RECENT DEVELOPMENTS IN ELDER LAW: IS THE SKY REALLY FALLING?

a presentation for

2004
NATIONAL LTCI PRODUCERS SUMMIT

by

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November 9, 2004

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1. Introduction[1]

"This country has come to feel the same when Congress is in session as when the baby gets hold of a hammer."

"The more you observe politics, the more you've got to admit that each party is worse than the other."

Will Rogers.

a. The Falling Sky

The field of Elder Law, having reached its adolescence, is experiencing upheavals in a number of areas. As this paper is being written, in mid-October, 2004, the elections (yes, elections plural; the battles within the states may be as important if not more so than the national election for some of the issues Elder Law attorneys face), are less than 3 weeks away. Whoever the next President is and which party controls Congress will undoubtedly have a significant impact on much of the public policy affecting seniors that is discussed below. The restructuring of Medicare has begun with the adoption of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Interestingly, the proposals for a major restructuring and/or modification of the Medicaid system both from the federal government and the states put forth over the last several years are all still on the table, unchanged and not acted upon. The HIPAA privacy statutes and regulations came into being with much hand wringing and anxiety but the actual impact apparently has been about as serious as the Y2K computer meltdown. And the governmental sector is not the only player. The housing market for seniors continues to be a booming, growth industry, evolving, redefining itself and adapting for the onslaught of the Boomers. All of these areas (and many more too numerous to mention), are creating opportunities and challenges for Elder Law attorneys as never before.

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b. Areas to be discussed

This paper addresses two (2) primary topics:

- Current Developments in Medicare and Medicaid;
- Long Term Care - The Legislative Outlook
- The Senior Driver: An Emerging Concern.

2. Current Political Issues In Elder Law

a. Introduction

The cost of health care continues to rise. Whether that cost is measured in out-of-pocket dollars for the patient, increased governmental expenditures such as those discussed below or the time-value of money in terms of lost wages/time in the workplace for family members caring for an ill family member, the costs continue to escalate at an alarming rate, especially towards the end of life. One study has estimated that in 2001 one-half (½) of all personal bankruptcy filings were the result of medical expenses.[2]

In 1900 the average life expectancy was 47 years. In 2000 it was 75 (77 for women, 73 for men). However, this longevity is not necessarily a rosy, vibrant, active retirement. It is estimated most Americans will spend two (2) of their last five (5) years of life disabled to the extent that they require assistance from another person with the routine activities of daily life.[3]

As the authors of the RAND study conclude:

> "Chronically ill elderly people and families living through the end of life of a family member deserve a better system than the one currently available. They depend on the health care system to serve their needs and certainly not to add to the burden of their or a loved one's final days. Meeting the most important of these patient and family needs will require developing a vision of good care, confronting the barriers to putting the vision in place, and marshaling the political will to change the system. Achieving sustainable

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[2]Harper's Index, August 2002, citing the Debs-Jones-Douglass Institute, Washington, D.C.

[3]The statistics cited in this introduction are all taken from Joanne Lynn and David M. Adamson, *Living Well At The End of Life*, RAND Health, June, 2003; www.rand.org.

reforms quickly will require focused innovation and research. Thus, all Americans are stakeholders in building a system that ensures that each person can count on living comfortably and meaningfully through to the end of life."

b. Medicare

On December 8, 2003 the President signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (hereafter "the Act" or "the 2003 Medicare Act")[4] making substantial changes to the Medicare program. The primary focus of the Act and the ensuing media discussion has been on the addition of a prescription drug benefit to Medicare (Medicare Part D). However, the Act also changes other aspects of the Medicare program as well, including the imposition of additional costs on participants for current Medicare services.

As finally adopted, the Drug Benefit Plan, which begins in 2006, will work like this:

- The plan is voluntary; no Medicare beneficiary is required to participate;
- For those who opt in, the premium will be approximately $35/month;
- There is a $250 deductible;. *i.e.* the participant pays 100% the first $250 of prescription drug expenses incurred;
- Medicare then pays 75% of the cost of drugs between $250 and $2,250;
- Medicare pays nothing for any amounts spent between $2,250 and $5,100 (this is known as "the doughnut hole");
- Medicare pays 95% of all prescription drugs over $5,100;
- The benefits are not provided by Medicare itself. They will be provided through private drug-only insurance plans, HMOs or PPOs. Coverages, premiums and deductibles will vary although the Act lays out a "standard plan;"
- The premium, deductible and coverage gap are waived for people earning up to $12,123 per year. To qualify, seniors may not have more than $6,000 in liquid assets. The subsidies are then phased out between $12,123 and approximately $15,000 in yearly income. It should be noted that this is the

[4]Public Law 108-173.

first time an income or asset requirement has been incorporated into the Medicare program since the program was established in 1965.

It is interesting to note that between two (2%) and nine (9%) percent of Medicare beneficiaries who currently obtain prescription drug benefits through their former employers may lose this coverage.[5] Current advice is that anyone eligible for employer sponsored drug coverage should keep it since the employer sponsored benefits are usually superior to the Part D benefit.

c. Medicare Drug Discount Card

Between now and 2006, most Medicare recipients are entitled to buy a Medicare Drug Discount Card. As of this date, Medicare has authorized approximately 28 companies to issue the cards, including AARP, insurance companies, and health maintenance organizations (HMOs). Before enrolling in any of these programs, we are suggesting that our clients do the following:

- Determine Their Needs:

  (1) What prescriptions are being taken?

  (2) What are the prices of those drugs?

  (3) Are the drugs "generic" drugs rather than brand names? If not, determine whether a generic equivalent will meet the client's needs since generics are usually less expensive.

- Find Out What Medicare Discount Card Options Are Available

  (1) The Medicare website (www.medicare.gov/assistanceprograms) has a significant amount of information about the program, including comparisons of the various cards. HOWEVER, a number of reports indicate that some of the information on the site is inaccurate. Therefore, while the Medicare site is a good place to start, the client should be sure to double-check the information. The same information can be obtained by calling 1-800-MEDICARE (1-800-633-4227).

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[5]Dallas L. Salisbury and Paul Fronstein, *How Many Medicare Beneficiaries Will Lose Employment-Based Retiree Health Benefits if Medicare Covers Outpatient Prescription Drugs?* Employee Benefit Research Institute (EBRI), July 18, 2003.

- Compare the Information About the Available Cards

  (1) What is the annual enrollment fee? ($30 is the maximum permissible charge, but many plans will probably charge less);

  (2) What drugs are discounted? Most of the cards have a "formulary." Clients should be sure that the drugs they need are on the formulary.

  (3) If all of the drugs the client is taking are not on the formulary, are the ones that cost the most on the list?

  (4) How much is the discount?

  (5) Will the client's pharmacy accept the discount card? If so, what does the pharmacy charge for the medications?

- **Beware:** Once a client chooses a drug discount card, the client cannot choose another plan until 2005. BUT, the card issuer can change its formulary and prices at any time. Thus, the drug the client needs the most may be on the formulary today but not next week!

- **General Information:**

  The Medicare prescription drug discount card is available to **everyone** receiving Medicare. Persons under age 65 receiving Medicare because they are disabled are eligible to enroll in the program. However, if the client is receiving Medicaid in addition to Medicare, then the client is <u>not</u> eligible to enroll in the program because the government is already paying for the medications through the Medicaid program.

- There are special benefits for people with low incomes (defined as $12,569 per year for individuals and $16,862 per year for couples). Someone who qualifies under these guidelines is entitled to a $600 per year subsidy and a waiver of the enrollment fee. The questionnaire at www.benefitscheckuprx.org is useful in determining if one qualifies for this benefit.

On a related front, last year the U.S. Supreme Court upheld Maine's implementation of the "Maine Rx" program. The Maine program, based on a Medicaid statutory provision permitting states to require prior authorization before certain drugs are purchased by Medicaid beneficiaries, required manufacturers seeking Medicaid coverage for sales to Maine Medicaid recipients to agree to rebate to the state 11-15% of all prescription drug sales within the state, whether to Medicaid or non-Medicaid recipients. The rebates are then

distributed among the participating pharmacies to compensate them for selling prescription drugs at discount prices.

d. Medicaid

The most important development in the area of Medicaid planning continues to involve attempts by a number of states to utilize waiver applications as a means of radically altering the statutory framework for Medicaid eligibility.

Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services authority to waive aspects of the law in order to permit states to undertake "research and demonstration" projects that further the purposes of Medicaid. These waivers allow states to use federal Medicaid funds in ways that are not otherwise permitted under federal law.

Connecticut, Minnesota, Massachusetts, New York, Florida, California and Tennessee have all either submitted waiver applications or are seriously considering submitting waiver applications to the Center for Medicare and Medicaid Services (CMS), seeking to allow them to issue harsher penalties against individuals who have transferred assets prior to seeking Medicaid coverage for long term nursing home care.

42 U.S.C. §1396p establishes that individuals who transfer assets for less than valuable consideration prior to applying for long term care nursing home coverage are disqualified from receiving Medicaid for long term care for a stated period of time. The amount of the disqualifying period is calculated by dividing the amount of the uncompensated transfer by the state's average monthly cost of nursing home care. The resulting number constitutes the "penalty period". Under the statute, the only transfers for which this calculation is used are those made within three (3) years prior to the filing of the application for Medicaid (or five (5) years in the case of transfers to trusts). This period is known as the "look-back period." Under federal law, the penalty period begins to run ***when the transfer is made***.

For example, both Connecticut's and Minnesota's waiver applications seek to have the penalty period begin to run ***when the application is filed***. Further, both applications would lengthen the penalty period. Connecticut seeks to lengthen the penalty period for real property transfers from 36 to 60 months. Minnesota would lengthen the penalty period for all transfers to 72 months. In addition, the Minnesota's proposal would prohibit certain transfers that are exempt under federal law, such as the transfer of the home to children who have cared for the Medicaid recipient for two years prior to application, transfers to disabled children, and modifications of the inter-spousal transfer rules.

As of the date of this paper, CMS has not acted on any of the pending applications.

Other states are watching CMS with interest. From a simple legal standpoint, these applications would seem to be on legally shaky ground since their goals are to save money through restrictions on eligibility. In addition, neither furthers the objectives of the Medicaid program, nor are they "experimental, pilot or demonstration" projects as contemplated by the statute.[6]

As Senator John Breaux stated in a letter to Tommy Thompson, Secretary of HHS regarding these waiver applications:

> "I urge you to consider the basic purposes of the Section 1115 waiver program, which was not created to simply enable states to change federal rules to balance their budgets, but instead to allow states to provide services in innovative fashions..."[7]

e. HIPAA

On April 14, 2003, the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) went into effect.[8] The amount of publicity, information, misinformation and, in some cases, virtual hysteria both within and without the medical profession has been amazing.[9] Fortunately, looking back a year later, most of the hysteria was just that. The sky didn't fall, but we all need to review and update our forms and procedures.

Every professional who deals with an individual's medical information is impacted by the HIPAA Regulations to one degree or another. From an Elder Law attorney's standpoint, the new regulations create two problem areas: (a) how to obtain information about our clients so we can do our jobs; and (b) how to assist our clients and their families in obtaining information for themselves.

The second issue is the easier to deal with. The statute and regulations specifically authorize privacy waivers and appointment of a Personal Representative (a term of art from the HIPAA regulations, not to be confused with the Executor of an Estate). Under HIPAA,

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[6]See for example *Beno v. Shalala*, 30 F3d 1057 (9th Cir. 1994) regarding the point that a cut in benefits saves costs but is not an experimental, pilot or demonstration project as contemplated by the statute.

[7]Letter from Senator John B. Breaux to Tommy Thompson, July 25, 2003.

[8]Pub. L 104-191, 110 Stat 1936; 45 CFR §§164.102-164.534.

[9]See for example, Pear, *Health System Warily Prepares for New Privacy Rules*, NY Times April 6, 2003, p A26, col 1.

unless state law is more restrictive than federal law, HIPAA controls.[10] Thus, attorneys and other professionals must determine whether their state privacy laws (if any), are pre-empted by HIPAA before attempting to obtain Protected Health Information (PHI). As an introduction to the HIPAA privacy regulations, anyone dealing with HIPAA should review the Summary of HIPAA Privacy Rules published by the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services on the HHS website at www.hhs.gov/ocr/hipaa.[11]

The more critical issue is how attorneys can gain access to information about their client's capacity. In pre-HIPAA days, it was not uncommon for a lawyer to pick up the phone, call the potential client's physician and have a casual conversation about the client's capacity. After all, both physician and lawyer were after the same goal: protecting the client. Or, in the case of potential conservatorship, the lawyer would call the physician (or *vice versa)*, to inquire as to whether a conservatorship was appropriate. Those days are over. Under HIPAA any such conversation runs the risk of violating the criminal provisions of the statute.[12] Penalties for violation can be as high as a $50,000 fine and one (1) year imprisonment. Anyone dealing with protected medical information needs to be cognizant of these provisions since they apply to **anyone** who comes into possession of protected medical information. Insurance professionals, for example, need to re-examine their office security procedures and verify that their employees understand what can be disclosed and what cannot be disclosed, both within their organizations and to the outside world.

The biggest fear the author (and others) have in this regard is that the medical community will use HIPAA as a sword, rather than a shield to further frustrate the wishes of our clients by refusing to release information and/or recognize the authority of the agents. The unfortunate result will simply be more litigation, a sharp increase in protective proceedings since one of HIPAA's exceptions to consensual disclosure is a disclosure "required by law," which presumably includes disclosure pursuant to court order.[13] One is reminded of the Chinese curse "May you live in interesting times..."

f. Long Term Care - The Legislative Outlook

The Long Term Care and Retirement Security Act, originally authored by Senators

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[10]HIPAA §264(c)(2).

[11]An excellent discussion of HIPAA and it's impact on estate planning can be found at R. Hughes *When worlds Collide: The Privacy Challenge to Casual User Of Protected Medical Information in Probate Courts and Estate Planning*, 24E.P. & Cal. Prob Rptr133,June, 2003.

[12]HIPAA §1177.

[13]45 CFR §164.501(a).

Graham and Grassley has been introduced in the last three Congresses, this time by Senators Bond and Mikulski, incorporating it in their S. 2533, a companion bill to the Ronald Reagan Alzheimer's Breakthrough Act of 2004 (H.R. 4595) authored by Representatives Ed Markey and Christopher H. Smith. As in the past, the act would provide assistance to patients and caregivers, including a $3,000 tax credit to help caregivers who provide home-based assistance to a loved one in their own home. It also includes a tax deduction for premiums paid in long-term care insurance.

Unfortunately, it appears action is unlikely this year on the bill. The initial momentum, inspired by President Reagan's death, seems to have faded. On the other hand, it is never wise to speculate on what a lame-duck Congress can do.

3. When Is It Time to "Re-Tire"? - Our Role In Advising Senior Drivers and Their Families[14]

a. Your Worst Nightmare

Consider the following nightmarish hypothetical: Your 85 year old client of many years calls you for an appointment. He asks if you can make a house call and you indicate that you do not make house calls, but he is welcome to come into the office as always. He says "O.K., as long as it's during the late morning or early afternoon, because I don't drive the freeways any more and I don't want to run into rush hour traffic on the surface streets. I also don't make left turns if I can avoid it, so It'll take me a little longer to get to your office, but don't worry; I just got my license renewed and passed the vision test with flying colors."

On his way to your office, he loses control of the car making one of the 4 right hand turns he needs to execute to avoid making one left hand turn, and plows into an outdoor café, killing a number of people and injuring a dozen others.

You feel awful. You feel even worse months later when you are served with lawsuits by the injured parties and their families, naming you as a co-defendant. Far-fetched? Consider the following:

b. The Rippling Pond Syndrome

In July 2003, when 86 year-old George Weller lost control of his vehicle in Santa Monica and killed 10 people, injuring dozens more, the public concern (outrage) was

[14]With apologies to the Fisk Tire Co. whose logo for decades was a small boy, yawning, holding a candle asking the question "Is it time to re-tire." Given the age of this advertising campaign, that young man is now one of the seniors discussed in this section.

directed towards him and to some degree his family who allegedly "let this happen." He was subsequently charged with vehicular manslaughter and is currently awaiting trial.

However, just as the case was working its way to the netherworld of the back pages of the newspapers and becoming a footnote in the "Where Are They Now" department, the National Transportation Safety Board announced its findings that the City of Santa Monica, California could have prevented the crash by installing heavy barriers around the weekly farmers' market where the accident occurred.

Now consider this: On May 13, 1996, Evelyn Sadler, an elderly driver, was in an automobile accident with motorcyclist Timothy Prophet. Mr. Prophet lost his leg as a result of the accident. He sued Ms. Sadler for $10 million dollars. Her insurance company paid out the policy limits of $100,000. The case settled for $1 million, well in excess of the policy limits. Ms. Sadler sued her insurance agent, Mr. Loomis, for $2 million, claiming that Mr. Loomis was negligent in permitting Ms. Sadler to be underinsured because he knew of her financial position and yet failed to provide her with information about additional insurance or other information to enable her to make an informed decision as to an appropriate level of liability coverage. Mr. Loomis won on Summary Judgment, Ms. Sadler appealed and lost.[15]

The driver's agent (in this case, an insurance agent), prevailed. This time. The City of Santa Monica will not be so lucky (just given the nature of the beast and the horrific facts). Will you, who declined to make a house call and thus (according to plaintiff's attorney), toppled the first domino in this tragedy, be so lucky? In the author's opinion, It depends.

c. The Background - Driving As An Inalienable Right

The importance in our society of the right to operate a motor vehicle cannot be underestimated. For most males (and probably many females), the memory of one's first driver's license and/or one's first car is at least equal to or more important than one's first love.

Thus, when discussing with a senior the possibility that he or she might need to "give up the keys," we are quite literally dealing with an issue, a "right," that goes to the essence of our being. Just as obtaining the license was the rite of passage into adulthood, the removal of that privilege represents probably the most tangible evidence of one's loss of independence.

[15]Sadler v. Loomis, 139 Md. App. 374, 776 A. 2d 25 (2001).

However, as the baby-boomers gray and as we continue to move towards a time when a huge portion of the population will fall within the statistical range of "senior driver," all professionals who deal with the elderly and/or their families need to be cognizant of the issues and have some understanding of the alternatives and solutions (few though they may be), that are available.

d. Let's Do the Numbers

Today, 80% of people over 65 have a driver's license. By 2025, it is estimated that the number of drivers 65 years of age or over will increase 250%.[16]

Although senior drivers drive less, they have more accidents per mile driven. Currently, the raw number of accidents for the elderly is low; drivers over 65 have fewer accidents than drivers in any other age group. However, the elderly drive fewer miles than do other age groups.[17]

Further, seniors are much more likely to be injured (and more severely so) than younger drivers. In fact, senior drivers are more likely to die as a result of an automobile accident than younger drivers, leading to the statistic that motor vehicle accidents are the second leading cause of death due to injury of those 55 and older.

Aging, by itself, is not necessarily the problem. Clearly, the incidence of chronic diseases such as cardiovascular disease, dementia, diabetes and visual impairment increases with age. But the impact of disease can be heightened by medications taken to control the diseases. Many of the medications frequently taken by seniors have been identified as having a potentially adverse effect on driving. Antidepressants such as amitriptyline/Elavil, antihistamines (excluding loratadine/Claritin and Allegra/fexofenadine), Valium and other members of the benzodiazepine family, insulin and opiods such as Percocet, codeine and Darvon all affect one's ability to drive. And of course alcohol consumption by itself can affect driving ability and this effect is frequently magnified by alcohol taken in conjunction with medication.[18]

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[16]Burkhardt, Jon. C., Berger, Arlene M., Creedon, Michael A, and McGavock, Adam T., "Mobility and Independence: Changes and Challenges for Older Drivers." (Washington D.C.: Administration on Aging, July, 1998). See www.aoa.gov/research/drivers.html.

[17]Bernstein, Leigh H., "Driving: Issues for the Elder-Law Attorney," NAELA Symposium, May, 2004.

[18]Schwager, Mark L., M.D., "the Elderly Driver," Medicine and Health/Rhode Island, vol. 82, No. 12, pp432-436 (1999).

e. The Issue: What Duty Does The Professional Have?

The Medical Community: Under current AMA Guidelines, physicians are permitted to report a patient's serious driving impairment to the DMV.[19] While geared towards physicians and other healthcare professionals, the Guide is an invaluable tool for any professional dealing with seniors.

While the Guide takes the position that reporting an impaired senior to the DMV does not violate physician-patient privilege, it does not address the issue of whether the physician must report the patient. At this time only eleven states require physicians to report patients who suffer from one or more diseases/conditions, including epilepsy, dementia and some sorts of neuromuscular diseases.[20] In states that require reporting, there would not appear to be any problem with the HIPAA Privacy Regulations since there is a HIPAA exception for disclosures required by law.

Other Professionals: No other professional group has a duty to report a suspected impaired driver. However, as discussed below, that does not mean that all professionals serving seniors and their families, especially (in the author's opinion) those involved with financial matters, should have this issue on their radar screen and should be discussing it with seniors and their families at the earliest opportunity.

f. The Answers

Professionals caring for seniors and their families should be asking questions about seniors' driving habits as part of their normal "intake" process. An excellent short driving quiz is available from AARP which can assist the professional in determining whether further investigation is warranted.[21]

Where the senior is the client, (or even better, when the client is not yet a senior), the professional should begin discussing with the client the possibility that driving may (at some point in the future) no longer be an option.

Discuss with the client the economics of driving, *i.e.* is the client adequately insured. Recommend regular "insurance checkups" for the client. This is particularly critical where

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[19]Wang, C.C., Kosinski, C.J., Schwartzberg, J.G., Shaklin, A..V., *American Medical Association's Physician's Guide to Assessing and Counseling Older Drivers* (Wash., D.C. National Highway Transportation Safety Administration; 2003).

[20]The states currently requiring reports are Arizona, California, Delaware, Idaho, Kentucky, Maine, Nevada, new Jersey, Pennsylvania, New Mexico and Oregon).

[21]The quiz is available on-line at www.aarp.org/drive/iq.html; See also www.aarp.org/drive.

the client is a Trustee or other fiduciary and the vehicle is owned by a Trust but used by an individual. (Whether or not this is a good idea is beyond the scope of this presentation.)

g. Possible Solutions

Leigh H. Bernstein, a Tucson, Arizona Elder Law attorney, recommends creating an Agreement, either stand-alone or included in a Durable Power of Attorney or Trust, along these lines:

> "I have discussed with my family my desire to drive as long as it is safe for me to do so. When it is not reasonable for me to drive, I would like [person's name] or [person's name] to tell me that I should no longer drive. I wish for [person's name] to assist by consulting with my physician or a driving rehabilitation specialist about my ability to drive safely. If I am unwilling or unable to surrender my driver's license after a professional concurs that I am unable to drive safely, I agree that the following steps may be initiated by [person's name]:
>
> She/he may contact my physician so that she/he may alert the state department of motor vehicles, or she/he may do so directly.
>
> She/he may take possession of my car keys.
>
> She/he may take possession of my car.
>
> She/he may sell my car and use the proceeds to pay for alternative transportation.[22]

The advantage of this concept is that it enables the senior to remain in control; to determine how and in what manner he or she will "retire" from driving in the same manner he or she determines when to retire from the workforce. The choice (and thus the empowerment) remains with the senior.

There are a number of programs available throughout the country that focus on driving skills and assessments for seniors. AARP's Driver Safety Program is probably the

[22]Bernstein, Leigh H., "Driving: Issues for the Elder-Law Attorney", NAELA Symposium, May, 2004.

most well known.[23] In addition, contacting local occupational therapists who specialize in driver rehabilitation or the local Area Agency on Aging or DMV can provide resources that can be passed on to the clients.[24]

4. **Questions & Answers**

[23]Information on course locations can be found at AARP's website, www.aarp.org/55alive/home.html. Or by calling 888-AARP-NOW.

[24]Nationally, the Association for Driver Rehabilitation Specialists (ADED) can provide the names of local assessment resources. 800-290-2344. www.driver-ed.org.