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Tools and traps in planning for incapacity

By Steven A. Heinrich, Ph.D.

At the risk of belaboring the obvious, incapacity planning is best done before the onset of incapacity. All too often clients seek help when a spouse or parent is already incapacitated, when the options may be limited to instituting a guardianship or a conservatorship, or seeking a spousal support order. The durable power of attorney, the advance directive for health care, the trust, and revised investments are some of the planning tools that would have been available earlier. Each, however, carries its own legal traps—some of which may not be immediately obvious.

Powers of attorney

It is important to avoid using generic powers of attorney if special provisions are needed. Failure to include provisions that would allow self-dealing by the attorney-in-fact, and/or that would allow gifting may in some circumstances constitute malpractice. Failure to include provisions that allow transfers which would facilitate applications for government benefits can be equally serious.

Because we cannot force any person or entity to accept the authority of an attorney-in-fact in Oregon, it may be important to update powers of attorney periodically, or to list particular assets and entities with which the attorney-in-fact is specifically authorized to deal. This increases the likelihood that the attorney-in-fact will be able to transact necessary business, and avoid the need for a conservatorship. It may also be helpful to advise still-competent clients to take their powers of attorney to their banks or other institutions to make sure they will accept them later. Sometimes it can be helpful to sign additional powers of attorney on forms provided by the bank or other institution.

Arrangements other than powers of attorney can sometimes have unfortunate consequences, if they are not coordinated with a client's estate plan. People may seek to avoid the need for a power of attorney by holding property jointly with right of survivorship, but do not adjust their estate plan to offset the resulting transfer to one beneficiary. In other cases, representatives of life insurance companies, brokerages, or other institutions may inadvertently convert items of property to joint property with right of survivorship, without understanding the significance of what they are doing. Such errors can result in subversion of a person's estate plan, with significant negative consequences.

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Tools and traps in planning for incapacity

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Some people create problems for themselves by selecting inappropriate out-of-state documents from the Web or other sources. For a period of time, between 2001 and 2003, this could have resulted in an apparent grant of authority to an attorney-in-fact to handle real estate matters in a way that would been technically illegal in Oregon, and which might even have been criminal. In some instances, for persons not appropriately related to the principal, this risk still exists.

Advance directives for health care

A valid advance directive for health care can be one of the most important documents in an attorney's tool kit. In addition to giving health care instructions, and designating a representative who can direct one's care if one is incapable of doing so oneself, the health care representative can be the only person who, under the intersection of state and federal law, is capable of signing an authorization for the release of protected health information under HIPAA if the principal is incapacitated. A health care representative also trumps a guardian in many health care decisions. ORS 127.545(6)(a).

Clients should not use living wills or other documents taken from the Web or other sources, which are technically invalid in Oregon. In most cases, only the form of advance directive for health care provided in ORS 127.531 is valid in Oregon. This form can be enhanced by the addition of special conditions. For some especially helpful language, see the addendum proposed by Kristianne Cox on page 1A-23 of the *Elder Law Essentials: Planning Tools and Practice Tips* materials from the Oregon State Bar Elder Law Section fall 2003 CLE seminar.

The authority of a health care representative is limited in regard to certain kinds of decisions, as outlined in ORS 127.540. The "Declaration for Mental Health Treatment" form set out in ORS 127.736 can provide a useful supplement to the advance directive for health care.

Trusts

Revocable living trusts are often valuable tools in planning for incapacity. One should carefully examine existing revocable living trusts of clients, however, if Medicaid planning is at issue. Some trusts were written with estate tax avoidance in mind. From a Medicaid perspective, these can produce highly inappropriate consequences. For example, if a joint revocable living trust splits into two trusts upon the incapacity of one spouse, and half of the assets are assigned to what becomes an irrevocable trust for the ill spouse, the assets then have to be spent for the care of this spouse, even though it would be more appropriate to save these assets for the support of the community spouse. Great tact can be helpful in such situations, since some clients have an unfortunate apprehension about probate and an unfounded fear of estate taxes, and have been assured that such a trust will help them avoid these perceived evils. Equally important, a good part of the client's ego may be involved in defending the earlier decision to purchase such a trust. If it is still possible, a complete restatement of such a trust can be very helpful.

One of the primary benefits of a trust is that it will allow someone else to manage one's funds after incapacity, or after the trustor reaches a stage where he or she no longer wishes to be involved in day-to-day financial matters. Although there is no court supervision of such administration, as there would be with a conservatorship, trusts can be written so that the trustor is required to present regular formal accountings to specific individuals or classes of individuals.

Other trust devices that can be helpful include both grantor-funded and third-party-funded special needs trusts or supplemental needs trusts, and/or similar arrangements made through the ARC of Oregon Pooled Trust. For more information, contact Mitch Teal of the ARC, at 877.581.2726. For further information on special needs trusts and supplemental needs trusts, consult the 2003 Oregon State Bar CLE publication titled *Special Needs Trusts*. The conditions under which such trusts are appropriate can require highly complex planning, and care should be taken to select a form of trust and a form of funding that will produce the desired result for a beneficiary, because such trusts can sometimes fail to provide the expected benefits when taken in conjunction with the benefit programs that affect the beneficiary. Such special needs trusts can be helpful in preserving quality of life for a beneficiary who gets public benefits.

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Medicaid income limits and income cap trusts

By Julia T. Greenfield

To qualify for Medicaid in Oregon, an applicant's income must be below a specified level. An applicant whose income exceeds this level may still qualify for Medicaid if he or she requires long term care and establishes an "income cap trust."

Medicaid income eligibility rules

A Medicaid applicant may qualify for benefits in 2005 if any of these situations applies:

- His or her only income is SSI benefits of $579 per month.
- His or her income is equal to or less than the SSI monthly benefit rate of $579 per month, and the applicant would otherwise be eligible for SSI except for some SSI eligibility rule that does not disqualify him or her for Medicaid.
- His or her income is less than three times the SSI monthly benefit rate (*i.e.*, less than $1,737 per month) *and* he or she requires long term care. This figure of $1,737 per month is known as the Medicaid "income cap" for people who need long term care. OAR 461-155-0250(1).
- He or she requires long term care, income exceeds the $1,737 income cap, and he or she establishes an income cap trust. OAR 461-145-0540(10)(c).

The Medicaid eligibility numbers are updated each year in January. The Elder Law Section posts current Medicaid eligibility figures on its Web page, which can be accessed through the Oregon State Bar Web site at **www.osbar.org**.The 2005 figures are also on page 16 of this newsletter.

Determining a Medicaid applicant's income

Only the applicant's income counts

Only the income of the person who requires long term care is counted for Medicaid eligibility purposes. If the applicant is married and his or her spouse does not require long term care, the income of this "healthy" spouse is not considered. The person in whose name income is paid is presumed to own the income. If the income is paid in the names of more than one person, the Medicaid program uses a rebuttable presumption that the income is divided equally among them. OAR 461-160-0600.

Determine total monthly gross income

Medicaid eligibility is based on the applicant's gross, not net, income. Thus, the Medicaid program counts income before any deductions or withholdings, including deductions for Medicare Part B premiums, other insurance premiums, union dues, and tax withholding. Documents that will help you verify a Medicaid applicant's total gross monthly income include: the annual notice of benefits sent by the Social Security Administration, current bank statements showing direct deposits (but remember to verify whether the amount deposited is a gross amount or a net amount after any deductions or withholdings), pension, Social Security, and annuity checks or check stubs, and tax statements.

Countable vs. excluded income

Although most income is counted for Medicaid eligibility purposes, there are minor exceptions—some types of income are excluded. See OAR 461-145-0001 through 461-145-0585 for discussion of various types of income and whether they are counted for Medicaid eligibility purposes.

Countable income includes, but is not limited to:

- Social Security benefits
- VA or Railroad Retirement benefits
- private pension benefits
- PERS and other government pension benefits
- worker's compensation
- annuity payments
- interest
- dividends
- investment income
- spousal support payments
- wages or royalties
- inheritances
- cash gifts and winnings
- personal injury settlements
- net income from an income-producing contract

Most of the income exclusions for the Oregon Medicaid program are based on the federal SSI income-exclusion regulations at 20 CFR 416.1103 *et seq*. The list of excludable income is actually quite long. Excludable income includes, but is not limited to: federal and state income tax refunds and property tax refunds; the principal portion of loan payments made to a Medicaid applicant; refunds of rental and utility deposits; lodger income in the month received; refunds on merchandise that was purchased or received as a gift; payments made for the Medicaid applicant's services as a representative payee for another person; and Veteran's Aid and Attendance payments. Note that although Veteran's Aid and Attendance payments a*re not* counted for determining financial eligibility for Medicaid, they *are* counted for purposes of calculating the amount of the Medicaid recipient's liability to a long term care facility for long term care services provided. OAR 461-145-0580(2)(b). Distinguishing what part, if any, of a Medicaid applicant's veteran's benefit constitutes an Aid and Attendance payment is difficult. Ask the applicant's Medicaid caseworker to get a definitive answer from the Veteran's Administration before establishing an income cap trust for an applicant who gets payments from the VA.

Options for making changes to income

In some cases, if changes can be made to the applicant's income to bring it under the Medicaid income cap, it may be possible for

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an individual to qualify for Medicaid without having to establish an income cap trust. Although Social Security payments and most pensions are generally fixed, some types of income can be adjusted. For example, if a Medicaid applicant is receiving income in the form of payments on a contract for a sale of property, it may be possible to renegotiate the repayment terms so that smaller payments are made over a longer period of time, thus reducing the Medicaid applicant's monthly income. Income from payment on a contract may also be converted from income to a resource by selling the contract. (Note that this article does not treat the subject of Medicaid resource limits. The Medicaid resource limit for an individual elderly or disabled recipient is generally $2,000.)

Income cap trusts

When the Medicaid applicant's monthly income has been examined, options for reducing that income have been reviewed, and the applicant's gross monthly income remains higher than three times the SSI monthly benefit level (i.e., higher than $1,737), a Medicaid applicant seeking long term care coverage can qualify for Medicaid only by establishing an income cap trust.

Attorney's fees for income cap trusts

Until 2003, an income cap trust could provide for payment of an attorney's fees from the Medicaid beneficiary's income for the service of drafting the trust. In 2003, the state changed this policy, and a trust may no longer provide for payment of an attorney's fees. However, in addition to having income above the Medicaid income cap, some Medicaid applicants also have resources in excess of the $2,000 resource limit. In order to qualify for Medicaid, they must "spend down" their resources to a level below $2,000. Paying an attorney to draft an income cap trust is a legitimate spend-down expenditure for a person attempting to qualify for Medicaid. Most practitioners charge a flat fee for drafting a Medicaid income cap trust. An hourly rate would overcomplicate the spend-down process, since the expenditure must be completed before the Medicaid applicant seeks Medicaid approval of his or her income cap trust.

Basic features of a Medicaid income cap trust

A Medicaid income cap trust is irrevocable. The Medicaid applicant is both the trustor and the lifetime beneficiary of the trust. A Medicaid income cap trust is funded by *all* the beneficary's income, and *only* by the beneficiary's income. Once the trust is established, the beneficiary receives only a small personal needs allowance each month from the trust—generally $30 for nursing home residents, and $122 for residents of other long term care facilities. A trustee who is willing and able to handle the Medicaid applicant's finances manages the trust. This is usually a family member or friend. The trustee disburses the trust income every month according to a strict distribution plan. Any funds that remain in the trust when the trustor/beneficiary dies are used to repay the state for Medicaid assistance received by the beneficiary in his or her lifetime. This should be a negligible amount, because the trust should be written to provide for the distribution of all the trustor/beneficiary's income each month.

Trust format

Although there is no mandatory format for an income cap trust, a basic form has been approved by state Medicaid policy staff. This form can be found online at **www.dhs.state.or.us/spd/tools/program/osip/wg5.htm.**

Effective date of the trust

A Medicaid applicant cannot become eligible for Medicaid before the effective date of the trust. The effective date of the trust may be retroactive to the first day of the month in which the trust is signed. The state begins paying toward the cost of long term care from the date of Medicaid eligibility, so if the trust is backdated to the first of the month, the state may cover the cost of long term care for the entire month. However, backdating the trust will only be possible if the applicant's income has not already been spent in a manner inconsistent with the trust distribution plan, since a backdated trust obligates the trustee to distribute all the beneficiary's income for that month according to the trust distribution plan.

Post-eligibility treatment of income: the distribution plan

Most of the attorney's work in preparing an income cap trust will entail drafting the trust's distribution plan, which sets forth exactly how the beneficiary's income will be spent each month after the applicant has been found eligible for Medicaid. The distribution plan starts with the beneficiary's gross monthly income, then lists monthly distributions from that income pursuant to the state Medicaid rules for post-eligibility treatment of income. Deductions from the beneficiary's gross monthly income (and the corresponding payments made by the trustee each month) must follow the order of distributions found at OAR 461-145-0540(10)(c) and OAR 461-160-0620, summarized below. If the beneficiary's income is insufficient in any given month for the trustee to make all the listed distributions, the trustee must still make distributions according to this hierarchy until the beneficiary's money for that month runs out.

Order of distributions from income

1. **Personal Needs Allowance/Maintenance Standard: OAR 461-145-0540(10)(c)(A)**

   This amount varies depending on the type of facility in which the Medicaid recipient resides and whether he or she is blind. The Personal

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Needs Allowance (PNA) *for nursing home residents* is $30 per month. (The PNA is higher for some veterans who have unusual medical expenses (UME) benefits.) See OAR 461-160-0620(1)(d)(A)–(B). The PNA is either paid directly to the nursing home resident by the trustee to purchase clothing and personal incidentals, or it is used by the trustee to purchase these items on behalf of the resident. The Maintenance Standard for *residents of community-based care facilities* (residential care facilities, adult foster homes, and assisted living facilities) comprises a personal needs allowance of $122 (or $129 if the resident is blind), and a room and board payment to the facility of $458.70, for a total maintenance standard of $580.70. See OAR 461-160-062)(1)(d)(C); 461-155-0270. The trustee distributes the maintenance standard in two parts: the personal needs allowance is paid directly to the resident or is used to purchase clothing or incidentals for the resident, and the room and board payment is paid directly to the facility.

2. Administrative Costs: OAR 461-145-0540(10)(c)(B)

The state authorizes a maximum administrative fee of $50 per month, which must cover bank service charges, check printing fees, copy charges, postage, income taxes attributable to trust income, preparation of tax returns, and any trustee fee. Guardianship or conservator fees approved by the court could theoretically be distributed from the trust as administrative payments as well, but keep in mind that total administrative costs, including these fees, cannot exceed $50 a month.

3. Community Spouse Income Allowance: OAR 461-145-0540(10)(c)(C)

The distribution plan may include a monthly payment from the trust to the Medicaid recipient's spouse to bring the spouse's monthly income up to a standard of $1,561 (or higher, to a maximum of $2,377.50, if the spouse's shelter costs exceed $468 per month). See OAR 461-160-0620(e).

4. Health Insurance Premiums: OAR 461-145-0540(10)(c)(D)

The distribution plan should account for payment of all the Medicaid recipient's health insurance premiums. *Note special treatment of Medicare Part B premiums:* Medicare Part B premiums will be paid by the state once the applicant qualifies for Medicaid. Confirm with the Medicaid caseworker the date on which the state will begin paying the Medicare Part B premium (usually two months after the applicant qualifies for Medicaid). In the meantime, for *nursing home residents,* the Medicare Part B premium should be listed under Health Insurance Premiums in the trust distribution plan. The trustee must pay the premium from the trust until the state takes over. For *community-based care facility residents*, the premium is automatically deducted from the resident's Social Security benefits. During the two months before the state takes over payment of the Medicare Part B premium, the trustee may decide to distribute a smaller personal needs allowance to the beneficiary (i.e., adjust the personal needs allowance downward to account for the Medicare Part B premium, and list the Medicare Part B premium in the trust distribution plan). Once the state takes over payment of the Medicare Part B premiums, it will make a retroactive payment to SSA to cover the last two months of premiums. This means the beneficiary's premiums will have been overpaid for those two months. The Social Security Administration will then refund the beneficiary the two months of overpaid premiums. The trustee should deposit this refund back into the trust, and can use it to pay an augmented personal needs allowance to make up for the reduced personal needs allowance that was paid during the first two months of Medicaid eligibility.

5. Other Reserves: OAR 461-145-0540(10)(c)(E)

The distribution plan may allow for some of the trustor/beneficiary's income to be reserved for certain anticipated future expenses, including other incurred medical expenses (payments toward expenses incurred prior to Medicaid eligibility or ongoing medically necessary expenses not covered by Medicaid); property and income taxes; burial plans; child support and alimony payments; and home maintenance.

6. Patient Liability: OAR 461-145-0540(10)(c)(F)

After the above distributions and reserves, the trustee pays directly to the care facility either the rest of the Medicaid recipient's monthly income, or the cost of services provided for his or her care, whichever is less. This obligation is called the Patient Liability. See OAR 461-160-0620(1)(d)(C), 461-155-0270. Note: If the Medicaid recipient resides in a community-based care facility rather than a nursing home, he or she must also pay $458.70 *for room and board*. The room and board obligation is prior to and distinct from the Patient Liability payment for *care services* provided by the facility. The room and board obligation is part of the maintenance standard, and is second in priority after the personal needs allowance. See OAR 461-145-0540(10)(c)(A); 461-160-0620(1)(j). However, the room and board obligation is sometimes incorporated into the Patient Liability figure on the distribution form, since for administrative ease the trustee generally writes only one check to the facility to cover both room and board and services.

7. Excess

After all distributions have been made, any excess should be negligible. Excess funds remaining in the trust should be paid to the state. After the distribution plan is

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This article reviews Medicaid income limits in Oregon and provides basic information regarding Medicaid income cap trusts. This article does not cover community spouse issues.

For more thorough treatment of Medicaid income limits and income cap trusts, consult Chapters 8 & 9 of the Oregon State Bar's 2000 Elder Law CLE publication (2005 supplement forthcoming). See also OSB CLE materials "Problem Solving in Elder Law Practice" (Sept. 22, 2000, by Penny Davis), and "Problem Prevention in Elder Law" (October 26, 2001, by Wesley Fitzwater and Karen Adams).

drafted, if it appears that the amount of excess is more than negligible, discuss with the Medicaid applicant whether Medicaid assistance is really the best option for the applicant. He or she may be able to negotiate with the facility for a private-pay rate that is more than the facility's Medicaid contract rate, but less than the facility's usual private pay rate. However, keep in mind that Medicaid eligibility qualifies a person for prescription drug coverage in addition to long term care services, and prescriptions can run hundreds of dollars a month, so it may be important to try to preserve Medicaid eligibility for this reason.

Finalizing the income cap trust

Communicating with the Medicaid caseworker

Before the trust is signed and made effective, the distribution plan should be submitted for review and approval by the applicant's Medicaid caseworker. Find out which caseworker will be handling the financial eligibility portion of the Medicaid application, and fax the distribution plan and any supporting documentation regarding income and expenses. The state will prepare a financial planning sheet for the trustee. Review this sheet and be sure the state's "client pays" or "owed to nursing home" figures match the trust distribution plan's "patient liability" figure. If there is a discrepancy, negotiate any needed changes with the caseworker prior to finalizing the trust. Remember that caseworkers can be of great assistance in this area, but it is primarily the attorney's obligation to prepare the distribution plan. Keep the lines of communication open with the caseworker and build trust. If the attorney and the caseworker have conflicting interpretations on rules or broad policy questions, contact the Medicaid Central Office, and speak to Joanne Schiedler at 503.947.5201, or Jeff Miller at 503.945.6410. The in-state toll-free number is 800.282.8096.

Advising the trustee

Once the distribution plan has been approved by the Medicaid caseworker, the trustee must establish an EIN (employer identification number) for the trust. To apply for an EIN, the trustee will fill out and submit IRS form SS-4, which can be obtained on the Web at **www.irs.gov**. Once completed, the form can be submitted over the phone, by fax, or online. Once the EIN has been assigned, the trustee should open a bank account for the trust.

The attorney's service is completed with a letter to the trustee explaining exactly what checks (to whom and in what amounts) should be written from the trust bank account. Explain how the monthly distribution plan works in practice, and advise the trustee regarding his or her obligations at the termination of the trust.

Termination of the trust

The trust terminates when the beneficiary dies. The trust may also terminate prior to the beneficiary's death if the beneficiary's health improves to where he or she no longer needs Medicaid long term care assistance, if income drops to a level under the Medicaid income cap, or if resources increase above the Medicaid eligibility threshold (e.g., through inheritance or sale of a home).

Upon termination of the trust, the trustee prepares a final report or accounting that details the proposed payment to the state, and if any money is left over, to any remaining beneficiaries. The trustee mails the report to the beneficiary (if still living), the successor trustee, the state, and any remainder beneficiaries identified in the trust. The final report should give interested parties 30 days to object to the proposed termination and proposed payments to the state and any remainder beneficiaries. If there are no objections, the trustee closes out the trust bank account and makes payments to the state and any remaining beneficiaries. The trustee also notifies the IRS that the trust is being terminated, and prepares a final tax return.

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Resource transfers will affect Medicaid eligibility

By Matthew J. Mullaney, Attorney at Law, McMinnville

With some important exceptions, the Medicaid program penalizes an applicant who gives away resources to accelerate financial eligibility. Controlling state regulations are OAR 461-140-0210 to 461-140-0300 and appear on the Web at **www.dhs.state.or.us/spd/tools**. Although some of the key points are addressed in this article, I encourage elder law practitioners to read the regulations and not rely on secondary sources for information.

Monetary gifts or equivalents

In general, a gift of money or property by a Medicaid applicant will create a period of ineligibility for Medicaid. The value of the gift is divided by $4,700 (for applications filed on or after October 1, 2004) and rounded down to the next whole number to arrive at the number of months of ineligibility. The month the gift is made is included in the penalty period, so a gift of $10,000 delivered on February 28, 2005 will make the donor ineligible for Medicaid only for the months of February and March, 2005. ($10,000/$4,700 = 2.13)

This leads to what can be called a "shift and sit" strategy. Consider the case of a 75-year-old widow whose sole countable resource is $60,000 in the bank. She has a monthly income stream of $1,200 and a care facility, pharmacy, and health insurance bill of $4,200 a month. She is spending $3,000 a month more than her income. If she gives her children a gift of $36,000 on February 28, 2005, she will be ineligible for Medicaid through the end of August, 2005 ($36,000/$4,700=7.66 months). During the ineligibility period, she will spend $21,000 of her cash reserves, leaving her at the threshold of Medicaid eligibility with $3,000 in cash. This strategy may be contraindicated for a number of reasons, including the widow's wish to pay her own way, loss of control, lack of authority in a fiduciary to make gifts, an increase in care costs, or discharge from the care facility because it does not accept Medicaid.

Real property gifts

Because transfers between spouses are "not disqualifying," attorneys routinely counsel transferring the family home to the spouse who is not applying for Medicaid in order to provide the "well" spouse with greater financial flexibility. Since many married couples have estate plans that leave the home and the rest of the assets to the surviving spouse, the well spouse should review whether the provisions of his or her existing plan needs to be changed, and what assets should be left to the ill spouse if the well spouse dies first.

Any transfer should be made sooner rather than later, and preferably before the Medicaid application is filed, to avoid issues on post-eligibility review. See OAR 461-140-0210(2).

Medicaid policy prefers home-based and community care to institutional care, and to that end exempts the gift of the home to a caregiver child under defined circumstances. If a parent expects a live-in adult child to provide his or her care for a period of two years or more, the parent could execute a deed right away, but defer recording the deed until two years have passed. Or the parent could execute a power of attorney to allow her or his agent to execute and deliver the gift deed to the caregiver child after two years. If the live-in adult child provides in-home care for less than two years, however, the exemption is lost.

If the family is unaware of this exemption and makes no plan to make a gift of the home to the caregiver child after two years, consider a one-order conservatorship if the parent is still alive, or negotiate with the Medicaid estate recovery unit if she or he is deceased. Perhaps there is an oral contract with part performance to take the transaction out of the statute of frauds.

Other exempt property transfers appear at OAR 461-140-242 and should be considered before or with the strategies discussed next.

Parent(s) may give the family home or a vacation home to the children to trigger the look-back period, with the expectation that the donor-parent(s) will still enjoy access and that the look-back period will expire in advance of any Medicaid application.

Alternatively, the family home or vacation home may be sold to one or more children at real-market value and at an acceptable interest rate over 20–30 years, making the transaction a sale and not a gift. When the seller-parent does not survive the term, the balance of the debt may merge with an inheritance. The Medicaid estate recovery unit will have a claim against the debt balance; therefore, the parent may want to forgive the debt in increments to increase the rate at which the debt balance falls. The parent can forgive up to $4,700 each month, keeping the agreed monthly payments running per the contract. When the parent dies, the Medicaid estate recovery unit will not be able to accelerate the remaining debt and may be willing to settle its claim for payment of a reduced amount.

It is possible that a parent might convey real property to children in a series of monthly fractional-share deeds, no gift deed exceeding $4,700 as a fraction of market value. A value discount for loss of control and fractional interest may allow a series of larger fractional-share deeds that exceed a mathematical $4,700 if a donor-parent is in poor health. Deed preparation and recording fees (and perhaps a fee appraisal of discounted fractional shares to satisfy Medicaid) may pale in comparison.

Parents who transfer property to adult

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Resource transfers

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children face significant risks associated with loss of control over the property, the effect on second marriages, and disputes among siblings. If the parent's competence is in question, the conveyance might be challenged, thereby clouding title. Conveying property to children may also result in loss of other benefits, including basis step-up at death, the personal residence capital gains tax exclusion, property tax deferral, benefits from the Oregon Department of Veterans Affairs, and a home maintenance reserve within an income cap trust.

Whatever strategy is to be used, clients must be warned that Medicaid programs across the country are under pressure to save money by deterring eligibility and by increasing estate recovery, and that an adversely changing regulatory landscape awaits. Powers of attorney with Medicaid planning must be broadly drawn, using the phrase "…or by whatever means might be available to my agent at the time of any health care crisis." If a Medicaid worker cites a written or unwritten "house rule" that blocks eligibility or increases estate recovery, this rule may be a back-door "regulation" under the Oregon Administrative Procedures Act (ORS 183.310) and void for want of lawful rulemaking procedures.

New addresses for Multnomah County Aging and Disability Services

The Multnomah County Aging and Disability Services Nursing Facility Program has moved. The new address is 600 NE 8th St., Gresham, OR 97030. The nursing facility program is located in the same building as the East County ADS office. The telephone and fax numbers have not changed.

The ADS central office is scheduled to move in June to 421 SW Oak St., Portland, OR 97204.

Tools and traps

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The proposed Oregon Uniform Trust Code (SB 275), which is currently before the Legislature, is not expected to significantly change trust-drafting strategies such as those outlined above.

Revising investments

Some plans for future limited capacity include simplifying holdings, or moving them to less risky investments. This can be a very good strategy, but the attorney should be very careful not to engage in financial planning or investment counseling. Clients should work with professionals in these areas, with a review by an elder law attorney as appropriate.

Just as some clients are reluctant to recognize they have an inappropriate trust, others may hesitate to admit they have made a bad investment. If a client does recognize this, state agencies that regulate the sale of such investments can be most helpful if there is difficulty in negotiating a return of the person's assets, particularly for more recently purchased investments.

Wills

It may seem odd to consider wills to be instruments for incapacity planning. However, wills can be useful in planning for the incapacity of loved ones. Testamentary trusts can provide for an incapacitated heir or preserve assets in the form of a special needs trust.

Post-incapacity planning

Post-incapacity planning devices range from shifts in income, which may be available through income cap trusts, to shifts in assets, which can be available through spousal support orders. Detailed discussion of these issues can be found in the Oregon State Bar CLE publication *Elder Law*.

Another consideration is the spousal elective share. Pursuant to ORS 114.105 *et seq*, a spouse can elect to take one-fourth of the net estate of a deceased spouse in lieu of property the surviving spouse would otherwise receive by will or intestate succession. This applies only to probate property, and not property passing outside of probate or through trust. Take care if there is any reason to expect a spouse will make an election against a will. Elder law practitioners should also recognize that in order to qualify or remain qualified for Medicaid, a surviving spouse may be required to make such an election, even though spend-down has already occurred, and the property of the well (but now deceased) spouse was exempt from Medicaid spend down. A working group of the Oregon Law Commission is considering proposals that if adopted will expand the elective share to also include non-probate property that the decedent transferred within two years prior to death. The group is also considering increasing from one-quarter to one-half the share a surviving spouse can claim against. If such proposals are adopted, corresponding legislation will likely follow, statutorily approving post-nuptial agreements that include a provision waiving the surviving spouse's right to an elective share.

In all the strategies outlined above, the implications for Medicaid planning and for other human concerns can be significant, and the ramifications of receiving timely and well-thought-out advice from a skilled elder law attorney can be significant.

Choosing a long term care facility: an interview with Letty Morgan

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

ELN: What is the first step when a person is searching for a long term care facility?

LM: Gathering information. You need to know the resources available in the county. The local office of Services for Seniors and People with Disabilities is a good place to start. Lane County has a very useful 12-page pamphlet that compares all the housing options in the county, and I'm sure this kind of information is available in other counties as well.

It's also important for someone to assess the elder's need for help with activities of daily living (ADLs). This assessment will help narrow down the choices, since different types of care are appropriate for people with different needs. If long term care insurance, Medicaid, or Medicare is going to pay, an assessment will be required, though facilities don't require it for private-pay residents. It's still a good idea. A private care manager can do this, often at little or no cost. If Senior Services is going to do a resource assessment, the worker can also do this assessment. You'll need correct medical information from the senior's doctor.

Assisted living facilities are appropriate for the most independent people. The resident has his or her own apartment, bathroom, microwave, and refrigerator. The facility provides meals and housekeeping and can accommodate more advanced needs as people age. A resident who needs more than the facility can provide must hire a private provider.

Adult foster homes are small and the only homelike facilities. They have at most five residents, who can have a range of needs. But a foster home is not suitable for someone who needs a lot of help at night, is likely to wander, or requires more than one person for help with transferring.

Residential care facilities are also for people with a range of needs, but they are much larger than foster homes. Each resident has his or her own room and usually a private bathroom. RCFs have staff at night and so are good for people who need night care, wander at night, or have heavy care needs.

Nursing homes have mostly become rehabilitation facilities, though they have some long term care beds for people with medical needs. They have nursing staff around the clock.

ELN: OK, so let's say that we know what general kind of facility is probably going to be best. Where should you go from there?

LM: It can be overwhelming to try to go to all of the facilities. So ask the person who did the assessment of the senior for a list of the best facilities of that type in the area. Each facility has a different personality, and the person who did the assessment should be able to give advice about which ones are most likely to work for this resident. It's very important to talk to someone who is in the facilities a lot, who really knows what's going on in them.

Then it's time to visit the facilities. Go to each one at least a couple of times, including during a meal and after hours or on the weekend. It's fine to take the official tour because you can learn a lot, such as how much care costs. Be sure to ask what the fee they quote you covers and how much extras cost. And ask about staffing. Be sure to find out what the staff-to-resident ratio is on every shift and what kind of training staff members have. Training is really important; find out the facility's requirements for new hires and what kind of ongoing training they provide or require. Also ask about medical personnel, both when they are present and what kind of training they have. Then, after the tour, go back on your own and poke around.

ELN: What should you look for when you're visiting a facility?

LM: Do the sniff test. Contrary to what some people believe, a good facility does not smell bad. Look at the physical plant to see if it's in good repair and clean. Check the noise level; is it too quiet or too noisy? Are the staff members yelling back and forth to each other?

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Letty Morgan has co-owned Eldercare Resources, Inc., a geriatric care management company in Eugene, since 1990. For four years before, she was a case manager for what is now Services for Seniors and People with Disabilities (SPD) in Lane County. She has a degree in gerontology from the University of Oregon. The Elder Law Newsletter asked her to discuss how to choose a long term care facility.

Resources for finding a long term care facility in Oregon

DHS Web site, Choosing a Long-term Care Setting: This Web site also offers "A Guide to Oregon Adult Foster Homes" and "Oregon's Consumer Guide to Assisted Living and Residential Care Facilities" as downloadable pdf files. **www.dhs.state.or.us/spwpd/ltc/ltc_guide.**

2004-2005 Lane County Assisted Living & Residential Care Facilities Comparison Guide**:** Available from the Senior & Disabled Services division of the Lane Council of Governments

Resources for finding a long term care facility outside Oregon

DHHS long term care site: From this page, go to the publications page, where you can download pamphlets entitled "Medicare Coverage and Skilled Nursing Facility Care," "Guide to Choosing a Nursing Home," and "Choosing Long Term Care." The site also has a useful nursing home checklist. **www.medicare.gov/LongTermCare/Static/Home.asp**.

Care Planner, a Web site funded by the Centers for Medicare & Medicaid Services. **www.careplanner.org**.

American Association of Homes and Services for the Aging: www2.aahsa.org

AARP Housing Choices: www.aarp.org/life/housingchoices

U.S. Administration on Aging Eldercare Locator: www.eldercare.gov/Eldercare/Public/Home.asp

DHHS makes the results of surveys of every nursing home in the country available at **Nursing Home Compare**, **www.medicare.gov/NHCompare**. This site also provides detailed information about Medicare-certified home health agencies. The information includes home health agency characteristics and quality measures. It is searchable by geographic area or agency name.

Finding a geriatric care manager
Letty Morgan recommends the National Association of Private Geriatric Care Managers **www.caremanager.org.**

Choosing a long term care facility

Continued from page 9

Look at the residents. Are they engaged with each other? Are they active, or just sitting in the hall sleeping? Look at the menu and activities plans. Ask if the facility has a van to take people to doctors' appointments and activities.

If possible, talk to the residents and friends or relatives who are visiting them. You can learn a lot from talking to residents about how they like the place, but remember that some of them may be delusional.

If the residents have roommates, try to find out about your resident's roommate, including his or her diagnosis and history. And be sure to find out whether the facility allows pets. It's important for some residents to have a pet with them, and then some residents don't want to be around others' pets at all.

ELN: How can someone get more information about the quality of a facility that's being considered?

LM: It's really important to check with Senior Services to find out if there have been any substantiated complaints against the facility. Complaints are part of the public record, and you can see them. Also, the state does an annual survey of nursing homes. The results should be posted in the facility, and all the results are posted on the Web.

In addition, I can't emphasize enough the importance of networking, of talking to someone who is in the facilities regularly and over time. Facilities change, and you can't rely on general reputation. This is one of the ways a geriatric care manager can be most helpful to an attorney. Care managers can also provide recommendations and reports about the need for various services, including guardianships and conservatorships. They can serve as guardians or conservators, provide money management services, coordinate nonmedical services, testify in court, and consult with attorneys, family members, trust officers, and others involved in making decisions for or about an elder.

ELN: How can one find a geriatric care manager?

LM: In the immediate area, you can get recommendations from doctors, SPD, or from a hospital social worker or discharge planner. But don't rely on the discharge planner for a placement recommendation; it's not his or her job to visit the facilities.

If you need to find a care manager elsewhere in the state or in another part of the country, I suggest the Web site of the National Association of Private Geriatric Care Managers. To be a member of the association, a manager has to satisfy educational and experience requirements. I've made a number of referrals from this list to managers around the country and have been happy with them.

An introduction to basic health coverage under Oregon's Medicaid program

By Steve Skipton, staff attorney for the Senior Law Service, a program of Lane County Law and Advocacy Center

Some elders and people with disabilities can get basic health coverage under Medicaid. Oregon's Medicaid program expanded in the 1990s through creation of the Oregon Health Plan (OHP) and more people became eligible, but the plan has been cut back in recent years. Today, eligibility for Medicaid health care is strongly linked to eligibility for other public assistance programs.

Eligibility categories

Those who are 65, blind or disabled, and who have limited income and resources, may be eligible for Medicaid through the Oregon Supplemental Income Program, Medical (OSIPM). OSIPM eligibility is limited largely to two groups:

- those who are eligible for Supplemental Security Income (SSI)
- those who reside in nursing homes or get long term care in the community and qualify financially (see Penny Davis's article in the Winter 2005 *Elder Law Newsletter*)

Your clients may also be eligible for Medicaid through another public assistance program, Temporary Assistance to Needy Families (TANF), if they are caring for a child related to them, and have limited income and resources. Applications for OSIPM and questions about OSIPM eligibility are handled by local Seniors and People with Disabilities offices (also sometimes known as Senior and Disabled Services offices). Applications for TANF and questions about TANF eligibility are handled by local Department of Human Services offices (also sometimes known as Adult and Family Services offices).

Elders and people with disabilities without the necessary categorical linkage to other programs are no longer eligible for Medicaid in Oregon. (You may, however, encounter a few such people who remain eligible for Medicaid under the OHP Standard program, which closed to new applicants in July 2004.) For example, a 65-year-old person with a Social Security retirement benefit large enough to preclude SSI eligibility (i.e., slightly more than $600 per month), who is not eligible for long term care under Medicaid and who is not a caretaker relative included in a TANF grant, is ineligible for basic Medicaid coverage.

Benefit package

Those who are eligible for Medicaid through the OHP, OSIPM, or TANF programs receive the "OHP Plus" package. This benefit package is more comprehensive than Medicare coverage, but not without its own limitations, most notably the prioritized list discussed below. Some of the medical services and items covered:

- in-patient hospital care
- physician care, including routine physicals and examination and testing (e.g., x-rays, lab) for all conditions
- dental and vision care
- prescription drugs
- hospice care
- mental health treatment
- diabetic supplies
- physical, occupational, and speech therapy
- medical equipment and supplies
- medical transportation

Within each of these general categories, specific coverage criteria and limitations apply. For example, there are six detailed criteria which must be met for a motorized wheelchair to be covered. OAR 410-122-0325.

Prioritized list

The benefit package is subject to a prioritized list of condition and treatment pairs that are numbered from 1 to 730. Only those conditions for which the legislature has approved funding are covered. Currently, the cut-off point is number 546, and conditions listed below 546 are not covered. For example, Bell's palsy (565), tension headaches (576), and chronic bronchitis (577) are conditions below the cut-off line, and no treatment is provided. There is a limited exception allowing coverage of below-the-line conditions in the case of "co-morbid" conditions. OAR 410-141-0480(8). Even for covered conditions, i.e., those listed at 546 or above, not all treatments are authorized.

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Some elders and people with disabilities can get basic health coverage under Medicaid.

Resources for Medicaid health care information

OAR chapter 410 contains Medicaid coverage, requirements for various services and items, and coverage limitations. OAR chapter 411 contains care facility requirements. OAR chapter 461 contains eligibility requirements for OSIPM and TANF.

www.ohppr.state.or.us/hsc/prioritized_hsc.htm has a link to the prioritized list

www.dhs.state.or.us/healthplan has information on OHP

www.dhs.state.or.us/spd/tools/index.htm has information on programs for elders and people with disabilities, as well as links to OAR chapters 410, 411, and 461.

Basic health coverage under Medicaid

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For long term care residents, the Medicaid rules specify that additional care and services must be provided, depending on the type of facility. (See OAR 411-050-0447 for adult foster homes, 411-056-0015 for assisted living facilities, and 411-055-0210 for residential care facilities.) For nursing home residents, an "all inclusive" rate requires the facility to provide a long list of items and services without additional charge. OAR 411-070-0085.

Managed care

Most Medicaid recipients are required to be in a managed care plan. A recipient may be enrolled in as many as three separate managed care plans: medical, dental, and mental health care. Medicaid managed care plans operate as most such plans do: the plan is paid a capitated rate, and a primary care provider serves as a gatekeeper who must authorize referrals to plan specialists. Some services require prior authorization. Each medical plan is required to have an Exceptional Needs Care Coordinator to assist plan members who are 65 or older or who have disabilities with special or complex care needs.

In some rural areas, there are no managed care plans to serve Medicaid recipients, or there may be a medical plan, but no dental plan, etc. When there are no plans available, a recipient may get services from any provider who participates in the Medicaid program. In some areas, a recipient will be required to have a primary care manager, i.e., a medical provider designated to coordinate and authorize care, instead of a managed care plan.

Also, some Medicaid recipients are exempt from being required to enroll in managed medical care plans. For example, those who have private major medical insurance coverage, such as a Medicare HMO plan or a traditional Medicare supplement, and those who have a "continuity of care" need to remain with a provider who does not participate in the managed care plan, are exempt.

Each Medicaid recipient is mailed a letter-size medical "card" monthly. This card lists the coverage package, the names and contact information for managed care plans, and the caseworker's number. It serves as proof of Medicaid coverage and should be shown to providers so they will bill Medicaid.

Appeal rights for coverage issues

Medicaid recipients have a right to appeal any denial, reduction, or termination of their services. A written notice of denial, reduction, or termination of services is required, and this notice must explain appeal rights. For recipients in managed care plans, the initial appeal must be made to the plan. If the matter is not resolved to the recipient's satisfaction by the plan, an administrative hearing with the state can be requested. For those not in managed care plans, the first step in an appeal is to request an administrative hearing with the state.

All recipients have the right to request that existing services continue during the appeal, and have the right to request an expedited appeal where there is an immediate and serious threat to life or health.

Practice tips

Since Medicaid eligibility is linked to eligibility for other programs, the threshold battle is to establish eligibility for the underlying program, e.g., SSI. Coverage issues can sometimes be resolved by obtaining more complete medical information, or by asking the medical provider to address whether the specific coverage criteria set out in the rules are met. Unfortunately, eligibility and coverage under Medicaid are constantly changing.

Member News

Scott Strahm has moved his office to
937 SW Evans Street
Portland, Oregon 97219

E-Mail and phone are unchanged.

Recent developments in elder case law

NJ courts issue decisions on commercial annuities

By Garvin Reiter, Attorney at Law, Portland

The Superior Court of New Jersey has issued a pair of decisions that severely limit that state's attempt to restrict the use of commercial annuities to avoid the impoverishment of the community spouse in Medicaid cases. The decisions are timely and relevant, because Oregon is considering rule changes similar to those invalidated in New Jersey.

Estate of F.K. v. Div of Med. Assistance & Health Servs., 863 A.2d 1065 (N.J. Super.Ct.App.Div. 2005)

A man entered a nursing home in May 2000, suffering from Alzheimer's disease. His wife continued to live at home. The couple purchased an actuarially sound commercial annuity for $273,538, which was fully funded by June 2001. The annuity was irrevocable and the wife was the sole income beneficiary. In anticipation of the adoption of a proposed rule (the subject of which is the issue presented by the second case below) the annuity named the state Medicaid agency as remainder beneficiary. Shortly after the annuity was funded, the state adopted a regulation which stated:

> "If an annuity is purchased for a community spouse with any portion of the couple's funds and the annuity purchase price exceeds the amount of the protective share of the community spouse...the amount in excess of the community spouse's protective share shall be counted in determining the applicant's eligibility."
>
> *N.J.A.C. 10:71-4.10.*

The "protective share" is the community spouse resource allowance (CSRA), which at the time was $91,000.

The county denied the Medicaid application, triggering this proceeding. The director of the state Medicaid agency overruled the administrative law judge's ruling that the new rule did not apply to the annuity in question, and the case was appealed to the Superior Court. The court remanded the matter for further consideration to address the applicability of a letter written by Thomas Hamilton, of the federal Centers for Medicare and Medicaid Services (CMS), stating the opinion that the states may not limit the amount of a couple's resources that can be used to purchase an annuity for the benefit of the community spouse. The state Medicaid director ruled that the agency was not required to defer to the legal opinion expressed by CMS. The director further found that the annuity was an available asset because it was readily marketable on a secondary market for such annuities.

The court initially noted that the federal Medicaid statute provides that CMS has the authority under 42 USC §1396p(d)(6) to regulate annuities, but has never issued any regulations on the question of whether a state can limit the amount of assets used to purchase an annuity. The only federal interpretation of the statute lies in Transmittal 64, which is not a regulation but part of the *State Medicaid Manual* written in 1994. The court, in keeping with the overall trend, determined that Transmittal 64 and the Hamilton letter would be given deference.

Transmittal 64 provides only that annuities must be actuarially sound. This means the expected return on the annuity must be commensurate with a reasonable estimate of the life expectancy of the beneficiary. A transfer-of-resources penalty applies to the extent the annuity does not meet this requirement. The purchase of the annuity does not violate federal law under this interpretation unless it violates this requirement.

The court concluded that the New Jersey regulation limiting the amount of the annuity to the CSRA was inconsistent with federal law and that federal law preempted the regulation under the Supremacy Clause.

The second issue raised in the case was whether the annuity was a countable resource because it could be sold on the secondary market. The state argued that since the wife might be able to find a buyer who would pay a lump sum of cash to buy her right to receive an income stream, the annuity is in fact a countable resource, not an excludable source of income for the community spouse. In dismissing this argument, the court ruled that for the purposes of Medicaid law, the wife had no ownership interest

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Recent New Jersey decisions provide a compelling argument that SPD's proposal to limit the use of annuities to provide income for the community spouse is inconsistent with controlling federal statute.

Recent case law *Continued from page 13*

in the annuity. She was entitled only to the income stream, which is exempt. Moreover, nothing in the record indicated that there is in fact a market for the income stream as alleged by the state.

A.B. v. Div. of Med. Assistance & Health Servs., 374 N.J. Super. 460, —A.2d—, 2005 N.J. Super. LEXIS 27 (N.J. Super.Ct.App.Div. 2005)

A woman was permanently institutionalized in a nursing home in April 2000. In November 1998, her husband had purchased an annuity with the following terms: the husband was the owner and annuitant, and a daughter was the remainder beneficiary upon his death. The court described the policy as a "standard, fixed-term commercial annuity," which was agreed to be actuarially sound. In August 2000, the husband exchanged the annuity for another immediate annuity at a higher interest rate for the then outstanding balance of $77,485. This generated monthly payments to him of $1,441.

Interestingly, the parties stipulated that the annuity was purchased not for the purpose of achieving Medicaid eligibility, but to provide income to the couple, and there was therefore no transfer of assets issue involved in the case. The principal issue before the court was whether Medicaid could be denied on the basis of a regulation that requires the annuity to name the state of New Jersey as remainder beneficiary.

In response to a request from the husband's attorney, Thomas Hamilton at CMS wrote a letter stating that the federal Medicaid statute does not require or authorize states to require the Medicaid program to be named as the remainder beneficiary of an annuity. He again stressed that the only legal requirement is actuarial soundness.

The administrative law judge agreed with this assessment, and ruled the payback provision unenforceable. The state Medicaid director overruled this decision, and an appeal was taken.

The court relied on its opinion in the *F.K.* decision (above), and reemphasized that deference would be given to letters of interpretation issued by CMS, as long as they are consistent with prior agency pronouncements and the plain language and purpose of the Medicaid Act. The court held that since under *F.K.* the state cannot deem the annuity to be a countable resource, it also cannot require the community spouse to name the state as remainder beneficiary as a condition of having the annuity, either as a regulation or as an informal policy.

The state once again argued that the annuity should be a countable asset because the income stream might be sold for a lump sum of cash. Once again, the court found there was no legally competent evidence in the record to support this position. Although a different CMS official had written a letter stating that if there were a secondary market for annuities this could be a problem, the court dismissed the letter as hypothetical. The court added that even if there were a secondary market for the annuity, the state produced no proof of its resale value. Furthermore, the resale value would be pennies on the dollar.

Oregon developments

Under subsection (8) of OAR 461-140-0220, Oregon currently does not deem the transfer of a resource to be disqualifying if the resource is an annuity, the client or the client's spouse is the annuitant, and the entire amount of principal and earned interest is paid during the life expectancy of the annuitant. However, the Department of Human Services recently gave notice of the following proposed rule changes to OAR 461-140-0220(8) that would effectively require that the State of Oregon be named as the beneficiary of any qualifying annuity:

> (8)(b): The resource is an annuity purchased on or after April 1, 2005 and—
>
> > (A) The client is the annuitant, the entire amount of principal and earned interest is paid in equal installments during the client's life expectancy, and the state will receive all funds remaining in the annuity upon the death of the client up to the amount of medical benefits provided on the client's behalf; or
> >
> > (B) The community spouse is the annuitant and the annuity was purchased at least 36 months prior to the date of request for medical benefits.

Subsection 8(a) of the new regulation would keep the current annuity rules in effect until March 31, 2005.

However, these proposed changes to rules for annuities have been temporarily withdrawn. The Department of Human Services Seniors and People with Disabilities (SPD) will set up a working group—which will include elder law attorneys—to review the issues. The target date for rules revision is July 1, 2005.

Conclusion

The recent New Jersey decisions, in addition to earlier decisions such as *Mertz v. Houstoun*, 155 F.Supp. 2d 415 (E.D. Pa. 2001), provide a compelling argument that SPD's proposal to amend OAR 461-140-0220 to limit the use of annuities to provide income for the community spouse is inconsistent with controlling federal statute, which preempts it under the Supremacy Clause.

Elder Law Section sponsors third unCLE

By Mark M. Williams, unCLE Program Chair

The Elder Law Section is again sponsoring a unique program that gives elder law practitioners the opportunity to get together for a day-long session of brainstorming, networking, and the exchange of ideas and forms. The sessions will be held in small group discussion formats with topics moderated by elder law attorneys willing to share their experiences. There will be no formal speakers, but there will be time to question and learn from our peers. The program is modeled on the highly successful NAELA unProgram, and this is the third time for our local version. The program has received very high ratings from attendees and may be the best educational opportunity available to us. Despite its title, the Oregon State Bar granted 5 general CLE credits for the last program.

Attendance is limited to 75 Elder Law Section members, so register early. Registration is $75, including meals and no-host reception; add $25 for Section dues if you are not already a member.

The program will be held on Friday, May 6, 2005, from 8:00 a.m. to 5:00 p.m. at the Valley River Inn, 1000 Valley River Way, Eugene, Oregon. A full buffet breakfast and lunch are included. The program is designed to get us away from our practices for a full day in a location that allows colleagues from all parts of the state to have reasonable access.

A registration form is printed below. Registration for the program is also available through the Oregon State Bar Elder Law Section by contacting the Oregon State Bar CLE service desk at 800.452.8260, ext. 413 or 503.684.7413.

You may want to stay overnight before and/or after the program. Room registration is available at the Valley River Inn at special conference rates ($71 per night single/$91 double) by calling Valley River Inn at 800.543.8266.

Do not miss this chance to mix and mingle with your peers in the elder law community and discuss substantive issues as well as nuts and bolts practice issues.

Elder Law "unCLE" Program *Friday, May 6, 2005*

Name Bar #

Firm Name

Phone Fax E-mail

Address

City State Zip Code

PROGRAM REGISTRATION:
Registrants must be Elder Law section members.
Enrollment limited to 75 registrants.

- ❑ $75 Registration .... $ ______
- ❑ $25 Join Elder Law Section .... $ ______
- ❑ (no fee) Friday Night Reception

TOTAL REGISTRATION FEES (SEL05) .... $ ______

THREE WAYS TO REGISTER OR ORDER:
Registrations and orders will not be processed without payment.

1. **MAIL with check:** Oregon State Bar, CLE Service Desk, PO Box 1689, Lake Oswego, OR 97035
2. **FAX with VISA or MasterCard number:** 503-968-4456
3. **PHONE:** 503-684-7413, or toll-free in Oregon at 1-800-452-8260, ext. 413

CANCELLATIONS:
Cancellations must be received in writing by April 22, 2005. Fax your request to 503-968-4456, Attn: CLE Cancellations. There is a $20 cancellation fee.

PAYMENT OPTIONS:
- ❑ Check Enclosed: Payable to Oregon State Bar
- ❑ Credit Card (VISA or MasterCard only)

**** All information below required when paying by credit card. ****

Credit Card Number

Expiration Date

Name on Credit Card (please print)

Credit Card Billing Address

City State Zip

Authorized Signature

Agency and Professional Relations Subcommittee report

By Sam Friedenberg

The Agency and Professional Relations Subcommittee met with SPD representatives on February 4, 2005. The following topics of discussion will be of interest to Section members.

Spousal support

A source of confusion in spousal support petitions is determining what interest rate to attribute to available assets when determining the MMMNA and the CSRA. The interest rate in the petition is then reviewed by Joanne Schiedler upon notice to SPD. Joanne has stated that she would like attorneys to use the current market interest rate for a one or two-year time deposit at a bank in the local community. The petitioner need not cruise the Internet for the best national rate. (For example, the current interest rate is about three percent.)

We also inquired whether an interest rate must be attributed to assets that are in fact not earning income, such as a fifth-wheel recreational vehicle. Joanne suggested that she would attribute interest unless there was a good reason to keep the non-income producing assets. Another issue is whether the petition can rely on the actual interest being earned by assets. Joanne suggested that she would continue to use the market rate.

Joanne also wanted to remind attorneys that as of approximately two years ago, the community spouse's health insurance (Medicare and supplement) has been paid for by the institutionalized spouse's income as part of patient liability. This means that in a petition for support, those expenses should not be used in the MMMNA and CSRA calculations. It would be prudent to note this in the petition so that SPD is aware that the MMMNA and CSRA request does not include the sums.

Medicare Part D prescription drug benefit

SPD wanted us to be aware that as of July of this year, Medicare beneficiaries may begin applying for their Medicare Part D benefits. While no one is clear about the rules, it appears that persons who are or will be on Medicaid must participate in Part D. If they do not, the state may not have sufficient funds for prescriptions and they may not cover them under Medicaid. In short, Part D may be critical for Medicaid patients.

Annuities

SPD proposed rules that would have changed the way Medicaid treats annuities after April 1, 2005. Under the proposed rules, a client's annuity would have to name the state as a remainder beneficiary. A community spouse's purchase of an annuity would have been a disqualifying transfer. Fortunately, SPD decided to withdraw the proposed rules pending further review. SPD has asked for a work group that includes Section representatives to address the issue.

Income Cap Trust

SPD gave notice of and then withdrew rules prohibiting clients from using funds to pay legal fees in income cap trusts when the money could have been used for medical expenses. These will be reviewed by a joint work group.

Important elder law numbers

as of Jan. 1, 2005

Category	Item	Amount
SSI Benefit Standards	Eligible individual	$579/month
	Eligible couple	$869/month
Medicaid (Oregon)	Long term care income cap	$1,737/month
	Community spouse minimum resource standard	$19,020
	Community spouse maximum resource standard	$95,100
	Community Spouse Minimum and Maximum Monthly Allowance Standards	$1,561/month; $2,377/month
	Excess shelter allowance	Amount above $468/month
	Food stamp utility allowance used to figure excess shelter allowance	$287/month
	Personal needs allowance in nursing home	$30/month
	Personal needs allowance in community-based care	$122/month
	Room & board rate for community-based care facilities	$458.70/month
	OSIP maintenance standard for person receiving in-home services	$580.70
	Average private pay rate for calculating ineligibility for applications made on or after October 1, 2004	$4,700/month
Medicare	Part B premium	$78.20/month
	Part B deductible	$110/year
	Part A hospital deductible per illness spell	$912
	Skilled nursing facility co-insurance for days 21-100	$114/day

Legislative Subcommittee update

By Ryan E. Gibb, Chair, Elder Law Section Legislative Subcommittee

The Elder Law Section has sponsored three bills this legislative session. These bills have been designated as HB 2289, HB 2290, and HB 2291.

HB 2289 has been proposed to amend ORS 114.515. The purpose of the amendment is to allow for the filing of an amended affidavit of claiming successor. Currently, some trial court clerks take the position that they are not authorized to accept an amended or supplemental affidavit of claiming successor after four months have passed from the original filing date. This bill would amend ORS 114.515 to allow the filing of amended affidavits, as long as the total value of the estate does not exceed the statutory limits for small estates. This bill passed through the House Judiciary Committee, and was passed on the House floor. It is now in the Senate, and should be referred to the Senate Judiciary Committee in the near future.

HB 2290 has been proposed to amend ORS 125.475 and ORS 116.083, which establish deadlines to file annual accountings in conservatorships and estates, respectively. This bill would extend the time to file these accountings to 60 days, which would provide the fiduciary with more time to gather the required documentation and prepare the accounting. This bill has passed through the House Judiciary Committee and was passed on the House floor. It is now in the Senate, where it has been referred to the Senate Judiciary Committee.

HB 2291 has been proposed to amend ORS 124.100, which designates who has standing to file a civil action for abuse of the elderly. Currently, trustees do not have standing to bring such an action on behalf of an elderly trustor. Standing is granted to the elderly person, a guardian, a conservator, a power of attorney holder, or the personal representative of the estate. HB 2291 would add trustees to this list. This bill has passed through the House Judiciary Committee and was passed on the House floor. It is now in the Senate, where it has been referred to the Senate Judiciary Committee.

The Elder Law Section Legislative Subcommittee continues to monitor these three bills as they make their way through the legislature. We are also monitoring other legislation that affects elder law practitioners and our clients. Of particular note is SB 275, which is the Uniform Trust Code bill. This bill is set for hearing in the Senate Judiciary Committee later in March. There are a number of Elder Law Section members who are actively involved with this bill.

All of the bills pending in the legislature can be located by number on the Web at **www.leg.state.or.us/bills_laws**, where you can also gather current information about the status of the bills.

There are still opportunities to be involved if anyone would like to participate in the legislative process. I would personally like to extend my thanks to those who have been active on the subcommittee during this legislative session.

Changes to SSI program rules

The Social Security Administration has adopted final rules for the SSI program that change the definition of in-kind income and increase the limits for certain types of resources. The effective date of the regulations is March 9, 2005. They can be found in 70 Federal Register 24, p. 6340-6345 (February 7, 2005).

20 CFR 416.1102, 416.1103, and related rules are being amended to exclude gifts of clothing from calculations of income and in-kind support. The revision to 20 CFR 416.1216 removes the dollar limit on household goods and personal effects that are exempt when calculating resources, and the change to 20 CFR 416.1218 excludes one automobile from being counted as a resource if it is used for transportation for the individual or a member of the individual's household, without regard to its value.

These changes simplify the financial eligibility requirements for the SSI program. Lifting some of the financial restrictions in the SSI program will also affect how special needs trusts can be drafted and administered. The Oregon Department of Human Services is expected to propose changes to the financial eligibility rules for the SSI-linked Medicaid program (OSIPM) to conform with the new federal regulations.

Elder Law 2005 supplement now available

The first comprehensive guide to elder law in Oregon has just been updated.

Written specifically for Oregon lawyers whose clients are facing issues of aging and disability, *Elder Law* contains a wealth of information, including planning for retirement, using Social Security and Medicare, making long term care choices, dealing with neglect and abuse, and planning for incapacity.

Elder Law focuses on many valuable topics specific for your type of practice, such as: expanded notice requirements for filing a petition to appoint a guardian or conservator; Medicare Prescription Drug, Improvement, and Modernization Act of 2003; latest information on Oregon's Death with Dignity Act; precautionary advice on managing joint accounts with a right-of-survivorship provision; expert advice on trusts, including analysis of new case law, and drafting trust documents; recent developments in the law regarding elder abuse claims; changes in requirements for establishing a prima facie case of age discrimination; and new federal rules regarding distributions from IRAs and retirement plans.

The *Elder Law* supplement also includes a completely revised chapter on family law issues that analyzes new statutes and case law on the custody rights of birth parents and grandparents, and the effect of new law on custody, visitation, and adoption and guardianship proceedings, as well as a unique age-discrimination chapter written from the consumer perspective. Numerous Web sites are listed, plus new forms, including a family lifetime care contract and several forms for special needs trusts to preserve public benefits assistance. In addition, the supplement contains scores of tips for effectively using federal, state, and community resources that serve older Oregonians and Oregonians with disabilities.

The editors for this book were Cynthia L. Barrett, Penny L. Davis, and Mark M. Williams, whose generous contributions of time, talent, and expertise made this publication a valuable resource for Oregon lawyers.

The 2005 supplement with forms on disk is $65. The 2000 edition with supplement and forms on disk is $215. This publication is available in print format or CD-ROM format.

To order, call the OSB Service Desk at 503.684.7413 or toll-free in Oregon 800.452.8260, ext. 413. You can also order online at **www.osbar.org.**

Letter to the editor

I just read the article "Paying family members for in-home care" in the Winter 2005 OSB *Elder Law Newsletter,* particularly the section on income tax benefits.

While the potential tax benefits are real, the dependency test is now far more complicated than the 50% support rule mentioned in the article. There are actually now five tests, the most difficult of which will commonly be the gross income test (which cost me the deduction for my daughter after she became a part-time college student). If the otherwise dependent parent has significant non-Social Security income, this test becomes a real problem.

Also note the (much ignored) rule enacted in the Health Insurance Portability and Accountability Act of 1996 (in IRC sections 213 and 7702B) that long term care services must be certified and prescribed by a licensed health care practitioner before they can be deducted, and the certification must be re-done every 12 months. (I have developed a form of Qualified Medical Certification, which I am willing to share, upon request.)

A final point of caution relates to another limit on the medical deduction added in 1996. Under IRC section 213(d)(ll), payments for long term care expenses provided to an individual by a spouse or other relative—as defined in IRC section 152(d)(2)—are not deductible as medical expenses. Family of the person claiming the dependency exemption will qualify only if they are not related to the patient. That greatly limits relatives who can qualify. Think in-laws.

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Resources for elder law attorneys

EVENTS

Medicine for Lawyers
OSB CLE Seminar
Friday, April 22, 2005
Oregon Convention Center
777 N.E. Martin Luther King Jr. Blvd.
Portland, Oregon
www.osbar.org
Presenting medical evidence; Working with health care providers; Acquiring, organizing and interpreting medical records; How to research medical literature; The nature and practice of medical assessment.

Health Plans, HIPAA, and COBRA Update
OLI CLE Seminar
Thursday, May 5, 2005
12:00 to 4:00 p.m.
OLI/Gus. J. Solomon Courthouse
620 SW Main Street, Suite 706
Portland, Oregon
www.lclark.edu/org

Annual Probate and Guardianship Update with Judge Elizabeth Welch, Helga Barnes, & Tim McNeil
Multnomah Bar CLE seminar
Thursday, May 5, 2005
3:00 to 5:00 p.m.
World Trade Center
Building Two Auditorium
26 SW Salmon, Portland
www.mbabar.org

Elder Law unCLE program
Friday, May 6, 2005
8:00 a.m. to 5:00 p.m.
Valley River Inn
1000 Valley River Way
Eugene, Oregon
See page 15 for details

2005 NAELA Symposium Building Bridges to Better Tomorrows
May 18 to May 22, 2005
The Fairmont San Francisco
950 Mason Street
San Francisco, California
Registration Deadline: May 18, 2005
www.naela.org
General Sessions: Advising Your Wards and Other Clients about Enrolling in a Medicare Prescription Drug Plan., Professionalism & Ethics in Elder Law, 2005 Case Law Update, Public Policy/Medicaid Update, Pearls & Gems of Successful Medicaid Advocacy

Alternative Dispute Resolution
OLI CLE Seminar
Friday, May 20, 2005
12:00 to 4:00 p.m.
Oregon Convention Center
Portland, Oregon
www.lclark.edu/org

Advanced Estate Planning
OSB CLE Seminar
Friday, June 10, 2005
www.osbar.org

ELDER LAW SECTION ELECTRONIC MAIL DISTRIBUTION LIST

Everyone in this Section is automatically signed up on the distribution list, but your participation is not mandatory. If you want out, simply unsubscribe.

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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 press "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>
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The fine print
Political fundraising messages, position statements, candidate endorsements and all other announcements or messages of a political nature are strictly prohibited. Obtain permission from the original sender before forwarding a message from the list to someone who does not subscribe to this list.

Elder Law Section unCLE

Informal group discussions moderated by elder law attorneys willing to share their experiences

Friday, May 6, 2005
8:00 a.m. to 5:00 p.m.
Valley River Inn
1000 Valley River Way
Eugene, Oregon.

Newsletter Board

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

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