

# Elder Law



Volume 15 | Number 1

Spring 2004

## Chairperson's Message

by William S. Hickman

I am pleased to report that the Elder Law Section has had a successful and prosperous year thus far. The Section did very well financially on its annual meeting CLE last September, as well as the "The New Essentials of Practicing Elder Law" CLE held in January. Jacob Menashe and Carol Hunter did excellent job in putting that seminar together. I also want to thank Rob Nettleton and Brad Mellotte for their service as CLE co-chairs for the Section. They have done an outstanding job during their tenure.

Looking to the future, the Section is sponsoring a full-day seminar on special needs trust scheduled for July 14, 2004. It promises to be an excellent program. I encourage you to save the date. We have scheduled September 10th for our 2004 annual meeting and CLE program to be held at the SeaTac Doubletree. That program is coming together nicely and will be well worth your time and money. Please plan to attend.

Let me take a moment to make a personal plea for more of you to get involved in the Section. Several of those currently serving on the Executive Committee and in other supporting roles have served faithfully for several years. It is time for others to enjoy the experience. We have a large section, in excess of 500 members. Certainly there is a wealth of talent and untapped ability out there. Your help and ideas are welcome and needed. We have specific need for someone who is technologically inclined to monitor the Section's website and recommend changes or improvements. If you have any interest in serving in any capacity or have any questions about what is involved, please contact either myself or Barbara West.

## Indemnity vs. Reimbursement: Which Type of Long-Term Care Insurance Policy is Better?

by Roger Jones, CLU, ChFC

Willows Financial Services, Inc. - 425-637-7809

At times, you may be asked to evaluate two or more Long-Term Care insurance policies from different insurance providers. After you have compared the obvious customer choices such as daily benefit amount, elimination period, benefit period, and benefit increase option, you should look at the more subtle terms of the contract. There are two in particular that you should consider reviewing: (1) the

*continued on page 3*

## Nominations Sought

Nominations for appointments to the WSBA Elder Law Section Executive Committee for the Section year beginning October 2004 and running through September 2005 are now being sought. Section By-Laws require that the nominations be identified and ballots be mailed to the nominations chair by August 1, 2004; elections will take place at the Annual Meeting scheduled for September (10). We welcome the participation of any Section members who have the time, energy and enthusiasm to work on the Executive Committee.

Please contact Barbara West, Nominations Chair, at (206) 624-6271 or via e-mail at [bwest@rlmalaw.com](mailto:bwest@rlmalaw.com) if you would like your name placed into nomination.

### In This Issue

Chairperson's Message .....	1	End-of-Life and Healthcare Decisions for the Incapacitated by Their Legal Fiduciaries .....	4
Indemnity vs. Reimbursement: Which Type of Long-Term Care Insurance Policy is Better? .....	1	Health Care Decisions for the Incompetent in Washington State .....	5
Nominations Sought .....	1	Statement Supporting an Increase in the Medically Needy Income Level .....	8
Announcements .....	2		

# Announcements

## Your Elder Law Section Needs You

- The CLE Committee, Legislative Committee and Grants Committee all seek leadership and member involvement.
- 2005 will be a full legislative session in Olympia and our current Legislative Chair, Mike Longyear, is interested in locating a Co-Chair to assist with the management of legislative proposals that affect our members and clients.
- Rajiv Nagaich serves as Editor in Chief of the newsletter and welcomes the participation of the membership.
- Continuing education programs are in need of volunteers to develop program ideas and see them through to completion. Julie Kocer has developed and implemented a Grants Program that is a model for other sections.
- Julie will depart the Grants Committee in September; the Section needs the participation of willing and able volunteers to review and process grant applications.

## Are You Proficient With Designing and Maintaining Web Sites -

*or know someone who is?*

The Elder Law Section web site is in need of a facelift and your assistance and participation is requested. If interested, please contact any officer on the Elder Law executive committee. Thanks for your anticipated assistance.

## ELDER LAW SECTION 2003-2004 OFFICERS & EXECUTIVE COMMITTEE

### Chair

**William S. Hickman**  
3400 188th St SW, Ste 484  
Lynnwood, WA 98037-4708  
(425) 744-5658  
(425) 771-3490 Fax  
[wschickman@msn.com](mailto:wschickman@msn.com)

### CLE Committee Co-Chairs

**Robert B. Nettleton**  
5302 Pacific Ave  
Tacoma, WA 98408-7626  
253-475-8600  
253-473-5746 Fax  
[rob.nettleton@neillaw.com](mailto:rob.nettleton@neillaw.com)

### Chair-elect

**Jacob H. Menashe**  
900 4th Ave, Ste 3250  
Seattle, WA 98164-1072  
(206) 340-2220  
(206) 382-9102 Fax  
[jacob@isenbleck.com](mailto:jacob@isenbleck.com)

### Bradley A. Mellotte

331 N 1st St  
Yakima, WA 98901-2303  
509-452-5256  
509-452-5112 Fax  
[mellotte@qwest.net](mailto:mellotte@qwest.net)

### Secretary

**John S. Palmer**  
800 Bellevue Way NE, Ste 300  
Bellevue, WA 98004-4229  
425-455-5513  
425-455-5546 Fax  
[john@palmerlegal.com](mailto:john@palmerlegal.com)

### Trustees

**Peter Greenfield**  
101 Yesler Way, Ste 300  
Seattle, WA 98104-2528  
(206) 464-5933  
(206) 382-3386 Fax  
[peter.greenfield@columbialegal.org](mailto:peter.greenfield@columbialegal.org)

### Treasurer

**Evelyn M. Zeller**  
10900 NE 8th St, Ste 900  
Bellevue, WA 98004-4448  
(425) 861-1765  
(425) 882-9404 Fax  
[evelyn@zellerlaw.com](mailto:evelyn@zellerlaw.com)

### Richard L. Sayre

201 W North River Dr, Ste 460  
Spokane, WA 99201-2262  
(509) 325-7330  
(509) 325-7334 Fax  
[dick@sayrelaw.com](mailto:dick@sayrelaw.com)

### Immediate Past Chair

**Barbara A. West**  
801 Second Ave, Ste 1415  
Seattle, WA 98104-1517  
(206) 624-6271  
(206) 624-6672 Fax  
[bwest@reedlongyearlaw.com](mailto:bwest@reedlongyearlaw.com)

### Peggy (Margaret) M. Moxley

P.O. Box 881  
Wenatchee, WA 98807-0881  
(509) 662-1211  
(509) 662-3311 Fax  
[peggimoxley@speidellaw.com](mailto:peggimoxley@speidellaw.com)

### Legislative Chair

**Michael J. Longyear**  
801 Second Ave, Ste 1415  
Seattle, WA 98104-1517  
206-624-6271  
206-624-6672 Fax  
[mlongyear@reedlongyearlaw.com](mailto:mlongyear@reedlongyearlaw.com)

### Newsletter Editor (ExOfficio)

**Rajiv Nagaich**  
33838 Pacific Hwy S, Ste B102  
Federal Way, WA 98003-6887  
253-838-3454  
253-838-9268 Fax  
[rnagaich@eldercounselor.com](mailto:rnagaich@eldercounselor.com)

### Grants Committee Chair

**Julie (Juliann) Kocer**  
301 NE 100th St, Ste 310  
Seattle, WA 98125-8006  
206-525-6919  
206-523-9077 Fax  
[kocerlaw@hotmail.com](mailto:kocerlaw@hotmail.com)

## *Indemnity vs. Reimbursement from page 1*

method the insurance company uses to determine the amount of benefit due the client at claim time; and (2) the total amount of benefit payable to the client where the client has chosen the dual benefits of nursing-home care and community-based care.

1. **METHOD USED TO DETERMINE THE AMOUNT OF BENEFIT DUE THE CLIENT AT THE TIME OF THE CLAIM:** There are two distinct methods used to determine the amount of money the client will be paid when he or she makes a claim. The methods are called a) reimbursement method and b) indemnity method.

a) **Reimbursement Method** A reimbursement contract pays the insured only the amount of money actually spent on long-term care expense. For example, if an insured purchased a policy with a daily benefit amount of \$150 per day and later entered a nursing home that charged \$150 or more per day, the insurance company would pay the \$150, or approximately \$4500 per month benefit. If however, the insured entered an assisted-living facility with a daily charge of \$110 per day, the policy owner only receives \$110 per day, or approximately \$3300 per month. GE Capital, John Hancock, Life Investors, and New York Life are names of some of the majority of insurance companies that issue a reimbursement contract. The principal advantage of such a contract is that they are less expensive than the indemnity contracts.

b) **Indemnity Method** By comparison, an indemnity contract pays the insured the amount of benefit purchased, regardless of actual expenditure. In the example above, the insurance company pays the \$150 per day even if only \$110 per day is spent on care. The indemnity policy would return \$40 per day, \$1200 per month or \$14,400 per year more to the policy owner. This additional money can help cover other expenses such as prescription drug costs. In many cases, the indemnity policy premiums are no more than a comparable reimbursement policy. As would be obvious, this is a more advantageous contract for the client. The client can save the excess money or can use it to cover other expenses. It can be more expensive, though the companies that issue this contract are mindful of keeping it competitive. Lincoln Benefit Life, a subsidiary of Allstate Insurance Companies, is an example of a company that issues an indemnity contract.

2. **TOTAL BENEFIT PAYABLE UNDER THE POLICY:** Another contract term that is not obvious is the number of *pools of money* available to the policy owner at the

time of claim. The pool of money in a policy is the *money available for care under the different sections* of the policy. For example, in a policy with one pool of money, if a customer chooses a five-year benefit period, and then receives benefits at home for 2 years under the Home and Community Care section of the policy, these benefits received while at home count against the total five-year benefit period. When that policy owner later moves into a skilled nursing facility, they only have 3 years left on their benefit period before the insurance benefits end.

If the policy had two pools of money, the policy owner could receive 5 years of benefits at home and still have up to 5 more years available in an assisted living facility or nursing home. This policy with 2 pools of money could provide up to twice the amount of money to the policy owner as the policy with only one pool of money. It appears that companies that issue reimbursement policies generally have one pool of money from which the client can draw against. Long-term care insurance policies issued by GE Capital, John Hancock, Life Investors, and New York Life are examples of policies that usually have a single pool of funds from which benefits are paid. Lincoln Benefit Life is an example of a company that has two pools of funds.

Each of the above contract terms are less obvious and may not be adequately pointed out to the customer by the insurance company representative, but are essential in making a fair and accurate comparison of two or more policies.

### **SERVICE CENTER... AT YOUR SERVICE!**

**800-945-WSBA or 206-443-WSBA**  
*questions@wsba.org*

We're here to serve you!

The mission of the WSBA Service Center is to respond promptly to questions and requests for information from our members and the public.

Call us Monday through Friday, from 8:00 a.m. to 5:00 p.m., or e-mail us at *questions@wsba.org*.

Assistance is only a phone call or an e-mail away.

## End-of-Life and Healthcare Decisions for the Incapacitated by Their Legal Fiduciaries

by Michelle Graunke

As attorneys for guardians, incapacitated persons, and family members of incapacitated persons, we often face unusual and difficult issues. One of those issues is making treatment and end-of-life decisions for incapacitated persons. Making this type of decision is tough enough in any situation, but it is made even more difficult in a guardianship where it is likely that the ward has not executed a health care directive or communicated with family about his or her wishes and does not have the present ability to communicate about his or her preferences. The decision is even more difficult if the guardian is not a family member, if the guardian has a different opinion from one or more family members, or if there are clashes of cultural or religious preferences and beliefs between family members.

Unfortunately, the guardianship statute and case law do not give us concrete answers. The guardianship statute states that a guardian has the duty to "assert the incapacitated person's rights and best interests." RCW 11.92.043(4). The guardianship statute also provides that a guardian is authorized to "provide timely, informed consent for health care of the incapacitated person." RCW 11.92.043(5).

So, how do we determine the "rights" the guardian is supposed to "assert"? And whose "rights" prevail: those of the incapacitated person or those of family members? And how does a guardian determine the best interests of an incapacitated person who has not executed an advance directive or named a health care attorney-in-fact?

It seems clear that the rights of the incapacitated person should prevail. Our legislature has determined that "adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn in stances of a terminal condition or permanent unconscious condition." RCW 70.122.100. In keeping with that finding, a *competent* person has a right to make a written directive regarding the withholding or withdrawing of life-sustaining treatment.

But what rights does an incompetent person have? Our Supreme Court has found that "an incompetent's right to refuse treatment should be equal to a competent's right to do so." *In re Grant*, 109 2d 545, 553, 747 P.2d 445 (1987).

### How do we make that happen?

*Grant* involved a 22 year old woman, Barbara, with an incurable neurological disorder. Barbara's condition had deteriorated to the point where she could not walk, talk, or feed herself. She had started life as a normal child, but the disorder began presenting itself when she was five. By the time the court became involved, her mental age was esti-

mated to be between two and six weeks. Her condition had affected her brain functions so that her cardiac and respiratory systems were impaired. Barbara's physicians agreed that she was in the latter stages of her disorder, with no hope of improvement and that there was no treatment that could improve her condition.

Barbara was no longer capable of expressing how she felt about her life, and her incapacity had started at a young age, such that she had not ever explicitly expressed her desires regarding the use of life-sustaining medical treatment.

However, her mother, who was also her guardian, believed that Barbara would not want to efforts made to sustain her life. Her belief was based on Barbara's dislike of taking medication, being made to use a cane, having suction tubes used on her, and her dislike for the medical staff.

Barbara's mother wanted her daughter to die as naturally and peacefully as possible, and Barbara's family was in agreement. As guardian, Barbara's mother sought court authority to withhold life-support systems, even though she was not yet faced with the need to make that decision. The trial court denied the motion partly because it considered the action to be premature.

The Supreme Court had, in prior cases, already established that a person in an irreversibly comatose or persistent vegetative stage with no reasonable chance of returning to a sapient state has the right to have life-sustaining treatment withheld. *In re Colyer*, 99 Wn.2d 114, 660 P.2d 738 (1983); *In re Hamlin*, 102 Wn.2d 810, 689 P.2d 1372 (1984).

The issue presented by the *Grant* case was whether an incompetent person, in the advanced stage of a terminal and incurable illness and suffering severe and permanent mental and physical deterioration, *but who was not comatose*, also has the right to have life-sustaining procedures withheld.

The Supreme Court accepted direct review of the matter and reversed the trial court, holding that in the absence of countervailing state interests, a person (whether competent or not) does have that right.

The *Grant* court held that although the state's interest in preserving life *might* require lifesaving treatment of patients who have not consented to it being withheld, the state's interest "weakens considerably . . . if treatment will merely postpone death for a person with a terminal and incurable condition. Where the treatment required will be highly invasive and intrusive, the terminally ill individual's right to refuse treatment (or *have it withheld in his or her behalf*) must prevail." *Grant*, at 556, citing *Colyer*. (emphasis added.)

### How does this play out in “real life”?

My law firm recently represented a professional guardian for an incapacitated woman in a somewhat similar situation. She suffered from end-stage renal failure and required bi-weekly dialysis. She had not made any advance directives or spoken with her family about her end-of-life preferences while competent. Due to mental illness and dementia, she was no longer competent.

The woman did not understand why she needed dialysis and violently fought the treatment. Because of her resistance to the treatment, she had to be hospitalized for each treatment. She had to be tied to the bed and sedated almost to the point of being comatose. In the guardian's eyes, continuing to force the woman to undergo dialysis was tantamount to an involuntary commitment. It had clearly become an invasive and intrusive procedure for her.

When awake, the woman begged the guardian to “help her die.” At the facility where she resided, she refused food and medications. The woman's actions indicated that she did not want further treatments. It was also the opinion of several treating physicians that the dialysis should be discontinued because the burden exceeded the benefit. The court order appointing the guardian was clear that the guardian had the authority to terminate her treatment. And it seems obvious under *Grant* that the guardian could do so.

Because the woman's husband disagreed with this approach due to his religious beliefs (beliefs not shared by the woman), the guardian sought court direction as to its

authority to give a “no code” order and to withdraw the dialysis treatment. At the hearing, the commissioner directed the guardian to exercise its discretion as to code/no code status and as to the continuation of the dialysis treatment. The husband obtained an order staying the commissioner's order and filed a motion for revision.

At the hearing on the revision, the judge determined that this case was a matter of first impression and set the matter for trial. The judge specifically stated that he wanted the woman's doctors to personally appear and testify.

While the guardian still believed that it was the ward's desire to terminate treatment and that such action was in the woman's best interests, the guardian dismissed its petition because it did not want to bankrupt the family with legal fees. The woman died within several months.

This was an extremely tough case for all involved. Fortunately or unfortunately, we live in a time where the point of death can be prolonged enormously. We have not yet answered the basic questions in cases such as this: does prolonging death when a patient can no longer cooperate and when her treatment is being forcibly administered demonstrate a reverence for life, and is it in the person's best interest? This writer does not have an answer. It is entirely possible that, even if there had been an advance directive, the guardian in this case may not have been able to implement it, given the depth of the husband's religious beliefs. This case is a reminder to all of us that advance directives and health care powers of attorney should be executed while a person is still competent and able to do so.

---

## Health Care Decisions for the Incompetent in Washington State

by Jeff Crollard

Making health care choices for another person is an awesome responsibility. Imagine, for the moment, someone else deciding whether you will receive chemotherapy, whether your food will be pureed, or whether you should get CPR. You would want them to make choices that you would if you could.

Fortunately, the law governing substitute (or surrogate) health care decisionmaking—the terms used for deciding on behalf of an incapacitated person—is consistent with this normal human desire to have our individuality respected. Two basic rules govern all substitute health care decisionmaking:

1. Choose what the incapacitated person (the patient), with his or her individualized preferences, would want done if he or she were competent to decide; and
2. If, and only if, this cannot be determined, make a decision that you believe is in the person's “best interests.”

These rules apply throughout the state to *all* substitute decisionmakers: guardians, holders of durable powers of attorney, and authorized, close family members, regardless of the health care setting. RCW 7.70.065(3); *In re Ingram*, 102 Wn.2d 827, 840-42 (1984). We should resist the natural temptation to turn too readily to the second standard—deciding what *we* think is best for the person—without first struggling to discern the person's wishes according to the first standard.

A threshold issue that triggers the surrogate's authority to act is the finding of incapacity or incompetence in the principal / ward. An obvious (though very basic) critical

---

question is: *how is "incompetence" or "incapacitated" defined?* RCW 7.70.065 cross-references the guardianship statute's definition of "incapacity" or "incompetence." The terms are broadly defined:

- a) "incompetence by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental incapacity," RCW 11.88.010(e); or
- b) incapacitated due to "a significant risk of personal harm based upon a demonstrated inability to adequately provide for nutrition, health, housing, or physical safety." RCW 11.88.010(1)(a).

The first definition is somewhat circular and potentially problematic. For example, a person may have a mental illness, but have the condition under control through medication or counseling. The best way to interpret this first definition is to read it in light of the phrase at the end of the sentence "... or other mental incapacity." Thus, the condition must cause a "mental incapacity." While "mental incapacity" is not defined, when read in the context of RCW 11.88.010(1)(a), it is most reasonably interpreted as an incapacity that causes a "significant risk of personal harm."

The second definition of incapacity is also troubling if read too literally. Arguably, some *physically* disabled persons may not be able to "provide for nutrition, health, or housing," e.g., to cook their own meals or to administer medications. However, they can direct others to do so, and thus would not be considered incapacitated.

A person who is incapacitated in some ways may still have the capacity to make decisions of some kinds. If there is a "limited" guardianship in place, it must delineate the remaining areas of competence and retained decisionmaking. RCW 11.88.095(3). In all cases, caregivers should look for areas of remaining capacity and involve the patient to the maximum extent possible. In long-term care facilities, this is an express requirement. See e.g., RCW 74.42.040; RCW 70.129.140.

Those who have experience in the guardianship field have no doubt encountered the question - *who determines whether the person is incompetent? Must it be determined by a doctor?* In general, all adults are presumed to be competent unless it is determined otherwise. *Foundation for the Handicapped v. DSHS*, 97 Wn.2d 691, 694 n.2 (1982). **However, for healthcare decisions, the law does not require that the determination of incompetence be made by a court.** In fact, the law clearly implies that for purposes of health care consent, the health care provider can decide whether a patient is competent.

One reason for this is the practical one: health care providers are not supposed to provide care without informed consent. RCW 70.050. By implication then, they must first determine whether the patient *can* consent to the care.

But who makes this determination—a doctor, nurse or social worker? RCW 7.70.065(2) implies that the determination of incompetence is made by the patient's doctor. The statute says: "If the physician seeking informed consent for proposed health care of the patient who is not competent to consent makes reasonable efforts to locate and secure authorization ... " The nursing home statute, RCW 74.42.040, states that each resident and guardian, if any, shall be "fully informed by a physician about his or her health and medical condition ...," which implies that the doctor first determine whether the resident/patient can understand the information. The nursing home regulations do not specify who decides whether a resident is incompetent, instead saying that the facility determines this according to state law. See WAC 388-97-055(5).

In practice, for purposes of health care consent, a health care professional (preferably with the involvement of the patient's doctor) makes the initial determination of competency. In the event of a dispute, the issue of competence should be brought to a court in a guardianship proceeding.

It must also be kept in mind that except in an emergency, or where the patient chooses *not* to be informed, care providers are permitted to provide care *only* with the informed consent of the patient or the authorized substitute decisionmaker. RCW 7.70.050. The patient has the right to be informed of his or her health status, treatment options, and the consequences of treatment choices. Informed consent is consent after the following has been explained, in language the patient can understand:

- Current and expected medical condition
  - Proposed treatment
  - Anticipated results
  - Recognized possible alternative treatments
  - Recognized possible serious risks, complications, and benefits from the proposed and alternative treatments, and
  - Consequences of non-treatment
- RCW 7.70.060.

In practice, studies and anecdotes report that an alarmingly high number of patients receive treatment without informed consent. One recent out-patient study, based on 1,057 audio taped medical encounters, concluded that in only 17% of the cases was there even rudimentary, basic informed consent, and in just 9% of the cases was there complete informed consent (similar to the criteria above).<sup>1</sup> These numbers should give us pause.

This brings us to the crux of the issue. Assuming that a situation exists where an incapacitated person is in the care of a legal fiduciary: (1) what weight do we give to statements—current, express wishes—made by the incapacitated person?; and, how do we know what an incom-

petent person would want done if he or she were competent to decide? Those questions have been answered by *Ingram*, a landmark guardianship case adjudicated in the Washington Supreme Court.

In *Ingram*, the guardian of a mentally ill woman sought court authorization for a laryngectomy to surgically remove the incapacitated person's cancerous vocal cords. The woman (called the "ward" in older guardianship cases) had a long history of delusion and paranoia. She had short-term memory loss and could not retain relevant information to evaluate her medical options. She thought her throat problems were caused by bad air in her apartment.

She was, however, described as "alert," had fluent speech, and generally was "goal directed." She repeatedly said she wanted radiation treatment, not throat surgery, even if surgery was necessary to avoid death. Radiation, according to her doctors, would cause significant pain, and surgery gave her by far the best chance of survival, but would leave her voiceless. The doctors acknowledged, however, that the patient's cooperation was important for successful post-surgery rehabilitation.

The *Ingram* court held that the guardian must try to choose what the particular incapacitated person would do if he or she were competent and was aware of all the circumstances, including the effect of one's incompetence. The *Ingram* court recognized that there are degrees of incompetence, with some individuals in a coma and unable to reason or communicate, and other incompetent individuals able to communicate and, to some extent, understand their condition and options.

In making a decision for another person, such as the ward in *Ingram*, the *Ingram* court ruled that the decisionmaker should try to consider all the factors that would influence the incapacitated person's wishes about proposed treatment:

These would include the ward's prognosis if she chose no treatment; the prognosis if she chose one treatment over another; the risk of adverse side effects from the proposed treatments; the intrusiveness or severity of the proposed treatments; the ability of the ward to cooperate and assist with post-treatment therapy; the ward's religious or moral views regarding medical care or the dying process; and the wishes of family or friends, if those wishes would influence the ward's decision ....

Finally, the ward's expressed wishes must be given substantial weight, even if made while the ward is incompetent .... The weight to be accorded the ward's preferences should ... be influenced by the extent to which the ward understands her problem and the possible treatment methods ... If the

ward, despite her inability to understand her needs, is persistent and determined in her preferences, it should be given additional weight in the determination.

*Ingram*, *id.* at 840-42.

The wishes of an incompetent person may be expressed verbally or through behavior. Expressed wishes do not have to be followed slavishly, but they are clues to what is wanted by the person, and must be given substantial weight. For example, an ambulatory, incompetent nursing home resident with dementia, who no longer appreciates the dangers of car traffic, would not really want the facility's door opened onto a nearby busy street even though she repeatedly stands "dead-ended" at the exit door. However, her behavior may indicate that she is bored, there are insufficient activities in the facility, she wants to walk outside, or this facility is not meeting her needs.

An obvious follow up question then is – being that *Ingram* was a guardianship case, does it apply to attorneys in fact named in powers of attorney or other decisionmakers? Generally yes. *Ingram* interpreted restrictions on a guardian's authority under RCW 11.92.043(5). The durable powers of attorney statute cross-references and incorporates these restrictions. RCW 11.94.010(3). Moreover, given the admonition in RCW 7.70.065(3) that substitute decisionmakers must try to choose what the particular person would want done, the lessons of *Ingram* are applicable to *all* substitute decisionmakers: guardians, DPOAs, and family members.

What one can then take away is that where health care decisions are concerned, the law is unclear and unsettled in some respects. While some clear rules can be found in case law or statutes, other guidelines require extrapolation or are based on "best practices." Generally speaking, there can be no denying that if the incapacitated person is able to articulate his or her own wishes, those wishes must be given substantial weight under *Ingram*. In the absence of instructions from the incapacitated as to his or her wishes pertaining to health care decisions, the surrogate appointed to speak in the stead of the incapacitated (guardian or attorney in fact or other) has a duty to make a choice that the incapacitated person would have made were he or she competent to decide. If it cannot be determined how the incapacitated person would have acted, then and only then should the surrogate make a decision based on the "best interests" of the principal / ward. These rules are deceptively simple to state. In the real world the application of these rules is difficult at best.

<sup>1</sup> Braddock, et al, *Informed Decision Making in Outpatient Practice: Time to Get Back to Basics*, JAMA, Vol. 282(24), 22/29 December 1999, pp. 2313-2320.

At its May meeting, the Elder Law Section Executive Committee unanimously adopted a position in support of an increase in the Medically Needy Income Level from \$571 to the Federal Poverty Guideline level of \$775. Trustee Peter Greenfield was asked to draft a statement for approval by Section chair William Hickman. Here is the statement:

## Statement Supporting an Increase in the Medically Needy Income Level

Thousands of poor elderly and disabled Washington residents who depend on Medicaid for essential medical care, but who don't get it automatically, face hard choices. Some are forced to choose between food and medical care; others are forced to accept nursing home or other institutional care instead of getting care at home.

If they apply for Medicaid under one of the State's "Medically Needy" programs, these people are expected to cover the costs of food, clothing, shelter and other expenses not covered by Medicaid on an allowance of \$591 a month. The \$591 is based on the State's "Medically Needy Income Level" or "MNIL" of \$571, plus an additional \$20 of "disregarded" income. Many can't do it.

By contrast to the \$571 MNIL, the 2004 Federal Poverty Guideline for one person is \$776. Following that Guideline, the personal needs allowance of a single person receiving in-home care under the State's COPES program is set at \$776. That allowance is required to be set based on "a reasonable assessment of need."<sup>1</sup> An MNIL based on the Federal Poverty Guidelines would provide significant relief for many of those who need it most.

The Medicaid rules are complicated. Two examples illustrate the effects of the current MNIL:

A is an elderly woman who lives alone. Her only income is Social Security of \$750 a month. Her rent is \$500 a month, and she needs medications that cost \$300 a month. When she applied for Medicaid, \$571 of her monthly income was allocated for food, clothing, shelter and other non-medical expenses. Another \$20 was disregarded. So out of her \$750 income, only \$591 is available for non-medical expenses. The rest – \$159 a month – is considered "excess income," available for medical expenses. She applied for Medicaid for a six-month period. She will not be eligible for coverage until she has incurred \$954 (\$159 x 6) in medical expenses. If she spends \$300 a month on her medications, her Medicaid coverage should start some time during the 4<sup>th</sup> month of the six month period. But during the first three months, she will only have \$450 left each month after she pays for her medications. This will not even be enough to pay her rent.

- If the MNIL were based on the \$776 Federal Poverty Guideline, this woman would have no "excess income," and would be eligible for Medicaid coverage for the full six-month period.

B is a disabled man who needs the level of care provided in a nursing home. He has less than \$2,000 in savings, and is eligible for Medicaid-funded nursing home care. He wants in-home care so that he can remain in his apartment. His rent is \$500. He would be eligible for in-home care under the COPES program, except that his monthly income is \$1,800 a month. He is eligible instead for in-home care under the new Medically Needy In-home Waiver program. For that program, as for the COPES program, he must pay all of his income toward the cost of his care, except for a personal-needs allowance and the disregarded \$20. The personal-needs allowance for the COPES program is \$776 (based on the Federal Poverty Level). The personal needs allowance of the Medically Needy In-Home Waiver program is based on the MNIL – \$571. (The Department of Social & Health Services sought federal permission to allow a personal needs allowance of \$776 for the Medically Needy In-Home Waiver program, but were told that, because it was a "medically needy" program the allowance must be no higher than the MNIL. To increase it, the State must increase the MNIL.) After B pays his rent, he will be left with \$91 a month for food and all other expenses not covered by Medicaid. Unless he can get by on that amount, he will be forced to leave his apartment and accept care in another setting, such as a nursing home, where all his needs are met. (Ironically, such care will be much more costly to the State.)

- If the MNIL were based on the \$776 Federal Poverty Guideline, he could get in-home care and have \$226 left after paying his rent to use for food, clothing and other expenses not covered by Medicaid. His chances of staying out of an institution would be much better.

The Elder Law Section of the Washington State Bar Association call on the Secretary of the Department of Social and Health Services to increase the Medically Needy Income Level to correspond to the Federal Poverty Guidelines, and call on the Governor and Legislature to seek and provide any appropriations needed for this purpose.

<sup>1</sup> 42 C.F.R. § 435.735(c)(1).

For further information about this statement, please contact William S. Hickman, president, WSBA Elder Law Section, 3400 188th SW, #484, Lynwood, WA 98037, (425) 744-5658.