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A client's capacity is defined in many ways

By Darin Dooley, Attorney at Law

The question of a client's capacity presents an ethical dilemma for attorneys and other practitioners. What compounds the attorney's difficulty in assessing client capacity is the fear of malpractice exposure and professional discipline resulting from the outcome of a decision he or she facilitates. Even without a prior clinical assessment by a medical or mental health professional, family members often report during intakes that the client exhibits some level of cognitive impairment. Attorneys must balance the opposing bioethical principles of client autonomy and client welfare in capacity assessments.

Legal capacity

The legal requirements for capacity are primarily based on case law, but are also codified in statutes. Oregon statutes provide the follow definitions:

Incapacitated is a condition in which a person's ability to receive and evaluate information effectively or to communicate decisions is impaired to such an extent that the person currently lacks the capacity to meet the essential requirements for the person's physical health or safety. ORS 125.005(5)

Financially incapable is a condition in which a person is unable to manage his or her financial resources effectively for reasons that include mental illness, mental deficiency, physical illness or disability, chronic use of drugs or controlled substances, chronic intoxication, confinement, detention by a foreign power, or disappearance. ORS 125.005(3).

However, under the advance-directive statutes:

Incapable means that in the opinion of the court in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal's attending physician, a principal lacks the ability to make and communicate health-care decisions to health-care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. ORS 127.505

Capable means not incapable. Id. Capable adults may make their own health care decisions. ORS 127.507. See also ORS 441.098.

Presumption of capacity

Oregon law presumes a person to be competent absent an adjudication of incompetence.[1] A diagnosis of dementia by itself does not mean a person lacks the requisite capacity to act. Memory disorders, personality changes, and impaired reasoning may be symptoms of dementia, and may be severe enough to interfere with the client performing daily activities. Only when the effects of dementia or other conditions prevent the client from having the necessary understanding for a specific act has the presumption of capacity been overcome.

Continued on page 2

In this issue

Focus on elder law basics

Client's capacity defined many ways 1
Overview of long term care 4
Acronyms in elder law 7
Planning for financial decisions 8
Government benefits 10
Medicare open enrollment 11
Changes to advance directive form 12
Health insurance options 13

Plus

Resources for elder law attorneys 17
Elder Law Section annual meeting 18
Index to Volume 21 18
Important elder law numbers 19

Capacity

Continued from page 1

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Capacity for specific acts

The requirements for capacity to perform a specific act cover a spectrum, as discussed below.

Testamentary capacity

The standard for testamentary capacity in Oregon is well established.[2] The person must (1) be able to understand that by signing the will he or she is disposing of his or her assets at death; (2) know the nature and extent of his or her property. An exact accounting is not required, however; (3) know, without prompting, who his or her heirs are; and (4) be cognizant of the scope and reach of the provisions of the document.

Even if a testator suffers from dementia or other conditions to the extent that testamentary capacity may be impaired, there can be lucid moments during which testamentary capacity exists. A will is valid if capacity exists at the time of the execution, notwithstanding the dementia of the testator before and after execution.[3] The Oregon Court of Appeals has defined a "lucid interval" as "[a] temporary restoration of testamentary capacity."[4] However, clear and convincing proof is required to show that a legal act is performed during a lucid interval.[5]

The capacity to create, amend, revoke, or add property to a revocable trust is the same as the capacity to make a will. ORS 130.500. This seems to be at odds with the common law requirement that the trustor must have the legal capacity to execute the conveyance(s) to fund the trust.[6] Arguably, a revocable trust as a will substitute can be viewed as a testamentary document designed to avoid probate so that the testamentary capacity is the appropriate standard.

Capacity to execute a durable power of attorney for finances

A power of attorney for finances creates an agency relationship.[7] This agency relationship presumes the principal has the ability to understand and approve the authority given to the agent to act on the principal's behalf.[8] The capacity to execute a valid power of attorney requires that at the time of the execution of the document the grantor is able to comprehend the nature of the business in which the grantor is engaged.[9] The grantor needs to understand the purpose, intent, and effect of granting authority to the agent, but not necessarily be able to perform every act under the power granted to the agent.

Capacity to execute deeds, contracts, and make lifetime gifts

The same basic standard applies to executing a deed, entering into a contract, or making a lifetime gift. The capacity required in all three situations is greater than testamentary capacity.[10] Presumably, this is because of the irrevocable nature of acts taken under deeds, contracts, and lifetime gifts. The capacity to make a deed requires that the grantor have the ability to understand the nature and effect of the act in which he or she is engaged and the business that he or she is transacting.[11] The grantor must be able to reason, exercise judgment, and compete with the other party to the transaction.[12] Note that Oregon's transfer-on-death deed is unique in relation to other statutory deeds. The capacity required to make or revoke a transfer-on-death deed is the same as that required to make a will. ORS 93.948 et seq. A person can enter into a contract if he or she has the ability to understand the nature and effect of the act.[13] Even if a person is easily influenced, is dependent on others, states that he or she does not understand the contract itself, or has below-average intelligence, the individual can enter into a legal contract.[14] The test of contractual capacity is measured as of the time of execution of the contract.[15] An inter vivos gift requires the same degree of capacity needed to enter into a contract. [16]

Capacity to make healthcare decisions

A capable adult is authorized by statute to make healthcare decisions. ORS 127.507. See also ORS 441.098. There is a presumption that an adult has the requisite mental capacity to give informed consent even if a guardian has been appointed for the person. ORS 125.300. The standard for mental capacity to consent to or refuse proposed medical treatment is the ability to understand the basic information necessary for informed consent and to understand the nature and consequences of authorizing treatment.[17] The Oregon Supreme Court has found that a physician must take into account the mental state and capabilities of the patient when explaining a proposed treatment.[18] The court held that the concept of informed consent presupposes that the patient is capable of understanding the risks of a proposed treatment and alternatives, and also of using that information in a rational decision-making process.[19]

Continued on page 3

Capacity

Continued from page 2

Capacity to retain counsel

The capacity to retain counsel is analogous to the capacity to contract. In general, attorneys owe a duty of competent and diligent representation to their clients. ORPC 1.1, 1.3, and 1.6. When the client's capacity is diminished, for whatever reason, the attorney should attempt to maintain a normal attorney-client relationship, as far as reasonably possible. ORPC 1.14. A respondent in a protective proceeding has the right to contact and retain legal counsel. ORS 125.300(3) and ORS 125.080(3).

Capacity in guardianship/conservatorship protective proceedings

When working with a client with diminished capacity who is under either a guardianship or a conservatorship, the attorney needs to be very familiar with the statutes that define the term "incapacitated person" and the case law that interprets these statutes. Clear and convincing evidence is required to show the respondent is incapacitated, and the appointment of a guardian is necessary to provide continuing care and supervision of the incapacitated person. ORS 125.305(1).

There is no requirement that a person lack legal mental capacity before being subject to the appointment of a conservator. ORS 125.005(3). A conservator may be appointed if it is shown by clear and convincing evidence that the respondent is financially incapable and has money and property that require management or protection. ORS 125.400.

Documenting capacity

In *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, the American Bar Association warns attorneys against administering clinical assessment tools such as the *Mini-Mental Status Exam* unless trained to do so. The handbook also cautions against video recording a client who is executing a legal transaction. The video may exaggerate cognitive impairment to a viewer or finder of fact. Unless the attorney video records all clients, opposing counsel may argue that the recording proves incapacity. Instead, the handbook emphasizes the following criteria for attorney capacity assessments, creating a "sliding scale" of capacity:

1. Ability to articulate reasoning behind the decision. Can your client articulate the reasons for his decision and are the reasons consistent with your client's goals and objectives?
2. The extent to which the client's cognition fluctuates from time to time.
3. The client's ability to understand the consequences of a decision.
4. The substantive fairness of the decision. We cannot "look the other way" if a client is being taken advantage of in a blatantly unfair transaction. Judging fairness risks substituting the attorney's own values and beliefs over the client's, so self awareness and caution must be used.
5. The consistency of a decision with a client's known long-term commitments and values. Although we all can change our values over time, a decision consistent with our client's long-term perspective may be easier to support.
6. Irreversibility of the decision. "The law historically has attached importance to protecting parties from irreversible events. Doing something that cannot be adjusted later calls for caution on the part of the attorney."[20]

The first three factors are "functional" in that they reflect the cognitive functioning of the individual. These may be supported by observing signs of diminished capacity. The latter three are "substantive" in that they look at the content and nature of a decision itself. Under this approach, the latter three factors may be thought of as a sliding scale of capacity.

The greater the concerns under these three substantive variables, the greater the level of function needed under the first three variables. That is, the higher the risk, measured by the client's values and the finality and fairness of an act, the more the attorney needs to ensure decisional capacity.[21] While doctors and other health care professionals can offer capacity evaluations based on their training and experience, ultimately the determination of capacity is in the hands of attorneys and the courts. ■

Footnotes

1. See *Schultz v. First Nat. Bk. of Portland,* 220 Or 350, 359, 348 P2d 22 (1960); *Kruse v. Coos Head Timber Co*., 248 Or 294, 306, 432 P2d 1009 (1967); *Van v. Van,* 14 Or App 575, 513 P2d 1205 (1973)
2. See *Kastner v. Husband*, 231 Or 133, 372 P2d 520 (1962), *In re Phillips' Will*, 107 Or 612, 213 P 627 (1923). See also, *In re Bond's Estate*, 172 Or. 509, 519 (1943)
3. *In re Provolt's Estate*, 175 Or. 128, 151 P.2d 736 (1944)
4. *Gentry v. Briggs*, 32 Or App 45 at 50, note 1
5. *Gentry v. Briggs,* 32 Or App 45, 49, 573 P2d 322 (1978)
6. See *George Bogert, Trusts and Trustees* § 44, at 447 (rev 2d ed 1984 & Supp 2003)
7. *Scott v. Hall*, 177 Or 403, 163 P2d 517 (1945)
8. Meiklejohn, *Indiana Law Journal*, Vol 61, No. 2 (1971)
9. *Wade v. Northup*, 70 Or 569, 140 P 451 (1914)
10. *Legler et al. v. Legler,* 187 Or 273 (1949), *First Christian Church v. McReynolds*, 194 OR 68, 241 P.2d 135 (1952).
11. *First Christian Church v. McReynolds* at 72
12. *Id.* at 73
13. *Kruse v. Coos Head Timber Co*., 248 Or 294 (1967)
14. *Id.*
15. *Uribe v. Olson*, 42 Or App 647, 651, 601 P2d 818 (1979)
16. *Kugel v. Pletz*, 22 Or App 249 (1975)
17.Fay A. Rozovsky, *Consent to Treatment, A Practical Guide* 21 (2d ed 1990 & Supp 1994); *Oregon Health Law Manual* §6.2-3 (Oregon CLE 2003)
18. *Macy v. Blatchford*, 330 Or 444, 8 P3d 204 (2000)
19. *Id.* at 454
20. *Id.* at 1087.
21. ABA Commn. on L. and Aging, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, 19, (2005)

An overview of long term care and support options and resources for clients and their families

By Andrea Ogston, Attorney at Law

Andrea Ogston is supervising attorney at the Portland Regional Office of Legal Aid Services of Oregon. For the past ten years her work has focused exclusively on issues that affect older adults.

A wide variety of long term care and support is available in Oregon. This article provides a broad overview of the types of settings and some of the resources for accessing care. Some familiarity with the programs can assist in effectively advising clients on the appropriate option for themselves or a family member.

Types of long term care and support

Long term care options range from in-home care to traditional nursing-facility care. In the middle are a variety of what have been termed "home and community based settings," which include, in addition to in-home care, assisted-living facilities, residential-care facilities, and adult foster homes. Despite the use of the word "facility" in their title, the goal of both assisted-living facilities and residential-care facilities is to maximize inclusion with the community. There are also a variety of other, more limited programs that can be of help for those who have fewer needs. Below is a brief description of the various settings and programs relevant to accessing long term care or support.

In-home care

Some older adults can be most effectively cared for at home. For others, it may be possible, but not medically optimal, to arrange in-home care. Many older adults prefer to accept the risks of suboptimal care rather than be forced to leave their homes. In such cases, it is especially vital to have active case management and care planning for in-home care, because the fear of displacement may discourage honest reporting of changing needs. For individuals who receive Medicaid, Aging and People with Disabilities can provide in-home management of caregivers.

Generally, cost is a crucial issue in arranging in-home care. If cost is not an issue, then excellent care can be provided in the person's home for a full range of care needs (e.g., around-the-clock registered nursing care). However, care in a facility is also very expensive and individuals are often able to stay in their homes longer if provided some support.

Under Oregon's current Medicaid delivery model, two additional considerations may create obstacles for older adults to access in-home long-term services and supports. First, the in-home maintenance allowance equals $500 plus the total Oregon Supplemental Income Program-Medical (OSIPM) standard. This means that an individual who receives in-home care services would need to have monthly expenses of $1,250 per month (in 2018). This is only feasible for individuals with very low housing costs, such as those who live in subsidized housing, older adults without a mortgage, or individuals who live with their spouse.

Second, the state preference for "cost effectiveness" may favor the delivery of long term care in an alternate home and community-based setting. The extent to which an individual's choice can be honored in light of cost effectiveness is an open question. It is clear, however, that there is a requirement for person-centered planning and that each individual should be presented with all options.

Medicaid in-home long-term services and supports are provided through the Consumer-Employed Provider Program, Spousal Pay Program, Independent Choices Programs, and other approved service providers. While cost-effectiveness is one factor, each individual is entitled to the care of his or her choosing. This includes in-home care, which may be the most cost-effective option if 24-hour care is not required. The Employer Resource Connection (formerly known as STEPS) can help families navigate the employer obligations that come with these programs.

Nursing facility care

A nursing facility (NF) is licensed to provide medical nursing care and rehabilitation to sick, injured, or disabled individuals. Most people in long term care do not need nursing-facility care. The term skilled nursing facility (SNF) is mainly relevant for Medicare coverage of skilled nursing care for a limited period of time following hospitalization. Eligibility for skilled-nursing care paid through Medicare requires that a physician determine that there is a need for ongoing care before the individual returns home.

Adult foster homes

Most adult foster homes are single-family homes in residential neighborhoods. Typically, residents of adult foster homes need assistance

Continued on page 5

Long term care

Continued from page 4

with personal care and with instrumental activities of daily living, such as cooking, transportation, and taking medications according to schedule. A caregiver is present in the adult foster home at all times to supervise, prepare meals, and provide personal care to residents. The caregiver is sometimes the homeowner, and other members of the caregiver's family may also reside in the house. Essential issues in the selection of an adult foster home include its record of past complaints, number and training of staff, and rate of staff turnover.

Residential-care and assisted-living facilities

Residential-care facilities (RCFs) and assisted-living facilities (ALFs) are subject to the same rules and typically differ only in their physical structure. ALFs generally, but not always, provide each resident with his or her own room or small apartment. Couples may share a unit. RCFs are less likely to be fully self-contained units. Both ALFs and RCFs must provide a minimum scope of services, including three meals each day, laundry services, social and recreational activities, assistance with all activities of daily living, housekeeping, administration of medications, transportation for both social and medical appointments, and ancillary services for medically related care.

Continuing-care retirement communities

Oregon has numerous continuing-care retirement communities (CCRCs) designed to enable residents to "age in place" by providing the option of stepped-up care as needs increase. A CCRC provides housing and health-related services for a period that must be greater than one year pursuant to a residency agreement between the resident and the community. OAR 411-067-0000(11). CCRCs must register with the state, which also requires the disclosure of certain information to residents and prospective residents, such as certain financial information to ensure ongoing solvency of the communities. OAR 411-067-0050. Basic services provided by CCRCs generally include meals, housekeeping, and transportation. Additional services such as assistance with activities of daily living, physical therapy, and nursing services are sometimes offered at additional cost. Entrance fees and monthly rates vary widely, depending on the geographic location and the services offered.

Adult day services

Adult day services provide a structured environment for adults with functional impairments. They are frequently used as an adjunct to in-home care. These structured, comprehensive, non-residential programs provide health, social, and related support services in a protective setting during part of a day, but not for 24 hours per day. Adult day services are eligible for Medicaid reimbursement as part of an individual service plan to augment in-home care. If an individual lives in an adult foster home, adult day services are eligible for Medicaid reimbursement only after there is a finding of a special need pursuant to OAR 411-027-0020(6). In those cases, an exception to payment limitations can be requested as provided in OAR 411-027-0050. Adult day services paid through Medicaid are subject to the rules for home and community-based settings.

Program of all-inclusive care for the elderly (PACE)

PACE is a joint Medicare and Medicaid program that provides services either at home or in a long term care facility. In order to be eligible for this program, the applicant must reside in the PACE program's service area, be 55 years of age or older, need nursing-services level of care (service priority levels 1 to 13), and be able to live safely in the community. PACE providers receive a capitated rate for Medicare and Medicaid beneficiaries and can sometimes offer more expanded services than a beneficiary would receive who was not enrolled in a PACE program. Under PACE, the organization must establish an interdisciplinary team at each center to create a team assessment of each individual's social, health, and emotional needs.

Memory-care communities

A memory-care community sometimes encompasses the entire facility. More frequently it refers to a separate area or unit within a facility for individuals with dementia. This area must meet rule requirements for the environment (such as lighting and surface finishes), and only staff who have received specialized training can be assigned to work with residents. OAR 411-057-0170; OAR 411-057-0150(1)(a).

Oregon Project Independence

Oregon Project Independence (OPI) can help persons who do not receive Medicaid services to pay for in-home care. OPI can cover payment for homemaker services, chores and errands, transportation assistance, personal care, adult day care, respite care, case management, registered nursing care, and home-delivered meals. Each year, the Department of Human Services publishes an OPI sliding-fee schedule for benefits. Annual updates of the fee schedule and other changes can be accessed through the State Unit on Aging website: www.oregon.gov/dhs/seniors-disabilities/sua/pages/opi.aspx . State funding for OPI is limited, and eligibility for assistance is based on priority of needs set by the local Area Agency on Aging (AAA). Other services are available through each AAA, including home-delivered meals, transportation, and more.

State plan personal-care services

An individual enrolled in the Oregon Health Plan who requires assistance in basic personal hygiene, toileting, mobility, nutrition, medication, oxygen use, or delegated nursing tasks can qualify for up to 20 hours per month of personal-care services. Additional hours can be requested through an exception process. There is no consumer pay-in for

Continued on page 6

Long term care

Continued from page 5

personal-care services, and there is no requirement to meet the resource limits or service priority levels 1 to 13, which would be required for the other Medicaid programs that offer long-term services and supports. However, if the individual receives supplemental security income (SSI), the resource limits would apply via eligibility for that program.

Housebound or Aid and Attendance benefits for veterans and surviving spouses

The Aid and Attendance (A&A) pension available through the U.S. Department of Veterans Affairs (VA) provides benefits for veterans and surviving spouses who require the regular attendance of another person to assist in eating, bathing, dressing and undressing, or toileting. To be eligible, the claimant need not require assistance with all of these. As of 10/18/2018, VA rules specifically require the regular assistance of another with at least two ADLs. Many families overlook A&A. This program provides assistance to older adults who can no longer live independently but may not meet the need requirement of Medicaid (and are not required to). Depending on the services provided, the rent from an assisted-living facility can count as a medical expense, which allows more individuals to qualify for this benefit. There is an asset requirement for eligibility. As of 10/18/2018, the requirement is that assets are less than $123,600.

Finding Quality Care

Gathering all the information necessary to select the best available option takes time. However, decisions must often be made on fairly short notice. An advocate for an older individual who needs long term care or support must know where to go to find the relevant information quickly. As this information becomes increasingly available online, individuals are able to make a more informed decision despite the need to move swiftly or respond to a crisis.

The Department of Human Services maintains a searchable online database of substantiated complaints of facility abuse: https://ltclicensing.oregon.gov/.

The Administration for Community Living (ACL) and the Administration on Aging (AoA) both provide online resources and guides on long-term services and supports. The ACL website provides helpful information regarding benefits, including the Eldercare locator, which allows an individual to search for long-term services and supports by zip code: http://eldercare.gov/Eldercare.NET/Public/Index.aspx.

Organizational Resources

The following organizations are excellent resources for individuals who seek long-term services and supports.

Oregon Home Care Commission

In 2000, the Oregon Home Care Commission (OHCC) was created to ensure the quality of home-care services funded by the Department of Human Services. As part of its charge, OHCC created a statewide registry of home-care workers that can be found at www.or-hcc.org. This site allows for posting by both individuals seeking care and home healthcare providers.

The OHCC also provides the Employer Resource Connection (formerly known as STEPS). It is a free program that provides training for consumer-employers to promote a successful working relationship with their home-care workers. This program is designed for individuals who receive Medicaid in-home services through the Client-Employed Provider Program (including the Spousal Pay program), Oregon Project Independence, or state-plan personal-care services. However, many online program resources are helpful to anyone who needs to hire in-home care providers. Information regarding the program can be found at https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/Pages/Steps.aspx.

Aging and People with Disabilities division offices and Type B Area Agency on Aging

The local Aging and People with Disabilities (APD) office or local Area Agency on Aging (AAA) office is another resource for persons seeking information on long term care options in their area. APD provides lists of local in-home-care agencies, nursing facilities, adult foster homes, assisted-living facilities, residential-care facilities, and adult day programs. The Aging and Disability Resource Connection of Oregon can be the best first stop in locating the appropriate office for your client. https://www.adrcoforegon.org/consite/index.php.

APD maintains files of all complaints against nursing facilities, residential-care facilities, assisted-living facilities, and adult foster homes. Records of such complaints (confidential information is deleted) are available from the Type B agency or the local APD office. Advocates can review recent complaints against the facility, note whether the complaints were substantiated after investigation, and learn the sanction imposed by APD.

APD can also provide detailed reports of the results of periodic state inspections of facilities. The reports describe any deficiencies in compliance with state and federal regulations for nursing facilities. APD also provides facility-abuse reports that detail complaints, investigation, and outcome in instances of alleged abuse of residents.

Long term care ombudsman

Ombudsman staff and volunteers act as advocates for residents in all types of long term care except for in-home care, to assist them in protecting their rights and resolving conflicts with the provider of the resident's long term support and services. The ombudsman also maintains records of all formal complaints, investigations, and findings against

Continued on page 7

Long term care

Continued from page 6

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nursing facilities, residential-care facilities (RCFs), assisted-living facilities (ALFs), and adult foster homes in the state.

Ombudsman volunteers spend significant amounts of time in long term care settings in their local area, and they often have a wealth of information about day-to-day operations and quality of care, including the amount of staff turnover.

The ombudsman offers consultations with individuals who need help selecting appropriate long-term-support. Prospective residents may also review licensing surveys, protective-services investigations, and sanctions. The office asks that applicants narrow their search to five or fewer facilities before requesting a consultation. An excellent list of resources for selecting a long term care facility is available on the ombudsman website: https://www.oltco.org.

Hospital discharge planners and social workers

Historically, hospitals employed discharge planners as part of care services. Discharge planners were often case managers or licensed social workers who helped patients and their families plan for needed care after a person was discharged from the hospital. However, in many current delivery models, nurses are now in these positions, with specific nurses holding "transition" roles within the hospital. These individuals function in a similar capacity to discharge planners and also preplan (before scheduled hospital admission) for care after discharge. Discharge planners or transition nurses help find care providers or facilities to meet the needs of the person immediately after leaving the hospital. They generally do not provide a comprehensive plan for the long term care needs of the person. ■

Acronyms used in elder law

- AAA: Area Agency on Aging
- ABLE: A Better Life Experience
- ADL: Activity of daily living
- ALF: Assisted-living facility
- APD: Aging and People with Disabilities
- CAWEM: Citizen Alien Waivered Emergent Medical
- CCRC: Continuing care retirement community
- CMS: Center for Medicare and Medicaid Services
- COBRA: Consolidation Omnibus Budget Reconciliation Act
- DHS: Department of Human Services
- DPOA: Durable power of attorney
- DRO: Disability Rights Oregon
- FBR: Federal benefit rate
- GA: General Assistance
- HIPAA: Health Insurance Portability and Accountability Act
- LTC: Long term care
- MAGI: Modified Adjusted Gross Income
- OHP: Oregon Health Plan
- OLTCO: Oregon long term care ombudsman
- OPI: Oregon Project Independence
- OSH: Oregon State Hospital
- PACE: Program of all-inclusive care for the elderly
- POA: Power of Attorney
- QDE: Qualified disability expense
- RCF: Residential care facility
- SGA: Substantial gainful activity
- SHIBA: Statewide Health Insurance Benefits Advisors
- SNAP: Supplemental Nutrition Assistance Program
- SNF: Skilled-nursing facility
- SSA: Social Security Administration
- SSI: Supplemental Security Income
- VA: Veterans Administration

Planning ahead for financial decisons

By Rebecca Kueny, Attorney at Law

Rebecca Kueny is a managing-partner at Kueny Douglas LLC in Salem, representing clients in estate planning, special needs planning, protective proceedings, and Medicaid and VA long term care planning. She is president of Marion County CourtCare and vice-chair of the Marion County Indigent Guardianship Committee.

Clients come to our offices to discuss their future and to react to life events that have occurred. While each of us has many client stories, the following is a scenario to illustrate big-picture planning for financial decisions, as well as how specific inquiries can lead to larger discussions.

Casey is a new client. He is meeting with attorney Adrienne. At the onset of the initial meeting, Casey tells Adrienne that he read an article that indicated he needs a power of attorney. Casey's statement creates a perfect talking point for Adrienne. She uses the moment to figure out Casey's legal and financial needs, using his statement as a starting point to gather more information and educate Casey on the various options and considerations that can help him achieve his goals. Luckily, Adrienne knows that while each client may have a different need or goal, there are some common options that are useful in educating clients like Casey.

Power of attorney

This document can be an extremely powerful tool in planning financial decisions. In a power of attorney, Casey may choose his agent (also known as an attorney-in-fact) who will have the legal authority to assist him with various financial and contractual duties. Casey has the option of choosing a succession of agents in case an agent is unable or unwilling to act. Casey may also name co-agents. Casey decides to appoint his son Sam. If Sam cannot act, then his daughter Dee will be his agent. Casey is wary of having Sam and Dee act as co-agents since they do not always get along and they live in different states.

Due to Casey's multiple assets, retirement accounts, and financial institutions, Adrienne discusses drafting a power of attorney and a trust. Casey remembers that he executed a power of attorney at his local bank. Adrienne explains that a financial institution has its own form that is useful only within the institution, and is thus limited in effect. Adrienne then explains the distinction between a general and specific power of attorney. General power of attorney means that son Sam has more latitude on decision-making authority, while a specific, special, or limited power of attorney means that Sam has a limited range of decision-making authority. For estate planning, many attorneys use durable general powers of attorney. The limited power of attorney is often used to complete a specific goal or to work with a specific financial institution. Adrienne can draft a general power of attorney that can be used for real property, multiple assets, retirement accounts, life insurance companies, and other types of institutions.

Adrienne goes on to explain that a durable power of attorney means the document will continue to maintain its integrity if Casey becomes incapacitated, while a springing power of attorney means that Sam cannot use the power of attorney until a named triggering event occurs, such as disability or incapacity. Casey jumps at the option of a springing power of attorney, because he can maintain full control over his assets until he is deemed incapacitated. Adrienne explains that it can be extremely difficult for Sam to obtain and provide sufficient documentation to financial institutions to prove Casey's incapacity.

Casey decides to proceed with a durable general power of attorney. Adrienne and Casey discuss the various types of provisions to include or exclude, such as the right to sell real property, the right to gift assets, and the right to exercise voting rights in Casey's family-owned business. Casey feels relieved that he finally has the beginning of a plan. He now appreciates the power and value of consulting an attorney. Adrienne is pleased that she can be creative in drafting documents to help Casey with his goals, while setting limitations on Sam's legal authority to manage his father's assets. Adrienne will put significant thought into the drafting of the document. She will balance the need for breadth in provisions to prevent obstacles that Sam could face against the need for specific instruction to prevent Sam from misuse of his father's assets.

Adrienne reminds Casey that Sam only has the right to follow through with the authorities given in the provisions. The power of attorney does not give Sam any ownership rights to the Casey's assets, but it will give him authority to manage assets upon signing the document. Casey appreciates that he can revoke the document at any time. Adrienne also explains that upon Casey's death, Sam will not be able to use

Continued on page 9

Financial planning

Continued from page 6

the power of attorney, because it has no legal authority after his father's death. Lastly, Adrienne explains that financial institutions like to see powers of attorney that have been executed in the past three to five years. Casey commits to reviewing his estate plan with Adrienne and executing a new power of attorney within that time frame.

Joint ownership

Recently, Casey added Sam to his main bank account to assist with bills. Adrienne tells Casey that adding an owner on an account can be beneficial, because it typically allows for the surviving owner to inherit the asset. Casey did not realize that Sam would inherit the asset and Dee would get nothing. Adrienne advises Casey about some of the legal issues that could arise from joint ownership. For instance, Sam would have a legal right to Casey's funds. Casey gasps when he finds out that joint ownership could subject his account to Sam's creditors, legal liability, and/or asset division in Sam's upcoming divorce proceeding. Casey states that he will change the ownership on this account.

Revocable living trust

Adrienne uses that cue to start a conversation about revocable living trusts. The discussion is similar to the power-of-attorney conversation, except Casey learns that most of his assets will be owned by the trust. Adrienne points out that if an asset is owned by the trust, the trustee will be making the financial and contractual decisions. If an asset is not owned by the trust, the agent under power of attorney will make financial and contractual decisions. If he becomes incapacitated, Sam will start managing the assets. If Sam cannot act, then Dee will be successor.

Adrienne explains that Casey's retirement account cannot be owned by the trust. They discuss beneficiary designations for the retirement account. Casey understands that Sam will use the power of attorney with his retirement accounts.

Adrienne offers some definitions for "incapacity" to use in the trust that will trigger the need for the successor trustee. Unlike the power of attorney, many financial institutions do not require medical documentation on incapacity, because the trust has stronger methods to appoint a successor trustee. Casey finds it appealing that trustees tend to have more success working with financial institutions than agents under a power of attorney.

Sam can continue to manage trust assets after Casey's death, and avoid a probate. Casey is ready to fund his trust.

Payment on death

Casey mentions that he and his brother, Brian, recently inherited funds. Upon his death, he wants the specific funds he inherited to go to Brian. Adrienne mentions that Casey may instruct his local bank to put a payment on death (POD) designation on the inheritance account, naming Brian as the beneficiary. The POD designation allows Brian to receive Casey's inheritance funds upon Casey's death. This will prevent a probate asset and is easy for Brian to administer himself. Alternatively, Casey can retitle this account to the trust and have a distribution to Brian. Casey chooses to keep the account separate from the trust.

Conservatorship

Having heard the word conservatorship, Casey asks Adrienne if he would ever need one. She explains that a conservatorship is a court proceeding used to get authority to obtain contractual and financial decision-making authority. Since Casey has a power of attorney and a trust, he will likely never require a conservatorship. A conservatorship is intended to be used as the last resort to assist those who lack capacity. Casey is relieved.

Representative payee

Casey receives Social Security income and a pension from the Department of Veterans Affairs. Adrienne warns Casey that if he becomes incapacitated, Sam will need to start a process with both the Social Security Administration program and the Department of Veteran Affairs (VA) program. Both programs are intended to assist income beneficiaries who are incapacitated. Adrienne informs Casey that each agency has its own process to appoint a representative payee. Neither of these agencies will accept powers of attorney or letters of conservatorship, but may use them as a factor in appointing a representative payee. So Sam may one day become representative payee of Casey for Social Security and the VA.

After this long meeting, Casey has realized that the power of attorney mentioned in the newspaper article is only one piece of a larger puzzle. Thanks to Adrienne's questions, legal knowledge, and practical skills about how financial decisions can be made, Casey left the meeting with a better understanding of his legal rights, and feeling relieved that he now knows how his financial plan will work upon his incapacity or death. ■

Government benefits provide a safety net for elders

By Amy Scott, Attorney at Law

Amy Scott is an attorney with the Oregon Law Center in Eugene.

Many elders in Oregon struggle to meet their basic needs. For elders who do not have sufficient income, food, healthcare, or housing, numerous public benefits are available.

Online resources provide information about the various program details and eligibility requirements. Useful websites include the Oregon Department of Human Services, Oregon Law Center, the U.S. Department of Veterans' Affairs, the Social Security Administration, Centers for Medicare & Medicaid Services, and Senior Health Insurance Benefits Assistance. Senior & Disability Services branch offices provide eligibility screenings, application assistance, and referrals to additional community resources.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal income-supplement program administered by the Social Security Administration. It is designed to help people who are 65 or older, or blind or disabled and do not have sufficient income and resources to maintain a standard of living at the established federal minimum income level. 20 CFR Part 416. The amount of payment is the federal benefit rate (FBR), which in 2018 is $750 for a qualified individual and $1,125 for a qualified couple. The Social Security Administration will subtract countable income from the FBR. Applicants under age 65 must meet the Social Security Administration's disability criteria, which means they must not be able to engage in any substantial gainful activity (SGA) because of a medically determinable physical or mental impairment that is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months. Generally, a person is engaged in SGA when his or her income is more than a certain dollar amount per month. In 2018, that amount is $1,180 for non-blind disabled applicants and $1970 for blind applicants.

Social Security

Social Security is a federal insurance program that provides monthly cash income through retirement-insurance benefits or disability-insurance benefits. 20 CFR Part 404. Social Security retirement benefits are available to individuals who have sufficient work credits based on their earning history. Benefits can begin as early as age 62. Social Security disability benefits are available to individuals who are under age 65, have sufficient work credits based on their earning history, and meet the Social Security Administration's disability criteria. The amount of the benefit is based on the individual's average yearly earnings.

Medical benefits

Medicaid is a federal program managed by the state to provide health insurance for low-income individuals. Oregon provides Medicaid services through the Oregon Health Plan (OHP). There are several programs and each one has different resource and income eligibility requirements, as well as non-financial eligibility requirements such as residency and citizenship status, age, other available healthcare resources, and disability status.

OHP Plus is for people aged 65 and over, blind, disabled, or SSI eligible. OHP Plus covers most medically necessary healthcare services for covered conditions. Coverage includes doctor, pharmacy, hospitalization, medical transportation, dental, preventative care, and mental health service. Income limits are based on 100% of the SSI limits, which in 2018 is $750 for an individual and $1125 for a couple.

OHP Plus MAGI is the Medicaid expansion program under the Affordable Care Act, also known as "Obamacare." This program is for individuals aged 19 to 64, who do not receive SSI and are not eligible for other Medicaid or Medicare programs. Benefits are the same as OHP Plus benefits, and income limits are 138% of the federal poverty level.

The **Citizen Alien Waivered Emergent Medical program** (CAWEM and CAWEM Plus) is for people who would be eligible for OHP if they were U.S. citizens or met the immigration requirements for those programs. It covers emergency medical services, and some pre-natal and delivery services.

Home and Community Based Waiver and Nursing Facility coverage provides opportunities for Medicaid beneficiaries to receive service in their own homes or community settings such as adult foster homes, assisted-living and residential-care facilities, and nursing facilities.

Continued on page 11

Government benefits

Continued from page 10

Oregon determines Medicaid eligibility for long-term-care services based on an individual limitation of activities of daily living as defined in OAR 411-015-000, or service priority level. Applicants currently eligible for Medicaid long-term care-services must have service priority level of 1–13. OAR Chapter 411, Division 15.

State Plan Personal Care Services is a program that provides up to 20 hours of personal-care service for individuals who need assistance with personal care and supportive services, but who are not eligible for home and community based care. OAR Chapter 411, Division 34.

Oregon Project Independence provides supplemental supportive services to help people live independently at home. Individuals must be age 60 and over or 19 to 59 and disabled, and have a qualifying need for assistance with activities of daily living and instrumental activities of daily living that meets the state requirements. OAR 411-015-0010

Medicare is a federal health insurance program for people over age 65, certain younger people with disabilities, and people with end-stage renal disease. Medicare is available to individuals if they or their spouse have worked for a certain number of years and have earned sufficient work credits. Medicare Part A is hospital insurance that provides coverage for in-patient hospital stays, limited care in a skilled nursing facility, hospice and some health care. Part B is medical insurance that covers certain physician services, outpatient care, medical supplies, and preventative services. Part C Medicare Advantage offers extra coverage like dental and vision, hearing, and or health and wellness programs. Part D is prescription drug coverage.

The **Medicare Savings Program** provides assistance for low-income Medicare beneficiaries by payingMedicare premiums, and in some cases, Medicare deductibles and co-insurance amounts.

Veterans' benefits

The Department of Veterans' Affairs provides a range of benefits to eligible veterans and their dependents, including disability compensation benefits, disability pension benefits, education, home loans, insurance, health resources, and reimbursement for burial expenses.

Oregon's veteran's property tax exemption allows eligible disabled veterans or their surviving spouse or registered domestic partner to exempt a portion of their homestead property's assessed value from property taxes. ORS 307.250-307.283.

Oregon Employment Department Veterans Services provides employment and training opportunities for eligible veterans and their spouses. Eligible veterans and their spouses may qualify for priority of service in employment and training services, and they can be connected with a veteran representative who provides job seeking case management services to assist veterans with finding employment.

Housing

Housing assistance may be available for low-income families and individuals, the elderly, and persons with disabilities through subsidized housing, public housing, or the section 8 voucher program which provides rental assistance to low-income families who find a home through the private rental market. Generally, tenants in federally subsidized housing pay 30 to 35% of their income as rent or a portion of the total rent in an amount determined by the agency or organization that provides rental assistance. The local housing authority is the best resource for determining eligibility and availability of assistance programs.

Nutrition and General Assistance Programs

The **Supplemental Nutrition Assistance Program** (SNAP) is a federal assistance program that offers food benefits to low-income individuals and families. OAR Chapter 461.

General Assistance provides assistance for individuals with disabilities who are homeless or at risk of homelessness. Applicants must meet the Social Security Administration's disability criteria, be receiving presumptive Medicaid medical assistance, meet all eligibility criteria for SSI, and have a pending SSI application. Qualifying individuals may receive up to $545 per month in housing assistance, $90 in utility assistance per month, $60 cash per month, and free assistance with Social Security application and appeals process. OAR Chapter 461. ■

Medicare fall open enrollment

Open enrollment runs from October 15 through December 7 each year. During this time, beneficiaries can make changes to health-insurance coverage, including adding, dropping, or changing Medicare coverage.

One can make as many changes as needed to Medicare coverage, including:

- Joining a new Medicare Advantage Plan
- Joining a new Part D prescription drug plan
- Switching from Original Medicare to a Medicare Advantage Plan
- Switching from a Medicare Advantage Plan to Original Medicare (with or without a Part D plan)

Things to consider:

- Access to providers one wants to see
- Access to preferred pharmacies
- Access to needed benefits and services
- Total costs for insurance premiums, deductibles, and cost-sharing amounts

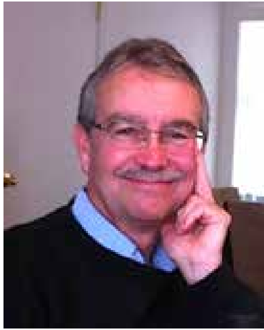
For information on Original Medicare, visit www.medicare.gov or read the 2019 *Medicare and You* handbook.

For information on a Medicare Advantage Plan or a stand-alone Part D plan, read the plan's *Annual Notice of Change* and/or *Evidence of Coverage*.

Changes made to Medicare coverage during fall open enrollment will take effect on January 1, 2019. ■

Changes to Oregon's advance directive form

By Michael A. Schmidt, Attorney at Law



Mike Schmidt is a former member of the Elder Law Executive Committee and has been practicing in Washington County since 1978.

Almost 30 years after its adoption, the Oregon advance directive form was showing its age. Never loved by most practitioners, it at least gave Oregonians a method by which to appoint health care representatives and indicate medical wishes if the person became unable to make and communicate health care decisions. But completing the form has had its difficulties, not the least being its reference to previous forms in existence in 1989.

A task force was formed that included representatives of the healthcare industry and the legal community to consider revision of the advance directive statute and form. It met over a period of three years, supported by the Oregon State Bar and Senator Floyd Prozanski.

The primary complaint of the medical community was that the form failed to allow patients a way to communicate how decision makers should go about reaching medical decisions that were not covered by the form; for example, the factors or values the decision maker should consider. The attorneys wanted to be sure that whatever form was developed would accomplish certainty of enforceability for clients who signed the forms. Everyone recognized the need to have the form reviewed, and if appropriate, modified, on a regular basis. The result was House Bill 4135. https://olis.leg.state.or.us/liz/2018R1/Downloads/MeasureDocument/HB4135/Enrolled

Effective January 1, 2019, there are two forms: one for appointing a healthcare representative only and one for appointing a healthcare representative and giving healthcare instructions. The Oregon Health Authority will post the advance directive forms to its website. Both forms can be found in Sections 5 and 6 of HB 4135. It is hoped that people will find these forms easier to understand and complete. Some changes you will notice are:

- The principal can now appoint a second alternative healthcare representative.
- As an alternative to two witnesses, the principal's signature can be notarized.
- The principal is to indicate whether the healthcare representative is to follow the instructions given, or instead is to use the instructions as a guideline to consider when making a decision; or the principal can give other instructions. See 3. of the advance directive form.
- The Directions Regarding My End of Life Care section provides definitions of certain terms.
- If the principal does not want life support or tube feeding to prolong life, that choice is at the beginning of the instructions rather than the end. See 4.A. of the advance directive.
- Additional writings can be attached by the principal to the advance directive as guidelines the healthcare representative can use. See 4.C. of the advance directive.
- The limitations on witnesses has been reduced to prohibiting only the healthcare or alternative healthcare representatives, or attending healthcare providers, as witnesses to the forms. See Section 8 (4), HB 4135.

Do not use these forms prior to January 1, 2019. See Sections 33 and 34(1) HB 4135. However, advance directives executed prior to January 1, 2019, on the old form remain effective, as do old forms executed after January 1, 2019 "if the principal relied in good faith on" the law as it existed prior to HB 4135. See Section 33, HB 4135.

Beginning in 2020, the Advance Directive Adoption Committee established by Section 2 of HB 4135 is to report any proposed change to the legislature by September 1 of even-numbered years, but no proposed change is effective until it has been ratified by the legislature during the following odd-numbered-year regular session. See Section 4 of HB 4135.

Remember: an advance directive is not a POLST (Physician Orders for Life-Sustaining Treatment). See Section 1.12 in the OSB publication *Elder Law—2017 Revision*. https://ebiz.osbar.org/ebusiness/ProductCatalog/Product.aspx?ID=220. The POLST is the order of the patient's doctor to other medical providers. It is signed by the doctor. In contrast, the advance directive is the act of the principal to appoint healthcare representatives and indicate preferences for life- upport or tube feeding. The advance directive is signed by the principal, not the principal's doctor. The POLST has a registry (See ORS 127.663). The advance directive, at present, does not have a registry. ■

Health insurance options for adults 55+ and the transition to Medicare

By Leslie Nori Kay, Attorney at Law

Leslie Kay is a semi-retired attorney and an active grandparent. She was the Regional Director of the Portland Office of Legal Aid Services of Oregon from 2002–2014 and has focused on Elder Law throughout her career. Leslie is currrently the Interim Executive Director of Youth, Rights & Justice in Portland.

The transition to Medicare at age 65 can involve a dizzying array of choices. Frequently, decisions about health insurance are being made at the same time as other crucial choices, including the timing for application for Social Security retirement benefits and perhaps the coordination of those benefits with one's spouse.

Health insurance options are typically affected by the source of one's health insurance prior to age 65. Should the individual remain on an employee group health plan (EGHP)? Should he or she opt for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) when employment ends—and how does that affect Medicare enrollment and dependent coverage? What about retiree health plans available from an employer? Or military health plans (Tri-Care) and veterans benefits? When should one enroll in Medicare Parts A & B? What are the pros and cons of original Medicare or a Medicare Advantage plan? How does one choose a stand-alone Medicare Part D Prescription drug plan? If one opts for original Medicare, does one need a supplemental Medigap policy? Is assistance available for payment of Medicare premiums, deductibles, co-pays, Part D prescription drug costs, and other health care costs if one is low-income? What about eligibility for the Oregon Supplemental Income Program (OSIPM), the Medicaid program for very-low-income/resourced seniors? What about eligibility for Medicare and Medicaid programs if one is a lawful permanent resident, but not a citizen? The list goes on—and this does not even touch on planning for long term care.

This article and accompanying chart on page 16 briefly summarize the health insurance options for

- Adults between the ages of 55 and 65 who are not Medicare eligible
- Medicare-eligible individuals 65+ or younger individuals who receive Medicare benefit due to disability. (People who qualify for Medicare before age 65 would generally be receiving Social Security Disability Insurance income for more than 24 months or have end-stage renal disease or amyotrophic lateral sclerosis.)

The transition years before Medicare eligibility at age 65

Prior to age 65, the aging population typically has the following sources of health insurance: employer, union, military, veteran or other group health insurance, including a retiree plan from a former employer or COBRA. Some individuals receive Medicare if they have been disabled for 24 months or more and receive Social Security Disability Insurance. Another sector of the eligible population obtains health coverage through the Affordable Care Act marketplace plans. Lower-income individuals 65 and under are eligible for Oregon's Medicaid Program, called the Oregon Health Plan/MAGI Medicaid. The latter three programs merit additional explanation.

Oregon health insurance marketplace plans (Affordable Care Act)

Private health insurance plans, and financial help with coverage, are available at Oregon's Affordable Care Act (ACA) portal that links to the federal ACA site, HealthCare.gov: https://healthcare.oregon.gov. Private health insurance plans in every Oregon county are offered. All plans include comprehensive health benefits, and the Oregon health insurance marketplace makes sure the plans meet state and federal requirements. Most Oregonians who enroll in these plans get help paying for their coverage.

Oregon Health Plan/Modified Adjusted Gross Income (MAGI) Medicaid

Low-income individuals under age 65 may be eligible to get health insurance through the Oregon Health Plan/MAGI Medicaid. MAGI Medicaid is a joint federal and state health care program for low-income people under 65 years of age. Sometimes it is referred to as the Medicaid expansion program. Oregon determines financial eligibility for MAGI Medicaid based on modified adjusted gross income. The MAGI formula does not count certain sources of income, including Veterans benefits. MAGI has no asset or resource test, which is a significant change from Oregon's OSIPM Medicaid program for people 65 years and older.

Continued on page 14

Health insurance

Continued from page 13

The Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA provides that certain former employees, retirees, spouses, former spouses, and dependent children have the right to temporary continuation of health coverage at group rates with specific qualifying events for employees, spouses, and dependent children. One of the qualifying events for spouses is when the covered employee becomes eligible for Medicare. Group health coverage for COBRA participants is typically more expensive than health coverage for active employees, because the employer pays a part of the premium for active employees. It may be less expensive, though, than individual health coverage before a person is Medicare eligible. Employers with 20 or more employees are usually required to provide COBRA coverage. Coverage is most often for 18 months, but may last up to 36 months.

The interaction of COBRA coverage and Medicare eligibility is complicated and can lead to coverage gaps and enrollment penalties for employee and dependents if not carefully planned. How Medicare and COBRA work together depends on which type of coverage a person has first. For more information, see https://www.ssa.gov/disabilityresearch/wi/medicare.htm#cobra.

AGE 65: Medicare

Most individuals who have a sufficient work history and meet residency and other criteria become eligible for premium-free Medicare Part A hospital benefits at age 65. One must pay a premium for Part B medical benefits. If one doesn't have sufficient work history, one must pay premiums for both Part A and B. One must be mindful of enrollment deadlines for Part A and B or face penalties. Enrollment can begin three months before or after one's age 65 birth month. Special enrollment periods (SEPs) apply if an individual or spouse is covered by an employee group health plan (EGHP) and potentially if one elects for COBRA coverage when one leaves work.

Assistance is available in sorting through Medicare enrollment issues from the staff and volunteers at Senior Health Insurance Benefits Assistance (SHIBA). SHIBA publishes the detailed Oregon Guide to Medicare Plans. Help is also available through licensed health insurance agents. See http://oregonhealthcare.gov/gethelp and its "Medicare agent" search tool.

Medicare beneficiaries can receive their benefits in the following ways:

- Receive Part A and Part B services through the Original Medicare program and obtain a stand-alone Part D prescription drug plan.
- Receive Part A and Part B services from a Part C Medicare Advantage Plan. Most plans include Part D prescription drug coverage and additional benefits such as dental, vision, hearing, fitness memberships, etc.

Original Medicare Part A. Medicare Part A covers basic hospital services, skilled nursing facility care (SNF), home health, hospice care, and blood services, but leaves part of the cost for a beneficiary to share. Most people have no premium for Part A if they have 40 or more work credits (ten years). Beneficiaries are liable for non-Medicare-approved charges.

Original Medicare Part B. Medicare Part B covers medical services such as physician services, emergency room, diagnostic tests, ambulance, diabetes supplies, durable medical equipment, prosthetics, orthotics, occupational, physical and speech therapy, home health care, preventive services, and mental health—but leaves part of the cost for a beneficiary to share. The Part B premium depends on income. There is an annual deductible and co-pays of 20% of Medicare-allowed amounts.

Optional Original Medicare supplemental coverage (Medigap). Because of gaps in Original Medicare Part A and B coverage, private insurance companies sell Medicare-supplement insurance policies also known as Medigap plans. You must have Medicare Parts A ad B to purchase a Medigap plan. A Medigap plan cannot pay if you also enroll in a Medicare Advantage plan. There are several options for Medigap plans:

Standard Medigap insurance. Medigap plans are named by letter: Plan A through Plan N. They generally pay deductibles and co-insurance not covered by original Medicare. There can be waiting periods for pre-existing conditions. Plan premiums may increase each year because you are a year older. During open enrollment periods or guaranteed issue periods, companies must sell policies without consideration of medical history. At other times, a company may refuse your application.

Medicare supplement select plan (Medigap). These are limited versions of standardized Medigap insurance that cost less because of limits on which clinics, doctors, and hospitals are covered for non-emergency and non-urgent care.

Medicare Supplement innovative plan (Medigap). These plans must follow federal and state laws and can offer some additional benefits at no extra cost to the Medicare beneficiary.

Medicare Part C Advantage plans. Medicare Advantage plans are Medicare-approved private health-insurance plans for individuals enrolled in Original Medicare, Part A and Part B. When you join a Medicare Advantage plan, you are still in the Medicare program and must continue paying your Part B premium.

Medicare Advantage plans provide all of your Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage. They generally offer additional benefits, such as vision, dental, and hearing, and many include prescription drug coverage. These plans often have networks, which mean you may have to see certain doctors and go to certain hospitals in the plan's network to receive care.

Continued on page 15

Health insurance

Continued from page 14

Medicare Advantage plans may save money because out-of-pocket costs in these plans can be lower than with Original Medicare. Costs will vary by the services you use and the type of plan you purchase. Each Medicare Advantage plan can charge different out-of-pocket costs and have different rules for how you get services (such as whether you need a referral to see a specialist or can use only doctors, facilities, or suppliers in the network).

Stand-alone Medicare Part D prescription drug plan. The Part D standard benefit requires the beneficiary to pay a monthly premium, an annual deductible, and a portion of costs during the deductible period, initial benefit period, the coverage gap ("donut hole"), and the catastrophic coverage period. In some cases, you may opt for a stand-alone Medicare Part D plan with a Medicare Advantage plan.

Programs that assist low-income individuals with healthcare costs

Programs that provide assistance with healthcare costs are constantly changing. Consult government websites listed in the resource section on page 17 for up-to-date information.

Medicare savings programs. There are four Medicare savings programs (MSP) in Oregon designed to help low-income Medicare beneficiaries with payment of Medicare premiums and in some cases Medicare deductible and coinsurance amounts. These programs are no longer subject to estate recovery by the state, and since 2016 have not had asset or resource limits. The programs are:

- Qualified Medicare Beneficiary Basic (QMB-BAS)
- Qualified Medicare Beneficiary—Disabled Worker program (QMB-DW)
- Qualified Medicare Beneficiary—Special Medicare Beneficiary program (AMB-SMB)
- Qualified Medicare Beneficiary—Supplemental Medicare Full (QMB-SMF)

Medicare Part D low-income subsidies (LIS). The federal low-income subsidy program saves qualifed Medicare beneficiaries money on their Medicare Part D plans. The assistance reduces the monthly premium (often to zero) cuts the yearly deductible to $0, and reduces pharmacy co-pays, and eliminates the coverage gap ("donut hole") of the Part D standard benefit. https://www.ssa.gov/pubs/EN-05-10508.pdf.

Oregon Medicaid (OSIPM). OSIPM is a Medicaid means-tested (income & resources) program for eligible Oregonians who are legally blind, have a physical or developmental disability, and/or are 65 or older. OSIPM limits resources to $2,000, with some excludable resources such as a home in which the beneficiary lives. OSIPM is often a secondary payer after Medicare for low-income Oregonians.

Dual-eligible beneficiaries. *Dual eligible* is the general term that describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits (OSIPM) and/or assistance with Medicare premiums from one of the Medicare savings programs (MSP) described above.

Oregon prescription drug program discount card (OPDP) is a bulk-purchasing pool and is free to all Oregon residents. You may have both Part D Medicare and an OPDP discount card, but can use only one for a purchase. https://www.oregon.gov/oha/HPA/CSI-OPDP/Pages/index.aspx.

Drug manufacturers' discount programs or patient-assistant programs. A good resource to be connected to these programs that provide financial assistance for purchasing medications is https://www.needymeds.org.

Charity care. Charity care is financial assistance administered by a hospital or some medical groups for medical services. If one cannot afford to pay a hospital bill, one may be eligible to have part or all of the bill forgiven as charity care. Charity care policies vary greatly from hospital to hospital and from medical group to medical group. Many hospital policies forgive the entire hospital debt for people living below 150% of the federal poverty level (FPL). Others forgive the entire hospital debt for people living below 200% of FPL. For more information about charity care see: https://oregonlawhelp.org/resource/charity-care-financial-assistance-for-hospita.

Transition to Medicare from employment-based health insurance

The timing of enrollment in Medicare is the major issue that faces retiring workers or individuals when they reach age 65.

Enrollment Periods. Various deadlines apply for enrollment or disenrollment in Medicare parts A & B & D and Part C Advantage Plans:

IEP: (Initial Enrollment Periods, Parts A & B) Seven-month period surrounding one's 65th birth month

OEP: (Open Enrollment Period)

AEP: (Annual Enrollment Period, Part D) October 15 to December 7

GEP "(General Enrollment Period, Parts A & B): January 1 to March 31

SEP: (Special Enrollment Period) A period of time that provides an opportunity to join or leave a plan outside regular enrollment periods

MADP: (Medicare Advantage Disenrollment Period): January 1 to February 14

Continued on page 16

Health insurance

Continued from page 15

If a person continues to work and becomes Medicare eligible, a number of issues arise as one transitions to Medicare plans. Employees should consult with their employers at least six months in advance of age 65 to understand what options may be available and obtain copies of the employer group health and/or other applicable retiree policies, so they can determine how the plan(s) works with Medicare. If one is enrolled in a veterans' or marketplace plan or other health plan, one must also analyze how Medicare eligibility will affect continuing eligibility and enrollment in that plan. If a spouse or other family member is covered by the employee group health policy, one also needs to analyze how an employee transition to an individual Medicare plan or retiree health plan may affect dependent coverage. Additionally, election of COBRA coverage must be carefully considered to see how it interacts with Medicare and affects dependent coverage.

Employer, union, or other group health insurance. If a person is working at age 65 and covered by an employer group health plan (EGHP), he or she may be able to delay enrolling into Medicare. The size of the employer determines whether one may be able to delay enrollment in Medicare Part A and Part B without having to pay a penalty. If eligible for the delay, you become eligible for a special enrollment period (SEP) for Medicare Parts A & B and additional Medicare-related insurance plans when your EGHP coverage ends.

TriCare and veterans' benefits. Veterans who are eligible for Medicare and VA health benefits may receive services through either program. They must choose which benefit they will use each time they see a doctor or receive medical care. They must also make enrollment timing decisions. Every county is assigned a veterans service officer to help with VA benefits. See http://Oregon.gov/odva/Pages/contact_us.aspx. (Phone: 800 828 8801.) Similarly, active-duty and retired service members who have TriCare must make enrollment decisions.

Retiree group plan from former employer. Retiree health-insurance plans available to former employees generally require enrollment in Medicare Part A & B. If one is enrolled in a retiree plan before age 65, one must find out what happens to retiree coverage (and any spouse or dependent coverage) when one is eligible for Medicare. Likewise, if Medicare eligible and still working, one must investigate eligibility to enroll in a retiree plan from either a current or former employee.

Individuals with Medicare are generally not eligible for the marketplace plans. If a person is enrolled in the Medicare program, he or she cannot enroll in a plan from the marketplace (called a qualified health plan, or QHP) to supplement Medicare coverage. There are limited situations in which one may enroll in a QHP and drop Medicare coverage.

Individuals with marketplace plans becoming eligible for Medicare. If a person is enrolled in a marketplace plan and becomes eligible for Medicare, he or she will need to investigate whether it is possible keep this plan and the impact of Medicare eligibility on the plan benefits.

Medicare coverage outside the United States. Original Medicare does not pay for health care services outside the U.S. except in limited situations. Some Medigap plans paired with Original Medicare may cover emergency care outside the U.S. Some Medicare Advantage plans may provide more robust coverage. Anyone who plans to travel extensively should research plan benefits, and also consider purchasing independent travel insurance. ■

HEALTH INSURANCE OPTIONS FOR ADULTS 55+

	Age 55-65 Not on Medicare	Age 65+ Medicare Eligible or 55-65 & SSDI	Eligibility or Subsidy Means testing
Employer or Union Group Health Insurance	X	X	
Retiree Group Plans from former employer	X	X	
COBRA	X	X	
Oregon Health Insurance Marketplace Plans (ACA)	X		X
Oregon Health Plan/Modified Adjusted Gross Income(MAGI) Medicaid	X		X
Oregon Medicaid (OSIPM)	X	X	X
Original Medicare Part A		X	
Original Medicare Part B		X	X
Optional Original Medicare Supplemental coverage (Medigap)		X	
Medicare Part C Advantage Plans		X	
Medicare Premium-deductible-Co-insurance Help Programs (QMB-BAS,DW,SMB,SMF)		X	X
Stand Alone Medicare Part D Prescription Drug Plan		X	
Medicare Part D Low Income Subsidies		X	X
Oregon Prescription Drug Program Discount Card	X	X	
Drug Manufacturers discount programs or patient-assistant programs	X	X	X
Charity Care	X	X	X
Veterans Benefits	X	X	X
Military Health Benefits (TRICARE)	X	X	

Resources for elder law attorneys

Events

The Science of Implicit Bias
November 9, 2018
Oregon State Bar Center, Tigard
https://ebiz.osbar.org/ebusiness/Meetings/Meeting.aspx?ID=1541

2018 NAELA Summit
November 15–17, 2018
Chicago, Illinois
https://www.naela.org/store/events/registration.aspx?event=2018SUMT

Basic Estate Planning and Administration
November 16, 2018
Multnomah Athletic Club, Portland
https://ebiz.osbar.org/ebusiness/Meetings/Meeting.aspx?ID=1658 ■

NAELA eLearning courses

Understanding Diminished Capacity
This course explores the topic area of diminished capacity. It is intended to assist in accessing capacity when using the *APA Handbook for Attorneys* and the accompanying *Capacity Worksheet for Lawyers*. In addition to the associated reference-based resources, the interactive format includes video instruction and analysis from NAELA members Roberta Flowers and Edwin Boyer, as well as simulated consultation for review.
https://www.naela.org/store/detail.aspx?id=E_CAPACITY

Traditional Medicaid Planning: Medicaid Coverage for Long Term and Nursing Home Care of a Single Person
This NAELA E-learning combines articles, expert videos, quizes and further suggested reading material.
https://www.naela.org/store/detail.aspx?id=E_ADVMEDICAID ■

Website

Elder Law Marketing 101
This blog from eldercounsel.com suggests ways to attract and retain elder law clients. https://blog.eldercounsel.com/elder-law-practice-marketing-101 ■

Health insurance information

Applying for Affordable Care Act (Obamacare) health plans: https://healthcare.oregon.gov/Pages/index.aspx

Medicare: https://www.medicare.gov

Medicare Premium Help: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/pages/qmb.aspx

Medicare Part D prescription drug coverage: https://www.medicare.gov/drug-coverage-part-d

Oregon Health Plan/Medicaid: https://www.oregon.gov/oha/hsd/ohp/pages/index.aspx

Applying for the Oregon Health Plan: https://www.oregon.gov/oha/HSD/OHP/Pages/Apply.aspx

OSIPM Program Information Sheet: https://apps.state.or.us/Forms/Served/de9831.pdf

OSIP Program Manual: http://www.dhs.state.or.us/spd/tools/program/osip/index.htm

Oregon Prescription Drug Program: https://www.oregon.gov/oha/HPA/CSI-OPDP/Pages/index.aspx

Needy Meds (Help with prescription drug purchasing): https://www.needymeds.org

Military Health System (Tricare): https://www.tricare.mil

Veterans Benefits: https://www.oregon.gov/odva/Benefits/Pages/Healthcare.aspx

Senior Medicare Patrol: 855 673 2372 (toll free). If a provider or plan can't answer billing questions, call this number.

SHIBA: 800 722 4134: Statewide network of certified counselors volunteering in their community to help all Oregonians make educated Medicare decisions.

Social Security Administration: www.ssa.gov

Legal Aid Services of Oregon & Oregon Law Center Public Benefit Hotline: The Public Benefits Hotline provides legal advice and representation to low income people living in Oregon who are having problems with government benefits. 800.520.5292

Multnomah County Senior Law Project: Free half hour legal consultations with attorneys at Multnomah County Senior Centers. https://oregonlawhelp.org/organization/senior-law-project

Publications:

SHIBA's *2018 Oregon Guide to Medicare Insurance Plans*: https://healthcare.oregon.gov/shiba/Documents/or-medicare-guide.pdf

Elder law booklet by Legal Aid Services of Oregon and the Oregon Law Center: (2014 and online updates) https://oregonlawhelp.org/files/CCDACC15-944D-570E-7F1F-7BBF3DEC0018/attachments/38BD41C4-C0C3-A5F6-3E23-D08050F29D32/elder-law-in-oregon-2014.pdf

An employer's Guide to Group Health Continuation Coverage Under COBRA. To request a copy, call toll-free 866.444.3272 ■

Elder Law Section annual meeting

The annual meeting of the Elder Law Section was held on October 5, 2018, at the Multnomah Athletic Club in Portland. Section Chair Jan E. Friedman presided.

The following members of the 2019 Executive Committee were elected:

Officers
Terms ending December 31, 2019

Chair:	Darin J. Dooley
Chair-Elect:	Theressa Hollis
Past-Chair:	Jan Elana Friedman
Treasurer:	Kathryn Belcher
Secretary:	Andrea Ogston

New Members-at-large
Terms ending December 31, 2020
Corey P. Driscoll.
Christopher David Hamilton
Julie C. Nimnicht

Continuing Member-at-large
Term ending December 31, 2020
Monica Pacheco

Members previously elected to the Executive Committee
Terms continuing through December 31, 2019
Kay Hyde-Patton
Jennifer Kwon
Michael Joseph Mayerle
Matthew C. McKean
Anastasia Yu Meisner
J. Thomas Pixton; and
Julie Meyer Rowett.

The Section's fund balance as of December 31, 2017 was $17,570. All Section financial statements can be found at http://www.osbar.org/sections/financials.html. ■

Index to Volume 21 of the Elder Law Newsletter

No. 1: January 2018
No. 2: April 2018
No. 3: July 2018
No. 4: October 2018

Elder Abuse
Suing a long term care facility ....No. 3, p. 1
Civil action for abuse .... No. 3, p. 4
Protection against financial abuse ... No. 3, p. 7
New law to curb financial abuse....... No. 3, p. 8
Bullying among elders .... No. 3, p. 9
Reporting elder abuse ....No. 3, p. 12
Grandparent scam ....No. 3, p. 12

Elder Law Basics
Client's capacity defined ....No. 4, p. 1
Overview of Long term care ....No.4, p. 4
Acronyms in elder law .... No. 4, p. 7
Government benefits .... No. 4, p. 10
Changes to advance directive form . No. 4, p. 12
Planning for financial decisions ....No.4, p. 8
Health insurance options .... No. 4, p, 13

Estate Planning
Appointment of a trustee.................. No. 2, p. 1
Avoiding trustee trouble....................No. 2, p. 3
Designation of a trust as beneficiary. No. 2, p. 5
Retirement benefits and trusts.......... No. 2, p. 7
Trust modification .... No. 2, p. 10
Pet trusts..No. 2, p. 11
Trust review by SSA & Medicaid ..... No. 2, p. 12
Planning for financial decisions ....No.4, p. 8

Ethics
Client's capacity defined ....No. 4, p. 1

Legislation
Legislative subcmmittee report...... No. 2, p. 18

Litigation
Suing a long term care facility ....No. 3, p. 1
Civil action for abuse .... No. 3, p. 4

Long Term Care
Overview of LTC options ....No. 4, p. 4
Suing a long term care facility ....No. 3, p. 1
Registration of placement agencies No. 3, p. 12
Changes to Oregon LTC program....No. 3, p. 12

Medicaid
Changes to long term care support ....No. 1, p. 1
Estate recovery .... No. 1, p. 4
Transfers to a disabled child .... No. 1, p. 8

Medicare
New Medicare cards ....No. 3, p. 14
Open enrollment ....No. 4, p. 11

Section News
Section unCLE program .... No. 3, p.15
2018 Annual meeting .... No. 4, p . 18

Trusts
Appointment of a trustee.................. No. 2, p. 1
Avoiding trustee trouble....................No. 2, p. 3
Designation of a trust as beneficiary. No. 2, p. 5
Retirement benefits and trusts.......... No. 2, p. 7
Trust modification .... No. 2, p. 10
Pet trusts..No. 2, p. 11
Trust review by SSA and Medicaid . No. 2, p. 12

Important elder law numbers

as of
October 1, 2018

Supplemental Security Income (SSI) Benefit Standards	Eligible individual .... $750/month Eligible couple $1,125/month
Medicaid (Oregon)	Asset limit for Medicaid recipient .... $2,000 Long term care income cap .... $2,250/month Community spouse minimum resource standard .... $24,720 Community spouse maximum resource standard .... $123,600 Community spouse minimum and maximum monthly allowance standards .... $2,057.50/month; $3,090/month Excess shelter allowance .... Amount above $617.25/month SNAP (food stamp) utility allowance used to figure excess shelter allowance .... $436/month Personal needs allowance in nursing home .... $61.38/month Personal needs allowance in community-based care .... $167/month Room & board rate for community-based care facilities .... $583/month OSIP maintenance standard for person receiving in-home services .... $1,250 Average private pay rate for calculating ineligibility for applications made on or after October 1, 2018 .... $8,784/month
Medicare	Part B premium .... $134.00/month* Part D premium .... Varies according to plan chosen Part B deductible .... $183/year Part A hospital deductible per spell of illness .... $1,340 Skilled nursing facility co-insurance for days 21–100 .... $167.50/day * Premiums are higher if annual income is more than $85,000 (single filer) or $170,000 (married couple filing jointly).

Elder Law Section

Newsletter Committee

The Elder Law Newsletter is published quarterly by the Oregon State Bar's Elder Law Section: Jan Friedman, 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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