Oregon State Bar

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Finding affordable housing is complicated

By Brian Brammer

The affordable housing landscape for elderly renters in Oregon is underfunded and complex, and often leads to negative outcomes for many of the state's most vulnerable citizens. An understanding of the system at least gives elderly renters and their support networks the best chance at a successful housing search. This article provides a brief overview of the system, housing options, eligibility criteria, and how to find housing.

It is important to know what entities provide low-income housing in the United States. The most significant providers are local housing authorities (HAs). Oregon's nine tribally designated housing entities (TDHEs) and 20 non-tribal HAs build and maintain housing stock, ensure regulatory compliance, and administer the department of Housing and Urban Development (HUD)'s Section 8 Housing Choice Voucher (HCV) program.

In this issue

Additional low-income housing is available at a much smaller scale from nonprofits.

Housing options

Although there are numerous funding streams at the federal and state level, a few forms of low-income housing for the elderly predominate. There are two primary issues for renters:

- Whether the prospective unit is subsidized or unsubsidized
- Whether a subsidized unit has a tenant-based or project-based subsidy

Subsidized units offer more stability, because the tenant's rent is calculated as a portion of their income, usually around 30%. In an unsubsidized low-income unit, the rent is a flat rate, which is kept below market value using state and federal tax credits, most commonly through the IRS Section 42 Low Income Housing Tax Credit (LIHTC) program.

In addition to paying less rent, subsidized renters often have the option to have their rents lowered or zeroed-out if their income is reduced by an emergency. There is no equivalent option for unsubsidized renters. If they cannot pay rent, their options are usually limited to getting outside help to pay, working with their landlord or the courts on a repayment plan, or surrendering their unit. For these reasons, subsidized units are often the only way to lasting housing stability.

Subsidized units can be further classified as tenant-based or project-based. A tenant-based subsidy, most commonly an HCV, enables renters to move their subsidy with them to a succession of units over their lifetimes. After a waiting period, HCV holders can even use

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their vouchers around the country. HCV holders can use their voucher in either a private market rental or an unsubsidized government-supported unit. Significantly, subsidies can almost never be combined, so an HCV holder would lose their voucher if they moved into an already subsidized unit.

For veterans, the Veterans' Affairs Supportive Housing (VASH) program couples HCVs with supportive services. Unlike traditional HCVs, VASH waiting lists are usually joined through VA hospitals, while HAs continue to administer the voucher. Unfortunately, VASHs have not proven to be a panacea for veterans' homelessness. Recent HUD data showed only 111 VASH units throughout Oregon in FY2020, with many HAs administering none at all.[1]

Landlords are prohibited from discriminating against voucher holders in Oregon and much of the country. While some stereotypes about voucher holders exist, experienced property managers are often happy to take voucher holders because the HUD portion of rent is guaranteed.

Project-based subsidies, commonly either Project-Based Section 8 (PBS8) or older subsidy models—often called "public housing"—are attached to the unit itself rather than the renter and will not follow a resident who moves. Project-based subsidies allow for a concentration of subsidized units in individual buildings or parts of buildings, which can allow for more efficient delivery of resident services.

Eligibility

There is no universal form of elderly-only housing. Because age is not a protected class under federal or state fair-housing laws, providers can set their own age standards depending on their funding requirements and community need. In practice, the definition of "elderly" usually begins between 55 and 62. Often, programs provide housing for both elderly and disabled renters in the same property. Once applicants fit a program's age range, they still must make sure they meet other eligibility criteria.

Most subsidized programs require applicants to have lived in the area previously and be a legal permanent resident of the United States. Applicants must also pass a criminal screening. Applicants subject to any lifetime sex offender registry are ineligible for all major forms of subsidized housing. Convictions for arson and the manufacture or delivery of controlled substances are difficult to overcome, even in low-barrier programs. Landlords will usually have an appeal process for failed screenings, which may allow for personal statements or letters from references.

Income restrictions for subsidized units are based upon a percentage of a renter's income in relation to the area's Median Family Income (MFI) or, less commonly, Area Median Income (AMI). https://www.huduser.gov/portal/datasets/il.html .

Renters may be required to have either less than a certain amount of income (e.g., less than 50% MFI) or to fall within a range (e.g., between 30% and 50% MFI). Earned income and Social Security benefits are generally counted as income while SNAP benefits are not.

Household assets under $5,000 do not count toward income for Section 8. Determining income levels for households with more than $5,000 in assets is complex and is addressed by property management during the application process.

Unsubsidized units will have lower and upper income limits for eligibility. Residents in many unsubsidized programs, including LIHTC, can usually keep their units, even if their income increases over the upper limit after a year or two, while subsidized renters must income-qualify for the duration of their tenancy.

Who can help?

Finding available units for low-income elderly renters is a learned skill and experience matters. Unfortunately, when it comes to housing the best person for the job often either does not exist or already has a full case load.

The ideal person to take on a housing search for a client is a housing case manager. The sole job of housing case managers is to find appropriate housing for clients. This requires detailed knowledge of the situation on the ground in

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their regions. Housing case managers are often attached to nonprofits which offer wider suites of services. Multnomah County's Outside In has programs specifically to help young people experiencing homelessness. Transition Projects, Inc., offers a broad swath of services to persons experiencing homelessness in the Portland area. The process for getting a housing case manager is almost identical to the process for accessing any services for low-income individuals in Oregon: first Google or call 211, then find agencies that serve your client's demographic. Next, make contact and hope to be lucky.

Case managers who do not specialize in housing are the next best option. Connecting to these case managers involves the same steps as a housing case manager. Because there are more generalist case managers there is a slightly higher chance of success. As a rule, HAs will not provide in-depth case management—so again, nonprofits are the best option.

The third and most common person to assist in a housing search is an enthusiastic amateur. This may be a family member, nurse, social worker, or anyone else with the client's best interests at heart. While they lack the experience and knowledge of a housing case manager, non-specialists can still provide invaluable service. It is hard to think of a well-meaning layperson representing someone in court simply because no one else is available, but that is often the reality of social services.

Finding a home

A good housing search begins with gathering the applicant's eligibility information and documentation. The most common forms of documentation required are an unexpired government-issued photo ID, proof of Social Security number, and proof of income. Social Security recipients will need an award letter, usually less than than 90 days old.

The next step is to find available units. The local HA is most likely to have open units. Local nonprofits may also have units, which can be found through the 211 website or Oregon's Aging and Disability Resource Connection (ADRC). People experiencing homelessness or who have other severe housing crises may also be eligible to enter coordinated entry systems. Under coordinated entry, Continuum of Care (CoC) programs attempt to integrate and streamline care options. Oregon has a number of CoCs. CoCs are organized geographically and each will have its own guidance for how best to access coordinated entry systems. More information, including the applicable CoC for your client, can be found on the website of the Oregon Housing Stability Council.

Although some unsubsidized units are first-come, first-served, all other vouchers and units will have waiting lists. Unfortunately, wait times are often measured in years, and it is not uncommon for there to be no open waiting lists in an area, even in major cities.

Certain circumstances can give applicants preference points to move up waiting lists faster. These can include terminal illness and sometimes veteran's or domestic violence survivor's status. Preference points are broadly discretionary, so they vary widely in their availability and application. Often, renters will have to move into unsubsidized units as a stopgap while they wait for a subsidized unit to become available.

If a unit becomes available, getting a lease signed and keys in hand takes consistent and speedy communication. Although not all landlords do it, fair housing best practice is to give the unit to the first applicant who is approved through screening. For a vulnerable applicant, the succession of deadlines and paperwork can be daunting, so support is critical.

Barriers to long-term success

Because of the extreme shortage of housing stock, many eligible and needy renters will not be able to find housing. Statewide, there are only 25 available affordable units for every 100 extremely low-income renter households. Portland is one of the five worst metro areas in the nation with a 21:100 ratio.[2] The state is roughly 300,000 units short of meeting the need. The lack of affordable units, especially subsidized ones, is reflected in the number of renters who are extremely rent burdened, spending more than 50% of their income on rent and utilities. In Portland, 79% of extremely low-income households and 36% of very low-income households are extremely rent burdened.[3]

Beyond rent, many other expenses can stretch renters beyond their budget. Moving costs, deposits, and application fees are rarely covered by subsidies. Some HAs, such as Home Forward in Multnomah County, no longer charge deposits or application fees for any of their units. Though nonprofits can sometimes offer grants or low-interest loans to help, the state is deeply under-resourced in this area.

Elderly renters also face many non-financial barriers to housing stability. The best way to overcome health or resource barriers for vulnerable elderly renters is to help them access case management and caregiving. Case managers are advocates who connect renters to resources. Caregivers assist with activities of daily living (ADLs) such as bathing or housekeeping. Case management can come from a variety of public and nonprofit agencies, while caregiving is usually obtained through the renter's county.

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Connecting case management and caregiving for elderly renters can depend on their insurance. Susan Sehm, a case manager at the Bud Clark Commons in Old Town Portland, says renters who have Medicaid or both Medicare and secondary insurance are automatically clients of the Department of Human Services (DHS) in their home county. DHS can refer them to their local Aging and Persons with Disability Services (APD). Renters who are elderly or disabled may already be in the system, but not know it.

For individuals eligible for caregiving services, elderly persons with Medicaid will often pay nothing out of pocket, while those with Medicare and secondary insurance will usually have a co-pay. Medicare recipients with a secondary insurance must enroll for services through their secondary insurer. Ms. Sehm says it is extremely rare for a client to have Medicare without a secondary insurer. When it happens, it has proven easiest to enroll them with a secondary insurance rather than try to overcome Medicare's limits on caregiver funding. For clients who are still slipping through the cracks, the best first step is usually contacting APD directly.

There are several programs and funding streams for in-home care. Medicaid-funded plans include the Independent Choices Program (ICP) or Spousal Pay Program, which can pay family members to provide care; as well as the PC20 program, which provides caregiving for up to 20 hours a week for eligible participants. In almost all cases, a DHS or APD worker will be best suited to help clients navigate the complex application requirements of these programs. Elderly renters' care teams are most helpful to assist in gathering documentation, scheduling interviews, and making sure clients have their questions answered.

Conclusion

The housing situation for low-income elderly Oregonians is bleak and unlikely to improve soon. Many will not be able to find affordable housing, and those who do will still face significant obstacles to long-term housing stability. Unfortunately, this leaves many vulnerable renters and their support networks with no better options than to hope to be one of the lucky ones.

Although individual renters and care teams may be able to find housing via the strategies outlined in this article, a systemic fix would require a five-fold increase in affordable housing stock in Oregon. Low-income housing for the elderly is zero-sum: each success for an individual closes off a unit to a host of equally deserving applicants. While this should not stop care teams from zealously advocating for their clients, it underscores the need for aggressive legislative action.

One of the many tragedies within the broader housing crisis is that earlier intervention could have saved lives and money. Persons experiencing chronic homelessness experience symptoms of aging at a rate far surpassing the housed who are 20 years older.[4] While geriatric medicine has advanced significantly in its recognition of this fact, the broader culture and public policy still defines elderly as a set age group. This excludes many people who have the same or greater vulnerabilities as older individuals who have not been chronically homeless. Many of the chronically homeless could have thrived in an unsubsidized apartment decades ago when they began to experience housing instability. But due to governmental disinvestment in low-income housing and the abject realities of life on the street, such individuals are unlikely to survive without more resource-intensive housing options.

The health and housing crises for elderly low-income Oregonians are not insoluble. We know from decades of research that housing saves lives. All that is missing, and it is a big "all," is the willpower to build more low-income housing. The alternative is the status quo: elderly renters and their care teams scrambling for a paucity of available units. The only question is how long we can go on moving through our streets, knowing that our elderly and disabled neighbors are living—and too often dying—within feet of us. ■

Endnotes

1. HUD-Veterans Affairs Supportive Housing, HUD VASH Awards (2008-2018) - Corrected for Recissions & 2020 Awards
2. Andrew Aurand et. al, "The Gap: A Shortage of Affordable Homes," National Low Income Housing Coalition, 9-10 (2021)
3. Oregon Housing and Community Services, Oregon Housing & Demographic Profiles
4. Margot Kushel, "Older Homeless Adults: Can We Do More?", *Journal of General Internal Medicine*, 5-6 (2012)

Adult Foster Home Program

When elderly people or adults with physical disabilities are no longer able to care for themselves in their own homes, adult foster care may be an option. Adult foster homes are single-family residences that offer 24-hour care in a home-like setting. The Oregon Department of Human Services has information about this option on its website.

Effects of special needs trusts on Section 8 housing

By Julie Nimnicht, Attorney at Law

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The housing choice voucher program—also known as "Section 8"—is a federal program designed to help low-income families, elderly individuals, and individuals with disabilities afford rent in the private housing market. Eligibility for the Section 8 program is based on the applicant's assets, income, and family status. 24 CFR § 982.201. For some individuals who receive means-tested government benefits, transferring assets to a special needs trust allows them to maintain eligibility for benefits like Supplemental Security income (SSI) and Medicaid while preserving assets for their future needs. In contrast to Social Security and Medicaid, however, the Public Housing Authorities (PHAs) that administer Section 8 programs across the country often treat distributions from special-needs trusts as income to the beneficiary, which can negatively affect the beneficiary's eligibility for housing benefits.

Asset and income limits

Assets. Under Section 104 of the Housing Opportunity Through Modernization Act (HOTMA), a family whose net family assets exceed $100,000 (as adjusted annually for inflation) will not be eligible for Section 8 assistance. 42 USC § 1437n(e)(1)(A). The Act contains a list of specific assets that are excluded from consideration, including certain personal property, the value of retirement accounts, and certain settlement and injury-award proceeds. 42 USC § 1437n(e)(2)(B)). Under 42 USC § 1437n(e)(2)(C)), funds held in a special-needs trust are not considered available resources as long as the trust is irrevocable and the trustee does not reside with the participant. Any income distributed from the trust, however, "shall be considered income for purposes of section 1437a(b) of this title and any calculations of annual family income, except in the case of medical expenses for a minor." 42 USC § 1437n(e)(2)(C).

Income. In order to qualify, a household's income cannot exceed 50 percent of the median family income for the area. 42 USC § 1437a(b)(2).

A Section 8 participant is typically responsible for paying 30 percent of the monthly adjusted income of the family toward rent, after which the PHA subsidizes the remaining rent. 42 USC § 1437f(o)(2)(A)(i).

HOTMA defines income very broadly as income from all sources of each member of the household, with very limited exceptions. 42 U.S.C 1437a(b)(4). Federal Housing and Urban Development (HUD) rules define adjusted income to mean annual income less specified deductions. 24 CFR § 5.611. The term *annual income* means all amounts—monetary or not—which go to, or on behalf of the tenant or the tenant's family, or are anticipated to be received from a source outside the family during the relevant year, and are not specifically excluded. 24 CFR § 5.609(a).

Also included under the definition of annual income are regular contributions or gifts received from organizations or from persons not residing in the dwelling. 24 CFR § 5.609(b)(7).

Distributions from special-needs trusts may constitute income

Some PHAs have interpreted the above definitions to mean that distributions from special-needs trusts constitute income to the trust beneficiary, even when the distributions for expenses unrelated to food and shelter are made directly to vendors and service providers on behalf of the beneficiary. As a result, some special-needs beneficiaries whose trusts pay for monthly expenses such as telephone, internet, cable TV, transportation, personal care, pet care, etc.—which, if paid directly to the vendor would not constitute income under the SSI and Medicaid programs—have had their Section 8 vouchers reduced or have lost their eligibility altogether because their local housing authority has interpreted such distributions to be income to the beneficiary.

Excluded income. The HUD rules exclude certain types of payments from the definition of income, including the following:

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Special needs trusts and Section 8 housing *Continued from page 5*

- Lump-sum additions to family assets, such as inheritances, and insurance payments
- Capital gains and settlement for personal or property losses
- Amounts received by the family that are specifically for, or in reimbursement of, the cost of medical expenses for any family member
- Temporary, nonrecurring or sporadic income (including gifts)

24 CFR § 5.609(c)(3), (4), and (9).

The rules do not, however, define temporary or sporadic, but instead leave it up to the PHAs to decide what constitutes temporary or sporadic income.

Case law. The treatment of distributions from a special-needs trust under the Section 8 program rules can vary from state to state, and even county to county. This has led to litigation, but the resulting decisions have not provided much clarity. In *DeCambre v. Brookline Housing Authority*, 826 F3d 1, 15–17 (1st Cir 2016), the First Circuit Court of Appeals considered whether a local PHA in Massachusetts properly deemed principal distributions from a first-party special-needs trust that did not fall into a regulatory exclusion at the time of disbursement as annual income to the trust beneficiary, a Section 8 recipient. The trustee had made distributions from the trust (primarily consisting of trust principal) directly to third parties to pay for goods and services provided to the beneficiary. The trustee purchased a car for the beneficiary, and paid for her cable TV, internet, and telephone services as well as veterinary care for the beneficiary's cats. The housing authority counted the trust distributions as income to the beneficiary and determined that she was "over income," resulting in the loss of her Section 8 subsidy.

The court in *DeCambre*, 826 F3d at 15, concluded that the word "income" as defined under 24 CFR section 5.603(b) does not include the principal that initially funded the trust, and found no reason why a lump-sum addition to family assets (such as the personal-injury settlement at issue in the case), which is excluded from the definition of income under 24 CFR section 5.609(c)(3), converted from an asset to income simply because it passed through an irrevocable trust. The court therefore concluded that the Brookline Housing Authority had erred when it counted the distributions from the principal of the tenant's special-needs trust toward her annual income.

The trust at issue in *DeCambre* was a first-party funded special-needs trust. It is not clear from the decision whether the holding would apply to third-party special-needs trusts, nor is it known whether housing authorities outside the First Circuit will change their policies wih regard to distributions from special-needs trusts in response to the First Circuit Court's decision.

Because the court in *DeCambre* decided the case on other grounds, it did not reach the issue of whether the PHA should have excluded certain distributions as excludable medical expenses under 24 CFR section 5.609(c)(4) or temporary, nonrecurring or sporadic income under 24 CFR section 5.609(c)(9). Instead, the court remanded the case back to the district court to determine what additional proceedings or remedies are required under the program rules.

Advising trustees

Achieving a Better Life Experience (ABLE) accounts are tax-advantaged savings accounts for individuals with disabilities and their families. In 2019, HUD issued a notice titled "Treatment of ABLE Accounts in HUD-Assisted Programs." in which the agency clarified that HUD will exclude amounts in the individual's ABLE account pursuant to 24 CFR 5.609(c)(17). The notice stated: "The entire value of the individual's ABLE account will be excluded from the household's assets. This means actual or imputed interest on the ABLE account balance will not be counted as income. Distributions from the ABLE account are also not considered income."

Accordingly, if a trust beneficiary is eligible to open an ABLE account, and the special-needs trust authorizes distributions to an ABLE account, a trustee could distribute funds to the beneficiary's ABLE account (subject to the annual contribution limits). The trustee could then use ABLE account funds to pay for the beneficiary's expenses in order to avoid any negative effect on the beneficiary's Section 8 eligibility.

Determine whether an exclusion applies. Because there is no rule that defines which distributions from special-needs trusts (both first-party and third-party trusts) will constitute income to the beneficiary, Oregon trustees should anticipate that regular monthly payments made from a trust (such as phone, internet, and cable TV costs) may be considered monthly income to the beneficiary for purposes of calculating the monthly Section 8 voucher benefit.

To the extent possible, however, trustees should take the position that medical expenses and any irregular or one-time trust distributions are excluded from the beneficiary's income, to minimize the impact of the trust distributions on the beneficiary's housing benefit. ■

Long term care insurance: its history and current status

By Cynthia Barrett, Attorney at Law

Cindy Barrett is a retired Portland elder law attorney. She is a volunteer with Oregon's SHIBA program, which provides health insurance counseling statewide on Medicare, health insurance issues, and long-term care.

Your elder law practice will encounter long term care insurance policies in both planning and crisis engagements. Planning for long term care (LTC) is part of the elder law practice. Even if clients are averse to discussing this fraught topic, the elder law attorney is aware of provider and cost issues. Long term care insurance (LTCI) is one source of payment for care. Private pay gives the client more provider choices.

Some of our clients come to us with existing long term care insurance policies; most have not purchased insurance. LTCI has become less and less common. But if the client has an existing policy or can afford to purchase one, then the economic strain of long term care costs is eased.

The problem of finding and paying for long term care services will not go away, and public policymakers will be trying to find ways to finance them. Traditional long term care insurance, a private market mechanism, has failed. Premiums are too expensive for all but the higher-income American.

Market failure: companies exit; premiums for existing and new policies skyrocket

Long term care insurance products were first developed in the 1960s. More than one hundred companies entered the market; but by 2020 fewer than twelve companies offered new policies. https://content.naic.org/cipr-topics/long-term-care-insurance

Policyholder lapse rate was less than projected. Policyholders lived longer and accessed the policy benefits more than predicted. Reserves proved unable to keep up with actual claims experience. Most companies stopped selling new policies, and put that bloc of business in "run-off" status (administering existing policy premium payments and claims).

Many LTCI companies hired third-party administrators to administer the closed blocs, collecting premiums and handling claims. The National Association of Insurance Commissioners (NAIC) described the LTCI market failure on its Center for Insurance Policy and Research website:

"In the past decade, the market has grown from covering less than three million lives to now covering more than seven million lives. And policies are issued such that premiums are age rated with premiums intended to be maintained at the same level over the life of the policy. Despite a growing need, standalone individual LTCI policies have fallen from 372,000 in 2004 to just under 70,000 in 2017. This dynamic translates into fewer new policies supporting an increasing cost of care from existing policies. Additionally, for the new policies being issued, there is an upward pressure to increase premiums, which of course further constricts the demand. Likewise, the number of insurers offering the coverage has diminished from slightly over 100 to about a dozen today. Less than half of a percent of employers offer LTCI. With relatively less competition, remaining carriers have refined their pricing with less incentive to keep new premiums low, and it can also restrict product offerings. These combined factors result in premium rates for newly issued policies having risen dramatically. Between 1990 and 2015, average annual premium rates rose from $1,071 to $2,772, though vast rate inconsistency exists among the states."

Clients who seek new policies find them very expensive, and medical underwriting is strict. Underwriting has become even more stringent as insurers factor in the risks of the current COVID pandemic. Some companies imposed waiting periods for coverage on those who had COVID. See "Covid's Effect On Long-Term-Care Insurance."

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LTC insurance *Continued from page 7*

Insurance regulators respond: NAIC, Oregon, Washington, Pennsylvania

Each company with a closed bloc of LTCI policies must re-visit actuarial assumptions periodically and add to reserves—usually by seeking policy rate increases from the diminishing pool of active policies. Rate increases must be approved in each state where the company does business.

NAIC

The National Association of Insurance Commissioners [NAIC] set up a research website on the long term care market, and organized workgroups on regulatory challenges. For an overview of the challenges facing regulators, see the introduction to a 2019 panel discussion on the website of the Center for Insurance Policy and Research (CIPR), and the NAIC website.

Oregon

Clients will consider dropping existing LTCI policies as premium rates skyrocket. When significant premium increases are presented to state regulators for approval, regulators require that the "approved premium rate notice letters" also include reduced benefit options (RBOs) to allow policy holders to retain some of the benefits of the original contract, at lesser cost.

Practice Tip: If a client tells the lawyer that the LTCI is becoming too expensive and she wants to drop the policy, encourage the client to call the company and discuss a reduced benefit option instead of canceling. The client need not wait for the regulators to demand RBOs in the next rate increase cycle. Companies want the risk off the books and are said to be open to case-by-case RBO arrangements.

The Oregon Insurance Commissioner, Andrew Stolfi, and his staff are aware of the LTCI market failure, and on January 31, 2020, sponsored a public forum on the problems in long term care insurance rate review.

According to a private email from Tashia Sizemore, Insurance Product Regulation and Compliance Manager, monitoring company solvency and tempering rate increases are the tools that Oregon regulators use as consumers age into needing their existing policy benefits.

Washington

Washington's insurance commissioner has an extensive website devoted to long term care insurance issues. Washington has passed a "Washington Cares Fund" tax. The Cares Fund will be used to pay for limited long-term-care benefits for all workers. The failure of the private LTCI market has pushed public policy makers to consider publicly mandated and even publicly run LTCI like the Washington Cares Fund.

Pennsylvania

Pennsylvania's failed efforts to resuscitate LTCI company Conseco has shown other state regulators the endgame: to avoid putting LTCI companies into receivership. In 2004, Pennsylvania allowed Conseco to offload its LTCI business to a new trust entity, called Senior Health Insurance Benefit Association. That entity could not survive the continuing LTCI market failure, and in 2020, the Pennsylvania Insurance Commissioner put the trust into court-ordered "rehabilitation"—a pre-liquidation stage. This Pennsylvania trust entity sought a 40% premium rate increase in 2017 for its 66 Oregon policyholders.

Challenges for state regulators

State regulators would prefer the insurer reduce its LTCI business losses without going into receivership. The purpose of Oregon's insurance regulation is to "protect the insurance buying public." ORS 731.008. Premium rate setting and claims practices monitoring are its most visible tools.

In rate setting, regulators must develop an understanding of the ways a huge company with multiple insurance lines tries to insulate its run-off bloc of LTCI policies from the operating revenues generated by the other lines. The insurance industry is a warren of multiple lines of business with different risk patterns, and complex reinsurance arrangements.

To protect consumers who file LTCI claims, regulators must develop a way to monitor the emerging third-party claims administrators such as LTCG, which according to its website manages "45,000 active claims and 90,000 claims transactions per month." LTCG was just purchased by a newly formed entity Illumifin, headquartered in Greenville, South Carolina. Illumifin is itself owned by Abry Partners, a Boston private equity firm.

How insurance regulators will manage to effectively oversee LTCI rate setting and the offloaded claims management is far outside the skill set of this retired elder law attorney. But all your clients who hold these traditional LTCI policies, and have been paying premiums for years, will want to know if their contract expectations will be met.

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LTC insurance *Continued from page 8*

Note: This article discusses traditional long term care insurance policies, not the "hybrid" life insurance/ annuity single-payment products with long term care cost withdrawal features.

Class actions: LTCI policyholders' dashed expectations; CalPERS case

There cannot be a wrong without a remedy, right? LTCI buyers who thought they had protection feel aggrieved as the game changes. The class action bar is exploring ways to provide a remedy.

The class-action bar has looked everywhere for some entity (not just the insurers, protected by regulators and threatening to go bankrupt) to blame for the dashed expectations of the policy purchasers. Finding misrepresentations by insurers or group plan sponsors is the basic approach. Class actions have been certified in Virginia (*Genworth* case), California (*CalPERS* case) and Massachusetts (*Prudential* case). Litigation theories include (1) fraudulent inducements to purchase, and (2) intentionally offering lower premiums initially to get market share, intending to increase prices dramatically later.

The settlement documents published online in *Skochin v. Genworth*, United States District Court for the Eastern District of Virginia (Richmond Division) Case No. 3:19-cv-00049-REP, show that the plaintiffs are not "made whole" but can select from an array of "reduced benefit options," including a refund of premiums paid or LTC benefit equal to premiums paid or damages of some multiple of premiums paid, or removal/ reduction of the inflation option.

Oregon elder law attorneys are likely to encounter retired California state employees who enrolled in the CalPERS group LTCI plan. The Sacramento Bee reported in May about the scuttling of a $2.7 billion settlement proposal, in the CalPERS certified class action:

> "An agreement in which CalPERS would have paid up to $2.7 billion to settle a lawsuit over the cost of its long-term care coverage has been scrapped, creating new uncertainty for tens of thousands of policyholders. A group of policyholders with inflation protection benefits sued the California Public Employees' Retirement System over an 85% rate hike that was announced in 2013. CalPERS had promised in marketing materials that the optional benefit, which increased coverage amounts for things like nursing home stays, wouldn't drive up their premiums. The policyholders argued in the lawsuit the rate hike violated their policy agreements. CalPERS argued they had the authority to raise rates and did so to keep the plans afloat. The settlement in the class-action lawsuit, reached last July, gave policyholders a choice: they could give up their plans and get a refund of all premiums they had paid — up to about $50,000 — or they could opt out of the settlement and keep their coverage, which got even more expensive last year. The agreement included the caveat that if more than 10% of policyholders chose to keep their plans, CalPERS could exit the deal. Last month, attorneys representing the plaintiffs announced 30% had decided to stay, and both sides had agreed the settlement was off."

CalPERS has stopped accepting new LTCI applications "due to current uncertainty in the LTC marketplace."

Advising clients about LTCI

Given its history, many questions arise about LTCI. Future issues of the *Elder Law Newsletter* will delve more deeply into the topic. Meanwhile, a few practice tips are in order.

In the trenches of the elder law practice, attorneys can help their clients get the most value out of a past LTCI investment by offering the following advice:

- Do not cancel the policy if it becomes unaffordable, but look for reduced benefit options.
- Prepare for the claims filing hurdles.

The elder law attorney can direct those clients who can afford LTCI to group plans and agents that still offer the product. In a crisis, the attorney can direct smarter claims filing to get benefits flowing sooner. ■

Coming in October: ***Advising clients who already have LTCI policies***

SHIBA helps navigate the complex Medicare system

By Peter Simons, Volunteer SHIBA Counselor

Peter and Sandi Simons are certified Medicare counselors. They have volunteered as a husband-and-wife team for the past four years. Peter's insurance and Sandi's human resources backgrounds have proven useful in their work with SHIBA. They regard volunteer Medicare counseling as the most consequential work they've ever done.

As beneficiaries of an outstanding elder law attorney's help, Peter and Sabdi would like to thank you for choosing this specialty. Together we are helping older Americans enjoy their golden years.

Imagine you are having a dream. You are far out at sea. You have a deep sense of dread that at any moment you may drown. You are too far away from shore to swim to safety and surrounded by sharks. Suddenly the sharks become meaningless acronyms and they are trying to pull you under. This is a world you do not understand and you are scared, confused, and frustrated. What you would give to be rescued by a passing ship. You awaken to discover the source of your anxiety. You have become a Medicare or Medicaid-eligible beneficiary.

Just as in your dream you are scared, confused, and frustrated. You are trying to navigate an ocean of acronyms, agencies, benefit eligibility requirements, rules, and regulations that govern the Medicare system. Fortunately, there is indeed a ship—or, to be more precise, a State Health Insurance Assistance Program (SHIP)—to rescue you.

SHIP is a national program created under the Omnibus Budget Reconciliation Act of 1990 which offers free one-on-one assistance, counseling, and education to Medicare beneficiaries, their families, and caregivers to help them make informed decisions about their care and benefits. In addition to helping average Americans aging into Medicare, SHIP services also support people with limited incomes, Medicare beneficiaries under the age of 65 with disabilities, and individuals who are dual eligible for Medicare and Medicaid.

Federally funded by the Administration for Community Living (ACL), there is a SHIP network in all 50 states, Puerto Rico, Guam, the District of Columbia, and the U.S. Virgin Islands.

Each SHIP network receives funding from ACL, the state in which they reside, and sponsor agencies. Some states use SHIP as their program name, while others choose to use a different name but are still SHIP agencies nonetheless. In Oregon the SHIP program is called Senior Health Insurance Benefits Assistance (SHIBA).

SHIBA operates with volunteer counselors

SHIBA counselors come from a vast array of backgrounds, but it is quite common for them to be retired pharmacists or medical professionals. Before a prospective SHIBA counselor can assist beneficiaries, they must first be certified by Medicare.

The certification process includes undergoing a background check, and signing a HIPAA agreement and other confidentiality and code-of-conduct documents. Prospective volunteer counselors must complete approximately 70 hours of training, including an online training course and a two-day intensive course.

Most important of all, they must shadow with a veteran counselor for approximately 30 hours. Shadow training continues until both the mentor and the freshman counselor believe the latter is ready to counsel solo. The mentor, as well as the entire counseling network, continues to be a resource for freshman and veteran counselors alike. Each year, counselors must complete 12 hours of continuing education to maintain their certification.

The length and breadth of our work with clients is not widely understood. By the end of this article, I hope you will understand the value SHIBA counseling provides to beneficiaries.

Clients are referred to the SHIBA network from a variety of sources. Some clients are referred by Medicare. Often the referral is from a partner agency which may be assisting with disability or low-income issues. SHIBA also conducts outreach programs to educate the community on the Medicare system. Some referrals are by word of mouth.

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SHIBA volunteers frequently screen clients to see if they are eligible for additional help, such as Medicaid, and refer them to an eligibility specialist, who will assist with the qualification process.

Medicare, Medigap, and Medicare Advantage

Before we explore specific case histories, I will briefly explain the three types of Medicare plans. Medicare by itself only covers roughly 80% of medical costs, which leaves the potential for thousands of dollars of out-of-pocket expenses. Medicare recipients can mitigate that 20% exposure by enrolling in a Medicare Advantage plan or, if they can afford to do so, a Medigap plan. Very low-income beneficiaries may have the 20% covered through state or federal programs.

A Medicare Advantage plan may have no monthly premium or a small premium, depending on the plan. With a Medicare Advantage plan, there is still financial exposure in the form of deductibles and co-pays. Annual out-of-pocket maximums are not insignificant, ranging from $5,500 to $6,500 for in-network services to as much as $10,000 if the patient received care from an out-of-network provider. However, the annual out-of-pocket maximum prevents running into tens of thousands of dollars of additional medical bills. Special Needs Advantage plans are specifically designed to serve people with a qualifying chronic condition.

Medigap plans are a "different animal" entirely. For a significant monthly premium—anywhere from $125 or more, determined by age and gender—a policyholder can cover the entire 20% Medicare did not pay. There are a number of Medigap plan levels, but the most comprehensive is a Plan G.

Our experiences

We frequently screen clients to see if they are eligible for additional help such as Medicaid, and refer them to an eligibility specialist, who will assist with the qualification process. We often coordinate with Aging and Disability Resource Connection (ADRC) for screening.

My wife Sandi and I recently worked on a case that was one of the most urgent situations we have handled. It included multiple phone calls, negotiations with a vendor, and filing an urgent appeal with Medicare on the client's behalf. The positive outcome profoundly affected the client's ability to receive the care needed, which provided peace of mind at the time when it was needed most. Outcomes like this are not unusual.

Knowing the positive effect we can have in someone's life can be an extremely gratifying and humbling experience.

Two case histories

William (a pseudonym)

William, in his mid-thirties, qualified for Medicare by virtue of being disabled for more than two years. He only received Original Medicare (Part A and Part B) coverage in the previous few months, and had no other medical coverage. His income was low, but not low enough to receive any government assistance to help with medical costs. William required a very expensive monthly infusion, possibly for life. Medicare paid approximately 80% of the cost, which still left him owing $1,200 each month. He had been unable to pay the monthly amount due, so the aggregate balance continued to increase by $1,200 every month. The infusion center was threatening to cease further treatment unless a significant payment was received. We counseled William and recommended the purchase of a Medigap Plan G, since he was still inside the eligibility window. Between original Medicare and Medigap, the out-of-pocket expenses would be entirely covered, except the small Part B annual deductible. We also contacted the infusion center. We were able to negotiate a substantial reduction of the outstanding balance, provided William showed them proof of the Medigap coverage. Although he would have to pay the monthly premium for the Medigap policy, the net yearly savings was about $13,000.

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Dozens of volunteer SHIBA counselors across the state of Oregon and SHIPs across the country help clients climb aboard their Medicare lifeboats each and every day.

Catherine (a pseudonym)

Catherine, in her late sixties, had Medicare A and B, but no supplemental coverage. She had been paying the 20% of medical bills not covered by Medicare with some assistance from family members. She had already been approved for help with the state paying the Medicare Part B premium and was receiving a reduction in drug costs. However, she was over the income limit for any additional help with medical bills, including deductibles and co-pays.

There are millions of Americans who have difficulty making ends meet, but many are "just not poor enough" to qualify for government assistance.

Three crucial elements led to a positive outcome. Our counseling session with Catherine was on the last day of September. Because of the government assistance she was receiving, she was entitled to a Special Enrollment Period (SEP). Extra help (also known as the Low-Income Subsidy) recipients can enroll or change plans once per quarter but only during the first three quarters of the year.

Catherine was under the care of a kidney-disease treatment facility. At the time of this case, End Stage Renal Disease (ESRD) disqualified a beneficiary from enrolling in a Medicare Advantage Plan. Some plans now offer coverage in certain geographic regions where Special Needs Plans are available. We contacted the kidney treatment facility and specifically asked if Catherine was ESRD as of today. We were told she was not, but was expected to be within the next two to four weeks. Medicare rules at that time stated you could enroll in a plan as long as you are not ESRD at the time of enrollment. We were able to sign Catherine up for a Medicare Advantage Plan effective the following day, which greatly helped pay her expenses.

Just one day later, it would have been the fourth quarter. Catherine would not have been entitled to an SEP. She would have had to wait until the annual enrollment period (October 15–December 7) with an effective date of January 1. She would likely have been an ESRD patient before October 15, and therefore ineligible for a Medicare Advantage Plan.

Based on the circumstances at the time, if one was enrolled in a Medicare Advantage Plan but later became ESRD, the beneficiary could not be terminated. However, the beneficiary would be unable to change to a different plan once that had occurred.

A lifeboat for elders

Cases like these illustrate how critical a role Medicare counseling plays in the health of our community. Dozens of volunteer SHIBA counselors across the state of Oregon and SHIPs across the country help clients climb aboard their Medicare lifeboats each and every day. In addition to navigating complicated cases, SHIP counselors act as client advocates with a variety of Medicare appeals. To be fair, not every situation is as complicated as the examples provided. However, even a basic "Medicare 101" discussion with a client requires us to analyze each unique set of circumstances to determine their best options, what they need to do next, and when they need to do it.

According to the Kaiser Family Foundation (KFF), in 2019 71 percent of Medicare beneficiaries did not compare plans during Medicare's annual enrollment period, potentially exposing them to thousands of dollars of unnecessary costs. Another study conducted by KFF in 2018 found that one in ten Medicare beneficiaries had no supplemental health plan, even though most of them could enroll in a zero-premium plan, thereby reducing their out-of-pocket expenses. This equates to 5.6 million Americans nationwide.

We hope attorneys who specialize in elder law will make clients aware of the services SHIBA provides. They can find a local counselor at https://shiba.oregon.gov/get-help/Pages/help-near-you.aspx or by calling the SHIBA hotline at 800. 722.4134.

SHIBA also conducts classes in a variety of settings, most of which are currently in the form of webinars. ■

Social atrophy as a byproduct of COVID, its impact, and a remedy for older adults

By Jamie Levin, Founder of Conversation & Company

Jamie Levin is a specialist on aging, and a former psychotherapist. She founded Conversation & Company which provides in-home and virtual social visits with older adults. Her work focuses on reducing loneliness and providing support during transitions through thoughtful conversation.

The global pandemic has changed our lives in measurable and definitive ways. Mandated social distancing and the fear of contracting COVID has led to what mental health professionals refer to as social atrophy, or the decline in interpersonal skills caused by limited social engagement.

The phenomenon of social atrophy has been universally felt, as in-person events, in-office meetings, dinner parties, family gatherings, and coffee dates resumed. In those first clunky social exchanges, reconnecting was often awkward. Feelings of discomfort around physical contact ("Should we hug, shake hands, or fist bump?") and the effort required to socialize were acutely felt. ("I don't remember meeting new people being so exhausting!")

Though the term social atrophy is new, researchers have spent years studying the concept in specific populations, including inmates in solitary confinement and individuals who choose hermitic lifestyles. Their findings have consistently shown that social isolation and its counterpart, loneliness, have profound detrimental effects on health and well-being, including higher rates of anxiety and depression, increased risk of heart disease and stroke, and reduced life satisfaction.

As in-person activities resume, those who have greater access to social occasions are more likely to quickly regain pre-COVID social aptitude. However, for individuals at a higher risk for loneliness, such as older adults, it won't be so simple.

Aging is often linked with increased rates of isolation and loneliness, which means that opportunities to regain losses in social ability are more limited for older adults. As the elderly fall out of practice, socializing may cause feelings of self-consciousness. Spending too much time alone tends to make it more difficult to relate to others and engage in small talk. It negatively affects self-esteem. With fewer positive interactions, people tend to isolate further to avoid the discomfort of being around others, thus perpetuating social atrophy, the loneliness cycle, and the negative health consequences that come with both.

How can we help alleviate social atrophy in older adults?

The main objective is to help them comfortably reengage and rebuild social networks. One-on-one visits tend to be more palatable and less anxiety-provoking than larger groups. When working with older adults whom I've recently met, I pair our conversation with an activity like taking a walk or working on a puzzle together. I find that having a secondary focus that doesn't require constant eye contact helps to alleviate discomfort and reduce the complications of social interplay (e.g., interpreting words, gestures, and expressions accurately and responding appropriately).

Another method I use—which requires a collaborative and focused approach with friends, family, and caregivers—is to create a social calendar with the goal of having at least one meaningful interaction per day. I recommend creating a schedule with set times to connect with others. For instance, every Tuesday is a phone call to a granddaughter, or a Thursday Facetime with an out-of-state friend. The key is creating opportunities for consistent social engagement, even if it lasts only 15 or 20 minutes. When working with older adults, reminders and prompts are particularly useful. Amazon Echo or Google Home Mini can be programmed to audibly announce calendar meetings before they begin, thus serving as handy reminders for upcoming appointments.

Rebuilding these skills will require patience and persistence. Reentering the social realm can be anxiety-provoking, but the best remedy is practice. Do your best to pleasantly encourage these interactions and engage the older adult at a pace that feels comfortable to them.

Social atrophy, if left untreated, has consequences that extend far beyond the bumbling social exchange. Research has proven strong social networks and meaningful interactions have a direct impact on quality of life and longevity. Consequently, it is important to proactively take steps to include social connectivity as part of a healthy lifestyle—right up there with diet, exercise, and rest. ■

The 2022 unCLE experience

By Daniela Holgate, Samuels Yoelin Kantor

For the first time since 2019, the Oregon State Bar Elder Law Section unCLE program was once again in person in Eugene, Oregon. If you didn't get the chance to join us this year, here is my account of what you missed.

After checking in to the Valley River Inn Thursday night, I attended the reception sponsored by Leahy Cox. It was great getting to reconnect with colleagues and meet some new practitioners.

On Friday we were offered four sessions of small group discussions on a variety of elder law topics. As my practice area focuses on guardianships, conservatorships, and estate administration and litigation matters, I chose four table talks on subjects I see coming up in my practice. The first session I attended was "Conforming and Nonconforming Wills," with the discussion led by Kathryn Gapinski. We had a lively discussion with practitioners from all over the state sharing their experiences with submitting nonconforming wills to the probate court and their experience with handling objections.

The second session I attended was "Protecting Protected Person's Rights," with Jan Friedman as our facilitator. We discussed a range of issues such as association rights and methods of giving a Protected Person notice of a guardianship. I walked away from this session with a better understanding of best practices to use in my guardianship cases.

The third session was on statutory changes and led by Christopher Hamilton. Of particular interest was the new program being tested in Multnomah County and Lane County where court-appointed attorneys for a respondent in a protective proceeding may be paid their fees through the Oregon Public Defense Services.

The final session I attended, facilitated by Theressa Hollis, was on handling creditors and claims in a probate. We went around the table sharing challenging scenarios we've encountered and tips and strategies for addressing claims. Invitations were extended for practitioners to reach out for examples of pleadings.

I always appreciate the "brain trust" of elder law attorneys who attend and contribute to this event. Looking forward to next year! ■

2022 unCLE topics

- Medicaid penalties
- Attorney fees: strategies, planning, set asides
- Conforming and nonconforming wills
- Protecting protected person's rights
- Medicaid estate recovery
- Annuities and analysis of when it works
- New landscape of proceedings—statutory changes
- Disclaimers: procedure to disclaim
- Dealing with creditors: handling creditors and claims
- Trust planning in relation to conservatorships
- Secure Act and charitable giving—what to do with the IRAs

Thank you, facilitators:

Amy Bilyeu, Jan Friedman, Kathryn Gapinski, Amber Gies, Christopher Hamilton, Alana Hawkins, Rebecca Kueny, Nathan Parker, Garvn Reiter, Julie Meyer Rowett, John Shickich, Rober Tozer.

Happy Hour sponsored by Leahy Cox LLP and the Elder Law Section

Helpful Websites

Elder Law Section website
https://elderlaw.osbar.org
Links to information about federal government programs and past issues of the Section's quarterly newsletters

National Academy of Elder Law Attorneys (NAELA)
https://www.naela.org
Professional association of attorneys dedicated to improving the quality of legal services provided to elders and people with special needs

National Center on Law and Elder Rights
https://ncler.acl.gov
Training and technical assistance on a broad range of legal issues that affect older adults

OregonLawHelp.org
https://oregonlawhelp.org
Helpful information for low-income Oregonians and their lawyers

Aging and Disability Resource Connection of Oregon
https://www.adrcoforegon.org/consite/index.php
Includes downloadable Family Caregiver Handbook, available in English and Spanish versions

Administration for Community Living
https://acl.gov
Information about resources that connect older persons, caregivers, and professionals to federal, national, and local programs

Big Charts
https://bigcharts.marketwatch.com
Provides the price of a stock on a specific date

National Elder Law Foundation
http://www.nelf.org
Certifying program for elder law and special-needs attorneys

National Center on Elder Abuse
https://ncea.acl.gov
Guidance for programs that serve older adults; practical tools and technical assistance to detect, intervene, and prevent abuse

Common Scams That Target the Elderly
Special report on scams related to covid-19
https://www.seniorliving.org/research/common-elderly-scams/

Guide to Transportation for Seniors
A helpful visual guide to getting older and getting around
https://www.seniorliving.org/research/transportation-guide/

Guardianship and the Right to Visitation, Communication, and Interaction
Legislative fact sheet from the American Bar Association Commission on Law and Aging
https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-40/issue-2-november-december-2018/guardianship-visitation/

CORRECTION

In the April 2022 issue the article entitled, **New electronic submission requirement for guardianship notices** should have referred specifically to notices to Disability Rights Oregon (DRO) required by ORS 125.082 (notice of appointment of guardian).

Although these are the only notices required to be filed with DRO electronically, DRO encourages all attorneys to file any other guardianship pleadings through their website. If you have any questions or issues with the online form, you may email DRO at welcome@droregon.org.

SAVE THE DATES

October 7, 2022
Advanced Elder Law CLE Seminar
In person at the Oregon State Bar and webcast
The seminar will discuss advanced long-term-care planning strategies, estate recovery, and changes to Oregon Medicaid rules and procedures.

February 3, 2023
Guardianship and Conservatorship CLE Seminar

Important elder law numbers

as of
July 1, 2022

Supplemental Security Income (SSI) Benefit Standards	Eligible individual ..... $841/month Eligible couple $1,261/month
Medicaid (Oregon)	Asset limit for Medicaid recipient ..... $2,000 Burial account limit ..... $1,500 Long term care income cap ..... $2,523/month Community spouse minimum resource standard ..... $27,480 Community spouse maximum resource standard ..... $137,400 Community spouse minimum and maximum monthly allowance standards ..... $2,288.75/month; $3,435/month Excess shelter allowance ..... Amount above $686.53/month SNAP utility allowance used to figure excess shelter allowance ..... $450/month Personal needs allowance in nursing home ..... $68.77/month Personal needs allowance in community-based care ..... $187/month Room & board rate for community-based care facilities ..... $654/month OSIP maintenance standard for person receiving in-home services ..... $1,341/SSI only $863 Average private pay rate for calculating ineligibility for applications made on or after October 1, 2020 ..... $9,551/month
Medicare	Part B premium ..... $170.10/month* Part D premium ..... Varies according to plan chosen Part B deductible ..... $233/year Part A hospital deductible per spell of illness ..... $1,556 Skilled nursing facility co-insurance for days 21–100 ..... $194.50/day

* Premiums are higher if annual income is more than $91,000 (single filer) or $182,000 (married couple filing jointly).

Oregon State Bar

Elder Law Section