OREGON STATE BAR 1935

Elder Law Newsletter

Volume 9
Number 2
Spring 2006

The Deficit Reduction Act of 2005: a sea change in Medicaid planning

By Geoff Bernhardt, Attorney at Law

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (DRA 2005), which includes the most significant changes in Medicaid law since the Omnibus Budget Reconciliation Act of 1993. Described below are the changes DRA 2005 makes to 42 USC § 1396p and 42 USC § 1396r-5.

Start of Medicaid penalty period is delayed

For the elder law attorney, the most significant change in DRA 2005 is the change in the start of the ineligibility period triggered upon a transfer of assets for less than fair market value. Prior to DRA 2005, if an applicant transferred assets for less than fair market value, he or she was ineligible for Medicaid assistance for a period of time, based on the amount transferred. Transfers by a married Medicaid applicant's spouse or agent have the same effect. The period of ineligibility or "penalty period" is determined by dividing the amount of the uncompensated transfer by the monthly average cost of long term care as determined by state administrative rule. The monthly average cost of care is called the "divisor." In Oregon, the current divisor is $4,700. Under this calculation, a $47,000 gift created a ten-month period of ineligibility for Medicaid assistance.

Pre-DRA 2005, the Medicaid penalty period started on the first day of the month in which the asset was transferred. This gave rise to the "transfer-and-wait" or "half-a-loaf" strategy. Under this strategy, an applicant with $100,000 could transfer $50,000 out of his or her name, and retain the remaining $50,000 to pay for care during the penalty period. At the expiration of the penalty period, the applicant could be eligible for Medicaid long term care assistance, so long as assets in the applicant's name were within Medicaid qualifying limits.

DRA 2005 shifts the start of the penalty period from the first day of the month of the transfer to the later of that date or the date on which the individual is eligible for medical assistance under the state plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period.

There are two significant components of this rule. First, the period of ineligibility does not begin until the individual has moved into "institutional level care," which is defined in the statute to include nursing home and waivered home or community-

Continued on page 2

In this issue...

Deficit Reduction Act & Medicaid planning *Continued from page 1*

based services. Second, the period of ineligibility does not begin until the applicant would be eligible for Medicaid assistance, meaning until a person has spent down to $2,000.

Example: (Pre-DRA 2005 Transfer): A Medicaid applicant transfers $112,800 to a child on January 1, 2006. She keeps $100,000 in her name. She goes into care April 1, 2006, and begins spending down her remaining $100,000. Since Oregon's monthly average cost of long term care is $4,700, under pre-DRA 2005 law, this applicant would be ineligible for Medicaid assistance for 24 months, beginning on the date of the transfer. On January 1, 2008, the Medicaid penalty period ends and is no longer a factor in determining her eligibility for benefits.

Example: (Post-DRA 2005 Transfer): A Medicaid applicant transfers $112,800 to a child on March 1, 2006 (post-DRA 2005). She goes into care shortly after that, and by January 1, 2008, she has spent her savings down to $2,000. The 24-month penalty period resulting from the $112,800 transfer does not even begin until January 1, 2008, meaning the applicant will not be eligible for assistance until January 1, 2010.

Look-back period increased from 36 to 60 months

States are required to determine if a Medicaid applicant has transferred assets for less than fair market value. Prior to DRA 2005, states had to determine if a Medicaid applicant transferred assets to an individual in the 36 months immediately preceding the date of the Medicaid application. In the case of a transfer to or from a trust, the "look-back" period was extended to 60 months. DRA 2005 extends the look-back period for all transfers to 60 months. Medicaid applications may become more burdensome, since applicants may have to provide financial documents going back 5 years. In addition, applicants may find themselves being penalized for transfers made years before long term care costs became a concern, such as holiday or graduation gifts, or charitable and religious contributions.

No "rounding down" of transfer penalty periods

Pre-DRA 2005, states could "round" penalty periods to the nearest whole month. For example, in Oregon, a $49,000 transfer, divided by the $4,700 divisor, creates a 10.42 month period of ineligibility. Pre-DRA 2005 rules allow Oregon to round the penalty period down to an even ten months. DRA 2005 forbids the practice. Under DRA 2005, the applicant making a $49,000 transfer would create a ten-month, twelve-day period of ineligibility. The Oregon Medicaid program is likely to have some difficulty adjusting to this change, because Medicaid payments to HMOs and other capitated care systems are made on a monthly basis.

Effective date of new transfer rules

The transfer rules apply to all transfers of assets made on or after February 8, 2006. However, states have a grace period to enact new legislation needed to bring their Medicaid rules into compliance with DRA 2005. Hence, there may be a short window of time in which transfers of assets after February 8, 2006, will be considered using pre-DRA 2005 state law and administrative rules. At this point, we do not know whether Oregon will treat all transfers made after February 8, but before the effective date of the proposed Oregon administrative rules (projected to be July 1, 2006) under the old rules, or whether the state will use the new rules to analyze those transfers if the Medicaid application is made on or after July 1, 2006.

Hardship waivers

What options are available to an elder who has created a period of ineligibility, yet lacks the resources to pay for his or her care? One possibility is to seek a hardship waiver. DRA 2005 requires each state to have a process for seeking a hardship waiver when a period of ineligibility would deprive the individual of medical care that would endanger the individual's life or health, or would deprive the individual of food, clothing, shelter, or other necessities of life. States have the option of paying for care for up to 30 days while the application for a hardship waiver is being considered. Since a care facility may not transfer an applicant for nonpayment unless alternative care exists, a care facility may apply for a hardship waiver of the transfer penalty on behalf of a resident if the resident consents.

Annuities: state must generally be the first remainder beneficiary

Pre-DRA 2005, many states allowed an applicant to reduce the value of his or her countable assets by purchasing an annuity, thereby changing an asset into a stream of income. Prior rules required that the annuity be irrevocable and nonassignable. The annuity also had to "actuarially sound," meaning the annuity had to provide for payment of all income and principal to the annuitant within the annuitant's actuarial life expectancy. Annuities that did not comply with these requirements were treated as a transfer of resources for less than fair-

Continued on page 3

Deficit Reduction Act & Medicaid planning

Continued from page 2

market value, resulting in a period of ineligibility for Medicaid.

DRA 2005 still permits this practice, but imposes some additional conditions. First, the state must be named as the first remainder beneficiary for at least the total amount of Medicaid assistance paid on behalf of the annuitant, unless the annuitant has a spouse living in the community, a minor child, or a disabled child. In that case, the spouse, minor child, or disabled child may be named as the first remainder beneficiary, and the state must be named as the second remainder beneficiary.

Second, the annuity must provide for payments in equal amounts during the term of the annuity, with no deferred or balloon payments.

Rules similar to the DRA 2005 annuity provisions are found at OAR 461-145-0020, which took effect on January 1, 2006.

Income-first rule is mandated for all states

Under the "income-first" rule, the community spouse may not retain resources in excess of the community spouse resource allowance to generate additional income for his or her monthly maintenance needs allowance until all available income of the ill spouse has first been transferred to him or her. Pre-DRA 2005 rules allowed the states to decide for themselves whether to follow the income-first rule, or to instead allow assets in excess of the community spouse resource allowance be transferred to the community spouse to generate income to meet the monthly maintenance needs allowance. Oregon administrative rules required the income-first rule to be followed even before DRA 2005; now it is mandatory for all states.

Substantial home equity may disqualify an applicant

Pre-DRA 2005, the equity in an applicant's home was an exempt resource, so long as the applicant resided in the home or intended to return home after receiving care, or the applicant's spouse, minor child, blind child, or disabled child resided in the home. DRA 2005 provides that an applicant with home equity in excess of $500,000 will not be eligible for assistance even if the home would otherwise be exempt. States have the option to increase this threshold to $750,000.

Entrance fees to continuing care retirement communities may be treated as available resources

DRA 2005 provides that entrance fees to continuing care retirement communities shall be considered an available resource if the individual has the ability to use the entrance fee to pay for care, or is eligible for a refund upon the individual's death or termination of the continuing care retirement community contract.

Constitutionality of DRA 2005

DRA 2005, as signed by President Bush, contains a flaw that may make it unconstitutional. Due to a clerical error, the version of the law that passed the House of Representatives had a different time period for reimbursing medical providers for some medical equipment than the version that passed the Senate. Democrats in the House and Senate unanimously opposed DRA 2005, and this clerical error could require another vote on the measure. In addition, elder law attorney Jim Zeigler has filed an action in the US District Court for the Southern District of Alabama for a declaratory judgment holding DRA 2005 unconstitutional.

Conclusion

DRA 2005 represents the most significant change in Medicaid planning since 1993. Strategies detailed in CLE materials published over the last 12 years are affected; these materials should not be relied upon unless read in conjunction with DRA 2005. Elder law attorneys should carefully study the provisions of DRA 2005 before advising clients on Medicaid and long term care issues. In particular, elder law attorneys should familiarize themselves with the new rules regarding transfers of assets, as reliance upon the old rules may result in clients being ineligible for needed Medicaid assistance for long periods of time, without assets available to pay for care. ■

Geoff Bernhardt is a Portland attorney.He serves on the board of directors of the Oregon Gerontological Association, the program committee of the Oregon Chapter of the National Multiple Sclerosis Society, and the Executive Committee of the Elder Law Section.

Ninth Circuit rules in favor of plaintiffs in Medicaid long term care case

By Steve Skipton, Lane County Law and Advocacy Center

In the case of *Watson v. Weeks*, the Ninth Circuit Court of Appeals reversed a lower federal court decision and ruled in favor of Medicaid recipients whose long term care benefits were terminated in 2003 because of state budget cuts. The court held that the plaintiffs had an enforceable claim under 42 USC § 1983 to nursing facility level of care, a mandatory service under the Medicaid Act.

Under Oregon's Medicaid program, long term care services are provided to those in nursing homes, and through a Medicaid waiver, to those who live in community based settings, such as assisted living facilities and their own homes.

Legal Aid Services of Oregon, Lane County Law and Advocacy Center, the Oregon Law Center, and the National Senior Citizens Law Center brought the case. An amicus brief was filed on behalf of the Elder Law Section.

The Court of Appeals held the plaintiffs satisfied the requirements of the Supreme Court's § 1983 decisions in *Blessing v. Freestone* and, more recently, in *Gonzaga University v. Doe*, and therefore have a private right of action to enforce their right to nursing facility level of care or community-based long term care. The court found this claim had the requisite focus on the rights of the individuals affected by the state's cuts. The court found Congress intended that poor, vulnerable persons who must rely on the Medicaid program for their health care are entitled to their day in court when federally mandated critical care under the Medicaid Act is at stake.

The court held the plaintiffs did not have a private right of action to enforce another provision of the Medicaid Act which requires states to use reasonable standards in determining eligibility. This provision, the court found, did not focus on individuals, but on the state, so that enforcement lies with the federal government, not private individuals.

The court's ruling prohibits Oregon and other states in this circuit from cutting required Medicaid services because of budget constraints, and then trying to prevent the very people who are hurt by the cuts from coming to court for relief. ■

Important elder law numbers

as of Jan. 1, 2006

Supplemental Security Income (SSI) Benefit Standards	Eligible individual . . . . . $603/month Eligible couple $904/month
Medicaid (Oregon)	Long term care income cap . . . . . $1,809/month Community spouse minimum resource standard . . . . . $19,908 Community spouse maximum resource standard . . . . . $99,540 Community Spouse Minimum and Maximum Monthly Allowance Standards . . . . . $1,604/month; $2,488.50/month Excess shelter allowance . . . . . Amount above $481/month Food stamp utility allowance used to figure excess shelter allowance . . . . . $292/month Personal needs allowance in nursing home . . . . . $30/month Personal needs allowance in community-based care . . . . . $136/month Room & board rate for community-based care facilities . . . . . $468.70/month OSIP maintenance standard for person receiving in-home services . . . . . $604.70 Average private pay rate for calculating ineligibility for applications made on or after October 1, 2004 . . . . . $4,700/month
Medicare	Part B premium . . . . . $88.50/month Part B deductible . . . . . $124/year Part A hospital deductible per illness spell . . . . . $952 Skilled nursing facility co-insurance for days 21-100 . . . . . $119/day

Client communication and the ADA—a case in point

By Bob Joondeph, Oregon Advocacy Center

In February 2002, Kathleen Rozanski filed a complaint with the US Department of Justice against attorney Gregg Tirone of Rochester, New York, who had represented her in her divorce. Ms. Rozanski, who had a hearing disability and used sign language and lip reading as her principal means of communicating, alleged that Mr. Tirone had failed to provide a qualified sign language interpreter during several meetings with her.

Ms. Rozanski stated that in the absence of a qualified sign language interpreter, Mr. Tirone communicated with her by pen and paper, fax, lip-reading, and on the telephone through the National Relay Service. She claimed that these alternatives took longer than communications by interpreter and resulted in higher legal fees. She also claimed that the lack of an interpreter resulted in her not understanding all that was conveyed.

Mr. Tirone responded that he had adequately and professionally represented Ms. Rozanski and had effectively communicated with her. He also asserted his belief that Ms. Rozanski understood him at all times.

The Department of Justice investigated the complaint (DOJ Complaint # 202-53-20) and ultimately entered into a settlement agreement with Mr. Tirone. (See www.ada.gov/tirone.htm) The agreement included a rendition of federal law governing the obligations of an attorney to a deaf client, which is summarized below.

What the federal law says

Title III of the ADA and its implementing regulation prohibit discrimination on the basis of disability by places of public accommodation. 42 U.S.C. § 12182 ; 28 C.F.R. § 36.201.

Section 36.303 (a) of the ADA regulation provides that a public accommodation:

> *(S)hall take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the public accommodation can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden, i.e., significant difficulty or expense.*

Attorneys are considered a public accommodation and must provide sign language interpreters when necessary to provide effective communication, which is the case when the client uses sign language as his or her primary means of communication. The commentary to the Title III regulation points out:

> *It is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication.* Commentary § 36.303.

The public accommodation (in this case, the lawyer) must:

> *(F)urnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities.* § 36.303(4)(c).

Auxiliary aids and services include but are not limited to "qualified interpreters." §36.303(b)(1). A "qualified interpreter" is one who:

> *(I)s able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary.* §36.104.

When an interpreter is required, the public accommodation should provide a qualified interpreter, that is, an interpreter who is able to sign to the individual who is deaf what is being said by the hearing person and who can voice to the hearing person what is being signed by the individual who is deaf. This communication must be conveyed effectively, accurately, and impartially, through the use of any necessary specialized vocabulary.

Signing and interpreting are not the same thing. Being able to sign does not mean that

Continued on page 6

Bob Joondeph is Executive Director of Oregon Advocacy Center, a federally funded non-profit provider of free legal services for Oregonians with disabilities.

Client communication and the ADA *Continued from page 5*

a person can process spoken communication into the proper signs, nor does it mean that he or she possesses the proper skills to observe someone signing and change the signed or finger-spelled communication into spoken words. The interpreter must be able to interpret both receptively and expressively.

Family members, friends, and close associates are not qualified interpreters in most cases, and generally should not be used to interpret. The commentary to the Title III regulation makes clear:

> *...(P)ublic accommodations have at times asked persons who are deaf to provide family members or friends to interpret. In certain circumstances, notwithstanding that the family member or friend is able to interpret or is a certified interpreter, the family member or friend may not be qualified to render the necessary interpretation because of factors such as emotional or personal involvement or considerations of confidentiality that may adversely affect the ability to interpret "effectively, accurately, and impartially."* Commentary to §36.303.

How the case was resolved

In applying the legal standards set out above, the Department of Justice found Ms. Rozanski's complaint to be meritorious. Mr. Tirone acknowledged a single violation of the ADA and agreed to the terms set forth below as a resolution of the investigation. In exchange, the United States agreed to terminate the investigation without resorting to litigation.

Mr. Tirone agreed that it is his obligation to ensure effective communication with his clients who have hearing disabilities, and that he cannot charge them for the cost of the interpreter services or charge any other surcharge to recover this cost. He agreed to post a statement to this effect in the local paper and in his office. He further agreed to compensate Ms. Rozanski $2,200, and to forgo any money due from her.

The implications of the case

The cost of an interpreter is the key ingredient leading to cases such as this. While a request for service by a hearing-impaired client may be a rare circumstance for many attorneys, they should be aware that the responsibility to provide effective communication lies with the attorney regardless of the fee arrangements. A public accommodation (e.g., attorney) may refuse to provide an auxiliary aid or service (e.g., interpreter) only if it can demonstrate that providing the aid or service would fundamentally alter the nature of the service, or would constitute an undue burden or expense. If it can make such a demonstration, it must nevertheless be prepared to provide an alternative auxiliary aid, where one exists. 28 C.F.R. §36.303(f).

There is no bright-line test for whether providing a particular auxiliary aid would constitute an "undue burden." Undue burden is defined as significant difficulty or expense when considered in light of a variety of factors, including the nature and cost of the auxiliary aid or service and the overall financial and other resources of the business. 28 C.F.R. §36.104. The undue burden standard is applied on a case-by-case basis. It is not measured by the amount of income the lawyer or other private business is receiving from a deaf client, but by the financial impact on the entity as a whole. Therefore, it is possible for a lawyer to be responsible for providing auxiliary aids for pro bono clients if the cost of the aid would not be an undue burden on the operation of the firm.

There are federal tax incentives for businesses that incur expenses for improving accessibility for people with disabilities. The "Tax Deduction to Remove Architectural and Transportation Barriers to People with Disabilities and Elderly Individuals" (Title 26, I.R.C. Section 190) allows a deduction for barrier-removal expenses not to exceed $1,500 for any taxable year. The "Disabled Access Tax Credit" (Title 26, I.R.C. Section 44) is available to small businesses. It provides a tax credit of 50 per cent of eligible access expenditures that exceed $250 but do not exceed $10,250 made for the purpose of complying with the ADA. For more information on these tax provisions, visit the IRS Web site at **www.irs.gov/businesses/small/article/0,,id=113382,00.html**.

For more information about a lawyer's obligations in general, visit the ADA Title II Technical Assistance Manual at **www.usdoj.gov/crt/ada/taman3.html#III-4.3200**.
(Excerpts from the manual are found on page 7.) ■

Resources

Oregon's Deaf and Hard of Hearing Services (ODHHS) Program Technical Assistance and Information Center:
www.oregon.gov/ODC/dhhap/tac.shtml

Access Services Northwest:
www.accessservicesnw.com/index2.html

To find an interpreter in your community, look in the Yellow Pages under "Translators & Interpreters."

Excerpts from *Americans with Disabilities Act Title III Technical Assistance Manual*
Covering Public Accommodations and Commercial Facilities

III-3.0000 GENERAL REQUIREMENTS

Regulatory references: 28 CFR 36.201-36.213

III-3.1000 General. A public accommodation may not discriminate against an individual with a disability in the operation of a place of public accommodation. Individuals with disabilities may not be denied full and equal enjoyment of the "goods, services, facilities, privileges, advantages, or accommodations" offered by a place of public accommodation. The phrase "goods, services, facilities, privileges, advantages, or accommodations" applies to whatever type of good or service a public accommodation provides to its customers or clients. In other words, a public accommodation must ensure equal opportunity for individuals with disabilities.

Several broad principles underlie the nondiscrimination requirements of Title III. These include

1) Equal opportunity to participate;
2) Equal opportunity to benefit; and
3) Receipt of benefits in the most integrated setting appropriate.

The specific provisions furnish guidance on how a public accommodation can meet its obligations in particular situations and establish standards for determining when the general requirement has been violated. Where a specific requirement applies, it controls over the general requirement.

ILLUSTRATION: Public accommodations are only required to remove architectural barriers in existing facilities if removal is "readily achievable." If making the main entrance to a place of public accommodation accessible is not readily achievable, the public accommodation can provide access to the facility through another entrance, even though use of the alternative entrance for individuals with disabilities would not be the most integrated setting appropriate.

III-3.2000 Denial of participation. The ADA prohibits discriminatory denial of services or benefits to individuals with disabilities. Just as under the Civil Rights Act of 1964 a restaurant cannot refuse to admit an individual because of his or her race under the ADA, it cannot refuse to admit an individual merely because he or she has a disability.

ILLUSTRATION: A theater cannot refuse to admit an individual with mental retardation to a performance merely because of the individual's mental disability.

III-4.1400 Surcharges. Although compliance may result in some additional cost, a public accommodation may not place a surcharge only on particular individuals with disabilities or groups of individuals with disabilities to cover these expenses.

ILLUSTRATION 1: The ABC pharmacy is located on the second floor of an older four-story building that does not have an elevator. Because the pharmacy's owner has determined that providing physical access to the pharmacy for those unable to climb stairs would not be readily achievable, she has chosen to provide home delivery as a readily achievable alternative to barrier removal. The pharmacy may not charge an individual who uses a wheelchair for the cost of providing home delivery.

ILLUSTRATION 2: In order to ensure effective communication with a deaf patient during an office visit, a doctor arranges for the services of a sign language interpreter. The cost of the interpreter's services must be absorbed by the doctor.

III-4.3000 Auxiliary aids

III-4.3100 General. A public accommodation is required to provide auxiliary aids and services that are necessary to ensure equal access to the goods, services, facilities, privileges, or accommodations that it offers, unless an undue burden or a fundamental alteration would result.

Who is entitled to auxiliary aids? This obligation extends only to individuals with disabilities who have physical or mental impairments, such as vision, hearing, or speech impairments, that substantially limit the ability to communicate. Measures taken to accommodate individuals with other types of disabilities are covered by other Title III requirements such as "reasonable modifications" and "alternatives to barrier removal."

ILLUSTRATION: W, an individual who is blind, needs assistance in locating and removing an item from a grocery store shelf. A store employee who locates the desired item for W would be providing an "auxiliary aid or service."

BUT: If G, who uses a wheelchair, receives the same retrieval service, not because of a disability related to commu-

Continued on Page 8

ADA Manual

Continued from page 7

nication, but rather because of his inability to physically reach the desired item, the store would be making a required "reasonable modification" in its practices.

III-4.3200 Effective communication. In order to provide equal access, a public accommodation is required to make available appropriate auxiliary aids and services where necessary to ensure effective communication. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the length and complexity of the communication involved.

ILLUSTRATION 1: H, an individual who is deaf, is shopping for film at a camera store. Exchanging written notes with the sales clerk would be adequate to ensure effective communication.

ILLUSTRATION 2: H then stops by a new car showroom to look at the latest models. The car dealer would be able to communicate effectively general information about the models available by providing brochures and exchanging notes by pen and notepad, or perhaps by means of taking turns at a computer terminal keyboard. If H becomes serious about making a purchase, the services of a qualified interpreter may be necessary because of the complicated nature of the communication involved in buying a car.

Who decides what type of auxiliary aid should be provided? Public accommodations should consult with individuals with disabilities wherever possible to determine what type of auxiliary aid is needed to ensure effective communication. In many cases, more than one type of auxiliary aid or service may make effective communication possible. While consultation is strongly encouraged, the ultimate decision as to what measures to take to ensure effective communication rests in the hands of the public accommodation, provided that the method chosen results in effective communication.

ILLUSTRATION: A patient who is deaf brings his own sign language interpreter for an office visit without prior consultation and bills the physician for the cost of the interpreter. The physician is not obligated to comply with the unilateral determination by the patient that an interpreter is necessary. The physician must be given an opportunity to consult with the patient and make an independent assessment of what type of auxiliary aid, if any, is necessary to ensure effective communication. If the patient believes that the physician's decision will not lead to effective communication, then the patient may challenge that decision under Title III by initiating litigation or filing a complaint with the Department of Justice.

Who is a qualified interpreter? There are a number of sign language systems in use by persons who use sign language. (The most common systems of sign language are American Sign Language and signed English.) Individuals who use a particular system may not communicate effectively through an interpreter who uses another system. When an interpreter is required, the public accommodation should provide a qualified interpreter, that is, an interpreter who is able to sign to the individual who is deaf what is being said by the hearing person and who can voice to the hearing person what is being signed by the individual who is deaf. This communication must be conveyed effectively, accurately, and impartially, through the use of any necessary specialized vocabulary.

Can a public accommodation use a staff member who signs "pretty well" as an interpreter for meetings with individuals who use sign language to communicate? Signing and interpreting are not the same thing. Being able to sign does not mean that a person can process spoken communication into the proper signs, nor does it mean that he or she possesses the proper skills to observe someone signing and change their signed or fingerspelled communication into spoken words. The interpreter must be able to interpret both receptively and expressively.

If a sign language interpreter is required for effective communication, must only a certified interpreter be provided? No. The key question in determining whether effective communication will result is whether the interpreter is "qualified," not whether he or she has been actually certified by an official licensing body. A qualified interpreter is one "who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary." An individual does not have to be certified in order to meet this standard. A certified interpreter may not meet this standard in all situations, e.g., where the interpreter is not familiar with the specialized vocabulary involved in the communication at issue.

III-4.3300 Examples of auxiliary aids and services. Auxiliary aids and services include a wide range of services and devices that promote effective communication. Examples of auxiliary aids and services for individuals who are deaf or hard of hearing include qualified interpreters, notetakers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDDs), videotext displays, and exchange of written notes. Examples for individuals with vision impairments include qualified

Continued on page 9

ADA Manual

Continued from page 8

readers, taped texts, audio recordings, Brailled materials, large print materials, and assistance in locating items.

Examples for individuals with speech impairments include TDDs, computer terminals, speech synthesizers, and communication boards. III-4.3400 Telecommunication devices for the deaf (TDDs). In order to ensure effective communication by telephone, a public accommodation is required to provide TDDs in certain circumstances. Because TDD relay systems required by Title IV of the ADA (which must be operational by July 26, 1993) will eliminate many telephone system barriers to TDD users, the auxiliary aids requirements relating to TDDs are limited in nature.

III-4.3410 Calls incident to business operations. A public accommodation is not required to have a TDD available for receiving or making telephone calls that are part of its business operations. Even during the interim period between the effective date of Title III and the date the TDD relay service becomes available, there is no requirement that public accommodations have TDDs. Of course, the ADA does not prevent a public accommodation from obtaining a TDD if, for business or other reasons, it chooses to do so.

III-4.3420 Outgoing calls by customers, clients, patients, or participants. On the other hand, TDDs must be provided when customers, clients, patients, or participants are permitted to make outgoing calls on "more than an incidental convenience basis." For example, TDDs must be made available on request to hospital patients or hotel guests where in-room phone service is provided. A hospital or hotel front desk should also be equipped with a TDD so that patients or guests using TDDs in their rooms have the same access to in-house services as other patients or guests.

III-4.3500 Closed caption decoders. Hospitals that provide televisions for use by patients, and hotels, motels, and other places of lodging that provide televisions in five or more guest rooms, must provide closed caption decoder service upon request.

III-4.3600 Limitations and alternatives. A public accommodation is not required to provide any auxiliary aid or service that would fundamentally alter the nature of the goods or services offered or that would result in an undue burden.

However, the fact that providing a particular auxiliary aid or service would result in a fundamental alteration or undue burden does not necessarily relieve a public accommodation from its obligation to ensure effective communication. The public accommodation must still provide an alternative auxiliary aid or service that would not result in an undue burden or fundamental alteration but that would ensure effective communication to the maximum extent possible, if one is available.

> **ILLUSTRATION:** It may be an undue burden for a small private historic house museum on a shoestring budget to provide a sign language interpreter for a deaf individual wishing to participate in a tour. Providing a written script of the tour, however, would be an alternative that would be unlikely to result in an undue burden.

What is a fundamental alteration? A fundamental alteration is a modification that is so significant that it alters the essential nature of the goods, services, facilities, privileges, advantages, or accommodations offered.

What is an undue burden? "Undue burden" is defined as "significant difficulty or expense." Among the factors to be considered in determining whether an action would result in an undue burden are the following:

1) The nature and cost of the action;
2) The overall financial resources of the site or sites involved; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements necessary for safe operation, including crime prevention measures; or any other impact of the action on the operation of the site;
3) The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity;
4) If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number, type, and location of its facilities; and
5) If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

Does a public accommodation have to do more or less under the "undue burden" standard than under other ADA limitations such as "undue hardship" and "readily achievable"? The definition of undue burden is identical to the definition of undue hardship used in Title I of the ADA as the limitation on an employer's obligation to reasonably accommodate an applicant or employee. Under both limitations, an action is not required if it results in "significant difficulty or expense." The undue burden standard, however, requires a greater level of effort by a public accommodation in providing auxiliary aids and services than does the "readily achievable" standard for removing barriers in existing facilities (see III-4.4200). Although "readily achievable" is therefore a "lesser" standard, the factors to be considered in determining what is readily achievable are identical to those listed above for determining undue burden. ■

How to address denial of coverage under a long term care insurance policy

By Peggy Toole, Attorney at Law

Peggy Toole is an attorney in Hillsboro, Oregon. Her practice includes health insurance planning and disputes, elder law, and civil litigation.

Clients and their families often contact elder law attorneys with questions about long term care (LTC) insurance and what it will pay for, particularly when the insurance company has refused to pay for care. This article discusses how attorneys should evaluate LTC insurance contracts, but it does not cover qualified plans and tax benefits or LTC insurance policies subject to ERISA.

Oregon's Long Term Care Insurance Act

ORS 743.650 *et seq*, 748.603, and 750.055.

Oregon statutes establish standards that LTC insurance policies delivered or issued in the state after December 31, 1989, must meet. The statutes apply to individual and group LTC insurance or nursing home insurance policies. Group LTC insurance policies issued in another state and offered to Oregon residents must substantially comply with Oregon's requirements. ORS 743.653.

Is there a LTC insurance policy?

You will save yourself and your client time if you first determine whether a LTC insurance policy is actually in effect. ORS 743.652(7) defines long term care insurance as:

> "[A]ny insurance advertised, marketed, or offered or designed to provide coverage for not less than 24 months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more functionally necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital."

Oregon's LTC statutes do not apply to disability income protection coverage and Medicare supplement policies. ORS 743.652(7). Clients often mistakenly think that Medicare or a Medicare supplement policy is LTC insurance. Although some Medicare supplement plans include co-insurance for days 21–100 in a skilled nursing facility, the policies are not LTC insurance.

Was coverage denied due to misrepresentations on the LTC insurance application?

A long term care insurer may refuse to issue a policy or exclude coverage for a "pre-existing condition." An insurer may not define "pre-existing condition" more restrictively than ORS 743.655(3)(a):

> "[T]he existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person."

An insurer also may not exclude coverage for Alzheimer's, related dementias, and conditions such as multiple sclerosis and Parkinson's disease. ORS 743.655(2)(d).

Coverage may be denied if the insured failed to disclose requested medical information on the application for long term care insurance. In this situation, the elder law attorney should review the LTC insurance application, the policy, and the insured's medical records. The attorney can then evaluate his or her client's medical history vis à vis the medical conditions disclosed on the application.

Oregon's appellate courts have not addressed "pre-existing condition" in the context of LTC insurance. However, two cases from other jurisdictions are instructive: *Wickland v. American Travellers Life Insurance Co.*, 204 W.Va.,430, 513 S.E. 2d 657 (1998) and *Smith v. AF&L Insurance,* 147 S.W.3d 767(2004).

In *Wickland*, when the insured applied for LTC insurance, she indicated no problems with or treatment for vertigo and provided a release for the insurer to obtain

Continued on page 11

Denial of coverage under LTC insurance policy

Continued from Page 10

medical records. The insured later fell because of vertigo and required long term care. The insurer denied coverage, saying the applicant failed to disclose previous episodes of dizziness. The court held that dizziness was a symptom, not necessarily the same as vertigo, and did not constitute an excluded pre-existing condition.

In *Smith*, the LTC insurance application requested medical information, including whether the applicant had been examined or treated for stroke, seizures, Alzheimer's disease, dementia, senility, forgetfulness, or other such disorders. The applicant answered "no" and disclosed that she had been treated for depression after her husband's death. She later required long term care for Alzheimer's disease. The insurer denied payment after reviewing medical records, which indicted episodes of forgetfulness that physicians noted could be caused by either depression or Alzheimer's disease. The applicant was unaware of the medical record entries. The court held the insured had not misrepresented her condition.

Have the contract conditions which trigger LTC benefits occurred?

LTC benefits start when the person is impaired or needs assistance with activities of daily living and any policy waiting period has passed. (The waiting or elimination period is further discussed below.)

Under ORS 743.656(1)(a), an individual is eligible for LTC benefits when he or she is functionally impaired and needs assistance in three or more activities of daily living. Under ORS 743.652(5), functionally impaired means a person is unable to perform activities of daily living independently because of either a physical or a cognitive impairment. Activities of daily living are defined by the state, not the insurer. ORS 743.565. An insurer may not define activities of daily living more restrictively than set forth in OAR 836-052-0565.

It is helpful to have health care professionals, family, and caregivers document the insured's cognitive problems. This is important because cognitive impairment may be the only reason a person cannot carry out necessary daily activities, and therefore needs long term care. OAR 836-052-0570(2) lists the documentation needed for cognitive impairment and determines eligibility for long term care:

> An insured under a long term care insurance policy shall be eligible for benefits if the insured is a danger to the insured or to others, as caused by an organic disorder as determined and documented by a physician, by frequently being disruptive or aggressive, or extremely agitated or anxious and, according to a physician's order, professional medical and nursing judgment is required to determine when to administer prescribed medication or to apply physical restraints.

Oregon prohibits prior hospitalization as a prerequisite for long term care insurance benefits. ORS 743.655(4)(a). This is in contrast to Medicare, which requires three days of prior hospitalization.

Insurers also cannot condition coverage on a prior higher level of institutional care. For example, an insurer cannot deny payment for long term care at an assisted living facility solely because the insured did not first require skilled nursing care.

Further, a LTC policy cannot limit coverage to skilled nursing facilities or offer significantly more coverage for skilled care in a facility than coverage for lower levels of care. ORS 743.656(2) and ORS 743.655(1)(c).

OAR 836-052-0586 sets minimum standards for home healthcare benefits in long term care policies. Benefits must be paid when the insured received services from any of the providers approved by the insurer, e.g., nursing home, assisted living, home care, and/or adult foster care. ORS 743.565.

Most LTC insurance policies do not pay for in-home care services provided by family members.

Continued on page 12

A long term care policy cannot limit coverage to skilled nursing facilities or offer significantly more coverage for skilled care in a facility than coverage for lower levels of care.

Denial of coverage under LTC insurance policy

Continued from Page 11

The Oregon Department Consumer & Business Services, Insurance Division Web site is an excellent resource for attorneys and consumers. ***www.cbs.state.or.us/ins***

Determine if the policy includes a waiting or elimination period

A long term care insurance policy may have a waiting or elimination period, which means benefits are not paid until a certain period of time after the start of long term care. ORS 743.652(4). Attorneys should be aware that there may be different elimination periods depending on the care setting, i.e., home care or skilled nursing facility.

How is your client supposed to pay for care during the waiting period? Coordination of benefits is an important consideration. For example, limited Medicare benefits apply when the individual is hospitalized for three days and then transferred to a skilled nursing facility for necessary care. Medicare benefits may cover a portion or all of the waiting period, followed by the LTC policy.

Also, your client's LTC policy may include a provision waiving premium payments when the insured is receiving benefits. The amount usually paid for premiums can be applied to the cost of care during the waiting period.

There may be coverage even if the policy has lapsed

Clients may forget to pay their premiums or be unable to pay the premiums at the time they most need LTC insurance. ORS 743.655(2)(b) requires the insurer to notify the insured in writing of non-payment before canceling a policy. Attorneys should inquire whether their client had LTC insurance in the past, whether it lapsed, and whether there was written notification. The original application may contain information about what happens in the case of a lapsed policy.

Some LTC policies include a provision for nonforfeiture of benefits, i.e., the insured receives some payment or reduced benefits if she or he drops the policy. There also may be a contingent nonforfeiture provision, which allows for reduced benefits when the policy lapses. Finally, if your client has difficulty paying premiums, consider requesting a reduced premium with corresponding decrease in benefits.

Resolving disputes

Policy coverage disputes are often resolved short of litigation through the internal appeal process set forth in the policy. A concurrent, well-documented complaint to the Oregon Insurance Division may be helpful. Before filing an administrative complaint, the attorney should have a complete copy of the application for LTC insurance, the actual policy and all addenda, a written statement as to why the insurer is denying benefits, and related medical records.

Litigation may be necessary—especially where the disputed policy provision is ambiguous. Standard insurance law analysis applies. However, LTC policies are a relatively new insurance product, and the elder law attorney may want to review reported cases from other jurisdictions regarding ambiguous provisions specific to LTC. For example, in *Gillogly v. General Elec. Capital Assur. Co.*, 430 F.3d 1284 (10th Cir. 2005), a licensed residential care home did not meet the policy definition of "nursing home," and in *Gregg ex rel. Gregg v. IDS Life Ins. Co. of New York,* 178 Misc.2d 895, 681 N.Y.S.2d 451(1998), affirmed 261 A.D.2d 799, 692 N.Y.S.2d 182 (1999), a residence was not a nursing home as defined by the LTC policy.

Planning ahead

Elder law attorneys routinely advise clients about LTC insurance, especially as part of an estate plan. Attorneys should tell clients who decide to purchase LTC insurance to retain copies of their application and the actual policy. In the event the client doesn't have a copy of the LTC insurance application, the insurer will provide a copy, if requested. ■

Authority of conservator and personal representative can conflict

By Warren C. Deras, Attorney at Law

Angelic Daughter called you in extreme distress. Poor Widow Mom had lived independently for many years in her home, with increasing assistance from Angelic and Medicaid. Mom had recently inherited $30,000 from Auntie Frugal, and Angelic's Evil Twin brother immediately moved into Mom's home with his drug-dealing girlfriend, three irresponsible adult kids, and two pit bulls. Angelic feared Mom's meager inheritance would be squandered and (when she could talk to Mom by phone, since she was afraid to go to the house with the pit bulls running loose in the yard) Angelic found Mom was so stressed by the situation that she was behaving very strangely.

You sprang into action, applying for appointment of Angelic as guardian and conservator for Mom. Evil Twin (with Mom's money, of course) objected, terrified the court visitor with the pit bulls, and forced you to trial. After a long trial, your judgment appointing Angelic guardian and conservator was finally approved by the court. As you consider framing the judgment you are also contemplating your $15,000 bill and petition for approval of attorney fees. Angelic calls to tell you that Mom just died.

You had in a moment of chivalry assured Angelic that your fee would be paid from her mother's inheritance and that Angelic would not be responsible for it. Now you learn that Evil Twin has filed to probate Mom's ancient will — the one she signed naming him personal representative before he dropped out of Harvard Business School with drug problems. Evil Twin's attorney (the same one who represented him in the protective proceeding and his various dealings with the criminal law) informs you that not only does DHS have a claim for half the value of the house on account of care provided Mom, but they have a claim for the other half for care provided Dad before his death. Mom's inheritance from Auntie Frugal is long spent ("protecting Mom's rights" the other attorney says, glibly), and the estate is insolvent.

So what do you do now?

Your first reaction may be to proceed under *Naito v. Naito,* 125 Or. App. 231, 864 P2d 1346 (1993), rev den 318 Or. 582 (1994), to advise Angelic as conservator to sell the house and secure court approval in the protective proceeding to pay a reasonable fee to Angelic and yourself. It is the position of this article that Naito is no longer good law in Oregon; that Evil Twin, as personal representative, is entitled to immediate possession of the probate assets; and that your fees probably will not be paid.

Naito was part of a long running feud in the prominent Portland family. After Hide Naito's death, his widow objected to a court order retaining assets in the conservatorship for use in paying fees and allowing the conservator to sell the residence. The court ruled against the widow, explaining:

> "A conservatorship may be terminated only by petition and court order. *Crofoot v. Oregon State Bar*, 54 Or. App. 151, 155 n 3, 634 P2d 284 (1981). If the protected person dies, the conservator's powers and duties are those described in ORS 126.337, including the duty to 'retain the estate for delivery to the personal representative of the decedent or other persons entitled thereto.' ORS 126.337(1). The conservator remains subject to the court's authority so that the purposes of the conservatorship are fulfilled. The conservator may deliver assets retained under ORS 126.337(1) only pursuant to an order terminating the conservatorship. ORS 126.387(2) provides, as material:
>
> 'The order of termination shall direct the conservator to deliver the assets in the possession of the conservator to the protected person or successors:
>
> (a) Immediately, to the extent that they are not required for payment of expenses of administration and debts incurred by the conservator for the account of the estate of the protected person...'

Continued on page 14

Warren C. Deras is a Portland attorney whose practice focuses on estate planning and probate. He prepared 1999 legislation authorizing the Chief Justice to adopt rules for accounts in probate and protective proceedings and served on the Uniform Trial Court Rules Committee, which adopted the rules. He also prepared the 2003 revision of Oregon's escheat statutes.

Authority of conservator

Continued from Page 13

In 1995 the statutes governing protective proceedings were completely revised. The statute clearly now applies only when the conservatorship assets are delivered to the protected person, not to successors.

" Under the statutory scheme, when the protected person dies, the conservator retains the estate for delivery to the personal representative or other proper person, ORS 126.337(1), and the court orders delivery of the retained assets to the protected person's successors, except for assets required for estate expenses. ORS 125.387(2)(a). Assets necessary to pay expenses remain in the conservatorship estate until the expenses are paid. ORS 126.387(2). Those assets remain subject to the conservator's power under ORS 126.313(7) to 'dispose of an estate asset including land wherever situated for cash or on credit, at public or private sale...' Funds of the estate, including those generated by a sale of estate assets, 'may be used to pay reasonable compensation to any...attorney...for services rendered...on behalf of the conservator...' ORS 126.263(1). Such payments must be approved by the court. ORS 126.263(2).

" The court's procedure here follows the statutory scheme. The court ordered that defendants, in accordance with ORS 126.337(1), retain estate property and, pursuant to their authority in ORS 126.313(7), sell the residence to generate funds necessary to compensate their attorneys. ORS 126.263(2). The court has statutory authority to make those orders. The court did not err. Because the conservators' duty to pay expenses of administration is not fulfilled, the court also did not err in denying plaintiff's motion to terminate the conservatorship."

The Court in *Naito* expressly relied on ORS 126.387 in reaching its conclusion. That is also true of the court in *Crofoot* (cited in *Naito*) and the later decision in *Herbuger v. Herbuger*, 144 Or. App. 89 (1996). Until 1995 that statute provided:

> (1) The protected person, *the personal representative of the protected person*, the conservator or any other interested person may petition the court to terminate the conservatorship. A protected person seeking termination is entitled to the same rights and procedures as in an original proceeding for a protective order.
>
> (2) The court, upon determining after notice and hearing that the minority or disability of the protected person has ceased, may terminate the conservatorship. *The order of termination shall direct the conservator to deliver the assets* in the possession of the conservator to the protected person *or successors*:
>
> > (a) Immediately, to the extent that they are *not required for payment of expenses of administration* and debts incurred by the conservator for the account of the estate of the protected person; and
> >
> > (b) Upon entry of an order approving the final account or surcharging the conservator, to the extent of any balance remaining." [*emphasis supplied*]

At the time the references to "the personal representative" and "successors" clearly contemplated that the statute applied on the death of the protected person. The statute clearly linked the termination order to delivery of the assets to those entitled to them.

In 1995 the statutes governing protective proceedings were completely revised. ORS 126.387 was replaced in part by ORS 125.525, which provides:

> An order terminating a conservatorship shall direct the conservator to deliver the assets in the possession of the conservator to the protected person:
>
> > (1) Immediately, to the extent that the assets are not required for payment of expenses of administration and debts incurred by the conservator for the account of the estate of the protected person; and
> >
> > (2) Upon entry of an order approving the final accounting or surcharging the conservator, to the extent of any balance remaining.

The statute clearly now applies only when the conservatorship assets are delivered to the protected person, not to successors. A

Continued on page 15

Authority of conservator

Continued from Page 14

court order is clearly needed under ORS 125.090(2)(d) to terminate a conservatorship on the death of the protected person. However, nothing in ORS Chapter 125 links any order for termination of a protective proceeding on death to delivery of assets to those entitled to them. There simply is no basis remaining in ORS Chapter 125 for the conclusion reached in *Naito* under old ORS Chapter 126. To the contrary, the statute clearly points to the opposite conclusion.

ORS 125.420 provides in part:

> The title to all property of the protected person is in the protected person and not in the conservator.

It follows from that provision that title to the probate property on death is governed by 114.215, which provides:

> (1) Upon the death of a decedent, title to the property of the decedent vests:
>
> (a) In the absence of testamentary disposition, in the heirs of the decedent, subject to support of spouse and children, rights of creditors, administration and sale by the personal representative; or
>
> (b) In the persons to whom it is devised by the will of the decedent, subject to support of spouse and children, rights of creditors, right of the surviving spouse to elect against the will, administration and sale by the personal representative.

That in turn leads us to ORS 114.225, which provides:

> A personal representative has a right to and shall take possession and control of the estate of the decedent, but the personal representative is not required to take possession of or be accountable for property in the possession of an heir or devisee unless in the opinion of the personal representative possession by the personal representative is reasonably required for purposes of administration.

To further confirm the limits of the power of a conservator on death of a protected person, ORS 125.230(1) provides in part:

> Except as provided in subsection (3) of this section, a fiduciary's authority terminates upon the ...protected person's death.

Subsection (3) only gives power to a guardian to control disposition of the decedent's remains.

Finally, former ORS 126.263 authorized court approval of payment of fees in the protective proceeding "from the estate." ORS 125.095 now provides that fees are paid from "funds of the protected person." As is clear under ORS 114.215, quoted above, on death the protected person no longer has any funds from which the court may approve payment.

Against this array of clear direction on what happens to the authority of a conservator on death of a protected person, the only remnant offering any continuing authority is in the last sentence of ORS 125.530, which provides:

> The conservator shall retain and administer the estate for delivery to the personal representative of the decedent or other persons entitled to the estate.

Nothing in that sentence overcomes the express statutes governing the effect of death on title to and possession of property, and nothing in it suggests that a court order is needed before delivery of the property to the personal representative or other persons entitled to it. Given the restrictions on the conservator's authority imposed by ORS 125.230(1) following death of a protected person, it is clear that the authority of the conservator to "retain and administer the estate" is limited to protection of the assets remaining in the possession of the conservator.

Once the personal representative replaces the conservator as the person responsible for an estate, a dramatic change occurs in distribution of the estate. Under ORS 125.520 (1), administrative expenses have top priority in the protective proceeding. Under ORS 115.125 governing probate, fees owed to the conservator or the conservator's attorney have the lowest priority, behind support of the spouse and children, probate administration expenses, funeral expenses, taxes, medical expenses, and the claim of DHS, among others.

HB 2314 in the 2005 legislature would have changed the law to allow payment of fees in the protective proceedings from available cash after death of the protected person. It also would have moved protective proceeding administration expenses up in the probate claims priority list in front of DHS. That bill was supported by the Estate Planning and Administration Section, but died in the Senate primarily because of opposition by the Elder Law Section. It is likely to be reintroduced in the 2007 session. ■

Confronting the issue of when to retire from driving

By Ellen Waldman, M.A., and Linda Bellinson, M.S.W, Senior Options, LLC

*Ellen Waldman,MA, (transpersonal psychology and counseling) and Linda Bellinson, MSW,(social work, specializing in geriatrics) are professional geriatric care managers. They are members of the National Association of Professional Geriatric Care Managers (**www.caremanager.org**). They provide services for care management, guardianships, and conservatorships in southern Oregon through Senior Options, LLC. They can be reached at 541.482.9489.*

For many people, driving a car is more than just a means of transportation. In their minds, it represents independence, spontaneity, convenience, competency as an adult, and freedom. It's a link to friends, social activities, and travel away from home. If they see driving as their primary way to stay active and connected in the world, giving up driving in old age may cause sorrow, a sense of loss, a decrease in self-esteem and confidence—or even anger, depression, and hostility.

For these reasons, families and friends are often reluctant to raise the issue with older adults of when to stop driving. Avoiding the issue, however, can have tragic results.

According to a 1998 Oregon State University publication entitled *Driving Decisions in Later Life*, elders are twice as likely as the average driver to be involved in an accident. Older people tend to have more accidents in driving situations that require a high degree of perception, problem-solving ability, immediate reaction, and decision-making. Elderly drivers are at higher risk of injury and death because they are less able to withstand trauma. The legal and financial consequences of having an accident can be devastating, particularly if the elderly driver is at fault.

While age alone does not determine when someone should stop driving, the cognitive and functional changes that occur with age do have an effect on one's ability to drive safely.

The issue is even more complicated when dementia, Alzheimer's disease, or stroke renders a person cognitively impaired. Because of the impaired brain function, the individual often does not recognize his or her deterioration or appreciate the potential driving risks. Family members may be in denial about the diagnosis and progressive deterioration of cognitive functioning. They may want to avoid confrontation or damage to the elder's self-esteem. While these are understandable concerns, they are not reason enough to allow continued driving by someone whose cognitive and/or functional ability is questionable and may be unsafe.

When to talk about it

Postponing the conversation about driving and the cessation of driving is detrimental to older adults, family members, and those who share the roads with unsafe drivers. The ideal time to broach the subject is long before it becomes an issue. Elder law attorneys are often involved in discussions about planning for incapacity, and are in an excellent position to point out that incapacity can be gradual, rather than sudden. As part of the planning materials you provide for clients, consider including a list of the signs that indicate it is time to limit or stop driving. (You can find a list of these warning signs on the AARP Web site.)

Certainly any discussions with clients about financial planning should include a discussion of transportation costs, and a matter-of-fact assumption that at some point automobile ownership will no longer be part of the picture. You can tell them about the tax advantage of donating their cars to a charity. If a client is talking about moving to a smaller residence, remind him or her to include access to public transportation as an evaluation criterion.

Personal decision-making is key to a person maintaining his or her dignity and autonomy. While no one likes to grow old, realistic planning for the changes the years bring is always preferable to crisis-mode triage. As an elder law attorney knows, the more you can do to get clients to acknowledge inevitable changes and plan for them, the fewer frantic calls you will get later from their families.

How to talk about it

Some older drivers will agree to limit or stop driving after caring conversations with family members or others they respect and

Continued on page 17

Retiring from driving

Continued from Page 16

admire. If an impaired driver refuses to limit or discontinue driving, family members may enlist the support of a doctor, lawyer, or other professional. It is important for any professional who routinely advises elders and their families to be familiar with the issues and the options.

When speaking with older drivers, it is important to discuss age-related changes, including decreases in vision and hearing, reaction time, coordination, and ability to make quick decisions. Medical conditions and side effects of medications are also important topics of discussion. Staying focused on universal age-related changes makes the decision to stop driving seem less personal. Avoid sounding critical or demeaning. Stress that these changes are beyond our control.

It is important to stay calm, focused, and professional. This will help ensure a productive discussion and defuse negative emotions about the topic. Concerns about driving need to be approached with sensitivity to both the symbolic meaning and practical significance driving has to the individual. It is important to be empathetic, acknowledging the losses that will occur with the cessation of driving, yet emphasizing the positive aspects of this action.

Discussions may also focus on the financial and legal implications of being involved in an accident and the medical and emotional implications of hurting oneself or others.

Several conversations are likely before an elder agrees to retire from driving.

Unless there is an obvious immediate crisis, a good place to begin is to suggest limits—for example, driving only during the day, driving within a 10-mile radius of the house, taking turns driving to events with friends, carpooling with family and friends, or taking taxis at night. Familiarize yourself with the transportation options available in the community, so that you can provide helpful information.

Let your clients know about the AARP Driver Safety Program. It is an eight-hour classroom refresher that focuses on the effects of aging on driving and how to adjust for them. Most classes are taught in two, four-hour sessions, and the course costs $10. Classes are taught frequently in many locations around the state. Dates and locations of classes are available on the AARP Web site or by calling 888.227.7669. Oregon is one of the states that requires insurance companies to provide discounts to older drivers who complete the course. ORS 742.490 *et seq*.

Referring an unsafe driver to DMV

If safety is seriously compromised, families or guardians may have to take unilateral action, such as contacting the motor vehicle licensing authority, or having someone else report for them.

Voluntary reporting

Family, friends, doctors, law enforcement officers, attorneys, or others who have concerns about a person's driving ability can write a letter to Department of Motor Vehicles (DMV) that describes the problem driver's unsafe driving situation or they can use the Driver Evaluation Request form #6066 that can be obtained from a local field office or downloaded from the DMV Web site at **www.oregon.gov/ODOT/DMV/driverid/reportprobdriver.shtml**. The form requires the name, address, and original signature of the person requesting the evaluation. Although he or she can request confidentiality, DMV may have to disclose the person's name if the driver requests a hearing or files a lawsuit. It is important to note that requests based on age, diagnosis, and/or general health alone will not be honored.

Based on the information provided, DMV may require the person to get a current medical exam or be retested. Depending on test results, DMV will determine whether or not the person may continue to drive (with or without restrictions) or whether the person should stop driving.

Mandatory reporting

Oregon requires physicians and health care providers to report patients with functional and/or cognitive impairments that are considered severe and non-correctable. OAR 735-074-0090, OAR 735-074-0110, ORS 807.710.

For cognitive impairments, a medical file and driving record are sent to the State Health Office for determination. The state does not retain a medical advisory board and this office makes all licensing decisions.

Physicians and health care providers must submit reports to the DMV on the Mandatory Impairment Referral form #7230, which is available at DMV field offices and online at **www.odot.state.or.us/forms/dmv/7230.pdf**.

Once a report is submitted to DMV, the person's driver license will usually be suspended. He or she still has the right to request the opportunity to demonstrate driving ability via knowledge and driving tests. ORS 807.090.

Transportation options

In a society that emphasizes private automobiles over public transportation, indepen-

Continued on page 18

Retiring from driving

Continued from Page 18

dence and driving often are linked. Most adults know little or nothing about public transit, so that when faced with loss of driving privileges, their lack of confidence makes them reluctant to accept public transit as an option. Obviously, friends and family members can help overcome this resistance—and in the process educate themselves—by learning how the transit system operates and accompanying elders on their initial trips. Those who are unable to use regular public transit due to disability may use the services of alternate transportation providers. A list of many of these is provided in the sidebar to this article.

People who choose to live in areas without public transportation have fewer options. Family members, neighbors, and caregivers can provide transportation to appointments and errands. The local senior center may offer a shuttle service. For resources in your community, call the Area Agencies on Aging (AAA) at 800.282.8096.

Explore options to have groceries or prescriptions delivered. Many health plans offer prescriptions by mail—often at a lower price. Oregon Health Plan (OHP) clients who do not belong to a managed health care plan may order prescriptions for home delivery. In the Portland area, the volunteer organization Store to Door provides grocery shopping and delivery for elders and persons with disabilities.

The decision to retire from driving need not be traumatic. As in every other aspect of aging, realistic planning makes a big difference. ■

Resources

Alternative transportation providers for elders and persons with disabilities

Portland metropolitan area
TriMet Lift Service: 503-802-8000 or **www.trimet.org/lift/liftguide.htm**
Ride Connection: 503.226.0700 or **www.rideconnection.org**

Clark County, Washington
C-VAN Paratransit: (360) 695-8918 or **www.c-tran.com**

Salem and Keizer
CherryLift: 503.763.0953 or **www.cherriots.org**

Albany
Call-A-Ride Service: 541.917.7770 or **www.ci.albany.or.us/publicworks/ats/car.php**

Corvallis
Benton County Special Transportation Program: 541.766.6916 or **www.co.benton.or.us/pw/STFweb**

Eugene and Springfield
Lane County RideSource: 541.682.5566 or **www.ltd.org**

Roseburg, Winchester, and Green
Umpqua Transit Dial-A-Ride & Senior Services: 541.440.3587 or **www.ur-cog.cog.or.us/dial-a-ride_&_senior_services.htm**

Medford and Ashland
Valley Lift: (operated through local taxi companies). 541-842-2050 or **www.rvtd.org**

Hood River, Odell, Parkdale, and Cascade Locks
Columbia Area Transit Dial-A-Ride: 503.386.4202 or **community.gorge.net/hrctd/Dial-A-Ride.htm**

Bend
Dial-A-Ride: 541.389.7433 or **www.ci.bend.or.us/depts/public_works/_dial_a_ride__public_transportation.html**

Klamath Falls
Basin Transit Service Dial-A-Ride: 541.883.2877 or **www.basintransit.com/dialaride.shtml**

American Public Transportation Association
A list of all sorts of transportation options, with links to Web sites. **www.apta.com/links/state_local/or.cfm#A2**

Oregon Safe Mobility Web site
Information for mature drivers and their families. Includes driving self-test. **www.oregonsafemobility.org**

AARP Driver Safety Web site
Includes list of warning signs that someone should begin to limit driving or stop altogether, locations and dates for driver safety course, and an excellent article "Driver's Ed for Grownups," by William Jeanes. **www.aarp.org/families/driver_safety**

Store to Door of Oregon
Low-cost personalized grocery shopping and prescription delivery service for Portland-area residents over 65 and those with disabilities. 503.413.8223 or **www.storetodooroforegon.org**

Elder Law unCLE 2006

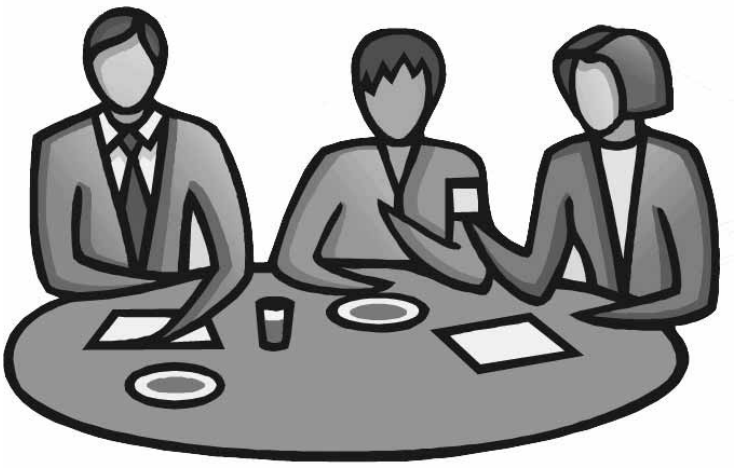
Answers to elder law's persistent questions

Don't miss your chance to be one of the 75 people who learn how to resolve issues raised by recent legislation, share practice tips (including documents and forms), and get to pick the brains of some of Oregon's most experienced elder law attorneys at the Elder Law Section's fourth annual unCLE program. This popular program will be held Friday, May 5, 2006, from 8:00 a.m. to 4:30 p.m. at the Valley River Inn in Eugene.

Individual sessions are limited to 20 people, and you get to choose the topics. There are moderators and resource people, but no formal presentations. Instead, Section members gather around a table to share practical strategies and come up with answers to some of elder law's persistent questions. Potential topics for 2006 include:

- Medicaid Changes in the Deficit Reduction Act of 2005
- Drafting Trusts under the New Oregon Uniform Trust Code (OUTC)
- Notice Requirements and Advising Trustees under OUTC
- Surcharging Beneficiaries
- Dealing with Problem Beneficiaries
- Filing Lawsuits for Elder Abuse (ORS 124.100)
- Medicare Part D Issues
- Long Term Care Insurance Benefits
- Documenting Incapacity After HIPPA
- Representing Elders When Adult Children Are Involved
- Representing Multiple Generations
- Useful Office Technology
- Getting Paid

There will be four groups of sessions, with three or four topics offered at a time. Please e-mail your suggestions for topics (as well as your reactions to the ideas above) to Steve Heinrich, CLE subcommittee chair, at heinric2@peak.org or Mark Williams, unCLE organizer, at mark@theelderlawfirm.com.



Participants should plan to bring 50 copies of documents (such as trust amendments, powers of attorney, demand letters, conflict disclosure and waiver letters, elder abuse complaints, administrative hearing decisions, and demand letters—with confidential information redacted, of course) and forms (such as intake forms, notices, releases, outlines, etc.) that they find useful and share them at a session or by leaving them on the "Documents and Forms" table.

The registration fee of $95 covers meals (buffet breakfast and lunch, as well as a reception following the program) where the informal information exchange continues over good food and drink. To register, please call the OSB CLE Service Desk at 503.684.7413 or 800.452.8260, ext. 413. To register through the Bar, please call by or before 5:00 p.m. May 1, 2006. You may also register at the unCLE itself, assuming that there is still space available. Call the OSB CLE Service Desk to check on the number of registrations and the likelihood of "at the door" registration being available.

Remember, you must be an Elder Law Section Member to register for the unCLE. Annual membership is available for $25, and may be obtained at the time of registration.

To reserve a room at the Valley River Inn, call 800.543.8266.

Section members are invited to stay for the Section's Executive Committee meeting which will be held at the Valley River Inn on Saturday, May 6, 2006, at 9:00 a.m.

Since this is an informal program, we must wait until after the event to apply for OSB MCLE credit. Despite its name, last year's unCLE program was approved for 5 hours of general CLE credit.

Resources for elder law attorneys

EVENTS

Essential Accounting & Finance for Lawyers
Oregon State Bar Seminar
Friday, May 19, 2006 • 9 a.m. to 4:30 p.m.
Oregon Convention Center, Portland

Mediation and Arbitration in Oregon
Oregon Law Institute Seminar
Friday, May 19, 2006 • 8:55 a.m. to 4:00 p.m.
Oregon Convention Center, Portland
Video Replay Dates & Locations:
Bend: 6/2/06; Eugene: 5/26/06
Medford: 5/26/06; Portland: 6/7/06

Sixth Annual Oregon Tax Institute
Oregon State Bar Seminar
June 2 and 3, 2006
Embassy Suites Downtown Portland

Hot Topics in Estate Planning
Oregon State Bar Seminar
June 9, 2006 • 8:30 a.m. to Noon
Oregon Convention Center; Portland

OSB Elder Law Section CLE Seminar
Friday, October 6, 2006
Save the date!

PUBLICATION

Willamette Law Review is releasing a special issue with the text of the Oregon Uniform Trust Code and the comments. All members of the Oregon State Bar Trust and Estate Section will be receiving a copy soon. If you are not a member of that section and would like to order a copy, send your name and mailing address with a check for $10 to *Willamette Law Review*; 245 Winter Street; Salem, OR 97301

INTERNET

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 (listserv)

All members of the Elder Law Section are automatically signed up on the list, but your participation is not mandatory.

How to use the 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."

How to make changes to your subscription

Send a message to listserver@lists.osbar.org with the following in the body of your message for each type of change:

- To remove yourself from the list: unsubscribe eldlaw *your name*
- To receive your message in digest form (combined into a single message sent once each day): set eldlaw digest *your name*