



Elder Law Newsletter

**Volume 5
Number 3
Summer 2002**

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Medicaid discrimination in long term care

By Jennifer L. Wright

Nursing homes, adult foster homes, residential care facilities (RCFs), and assisted living facilities (ALFs) may decline to accept any Medicaid residents. However, when a facility accepts Medicaid for any resident, it becomes subject to state and federal Medicaid rules. One such rule is that facilities generally may not discriminate against a resident because he or she applies for, plans to apply for, or receives Medicaid benefits.¹ Elder law practitioners soon learn that some facilities engage in subtle and sometimes not-so-subtle forms of Medicaid discrimination. Practitioners must be prepared to counsel clients and family members about how to deal with these issues.

The first decision point comes when the client seeks admission to the facility. Some facilities—particularly ALFs—require an agreement, by the client or his/her agent, not to apply for Medicaid for a period of time (“duration of stay agreement”). This agreement may be sought in writing; more commonly, it is communicated orally. Some facilities ask family members to agree that they will be personally responsible for paying for the client’s care (“responsible party agreement”).

Federal and state laws clearly make such requirements by nursing homes illegal.² State rules that govern other long term care facilities are less clear. Adult foster homes are permitted by state rules to refuse admission based on Medicaid as source of payment in some circumstances.³ The state rules governing RCFs and ALFs are silent about Medicaid discrimination in admissions.

Medicaid coverage of long term care in adult foster homes, RCFs, and ALFs is provided in Oregon through a waiver to the federal Medicaid rules, which limits Medicaid coverage of long term care to nursing home care. Any federal nursing home rules that have not been specifically waived apply to waived care facilities. Where the state rules are silent, the federal prohibition on Medicaid discrimination in admissions should apply.⁴

When a care facility other than an adult foster home indicates that it will not admit an individual unless s/he (or an agent) accepts a duration of stay agreement, that person must weigh the options. If there are funds for a period of private pay, if there is urgency to place the person, and/or if there are few or no other acceptable placements, the individual may choose to acquiesce. In other situations, the individual may refuse to comply, may ask his/her attorney to discuss the legal issues with the care facility admin-

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istrator, or may file a complaint with SPD. It is important to advise clients that choices made at this point do not foreclose subsequent choices.

A second decision point arises when the resident applies for Medicaid. If such application comes before the duration of stay period ends, some facilities may respond by putting informal but intense pressure on the resident and/or family members not to apply. Facilities may invoke the duration of stay agreement. Such agreements are generally not legally enforceable. Some facilities are aware of this fact, and will not go beyond informal pressure. Other facilities may seek to enforce such agreements by attempting to transfer the resident.

All care facilities in Oregon are subject to rules that limit their rights to transfer residents.⁵ Facilities may only transfer a resident for one of a list of approved reasons. Failure to pay for care is a listed reason. However, the rules make it clear that nursing homes cannot transfer for failure to pay if payment for current charges is available from Medicaid.⁶ Again, the rules for other kinds of facilities are silent (except that an adult foster home may not transfer a resident because he/she applies for Medicaid, even if the home could have refused admission on that basis).⁷ The federal nursing home rules therefore should apply to waived care as well.

A care facility is more likely to assert behavior problems or an inability to provide needed care as a pretext for transfer. For this reason, it may be useful to wait to apply for Medicaid until the resident has been in the facility long enough to clearly establish

her/his care needs. At that point, the facility will need to show a change in those needs sufficient to justify the transfer.

If a client wishes to apply for Medicaid despite a duration of stay agreement, there is no legal barrier to doing so. Clients need to be aware of this fact when they make their decisions. Such an action can have other repercussions in the long-term relationship between the resident and the facility. On the other hand, a resident who is well-informed as to his/her legal rights, and with zealous and capable representation, is less vulnerable to informal sanctions by the facility.

A third decision point comes when family members are confronted with demands from a care facility to pay for care as responsible parties, either in addition to Medicaid payment, or for care which was not paid and which is not covered by Medicaid. This demand may come after the resident has passed away or moved out of the facility. Since responsible-party agreements cannot legally be a condition for admission, there was no consideration received by the relative who signed such an agreement, and therefore there is no enforceable contract.

Clients have many values and goals, and not all seek to maximize their financial gain above other goals. For some clients, paying privately on a temporary or permanent basis may be the best choice. Some individuals may choose to comply with a demand or condition that a facility has no legal right to impose. However, all clients should know their rights and the limits of what long term care facilities may legally do, and should be supported in asserting those rights when that is their choice. All elder law attorneys should continually seek to educate elders, their families, and long term care facilities about the requirements of the law, and should continually press in every way consistent with zealous, ethical representation, for care facilities to comply fully with the law.

Footnotes

- 1 For example, OAR 411-070-0010(2)(b): "The facility shall not discriminate based on source of payment" (nursing homes).
- 2 42 CFR 483.12(d)(1): "The facility must (i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and (ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits." OAR 411-070-0010(2)(c): "The facility shall accept Medicaid payment as payment in full. The facility shall not require, solicit or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a 'responsible party.'" 42 CFR 483.12(d)(2): "The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility." OAR 411-070-0100(2)(d): "No applicant shall be denied admission to a facility solely because no family member, relative or friend is willing to accept personal financial liability for any of the facility's charges."
- 3 OAR 411-050-0435(1)(d): "The provider who elects to provide care for a Medicaid recipient is not required to admit more than one Medicaid recipient."
- 4 State rules also provide that facilities cannot require applicants to waive any rights as a condition of admission. OAR 411-085-0310(19) & (20) (nursing homes); OAR 411-050-0435(3) (adult foster homes); OAR 411-055-0170(2) (residential care facilities); OAR 411-056-0030(b) (assisted living facilities).
- 5 42 CFR 483.12(a)(2), OAR 411-088-0000 to 0080 (nursing homes); OAR 411-050-0447(11)(a)(A) (adult foster homes); OAR 411-055-0190 (residential care facilities); OAR 411-056-0020(1) (assisted living facilities).
- 6 42 CFR 483.12(a)(2)(v); OAR 411-088-0020(2)
- 7 OAR 411-050-0435(1)(d). However, an adult foster home may terminate its Medicaid contract with the state, and cease accepting Medicaid for any resident, with only 30 days' notice.



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Resolving problems in long term care facilities

By Todd Logan

Long term care (LTC) facilities are an uncomfortable arena for many attorneys. Facilities confusingly mingle concepts and terms from the realms of law, medicine, and social services. To their discomfort, lawyers find that many problems clients experience in LTC facilities don't have a ready legal solution, even when they entail clear-cut contractual breach or personal injury. Still, with an awareness of the regulatory standards and complaint resolution mechanisms available for LTC facilities, attorneys can play a valuable role in assisting their facility-bound clients to receive quality care. Use of these mechanisms also allows the attorney to begin to assemble a written record to support legal action, if a less formal resolution proves unattainable.

In assisting a facility resident, a lawyer should first spend the time to clarify a client's specific objectives. The primary interest of long term care clients is seldom to maximize their monetary recovery, but rather to correct the problem quickly and permanently. Attorneys should also familiarize themselves with the regulatory structure for long term care. Oregon licenses four different types of LTC facilities, each with separate administrative rules that define standards for the building, the care, and the services. While the rules differ, all long term care residents are provided with a series of basic rights and protections, including freedom from abuse, protections against involuntary transfers, limitations on the use of restraints, and a resident bill of rights which guarantees free availability of records, participation in care planning and medical decision-making, open access to visitors, freedom from retaliation, and other rights.

Keep client's dependency in mind

Remember that residents are absolutely dependent on the facility staff for a spectrum of deeply intimate services, which range from personal hygiene to life-sustaining medical treatment. Because of this dependence, fear of retaliation is a factor for one hundred percent of care facility residents, even those placed among providers of high quality and good intent. Though retaliation is against the law, as a practical matter it is virtually impossible to prevent, and often difficult to prove after the fact. Residents

know there are a thousand ways to subtly withdraw services and courtesies, and to send a message that a resident had better toe the facility line. A bullheaded approach or an aggressive display of legal muscle can result in a client experiencing sleepless nights or worse. It may also be less effective for resolving the problem. Starting informally within the facility is usually the best option for resolution.

For instance, all long term care facilities must have policies to resolve grievances. Review whatever mechanism has been set forth in facility policy. These systems are seldom complex, and can occasionally result in speedy resolution. Grievance policies are not self-executing: Complaints must be followed up to prevent the initial response of "We're looking into it" from ossifying into the final response. Remember to propose a specific remedy for each problem you identify when filing a grievance, so that the facility understands you are seeking more than an opportunity to vent.

Sometimes group pressure succeeds where an individual approach fails. Many facilities have resident councils to provide the residents a voice in the running of the facility. A problem experienced by one person is often an issue for other residents as well, and an unresponsive facility may be more flexible if ten voices join together with the same concern. Resident councils can be particularly useful in resolving food and maintenance complaints, since these are problems which usually affect the entire resident population.

For specific care-related problems, such as the failure to provide scheduled medications, a check of the resident care plan is always wise. Despite mandated regular reviews, care plans can become outdated, and often a service which a resident assumes he or she will receive is not included in the care plan which guides the staff. A care plan review provides a non-confrontational setting in which the focus of the discussion is the shared goal of quality care. It allows a facility to plan against identified problems, and facility response tends to be better when planned rather than improvised. If problems continue after arrival at an appropriate care



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Resolving problems in long term care

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plan, the problem is probably performance-based rather than plan-based, and renewed efforts at resolution can be directed at poor execution.

Don't hesitate to seek resolution up the facility's corporate chain of command. In today's corporate-dominated long term care arena, less and less decisionmaking is left in the hands of local administrators, and more is set as a matter of corporate policy—which does not mean that a parent corporation is always unwilling to make adjustments in an individual case. Let them know you are aware of the rules and available options. They don't want adverse regulatory scrutiny, nor do they want to lose lucrative private paying clients.

Ombudsman offers help

If problems can't be resolved promptly, assistance from outside the facility may be the next step. The Office of the Long Term Care Ombudsman is a valuable resource for resolving facility complaints. The ombudsman has a statutory mandate to investigate and resolve complaints that affect the health, safety, welfare, and rights of facility residents. Many of the steps to investigate or resolve a claim for which an attorney might otherwise have to charge a client, can be provided by the ombudsman free of charge. The agency operates mostly with a network of trained and certified volunteers who are assigned to specific facilities and visit regularly to make their services easily available to residents. In complex cases or unassigned facilities, professional staff may respond. Certified ombudsmen can be particularly useful in providing regular follow-up to assure that problems do not reemerge. The Office of the Long Term Care Ombudsman accepts confidential complaints. Its toll-free number (800.522.2602) must be posted in all long term care facilities.

Regulatory remedies

If these methods are unfruitful, resolution can be sought through the regulatory program. The Oregon Department of Human Services, Seniors and People with Disabilities Program (DHS/SPD) administers Oregon's long term care system. The agency's statewide licensing unit (the Client Care Monitoring Unit) responds to regulatory concerns. Adult foster homes are licensed and inspected at the local level rather than by CCMU, and the foster home licenser is usually found in the local branch office of SPD or the Area Agency on Aging. SPD also runs the adult protective service program to respond to cases of harm and abuse. Protective service response is handled according to regulatory time frames, and a complaint will eventually result in a written report that summarizes the investigation findings. In addition to the possibility of a civil penalty, the written conclusions and fact-finding of a protective service investigation can be a valuable tool for attorneys to assess whether the resident has a legal cause of action.

The final stages of problem resolution are follow-up and follow-through. The long term care world is seldom static. Resident conditions can change quickly, as can a facility's quality, in light of frequent turnover of staff and ownership. The price of quality care is constant vigilance.

Sources of information for clients who seek LTC

It is a good idea to have some information on hand to give to clients who ask for advice on finding long term care.

Medicare has some helpful publications which one can view, print, or order online, or obtain by calling 800.633.4227. One is *Guide to Choosing a Nursing Home* (publication number 02174) and another is *Choosing Long Term Care* (publication number 02223).

The Medicare Web site at www.medicare.gov also has Nursing Home Compare, a database that lets you search for Medicare or Medicaid certified nursing homes by state, county, city, ZIP code, or name and then compare statistical data on each facility. It provides information on nursing home and resident characteristics, staffing, and the results of inspections. All data are compared to state and national averages.

The National Citizens' Coalition for Nursing Home Reform publishes an eight-page *Consumer Guide to Choosing a Nursing Home* that advises consumers on how to use Nursing Home Compare, what to look for on a visit to a facility, and how to get other expert advice. It is available on the Web at nccnhr.newc.com/public/50_155_3274.CFM. and from NCCNHR at 1424 16th Street NW, Suite 202, Washington, DC 20036 (Phone: 202.332.2275; Fax: 202.332.2949).

Oregon's Department of Human Services, Seniors and People with Disabilities publishes a helpful consumer guide to assisted living and residential care facilities. It is available on the Web at www.sdsd.hr.state.or.us. The booklet includes information on how to evaluate a facility and what questions a person should ask about services and costs.

The Oregon Health Care Association, a trade association for long term care providers, has *Oregon Resource Guide for Older Adults and Their Families* on its Web site at www.ohca.com. Among resources listed are assisted living communities, nursing facilities, and residential care facilities.

Area Agencies on Aging offer free assistance to older adults and caregivers, and can provide information on finding long term care. Each county has an AAA office, and a list of offices can be found on the Web site of SPD at www.sdsd.hr.state.or.us/community/county.htm.

Long term care insurance helps with high care costs

By Verena Lewandowski

While most people realize that long term health care can be extremely costly if the appropriate planning isn't done, few have made provisions for that very real possibility. For every happily retired 65-plus couple, chances are high at least one spouse will eventually require long term health care. Yet in a 1996 study by the National Council on Aging, nearly 40 percent of all respondents said they planned to deal with the need for long term care if and when it arose. When an individual or couple delays planning for long term care, the financial impact can be devastating. Nationally, the cost of long term nursing care has risen to an estimated \$61,000 per person annually. According to the 1994 U.S. Senate Special Committee on Aging, failure to plan for this need is the number one cause of poverty among the elderly.

Long term care is defined as medical, social, and/or personal care services required by a person with a chronic illness or disability over a long period of time. These services are designed to help people maintain their independence, and may be provided in the home, community, alternate living facilities, or nursing home.

Who provides long term care?

The Administration on Aging has reported that more than seven million Americans are caregivers who provide unpaid assistance to older spouses, parents, neighbors, or friends who live in the community. What happens when a person's care needs surpass what friends and family are able or willing to provide?

Health insurance, Medicare provide only short-term help

Many people mistakenly believe their traditional medical insurance or government agencies provide for long term care. Most medical insurance plans cover only hospital stays and doctors' bills, not long term custodial care. Similarly, Medicare focuses on short-term medical needs, covering only two percent of all nursing home care costs and 15 percent of all home health care services on an annual basis, according to the Centers for Medicare and Medicaid Services (CMS).

People suffering from a progressively debilitating chronic condition such as arthritis, diabetes, Parkinson's, or Alzheimer's Disease, and elders living on their own and needing assistance with one or more of the basic activities of daily living (bathing, dressing, ambulating, toileting, etc.), cannot rely on Medicare to pay for that assistance.

Medicaid not always the answer

To qualify for coverage under Medicaid, a patient must first "spend down" most of his or her assets and income. State laws vary on how much money and other assets may be kept before a person qualifies for Medicaid. Generally, couples can own only modest resources, including a home and car, and receive a limited monthly income before Medicaid will pay their bills. Single persons are allowed even less than couples.

Certainly, most people do not want to deplete money and possessions that took a lifetime to acquire. The financial implications for a surviving spouse could be tremendous. And many parents who dreamed of leaving their children a legacy must watch their assets deplete, adding to an already stressful situation.

Long term care insurance is another option

Long term care insurance presents another answer. It reimburses many expenses, such as costs of nursing homes, assisted living

facilities, and in-home health care. Additionally, it gives the policy owner options on when, where, how much, and what type of care is received.

The average cost for this type of protection ranges from \$1,600 to \$1,700 annually. In general, individuals who buy a policy in their late 40s and 50s will pay lower premiums than those in their 60s and 70s.

Important questions

Individuals considering long term care coverage should ask the following questions:

- Are policy reimbursements protected against taxes? A "tax-qualified" policy provides tax-free payments. Benefits received from a "non tax-qualified" policy may or may not count as income. The federal government has not yet made a determination on this issue.
- What is the financial stability of the company offering the policy? A.M. Best, Standard & Poor's, Moody's, and Fitch (formerly Duff & Phelps) provide ratings for most insurance companies. These ratings analyze the financial health of insurance companies. According to *Kiplinger's Retirement Report* (December 1998), an individual should look for long term care insurance companies that have top ratings from at least three credit rating agencies. The public library can provide information on how these services have rated various companies.
- Is an inflation protection benefit available? As costs escalate, a policyholder will want to keep pace with inflation, to ensure top-quality care many years into the future.
- What type of care is covered? Long term care can encompass a variety of types of health care, from nursing homes to adult day care centers, assisted living facilities, and in-home health care. For adequate

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Claiming long term care benefits

How the process works at a typical company

When you learn that you may require long term care services, call the agent who sold you the policy. He or she will walk you through the claim process and help answer questions that might come up.

Your agent will refer you to the insurance company's Long Term Care Administration Office, where a representative will ask questions about your condition and long term care services received to date. The claims representative will explain policy benefits, qualifying expenses, and the claim kit, which the company will mail to you. The kit includes information regarding the long term care claims process and the in-person benefit eligibility assessment. An "Authorization to Obtain Information" form in the kit must be completed and returned at this time.

Face-to-face contact

The claims representative may determine that an in-person benefit eligibility assessment (BEA) is necessary to evaluate the need for long term care. A local licensed health care practitioner will conduct the BEA, and will schedule an appointment within two business days of the intake call.

Claim Review

Under Federal and company requirements for tax qualified LTC policies, you are eligible for benefits when a licensed health care practitioner has certified that within the last 12 months you have met the requirements for being chronically ill. The claims representative must also determine that such certification has been or can be made. The claims representative evaluates the information on the claim and details provided in the BEA on an individual basis. Additional medical information may be needed to reach a claim decision.

Claim Decision

When the claims representative has determined that you meet the requirements for long term care and have been certified, he or she will communicate the decision directly to you. Your insurance agent will also be notified.

LTC insurance Q&A

Verena Lewandowski, author of the page 5 article on long term care insurance, responds to some questions.

Q. Who is a candidate for long term care insurance?

A. Long term care policies are well suited to those who have the most to lose if long term care needs arise. This generally includes most families with middle and high net worth.

You should *not* buy long term care insurance if:

- You can't afford the premiums
- You have limited assets
- Your only source of income is a Social Security benefit or Supplemental Security Income (SSI)

You should *consider* buying long term care insurance if:

- You have significant assets and income
- You want to protect some of your assets and income
- You want to pay for your own care
- You want to stay independent of the support of others

Additional considerations:

- Women tend to outlive men, which makes them more likely to need long term care services. In fact, according to CMS, women represent 75 percent of the nursing-home population.
- Children of aging parents may want to consider purchasing coverage for their parents. If long term care services are required, it can enable children to ensure quality care for their parents, as well as avoid the time, cost, and emotional demands of caring for their parents themselves.
- Married couples should consider long term care insurance that includes a home health care benefit. If one spouse needed care, the home health care benefits would allow the healthy spouse to keep the other spouse at home. In other words, they can supplement care.
- Finally, those with a family history of debilitating illnesses or diseases, such as strokes or Alzheimer's disease, should consider long term care coverage.

Q. What are current costs of LTC in our area?

A. Nursing homes cost an average of \$50,000 to \$70,000 in this area depending on the type of care that is provided. Around-the-clock in-home nursing care can cost substantially more. Foster care or care in the community can range on average from \$24,000 to \$40,000 a year.

Q. What options do LTC policies offer?

A. Insurance policies may vary as to:

- Types of services covered: skilled nursing care, alternate living facilities, custodial care, home health care
- Amount the policy pays per day for each type of service (Can range from \$50 per day to \$250 per day)
- Length of time benefits last for each type of service (three years, six years, lifetime)
- Waiting period before benefits begin (commonly 90 or 45 days)
- Adjustment for inflation
- Guaranteed renewal
- Waiver of premiums while benefits are being claimed

Editor's Note: The Senior Health Insurance Benefits Assistance program (SHIBA) publishes *Oregon Long Term-Care Insurance: Companies & Consumer Tips*. The booklet, which includes information on the State of Oregon's legal requirements, is available on the Web at www.oregonshiba.org—or call 800.722.4134.

Some employers offer long term care insurance

By Cynthia L. Barrett

When clients come in to talk about estate or health care cost planning, they appreciate learning about cost-effective long term care (LTC) insurance plans. Often they are not aware that their employer, or a relative's employer, may offer a fairly inexpensive group LTC program.

Many large employers offer optional, employee paid, group LTC plans. These plans may feature less onerous medical underwriting criteria than individually purchased policies. Group LTC policies are portable; that is, the policy stays in place after the employee leaves the job, as long as the monthly premiums are paid by the employee or plan participant.

If a client is interested in long term care insurance and has access to a group plan through a job, a spouse's job, or a relative's job, then any individual plan being considered can easily be compared (in benefits, cost, and medical underwriting) to the group plan. In the future, the employer may drop a group long term care plan or go bankrupt and end the group, as with any employment-related benefit.

Because the typical group LTC plan costs the employer nothing (i.e., the premium is entirely employee paid), complete loss of the plan is unlikely unless the company goes out of business and all group benefits end. Group LTC plans offer "conversion" options, however, to permit individuals to continue coverage under the bankruptcy scenario.

New federal long term care insurance program

To get the flavor of a group plan, consider a visit to the excellent new federal long term care group plan Web sites. The Office of Personnel Management's Web site has "Frequently Asked Questions" and a premium calculator:

www.opm.gov/insure/ltc/index.htm. The insurance carriers' Web site has an overview of benefits, applications, and other information: www.ltcfed.com.

The new federal plan, which opened for early enrollment March 25, 2002, is the largest employer-based group LTC plan in the world, with more than 20 million poten-

tial plan participants. Although not all the plan materials are yet online, you can find the application and premium calculators for current federal and postal employees and annuitants, uniformed service members and retirees, and qualified relatives.

Current federal employees and members of the uniformed services will fill out a short-form medical underwriting application—a huge benefit—and their parents and spouses will fill out a more detailed medical history, with more restricted underwriting. Qualified relatives include parents, parents-in-law, and step-parents of living employees. Adult children of living employees or annuitants will also be eligible to apply. Each eligible person has an independent right to apply, and the employee or annuitant need not also apply. The program may be extended to other relative groups in the future.

When you meet with a client who is employed by the federal government or has a child so employed, you can suggest the client visit the federal Web sites for information. If the client does not have Internet access, you can go to the sites yourself, run off a premium calculator (all you need is the client's age), and provide the printout to the client at your next meeting. Although the federal plan will not offer all the bells and whistles of a privately purchased plan (i.e., only up to five years of coverage, potential of only 365 days of coverage for pay to unlicensed family members providing care in the home, etc.), the purchasing power of the huge group means that premiums are affordable. Private marketers of individually sold policies are bound to point out the limits of a federal option for a client, so have the client compare the federal group option with an individually marketed plan.

Oregon public employee access to group LTC plans

Senate Bill 979, passed during the 1997 legislative session, mandated that the Public Employees Benefit Board (PEBB) make long term care insurance available to state employees. The PEBB designed a plan, and began to offer it in 2000. Current state employees were offered guaranteed issue without medical screening during an initial



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Employer LTC insurance

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enrollment period. PEBB advises you to call 800.227.4165 for an enrollment packet from UNUM Provident, the provider.

My clients who currently work for the state of Oregon are reporting that different state agencies are doing LTC informational campaigns at different times. Spouses or domestic partners, parents, grandparents, adult siblings, or adult children of the employee may also qualify for participation in the PEBB group, after medical underwriting.

The Oregon Public Employees Retirement System (PERS) also began offering a group long term care plan recently to PERS retirees. The PERS plan does require the applicant to fill out a medical questionnaire. Spouses and "eligible dependents" can also qualify, after medical underwriting. PERS does not have a good informational Web site on its plan. PERS suggests that you call 800.227.4165 for an enrollment packet from UNUM Provident, the provider.

When clients come in who work for the state of Oregon, or are already PERS retirees, I show them the premium cost sheet for the PERS or PEBB plans and urge them to investigate the state group coverage.

Practice tip for lawyers with a Web site

I posted the two federal Web sites on the news section of my Web site, www.cynthiabarrett.com, in early April. My NAELA contacts around the country immediately noticed the posting, and started spreading the word. My clients (and their qualified relatives) appreciate the easy access to the federal Web sites from my news section.

How Medicaid views long term care insurance payments

By Steven A. Heinrich, Attorney at Law, Corvallis

A person may receive Medicaid even though he or she also has long term care insurance. Medicaid analyses of payments from an insurer may vary, depending on whether the policy was written to provide reimbursement for costs of care, or to pay a set benefit once the insured meets certain criteria, such as living in a nursing home. The words "reimbursement" and "benefit" can be significant in the Medicaid program. OAR 461-145-0440 defines reimbursement as "money or items provided specifically for an identified expense." If the payment is a reimbursement, the state may try to claim the funds, relying on a subrogation argument. However, OAR 461-145-0440(c) directs the Medicaid worker to count "reimbursements not used for the specific expense and reimbursements for items already covered by the benefit group's benefits as periodic or lump sum income."

If the payment is delayed for several months, the insured may receive a lump sum payment of \$10,000 or more. Such delayed payments may be considered lump sum income, either under OAR 461-145-0440(c) as described above, or because it is defined by the insurance carrier as the payment of a set benefit. OAR 461-140-010(2) defines lump sum income to include one-time or irregular payments, and specifically includes retroactive benefits that cover more than one month. Under OAR 461-140-0120(6)(a), lump sum income is counted as unearned income in the month that it is received, and as a resource after that month.

The Medicaid recipient may wish to transfer the lump sum payment to his or her spouse during the month when the payment is received, since a transfer to a spouse is not a disqualifying event. The Medicaid program may assess an overpayment for the month of receipt, but cannot decrease the Medicaid benefits in order to recover an overpayment.

Practitioners should be aware, however, that item 13 of the Medicaid application contains an assignment clause that gives the state all rights to such health insurance coverage, starting the date the application is signed. This should not affect amounts paid by an insurance company for any period before a person applied for Medicaid. An argument can be made that it should also not apply to the period between Medicaid application and qualification for Medicaid.

Most long term care insurance policies contain an exclusion period, so that the insured will not qualify for payment until after he or she has met the policy criteria for a certain time. The Medicaid program will sometimes allow the insured or the insured's spouse to keep the amount of the insurance payment equal to the daily benefit or reimbursement for the entire period a person was in long term care prior to qualifying for Medicaid—even though some of the insurance money actually received was paid in respect of time covered by Medicaid, because of the initial insurance exclusion period.

Continuing monthly long term care insurance payments will usually be treated either as monthly reimbursements/health care insurance benefits, or as regular monthly income. In either case, they increase the patient liability amount—unless otherwise directed by court order, an income cap trust payment schedule, or the like—and in most cases will have to be paid toward the cost of care.

Taxability of long term care policies

By Shirley A. Bass, Attorney at Law, Portland

With enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress provided for favorable tax treatment of qualified long term care (LTC) insurance policies. Unlike disability insurance policies—where either the premiums or the benefits, but not both, are tax deductible—it is possible to obtain tax deductions of both premiums and benefits for LTC policies.

Taxability of benefits

Benefits received from an LTC insurance policy that reimburses expenses incurred for qualified long term care are excludible from taxable income. Qualified long term care is defined as “medically necessary,” which generally boils down to doctor’s orders.

Benefits received from a policy that pays “per diem” benefits for qualified LTC are excludible from taxable income up to \$210 per day for tax year 2002. If the per diem benefit exceeds the daily benefit limit, the excess amount is includible in taxable income to the extent that it exceeds the actual expense incurred for LTC.

Example: The client receives benefits of \$220 per day in 2002. Medical expenses are less than \$210 per day. An amount equal to \$10 per day (\$220 minus \$210) would be taxable income. If, however, the client’s expenses exceed \$220 per day, the entire benefit would be excluded from his or her taxable income.

Deductibility of premiums

Under Internal Revenue Code Section (IRC) 213, qualified LTC premiums and expenses are deductible personal medical expenses for taxpayers who itemize. Unfortunately, the taxpayer must clear two hurdles. First, normal thresholds apply for LTC medical expenses. In other words, only medical expenses in excess of 7.5% of adjusted gross income are deductible. Second, premiums are deductible subject to the following dollar limits based on attained age before the close of the applicable tax year:

Age	2002 Premium Limit
40 or younger	\$240
41 – 50	\$450
51 – 60	\$900
61 – 70	\$2,390
70 and over	\$2,990

Example: A client age 62 purchases a qualified LTC policy with an annual premium of \$2,400. In 2002 the client has gross income of \$50,000 and unreimbursed medical expenses of \$5,000. The medical expense threshold is \$3,750 (7.5% of \$50,000 adjusted gross income). Since unreimbursed medical expenses, excluding the LTC premium, are \$5,000, the threshold is already met. The client is allowed to include up to \$2,390 of the \$2,400 qualified LTC insurance premium as a medical expenses, calculated as follows:

Schedule A Calculation	
Unreimbursed medical expenses	\$5,000
Plus qualified LTC insurance premium	+\$2,390
Total eligible medical expenses	\$7,390
Less 7.5% of adjusted gross income (.075 x \$50,000)	-\$3,750
Medical expense deduction on Schedule A	\$3,640

Note that some LTC insurance policies provide for waiver of premiums when benefits are being paid out.

Caveat: The above calculations apply only to individually purchased policies. The client’s tax burden changes if premiums are paid by a C corporation, professional corporation, S corporation, partnership, or limited liability corporation, or there is a contributory (split premium)

arrangement. In general, the entity that provides premium payment can deduct its payment as a reasonable and necessary business expense under IRC 162, and the client’s deduction for the premium is reduced or nonexistent. The self-employed client may deduct 70% of the eligible premium as an above-the-line business expense, so long as the client is not covered by an LTC policy maintained by some other employer-paid policy. Under the Tax and Trade Relief Extension Act of 1998, the 70% factor increases to 100% in 2003.

Special Oregon rules

Under ORS 315.610, Oregon allows a tax credit for LTC insurance premiums. To qualify, the client must hold a policy that was issued on or after January 1, 2000. The credit is the lesser of 15% of the premiums paid or \$500.

Under ORS 316.680, if the client claims a deduction for premiums paid on federal Schedule A and wishes to claim the Oregon LTC insurance premiums credit, then certain calculations are in order in the form of an “Oregon addition” and a special Oregon medical deduction subtraction.

Example: A client, age 65, paid premiums of \$2,400 during the tax year. On the federal return he or she is limited to a \$2,200 medical deduction for the premiums. The client has other medical expenses of \$3,600, or a total of \$5,800. Federal adjusted gross income is \$40,000. The client must reduce expenses by the 7.5% federal limitation (\$3,000). The allowed medical deduction is \$2,800. He or she then computes the Oregon addition as follows:

$$\begin{aligned} &\$2,200 \\ &\$5,800 \times 2,800 = \$1,062 \end{aligned}$$

The client must add back \$1,062 on the Oregon return before claiming the Oregon LTC insurance premiums credit.

Since the client is over age 62 and is itemizing deductions, he or she will be able to claim the special Oregon medical deduction subtraction. This is in addition to the credit. The Oregon subtraction will be the client’s total qualifying medical expenses less the amount subtracted on federal Schedule A (\$5,800 – \$2,800 = \$3,000).

Footnote

Federal tax examples taken from *Qualified Long-Term Care Tax Information 2002*, published by CNA Financial Corporation, January, 2002. State tax example taken from Oregon Department of Revenue’s *Publication 17 1/2*.

Medicare: an overview

By Matthew J. Mullaney, Attorney at Law, McMinnoville

Medicare is a federal health insurance program for persons 65 years or older, persons who have been receiving Social Security Disability benefits for two years, and persons with end-stage renal disease. The program is linked to Social Security eligibility, and like Social Security, Medicare eligibility does not depend on wealth or income. (It is not "means tested.") Persons who receive Railroad Retirement Board and Civil Service Retirement checks may also participate in Medicare.

Medicare has two parts: Part A coverage, which a Medicare recipient automatically receives, and Part B coverage, which the recipient must choose and pay for. Some people with low income and few assets may receive help with Part B premiums, deductible, and co-pay costs via Oregon's Medicaid Qualified Medicare Beneficiaries (QMB) program.

Part A pays for hospital stays and may help pay for in-patient hospital care, skilled nursing and rehabilitation in a skilled nursing facility (after a mandatory 3-day hospital stay), some home health care, and certain hospice care. Think "hospital-like" care for Part A. Medicare Part B may help pay for doctors' services, outpatient hospital care, other medical and allied services, laboratory tests, emergency ambulance service and emergency department care, certain medical supplies, and limited chiropractic care. Think "doctor's office and outpatient" care for Part B. Medicare may cover psychiatric and mental health care for up to 190 days during an insured's lifetime.

Each time a person covered by Medicare receives a health-care service, he or she receives an explanation of medical benefits (EOB) from a federal contractor (a fiscal intermediary or a Medicare carrier). The EOB states whether the claim for service is allowed or denied, the deductible and co-pays, reasons for action, and appeal rights. Both sides of the EOB form carry relevant information.

Classic "fee-for-service" Medicare does not pay for outpatient prescription drugs, routine foot and eye care, orthopedic shoes, eyeglasses, routine examinations, dental care, hearing aids, routine medical examinations, cosmetic surgery, and most care while traveling outside the United States. Medicare does offer prescription drug benefits to those persons who have end-stage renal disease or

who are enrolled in an end-of-life hospice program. Medicare has deductible and co-insurance (co-pay) costs. Many people on Medicare buy Medicare Supplemental Insurance (Medigap) from private insurers to help meet these costs. Medicare is almost always "primary" coverage, meaning Medicare pays medical expenses first, and supplemental insurance is applied secondarily.

A person may choose to join a Medicare managed care plan (HMO). The plan receives the Part A and Part B premiums from Medicare together with a supplemental insurance premium (\$60 more or less), then provides a combination of broader coverage and reduced deductible and co-pays. HMOs are private insurers subject to market forces, and some HMOs have had to close down completely or withdraw from certain geographic service areas. Many people covered by Medicare/HMOs have had to revert to classic Medicare.

Neither classic Medicare care nor Medicare/HMO covers "custodial care," which is broadly defined as assistance with bathing, dressing, toileting, feeding, and similar activities of daily living. These services must be paid from private funds, Medicaid, or long term health care insurance.

Medicare crisis management

Getting Medicare to cover continuing hospital costs can be difficult if a hospital wants to discharge the patient. The patient who receives a written notice of non-coverage from the hospital may demand a review of the pending discharge by a Peer Review Organization (PRO). Ask for a copy of a form letter entitled "An Important Message About Medicare Rights: Admission, Discharge, and Appeals." The hospital can't force the patient to leave before the PRO makes a decision, and even if the decision is adverse to the patient, the patient is not responsible for the Medicare share of care costs while the review is pending. Generally, a demand for PRO review will buy the patient up to three days more in the hospital even if the review is adverse. The author's local hospital reports it issues only two non-coverage notices a year.

Another problem arises when a nursing home decides that the patient no longer requires the "skilled care" covered by Medicare, and the patient will now be treated as uninsured (private pay). At the nursing home, the patient may demand that the facility submit a bill to Medicare (a "demand bill") for an official decision. You may need to deal with the "fiscal intermediary," the federal contractor that administers Medicare Part A. The nursing home is not allowed to require a deposit to cover the Medicare fraction, but may require the patient to cover the co-pay and any services not routinely covered by Medicare while the demand bill is pending. However, the patient is responsible for the entire cost of care if Medicare agrees with the nursing home. A nursing home must eat the Medicare fraction-of-care costs if the nursing home is too optimistic and waits too long to decide the patient no longer requires skilled care. Nursing homes may err on the side of early notice to protect their bottom line. While the demand bill is pending, you should investigate Medicaid eligibility immediately.

Some helpful phone numbers are: Social Security at 800.772.1213; Medicare at 800.633.4227 (ask for the booklet *Medicare & You* to learn more); Oregon's fiscal intermediary (Part A) at 503.721.7000; Oregon's PRO at 800.344.4354; Oregon's Medicare carrier (Part B) at 800.444.4606. For the Railroad Retirement Board, call 800.808.0772. For Region X (Seattle) Medicare, call 206.615.2354.

Medicaid: an overview

By Matthew J. Mullaney, Attorney at Law, McMinnville

Medicaid is a jointly funded federal-state program to pay for health care and long term care for eligible persons. Federal guidelines govern the program, but offer some flexibility among the states. Each state adopts its own rules and practices. Oregon's Medicaid laws can be found at ORS 414.025 *et seq.* and OAR Chapters 410, 411, and 461. To get copies of Oregon's Medicaid publications, contact Ann Birch at 503.945.6089.

Unlike Medicare, Medicaid is a "needs-based" medical welfare program paid for with general tax revenues. The State of Oregon Department of Human Services administers the program through its Division of Seniors and People with Disabilities (SPD). Medicaid applications are made to state or Area Agency on Aging offices based in Oregon counties. Eligibility for elders is determined by local Medicaid eligibility workers, and is based on the Medicaid application and a resource and income assessment. Get to know your local eligibility workers.

Medicaid may pay for services at skilled or intermediate nursing home, residential care facilities, assisted living care facilities, adult foster care homes, care in the beneficiary's home, physician services, prescription drugs, and medical transport. Services can range from household cleaning and shopping for the homebound to round-the-clock nursing home care. Important distinctions can exist between nursing home care on the one hand and home and community-based care on the other.

Through Oregon's Medicaid Qualified Medicare Beneficiaries (QMB) program, Medicaid will also pay Medicare Part B premiums, co-payments, and deductible, depending on levels of income and resources. Think of QMB when advising a Medicare beneficiary who qualifies for welfare benefits such as food stamps, Section 8 housing, or Supplemental Security Income.

Eligibility

To be Medicaid eligible, a person must be categorically eligible and financially eligible. Eligible categories are aged (over 65 years), blind, or disabled (according to Social Security criteria). Persons who live in a nursing home or would be living in a nursing home were it not for home and community-based alternatives may also be eligible.

Financial eligibility is broken down into income and resource elements. Gross income in excess of \$1,635 per month will make a person ineligible without an "income cap trust," which commits the beneficiary's monthly income to certain limited uses. Exempt resources include a home, a car, household furnishings, funded burial reserves, medical equipment, and term life insurance. Non-exempt (countable) resources (generally cash and "available" cash equivalents) cannot exceed \$2,000 for a single person. A married couple with both on Medicaid cannot have countable resources that exceed \$3,000. Generally, if only one member of a married couple is applying for Medicaid, they cannot have countable resources in excess of \$19,856. Gift transfers to reduce countable resources are penalized by delay of Medicaid eligibility.

Medicaid issues the beneficiary a notice of eligibility form (Form 541). Then the program issues a medical "card" each month—actually a letter-sized green and white piece of paper. Medicaid eligibility workers perform annual reviews of eligibility. Medicaid beneficiaries have a duty to report changes in financial or medical circumstances that might affect eligibility.

The Medicaid program has special rules to benefit the "community spouse" of a Medicaid beneficiary. Frequently, income and resources that belong to the Medicaid beneficiary may be diverted to the still-at-home spouse to avoid his or her impoverishment. A community

spouse is guaranteed a minimum monthly income of \$1,493 from the joint monthly incomes of both spouses, which amount may be raised by an excess shelter allowance. Jointly owned resources are often retitled into the name of the still-at-home spouse alone. Like the unlimited marital deduction in estate tax planning, a transfer between spouses triggers no Medicaid transfer penalty.

Resource transfers to the still-at-home spouse do not endanger eligibility for a Medicaid beneficiary who survives the still-at-home spouse. They may frustrate Oregon's aggressive Medicaid estate recovery program and benefit the couple's children. A still-at-home spouse may amend his/her will to bypass the Medicaid beneficiary spouse for the same reasons. The Oregon Medicaid program has voiced its intention to force an elective share against the will by or on behalf of the Medicaid spouse.

States which participate in the Medicaid program are required to make diligent efforts to recover money paid on behalf of the Medicaid beneficiary after his or her death. Oregon recovered \$36 million in the last reported biennium. Oregon is not a "lien state," and does not encumber titles to property while a beneficiary is still alive. State law requires that notice of all probates, small estates, and quasi-probate trust administration (ORS 128.256 *et seq.*) be given to Oregon's Estate Administration Unit. Medicaid compares state death records with the Medicaid beneficiary roster. Demand letters for repayment are sent out, often blindly. Medicaid is a preferred claimant under Oregon's probate law (ORS 115.125). Medicaid can also demand payment on accounts of \$25,000 or less in Oregon banks, savings and loans, and credit unions, using a claiming affidavit without the benefit of a probate proceeding or claim. (ORS 708A.430, 722.262, and 723.466) Estate recovery is deferred if the Medicaid beneficiary dies leaving a surviving spouse or a disabled or minor child.

Other programs that may provide some benefits akin to Medicaid are the Oregon Health Plan (with an income standard of \$738 per month) and Oregon Project Independence (which is not needs-based). Persons under 65 years of age who are denied private medical insurance due to medical underwriting may be able to secure coverage via the Oregon Medical Insurance Pool administered by Regency Blue Cross. Call 800.848.7280 for more information.

Representation of former client's spouse leads to conflict of interest admonition

The Spring 2002 issue of the *Elder Law Newsletter* included a thought-provoking article by Dady K. Blake on the potential for conflicts of interest when an elder law attorney has represented a married couple in connection with estate planning and disability planning.

The Oregon State Bar Professional Responsibility Board recently sent a letter of admonition on the conflict issue to attorney Mark M. Williams, who continued to represent a disabled man after receiving his wife's consent.

Mr. Williams agreed to share the letter of admonition, which is reprinted here, so that elder law attorneys can better understand how the disciplinary rules are being analyzed and applied to a common situation.

The name of the client has been omitted.

Mark M. Williams, Esq.
Re: case No. 02-57

Dear Mr. Williams:

The State Professional Responsibility Board has considered the above-referenced matter and has examined the statements and materials submitted by you and by Ms. P___. The State Professional Responsibility Board has directed me to advise you of its opinion that your conduct in this matter did not comply with disciplinary rules.

Specifically, the Board found that you failed to obtain client consent after proper full disclosures in a former client conflict of interest situation in a matter involving a husband and wife.

You had represented both the husband and wife in connection with their planning for husband's anticipated disability from Alzheimer's disease. The purpose of this planning was to provide for husband's future care and for wife's retirement. With your assistance, the couple agreed upon a plan that would allow them to obtain Medicaid assistance for husband and preserve marital assets for wife's benefit.

Shortly after this couple consulted with you, husband unexpectedly suffered a stroke, requiring his placement in an adult foster care facility. Immediately afterwards, wife came to you with questions about how to effectuate the agreed-upon plan in light of this new development. You referred wife to independent counsel and advised her about a possible separation/dissolution action that would allow marital assets to be shifted to wife and enable husband to qualify for Medicaid. You pointed out to both husband and wife that you could not represent them both in the separation/dissolution process because it was adversarial in nature. You also told them that you could continue to represent husband as long as wife consented and had separate counsel.

You thereupon sent wife a letter giving her full disclosure of her right to object to your continuing representation of husband because of your prior representation of them both. You discussed the current adversity of the couple's legal interests and noted that you had gained a "detailed knowledge" of their financial affairs in connection with the earlier representation. You noted that wife had discussed the matter with independent counsel and had agreed upon your continuing representation of husband. Wife signed the disclosure, thereby consenting to your continuing representation of husband.

Your disclosure fulfilled the requirements of DR 5-105(D) as to wife. The rule allows former client conflicts of interest to be waived when both the current and the former clients consent to the representation after full disclosure.

However, you made no such full disclosure of the former client conflict to husband at this time. While you discussed these conflict issues with husband orally, and he consented to your ongoing representation, "full disclosure" is required under DR 10-101(B) to be in writing. By failing to confirm your full disclosure to husband in writing, you failed to comply with the technical requirements of DR 10-101(B) and thereby violated DR 5-105(C).

It has been determined that no formal disciplinary proceedings will be instituted against you, but the matter will be concluded with this letter of admonition. You are urged to take this matter into account when faced with similar circumstances in the future.

Very truly yours,
Mary A. Cooper
Assistant Disciplinary Counsel

Supplemental Security Income (SSI) Benefit Standards	Eligible individual \$545/month Eligible couple \$817/month
Medicaid (Oregon)	Asset limit for Medicaid recipient \$2,000 Burial account limit \$1,500 Personal needs allowance in nursing home \$30/month Room & board rate for community-based care facilities \$446.70/month OSIP Maintenance Standard for person receiving in-home services \$546.70 Long term care income cap \$1,635/month Community spouse minimum resource standard \$17,856 Community spouse maximum resource standard \$89,280 Community spouse minimum monthly maintenance needs allowance \$1,493/month Excess shelter allowance Amount above \$448/month Food stamp utility allowance used to figure excess shelter allowance \$246/month Average private pay rate for calculating ineligibility for applications made after October 1, 2000 \$3,750/month
Medicare	Hospital deductible per illness spell \$812 Skilled nursing facility co-insurance for days 21-100 \$101.50/day Part B premium \$54/month Part B deductible \$100/year

Important elder law numbers

July 1, 2002

Elder Law Section member news

Kristianne Cox was chosen by the Multnomah Bar Association as Senior Law Project Volunteer of the Year. She has been a volunteer with the project for nine years. Last year, she volunteered at five Senior Law Project clinics and helped more than 20 pro bono clients.

Timothy McNeil has joined **Mark M. Williams, PC**, as an associate. Tim is a 1995 graduate of the Northwestern School of Law. The firm, which also includes Edward Amundson MSW, recently moved to 1850 Benjamin Franklin Plaza, 1 SW Columbia St., Portland 97258. The phone is 503.224.6229.

Participation in the Internet discussion list is open only to Section members who have e-mail addresses registered with the Bar.

How to use the list:

To subscribe, send a message to listserv@lists.osbar.org with the following in the body of the message:
 Subscribe eldlaw<yourname>

To send a message to all members of the list, e-mail it to eldlaw@lists.osbar.org.

Replies are directed by default to the sender of the message *only*. To send a reply to the entire list, you must change the address to eldlaw@lists.osbar.org.

To receive your messages in digest form, (combined into a single message sent once each day): send this message to listserv@lists.osbar.org :
 digest eldlaw<yourname>

Rules and guidelines

- Include a subject line in messages.
- Be polite.
- Sign your messages with your full name, firm name, and contact information.
- Do not send attachments.
- Get permission from the original sender before forwarding a message.

Elder law Internet discussion list

Resources for elder law attorneys

Events

Administering Oregon Estates

OSB CLE Seminar
Friday, June 14, 2002
Oregon Convention Center
Portland

For beginning and intermediate practitioners. Includes spousal and family issues, claims against the estate, application for instructions, trust settlement, Oregon inheritance/estate tax. To register, call OSB CLE at 503.684.7413 or 800.452.8260, ext. 413.

Financial Exploitation of Vulnerable Adults, Investigation and Prosecution Strategies

June 18-20, 2002
Hilton Hotel
Eugene, Oregon
Annual conference on elder abuse. Sponsored by DHS Seniors and People with Disabilities, Oregon Bankers Association, Washington Mutual, Oregon Department of Justice, DPSST, Oregon District Attorneys Association

Web site: www.sdsd.hr.state.or.us
Contact: Laura Segrest at 503.947.5054;
e-mail: Laura.F.Segrest@state.or.us

Probate & Guardianship Update with Judge Welch

Wednesday, June 19, 2002
3:00-5:00 p.m.
World Trade Center Auditorium, Building 2
26 SW Salmon, Portland
Info: Multnomah Bar Association
503.222.3275
e-mail: mba@mbabar.org

Eighth International Conference on Alzheimer's Disease and Related Disorders

July 20-25, 2002
Stockholm, Sweden
Hosted by the Alzheimer's Association
Web site: www.alz.org
e-mail: internationalconference@alz.org

Basic Estate and Gift Taxation & Planning

August 21-23, 2002
Seaport Hotel
Boston
Sponsored by American Law Institute
Web site: www.ali-aba.org

OSB Elder Law Section CLE

Friday, October 11, 2002
Oregon Convention Center
Portland

International Conference on Family Caregiving

Oct 12-14, 2002
Washington, DC
National Alliance for Caregiving
Phone: 800.537.9728
Web site: www.caregiving.org
e-mail: info@asaging.org

National Aging and Law Conference

October 23-26, 2002
Arlington, Virginia
Sponsored by AARP Foundation, ABA Commission on Legal Problems of the Elderly, National Senior Citizens Law Center, Center for Social Gerontology, NAELA, National Consumer Law Center, and National Association of State Units on Aging
Web site: www.aarp.org/nlttrpro
e-mail: Aalbright@AARP.org

2002 NAELA Institute

November 14-17, 2002
Hyatt Regency Albuquerque
Albuquerque, NM
Contact Jenifer Mowery at 520.881.4005 ext 114, or jmowery@naela.com

Elder Law Section Executive Committee Meetings

Lake Oswego OSB Center
2:00 p.m.-5:00 p.m. on the following days:
July 12, 2002
Sept. 13, 2002
Nov. 8, 2002

Monthly Elder Law Discussion Groups

Elder Law I meets second Thursday
Lloyd Center Tower, NE Portland
Elder Law II meets first Thursday
Legal Aid Services, Downtown Portland
Details: Anne Stacey 503.224.4086

Web sites you can use

We are often expected to be up-to-date in not just the law, but news relating to the law. There are many Web sites that can help us with this gargantuan task, whether we need the information for a specific client, or just to be current on what is happening in our community, state, and world.

General News and Information

One of my favorite news services is the New York Times: www.nytimes.com. It provides a free daily e-mail service that can be customized to send you only certain topics. It also offers several special-interest weekly e-mail newsletters. Like many free newsletters, this one does come with certain annoyances, including pop-under ads that appear when you click on the link to the full articles excerpted in the e-mail. There are a number of small utility programs that help eliminate these ads. The one I use is Pow!, a free utility from AnalogX: www.analogx.com/contents/download/network/pow.htm.

Many other large metropolitan newspapers have useful news Web sites.

- *Washington Post*: www.washingtonpost.com
- *Boston Globe*: www.boston.com
- *Los Angeles Times*: www.latimes.com
- *Seattle Times*: www.seattletimes.com

Often the best news reporting comes from the newspaper where the incident occurred. Listings of local newspapers can be found at newsdirectory.com or www.naa.org.

For those interested in the latest technology news, the San Jose Mercury News offers a daily e-mail, Good Morning Silicon Valley: www.siliconvalley.com.

Of course, each of the television networks also has a Web site with news information, although those sites usually have extensive and somewhat intrusive advertising. See www.abcnews.com, www.cbsnews.com, www.msnbc.com, and www.foxnews.com.

The wire services from which most of the news organizations obtain their national and international news also maintain Web sites with current and breaking news.

Associated Press: www.ap.org

Reuters: www.reuters.com

Many local Oregon newspapers also have Web sites, some better and more functional than others. Among those papers with sites are the Albany *Democrat Herald* at www.dhonline.com and the Ontario *Argus Observer* at www.argusobserver.com.

A list of Oregon and other states' newspapers can be found online at the Newspaper

Association of America: www.newspaperlinks.com. Such a listing can be quite useful if you need to find a local paper to publish legal notices when you are not familiar with the community.

Legal-specific news

The Web site www.law.com offers a free daily e-mail with legal headlines and some in-depth legal news. A recent issue contained an interesting analysis of legal memos from Stoel Rives and Brobeck, Phleger & Harrison, analyzing the trading done by Portland-based Enron energy traders during the California energy crisis.

LexisOne (www.lexisone.com) also offers periodic e-mails with legal news, although theirs are generally not as in-depth as those at Law.com.

Court news and decisions

Oregon appellate and tax court decisions are regularly posted on the Web by the Oregon Judicial Department: www.publications.ojd.state.or.us. The OJD site also has many other state court-related publications.

Decisions from 1998 through the present can be searched using the Oregon State Library's search engine. However, it is somewhat cumbersome, and many commercial legal databases have better, more comprehensive search engines: Lexis (www.lexis-nexis.com), Westlaw (www.westlaw.com), Versuslaw (www.versuslaw.com), Lois Law (www.loislaw.com), and others.

Important rulings and decisions by the U.S. District Court for Oregon can be found on the District Court's Web site at ord.uscourts.gov/rulings/rulings.html. The U.S. District Court also publishes a bi-weekly summary of topical decisions that can be accessed at ord.uscourts.gov/news/cthsnews.html.

Willamette University Law School provides a great service to the Oregon legal community by hosting a number of free e-mail case summaries of the decisions published by the Oregon Court of Appeals and Oregon Supreme Court. Willamette also has summaries available for the U.S. Supreme Court, Ninth Circuit Court of Appeals, and the Alaska, Washington, California, and Utah Supreme Courts. The school offers compilations of nationwide published decisions in the following areas of law: Intellectual Property, Conflict of Laws, Indian Law, and Dispute Resolution. To receive case summaries by e-mail, subscribe at www.willamette.edu/law/wlo.



By Susan Ford Burns,
Attorney at Law
Portland

Some changes to note

Oregon probate

Effective January 1, 2002, ORS 113.145(6) now requires that a copy of the decedent's death certificate be mailed or delivered within 30 days of appointment to the Estate Administration Unit of the Department of Human Services. Address: Estate Administration Office, Department of Human Services, PO Box 14021; Salem, OR 97309-5024.

ORS 114.525 regarding small-estate affidavits requires that copies of the affidavit, which includes a death certificate, are to be mailed to the Department of Human Services. This statute has been clarified to specify mailing to the Estate Administration Office of the Department of Human Services.

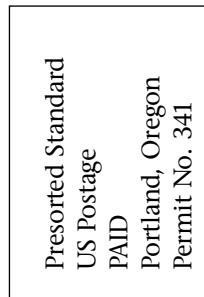
Medicare payments for Alzheimer's treatment

The Centers for Medicare and Medicaid Services recently issued a program memorandum that prohibits the automatic denial of claims for medical services based solely on the diagnosis of dementia. For years, Medicare has refused to pay for some medical services for beneficiaries with Alzheimer's disease solely because of their diagnosis. Under the new guidelines, Medicare will not use the dementia diagnostic codes alone as a basis for determining whether Medicare covered services are reasonable and necessary. The program memorandum, entitled *Medical Review of Services for Patients with Dementia*, can be obtained on line at

www.hcfa.gov/pubforms/transmit/AB01135.pdf or from Leslie Friedl at the American Bar Association Commission on Legal Problems of the Elderly 202.662.1000; e-mail friedl@staff.abanet.org.

Federal gift tax

The annual gift tax exclusion amount became \$11,000 at the start of 2002 because of an inflation adjustment required in IRC Section 2503(b)(2). The 2002 adjustments were announced in Rev. Proc 2001-59.



Newsletter Board

The *Elder Law Newsletter* is published quarterly by the Oregon State Bar's Elder Law Section, Tim Nay, Chair. Statements of fact are the responsibility of the authors, and the opinions expressed do not imply endorsement by the Section.

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