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What federal health care reform means for older Oregonians

By Gerald J. "Jerry" Cohen, J.D., M.P.A., AARP Oregon State Director

President Obama signed the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and the Health Care and Education Affordability Reconciliation Act of 2010 (P.L. 111-152) into law on March 23 and March 30, 2010, respectively. This landmark legislation is the culmination of more than a year of Congressional effort. But for many, including AARP, it marks a four-decades-long effort to expand and enhance high quality, affordable care for all Americans. Nearly 13 percent of our state's population is age 65 or older while 20 percent is age 50-64. Both of these averages are among the highest in the country. So what will older Oregonians experience with the enactment of these two acts? Oregon has a significant older population who will see both immediate and long term benefits from many key provisions in this health reform package.

In this issue...

The health reform package will strengthen and improve the Medicare program

Medicare was enacted because no one should be left to struggle with medical bills after a lifetime of hard work. About 524,000 Oregonians depend on Medicare for stable, affordable health care. And yet, because of skyrocketing health care costs and the current economic crisis, the program's gaps are becoming more apparent. The new legislation:

- Improves access to primary care doctors. Primary care doctors will receive bonuses for treating people in Medicare, helping to ensure that the 524,000 Medicare beneficiaries in Oregon have continued access to important primary care services. The legislation also requires the Centers for Medicare & Medicaid Services (CMS) to re-evaluate the reimbursement formula used on fee-for-service payment to providers, a major concern to Oregon's providers who have faced fees set lower due to Oregon's more efficient care.
- Closes the Medicare Part D coverage gap or "doughnut hole." In 2010, elders who reach the gap in coverage will receive a $250 rebate to help pay for prescriptions. Beginning in 2011, they'll receive a 50 percent discount on brand-name drugs if they reach the gap. The doughnut hole will be fully closed over the next 10 years. (See sidebar for additional specifics.)
- Provides preventive care, such as screenings for cancer and diabetes, free of charge. Older adults will no longer have to pay out of pocket for preventive care services. They will also be able to work with their doctors to develop their own plan to keep as healthy as possible.

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Jerry Cohen has served as AARP Oregon's State Director since 1996. Before coming to AARP, Jerry led a research and training center on aging and developmental disabilities for the University of Missouri-Kansas City, worked for Legal Services of Western Missouri, and was the Missouri Division of Aging's first Legal Services Development Specialist. Jerry holds a law degree from Washington University-St. Louis, and an MPA from the University of Missouri-Kansas City, where he concentrated in gerontology and health care administration.

- Improves the coordination of care for people with chronic health conditions, and begins a new program that provides benefits to help older Americans and people with disabilities stay in their own homes and communities.
- Extends the solvency of Medicare. Health insurance reform will extend the life of the Medicare Trust Fund by nearly a decade.
- Phases out the added subsidy to Medicare Advantage plans, but plans that can show higher quality and efficiencies such as many in Oregon will also be eligible for an added five percent reimbursement.

It is also probably important to note what is *not* changing under health insurance reform: the law explicitly prohibits any cuts to elders' guaranteed Medicare benefits.

The health reform package will help older Americans who struggle with the high cost of prescription drugs

Today, people in Medicare spend on average about 30 percent of their income for out-of-pocket health costs—including premiums for supplemental coverage. These costs are six times greater than for people with employer coverage. Skyrocketing drug costs are a particular problem for people in Medicare. In 2007, 22 percent of the Medicare beneficiaries in Oregon fell into the Part D "doughnut hole," or coverage gap, which meant that they had to pay the entire cost of their medication and their premiums. The legislation:

- Offers a one-time $250 rebate for Part D enrollees who fall into the doughnut hole in 2010
- Reduces brand name drug costs by 50 percent for enrollees in the doughnut hole starting in 2011
- Gradually closes the doughnut hole by reducing enrollees' brand name and generic drug costs in the doughnut hole so that by 2020 enrollees will be responsible for 25% of their brand name and generic drug costs from the time they meet their deductible until they enter catastrophic coverage

This could add up to savings of nearly $2,000 next year for Oregonians with high prescription-drug costs.

The health reform package will make coverage more affordable for Oregonians aged 50-64

As the baby boomers age, the ranks of people without health insurance age 50 to 64 are soaring. Oregon has 105,000 uninsured age 50-64 and another 85,000 in that same age group who buy coverage in the individual market. Although more than half of those uninsured work, they may not be able to get insurance through their employer because they work for a small business that doesn't offer insurance, or they are self-employed and can't buy or afford coverage in the individual market. Those without employer-sponsored coverage are forced to try to find affordable coverage. People in this age group are more likely to have a pre-existing condition and are routinely denied individual insurance in the private market. And those who can get coverage end up paying three times more in premiums and twice as much in out-of-pocket costs than a person with job-based coverage.

The longer people in this age group go without insurance, the more likely they'll enter Medicare with health problems. This places a greater financial burden on Medicare and ultimately undermines the program's ability to provide coverage for our children and grandchildren when they're ready to retire. The legislation:

- Creates new rules for insurance companies so they can no longer discriminate against people who are sick, and can no longer charge unaffordable rates based on age
- Provides help purchasing coverage
- Provides tax credits to small businesses to help make employee coverage more affordable
- Creates a temporary high-risk program for the uninsured with pre-existing conditions

The package holds insurance companies accountable and removes barriers to high quality, affordable care. Insurance plans will have to cover care—even when people get sick. In Oregon, insurance companies have had no limits on how much they can charge older people for coverage in the individual market. The package will make important strides toward limiting this practice by preventing insurers from charging no more than three times what younger people pay for the same health insurance.

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As many as 285,700 people age 50-64 in Oregon may be eligible for a tax credit that helps make premiums affordable. And 70,125 lower-income Oregonians in the same age group will qualify for even more protection from unaffordable health care costs through the state's Medicaid program, with the federal government paying the entire cost for three years.

The health reform package increases access to long-term care services and supports

As many as 96,019 Oregonians currently have a disability and need greater access to long-term services and supports (LTSS). The Community Living Assistance Services and Supports (CLASS) provision in the new law creates a new national voluntary insurance program that could help Oregonians pay for the LTSS they need to remain independent in their homes and community. CLASS provides a cash benefit (with a minimum benefit averaging not less than $50/day) for eligible participants with qualifying disabilities.

Benefits may be used to pay family caregivers. Individuals can participate in CLASS through automatic payroll deductions through their employers. They will also be able to enroll if their employers do not participate in CLASS. There is a five-year vesting period and individuals must be working a certain amount at least three of those five years. As long as individuals remain eligible, there is no lifetime limit on the benefits that participants may receive.

In addition to benefiting individuals, the CLASS program could be an economic win for states like Oregon in the longer term, because an individual's participation could delay or prevent his or her need to use Medicaid long-term services and supports.

Nearly 90 percent of individuals who are over 50 express a desire to remain in their homes as long as possible. A bit more than half (56 percent) of Oregon's Medicaid long term care spending for older people and adults with physical disabilities pays for home and community-based care (HCBS). This is the second best percentage in the nation at balancing home care over nursing home care in state expenditures. However, this percentage has been slipping and Oregon hasn't been able to invest in HCBS despite a growing aging population. The new law offers some new options and financial incentives to states to expand access to home and community-based services. The Community First Choice Option would provide states with a six percent enhanced federal Medicaid match rate if they opt to provide certain HCBS to individuals with disabilities eligible for an institutional level of care. In addition, the new law makes improvements to the existing Medicaid HCBS state plan option to help encourage states to make use of this tool to expand access to HCBS.

The legislation also:

- Provides better information and accountability for nursing home care. It will also be easier to file complaints about the quality of care in a nursing home and obtain greater access to information on nursing home quality and resident rights.
- Extends financial protections to more spouses of people on Medicaid. For those married to someone on Medicaid who is receiving care services at home, they will have the same protections for their income and other resources as do spouses of those on Medicaid who live in a nursing home.

The health reform package also benefits those under age 50

The legislation:

- Eliminates discriminatory insurance practices. Effective in 2010, health insurance companies will no longer be able to drop health coverage if people become sick. Health insurance is guaranteed, as long as people continue to pay their premiums. Starting in 2014, people can't be denied health insurance because of a pre-existing condition.
- Eliminates lifetime and annual coverage limits. Insurance companies can no longer place lifetime (begins 2010) or restrictive annual limits (begins 2014) on health coverage—giving peace of mind that benefits won't run out when they are needed most.
- Allows Americans to keep their coverage if they like it.
- Provides preventive care. Starting in 2010 for new plans, insurance companies will be required to provide preventive services like mammograms, immunizations, and screenings for cancer or diabetes, free of charge.
- Helps young adults. A young adult son or daughter who needs health insurance can now be covered on parents' insurance policies until age 26, which may provide a new option for about 124,000 18-25 year olds in Oregon without insurance.
- Helps small businesses**.** Employers may be eligible for tax credits that would cover up to 35 percent of their premiums.

Those are some of the highlights of the health reform package. It is simply not possible to summarize in this space all the ways that older Oregonians—and all Americans—will be affected by the new health insurance reforms. And many details are yet to be ironed out through the implementation process and phase.

I encourage you to learn more about these new provisions. Many non-partisan Web sites and organizations offer useful information about the law, including AARP at **www.aarp.org/getthefacts**. Knowledge about these different benefits may prove extremely valuable to you, your family, and your clients. ■

Options for residents in care facilities often depend on Medicaid contract

By Steve Skipton, Attorney at Law

Steve Skipton is the staff attorney for the Senior Law Service, a program of Lane County Legal Aid and Advocacy Center.

Oregon has been a national leader in using Medicaid funds to allow individuals to receive needed long term care in community-based care facilities, such as a residential care facility, an assisted living facility, and an adult foster home. This use of scarce Medicaid resources is good for our clients and good for the state, as many of our clients prefer to get the care they need in community-based facilities, or at home, and care in these settings is less expensive than care in a nursing facility. However, the legal protections for residents of community-based care facilities are not the same and are not as good from our clients' perspective as the legal protections which apply to nursing-facility residents.

Comprehensive federal law and regulations apply to nursing facility admission and discharge practices, but community-based care facilities are governed solely by state law and regulations. Oregon law does not extend the same admission and discharge protections to residents in community-based care settings as federal law and Oregon law provide to nursing facility residents.

Can a care facility require a resident to pay privately for a certain length of time before going on Medicaid?

The answer to this question depends on the type of care facility. A nursing facility cannot require a resident to pay privately. A residential care facility, an assisted living facility, or an adult foster home can ask about a prospective resident's finances and expect a resident to pay privately for a certain period of time.

What happens when a resident can no longer pay privately?

All facilities must allow a resident, who is no longer able to pay privately, to remain as a Medicaid eligible resident, so long as the facility has a Medicaid provider agreement with the state.

Nursing Facilities

Federal regulations are very specific in prohibiting a nursing facility that participates in the Medicaid program from requiring a resident to pay privately for any length of time. 42 CFR 483.12(d) governs NF admission policy. It says a facility must not require a resident or potential resident to waive her right to apply for Medicaid, or to agree not to apply for Medicaid, i.e., promise to pay privately for a certain length of time as a pre-condition to admission. In other words, a nursing facility cannot require a potential resident to sign an agreement promising to pay privately for, say, 12 months, before applying for Medicaid. If a person applying for admission to a nursing facility that participates in the Medicaid program is Medicaid eligible on day one, and is accepted as a resident, the nursing facility cannot require private payment rather than payment from Medicaid.

A nursing facility resident is also protected under federal and Oregon law from being discharged from the facility if payment of current charges is available from Medicaid. 42 USC 1396r(c)(2)(f) and 42 CFR 483.12(a)(2)(v); OAR 411-088-0020(2),

Community-based care facilities

Since the admission and discharge practices of community-based care facilities are not regulated by federal law, our clients who try to get into such facilities and stay in them must look to Oregon regulations and the Medicaid provider agreements the facilities sign with the state for their rights. OAR 451-054-0034(1), which applies to residential care facilities and assisted living facilities, and OAR 411-050-0447(1), which applies to adult foster homes, both just generally provide that such facilities must do a screening at admission to determine whether the facility can meet the prospective resident's needs, taking into account the needs of other residents and the facility's overall service capability.

The issue of whether a community-based facility can require someone to pay privately for a certain length of time comes up most often in the context of assisted living facilities. Oregon's rules at OAR 411-054 do not expressly prohibit an assisted living facility from asking about a prospective resident's finances, and they often do. Nor do Oregon's rules expressly forbid an assisted living facility from asking an applicant to agree to pay privately for a certain

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period of time. A facility may agree to admit a resident with the expectation the resident has enough money to pay privately, for example, for 12 months. This expectation could be put in writing, and become part of the admission agreement.

So, what happens when a resident who has signed an agreement promising to pay privately for 12 months runs out of money and can no longer pay privately? Assisted living facilities are governed by the terms of the Medicaid provider agreements they sign. The Medicaid provider agreement states that all beds in the facility are available to Medicaid recipients. When a resident in an assisted living facility exhausts his or her savings and becomes Medicaid eligible, the resident is entitled to remain in the facility with Medicaid paying for care. This is true even if the resident has signed an agreement at admission promising to pay privately for 12 months, but has exhausted her funds sooner than expected and needs Medicaid assistance after six months. Note , however, that room and board is the responsibility of the client and is not a part of the Medicaid service payment. The room and board amount is regulated by the state and covers a studio apartment in an assisted living facility, not a one-bedroom unit. So, a private paying resident in a one-bedroom unit who becomes Medicaid eligible can be asked to move to a studio unit, but cannot be evicted from the facility for non-payment.

Oregon regulations limit the reasons for which a resident can be evicted. OAR 411-054-0027(1)(t); 411-054-0080(4). One permissible basis is non-payment. OAR 411-054-0080(4)(g). Non-payment does not exist if the resident is Medicaid eligible and the facility participates in the Medicaid program. Breach of an agreement to pay privately is not one of the reasons listed as a legal basis for the eviction of the resident. As a practical matter, it seems doubtful an assisted living facility would attempt to enforce the agreement by suing a Medicaid-eligible resident for uncollectible damages.

It is important to note this analysis assumes the assisted living facility is still participating in the Medicaid program. For an excellent discussion of what happens to residents of an assisted living facility that withdraws from the Medicaid program, see Linda Gast's article in the October 2008 edition of this newsletter, "Spending down and moving out: assisted living facilities withdraw from Medicaid." Ms. Gast explains that facilities enter into two-year Medicaid provider contracts. At the end of the two-year term, the facility can renew the contract, terminate it, or enter into a Medicaid gradual withdrawal-contract. Under a Medicaid gradual-withdrawal contract, which is also typically for a two-year period, the assisted living facility must allow existing Medicaid residents to stay and must allow those who become Medicaid eligible after the date of the withdrawal contract to stay. Those applying after the date of the withdrawal contract must pay privately.

Assisted living facilities that do not participate in the Medicaid program are not prohibited under the state's rules from evicting a resident who can no longer pay privately. Because an assisted living facility can evict a resident for non-payment under OAR 411-054-0080(4)(g), a facility which does not participate in Medicaid will assert non-payment as a basis for evicting a resident who is no longer able to pay privately.

The rules applying to adult foster homes also allow them to evict a resident for non-payment. OAR 411-050-0444(11)(b)(D). However, if an adult foster home has a valid Medicaid contract, it cannot evict a private paying resident who becomes eligible for Medicaid on the basis of the resident's Medicaid eligibility. OAR 411-050-0435(1)(f).

More protection needed for residents of community-based care facilities

Our clients in community-based facilities are subject to discriminatory treatment both in getting into a facility and in staying in the facility if they are not able to pay privately. I have had a number of clients and their families say, "I have called every assisted living facility in town, but none of them have openings for Medicaid. The best I could do was to get on a couple of Medicaid waiting lists." Though assisted-living provider agreements do not limit the number of Medicaid recipients they can admit, the facilities often limit the number they will admit. In short, Oregon does not require community-based facilities to accept Medicaid paying and private paying individuals on an equal footing. Many assisted living facilities do not regard Medicaid payment as adequate, and consequently prefer private paying residents over Medicaid paying residents.

Advocates for reform propose changes in federal or state law to level the playing field, at least to some extent, for Medicaid-eligible individuals. To address the problem Medicaid recipients face when trying to find a facility, the National Senior Citizens Law Center (NSCLC) has proposed that Medicaid-certified assisted living facilities should be required to accept Medicaid coverage from Medicaid-eligible residents. This proposal includes a prohibition against a facility requiring a certain number of months of private pay as a prerequisite for accepting Medicaid. [1]

New Jersey has taken a step in this direction. New Jersey law requires assisted living facilities which are newly licensed or which expand their capacity to reserve at least ten percent of their total beds for Medicaid-eligible residents. NJSA 26:2H-12.16. A recent study by the New Jersey Public Advocate's office, in response to wholesale evictions by Assisted Living Concepts, Inc., when facilities it owned withdrew

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Our clients in community-based facilities are subject to discriminatory treatment both in getting into a facility and in staying in the facility if they are not able to pay privately.

from the Medicaid program, recommended the existing New Jersey ten-percent law be extended to all facilities at the time of license renewal, to increase access for Medicaid recipients. [2]

Our clients on Medicaid are equally vulnerable to being evicted because they are on Medicaid. There is no requirement in Oregon in the regulations that govern such facilities that they participate or continue to participate, to any degree in the Medicaid program. An assisted living facility can, for example, terminate its Medicaid contract and evict all its Medicaid residents for non-payment, as Ms. Gast's article shows. Residents being dumped by care facilities because of their Medicaid status have few options for finding suitable care at another facility—especially another assisted living facility. They may well suffer both physical and emotional trauma if they are forced to move out.

To address dumping of Medicaid residents, NSCLC has proposed: "A facility's withdrawal from Medicaid should not limit the rights of already admitted residents to access Medicaid coverage. "[3] That is, if a facility withdraws from Medicaid, it should be required to accept Medicaid reimbursement on behalf of any Medicaid eligible resident who lived in the facility at the time of withdrawal, even if the resident did not become Medicaid eligible until after the withdrawal date. The New Jersey Public Advocate's study similarly recommends that all assisted living facilities allow residents to remain after they have spent their savings and become Medicaid eligible. The Assisted Living Consumer Alliance has proposed that Congress should extend the protection nursing facility residents have under 42 USC 1396r(c)(2)(f) to assisted living residents who use Medicaid.[4] Under this federal law, a facility's voluntary withdrawal from the Medicaid program is not a legal basis to evict a resident, so all residents in the facility at the time the facility withdraws from Medicaid can remain. Oregon's use of Medicaid gradual-withdrawal contracts achieves this goal of retaining Medicaid residents and those who later spend down and become Medicaid eligible, but only if the facility is willing to enter into such a contract. Washington passed a law in 2008 that would have required facilities withdrawing from the Medicaid program to continue to care for Medicaid residents and for some privately paying residents. This law was struck down by a federal court which held its retrospective application violated the Contract Clause of the U.S. and Washington constitutions, because the existing Medicaid contracts could be terminated by the facility.[5] After the court decision, when Washington now renews a facility license, it includes a prospectively applied provision that requires the facility to retain current Medicaid residents if the facility later chooses to withdraw from Medicaid.

Conclusion

We can advise our clients entering into a nursing facility that participates in the Medicaid program (and most in Oregon do so) that they cannot be required to agree to pay privately for any length of time as a condition of admission. We can also advise them they cannot be evicted when they are no longer able to pay privately.

Our advice to our clients who want to reside in community-based facilities must be more equivocal and less reassuring. If they are on Medicaid or are not able to pay privately for very long, they may be refused admission. If they are residents and are not able to pay privately, they may be evicted if the facility chooses to withdraw from the Medicaid program. ■

Footnotes

1. National Senior Citizens Law Center, *Medicaid Payment for Assisted Living: Current State Practices, and Recommendations for Improvement*, January, 2010. **www.nsclc.org**
2. New Jersey Department of Public Advocate, *Aging in Place, Promises to Keep, An Investigation into Assisted Living Concepts, Inc. and Lessons for Protecting Seniors in Assisted Living Facilities*. **www.njpublicadvocate.gov**
3. NSCLC, *Medicaid Payment for Assisted Living*, *supra*, footnote 1.
4. ALCA Position Paper #1*: Federal Legislation Must Be Passed to Protect Assisted Living Residents Whose Facilities Choose to Stop Participating in Medicaid*, June 2009. **www.assistedlivingconsumers.org**
5. *Washington Health Care Association v. Robin Arnold-Williams, Order on Motions for Summary Judgment,* 601 F. Supp. 2d (W.D. Wash. 2009)

Will Oregon's recent amendments to CCRC law help residents?

By Katherine C. Pearson, Professor of Law, Penn State University, Dickinson School of Law

Katherine C. Pearson is Professor of Law in the Dickinson School of Law at Penn State University. In addition to teaching traditional doctrinal courses, Professor Pearson has developed a dynamic approach to advocacy on behalf of the elderly. She created an integrated elder law curriculum that includes seminars or workshops on law and aging policy as well as an Elder Law and Consumer Protection Clinic that offers students opportunities for direct representation of older adults and their families on cutting edge issues. In the fall of 2009, Professor Pearson was the Petersen Visiting Scholar in Gerontology and Family Studies at Oregon State University.

Continuing Care Retirement Communities (CCRCs), also called life-care communities, are often attractive to aging adults because of their campus-like settings and a range of service options. In late 2009, however, the federal General Accounting Office (GAO) opened a congressionally mandated investigation, sparked by reports of recent financial instability of well-known operations. The GAO report to Congress is pending.

In the meantime, Oregon was one of several states that responded to long-simmering concerns by passing House Bill 2138 in 2009 to amend Oregon's existing Continuing Care Retirement Community Provider Registration Act, O.R.S. § 101.010 to 101.160. The changes are largely pro-consumer, but the real test of the statute will come from resident groups. Elder law attorneys who have a sophisticated understanding of Oregon law may have a role to play in determining whether the changes are substantive or only cosmetic.

For several years, in my role of teaching and working with students and clients in Penn State's Elder Law and Consumer Protection Clinic, I have come to know the concerns of CCRC resident groups in Pennsylvania and nationally, including those of the National Continuing Care Residents Association. Two themes emerge: the desire of many resident groups for a greater voice in the governance of their communities, and the demand for complete transparency on a wide range of financial issues that affect costs and increase the fees for residents. Both of these topics receive attention in Oregon's recent amendments.

On the issue of governance, resident groups frequently express annoyance with management of even the most highly regarded nonprofit and for-profit CCRCs, especially when management treats their inquiries with a paternalistic attitude, suggesting that "elderly" residents should not worry their graying heads about management issues. Existing Oregon law governing requirements for meetings and notices on changes in fees or charges, now contained in Section 101.112 (1), required CCRCs to hold regular open meetings with residents "at least twice a year" about topics such as "facility income, expenditures, financial trends" and any changes in policy, programs or services.The amendment to the meeting requirement appears to be an attempt to make communications more effective. Section 101.112(1) now also requires management to address "for discussion any topic presented by a resident council or resident," whether orally or in writing 14 days or more before the meeting. Amendments also require 45 days advance notice for proposed changes in fees and service charges, with an accounting that supports any changes. CCRCs are now required to provide residents with financial statements that compare actual costs to budgeted costs, broken down by expense categories.

As many residents are aware, meetings between residents and management can be frustrating. Residents express concern that the most important discussions occur in closed door meetings of the CCRC's governing boards. Oregon law at Section 101.112 (6) attempts to meet this concern by mandating that CCRCs must now include "at least one resident from each CCRC operated in [Oregon]" as a "nonvoting resident representative" in meetings of the governing board or "along with the owners and managers." The amended law permits the representative to be excluded from certain executive sessions, but mandates that the representative shall not be excluded from discussion of the annual budget, increases in charges, the provider's indebtedness and expansion in new or existing facilities. The statute provides a mechanism for selection of the resident representative and makes clear that the facilities can provide residents with greater representation on governing boards.

Oregon's CCRC law adds a new provision, Section 101.112, that sets forth a brief set of basic resident rights, including the residents' rights to be free from discriminatory treatment on the basis of sex, marital status, race, color, and national origin, and significantly, sexual orientation. The new provision includes a right for residents to "submit grievances and to suggest changes in policies and services either orally or in writing . . . without fear of . . . reprisal by the provider." Further, "the provider

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Resident groups frequently express annoyance when management suggests that "elderly" residents should not worry their graying heads about management issues.

must listen and respond promptly to a grievance or suggestion from a resident."

On the financial side, Oregon's law continues to be a "disclosure" law, emphasizing the obligation of providers to give information to prospective or current residents, rather than the state's obligation to affirmatively analyze the operations' financial soundness. Oregon requires facilities to submit audited financial reports to the state on an annual basis, and the amendments add details about disclosures that must be made at Section 101.052. It is unclear what "disclosure" states, such as Oregon, do with the collected information, at least in the absence of a complaint by residents or a declaration of insolvency, although a long-standing Oregon provision, Section 101.120, gives the Department of Human Services the power to sanction or enjoin violations of the Act.

One new financial disclosure provision is potentially useful given complaints in other states about interlocking ownership of facilities. In California, for example, litigation has raised concerns that "plush" facilities (and financially strong residents) are expected to carry facilities with weaker income streams. The financial stability of such interlocking facilities can be threatened by the weakest link, whether in for-profit or non-profit operations. The amendments to Oregon's CCRC law expand the providers' obligations to provide information about their extended financial operations. Section 101.050(n) requires providers to give "full descriptions of all contracts that the provider has entered into with affiliated organization and an explanation of the financial impact that the contracts may have on residents."

Is it enough for facilities to disclose such financial entanglements or should there be restrictions on interlocking financial operations? This is a basic theme in regulatory approaches that haunts consumers and business people alike in virtually all segments of financial industries. ■

Warning about new Medicare scam

Elders in several states are receiving fraudulent phone calls that ask for personal information "so that new Medicare cards may be issued to the consumers."

The caller claims to represent Medicare or the Social Security office and asks the consumer to verify or provide personal information that could lead to identity theft.

Consumers should never verify or provide personal information to someone who has called them. When in doubt on Medicare or Social Security, consumers should hang up and call Social Security at 1.800.772.1213 or Medicare at 1.800.Medicare.

The warning about this scam comes from the National Legal Resource Center, a collaborative effort developed by the Administration on Aging, US Department of Health and Human Services. ■

2010 *NAELA Student Journal* writing competition

The National Academy of Elder Law Attorneys is holding its Fifth Annual NAELA Elder Law Writing Competition, which offers a $1,500 cash prize for the best article submitted. In addition to the $1,500 first prize, the winner will be interviewed for a future issue of *NAELA News*. The second-place winner will receive $1,000 cash, and the third-place winner will receive $500 cash. The top eight articles will be published in *NAELA Student Journal*, an annual publication, and the top eight authors also will receive a complimentary one-year student membership to NAELA.

Articles can address any topic regarding legal issues that affect elders or people with disabilities. The contest is open to part-time and full-time JD candidates who have not yet graduated. All articles must be original and previously unpublished. Articles written for law school credit are acceptable. Jointly authored papers are not acceptable.

Each entry must be submitted by 12:00 p.m. EDT on May 31, 2010 to mhansen@naela.org

Complete contest rules are available on the NAELA Web site: **www.naela.org**. ■

Providence ElderPlace provides complete care system for elders

By Providence ElderPlace Staff

Resources for information on PACE programs

National PACE Association: ***www.npaonline.org***

www.pace4you.org

Petigara, Tanaz and Gerard Anderson. "Program of All-Inclusive Care for the Elderly." Health Policy Monitor, April 2009. (available online at ***npaonline.org*** *under "Research")*

Mukamel, DB, et al. Program characteristics and enrollees' outcomes in the Program of All-Inclusive Care for the Elderly (PACE) The Milbank Quarterly 85(3), 2007. (available online at ***npaonline.org*** *under "Research")*

Providence ElderPlace, a federally recognized part of the nationwide Program of All-inclusive Care for the Elderly (PACE), is centered around the belief that it is better for the well-being of elders with chronic care needs and their families to be served in the community whenever possible. There are more than 72 PACE programs nationwide, but Providence ElderPlace is currently the only PACE program in Oregon.

Providence ElderPlace offers a unique solution to today's often-complicated care system for elders. Its integrated team of medical and social care providers—doctors, nurses, social workers, therapists, and others—gets to know participants on a personal level. The care team has regular, frequent contact with their participants, which enables the team to watch for changes in condition and provide the services needed to help the elder remain as active and independent as possible. Because it delivers all needed medical and supportive services, ElderPlace is able to provide the entire continuum of care and services to elders with chronic care needs while maintaining their independence for as long as possible.

There are residential options, but most ElderPlace facilities are day centers. Although all ElderPlace participants qualify for long term care, the vast majority live independently or in foster homes.

Providence ElderPlace serves individuals who are age 55 or older, in need of support services as defined by the state of Oregon, able to live safely in the community at the time of enrollment, and live in or are willing to relocate to Multnomah County.

Care and services include:

- Adult day care that offers meals, personal care, recreational , and therapeutic activities
- Primary medical care by physicians and nurse practitioners trained in geriatrics
- Specialty medical care, including dental, hearing, vision, and foot care
- Physical, occupational, and speech therapy
- Social work services and nutrition counseling
- Prescription and over-the-counter medications
- All necessary medical equipment and supplies
- Laboratory tests and procedures
- Emergency services
- Hospital and nursing home care when necessary
- In-home care and services
- Housing options, as needed
- Transportation to and from medical appointments and the social center

Medicaid covers Medicaid-eligible participants. Those who do not qualify for Medicaid pay the ElderPlace premium, which equals the current Medicaid rate. There are no co-payments or deductibles. ElderPlace covers all necessary medical and social services, and the premium rate does not change as the needs of a participant change.

There are six ElderPlace locations in Multnomah County, with a seventh scheduled to open soon.

- **Providence ElderPlace in Laurelhurst**
  4540 N.E. Glisan St., Portland 97213
- **Providence ElderPlace in Gresham**
  17727 E. Burnside St., Portland 97233
- **Providence ElderPlace in Cully**
  5119 N.E. 57th Ave., Portland 97218
- **Providence ElderPlace in Glendoveer**
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Case Note

The right of reimbursement from special needs trusts under ERISA

By Jeremy Hambly, Attorney at Law

Ana Martinez v. The Beverly Hills Hotel and Bungalows Employee Benefit Trust Employee Welfare Plan, No. CV09-1222, (C.D. Cal. Mar. 9, 2010), provides insight on the intersection between the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq*., settlement agreements, and special-needs planning. The ruling is consistent with established precedent; an ERISA-governed plan has the rights of subrogation and reimbursement only to the extent the plan's documents grant the plan such rights.

Factual background

On April 15, 2005, plaintiff Ana Martinez's son, Steve, suffered a severe epileptic seizure while at school, resulting in severe brain damage that left him permanently disabled and in a "minimally-conscious state." Steve's care required a ventilator, 24-hour supervision, and pump-feeding.

Martinez's employer, the Beverly Hills Hotel, provided a health plan through Blue Cross. This health plan, like most private-sector health plans, was covered by ERISA. After the injury, and through the end of 2007, the Blue Cross plan paid for Steve's medical expenses. Although the Blue Cross plan included a subrogation/reimbursement provision, Blue Cross did not subrogate its claims and never sought reimbursement for the benefits it paid.

A civil suit was filed in state court on behalf of Steve against the Los Angeles Unified School District. The jury returned a verdict in favor of Steve for $7.6 million, of which approximately $3.7 million was awarded for Steve's "future medical, nursing, hospital, attendant care, equipment, and supply expenses." Soon after the verdict, in May 2007, the parties to the civil suit agreed to a $7 million structured settlement. $3.7 million, in the form of a large payment and annuity, was placed into the Steve Martinez Special Needs Trust (SNT), which was established under the California probate code and approved by the court in an order that approved the settlement.

At about the same time as the trial, the Beverly Hills Hotel began considering alternatives to the Blue Cross plan because of expected increases in premium rates. It ultimately decided to use a self-funded plan. The plan was funded through a trust fund, The Beverly Hills Hotel and Bungalows Employee Benefit Trust, which in turn was funded by the Beverly Hills Hotel. This self-funded plan, called "The Beverly Hills Hotel and Bungalows Employee Benefit Trust Employee Welfare Plan," was formed on January 1, 2008.

In early 2008, Martinez requested benefits from the employee welfare plan for Steve's seizure-induced medical condition. The company attempted to get Martinez to sign a lien and reimbursement agreement. She declined to do so. In April 2008, the employee welfare denied her request. She appealed to the plan administrator. In July 2008, the appeal was denied. The plan administrator wrote that the plan documents' coordination of benefits, subrogation, and reimbursement provisions all required the denial of benefits because a third party was determined to be responsible for Steve's injuries and because Martinez refused to sign the lien and reimbursement agreement.

Martinez (the plaintiff) subsequently filed suit against the employee welfare plan (the defendant) in federal court seeking reimbursement for Steve's medical expenses arising out of the seizure and brain injury. The plan, in turn, filed a counterclaim against Martinez and a third-party complaint against the trustee of the SNT seeking reimbursement if it was forced to pay for Steve's medical needs.

This case is about the plan administrator's abuse of discretion in interpreting the plan documents.

Much of the court's analysis in its 60-page final judgment concerns the proper standard of review for the plan administrator's decision to deny the plaintiff's request for benefits. Under ERISA, a court reviews a denial of benefits decision *de novo* unless the plan administrator is given discretionary authority to construe the terms of the plan or make eligibility determinations, in which case the abuse of discretion standard is used.

The court ultimately decided that it would review the defendant's decisions under the abuse of discretion standard, but with a "skeptical" eye considering the defendant's structural conflict of interest and widespread "but technical" procedural violations. Applying this standard, the court concluded that the defendant had abused its discretion in denying the plaintiff's request for benefits by misconstruing the "plain language" of the plan and committing "errors of law" in its analysis.

The court ruled that the plan's subrogation and reimbursement provisions did not apply to the plaintiff's request for benefits.

The defendant's plan documents included both subrogation and reimbursement provisions. These provisions are typically included in all ERISA-governed plans and give the benefit plan the right to reimbursement for benefits it pays to, or on behalf of, a member or eligible dependent. A subrogation provision entitles a plan to collect directly from a third-party tortfeasor and gives rise to an equitable lien on any

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judgment or settlement funds. A reimbursement provision entitles a plan to collect from the member to the extent that the member was compensated by a third party for expenses for which the benefits were paid. Once the member exerts possession or control over funds subject to a reimbursement provision, a constructive trust may be placed on the funds.

A benefit plan may require a member to satisfy conditions precedent to the recovery of benefits. For instance, the plan may require the member to execute a reimbursement agreement. However, any such right must be included in the plan documents. The defendant argued that its documents required the plaintiff to execute a lien and reimbursement agreement as a condition precedent to the recovery of benefits. Because the plaintiff refused to do so, the defendant concluded that plaintiff was not entitled to any benefits.

The court disagreed. It noted that the subrogation provision applied if the plaintiff "recovers" or "has the right to recover" from a third party. It reasoned that the subrogation provision simply did not apply because, by being in the "present and future tenses," it had only a prospective effect. In other words, the subrogation provision would only apply if a responsible third party still had liability for Steve's medical expenses. The provision did not apply because the responsible third party, the school district, had already extinguished its liability by entering into a settlement agreement with the plaintiff's son.

The court also concluded that the reimbursement provision did not apply to the plaintiff's request for benefits. It noted that the reimbursement provision applied only to injuries that are sustained while the covered individual "is covered under the plan." It observed that Steve's injuries were sustained while he was covered under the Blue Cross plan, not while he was covered under the defendant's plan. The court concluded that the reimbursement provision was inapplicable because of the timing of Steve's injury.

The court concluded that the plan's coordination of benefits provision did not apply to the plaintiff's request for benefits.

The defendant's documents also included a coordination of benefits provision. Generally, a coordination of benefits provision is used to specify the primary and secondary insurers with respect to a claim by an insured. The defendant, however, argued that its coordination of benefits provision applied not only to other insurance policies covering Steve but also to the SNT. The defendant pointed to language in the plan documents stating that benefits would be disbursed only after "all available benefits have been exhausted from any other coverage, plan, or policy for which a covered participant is eligible for benefits…." In particular, the defendant argued that the words "any other coverage" applied to the SNT. Therefore, the defendant reasoned, because SNT funds were available to pay for Steve's medical needs, the plaintiff was not entitled to receive the benefits she requested.

The court rejected the defendant's argument on the basis that the words "policy, plan, or coverage" embrace only insurance and the SNT is not a form of insurance. As a result, the coordination of benefits provision did not allow the defendant to deny the plaintiff's request for benefits. The court did note, however, that it might have reached a different conclusion "if it were engaging in a pure abuse of discretion review without adding any additional skepticism to its review."

The court declined to rule on the defendant's counterclaim and third-party claim.

Pursuant to ERISA, the court remanded to the plan administrator to apply the plan terms correctly. As a result, it concluded that the defendant's counterclaim and third-party claim for reimbursement from the plaintiff and the SNT were not ripe for decision and dismissed those claims without prejudice.

The court did *not* rule that funds in a special needs trust can never be recovered by a plan administrator.

Although the Court ruled that benefits were improperly denied by the defendant, it did not reach the issue of whether the defendant could ultimately obtain reimbursement from the SNT. The case merely stands for the proposition that when a member or eligible dependent has satisfied all prerequisites to the recovery of benefits as set forth in the plan documents, the benefit plan must pay that person any benefits owed.

Ultimately, the case turned on the construction of the plan documents. Had the reimbursement provision been written in a way that would have covered Steve's injury, it is likely that the court would have applied the provision, although the particular factual circumstances of this case may have nevertheless resulted in the same decision. (There were deficiencies with the actual lien and reimbursement agreement that the defendant attempted to get the plaintiff to sign. For instance, the lien form required the plaintiff to swear that she would not prejudice the defendant's right of subrogation against the school district. However, the settlement had already been entered into. The court stated that the defendant could not require the plaintiff to enter into an invalid lien as a prerequisite to the recovery of benefits.)

The court observed that case law existed to suggest that a plan "may, in its discretion, require a participant to sign a reimbursement agreement before obtaining reimbursable benefits." *Id. at 37* (citing *Cagle v. Bruner*, 112 F.3d 1510, 1519-20 (11th Cir. 1997)). However, the plan documents must give the plan that right, and the defendant's documents, as noted above, did not.

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Only equitable remedies are available in ERISA cases.

The defendant sought to hold the plaintiff personally liable for the benefits paid for Steve's medical care. The court noted that the United States Supreme Court had held that a plan cannot hold a member personally liable for reimbursement. *Id.* (citing *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002)). Rather, the Court observed, under ERISA, a plan "may only seek equitable relief via a constructive trust on funds directly traceable to a particular fund or account." *Id.* The Court concluded that Defendant could not impose a constructive trust on Plaintiff's personal funds because she had not received settlement funds related to Steve's medical care. Had Plaintiff received settlement funds related to Steve's medical care, Defendant likely could have obtained a constructive trust over those funds because they would have been directly traceable to the settlement. *Id. at 38 n 21* (citing *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 2006).

Can a benefit plan's right of reimbursement be avoided by having settlement funds placed directly into a special needs trust?

The court's discussion raises an important question: can a benefit plan obtain reimbursement from settlement funds directly deposited into a special needs trust? The defendant argued that settlement funds contained in a special needs trust may be used to satisfy a plan's reimbursement right. The court did not reach this issue on the basis that it was not ripe for decision.

There have been no cases in the Ninth Circuit that resolve this question. Although the United States Supreme Court has in the recent past tackled issues on the periphery of this question, there has been no direct holding that an ERISA-governed plan can obtain reimbursement from a special needs trust. Indeed, in *Knudson, supra,* the Supreme Court specifically withheld opinion on that question. *Knudson*, 534 U.S. at 220. Later, in *Sereboff, supra*—although the case did not involve a special needs trust—the Supreme Court appeared to relax the requirements for the imposition of a constructive trust in ERISA cases. It stated that so long as the plan documents identify a particular fund that the rights of subrogation and reimbursement may be exercised against, and a particular share of that fund to which the plan is entitled, the plan may seek an equitable lien or constructive trust as a remedy. *Sereboff*, 545 U.S. at 364-65.

The *Sereboff* ruling appears to abrogate Ninth Circuit cases that held that ERISA-governed plans could claim a constructive trust only if the "traditional requirements of fraud or wrong-doing are satisfied." See *Providence Health System-Washington v. Bush*, 461 F. Supp. 2d 1226, 1232-33 (W.D. Wash. 2006). In *Bush*, the District Court held that *Sereboff* allowed a plan to seek a constructive trust over settlement funds held in a special needs trust because the plan "target[ed] a readily traceable fund and [did] not seek to impose personal liability on the trustee." *Id. at 1233*.

The Eighth and Eleventh Circuits are in accord with the *Bush* decision. *Administrative Comm. of Wal-Mart Stores v. Shank*, 500 F.3d 834 (8th Cir. 2007); *Administrative Committee for Wal-Mart v. Horton*, 513 F.3d 1223, 1228-29 (11th Cir. 2008). In *Horton*, the Eleventh Circuit stated that "the most important consideration is not the identity of the defendant, but rather that the settlement proceeds are still intact, and thus constitute an identifiable *res* that can be restored to its rightful recipient." 513 F.3d at 1229. Because the plan's terms required reimbursement out of a tort judgment or settlement for 100% of any benefits paid, the plan had a "paramount interest" in the funds that were deposited into the special needs trust. *Id.* Therefore, the trustee was required to reimburse the plan out of the trust.

What happens if a settlement agreement does not fully compensate the member for his or her loss?

The plaintiff argued that even if the defendant could seek reimbursement from the SNT, the make-whole doctrine precluded the defendant from actually recovering anything. The court did not reach this issue because it determined the reimbursement question was not ripe for review.

Black's Law Dictionary (8th ed. 2004) provides the following definition for the make-whole doctrine: "The principle that, unless the insurance policy provides otherwise, an insurer will not receive any of the proceeds from the settlement of a claim, except to the extent that the settlement funds exceed the amount necessary to fully compensate the insured for the loss suffered."

Although the make-whole doctrine arose in insurance law, a number of circuits, including the Ninth Circuit, have imported the doctrine into the federal common law with respect to ERISA-governed plans. The rule in the Ninth Circuit is that the make-whole doctrine is merely a "gap-filler" for ERISA-governed plans. *Barnes v. Independent Automobile Dealers Ass'n. of Cal. Health & Welfare Plan*, 64 F.3d 1389, 1394 (9th Cir. 1995). In other words, the doctrine only applies if the plan is silent on the issue of whether a make-whole right exists. *Id.*

If the court were to address this issue, it would have to determine whether a make-whole right exists under the defendant's plan documents and, if so, whether the right precludes the exercise of the plan's reimbursement rights in whole or in part. In the context of Steve's situation, the question would be whether the amount of settlement funds received plus plan benefits received exceeded his future medical expenses, pain and suffering, and loss of earning capacity. ■

Oregon Medical Insurance Pool provides health-insurance option for some

The Oregon Medical Insurance Pool (OMIP) is the high-risk health insurance pool for the state. OMIP was established by the Oregon legislature to cover adults and children who are unable to obtain medical insurance because of health conditions. OMIP also provides a way to continue insurance coverage for those who exhaust COBRA benefits and have no other options.

OMIP is not an insurance company. It is a state program that works like a self-insured employer, and is exempt from many of the provisions of the Oregon Insurance Code. OMIP currently contracts with Regence BlueCross BlueShield of Oregon to administer the program.

A person may be eligible for coverage if he or she is an Oregon resident and meets any of the following medical or portability requirements.

Medical requirements

In past six months:
- Has been declined individual health insurance coverage because of health reasons
- Has one or more of the medical conditions listed in Section C of the OMIP application
- Was offered individual health insurance coverage that contained a restrictive waiver that substantially reduced the coverage offered by excluding coverage for a specific medical condition
- Was offered individual health insurance coverage, but was limited by the choice of plans the carrier was willing to offer because of a specific medical condition

Portability requirements

To be eligible under portability criteria, a person must apply to OMIP within 63 days of any of these events:
- COBRA benefits have been exhausted
- No COBRA or portability coverage available through previous plan
- Moved from prior insurance carrier's service area
- Insurance carrier no longer serves the area where person lives
- Moved to Oregon and has been continuously covered by health insurance for 18 or more months, with no single gap in coverage greater than 63 days, and the last coverage was group coverage

To apply for OMIP, call the customer service department number at 800.848.7280 and ask for an "OMIP packet." The OMIP packet contains further details on eligibility and coverage and includes the application, premium rates, and provider directory.

One can also obtain more information and download an application from the OMIP Web site at **www.omip.state.or.us**. ■

In the news

SSA to expedite cases of early-onset Alzheimer's

Recognizing that the cognitive impairment caused by early-onset Alzheimer's disease leaves individuals unable to maintain gainful employment, the Social Security Administration (SSA) has announced that it will add early-onset Alzheimer's disease to its Compassionate Allowances Initiative.

The initiative identifies debilitating diseases and medical conditions that meet the SSA's disability standards for Social Security Disability Income (SSDI) or Supplemental Security Income (SSI). Inclusion in the initiative allows for faster payment of Social Security benefits to individuals with Alzheimer's disease. ■

Congress increases funds for affordable housing

Congress recently approved a $60 million, or 8%, increase for the Section 202 program this year. Section 202 is the government's affordable housing program dedicated to lower-income persons, age 62 and older. It provides grants and rental help through nonprofit sponsors of low-income housing for elders. Residents typically pay no more than 30 percent of their income for rent.

To find this type of affordable housing in your area, call your local housing authority (see **www.hud.gov/pihforseniors** or call 800.955.2232 for contact information) or your area agency on aging (call 800.677.1116 to get your local number)—or you can do a search online at **www.hud.gov/apps/section8**. ■

Family leave laws help balance jobs with caregiving

By Leslie J. Harris, Dorothy Kliks Fones Professor of Law, University of Oregon

Leslie Harris is the Dorothy Kliks Fones Professor of Law at the University of Oregon, where she teaches Family Law and other courses and directs the Oregon Child Advocacy Project, which provides education and assistance to attorneys who advocate for the interests of children. She is an elected member of the American Law Institute and serves on advisory boards for the Oregon Juvenile Court Improvement Project and several other organizations.

According to the AARP, almost 60 percent of all family caregivers are employed.[1] Trying to care for a sick or disabled person while holding down a full-time job is at best very stressful. For many people, the alternative of taking temporary leave from work to provide care may be the only thing that makes handling both responsibilities feasible.

The federal Family and Medical Leave Act (FMLA) and the Oregon Family Leave Act (OFLA) both require that some employers provide job-protected (but unpaid) leave to workers to care for sick relatives, as well as parental leave to workers who have a newborn or have just adopted a child. The rules governing caregiver and parental leave are not identical under the state and federal laws. The state law provides for leaves in other circumstances that the federal law does not, and vice versa. Where the laws' provisions overlap, the benefits run concurrently. **Fortunately for workers, both the federal and state laws provide that where the state and federal laws do not overlap, employees are entitled to whichever benefits are more favorable to them.** The chart on page 16 shows the most important differences in the eligibility and leave provisions of the state and federal laws.

The most fundamental protection the two acts provide is the right to be reinstated to the position the employee held before the leave—or to an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.[2] An employee cannot be deprived of any benefits accrued before the leave, but the employer does not have to allow an employee to accrue seniority or employment benefits during the leave. An employee on FMLA or OFLA leave cannot claim unemployment benefits.

Because an employee is entitled to the most favorable leave provisions under state or federal law, it is possible that an employee could, for example, take 12 weeks of leave under the FMLA military leave provision and then take 12 more weeks under the OFLA to care for a sick parent-in-law or grandparent.

If spouses work for the same employer and both want to take leave because of the birth or adoption of a child, the FMLA allows the employer to limit the total amount of time that the two take to 12 weeks. In comparison, the OFLA provides that both parents are entitled to a full 12 weeks of leave, but the employer may require them not to take leave at the same time. These limitations on spouses do not apply to other types of family and medical leave.

The FMLA also requires the employer to provide the employee with the same health-care coverage that would have been provided if the employee had been working. If employees have to contribute to the cost of the coverage, a worker on leave can be required to continue contributing. However, if the employee fails to return to work for any reason other than the continuation, recurrence, or onset of a serious health condition or circumstances beyond the employee's control, the employer can recover the premiums paid for health insurance during the leave.

The possibility of working shorter days or weeks

In some situations an employee who is caring for another person does not need to quit work entirely, but rather needs shorter work days or work weeks. Both the FMLA and the OFLA provide that employers must allow workers to take their leave in this form (called intermittent leave), without reducing the total number of hours of leave that the employee is entitled to. In contrast, an employee who takes leave because of the birth or adoption of a child may take intermittent leave only with the employer's approval.

The relationship between paid and unpaid leave

Generally, under both the FMLA and the OFLA, an employee may choose to use accrued paid vacation, personal time, or family leave to cover any part of a 12-week leave under the statutes. The employer may also require the employee to use accrued paid leave and to count that time off as leave under the statutes.

Employers must state in writing whether they are designating a leave as an FMLA leave within five business days of when the employer is able to determine whether the leave was requested for an FMLA-qualified reason.

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Family leave laws

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How ill must a relative be for an employee to get caregiving leave?

Caregivers for elderly or disabled relatives would most likely claim leave on the basis of a serious health condition. Under the FMLA, a serious health condition is an illness, injury, impairment, or physical or mental condition that involves one of these situations:

- any period of incapacity or treatment related to inpatient care in a hospital, hospice, or residential medical facility
- continuing treatment by a health care provider, which includes any period of incapacity of more than three calendar days, and any subsequent treatment or period of incapacity relating to the same condition that also involves continuing treatment by health care providers
- continuing treatment by a health care provider for a chronic or long-term condition that is incurable or so serious that, if not treated, it would likely result in a period of incapacity of more than three calendar days, or for pregnancy or prenatal care. See 29 C.F.R. § 825.113.

In turn, "continuing treatment by a health care provider" means:

- treatment two or more times for the injury or illness by a health care provider or at least one time followed by a regime of continuing treatment under the provider's supervision (which could include a course of medication or therapy)
- being under the continuing supervision of, but not necessarily being actively treated by, a health care provider for a serious long-term or chronic condition or disability which cannot be cured, such as Alzheimer's, a severe stroke, or the terminal stages of a disease. 29 C.F.R. § 825.115.

By way of comparison, the leave to care for a sick child, available under the OFLA but not the FMLA, allows a parent to take time off to care for a sick child who does not have a serious health condition but requires home care.

Under the FMLA, an employer may require that the request for leave based on a serious health condition be supported by certification from a healthcare provider. If the leave is to care for another, the certification must state that the person is needed to care for the family member and give an estimate of how long care will be needed. If the employee is taking intermittent leave, the certification must say this is medically necessary.

The process for claiming FMLA or OFLA leave

Employees should check with their employers' human resources offices to learn the specifics of what kind of leaves are available and how to claim them. In general, the FMLA allows employers to require that employees give 30 days' prior notice if the leave is foreseeable. For planned medical treatment, the employee can be required to attempt to schedule procedures at times that do not disrupt employer operations unduly. The OFLA also allows employers to require 30 days' written notice except in an emergency.

Remedies for employer violations of the FMLA or OFLA

The U.S. Department of Labor must investigate and attempt to resolve complaints under the FMLA and may bring suit on behalf of an employee to recover lost wages or benefits. Employees may bring private suits that seek damages for lost wages and benefits, any actual losses that result from the violation, and interest. Similar remedies are available under state law for violation of the OFLA.

In addition, if an employer discriminates against an employee based on family status or family responsibilities, the employee may have a cause of action under state and federal laws prohibiting sex and disability discrimination. Suits brought on this kind of fact pattern have increased dramatically in the last five years. For example, a good claim would arise if an employer fired a single mother for rescheduling a meeting when her child was ill, when it regularly allowed employees to reschedule work or miss work for other personal reasons, such as plumbing problems at home. This developing body of law is discussed in Stephanie Bornstein & Robert J. Rathmell, *Caregivers as a Protected Class?: The Growth of State and Local Laws Prohibiting Family Responsibilities Discrimination* (December 2009), Center for WorkLife Law at Hastings College of Law.

Local laws in 22 states explicitly protect against discrimination based on family status. Communities in Oregon with these ordinances include Beaverton, Corvallis, Eugene, Hillsboro, Multnomah County, Portland, and Salem. Benton County prohibits discrimination based on familial status and family responsibilities. Most of these ordinances apply to all businesses, although the Multnomah County rule applies to county employees. By and large the family status rules apply to people with minor children. ■

Footnotes

1. Sheel M. Pandya, *Caregiving in the United States (*AARP Public Policy Institute 2005).
2. The right to reinstatement does not apply to salaried employees who are among the highest paid 10 percent of employees, provided that denial of reinstatement is necessary to prevent substantial and grievous economic injury to the employer.

The chart on page 16 shows the most important differences in the eligibility and leave provisions of the state and federal family leave laws.

A quick look at federal and state leave acts

Where the state and federal laws do not overlap, employees are entitled to whichever benefits are more favorable to them.

	Federal Family & Medical Leave Act	**Oregon Family Leave Act**
Eligibility	Employer has 50 or more employees; employee has worked for employer at least 12 months in total and at least 1,250 hours in last 12 months	Employer has 25 or more employees; employee has worked for employer at least 180 days before taking leave for at least 25 hours per week
Parental leave (birth or adoption of a child)	Up to 12 weeks, must be taken within 12 months of child's arrival	Same
Sick leave (self)	Up to 12 weeks in a 12-month period	Same
Leave to care for seriously ill relative	Up to 12 weeks in a 12-month period to care for spouse, child, or parent	Up to 12 weeks in a 12-month period to care for spouse, domestic partner, child, partner's child, stepchild, parent, parent-in-law, grandparent, grandchild
Leave to care for sick child	None	Up to 12 weeks in a 12-month period to care for a sick child who requires home care
Pregnancy disability leave	None	Up to 12 weeks in a 12-month period
Military leave	Up to 12 weeks in a 12-month period to make arrangements because of exigencies arising because of person's own military obligations or those of spouse, child, or parent on active duty	Up to 14 days during a period of military conflict to make arrangements because a person's spouse has been notified of an impending call or order to active duty, or impending leave from deployment
Military caregiver leave	Up to 26 weeks to care for a spouse, child, parent, or next of kin on active duty, or a veteran who is injured or ill	None

Useful online resources

Oregon Bureau of Labor & Industries: **www.oregon.gov/BOLI/CRD/C_Oflafacts.shtml**

Regulations implementing the OFLA – OAR Chapter 839, Division 9, available on the state archive Web site: **http://arcweb.sos.state.or.us/rules/number_index.html**

U.S. Dept. of Labor, Wage and Hour Division site: **www.dol.gov/whd/regs/compliance/whdfs28.htm** and **www.dol.gov/whd/regs/compliance/1421.htm**

New legislation limits garnishment of electronically-deposited public and retirement benefits

By Leslie Kay, Attorney at Law, and John Cathcart-Rake

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The Oregon Legislative Assembly enacted legislation in 2009 that makes it easier to protect certain public benefits and retirement benefits from garnishment when the funds are deposited into a bank or credit union by direct deposit or electronic payment. Senate Bill 731, which became effective January 1, 2010, changes garnishment procedures to better protect funds, such as Social Security, veterans' benefits, unemployment compensation, public assistance, workers' compensation, payments from public or private retirement plans, and Black Lung benefits, that are exempted from garnishment by private creditors under state and federal law.[1]

Before Senate Bill 731: Benefits protected in theory, but procedural burden on debtor

Legislatures and courts have established protections for public and private benefits deposited in bank accounts that are necessary for basic survival. Federal and state governments have expressly exempted most government benefit, assistance, unemployment, and workers' compensation payments under the specific statutes governing such programs. Additionally, federal and state statutes exempt portions of wages and payments from private retirement plans from garnishment. In Oregon, up to $7,500 of these assets remain exempt when deposited in a bank account. ORS 18.348. Even though these assets are "exempt" from garnishment, prior to 2010 banks and credit unions in Oregon were required to garnish a debtor's account. *See* ORS 18.665 (describing duty of garnishee to hold and deliver property to satisfy writ of garnishment). To recover the exempt funds, the debtor had to challenge the garnishment in court by filing a "claim of exemption." In addition to being deprived of the expected funds and enduring a lengthy court process, a debtor could face garnishment fees, overdraft fees, and late charges from the financial institution.

After Senate Bill 731: Benefits protected in theory, and procedural protection to debtor

With Senate Bill 731, the legislature sought to ensure that a debtor's basic needs are protected. The bill makes a portion of exempt assets "not subject to garnishment." Now, financial institutions may not garnish the lesser of (1) the sum of exempt funds received by direct deposit or electronic payment in the previous month, or (2) the total account balance. 2009 Oregon Laws Ch. 430 § 2(1). Additionally, financial institutions may not charge a garnishment processing fee if none of the debtor's property is subject to garnishment. *Id.* § 5(7) (amending ORS 18.790). Senate Bill 731 does allow a financial institution to garnish an account for an amount in excess of the previous month's exempt benefits, even if those amounts originated from an exempt public benefit or retirement benefit payment. To recover these amounts that are exempt, a debtor must file a claim of exemption and challenge the garnishment in court.

To understand the operation of Senate Bill 731, consider the following example: A person receives $500 from the Social Security Administration and $250 from the Veterans Benefits Administration each month as a direct deposit payment to a bank account. He has a current account balance of $1,250, and no money in the account originated from a source other than Social Security or Veterans' benefits payments. The person's bank receives a writ of garnishment for a $2,000 judgment. In this example, $750 (the sum of exempt funds electronically deposited in the previous month) is "not subject to garnishment." The bank must garnish the excess $500, even though the excess amount originated from an exempt source and the account balance is below the $7,500 threshold. The account holder may challenge the garnishment of $500 of exempt funds in court. In this situation, the bank may charge a garnishment processing fee.

How to put financial institutions on notice that account assets are exempt by affidavit

To protect the maximum amount of exempt funds from garnishment, a financial institution must be able to identify a credit to an account as a type of exempt payment. *Id.* § 2(3). Some

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Garnishment of funds *Continued from page 17*

payments may be readily identifiable by the identity of the payor. For example, financial institutions can likely identify funds electronically transferred by the Social Security Administration or Veterans Benefits Administration as exempt payments. Other payments, such as those from a private retirement account, may not be readily identifiable. Thus, an account holder should help financial institutions identify exempt payments by providing written notice of exempt payments. Under Senate Bill 731, financial institutions must make available affidavits that enable customers to provide written notice. *Id.* § 2(4)(b). Affidavits are also available from Oregon Legal Aid offices and online at **www.oregonlawhelp.org**. Affidavits must be signed in front of a notary public and should be copied for the account holder's personal records. If his or her financial situation changes, the account holder should submit a new affidavit to the financial institution.

How to recover exempt assets that have been garnished by claim of exemption

A debtor must file a challenge to garnishment in state court to recover exempt property. A debtor will receive a challenge to garnishment form, also known as a "claim of exemption," when he or she receives notice of garnishment. ORS 18.658(1)(d). A debtor should file this form with the court in the manner specified in the writ of garnishment as soon as possible, at the latest within 30 days.[2] ORS 18.700(2). Additionally, a debtor must send a copy of the challenge to the garnishor via first class mail. Courts may not charge filing fees to a debtor challenging a garnishment. ORS 18.700(4). While a challenge is pending, the court administrator is responsible for retaining garnished payments. ORS 18.700(3). The court will ultimately decide the challenge to garnishment in a summary manner at a hearing. ORS 18.710(1). If the court agrees that the assets are exempt, the creditor must return the assets to the debtor within ten days. ORS 18.712(1).

How to put judgment creditors on notice that assets are not subject to garnishment

If a debtor's only assets are payments of public benefits or private retirement benefits that are not subject to garnishment, the debtor should provide notice to a judgment creditor that the debtor is "judgment proof."

Before providing notice to the creditor, the debtor should file an affidavit with the debtor's financial institution. Then, the debtor should send a letter to a creditor that states that the debtor's only assets are exempt from garnishment. The letter should mention that the debtor has filed an affidavit with her financial institution, but the letter should not include a copy of the affidavit, because it contains specific bank account information that should not be disclosed to the creditor. ■

Footnotes

1. Note that some public and private benefit payments may not be protected from certain debts, such as child support, spousal support, federal and state taxes, and criminal fines and restitution.
2. For challenges to garnishment based on exempt wages, a debtor has 120 days to challenge. ORS 18.700(2)(a).

NOTE: A proposed rule from Social Security Administration. would extend protections against bank garnishment of SSI and social security benefits, similar to our recent state law. Some of the main differences are that this law protects 60 days worth of benefits (more than the state law), doesn't have a provision for an affidavit (the bank is expected to examine the account to determine where the funds are from), and involves only federal benefit payments such as VA and SSA benefits .

New state laws

Here is a brief summary of some of the bills recently passed by the Oregon legislature:

- Senate Bill 991: Allows parents to sign parental authority over to a respite worker by means of a Power of Attorney.
- Senate Bill 1046: Makes Oregon the first state to allow specially-trained psychologists to prescribe psychiatric medications without the supervision of a doctor.
- House Bill 3618: Directs the state to collect names of people who provide home and community support services to clients with developmental disabilities or mental illness, or medically fragile children, so that they may receive workers compensation insurance. They will also have the option of joining home-care workers in the Seniors and People with Disabilities sector who have opted to collectively bargain for wages and benefits.
- House Bill 3631: Health insurers are prohibited from treating injuries resulting from sexual violence as pre-existing conditions.
- House Bill 3642: Allows Physician Assistants to practice medicine under the supervision of a physician's group, not just a single doctor.
- House Bill 3659: Creates a new high-risk pool for Oregonians who cannot find health insurance coverage.

You can find these and all the other legislative bills at: **www.leg.state.or.us/bills_laws**. ■

Social networking sites: what happens when user dies?

With so many people using social networking sites, the question may arise about what to do about a deceased person's social-network accounts.

Facebook

When a user passes away, Facebook lets people turn the deceased person's account into a memorial. This preserves that person's identity online so that people can come to the page, read about him or her, and leave posts in remembrance. Memorializing an account removes certain sensitive information (e.g., status updates and contact information) and sets privacy so that only confirmed friends can see the profile or locate it in a search. Memorializing an account also prevents all login access to it, and the company will not provide login information for the account to anyone.

A family member or friend can report the death to Facebook on a form provided via the Facebook help center. The form asks for the deceased person's e-mail address and a link to an obituary or other proof of death.

Facebook will also honor requests from close family members to close the account completely.

MySpace

In the case of a MySpace profile, a next of kin must contact MySpace via e-mail with proof of death and the user's MySpace ID number. This could be a problem if the next of kin doesn't have this number.

Twitter

It appears the company does *not* have any sort of published policy on this matter. It's likely the account will be kept around indefinitely.

Google accounts: Blogger, Gmail, Buzz

One benefit to having all of Google's services tied into the same Google account is that the company's policies and procedures generally cover everything. When a user passes away, concerned parties just need to go through the steps once in order to gain access to everything. Google says it won't delete the blog, Buzzes, or anything at all of the deceased user until someone asks it to. This means that without any intervention a deceased friend or family member's posts could remain online indefinitely.

If a survivor doesn't want them to remain, or needs access to the deceased person's Gmail account for whatever reason, he or she must follow the steps outlined in Google's help section. Google has strict guidelines on who can access the account, because it isn't just someone's social networking profile, it's his or her e-mail, contacts, and everything else contained in the account.

The person filling out the application must be a lawful representative of the deceased and be able to provide proof of that authority. He or she must also include proof of death and a full e-mail header from the deceased to show a history of contact. Google needs 30 days to process the documents, but notes that a "valid third party court order or other appropriate legal process" will speed up the process. ■

Resources for elder law attorneys

CLE seminars

Best Practices and Recent Trends in Electronic Discovery
OSB CLE Seminar
May 6, 2010; 9 a.m. to 4:15 p.m.
Oregon State Bar Center, 16037 S.W. Upper Boones Ferry Rd., Tigard
www.osbar.org

Elder Law Section unCLE Program
Friday, May 7, 2010; 8:00 a.m. to 5:00 p.m.
Valley River Inn, 1000 Valley River Way, Eugene

Choice of Entity for Service Businesses, Including Law Firms
OSB "Quick Call" Program
May 18, 2010; 10 a.m. to 11 a.m..
www.osbar.org

Incentive Trusts: Carrots and Sticks to Encourage Good Behavior and Discourage Bad
OSB "Quick Call" Program
May 25, 2010; 10 a.m. to 11 a.m.
www.osbar.org

2010 Estate Planning Update
OSB "Quick Call" Program
Part 1: June 15, 2010: 10:00 a.m. to 11:00 a.m.
Part 2: June 16, 2010: 10:00 a.m. to 11:00 a.m.
www.osbar.org

NAELA Telephonic Training Programs

Effective Marketing Techniques in an Elder Law Practice: Clients, Public and Referral Sources
April 22, 2010; 11:00 a.m. to 12:30 p.m. PDT

The Nuts and Bolts of a VA Application
May 6, 2010; 11:00 a.m. to 12:30 p.m. PDT

Alternative Housing: Quality Indicators
June 22, 2010; 11:00 a.m. to 12:30 p.m. PDT

Personal Injury and Wrongful Death Actions on Behalf of the Elderly Population
July 7, 2010; 11:00 a.m. to 12:30 p.m. PDT
www.naela.org

Elder Law Section Web site

www.osbar.org/sections/elder/elderlaw.html

The Web site has useful links for elder law practitioners, past issues of the *Elder Law Newsletter,* and current elder law numbers.

Elder Law Section electronic discussion list

Send a message to all members of the Elder Law Section distribution list by addressing it to: **eldlaw@lists.osbar.org**. Replies are directed by default to the sender of the message *only*. If you wish to send a reply to the entire list, you must change the address to: **eldlaw@lists.osbar.org**—or you can choose "Reply to all." ■

Important elder law numbers

as of
January 1, 2010

Supplemental Security Income (SSI) Benefit Standards	
Eligible individual	$674/month
Eligible couple	$1,011/month
Medicaid (Oregon)	
Long term care income cap	$2,022/month
Community spouse minimum resource standard	$21,912
Community spouse maximum resource standard	$109,560
Community spouse minimum and maximum monthly allowance standards	$1,822/month; $2,739/month
Excess shelter allowance	Amount above $547/month
Food stamp utility allowance used to figure excess shelter allowance	$385/month
Personal needs allowance in nursing home	$30/month
Personal needs allowance in community-based care	$152/month
Room & board rate for community-based care facilities	$523.70/month
OSIP maintenance standard for person receiving in-home services	$675.70
Average private pay rate for calculating ineligibility for applications made on or after October 1, 2008	$6,494/month
Medicare	
Part B premium	$96.40/month*
Part B deductible	$155/year
Part A hospital deductible per spell of illness	$1,100
Part D premium:	Varies according to plan chosen
Skilled nursing facility co-insurance for days 21-100	$137.50/day

* For those already enrolled. $110.50 for new enrollees. A person whose income is more than $85,000/year will pay a higher premium.

Annual unCLE program

On Friday, May 7, the Elder Law Section is sponsoring a unique program to give elder law practitioners the opportunity to get together for a day-long session of brainstorming, networking, and the exchange of ideas and forms. Topics will range from estate planning to guardianship to Medicaid to practice management.

There will be no formal speakers. The sessions will be small-group discussions moderated by elder law attorneys willing to share their experiences.

The program runs from 8:00 a.m. to 5:00 p.m. and includes a full buffet breakfast, lunch, and post-program reception. The venue is the Valley River Inn in Eugene.

The number of participants is limited and at this writing registration is near capacity. To see if space is available, contact the Oregon State Bar order desk at 800.452.8260 ext. 413 or 503.684.413. ■