in the amount of three hundred thousand dollars. We also discovered that the premium for the policy was $375,000. It was, of course, a ridiculous situation, but it made me even more concerned than ever about how some nursing homes and assisted living facilities are structured and operated. This particular nursing home was owned by a married couple, but it was a part of a corporate network facilities located in several states. We suspected a scheme to thinly capitalize the corporate network to the prejudice of creditors, and we filed a suit to "pierce the corporate veil." I tell you all of this because, more and more, nursing homes and assisted living facilities are owned by out-of-state individuals and companies, and Virginia's regulatory oversight is inadequate regarding corporate structures and liability insurance.

The General Assembly has been active in recent years in efforts to improve the quality of nursing homes and assisted living facilities, but there is much to be done. Assisted living facilities are looking more like nursing homes every day. When some of our mental hospitals were downsized years ago, many people who should have been put in nursing homes or other medical settings ended up in assisted living facilities. There has been much controversy about that trend, and the General Assembly needs to do more to regulate in that area.

The SLC is still wrestling with the question of what we can do to help the General Assembly improve these institutions. One thing we have planned is a program at the Annual Meeting of the Virginia State Bar in Virginia Beach in June 2006 entitled "So You Are Going to a Nursing Home/Assisted Living Facility." It is my hope that we can bring together a panel that will paint a broad picture of what is going on at nursing homes and assisted living facilities and that will suggest possible improvements in those institutions. I hope that many of you will attend.

I would now like to talk a little bit about hospital-acquired staph infections, another subject I addressed in my October 2005 column of the *Virginia Lawyer*. To quote a Legis Brief (October, 2005, Vol. 13, No. 42) of the National Conference of State Legislatures:

> Hospital acquired infections, also known as healthcare-associated infections, are garnering greater attention as the debate over health safety grows. Legislation forcing hospitals to detail the number of patients infected while under their care may provide patients and insurers with information they can use in their role as consumers. It may also give hospitals an incentive to adopt better infection control practices. The Centers for Disease Control and Prevention reports that roughly two million patients contract an infection while in a hospital each year in America. These infections result in 90, 000 deaths and an estimated total cost of $4.5 billion.

That article states that hospitals have never thoroughly tracked infection rates. There is, however, a voluntary survey of hospitals which has been conducted by the U.S. Centers for Disease Control and Prevention since 1970. Approximately three hundred hospitals throughout the United States participate in that survey. The survey deals only with large hospitals,

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however, and the procedures which are reported are limited. The responses of individual hospitals are never made public. In my judgment, the time to shine the light of day on the hospital-acquired infection situation is at hand. I am happy to report to you that through the efforts of, among others, Delegate Harry R. "Bob" Purkey of Virginia Beach, legislation was passed in the 2005 General Assembly that requires Virginia hospitals, beginning July 1, 2008, to report hospital-acquired infections. I do not know why the start-up date is so far off when so many deaths and injuries occur because of this problem. Although I realize that there are technical issues involved and that reporting infection rates can have a negative impact on some hospitals, the overall good of the public should be the dominating factor, and now is the time to gather this information. Hospitals and doctors are concerned about this problem, but historically they have tried to deal with it internally without involving the General Assembly or the public. During a program on healthcare and senior citizen-related issues at the VSB Annual Meeting last June, I asked for a showing of hands from those who either had personally contracted a hospital infection or had family members or close friends who had. Almost everyone in the room raised a hand. Several years ago, a member of my immediate family almost died from a hospital-acquired staph infection. What should have been a relatively straightforward lung operation with a short convalescence turned into months of agony and rehabilitation. This experience brought the problem to my attention. In that case, the hospital wrote off well over $150, 000 in medical costs.

For those of you who really want an eye-opener, I refer you to "Infection Epidemic Carves Deadly Path," a series in the *Chicago Tribune* in July 2002, as well as the aforementioned Legis Brief article.

I have been in touch with Delegate Purkey about this subject, and he has promised to make his staff and his resources available to the SLC. The SLC has not taken on this issue as a part of its 2005–2006 program, but the board of governors is receiving information from me on the subject so that it will be better informed.

If you have questions or comments regarding nursing homes, assisted living facilities or hospital-acquired staph infections, please send them to Patricia Sliger, SLC Liaison, at Virginia State Bar, 707 East Main Street, Suite 1500, Richmond 23219-2800; fax (804) 775-0501; or sliger@vsb.org. ■

Preventing Elder Abuse

From A Series of Guides from MetLife® in Cooperation with the National Alliance for Caregiving

About the Subject

It is often difficult to believe that an older family member or friend may be subject to any form of maltreatment. However, it is estimated that 2.1 million older Americans a year are victims of physical, psychological and other forms of abuse and neglect.[1] That number may still be underestimated, as it is believed that for every abuse case reported, there are five more that are not.[2] These are compelling statistics for a society whose fastest growing segment of the population is over the age of 85.[3] Federal definitions of elder abuse first appeared in the 1987 Amendments to the Older Americans Act, intended to serve as guides in order to define the problem.[4] Today, all 50 states have laws to prevent elder abuse, but state-to-state definitions and enforcement of abuse violations vary.

Researchers have various theories on what leads to elder abuse, but all believe it is a complex issue encompassing economic, societal, psychological and physiological issues of both the abuser and the abused. There seems to be a greater possibility for abuse among older adults who need more physical assistance and/or who have a poor level of cognitive function. Studies show that three out of four elder abuse and neglect victims suffer from physical frailty. About 48% of substantiated[5] (proven) incidences of abuse and neglect involve older adults who are not physically able to care for themselves.[6]

What may be surprising to many people is that the most frequent perpetrators of abuse are family. The 2000 State Adult Protective Services Survey reported that abuse by a family member accounts for 61.7% of

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abuse cases. Spouses or partners account for 30.2% and adult children for 17.6%.[7] There is no solid evidence as to why abuse is more common within the family structure, but it is thought to be due to a variety of factors.

Families with a history of prior abuse or hostile relationships may have a greater chance of experiencing abuse. Social isolation of the elder or family caregiver can be as much a risk factor, as it can be a sign of abuse. Changes in family dynamics due to an elder's physical presence in a home may result in increased demands and stresses on the caregiver as well as additional financial considerations. These are all factors that may increase the possibility of elder maltreatment.

Things You Need to Know

Any form of mistreatment that results in the harm of or loss to an older person can be defined as abuse.[8] The National Committee on Elder Abuse (NCEA) broadly defines and places abuse into three categories:[9]

Domestic Abuse

This is abuse within a person's own home or the home of a caregiver. This applies to several forms of maltreatment of an older adult by someone such as a spouse, adult child or other relative. Additionally, a paid caregiver providing home care services may also mistreat an older adult.

Institutional Abuse

This is defined as maltreatment that occurs to older adults residing in a facility such as a nursing home, assisted living facility, foster home, or group home. In instances of institutional abuse, the perpetrator is usually a staff member or other paid care provider who has a legal or contractual agreement to provide care to the victim. In some instances another resident may be the cause of the abuse.

Contrary to conventional belief, reports indicate that 42.5% of abuse claims occurred in domestic settings while 8.5% of reports occurred within a facility.[10] However, this does not minimize the incidence of facility abuse. With a rapidly growing elderly population, longterm residential facility use is expected to rise. Studies monitoring abuse in long-term care residential facilities are ongoing.

Self-Neglect or Self Abuse

Self neglect or abuse refers to the fact that individuals may threaten their own health or safety by failing to provide for their own basic daily needs.

This may result when an individual is cognitively impaired or when an individual has a chronic illness that leads to the person being physically not capable of providing for his or her own needs. It is important to recognize that individuals who are mentally competent and physically capable may also neglect themselves. Understanding the consequences of their actions, they may make a conscious and voluntary decision to engage in acts that threaten their health or safety. According to the National Center on Elder Abuse, self-neglect accounts for 41.9% of the reported incidences of maltreatment.[11]

Types of Abuse

Most often abuse victims are thought of as bruised and battered individuals, but physical maltreatment is only one of several types of abuse as described by the Administration on Aging (AoA). Generally accepted definitions are:[12]

Physical: The willful infliction of physical pain or injury. having problems walking and may be reluctant to say what caused the bruises. An evasive answer, combined with the physical evidence, could lead someone to jump to an incorrect conclusion. Side effects of medications or bruises or injuries as a result of a chronic illness might resemble abuse. Further investigation must be undertaken in order to determine the cause for concern.

Sexual: The infliction of non-consensual sexual contact of any kind.

Psychological/Emotional: The infliction of mental or emotional anguish, humiliation, intimidation or threats.

Financial/Material Exploitation: The improper act or process whereby an individual uses for his or her own benefit the resources of an older person without obtaining consent from the older person.

Neglect: The failure of a caregiver to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. Examples of these are abandonment, neglecting to provide care or supervision and denial of food or health related services.

Signs and symptoms of abuse should not be viewed out of context as conclusive evidence of abuse.

For example, an elder with issues of balance might fall or bump into obstacles. There might be residual bruising in areas such as their back or thighs. The person may not want to admit that he or she is having problems walking and may be reluctant to say what caused the bruises. An evasive answer, combined with the physical evidence, could lead someone to jump to an incorrect conclusion. Side effects of medications or bruises or injuries as a result of a chronic illness might resemble abuse. Further investigation must be undertaken in order to determine the cause for concern.

Physical

Physical abuse, in many instances, is the easiest type of maltreatment to spot. It accounts for 20.1% of abuse allegations.[13] Physical maltreatment may result in obvious injuries such as black eyes, welts over the body from objects used to hit an elder or from restraints at the wrists, ankles or waist. There may be indications of burns, acute signs of hair and tooth loss, broken bones or internal injuries. Bruising, both old and new, particularly those indicating specific objects or fingers, on areas such as the wrists, upper arms and neck could be worrisome. The improper use of medication such as an overdose of a tranquilizer, as a form of restraint, can also be considered physical abuse.

Sexual

Sexual abuse accounts for 0.8% of abuse reports.[14] Sexual abuse is defined as any sexual contact with a non-consenting elder or with an elder unable to give consent. Sexual abuse is not just non-consensual physical contact, but may also be in the form of lurid photos or exhibition of the elder. Signs of sexual abuse of an elder may not be as readily visible to family and friends. Suggestions of such maltreatment may be more apparent during a routine physical exam or when medical or personal care assistance becomes

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20th Annual

Tradition of Excellence Award

sponsored by the

VIRGINIA STATE BAR
GENERAL PRACTICE SECTION

The General Practice Section of the Virginia State Bar is seeking nominations for its 17th Annual Tradition of Excellence Award, which will be presented at the Virginia State Bar Annual Meeting in Virginia Beach on Saturday morning, June 17, 2006.

This award recognizes an outstanding lawyer who embodies the highest tradition of personal and professional excellence in Virginia and, in doing so, enhances the image and esteem of attorneys in the Commonwealth.

Nominations are due by close of business on Friday, April 7, 2006. For entry information and rules, please visit http://www.vsb.org/awards.html#tradition.

necessary. Indicators of sexual abuse can be venereal disease, vaginal infections, anal bleeding, bruising around the breasts and genital area, or torn and/or bloodied undergarments.

Psychological

Psychological abuse may be one of the more difficult forms of maltreatment to recognize. It accounted for 8.1% of abuse allegations in the Adult Protective Services 2000 survey.[15] Emotional abuse belittles elders and robs them of their dignity and self-respect. Abuse may be in the form of threats, intimidation and humiliation. Psychological abuse may occur when an elder is isolated fromothers such as friends and family against his or her will. Victims may be made to feel like they are incapable of doing or providing for themselves without the help of the individual who is inflicting the emotional abuse.

Some indications that an elder might be experiencing emotional abuse are:
- Hesitation in speaking openly with others, especially when a particular person is around
- Withdrawal and unresponsive communication
- Fear, agitation, anxiety, and helplessness
- Changes in sleep patterns, appetite and behavior

Financial/Material Exploitation

Financial/material maltreatment accounts for only 9.8%[16] of abuse allegations but it is an area of growing concern. Financial gain can be a motivating factor behind other forms of elder abuse.[17] Physical and/or psychological maltreatment or caregiver neglect may be ways in which another person mistreats an elder hoping to gain access to the elder's financial or material assets. Exploitation may be at the hands of a family member who feels that they are "owed" the money, either for caregivingduties or as an inheritance. An unscrupulous legal representative, such as someone who has power of attorney for finances or a guardian/conservator may take advantage of an elder's finances, property or other assets. There is also risk that a paid caregiver may financially exploit an older person especially if that person does not have involved family or friends.

Indications that an elder may be a victim of financial exploitation are:
- Lack of care when the older adult has sufficient funds available
- Changes in banking habits
- Excessive use of ATM and credit cards, especially for non-care related items
- Forged signatures on checks
- Missing personal property
- Changes in a will or creation of a new one without sufficient reason

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- Unpaid bills and utilities
- Documents signed under duress (forcing an individual to sign a document against their will)

Neglect

Caregiver neglect can be either intentional or unintentional. When a caregiver knowingly and purposely fails to provide those items or services needed to keep an elder from physical, mental and emotional harm, they are committing intentional neglect. In this instance, the caregiver is aware of the needs of the elder but does not provide for them. Unintentional neglect is usually rooted in a lack of knowledge or an inability on the part of the caregiver to provide care for the elder. Caregiver neglect accounts for 13.2% of abuse allegations.[18]

Indications that an elder may be suffering from caregiver neglect are:
- An unkempt appearance
- Breakdown of the skin
- Malnourishment
- Dehydration
- Lack of necessary assistive equipment such as walkers, dentures or hearing aids
- Excuses for the caregiver made by the care recipient

Indicators of all types of abuse may not always be clearly visible. The signs and symptoms listed in the above types of abuse are not all-inclusive. Sometimes elders do not know they are being abused or they may blame themselves for their circumstances, and are therefore reluctant to talk about their fears.

Self-Neglect

At 41.9% self-neglect represents the highest number of reported allegations of elder mistreatment.[19] Self -neglect is more common among individuals 85 years and older (the "oldest-old") who may be confused and are often isolated. Family may be involved, to a limited extent, but the elder wishes to remain independent, often at his or her own expense. Frequently people who neglect themselves have dementia, chronic illness, or a substance abuse problem that interferes with their ability to safely manage their health and affairs.

Indications of self-neglect are similar to those of neglect by a caregiver. Individuals may be unkempt, have poor dental and personal hygiene, or appear malnourished and/or dehydrated. They may not be taking their medications properly or appear listless, confused and depressed. Their living environment may be dirty, lacking in electricity or water, and unsafe. Frequently there is a need for an assessment to determine the competency of the elder and his or her ability to appropriately manage health and safety issues.

Scams and Fraud

Individuals over the age of 50 control 70% of the nation's wealth.[19] As a result, they are frequent targets for telemarketing abuse, internet scams, and investment fraud. Many people of all ages find it difficult to determine the legitimacy of these operations. Older adults should be reminded to speak with family or trusted friends before sending money or providing credit card or Social Security numbers to any solicitors, whether by telephone, mail, the internet, or in person.

Most elders aren't aware that over 40 billion dollars a year is lost on fraudulent telemarketing. Adults over age 50 make up more than 56% of the cases.[20] Reassure individuals who are being solicited that they are not being rude by simply hanging up the phone, deleting e-mail messages or refusing to open the door to a stranger. Suggest that individuals may use an answering machine to screen phone calls if they find telephone solicitors particularly troublesome. Individuals may add their name and phone number to the "National Do Not Call Registry" by calling 888-382-1222. The phone call and registration is free.

Reporting Abuse

If an older adult tells you that he or she is being abused or exploited, take the report seriously, and try to get as much detail as possible. The situation will usually worsen if it is allowed to continue. While the definitions of abuse—physical, financial and sexual—may vary within the United States, all are considered crimes and are subject to prosecution. In some circumstances, depending on the situation, emotional abuse and neglect can also be criminally prosecuted. When making a report, the more information you have to supply to the investigating agency the better. Provide the name, address, and phone number of the victim. Also, obtain the name, address, and phone number of the alleged perpetrator (if applicable). Try and gather information on the mental health, disability or illness of both parties. Be prepared to state your reason for concern. The information you report is kept confidential and you're protected from liability in the event that the suspicion cannot be substantiated. If, for some reason, you are unable to make a report, consider bringing the elder to the doctor. If the physician feels there is evidence of abuse, he or she is required to report it. Unfortunately, prosecution of an abuser is not always followed through, due in part to fears of perpetrator retaliation, especially if the perpetrator is a family member. Or an elder may be incapacitated and

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unable to be a witness. If the abuser is also the caregiver, a conviction could mean facility placement for the elder. However, it is important to report suspected abuse so that it can be properly investigated and the older person can be protected from further abuse wherever possible.

In an instance when you fear an elder might be in immediate danger, call your local police or sheriff's department or 911. Police will investigate any suspected criminal abuse.

Social Service Agencies

All states have reporting systems to accept and investigate allegations of abuse. Most frequently abuse is reported to Adult Protective Services (APS). APS provides protective and supportive services to elder and vulnerable adults who are abused, neglected and exploited. The number for APS can usually be found in the area of Department of Human or Social Services in the blue pages of your phone book. Or, you may call the Eldercare Locator at 800-677-1116 and they will assist you with locating the appropriate agency. You will need the zip code of the area in which the elder resides. APS will investigate all reports of suspected abuse or neglect. Once the investigation is completed APS will work with the elder and his or her family or support system and other community resources to address any identified problem areas. APS is concerned with protecting the safety and dignity of the older person. In certain situations, the older person may choose not to accept any assistance or intervention. If the person is mentally competent that is his or her right. In these situations it is often necessary to move slowly and support the individual.

Sometimes changes will occur over time. Protecting the individual's right to autonomy is a very important consideration. In other situations, where the individual is not mentally competent, is unable to protect himself or herself, and would be at serious risk if left alone more immediate steps need to be taken to assist the individual. This may at times involve intervention from the police, especially in situations where there is evidence of a crime.[22]

Long-Term Care Ombudsman

If you suspect abuse of an elder residing in a nursing home or residential care facility, contact your area's longterm care ombudsman. The ombudsman program is a federally funded program that acts on the behalf of nursing home and residential care residents to make sure that their rights are protected. The ombudsman will investigate concerns of abuse and exploitation of an elder in a long-term care facility. The number of your ombudsman is available from the Area Agency on Aging in your area or the Eldercare Locator. The ombudsman number must also be posted prominently in every facility. Prevention Elder abuse, like other forms of domestic abuse, has no tried and true cause. It is the result of a multitude of factors. Its cause might be found in the complex social, physical, economic, psychological and cognitive components of the people in whose lives it appears. And while there are various theories as to its actual cause there are no definitive factors that explain all elder mistreatment. Without solid indicators, abuse is more difficult to prevent. However, by identifying the risk factors, the likelihood of abuse may by lessened.

For Elders

- Avoid isolation. Isolation can lead to loneliness, sadness, and depression, and increase the possibility of abuse or neglect including self neglect.
- Stay social and stay active. Keep in touch with old friends and make new ones. Consider volunteering in the community or becoming a surrogate grandparent or a mentor.
- Don't live with another person who has a history of abusive or violent behavior. Be aware of caregivers, including family, who might have a need for financial assistance or who have substance abuse issues.

For Caregivers

- Look into respite care to relieve some of the caregiving responsibilities. Being overburdened with caregiving and other responsibilities may make a caregiver more inclined to abuse the care recipient.
- Consider counseling for yourself or your elder if behavioral issues are a problem.
- If your elder is being cared for either in a facility or by paid caregivers at home on a full or part-time basis remain involved and observant to be assured he or she is receiving quality care and that there are no signs of abuse or neglect.

If you are considering confronting an abuser, be certain that you are not putting the elder in a more vulnerable position. Make sure you have the victim's consent and that you are able to remove them from the situation immediately if necessary.

Helpful Hints

- If you have an elder in a longterm care facility, visit often and at various times of the day or evening. Note how your loved one is cared for. Watch interaction with caregivers. Do you see conversation and smiles or hesitancy, anxiety, and fearful behavior on your loved one's part? Report any concerns immediately to the nursing supervisor.

- If you are a caregiver, contact the local Area Agency on Aging (AAA). There is a new program called the National Family Caregiver Support Program (NFCSP) which supplies support services to family members and friends who are caregivers. Information is available on the AoA Web site at www.aoa.gov/eldfam/For_Caregivers/For_Caregivers.asp or by calling the local Area Agency on Aging (AAA), usually found in the blue pages of your phone book.

- Most older adults value their independence. However, it is important to recognize when a few simple changes can help an older adult remain safe and independent, and when it is in their best interest to relocate or obtain caregiving services from another individual. If an older adult is capable, don't make decisions for them. Discuss problems. Listen to the older adult's concerns and then offer advice. Don't dictate.

- Victims of financial abuse may be reluctant to tell family members that they were "duped." It is important that older adults understand they are not alone in their victimization. For consumer information on internet

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and telemarketing fraud or to report a fraud complaint contact the National Consumers League Fraud Information Center at 800-876-7060, 9AM to 5PM, Eastern Time or via the internet at www.nclnet.org.

- If the management of finances is an issue of concern for you and or your elder, consider looking into a Daily Money Management (DMM) program. Daily Money Management programs provide an array of formal and informal services related to financial management. Not all DMM programs offer the same services. DMM is a growing field, but unregulated, and care should be exercised when enlisting services. Check with your local Area Agency on Aging for recommendations or with professional organizations such as the American Association of Daily Money Managers (AADMM). AADMM can be accessed at www.aadmm.com or by calling 703-492-2913.

Resources to Get You Started

Books and Publications

A/PACT: Aging Parents and Adult Children Together This is a series of 10 articles created by the Federal Trade Commission (FTC) together with AARP. It addresses such eldercare issues as fraud and the older adult, daily money management and care of the caregiver. You may access the series on the Internet at: www.ftc.gov/ bcp/conline/pubs/services/apact/index.html or order it from the FTC at Consumer Response Center, Federal Trade Commission, Washington, D.C., 20580. 877-382-4357 TDD 866-653-4261

Elder Rage, or Take My Father…Please!: How to Survive Caring for Aging Parents This book, written from personal experience, is a realistic self-help book on managing the oft-times challenging behavior of resistant elders. It discusses such issues as giving up driving, changing doctors, visiting doctors, moving, accepting outside services. It also provides recommended reading and Web sites. Marcell, J. (4/01). Impressive Press, 2nd Ed. $13.97 ISBN: 0967970318

Ending Elder Abuse: A Family Guide This book provides a creative, practical and compassionate guide to caring for aging parents. It addresses the unfortunate but undeniable existence of elder abuse. The author writes from a first-hand account of abuse of her mother while in a nursing home. The book provides very helpful appendices and detailed guides to choosing and monitoring care in any type of long-term care facility. Sandell, D.S. & Hudson, L. (10/ 2000). Q.E.D. Press, $11.87 ISBN: 0936609419

Is Your Parent in Good Hands?: Protecting Your Aging Parent from Financial Abuse and Neglect. This book is written by a practicing attorney of over thirty years. As an advocate for the older adult, the author talks about ways of protecting the elders from financial exploitation. He discusses legal issues, health care issues, caregivers, estate planning, and physical issues. Useful self-help guides are provided, with information presented in an informative easy to read format. Carnot, E.J. (11/2003). Capitol Books, $13.27 ISBN: 1931868379

Internet Sites

AARP – Consumer Protection

The AARP site offers a comprehensive consumer protection section which includes articles on home loans and home improvement, articles that discuss various types of fraud, advice on shopping for utilities, tips for being a wise consumer and how to purchase cell phone service, long-distance service and other types of utilities. Once in the website, type "consumer protection" under search to locate the information. www.aarp.org

Children of Aging Parents (CAPS)

CAPS provides outreach and support group information, education and resources for the caregivers of aging and chronically ill individuals. The site also provides links to other helpful and informative Web sites, and a multitude of informational literature that is available to order off of their Web site. Access it at www.caps4caregivers.org.

Eldercare Locator

Toll free: 800-677-1116 (9 a.m.–8 p.m. ET)

The Eldercare Locator is a public service of the U.S. Administration on Aging. The Locator helps older adults and their caregivers find services in their area. The Eldercare Locator can be accessed through its toll-free telephone line, staffed by trained information specialists, or through its Web site. www.eldercare.gov.

Family Caregiver Alliance (FCA)

This site is a national information center of caregiver resources. This site provides a wealth of information and online services for caregivers. It also provides extensive Web links to other useful sites. Access it at www.caregiver.org. Or call 800-445-8106.

The National Center for Elder Abuse (NCEA)

The NCEA is a partnership of six organizations, federally funded by the Administration on Aging, an agency of the Department of Health and Human Services, which is involved with preventing elder abuse. This is a comprehensive Web site that explores the causes of elder abuse, and discusses state laws, statistics and information, research, legislative news and fact sheets. The site provides numerous Web links to other state and national sites. Access it at www.elderabuse center.org.

The National Consumers League (NCL)

Formed in 1899, the NCL is the nation's oldest consumer organization. The NCL works to protect the American consumer and worker in marketplace and workplace issues. The Web site provides information on fraud, telemarketing, computer issues and publications. You can access their site at www.neglect.org. You may also contact the organization by phone at 202-835-3323 or fax 202-835-0747. The NCL created the National Fraud Information Center (NFIC) in 1992. The NFIC provides information as well as a means to report telemarketing and Internet fraud. You may call the toll-free hotline for consumers at 800-876-7060 to speak to a NFIC counselor about possible fraud issues. ■

Endnotes

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View From the Bench

The Honorable William H. Ledbetter Jr.

Trial on the merits should be the main event … rather than a "tryout on the road." Anderson v. Bessemer City, 470 U.S. 564 (1985).

Civil Litigation is comprised of four stages: pleadings, discovery, trial and post-trial including appeal. Each of these components has its own raison d'être and its own evolutionary history. But the heart of the process is and always has been the point at which the dispute is adjudicated in a formal, neutral setting—i.e., the trial.

Litigators should keep this in mind. It is easy to stray, to lose focus and to give too much emphasis to the other stages of the litigation process.

Two distractions bear comment.

Discovery

Discovery is a particularly alluring diversion. In modern practice, it can take on a life of its own.

As long as pleadings were lengthy and detailed expositions of each party's position in the case, there was little need for formal discovery. Everything one needed to know about the claim or defense could be gleaned from the pleadings, set forth there with tedious specificity. With the reforms of the nineteenth and twentieth centuries, however, pleadings were converted into little more than succinct assertions and general denials. This development gave rise to discovery—the new set of mechanisms by which a litigant could learn the specifics of the other party's position in the dispute.

So, by modernizing pleadings, the reformers who sought to eliminate excessive controversy from pleadings merely transferred those issues—i.e., notification-and-clarification issues—and the contentiousness surrounding them, from the pleading stage to a later stage—discovery. *See* e.g., Bryson, Virginia Civil Procedure (3rd Ed.) p. 199.

In fact, the reformers not only postponed the contentiousness, they exacerbated it. With notification-and-clarification issues delayed until just before trial, anxiety levels are elevated, increasing the risk of friction.

No one would suggest that discovery should be avoided, or that it is unimportant. Every litigant should know what the other is claiming. Further, the materiality—and thus, admissibility—of evidence proffered at trial is defined by reference to the issues genuinely in dispute, which in turn is determined in modern practice from discovery as much from the pleadings.

Nevertheless, trial lawyers should engage in discovery with a sane mission and purpose. Trial is just around the corner. At the stage of the process when discovery is usually carried out, the lawyer must be more concerned with preparing his or her own case for trial than plumbing for minutiae in the adversary's case.

… litigators must stay focused: the trial is the critical stage of the process; adducing persuasive proof and presenting compelling arguments to the finder(s) of fact is the heart of the process.

At bottom, discovery should be used carefully and purposefully, in the manner for which it is intended, so that counsel can stay focused on the trial, the "main event."

Preserving the Record

Another distraction is undue attention to "preserving the record" for appeal.

Clearly, litigators must be attuned to the need for well-crafted objections in appropriate circumstances at trial. Appealing "specialists" and appellate court judges and justices routinely emphasize the importance of this aspect of trial practice at CLE seminars and workshops. On the other hand, an obsession with "preserving the record" can divert one's attention from the trial itself—at considerable cost.

continued on following page

It is elementary, learned in Trial Practice 101, that objections are irritants. When objections are frequent, accompanied by lengthy commentary, the irritation increases. Jurors shift in their chairs, glance at one another and look pleadingly at the trial judge as if to implore, "spare us this."

In *Riner v. Commonwealth*, 286 Va. 296 (2004), the Supreme court held that the defendant had waived his objection to hearsay testimony because the hearsay actually was double hearsay and counsel had failed to call the judge's attention to the fact that he had ruled on just one of the two levels of hearsay.

In a recent issue of *Litigation News*, the Newsletter published by the Litigation Section of the Virginia State Bar, Monica Taylor Monday of Roanoke aptly expressed concern about the implications of *Riner*. *See Litigation News* Vol. X11 No. 1 (winter 2005) p.1. In the article, she pointed out the pitfalls of failing to make an articulate contemporaneous objection and/or failing to ensure that the trial judge has addressed all grounds of the objection, or at least has been alerted that he or she has not ruled on them all.

Whether *Riner* ratchets up the requirements of the so-called contemporaneous objection rule in Virginia, which is already strictly applied notwithstanding Virginia Code § 8.01-384 (A), or is merely an iteration of earlier holdings such as *Reid v. Baumgardner*, 217 Va. 769 (1977) and *Rose v. Jacque*, 268 Va. 137 (2004), is open to debate. Only time will tell. Meanwhile, litigators must stay focused: the trial is the critical stage of the process; adducing persuasive proof and presenting compelling arguments to the finder(s) of fact is the heart of the process.

There is another reason why many lawyers gravitate to other stages of litigation rather than focus on the trial itself. Our common law tradition of trial puts heavy stress on "orality."

> [T]he spoken word is the heart of the common law trial—testimony fresh from the mouths of living, breathing witnesses, who stand or sit in plain view in the courtroom, examined and cross-examined by lawyers. The system is so familiar—so ingrained—that we take it for granted. Americans find it astonishing that there are other ways of running trials—that there are systems which, basically, judges proceed by shuffling paper and documents. Friedman, American Law at 68 (1984).

Thus, Lawyers who are more comfortable with the written word will be tempted to allow the other stages of litigation, all paper-driven, to trump trial preparation and presentation. Lawyers who are more inclined to oratory, those with a commanding presence, those with a little thespianism in their blood, and those who are propelled by the urge to be eloquent on their feet rather than with their pens, will naturally stay focused on the trial as the "main event."

Good lawyers can and do attend to all phases of the litigation process by assigning to each stage its proper due. But the best lawyers never lose sight of the primary objective: obtaining a favorable decision on the merits at trial. ■

The Honorable William H. Ledbetter Jr. is a retired judge of the 15th Judicial Circuit. He is a member of The McCammon Group and serves on the Board of Governors of the VSB Litigation Section.

VIRGINIA UNIFORM TRUST CODE

Frank O. Brown, Jr.

The Virginia Uniform Trust Code (2005 Acts, ch. 935) becomes effective on July 1, 2006. Because there is an intervening session of the General Assembly before the effective date, it is possible that there may be amendments or modifications made by the 2006 session, which convened in January 2006. This can be checked by going on the Senior Lawyers Conference web site at www.vsb.org/slc under Attorney Resources, then Links, then Government Resources, then the Virginia General Assembly home page. With permission of the University of Richmond Law Review, we present "The Uniform Trust Code," by John E. Donaldson and Robert T. Danforth, from the *University of Richmond Law Review*, 40 U. Rich. L. Rev. 325 (2005). See the following link to access the full text of the law review article: www.vsb.org/slc/attorney/newsletterwinter06/UTC_401.pdf

Medicare Part D continued from page 1

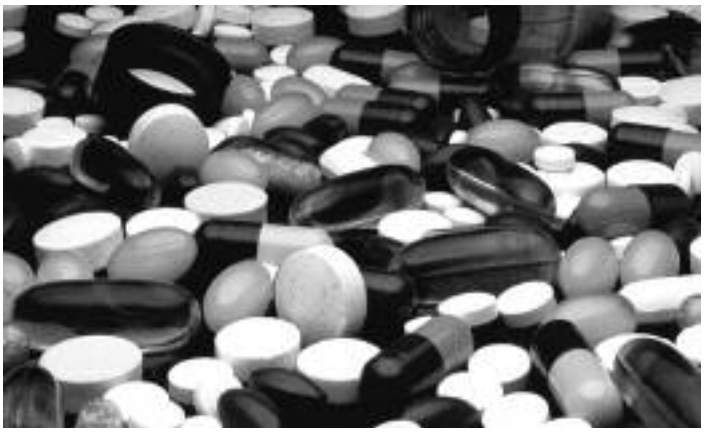
Limited Income and Resources

People with limited income and resources may qualify for extra help in paying for Medicare prescription drug costs. Some will qualify automatically, others will need to apply through the Social Security Administration.

Items to Consider

How much do you spend on prescription drugs today? The Kaiser Family Foundation projects Medicare beneficiaries will spend an average of $1,339 for prescription drugs this year and projects:

- 60% will spend $750 or less
- 33% will spend $751 - to - $3,600
- 7% will spend $3,601 or more



For people with little or no current drug expenses it may be easy to disregard the Part D initial enrollment and seem illogical to spend about $30 per month needlessly. However, the reality is that as we grow older, we often get sicker and high drug costs can hit at an older age. Thus, the Part D penalty at a later date encourages people to apply now. You may want to ask yourself how much you will spend on prescription drugs in the future. While not everyone will gain from enrolling in Part D, it will be helpful to remember two important items. First, this program is heavily subsidized by the federal government and no one may be helping you with your prescription drug costs today. Second, Part D will provide a safety net against catastrophic prescription drug costs that can attack people beyond their income producing years.

If you keep your current prescription drug coverage that is built into your current Medicare supplement there is the possibility that this coverage may become extremely expensive in the future. No new people (young – 65 years olds) will be added to this pool and eventually the group could consist of older retirees with expensive medical issues.

Many of the PDPs will establish pharmacy networks that must be used. If you have a local pharmacy you enjoy, you will want to find out which plans your pharmacy participates with. Either the PDP or Medicare should be able to confirm if a pharmacy is in a specific PDP.

If you are taking a specific medication you will want to ask if the drugs you are taking are on the PDP's formulary. Some brand name drugs may not be covered or could be listed as "non-preferred" and will carry a higher copayment or coinsurance.

You may also want to find if "prior authorization" is required, or if the PDP requires retirees to try less expensive medicines first before paying for some more expensive drugs.

For many retirees the "coverage gap" or "doughnut hole" will be difficult to evaluate. Others with numerous medications may easily reach $2,250. And still others may reach $3,600 easily and would benefit by having Part D paying at least 95% of subsequent prescriptions.

Some PDPs will offer plans that eliminate the deductible and the doughnut hole. These PDPs will have higher monthly premiums.

Finally, seniors who want more information about prescription drug coverage can call 1-800-Medicare (1-800-633-4227) or access more information at www.medicare.gov. ■

The Insurance Center for Virginia State Bar Members is pleased and honored to be the Virginia State Bar endorsed broker/administrator for the Virginia State Bar Personal Insurance Plans. The Virginia State Bar's Personal Insurance Plans for members include health, term life and disability insurance. These plans are overseen by the Virginia State Bar's Personal Insurance for Members Committee. The Insurance Center's toll free phone number is 877-214-5239. The Website is www.icvsb.org.

Calendar

Tuesday, Feb. 7, 2006
Senior Lawyers Conference Board of Governors Meeting
2nd Floor Conference Room, 707 E. Main St.
Richmond
11:00 a.m.

Tuesday, April 18, 2006
Senior Lawyers Conference Board of Governors Meeting
2nd Floor Conference Room, 707 E. Main St.
Richmond
11:00 a.m.

June 15–18, 2006
VSB 68th Annual Meeting
Cavalier Hotel & Holiday Inn Sunspree, Virginia Beach