NOVA LAW REVIEW
An Elder Law Symposium: Contemporary Issues for a Golden-Aged Society

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Introduction: What Is Elder Law Anyway?

Amelia E. Pohl

Many of us who now consider ourselves “Elder Law” attorneys were practicing elder law long before it had a name. We were a group of attorneys concerned with problems unique to the elderly who worked as their advocates. Through various publications by agencies such as the Center for Social Gerontology, the American Association of Retired Persons, the Center for Public Representation, and the Legal Counsel for the Elderly, we became aware that other attorneys and agencies had similar interests and concerns. Because of the concern for the unique legal problems facing the elderly during the 1970s, the Department of Health, Education and Welfare awarded grant monies to provide direct legal services to the elderly in 1975.

The legal profession’s involvement with the elderly began in 1978 when the American Bar Association formed the Commission on Legal Problems of the Elderly (“Commission”). Since 1988, the Commission has published a quarterly newsletter, BIFOCAL, and a bimonthly bulletin to various bar committees on the elderly. Attorney participation in elder law on the national level began with the formation of the National Academy of Elder Law Attorneys (“NAELA”). The initial group of twenty-six founding members decided to form NAELA while they were attending a joint conference on Law and Aging held in Washington, D.C. The term, “Elder Law,” was coined by Michael Gilfix, Esquire, one of NAELA’s founding members. The NAELA headquarters were established in Tucson, Arizona in 1987. NAELA grew rapidly to 1150 members in forty-eight states and the District of Columbia by 1991.

It is not surprising that the practice of elder law organized on a national level since much of elder law relates to federal programs that benefit the elderly in general, such as the Medicaid program. Many elder law attorneys

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2. Id.
join NAELA to meet with other attorneys throughout the United States at
the various symposia and institutes offered by NAELA, to exchange
information and to determine how government benefit programs are
administered in different states of the union. For example, one problem that
confronted the elderly was the income cap under Medicaid. In most states,
persons cannot qualify for Medicaid if their income exceeds 300% of the
Supplemental Security Insurance ("SSI") benefit rate (currently $1338 per
month). Many elderly persons, therefore, had too much income to qualify
for Medicaid and too little income to afford the nursing care they required.

To resolve the income gap dilemma, attorneys in Colorado came up
with the idea of creating a trust whereby monies in excess of the income cap
were placed in trust until the Medicaid recipient died. At that time, all of
the trust funds reverted to the State of Colorado. This procedure was
initially challenged in the courts in Miller v. Ibarra.4 Later, it was
recognized by the Colorado legislature,5 and finally sanctioned by the
federal government as part of the Omnibus Budget Reconciliation Act of
1993.6

Other benefits were realized by elder law attorneys through their
association with NAELA. By 1992, the express mission of NAELA was to
"ensure delivery of quality legal services for the elderly and to advocate for
their rights."7 Its stated purpose was to "provide information, education,
networking, and assistance to attorneys, Bar organizations, and other
individuals or groups advising elderly clients and their families."8 NAELA
also seeks to promote "technical expertise and ethical awareness among
attorneys, Bar organizations . . . [and t]o develop awareness of the issues
surrounding legal services for the elderly."9

The prominence of NAELA has helped to establish and to define the
practice of elder law. At the first NAELA annual institute, held in
November 1991 in San Antonio, Texas, a survey was taken of the attorneys
attending the institute to determine how those attorneys defined elder law.
NAELA found the three major categories to be: 1) estate planning and
administration, including tax questions; 2) disability, Medicaid, and other
long-term care issues; and 3) guardianship, conservatorship, and commit-

5. COLO. REV. STAT. § 26-4-526 (1994).
7. Speaking About the Academy, 4 NAELA NEWS (Nat’l Acad. of Elder Law Att’ys,
8. Id.
9. Id.
ment matters, including fiduciary administration.\textsuperscript{10} Other areas cited by NAELA included retirement benefits, Medicare, disability benefits, litigation in the areas of elder abuse, and elder fraud.\textsuperscript{11}

NAELA membership has now grown to 2400 members with chapters in Massachusetts, the Carolinas, Arizona, and New York.\textsuperscript{12} Florida formed the Academy of Florida Elder Law Attorneys in 1994, the fifth local chapter of NAELA. Russell E. Carlisle is the first Chapter President of the Florida chapter and he has reported an initial membership of sixty-five attorneys.\textsuperscript{13}

In 1991, the Elder Law section of the Florida Bar was formed with Joseph W.N. Rugg as Chair, Jerome Ira Solkoff as the first Chair-elect, and an initial membership of 325 members. Rebecca C. Morgan is the 1994-1995 Chair, and current membership has grown to 1037. The bylaws of the Elder Law section allow for nonvoting affiliate membership, which is limited in number to one-third of the current membership. One of the criteria for acceptance as an affiliate is that the person provides services to elder citizens in the fields of health, welfare, or financial counseling. There are currently sixty affiliate members.

The reasons for encouraging affiliate membership are practical. One cannot practice elder law for any period of time without understanding that the needs of the clients extend beyond their legal problems. The clients may be frail or ill and require home health care or placement in an institutional facility. The clients may be well but fearful that future illness may deplete financial resources, and thus may need to consider a long-term care insurance policy. If a client is a caretaker and is overwhelmed with the demands of caring for a person who is suffering from some form of dementia, the client may need other support services offered by various religious organizations or nonprofit organizations, such as the Alzheimer’s Association. Peter J. Strauss, author of many elder law publications, notes in his book, \textit{Aging and the Law}, that

meeting the needs of the client(s) depends on moving beyond conventional legal work to offering practical assistance. Quite often, the attorney is the right person to provide information about home care, nursing homes, special geriatric health programs, adult day care, and

\begin{enumerate}
\item Janet L. Kuhn, \textit{Who Are We? Highlights from the NAELA Institute Questionnaire}, NAELA Q., Spring 1992, at 11.
\item \textit{Id.}
\item \textit{Id.} at 9.
\end{enumerate}
respite care; handling even a few elder-law cases quickly leads to an accumulation of such information and contacts with the right people.\textsuperscript{14}

Because so much of an elder law practice involves contact with insurance agents, geriatric care or case managers,\textsuperscript{15} and social service agency personnel, these persons have been invited to join the Elder Law section of the Florida Bar as affiliate members to work with attorneys to meet the needs of the elderly.

As the field of elder law expands, the various bar associations throughout the State of Florida are forming elder law committees. There are now elder law committees in the Hillsborough County Bar Association and in the Clearwater Bar Association. The Palm Beach County Bar Association formed an Elder Law Practice committee in 1993, with C. Mark Shalloway as Chairman. This year, the South Palm Beach County Bar Association is forming an Elder Law committee with this author as Chairperson. The Elder Law committee in Palm Beach County has endeavored to establish a substantive practice experience exchange and to establish an Elder Service Provider Information Exchange for its members. Thus, an important function of these local committees is to promote education and disseminate information on issues relating to elder law.

There is no elder law certification in the State of Florida. However, the National Academy of Elder Law Foundation ("NAELF"), an organization created by the Board of Directors of NAELA, is, for the first time, offering, board certification upon meeting of the requirements set by NAELF. One of these requirements is successful completion of an examination covering the following topics: 1) Health and Personal Care Planning (including advance medical directives and living wills); 2) Pre-Mortem Legal Planning (wills and trusts); 3) Fiduciary Representation (including guardianship, trustees and personal representatives); 4) Legal Capacity Counseling (advising how capacity is determined and the level of capacity required for various legal activities); 5) Individual Representation (of those who are or who may be the subject of guardianship or conservatorship procedures); 6) Public Benefits Advice (including Medicaid, Medicare, social security, and veteran’s benefits); 7) Advice on Insurance (including health, life, long-term disability, and burial/funeral policies); 8) Resident Rights Advocacy (including advising patients of their rights and remedies in matters such as admission, transfer, discharge policies, and

\textsuperscript{14} STRAUSS ET AL., supra note 1, at 4.

\textsuperscript{15} Care or case managers coordinate social and medical services.
quality of care); 9) Housing Counseling (reviewing options and financing of options such as mortgage alternatives, life care contracts, and home equity conversion); 10) Employment and Retirement Advice (pensions, retiree health benefits, and unemployment benefits); 11) Income, Estate, and Gift Tax Advice; 12) Counseling about Tort Claims Against Nursing Homes; 13) Age and/or Disability Discrimination Counseling (including employment and housing, and Americans with Disabilities Act); and 14) Litigation and Administrative Advocacy (including will contests, contested capacity issues, and elder abuse). 6

Then what is elder law? Is it all of the fourteen areas identified above? Or is it better understood as described in NAELA’s brochure, Elder Law: A Legal Practice Coming of Age? Rather than being defined by technical distinctions, the brochure defines elder law by the client to be served. 17 What is the role of an elder law attorney? As Jerome I. Solkoff stated, the role of the elder law attorney is to be concerned with and to meet the current needs of the elderly client.18 This concern must take precedence over the disposition of the client’s estate upon his or her demise.

Finally, who is an elder law attorney? As stated above, as of this date there is no elder law certification in the State of Florida. Rule 4-7.4(c) of the Rules Regulating the Florida Bar, however, states that an attorney “who is certified by a national group which has standards for certification substantially the same as those set out in chapter 6, may inform the public and other lawyers of his or her certified areas of legal practice.” 19 The minimum standards for certification as stated by NAELA 20 are as follows:

1) **Licensure:** Applicants must be duly licensed to practice law in at least one state or the District of Columbia.

2) **Practice:** Applicants must be engaged in the practice of law for the five-year period immediately preceding the date of application.

3) **Integrity:** Applicants may not be certified for three years following any public discipline, final criminal conviction, or malpractice judgment.

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18. Interview with Jerome I. Solkoff, Attorney and former NAELA Chair, in Ft. Lauderdale, Fla. (July 1, 1994).

19. FLA. BAR RULES OF PROFESSIONAL CONDUCT Rule 4-7.4(c) (1987).

4) **Substantial Involvement:**
   a) **Number of Hours:** In each of the three years immediately preceding application, the applicant shall have practiced elder law an average of sixteen hours per week.
   b) **Task Requirement:** During the three years immediately preceding the application, the applicant shall have provided legal services in at least sixty elder law matters, as defined above, with no more than ten matters in any one of the areas.

5) **Continuing Legal Education:** Within the three years immediately preceding application, the applicant shall have participated in at least forty-five hours of continuing legal education in elder law.

6) **Peer Review:** The applicant shall submit as references the names of five attorneys, all of whom are familiar with the competence of the applicant, and none of whom are persons related to or engaged in legal practice with the applicant. Three of the named attorneys shall have devoted a minimum of 800 hours to the practice of elder law.

7) **Examination:** The applicant shall successfully complete a written examination prepared and graded by the Examination Committee.

These standards are similar to the standards required by Rule 6-3.5 of the Rules Regulating the Florida Bar. This author has submitted the NAELA requirements to the Florida Bar for a written opinion as to whether NAELA standards comply with the regulation of Rule 4-7.4(c).

Although we do not know at this writing if possession of NAELA certification will allow attorneys to hold themselves out as elder law specialists, it is proper for an attorney to say that a majority of his or her practice is in the field of elder law, that he or she belongs to any of the various elder law organizations as above identified, and that he or she has made a study of elder law by attending various Continuing Legal Education courses and NAELA symposia and institutes. In view of the foregoing, in this author’s opinion, it would then be proper to consider oneself an elder law attorney.

Much progress has been made in providing the elder client with legal representation that addresses his or her unique needs. However, there still remains much to accomplish toward recognizing elder law practice as a unique specialty.

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21. See id. at 7-8.
23. To date, no response has been received.
The Incarceration of Older Criminals: Balancing Safety, Cost, and Humanitarian Concerns

William E. Adams, Jr.*

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I. INTRODUCTION

Until the last two decades, little attention was paid to the elderly criminal. This was partly because older persons constituted the age group least likely to commit crimes. The first notice of the intersection of old age and crime occurred in the late 1970s when the media and some academic researchers focused upon the problem of older persons as the

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1. Criminal justice researchers have traditionally found a decrease in the arrest and incarceration rates as people age. Kenneth E. Gewerth, Elderly Offenders: A Review of Previous Research, in OLDER OFFENDERS: PERSPECTIVES IN CRIMINOLOGY & CRIMINAL JUSTICE 14 (Belinda McCarthy & Robert Langworthy eds., 1988) [hereinafter OLDER OFFENDERS].
victims of crime. In the 1980s, however, researchers and the press turned the focus to the increasing number of crimes committed by the elderly. Although the claims of an "elderly crime wave" may have been overstated by the media and some researchers, the potential problems posed by a growing number of elderly prisoners should not be ignored. Florida, with its large and growing elder population, should be especially concerned about the impact of the current popularity for lengthening prison sentences because of the higher costs of keeping older prisoners incarcerated. Although it would be foolhardy to release all older prisoners into society, the trend to increase sentence lengths may allow more dangerous younger criminals to be released from prison while much less dangerous older persons remain incarcerated for their full prison terms. In addition to the economic costs of keeping older prisoners incarcerated, it is important to consider whether the infringement upon the liberty interest of an older prisoner who is no longer dangerous is justified.

4. During the 1980s, the television network news shows, Sixty Minutes and Today, both featured segments on elderly crime. Craig J. Forsyth & Robert Gramling, Elderly Crime: Fact and Artifact, in OLDER OFFENDERS, supra note 1, at 3. In 1985, a group of researchers, educators, and practitioners formed the Society for Interdisciplinary Research on Elderly Offenders ("SIREO"). Id. at 4. Although Forsyth and Gramling believe that elderly crime is on the rise, they dispute the notion that an "elderly crime wave" is occurring. Id. at 13; see also discussion infra, notes 13-16. They note that some researchers have argued that the media, "hungry for news," has provided coverage of this "crime wave" that has tended to be misleading. Forsyth & Gramling, supra, at 9.
5. For a discussion of why studying elderly crime and the response by the criminal justice system is important to understanding our criminal justice system, see Belinda McCarthy & Robert Langworthy, Elderly Crime and the Criminal Justice System Response: Conceptualizing the Problem, in OLDER OFFENDERS, supra note 1, at xxi.
6. In addition to the popularity of increased sentencing for criminals espoused by politicians, one proposed ballot initiative for the 1994 elections attempted to amend the Florida Constitution to require that state prisoners serve at least 85% of their sentences. The initiative was struck from the ballot because of a misleading ballot summary. See Advisory Opinion to the Attorney General Re: Stop Early Release of Prisoners, 642 So. 2d 724 (Fla. 1994).
II. THE ELDER CRIMINAL—STATISTICS AND CHARACTERISTICS

A. Interpreting the Studies

It is difficult to draw precise conclusions about the extent of elderly crime by reviewing the academic research. The studies often fail to use the same definitional categories, which can cause results to at first appear contradictory. The first interpretational problem arises with the definition of “elderly.” Social scientists who have researched older persons and their criminal behavior have failed to come to a uniform agreement on what age constitutes “old.” This reflects a similar confusion in the law and in American society in general.7 Social Security retirement benefits, for example, begin at age sixty-five, or sixty-two if one takes “early” retirement.8 On the other hand, the Older Americans Act provides benefits for persons aged sixty and over.9 The National Institute of Corrections chooses the even younger age of fifty as the age which defines the older criminal.10 Therefore, it should not be surprising that the studies reviewed in this article use the term “elderly” to mean ages ranging from fifty to sixty-five and older.

In addition to the age discrepancies in the studies, there are also differences in the crimes reviewed. Furthermore, the percentage increases can sometimes be misleading because the absolute numbers of elder arrests in previous decades were so small. Even though there does appear to be an increased number of older persons in the criminal justice system, there are

7. It is arguable that the inability to reach a consensus partially results from the “ageism” of our society. Many people object to being labelled “old” in American society because of the various negative ramifications of such a designation. A number of commentators have discussed the impact of myths concerning older persons in American society. See, e.g., SIEGFRIED J. KRA, AGING MYTHS, REVERSIBLE CAUSES OF MIND AND MEMORY LOSS (1986); Alison P. Barnes, Beyond Guardianship Reform: A Reevaluation of Autonomy and Beneficence for a System of Principled Decision-Making in Long Term Care, 41 EMORY L.J. 633 (1992); Judith Rodin, Sense of Control: Potentials for Intervention, ANNALS AM. ACAD. POL. & SOC. SCI., May 1989, at 29.
9. Id. § 3026.
10. JOANN B. MORTON, U.S. DEP’T OF JUSTICE, AN ADMINISTRATIVE OVERVIEW OF THE OLDER INMATE 1, 4 (1992). While age 50 seems closer to middle age than to elderly status, the socioeconomic status, lack of access to medical care, and lifestyle of older criminals may create a 10 year differential between the health of inmates in the Bureau of Prisons and the general population. Id.; see also Peter C. Kratcoski & George A. Pownall, Federal Bureau of Prisons Programming for Older Inmates, 53 FED. PROBATION 28, 30 (June 1989).
reasons to be skeptical that this constitutes a rising elderly crime wave. Figures from 1979 indicate that while 15% of the population in the United States was then sixty years of age or older, only 1% of state inmates were sixty or older. Persons aged eighteen to fifty-nine were 13.3 times as likely to be arrested for index offenses as were persons sixty or older. With past statistics so low, any increase may seem dramatic.

More recent studies indicate that the ratio of younger persons to older persons violating the law has not changed, and that the proportion of crime committed by older persons is still quite low. However, other studies seem to indicate that elderly crime is increasing at a significant rate. While some may take solace in the statistics of proportion, the problem of elderly crime, measured in real numbers, is growing.

The number of older persons currently serving prison sentences is clearly increasing. This is due, in large part, to the aging of the population in general. The growing number and percentage of older persons in the

11. Wilbanks, supra note 2, at 276.
12. Id. The term "index offenses" includes more serious crimes such as murder, robbery, rape, aggravated assault, burglary, larceny, auto theft, and arson. Id.
13. Id. The ratios ranged from 86.5 to 1 for robbery, to 8.7 to 1 for larceny. Id. Although arrest rates may differ from the rate of commission of the crime, Professor Wilbanks discounts this possibility. But cf. Karen M. Jennison, The Violent Older Offender: A Research Note, 3 FED. PROBATION, Sept. 1987, at 60 (citing a number of studies that indicate that the rate of violent crimes committed by the elderly is rising twice as fast as the rate among younger persons).
15. Arrests for index crimes among the elderly (age 65 and over) between 1964-1974 increased by 224% while index crime arrests for youth increased about 40%. Victoria K. Kidman, The Elderly Offender: A New Wrinkle in the Criminal Justice System, 14 J. CONTEMP. L. 131, 131 (1988). Once again, the percentages are a bit misleading since the absolute numbers of crimes are much smaller among the elderly.
16. This academic dispute among criminal justice researchers has been characterized as a battle between "constructionists" and "traditionalists." The constructionists believe that the perceived increase is due to an increase in the criminal justice bureaucracy, academics in search of "hot" new topics to research, and media hype. The traditionalists believe that the increased interest is due to actual numerical increases in the number of crimes committed by older persons. Forsyth & Gramling, supra note 4, at 12.
17. There was a 54.4% increase in the segment of the population over 65 between 1965 and 1984. Id. In 1985, there were approximately 27 million Americans over the age of 65, close to 12% of the total population. Forecasters predict that this number will.
Adams

overall population has resulted in a substantial number of crimes committed by older persons. One researcher has indicated that persons fifty-five and older may have committed 4,000,000 criminal violations in the United States in 1979, although not all of the violators were arrested nor were all of the incidents reported.\(^8\) In 1985, 91,709 persons over age sixty-five were arrested, including 15,265 for theft, 17,937 for drunkenness, 19,411 for driving while intoxicated, and 2442 for aggravated assault.\(^9\) The 1985 statistics seem to indicate a decrease when compared to 1981, when the number of elderly arrested reached 213,000.\(^{20}\) Note, however, that the 1981 statistics are not comparable because they were based on the larger age group of persons age sixty and older. Statistics from 1992 based on this larger age group of persons sixty and older indicate the total arrested was 165,463, representing a decrease from 1985.\(^{21}\) Although these 1992 arrest statistics support the argument against the notion of an elderly crime wave, the ratio of arrests actually leading to conviction and imprisonment seems to have increased due to changes in sentencing practices, as discussed below. Nationally, the number of inmates fifty-five and older more than doubled from 1981 to 1990.\(^{22}\)

In addition to the aging of the baby boom population,\(^{23}\) changes in sentencing practices resulted in a larger population of older inmates. Even in the 1980s, researchers warned that the prevalence of determinant

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\(^8\) Kercher, supra note 14, at 258.
\(^9\) Kidman, supra note 15, at 131.
\(^{20}\) Of these, 36,000 were arrested for murder, forcible rape, robbery, aggravated assault, burglary, larceny, motor vehicle theft, or arson; 56,000 were arrested for drunkenness; 49,000 for driving while intoxicated; and 15,000 for disorderly conduct. Gary Feinberg & Dinesh Khosa, Sanctioning Elderly Delinquents, TRIAL, Sept. 1985, at 46.
\(^{22}\) YOUTH & SPECIAL NEEDS PROGRAM OFFICE, FLA. DEP’T OF CORRECTIONS, STATUS REPORT ON ELDERLY INMATES at 5 (1993) [hereinafter STATUS REPORT].
\(^{23}\) See supra note 17.
sentences, mandatory minimums, and extended terms\textsuperscript{24} would result in an increased number of older inmates.\textsuperscript{25} With increased political pressure to once again increase prison sentence length in the 1990s, the numbers could grow even larger. Prior to the renewed efforts, it had been estimated that the number of prisoners over age fifty would reach 125,000 by the year 2000, with 40,000 to 50,000 being over age sixty-five.\textsuperscript{26} In 1988, almost 12\% of the Federal Bureau of Prisons inmate population was aged fifty or older, and it was estimated that by the year 2005, that figure would rise to 16\%.\textsuperscript{27} Consequently, it can be seen that both the number of elderly prisoners and the percentages of prisoners who are elderly are increasing.

\section*{B. Common Traits of the Elder Criminal}

Despite existing research concerning the rapidly increasing elder population and the rise in the number of crimes committed by the elderly, there is still insufficient empirical research on the older lawbreaker.\textsuperscript{28} As noted previously, researchers disagree about whether an increase in the rate of crime committed by older persons actually has occurred. There is also

\begin{itemize}
  \item 25. Michael J. Sabath & Ernest L. Cowles, \textit{Factors Affecting the Adjustment of Elderly Inmates to Prison}, in \textit{OLDER OFFENDERS}, supra note 1, at 179. A determinate sentencing system removes judicial and parole board discretion in determining sentence length. The sentence is determined at the time that the judge announces it at the sentencing hearing, and the judge is limited to a narrow range of sentences that he has the discretion to impose. Mandatory minimums refers to the prescription that a minimum duration of time be imposed as a sentence for criminal convictions. \textit{See} Comment, \textit{Structuring Determinate Sentencing Guidelines: Difficult Choices for the New Federal Sentencing Commission}, 35 CATH. U. L. REV. 181, 182 n.6 (1985).
  \item 27. MORTON, supra note 10, at 2.
  \item 28. Kercher, supra note 14, at 261.
\end{itemize}
disagreement as to whether the factors predicting illegal behavior are the same at all ages. The consensus seems to be that crimes such as fraud, embezzlement, and theft are the crimes for which the elderly are most often arrested. A distinct increase in the number of shoplifting arrests of elderly persons has also been noted. Many of these involve first-time offenders; one study of elderly inmates in Florida found that a majority of the elderly inmates in the sample had either one or no prior arrests. The 1987 Uniform Crime Reports indicates that arrests of persons aged fifty and over encompass approximately 5% of total arrests for all offenses. The same report indicates that 8.5% of persons over fifty years of age were arrested for driving under the influence and 12.4% for drunkenness. Although older persons are most likely to be arrested for alcohol-related offenses, at least one study has found that when asked to self-report on illegal activity, residents of retirement communities, age sixty and older, reported illegal gambling as the offense in which they most often engaged.

29. A number of factors have been postulated as influencing criminal behavior. These include: age, race, sex, marital status, religious commitment, residential mobility, prior criminal behavior, socioeconomic status (income, occupation, education, and employment status), criminal associations, attachment to significant others, criminal (moral) beliefs, anomie, and formal and informal deterrence. It has been theorized that two primary influences upon illegal behavior include: 1) the calculation of personal gain derived from legitimate versus illegitimate activities, and 2) the extent to which an individual undergoes social integration and internalization of conventional norms. Id. at 258-59.

30. Id. at 261; see also Ronald L. Akers et al., Theoretical Perspectives on Deviant Behavior Among the Elderly, in OLDER OFFENDERS, supra note 1, at 35 (noting both parallels and differences between juvenile and elderly criminals); William Wilbanks & Dennis D. Murphy, The Elderly Homicide Offender, in ELDERLY CRIMINALS 79, 80-91 (Evelyn S. Newman et al. eds., 1984) (suggesting that the elderly are less sensitive to social and cultural variables than younger persons).

31. Assaults and sex offenses are also somewhat common among elderly arrestees. Kercher, supra note 14, at 257.

32. This increase is even more pronounced for elderly females than for elderly males. Approximately 50% of all arrests of elderly females were for theft, compared to only 12% of arrests of elderly males. Steffensmeier, supra note 14, at 301. However, part of this increase may be due to increased surveillance and enforcement. Id. at 291.

33. Fifty-eight percent of the inmates reported either one or no prior arrests, and none reported a juvenile record. Manuel Vega & Mitchell Silverman, Stress and the Elderly Convict, 32 INT'L J. OF OFFENDER THERAPY & COMPAR. CRIM. 153, 158 (1988).

34. Kratcoski & Pownall, supra note 10, at 28.

35. Id.

36. Ronald L. Akers & Anthony J. La Greca, Alcohol, Contact with the Legal System, and Illegal Behavior Among the Elderly, in OLDER OFFENDERS, supra note 1, at 57.
In addition, the statistics reflect that older persons do commit some violent crimes. For example, approximately 5% of homicide arrestees are fifty-five and older. Although this percentage is less than the proportion of elderly in the population, it nevertheless demonstrates that stereotypes of the harmless elderly person are not completely accurate. While disagreement over the causes of criminal behavior by the elderly continues, it is agreed that violent crime by older persons tends to be against those who are related to or are acquaintances of the perpetrator. These are usually the people who are present to suffer the effects of the elderly criminal’s drinking habit.

Alcohol abuse and, consequentially, unstable social relationships are frequently found among older offenders. Studies have identified a nexus between these conditions and criminal behavior among the elderly, as with other age groups. One national study of prisoners over age fifty found that 59% had previously been convicted of a violent crime in which alcohol use was connected. The study also indicated that older offenders who committed violent crimes were likely to be unmarried males, nonwhite, with lower incomes and fewer dependents. The older criminal was found to have a history of part-time employment and unemployment. This combination of joblessness, lack of family ties, and alcohol abuse increases the likelihood of criminal behavior, even more so than in younger drinkers.

The factor most predictive of violent behavior, however, is past offenses. Aggravated assault is the violent offense most often committed by persons over age sixty-five. Murder ranks second. The increased

39. Jennison, supra note 13, at 60.
40. Id. Thus, Jennison has concluded that there is a strong need for alcohol use screening and alcohol rehabilitation programs for older offenders. Id. at 64.
41. Id. at 60; see also Akers & La Greca, supra note 36, at 60; Gewerth, supra note 1, at 23; Steffensmeier, supra note 14, at 301.
42. Jennison, supra note 13, at 64; see also Kidman, supra note 15, at 137 n.48.
43. Jennison, supra note 13, at 63. The prisoners in this study had committed the following crimes: homicide, 20%; robbery, 11%; sexual assault, 6%; aggravated and simple assault, 42%. Id.
44. Id. at 62.
45. Id. at 63.
46. Id. at 64.
47. Jennison, supra note 13, at 64.
attention being given to the types of crimes more frequently committed by older offenders, such as shoplifting, alcohol-related offenses, and family violence, will likely result in even more older persons being sentenced to prison.\textsuperscript{49} The impact of this growing problem on states like Florida, which has a disproportionate share of the elderly population, will be felt even more severely.

III. THE SCOPE OF THE PROBLEM IN FLORIDA

Florida, with its large elderly population, is particularly vulnerable to the problems that may result from this burgeoning elderly prison population. Sentencing guidelines and the escalating drug problems have increased the prison population in excess of previous estimates.\textsuperscript{50} The Department of Corrections and the Department of Elder Affairs have formed a task force to examine the growing costs of this social problem.\textsuperscript{51} The Department of Corrections has been urged to accept the federal recommendation to adopt age fifty as the chronological starting point for the definition of older offenders because of their mental and physical health and their need for different medical care and lifestyles.\textsuperscript{52} The number of older inmates in Florida has risen to nearly 3000, more than double the number from ten years ago.\textsuperscript{53} Over 750 of the inmates admitted during fiscal year 1992-93 were age fifty and above.\textsuperscript{54} Their percentage of the total prison population has increased from 3.4\% in 1982 to 5\% in 1992.\textsuperscript{55} In fact, Florida has the third largest number of prisoners over age fifty in the nation.\textsuperscript{56} Over half of those older criminals currently incarcerated committed drug-related or property crimes.\textsuperscript{57} Thirty-five percent had two or fewer prior admis-

\textsuperscript{49}. Gewerth, \textit{supra} note 1, at 26.
\textsuperscript{50}. \textit{See} Holten \& Handberg, \textit{supra} note 24, at 261-64.
\textsuperscript{51}. The task force has fourteen members. Bruce T. Seeman, \textit{Can State Afford Its Aging Inmates?}, MIAMI HERALD, July 24, 1994, at 14A.
\textsuperscript{52}. \textit{STATUS REPORT}, \textit{supra} note 22, at 4, 14.
\textsuperscript{53}. Seeman, \textit{supra} note 51, at 14A. According to the Florida Department of Corrections' figures, the number of older inmates on June 30, 1993 was as follows: age 50-54, 1246 (2.5\% of inmate population); 55-59, 662 (1.3\%); 60-64, 353 (.7\%); 65-69, 198 (.4\%); 70 and over, 145 (.3\%); for a total 50-plus population of 2604 (5.2\%). \textit{FLORIDA DEP'T OF CORRECTIONS, 1992-93 ANNUAL REPORT} 71 (1993).
\textsuperscript{54}. Age 50-54, 405; 55-59, 188; 60-64, 100; 65-69, 47; 70 and over, 29. \textit{Id.} at 58.
\textsuperscript{55}. \textit{STATUS REPORT}, \textit{supra} note 22, at 8.
\textsuperscript{56}. \textit{Id.} at 9.
\textsuperscript{57}. The crimes committed were:

\begin{verbatim}
Murder, Manslaughter  76  (9.9\%)
Sexual Offenses       132 (17.2\%)
\end{verbatim}
At present, over 80% of the older inmates have sentences of five years or longer. In sum, the elderly now constitute the fastest growing segment of the Florida prison population.

This aging prison population has created higher health care costs for Florida correctional institutions. It costs the Department of Corrections three times more per day to keep an elderly person in prison than it does a younger person. Consequently, the politically popular "three strikes and you're out" proposals currently being advanced make corrections officials wince. Many older prisoners will have health problems similar to or more severe than those encountered by their fellow seniors outside of the prison system. One Florida study revealed that 80% of elderly inmates reported one or more medical problems, with 60% claiming multiple medical problems. Another study projects that 30% of the inmate population aged fifty or older will have some form of cardiac and hypertensive disorder requiring substantial medical attention. Special health units

<table>
<thead>
<tr>
<th>Offense</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robbery</td>
<td>16</td>
<td>2.1%</td>
</tr>
<tr>
<td>Violent Personal Crime</td>
<td>76</td>
<td>9.9%</td>
</tr>
<tr>
<td>Burglary</td>
<td>49</td>
<td>6.4%</td>
</tr>
<tr>
<td>Theft, Forgery, Fraud</td>
<td>137</td>
<td>17.8%</td>
</tr>
<tr>
<td>Weapons, Escape</td>
<td>32</td>
<td>4.2%</td>
</tr>
<tr>
<td>Drugs</td>
<td>197</td>
<td>25.6%</td>
</tr>
<tr>
<td>Other Offenses</td>
<td>53</td>
<td>6.9%</td>
</tr>
</tbody>
</table>


58. Of inmates admitted during fiscal year 1992-1993, 11.9% had no prior admissions, 27.5% had one or two, and 60.6% had three or more prior admissions. Id. at 29.

59. The length of sentence for Florida inmates over 50 is:

<table>
<thead>
<tr>
<th>Length of Sentence</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 years</td>
<td>426</td>
<td>17.5%</td>
</tr>
<tr>
<td>5+ years</td>
<td>388</td>
<td>16.0%</td>
</tr>
<tr>
<td>10+ years</td>
<td>380</td>
<td>15.6%</td>
</tr>
<tr>
<td>15+ years</td>
<td>159</td>
<td>6.5%</td>
</tr>
<tr>
<td>20+ years</td>
<td>369</td>
<td>15.2%</td>
</tr>
<tr>
<td>Life</td>
<td>689</td>
<td>28.3%</td>
</tr>
<tr>
<td>Death</td>
<td>21</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Status Report, supra note 22, at 11.

60. Phil Long & Mark Silva, Rehabilitation? Some Old Cons Never Got Chance, Miami Herald, May 24, 1993, at 1A.

61. Seeman, supra note 51, at 14A.

62. Unfortunately, this study used a relatively small sample (40 inmates). Vega & Silverman, supra note 33, at 158.

for such prisoners will almost certainly need to be developed.64 The Americans with Disabilities Act65 will require prisons to make certain accommodations for the disabled.66 A study by the Florida task force, reviewing the health care costs of a dozen older prisoners in 1992, found costs to range from a few thousand dollars to over $80,000.67 The Pennsylvania Department of Corrections has experienced a similar increase, with its prison health services expenditures soaring from $1.23 million in 1973 to $16.7 million in 1986.68 Although not all of this is attributable to older prisoners, states which house older prisoners are likely to see larger expenditures for health services.

In addition, elderly prisoners in Florida, similar to those elsewhere, encounter social and psychological problems. One study found that older prisoners in the Florida prison system experienced more interpersonal problems with other inmates than with the prison staff.69 The majority of elderly inmates in this study indicated they did not receive family visitors.70 Despite the fact that the older inmates generally adjust well to the prison environment, they also demonstrate high levels of stress. Such problems may necessitate building additional geriatric units or prisons. States such as Ohio, North Carolina, and Minnesota already have separate facilities for older inmates.71 The Florida Department of Corrections provides special services for older male inmates at the Lawtey Correctional Institution and the Hillsborough Correctional Institution, and for older females at the Florida Correctional Institution.72 In addition to providing medical care, such facilities may be necessary to protect older inmates, who are vulnerable to attacks from younger prisoners.

64. Barry Krisberg, Director of the National Council on Crime and Delinquency, notes that “[s]tates like Florida are going to be doing open-heart surgery every week. We’re talking about prisons that will have their own cancer units.” Seeman, supra note 51, at 14A.
67. Seeman, supra note 51, at 14A.
68. Chaneles, supra note 26, at 51.
69. Although 92% of prisoners indicated few interpersonal problems with prison staff, 78% revealed problems with other inmates. Vega & Silverman, supra note 33, at 156.
70. However, 90% indicated that they were in contact with relatives by telephone or mail. Id.
71. Seeman, supra note 51, at 14A.
72. MORTON, supra note 10, at 22.
IV. SENTENCING AND PAROLE STANDARDS—SHOULD AGE BE A FACTOR?

A. Humanitarian Concerns

The extent to which age is a factor in sentencing depends upon the weight given to each of the four theories of punishment: retribution, deterrence, prevention, and rehabilitation.\(^\text{73}\) Retribution (also called "revenge" or "retaliation") theory imposes punishment in order to compensate for the harm to the victim.\(^\text{74}\) Deterrence theory posits that the threat of punishment will dissuade the rational person from committing a crime.\(^\text{75}\) Prevention is a form of deterrence theory in which the punishment is meant to incapacitate the offender in order to prevent other crimes from being committed. An educational program as punishment may serve this preventive function.\(^\text{76}\) Rehabilitation is the process through which the punishment restores the criminal so that he may return to society with skills that reduce the likelihood of further criminal activity.\(^\text{77}\) Although these goals are not mutually exclusive, the punishment given to a criminal may vary depending upon the weight given to each.

These theories may necessitate different results depending upon the type of crime committed and the characteristics of the older offender. Some older prisoners are clearly more dangerous than others. In order to deter or prevent future crime, some would argue that the violent prisoners should stay incarcerated. Some offenders who have committed very violent crimes may no longer be physically able to commit a violent crime because of failing health. Under a retributive theory, such a person would be kept in prison if he had not served an appropriate length of time even if he were no longer dangerous. On the other hand, those who value rehabilitation strongly might approve the release of a person who had committed a particularly heinous crime once rehabilitation is demonstrated, even if the time served were so short as to not fully serve the interests of retribution. Penalties will also have a more serious effect on some persons than on

\(^{73}\) Kidman, supra note 15, at 142-46. For further discussion of theories concerning incarceration of older persons, see Fred Cohen, Old Age as a Criminal Defense, 21 CRIM. L. BULL. 5, 11-17 (1985); Molly James, The Sentencing of Elderly Criminals, 29 AM. CRIM. L. REV. 1025, 1039-43 (1992).

\(^{74}\) Kidman, supra note 15, at 142.

\(^{75}\) Id. at 143.

\(^{76}\) Id.

\(^{77}\) Id.
others. For example, fines or economic sanctions, which may seem more appropriate for non-violent offenses, may have a harsher effect on an elderly person who shoplifted because of economic need. The fine may worsen the economic condition of the offender, thus contravening any deterrent effect. Further imprisoning people past a stage where they are dangerous, particularly if more dangerous criminals are released, puts society at greater risk of harm. However, releasing older prisoners into society raises special problems for probation officers, as discussed below.

B. Sentencing

The vulnerability of older inmates has led some commentators to suggest that age be considered an appropriate criminal defense under a diminished capacity theory. While not all older persons suffer from functional mental impairments, it is recognized that as persons get older, the likelihood of decline in mental functioning increases. This decline is probably not significant in those prisoners who are in their early fifties. However, it may be a relevant factor for older offenders. These physiological changes can affect behaviors which the older person was previously able to hold in check. A large number of violent older offenders suffer from mental disabilities associated with aging.

The fact that elderly criminals sometimes suffer from diminished mental capacities may have an impact on the way in which elder criminals are treated by the criminal justice system. Although the sentencing guidelines and case law do not require leniency toward the elderly, a number of researchers have found that police and the judicial system treat

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78. Cohen, supra note 73, at 8-10. It could also be argued that an older person could be considered more culpable because of greater life experience. Id. at 11; see also Kidman, supra note 15, at 146-47.

79. Such a blanket presumption would also help perpetuate negative stereotyping of the elderly which is unfair because it is untrue of a large number of older persons. Cohen, supra note 73, at 25.

80. Id. at 9.

81. Those who suddenly commit a violent offense at an older age may suffer a loss of inhibitions due to some factor like chronic brain syndrome. Kidman, supra note 15, at 133.

82. Id. at 134 (citing Wilbanks & Murphy, supra note 30, at 88).

83. Id. at 138 n.62 (citing Stephen J. Hucker, Psychiatric Aspects of Crime in Old Age, in Elderly Criminals, supra note 30, at 68).

84. See, e.g., Bevins v. Commonwealth, 712 S.W.2d 932, 936 (Ky. 1986) (holding that consideration of the 70 year old defendant’s age was within the court’s discretion), cert. denied, 479 U.S. 1070 (1987).
elderly persons more leniently.  

85. Donald J. Bachand & George A. Chressanthis, *Property Crime and the Elderly Offender: A Theoretical and Empirical Analysis*, in *OLDER OFFENDERS*, supra note 1, at 79. One study of federal judges across six different circuits found that offenders aged 60 and over received sentences through plea bargains which were less than half as severe as those received by younger offenders. The disparity was even greater where the defendant was convicted at trial. It should be noted that this study was conducted prior to implementation of the Federal Sentencing Guidelines. Dean J. Champion, *The Severity of Sentencing: Do Federal Judges Really Go Easier on Elderly Felons in Plea-Bargaining Negotiations Compared with Their Younger Counterparts?*, in *OLDER OFFENDERS*, supra note 1, at 154.


87. Gary Feinberg, supra note 18, at 124.

88. Feinberg & Khosia, supra note 20, at 47. Only 59% reported being sympathetic towards the elderly, with 22% reporting being distinctly unsympathetic and 20% reporting neutrality. *Id.* Only 38% of the judges reported that elderly misdemeanants should be accorded special consideration. *Id.*

89. While 33% reported pretrial intervention as an ideal sanction, only 6% used it. While 30% recommended counseling as ideal, only 12% used it as a sanction. On the other hand, 39% used fines, court costs, or both while only 12% characterized them as ideal. This contradiction is compounded by the fact that the judges rated psychological problems as the most common cause of elderly shoplifting with economic need ranked second. *Id.* at 49. One study challenges the belief that elderly persons shoplift for subsistence purposes. Kidman, supra note 15, at 135.

90. Of 31 judges who believed misdemeanor shoplifting was caused by economic need, 45% levied fines, court costs, or both, thus exacerbating the problem that they perceived triggered the offense. The judges who attributed the shoplifting to psychological problems were also much more likely to apply economic sanctions rather than counseling. Feinberg & Khosia, supra note 20, at 49.

91. For some offenses, such as negligent vehicular manslaughter, aggravated assault with a weapon, motor vehicle theft, fraud, dangerous drugs, child molestation, and public order
which result in arrest or other dispositions of persons suspected of criminal activity. At least one study has also found that the elderly were less likely to invoke their due process rights than younger accused, although there is a trend towards increased assertion of rights by older defendants.92

Some commentators argue that courts should consider a person's age when imposing a sentence. A thirty year sentence for a forty year old or a fifteen year sentence for a sixty year old may be the same as a life sentence for a younger person. Similarly, fines may be more onerous for older persons on a fixed income.93 The Federal Sentencing Commission,94 in its policy statement to the Federal Sentencing Guidelines, allows age to be considered in certain circumstances, although it states that it is not ordinarily relevant.95 Although many states have statutes which allow courts to consider age in sentencing,96 the courts have been reluctant to permit departures from sentencing guidelines where age or physical impairments are present.97 Some state courts permit advanced age to be considered a

92. In a study of persons aged 60 and over accused of misdemeanors in Dade County, Florida, researchers found that a higher percentage of older defendants pled guilty and a lower percentage asked to be represented by counsel or to obtain a jury trial than younger defendants. Feinberg, supra note 18, at 132-39. But see Champion, supra note 85, at 155 (finding that older defendants in federal courts were more likely to proceed to trial). Note, however, that the latter study involved felonies whereas the former involved misdemeanors. It may be that the disincentives for the elderly appearing in court are outweighed by the seriousness of a felony conviction. Id.

93. Gewerth, supra note 1, at 27; see also Feinberg & Khosia, supra note 20, at 50.


95. The Policy Statement says:

Age (including youth) is not ordinarily relevant in determining whether a sentence should be outside the applicable guideline range. Age may be a reason to impose a sentence below the applicable guideline range when the defendant is elderly and infirm and where a form of punishment such as home confinement might be equally efficient as and less costly than incarceration. Physical condition, which may be related to age, is addressed at 5H1.4 (Physical Condition, Including Drug or Alcohol Dependence or Abuse).


96. James, supra note 73, at 1032 n.68; see also Long, supra note 21, at 86.

97. Courts have been reluctant to strictly require sentencing departures for age or physical disabilities. See United States v. Carey, 895 F.2d 318 (7th Cir. 1990). In Carey, the court reversed a departure for a defendant convicted in a check-kiting scheme who was
mitigating factor under common law principles. However, allowing all older persons to receive leniency in sentencing might be a mistake since some older criminals will have a lengthy criminal history with little hope of rehabilitation and may therefore still pose a threat to society. One study of elderly homicide perpetrators found that older killers were likely to have criminal backgrounds. Nevertheless, considering age as a mitigating factor is probably appropriate in some cases.

C. Parole and Probation

As in other areas of elderly crime, little research has been conducted on elderly probationers. One study of elderly probationers in California found a large percentage with a prior criminal record. Males in this study had most commonly committed prior sex offenses, while the elderly...
females had most often committed welfare fraud. A majority were in poor health. Although those who committed welfare fraud are probably not dangerous, those who committed sex offenses may still pose a threat if released. On the other hand, a review of the elderly inmates in the Federal Bureau of Prisons indicates that a majority are not considered dangerous.

Many existing probation programs are not designed to provide for the needs of older persons. Nevertheless, one study found that elderly convicts are much more likely to be offered probation than younger persons convicted of crimes. There have been attempts to create special diversion programs for elderly offenders. The earliest models tended to focus on persons who were either first-time offenders or who committed minor crimes. These programs offered individual counseling, social activities, and emotional support; some met in group sessions where members helped each other. Although proponents of these programs claimed dramatic success rates, some researchers argue that the restrictive criteria for entrance to the programs artificially increased the success rate. The researchers concluded that these and similar prison programs failed to meet the inmates' needs, and they suggested the creation of special institutions for older prisoners, with programs tailored to address their problems.

101. Almost one-third of the males had committed sex offenses, primarily offenses connected with minors, and 42.9% of the females had committed welfare fraud. Id. The level of sex offenders among males is troubling since arguably they still pose a threat to the community. The researcher notes that some of their reports stated that imprisonment would have been recommended if the offender had been younger. Id.

102. Id. at 168-69.

103. Some believe that both deterrence and retribution are served by keeping persons who committed welfare fraud in prison, but the question is whether these goals outweigh safety concerns of more dangerous inmates being released.

104. Forty-six percent were classified in the lowest security level and 71% were classified in the three lowest security levels. Kratcoski & Pownall, supra note 10, at 31.

105. Gewerth, supra note 1, at 27.

106. Persons aged 60 and over received probation recommendations 68% of the time as opposed to 16% of the time for younger offenders. The researcher attempted to control other variables so as to guard against the differences being due to factors other than age. Champion, supra note 85, at 156.

107. One example is the Broward Senior Intervention and Education Program established in 1979 for elderly shoplifters in Broward County, Florida. The program claimed that in its first 1400 cases, there had been only a 1.5% recidivism rate. Kidman, supra note 15, at 148-49. A similar program, The Advocate Program, was started in Dade County in 1978. Alvin Malley, The Advocate Program Sees the Elderly Through, 55 FLA. B.J. 207 (1981).

108. Gewerth, supra note 1, at 28.

If disparate treatment is called for in providing parole or probation to older offenders, it is important, for prison release purposes, as with the application of sentencing guidelines, to decide what age is to be considered "older." There is a higher crime rate for the "young" elderly population. Moreover, the recidivism rate for older prisoners is less than 5%, and it gets even lower as age increases. Many states and the federal prison system take this lower recidivism rate into account when making parole decisions. Florida, however, does not.

V. PROPOSED SOLUTIONS

Regardless of the ultimate scope of the elderly crime problem, it is troubling that legal commentators have generally failed to address the issue of an elder offender's criminal responsibility. Some investigators suggest that there are three types of elderly criminals: 1) those incarcerated for the first time; 2) those who have long criminal histories in which they have alternated between periods of freedom and periods of imprisonment; and 3) those who are growing old while serving a long sentence for a serious crime such as homicide. The question posed by these separate categories is whether all of these prisoners should be treated the same in determining the appropriate sentence for them. The first group often commits serious crimes, has adjustment problems, and is at the highest risk for victimization by other inmates. The second group adjusts to prison life, but often lacks the skills necessary to cope in the community and may have substance abuse problems. The third group adjusts well to institutional life, but is very difficult to place in the community.

Commentators suggest that special courts may be necessary to deal with older criminals. Such courts could be similar to the juvenile court system, which is also based upon the notion that age is a factor necessitating special expertise. These courts could displace both criminal and guardianship courts in determining an appropriate remedy for elderly persons.

110. Forsyth & Gramling, supra note 4, at 6.
111. Status Report, supra note 22, at 15.
112. Cohen, supra note 73, at 20.
113. One study found that 50% of elderly inmates were incarcerated for the first time after age 50. Kidman, supra note 15, at 134 (citing Gary Feinberg, White Haired Offenders: An Emergent Social Problem, in Elderly Criminals 83, 90 (William Wilbanks & Paul K.H. Kim eds., 1984)).
116. Forsyth & Gramling, supra note 4, at 6.
experiencing problems in complying with societal rules and norms. At least one legal commentator has criticized the concept of a court for older persons that would mirror juvenile courts because of the lamentable history of the juvenile justice system in helping and rehabilitating young persons. As noted previously, there is disagreement about the leniency given to elders in sentencing. Even if the courts are properly using their discretion in dealing with older offenders, there is the possibility of erratic application of this discretion without a clearly defined policy. In addition, a system open to public scrutiny, such as the American judicial system, will ultimately be called upon to justify its disparate treatment of offenders based upon their age, if that is what is actually happening.

For those who remain incarcerated, the system must decide if older prisoners should be segregated in special units or facilities, or distributed throughout the prison system. Experts disagree as to which is the best approach. Those who argue for separate housing assert that it may increase self-respect, diminish feelings of loneliness, stimulate social interaction, encourage identification with peers, and generate programs geared to that age group. Critics worry that such separation may prevent assignments to appropriate work programs, deny access to some of the more numerous programs for younger offenders, and violate preferences of older inmates who prefer to be with younger inmates. While prison officials also argue that older inmates tend to stabilize and counter the aggressive tendencies of younger inmates, it is questionable whether inmates in the upper age ranges are as effective as those "younger old" inmates. Proponents argue that age segregation is important for safety reasons since older prisoners may be more frail and vulnerable to physical assault. While some have advocated for separate facilities for older prisoners for health and security reasons, others have suggested that this would result in some being separated from their families, which would be counterproductive. Critics of age

118. Id. at 25-27.
119. Some of the evidence even indicated that elder felons might have received leniency at the conviction level, although the lack of controls prevented definitive conclusions. Wilbanks, supra note 2, at 286-87.
120. Cohen, supra note 73, at 34-35.
121. Elmer H. Johnson, Care for Elderly Inmates: Conflicting Concerns and Purposes in Prisons, in OLDER OFFENDERS, supra note 1, at 162-63.
122. Id.
123. While a separate unit could be housed in separate buildings in the same prison with other inmates, it is also possible that entirely separate prisons could be built for elderly
segregation believe that age is a less important factor in placement than custody level.\footnote{Lincoln J. Fry, The Concerns of Older Inmates in a Minimum Prison Setting, in OLDER OFFENDERS, supra note 1, at 165.} Disagreement also exists concerning the effects of prison upon older persons.\footnote{Some researchers found older convicts better off in prison because of better diet and medical care and less exposure to hard labor and alcohol. Still others have found deleterious sociological and psychological effects. This included an unhealthy dependence upon the prison system resulting in a fear of leaving institutional life. \textit{Id.} at 165-66; see also Sabath & Cowles, \textit{supra} note 25, at 180.} A 1990 study found 6% of inmates age fifty and older were housed in special units.\footnote{MORTON, \textit{supra} note 10, at 12.} A 1991 study found that thirteen states and the Federal Bureau have some type of special unit or housing for older inmates, although none used age as the sole criterion for assignment.\footnote{\textit{Id.}}

Whether segregated or not, the elderly prisoner population will require special medical and psychiatric care.\footnote{Richard Rosner et al., Geriatric Offenders Examined at a Forensic Psychiatry Clinic, 36 J. OF FORENSIC SCI. 1722, 1730 (Nov. 1991).} Persons age sixty-five and older are likely to spend twice as much time in medical facilities and have three times the health care costs of younger adults.\footnote{\textit{Id.} at 10, at 6. One heart bypass operation can cost in excess of $150,000. \textit{Id.}} The Federal Bureau of Prisons found older inmates have higher incidences of chronic illnesses. It is projected that by the year 2005, the inflation-adjusted cost to the Bureau for care of inmates with cardiac and hypertensive disorders alone will exceed $93 million per year.\footnote{\textit{Id.} at 13.} Moreover, the need for alcoholic treatment programs is clearly exemplified by the proportion of alcohol-related offenses perpetrated by older offenders.\footnote{Rosner et al., \textit{supra} note 128, at 1729.}

The health needs of older prisoners necessitate the provision of a number of special services.\footnote{It has been suggested that the ideal geriatric unit would need to provide for the following needs: 1) special diets and nutrition monitoring; 2) special exercise needs for prevention of bone deterioration; 3) personal hygiene issues, such as problems of incontinence; 4) decline in sight, hearing and memory impairment; 5) slowing of physical and mental processes; 6) treatment for mental health reasons; and 7) social services to assist in reintegration.\textit{Id.}} The Federal Bureau established a special...
unit for male inmates with chronic medical problems in Fort Worth, Texas. The Bureau estimates that it will need to set up several of these facilities throughout the country as the older prisoner population continues to grow.\textsuperscript{133} Most existing prisons are not structurally or programmatically appropriate for older inmates.\textsuperscript{134} In order to meet all of the needs of older inmates, it may be necessary to change existing facilities in order to minimize falls, modify schedules and diets, and implement preventive health programs.\textsuperscript{135}

Beyond the additional research needed to determine the best approach for dealing with older prisoners, it is also important that personnel in the criminal justice system receive additional education and training about older criminals.\textsuperscript{136} According to a 1991 study of thirty-nine states, only six states reported having specialized training for staff working with older inmates.\textsuperscript{137} Present prison programs, generally geared toward the needs of younger inmates, often have little relevance for the older prisoner.\textsuperscript{138} Few agencies have pre-release programs geared for older inmates.\textsuperscript{139} If older prisoners are to be released to the community, it will be necessary to increase the number of community programs and services so that successful reintroduction into society is possible.\textsuperscript{140} At the very least, programs which identify appropriate candidates for early release should be encouraged. This is one of the options being considered by the Florida task force; such programs have worked in other states.\textsuperscript{141}

\section*{VI. CONCLUSION}

The debate over whether there is a significant increase in the proportion of elderly persons committing crime remains unresolved. However, it is clear that the number of elderly prisoners is growing and this growth is
evident in the Florida prison system. The political popularity of increased prison terms will exacerbate this situation. Before implementing such plans, it is important to weigh the costs of such measures against the benefits. The costs, both financial and human, are significant. Even without the new policies, Florida faces increased costs for housing older prisoners. Identification of those persons whose early release would pose little risk to the community is a possible solution. Before implementing such a program, however, programs which would insure a smooth transition into the community would need to be developed. For those older prisoners who are ineligible for early release under such a program, the system will have to struggle with the development of policies and programs to meet their special health and safety needs. Absent proper consideration of all of the factors, the renewed zeal for longer prison terms may cost the state significantly without making society appreciably safer.
The Policy and Politics of Community-Based Long-Term Care

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I. INTRODUCTION

The health services industry in the United States is in transition. Financing is changing from primarily fee-for-service to capitated payments, and control of service delivery and quality assurance are moving from individual physician dominance to institutional control. The states and private sector are making sweeping changes in the finance and delivery of health care and are likely to proceed with increased determination with the failure of federal legislative reforms in the 103d Congress. Indeed, the provisions of the most comprehensive health care reform bill, President Clinton's Health Security Act, mirrored and anticipated the evolution of the health care market.

The impetus for change includes the demand for more effective cost containment than has been achieved by the implementation of prospective payments systems in government programs. Health care costs increased from over $600 billion in 1990 ($2566 per person) to nearly $900 billion in 1993 ($3380 per person), far more than in other developed countries with similar constellations and rates of disease. States are motivated to curb...
spending on medical assistance programs for the poor, and private sector entities are seeking mergers to consolidate providers into tightly managed delivery systems in order to maximize economies of scale. Equally important to legislative change is the desire for access to coverage, an array of services, and modes of delivery acceptable to an increasingly dissatisfied health care consumer population.

Individual opinion regarding the need for reform is mixed. However, it is undisputed that United States health care coverage is increasingly fragmented. A growing number of Americans fail to maintain adequate

spent 9.9%; Japan, 6.8%; and the United Kingdom, 6.6% of its GDP. See Paul Spector, Failure, by the Numbers, N.Y. TIMES, Sept. 24, 1994, at A12. Most countries use GDP as the official measure of the total value of economic activity, rather than gross national product ("GNP"). The difference between the two measures is that GNP takes into account all economic activity of citizens living outside the nation's borders, whereas GDP involves only economic activity conducted within the geographical boundaries of the country.

7. Total spending on Medicaid almost doubled to $92 billion in 1991, from $49.3 billion in 1987, with most of the growth concentrated in the last two years. CONGRESSIONAL RESEARCH SERV., MEDICAID: RECENT TRENDS IN BENEFICIARIES AND SPENDING (Mar. 27, 1992). Medicaid (called medical assistance ("MA") in some states and "Medi-Cal" in California) is authorized under Title XIX of the Social Security Act to provide medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. 42 U.S.C. § 1396 (Supp. V 1993). It is financed by a mix of state and federal funds (the federal portion ranging from 50% to 83%) according to a formula keyed to the average per capita income in the state. States submit plans developed under federal guidelines identifying how mandatory and selected optional services will be delivered to its citizens. Since all states must enact balanced budgets, unlike the federal government which can run a deficit, the pressure to control costs is intense.


10. See, e.g., Richard Morin, A Health Care Reform Post-Mortem, WASH. POST WKLY., Sept. 12-18, 1994, at 37 (noting that the number of Americans who believe the health care system needs to be "completely rebuilt" declined from 55% in April 1993 to 37% in August 1994, while the percentage who said only minor changes were needed nearly doubled).

11. In 1994, the United States remained the only developed country with health care programs only for elderly persons (Medicare) and some very poor persons (Medicaid) because health care programs developed from welfare initiatives. In Europe and the United Kingdom, health care programs developed from labor reform movements covering persons of all ages and income levels. See LAWRENCE A. FROLIK & ALISON P. BARNES, ELDERLAW 300-02 (1992).
insurance coverage, either because they cannot, or choose not to, afford its rising costs or because preexisting conditions cause insurers to deny coverage. Since about three-fourths of United States health insurance is employment-based, job changes produce the most policy lapses, and more people are uninsured in a weak economy. As a result of coverage gaps, approximately twenty-five percent of Americans will lack health care coverage at some time between 1993 and 1998. The sharpest increase in uninsured rates has been among middle class children over age seven. Health care reform is therefore inevitable and in progress; the rate of change, choice of services, administration, and ultimate effectiveness remain to be determined.

12. See generally EMPLOYEE BENEFIT RESEARCH INST., SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 1991 CURRENT POPULATION SURVEY (1992). An estimated 38 million Americans were uninsured in 1992, and an equal number were underinsured (i.e., having coverage inadequate to avert a financial disaster in the event of a serious or prolonged illness), an increase of four million people since 1987.


14. See Number of Uninsured Americans Reached 36.6 Million in 1991, NEWS RELEASE (Employee Benefits Research Inst., Washington, D.C.), Oct. 30, 1992, at 1 (news release on file with author). Most uninsured individuals live in households in which at least one person is employed, usually for low wages in such industries as food services, hospitality, and agriculture, in which health care coverage is not typically offered by employers. CONGRESSIONAL RESEARCH SERV., SPECIAL COMM. ON AGING, NO. 100-0, INSURING THE UNINSURED: OPTIONS AND ANALYSIS 2-3 (1988) [hereinafter INSURING THE UNINSURED].


Proposed changes fall generally into two categories: reform of health care financing mechanisms and reform of health services organization and delivery for cost containment. Typically, financing reforms either require employers to provide employee insurance, to contribute to a public trust fund, or to expand expenditures and eligibility for subsidized care. Reform of delivery systems either group together health care personnel to provide access to comprehensive health services for a set price, or establish insurance purchasing cooperatives to limit premiums through bargaining power.

Managed competition, the cornerstone of President Clinton's plan and a component adapted by most proposals, uses all four approaches to limit entrepreneurial profits. See CONGRESSIONAL RESEARCH SERV., HEALTH CARE REFORM: MANAGED COMPETITION CRS-1
One of the most problematic aspects of health care reform is the absence of well-developed and funded plans for providing long-term home and community-based care to aged and disabled persons. Changes in medical technology and life expectancy have caused a dramatic increase in the number of individuals with chronic illnesses which limit their ability to care for themselves. Though many persons with disabilities from chronic conditions or advanced age are unable to afford appropriate

(1993).

17. Community-based chronic care encompasses such medical and social services as home health, housekeeping, congregate and home delivered meals, and transportation. In addition, it includes housing, with or without services. Services for aged persons with disabilities have more often been termed “long-term care,” while services to younger adults have been called “chronic care.” The reasons for and results of this split in terminology, funding, and delivery are discussed in this article. See infra notes 31-70 and accompanying text. With a growing recognition among policy makers that such a division poses obstacles to enacting legislation for effective services programs, there is a trend to include all ages in proposals for home and community-based care initiatives. In accord with that view, this article will use the terms interchangeably, preferring “long-term care” as the term most often heard in the health reform debates. See generally A.E. Benjamin, An Historical Perspective on Home Care Policy, 71 Milbank Q. 129 (1993) (labeling home care a re-discovered type of assistance).

18. STEVEN A. SCHROEDER, ROBERT WOOD JOHNSON FOUND., ANNUAL REPORT 1993: CHRONIC HEALTH CONDITIONS 1, 1 (1993) (citing the number of American with disabilities as over 35 million). Figures vary widely according to the criteria of disability. See FAMILIES USA FOUND., THE HEAVY BURDEN OF HOME CARE 10 (1993) [hereinafter HOME CARE STUDY] (noting that 8.1 million persons living in the community have disabilities).

“Disability” refers to a limitation in function or activity resulting from a physical or mental impairment. Chronic condition refers to the presence of a specific diagnosed impairment that may or may not result in a functional or activity limitation. Since both people with disabilities and people with chronic conditions, as groups, have difficulty gaining access to an adequate range of health-related services, they are considered together in this article. A full consideration of programs and policies on mental impairments is beyond the scope of this article.

19. Major activities include both self-care activities of daily living (“ADL”) and instrumental activities of daily living (“IADL”) such as meal preparation, shopping, managing money, using the telephone, and doing housework. CYNTHIA M. TAEUBER, U.S. DEP’T OF COM., SIXTY-FIVE PLUS IN AMERICA 3-11 (1992); see infra note 43 and accompanying text.

20. Most chronic conditions are caused by a disease, such as diabetes, asthma, arthritis, epilepsy, arteriosclerosis, or muscular dystrophy. Some are caused by injury or a condition such as congenital heart disease. While chronic illness is not synonymous with advanced age, incidence increases with age and is more prevalent among older women. TAEUBER, supra note 19, at 3-11. For example, among those 80 years of age and older, 70% of women and 53% of men had two or more of the nine common conditions of arthritis, hypertension, cataracts, heart disease, varicose vein, diabetes, cancer, osteoporosis or hip fracture, and stroke. Id.
care, existing public benefits fail to meet their needs, and private insurance coverage for long-term care is relatively costly and rare. Restrictions on acute care benefits are increasing the demand for home and community-based care and contribute to the change in provider organizations from small nonprofit providers to minor components of large, for-profit corporations. In addition, the highest inflation rate in service costs has moved from acute care to long-term care.

Despite apparent need, proposed legislation falls short of bridging the gap between health care and long-term care. Most state reforms perpetuate an acute care bias by deferring long-term care proposals until the completion of feasibility studies or by making home and community-based services optional. President Clinton's proposal, based on a policy of identifying long-term care as an important component of health care reform, proposed to provide some long-term home and community-based care for severely disabled persons. However, the services would be limited to those

21. See discussion infra parts IIIB, IIC.

22. Sales of long-term care insurance policies totaled 2.9 million at the end of 1992, an increase of about 500,000 policies in one year. The number of policies has increased an average of nearly 30% annually since 1987. Sales of Long-Term Insurance Increase, 3 Health Law Rep. (BNA), at 291 (Mar. 3, 1994) (citing survey results from the Health Insurance Association of America, Washington, D.C.).


26. See CENTER FOR POL'Y RESEARCH, NATIONAL GOVERNORS' ASS'N, STATE HEALTH CARE REFORM INITIATIVES (1992). Plans in Colorado, Delaware, Maine, Maryland, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, and Virginia, for example, include no specified expansion of long-term care services. Florida will seek federal permission to expand home and community-based long-term care. Hawaii established a long-term care financing advisory board. Montana plans tax incentives for family care and long-term care insurance. Vermont established a Health Care Authorization Board to develop recommendations for long-term care services.

27. H.R. 3600, 103d Cong., 1st Sess. (1993); S. 1757, 103d Cong., 1st Sess. (1993) (establishing a program for home and community based services separate from Medicare and general health care plans). The only other federal proposal with a defined long-term care benefit is the McDermott/Wellstone Bill. S. 491, 103d Cong., 1st Sess. (1993); H.R. 1200, 103d Cong., 1st Sess. (1993). The bill includes home and community-based care (as well as nursing home care) in the benefits package. The bill has received consideration primarily as a "marker" establishing the broadest scope of nationalized health care benefits under a single payer system.
selected by each state for its citizens and would be subject to capped allocations.\textsuperscript{28} In addition, the proposal had no concrete plan to fund an array of services.\textsuperscript{29} In general, there is little agreement on how to respond to the complex questions of the organization and financing of chronic care.\textsuperscript{30}

This article examines the evolution of long-term care in response to the needs of the United States population and the practical and policy justifications for including home and community-based care in the current wave of health care reform. The article concludes with consideration of specific issues and recommendations in the financing and delivery of publicly funded home and community-based care.

II. THE NEED FOR LONG-TERM CARE COVERAGE

The meaning of “long-term care” varies from state to state and program to program. At its most comprehensive, long-term care includes a wide array of health and social services, institutional care, and adapted or dedicated housing to meet the needs of persons who have lost some capacity for self-care. Long-term care services are usually differentiated by the settings in which they are provided: either in nursing homes and other institutions or in home and community-based settings. Two adult populations, traditionally considered separately in policy and programs, utilize community-based long-term care: adults with impairments from injury or chronic illness, and aged persons with chronic impairments or the general frailty of extreme old age.

A. Defining Community-Based Long-Term Care

Community-based long-term care includes congregate living arrangements with supportive services and community-based assistance such as home health care, congregate and home delivered meals, transportation, and


\textsuperscript{29} See April Thompson, Healthcare Professionals Eye Gaps in Clinton LTC Reforms, AGING TODAY, May-June 1994, at 8.

shopping assistance.\textsuperscript{31} Other long-term care services, such as respite care\textsuperscript{32} and adult day care,\textsuperscript{33} help family caregivers cope with their continuous responsibilities.\textsuperscript{34} The great majority of persons needing long-term care reside in the community.\textsuperscript{35}

Formal long-term care is a relatively recent innovation, defined primarily by government programs intended to extend or substitute for caregiving families. The need for government assistance arises from a combination of demographic, technological, philosophical, and sociological changes in American society. Perhaps most important are longer life spans resulting in extended old age and unprecedented survival rates from disabling illnesses due to new medical technology.\textsuperscript{36} Simultaneously, families are less likely to be available as caregivers; they tend to live far away, and women, the traditional caregivers, have entered the work force and are no longer available to provide care.\textsuperscript{37} Nevertheless, most assistance is still provided informally by family members and others.\textsuperscript{38}

Appropriate housing is also critical to the well-being of disabled and elderly persons living in the community, although housing has traditionally been funded separately from services. Factors which distinguish a home from a prison for incapacitated residents may include: access to transportation and shopping, neighborhood safety, availability of informal help and oversight by concerned neighbors, relatives, and friends, access to formal services, such as home health care and home delivered meals, and user-
friendly design of entrances and in-home facilities. Some older people, who stayed in their homes while their neighborhoods deteriorated, are isolated from assistance. Appropriate housing must also be affordable housing, taking into account the fact that many elderly and disabled persons have limited resources to finance the extra services that enable them to live as independently as possible.

Because many persons with disabilities can manage most of their life activities with only occasional assistance and/or watchful oversight, and because it is natural for many to prefer the company and informal help of individuals with similar concerns, housing for persons with disabilities has often gravitated toward group living. Visiting services, such as homemaking, home health care, and home delivered meals, are also provided more efficiently where a number of recipients live in close proximity.

B. Persons with Chronic Disabilities and Health Care Coverage

According to a definitive 1984 survey, an estimated 37.3 million Americans, age fifteen and older, have at least one physical functional limitation due to a chronic condition. Over fifteen million people required assistance with activities of daily living ("ADL") such as bathing, dressing, grooming, eating, transferring and using the toilet, or instrumental activities of daily living ("IADL") such as meal preparation and light housework. In 1993, the number of persons receiving assistance has increased to an estimated thirty-five million.

The status of younger persons with disabilities is particularly significant to health care reform because of their higher than average health-related costs and lack of private health insurance. People with severe disabilities...
are estimated to use an average of six times the health care resources as those with no disabilities.\textsuperscript{45} Many lack adequate health care coverage. Those who are unemployed\textsuperscript{46} are excluded from the country's most common source of group insurance, and less than twenty-eight percent of persons under age sixty-five with disabilities were eligible for Medicare\textsuperscript{47} or Medicaid benefits.\textsuperscript{48} Just over fifteen percent have no insurance—about the same proportion as persons without disabilities.\textsuperscript{49} However, people with disabilities are far more likely to be underinsured and to spend a substantial proportion of their incomes on health-related care.\textsuperscript{50} The family incomes of persons with disabilities are much lower on average than those of persons without disabilities. In 1992, nearly one-half had incomes under $15,685, the lowest family income quintile for the population as a whole.\textsuperscript{51}

Individuals with disabilities are also subject to exclusion from coverage, due to the structure of the casualty insurance market, which utilizes experience rating to set premiums according to anticipated costs.\textsuperscript{52} A person with a disability is likely to be literally priced out of the market for coverage. Once without coverage, an individual may find that insurers are unwilling to issue a policy at any price or that coverage for specific services is denied because of the preexisting condition.\textsuperscript{53}

The second population of long-term care users, age sixty-five and older, raises significant concerns because it is expected to double by the middle of the next century.\textsuperscript{54} In 1990, thirty-one million Americans, or nearly

\textsuperscript{46} "Fewer than 40% of people with disabilities are employed; only about 25% work full time." Batavia, supra note 42, at 51 (citing LOUIS HARRIS & ASSOC., N.Y., INT'L CTR. FOR THE DISABLED, THE ICD SURVEY OF DISABLED AMERICANS: BRINGING DISABLED AMERICANS INTO THE MAINSTREAM (1987)).
\textsuperscript{48} TAEUBER, supra note 19, at 4-11.
\textsuperscript{49} ROBERT GRISs, WORLD INST. ON DISABILITY, Access to Health Care (1988).
\textsuperscript{50} Person with disabilities who received home care in 1992 had average expenses of $5415 and paid $1700 out-of-pocket. HOME CARE STUDY, supra note 18, at 3.
\textsuperscript{51} Id. at 10.
\textsuperscript{52} See INSURING THE UNINSURED, supra note 14, at 21.
\textsuperscript{53} According to one study, 16.6% of working age persons with disabilities had services denied because of preexisting condition exclusions. ROBERT GRISs & S. HANSON, WORLD INST. ON DISABILITY, THE ADEQUACY OF PRIVATE AND PUBLIC HEALTH INSURANCE AMONG PERSONS WITH DISABILITIES OR CHRONIC ILLNESS (1988).
\textsuperscript{54} TAEUBER, supra note 19, at 2-1.
thirteen percent, had reached the age of sixty-five.\textsuperscript{55} Over the next twenty years, the elderly population will increase steadily but unspectacularly, due to low birth rates during the Depression. After 2010, however, the number of people reaching their sixty-fifth birthday each year will soar and remain high until around 2030, when the last baby boomer reaches the threshold of old age.\textsuperscript{56} By then, people age sixty-five or older are expected to make up twenty percent of the population.

Dramatic demographic growth is already occurring in that portion of the population age eighty-five and older, due to increasing life expectan-
\textsuperscript{cies.\textsuperscript{57}} In 1990, there were approximately three million people age eighty-five and older.\textsuperscript{58} By the year 2010, it is estimated that this number will double to 6.1 million. By 2030, given current trends, there will be over eight million people age eighty-five and over.\textsuperscript{59}

Older people are more likely to suffer from chronic conditions which limit their ability to care for themselves.\textsuperscript{60} Multiple impairments and longer recovery periods from acute illnesses contribute to longer hospital stays. As a result, it is estimated that people age sixty-five and older (comprising 12.6% of the United States’s population) account for one-third of the nation’s annual health care expenditures, or about $300 billion out of a total $900 billion in 1993.\textsuperscript{61} It is not widely doubted that growth in the aging population contributes substantially to rising health expenditures,\textsuperscript{62} though one analysis indicates that other factors, including medical inflation and greater volume of services, have been more significant causes since 1970 and will account for most of the increase until 2005.\textsuperscript{63} After that time, the aging of the population is likely to cause rapid acceleration in health care spending unless effective cost containment is implemented.\textsuperscript{64}

\begin{itemize}
  \item \textsuperscript{55} Id. at 2-3.
  \item \textsuperscript{56} Id. at 2-4 to 2-5.
  \item \textsuperscript{57} Id. at 2-4.
  \item \textsuperscript{58} Id. at 2-3.
  \item \textsuperscript{59} Taeuber, \textit{supra} note 19, at 2-2.
  \item \textsuperscript{60} United States Senate Special Comm. on Aging, Am. Ass’n of Retired Persons, Fed. Council on the Aging, & U.S. Admin. on Aging, \textit{Aging America: Trends and Projections} 112 (1991) [hereinafter \textit{Aging America}].
  \item \textsuperscript{61} Burner et al., \textit{supra} note 5, at 1.
  \item \textsuperscript{62} But see Robert H. Binstock, \textit{Healthcare Costs Around the World: Is Aging a Fiscal ‘Black Hole’?}, \textit{Generations}, Winter 1993, at 37 (arguing that the impact is overstated).
  \item \textsuperscript{63} Daniel N. Mendelson & William B. Schwartz, \textit{The Effects of Aging and Population Growth on Health Care Costs}, \textit{Health Aff.}, Spring 1993, at 119, 120.
  \item \textsuperscript{64} See \textit{id.} at 120-23.
\end{itemize}
Over ninety-eight percent of persons age sixty-five and over are covered by Medicare,65 and thus add little to statistics on the number of uninsured Americans. A substantial proportion are underinsured, however, as the Medicare hospital insurance deductible rises,66 and co-payments for hospital and physician care increase with the cost of health care.67 Most purchase a Medicare supplement, or “Medigap” policy, which must cover these costs68 and may also cover additional items such as prescription drugs.

However, some older people cannot afford the Medigap premiums. The median income of elderly individuals in 1989 was a modest $9422—approximately half that of comparable younger adults.69 Income to people age eighty-five and older averages about seventy-five percent of income to younger retirees (under $7000 annually). Twice as many women as men have incomes below the poverty line and, among women age eighty-five and older, one in five is poor.70 The oldest and poorest living alone are often the most in need of care, and the least able to meet patient financial responsibilities.

C. Individual Payment for Long-Term Care

Individuals might finance long-term care costs privately by saving enough to pay for care.71 Government might encourage such savings by providing favorable tax treatment as it does for individual retirement accounts.72 Who among the elderly can afford chronic care is a matter of some controversy. The median assets in an elderly household totaled over

65. In 1987, for example, only 300,000 persons age 65 and older were uninsured. INSURING THE UNINSURED, supra note 14, at 2.
66. 42 U.S.C. § 1395r-s (1988). The Medicare Part A (hospital insurance) deductible was $694 in 1994, a figure adjusted annually by the Department of Health and Human Services to reflect the average cost of one hospital day nationwide. The Medicare Part B deductible remains at $100 and the cost of the first three pints of blood supplied.
67. In 1994, through days 61-90 of hospitalization, a Medicare beneficiary incurs co-payments of $174. An additional 60 “lifetime reserve days” are available, for co-payments of $348 a day.
69. See TAEUBER, supra note 19, at 4-6 to 4-8 (discussing income distribution among the elderly).
70. Id.
72. For more information on individual medical accounts (“IMA”), which are similar to the more familiar individual retirement accounts (“IRA”), see id. at 19, 109-22.
$70,000, higher than any age group except age fifty-five to sixty-four.\textsuperscript{73} About one-third of the elderly have assets valued at more than $100,000.\textsuperscript{74} The distribution of income and assets varies enormously, however. Only ten percent of persons age eighty-five and over have assets over $100,000.\textsuperscript{75} Among people over sixty-five, widows have a net worth only forty percent of the net worth of families with the head of the household in the same age group.\textsuperscript{76} Most assets consist of home equity, rather than cash.\textsuperscript{77} Seventy-five percent of elderly people own their own homes, and eighty percent of the homeowners have no mortgage.\textsuperscript{78} Home equity represents eighty-nine percent of net wealth for elderly homeowners.\textsuperscript{79}

The low average incomes and high health-related expenses of many adults with disabilities make it impossible to consider self-financing a complete solution for long-term financing. A substantial proportion of elderly people could afford such expense only by liquidating home equity. Though reverse income mortgages\textsuperscript{80} could be structured to protect a mortgagor who outlives the term of the mortgage, Americans are ambivalent about requiring individuals to expend their life savings, particularly by encumbering ownership of the home.\textsuperscript{81}

One might ask whether the underfunding of retirement is a temporary phenomenon, a result of unanticipated longer lives. The current generation

\textsuperscript{73.} Id. at 4-17.
\textsuperscript{74.} Id.
\textsuperscript{75.} Id.
\textsuperscript{76.} AGING AMERICA, supra note 60, at 39.
\textsuperscript{77.} An older homeowner can access equity by taking out a "reverse annuity mortgage," which commits the lender to paying monthly payments for a fixed term based on the value of a house. Generally, homeowners with mortgage balances less than 25% are allowed to borrow up to $100,000, or up to 80% of the unmortgaged value of their homes. To help prevent a forced move at the end of the pay out, many mortgages require the lender to wait to take possession of the home. However, the strategy does not assure the former homeowner will have sufficient income to maintain the house once the payments stop. The concept has had limited success in attracting mortgagors. See generally NATIONAL CTR. FOR HOME EQUITY CONVERSION, AMERICAN ASS’N OF RETIRED PERSONS, HOME EQUITY CONVERSION IN THE UNITED STATES: PROGRAMS AND DATA 1 (1991).
\textsuperscript{78.} U.S. SENATE SPECIAL COMM. ON AGING, S. REP. NO. 261, DEVELOPMENTS IN AGING: 1991, at 294 (1992) [hereinafter DEVELOPMENTS IN AGING].
\textsuperscript{79.} FRIEDLAND, supra note 35, at 179.
\textsuperscript{80.} Reverse mortgages provide a series of monthly loan advances to homeowners with repayment of all interest and principal deferred until an agreed-upon future time. See ELDERLAW, supra note 11, at 606-13.
\textsuperscript{81.} For more information on spending down assets for long-term care benefits, see infra notes 183-90 and accompanying text.
of elderly people is the first to experience in large numbers the effects of extended old age and retirement. It is therefore reasonable to think that many would have saved more in anticipation of their current situation and that future generations of elderly people should be in a better position to anticipate the true costs of their retirement years and save accordingly. Instead, opportunities to save for retirement are quite limited for many workers, particularly those in the growing minimum wage culture. The immediate costs of housing, health care, and education for children is beyond the means of many; the cost of elder care is significant for some “sandwich generation” adult workers who find themselves providing elder care and child care simultaneously.

Only a minority of the next generation of retirees will be able to live comfortably on their savings and pensions. Some will need assistance in the form of subsidized housing and services, and a small proportion will require assistance to obtain extended long-term care. As with health care, individual savings are not enough.

III. A RIGHT TO LONG-TERM CARE?

Given the need for community-based care, it is remarkable that such assistance is not readily available for a modest cost, like public utilities. To determine why, a good starting point is an examination of the societal values that have impeded development of long-term care programs, or of reasons society is reluctant to invest in the task of care for impaired members. Further, it is reasonable to consider whether the obligations of society to less

82. See Guy Gugliotta, The Minimum Wage Culture: As America Gets Lean to Compete, Our Working Underclass Is Growing, WASH. POST WKLY., Oct. 3-9, 1994, at 6. The culture includes workers who, at minimum wage, earn $8,500 annually, and a growing contingent of part-time, temporary, and pieceworkers. In 1992, the Labor Department counted 2.5 million temporary employees nationwide, three times the number counted in 1978. Id. Virtually all temporary employees lack health care benefits.

83. See EXPLODING THE MYTHS, supra note 37, at 26-27 (stating that 166,000 women provided elder care and child care simultaneously in 1987); see also Joan M. Mitric, Baby Boomers Not Yet Ready for Prime Time, AGING TODAY, May-June 1994, at 1 (reporting on a symposium on retiring baby boomers). Symposium speaker Richard A. Easterlin, economist at the University of Southern California, predicts baby boomers will have more funds for retirement than their parents because more of them went to college and more women will have pensions. An opposing opinion was presented by Ken Dychtwald, president of AgeWave Marketing Research Corp., who predicts baby boomers are not planning to cover retirement costs. Id. at 2.
capable persons, or an interest in social order through individual well-being, warrant the implementation of long-term care programs.84

A. The Values of Long-Term Care

Reluctance to provide long-term care may be found in the undervaluing of members of society with less than full physical or mental abilities. The treatment of older people is based to some degree on ageism, a negative perception of individuals due solely to their chronological age.85 A more recent outgrowth of ageism is hostility directed specifically toward the ill and disabled elderly.86 Particularly in America, society has responded to physical impairment and emotional need among the elderly with a denial of full personhood and respect,87 a view that has been termed "gerontophobia."88 As a result, elderly people are more likely to receive inferior quality professional services, particularly in health care.89

84. See Jeffrey Merrill, A Test of Our Society: How and for Whom We Finance Long-Term Care, INQUIRY, Summer 1992, at 176-77.

85. A recent study of the relationship between age and “do not resuscitate” (“DNR”) orders, corrected for differences in severity of illness is instructive. The study found that in general hospital populations physicians issued the same proportion of DNR orders for persons age 65 to 75 as for younger persons, about one and a half times as many DNR orders for patients age 75 to 85, and about two and a half times as many for patients age 85 and over. The finding is particularly disturbing since the instrument used to predict whether the patient would survive, the Mortality Probability Model, already includes an adjustment for age. DNR was defined broadly as less than full care, including withholding cardiopulmonary resuscitation in the event of cardiac arrest. Daniel Teres, Address at the First Concurrent Meeting of the American Association of Bioethics, Society for Health and Human Values, Society for Bioethics Consultation, and American Society of Law, Medicine, and Ethics (Oct. 7, 1994).


89. DIANA CRANE, THE SANCTITY OF SOCIAL LIFE: PHYSICIANS’ TREATMENT OF CRITICALLY ILL PATIENTS 52 (1975) (equating advanced age with a decline in social value); DAVID SUDNOW, PASSING ON: THE SOCIAL ORGANIZATION OF DYING 104-05 (1967). The Harvard Malpractice Study found that the risk of adverse events increased nearly tenfold with increasing age. See REPORT OF THE HARVARD MEDICAL PRACTICE STUDY TO THE STATE OF NEW YORK, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 6-23 to 6-25 (1990).
A similar distortion of reality applies to lives of persons with disabilities, who are often treated with "thoughtlessness and indifference" and "benign neglect." Sometimes considered less than human or as examples of cruel or indifferent fate, persons with disabilities have been removed and hidden from the mainstream of society. The courts have found that competent, aware individuals are justified in their wishes to die rather than live with their disabilities.

Society's negative perception has informed the advocacy of persons with disabilities for integration into mainstream society and equal opportunity. The disability rights movement began in the 1960s, paralleling the civil rights and women's movements, and includes among its principles the importance of individual empowerment and consumer involvement. Advocacy groups lobby for legislation to support the rights of persons with disabilities to join the mainstream of society in employment and housing. The groups emphasize self-reliance and other traditional American ideals to the exclusion of a genuine discussion of the special health, social services,

94. See, e.g., Bouvia v. Superior Ct., 225 Cal. Rptr. 297, 300 (Ct. App. 1986) (holding that a 28 year old college-educated woman with cerebral palsy was justified in her request to starve herself to death); McKay v. Bergstedt, 801 P.2d 617, 628-32 (Nev. 1990) (approving a quadriplegic man's petition to remove a ventilator). In McKay, the court reasoned that the petitioner was competent to determine whether he was "willing to have a devastated life continued artificially," ignoring the significance of his father's recent diagnosis of terminal illness. Id. at 621; see also Rebecca Dresser & John Robertson, Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach, 17 J.L. MED. & HEALTH CARE 234, 236 (1989).
95. The disability movement emphasized the importance of support in attaining a decent quality of life after recuperation. Sara D. Watson, Reality Ignored: Health Reform and People with Disabilities, J. AM. HEALTH POL'Y, Mar.-Apr. 1993, at 49, 50 (noting that people with disabilities provide the starkest example of the health system's misguided emphasis on acute care to the exclusion of all other types of care).
and housing needs of their constituency. The effects of bias are likely to be exacerbated by cost containment.

Social forces in favor of long-term care might also lack power to implement change because of the predisposition of the American national character toward decisive individual action and swift resolution. The incompatibility of such a view with long-term care is distinctly apparent when the methods and results of services delivery are contrasted with those of the current health care culture of scientific, high technology medicine. Physicians are trained in dedication to decisive intervention and cure, resulting in an inclination toward aggressive and invasive treatment and to heroic measures in attempts to defeat the effects of ill health or injury. The culture of long-term care delivery, by contrast, suggests ambivalence regarding the usefulness of many repetitive acts of assistance, any of which are of debatable significance to the ultimate well-being of the person receiving care. Persons with chronic disabilities by definition are not cured, though symptoms might be alleviated. Generally, the goal of care is to maintain capabilities and mental health. Sometimes, the goal is to alleviate suffering and fear from inevitable decline. There is little opportunity for technological heroism. Even the site of care has an ambivalent quality, a quality of compromise to accommodate conflicting interests and values, in contrast with the institutional settings of acute care in which professional opinion and goal orientation dominate. Home and community-based care is provided in all-purpose, sometimes inconvenient environments, in which the needs and wishes of the person with chronic impairment coexist with the needs and wishes of caregivers. As a result, the care itself must represent a compromise between caregiver and care receiver regarding the choice and timing of assistance.

97. See infra notes 114-36 and accompanying text.
98. Many have observed that the American view is predicated on individualism, rather than the good of society. See e.g., David Brown, Darwin's Theory of Health Care: Coverage for All Means Less Care for Many, WASH. POST WKLY., Sept. 19-25, 1994, at 24. “In American medicine, the ascendancy of the individual exists in nearly pure form. American physicians are taught (and believe) that the ‘good of the patient’ is the one consideration that trumps all others.” Id.
99. The doctrine of informed consent is law’s effort to balance the power of the physician to control the course of treatment by providing the patient with the ultimate trump card of refusal. See ELDERLAW, supra note 11, at 933-50.
100. Bart Collopy et al., The Ethics of Home Care: Autonomy and Accommodation, HASTINGS CENTER REP., Mar.-Apr. 1990, at 1, 2.
Viewed in the context of health care in the late twentieth century, the narrow focus of acute care on physical improvement has failed to provide a sense of well-being for many. That viewpoint has never been monolithic and currently is yielding to more humane values, which would make health care more personalized and would better accommodate the unique needs of individual patients. Such values are more suitable than traditional American values to the provision of effective long-term care, and their growing authority is compatible with the enactment of national publicly-funded long-term care.

Although prejudice against persons who are aged or have chronic disabilities may be pervasive, it is difficult to argue convincingly for such a basis for public policy. Even those who advocate age-based discrimination for health care cost containment are referring to acute care, not comfort care. Rather, it appears the idea is widespread that basic home care represents values the society would like to cultivate, values neglected by the health care system to the dissatisfaction of its patients.

Despite the volume of long-term care legislation and programs, there is no constitutional right to assistance for persons who are aged or disabled and living in the community. Government programs provide only a small fraction of assistance, and the right to equal protection generally does not extend to appropriations from public funds without statutory authorization. Nevertheless, programs create standards which do attach once services are available. These standards generally tend to assure the fair determination of eligibility, the opportunity to object to a denial of services, and the right to appeal a denial to an impartial decision maker. The existence of service programs tends to drift in the direction of a right to

101. See, e.g., Bruce Jennings et al., Ethical Challenges of Chronic Illness, HASTINGS CENTER REP., Supp. Feb.-Mar. 1988, at 6-8. The authors note that the distinction between “person” and “patient” goes to the heart of a new bioethics, challenging the concept of patient, the nature of the relationship between physician and patient, and the basis of medical decisionmaking. Id.

102. See Daniel Callahan, What is a Reasonable Demand on Health Care Resources? Designing a Basic Package of Benefits, 8 J. CONTEMP. HEALTH L. & POL’Y 1, 9 (1992) (advocating care over cure and public good over personal health as rationale for defining a health care benefits package).

103. More than 80 federal programs support long-term care, if retirement and disability income benefits are included with social services and housing programs. CONGRESSIONAL RESEARCH SERV., FINANCING AND DELIVERY OF LONG-TERM CARE SERVICES FOR THE ELDERLY CRS-6 (May 25, 1988).

104. See EXPLODING THE MYTHS, supra note 37, at 4 (indicating that “the bulk of long-term care is provided by informal caregivers”).
receive care. A statute providing a benefit may imply action in good faith on the part of government to assure that eligible persons can receive it. As a result, an individual may have an enforceable legal claim, based on the right to a minimum quality of life which is unavailable without state assistance.

B. The Least Restrictive Alternative

In Dixon v. Weinberger, the United States District Court for the District of Columbia found that the plaintiffs, who were involuntarily committed mental hospital patients, had a right to community-based care. The court observed that the fundamental goal of the governing statute was to return patients, through care and treatment, to a full and productive life in the community as soon as possible. It found that the 1964 District of Columbia Hospitalization of the Mentally Ill Act must be broadly construed so that authorized social and medical services would meet the goals, and that care must allow some patients to elect community-based services. The funding formula for the Act placed responsibility for developing community-based services with the District of Columbia and federal governments. It created a plaintiff's right to have public funds spent for their community-based care to enable the patient to leave the institution.

Commentators have recognized the similarity between the situations of civilly committed patients and persons institutionalized in nursing homes. Over the past twenty years, society has recognized the tension

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105. Regarding rights to housing derived from benefits, see Frank I. Michelman, The Advent of a Right to Housing: A Current Appraisal, 5 HARV. C.R.-C.L. L. REV. 207, 209 (1970) (noting that a "movement in the general direction of a . . . right to be housed" was justified by the policy that every American family should have a decent home).
106. 405 F. Supp. 974, 979 (D.D.C. 1975); see also Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Burnham v. Department of Pub. Health, 349 F. Supp. 1335, 1339 (N.D. Ga. 1972). In Covington, the court held that the mental hospital administration had not made a reasonable decision in confining to maximum security a man with an I.Q. of 38, a diagnosis of psychotic reaction, and a 25 year old murder conviction. The court reasoned that there was no evidence that he was dangerous and that he had a right to the least restrictive form of treatment likely to effect improvement. Id. at 623-24, 628.
108. Id. at 977-78.
109. Id. at 978-79.
110. See, e.g., Lawrence A. Frolik, Plenary Guardianship: An Analysis, a Critique and a Proposal for Reform, 23 ARIZ. L. REV. 599, 603 (1981) (concluding that guardianship
between fundamental liberties and benevolent assistance such as nursing home placement, and has opted for guardianship, which typically results in institutionalization, with similar due process standards to those required for civil commitment. Further, it is reasonable to find, even in the absence of specific least restrictive alternative language, that the purpose of providing community-based care is to enable an individual to maximize self-care. The concept is an easy fit with changes in health care delivery to outpatient procedures and early hospital discharges, and is supported by legislative cost containment. Less intensive services imply less expense.

Dixon is not widely followed since courts have seldom been willing to find that the intention to provide assistance supports an order for creation of an entire system of service delivery. However, statutes conferring benefits may find in the courts special sensitivity to their broader purposes, and to the vulnerability of the intended beneficiaries.

C. Disability and Discrimination

Statutes may also provide important statements of public policy regarding persons with disabilities which support the appropriateness of public long-term care benefits. The Americans with Disabilities Act of 1990 reform should include procedural reforms); Annina M. Mitchell, *The Objects of Our Wisdom and Our Coercion: Involuntary Guardianship for Incompetents*, 52 S. CAL. L. REV. 1405, 1421-22 (1978-1979) (discussing the lack of constitutional due process in competency hearings); see also Cathrael Kazin, Comment, "Nowhere to Go and Chose to Stay": Using the Tort of False Imprisonment to Redress Involuntary Confinement of the Elderly in Nursing Homes and Hospitals, 137 U. PA. L. REV. 903, 905 (1989) (arguing that elderly nursing home patients can use the tort of false imprisonment to protect their legal rights).


112. See Michelman, supra note 105, at 212. Statutes authorizing benefits "are understood, rather, as the public talking to itself and its agents—ordering, guiding, legitimating, and to some extent predicting the conduct of public affairs. But when the duly appropriated . . . money runs out, lawsuits do not pry loose more money—despite unappropriated authorizations or unfilled need." Id.

113. See ELDERLAW, supra note 11, at 540-53. The authors discuss the series of cases arising from a class action in Colorado. See, e.g., *In re Estate of Smith*, 557 F. Supp. 289, 299 (D. Colo. 1983) (noting that "[t]here is a manifest need for improvement in the conditions of nursing homes and the care which is provided to welfare patients"), rev’d sub nom. 747 F.2d 583 (10th Cir. 1984). On appeal, the Tenth Circuit Court of Appeals found that the Secretary of Health and Human Services ("HHS") had more than a passive role in handing out money to the states for nursing home care and required the agency to redesign its quality assurance system to focus on resident assessment. *Smith*, 747 F.2d at 583.
("ADA"), for example, prohibits discrimination against qualified persons with disabilities in public services, regardless of the receipt of federal financial assistance to service providers. Specifically, Title II of the ADA provides that no qualified individual with a disability shall be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. The ADA, like its predecessor, the Rehabilitation Act of 1973, has been applied to health programs to determine whether their structure and benefits are discriminatory.

The Clinton administration initially considered the Oregon Basic Health Services Plan to be in violation of the ADA. The Oregon Plan is the most comprehensive design for cost containment and public allocation of health resources enacted by the states. It proposed, in pertinent part, to amend the state’s Medicaid program, upon approval by federal authorities, by expanding the number of eligible beneficiaries and placing certain limitations on their benefits based on a formula used to rank the value of various treatments to be funded by the state. The Oregon ranking consists of seventeen categories of care, ranked as "essential," "very important," and "valuable to certain individuals."


115. The Act also prohibits discrimination against the disabled in employment, public accommodations, and telecommunications. 42 U.S.C. §§ 12112, 12182 (Supp. V 1993). A person with a disability is one who has a physical or mental impairment that substantially limits one or more of that individual’s major life activities, has a record of such an impairment, or is regarded as having such an impairment. Id. § 12102(2)(A)-(C). On regulations interpreting the ADA, see generally Bonnie P. Tucker, The Americans with Disabilities Act of 1990: An Overview, 22 N.M. L. REV. 13 (1992).


118. The essential category includes such condition-treatment categories as “acute fatal,” or conditions that require treatment to prevent death, ranked according to whether they result in full recovery; maternity care; and preventive care for children. OFFICE OF TECHNOLOGY ASSESSMENT, EVALUATION OF THE OREGON MEDICAID PROPOSAL 6 (1992) [hereinafter MEDICAID PROPOSAL].

119. The important classification includes treatments for conditions which are "acute nonfatal," prioritized according to whether the patient is returned to the previous state of health. Id.

120. This category of care includes treatments that expedite recovery from self-limiting conditions and infertility treatment. Id.
Through a process of public hearings and professional consultation, the Oregon Health Care Commission ranked medical care into 709 condition-treatment ("CT") pairs, prioritized under the three categories according to their net benefit. The legislature determined, and will redetermine annually, how much to allocate to health care, the extent to which services are likely to be funded for all eligible persons, and the cut-off line below which no CT will be funded by the state. As a result, the state can fund health services for all of its citizens up to the federal poverty line, covering all major diseases women and children experience and some services which are not mandated for Medicaid programs under federal guidelines.\(^{121}\)

Critics of the plan pointed out that services "valuable to certain individuals" refer to a greater proportion of disabled than able persons.\(^{122}\) Waiver of the federal requirement that Medicaid provide all "medically necessary" services, including some of those in this category, is discriminatory because services which fall below the cut-off may be critically important to persons with disabilities. For example, the list assigned a value of 690 to liver transplants for alcoholic cirrhosis (above the cut-off of 587), but assigns a value of 366 to transplants for non-alcoholic cirrhosis.\(^{123}\) Since there is no difference in the likelihood of a successful transplant in itself (without complicating multiple impairments or assumptions about patient behavior), the decision regarding coverage is made on the basis of the existence of a disabling condition, alcoholism.\(^{124}\)

The rankings would present less risk of bias against persons with disabilities if evidence of societal values, gathered in a public survey, were eliminated. The suspect component of CT ranking is "quality-of-life" with which all chronic services are weighted.\(^{125}\) To the extent treatments are

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123. *Id.* at 591.

124. This position is one adopted by DHHS Secretary Dr. Louis Sullivan. See *id.* at 584 n.17, 592 n.53 (citing Letter from Dr. Louis Sullivan to Barbara Roberts, Oregon Governor (Aug. 3, 1992)).

125. Essential care also includes "chronic fatal" treatment which improves life span and quality of life; very important services include "chronic nonfatal" treatment such as hip replacement; services valuable to certain individuals includes a category "fatal or nonfatal" in which treatment causes minimal or no improvement in quality of life. **MEDICAID**
for chronic disabilities which do not yield a return to total health and function, they are more likely to fall outside funding limits.

The federal agency granted Oregon a Medicaid waiver upon receiving a revised state plan deleting all effects of data generated by references to "quality-of-life" judgments. Federal monitors also imposed conditions on the plan to protect against discrimination, requiring that Oregon re-rank the CT pairs without relying on data concerning the patient's return to an asymptomatic state. Further, before denying treatment, the state must ensure that an individual does not have a covered condition that would entitle that individual to treatment.

The Oregon Plan controversy suggests that societal reaction to disability is so strong that even well-intended initiatives may be deeply flawed, and the ADA is a strong statement of society's intention to prevent discrimination which might provide a remedy. However, the ADA does not prohibit disparate treatment based on real differences in health care use and costs among individuals, or even based on actuarially sound categories of individuals. The state is not obligated to provide as much care as is required to make a person with disabilities as healthy as possible.

The difference is illustrated by Alexander v. Choate, in which the Supreme Court found that section 504 of the Rehabilitation Act of 1973 did not support a claim for disparate impact on persons with disabilities when the State of Tennessee reduced authorization for inpatient hospital days for Medicaid beneficiaries from twenty to fourteen per year. The evidence showed that 27.4% of all disabled Medicaid beneficiaries required more than fourteen days of inpatient care, as opposed to only 7.8% of non-

PROPOSAL, supra note 118, at 6. The more control the government has over health services, and the tighter the squeeze on acute care, the more likely courts will be sympathetic to individuals seeking assistance.


126. The original 709-item list of conditions was consolidated into a list of 688 items, and the cut-off line moved from 587 to 568.

127. Garvey, supra note 122, at 581. Advocacy groups continue to assert that the Oregon Plan violates the ADA. See infra notes 117-24 and accompanying text.

128. See Alexander, 469 U.S. at 287.

129. Id.

130. Title II of the ADA is to be interpreted consistently with Alexander. See 28 C.F.R. § 35 app. A at 440 (1992).

131. Alexander, 469 U.S. at 289.
disabled beneficiaries.\textsuperscript{132} Reversing the Sixth Circuit decision that plaintiff/respondents had made a prima facie case by showing disparate impact and ordering the state to explain its choice, the Supreme Court rejected the argument that section 504 prohibits all actions disparately affecting persons with disabilities.\textsuperscript{133} Rather, the state needed only to make “reasonable” modifications in programs in order to accommodate persons with disabilities; it did not need to make “substantial” or “fundamental” changes in the program.\textsuperscript{134}

Thus, the Court left the door open for claims to reasonable changes in public programs to accommodate the needs of persons with disabilities due to age or chronic conditions and left significant questions about what is an “undue burden.”\textsuperscript{135} Clearly, an order to make community-based care available is likely to create a significant burden on a state. However, it is also unclear to what extent that burden should be weighed against the benefit, which, as in Dixon, might be the difference between an acceptable lifestyle and unwanted, unnecessary institutionalization.\textsuperscript{136} The variety of statutes passed by the states concerning health care reforms, including not just home and community-based care but also policies on access and the purposes of acute care programs, might imply that individuals have a right to access which the state must support.

D. \textit{Patient Dumping}

Another federal health care law which might provide insight into long-term care policy is the Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA"),\textsuperscript{137} which was enacted to prohibit hospitals and physicians from refusing care to indigent patients in emergencies or transferring them to other facilities for other than medical reasons, i.e.,

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\textsuperscript{132} Id. at 290, 291 n.3.
\textsuperscript{133} Id. at 298.
\textsuperscript{134} Id. at 300.
\textsuperscript{136} Institutionalization for frail, elderly persons is frequently followed by rapid physical decline and death. See Jerry Avorn & Ellen Langer, \textit{Induced Disability in Nursing Home Patients: A Controlled Trial}, 30 J. AM. GERIATRICS SOC'Y 397, 399-400 (1982) (lack of control may be expected to have negative effects on happiness, alertness, socialization, health, and mortality rates).
\end{flushleft}
"patient dumping." The legislation was targeted at the growing practice of sending potentially high-cost patients away from hospital emergency rooms because they are uninsured or will generate low reimbursements through state Medicaid programs. The statute requires hospital emergency rooms and their physicians to provide medical examination and treatment required to stabilize the medical condition or to transfer the individual to another facility only after assuring that the facility has available space and qualified personnel, and has agreed to accept transfer.138

Absence of community-based care is a form of patient dumping which has already been created by the prospective payment system for Medicare hospital care. With the inception of prospective payment, the number of Medicare hospital stays dropped ten percent and the length of stay declined from 9.5 days to 7.5 days.139 Investigations by Congress showed that hospital discharge planners had difficulty securing needed home care services.

With the enactment of health care reform managed care, it is possible that still more patients will be “dumped” from the acute care system, unable to qualify for nursing home care under Medicare’s restrictive skilled care standards, and unable to secure or afford home care. The lack of a coherent system of community-based care creates a population of individuals who have inadequate support for a reasonable quality of life at home. The omission undermines the reasons to provide public health benefits programs, making it likely the individual will deteriorate and need re-institutionalization. It deprives the patient of the opportunity to live at home, in the least restrictive environment. It also perpetuates a pattern of substituting higher-cost institutional services for lower-cost home care, thereby sabotaging attempts at cost containment.140 The government’s control of the acute care system through the managed care structure suggests a responsibility to prevent such dumping.

It is also likely that patients with multiple impairments and poor prognoses, specifically the aged and disabled, will be denied acute care intervention. This might come about either by overt age-based/disability-based rationing, by which the public financing system excludes specific services for persons over a given age on the assumption the benefits are too

138. Id. § 1395dd(b)-(c).
139. ELDERLAW, supra note 11, at 441-43.
140. Research into the cost-efficiency of home care versus institutional care yields very mixed results. See William G. Weissert & Susan C. Hedrick, Lessons Learned from Research on Effects of Community-Based Long-Term Care, 42 J. AM. GERIATRICS SOC’Y 348 (1994).
limited, 141 or cost-based rationing, by which the state declines to cover certain high-tech, high-cost procedures. The original Oregon Plan, 142 for example, represented both of these types of rationing. 143 Critics say it still does, though federal authorities are satisfied the state is making only cost-based choices.

While none of these statutes provides for any specific long-term care services, any one of them might in the right circumstances be the basis for a claim for long-term care from states which restrict acute care to aged or disabled persons. The more severe the restrictions placed by the state on acute care, and the greater control exercised by the state over health care expenditures, the more likely it is that individuals will claim assistance in securing long-term care. For those who can pay, the claim might be one of access to qualified providers. 144 For those who cannot pay the full cost directly, the state might be responsible for establishing a funding mechanism.

141. Elderly people are denied treatment through professional and family decisions to enter do-not resuscitate orders. See Joan M. Teno et al., Simulation of Potential Impact of Futility Guidelines in Seriously Ill Adults, Address at the First Concurrent Meeting of the American Association of Bioethics, Society for Health and Human Values, Society for Bioethics Consultation, and American Society of Law, Medicine, and Ethics (Oct. 7, 1994). The address studied decisions about life sustaining treatment and total hospital charges for 4301 seriously ill patients in two hospitals, applying a prognostic model to determine who was expected to survive for two months, and calculating savings if life sustaining treatment was stopped on the third day. Id. Patients used a median of seven days of hospital admission at a median cost of $40,909. Researchers concluded that only some patients with poor prognoses could be identified, such persons die quickly (more than two thirds within three days), and that life sustaining treatment is already being withheld for most of the patients. As a result, savings would be modest and would be distributed somewhat inequitably. Id; see also Daniel R. Longo et al., “Do not Resuscitate:” Policy and Practice in the Long-Term Care Setting, J. LONG-TERM CARE ADMIN., Spring 1988, at 5.

142. See supra notes 118-28 and accompanying text.

143. Another rationing technique, situated at the professional rather than the legislative level of discretion, is a decision of medical futility. Services which are futile would certainly not provide the patient any benefit for the condition being treated, such as a lobotomy for a complaint of influenza, or more controversially, bone marrow therapy for advanced breast cancer. Physicians' decisions regarding futility are not purely scientific because many cannot keep pace with the speed of technological advances and simple biases such as ageism. See Crane supra note 89, at 52; see also Stuart Younger, Who Defines Futility?, 260 JAMA 2094, 2094 (1988).

144. See infra notes 201-04 and accompanying text.
IV. LONG-TERM CARE IN HEALTH CARE REFORM

It is also essential to determine what mix of private and public funds should be used to finance care, the nature of need which will trigger eligibility, and which long-term care services best respond to the needs of the population.145

A. Public Benefits

Determining how to choose, fund, and deliver any new program of long-term care benefits requires an understanding of existing public programs. It is estimated that over eighty federal social services and housing programs fund some aspect of long-term care,146 each with its own rules for eligibility and definition of services.147 Because funds devoted to social services programs shrank throughout the 1980s148 and health care reform proposals are calling into question the very definition of health services, it is not unexpected to find that most long-term care benefits are provided as aspects of health.

1. Health Programs

The principal health care program for the elderly, Medicare, pays chronic care benefits only incidentally, when a patient recovering from an acute episode cannot be discharged from a hospital. Medicare’s nursing home benefits are limited to skilled care provided after a hospital discharge,149 and its home care benefits, while theoretically quite generous, are limited to home health aide care delivered in conjunction with skilled care on an intermittent basis to persons who are homebound.150 The Medicaid program’s benefits are more comprehensive, because it is intended to be a program of last resort. In addition to mandatory categories of health

145. Merrill, supra note 84, at 186 (noting in contrast that existing long-term care programs were designed from the perspective of how to pay providers).
146. Other public programs fund long-term care indirectly, through income assistance such as Social Security retirement and disability benefits. Health and social services are also funded by federal block grants for low income elderly and by state community care programs.
147. See LONG-TERM CARE FOR THE ELDERLY, supra note 31, at 41.
148. DEVELOPMENTS IN AGING, supra note 78, at 334.
150. See id. §§ 409.40-46.
care benefits and nursing home care\textsuperscript{151} and home health care for persons eligible for such nursing services, states may elect to provide any of thirty-two optional services, such as dispensing eyeglasses, prescription drugs, dental services, and personal care.\textsuperscript{152} All Medicaid services are required by federal law to be equally available to all eligible persons on a statewide basis,\textsuperscript{153} and must be of an amount, duration, and scope adequate to achieve the objectives of the program.\textsuperscript{154}

Home and community-based care outside the traditional acute care model have been the subject of growing interest in the states. Since 1981, federal law has allowed states to use Medicaid funds for a wide variety of home and community-based services upon approval of state applications for a waiver of state-wide proportion and equal access requirements.\textsuperscript{155} Under most waivers, individuals are eligible only if, but for the services, they would need nursing home care, and the cost does not exceed nursing home costs.\textsuperscript{156} Waiver programs vary greatly in size and services. Most serve a single population with disabilities, such as mentally retarded persons, the aged, or physically or mentally disabled adults.\textsuperscript{157}

\begin{itemize}
\item \textsuperscript{151} The traditional division into nursing home levels of care (skilled, intermediate, and custodial) has been eliminated from federal regulation. Instead, states are authorized to use case-mix reimbursement plans approved by federal authorities, which specify the amount of payment a facility will receive according to the nature of care an individual resident requires. See \textit{Elderlaw}, \textit{supra} note 11, at 519-23.
\item \textsuperscript{152} 42 U.S.C. § 1396d(a) (1988) (mandatory and optional services).
\item \textsuperscript{153} \textit{Id.} § 1396a(a)(1).
\item \textsuperscript{154} See, e.g., Clark v. Kizer, 758 F. Supp. 572 (E.D. Cal. 1990) (finding that low dentist reimbursement rates which severely restricted the number of providers in the state were not a violation of federal requirements that services meet the objectives of the program).
\item \textsuperscript{155} See 42 U.S.C. § 1396n (1988).
\item \textsuperscript{156} See \textit{Congressional Research Serv., Medicaid Home and Community-Based Care Programs CRS-25} (1992). The most numerous type of waiver is the 1915(c) (formerly called a "2176 waiver," in each case after authorizing legislation) under which states can offer selected home and community-based services to individuals who otherwise would be institutionalized, or elderly persons at risk of institutionalization. The waiver process requires the state to show that the community-based services result in reduction in the nursing home bed capacity within the state, the so-called "cold bed formula," which has prevented a number of states with a shortage of nursing home beds from qualifying.
\item \textsuperscript{157} See Donna Folkemer, \textit{American Ass’n for Retired Persons, Pub. Pol’y Inst. No. 9405, State Use of Home & Community-Based Services for the Aged Under Medicaid: Waiver Programs, Personal Care, Frail Elderly Services and Home Health Services} (1994) (providing results of a survey of the various Medicaid home and community-based care options offered by states to persons with disabilities).
\end{itemize}

In New York, in fiscal year 1991-1992, for example, the Nursing Home Without Walls program provided a very broad range of services, including homemaking, nursing, respite,
In 1990, Congress introduced a new waiver program, Optional Home and Community-based Services for the Frail Elderly, through which states may provide a broad range of home and community-based care to "functionally disabled" individuals who are sixty-five years of age or older and who receive Supplemental Security Income or who qualify as medically needy under the state's Medicaid eligibility guidelines. Any person over age sixty-five is entitled to receive a determination of functional need.

and adult day care, to 12,993 people statewide at a cost of $92.5 million. In Louisiana, by contrast, the Adult Day Health Care program provided that service alone to 305 persons statewide at a cost of $300,000. See Ellice Fatolah, Medicaid Home Care for the Elderly and Persons with Disabilities, 26 CLEARGROUSE REV. 882 (1992).


159. States may provide homemaker/home health aide services, chore services, personal care, respite care, adult day care, and training for family members in caring for the individual, in addition to more traditional services.

160. This includes adults of all ages who are unable to perform three or more ADLs or who require cuing to perform them. Persons with Alzheimer's disease and related dementias typically require cuing, i.e., an attending person to prompt a physically capable person to perform ordinary activities of daily living when mental impairments prevent sufficient comprehension or concentration.

The 4711 eligibility standards were adopted for home and community-based care in the Health Security Act. The Act defines an "individual with disabilities" as someone who meets one or more of the following conditions:

1) Requires hands on or stand-by assistance, supervision or cuing to perform three or more activities of daily living ("ADL"s) and is expected to require such assistance for at least 100 days;

2) Presents evidence of severe cognitive or mental impairment, as defined by the Act, and the need for specified assistance, which is expected to last at least 100 days;

3) Has severe or profound mental retardation according to a protocol specified by the Secretary;

4) For children under the age of six, has a severe disability or chronic medical condition and who without receiving personal assistance services would require institutionalization, and is expected to require such services for at least 100 days.


161. 42 U.S.C. § 1381 (1988). Supplemental Security Income ("SSI") provides a guaranteed minimum income for individuals who are aged, blind, or disabled, who have insufficient workforce participation to be eligible for SSDI.

162. Medically needy eligibility applies to individuals who meet all the criteria for categorical eligibility for Medicaid (i.e., are aged, blind, or disabled, or living in a family eligible to receive Aid for Dependent Children) but have income above cash assistance eligibility levels. Individuals qualify for Medicaid assistance by a "spenddown" process which allows them to deduct incurred medical expenses from excess income until that income is within categorically eligibility levels. Thereafter, medical expenses are paid by the Medicaid program. See 42 C.F.R. §§ 435.200-.350 (1994).
disability, which is conducted by a multi-disciplinary team. However, very few states have applied for 4711 waivers, and still fewer have received them due to restrictive rules and funding. Funds must be allocated in proportion to the number of low-income elderly persons living in the state, and federal costs cannot exceed $200 million over five years beginning in 1991. In addition, the cost of services for a particular recipient is capped at fifty percent of the statewide average Medicaid per diem rate for skilled nursing care. In sum, the services cannot be delivered effectively to the state’s chronically disabled population because the state is too drastically under-funded, on both programmatic and individual levels.

Waiver programs allow the states to try new services on target populations. Costs are manageable because the waiver authorization avoids creating an entitlement. Waivers are effective indefinitely if renewed periodically by the federal government. The limited target population of many waivers also prevents implementation problems such as worker shortages. On the other hand, limited benefits may not assist those in greatest need, and the unfairness to those who cannot receive services would be perceived as intolerable if there was agreement on long-term care as a social good which should be equally available to all regardless of the ability to pay market value. In terms of health care benefits, the waiver authorization is tantamount to declaring the services permanently experimental. The variation in services and target populations may be appropriate, cost-efficient choices for the state budgets, but not for all citizens. The expanding use of the waiver process indicates not only widespread need for public long-term care benefits, but also which benefits are most effective.

2. Housing Programs

The financing and administration of housing programs has traditionally been a state-federal partnership, with federal guidelines determining most of the assistance generally available to citizens of the states. Policy and practice regarding housing for disabled and elderly persons has been in flux for over a decade, as impaired but functional people are turned away from institutional care and back into the community to rely on less intensive

164. The most common waiver services are homemaking and personal care. See generally FOLKEMER, supra note 157. The Health Care Financing Administration eased waiver rules in the fall of 1994, eliminating the “cold bed formula” and making other changes which will enable more states to provide more home and community-based care. See HCFA Eases Medicaid Waiver Process—Again, McKNIGHTS LONG-TERM CARE NEWS, Oct. 1994, at 3.
service settings. National housing policy is called upon to define the alternative settings appropriate for impaired persons of widely varying needs, and states are challenged, despite their generally severe economic constraints, to participate in programs that meet their citizens’ needs. The economic incentive is potential savings in more costly institutional care programs.

Three concepts have dominated the prospects for housing elderly and disabled persons: public housing, congregate housing, and rental subsidies. Unfortunately, since the late 1970s, public policy has favored the idea that subsidizing rents for existing dwellings throughout the community is a more economical mechanism than the other options. Emphasis shifted for more than a decade from “supply side” assistance with building to “demand side” housing allowances, and beneficiaries were to some extent dispersed throughout the community. While such policy has some benefit for non-disabled low-income families, it is counterproductive for persons with disabilities who are in need of visiting services.

The principal program of housing and services is the Congregate Housing and Services Program (“CHSP”), authorized as a demonstration in 1978. The program was intended to prevent premature institutionalization of elderly and handicapped residents of federally subsidized housing by providing non-medical, in-home services and was found by Congress to be quite successful. However, the program has never flourished or grown, in part due to poor management of services by the Department of Housing and Urban Development and its grantees. While the program has been reviewed and re-authorized after suspension of a number of projects during

165. 24 C.F.R. § 941 (1994); see ELDERLAW, supra note 11, at 682-83.
167. ELDERLAW, supra note 11, at 676-77.
170. See, e.g., Gonzalez v. St. Margaret’s House Housing Dev. Fund, 668 F. Supp. 187 (S.D.N.Y. 1987) (supporting the controversial mandatory meals program in elderly congregate housing). HUD was found to have altered the tone and substance of the reports of independent evaluators to portray services programs as negatively as possible. See ELDERLAW, supra note 11, at 772-74.
the HUD scandals of 1989, it is not clear whether, or how, the persistent problems will be solved while the programs are under HUD’s authority.

The greatest growth in housing for persons with disabilities in the past decade has been in assisted living, which combines the medical aspects of long-term care with a model of supported housing and social services. The assisted living movement for non-elderly chronically disabled people emphasizes utilization of community-based services in a neighborhood or project with non-disabled persons. For the elderly, assisted living more often contemplates a specialized housing project where a range of services can be delivered by staff or visiting professionals. Initiated in the private sector for more affluent older people, assisted living facilities may now receive Medicaid support under new waiver rules.

B. Of Means Tests and Subsidies

The most apparent type of means testing is financial, i.e., a bureaucratic process to ascertain whether an individual’s income and assets fall within established limits before providing services at public expense. However, another type of means testing is at least as important in determining an impaired individual’s ability to remain in the community: the extent of social support provided by family members and others. It is reasonable to consider whether either or both should be implemented in a national long-term care program. If implemented in tandem with social insurance, subsidies would be provided for premiums for low-income individuals. If the benefits are paid from general funds, like Medicaid, low-income individuals would be eligible.

1. Financial Responsibility

Many assumptions about financial eligibility criteria are dictated by the current era of deficits and shortages. Clearly, a program with financial means testing is more acceptable because, having fewer eligible recipients, it is cheaper. It is also perceived to be fairer, in that means testing targets assistance to those individuals who cannot purchase assistance; services in chronic short supply will not be “wasted.” On the other hand, means testing is universally disliked by prospective beneficiaries, given its potential to be


stressful, labor-intensive, and a demeaning invasion of ordinarily private matters. Because determining eligibility is simple only for the very poor, it is also expensive for the state. In addition, complex rules, the need for proof, and incentives to cheat the system produce unfair results which burden individuals and erode the legitimacy of the system itself.

Programs with and without means testing have been enacted for elderly persons, and their current status reveals the likely path to pursue with any new program. The principal non-means tested program is the Older Americans Act of 1965 ("OAA"), which provides an array of community services to older persons. The OAA originally was interpreted to prohibit providers from inquiring into the financial capabilities of service recipients. Over the years, successive amendments have required providers to target older persons with the greatest economic or social need, particularly in the nutrition program which receives nearly seventy percent of the total budget allocation. While the legislation did not establish procedures for a means test, it required providers to assure that actual recipients are those most in need as defined by the amendments. The

174. The Act contains six titles: Title I includes broad social policy statements regarding improving the lives of all older persons in areas of income, health, housing, long-term care, and transportation. Id. §§ 3001-3003. Title II establishes the administrative structure of the program, including the Administration on Aging and the Federal Council on Aging. Id. §§ 3011-3020d. Title III authorizes nutrition programs and related services under the administration of State Agencies on Aging and Area Agencies on Aging. Id. §§ 3021-3030p. Title IV provides for funding of research, training and demonstration programs. Id. §§ 3030aa-3037b. Title V provides for a job creation program for older workers. 42 U.S.C. §§ 3056-3056g (1988). Title VI authorizes supportive and nutrition services for older Indians and native Hawaiians. Id. §§ 3057-3057n.
175. The OAA was based on legislative intent to benefit "the older people of our Nation." Id. § 3001. As well as to “assist our older people to secure equal opportunity to the full and free enjoyment of . . . [r]etirement in health, honor, dignity—after years of contribution to the economy.” Id. §§ 3001, 3001(6). Some of the services provided are not limited to persons in economic need, such as "protection against abuse, neglect, and exploitation.” Id. § 3001(10).
176. “[G]reatest economic need” is defined as “need resulting from an income level at or below the poverty levels established by the Office of Management and Budget” ($6810 for a single person in 1992). “[G]reatest social need” is defined as “need caused by noneconomic factors, which include physical and mental disabilities, language barriers, and cultural, social or geographical isolation including that caused by racial or ethnic status which restricts an individual’s ability to perform normal daily tasks or which threatens such individual’s capacity to live independently.” See CONGRESSIONAL RESEARCH SERV., OLDER AMERICANS ACT: REAUTHORIZATION AND FY 1993 BUDGET ISSUES 3 (1993)).
177. Id. at 2.
1992 amendments to the OAA associated more support services with Title III and its targets, 178 and included a new provision, Title VII, authorizing programs for prevention of abuse and neglect and the provision of legal assistance. 179 The administration of Title VII funds differs from Title III in that states can bypass administration by the network of federal administrative Area Agencies on Aging. States were also given permission to transfer funds between service and nutrition programs to maximize their ability to meet the needs of target groups.

The pattern of the OAA represents a number of policy choices for community-based long-term care so that age is no longer a proxy for need. When the OAA was enacted, approximately one third of the population age sixty-five and older had incomes below the official poverty level; many had no reasonable access to health care since Medicare and Medicaid were enacted in the same year; and the elderly living alone were excluded from public housing. 180 Currently, the picture is more complex. 181 In the absence of a clear sense of need, the focus of assistance has shifted to persons who are physically frail and vulnerable to exploitation by others.

The authorization in the OAA is similar to the authorization in Medicaid waivers, in the that the benefits are not an entitlement; rather, benefits are limited to the funds allocated and, but for community pressure, could be zeroed out at any time. Also, benefits are targeted to a specific group perceived to be in greatest need. The concept is quite similar to

178. See CENTER FOR SOCIAL GERONTOLOGY, BEST PRACTICE NOTES ON THE DELIVERY OF LEGAL ASSISTANCE TO OLDER PERSONS 3-4 (1994) [hereinafter DELIVERY OF LEGAL ASSISTANCE].

179. Id. at 6-7; 42 U.S.C. §§ 3058-3058k (Supp. V 1993).

180. DELIVERY OF LEGAL ASSISTANCE, supra note 178, at 4.

181. Though the official rate of poverty among the elderly is about 12%, the figure is misleading, primarily because the official poverty line for retirees is different than for other age groups. Poverty is probably more widespread among the aged than in any other adult age group, particularly among such subgroups as older women, minorities, the oldest old, and elderly people living alone. See VILLERS FOUND., ON THE OTHER SIDE OF EASY STREET: MYTHS AND FACTS ABOUT THE ECONOMICS OF OLD AGE 12 (1987).

Changes in benefits for the aged reflect conflict over “intergenerational equity,” and concern over competing needs such as assistance and education for children. See, e.g., Paul S. Hewitt & Neil Howe, Generational Equity and the Future of Generational Politics, GENERATIONS, Spring 1988, at 10 (slow economic growth and increase in the aged population dictates a reallocation of resources); Ronald F. Pollack, Serving Intergenerational Needs, Not Intergenerational Conflict, GENERATIONS, Spring 1988, at 14 (many elderly persons are still in need of economic and other assistance).
health care reform proposals, in that the services are intended to be available to those in need, but are subject to a budget cap—a capped entitlement. 182

The problems with means testing long-term care, particularly for the elderly who have accumulated some assets, are amply illustrated by the current process of qualifying for Medicaid nursing home care. Generally, a single applicant must have less than $2000 in assets to qualify for Medicaid assistance. 183 In most states, however, an applicant whose assets exceed the Medicaid eligibility limit can "spend down" by deducting incurred medical costs until the value remaining is small enough to qualify for Medicaid assistance. If a Medicaid applicant sells an asset for less than its fair market value, for instance by giving it to a family member, the value may be counted as money available to pay the nursing home bill. 184 As a result, an applicant can be denied eligibility for a period in proportion to the amount transferred. 185 The state is entitled, under federal law, to examine the applicant's financial records for up to thirty-six months prior to the time of application. 186

Some individuals simply make illegal transfers when faced with long-term institutionalization, but generally such transfers are quite modest in value. Some applicants, often with legal assistance, use more sophisticated strategies: placing the applicant's funds into a joint account from which the new joint owner can withdraw at will; placing funds in trust with someone other than the applicant as beneficiary; buying an annuity which pays upon the applicant's death; or making "multiple divestments," so periods of penalty overlap and the applicant is eligible when the retained assets run out. 187


183. The amount is set by the state, and excludes such resources as a homestead. See 42 U.S.C. § 1382b(a)(1) (1988); 20 C.F.R. § 416.1212 (1994).


185. Id. § 1396p(c)(1)(E)(i)-(iii) (the amount transferred is divided by the average cost of nursing home care per month, yielding the number of months of ineligibility).

186. Id. § 1396p(c)(1)(B).

187. For example, Mrs. Jones transfers to her son just under $30,000 in January, and care costs $3000 per month; Mrs. Jones is ineligible for 10 months. In February, she transfers just under $27,000, incurring a penalty of nine months concurrent with the first penalty; and so on. Mrs. Jones can transfer just under $165,000 and still be eligible for Medicaid in November. New strategies after legislation prohibiting concurrent penalties include variations on a "half a loaf" theory which substantially accelerate eligibility.
While all of these strategies have been addressed by legislation in many states, new ways to qualify replace them so long as individuals want to preserve their property and receive the benefits. The Medicaid eligibility game began when benefits were extended to middle-class persons who were concerned with saving and managing their money and were likely to seek legal counsel regarding the precise meaning of eligibility rules. Such individuals reject the rules governing a culture of poverty according to which authorities require that Medicaid beneficiaries turn over all information requested and accept without meaningful explanation the authorities' decision about what help will be given. A middle-class view, in contrast, requires the applicant to be aware of the rules and make use of exceptions as one would in preparing a prudent tax return.

Because it makes no sense to drive an individual living in the community into poverty before providing coverage for home and community-based care, a public long-term care program is likely to have similar difficulty writing airtight eligibility guidelines. Means testing for community-based long-term care would be time-consuming, contentious, and expensive.

2. Family Responsibility

Many would hesitate to provide formal long-term care assistance on the assumption that informal care providers would abandon their roles when

188. Michigan, for example, will nullify trusts funded by Medicaid applicants to divert assets and income to others. Iowa considered legislation to increase the federally-determined 30 month terms it can "look back" for asset transfers at less than fair market value and declare a nursing home resident ineligible for Medicaid assistance. Many states are emphasizing estate recovery programs similar to those which in 1992 netted $22 million in California, $13.4 million in Wisconsin, and $2 million in Maryland.

189. Some Medicaid officials believe it is more often the adult children of Medicaid applicants who use such tactics to preserve their inheritance.

190. The opportunity for middle class eligibility for Medicaid nursing home benefits increased substantially when Congress extended protection for spouses of nursing home residents in the Medicare Catastrophic Coverage Act of 1988. If a spouse is institutionalized, federal law allows a one time transfer to the spouse living the community of half the couple's assets, up to $70,740 in 1993. The institutionalized spouse must spend down, but states must allow the community spouse to keep at least $14,148.

Income generally belongs to the person in whose name it is received, though the community spouse with limited income can claim a maintenance needs allowance from the income of the institutionalized spouse. See 42 U.S.C. § 1396r-5(b)(1) (1988); BRIAN BURWELL, MIDDLE-CLASS WELFARE: MEDICAID ESTATE PLANNING FOR LONG-TERM CARE COVERAGE 1 (1991).
Limiting formal assistance to needs that cannot be met by family or friends also limits the dreaded "woodwork effect," a metaphor for the number of persons in need who are expected to appear with the creation of a public long-term care benefit. Certainly, the existence of family or other social support is relevant to an individual's ability to live at home because the existence of social supports is the most significant factor in determining whether an individual will be institutionalized. The actual effect of adding formal care is difficult to measure and explain, as is the balance of social and economic issues which make family withdrawal from care such a sensitive issue. Possibly, formal services would partially replace informal care at increased public expense, but the lives of caregivers and care receiver would be enhanced. Also, formal services might primarily enable informal caregivers to carry on longer, resulting in a public savings.

The consensus of studies is that some informal caregivers do stop. The extent is small, and the substitution appears to be primarily in IADLs, such as making and driving to appointments. The caregivers most likely to reduce their participation were those who were not closely related to the care recipient, such as friends or neighbors, and relatives other than spouses and children. It is unclear whether caregivers overall provide more or less care when formal care is available.

States have been reluctant to enforce family support laws which might create intrafamily hostility and violence, and nearly all have eliminated such statutes. The privacy of the caregiving relationship, particularly among family members, makes it very difficult for the state to detect abuse and

191. *But see* Leonard Heumann & Duncan Boldy, *Housing for the Elderly* 19 (1982) (the family is not abandoning in large numbers its role as primary housing and support provider to the functionally impaired elderly, but fewer family members are available on a 24-hour basis). *See generally* Susan L. Ettner, *The Effect of the Medicaid Home Care Benefit on Long-Term Care Choices of the Elderly*, ECON. INQUIRY, Jan. 1994, at 103 (indicating that home care subsidies reduce the probability of at-risk elderly entering nursing homes, but also increases the substitution of formal for informal care, thus raising costs).


194. Peter Kemper et al., *Community Care Demonstrations: What Have We Learned?*, HEALTH CARE FIN. REV., Summer 1987, at 87, 94.

195. *Id.*
intervene. Given that families do not abandon care in significant numbers, it is very likely that informal supports should be taken into account only when the care is voluntarily and consistently provided, because the caregiving relationship leaves the person with disabilities vulnerable to financial exploitation and physical abuse.

C. Long-Term Care Insurance

The need for long-term care has the characteristics of an insurable event, i.e., it has a very high cost, but is unlikely to happen. Long-term care insurance is an alternative which has gained a modest market in the past decade. Long-term care coverage typically pays an indemnity benefit of, say, $100 per day of nursing home care up to a maximum term per admission, and perhaps a maximum per policy holder. In addition, a number of states require that long-term care policies provide home care benefits, which may be substituted for nursing home care. Coverage is improving with the adoption of model standards by the states.

Whether long-term care insurance is too expensive is a matter of some debate. Some analysts estimate that at an average cost of $1346 annually for a sixty-seven year old, a basic long-term care policy is unaffordable for eighty percent of potential purchasers. Insurance proponents assert, on the other hand, that the definition of affordability should include consideration of home equity assets, rather than fixing on a percentage of income alone. Proponents also argue that the sale of long-term care insurance policies is inhibited by the existence of Medicaid long-term care benefits,

196. See Barnes, supra note 86 (family guardianships cannot be monitored without destructive effects on the caregiving relationship). The most recent example of caregiver abuse is in durable powers of attorney. See generally GOVERNMENT LAW CTR. OF ALBANY LAW SCH., ABUSE AND THE DURABLE POWER OF ATTORNEY: OPTIONS FOR REFORM (1994).

197. Several major insurers offer policies which cover twice as many home care days as nursing home days.


199. See GENERAL ACCT. OFFICE, No. 90-154, LONG-TERM CARE INSURANCE: PROPOSALS TO LINK PRIVATE INSURANCE AND MEDICAID NEED CLOSE SCRUTINY 12 (1990). Affordability is typically defined as between 5% and 10% of income for health insurance. See also RIVLIN & WIENER, supra note 71, at 20.

200. See DEVELOPMENTS IN AGING, supra note 78, at 215 (state-by-state analysis shows that in no state can more than 25% afford the average cost of nine basic long-term care insurance plans).
which provide a safety net for indigent nursing home residents.\textsuperscript{201} A higher level of risk might prompt many more individuals to purchase coverage in advance, even if paying the premiums required the purchaser to liquidate assets.

However, there are significant problems with marketing effective long-term care coverage, primarily because of the long lag between purchase and benefits payout. Many policies lack mandatory inflation protection; most policies sold to date will lapse without paying benefits. Many fail to include nonforfeiture provisions, so all premiums paid over the years are lost if the purchaser lets the policy lapse.\textsuperscript{202} If the policy continues in force without inflation protection, coverage will almost certainly be inadequate by the time it is needed.\textsuperscript{203} In addition, there are no standard definitions which would clarify the extent of coverage.\textsuperscript{204} While there are well-written policies on the market which take all these concerns into account, they are expensive. Indeed, when a sixty-five year old purchaser elects all three, premiums increase over two hundred percent.\textsuperscript{205}

Premiums could be reduced, however, by having a single program of long-term care coverage which would eliminate as much as thirty-five percent of the cost of a policy.\textsuperscript{206} For example, California’s Public Employees Retirement System ("CalPERS") will create the nation’s first

\textsuperscript{201} See, e.g., LTC NEWS AND COMMENT, SPECIAL EDITION ON MEDICAID ESTATE PLANNING 4 (Jan. 1991) (including excerpts from previous editions by Steven Moses and Brian Burwell highlighting the "Medicaid muddle," i.e., the efforts of middle class elderly to qualify for Medicaid nursing home assistance); see also infra notes 189-90 and accompanying text.

\textsuperscript{202} Most purchasers allow their long-term care policies to lapse without collecting any benefits. See Albert B. Crenshaw, \textit{State Regulators Target Long-Term Care Insurance}, WASH. POST, Nov. 8, 1992, at 8.

\textsuperscript{203} See David G. Larson, \textit{The State of the Art in LTC Insurance}, 3 LTC NEWS \\& COMMENT 5, 6 (April 1993).


\textsuperscript{205} See \textit{CONSUMER REP., supra} note 198, at 430-31. Because of limits on coverage, a 15% risk of loss of assets would remain.

\textsuperscript{206} The figure is based on the standards for loss ratios. The amount of premiums returned in the form of benefits would be a minimum 65%. The balance is profit to the insurer or is used for administrative costs.
self-insuring long-term care program in January 1995.\textsuperscript{207} CalPERS has used the size of its purchasing alliance to negotiate a plan that has reduced premiums by about twenty-five percent.\textsuperscript{208}

An alternative strategy to reduce premiums while limiting costs to state Medicaid programs was underway in several states in 1994. The Connecticut and New York programs represent two basic models of public/private partnership supported by the Robert Wood Johnson Foundation.\textsuperscript{209} The Connecticut model, based on assets, disregards personal assets up to the amount paid for long-term care by private insurance on a dollar-for-dollar basis. The New York model, based on time, allows eligibility for Medicaid regardless of the amount of remaining after the individual has used private insurance to pay for three years of nursing home care or six years of home care, or a combination in which home care days substitute for nursing home days on a two-for-one basis. Insurers whose policies meet the standards of the partnership program provide their policyholder with the assurance of asset protection though coverage has significant limitations. In New York, policies cost between $1500 and $2000 for a person age sixty-five, and will at a minimum provide $100 per day nursing home benefit and a $50 per day home care benefit. In Connecticut, policies which pay $80 per day for one year of nursing home coverage and $40 for home care, with a 100 day elimination period and five percent lifetime inflation protection, cost $788-$947 annually. The buyer who makes a commitment to coverage for more than a year pays less annually. With a public/private partnership, approximately forty-one percent could afford long-term care coverage, with complete asset protection.\textsuperscript{210}

\textsuperscript{207}See Paul Kleyman, \textit{All Eyes are on California's Proposition 186}, \textit{AGING TODAY}, Sept.-Oct. 1994, at 1.

\textsuperscript{208}John Reichard, \textit{Alliances May Open Door to Cheaper Long Term Care}, \textit{J. AM. HEALTH CARE}, Sept.-Oct. 1994, at 20. Under the CalPERS proposal, a 40 year old would pay $46 per month for a policy that pays $120 a day for facility-based custodial care, with an annual adjustment of five percent for inflation. CalPERS will also negotiate with institutional and home care providers for lower rates, which will extend the benefits for policyholders.


\textsuperscript{210}The impact on Medicaid budgets is less significant than one might expect. New York, for example, anticipates a one percent decrease in its Medicaid long-term care budget. The Center on Aging at the University of Maryland, which includes the Robert Wood Johnson Foundation Program to Promote Long-Term Care Insurance for the Elderly,
A remaining significant problem with the current state of long-term care coverage is that policies are purchased primarily by persons with a relatively high expectation of need for care. Under a casualty model of insurance, such adverse selection results in high premiums which are set on the basis of expected losses. The purpose is not only to create an adequate pool for payment of benefits, but also to provide incentive for the insured to avoid risk-inducing behaviors. The theory is ineffective when it relates to individuals who already have a condition which imposes costs beyond the individual’s control. The casualty model is particularly unfair when the cause of the disability itself was beyond the individual’s control.211

The social model of insurance, by contrast, calculates expected loss in the aggregate, rather than individually, and sets an average premium for the entire insured population. The result is community rating, i.e., all individuals pay the same rate and receive as much in the way of benefits as they need. Incentives to reduce risks are typically included in a social insurance model through cost-sharing mechanisms, such as deductibles and copayments. Managed competition proposals, including President Clinton’s plan, are based on the social model. To make it effective, the risk pool must include a substantial number of individuals who pay premiums without having a need for care; a universal system would minimize premiums for all.

A social model of universal coverage is ideal for covering long-term care costs, provided participation is universal.212 Persons with disabilities or frailties of age would pay just what others pay, which may be the greater burden but also offers the greater benefit. The cost would be minimized to the population as a whole.

D. Managed Care and Competition

A principal aspect of health care reforms is reorganization of the delivery system.213 Health care services are to be delivered by organiza-

estimates state savings will be up to seven percent of Medicaid budgets.

211. Other regulatory changes are recommended in GENERAL ACCT. OFFICE, NO. 89-67, LONG-TERM CARE INSURANCE: STATE REGULATORY REQUIREMENTS PROVIDE INCONSISTENT CONSUMER PROTECTION 35 (1989).

212. A social insurance model was recommended by the Pepper Bipartisan Commission on Comprehensive Health Care in 1989. Eligibility was based on ADL deficits, and benefits included a broad array of personal care, homemaker, shopping, respite, and other services in a medical/social model. PEPPER COMM’N, ACCESS TO HEALTH CARE AND LONG-TERM CARE FOR ALL AMERICANS 13 (1990).

213. The other principal aspect, financing reform, is discussed in the section below.
tions of providers, or through insurance purchasing cooperatives which offer alternative packages of access to care (formerly called insurance policies) paying capitated costs, often only to specified providers. In capitated plans, tension between costs and quality of care is fundamental. Much health care reform rhetoric about the need for individuals to have their choice of a trusted physician arises from recognition of this tension in all cost-contained systems, and the hope the physician will continue to put the patient's good foremost. 214

Long-term care programs, limited as they are in quantity and scope of services, are virtually all administered through case management programs, in which professionals determine eligibility, assess client needs, determine service needs, and prepare care plans requiring the procurement and coordination of services from inhouse staff and independent contractors. Throughout the course of care, case managers also monitor the quality of services and the appropriateness of services in light of the client's changing abilities.

One model of comprehensive case management in community-based care is the Miami Channeling Program, which makes the case manager an integral part of the financial planning process and permits the case manager a great deal of latitude in the allocation of services. 215 Another natural development from care management is so-called bundling of services. In community-based services the definitive bundle is the social/health maintenance organization, or S/HMO. Four projects have demonstrated the effectiveness of S/HMOs, which utilize standard assessments of function and self-rated well-being. 216 Other demonstrations have combined the delivery of acute medical care and long-term care services under one umbrella provider organization in fifteen projects of The Program of All-inclusive Care for the Elderly ("PACE"). The PACE program is financed, like an HMO, by capitated per person fees. 217 The elderly have had good results


215. See Donald Humphreys et al., The Miami Channeling Program: Case Management and Cost Control in CASE MANAGEMENT: GUIDING PATIENTS THROUGH THE HEALTH CARE MAZE 45, 49 (Karen Fischer & Ellen Weisman eds. 1988) [hereinafter CASE MANAGEMENT].

216. See Ruby Abrahams & Sara Lamb, Developing Reliable Assessment in Case-Managed Geriatric Long Term Care Programs in CASE MANAGEMENT, supra note 215, at 117.

217. When left to selective enrollment, S/HMOs are particularly susceptible to adverse selection, which is discussed below.
from the integration of services in such programs, despite the conflict of interest posed by capitated payments.

Long-term care management has been informed from the outset with ethical sensitivity to the conflicts between client need and scarce supply. The philosophy of care, as expressed in one national organization’s practice guidelines, includes a commitment to addressing each client’s unique needs in the context of family care. Clients have the right to refuse any recommended service, to be notified in writing of any change in services, and to know the cost of service in advance. Case management is considered a tool not only for cost containment, but for genuine improvements in the quality of services which are better attuned to the individual client. While the ethical tensions are by no means resolved, they continue to have a prominent part in professional dialogue.

E. Quality Assurance

A benefit to all from including long-term care in the health care reform package is the possible development of quality measures. Little has been done thus far to craft a single measure of quality in community-based, long-
term care. Even the traditional measure of setting the ideal and identifying and reducing errors is a haphazard process in long-term care. Providers have such a pessimistic view of the possible outcomes of care that the use of outcomes measures has not even begun. A demonstration of total quality management techniques began in 1994. Long-term care quality assurance has the potential to catch up with health care quality assurance; integrating the two into a single system can only help the development of both measures.

V. CONCLUSION

Clearly, society has a growing need for long-term care services. Yet, existing service programs fail to address the real scope of need, or to assess the specific problems with meeting that need. The systemic problem lies in separate funding streams, and lack of coordination of providers and services at every level of administration and delivery. Perhaps most important at this juncture is the division between acute and long-term care; the former funded with nearly one sixth of the GDP, and the latter funded as an exception to the rules with a small fraction of that amount. Equally important to the future is the development of housing with services similar to assisted living in the private sector, which provides residents the non-medical services options they need to function independently.

The outcome of health care reform and the funding of long-term care should be addressed together because the very excellence of American health care results in a growing proportion of survivors—with disabilities. Given a mobile society with small families and a growing number of single person households, acute care patients cannot be released to their homes without support. Even those who can afford care will in many instances need assistance in identifying and supervising a provider. Regulating the home care industry is a half-measure which cannot remove the profit motive

226. Id. at 71.
227. According to a 1994 report by the General Accounting Office, the demand for long-term care services at all ages will outstrip current funding. GENERAL ACCT. OFFICE, No. 94-140, LONG-TERM CARE: DEMOGRAPHY, DOLLARS AND DISSATISFACTION DRIVE REFORM (1994).
which simply cuts unprofitable services, requires minimum payments, and inflates government subsidies for services to indigent long-term care recipients. Only a broad package of benefits to meet genuine needs can succeed in the reform of health and long-term care.

The time is ripe for incorporating long-term care into the health care system as any reforms are enacted. Any savings recouped from widespread managed care must peak in the early years of the program; once the system is implemented and a baseline established, costs will surely rise slowly or quickly according to the effectiveness of cost containment and inflation generally. Also, a delay of little more than a decade will bring society to the brink of baby boomer retirement, when the numbers of potential care recipients will make long-term care a much bigger bullet to bite.

It may be said, realistically or cynically, that long-term care is politically impossible. If so, it is nevertheless essential to establish at every opportunity the scope of need, the models for optimum care, and the financing essential to reach the goal. Within the foreseeable future, long-term care must be integrated with health care to address the realities of chronic illness.
Medicaid Estate Planning and Implementation of OBRA '93 Provisions in Florida: A Policy Context

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I. INTRODUCTION

This article is presented in four principal sections. The first section presents an analysis of three policy areas (a medically needy program for nursing home care, long-term care insurance, and an asset recovery program), and their interrelationships in Florida prior to the passage of the Omnibus Budget and Reconciliation Act of 1993 ("OBRA '93"). Following this introduction, the second section describes specific changes brought about by the provisions of OBRA '93 which pertain to these policy areas. The third section then attempts relates the conclusions reached in 1992 regarding the interplay of these multiple policy issues to new considerations introduced by the OBRA '93 provisions. The fourth and final section sets forth new conclusions and recommendations reflecting the legislative mandates.

The new conclusions and recommendations reflect the current situation in Florida, as it can best be determined, with respect to these policies as of late summer, 1994. However, it should be noted that regulations implementing the OBRA '93 provisions have not been finalized and that these new provisions will be subject to varying interpretation over the next several months.

II. BACKGROUND

Florida currently has a senior population of more than three million people, including more than one million who are age seventy-five and older. It has the highest proportion of elders and one of the fastest growing old-old (age eighty-five and over) populations of any state. Because of demographic and morbidity trends, Florida will face rapidly escalating Medicaid


expenditures well into the twenty-first century. Long-term care costs, primarily nursing home costs, will continue to be the largest single contributor to escalating Medicaid expenditures in Florida. The increase in the Medicaid nursing home budget alone for 1992-1993 exceeded $100 million. Confronted with Medicaid expenditures for nursing homes projected to reach at least $3 billion and perhaps as much as $4 billion by the year 2000, Florida has begun to explore alternative approaches to financing long-term care (“LTC”). At the same time, the state is increasingly concerned that residents with incomes just one dollar above the Medicaid income eligibility cut-off have no access to Medicaid-supported services should they need costly long-term care. Some other states deal with this “Medicaid Gap” by allowing subtraction of medical expenses from income to meet the eligibility level (spend-down) through a Medicaid “Medically Needy” provision that includes coverage of nursing home care (“MNNHP”). Florida is now interested in exploring the possibility of changing from an “Income Cap” state to a “Medically Needy” state under Medicaid.

For these reasons, the Aging and Adult Services Program Office of the Department of Health and Rehabilitative Services and the Department of Elder Affairs contracted with the Southeast Florida Center on Aging at Florida International University to conduct an analysis of three long-term care policy areas: 1) medically needy nursing home programs; 2) state supported long-term care insurance (“LTCI”) initiatives for indigent elders; and 3) aggressive programs to acquire assets (property liens) of those using state resources (Medicaid) for long-term care.

In addition to analyzing the feasibility of implementing one or more of these programs—including cost and cost-savings estimates, the Center on Aging was asked to describe the potential interrelationships of these programs in Florida, if they should be implemented. The Center on Aging was further asked to provide a set of recommendations for a comprehensive public/private sector long-term care policy that could be formulated into a legislative budget proposal.

III. METHODOLOGY

The methodology for this study included a literature search, a brief mail survey of the fifty states and the District of Columbia, and a heavy reliance on telephone interviewing of key state officials in selected states. The literature search encompassed the combined resources of the computerized

3. Id.
library systems of Florida International University, the University of Miami main campus and Medical School libraries, the electronic special projects data base at the National Association of State Units on Aging, and the combined data bases of the Denver and Washington offices of the National Conference of State Legislatures.

Available literature in the three long-term care policy areas revealed that most articles of real significance appeared in government documents, highly specialized trade journals, and unpublished reports. Only recently have articles begun to appear in professional journals. In addition, articles on long-term care insurance initiatives are under development in several states, and attempts by some states to engage in more aggressive asset recovery from Medicaid recipients are beginning to appear in newspapers and periodicals.

After preliminary review of the literature which revealed only scant information on the first policy area, “Medically Needy Nursing Home Programs,” it became clear that a mail-out survey to all states would be needed. The literature search, however, did reveal more material on both the second policy area, “Long-Term Care Insurance Initiatives,” and the third policy area, “Medicaid Asset Recovery.” Analysis of the literature was followed by detailed telephone surveys to key state officials regarding these two policy areas.

In order to identify states in the forefront of LTCI initiatives and programming in the three policy areas, contact was made with federal and regional Medicaid offices, the National Governors’ Association, the National Conference of State Legislatures, and the National Association of State Units on Aging. Information from the Robert Wood Johnson Foundation’s Long-Term Care Insurance Multi-State Initiative also was used. Regional Medicaid offices supplied the names of the appropriate individual in each state Medicaid office who could respond to inquiries on medically needy coverage for nursing home applicants. The survey form also contained one question on policy areas two and three as a “validity” check to the telephone survey, so that no state with an initiative in these areas would be overlooked.

A telephone call to respondents alerted them to the arrival of the mail survey, and a follow-up call was made one week after expected receipt to

5. Findings from the literature search are discussed under each policy area.
6. See infra Form One.
7. See infra Forms Two and Three.
improve the response rate. Collateral information from the states administering MNNHPs was also requested and, in some instances, later clarified by telephone contact. Because the number of states at the forefront of long-term care insurance and asset recovery initiatives was far fewer than those engaged in MNNHPs, appropriate officials, as mentioned above, were contacted by telephone to pursue these topics.

Long-term care insurance has been slow in catching on in the United States. Insurance carriers have entered this product field gingerly. As a result, until recent times, policies have been relatively expensive and coverage has been limited. Furthermore, the idea of purchasing insurance to cover long-term care is novel to most people. A total of approximately two million policies have been sold thus far.8

Consequently, beginning in 1987 and 1988, the Robert Wood Johnson Foundation ("RWJF") provided funding to eight states9 to explore the possibility of participation in the design and marketing of LTCI policies that would meet established Medicaid and State Insurance Commission criteria. After more than four years, insurance companies in one of these states, Connecticut, began selling state-approved policies in March 1992. Four states—Massachusetts, New Jersey, Oregon, and Wisconsin—dropped out of the initiative. Indiana and New York insurers began selling policies in March 1993, while California lagged one year behind that schedule.10

In order to gain as much information as possible, a detailed telephone survey11 was designed and used not only with the RWJF states but also with Missouri and South Carolina. Investigators determined from the mail survey and telephone contact with the RWJF states that these two states were also initiating LTCI programs. This information is reviewed later in this article in the sections on survey results.12

The literature search revealed that only a few states were actively pursuing controls on the transfer and sheltering of assets or were aggressively seeking to recover assets after the death of the Medicaid recipient. Each survey instrument asked respondents to identify any other states conducting

11. See infra Form Two.
12. See infra parts IV.B, V.B, and VI.B.
similar initiatives. This led investigators to two additional states, Colorado and Wisconsin, which have recently passed legislation authorizing aggressive asset recovery programs. In order to obtain the latest information on this type of initiative, a second detailed telephone survey was developed. States known to be pursuing increased revenues were targeted and contacted. Analysis of the telephone interviews regarding this policy area is included in the section on survey results. In the remainder of this report below, there is a summary of the literature review, an analysis of data gathered using both mail and telephone surveys, and the conclusions presented for each of the three policy areas. Next, interrelationships among the policy areas are explored and discussed within the Florida context. Finally, some of the budget implications of the initiatives in each of these three areas are addressed and recommendations are offered for a state plan of action to address these LTC initiatives.

IV. POLICY AREA ONE: EXTENDING INSTITUTIONAL CARE TO THE MEDICALLY NEEDY POPULATION UNDER MEDICAID

A. Literature Review

Literature in the medically needy area is limited. A recent study was conducted of those who would typically qualify for Medicaid under a medically needy provision, i.e., “those whose income exceeds state guidelines for categorically needy but who become eligible when their income minus their medical expenses falls below the state guideline.” It reported that Medicaid-allowable income and resource eligibility caps have changed several times, states have added or dropped various options, and federal Medicaid waivers have changed. Thirty-seven states provide some level of Medicaid medically needy coverage, but only thirty states include those residing in nursing homes under this coverage.

Florida was among the seven states with medically needy coverage of acute care, but was without a medically needy provision for covering nursing home care. The study focused on the difficulties of older Floridians with monthly incomes between $1158, three times the basic Social Security Income (“SSI”) payment level in 1991, and $2300, the median monthly cost of nursing home care, who fall into what the study’s author terms the

13. See infra Form Three.
15. Id. at 521-22.
“Medicaid Gap.” It has been observed that those who fall into that Gap typically are also ineligible for home and community based services under Medicaid waiver programs because income limits are the same or even more restrictive. Because they are ineligible on the basis of income, not assets, which they could intentionally spend down, they can never become eligible for Medicaid. The study provides a detailed profile of this population as being basically middle-class individuals with some pension income in addition to social security. However, the costs of medical care and LTC leave them and their primary caregivers with serious financial problems. The study contends that expansion of Florida’s medically needy program to cover institutional care represents the appropriate policy solution, but concludes that this is unlikely in the face of current and anticipated budget realities.

B. Mail Survey Results

The return rate from the mail survey was eighty-two percent. Of the forty-one states that responded, twenty-one indicated that they had no provision for the medically needy under Medicaid, or if they did, coverage was not extended to the institutional care population. Officials in twenty states indicated that they did extend eligibility to this population. Follow up telephone calls further clarified some responses. States with MNNHP noted that they experienced problems related to the costs and complexity of administering eligibility spend-down criteria. Likewise, the major reasons given by those states that do not have a provision for MNNHP coverage were the cost and the complexity of eligibility determination.

C. Conclusions on MNNHP

Florida’s income cap (“ICP”) for institutional care under Medicaid is set at the maximum level allowed by federal law—three times the SSI level. The current ICP level is $1266 per month or $15,152 per year. Moreover, Florida provides access to either nursing home care or home and community based services (“HCBS”) for many moderate income elders who

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16. Id. at 522.
17. Id.
18. Id. at 522-23.
19. Quadagno et al., supra note 14, at 526.
have a monthly *household* income higher than $1266, because the income of only the applicant is considered in determining eligibility.\(^2\)

Despite these considerations, however, a substantial number of elders whose total income is just above the $1266—perhaps just $0.51 above—cannot qualify for Medicaid coverage for either nursing home or HCBS under any circumstances unless they are somehow able to reduce their incomes. Eventual qualification may be difficult, if not impossible, because the principal sources of income of many elders whose incomes fall between $1266 and the cost of nursing home care are likely to be social security and other fixed benefits, e.g., pension annuities, rather than interest from assets which can be spent down, in order to shrink the income. This is the "Medicaid Gap" quandary in Florida described by the Quadagno study.\(^2\) The State of Florida's 1992 Long-Term Care Plan estimates that 11,000 elder Floridians currently fall in this Gap and are, therefore, without protection against the risk of long-term care.\(^2\) The initial annual cost of covering this population, according to state estimates, would be $45 million in state funds.

By federal law, a MNNHP cannot be restricted to just nursing home care. It must also include HCBS. Additionally, as will be discussed below, the increased Medicaid costs of such a program could turn out to be substantially higher than state estimates, depending on what is done with other long-term care policies, especially asset transfer and asset recovery programs.\(^2\)

V. POLICY AREA TWO: STATE SUPPORTED LONG-TERM CARE INSURANCE FOR INDIGENT ELDERS

A. Literature Review

In order to demonstrate different approaches to expanding private LTCI coverage through public-private arrangements, in 1987, RWJF began a multi-state initiative involving eight states. This effort has been reviewed by the Brookings Institution, the United States Pepper Commission, and the

\(^2\) Florida Dep't of Health and Rehabilitation Servs., SSI-Related Programs Fact Sheet: Florida's Medicaid Institutional Care Program 4 (1992).

\(^2\) Quadagno et al., *supra* note 14, at 521.

\(^2\) Florida Dep't of Elder Affairs & Fla. Dep't of Health and Rehabilitative Servs., Long Term Care in Florida: A Plan for Building and Integrating A Continuum of Community-Based and Institutional Long Term Care for Florida's Elders 11 (1991) [hereinafter Elder Affairs].

\(^2\) For a discussion of the Interrelationships of the four policy areas, see *infra* part VII.
Government Accounting Office. Numerous articles about the initiative relate to the fundamental issues and topics as outlined in the RWJF Program Summary.

1. Impact of LTCI on Nursing Home Expenditures

Most of the basic advantages and disadvantages of the leading strategies for financing LTC, including private LTCI, were laid out in a book published by the Brookings Institution. The authors explored the financing potential of LTCI by modeling five different policies and estimating their effects on the level of participation and the proportions of total expenditures, public expenditures, and private expenditures. Acknowledging that private LTCI is still in its infancy and is rapidly changing and developing, the authors concluded that the potential future market for such insurance may be large, but it is likely to be primarily confined to upper and middle income people who are not relying on Medicaid. As such, it has limited potential for reducing future public costs. The authors state that “even with maximum likely development of private options, public spending for long term care, mostly under Medicaid, will increase rapidly for the foreseeable future.”

It is not realistic to envision the private sector supplanting public spending.

Specifically, the authors carried out a computerized simulation of the effects of varying LTCI policies on consumer purchase and on nursing home expenditures projected to 2016-2020. From this simulation, they estimated that the proportion of total national nursing home expenditures that would be paid for by LTCI in that time period would be seven to twelve percent. More to the point, in estimating that Medicaid nursing home expenditures would be from one to eighteen percent less than the base case, the authors noted no changes in the way long-term care services are organized, used, and reimbursed. The authors did not make estimates with respect to Medicaid in-home service costs. Even with their optimistic assumptions regarding rate of purchase among those who could “afford”

26. See UNIVERSITY OF MD. CTR. ON AGING, supra note 10, at 1.
27. See Rivlin & Wiener et al., supra note 4, at 3.
28. Id. at 9.
29. Id. at 7.
LTCI, the authors stressed that LTCI should not be viewed as a major offset to public expenditures for long-term care.\textsuperscript{30}

Another recent study, researching Medicaid spend-down in Wisconsin’s nursing homes, found that fifty percent of those entering nursing homes as private-pay residents spent down within the first twelve months of their stay.\textsuperscript{31} This study observed that the Wisconsin elders, as evidenced by their “rapid” spend-down, possessed resources too limited to have been able to purchase LTCI.\textsuperscript{32} From this data, the authors of the Wisconsin study suggest that the market for LTCI may be more restricted than is normally assumed. It should be noted, however, that some portion of this group of individuals may have “spent down” ample resources quickly because they have either successfully sheltered or transferred most of their assets or they had exhausted extensive assets over several years on home health care, other medical services, or even a former nursing home stay prior to entering the nursing home in which they resided when the study began.\textsuperscript{33}

2. Reasons Elders Purchase LTCI

A very small number of studies on the reasons elders do or do not purchase or non-purchase of LTCI have been undertaken. This is understandably a difficult research area. Only two surveys reviewed pertained to actual purchase. Another survey posed questions concerning hypothetical situations. The only common denominator in the findings of these three studies was that cost is a major consideration. Of the two studies focusing on survey populations which presumably could afford LTCI, one found non-purchasers less concerned with protecting assets than purchasers, while the other discovered that although asset protection was important, the single most important reason cited among the choices offered for buying LTCI was to avoid depending on others.\textsuperscript{34} Interestingly, purchasers saw a greater likelihood of needing nursing home care, but saw the same likelihood as non-purchasers of needing home based care. This suggests they were buying LTCI more to cover nursing home care than in-home care. However, the decision calculus of an individual in deciding to buy or not

\textsuperscript{30} Id. at 5.
\textsuperscript{32} Id. at 180-81.
\textsuperscript{34} See Cohen et al., supra note 8, at 215.
to buy LTCI is almost certainly complex and therefore has probably only been captured partially by these initial efforts to understand this decision. Insurance company sales representatives have observed, for example, that LTCI customers want coverage for services that can be delivered at home and do not want to deal with the prospect of entering a nursing home.\textsuperscript{35}

3. Medicaid Estate Planning

A new factor in the LTCI purchase equation is the recent, apparently rapid growth of “elder care law” or “Medicaid estate planning” practice among attorneys and financial planners in the United States, especially since the adoption of the Community Spouse Resource Allowance provision in the Medicare Catastrophic Care Act of 1988. Since 1988, there appears to be an increasing market for counseling services with regard to transferring and sheltering assets and in qualifying for Medicaid among the middle income population of elders, or perhaps, among their children. Purportedly, this development is considerably dampening the interest in LTCI among that subpopulation who otherwise might have been expected to consider purchasing LTCI in order to protect assets.\textsuperscript{36}

B. Survey Findings

Two different approaches to a LTCI strategy have evolved among the four states remaining in the RWJF initiative: the Connecticut partnership model and the New York partnership approach. Two other states, California and Indiana, are using the Connecticut model with minor variations.

Under the Connecticut model, entitled the Connecticut Partnership for Long-Term Care (“Partnership”), individuals are encouraged to purchase state certified private long-term care insurance in amounts commensurate with their assets. The Partnership also tries to make coverage more affordable by supporting the availability of shorter-term coverage. Should the purchaser exhaust the benefits and still require care, the individual could apply for Medicaid benefits under special rules that disregard assets for eligibility purposes on a dollar-for-dollar basis. In other words, insurance payments for long-term care services would be considered equivalent to the depletion of assets that occur in spending down to Medicaid eligibility. The

\textsuperscript{35} Interview with Samuel Kron, Independent Insurance Sales Representative, in Dade County, Fla. (July 6, 1992) [hereinafter Kron Interview].

individual would still have to spend down any remaining assets in excess of
the normal eligibility level to meet the income eligibility criterion and to
apply income toward the cost of care. Connecticut does have a MNH, so it allows Medicaid applicants to meet the income eligibility criterion if
their income falls below the cost of care. The intent of the Partnership
program is to provide incentives to individuals to plan ahead for their long-
term care needs while also reducing the pressure on the state’s Medicaid
budget. Connecticut expects to have 50,000 elders enrolled in the Partner-
ship program in five years.\footnote{See University of Md. Ctr. on Aging, supra note 10, at 3.}

Each state targets a slightly different population. Connecticut is
implementing its program on a statewide, voluntary basis to individuals of
all ages, but public awareness campaigns, through selective advertising and
special promotions, will target those elders who are the most likely to spend
down, i.e., those who are neither the very wealthy nor the near-poor. The
state emphasizes the importance of its “Partnership” in establishing “precerti-
fication standards” for policies, including minimum daily benefits,
mandatory inflation protection over the life of the policy, expanded home
care benefits, and strict reporting requirements.\footnote{See infra Exhibit 1 for a listing of the standards that all LTCI policies sold in
Connecticut must meet.} The Department of Aging also conducts an educational campaign and assists individuals in
choosing appropriate coverage, while insurers share aggregate data with the
state regarding denials of coverage, that otherwise would be considered
proprietary. The program is intended to be at least budget neutral, if not
cost-saving. Legislation that created the program mandates an annual
evaluation of its cost-effectiveness. An annual savings to Medicaid of
approximately four percent per year is anticipated by the year 2020.
Policies under the program became available for sale in March 1992,\footnote{Telephone Interview with Kevin Mahoney, Ph.D., Former Executive Director of the
Connecticut Partnership for Long-Term Care (June 6, 1992) [hereinafter Mahoney Interview].} and
as of the end of September 1992, 609 individual policies had been sold by
three insurers under the Partnership program. Two more companies had
individual policies approved in October 1992. In addition, policies from
three other insurers are under review by the state.\footnote{Telephone Interview with David Gutchen, M.A., Executive Director of the
Connecticut Partnership for Long-Term Care (Sept. 27, 1992) [hereinafter Gutchen Interview].}

California will offer its product to individuals of all ages of modest and
middle-income who are at risk of spending down to Medi-Cal should an
extended LTC episode occur. Special attention will be paid to including HMOs in the program as insurers. Indiana does not limit coverage by age, but extends asset protection only to individuals sixty-five years of age and older.\textsuperscript{41} Indiana also requires that the policyholder be eligible for Medicare Parts A and B, and that he or she possess Medigap insurance. However, Indiana extends the program’s asset protection provisions to other public long-term care programs that consider assets when determining eligibility. These include state funded, in-home, and community based programs.

New York has taken a different approach, in part, because of its liberal Medicaid eligibility criteria and the perception by state officials that asset transferring is widespread. After exhausting benefits under a private LTCI policy, which must provide a minimum of three years of nursing home coverage, six years of in-home care coverage, or must be approved by the New York State Insurance Department, policyholders will be reinsured under Medicaid for life.\textsuperscript{42} Under the State Medicaid Program, all needed long-term services will be covered, regardless of assets. Similar to the requirements in Connecticut, policyholders must satisfy Medicaid income eligibility requirements and recipients are required to share costs.\textsuperscript{43} New York also requires that each policy offered include inflation protection and that the inflation adjustment be pre-funded.

The State of Florida should carefully consider the pros and cons of the Connecticut and the New York approaches. Connecticut’s chief advantage is affordability because the amount of coverage a person may buy is flexible. In addition, it promotes care management to police LTCI expenditures that are credited as spend-down. In general, the principal disadvantage is the additional apparatus needed to administer the program, because the state must still determine asset eligibility (subtracting insurance pay out from remaining assets) and income eligibility. Connecticut must also case manage the application of insured event criteria and the expenditures for covered services which can qualify as spend down. The apparent advantages and disadvantages of New York’s program are inverse to those of Connecticut. That is, the New York program requires significantly less administration; but, because it requires a minimum of three years of nursing home coverage, six years of home health care coverage, as well as pre-funded inflation adjustment, New York’s LTCI is affordable to a fewer number of elders. In effect, New York’s program, juxtaposed to Conn-

\textsuperscript{41} See UNIVERSITY OF MD. CTR. ON AGING, \textit{supra} note 10, at 4.
\textsuperscript{42} Id. at 7.
\textsuperscript{43} Like Connecticut, New York also has a MNNHP.
ecticut’s, targets a narrower band of the population who, if they resided in Connecticut would, at least, be less likely to spend down to Medicaid.

Unfortunately, it will be some time before a judgment can be made as to which model works best, if indeed any of the models are embraced by the public. Exhibit 1, supra, compares the generic New York approach with the Connecticut model along five key dimensions. A specific issue with respect to income cap states, such as Florida, is that all of these models require Medicaid applicants to meet an income eligibility criterion—average cost of nursing home care—thus, states may need to have a MNNHP to allow applicants to spend down their income to the threshold.

Perhaps an important deterrent to marketing these products to some segments of the population, is that in most states, there are numerous ways that an individual can protect assets from Medicaid eligibility requirements. This can be accomplished through transfers or shelters, and thus, the individual could qualify for Medicaid coverage, asset wise, without having to purchase a partnership-LTCI policy. As indicated above, this “Medicaid estate planning” activity is increasing.

Notwithstanding the above discussion, most state officials contacted believe that state-sponsored LTCI programs have the potential to reduce Medicaid expenditures. Furthermore, the availability of LTCI is viewed by many as a critical factor in how aggressively a state pursues asset recovery, particularly from the estates of former Medicaid recipients. Several respondents pointed out that it would be politically difficult for any state with a substantial senior population to step up an asset recovery program without offering some form of LTCI initiative that could protect a recipient’s estate. They also argued that government intervention in the former area quickly leads to opposition, and as a result, would only further encourage people to divest. As an example, the respondents cite Massachusetts, which recently initiated an aggressive asset recovery program after dropping out of the RWJF project. Reportedly, unprecedented numbers of residents there immediately began to seek ways to shelter their assets.

State respondents believe that the key to any successful venture in expanding LTCI coverage lies with collaboration between the public sector and the insurance industry. They acknowledge that the anticipated Medicaid savings are heavily dependent upon the expanded purchase of LTCI. This greatly expanded market also hinges upon efforts to agree on standards for policies which are acceptable to both state insurance commissioners and participating companies, and which are affordable for the target population. In fact, two states, Oregon and Wisconsin, apparently dropped out of the RWJF project because these two criteria could not be met. Massachusetts, as already mentioned, also dropped out following the election of a new
### EXHIBIT 1: COMPARISON OF CONNECTICUT AND NEW YORK LTCI PARTNERSHIP PROGRAMS

<table>
<thead>
<tr>
<th>Category</th>
<th>Connecticut</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Target Population</td>
<td>Middle-class elders (those who would spend down).</td>
<td>Those with a minimum of $20,000 income and $40,000 in assets.</td>
</tr>
<tr>
<td>2) Treatment of Assets</td>
<td>Assets above insured amount must be spent down to Medicaid eligibility level.</td>
<td>Assets ignored if three years of insurance for nursing home or six years for home care is paid out.</td>
</tr>
<tr>
<td>3) Minimum Insurance Purchase</td>
<td>None. But program aimed at the middle-class (those who would spend down) and coverage equivalent to value of assets encouraged.</td>
<td>Three years of nursing home or six years of in-home coverage.</td>
</tr>
<tr>
<td>4) Role of Case Management</td>
<td>Case managers monitor, including application of insured event criteria.</td>
<td>Left to insurance carriers, but state monitors denied claims.</td>
</tr>
<tr>
<td>5) Insured Event Criteria</td>
<td>Based on measurement of functional and mental disabilities.</td>
<td>Presumptive eligibility based on eleven designated groups of &quot;conditions.&quot; Denied claims compared against state's nursing home care mix categories.</td>
</tr>
</tbody>
</table>
governor who did not support the RWJF partnership approach and who wanted to emphasize asset recovery from those on public assistance. New Jersey failed to get required state legislation and federal waiver approval and thus, decided not to proceed.

Missouri, without RWJF funding, but in consultation with the four states that do have RWJF backing, enacted legislation establishing a program entitled, “Missouri Partnership for Long-Term Care,” the elements of which are consistent with the Connecticut model. Missouri anticipated approval by HCFA of its waiver request and expected marketing to begin in 1992.

South Carolina amended its Long-Term Care Insurance Act in 1991 to require that all insurers of nursing home care offer optional benefits in the home or community and to permit insurers to offer a home health care benefit when only home care is necessary. However, South Carolina does not participate in any other manner similar to the RWJF model in terms of providing asset protection.

C. Conclusions on LTCI

Neither the literature nor the survey of the states uncovered any instance of serious consideration being given to state subsidization of LTCI for indigent elders. All programs are aimed at the middle class who would normally spend down their liquid assets to Medicaid eligibility if faced with a stay of more than one year in a nursing home. Existing state self-insurance that covers the poor through Medicaid is, undoubtedly, far more efficient than paying for private insurance to cover such a population, because relatively few people would end up using the covered benefit. Nursing home admission, and the need for formal in-home services, is still a “rare event” from an insurance standpoint.

Several states, including California, Connecticut, Indiana, New York, and Missouri, are beginning to experiment with LTCI initiatives that allow policyholders to protect part or all of their assets when they apply for Medicaid coverage, if they have purchased private insurance policies. RWJF is underwriting an independent evaluation of the success of the initiatives in four of these states. These initiatives are so new that the first state to receive approval from HCFA, Connecticut, began selling state approved policies in March 1992. Obviously, it is too early to determine the level of consumer interest, let alone the effectiveness of this strategy in actually reducing costs under the Medicaid program. Connecticut does not expect to begin to experience cost savings until approximately the year 2020.
Several other states, including New Jersey, Oregon, and Wisconsin, attempted to launch LTCI programs but, after years of study and negotiations with the insurance industry, abandoned their initiatives primarily because they failed to achieve agreement regarding affordable policies which would meet state standards. Massachusetts terminated its efforts after a change in gubernatorial administrations.

1. Factors Affecting Market Appeal of State Sponsored LTCI

Very little is known about the considerations that come into play when the typical consumer decides to buy a LTCI policy. Early research findings suggest that elders insure more to cover the expenses of a nursing home stay than to pay for formal in-home care, and that a common motivation is to avoid dependence on others for their care.\(^{44}\) While agreeing that maintaining financial independence and care choice is the driving motivation behind the purchase of LTCI, insurance company representatives have observed that purchasers express greater interest in coverage for home based care than for nursing home care.

The potential purchaser’s weighing of the costs and the benefits becomes even more complex for the individual or family when the purchase could affect future Medicaid eligibility status, as in the state partnership programs. Thus, LTCI might be purchased so that the individual may qualify more readily for Medicaid coverage or, on the other hand, in order to insure the individual against ever having to depend on Medicaid, that is, to stretch or supplement their own resources to pay for care.

Several considerations could affect the “take up” rate of state-sponsored LTCI. LTCI may be rendered less attractive as a wise “investment” to potential consumers who recognize that, under federal law, no penalties exist for transferring assets in order to become eligible for in-home services under Medicaid. Delays of up to thirty months in eligibility approval for those who have transferred assets in order to qualify for Medicaid, apply only if application is made for nursing home care coverage. Furthermore, a recipient of HCBS is not required to share any of the costs of in-home services. Therefore, elders knowledgeable about Medicaid, looking primarily for coverage of home care, may perceive that such coverage will be available at no cost under Medicaid and that they need not be concerned with the potential loss of their assets in order to qualify.

Even in regard to coverage of nursing home care, many married couples may see little value in purchasing LTCI. Married couples tend to

\(^{44}\) See Cohen et al., supra note 8, at 211.
assume that the healthy spouse will be able to provide for or arrange for the needed care of the ill spouse. In addition, it is markedly easier for a married person, rather than for a single individual, to become eligible for nursing home care under Medicaid and to preserve his or her assets and income. The married applicant can transfer assets to a non-applicant spouse, who can retain up to $68,700 of liquid assets, in addition to "exempt" assets which include a homestead (of any value), automobiles, furnishings, and jewelry.45 On the other hand, for the individual applicant for Medicaid nursing home coverage liquid assets cannot exceed $2000. In addition, there are penalties imposed in the form of waiting periods for coverage, if assets are transferred to anyone except a spouse for the purpose of qualifying for Medicaid. Thus, the unmarried nursing home applicant has fewer options available for preserving assets without jeopardizing his or her application for Medicaid coverage. An example of this can be seen in Wisconsin, where researchers found that married nursing home residents tended to spend down more quickly for Medicaid eligibility than did unmarried residents.

Although the income of an institutionalized spouse in Florida cannot exceed $1266 in order to be eligible for Medicaid covered nursing home care, the income of the spouse remaining at home is not considered. Moreover, in Florida up to $986 ($1266, if needed) of the institutionalized spouse’s income is reserved for maintenance of the spouse at home. However, in regard to nursing home care for the unmarried applicant, the totality of that person’s income, except for a personal needs allowance, is treated as available for payment toward the cost of care.

Elder Floridians, compared to elders in many other states, may have even less incentive to purchase LTCI in order to protect their assets when applying for Medicaid. This is because in Florida it is relatively easy to transfer assets to anyone.46 In addition, Florida has a limited administrative apparatus in place to recover the costs of Medicaid services from the estates of deceased Medicaid recipients. Moreover, Florida has no MNNHP

45. More transfer allowance is allowed in Florida and 15 other states if those additional assets are needed to maintain the income level of the community spouse at least at $986 per month. Thirty-one states set the basic Community Spouse Resource Allowance level lower, 31 as low as $13,296 in 1991. See Brian Burwell, Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage 11 (1991) (This study was conducted by SysteMetrics/McGraw-Hill under contract to the Health Insurance Association of America.). In a decision not to purchase LTCI, of course, a couple might be assuming that both will still be alive by the time one of them needs LTC and that both will not need institutionalization.

46. For example, one may transfer assets as simply as setting up a joint savings account.
which would allow spend down of income to the Medicaid eligibility level of $1266 if one’s monthly income is $1267 or higher.

Notwithstanding the preceding discussion, the proportion of elders who wish to protect their assets and who do not want to expend them to pay for long-term care, but are totally uninterested in qualifying for Medicaid covered nursing home care, is unknown. Perhaps this is because they see Medicaid as welfare, or perceive that the Medicaid benefit is inadequate to provide for high quality care. Based upon the results of the initial studies of the LTCI purchasing decision, it appears that elders may buy LTCI to avoid going on Medicaid, which perhaps to them is a way of preventing a loss of independence.47 Thus, they might be interested in purchasing LTCI just to make their assets “stretch further,” should they require an extended period of formal long-term care. Therefore, these people might buy a year or two of LTCI coverage so that even if they ended up needing three or four years of care, their assets would cover the cost of high quality care after their LTCI benefit has been exhausted.

2. Fiscal Value of LTCI to the State

Aside from the above factors, which could shrink the potential market for LTCI, there are other reasons to question whether developing a state-sponsored LTCI program, even if all else remains the same is, of fiscal value to the state. First, under LTCI “partnership” arrangements, as in Connecticut and New York, the state, on average, is likely to assume the costs of LTC at about the same point as it would if people were spending down their assets to pay for LTC.48 This would especially be true where elders insure for the exact value of their assets. In the absence of asset divestiture or sheltering, New York would assume costs earlier for all those whose assets significantly exceed pay out under a three-year policy. Obviously, a state would begin pay out later for a person who purchases more LTCI than the true market value of their assets.

In Connecticut, the elder population may tend to under insure and then transfer or otherwise shelter any assets above the value insured. This may happen because the state leaves the decision regarding the amount of insurance coverage purchased, beyond a minimum policy that pays out eighty dollars per day over a period of one year or a face value of $29,200,

47. See Cohen et al., supra note 8, at 215.
48. For example, the state may treat insurance pay out for selected LTC services like spend-down for eligibility purposes, or effectively waive asset eligibility requirements when a threshold amount of LTCI coverage is purchased.
to the individual.\textsuperscript{49} It is unclear how such behavior could be policed effectively without strictly enforcing strong asset transfer restrictions. If it were policed effectively, individuals would still obviously have to spend down any remaining assets, beyond those insured before becoming eligible for Medicaid coverage. Obviously, even if elders successfully transfer all of their assets but still purchase LTCI, a state will assume the costs of care later than if they had not purchased LTCI.

Finally, New York's plan may have more potential for reducing Medicaid expenditures in the sense that more elders will die before using up their minimum three to six year LTCI benefit than would be the case in Connecticut, if most purchasers there chose less lengthy coverage and they possessed few additional countable assets to spend down to eligibility at the point the insurance benefit expires. However, the number of policies purchased in New York is likely to be proportionally lower, because a smaller segment of the population will be able to afford the higher minimum coverage required.

In launching its program, Connecticut was vitally concerned with maintaining budget neutrality. Connecticut employed the first version of the Brookings/ICF simulation model to estimate fiscal impact of the impoverishment protection incentive on its Medicaid program and concluded that budget neutrality would be achieved in the early years, with eventual savings of approximately four percent annually by the year 2020.\textsuperscript{50}

The Connecticut model offers the apparent advantage that it will control, through care management plans administered by state contracted case managers, the rate of pay out of the insurance benefit that is counted as spend down, so that spend down will occur more slowly than it might under a typical MNNHP. "Insured event" criteria based on functional and mental disabilities are used to determine when insurance benefits count toward asset protection. Conceivably, this control could result in moderate or even substantial Medicaid savings over a situation in which no agent is specifically charged with monitoring pay out or in which it is assumed that the insurance companies will perform this function effectively.

Unless the states or the insurance companies establish effective care management or monitoring systems, including the use of "insured event criteria," under a partnership arrangement, insured individuals might begin to use insured services earlier because they would not be paying out-of-pocket. This behavior, known as moral hazard, could result in their

\begin{thebibliography}{99}
\bibitem{note39} Guttchen Interview, \textit{supra} note 40.
\bibitem{note40} Mahoney Interview, \textit{supra} note 39.
\end{thebibliography}
receiving Medicaid earlier than would be the case if they were faced with paying for the care themselves.

Finally, the Arling study also raised the specter that beyond failing to save state Medicaid dollars, LTCI could end up increasing Medicaid expenditures for LTC. That study maintains that this could come about if LTCI increases the demand for services, and thus, in turn, raises the prices that Medicaid must pay for the services. Again, the presence of a case management component may dampen the demand somewhat, though, in itself, it probably would not prevent a price increase in the aggregate.

3. Other State Considerations in Sponsoring LTCI

Despite the questions regarding the fiscal impact of LTCI, the state may want to encourage its expansion for other reasons. It might be encouraged as a public service and, as will be discussed in the section of this report on interrelationships, it may be needed in order for the state to effectively implement other policies for reducing Medicaid expenditures. In fact, those who designed the policy for the Partnership program in Connecticut, for example, decided that it was politically and ethically necessary to make an affordable and high quality long-term care insurance option available to its citizens prior to enacting more aggressive programs to restrict transfers and to recover assets from deceased Medicaid recipients.

If Florida decides to launch an effort to encourage elders to buy LTCI, it must, at a minimum, facilitate such purchase by certifying the “good value” of insurance products, and by making that information, and the factors that consumers should consider in purchasing such a policy, widely known. The RWJF assisted projects have made such consumer education a key component of their partnership programs. The state also would need to guarantee policy renewability. In Florida, this type of initiative would obviously require a close working relationship between the Department of Elder Affairs (“DOEA”), Health and Rehabilitative Services (“HRS”), insurance companies, and the state Insurance Commissioner.

Whether a state must provide an asset protection incentive under Medicaid in order to encourage substantial sales of LTCI among the elder population has not been conclusively determined. Perhaps just facilitating purchase via education and certification of policies (e.g., a state “Good

51. See Arling et al., supra note 31, at 180.
52. Id.
53. This includes providing consumer information and protection from fraud and abuse.
54. Kron Interview, supra note 35.
Housekeeping Seal of Approval") would be sufficient. However, as noted above, state officials interviewed for this study believed that asset protection is an essential part of state sponsorship of LTCI. Moreover, stays in nursing homes are often lengthy, with thirty percent of nursing home residents staying more than three years, and twenty-six percent of residents staying more than four years.\(^{55}\) Therefore, to fully ensure protection for $100,000 in assets until the end of the nursing home stay in Connecticut, where nursing home charges are often $50,000 or more per year, one must purchase at least $250,000 of insurance coverage. Translated to Florida, where average annual nursing home charges are approximately $28,000, one would need to purchase coverage for at least five times that amount, or $140,000, to fully protect assets worth as little as $30,000. Thus, an asset protection incentive component of the public-private partnership approach to fostering LTCI coverage may be necessary in order to make "truly adequate" coverage affordable to those persons who would spend down their assets to Medicaid eligibility, if faced with a nursing home stay of more than one year. However, it is unclear at this point whether "truly adequate" in the eyes of most potential purchasers of LTCI means coverage for all of their liquid assets or coverage for some lesser portion of their wealth. The full partnership approach, of course, requires a federal waiver.

Adoption of a LTCI initiative is also likely to require other prior or concurrent state policy steps. These other policy steps—restricting asset transfer, an asset recovery program, and implementing a medically needy program—are discussed in relation to LTCI in the section of this report on policy interrelationships.\(^{56}\)

**VI. POLICY AREA THREE: AGGRESSIVE PROGRAMS TO ACQUIRE ASSETS OF THOSE USING STATE RESOURCES FOR LONG-TERM CARE AND TO CONTROL ASSET DIVESTITURE**

Because of the growth of Medicaid payments for nursing home care in Florida to more than $1 billion in fiscal year 1992-1993, the state is continuing to explore options that may reduce the rate of growth in expenditures. Although many older persons covered by Medicaid are in the low income category and without appreciable assets, others deplete their assets by paying for nursing home care until they are impoverished and qualify for Medicaid coverage. The number of persons in Florida who actually "spend

\(^{55}\) Telephone Interview with Leonard Gruenberg, Ph.D., President, Long-Term Care Data Institute (Sept. 8, 1992).

\(^{56}\) See infra part VII.
down” their assets in this manner is unknown, although a few estimates from national studies are available. Estimates of spend down range from ten to twenty-five percent.57

Furthermore, it is unknown to what extent people transfer or shelter their assets legally in order to qualify for Medicaid; however, there is growing evidence to suggest that “Medicaid estate planning” is expanding in an increasing number of states. The costs to Florida’s Medicaid program from failure to intervene in these asset planning activities deserves research attention. As will be noted, the income cap restricting Medicaid eligibility may dampen such activity in Florida. However, anecdotal evidence from several sources suggests that Medicaid estate planning is a relatively common and growing phenomenon in Florida.

This section explores current practices among the states in establishing programs to recover assets from those using state Medicaid resources for long-term care in order to determine if there are actions Florida could take to improve its performance in asset recovery. Policy regarding controlling asset transfers, a distinguishable, but closely related area of potential state policy action, is also addressed.

A. Literature Review

In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act, which authorized, but did not mandate, states to: 1) restrict asset transfers within twenty-four months of Medicaid nursing home eligibility; 2) place liens58 on the property of living recipients; and 3) recover from the estates of deceased recipients the value of Medicaid expenditures on behalf of the recipient.59 In his extensive review, Stephen A. Moses has found weak state enforcement of these asset transfer restrictions.60 By 1985, for example, only one state, Alabama, fully used the lien power authorized by the federal statute. In addition, although eighteen states recovered from estates, most did so with little success. A 1985 draft report of the Health Care Financing Administration, which was based on a phone survey of the

58. Liens are legal encumbrances which forbid a property to pass to another owner until a claim is satisfied or a creditor is reimbursed for past goods or services rendered to the property owner.
states and a sample of cases in Idaho, "speculated that estate recoveries could leap from $36 million nationally per year to $535 million if all states followed the asset control methodologies of Oregon's exemplary program."61 Maryland and Alabama implemented the lien provision by 1988. Texas also tried to implement a lien law, but repealed it in response to complaints from the public.

In his summary of a report from the Office of the Inspector General ("OIG"), Moses reiterated that states found the federal lien authority too narrow because, according to the OIG, the law excludes everything but real property, of permanently institutionalized recipients, which is unoccupied by specified dependent relatives. Other methods, such as Oregon's aggressive identification of assets, reversal of illegal transfers, and challenges of resource shelters, were more effective. Moses argued in his report summary that without some means of effective encumbrance, there can be no effective estate recovery program. The OIG report also concluded that twenty-three states and the District of Columbia recovered $42 million from Medicaid recipients' estates in 1985, but that states, nationally, could recover $589 million annually if they collected at the same rate as Oregon.

Moses also summarized a 1989 General Accounting Office study of the same subject, also based on Oregon's experience, which concluded that states could recover two-thirds of the amount spent on Medicaid nursing home recipients from their estates or the estates of recipients' spouses. It found that Oregon was recovering ten dollars for every one dollar spent administering the program, which represents twice the annual recovery per recipient of any other of the seven states reviewed.

The OIG could expand the use of liens or use some form of legal encumbrance as a condition of eligibility for the Medicaid program. As indicated, only two states employed liens as a condition of Medicaid eligibility in 1989; although some other states impose encumbrances after the death of a recipient. Recovery would occur after death of the recipient or dependents, as appropriate. The OIG believes that this approach would encourage home equity conversion to pay for care or coverage through insurance. Furthermore, the OIG argues for mandatory estate recovery programs, federal technical assistance to states on estate recoveries, and recovery from the estates of spouses or upon the age of majority of any dependents. Even under current law, the OIG estimated that, based on experience in Oregon, recoveries could recoup five and two-tenths percent of Medicaid nursing home expenditures.

61. Id.
In a related study of Massachusetts, Moses concluded that in 1990 a three person unit recovered $6 million per year, or fifty-one dollars for every one dollar in administrative costs.\textsuperscript{62} This is an average of $17,000 per case. This study includes a summary of estate recovery "best practice" that provides additional recommendations for enhanced recovery.

In a December 9, 1991 article, Laura Saunders cited recent aggressive recovery strategies in a few states.\textsuperscript{63} One state, Massachusetts, requires that applicants submit copies of back tax returns and requires the executor of an estate to notify welfare officials if the decedents were Medicaid recipients.\textsuperscript{64} Another state, Missouri, has authorized the recovery of Medicaid benefits received by the first spouse from the estate of the second spouse.

On the other hand, aggressive actions on the part of state governments—especially if not part of a comprehensive and well understood strategy—hold the potential for arousing strong negative reactions from advocacy groups in the aging network. The November 22, 1991 issue of \textit{Older Americans Report}, for example, cited a lawsuit brought by a non-profit group in Massachusetts against the Massachusetts Department of Public Welfare. The lawsuit alleged that a new Medicaid regulation forced nursing home residents to sell their homes to pay for care if a doctor determined they could never return home. The regulation was withdrawn. As a result of protest from elder advocates, Wisconsin similarly was forced to back off from attempts to recover from the assets of institutionalized Medicaid recipients.

The OIG report emphasizes that states need to focus attention on reduction in the level of asset transfer activity as well as aggressive estate recovery. The latter may be moot if nonexempt assets have been transferred successfully. Under the Medicare Catastrophic Coverage Act of 1988,\textsuperscript{65} the spouse of any institutionalized person covered by Medicaid may retain (in 1992) $68,700 in controllable assets. This provision is known as the Community Spouse Resource Allowance ("CSRA"). The community spouse also may retain income, known as the Minimum Monthly Maintenance Needs Allowance, equal to at least 133\% of the federal poverty level for a couple ($985 plus excess shelter costs, or higher if court-ordered). The

\textsuperscript{62} LTC, INC., \textsc{Medicaid Estate Recoveries \textsc{in} Massachusetts: \textsc{How} \textsc{to} Increase \textsc{Non-Tax} \textsc{Revenue} \textsc{and} \textsc{Program} \textsc{Fairness} 5 (1990).

\textsuperscript{63} Laura Saunders, \textit{The King Lear Strategy}, \textsc{Forbes}, Dec. 9, 1991, at 164.

\textsuperscript{64} \textit{Id.}

1988 Act mandated states to implement restrictions on transfer of assets by those in the community applying for Medicaid HCBS benefits.

Many observers perceive that the CSRA prompted elders and their attorneys to begin thinking seriously about “Medicaid estate planning.” A December 18, 1989 Newsweek article entitled Do Only the Suckers Pay? reported that the National Academy of Elder Law Attorneys had increased from eighty-eight members in 1988 to four hundred and fifty members in 1989. Indeed, evidence exists that efforts to transfer, or in other ways shield, assets from state scrutiny for Medicaid eligibility purposes are rising dramatically. Moses cited the OIG Report of 1988 in concluding that “Medicaid eligibility rules permit knowledgeable individuals to transfer or shelter property from Medicaid resource limitations in a manner reminiscent of income tax avoidance.”

To determine the extent of transfers and shelters, the OIG conducted an additional study in the State of Washington. Moses summarized the study, finding that persons denied at the time of application, but subsequently approved within a few months for Medicaid nursing home benefits, possessed $27.5 million in assets at the point of application (representing fifty-seven and six-tenths percent of all applications denied). In order to qualify, these assets had to be disposed of in some fashion. More than eighty percent of them were sheltered through transfers to spouses (fifty-nine percent), adult children (eleven percent), or were retained as exempt (eleven percent). Professionals interviewed in the study reported an extensive network of “elder law” attorneys and others who counsel elders and their families on qualifying for Medicaid.

Moses argues that elders and their families currently have no incentives either to pay for care or to insure against the risks of needing nursing home care. He contends that they should be given a clear choice between access to public funding of long-term care or preservation of their estates—not both. To force such a choice, he notes the recommendations for state action from the 1988 OIG report. These recommendations address both asset transfer and asset recovery activities:

1) Change Medicaid rules to permit families to retain and manage property while their elders receive long-term care.

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67. See Moses, supra note 60, at 22.
68. Id. at 23.
69. Id.
70. Id. at 25.
2) Strengthen the transfer of asset rules so that people cannot give away property to qualify for Medicaid.

3) Require a legal instrument as a condition of Medicaid eligibility to secure property owned by applicants and recipients for later recovery.

4) Increase estate recoveries as a non-tax revenue source for the Medicaid program while steadfastly protecting the personal and property rights of recipients and their families.71

Moses emphasizes that increased non-tax revenue is not the critical objective of these recommendations. Rather, elders and their families would be required to recognize that if they do not insure against the risk of long-term care, the government would pay for such care and recover the costs from their estates. Consequently, he argues, elders would then utilize home equity or other assets to purchase insurance and adult children would assist in the purchase of coverage to preserve their parents’ assets (i.e., the children’s inheritances). This behavior will then allow Medicaid to serve the low-income population for which it was intended originally.

Brian O. Burwell, a researcher at SysteMetrics, conducted a broad study of estate planning under contract to the Health Insurance Association of America.72 His analysis included a review of federal Medicaid rules and practice in six states, including Florida. Burwell observed that states have more incentive today to seek recovery of assets because of the growth in wealth of older households nationally, from a median net worth of $68,600 in 1984 to a medium net worth of $73,471 in 1988.73 Over sixty percent of households sixty-five and above have a median net worth over $50,000, and forty percent have a net worth over $100,000, with much of that consisting of home equity. There is some evidence to suggest that the figures are higher in Florida.74

Regardless of Medicaid restrictions, Burwell points out, “it’s much easier to get poor than it is to get rich,” particularly since a state can disqualify an applicant only if the state can prove that divestiture occurred solely to obtain Medicaid, and not for some other valid reason.75 He concludes that it is difficult to prove unlawful transfer or sheltering by anyone who has engaged in planning for this purpose, especially because of the

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71. Id.
72. See BURWELL, supra note 45, at 1.
73. Id. at 5.
74. See generally MUNROE ET AL., supra note 2.
75. See BURWELL, supra note 45, at 15.
availability of exempt assets such as the home. Furthermore, because of the thirty-month rule, a person about to enter a nursing home can set aside sufficient resources to pay for thirty months of care, or purchase equivalent insurance coverage, and then transfer the balance without encountering any difficulty in establishing eligibility for Medicaid. In Florida, it is even still easier to establish eligibility merely by setting up a joint bank account. Under the "Streimer rule," the cosigner on a joint account can withdraw funds without penalty to the Medicaid applicant.

Burwell proceeds to describe numerous other ways people can protect assets without jeopardizing eligibility for Medicaid, including the use of trusts and additional strategies to protect home equity property. Relevant to Florida, Burwell observes that asset transfers have far less impact on the Medicaid budget in states with income caps (the ICP in Florida) than in states with MNHNP, because the cap greatly limits access to Medicaid eligibility. Regardless of asset level, individuals with monthly incomes above $1266 in Florida cannot become eligible for Medicaid because "spend-down" of income for private cost of health care is not recognized for eligibility determination purposes.

In summary, Burwell, like Moses, maintains that Medicaid estate planning reduces demand for LTCI (the markets are congruent) and forces states to spend more resources on nursing home care through the Medicaid program. Further, Burwell notes, each state needs to know how many people engage in such planning and what policy measures can be adopted to limit the effects of such planning on eligibility, and on recovery of assets. Burwell further advocates in-depth case studies in individual states to identify specific state issues and to recommend policy and administrative strategies to address such issues.

B. Survey Findings

Telephone contacts with the various states identified in the literature as aggressive in asset recovery provided further insights into factors involved and some requirements for effective implementation. They also led to two other states, Wisconsin and Colorado, which have recently enacted legislation effectively strengthening their capacity to identify, pursue, and recover assets. Wisconsin legislation passed in 1991, allows for placing of a lien on the home of a Medicaid-funded nursing home resident if the person "cannot reasonably be expected to be discharged from the nursing home and return home." Colorado legislation, also passed in 1991, establishes a formal estate recovery program, with a budget of $1,027,561, and authorizes the filing of liens against property of institutionalized per-
sons. It also limits the judiciary’s ability to approve “Medicaid qualifying trusts” for nursing home care coverage.

Florida does not have a program comparable to these few states with aggressive recovery initiatives. Presently, Florida has only a Claims and Recovery Law which governs third party recoveries. Florida does not have a lien law to support recovery of real property from Medicaid recipients, nor does it have a formal estate recovery program like those programs in Oregon and Colorado. In 1987, Florida recovered $641,000, or seventeen dollars per Medicaid nursing home resident, compared to $327.44 per Medicaid nursing home resident recovered in Oregon.

Ironically, the more aggressive states like Oregon, Massachusetts, Wisconsin, and Colorado, potentially have far less to gain than Florida, given Florida’s demographics. Although the LTC, Inc. report found a fourteen to one ratio of recovery in Oregon, an Oregon official reported a ratio of dollars recovered to dollars spent on recovery of ten to one. These figures were achieved with a recovery unit of twelve people. As indicated earlier, LTC, Inc. reported a recovery ratio in Massachusetts of fifty-one to one, with only three people in the recovery unit.

In Florida, the state’s ability to recover assets from estates of Medicaid recipients has been constrained further since 1988. A Florida Supreme Court decision, Public Health Trust of Dade County v. Lopez, effectively held that an individual’s homestead is “off-limits” from state claims against a deceased recipient’s estate. Lopez was prompted by a 1985 amendment to the Florida Constitution that redefined the owner of the homestead from being a “head of family” to simply “any natural person.” Thus, there does not have to be a spouse or dependent child present. Following Lopez, Florida courts have consistently held that the “homestead” in question may pass free and clear to any “heir at law” without entering the estate and being made subject to state claim or lien. Since more than seventy percent of the real assets of Medicaid recipients in Florida are found in their homes, the potential pool of recoverable assets was thereby dramatically reduced by this court ruling. Limited recovery potential still exists, however, because some heirs live out of state and cannot claim two “homesteads” and because some decedents have no natural heir. If Florida were to consider a more aggressive policy in this area, there would be a need to conduct a comprehensive legal review of the status of recent judicial rulings and to explore options for new legislation.

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76. 531 So. 2d 946, 950 (Fla. 1988).
77. Id. at 948; see also FLA. CONST. art. X, § 4(a).
Respondents emphasized that, under a more aggressive policy, staff responsible for administering the recovery program must clearly understand the mission of the program and the reasons behind it. They must be well-trained and motivated to succeed because the task is complex. Legal counsel must also be readily available. State legislators must be solidly behind the effort and willing to take some "political heat" from constituents faced with loss of some assets. Not surprisingly, the children of recipients often appear to be more vocal and agitated than their parents when they see what they view as their inheritance placed in jeopardy.

Evidence of the increasing influence of "Medicaid estate planning" on the long-term care picture of the United States uncovered in the literature was also corroborated by Medicaid eligibility staff across the country. For example, in Maryland "[p]eople are starting to use a lot of fancy footwork to avoid losing the 'family fortune.' "78 In Minnesota, "[m]any, many, many attorneys call on a daily basis looking for 'loopholes.' There are lots of welfare resource specialists who help people avoid welfare resource limits."79 And in California, "[w]e recover from people who are not clever enough to transfer property, and everyone else goes scot-free."80 This type of planning exists to an unknown degree in Florida, although workers report a high level of inquiry from elders or their attorneys regarding the Medicaid eligibility rules.81 Policy makers should address any policy reform with this factor clearly in mind.

C. Conclusions on Asset Recovery and Medicaid Estate Planning

Aggressive asset recovery has been reported as a cost-effective strategy for securing more resources for long-term care in some states. In the area of assets recovery, however, only a handful of states have coupled strong legislation with an investment in the manpower and the resources needed to aggressively pursue this option. Oregon has aggressively followed this strategy for almost twenty years. More recently, Massachusetts, Wisconsin, and Colorado have enacted legislation strengthening asset recovery.

Florida has a claims and recovery law governing third-party recoveries, but does not have a significant investment in the resources needed to seek

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78. Moses, supra note 60, at 22.
79. Id.
80. Id.
81. Telephone Interview with Lynn Rachelson, M.A., Aging and Adult Services, Florida Department of Health and Rehabilitative Services, Office of SSI Related Programs (Nov. 4, 1992).
asset recovery more effectively. In addition, Florida's recovery efforts were hampered by the 1988 Florida Supreme Court decision of Public Health Trust of Dade County v. Lopez, in which the court held that the homestead may pass free and clear to any heir at law.\(^8^2\) Prior to 1985 in Florida, only the surviving spouse and/or dependent children under the age of twenty-one could inherit the property lien-free.\(^8^3\) Heirs, however, still cannot claim two homesteads and many heirs reside outside of Florida. Moreover, some decedents have no heirs. Florida also has one of the more lenient legal climates for transferring and sheltering assets prior to entering a nursing home under Medicaid. Joint bank accounts, for example, can be used to transfer assets without penalty.

A consensus appears to be emerging among those who have examined these issues closely that a program of aggressive asset recovery and the availability of LTCI are interrelated, and that states should pursue both initiatives simultaneously. They also argue that vigorous asset recovery without state sponsorship of LTCI may prove politically infeasible. At the same time, they also perceive that the "threat" of asset recovery from Medicaid recipients may be needed to motivate most elders to purchase LTCI.\(^8^4\)

However, the two strategies above in tandem could clearly still fail to reduce the public costs of long-term care appreciably unless they are accompanied by a new state policy that would mitigate divestiture of assets in order to qualify for state Medicaid-funded programs. The implementation of asset recovery in the absence of this third policy could exacerbate the problem by encouraging divestiture over LTCI purchases.

For another reason, however, the impact of asset sheltering or divestiture on Medicaid eligibility (and hence on Medicaid costs) in Florida is unclear. The impact may be far less than in states having MNNHPs because Florida's ICP income cap serves as an income eligibility barrier to that class of residents who would need to shelter or transfer assets in order to meet the Medicaid asset eligibility criteria.\(^8^5\) A growing body of anecdotal evidence suggests that "Medicaid estate planning" is on the increase in Florida. It is unclear, however, whether those engaging in such planning are aware of the limits to Medicaid eligibility imposed by the

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82. 531 So. 2d 946, 949 (Fla. 1988).
83. Id. at 948.
84. Presumably because LTCI will allow purchasers to avoid ever having to go on Medicaid, under which they would be subject to recovery of state expenditures on their behalf from the sale of their homestead or other assets contained in their estates.
85. Levels of assets and incomes among elders tend to be highly correlated.
income cap (Florida’s ICP). Thus, it is possible that such activity is growing in pervasiveness but that it will have negligible, if any, effect on Medicaid expenditures.

It is important to bear in mind that asset shelters may still allow for eventual recovery, but that asset transfers do not. Even if the value of personal property is exempt (sheltered) from eligibility consideration under Medicaid, the state can still impose a lien or other property encumbrance which allows recovery of the value of state expenditures from the estate of a Medicaid recipient. Therefore, the state may want to concentrate its greatest efforts on stemming transfers, especially if the state were to implement a vigorous asset recovery program which, potentially, could capture sheltered assets.

VII. POLICY AREA INTERRELATIONSHIPS

This section of the article presents conclusions on the potential interrelationships among the following policy initiatives: 1) LTCI; 2) MNNHP; 3) asset recovery; and 4) asset transfer. Asset recovery and asset transfer policies are distinguishable because a state could adopt one without the other; although, in practice, asset recovery is likely to be quite limited in most states unless transfer restrictions are in place and are enforced.

A. LTCI and MNNHP

A MNNHP may be needed for those in the “Medicaid Gap.” It also may be needed to encourage an adequate level of LTCI sales. Without a MNNHP, a substantial segment of the population to whom LTCI policies otherwise might be sold, is likely to have incomes too high, relative to Florida’s ICP cap, to ever qualify for Medicaid. In fact, the retention of assets which LTCI makes possible among that segment of the population which purchases it, often will result in continued higher income, decreasing further the chances of qualifying for Medicaid in the absence of a MNNHP. Over the long-term, state financing of a MNNHP may be politically feasible only if the state experiences substantial Medicaid savings over what the Medicaid budget would have been otherwise. However, given findings from microsimulation analyses carried out to date, it appears unlikely that the state would realize significant savings from elders paying for LTCI with private insurance, even if a large number of elders purchased policies.
B. LTCI and Asset Transfer Restrictions

A third factor, asset transfer, helps determine the extent of Medicaid expenditure reduction under LTCI. Actual savings from increased LTCI coverage may be quite small, even if transfers of assets are effectively restricted. As noted in the Conclusions on LTCI section, supra, Medicaid, on average, is likely to pick up the costs at about the same point under either a LTCI program, or without—but only if asset transfers are effectively restrained. If they are not restricted, elders will have less incentive to purchase LTCI in the first place; and, as a consequence, Medicaid would begin picking up the costs of persons much sooner who transfer their assets.

Although there may be other good reasons (e.g., promoting the general welfare of its citizens) for a state to encourage individual planning for later years, including consideration of LTCI purchase, reaping significant Medicaid savings from this endeavor may prove a highly elusive goal. In general, stemming asset transfers, more than expanding LTCI, is the key to slowing the rate of increase in Medicaid expenditures for long-term care. However, in states such as Florida, which do not have MNNHPs, Medicaid estate planning may be less pervasive because these states have income caps limiting access to Medicaid coverage of LTC. This dampening effect, however, would occur only to the extent that elders with incomes above the ICP level are aware of the income cap.

Connecticut and New York are launching their LTCI “partnership” initiatives with the assumption that elders will choose not to transfer assets in order to qualify for Medicaid coverage of LTC if an attractive, affordable LTCI policy which protects assets and has the state’s “seal of approval” is made accessible. However, Connecticut, which has a MNNHP, passed legislation this year which allows the state to break irrevocable trusts at Medicaid eligibility and authorizes the state to seek a Medicaid waiver in order to effect a sixty-month look-back for asset transfers among applicants for Medicaid-covered nursing home care. Though not initiated by partnership officials, they supported it and believe that the availability of LTCI through the partnership program enhances the ability of the state to take such politically sensitive actions.

87. Guttchen Interview, supra note 40.
C. **LTCI and Asset Recovery**

The relationship between LTCI and asset recovery also appears to run in both directions. LTCI may not be attractive unless vigorous state asset recovery efforts threaten assets that elders wish to preserve for their heirs. Furthermore, a policy of vigorous state asset recovery may be politically untenable unless citizens are offered a way to protect their assets from recovery through a state certified LTCI program. This is the assumption among promoters of both Connecticut’s and New York’s “partnership” programs. The interrelatedness of these initiatives may be key to the success of either one. Now that Connecticut has a partnership program for making LTCI more accessible to elders, it plans to step up its enforcement of its asset recovery authority, which has been in place for several years.  

D. **MNNHP and Asset Recovery**

Because, at best, it will take several years for LTCI to have any appreciable effect on Medicaid expenditures, states should use substantial asset recovery, a shorter-term method of partially offsetting the cost of a MNNHP. The return from an investment-in-assets recovery could be greater with a MNNHP in place because the medically needy population is likely to possess greater recoverable assets than the categorically eligible population. At the same time, the medically needy population may be more prone to divest assets, making recovery impossible, because they have more to protect and are more aware of Medicaid estate planning techniques.

E. **MNNHP and Asset Transfers and Shelters**

With enforcement of restrictive asset transfer and sheltering policies, fewer persons would qualify as medically needy. Even fewer persons would qualify as categorically eligible for Medicaid as a result of divesting their assets. Conversely, adopting a MNNHP without creating effective barriers to asset transfers and shelters could make qualifying for Medicaid a more attractive option to elders who, otherwise, would have fallen in the “Medicaid Gap.” This is because a MNNHP would remove the income cap under the ICP that presently limits access to Medicaid.

88. *Id.*
F. Asset Transfers/Shelters and Asset Recovery

Without placing legal and administrative restrictions on asset shelters and transfers, the prospects for the success of asset recovery are diminished, although it is difficult to judge by how much. Theoretically, people who have moved their funds to the exempt category or have sheltered in other ways at the point of Medicaid eligibility could still recover them. However, this is true only if the funds are just sheltered from eligibility consideration and not permanently lost through divestiture (transfer). Thus, erecting barriers to divestiture influences the success of an asset recovery program more than shelter restrictions. A policy of restricting asset transfers, even in the absence of an asset recovery program, would reduce Medicaid expenditures because fewer persons would become Medicaid eligible and others would become eligible at a later date.

VIII. Budget Implications of Long-Term Care Policy Initiatives

A. Medically Needy Program for LTCI

In the "Long Term Care in Florida Plan," Florida's DOEA and HRS have estimated that 11,000 elders could be eligible if the state adopts a MNNHP for institutional care. The state's estimate of its share of the costs for a program of this stature is $45 million per year. However, this estimate could turn out to be too low. Elders who are currently above the "spend-down" population in income would transfer their assets, thus lowering their income from (return on) assets and reducing their total income to a level less than the cost of institutional care. This would make them Medicaid eligible. Thus, policy initiatives in the asset transfer area would influence this estimate. Also, the state's estimate could be inaccurate to the extent that projections of in-home services used under Medicaid are not included or miscalculated. A state that adopts a MNNHP must cover in-home services as well as institutional services.

On the other hand, the state's projected net costs will be slightly higher than the estimate if Florida implements a strong asset recovery program, since the MNNHP population usually has greater significant recoverable assets than does the categorically needy population. The MNNHP population is likely to have more income to pay toward the cost of its care

89. See Elder Affairs, supra note 23, at 15.
because of greater income levels. As a result, Medicaid’s contribution for categorically eligible persons is lowered. In the final analysis, the net costs of a MNHNP to Florida are highly dependent upon the state’s action regarding asset transfers and recovery, as they directly affect Medicaid eligibility and recipient financial responsibility.

B. Long-Term Care Insurance

It is awkward to apply the Brookings’ simulation model estimates of savings to Florida’s Medicaid nursing home expenditures because of the time periods involved are incongruous. Florida needs a savings estimate by the year 2000, if not earlier, rather than by the year 2020. Also, it is difficult to guess the possible national savings resulting from early implementation. Early savings would result because many more policies are likely to be in effect in two to three decades than in one decade and because policy benefits are unlikely to be used until as much as a decade after the policies are purchased.

An optimistic estimate of savings by the year 2000, taking both of these time factors into account, is three percent. Three percent of a projected state expenditure of $3 billion for nursing home care in 2000 is $90 million. Connecticut estimates that it will spend four percent less on nursing home care by the year 2018 than it would have spent without its LTCI program. However, cost savings are unlikely to be realized before that time. Excluding administrative costs, which are not insignificant—particularly if the Connecticut model was adopted—the single biggest policy design factor affecting state costs is the degree to which the state extends assets protection to LTCI purchasers.

C. Asset Recovery

Oregon’s return on its investment in the administrative apparatus to recover assets from Medicaid recipients is estimated from ten-to-one to fourteen-to-one. The value of assets recovered from the estates of deceased recipients constituted about one and seven-tenths percent of Oregon’s Medicaid budget. Transposed to Florida’s forty-five percent share of the projected 1992-1993 Medicaid LTC budget (approximately $1.0 billion), one and seven-tenths percent equates to about $10.7 million. In the year 2000, when the Medicaid budget is expected to approach $3.0 billion, a one and

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90. This amount equals one-third of the median percentage (9%) of Medicaid expenditures saved (between 1-18%) by the year 2018.
seven-tenths percent recovery rate would represent $32 million. At this rate, it would take about four years of recovery efforts, until 1996-1997, to pay for the first year’s cost of a MNNHP (estimated to cost $45 million). Moreover, it would be well past the year 2000 before the state would be able to offset the yearly cost of a MNNHP with recovery revenues from that same year. A budget-neutral MNNHP will remain an elusive goal for the foreseeable future. To offset its costs, if that proves necessary, policy initiatives other than asset recovery will have to create savings.

IX. CONCLUSIONS

Conclusions drawn with respect to policy initiatives in the areas of asset transfers and shelters, asset recovery, medically needy coverage for institutional care, and long-term care insurance are based on existing information. Further studies are needed. The results of these studies, of course, could modify other conclusions contained in this article.

A. MNNHP

Individuals who would become newly income eligible for Medicaid coverage under a MNNHP, i.e., those whose 1992 monthly income falls between $1266 and the average monthly charge for nursing home care, make up a clearly defined and relatively small group. These persons could become impoverished quickly if faced with the need for intensive, formal care over a sustained period of time. The state will need a MNNHP to encourage LTCI purchase if it sponsors the type of public-private partnership that provides protection for policy holders have exhausted their insurance coverage. A MNNHP would enhance the state’s rate of return if the state implemented an aggressive asset recovery program.

B. LTCI

A LTCI initiative, by itself, is unlikely to have a substantial impact on Medicaid expenditures. A LTCI program should not be implemented for reasons other than direct fiscal benefit to the state. A LTCI program specifically designed for indigent elders should not be considered. Rather, a LTCI program should be targeted at individuals with annual incomes above $15,000 and with liquid assets of at least $40,000. A LTCI initiative is needed if the state implements aggressive Medicaid asset recovery or
restrictions on asset transfers and shelters. Connecticut's public-private partnership initiative for encouraging purchase of LTCI is the most appropriate general model for Florida. It should be followed, at least initially, in the LTCI planning, but only if Florida puts a MNNHP in place and is able to effectively limit Medicaid estate planning.

C. Asset Recovery

Very few states have aggressively sought to recover assets from Medicaid beneficiaries and Florida is no exception. Vigorous asset recovery requires high resolve, a concentrated administrative effort, and frequently engenders strong political opposition. Florida has a limited arsenal of legal weapons with which to recover Medicaid expenditures from assets of beneficiaries, although some potential for recovery exists. The likely investment returns, even in an aggressive asset recovery program, is unlikely to be worth the political and administrative costs which are required to implement such a program without a MNNHP. One potential justification for incurring the costs involved in launching an effective asset recovery program is the ability to encourage elders, who wish to avoid going on Medicaid, to purchase LTCI instead.

D. Asset Divestiture and Sheltering

Asset transfers and sheltering, even for purposes of qualifying for Medicaid coverage of LTC, are easy to accomplish in Florida. Asset transfers, rather than sheltering, are a more serious potential problem because transferred assets would be lost if the state decides to pursue a more aggressive recovery policy at some point. Restrictions on asset transfers and shelters are needed if a MNNHP is implemented. The above restrictions are needed to encourage widespread consumer purchase of LTCI because LTCI's costs are perceived to be high.

E. Needed Research

Research in the following areas is needed: 1) Identification of the following factors, possibly including the Medicaid income cap and easy asset transfer rules that are considered in the decision to purchase LTCI among Floridians; 2) Determination of the factors influencing Medicaid estate planning in Florida; 3) Estimation of the impact of Medicaid estate

91. Conversely, these restrictions, and perhaps vigorous asset recovery, may be needed to encourage widespread purchase of LTCI.
planning on Florida’s Medicaid budget; 4) Determination of options open to Florida in restricting asset transfers and sheltering to qualify for Medicaid; 5) Analysis of the barriers restricting opportunities (and the options available) for state asset recovery from Medicaid beneficiaries; and 6) Estimation of the MNNHP’s effect on rate of return in an asset recovery program.

X. RECOMMENDATIONS

The issues raised in this article are interconnected and complex. There is no single strategy available to address them; numerous actions must be taken. Generally, the order of policy steps recommended here reflects the optimal sequencing of implementation. However, most steps will require a great deal of simultaneity in policy actions. The recommendations are also designed to keep the state’s options open for moving flexibly in one or more of the interrelated policy areas.

Florida needs to develop policies in these politically delicate areas that will win the support of elder Floridians and their legislative representatives. To accomplish this, the state must clearly articulate both the rationale and the equity behind such policy actions and the benefits of such actions both to seniors and to state policy makers. The benefits might include protecting consumer and client choice as well as assuring state fiscal integrity. All major actors, from elders to legislators to state staff who operate the adopted programs on a daily basis, must be convinced that state policies in these areas are rational, compassionate, and fiscally sound. Otherwise, the chances for success of any of these policy initiatives would be narrowed considerably.

1) **DOEA and HRS should immediately launch a study in Florida to determine the extent of asset sheltering and divestiture taking place in order to qualify for Medicaid nursing home coverage (and estimate present and future impacts on the state’s Medicaid budget).**

The study should address to what extent Medicaid income eligibility requirements are considered by elders in Medicaid estate planning. The study also should determine how Medicaid estate planning affects the purchase of LTCI. This study may reveal that this behavior is quite limited (or even if it is substantial, that it has little affect on the Medicaid budget), because the income cap functions as a control on access to Medicaid LTC benefits. Thus, the state may only need to address the issue of Medicaid estate planning if a MNNHP is implemented or if the state wishes to
encourage LTCI purchases. The state should complete this study within nine months.

2) **DOEA and HRS should initiate as soon as possible an in-depth study of current law, federal and state judicial decisions, and regulations which are germane to asset transfers, shelters, property encumbrances, and other Medicaid expenditure recovery strategies so as to identify state options for policy initiatives in these related areas.**

The state needs this analysis to determine its options regarding effective asset recovery administration and whether a more vigorous asset recovery effort is needed to encourage LTCI purchases. Retaining the status quo of recovery, principally from third parties, might be an option. Florida already is relatively high up (third) in the probate claimant queue. This analysis should include consideration of the potential interactions with other policy initiatives in areas of asset sheltering, asset transfers, and a MNNHP, as well as political repercussions from actions taken independently of, and in conjunction with, other policy actions. The state should also monitor the experiences of other states, such as Wisconsin, that are in the process of implementing asset recovery programs. The state should be complete this study within nine months.

3) **Begin immediately to plan for a LTCI partnership program.**

While LTCI should not be viewed as a substitute for state Medicaid expenditures, state involvement clearly is needed in this area, at a minimum, to ensure that the public is adequately educated regarding insurance options. The state may need to sponsor the program if it decides to tighten asset transfers and asset recovery under Medicaid. Florida should initially plan for a Connecticut-type, full partnership arrangement, i.e., asset forgiveness from eligibility and recovery consideration, as well as state certification, care management, and consumer information dissemination aspects. In order to prepare for program implementation, the state will need to apply for a waiver of Medicaid asset requirements. In addition, if the New York model is followed, the state will need to apply for waiver of income eligibility requirements from the Health Care Financing Administration. One variation on this comprehensive approach is to exempt assets only for eligibility determination, and not exempt assets for recovery once the Medicaid recipient has died. This still would allow the elder recipient to control his or her assets while living. At the conclusion of the program planning period, the state could decide to provide state policy certification, consumer information dissemination, and perhaps, insurance agent training. The state could not disregard assets or income from eligibility calculation or recovery
for LTCI purchases. However, the state should be prepared to implement the full partnership model in case it determines that this model is necessary to pursue asset recovery or asset transfer restrictions.

Florida should closely follow other partnership states’ developments during its program development process, and also observe the other states’ degrees of success in these other related policy areas. The state should complete this planning process within twelve months. Florida should implement the plan within an additional twelve to twenty-four months, depending on whether a basic or a full partnership model is adopted.

4) **DOEA should collaborate with HRS and other relevant state agencies to reduce any unacceptable level of asset transfers and sheltering for Medicaid qualification (as determined from the studies in Recommendations 1 and 2).**

The effectiveness of the other initiatives could depend heavily on the success of this action. More importantly, success will control Medicaid cost increases for LTC; if not now, then whenever a MNNHP is in place. This action should be taken when the results of the study in Recommendation 1 are understood and the necessary political support is available for administrative actions or legislation required.

5) **If the state decides to implement a MNNHP, or to sponsor a LTCI program, DOEA should work with HRS and other relevant agencies to establish an asset recovery initiative modeled as closely as possible after Oregon’s program and that takes into account state options which are identified from the in-depth legal study.**

A successful asset recovery initiative requires clear policy, well-trained staff, and on-going evaluation. The state should take this step as soon as the three stated stipulations are satisfied.

6) **DOEA and HRS must implement a rigorous data collection effort to assess the cost effectiveness of any asset transfer or recovery initiatives that the state might implement in carrying out Recommendations 4 and 5.**

This plan will measure the success rate of asset transfer and recovery policies on an on-going basis and should exist at the beginning of any new or rejuvenated asset recovery or divestiture restriction activity.

7) **DOEA and HRS should begin immediate planning for the eventual adoption of a MNNHP so that the state is prepared to move quickly to implement such a program.**
The state should have the MNNHP plan ready within six months after the studies in Recommendations 1 and 2 above are completed.

8) As soon as any needed asset recovery and asset divestiture controls are solidly in place, or it is determined from the recommended studies that new initiatives will not be needed, DOEA, HRS, and other relevant agencies should pursue legislation or administrative actions to implement a MNNHP.

The establishment of any asset recovery and divestiture control programs, which would allow the state to create a MNNHP, is likely to take three to five years. Should asset transfer controls or asset recovery actions not be needed, the state could adopt a MNNHP program immediately after the studies under Recommendations 1 and 2 are fully analyzed (in twelve to fifteen months).

XI. CHANGES BROUGHT ABOUT BY OBRA ’93

The Omnibus Budget and Reconciliation Act of 1993 (OBRA ’93), passed by Congress in October 1993, may eventually be viewed as landmark legislation, at least in those states with Medicaid income caps. It contains several key provisions affecting eligibility for long-term care benefits under Medicaid:

1) A number of widely-used methods of asset transference in Florida, such as joint accounts and revocable trusts, are disallowed. The Streimer rule is negated.

2) The cap of thirty months on penalty periods for asset transfers is removed, and several loopholes, such as concurrent running transfer penalty periods for minimizing the length of the penalty period, are closed.

3) The look-back period for determining whether asset transfer has occurred is increased from thirty to thirty-six months (and to sixty months for trust funds).

4) States must establish asset recovery programs.

5) In the twenty income-cap states like Florida, elders who meet asset eligibility criteria, but whose incomes are above the income cap, can set up irrevocable Miller-type trusts in order to become eligible for Medicaid. Income deposited in the month it is received is excluded in determining eligibility. However, the trusts must state that any funds remaining in them upon the Medicaid recipient’s death, up to the amount expended on the recipient during his or her lifetime, go to the state.
XII. OLD CONCLUSIONS AND NEW CONSIDERATIONS

A central thrust of the state’s call for policy analysis in these areas was to explore the feasibility of implementing programs such as asset recovery and LTCI in order to offset or reduce, directly or indirectly, the added costs to Medicaid in implementing a MNNHP. Some type of state LTCI initiative might be needed to offset the “political fallout” from tightening up on asset transfers and shelters or from instituting more aggressive asset recovery. LTCI could not be expected to produce anywhere near the state-estimated $45 million per year in Medicaid savings needed to make the MNNHP budget-neutral, even in the long run.

Also, the authors argued that expenditures saved from tightening up on asset transfers would reflect the amount of transference already taking place—probably not much because of the income gap. After all, why would elders or their families attempt asset transfers or sheltering if they could not qualify based on their income? This would make sense only in cases where an elder’s asset-generated income put him above the eligibility threshold.

Finally, it is unlikely that revenues from asset recovery will offset the estimated cost of a MNNHP. Florida’s homestead exemption in Florida makes substantial asset recovery especially difficult. If the state’s estimate of $45 million to cover 11,000 individuals caught in the “Medicaid Gap” under a MNNHP were high, these other measures might come a little closer to offsetting costs. The estimate may be high because of the relatively generous eligibility threshold of $1338 (three times the SSI income level) that Florida uses, i.e., the state denied Medicaid coverage to a relatively modest number of elders using the income cap. Further, some elders may not seek Medicaid coverage because they are unwilling to qualify because they consider Medicaid-covered care stigmatizing or below acceptable quality.

Since the state’s estimate raises questions, it is helpful to consider whether the level of trust fund activity under OBRA ’93 is a good barometer of the demand for Medicaid coverage of long-term care that would likely occur under a MNNHP. There are several possible reasons that it may not be. Substantial barriers to the use of trust funds exist, including: 1) lack of knowledge about the availability of trust funds; 2) lack of knowledge concerning creation of a trust, or reluctance to pay an attorney to establish the trust (costs can run as high as $8000); and 3) the distastefulness of leaving one’s assets or “the children’s inheritance” to the state. The ignorance factor should diminish as time passes. In addition, as the trusts become more common, attorney’s fees may decrease substantially. Even the
distaste of leaving one's wealth to the state may subside, albeit more slowly, as elders and their families come to realize that, typically, very little will be left in the trusts at the Medicaid recipient's death. Few funds are left because the income entered into the trust account at the beginning of the month will be drawn out by month's end to pay for the recipient's share of the cost of long-term care services. This is especially likely when the care occurs in a nursing home, where total charges, on average, exceed $2000 per month. The recipient will be allowed to retain a personal needs allowance of at least thirty-five dollars per month that is not figured into his or her share of costs. However, this amount is likely to be depleted for personal needs or, perhaps, to defray any trust account processing fees that a bank or other institution holding the trust may charge for its services. Federal regulations have not yet made allowances for such fees in administering these accounts.

The larger question is whether the removal of the income barrier either through the trust, or alternatively, under a MNNHP, will increasingly encourage asset transfers, and especially sheltering, among those persons higher up the income scale. If this occurs to a significant degree, the number of eligibles could swell beyond the State's estimate of 11,000 who are expected to benefit immediately from the adoption of a MNNHP.

XIII. NEW CONCLUSIONS AND RECOMMENDATIONS

Florida, much like all income cap states, is required to implement a provision for income trusts under OBRA '93. However, there is a significant administrative burden in verifying and monitoring the trust funds, the costs to elders of setting up the trusts are not minimal, and the state expects little recovery from the trust funds. As a result, state policy makers may more seriously consider the establishment of a MNNHP to enhance access to Medicaid coverage for long-term care among older Floridians. Whether the added costs of monitoring the income trusts and meeting the needs of more eligible persons will match the expected added costs of a MNNHP is an empirical question.92

For a brief period, the state may want to see if the take-up level on trust funds accelerates as the elder population gains wider familiarity with them. Also, it should determine if the trust funds encourage substantially more asset transfer and sheltering among the population with incomes above

92. Costs would be added by a MNNHP, presumably because fewer psychological barriers to applying for Medicaid exist under a MNNHP than with the trust funds.
the private charge for nursing home care. Unfortunately, the state currently has no reliable research mechanism to measure the level of asset transference and sheltering that is occurring. On the other hand, potential barriers to the take-up of income trusts under OBRA '93, i.e., the legal expenses of setting up the trust and the perceived negative prospects of handing over one's wealth to the state at one's death, would not exist under a MNNHP. These barriers may turn out to be important factors to the less-well-off in discouraging applications. Consequently, an observation period may provide a better indication of the take-up rate under a MNNHP among those with high incomes than among those in the Medicaid Gap.

The added federal restrictions on asset transfers under OBRA '93 may be largely inconsequential because there always seem to be new methods created for getting around the barriers. Furthermore, it is still appropriate to shelter assets in exempt categories such as the homestead exemption. This is likely to happen on a greater scale now that some of the established methods of transferring assets have been curtailed by OBRA '93. In Florida, this particular way of "sheltering" becomes a means of asset transfer, because with the homestead passing to "any natural heir," the state has no means of recovering it.

The homestead exemption means that asset recovery is likely to be relatively modest in Florida. The state is highly unlikely to attempt to instigate a change in that precedent for the foreseeable future and probably beyond because it is widely viewed as sacrosanct. By allowing income trusts, however, OBRA '93 should allow proportionately more persons to come under Medicaid who have recoverable assets. This is because asset values and income levels are highly correlated among elders, and those with the level of resources that have placed them in the Medicaid Gap in the past are unlikely to have maximized their exemption during their estate planning. Moreover, some individuals die without natural heirs, as pointed out above, and will therefore leave recoverable property. As the state includes more recipients to the trust fund, more situations of this kind will be created. Thus, the state probably will realize a somewhat greater return from recovery efforts than it would have realized without the trust fund provision of OBRA '93.

Finally, because the relatively passive asset recovery effort that is likely to take place will pose little threat to the "estates" of those who are most likely to make their voices heard in the political process, i.e., those with the

---

93. This is especially true now that the Medicaid income threshold barrier has been removed.
resources and information to plan their estates and thus who are likely to shelter their wealth in resource categories exempt from recovery, there is no compelling need for the state to undertake a LTCI initiative program such as Connecticut's LTCI Partnership model as a political offset. Besides, state policy makers can probably avoid any political fallout from asset recovery as well as from the new barriers to asset transfers by simply pointing out that "the feds made us do it."

94. The state, however, may choose to go this route for other "public service" reasons.
XIV. FORM ONE: MULTI-STATE SURVEY

SOUTHEAST FLORIDA CENTER ON AGING
Florida International University
North Miami, Florida 33181

LONG TERM CARE CONTEXT
DEVELOPMENT PROJECT

Multi-State Survey

RESPONDENT INFORMATION:

<table>
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<tr>
<th>State</th>
<th>Agency</th>
<th>Individual</th>
<th>Title</th>
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Address
Phone

City
State
Zip Code

1a. Does your Medicaid State Plan include the option to cover institutional care as part of your medically needy program?

☐ ☐
Y ☑

b. Does your state have statutory language specifically authorizing this program?

☐ ☐
Y ☑

If yes, please send us a copy of the language.
If no, skip to question 6.

2. Do you have expenditure or other data, i.e. client numbers, unit costs, agreements with nursing homes, etc. that you can share with us by phone?

☐ ☐
Y ☑

If yes,______________________________________________

Person to call
Phone

3. Do you have any descriptive brochures on the program that you could share with us?

☐ ☐
Y ☑

4. Have you encountered any problems with the medically needy institutional care program?

☐ ☐
Y ☑
5. Are any changes or amendments contemplated in state policy procedures, or financing?
   □ □
   Y N

   If yes, please describe (briefly):
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

6. If a medically needy institutional care program was under consideration but not adopted, what factors were key in deciding not to adopt?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

7. Is your State involved in any long term care insurance initiatives that would creatively use state general revenue to purchase policies for potential Medicaid clients?
   □ □
   Y N

   If yes, _____________________________________________________________________

   Person to call    Phone

8. Who is the contact person in your state who handles third-party recovery or knows the procedures used in your state?
   ____________________________________________________________
   ____________________________________________________________

   Person to call    Phone
9. If the answer to 1 or 3 was yes, please forward referenced materials to:

John Stokesberry
Southeast Florida Center on Aging
Florida International University
North Miami, FL 33181
XV. FORM TWO: LONG TERM CARE INSURANCE—TELEPHONE SURVEY

SOUTHEAST FLORIDA CENTER ON AGING
Florida International University
North Miami, Florida 33181

LONG TERM CARE CONTEXT DEVELOPMENT PROJECT
LONG TERM CARE INSURANCE—TELEPHONE SURVEY

RESPONDENT INFORMATION:

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1. Does your state have any long term care insurance (LTCI) initiatives other than regulating companies that sell these products?

2. Does your state have a fiscal involvement in these initiatives? (Subsidized premiums, tax incentives, special allowances)

3. To whom are these initiatives targeted? (Specific age groups, state employees, low to middle income, retirees only)

4. How do these initiatives relate to your other Medicaid or long term care efforts?
5. Are any changes contemplated in your current state LTCI policies or procedures?


6. Do you have any statistics on LTCI you could share with us? (Cost data, number of policies sold, budget estimates)


Contact Person | Title | Phone

7. Do you know of other states involved in similar activities?


State | Contact | Phone

State | Contact | Phone

State | Contact | Phone
**XVI. FORM THREE: MEDICAID ASSETS RECOVERY—TELEPHONE SURVEY**

**SOUTHEAST FLORIDA CENTER ON AGING**  
Florida International University  
North Miami, Florida 33181

**LONG TERM CARE CONTEXT DEVELOPMENT PROJECT**  
**MEDICAID ASSETS RECOVERY—TELEPHONE SURVEY**

**RESPONDENT INFORMATION:**

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<td>Individual</td>
<td>Title</td>
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1. Does your state have a mechanism for third-party recovery of Medicaid expenditures? Is one contemplated? Statutory reference and could we have copy of the language?

2. Describe the techniques used to recover assets. (Lien laws, pre-admission agreements, etc.)

3. How aggressively are these techniques pursued? (Dedicated full time staff, coordination with other public agencies, computer assisted)

4. Are you contemplating any changes in current policies and procedures regarding assets recovery?
5. Do you have any data you could share with us on your program? (Fiscal & budget figures, client counts, staff structure, etc.)

6. How does your assets recovery program relate to your other Medicaid and long term care initiatives?

7. Do you know of other states that are aggressively pursuing assets recovery?

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Taxes and the Elderly: An Introduction

Gail Levin Richmond*

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* Professor of Law and Acting Dean, Nova Southeastern University Shepard Broad Law Center. A.B., University of Michigan, 1966; M.B.A., University of Michigan, 1967; J.D., Duke University, 1971.
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Older individuals may retire from the workplace, but they cannot retire from paying taxes. The number of taxing jurisdictions, and types of taxes imposed, preclude total escape. Because the federal income tax applies to many types of retirement income, it remains a factor for many individuals after retirement. Even those whose incomes, after retirement, are modest enough to avoid federal income tax still face sales, excise, property, and wealth transfer taxes. In this regard, the elderly differ little from everyone else.

There are, however, tax rules that apply only, or primarily, to older taxpayers or that involve different treatment for taxpayers who have attained a certain age. These rules apply in situations such as selling a home or taking a pension plan distribution. In addition, older taxpayers may be unaware that they qualify to use provisions commonly thought to cover younger taxpayers. The dependent care credit is one such provision. In dealing with these varied rules, attorneys representing older clients must remember three guidelines. First, tax rules affecting older clients cannot be isolated by including a particular age in a LEXIS® or WESTLAW® search. Many nominally age neutral tax rules affect a greater percentage of older clients than of younger ones. Second, younger clients' taxes may be affected by actions they take to assist their elderly parents, as well as by

1. All examples contained herein are based on a single individual with no dependents, age 65, unless the facts indicate a different set of data. Rev. Proc. 93-49, 1993-2 C.B. 581 provides 1994 inflation adjusted information for tax rates and deduction levels.

2. Some taxes vary based on overall wealth or income level. Others vary based on a particular type of wealth or income level. Tax rules vary based on geographic domicile or even former domicile.

actions they take to plan for their own old age. Third, certain economic disincentives, although not formally called taxes, impose the same adverse consequences as taxes. The effects of inflation and the phaseout of social security benefits are both examples of disincentives affecting older taxpayers.

If we reconfigured Parker Brothers' game of Life®, the graphic depiction of tax rules affecting older clients would easily fill the board of the game of "Tax Life." Not surprisingly, a comprehensive discussion of those aspects easily fills a treatise and would overwhelm the pages allotted this article. Thus, the resulting inclusion and omission decisions reflect the author's perceptions about this article's audience and the type of materials available elsewhere.

First, the discussion that follows includes investment decisions, medical care outlays, problems involving the personal residence, and retirement and related benefits, including those involving involuntary retirement. Discussion of financial assistance from children appears in some of these materials. Because this article appears in a "general jurisdiction" law review, this article will ignore tax specialists and will target attorneys in general practice, irrespective of whether they specialize in elder law.

Second, this article omits most situations involving complicated estate planning. The estate planning problems of the wealthy elderly rarely involve the client's financial interest. Because the unlimited marital deduction postpones federal transfer taxes until the second spouse dies, transfer tax avoidance discussions largely focus on means of preserving wealth for another generation. In addition, the $600,000 cumulative exemption from gift and estate taxation allows the majority of taxpayers to transfer that amount, free of those federal taxes, to any beneficiary or group of beneficiaries they wish.

4. Younger clients' tax planning may also be affected by actions their elderly parents take in transferring wealth to the younger generation.


6. Clients with highly appreciated, low-yield assets are one exception. They may find that transferring those assets to a charitable trust or pooled income fund provides increased current income and avoids the income tax they would pay on selling the underlying property. I.R.C. §§ 642(c)(3), 664 (1994).

7. One caveat is in order. A deceased client can easily be worth more than $600,000 despite being worth significantly less as a living client the day before. The estate tax applies to items in the taxable estate, which is based on the gross estate (a federal tax concept), not on the probate estate (a state property concept). The gross estate includes several assets that
Finally, because so many jurisdictions are involved, this article limits its discussion of state taxes to a few potential problem areas. These appear in discussions about investment decisions, sale of the taxpayer's home, and receipt of retirement benefits.

Section II of this article lists various ages at which a taxpayer might be considered elderly, as there is no uniform statutory age. Section III introduces the components involved in computing federal income tax. Some rules involving the elderly involve their gross income; others involve their adjusted gross income or a specific aspect of their gross income. Tax-planning opportunities can be lost if attorneys fail to understand these terms. The remainder of the article deals with how taxes may affect particular decisions or be affected by those decisions.

II. WHEN IS A TAXPAYER ELDERLY?

Federal income tax consequences flow from the interaction of age-based status and a particular activity. For example, being age fifty-five is important for federal tax purposes if the client is selling a home, but not if the client is considering a vacation in Bermuda. Social security recipients' tax consequences are affected by their other income and by their decision to continue working to supplement benefits. For those who do continue to work, their age also affects the amount of benefits they retain. This section briefly introduces the ages that appear elsewhere in this article.

The age which an individual becomes "elderly" is not fixed in the Internal Revenue Code ("tax code" or "Code"). The tax code provides age-based rules beginning before age one and ending shortly after age seventy and a half. The number of different relevant ages adds complexity to a statutory scheme that is unlikely to win an award for clarity. In addition, situations that do not involve a specific statutory age may interact with those that do. A taxpayer in poor health may desire a deduction for amounts spent on various types of medical care. The taxpayer's ability to do so is not dependent upon attaining a specific age. If that same taxpayer is too infirm to remain at home, guidance as to the tax consequences of selling that home becomes relevant. Those consequences do vary based on age.

may bypass the probate estate, most notably life insurance proceeds, pension benefits, and property in revocable trusts.

8. Children who are at least one year old must have social security numbers or they cannot be claimed as dependents on tax returns. I.R.C. § 6109(e) (1994). To avoid excise tax, taxpayers must begin withdrawing funds from their pensions and individual retirement accounts by April 1 of the calendar year following the year they attain the age of 70 1/2. Id. § 4974.
The following list briefly introduces several ages that are relevant to a discussion of elderly taxpayers.

1) Age 40 is the minimum age for coverage under the Age Discrimination in Employment Act of 1967 ("ADEA").

2) Age 55 is the minimum age for excluding forever up to $125,000 of gain with respect to a principal residence.

3) Age 59 ½ is the minimum age for beginning pension benefits without risking the excise tax on premature withdrawals.

4) Age 64 is the maximum age for claiming the earned income credit unless the taxpayer has a qualifying child.

5) Age 65 is the minimum age for a taxpayer who is not blind to claim the additional standard deduction and, unless the taxpayer is permanently disabled, the credit for the elderly and permanently disabled.

6) Age 70 is the minimum age for avoiding completely the phaseout of social security benefits because of excess post-retirement earned income.

7) Age 70 ½ is (by April 1 of the year following the taxpayer's reaching this age) the cut-off for either beginning to receive retirement benefits or paying an excise tax.

III. THE FEDERAL INCOME TAX COMPUTATION

A. Basic Computation

Taxable income is computed using the following formula:

\[
\text{Gross Income} - \text{Deductions} = \text{Adjusted Gross Income} - \text{Either Standard or Itemized Deductions} - \text{Personal Exemption Deductions} = \text{Taxable Income}
\]


11. Id. § 72(t)(2)(A).

12. Id. § 32(c)(1)(A)(ii).

13. Id. §§ 22(b)(1), 63(f).


After ascertaining taxable income, the taxpayer computes a tentative liability based on the rate structure for marital status. Before paying the tax computed, the taxpayer reduces that liability by any tax credits for which he or she is eligible.

B. Gross Income

As a general rule, a taxpayer has gross income as a result in any increase in net wealth. Borrowing does not involve gross income because the increase in assets is offset by an increase in liabilities, which yields no net increase in wealth.

Even if net wealth increases, the taxpayer has no gross income if the Code provides an exclusion section governing the particular increase in wealth. For example, although interest received because the taxpayer owns state and local government bonds is excluded from gross income, interest received from United States government bonds is not excluded. In addition, if the increase in wealth arises from appreciation in assets, gross income is postponed until the taxpayer "realizes" the gain by a sale or other disposition of the property.

C. Adjusted Gross Income

Many of the tax consequences discussed in this article are affected by the amount of the taxpayer's adjusted gross income, defined as gross income reduced by a limited number of deductions listed in section 62 of the Code. Section 62 includes expenses associated with being a sole proprietor, owning rental property, and paying alimony. It also includes the deduction for capital losses. If a taxpayer withdraws funds from a certificate of deposit before its maturity date, the amount forfeited is a section 62 deduction.

---

16. See id. § 61 (providing an expansive concept of gross income). Gross income includes "all income from whatever source derived." Id.
17. Id. §§ 71-135.
18. Id. § 103(a). The exceptions to this rule of exclusion are beyond the scope of this article. However, if the exclusion is the reason for investing, the attorney should caution the client that some municipal bonds do not qualify.
20. Id. § 62(a)(9). Because they often view certificates of deposit as a safe investment vehicle, elderly taxpayers who receive no tax benefit from itemized deductions may benefit from this provision.
D. **Itemized and Standard Deductions**

Most taxpayers are entitled to deduct either a standard deduction or itemized deductions. The standard deduction is a flat amount that varies based on the taxpayer’s filing status and increases slightly each year to reflect inflation.\(^\text{21}\) If a taxpayer is at least age sixty-five and takes the basic standard deduction, the taxpayer is also entitled to an additional standard deduction of $950.\(^\text{22}\) Most itemized deductions involve personal items, such as mortgage interest and charitable contributions, authorized by a particular Code section.\(^\text{23}\)

In computing their taxable incomes, most taxpayers can choose between taking the standard deduction or itemizing and will select whichever is larger.\(^\text{24}\) However, there is no need to compute the larger number unless gross income exceeds the sum of the standard deduction and personal exemption deduction.

E. **Personal Exemption Deduction**

Unless a taxpayer is claimed as a dependent on another taxpayer’s return, he or she is entitled to a personal exemption deduction of $2450.\(^\text{25}\) In addition, the taxpayer’s spouse is also entitled to this deduction, and the taxpayer can take the deduction for each eligible dependent.\(^\text{26}\)

---

21. *Id.* § 63(c), (f). Taxpayers who are claimed as dependents by other taxpayers are limited to a standard deduction based on their earned income unless the minimum deduction of $600 is greater. *Id.* § 63(c)(4)-(5). No such limit applies to taxpayers who itemize their deductions. *Id.* § 63(d). Elderly parents will be subject to this limitation if their children are able to claim them as exemptions.

22. I.R.C. § 63(f) (1994). If the taxpayer is married, the 1994 additional amount is $750 per spouse who is age 65 or older. *Id.* § 63(f).

23. *Id.* §§ 163-165(c)(3), 170, 213. Unreimbursed employee business expenses, investment expenses for property that does not produce rental or royalty income, and expenses to compute or contest tax liability are also potential itemized deductions. *Id.* §§ 162, 212. On the other hand, the alimony deduction is used in computing adjusted gross income and is therefore available to taxpayers taking the standard deduction as well as to those who itemize. *Id.* §§ 62(a)(10), 215. Itemized deductions are those items, other than the deduction for personal exemptions, that are not listed in Code section 62. *See I.R.C.* § 63(d) (1994).

24. *See id.* § 63.

25. *Id.* § 151(d)(1). This amount increases slightly each year to reflect the effects of inflation. *Id.* § 151(d)(4).

26. *Id.* § 151(b)-(c).
F. Taxable Income

Taxable income is the base upon which the federal income tax is computed.

G. Applicable Tax Rates

The federal income tax is a progressive tax. Successively higher rates apply to incremental amounts of income. The five current rates are 15%, 28%, 31%, 36%, and 39.6%. The amount of taxable income subject to each of these rates depends on three factors: 1) the taxpayer's filing status; 2) the annual inflation adjustment; and 3) the type of income. A taxpayer's filing status generally reflects marital status, with limited relief for unmarried taxpayers with certain family responsibilities. Different rate schedules apply to taxpayers classified as unmarried, as unmarried head of household, as married filing a joint return, and as married filing a separate return. These schedules undergo annual revision to reflect reductions in purchasing power caused by inflation. Special tax computations apply to long-term capital gains and to certain distributions from pension plans. In addition, special excise taxes and Social Security taxes may also be assessed. These items are discussed elsewhere in this article.

H. Credits

Qualifying elderly taxpayers may reduce their taxes by the earned income credit, by the dependent care credit, and by the credit for the elderly and disabled. Unlike a deduction, which reduces taxes by the tax rate applied to the deduction, a dollar of credit translates into a dollar of tax savings.

28. For example, the 15% rate applies to the first $38,000 of taxable income on a joint return. If the taxpayer is unmarried and not a head of household, the 15% rate applies to only $22,750. If both sets of taxpayers have $25,000 of taxable income in 1994, the couple never leaves the 15% bracket; $2250 of the unmarried taxpayer's income is subject to the 28% tax rate. Id. § 1(c), (f)(3).
29. Id. § 1(f). For example, the 28% rate applies to a joint return in 1994 only if taxable income exceeds $38,000. It applied in 1993 to amounts exceeding $36,900.
30. This article omits coverage of the alternative minimum tax, which applies to taxpayers who use "too many" of the tax deductions Congress enacted. See id. §§ 55-58.
31. Id. § 32.
33. Id. § 22.
The earned income credit is a refundable credit. An eligible taxpayer receives the full amount of this credit even if the taxpayer has no income tax liability. If this credit applies, it is imperative that the client file a return. The other two credits are nonrefundable. They can offset an existing tax liability but cannot generate a negative income tax.

IV. INVESTMENT DECISIONS

Choices made about the type of income a taxpayer receives affect the amount of gross income, the amount of adjusted gross income, and ultimately the amount of tax due. In addition, an elderly taxpayer's investment decision may have tax ramifications for children who are supporting the taxpayer. The most common choice involves the question of investing in an asset that yields a lower rate of return before taxes but a higher rate after taxes.34

A. Self-Supporting Taxpayer

1. Basic Effect on Tax Paid

Consider for example, a taxpayer who receives a $22,000 per year pension, has savings of $500,000, and is not eligible for any section 62 deductions. The taxpayer is single and takes the standard deduction, including the additional standard deduction for a taxpayer who is at least sixty-five. The taxpayer has a choice between purchasing certificates of deposit paying 5% interest or municipal bonds paying a tax-free 4% interest.35 Without invading principal, he or she can expect annual income of $25,000 from the certificate and $20,000 from the bonds. Thus, selecting the certificate results in gross income of $47,000, while selecting the municipal bond results in only $42,000.

34. Because many elderly individuals are risk-averse, they forgo the higher potential returns associated with equity investments. In so doing, they risk the purchasing power erosion caused by the hidden tax of inflation. Even modest levels of sustained inflation result in significant erosion over time. For example, the purchasing power associated with a fixed fund will be cut in half in approximately 12 years if inflation averages 6%, and in less than 20 years if it averages 4%. Many elderly individuals can expect to live that long after retiring at age 65.

If the taxpayer selects the certificate of deposit, he or she will pay 1994 federal income tax of $8186.50. If he or she selects the municipal bonds, the tax bill is a mere $2220, reflecting $25,000 less of taxable income. In other words, the $5000 increase in income before taxes resulted in a $5966.50 increase in the taxpayer’s federal income tax bill. The differential may be even larger in a state that imposes a state income tax.

2. Additional Consequences of Decision

a. Medical Expense Deduction

The taxable investment may cause other adverse tax consequences. If significant medical expenses were incurred, the taxpayer might be eligible to itemize deductions. Because the medical expense deduction declines as adjusted gross income rises, the $25,000 increase in adjusted gross income will cost $1875 in medical expense deductions.

b. Dependent Care Credit

Because the credit for dependent care is often referred to as the child care credit, qualifying elderly taxpayers may not realize they are eligible to use it. If a taxpayer has a spouse or dependent, irrespective of age, who is physically or mentally incapable of self-care, the credit is available for amounts paid to care providers to enable the taxpayer to work.

The credit amount depends on the number of individuals requiring care, the amount spent on care, the taxpayer’s earned income for the year, and the taxpayer’s adjusted gross income for the year. If one individual needs care, the amount eligible for the credit is the lesser of the taxpayer’s earned income, the amount spent on care, or $2400. If two or more individuals require care, the last of those three limits increases to $4800. The credit itself begins at 30% of the amount eligible for the credit and declines by one

36. The taxpayer’s gross income will be reduced by the 1994 standard deduction of $3800, the additional standard deduction of $950, and the personal exemption deduction of $2450, leaving taxable income of $39,800 subject to the rates for unmarried individuals. See id. § 1(c).

37. Of course, that taxpayer loses some advantage at the state tax level unless the taxpayer only purchases bonds issued by that state or its municipalities. See, e.g., ALA. CODE § 40-18-14(2)(f) (1975).


39. See discussion infra section VI.

percentage point for each $2000 of adjusted gross income in excess of $10,000. In no event can the credit percentage fall below 20%.\(^\text{41}\)

Because the credit declines as adjusted gross income rises, municipal bonds may again provide attractive tax advantages. If the taxpayer described above paid for expenses for the care of a qualifying spouse or dependent, $25,000 in certificate of deposit interest would cause the credit to fall to 20%. Municipal bond interest would not reduce the credit percentage below 24%, the amount that reflects a six percentage point reduction for his $22,000 salary.

\section*{B. Lower Income Working Taxpayer}

\subsection*{1. Basic Effect on Tax Paid}

A taxpayer whose salary is only $11,000 per year and who is concerned about investing a much smaller sum, say $10,000, has different concerns. The basic income tax cost of receiving $500 of taxable interest instead of $400 of tax-exempt interest is no more than $75, because this taxpayer is in the 15% bracket for his or her entire taxable income.\(^\text{42}\) Obviously, no one would give up $100 of extra income to save $75 in taxes.

\subsection*{2. Additional Consequences of Decision}

As noted for his or her higher-salaried counterpart, the taxpayer’s selection of taxable interest may reduce the medical expense deduction and the dependent care credit. However, because both the salary and the investment amounts involved are so low, the medical expense deduction would be reduced by only $37.50\(^\text{43}\) and the dependent care credit would not be reduced at all.\(^\text{44}\)

\begin{itemize}
\item \textit{41}. Id. \S 21(a)(2), (b)(2), (c)-(d).
\item \textit{42}. Id. \S 1(c). If this taxpayer is married and filing a joint return, he or she has no tax liability at all. The $11,500 gross income is fully offset by the standard deduction of $6350, the additional standard deduction when both spouses are at least 65 of $1500, and a personal exemption deduction of $2450 for each spouse. Id. \S\S 63(c)(2), (f), 151(b), (d).
\item \textit{43}. Unless the taxpayer’s medical expenses and other itemized deductions exceed the $4750 standard deduction ($3800 if he or she is under 65), the taxpayer will not be deducting medical expenses and the $37.50 is irrelevant.
\item \textit{44}. Note that these examples are fact specific. The dependent care credit would not be reduced because the phaseout is based on each $2000 of adjusted gross income above $10,000. The $11,000 salary already resulted in a one percentage point phaseout. Adding $500 in interest income does not take the taxpayer to the next $2000 level. In addition, if this taxpayer qualifies for the dependent care credit, it will likely offset the entire income tax
\end{itemize}
The earned income credit is the most significant additional tax consequence this taxpayer must consider. The earned income credit reduces the tax burden on low income workers, who may pay more in Federal Insurance Contribution Act ("FICA") taxes than they do in income taxes.\textsuperscript{45} This credit is refundable and will be paid to the taxpayer even if it exceeds the taxpayer's income tax for the year. The credit varies based on three factors: 1) the number of qualifying children in the home; 2) the taxpayer's earned income; and 3) the taxpayer's adjusted gross income.\textsuperscript{46}

a. Qualifying Children

An individual ceases to be a qualifying child at age nineteen. This limitation is extended to age twenty-four if the child is a student. There is no outer limit if the child is permanently and totally disabled.\textsuperscript{47} In addition, the child can be the taxpayer's own child or stepchild, a descendant of the taxpayer's child, or a foster child being cared for as the taxpayer's own child. An individual is not a qualifying child unless that individual and the taxpayer share the same principal place of abode.\textsuperscript{48} The taxpayer does not have to be eligible to claim the child as a dependent unless the child is married.

The lowest percentage credit applies to individuals with no children (7.65%), with a larger percentage available for individuals with one child (34%). The largest credit percentage goes to individuals with two or more children (40%). Once a taxpayer reaches age sixty-five, taking the credit requires having a qualified child.\textsuperscript{49}

b. Earned Income

The amount of earned income eligible for the credit also varies with the number of children, ranging from $4000 for a taxpayer with no children to

\textsuperscript{45} See I.R.C. §§ 3101, 3121 (1994). FICA taxes, which are withheld from a wage-earner's paycheck, are computed based on gross wages, with no offset for a standard deduction or personal exemption. \textit{Id.} § 3121(a).

\textsuperscript{46} \textit{Id.}

\textsuperscript{47} \textit{Id.} § 32(c)(3)(C).

\textsuperscript{48} \textit{Id.} § 32(c)(3)(A)(ii), (B)(iii). Children other than foster children must have the taxpayer's home as their principal place of abode for more than one half of the year; for foster children, the requirement is the entire year.

$8425 for a taxpayer with two or more qualifying children.\textsuperscript{50} Unless the taxpayer's total adjusted gross income is too high, a taxpayer with two children and earned income of at least $8425 will receive a credit of $3370.

c. Adjusted Gross Income ("AGI")

The taxpayer's eligibility for this relief measure phases out as his or her adjusted gross income increases above a statutory base, which varies with the number of qualifying children. The phaseout begins at $5000 of AGI if there are no children and at $11,000 if there are one or more children. As a result, a taxpayer with 1996 earned income of $8425, and adjusted gross income of $11,000 or less, receives a credit of $3370 if he or she has two or more qualifying children. However, the credit is reduced by 21.06% of each dollar of adjusted gross income greater than $11,000.\textsuperscript{51} The income phaseout affects a taxpayer's choices as to savings vehicles, assuming there is the ability to save.\textsuperscript{52} If the taxpayer earns $11,000 in salary and receives $500 of interest from a bank account, $105.30 of the credit is lost. The taxpayer may also pay $75 in income tax unless the children are dependents or the itemized deductions are large enough. If the taxpayer instead earns $400 in municipal bond interest, none of the credit is lost and no income tax is due with respect to this interest. One hundred dollars in foregone income yields up to $180.30 in tax reduction.

The income phaseout does not affect a taxpayer's decision to accept Social Security benefits while still working. If a taxpayer earns $11,000 in salary and receives another $5000 in Social Security benefits because of post-retirement employment, he or she has nothing to fear. At this income level, Social Security benefits are excluded from gross income and do not affect adjusted gross income.\textsuperscript{53}

C. Taxpayer Eligible for the Credit for the Elderly

Unlike the earned income credit, the credit for the elderly is nonrefundable. It can be applied to reduce the income tax liability, but it cannot be taken if the tax liability is zero. This credit varies based on three factors: 1) the taxpayer's marital status; 2) the taxpayer's tax-free retirement benefits; and 3) the taxpayer's adjusted gross income.

\textsuperscript{50} Id. § 32(b)(2).
\textsuperscript{51} Id. § 32(b)(1)(A).
\textsuperscript{52} If the older taxpayer has already retired a mortgage, his or her income needs may allow for modest savings so long as the taxpayer remains in good health.
\textsuperscript{53} See I.R.C. § 86 (1994).
1. Marital Status

The largest maximum credit is $1125, and it can be claimed by married taxpayers filing a joint return. However, both must qualify for the credit based on age or disability. If only one qualifies, their maximum credit is the same as that of a single individual ($750). A married taxpayer who files a separate return is limited to a maximum credit of $562.50 and can take the credit only if he or she lived apart from the spouse the entire year. 54

2. Tax-Free Income

The credit is computed as 15% of a base amount, 55 but that base is reduced by tax-free Social Security benefits, veterans’ benefits, and Railroad Retirement Act benefits. 56 If these benefits exceed the base amount, no credit is allowed. Because the available amount is so small, it is difficult to imagine a taxpayer forgoing these benefits solely to remain eligible for the credit.

3. Adjusted Gross Income

The taxpayer’s eligibility for this credit is reduced by 50% of each dollar of adjusted gross income over a limit based on marital status. 57 The phaseout for a single individual begins with adjusted gross income of $7500; that for a married couple, at $10,000. 58

This income phaseout also affects a taxpayer’s choices as to savings vehicles, but only if he or she has major income-producing assets. Because this credit is nonrefundable, however, it has little effect on savings choice for taxpayers of modest wealth. For example, if $500 in interest income is added to a $7500 salary, the credit would be reduced by $250 to $500. However, the maximum pre-credit income tax liability was $120, making the reduction irrelevant. A switch to the municipal bond would reduce the income tax liability to $45, which would be fully offset by the credit. In this case, the taxpayer is ill-advised to seek a tax-free investment, as he or she foregoes $100 in interest and reaps no tax benefit whatsoever. The taxpayer with a $500,000 nest egg and $7500 in gross income could retain the full $120 credit by investing in municipal bonds yielding 4%; a switch

54. Id. § 22(a), (c).
55. Id. § 22(a).
56. Id. § 22(c)(3).
57. Id. § 22(d).
to certificates of deposit yielding 5% would fully eliminate the credit and increase tax liability by approximately $4000.

D. Taxpayers Being Supported by Children

Children who support their parents may seek three tax advantages: 1) a dependency exemption,\(^{59}\) 2) head of household status,\(^{60}\) and 3) a deduction for paying the parents' medical expenses.\(^{61}\) Only the medical expense deduction is unaffected by the parents' choice between taxable and tax-free income.

1. Dependency Exemption Deduction

As a general rule, a taxpayer cannot be claimed as a dependent unless his or her gross income is less than the exemption amount.\(^{62}\) Even though a child provides the vast majority of an elderly parent's support, the gross income test may prevent the child from claiming the deduction. If the parent is still working, it is likely the parent's salary will at least equal the dependency exemption amount and preclude the child from claiming a deduction. The same result is likely if the parent receives a pension.\(^{63}\) If, on the other hand, the parent's sole source of gross income is attributable to an interest-producing investment, a switch from taxable to tax-free interest may gain the child a deduction.\(^{64}\)

Before the parent selects the tax-free investment, the family must investigate whether the tax savings exceed the lost income. Because the maximum income tax rate is currently 39.6%, an additional $2450 exemption deduction will save the child no more than $970.20 in income tax.\(^{65}\) If the parent's choice is between taxable interest of $25,000 and tax-free interest of $20,000, the former choice deprives the child of the

\(^{59}\) Id. § 151(c).

\(^{60}\) Id. §§ 1(b), 2(b).

\(^{61}\) Id. § 213.

\(^{62}\) The gross income test is waived only if the dependent is the taxpayer's child who is either under 19 years or under 24 years and a full-time student. Id. § 151(c)(1)(A)-(B).

\(^{63}\) However, Social Security benefits are not included in gross income if the recipient's other income sources are low enough. See I.R.C. § 86 (1994). Thus, a child can claim a dependency exemption for a parent whose sole source of income is Social Security benefits if the child is providing more than one-half of the parent's support.

\(^{64}\) Id. § 151(c)(1)(A)-(B).

\(^{65}\) If the child's adjusted income is sufficiently high, he or she may be subject to an exemption phaseout and will save even less. See id. § 151(d)(3). On the other hand, a high state income tax may enhance the value of any exemption the child can claim.
exemption and subjects the parent to an annual income tax of $2670. The latter choice preserves the exemption for the child, and results in no tax paid by the parent. Because the parent would forego $2330 in after-tax income to save the child $970, this would be a poor choice. If, on the other hand, the parent’s choice was between $3000 of taxable interest and $2400 of tax-free interest, the tax-free interest is the better choice so long as the child’s tax savings exceed $600 and the parent benefits from that savings.

2. Head of Household Status

The savings discussed in the preceding paragraphs are dependent on the parent’s after-tax return being exceeded by the child’s potential tax saving; less than $1000 per year is saved, and the results may vary from year to year. Shifting the parent’s investment assets from year to year, as the above factors change, may not be worth the small savings available. However, if the child is single and can qualify for head of household status by having the parent as a dependent, the family’s savings are further magnified. For example, assume an unmarried child whose taxable income is $50,000 cannot claim a parent as an exemption because the parent receives $3000 in taxable interest. The child’s 1994 income tax liability is $11,043. If the child can claim the parent as a dependent, his or her income tax drops $686 to $10,357. If the child can claim the parent and qualify for head of household status, the resulting income tax liability is reduced to $9349. The savings are even greater if the child is in a higher tax bracket.

The child can qualify as a head of household even if the parent does not move into the child’s home. In addition to being eligible to claim the parent as a dependent, the child must provide more than one-half of the cost of maintaining the parent’s household. The household maintenance costs count toward showing the child is providing more than one-half of the parent’s support and is therefore eligible to claim the dependency exemption.

3. Medical Expense Deduction

Children may assist an elderly parent who cannot afford a particular item and cannot obtain it through Medicare or Medicaid. Taxpayers can deduct medical expenses for their dependents, and that term is defined more...
leniently than it is for purposes of taking a dependency exemption deduction. A parent can be a dependent for medical care purposes by satisfying three tests. First, the patient must be related to the payor. Second, the patient must be a United States citizen or national or a resident of the United States or a contiguous country. This requirement may prove difficult for immigrants supporting parents who never came to the United States, unless the parents reside in Canada or Mexico. Third, the taxpayer must provide over one-half of the patient’s support. If medical expenses are high enough, the taxpayer should take steps to pay them all, rather than having the parent pay for some and the taxpayer pay for nondeductible items such as vacations.

No matter how much is spent for a parent’s medical expenses, the taxpayer need not worry about gift or estate tax liability because there are two important exclusions from the gift tax base. First, a present interest gift of up to $10,000 per year per donee is outside the tax base. Second, payments to medical care providers are excluded from the gift tax base.

V. ITEMIZING VERSUS THE STANDARD DEDUCTION

The 1994 standard deduction ranges from $3800 for a single individual to $6350 for a married couple filing a joint return. If the taxpayer is unmarried and at least sixty-five years old, the standard deduction increases by $950. If the taxpayer is married, it increases by $750 for each spouse who is at least sixty-five. When the standard deduction is added to the personal exemption deduction, which is $2450 per person for 1994, many individuals are eliminated from the ranks of those paying federal income

69. Id. § 213(a).
70. Id. § 152(a)-(b).
71. Id. § 152(a). If a group of children support their parents, a multiple support agreement procedure allows them to select which group member will claim the parent. Id. § 152(c).
72. To maximize tax advantages in a multiple support agreement situation, the child treated as providing over one-half of the parent’s support should pay for the parent’s medical expenses. The other group members should pay for nondeductible items. I.R.C. § 152(c) (1994).
73. These transfer taxes apply when cumulative giving inter vivos and at death exceeds $600,000. The rate on the first dollar subject to tax is 37%. Id. §§ 2001(c)(1), 2502, 2010.
74. Id. § 2503(b). These amounts double when two recipients are involved. Married donors also have a means of doubling their gifts even if only one of them has assets. For rules governing joining in a spouse’s gift to third parties, see id. § 2513.
75. Id. § 2503(e).
A married couple, both of whom are at least sixty-five, are entitled to total deductions of $12,750, while a single individual with no dependents is entitled to $7200. Therefore, unless the taxpayer's gross income exceeds that figure, itemizing provides no benefit because the taxpayer has no tax liability to reduce. Likewise, there is no tax liability to reduce if the only other source of income is interest from municipal bonds or Social Security benefits.\textsuperscript{77}

Taxpayers whose gross incomes are high enough to justify itemizing may enhance the benefits by itemizing and taking the standard deduction every other year. For example, return to the illustration in section IV(A) and assume the taxpayer invested in the certificate of deposit and has $47,000 of gross income. If the taxpayer owns a mortgage-free home, as is not unlikely, the available itemized deductions are limited to property taxes, state and local income taxes, medical expenses, and charitable contributions.\textsuperscript{78} A taxpayer living in Florida, which has no state or local income taxes and a $25,000 homestead exemption for a primary residence, may have great difficulty in accumulating sufficient annual deductions to make itemization worthwhile. If the taxpayer's charitable gifts and property taxes averaged $4000 per year, the standard deduction would always be larger. What if, however, the taxpayer paid both even year and odd year property taxes and charitable gifts in the odd year? He or she would take the $4750 standard deduction in 1994 and deduct $8000 of itemized deductions in 1995. By foregoing a modest prompt payment discount for the even year property tax, the taxpayer reduces the income tax in the itemized deduction years by several hundred dollars.\textsuperscript{79}

\textsuperscript{77}See id. § 86. Married taxpayers filing a joint return are taxed on a portion of these benefits only if their modified adjusted gross income, augmented by one-half of their Social Security benefits, exceeds $32,000. For example, if our hypothetical taxpayers received taxable interest income of $12,750 and Social Security benefits of $38,500, the Social Security benefits escape income tax ($12,750 + $19,250 = $32,000). The single individual is not taxed until the excess exceeds $25,000, thus allowing for Social Security benefits of $35,600 if the only other source of income does not exceed the $7200 sum of the standard and personal exemption deductions. Because the maximum 1994 Social Security benefit is $13,764, federal income tax does not concern these individuals. Id. § 86. Taxpayers receiving municipal bond interest and Social Security benefits must use the bond interest in computing the amount of Social Security benefits that are taxed even though the bond interest itself remains tax-free. Id. § 86(b)(2)(B).

\textsuperscript{78}There are no business-related deductions, as this taxpayer is retired. The fact pattern ruled out investment expenses, and we can assume there were no casualty losses.

\textsuperscript{79}This strategy can also benefit residents of states with an income taxes if the income tax is less than the standard deduction amount.
VI. MEDICAL CARE EXPENSES

Health is age-related because the likelihood of health problems increases with advancing age. However, younger taxpayers may be interested in planning for possible poor health in the future and be interested in the tax consequences of their current actions. In addition, younger taxpayers may need guidance on tax consequences of paying for their parents' medical expenses. 80

Medical care expenses fall into several categories listed in section 213(d) of the tax code. The first category involves amounts spent for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. These outlays range from routine checkups to major surgery. 81 The second category is transportation to obtain medical care. The third category is for insurance covering the other two categories of medical care; Medicare Part B is included in this category. 82

The following paragraphs introduce a few of the more common problems involving health care costs.

A. Limitations Based on Income

The greatest impediment to deducting health care costs in any given year is the requirement that out-of-pocket outlays exceed 7.5% of the taxpayer's adjusted gross income. Expenditures covered by insurance or other compensation, such as tort damages, cannot be included in determining whether the taxpayer exceeds the 7.5% threshold. 83 Because the limitation is based on adjusted gross income, choices made about the nature of income received affect the taxpayer's ability to meet this threshold.

Consider once again the taxpayer introduced in section IV(A). What if that taxpayer must incur a $7000 medical expense that is not covered by insurance? Medical expenses are an itemized deduction, which means that they provide tax benefits only if the total of all itemized deductions exceeds the available standard deduction, $4750 for a single taxpayer who is at least sixty-five years old in 1994. Because the taxpayer who chooses the certificate of deposit has an adjusted gross income of $47,000, he or she

80. See supra section IV(D).
81. However, cosmetic surgery is included only if "necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease." I.R.C. § 213(d)(9) (1994).
82. Id. § 213(d)(1)(A)-(C).
83. Id. § 213(a).
must ignore the first $3525 of medical expenses since that amount is less than 7.5% of adjusted gross income. The taxpayer who selected the municipal bonds need only ignore the first $1650 of expenses. The remaining sum of $5350 exceeds the standard deduction and will provide additional tax benefit.  

B. Capital Expenditures

An important item for taxpayers who wish to remain in their homes is the cost of renovations to accommodate a particular disability. Because these are unlikely to be covered by insurance, their cost could easily take a taxpayer over the 7.5% threshold.

1. Renovations

Renovations are potentially nondeductible because the useful life of a renovation is greater than one year. In addition, while some capital expenditures add little to a home’s resale value, others will be recovered when the residence is later sold. Thus, the taxpayer has not lost the funds invested. Finally, some renovations create problems because, as is true for swimming pools, they are likely to benefit other household members. The general prohibition against deductions for personal, living, or family expenses may justify nondeductibility if there is use (or potential use) by other family members, or even by guests to the home.

Fortunately for most taxpayers, government regulations provide for deductibility if the taxpayer can establish that the capital expenditure qualifies as medical care. However, the taxpayer must subtract any increase in the property’s value before treating the remaining outlay as medical care. If the outlay involves architectural changes to accommodate a

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84. Presumably the taxpayer has other medical expenses, such as insurance, that normally were too small to provide tax relief. Other potential itemized deductions, such as charitable gifts, also can be deducted in years when the taxpayer benefits from itemizing.  
85. Outlays whose useful life exceeds one year are generally nondeductible capital expenditures. See I.R.C. § 263 (1994). Moreover, present law precludes deducting this cost over several years. The depreciation deduction is limited to property used in a trade or business or held for the production of income. Id. § 167(a). In addition, spreading the cost over the property’s useful life reduces the likelihood that the cost allocated to any particular year will exceed 7.5% of the taxpayer’s adjusted gross income.  
86. Id. § 262(a).  
87. Treas. Reg. § 1.213-1(e)(1)(iii) (1994). Items that relate only to the person needing care and do not involve permanent improvements escape this subtraction. The entire cost of a room air conditioner, for example, can be a medical care expense, while only a portion of
disability, the Internal Revenue Service accepts the proposition that there is no increase in value and thus no offset.\textsuperscript{88}

2. Other Capital Expenditures

Capital expenditures that are not part of the home, but that benefit the individual needing care, also qualify as medical care expenses. These include a wide variety of items, ranging from the essential\textsuperscript{89} to those that enhance the quality of life but are not absolutely necessary.\textsuperscript{90}

3. Operating and Financing Costs

Two questions that may arise with respect to capital expenditures are their operating costs and their financing costs. The regulations provide that operating costs qualify as medical care costs so long as there is a medical need for the capital expenditure.\textsuperscript{91} These costs include repairs and electricity.

The regulation is silent on the subject of financing costs, which generally provide larger deductions if treated as qualified residence interest than if treated as personal interest or as a medical expense. No deduction is allowed for most types of personal interest, and interest on medical

\textsuperscript{88} See Rev. Rul. 87-106, 1987-2 C.B. 67, 68. The following are included among the items qualifying as medical care: constructing entrance or exit ramps, widening doorways at entrances or exits, widening or otherwise modifying hallways and interior doorways, installing railing, support bars, or other modifications to bathrooms, lowering or modifying kitchen cabinets and equipment, moving or modifying electrical outlets and fixtures, installing porch lifts and other forms of lifts (but generally not elevators), modifying fire alarms, smoke detectors, and other warning systems, modifying stairs, adding handrails or grab bars anywhere (whether or not in bathrooms), modifying hardware on doors, modifying areas in front of entrance and exit doorways, and grading the ground to provide access to the residence. Id.

\textsuperscript{89} For example, eyeglasses and wheelchairs. See Treas. Reg. § 1.213-1(3)(1)(e)(iii) (1994).

\textsuperscript{90} For example, the initial cost of special telephone equipment for a hearing impaired person. Repair costs for qualifying items are also considered medical care. See Rev. Rul. 71-48, 1971-1 C.B. 99 (amplified by Rev. Rul. 73-53, 1973-1 C.B. 139); see also Rev. Rul. 80-340, 1980-2 C.B. 81 (allowing the cost of a specially equipped television, that provided visual display of the audio broadcast for hearing-impaired individuals, limited to the amount by which the television's cost exceeded the cost of a television that had not been adapted in this manner).

indebtedness is personal interest. In addition, medical expenses are subject to the 7.5% of adjusted gross income floor each year.

The limitations on deducting qualified residence interest are far more generous. Assume that a taxpayer added a swimming pool to his or her home for purely personal reasons. The interest on that addition would qualify so long as the addition qualified as a substantial improvement or the amount borrowed qualified under the limited exception for home equity indebtedness. The pool’s cost would be added to the taxpayer’s basis for the residence and would reduce any gain reported when the home was sold. If that same swimming pool were added for medical reasons, only the portion of its cost that represented the increase in property value would be added to basis, and the remainder would be treated as a deductible medical expense. Must the second taxpayer limit the interest expense deduction to that portion of the original debt that did not qualify as a medical expense? Neither the statute nor the regulations provides specific guidance. However, it should be noted that the definition of qualified residence interest contains no requirement that basis be increased. In addition, most taxpayers will find this discussion academic, as the home equity indebtedness limits will generally be large enough to cover the debt giving rise to the interest.

C. **Institutionalization and Care Away from Home**

Depending upon the nature of their medical needs, taxpayers may need hospitalization, hospital-based outpatient lodgings, or nursing home care. Some health problems may be alleviated by a change of environment, particularly climate. Each situation involves outlays, particularly the basic cost of meals and lodging, that would be incurred, albeit in different surroundings, in the absence of a medical need. However, the rules governing deductibility differ in each situation.

1. **Inpatient Care**

If inpatient hospital care is involved, meals and lodging costs are treated as medical expenses. In other institutional settings, meals and lodging qualify as medical care if a principal reason for the patient’s presence in the institution is the availability of medical care. If the patient

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92. Personal interest is defined in terms of what is excluded. The excluded items are interest allocable to a trade or business, investment interest, passive activity interest, qualified residence interest, and interest on certain deferred estate taxes. I.R.C. § 163(h)(2) (1994).

93. A taxpayer can deduct interest on up to $100,000 of home equity indebtedness no matter how the borrowed funds are spent. Id. § 163(h)(3)(C).
is institutionalized for personal or family considerations, only the costs attributable to medical care and nursing attention qualify as medical expenses.  

2. Outpatient Care

When outpatient care is involved, but the patient is away from home to get such care, the statute provides its own limitations. Lodging, but not meals, is deductible if the patient is away from home primarily for medical care. The care must be provided by a physician in a licensed hospital or in a medical care facility that is equivalent to a licensed hospital. For example, this provision would cover spending a week at the Mayo Clinic for testing and residing nearby during that period. However, even this allowance has its limitations. First, the taxpayer must show that the travel away from home involves no significant element of personal pleasure, recreation, or vacation. Second, no more than $50 per night will qualify as medical care.

3. Life Care Communities

A taxpayer may choose to move to a community that provides housing options that vary based on his or her health. As a condition of accepting the taxpayer, the facility may require a large deposit for which the taxpayer will receive no interest. These loans could present an unexpected problem in a different context, because lenders report hypothetical interest income in many situations involving loans for no interest or interest below the “market” rate. For example, what if the taxpayer in section IV(A) loaned a $500,000 nest egg to his or her child, charged no interest, and the child invested the funds in the certificate of deposit? Despite charging no interest, the parent would be treated as having gross income from interest equal to an amount established by the government. Loans to continuing care facilities are

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96. Id. The limitation is $50 per individual. If both spouses were receiving medical care, a couple could treat $100 per night as medical care. The $100 limit would also apply if one spouse was needed to provide medical care to the spouse receiving outpatient care.
97. Id. § 7872. These very complex rules apply to loans made for compensatory reasons as well as to loans made in a donative setting.
98. Id. In addition, the parent would also have transfer tax concerns, as this provision treats the foregone interest as being transferred gratuitously to the borrower. There are
subject to this rule if the loans exceed a statutorily prescribed amount.\textsuperscript{99} The taxpayer will continue to report gross income despite receiving no interest, and this amount will affect his or her ability to deduct medical expenses and other items computed as a percentage of adjusted gross income.

Alternatively, a life care community may charge a fee that includes payment for its promise to render medical services when needed. Only that part of the fee allocable to this promise is considered a medical care expense.\textsuperscript{100}

4. Travel

No deduction exists for meals and lodging incurred in other situations, such as travel to a more temperate climate to alleviate a chronic condition. Even transportation costs are disallowed if the stay is merely for the taxpayer's general health.\textsuperscript{101}

D. Insurance

Insurance to reimburse a taxpayer for the costs of medical care is a medical expense.\textsuperscript{102} Both private insurance premiums and Medicare Part B premiums\textsuperscript{103} qualify. If a policy covers both insurance for medical care and other items, the premium qualifies only to the extent of the separately stated charge for medical care.

Special rules apply to insurance premiums paid before age sixty-five for care that will be rendered after the taxpayer reaches age sixty-five.\textsuperscript{104}
These premiums are treated as medical care in the year paid only if they will be payable for a period of at least ten years or the shorter period that ends with the insured individual reaching age sixty-five. In no event will these premiums qualify if they are payable for less than five years.

E. *Personal Services*

If a taxpayer requires an attendant to perform medical care services, the attendant’s salary qualifies as a medical expense. The attendant need not be a licensed professional so long as the care itself qualifies as medical care. Several items related to the attendant are also considered medical care. These include Social Security taxes paid by the person receiving care and the cost of the care giver’s meals. The Internal Revenue Service even allows the extra rent paid because housing the attendant necessitated moving to a larger apartment as well as extra utilities costs attributable to the attendant.\(^{105}\)

VII. *The Family Home*

Post-retirement income shortfalls or health problems may require an elderly client to contemplate moving to a less expensive residence, moving in with children, or moving to a nursing home.

A. *Sale of Home—General Rules*

If a taxpayer sells one principal residence and replaces it with another within the statutory time period, he or she is precluded from reporting gain so long as the new residence costs at least as much as the adjusted selling price of the old residence.\(^{106}\) If the new residence costs less than the selling price of the old residence, the taxpayer pays tax on his or her actual gain or the amount of unspent proceeds. Thus, taxpayers can sell and replace residences without paying tax so long as they continue to reinvest the full adjusted selling price or more. Each time this occurs the taxpayer’s


\(^{106}\) I.R.C. § 1034(a) (1994). The statutory replacement period begins two years before the actual sale and ends two years after that sale. *Id.* Special rules apply to taxpayers who dispose of more than one residence within a two-year period and taxpayers who defer replacing a residence during a period of military service. *Id.* § 1034(c)(4), (d)(1)-(2), (h).
basis in the new residence is reduced below its cost to reflect the deferred gain for tax purposes.107

Assume your client purchased a first home for $50,000 thirty years ago, sold it twenty years ago for $72,000, and immediately purchased a replacement residence for $90,000. The client paid no tax on the original $22,000 gain. However, the basis in the second home is reduced by that $22,000, from a $90,000 cost basis to a $68,000 basis. Further assume that your client just received an offer to sell the second residence for $130,000. If the offer is accepted, there will be a gain of $62,000. None of that gain will be taxed if the client purchases or constructs a replacement residence that costs at least $130,000.

What if your client wants to purchase a smaller residence, become a renter, or enter a nursing home? For example, if your client purchases a condominium that costs $100,000, the retained $30,000 will be taxed as gain. If your client purchases no home at all, the entire $62,000 gain is taxed.108 This tax liability can be avoided only if your client qualifies for the relief granted taxpayers age fifty-five or older.

B. Taxpayers Age Fifty-Five or Older

Qualifying taxpayers age fifty-five or older may exclude up to $125,000 in gain from the sale of a principal residence.109 This exclusion is available only once in the taxpayer’s life110 and only if the taxpayer elects it. In the example above, a taxpayer electing this exclusion would pay no tax on the sale of the $130,000 home.

To qualify for the exclusion, the taxpayer must have owned and occupied the residence as a principal residence for three of the five years preceding the sale.111 In addition, if the taxpayer is married at the time

107. Id. § 1034(e). The examples in this section ignore the payment of selling expenses, such as a broker’s fee, and investments in improvements to the residence. These items would reduce the gain and the resulting income tax liability.
108. Id. § 1034(a). Because this gain will qualify as long-term capital gain, the maximum federal income tax rate applied will be 28%. I.R.C. § 1034(a) (1994).
109. Id. § 121. Many Code provisions apply if a taxpayer attains a particular age at any time during the year. Section 121 does not follow that pattern. Unless the taxpayer has reached age 55 by the date of sale, he or she is ineligible to claim the exclusion. Id. § 121(a)(1).
110. Exclusions claimed on sales before July 27, 1978, are ignored. Id. § 121(b)(3).
111. Id. § 121(a)(2). Three years of ownership and three years of occupancy are each required during the five years preceding the date of sale. The occupancy period and the ownership period do not have to coincide. Therefore, a taxpayer who rented a house from its owner throughout 1990, purchased the house on January 1, 1991, and continued to live...
of the sale, that spouse must consent to the election.¹¹² Spousal consent is required even if they file separate returns. It is also required even if the spouse is not a co-owner of the property, whether or not they file a joint return for the year of sale. By consenting to the election, the spouse relinquishes the opportunity to claim the exclusion in his or her own right with respect to a different residence.

Section 1034 is mandatory and section 121 is elective, but section 121 applies first if the election is made. Thus, it is important to discuss the clients’ future home-buying plans in great detail before counseling the section 121 election. Assume that the client discussed above planned to replace the $130,000 home with a $128,000 home. By electing section 121, he or she excludes the entire $62,000 realized gain. By foregoing the election, the client becomes subject to section 1034, which defers all but $2000 of that gain and preserves the ability to elect section 121 for a future sale.¹¹³

C. Timing of the Sale

1. In Relation to Retirement

Tax considerations may influence the timing of a sale. If the client sells property just before retirement, the gain will be taxed as part of that year’s income. If post-retirement income will be lower than pre-retirement income, the client may wish to sell the residence in the year following retirement rather than in the final year of employment. Moving the gain to a lower income year is important for taxpayers who cannot shelter the entire gain through the use of the section 121 exclusion and the section 1034 deferral described above.

¹¹² I.R.C. § 121(c) (1994).
¹¹³ See Robarts v. Commissioner, 103 T.C. 72 (1994). Robarts involved a taxpayer who used section 121 in a situation where section 1034 would have deferred the entire gain. The court refused to allow a retroactive revocation of the § 121 election because the statute of limitations had run on the earlier year.
2. In Relation to Domicile

Differences in state income tax rates may also affect the timing decision. A taxpayer selling a home in New York, who plans to rent a home in Florida, may benefit by postponing the sale until the tax year following the move. Although New York can still tax the sale because it reflects a gain on property whose situs is New York, it will not tax other sources of income, such as dividends and interest, whose situs follows the taxpayer’s domicile. Of course, the reverse would be true if the taxpayer were selling a home in Florida, which has no income tax, and is moving to New York. In that case, it would be important to complete the sale while the taxpayer still resided in Florida.

3. Following a Compulsory or Involuntary Conversion

In computing the three-year ownership and use periods, a taxpayer is generally limited to the particular home being sold. Thus, if a taxpayer sold one home and reinvested the proceeds in a second home, the required periods include only those associated with the new home. This rule applies even though the taxpayer reported no gain on selling the old home because section 1034 is a mandatory provision. Only if a taxpayer’s home was condemned or destroyed can he or she include ownership and occupancy of the previous home in computing those periods for the new home.115

4. In Relation to Marital Status

The client’s marital plans are another important factor in selecting the time to sell. Two possibilities include a client who is about to marry and a client who is about to dissolve a marriage. If an elderly client is about to marry and plans to sell a home, a premarital sale preserves the new spouse’s future ability to elect under section 121.116 Likewise, if a client is divorcing, a post-divorce sale allows both spouses to elect under section 121 with

114. N.Y. Tax Law § 631(b)(1) (McKinney 1987). The taxpayer may also be eligible to shield the gain using Code §§ 121 and 1034.

115. I.R.C. § 121(d)(8) (1994). The prior ownership and occupancy can be included only if the taxpayer deferred his or her gain using section 1033 of the Code and his basis for the replacement home is computed with reference to his or her basis for the original residence.

116. If both elderly clients plan to sell their homes, each can take advantage of § 121, assuming each is otherwise qualified, by selling their homes before the wedding. After the marriage occurs, only one § 121 election is available.
respect to their halves of the proceeds. A pre-divorce sale reduces the exclusion to $125,000.

5. In Relation to Death

The dying client may be counseled to avoid selling altogether, particularly if the individual is unmarried and the gain exceeds $125,000. No gain is reported when a taxpayer dies, and heirs and devisees take a fair market value basis for property received.\(^{117}\) Assume the client purchased a New York City cooperative apartment for $300,000 and could sell it today for $500,000. If a section 121 election was made, the client would still be taxed on $75,000 of the $200,000 gain. On the other hand, if the client died owning the property, the heirs would take a basis of $500,000, and no one would pay income tax on the $200,000 gain.\(^ {118}\)

A married client’s decision is somewhat more complex. Even if the gain is under $125,000, a current election precludes the other spouse from a later election with respect to another residence. If the dying spouse is the sole owner of the property, holding it until death should yield tax consequences at least equal to those associated with selling the property. If the spouses hold the property jointly, the survivor receives a fair market value basis for half the property and retains the original basis for the other half.\(^ {119}\) If the married client owned the cooperative jointly with a spouse, the spouse would have a post-death basis in the property of $400,000 and could exclude the remaining $100,000 gain using section 121 on a subsequent sale.\(^ {120}\)

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\(^{117}\) I.R.C. § 1014(a) (1994). Inter vivos gifts may avoid probate costs, but they do not confer the basis advantages of testamentary transfers. An inter vivos donee takes the donor’s basis and will report gain on sale unless the donee first lives in the property long enough to qualify for relief under §§ 121 and 1034 of the Code. An attorney assisting the client in making a transfer that avoids probate but is still sufficiently testamentary to qualify under § 1014, the attorney structuring the transfer must consider possible loss of homestead exemption or other protection.

\(^{118}\) If the client is single and the gain is less than $125,000, the decision to sell or devise can be made without regard to income tax consequences.

\(^{119}\) Section 1014(b)(9) applies to only half of the property because § 2040(b) excludes the other half from the deceased spouse’s gross estate.

\(^{120}\) If the couple ended the tenancy and transferred full title to the dying spouse, they would succeed in obtaining the $500,000 basis for the surviving spouse if the survivor took the property under the terms of the decedent’s will (or the applicable laws of intestacy) and the decedent lived more than one year after the transfer. See id. § 1014(e).
D. Withdrawing Equity

Perhaps the client wants to remain in the home, and is physically able to do so, but needs funds for necessities other than housing. A reverse mortgage loan might be advisable as a means of giving the client access to the equity without necessitating a move and without incurring any immediate adverse tax consequences. 121

This loan operates much like a line of credit securing the home in that the lender provides funds over a period of time. Unlike a conventional line of credit, the reverse mortgage may not require current payment of interest. Instead, interest will be added to the loan principal and be paid to the lender when the home is sold. Although qualified residence interest is normally deductible, interest added to the loan balance is not deductible until the lender is ultimately paid. 122

VIII. Retirement

Retirement benefits include pensions, whether funded by the employer, the employee, or both, as well as Social Security and other government-funded benefits. Employer-based plans include pension plans, self-employed pension plans ("Keogh plans"), individual retirement accounts ("IRAs"), cash or deferred accounts (section 401(k) accounts), and annuities provided by tax-exempt employers (section 403(b) accounts). In addition, an individual may have used an annuity or other insurance product to save for retirement on an after-tax basis.

Taxpayers approaching retirement age face many decisions. Should they work past the time when they are entitled to receive benefits without tax penalties? When should they take Social Security benefits? Should they withdraw funds from an employer’s plan? If so, what alternate investment offers the best income tax advantages?

These questions involve factors other than taxes. The taxpayer’s health may preclude further work. An employer may offer an extraordinarily generous early retirement package. An attractive investment opportunity

121. Although part of the amount borrowed may reflect appreciation in the home’s value, it is not reported as gain. Because the amount borrowed will be repaid, the homeowner is not treated as having realized any portion of that gain.

122. Cash method taxpayers deduct expenses in the year they pay them. In any event, only interest on a loan balance of less than $100,000 could qualify for deduction. If the taxpayer is not using the funds to fund home improvements, the debt is home equity indebtedness and not acquisition indebtedness. See I.R.C. § 163(h)(3)(B), (C) (1994).
may require the taxpayer’s time as well as an infusion of capital. If the taxpayer has more than one post-retirement financing option available, tax consequences may well determine which one is selected.

This area of tax law is one in which expert guidance is critical. The following paragraphs provide only a cursory introduction to possible tax consequences. The discussion in this section relates to benefits in situations where retirement was contemplated as the means for collecting these benefits: pensions, annuities, and Social Security. Section IX involves less voluntary departures from the work force: disability, workers’ compensation, unemployment compensation, life insurance, and wrongful termination.

A. Pension Benefits

Taxation of retirement benefits includes both income and excise taxes. Tax treatment depends upon the funding source, the method of taking benefits, the recipient’s age, and the amount of benefits.

1. Funding Source

Most retirement benefits can be traced to the following funding sources: employer contributions that were not included in the employee’s gross income; employee contributions made on a pre-tax basis; and income earned on funds invested in the retirement plan. Prior to receiving a distribution, the employee has not reported these amounts as gross income. In addition, the employee may have contributed nondeductible funds, generally referred to as contributions made on an after-tax basis. Although the employee is taxed on the initial investment, earnings attributable to these contributions also escape taxation until withdrawn from the plan.\(^{123}\) When funds are withdrawn from one of these plans, the recipient is entitled to recover his or her contributions without additional income tax. Remaining benefits are included in gross income.

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\(^{123}\) Taxpayers who are active participants in various retirement plans are precluded from making deductible contributions to an individual retirement account if their adjusted gross income exceeds the statutory limit. Nondeductible contributions are allowed. See id. § 219.
2. Method of Taking Benefits

a. General Rule

Payment of benefits generally takes one of two forms: lump sum or annuity. If the employee receives the entire benefit in a lump sum, his or her gross income includes amounts received in excess of after-tax contributions. If the benefit is taken as a stream of payments, any tax-free amount is recovered on a pro rata basis. For example, the employee receives $10,000 a year for twenty years, a total of $200,000. If the employee’s after-tax contribution was $5000, he or she is entitled to exclude 2.5% of each payment. The employee will be taxed on $9750 per year ($195,000 for the twenty-year period), and the remaining $250 per year is a tax-free recovery of the initial contribution. If payments are based on life expectancy rather than on a fixed term, actuarial tables provide the information necessary to determine the amount of benefits to be received. That amount can then be allocated into taxable and tax-free amounts.

b. Special Rules

i. Lump-Sum Treatment

Special rules apply to lump-sum distributions from qualified retirement plans. Without special treatment, a lump-sum distribution might be seriously depleted by income taxes assessed at federal rates as high as 39.6%, as well as any applicable state income tax. A five-year averaging provision results in treating the lump sum as if it was actually received in five taxable years. Employees born before 1936 are entitled to additional computation benefits involving a special 20% capital gains rate and a ten-year averaging election.

A lump-sum distribution must be paid within a single tax year. It is the distribution of a plan participant’s entire balance from the employer’s qualified plan. That balance does not include any deductible voluntary contributions.

124. See Treas. Reg. § 1.72-9 (1994). If the employee “outlives” the prescribed life expectancy, and receives benefits after fully recovering the investment, 100% of the pension is included in gross income. See I.R.C. § 72(b)(2) (1994). However, if the employee retired and began receiving benefits before 1987, the $250 annual exclusion survives. See Pub. L. No. 99-514, § 1122(c)(2), (h)(2)(B), 100 Stat. 2467, 2470 (1986).


employee contributions or certain forfeited amounts. In addition, the payment must be made after the employee reaches age fifty-nine and one-half dies, or separates from service.\(^{127}\) The employee’s after-tax investment remains tax-free. The remaining benefit amount has two segments—any portion eligible for special capital gain treatment, and subject to a 20% tax rate, and the portion eligible for special averaging treatment.

The taxpayer described in Section IV(A) receives a $22,000 per year pension, none of which was attributable to after-tax contributions. What if the taxpayer had elected to take a lump sum of $440,000 at retirement in 1994 at age sixty-five? Even if that were the only income for the year, a significant portion of the distribution would be taxed at 39.6%. On the other hand, if the taxpayer elected five-year averaging, the tax would be based on a benefit of one-fifth of the lump sum, $88,000, being received in each of five years, and none of the distribution would be taxed at a rate exceeding 31%.

ii. Rollovers

An employee may receive a lump-sum distribution and avoid current taxation by rolling it over into an individual retirement account.\(^{128}\) An employee who is uncomfortable with an employer's investment options can use this mechanism to substitute a personal investment strategy without surrendering the tax deferral advantages of leaving funds in a retirement plan.

iii. Death Benefit Exclusion

Up to $5000 in death benefits can be excluded by the beneficiary of a deceased employee.\(^{129}\) The exclusion is available for amounts received because the employer continues the deceased employee’s salary. It is also available for lump sums from qualified retirement plan benefits. Because amounts the employee had a guaranteed right to receive do not qualify, the survivor of an employee who was already receiving a pension cannot exclude any portion of payments received as a surviving joint annuitant. No more than $5000 can be excluded with respect to any employee. The

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127. If the recipient is a self-employed individual, he or she must be permanently and totally disabled rather than merely separated from service.

128. I.R.C. § 402(c) (1994). Rollovers can also be made into other qualified plans if they accept rollover distributions.

129. Id. § 101(b).
number of beneficiaries, employers, or years in which payments are received are irrelevant.

3. Recipient’s Age

Special rules apply to distributions when the employee is under age fifty-nine and one-half or over age seventy and one-half. Distributions prior to age fifty-nine and one-half may involve a 10% excise tax. Unless distributions begin by April 1 following the year the employee reaches age seventy and one-half, a 50% excise tax may apply to the amount that should have been distributed.

The 10% excise tax on premature distributions can be avoided if the employee died, became totally and permanently disabled, or separated from the employer’s service and was at least fifty-five years old in the year of separation. In addition, the excise tax is waived for distributions used for medical care expenses or paid to an ex-spouse under a qualified domestic relations order. Finally, there is no excise tax liability for distributions that will be received in substantially equal payments for the employee’s life or the joint lives of the employee and a beneficiary.\textsuperscript{130}

Once the worker reaches age seventy and one-half, he or she has until April 1 of the following year to begin taking distributions.\textsuperscript{131} The required annual distribution amount cannot be less than an amount designed to exhaust the fund if it is paid for the remainder of the employee’s life or the joint lives of the worker and a designated beneficiary.\textsuperscript{132} Distributions cannot be avoided merely because the employee has not retired.

4. Size of the Fund

It is possible to have too much of a good thing, at least when the good thing represents tax-deferred retirement benefits. The government assesses a 15% excise tax on excess retirement distributions from retirement plans.\textsuperscript{133} In addition, if “excessive” undistributed amounts remain when

\textsuperscript{130} Id. § 72(t). In addition, exceptions apply to payments to correct prior excess deferrals and payments made to individuals who retired by 1986 under an election. The exceptions for separation from service, medical expenses, and qualified domestic relations orders are not available for distributions from individual retirement accounts. \textit{Id.}

\textsuperscript{131} Id. § 4974.

\textsuperscript{132} I.R.C. § 401(a)(9) (1994).

\textsuperscript{133} Id. § 4980A(a). Annual distributions of $150,000 are exempt from this tax. In addition, there is a formula inflation adjustment based on a $112,500 initial amount that could result in a greater exemption. \textit{Id.} § 4980A(e).
the worker dies, a 15% additional estate tax is assessed on the excessive amount.\textsuperscript{134}

B. Annuity and Endowment Account Benefits

If an individual acquires an annuity outside a qualified retirement plan, the cost of the annuity has already been taxed and the taxpayer can recover it on a tax-free basis. Income earned on the annuity account accumulates free of income tax until distributions begin. At that time, the taxpayer spreads his or her investment in the contract over the total amount to be received in much the same way as was described in the preceding section for retirement plans.\textsuperscript{135}

Distributions from annuities are also subject to a 10% excise tax for premature distributions.\textsuperscript{136} The tax is waived for distributions made after the annuitant's death, if the annuitant is permanently and totally disabled, or if the annuitant is taking installment payments over life expectancy (or over joint life expectancies of the annuitant and a beneficiary). Other exceptions apply to investments made before August 14, 1982, and to annuities used to fund personal injury awards. However, no exemption exists for distributions because of medical expenses or for a qualified domestic relations order.\textsuperscript{137}

If a taxpayer purchased an endowment policy as a means of saving for retirement or other needs, the earnings accumulated while the contract is in effect are not taxed. When the policy matures, the amount received is gross income to the extent it exceeds the taxpayer's investment in the contract. Tax can be deferred by taking payments in installments, using the annuity rules to compute the amount taxable each year. However, that option will

\textsuperscript{134} Id. § 4980A(d). The excess plan amounts are computed under IRS actuarial rules by comparing the value of plan assets to the value of a hypothetical life annuity. Taxpayers whose interest in these plans was worth more than $562,500 on August 1, 1986, were given an election to exempt benefits accrued on that date. The election "window" ended with the tax return due for 1988. Id. § 4980A(f).

\textsuperscript{135} If the annuity was purchased before 1987, the taxpayer can exclude more than the designated cost by outliving life expectancy, but the deduction is forfeited if the taxpayer dies before recovering his or her investment on a tax-free basis. The opposite rule applies to annuities purchased after 1986. The exclusion ends when the annuitant has recovered the cost free of tax, and an itemized deduction is allowed if the annuitant prematurely.

\textsuperscript{136} I.R.C. § 72(q)(1) (1994).

\textsuperscript{137} These exemptions do apply to distributions from retirement plans other than individual retirement accounts. Id. § 72(t). The different early distribution rules applicable to withdrawals from these various savings devices make planning by taxpayers who are not yet age 59 ½ extremely difficult.
be recognized for tax purposes only if the taxpayer elects it within sixty
days of the policy’s maturity date. 138

C. Social Security Benefits

Eligibility for Social Security benefits requires consideration of both the
possible income tax imposed on those benefits and the loss of benefits
associated with continued employment while under the age of seventy.

1. Income Tax on Benefits

Recipients of Social Security benefits must compute the tax conse-
quences of those benefits annually, because the taxable portion depends on
the benefit amount, the amount of other income, and marital status. Possible
outcomes include no gross income, inclusion of 50% of the benefit in gross
income, and inclusion of 85% of the benefit in gross income. Both the 50%
and 85% inclusion rates may apply to married taxpayers filing joint returns
and unmarried taxpayers. 139

A married couple filing a joint return reports none of their benefits as
gross income if one-half of those benefits plus their other gross income plus
interest they receive from municipal bonds140 is $32,000 or less. For
unmarried individuals, the base number is $25,000. If the amount computed
in the preceding paragraph exceeds $44,000 for the married couple or
$34,000 for unmarried individuals, up to 85% of the benefit above these
adjusted base amounts is included in gross income. 141

What effect would marriage have on the taxability of Social Security
benefits? The answer depends, of course, on the amount of each person’s

138. Id. § 72(h).
139. Id. § 86. A married individual who files a separate return and does not live apart
from a spouse for the entire year is taxed on 85% of the Social Security benefits. If he or
she lives apart from the spouse, the taxable portion of the benefit is computed using the rules
for unmarried taxpayers.
140. Id. § 86(a)(1), (c)(1). In this instance, the decision between the certificate of
deposit yielding $25,000 interest and the municipal bond yielding $20,000 results in a base
reduction of only $5000. The taxpayer selecting the municipal bond interest still pays less
tax because $5000 less in benefits will be taxed and the $20,000 bond interest escapes
taxation. If the bond interest were omitted from this special computation, as it is for all other
purposes, a much smaller portion of the benefit would be exposed to taxation. This backdoor
means testing for taxation favors Social Security recipients who do not need current income
and can invest in growth stocks and unimproved land, which yield little or no gross income
but which provide borrowing opportunities when funds are needed.
benefit and other income. If, for example, two unmarried individuals each received a $10,000 benefit and a $15,000 pension, neither would report gross income from Social Security. The pension plus one-half the Social Security benefit equals $20,000. Only the $15,000 pension is included in each taxpayer’s gross income. If they married, their combined pensions plus one-half their Social Security benefits equals $40,000. Because that exceeds $32,000, $4000 of the Social Security will be included in their gross income.142 Although there is no change in their total income, each reports gross income of $15,000 if they remain unmarried. As a married couple, their combined gross income is $34,000.

The relevant amount, at least for tax purposes, is not the difference in gross income. Differences in gross income are relevant only if they translate into differences in tax paid. In this situation, the single taxpayers would each report taxable income of $7800 and pay $1170 in tax. As a married couple, they would report taxable income of $21,250 and pay $3187.50 in tax. The marriage increases their annual tax liability by almost $850.143

2. Benefits Phaseout

Taxpayers between sixty-five and sixty-nine years of age forfeit one dollar in benefits for every three dollars earned above $11,160. The benefits phaseout for a taxpayer in the sixty-five to sixty-nine year age range amounts to a 33 1/3% tax over and above any income tax imposed on the remaining benefits and over and above the Social Security tax assessed on the salary received that year. Because the taxpayer’s initial benefit will increase to reflect the decision to delay taking benefits until a later age, taxpayers who plan to work full-time past age sixty-five should seriously consider postposing the start of benefits.144

142. The amount included in gross income is the lesser of 50% of the benefit or 50% of the amount by which the other income, augmented by one-half of the benefit, exceeds the $32,000 base amount.

143. These computations assume that the taxpayers deducted the standard deduction ($3800 single; $6350 married); the additional standard deduction for taxpayers who are 65 years old ($950 single; $1500 married); and the personal exemption deduction ($2450 per taxpayer). The single taxpayers paid less tax because none of their Social Security benefits were included in gross income, and because their two standard deductions were greater than the married couple’s combined standard deduction.

144. 20 C.F.R. § 404.430 provides for the benefits phaseout, which is even more onerous for taxpayers who are under age 65.
IX. INVOLUNTARY RETIREMENT

A. Disability Benefits

Disability payments financed by an employer are generally included in an employee's gross income. Disability payments financed by an employee with after-tax dollars are not included in his or her gross income; those finances with pre-tax dollars are included. When both the employer and employee contribute to the plan, the tax treatment is allocated based on the relative amount each contributes to financing the plan.

Because the employee takes no tax deduction for purchasing disability insurance, a review of tax returns will not enlighten you as to whether your client paid premiums with after-tax dollars. A payment with pre-tax dollars was made through an employer-provided flexible benefits plan, which reduces the employee's reported salary by the amount of the premium he or she elects to pay on a tax-free basis.

When advising a client about avoiding current tax by using such a plan to pay premiums, the attorney must explain the risk involved. In the short term, an employee saves both income and FICA tax on the amount used to fund premiums. If the client never becomes disabled, he or she has made the right decision. If the client becomes disabled, the resulting benefits will be fully taxed. The amount remaining after tax will, of course, depend on his or her other sources of income and the applicable tax rates.

B. Life Insurance Benefits

When life insurance benefits are paid in a lump sum because the insured dies, the beneficiary usually reports no gross income. What if, however, funds are received before the insured dies or are received after death but not in a lump sum?

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145. I.R.C. § 105(a) (1994). If the employer funds these payments by purchasing insurance, which the employer deducts as a business expense, the employee does not report the insurance premiums as gross income. Id. § 106. Section 105 does not tax payments an employee receives as compensation for medical expenses or as a payment for loss of use of a part of the body or a bodily function. The exclusion is lost if these payments are based on the time the employee is away from work.

146. Id. § 125. The employer's benefits office should have this information if the employee is unable to provide it because of, for example, a disability involving ability to communicate.

147. Id. § 101(a). The proceeds are not exempt from estate tax if they are payable to the insured's estate or if the insured had incidents of ownership, such as the ability to change the beneficiary. See id. § 2042.
If the insured has outlived the beneficiaries, no harm is incurred by surrendering the policy. In addition to being spared the obligation to pay premiums, the insured acquires a pool of capital that can be invested or spent for necessities. If the amount withdrawn exceeds the premiums paid in prior years, the insured reports that excess as gross income and pays any resulting income tax, thus depleting the available fund. Alternatively, the insured can borrow against the policy’s value. Unless the amount borrowed exceeds the owner’s investment in the insurance contract, current taxation is avoided. The death benefit will be reduced by the unpaid loan whether or not the loan itself results in gross income.

If the beneficiary leaves the death benefit on deposit with the insurance company and receives an interest payment, it is included in gross income. If the policy proceeds are taken as installment payments, part of which are the policy amount and part of which represent interest, only the interest element is taxed. A widow or widower is entitled to exclude $1000 per year of otherwise taxable installment payment interest if the insured died by October 22, 1986. That exclusion is unaffected by a subsequent remarriage and is available only if the funds remain on deposit with the insurance company.

148. Whole life insurance has a cash surrender value, but term insurance does not. However, because term insurance premiums may be significantly higher than whole life premiums when the insured is elderly, surrendering an unneeded term policy will at least improve the client’s cash flow.

149. See Prop. Treas. Reg. § 1.7702-2 (1992) (allowing tax-free withdrawals for taxpayers who are expected to die within a year).

150. See I.R.C. § 72(e) (1994). A life insurance policy’s loan value is attributable to the policy owner’s investment (premiums) and to untaxed investment earnings (inside buildup). More liberal rules apply to taxpayers who borrow from life insurance policies than to taxpayers who borrow against the value of annuity policies. See id.

151. Id. § 101(c)-(d). To determine the excluded amount of each payment, divide the policy’s death benefit by the number of payments. Any additional amount received is included in the beneficiary’s gross income. If a life payment option is selected, the number of payments used in this formula is based on the beneficiary’s life expectancy. Unlike the rules for annuity contracts and pensions, this exclusion is not limited to the taxpayer’s investment, which is represented by the death benefit. Treas. Reg. § 1.101-4(c) (1994).

C. **Unemployment Compensation**

Unemployment compensation benefits are included in gross income.\textsuperscript{153}

D. **Workers’ Compensation**

Workers’ compensation benefits are excluded from gross income.\textsuperscript{154} However, the Internal Revenue Service does not allow an exclusion for benefits paid to supplement salary if an employee returns to work in a reduced capacity.\textsuperscript{155}

E. **Tort Damages**

Tort damages are excluded from gross income so long as the amounts are deemed received on account of personal injury or sickness. If a taxpayer successfully sues an employer for age discrimination under the Age Discrimination in Employment Act ("ADEA"), the damages may be excluded even though the employee would have been taxed on the additional wages received had there been no discrimination.\textsuperscript{156} If the employer and client agree to a settlement, and the initial cause of action included claims other than those that would yield tax-free damages, the exclusion should be preserved by specific allocation of damages in the settlement agreement. The attorney’s fee is deductible only to the extent allocable to damages that are included in the client’s gross income.\textsuperscript{157}

\textsuperscript{153.} I.R.C. § 85(a) (1994).
\textsuperscript{154.} Id. § 104(a)(1).
\textsuperscript{156.} The IRS has ruled that damages are excluded if received because of discrimination based on sex, race, or disability. Rev. Rul. 93-88, 1993-2 C.B. 61. The ruling does not cover ADEA discrimination. Most court decisions in this area favor the taxpayer. See Schleier v. Commissioner, 26 F.3d 1119 (5th Cir.), cert. granted, 115 S.Ct. 507 (1994); Schmitz v. Commissioner, 34 F.3d 790 (9th Cir.), petition for cert. filed, 63 U.S.L.W. 3462 (U.S. Nov. 23, 1994) (No. 94-944); Redfield v. Insurance Co. of N. Am., 940 F.2d 542 (9th Cir. 1991); Rickel v. Commissioner, 900 F.2d 655 (3d Cir. 1990); Pistillo v. Commissioner, 912 F.2d 145 (6th Cir. 1990); Bennett v. United States, 30 Cl. Ct. 396 (1994); cf. Downey v. Commissioner, 100 T.C. 634 (1993), rev’d, 33 F.3d 836 (7th Cir. 1994); Maleszewski v. United States, 827 F. Supp. 1553 (N.D. Fla. 1993); Shaw v. United States, 853 F. Supp. 1378 (M.D. Ala. 1994).
X. STATE TAXES

Although the array of state taxes are beyond the scope of this article, the attorney must consider state taxes in two contexts. First, state income tax rules may not follow their federal counterparts. A state may be more or less generous in its treatment of an item than is the federal government. If the state has an income tax, its rules must be considered in evaluating the economic consequences of a particular action. Second, differences between states are an important consideration if the client is considering relocating. For example, some states impose sales tax on grocery purchases, some states impose no income tax or have much lower tax rates than do other states, and some states impose property tax on the value of personal property, such as automobiles, as well as on the value of real property. 158

XI. CONCLUSION

Older individuals share many, if not all, of the tax problems faced by younger taxpayers. Several other provisions apply to them because they have attained a particular age or because older taxpayers are more likely to have a particular characteristic, such as poor health. By considering tax consequences in their planning, attorneys representing older clients will enhance their clients’ ability to retain assets needed for their support.

158. North Carolina imposes its sales tax on groceries and imposes an ad valorem property tax on automobiles. N.C. GEN. STAT. §§ 105-164.13(38) (1993) (excluding only food purchased with food stamp coupons); id. §§ 105-274 (1992 & Supp. 1993) (ad valorem tax). Florida is one of the few states that imposes no individual income tax. California, on the other hand, not only has an income tax but imposes it on nonresidents who receive pensions based on their prior work experience in California. CAL. REV. & TAX CODE § 17951 (Deering 1988) (“In the case of nonresident taxpayers the gross income includes only the gross income from sources within this State.”). See Jerry McTeague, Consider the Source, Nov. 1, 1993, available in LEXIS, Fedtax Library, State Tax Notes File.
Protecting the Rights of Nursing Home Residents: How Tort Liability Interacts with Statutory Protections

Jeffrey Spitzer-Resnick
Maya Krajcinovic

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I. INTRODUCTION

As a private practitioner who regularly deals with clients who have dealt with physical and/or emotional abuse while either they or their loved ones were residents of a nursing home, this writer finds it necessary to utilize all available legal tools to achieve compensation for those rights violations. This article will explore both the avenues and barriers which private litigants may encounter in their quest for compensation or other remedies for abuse of nursing home residents.

In May 1993, this author wrote an article exploring the limitations of Wisconsin's statutory private cause of action for nursing home residents which called for legislative action to make section 50.10 of the Wisconsin Statutes a more useful tool to remedy the abuse of nursing home residents.¹ Despite the fact that Wisconsin's private right of action statute has not been reformed since that date, statutes and regulations still have an impact upon the civil prosecution of those who abuse nursing home residents' rights. This article will explore alternative strategies, such as actions in tort, which have been successful in Wisconsin as well as other states. Specifically, it will focus on this author's experience as co-counsel in Snow v. Beverly Enterprises-WIS, Inc.,² where a federal jury in the Eastern District of Wisconsin awarded the plaintiff $125,000 in damages for loss of society, companionship, and conscious pain and suffering.³ In addition, this article will explore many of the potential barriers to successful prosecution of such claims.

II. NURSING HOME RESIDENTS' RIGHTS

Nursing homes are highly regulated institutions. A significant portion of those regulations are designed to protect the vulnerable nursing home resident from abuse, neglect, or mistreatment while in the nursing home. The regulations are found in both state and federal law and have as their

¹ Jeffrey Spitzer-Resnick, Protecting the Rights of Nursing Home Residents, Wis. L AW., May 1993, at 22.
² No. 91-C-597 (E.D. Wis. Dec. 21, 1992) (additional information regarding this case is available through the author).
³ The loss of society and companionship damages for wrongful death were assessed at the statutory cap of $25,000 which was in effect at the time of death. Wis. Stat. § 895.04(4) (1990). This section has since been amended and the cap has been raised to $150,000 for actions accruing as of May 16, 1992. See Act of May 1, 1992, 1991 Wis. Act. 308, 1992 Wis. Legis. Serv. 2145, 2146 (codified as amended at Wis. Stat. § 895.04(4) (1993)).
root, the Nursing Home Reform Amendments Act, which was contained within the Omnibus Budget Reconciliation Act of 1987 ("OBRA '87"). Though passed in 1987, the law did not truly become effective until the United States Department of Health and Human Services ("HHS") implemented regulations on September 26, 1991.

The various states have not fully implemented all the residents’ rights provisions set forth in the federal statutes in their regulations. An examination should be made of whether the state’s statutory provisions are written with the assumption that the federal residents rights provisions set forth the standards by which nursing home residents should receive their care. The federal provisions are numerous and include everything from adequate assessment of the resident’s needs upon admission, to the quality of life (including the right to be treated with dignity), to the actual quality of care delivered to the resident. These regulations are so specific that they suggest that residents who enter a nursing home without pressure sores or urinary incontinence should not develop them without a demonstration that the resident’s clinical condition made such a development unavoidable.

The practitioner in this area must look further than the section of the regulations that delineates residents’ rights. While important in dealing with critical issues, such as the right to privacy and confidentiality, the delineated residents’ rights regulations do not focus on the actual quality of care requirements as much as the previously mentioned regulations. The few rights mentioned here are by no means exhaustive. They should, however, lead an attorney reviewing a case involving nursing home abuse or neglect to delve into the regulations to determine whether the nursing home had sufficient notice that it was legally obligated to maintain certain minimum standards of care provided to residents. This examination then

6. The regulations in any given state should be examined nevertheless. See, e.g., Wis. ADMIN. CODE § HSS 132.31 (Oct. 1991).
7. See, e.g., Wis. STAT. § 50.09 (1993).
9. See id. § 483.15.
10. See id. § 483.25.
11. See id. § 483.25(c)-(d).
12. See id. § 483.10.
requires the attorney to determine whether the case has potential as a private cause of action.

III. PRIVATE RIGHTS OF ACTION

A. Federal Statutes and Regulations

The federal law does not give nursing home residents an explicit private right of action. However, in dealing with the enforcement provisions of OBRA '87, Congress explicitly stated that any state or federal remedies\textsuperscript{14} "shall not be construed as limiting such other remedies, including any remedy available to an individual at common law."\textsuperscript{15} The House Energy and Commerce Committee Report on the provision specifically states that the law was not meant to "limit remedies available to residents at common law, including private rights of action to enforce compliance with requirements for nursing facilities."\textsuperscript{16}

In \textit{Cort v. Ash},\textsuperscript{17} the Supreme Court established the following four-part test to determine whether a private right of action is implied by federal legislation: 1) whether the plaintiff is part of the class for whose benefit the statute was enacted; 2) whether legislative intent, either explicitly or implicitly, indicates that Congress intended to create a private remedy; 3) whether implying a private remedy would be consistent with the purposes of the legislative scheme; and 4) whether the cause of action is "traditionally relegated to state law" so that inferring a cause of action based on federal law would be inappropriate.\textsuperscript{18}

Under the \textit{Ash} test, there have been mixed results on the issue of whether the federal nursing home provisions provide a private cause of action.\textsuperscript{19} Whether one pursues such a private cause of action may depend upon how strong the resident's case is for damages under common law theories of liability, as explored below.\textsuperscript{20}

\begin{itemize}
\item\textsuperscript{14} Such remedies include administrative enforcement through survey and certification.
\item\textsuperscript{15} 42 U.S.C. § 1396r(h)(8) (Supp. IV 1993).
\item\textsuperscript{17} 422 U.S. 66 (1975).
\item\textsuperscript{18} Id. at 78.
\item\textsuperscript{20} The author acknowledges the argument for a federal private cause of action and recommends for further reading: Toby S. Edelman, \textit{The Nursing Home Reform Law: Issues...
B. Explicit State Statutory Private Rights of Action

1. Wisconsin

Unlike federal law, Wisconsin does have an explicit private right of action for nursing home residents. However, section 50.10 of the Wisconsin Statutes is severely limited as it only enables the resident to bring an action for mandamus against the state enforcement agency, the Department of Health and Social Services ("DHSS"), or injunctive relief against DHSS or the nursing home. As such, there are no reported cases utilizing this statute.

However, analogous to the federal situation described above, and perhaps more explicit, is section 50.11 of the Wisconsin Statutes, which provides for remedies that exist apart from those provided by statute, such as in the common law. While cases which have limited damage value may certainly benefit from a stronger private cause of action provision, those representing nursing home residents should take the call of section 50.11 and explore the opportunities outside of statutory remedies as explained below.

2. New York

New York has developed one of the best statutory schemes granting a private right of action for nursing home residents. If a nursing home resident’s rights or benefits are denied, the resident is entitled to compensatory damages for each day the resident is injured, equivalent to no less than twenty-five percent of: 1) the daily per-patient rate of payment; or 2) the average daily total charges per patient for the facility. Punitive damages are also available if the deprivation of any right or benefit is found to be willful or in disregard of the lawful rights of the resident.

In Begandy v. Richardson, a nursing home resident brought an action pursuant to New York’s private right of action. The complaint alleged that the resident wandered down a hallway leading to a stairway and fell down the stairs. Although the court lauded the statutory scheme, it refused to apply it in this case. The court reasoned that New York’s private right of action statute was not designed to change the normal...
negligence burden of proof. Accordingly, the court refused to impose strict liability on the nursing home because it determined that the statutory private cause of action was limited to those instances where the injury involved a deprivation of a personal right or benefit contemplated by the New York resident bill of rights.\textsuperscript{26}

3. Illinois

The State of Illinois provides nursing home residents with a private cause of action for infringement of their rights. A successful plaintiff may recover treble damages or $500, whichever is greater, in addition to costs and attorney’s fees.\textsuperscript{27}

In \textit{Harris v. Manor Healthcare Corp.},\textsuperscript{28} a nursing home resident filed suit against a nursing home, alleging that an ulcer had developed on the resident’s heel, which subsequently became infected and necessitated the amputation of her leg. The plaintiff claimed that this injury was a result of the improper care and treatment of the nursing home staff and brought an action under the Illinois private cause of action statute.\textsuperscript{29} The Illinois Supreme Court held that the private cause of action statute was constitutional and a legitimate exercise of legislative power, and remanded the case to the trial court for assessment of damages.\textsuperscript{30}

In dicta, the court commented that the private right of action statute was enacted to encourage private enforcement of violations of nursing home residents’ rights. The court emphasized that since many residents’ rights violations will not yield significant actual monetary damages, such as violations of a resident’s privacy, religious freedom, or free speech, the availability of treble damages and attorney’s fees created a realistic possibility that such rights violations would achieve remedies in court.\textsuperscript{31}

4. Missouri

The State of Missouri also allows a private right of action by nursing home residents. However, the plaintiff must first file a written complaint with the attorney general, and may only proceed to court if the attorney

\textsuperscript{26} \textit{Id.}  \\
\textsuperscript{27} ILL. ANN. STAT. ch. 210, para. 45/3-602 (Smith-Hurd 1993).  \\
\textsuperscript{28} 489 N.E.2d 1374 (Ill. 1986).  \\
\textsuperscript{29} ILL. ANN. STAT. ch. 210, para. 45/3-602 (Smith-Hurd 1993) (enacted as part of the Nursing Home Care Reform Act of 1979).  \\
\textsuperscript{30} \textit{Harris}, 489 N.E.2d at 1384.  \\
\textsuperscript{31} \textit{Id.} at 1382-83.
general fails to initiate legal action within sixty days of receipt of the complaint. 32 Actual damages are available as well as punitive damages which are limited to the larger of $500 or five times the amount of special damages. 33 However, damages are not limited if the rights violation is the result of an intentional act or omission causing physical or emotional injury. Attorney’s fees are also available. 34

In Stiffelman v. Abrams, 35 the Supreme Court of Missouri expressly stated that it is for the private sector to police the adherence to the state’s statutory scheme to protect nursing home residents. 36 In Stiffelman, kicks and blows from nursing home attendants over a period of several weeks resulted in the death of Joseph A. Stiffelman, a ninety-year-old nursing home resident. These rights violations prompted the executors of his estate to bring suit for damages against the operators, individuals, and corporate owners of the nursing home. 37 The circuit court granted the nursing home’s motion to dismiss for failure to state a claim upon which relief could be granted. 38

The Supreme Court of Missouri reversed the decision of the circuit court and remanded the case for further proceedings. 39 The Missouri Supreme Court held that the circuit court erred in granting the nursing home’s motion to dismiss since the private right of action statute expressly demonstrates that the legislature “looks to private parties for some degree of policing.” 40 The court reasoned, based on legislative interpretation, “that [the] government cannot do everything and that some requirements of the Act can best be enforced by those most directly involved.” 41

The court noted that section 198.093 of the Missouri Statutes also grants standing to the estate of a former resident and thus, the plaintiffs were entitled to damages beyond wrongful death. 42 Accordingly, through its opinion, the court’s decision substantiated the legislative intent, thus

33. Id. § 198.093(3).
34. Id.
35. 655 S.W.2d 522 (Mo. 1983) (en banc).
36. Id. at 530.
37. Id. at 525.
38. Id. at 527.
39. Id. at 525.
40. Stiffelman, 655 S.W.2d at 530.
42. Id. at 530.
giving police power to the private sector to enforce Missouri’s residents’ rights regulations against nursing homes.

IV. COMMON LAW REMEDIES—AVAILABILITY AND BARRIERS

Whether or not one can fashion a private cause of action based on the federal or state regulations which control nursing homes should not be the end of an attorney’s inquiry into whether an abused or mistreated nursing home resident can maintain an action in court. Indeed, the inquiry should always include consideration of whether or not there are common law causes of action based on the mistreatment. The following examination of how the Snow case played out at trial, as well as how the reported decisions present both openings and barriers to common law tort actions, will demonstrate both the availability of, and barriers to, common law actions in the nursing home residents’ rights context.

In Snow, a federal jury trial, the plaintiffs brought an action that raised a number of common law issues, including breach of contract and negligence resulting in the wrongful death of Edna Snow, as well as her conscious pain and suffering prior to death.43 Although examination of the nursing home admissions agreement regarding the contract claim should not be overlooked in cases such as these, the legal team in Snow concentrated on the negligence claim.

The plaintiffs claimed that the defendant had a history of operating the Glenfield Health Care Center in a deficient manner. For example, during the two years prior to Snow’s admission to Glenfield, the nursing home routinely failed to document its patients’ dietary and rehabilitative needs and progress. Less than one month after her admission to Glenfield for post-stroke recuperative care, Snow’s condition deteriorated to the extent that she was hospitalized, where she died eight days later.

The plaintiffs sought to use annual surveys conducted by Wisconsin’s Bureau of Quality Compliance to demonstrate the nursing home’s knowledge of its care deficits prior to, and during, Snow’s stay at Glenfield. The court refused to admit these surveys into evidence, ruling that they did not specifically apply to the cause of action for negligence regarding Snow. As a result, the plaintiffs were unable to present a strong case for punitive

44. While the author provided assistance as local counsel in Snow, the bulk of the effort in putting the case together and presenting it at trial was done by lead attorney Jack Harang, his associate, Marvin Jeffers, and his paralegal, Suzanne Harang of New Orleans, Louisiana, who is a former nursing home administrator.
damages based on the willful disregard of Snow's needs while she was in the nursing home. Ultimately, the court ruled against allowing the issue of punitive damages to go to the jury.

Without evidence pertaining to punitive damages, the jury based its $125,000 award on the following evidence. Snow's therapeutic goals were not achieved when the nursing home failed to put her lap and shoulder brace in place. Further, the nursing home failed to toilet Snow every two hours to help her reestablish her continence. On one occasion, she was left to lie in her own feces for more than an hour while family members tried, with great difficulty, to obtain staff assistance to clean her. The jury concluded that the lack of care and the rough way in which she was finally cleaned added significantly to the loss of dignity suffered by Snow prior to her death.

Perhaps most important to the jury was the nursing home's failure to meet Snow's nutritional needs. Snow's chart was replete with instances where little or no food intake was recorded. As a result of a stroke, Snow was paralyzed on her left side and thus, needed assistance to make sure that she had sufficient dietary intake. Despite this left-side deficit, nursing home personnel regularly placed food on her left side. The jury concluded that these nutritional deprivations ultimately led to Edna Snow's untimely death.

V. ESTABLISHING A STANDARD OF CARE—NEGligence PER SE

If there is no clear private right of action to enforce nursing home residents' rights, these rights and regulations may be used to establish negligence per se. In Snow, the plaintiffs attempted to utilize this concept under Wisconsin law. To establish negligence per se in Wisconsin, the nursing home regulations must have a purpose, exclusively or in part, to protect: 1) a class of persons which includes the plaintiff; 2) the interests of the plaintiff that were invaded; 3) the plaintiff's interests against the kind of harm that resulted; and 4) the plaintiff's interests against the particular hazard from which the harm results.45

Although the court in Snow did not instruct the jury on negligence per se, the residents' rights regulations still proved valuable. In Snow, the plaintiffs were able to use the nursing home regulations to establish the standard of care that the defendant nursing home was required to meet. Moreover, the court allowed the nursing home regulations to be used by the jury as further guidance in deciding whether the nursing home breached its duty to Edna Snow.

The fact that nursing home regulations may establish the standard of care or even negligence per se does not mean that nursing home defendants will not try to utilize their compliance with these regulations to avoid liability for injuries to residents.

In *Carlo v. Americana Healthcare Corp.*, a nursing home resident sued to recover damages for personal injuries sustained when another nursing home resident opened a door, striking her and knocking her to the floor. The lower court entered judgment for the nursing home owner. The Georgia Court of Appeals reversed the decision of the lower court. In so ruling, the court established another safeguard protecting nursing home residents from nursing home abuse. The court dictated, with respect to regulations established by the Georgia Department of Human Resources, that nursing homes are not relieved of their liability by simply complying with regulations. The *Carlo* court, in determining whether the nursing home exercised ordinary care, found that:

The fact that the defendant has complied with all the regulations prescribed by the . . . authorities would not relieve it of liability if it has been in fact negligent. The question as to whether the defendant has used ordinary care and diligence [is generally] one for the jury. . . although the defendant complied fully with all the . . . regulations, it was still negligent. The defendant owed to the plaintiff the duty of a certain degree of care to avoid damaging her, and that degree of care would not be lessened or changed by any regulations . . . given by the . . . authorities.

Therefore, the *Carlo* court held that a nursing home cannot escape liability for negligence simply because it was in compliance with the applicable regulations. The fact that the nursing home knew of a potentially dangerous situation, regardless of the fact that it may have been

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47. *Id.* at 283.
48. *Id.*
49. *Id.* at 286.
51. *Id.*
53. *Id.* at 284.
in compliance with applicable regulations, leaves room for a plaintiff to recover damages for personal injuries under a negligence theory.\textsuperscript{54}

VI. PROCEDURAL IMPEDIMENTS TO PROSECUTION OF RESIDENTS’ RIGHTS CASES

A. Government Immunity

Many nursing homes are run by public entities, such as the local county government. Such nursing homes may try to avoid liability by claiming full or qualified immunity. In \textit{Kizer v. County of San Mateo},\textsuperscript{55} the court erased the distinction between privately and publicly run health care facilities by holding them to the same standards, both in terms of liability and penalties.\textsuperscript{56} In \textit{Kizer}, the State Department of Health and Social Services brought suit to affirm citations and assess penalties against county operated long-term health care facilities.\textsuperscript{57} The court granted review and held that Government Code section 818\textsuperscript{58} does not “prevent[] the state from imposing statutory civil penalties pursuant to the Long-Term Care, Health, Safety, and Security Act of 1973, on a state-licensed, county-operated, long-term health care facility.”\textsuperscript{59}

In \textit{Kizer}, the defendant, County of San Mateo, Department of Health and Social Services (“County”) was licensed by the State Department of Health and Social Services (“Department”) to operate a long-term health care center, Crystal Springs Rehabilitation Center (“Crystal Springs”).\textsuperscript{60} The County argued that the penalties were punitive or exemplary damages and thus, forbidden under section 818, since they were, as a public entity, entitled to immunity from such damages.\textsuperscript{61}

However, the Supreme Court of California disagreed. The court interpreted the provisions under section 818 as implementing the legislature’s declared public policy objective of providing the highest level of

\textsuperscript{54} Id. at 284-85.
\textsuperscript{55} 806 P.2d 1353 (Cal. 1991).
\textsuperscript{56} Id. at 1360.
\textsuperscript{57} Id. at 1354.
\textsuperscript{58} This section of the California Tort Claims Act prohibits assessment of punitive damages against public entities. \textsc{Cal. Gov't Code} § 818 (Deering 1982 & Supp. 1994).
\textsuperscript{60} Id.
\textsuperscript{61} Id. at 1355.
care in long-term health care facilities. The court held that section 818 was "intended to limit the state's waiver of sovereign immunity and, therefore, to limit its exposure to liability for actual compensatory damages in tort cases." Therefore, the court viewed section 818 as a legislative tool to promote the health, safety, and welfare of long-term health care facilities by applying the civil penalties under section 818 to offset the state's costs in enforcing such regulations.

Whether state enforcement agencies do an adequate job of enforcing their own nursing home regulations is open to debate and beyond the scope of this article. However, Kizer clearly demonstrates that when faced with a potential defense of governmental immunity, those seeking to enforce nursing home residents' rights should consider availing themselves of the power of public prosecution.

B. Expert Testimony

A standard tool used to demonstrate whether a nursing home breached its duty of due care is the employment of expert testimony. Both parties may attempt to use doctors, nurses, and nursing home administrators for this purpose. Under a negligence cause of action, expert testimony provides the trier of fact with a reasonable understanding of the nature of the standard of care required by the nursing home, and to determine whether there was a deviation therefrom. If, however, the trier of fact is fully capable of determining the applicable standard of care through use of common knowledge, the court may exclude the proffered expert testimony.

In Juhnke v. Evangelical Lutheran Good Samaritan Society, the Court of Appeals of Kansas held that when "treatment and care of this patient was so obviously lacking in reasonable care and had such serious consequences that the lack of reasonable care would have been apparent to and within the common knowledge and experience of mankind in general," expert testimony was not required. In Juhnke, Myrtle J. Strong sustained

62. Id.
63. Id. at 1357.
64. Kizer, 806 P.2d at 1358.
67. Id. at 1136.
68. Id. at 1132.
69. Id. at 1136-37.
serious injuries resulting from being pushed by another patient with a known history of violent behavior. The personal representatives and guardians of Ms. Strong's estate pursued a personal injury action against Ms. Strong's nursing home for negligence in failing to exercise ordinary care to protect Ms. Strong from assault and injury by a fellow patient.

The Kansas Court of Appeals reversed and remanded the decision of the district court. The court held that the district court was in error by directing the verdict for the nursing home. The trial court had sustained the defendant's motion for a directed verdict because the plaintiff had not shown through expert testimony the standard of care for a nursing home and deviation from that standard. Part of the appellate court's reasoning was that expert testimony was not required to prove the nursing home's negligence given the obvious breach of the required standard of care. The court based its decision on the proposition that "as a general rule, the proprietors of a nursing home are under a duty to exercise reasonable care to avoid injuries to patients, and the reasonableness of such care is to be assessed in the light of the patient's physical and mental condition." Therefore, the court reiterated its prior decision that expert testimony is to be used when the standard of care is defined by technological complexities, which would preclude an intelligent decision to be reached by an ordinary trier of fact.

Contrary to the conclusion of the Kansas Court of Appeals in Juhnke, the Court of Appeal for Louisiana held that given the lack of expert testimony, the applicable standard of care was not established in a nursing home abuse case. In Roberson v. Provident House, a quadriplegic resident brought a personal injury action against the nursing home for negligently using an internal catheter which produced extreme discomfort and complications, when an external catheter was specified by a physician and preferred by the patient.

70. Id. at 1135.
71. Juhnke, 634 P.2d at 1134.
72. Id. at 1137.
73. Id.
74. Id. at 1134.
75. Id. at 1136.
76. Juhnke, 634 P.2d at 1136 (citing 40 AM. JUR. 2D. Hospitals and Asylums § 36 (1968)).
77. Id. at 1137 (citing Seaman Unified Sch. Dist. v. Casson Constr. Co., 594 P.2d 241 (Kan. Ct. App. 1979)).
79. Id. at 839-40.
The Louisiana Court of Appeal upheld the civil district court's decision in favor of the nursing home. The appellant specified three trial court errors, one of which fixated on the failure to consider the testimony given by one of Mr. Roberson's past physicians. The court failed to provide reasoning why Mr. Roberson's past physician's testimony, in which the physician stated that the nursing home did not follow standard procedures commonly known and upheld in the medical community, was not sufficient to constitute expert testimony. Suffice it to say that litigants may not want to risk relying on attending physicians as their only expert witnesses in cases such as these.

It is interesting to note that the dissenting opinion in Roberson focused on a theory of battery rather than negligence by stating that a catheter which was inserted without the patient's consent "clearly constitutes a battery." Thus, depending on the facts of the case, plaintiffs' attorneys in cases such of these may want to expand the realm of torts under which they consider bringing causes of action.

C. Statutes of Limitation

Nursing home abuse cases often present themselves after the death of a resident. Such abuse may also occur upon a resident who has cognitive limitations and may not be fully aware of the abuse. In Arthur v. Unicare Health Facilities, Inc., the Second District Court of Appeal of Florida expanded the guidelines developed in the earlier case of University of Miami v. Bogorff, which set forth when knowledge of possible malpractice is imputed to the injured person. Bogorff states that notice of possible malpractice is imputed to the injured person "when the plaintiff should have known of either (1) the injury or (2) the negligent act."

In Arthur, the personal representatives of John Arthur's estate, a nursing home resident, brought an action against a physician and a nursing home seeking damages for wrongful death and personal injury. It was alleged that Mr. Arthur's death was negligently caused by the failure to prevent or control the development of decubitus ulcers which resulted in an

80. Id. at 842-43.
81. Id. at 842.
82. Id. at 843 (Barry, J., dissenting).
84. 583 So. 2d 1000 (Fla. 1991).
85. Id. at 1002.
86. Arthur, 602 So. 2d at 597-98.
infection and the amputation of his leg. Finding that the statute of limitations had run, the circuit court granted summary judgment to both defendants.

The Second District Court of Appeals of Florida reversed and remanded the lower court's decision by expanding the holding of Bogorff to provide for the exception of senility as a factor in determining if the person "knew" when and if he was injured. The court felt that since the Bogorff standard implied knowledge or conscious awareness, the same standard could not be applied to someone with little or no conscious faculties, like that of a senile adult such as Mr. Arthur. The court based its reasoning on the standard statutory interpretation that "words are to be given their clear and unambiguous meaning." The court concluded that the legislature's intention was that the Bogorff standard was to apply to a person with conscious awareness to trigger the statute of limitations for a medical malpractice lawsuit.

D. Standing to Bring Suit and Recover Damages

In Downtown Nursing Home, Inc. v. Pool, the Alabama Supreme Court decided that to maintain an action for wrongful death under Code 1975, section 6-5-410, the plaintiff must be an administrator or executor of the estate of the deceased. The court further stated that when an amended complaint to substitute, as party plaintiff, a person who was duly appointed administrator of the estate after the two-year statute of limitations period had expired, the plaintiff could not use that appointment to relate back to the time of the initial filing.

In Pool, Johnnie E. Parker filed suit for the wrongful death of his father, Eddie B. Parker, one year after his father's death. Through the discovery process, it was determined that Johnnie E. Parker had never been

87. Id. at 598.
88. Id.
89. Id. at 599.
90. Id.
91. Arthur, 602 So. 2d at 599 (citing Silva v. Southwest Fla. Blood Bank, Inc., 601 So. 2d 1184 (Fla. 1992); Sheffield v. Davis, 562 So. 2d 384, 386 (Fla. 2d Dist. Ct. App. 1990)).
92. Id.
93. 375 So. 2d 465 (Ala. 1979).
94. Id. at 466 (citing Hatas v. Partin, 175 So. 2d 759 (Ala. 1965)).
95. Id.
96. Id.
appointed executor or administrator of his father’s estate. It was only through the filing of an amended complaint, that Johnnie, more than two years after his father’s death, filed to substitute the administrator of the estate as the party-plaintiff. The court followed previous decisions in determining that “any action by the administrator occurring prior to his appointment was a nullity and therefore there was nothing to which an amendment could relate back.” Since Johnnie E. Parker filed suit without having been appointed executor or administrator, he did not qualify as a personal representative and thus, the doctrine of relation back did not apply.

The question of whether the next of kin should be able to recover damages for the decedent’s pain and suffering was discussed by the Superior Court of New Jersey in Profeta v. Dover Christian Nursing Home. In Profeta, the next of kin of a deceased nursing home resident brought an action against the nursing home for a violation of the decedent’s rights. The alleged rights violations ranged from a failure to notify the next of kin of any change in a patient’s medical condition to failure to comply with the statutory duty imposed on nursing homes. The court, upholding the lower court’s decision, found that the next of kin did not have standing to bring suit under the Nursing Home Residents’ Bill of Rights. The court looked to the legislative intent and determined that since the legislature did not expressly provide for the next of kin to have standing in nursing home residents’ rights suits in which a wrongful death is alleged, standing is only to be provided for the legal guardian.

97. Id.
98. Pool, 375 So. 2d at 466.
99. Id.
100. See Ala. R. Civ. P. 15(c).
101. Pool, 375 So. 2d at 466.
103. Id. at 1308.
104. Id. The complaint against the defendant Dover Christian Nursing Home (“DCNH”) alleged four counts: 1) that DCNH violated its statutory duty to notify next of kin of any change in a patient’s medical condition; 2) that the nursing home was negligent in its failure to give such timely notice; 3) that the nursing home’s failure to give notice arose out of willful and wanton conduct; and 4) that the nursing home’s disregard of its statutory duty was intentional. Id.
105. Id. at 1309.
106. Profeta, 458 A.2d at 1311.
VII. MAKING THE CASE FOR SIGNIFICANT DAMAGES

Now that the procedural avenues and barriers have been set forth, the next factor to consider is damages. While entire treatises have been written on damages in the tort context, the focus here is on presenting the damages element to the jury for a nursing home resident whose rights have been abused. It has been this author’s experience that many attorneys are reluctant to take on any personal injury cases for elderly individuals due to the perceived inability to collect significant damages even if liability is readily apparent. This problem comes from the concept that damages flow from loss of earning capacity and life expectancy, both of which usually are negligible in an elderly person’s case.

However, the Snow case, discussed earlier, demonstrates that a jury can look at an older individual and assess significant damages based on both wrongful death and pain and suffering prior to death.107 Presentation of damages to the jury significantly depends on both establishing the resident’s loss of dignity and convincing the jury that the final days of an elderly person’s life are extremely valuable. Asking jurors to think of how much they should value the last days of one’s life if told there was only a short time left to live has proven very effective. Such techniques are necessary to counteract the prejudice against awarding significant damages to elderly individuals.

VIII. CONCLUSION

The foregoing review of the state of the law around the country as it applies to the prosecution of nursing home residents’ rights cases demonstrates a number of things. First, in states where statutory private causes of action are available to obtain damages for violations of nursing home residents’ rights, such statutes can be a helpful tool as long as the procedural requirements of the statute are followed.

In addition, in states with either no statutory private causes of action or restrictive versions of such statutes, plaintiffs must look to common law causes of action such as negligence, negligence per se, battery, and breach of contract, to name just a few, in order to find their remedies. While it is

107. Recall that in Snow, where the jury awarded the plaintiff $125,000, the wrongful death damages were statutorily capped at $25,000 due to the date the cause of action accrued. With the raising the cap to $150,000 in Wisconsin, or in states without any such cap, actions similar to Edna Snow’s have an even higher potential for damages. See supra note 3.
certainly possible for plaintiffs to succeed with such causes of action, there are often procedural barriers which must be carefully examined in order to ensure that the plaintiff will be allowed to reach the merits of his or her case.

Finally, as nursing home abuse cases become more prevalent with our aging population, a paradigm shift in the award of damages is occurring which recognizes that an older person’s worth goes beyond life expectancy and earning capacity. However, plaintiffs must press this point with all earnestness, as the basic assumption still remains that regardless of how heinous the abuse, an older person’s life and the suffering which they endured due to that abuse, has limited monetary value.

The Snow case should be viewed as an example of how common law theories play out when presented to a jury. When the facts are right, juries are willing to award significant damages. Bringing such cases will not only enable nursing home residents to achieve some vindication for violations of their rights, but will also help to bring an end to the myth that an older person cannot collect a significant level of personal injury damages.
The Interdisciplinary Team Focus: A Strategy for Developing a Successful Practice of Elder Law

Lisa Stewart et al.

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I. INTRODUCTORY REMARKS FROM THE NATIONAL COUNCIL ON THE AGING, INC.¹

This article consists of four sections designed to present practice and research-based information and guidance to attorneys interested in practicing elder law. Four members of the Board of Advisors of the National Council on the Aging’s (“NCOA”) Institute on Financial Issues and Services for Elders² (“NIFSE”) were selected to contribute their expertise in the areas of: 1) techniques for effective counseling and communication with older clients; 2) understanding the role of geriatric care management and financial planning; 3) understanding the role of the long-term care insurance professional; and 4) understanding issues involved in guardianship that reflect the importance of developing an interdisciplinary team approach to serving the older client. In its interdisciplinary approach, this article is different from those typically found in law review journals; the leadership of NCOA/NIFSE is deeply committed to providing information that will encourage and facilitate interdisciplinary relationships where the older client is concerned. The authors believe this information will be helpful in developing or expanding the practice of elder law and welcome your responses and comments.

II. WHY AN INTERDISCIPLINARY APPROACH?

Concerned about the proliferation of fiduciary services for elders and the concomitant complexity of needs among a rapidly increasing older population, the NCOA founded NIFSE in 1991. NIFSE’s mission is based on the premise that complex financial management and legal needs of the expanding population of mid-life and older adults require an interdisciplinary professional approach. A strategy common to many elder law attorneys is based upon the development of business relationships with professionals allied with the field of law. Successful elder law attorneys realize the value

¹. The National Council on the Aging, Inc. (“NCOA”) is a private nonprofit organization founded in 1950, committed to promoting the dignity, self-determination, well-being, and contributions of older persons—both as individuals and within the context of their families and communities. NCOA members are practitioners, volunteers, academics, and organizations which study and deliver services that enhance or extend independent living. NCOA offices are located at 409 Third Street SW, Washington, D.C. 20024.

². NCOA’s National Institute on Financial Issues and Services for Elders (“NIFSE”) is an interdisciplinary organization of professionals and leaders in the field of financial and related services for mid-life and older adults. NIFSE’s mission is to educate financial service professionals, professionals in aging, and the public at-large about the financial, legal, and insurance needs of older adults of all socioeconomic levels.
of working with a team of experts, such as a financial planner specializing in retirement issues, a geriatric care manager skilled in nursing home placement or community-based long-term care services, and a long-term care insurance specialist who can advise clients on selecting an appropriate long-term care insurance policy.

One of the major challenges practitioners face today is managing an overwhelming amount of information. Developing a team of professionals is one strategy for developing a successful elder law practice. It is the purpose of this article to address four issues that will inform the legal community about resources and professional networks that can help bridge the gaps and delineate some of the gray areas practitioners face when serving older clients.

III. OUR AGING SOCIETY: YOUR CHANGING PRACTICE

Drawing upon current research and practice with older clients in long-term care planning, it becomes clear that older clients require a counseling approach different from the young to middle-aged because of both physical and psychosocial factors. As a result, attorneys wishing to provide high quality service to the elderly must develop special skills and sensitivity.

A. A Demographic Overview

Our older population is growing at a very rapid pace. The segment of the population referred to as the very old (those over the age of eighty-five) is growing even faster. It is estimated that by the year 2000, fifty percent of the elderly population will be age seventy-five and older. The eighty-five and over segment is expected to be seven times larger in 2050 than it was in 1980.

The greater numbers of the very old will bring an increase in people seeking assistance for questions involving Medicare, Medicaid, Social Security, long-term care planning, estate planning, living wills, guardianship, and retirement living options, to name but a few. Providing effective and sensitive legal counsel for this segment of our population will require special thought and planning.

B. A Short List of Practical Considerations

While knowledge of the “normal” aging process is essential to increasing an attorney’s sensitivity to his or her older clients, it is certainly worth stating that no two people are alike, and that an individual’s chrono-
logical age in no way determines his or her physical, mental, or emotional state.

Surveys have shown that when clients evaluate their lawyers, factors involving the attorney-client relationship are given much more weight than technical skill and expertise. After a recent public seminar, one woman complained that she was not happy with her current lawyer and would appreciate the names of several other attorneys specializing in elder law. With a few questions, the speaker at the seminar was able to determine that this newly widowed woman had consulted a well-respected, competent elder law practitioner. Her criticisms, however, came forth in a wave of emotion: "He rushed me. He was so intense." And the final and most revealing comment from the woman was the statement, "I could never be married to someone like that!" To avoid such criticisms, the practitioner may wish to implement the following considerations:

1) Older clients want to feel that their lawyer respects them as individuals. This means, on a simple level, slow down and get to know the client. A feeling of being rushed can cause an otherwise alert and mentally competent individual to appear confused and disoriented. Allow time in the counseling session for the client to express his or her thoughts. In fact, it might be helpful to send a written set of questions for consideration in advance of the scheduled meeting.

2) Explain the "process." Keep in mind that this may be the very first time that this elderly person has consulted an attorney. This is especially true for many older widows. Older women in our society often perceive themselves as inept in financial and legal matters. "Someone else" always took care of these matters in the past. Let the client know how long this meeting will last and what will happen next. If there will be a lapse of time before the next meeting or telephone contact, tell them. Involve the client as much as possible in the process and stay in touch.

3) Stress the confidential nature of the attorney-client relationship. Remember that this older individual may be somewhat fearful about an attorney. You will be discussing matters that have to do with the last phase of a lifetime. There may be some denial and fear of losing what remains of their independence. Also, if the client is there at the urging of (and often accompanied by) a son or daughter, you may sense a great deal of resentment. No one likes to have their increasing age or frailty underscored!

4) The relationship should be as open as possible in order to have the most successful outcome. A client fearful of losing his or her independence may not truthfully report physical or cognitive problems. Another problem occurs more often among women. For instance, in a desire to "please" their counselor and receive a smile and an approving nod, women may sometimes
try give what they perceive as "the right answer." There will be a greater chance of success if the client perceives that you are truly concerned for her benefit. Remember, you are building trust and involvement.

5) On a purely physical level, be sensitive to possible problems with loss of hearing or vision. Not every elderly person suffers such losses, but certainly these impairments are much more prevalent at older ages. If you notice a client not responding to questions immediately or responding inappropriately, it might be a hearing loss, not a cognitive problem. Be sure you face the client when speaking to him or her and enunciate clearly. You do not have to raise your voice, unless the client requests it. However, do be certain that background noise is reduced to a minimum. If a particular point is a crucial one, take your time stating it and make sure it is understood.

In addition, be sure that the office is well-lit, with no low-lying obstacles to negotiate. Try to avoid harsh glares or exceedingly bright lights. Older clients who have had cataract surgery, for example, may find bright sunlight or glare painful. Also, for ease in reading, most older clients appreciate written materials that are at least double-spaced.

6) When confusion exists, and it is not due to hearing or vision loss, keep in mind that it may be a temporary state. Loss of a loved one can devastate an individual so completely that there may be a period in which rational and logical thought is not possible. In other cases, you may be confronted with the effects of poor nutrition or abuse of medication. In any of these situations, you might want to consider an appropriate referral. In any practice involving the elderly, attorneys should be acquainted with professionals in complementary fields with specialized knowledge. Such specialists may include geriatric care managers, long-term care insurance specialists, financial planners, and geriatricians. When a referral is appropriate, give your client as much positive information about the new professional as possible. You will want your client to be comfortable calling the specialist and to feel assured that the existing problem will be solved.

7) Listen very carefully. Paying attention and maintaining eye contact can reassure your older client that you are concerned with his or her well-being. It is important also to paraphrase, in a respectful manner, what your client is telling you. This assures your client that you understand exactly what it is he or she is trying to communicate. It also allows your client to hear the problem "in a new way." This can allow your client to explore the meaning of what was said and gain some insights into possible solutions.

Attorneys can play a very important role in helping maintain the independence of older clients and enhancing their overall quality of life.
The sensitivity and concern with which the attorney approaches the older client can make the difference between having a reassured, confident client, and an angry, resentful one.

IV. GERIATRIC CARE MANAGEMENT AND FINANCIAL COUNSELING: A GUIDE FOR ATTORNEYS

As the United States’ population steadily ages, the scope of an attorney’s duties also widens to meet the diverse needs of his or her clients. Increasingly, attorneys find themselves in situations in which they are required to know about issues and services related to the needs of their older clients, such as health care, Medicaid, and nursing home placement or community-based long-term care services.

While it is impossible for any attorney to become a specialist in all the fields relevant to growing older, knowing some key points and key people will make the job easier. Familiarity with young and evolving disciplines such as geriatric care management and financial counseling is imperative to a successful elder law attorney. This section focuses on various issues related to these two disciplines and some important things attorneys should know about working with care managers and financial planners.

Most of the literature on health care finances focuses so much on Medicaid eligibility that little has been written on the noninstitutionalized disabled elderly. It has been estimated that six percent of the population of persons over age sixty-five are in nursing homes. The Health Care Finance Administration ("HCFA"), the overseer of Medicare, estimates that seventy percent of noninstitutionalized elderly live in the community, and are cared for informally by spouses, daughters, and daughters-in-law.3

Community-based long-term care services such as in-home care and adult day care are becoming more prevalent in response to the needs of frail adults and are viable alternatives to nursing home care. The family caregiver or consumer may find it difficult and overwhelming to locate, access, or screen these services, especially if the care is to be provided in a different state or community.

The likelihood that an older person will be placed in a nursing home after hospitalization is greater when the combination of Medicare and Medicaid financing is available. Oddly though, factors such as gender, race, age, and attitude toward formal care arrangements do not have as much

influence on placement decisions as the availability of a payor. Not recognizing this phenomena can become a trap when counseling the family on nursing home placement. Placement officers should consider the patient’s wishes and his or her true care needs when counseling the patient or arranging for long-term care services. If clients seek the advice of legal counsel regarding nursing home or community-based care, attorneys should be aware of a valuable professional resource, namely a geriatric care manager ("GCM").

A. The Geriatric Care Manager

The geriatric care management movement has evolved in response to the increasing longevity of our population. As the population ages, the need for multiple services increases as well. Hence, the need for a professional, skilled in the screening of and arranging of appropriate long-term care services, also increases. In much the same way, financial counseling (usually called financial planning) has become more prevalent because the increasing number of years spent in retirement requires careful planning, so that a client need not fear outliving his or her financial resources.

Geriatric care management developed from the social services and the publicly funded arena. GCMs who are admitted to full (advanced) membership in the National Association of Professional Geriatric Care Managers have master’s degrees in social work, nursing, human services, or gerontology. The largest groups of GCMs are social workers in private practice with backgrounds in family and psychotherapy or geriatric services, and discharge planners from hospitals or nursing homes. Other GCMs may be registered nurses, working either privately or in home health agencies, or in other professional practices or agencies. GCMs are fee-for-service professionals who may or may not receive third-party payments from Medicare or private insurance. Care management services are not covered by Medicare or private insurance, although a few long-term care insurance companies are including this service in their menu of care options.

GCMs help families learn new skills to cope and care for their dependent family member. They also work with the practical side of elder


5. For a list of referrals to GCMs in your area, call: (612) 881-8008, or write to: The National Association of Professional Geriatric Care Managers, 655 N. Alvernon, Suite 108, Tucson, AZ 85711.
care, but rarely with financial management. Often GCMs develop plans of action that may enlist informal caregivers, as well as formal (paid) caregivers, community programs, legal assistance, and resources such as “Meals on Wheels.” Additionally, these professionals make recommendations on housing options, housing costs, and housing availability within local communities. They may also aid in nursing home placement. GCMs assist in paperwork issues with Medicare, insurance, and bill paying. They also act as a liaison between the family and service providers, especially for family members who live a great distance from their frail relative.

B. The Financial Planner

An equally important field in serving the needs of older adults is proper financial counseling. Financial counselors, or financial planners, are traditionally stockbrokers or insurance agents who have evolved into fee-for-service advisors. There are a few financial planners who specialize, or have expertise, in elder care issues. Others specialize in retirement planning issues.

Financial planners who have received the designation of certified financial planner (“CFP”) or chartered financial consultant (“ChFC”), and are registered with the Securities and Exchange Commission as investment advisors, are persons who can legally hold themselves out to the public as financial planners.6 A financial planner evaluates a client’s and their family’s overall financial situation and prepares a written report on the client’s current financial position.7 Factors such as social security, pension, investment and insurance proceeds, future income, inflation assumptions, taxation, and family demands (such as privately paid long-term care services for a parent or family member) are all taken into consideration in the analysis.

It is important that the professional recognize the needs of older clients in light of their financial and emotional well-being as the clients engage in the services of long-term care.8 Nursing home beds are in short supply and, especially in rural areas, there may be a shortage of home care agencies as well. Other kinds of services may aid in caring for a frail and/or demented

7. For a list of referrals to CFPs in your area, call the Institute of Certified Financial Planners in Denver, Colorado at (800) 282-PLAN, or call the International Association for Financial Planners at (800) 945-IAFP.
8. See Cooper, supra note 3, at 3-6.
older person who requires custodial services for the rest of his or her life or may provide temporary assistance while the older person recovers from surgery or other similar conditions. Assisted living facilities are not nursing homes and thus, are not qualified for Medicaid or many private insurance plans. Yet, assisted living facilities are less expensive than nursing homes and may provide the most appropriate level of services or care. A GCM can play a valuable role in this process.

Medicaid planning and its controversial divestiture planning provisions may not totally serve the client. Medicaid requires that a client need a more intensive level of care, known as intermediate care, in order to qualify for long-term care services. Depending on the state in which the client resides, a person financially eligible for Medicaid may not be eligible from a medical care perspective. Balancing the financial needs of the client with the financial and emotional needs of the client’s spouse or dependents may prove difficult.

Herein lies the need for geriatric care management with financial counseling, separate and distinct from elder law, but which plays an integral role in an attorney’s elder law practice. Law addresses the empowerment of another to act for a principal (power of attorney or a guardian/conservator). Financial planning addresses the payor sources and the financial ability of the client to pay for a variety of services. The GCM counsels the client and his or her family in deciding which services are most needed or appropriate, given the client’s legal and financial circumstances.

C. Forming Strategic Alliances

How would an attorney establish a strategic alliance with GCMs and financial planners to assist with the elder client’s needs? In most situations a collaborative effort is most appropriate.9 Because lawyers cannot, and should not, share fees with other professionals, especially nonlawyers, a collaboration of the different professionals (lawyer, GCM, and financial planner) is the only legal method of client engagement.

There are several issues to consider when collaborating with GCMs and financial planners. Understand how each is to be paid, outline the services that each professional will provide, and require each professional to disclose whether they are employed by any agency, hospital, or firm that may cause a conflict of interest in their objectivity. Each of these concerns should be

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spelled out in a letter of engagement or contract for services with your client.

When selecting a GCM or financial planner, ask for professional and client references. If there are no geriatric care managers or financial planners in your area, a few alternatives are available to fill this void. One alternative is to complete graduate work in gerontology or take the examinations to become a certified financial planner. If that sounds too intensive, you can recruit a professional from an agency or institution that could serve as a GCM. For example, you can recruit a social worker (preferably one with a master’s degree and independent licensing to enable third-party billing for psychotherapy) or a registered or licensed practical nurse from a long-term care facility or home health agency, who could conduct physical assessments, make nursing care recommendations, and possibly, teach the family how to take better care of the elderly family member at home. If these assessments are performed by a registered nurse working for a Medicare-certified home health agency, Medicare will pay for these visits, provided there has been prior hospitalization. Financial planning could be performed by an accountant, tax preparer, life insurance underwriter, bank trust officer or other financially trained person, as long as specific investment advice is not given. Investment advice can only be legally given by a registered investment advisor.

Elder law and elder care are processes that naturally go together. In order to best serve the elder client, the attorney at law needs to have an understanding of the issues facing the client and know who in the professional community can, most effectively serve the client’s best interest.

V. IDENTIFYING THE LONG-TERM CARE INSURANCE SPECIALIST

The process of evaluating and implementing a comprehensive retirement planning strategy for your client, one that encompasses legal, financial, and health provisions, is an extremely challenging proposition. Each discipline within these allied professional areas has experience that can be best utilized to analyze and recommend specific planning techniques. As stated earlier, the focus of this article is to provide guidelines for the elder law attorney to identify an experienced and competent long-term care insurance specialist. A qualified long-term care specialist can provide many of the answers that consumers address when reviewing long-term care insurance issues.

One goal of each retirement planning professional is to provide clients with a comprehensive plan that takes all future legal, financial, and health scenarios into consideration. In order to provide this service, one must network and develop relationships with other allied professionals. Before referring your client to other sources, you must be able to accurately identify qualified specialists and be confident of their ability. Identifying a long-term care specialist and building a mutually satisfying relationship requires a diligent researching process.

A qualified long-term care specialist can be difficult to identify, primarily because the insurance industry and regulatory bodies have not provided, nor required, specific training, accreditation, or licensure. In contrast to many other insurance product lines (auto, life, commercial), carriers of long-term care insurance provide limited training and educational resources to their marketing representatives. The current, state of the art, long-term care policies that most consumers are interested in purchasing have only been available in the marketplace only since the mid-to-late 1980s. Because most insurance carriers have been down-sizing and reducing educational and recruitment budgets during this period of time, long-term care has entered the marketing distribution cycle without the industry’s proper support. In the absence of insurance company structured and supplied educational materials and workshops, the majority of marketing representatives are not adequately trained to provide clients with the same level of expertise available in other product lines.

The lack of accreditation programs within the insurance industry for long-term care contributes to the difficulty of identifying a qualified long-term care expert. Life insurance, for example, has many accreditation programs including: Certified Life Underwriter (“CLU”); Chartered Financial Consultant (“ChFC”); and Life Underwriter Training Counsel Fellow (“LUTCF”). These credentials can help identify the commitment and experience that an insurance professional has demonstrated in a particular product field. Not only does long-term care not have an accreditation program, but many of the life and health insurance licensure examinations across the country have not included or required questions relevant to long-term care products and coverage until recently. A few states now require licensed agents to fulfill annual long-term care continuing educational credits. Until formalized mandatory training, continuing education, licensure, and accreditation are required nationwide, we will not be able to easily identify an experienced long-term care specialist.
A. *The LTC Specialist Should Know All the Basics*

In light of the lack of accreditation opportunities, experienced long-term care insurance specialists qualified to assist you and your client base have usually learned their trade through a self-study program. Their backgrounds may have begun in the financial services field, in the life/health insurance area, or even as a health care service provider. Regardless of background, they should be well versed in the basic fundamentals of elder law, financial/retirement planning, health care services/providers, Medicare, and Medicaid. It is essential that a long-term care expert be familiar with these related issues in order to properly evaluate and analyze all available data while interfacing with other allied professionals. When interviewing a long-term care specialist, the initial discussions should not focus solely on insurance product benefits and contractual provisions, but should include a broader conversation on the array of topics mentioned above. This discussion should help you determine whether the long-term care representative has an emphasis only on product sales.

B. *The LTC Specialist Should Have Contacts*

One of the authors’ observations as long-term care specialists is the inherent problem that develops between a client and retirement professional when the specialist is exclusively marketing an insurance product sale, and not offering a full-service plan. Analyzing a long-term care product for its value-orientated policy benefits and the strength of contractual coverage is a valuable part of an LTC specialist’s responsibilities, but servicing your client from the initial consultation through the claim is just as important. For example, when insured elderly persons have health conditions that lead their physicians to prescribe some form of long-term care services, either in the home or in a facility, they usually call the agent for assistance in coordinating the needed and appropriate health care services. Few physicians are as familiar with assisting patients in this process as a qualified long-term care specialist. Specialists should have established contacts and relationships with certified case managers in their geographical area to whom they may personally introduce clients and their families. A long-term care insurance specialist works with policies designed to reimburse expenses for long-term care, not to coordinate the care alone.
C. The LTC Specialist Should Be Involved in the LTC Network

Another factor that may help identify long-term care experts is their involvement in the developing and growing long-term care marketplace. Are they serving with any insurance carrier's agent advisory boards or product development committees? Have they developed educational materials or workshops for other long-term care agents, financial planners, certified public accountants, or health care providers? Are they approved by the state as instructors to teach long-term care certified continuing education classes? Do they work with any local, regional, or national consumer groups that provide health-related information to the public or lobby on legislative health care issues pertaining to long-term care? Can they provide you with references of allied professionals they have worked with in a cooperative reciprocal relationship?

D. Meeting the LTC Specialist

Participating in a joint client presentation with the long-term care specialist will allow you to observe the specialist's data collection, needs analysis, policy and contract review, pre-underwriting process, question-and-answer responsiveness, recommendations logic basis, and application completion. The primary goal of the specialist should be to educate the client as to the long-term care health-related risks and expenses that each senior faces. Illustrating policy coverage benefit options and premium costs will enable your client to select one of the four following strategies: 1) self-insure; 2) fully insure with a private long-term care policy; 3) partially insure with a private long-term care policy; or 4) rely on government assisted Medicaid/Medicare programs. Clearly defining each option will allow your client to make an educated, informed planning strategy decision. The specialist should not emphasize one particular strategy over others. It is helpful to discuss with the long-term care specialist what specific insurance company policies they currently market and the due diligence that has been performed. They should also have policy benefit and premium cost spreadsheets available for you and your client to review. The specialist should be an independent agent that does not have any added incentive to place business with one particular company. Many insurance carriers distribute their products through captive representatives, a practice which results in less than objective analysis and recommendations.

The long-term care insurance marketplace is changing at a rapid rate. Insurance carriers are currently introducing new-generation, enhanced products every twelve to eighteen months. As additional claim experience

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is compiled on this relatively new product field, actuaries are able to streamline pricing and to expand benefits such as liberalized "activities of daily living" benefit triggers. The National Association of Insurance Commissioners is continuing to propose stricter product design, marketing limitations, and licensure requirement guidelines on the long-term care field. Cooperative joint ventures between the public and private sector, such as the Robert Wood Johnson Foundation sponsorship of a long-term care partnership program, is continuing. Government health care reform may alter some long-term care coverage under Medicare, without significantly expanding overall long-term care expense reimbursement. Reform, on the other hand, may offer favorable tax treatment for employer-sponsored long-term care plans, as well as for individual policyholders, which will encourage consumers to consider private long-term care policies as an attractive alternative to self-insuring.

Local life insurance and financial planning associations as well as insurance carriers can provide you with referral sources in finding a qualified long-term care expert. These allied retirement professionals can provide your practice and client base with information that is essential in designing a comprehensive full-service plan to meet the needs of elderly clients today and tomorrow.

VI. WHEN IS A GUARDIANSHIP APPROPRIATE AND WHAT ALTERNATIVES ARE AVAILABLE?

A major demographic change is taking place in our society. With continuing advances in medical knowledge and technology, Americans are living much longer than at any point in history. Unfortunately, many seniors are discovering that their golden years bring even more complex legal issues. Attorneys must recognize the problems which their elderly clients are likely to have and be aware of resources available to address these problems.

The scope of services that the practitioner may be asked to provide continues to expand rapidly. It is now uncommon for an elderly client to simply seek preparation of a will or trust. For example, an issue frequently presented to an attorney with senior clients is the client’s need for in-home assistance with dressing, bathing, and other activities of daily living. The client may need legal advice concerning allocation of assets to provide for

11. The participating states are Connecticut, New York, Indiana, and California.
12. Some insurance carriers providing referrals include: AMEX, (800) 456-3399; CNA, (800) 327-2430; TRAVELERS, (800) 842-0197; and UNUM, (800) 638-7747.
in-home assistance, and how best to protect the client’s assets from depletion. The attorney must therefore be familiar with federal and state programs providing financial assistance to seniors and disabled persons.

An attorney representing elderly clients may be confronted with a client who clearly does not have the ability to make appropriate decisions concerning medical needs or property. Occasionally, the attorney may discover during the course of a meeting or conversation with the client that the client is impaired. If the attorney has already undertaken representation of the client, the attorney must attempt to maintain a normal attorney-client relationship. This can be difficult, especially where the client requests that the attorney prepare documents which, in the opinion of the attorney, the client does not have the capacity to execute. In such a circumstance, the attorney has an ethical obligation not to join in the perpetration of a fraud. The attorney should therefore advise the client that unless the client can obtain a medical opinion supporting the client’s competence, the attorney will not prepare the documents.

Where an elderly client visits an attorney along with other family members, the attorney must be careful discerning which person he or she represents. For example, if the attorney has undertaken representation of the elderly person for preparation of a power of attorney, and comes to the conclusion that the client cannot execute the documents, the attorney cannot ethically represent the family in obtaining guardianship/conservatorship for the senior. If, however, the attorney is representing the family members, guardianship may be the only viable legal option available.

A guardian/conservator is generally defined as an individual who is appointed by a court to serve as the court’s agent under a theory of parens patriae. In most states, a guardian will be appointed for an individual unable to make or communicate responsible decisions regarding health care or property. Oftentimes, the guardian will be a spouse, child, or other close family member. Where the disabled person has no family or the family is

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The attorney’s duty is to maintain as reasonably normal a relationship as possible and advocate on behalf of the elder. Even though an incapacitated person may not have the power to make legally binding decisions, “nevertheless, a client lacking legal competence often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client’s own well being.” *Id.* (quoting MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.14 cmt. (1983)).

14. Under some circumstances, if the senior has the ability to consent to a guardianship and knowingly does so, an ethical violation can be mollified.
disinterested or inappropriate, the court may appoint a local or state agency as guardian.

The guardian is empowered to make health and/or financial decisions on behalf of the individual who is unable to make or communicate their own decisions. For example, a guardian of a disabled person's property would be responsible for collecting the disabled person's income and paying the necessary expenses for care. The guardian's powers are usually enumerated by statute or by common law. As a fiduciary, the guardian must prudently manage the affairs of the disabled person.

A guardian appointed to make medical decisions has a variety of functions. He or she may have to arrange for appropriate medical examinations on behalf of the ward, give informed consent for medical treatment, and arrange for a safe living environment. Depending on the state, the guardian may also have the power to decide whether to withhold or withdraw life-sustaining medical treatment.

The attorney presented with a potential guardianship matter must communicate with the physician(s) of the alleged disabled person to ensure that the appropriate legal standard for disability/incompetence can be satisfied. The physician is generally required to attest in writing that the person meets the appropriate standard, prior to the institution of proceedings, for the appointment of a guardian. Once the petition for guardianship is filed with the court, if the alleged disabled person does not have an attorney, one will be appointed by the court. Although differing by state, the attorney is usually required to act as an adversary in defending against the guardianship. In some states, a guardian ad litem is appointed to investigate and report his or her findings to the court.

Some states or local jurisdictions require jury trials in each guardianship case. In other states, the practice is for the case to proceed without testimony unless the alleged disabled person is contesting the facts set forth in the petition. The practitioner must determine what the local rules and customs require, and prepare accordingly. If medical testimony will be required, physicians should be contacted and, if necessary, subpoenaed, as quickly as possible. Many physicians do not bill for their time testifying in guardianship cases because they are performing a public service by helping protect their patient from harm.

Once a guardian is appointed, that individual is faced with many decisions to make on behalf of his ward. For example, the guardian must immediately decide what arrangements need to be made regarding the disabled person's daily care. In the event nursing home placement is needed, the guardian may need to contact several long-term care facilities.
prior to finding an acceptable facility with an available bed. Depending on
the level of care required, this process may take days or even weeks.

Several issues must be evaluated prior to approval of the client’s
admission to the facility. First, the disabled person must be medically
approved for admission. This is necessary in the event the disabled person’s
cost of care will be covered by Medicare or another type of health
insurance. In addition to medical approval, an evaluation must be made to
determine the method of payment for the disabled person’s care. Payment
can be made privately if the client has funds to cover the monthly fee, or
payment may be made by Medicaid or by the client’s health insurance
carrier. Therefore, the guardian can expect to be in contact with the
disabled person’s physician and nurses, as well as insurance carriers and
Medicaid caseworkers, when making arrangements for the ward’s placement
in a long-term care facility.

As previously mentioned, the guardian is responsible for protecting the
property of the disabled person, collecting income, and paying bills. The
guardian is often confronted with the need to sell the disabled person’s
home and some personal property. Perhaps the disabled person listed the
property with an agent who may have procured a buyer but was unable to
complete the sale due to the disabled person’s mental status. More
frequently, a change in the disabled person’s physical condition renders
continued residence at home impossible. In order to obtain funds necessary
to pay for a group home or nursing home, the guardian may be required to
sell the disabled person’s house and apply the proceeds to pay for the
disabled person’s living arrangement.

In addition to protecting the property, the guardian must advise all
financial institutions where the disabled person maintains assets of the
guardianship. The institutions will require the guardian to present the order
evidencing the appointment of a guardian before access to the account can
be granted to the guardian. Thus, the guardian would be protecting the
assets by preventing other joint account owners or the disabled person from
accessing funds without the guardian’s approval. Similarly, stocks, bonds,
and other assets must be re-titled to reflect the appointment of a guardian.

These are a few of the responsibilities that guardians have in protecting
a ward. Obviously, each client’s needs will differ depending upon their
medical and financial needs. In addition to the ward’s needs, the guardian,
as the court’s agent, must report his or her activities on behalf of the ward.
For example, state or local procedures may require that an annual account-
ing be filed with the court, setting forth all income, assets, and expenditures
for the disabled ward in the calendar year. This procedure enables the court
to evaluate the activity of the guardian as well as the continuing need for the
guardianship. Additionally, this requirement affords the disabled person procedural protection in the event his or her assets are not being properly managed.

The information presented above has focused on the need for a guardian and the guardian's responsibilities when a person is no longer able to make or communicate reasonable decisions about his or her own affairs. Often, a guardianship is viewed as an evil that should be avoided at all possible costs. It does involve intervention by a stranger, the judge, in the affairs of a disabled person. It tends to be more costly and restrictive than other alternatives. Despite these negatives, guardianship is often the best protection available for persons unable to protect themselves. However, if done properly and timely, adequate advance planning by an attorney familiar with elder law can eliminate the need for guardianship.

To plan in advance for an agent to make decisions concerning financial affairs, the elder client (as long as he or she is competent), can execute a power of attorney for finances. The client can designate an agent to act on his or her behalf in the event the principal is unable to act. The power of attorney will set forth the specific authority granted to the agent to prevent questions as to the extent of the agent's authority. Usually, a second agent is appointed with authority to act if the first agent is unavailable to act. Additionally, an attorney should draft a power of attorney containing language which provides that the document will remain valid despite the principal’s subsequent incapacity. Therefore, when appropriate, a guardianship for financial affairs may be avoided so long as the client has previously executed a financial power of attorney.

In addition to planning for the protection of assets, many states also have provisions for designating agents to make health care decisions in the event the patient is unable to consent to a medical procedure. The legal standard necessary for the agent to be able to provide consent will vary by state. Depending on the individual state, the document may become effective only upon a finding by the person's physician(s) that he or she is unable to make or communicate responsible decisions regarding medical treatment, or it may take effect immediately upon its execution.

The advance directive or health care power of attorney enables the individual to plan for eventualities such as withholding or withdrawing life support under certain circumstances. It should specifically describe the authority given to the agent. The drafting of such a document is critical, as it may be scrutinized by a hospital attorney at a point in time when vital life decisions are to be made. Care should be given to ensure that the document is tailored to reflect compliance with state law. A broad statement that an agent has power to make "all necessary decisions concerning health care"
is generally ineffective. Such a statement does not show adequate reflection on the part of the principal and may not be satisfactory, especially for decisions pertaining to life-sustaining medical treatment. Accordingly, the practitioner must spend time with the client to ascertain the client’s wishes under specific circumstances and then draft a document which will withstand scrutiny.

VII. CONCLUSION

The field of elder law is growing as rapidly as the population is aging. Because the issues one is likely to be confronted with when practicing in this area are changing and compounding with the nation’s changing demographics, practitioners must stay abreast of new statutes, regulations, and cases. Even within the field of elder law, specialization is occurring. Some practitioners focus on Medicaid issues, others on guardianship. The wise attorney will seek counsel with a local attorney concentrating his or her practice in this field in order to ensure that the client is being best served.
Baker Acting the Elderly

Michael J. Trombley

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I. INTRODUCTION

Demographics in Florida are changing daily with the continuing influx of elder persons. This growth is particularly sensitized in counties with populations that are small to medium sized, such as Highlands County, Florida, where 33.5% of the population is presently age sixty-five or older. With this growth, there is an increase in the number of persons subject to the provisions of the Florida Mental Health Act, ("Baker Act"), particularly to the provisions for involuntary examination. Current figures in a county such as Highlands County, Florida, as set forth by the Highland County Sheriff's Department, indicate that in 1992, two hundred persons were processed under this Act; in 1993, two hundred fifty-six persons; and

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1. FLORIDA DEP'T OF COMMERCE, FLORIDA COUNTY COMPARISON A-12 (1994).
3. Id. § 394.451. The Florida Mental Health Act is also known as the Baker Act.
4. Id. § 394.463. When an individual is involuntarily hospitalized for a mental health evaluation, the individual is said to have been "Baker Acted."
sixty persons as of April 1, 1994.5 Although no concrete statistical
information is available concerning the ages of these persons, a substantial
portion, i.e., in excess of fifty percent of the processed individuals under the
"Baker Act" may be persons classified as elderly persons.6

II. STATUTORY DEFINITIONS AND CRITERIA

Section 394.463(1) of the Florida Statutes defines the criteria for
involuntary examination as follows:

CRITERIA.—A person may be taken to a receiving facility for
involuntary examination if there is reason to believe that he is mentally
ill and because of his mental illness:

(a) 1. He has refused voluntary examination after conscientious
explanation and disclosure of the purpose of the examination; or
2. He is unable to determine for himself whether examination is
necessary; and

(b) 1. Without care or treatment, he is likely to suffer from neglect
or refuse to care for himself; such neglect or refusal poses a real and
present threat of substantial harm to his well-being; and it is not
apparent that such harm may be avoided through the help of willing
family members or friends or the provision of other services; or
2. There is a substantial likelihood that without care or treatment
he will cause serious bodily harm to himself or others in the near future,
as evidenced by recent behavior.7

The involuntary examination statute sets forth three general ways for
the process to be initiated.8 First, a judge may enter an ex parte order
stating that the person before the court appears to meet the criteria for
emergency admission; setting forth findings on which the conclusion is
based; and directing law enforcement officers to take the person in custody
to the nearest receiving facility or examination and treatment.9 Second,
a law enforcement officer may take a person who appears to meet the
criteria for involuntary examination into custody and deliver that person to

5. Interview with Delbert C. Stover, Legal Counsel for Highlands County Sheriff's
Department, in Sebring, Fla. (Oct. 14, 1994).
6. See generally Fla. Dep't of Commerce, supra note 1, at A-12.
8. Id. § 394.463(1)(a)(1)-(3).
9. See id. § 394.455(8) (defining receiving facility).
10. Id. § 394.463(2)(a)(1).
the nearest receiving facility for examination and treatment. The officer must execute a written report detailing the circumstances under which the person was taken into custody. The report that must be completed by the police officer in such situations as reproduced in Form One. Finally, a physician or mental health professional may execute a certificate stating that the person has been examined within the preceding forty-eight hours and that the person appears to meet the criteria for involuntary examination. Additionally, the observations upon which the conclusion is based must be disclosed in the certificate.

The patient will then be admitted for an emergency examination at the receiving facility and must be examined by a mental health professional. If the examining mental health professional concludes that the patient need not be detained in a receiving facility or that further evaluation is not necessary, the patient must be discharged immediately, unless the patient is facing criminal charges. Patients must be released within seventy-two hours of the their admission, except: 1) when the patient is charged with a criminal offense, in which case the patient must be released to the custody of a law enforcement officer; 2) when the patient voluntarily gives expressed and informed consent to evaluation or treatment; or 3) when a proceeding for involuntarily placement has been initiated.

Action taken under the Baker Act requires that the alleged incompetent person before the officer, judge, or health care professional, satisfies the statutory definition for mentally ill persons, which provides:

“Mentally ill” means an impairment of the emotional processes, of the ability to exercise conscious control of one’s actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person’s ability to meet the ordinary demands of living, regardless of etiology; except, that for the purposes of this act,
the term does not include retardation or developmental disability as
defined in chapter 393, simple intoxication, or conditions manifested
only by antisocial behavior or drug addiction.\textsuperscript{21}

The problems that arise when dealing with elders and the above
standard under the Baker Act are tremendous.\textsuperscript{22} The real issue is whether
and to what extent the elder person's competency is truly impaired. The
terms "incapacitated," "impaired," and "unable" are often utilized inter-
changeably in the context of mental health. However, when evaluating elder
persons, these terms may not accurately reflect the person's mental
competency. One author observed:

Lawyers are not trained to recognize the differences between the natural
effects of age and the effects of mental impairment, the types of mental
incompetency that may be temporary or reversible, and the subtle
indications that a person's mental health may be in the process of
decreasing and may soon leave him incapable of carrying out legal a
transaction.\textsuperscript{23}

This briefly describes the problem faced by any person evaluating an elder
under the standards set forth in section 394.455(3) of the Florida Stat-
utes.\textsuperscript{24} When dealing with an elder, certain factors must be considered.
When an elder person is Baker Acted, are police officers, judges, and
physicians considering the natural effects of aging; whether the behavioral
effects are temporary or reversible; or the subtle indications of deteriorating
mental health?

This concern has recently been addressed in various newspaper articles.
One writer stated:

Court-ordered competency examinations can be quick and shallow.
They involve guesswork. Diagnoses are often reached without medical

\textsuperscript{21} Id. § 394.455(3).

\textsuperscript{22} See Jan E. Rein, Clients with Destructive and Socially Harmful Choices—What's an
Attorney to Do?: Within and Beyond the Competency Construct, 62 FORDHAM L. REV. 1101
(1994).

\textsuperscript{23} John R. Murphy, Older Clients of Questionable Competency: Making Accurate
Competency Determinations Through the Utilization of Medical Professionals, 4 GEO. J.

\textsuperscript{24} FLA. STAT. § 394.455(3) (1993).
records. Sometimes they are conflicting. A few are based on brief chats with hostile people through screen doors.

... 

Pinellas Circuit Judge Thomas E. Penick Jr. . . . is troubled by the system's shortcomings.

"I am concerned about . . . [the doctor] going up to the door, talking for five minutes and coming back and saying a person's incompetent," Penick says. "You've got to have a more in-depth examination up front."

"Many tests for and approaches to determining competency have been promulgated by legal experts, medical experts, and various commissions, with new recommendations, refinements and prototypical statutes continually pouring forth." One such approach is exemplified in the ability-to-function test which is codified in section 744.102(10) of the Florida Statutes:

"Incapacitated person" means a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of such person.

(a) To "manage property" means to take those actions necessary to obtain, administer, and dispose of real and personal property, intangible property, business property, benefits, and income.

(b) To "meet essential requirements for health or safety" means to take those actions necessary to provide the health care, food, shelter, clothing, personal hygiene, or other care without which serious and imminent physical injury or illness is more likely than not to occur.

The guideline that the legislature has enunciated is whether the alleged incapacitated person meets the "essential requirements for health or safety." Accordingly, the courts, law enforcement officials, and health care professionals must essentially determine that the person does not have the ability to meet the ordinary demands of living. Stephen Anderer argues that for a proposed ward to be adjudicated incapacitated, he or she must:

25. See Rein, supra note 22, at 1122 n.77 (quoting Jeffrey Good & Larry King, Exams Are Often Shallow, reprinted in CHAIRMAN OF SUBCOMM. ON HEALTH & LONG-TERM CARE OF THE HOUSE SELECT COMM. ON AGING, 100TH CONG., 1ST SESS., ABUSES IN GUARDIANSHIP OF THE ELDERLY AND INFIRM: A NATIONAL DISGRACE 59, 66-67 (Comm. Print 1987)).

26. Id. at 1128.

27. FLA. STAT. § 744.102(10)(a)-(b) (1993).

28. Id. § 744.102(10); see id. § 394.455(3).
1) be functionally unable, wholly or partially, to care for self or property,  
2) be unable, wholly or partially, to make or communicate decisions regarding care for self and property, and 3) suffer from a demonstrative disorder or disability which causes the ability to make or communicate decisions to be impaired.²⁹

Based upon the numerous writings searching for answers to the dilemma, as well as the actual language in the *Florida Statutes*, it is obvious that the bottom line is determining what compromises an elder’s capacity. A review of psychiatric disorders that may compromise capacity is in order.

III. PSYCHIATRIC DISORDERS

A. Dementia

Dementia is a clinical syndrome which is characterized by generalized cognitive impairment of a normal level of consciousness (e.g., normal levels of attention and wakefulness).³⁰ The American Psychiatric Association’s (“APA”) criteria for dementia are summarized as follows:

1) Demonstrable evidence of impairment in short and long-term memory.

2) At least one of the following:
   a) impairment in abstract thinking;
   b) impaired judgment;
   c) other disturbances of higher cortical function, such as aphasia (language disorder), apraxia (inability to carry out motor activities despite intact comprehension and motor function), agnosia (failure to recognize or identify objects despite intact sensory function), and “constructional difficulty” (e.g., difficulty copying a geometrical figure);
   d) personality change.

3) The above disturbances significantly interfere with work or usual social activities or relationships with others.

4) The disturbances do not occur exclusively during the course of delirium.³¹


³⁰. AMERICAN PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 103-04 (3d ed. rev. 1987) [hereinafter *DIAGNOSTIC MANUAL*].

³¹. Id. at 107.
About five percent of persons over sixty-five and twenty percent of persons over eighty are affected severely by dementia. The primary deficits occur in the realms of orientation, memory, and reasoning; however, hallucinations, delusions, major depression, and a host of behavioral symptoms (e.g., wandering, yelling, banging, combativeness, and agitation) may also occur.\(^\text{32}\)

When is a person incapacitated due to dementia? It is critical to know the cause of the dementia and its likely duration before making any determination concerning incapacitation. Even more important is whether an elder person suffering from dementia can be involuntarily hospitalized under the emergency provisions of the Baker Act.

### B. Delirium

Delirium is a clinical syndrome of confusion in association with fluctuating levels of consciousness and attention. The most distinctive characteristic which distinguishes delirium from dementia is a reduced ability to focus attention on external stimuli and to shift attention to new stimuli, usually exhibited by drowsiness or distractibility.\(^\text{33}\) Other symptoms include disorganized speech, visual hallucinations, auditory hallucinations, paranoid delusions, disorientation, and memory impairment.\(^\text{34}\) These signs and symptoms generally develop over a period of hours or days and vary in severity over time. Additionally, periods of profound confusion and agitation typically alternate between lucid intervals.\(^\text{35}\)

The most frequently observed manifestations in persons suffering from delirium are enumerated in the APA’s *Diagnostic Manual* as follows:

1. Reduced ability to maintain attention to external stimuli (e.g., questions must be repeated because attention wanders) and to appropriately shift attention to new external stimuli (e.g., perseverates answer to a previous question).

2. Disorganized thinking.

3. At least two of the following:
   a) reduced level of consciousness;
   b) perceptual disturbances;
   c) disturbance of sleep-wake cycle;
   d) increased or decreased psychomotor activity;

\(^{32}\). See id. at 103-05.
\(^{33}\). See id. at 100.
\(^{34}\). See id.
\(^{35}\). See *DIAGNOSTIC MANUAL*, supra note 30, at 101-02.
e) disorientation to time, place or person;
f) memory impairment.

4) Clinical features develop over a short period of time (usually hours to days) and tend to fluctuate over the course of a day.\textsuperscript{36}

Unlike most dementia syndromes, delirium is usually transient and reversible, often making delirium-related decisional incapacity only temporary. Therefore, it is very important to attempt to distinguish delirium from dementia at the initial stages of examination, especially for purposes of confinement under the Baker Act. Conversations with law enforcement officers who frequently execute the required forms for involuntary commitment indicate that the foregoing characteristics listed above are the most frequent symptoms that they observe.

C. \textit{Major Depression}

Sadness is a normal part of the elder's repertoire. It may occur in response to the loss of a loved one or other disappointments, and gradually subsides as the person adjusts to the loss or absence. In contrast, a major depression is a clinical syndrome of which sadness is just one component.\textsuperscript{37} The principal diagnostic criteria for major depression are listed below:

1) Sleep disturbance; insomnia.
2) Loss of interest; anhedonia.
3) Inappropriate guilt; irrational self-reproach.
4) Diminished concentration.
5) Change in appetite; weight loss/gain.
6) Psychomotor retardation or agitation.
7) Suicidal or has passive death wish.\textsuperscript{38}

Law enforcement officers and mental health professionals who deal with the elderly indicate that elderly persons often manifest symptoms which fall under both the dementia and depression criteria.\textsuperscript{39} In one case, a law enforcement officer responded to a call at a mobile home park concerning a recently widowed eighty-two year old woman who was wandering around, knocking on doors, looking for her deceased husband. She was slightly agitated because she had prepared supper, the table was set, and her husband was not home. When the officer took the elderly woman home, he noted that the house was clean, the table was set, and dinner had been prepared.

\textsuperscript{36} Id. at 103.
\textsuperscript{37} See id. at 219.
\textsuperscript{38} See id. at 222.
\textsuperscript{39} See id at 221.
Moreover, the woman seemed very rational except for the fact that she did not remember that her husband had been dead for a year. After further discussions with the woman, the officer determined that there was insufficient evidence to satisfy the criteria for involuntary commitment under the Baker Act. However, he did ask her neighbors to keep an eye on her and call if something further occurred which indicated severe mental deterioration.

Viewing the diagnostic criteria for delirium, the elderly woman may have been disoriented as to time, place, and person, and may have suffered from memory impairment. Under the diagnostic criteria for major depression, her behavior could have been characterized as a sign of diminished concentration and agitation. Moreover, there was no evidence of a threat of substantial harm to the woman’s well-being or that she would cause serious bodily harm to herself or others in the near future. Thus, the present mental health evaluation system worked in this incident. In other situations, however, that may not be the case. Based upon the same criteria, another initial examining person may have certified the elder under the Baker Act.

Other disorders include manic depressive illness, mood disorders incapacity, and schizophrenia. An additional problem is that patients with dementia, delirium, schizophrenia, manic bipolar disorder, and other psychiatric conditions may be capable of making responsible decisions. Establishing that a patient lacks decisional capacity requires more than making a psychiatric or visual diagnosis; it also requires demonstrating that the specific symptoms of a disorder interfere with making or communicating responsible decisions about matters at hand. This is a practical, functional consideration which must be factored in with each individual set of facts.

IV. CONCLUSION

It is natural and proper to be concerned about a person’s proclivity to endanger him or herself and others simply because of the person’s age. There seems to be a presumption that elderly people do not know what is going on and are “helpless.” As the results of studies in this field are publicized, this belief is being dispelled. Nevertheless, there are no clear and defined guidelines to assist judges, lawyers, health care providers, and law enforcement personnel regarding which symptoms must be manifested in order to involuntarily hospitalize an elderly person under the Baker Act.

40. See generally DIAGNOSTIC MANUAL, supra note 30, at 221-22.
41. See generally id. at 221.
In addition to, and lingering in the background, is always Title 42 of the United States Code which states:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.  

The problems addressed here have not been resolved to any significant extent by persons allegedly "wrongfully Baker Acted." However, fertile grounds may exist for the escalation of the unique problems of elder persons who are "Baker Acted." If that is the case, then at some point the legislature may have to revisit the guidelines and criteria of the Baker Act. Otherwise, there are a number of federal court cases providing that failure by a state to comply and conform within a reasonable time with a federal law may constitute a violation of an individual's civil rights.

V. FORM ONE: REPORT OF LAW ENFORCEMENT OFFICER

REPORT OF LAW ENFORCEMENT OFFICER

STATE OF FLORIDA, COUNTY OF __________, FLORIDA TO

______________________________
Receiving Facility and Address

Pursuant to Section 394.463(2)(a)2, Florida Statutes, requiring a written report detailing the circumstances under which ________________ was taken into custody, I report herewith as follows:

Time and Date:________________________

Family Members or others present when patient was taken into custody:
Name: ____________________________
Address: __________________________
Relationship: ______________________
Telephone Number: ________________

Name: ____________________________
Address: __________________________
Relationship: ______________________
Telephone Number: ________________

Indicate personal knowledge by family members and others about patient:
________________________________
________________________________
________________________________

Physical Restraints, if any:
________________________________
________________________________
________________________________

This section is to be completed only if the law enforcement officer is initiating the involuntary examination (i.e., when a “certificate of Professional Initiating Involuntary Placement” has not been completed or a court order has not been entered).

In my opinion this person appears to meet the following criteria for involuntary examination:

(a) There is reason to believe said person is mentally ill pursuant to Chapter 394.455(3), F.S.; and
(b) Said person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; and 
(c) Said person is unable to determine for himself whether examination is necessary, and:
(d) Either (check 1 or 2)

_____ (1) Without care or treatment said person is likely to suffer from neglect or refuse to care for himself, and such neglect or refusal poses a real and present threat of substantial harm to his well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; OR,

_____ (2) It is more likely than not that in the near future said person will inflict serious, unjustified bodily harm on another person, as evidenced by behavior causing, attempting, or threatening such harm, including at least one incident thereof within 20 days prior to the examination.

Observations which support this opinion:

Delivered to Receiving Facility on ___________ , 19__, at __________ A.M./P.M.

This report shall be made a part of the patient's clinical record.

Date:__________________________

(Law Enforcement Officer)

Use Rest of Page for Additional Information

(By authority of Chapter 394.463(2)(a), Florida Statutes)

HRS-MH Form 3052A, Oct. 82 (Obsoletes HRS-MH 3052 and DMH-BA-52)
OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context

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I. INTRODUCTION

On August 10, 1993, President Clinton signed into law the Omnibus Budget Reconciliation Act of 1993 ("OBRA '93"). Part Two of OBRA '93 is entitled "Eligibility," and renders significant changes to the rules under the Medicaid program for treatment of asset transfers by applicants for medical assistance, availability of trusts for eligibility purposes, and recovery from estates of recipients.

The new Medicaid rules are designed to restrict individuals from arranging their financial affairs in order to retain the economic benefit of their wealth, but nevertheless securing government paid long-term care services. This is accomplished in three principal ways: 1) increasing the periods during which Medicaid eligibility would be precluded because of assets transferred prior to institutionalization; 2) eliminating, to the greatest extent possible, the ability of individuals receiving public assistance to be direct or indirect beneficiaries of wealth sequestered in trust arrangements; and 3) enhancing state recoveries from deceased Medicaid recipients' estates.

This article will address the Medicaid related portions of OBRA '93 in three respects. Foremost, it will describe the operation of OBRA '93 as it relates to Medicaid eligibility. Often, this will be undertaken through comparison of the corresponding law prior to OBRA '93. This article will also analyze the historical and political context from which OBRA '93 emerged. Finally, this article will examine the extension of both the

2. Id. §§ 13611-13612, 107 Stat. at 622-29.
4. At hearings held April 1, 1993, before the United States House of Representatives Committee on Energy and Commerce and the Health and Environment Subcommittee, the Administration argued that "[t]his proposal would close numerous loopholes in the Medicaid law which allow persons with substantial assets to qualify for Medicaid and ensure that those with substantial personal assets pay a fair share for nursing home care and other medical services before Medicaid starts to pay." Hearings on H.R. 2264 Before the Subcomm. on Health and the Environment, 103d Cong., 1st Sess. 6 (1993) [hereinafter "Hearings"].
6. Id. § 13611(b), 107 Stat. at 624 (amending Social Security Act § 1917(d), 42 U.S.C. § 1396p(d)).
7. Id. § 13612, 107 Stat. at 627 (amending Social Security Act § 1917(b)(1), 42 U.S.C. § 1396p(b)(1)).
operational and contextual perspectives through the implementation of one of the OBRA '93 provisions. This provision ran contrary to the underlying theme of the legislation; it expanded, rather than restricted, eligibility.

II. HISTORICAL AND CONTEXTUAL PERSPECTIVE ON OBRA '93

The Medicaid eligibility issues addressed in OBRA '93 were not self-evident. Rather, the identification of these issues and representation of their scope were developed for the legislative agenda by special interest groups; particularly the long-term care insurance industry and state Medicaid authorities. Each of these two groups sought to curtail the program for purposes which were not associated with the scope or quality of long-term care to the elderly: to increase revenues and to reduce expenditures. The intention of this article is not to judge the appropriateness of these positions, or their advocacy, since such activity is the political process. Neither of these groups, nor others, motivated Congress to take action which it was not, at least emotionally, predisposed. What is hoped for is that a more complete understanding of OBRA '93 will be achieved through a description of the efforts of these two particular influences, framed by the conversation at the legislative level.

The changes in Medicaid eligibility criteria contained in the new law represent a considerable regression from the expansion of Medicaid accessibility characterized by the Medicare Catastrophic Coverage Act of 1988 ("MCCA"). However, this restrictive focus does not represent a reversal of congressional concern for the long-term care needs of the elderly. Rather, a congressional perception was created that MCCA was being inappropriately manipulated and abused. The perception that well-to-do


10. The first major restriction in the Medicaid program came in 1980 with the Boren-Long Amendment, 42 U.S.C. § 1396p(c)(2) (1988). That amendment allowed states to restrict transfers of exempt assets made for the purpose of qualifying for Medicaid. A more comprehensive statutory framework was subsequently enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. No. 97-248, 96 Stat. 325 (1982). TEFRA allowed states to restrict asset transfers made within 24 months of Medicaid application, to place liens on property of living recipients, and to recover assets from the
elders, through artifice and scheme, were obtaining public payment of their nursing home care while preserving their financial security and their ability to transmit wealth to younger generations, was crystallized by concerns raised primarily from the state Medicaid agencies and from the long-term care insurance industry.

Believing the progressive relief from impoverishment protection aspects of MCCA were opening an already burgeoning Medicaid budget to wealthy Americans looking to beat the system, Congress sought to correct the opportunity for such activity. This activity had been defined as, "conflict[ing] with the real policy objectives of the Medicaid program." The scenario of abuse and manipulation, portrayed as emanating from the provisions of MCCA, coupled with legitimate budgetary crises at the state levels, finally garnered a congressional, or perhaps presidential, ear in 1993.

The genesis of the new law first surfaced at the congressional level on April 1, 1993, with hearings held before the Health and Environment

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13. Id. at 4.

Subcommittee of the United States House of Representatives' Committee on Energy and Commerce, chaired by Congressman Waxman.\textsuperscript{15} The subject of the hearings was designated "Medicaid Budget Reconciliation."\textsuperscript{16} Rather than foreshadowing the Administration's massive health care reform initiative\textsuperscript{17} by enhancing elder access to long-term care, or addressing the quality and availability of services, the focus centered on eliminating $7.8 billion from the Medicaid budget.\textsuperscript{18} Avoiding significant deprivation of services provided to the elderly resulting from the cutbacks was a political necessity.\textsuperscript{19}

\textsuperscript{15} The legislation culminating in OBRA '93 had numerous components. After conducting hearings on Medicaid on May 6, 1993, Congressman Waxman presented a legislative proposal that did not contain administration proposals for closing "loopholes." While some labeled the House Bill as the Waxman Bill, this was not correct. Congressman Waxman indicated that he felt that the Administration proposal swept far too broadly. Representative McMillan offered the Clinton proposal (this being sometimes referred to as the original House Proposal, or the Administration Proposal) as an amendment. This proposal passed, over Waxman's objection, 17 votes to 9. Waxman and McMillan joined in an amendment when the proposal came before the full Energy and Commerce Committee on May 11, 1993. That amendment is referred to in this paper as the "Waxman Amendment." This amendment was adopted and incorporated in the House Bill. See Margolis, \textit{supra} note 8, at 2.

\textsuperscript{16} During his opening remarks, Congressman Waxman stated: "Today's hearing is about reducing spending in this Nation's largest health care program for the poor, Medicaid." \textit{Hearings, supra} note 4, at 4.

\textsuperscript{17} \textit{CLINTON ADMINISTRATION DESCRIPTION OF PRESIDENT'S HEALTH CARE REFORM PLAN, AMERICAN HEALTH SECURITY ACT OF 1993, SPECIAL SUPP. 1} (1993).

\textsuperscript{18} Congressman Waxman has stated that "[a]s requested by the Clinton Administration, the [fiscal year 1994] Budget Resolution directs this Committee to reduce Federal Medicaid outlays by $7.8 billion over the next five fiscal years." Congressman Waxman indicated that the Administration directive to cut $7.8 billion over five years, "dwarfs the $2.9 billion in Medicaid cuts enacted in 1990. It is also the largest cut in Federal Medicaid spending since the 1981 Reagan-Stockman cuts, which totalled $2.9 \ldots billion over three years." \textit{Hearings, supra} note 4, at 4.

\textsuperscript{19} In fact, according to the hearings:

The last time the Federal government reduced its Medicaid spending by this order of magnitude was during the Reagan-Stockman years. The States, hit by the loss of Federal funds and by the 1982 recession, cut back on eligibility and benefits. Hundreds of thousands of low-income women and children lost coverage.

We need to be extremely careful that we do not repeat this mistake. \textit{Id.}
To a significant extent, the agenda of the “asset transfer” session of the hearings consisted of detailing loopholes and closure techniques recommended by Brian Burwell, a major figure in setting the agenda for the long-term care industry. As will be shown below, a significant portion

20. The hearings were divided into six panels, each addressing a different goal. Panel four, charged with the goal of tightening the transfer of assets, prohibitions, and estate recovery procedures, consisted of Brian Burwell, Division Manager, SysteMetric/MEDSTAT Systems; Gerald Rholfes, Chief, Third Party Liability Branch, California Department of Health Services; Sheldon Goldberg, President, American Association of Homes for the Aging; Patricia Nemore, Staff Attorney, National Senior Citizens Law Center; Bruce Yarwood, Legislative Counsel; and Vincent Russo, President, National Academy of Elder Law Attorneys, Inc. (“NAELA”) See Hearings, supra note 4, at 6. The panel was presented with the following queries:

1) What techniques do individuals with substantial assets now use in order to qualify for Medicaid nursing home services?
2) How prevalent is divestiture behavior?
3) Are there reasons for divestiture other than transmission of wealth to siblings or offspring?
4) As of March 24, 1993, the Administration has not specified what changes it would make in current law. However, it has stated that “[t]his proposal would close numerous loopholes in the Medicaid law which allow persons with substantial assets to qualify for Medicaid and ensure that those with substantial personal assets pay a fair share for nursing home care and other medical services before Medicaid starts to pay.” Should these “loophole” closures extend beyond nursing home care to “other medical services?”
5) What statutory changes would you recommend to “close the loopholes” in current Medicaid law?
6) If we close these “loopholes,” how will applicants, their adult children, and estate planning professionals respond? Id. at 6.

21. Burwell proposed 16 specific policy objectives relating to “loophole” tightening. See infra note 48. The predominance of these points in setting the Committee’s focus is evidenced by Congressman Waxman’s request to Vincent Russo, President of NAELA who testified at the hearing, to respond to these 16 points and recommendations made by Burwell. NAELA’s Public Policy Committee’s subsequent response was submitted to the Committee in April 1993.

The 16 points propounded by Burwell were:
1) Clarify that withdrawals of an applicant’s resources from a joint bank account, even when made by non-applicants, are subject to Medicaid transfer of asset penalties. However, penalties should not be applied to withdrawals of funds originally deposited by non-applicants. See BURWELL, supra note 12, at 18-19.
2) Determine that putting property into joint form, even if the Medicaid applicant retains ownership rights, should be treated as an illegal transfer if the act of placing the property in joint tenancy makes the resource unavailable to the applicant. See id.
3) The penalty period for prohibited asset transfers should begin on the day that the individual would have otherwise been eligible for Medicaid while receiving institutional care, not on the date of the transfer. See id. at 20.
4) Clarify that in computing the penalty period for illegal transfers, penalty periods for multiple transfers do not run concurrently, but consecutively. This common practice has allowed applicants to divest significant amounts of assets, yet minimize the penalty period to which they are subject. See id. at 20-21.

5) Eliminate the time limit on the length of the penalty period, which is currently 30 months. The penalty period should equal the value of the assets transferred for less than fair market value, without limitation. However, assets transferred more than 30 months prior to Medicaid application should remain exempt from Medicaid asset transfer rules. Most states believe that “looking back” more than 30 months for illegal transfers would not be cost effective. See id. at 17-18.

6) Clarify that transfers of assets made by persons acting as agents of the applicant (guardians, conservators, person authorized to make such disposition under a power of attorney) are treated the same as if made by the Medicaid applicant/recipient. See BURWELL, supra note 12, at 19.

7) Clarify that transfers of lump sum payments, such as inheritances, that are made in the month in which they are received, are to be treated as transfers of assets, and therefore subject to penalties, and are not considered transfers of income. See id. at 21.

8) Clarify that disclaimers of inheritances or other lump sum payments, such as court settlements, are to be treated as asset transfers, subject to penalties. See id.

9) Limit the amount of funds that can be placed in an irrevocable funeral contract, not subject to penalties, to $1500 or some other reasonable amount. See id. at 10.

10) Stipulate that any inter vivos trust to which an applicant has transferred assets within 30 months of applying for Medicaid, regardless of whether the trust is discretionary or non-discretionary, revocable or irrevocable, is null and void, and the resources in the trust are considered immediately available to the applicant. Congress may wish to exempt, however, certain “supplemental needs” trusts created for severely disabled individuals, the income from which is used to purchase necessary equipment and/or services for the maintenance of the disabled individual which are not available under the regular Medicaid benefit package. See id. at 22-24.

11) Clarify that while certain types of “income trusts” may be used as mechanisms for allowing certain individuals to qualify for Medicaid nursing home coverage in so-called “income cap” states (in accordance with the federal district court ruling in Miller v. Ibarra, 746 F. Supp. 19 (D. Colo. 1990)), states may be allowed to impose conditions on the creation and use of such trusts, as was recently done in the State of Colorado. See BURWELL, supra note 12, at 31-32.

12) Clarify that retroactive payments for “care” provided by relatives do not constitute “fair market value” for transferred assets. Prospective payments, however, can be made, as long as they are made under a written agreement and the payments made represent reasonable compensation for the care or services provided. Id. at 21.

13) Allow states to apply transfer of asset penalties to that portion of a purchased annuity that exceeds the value of the benefit that is likely to be returned to the annuitant over his or her remaining life expectancy, using life expectancy tables. See id. at 22-25.

14) Clarify that in the determination of the Community Spouse Resource Allowance (“CSRA”) under the Medicaid spousal impoverishment rules, the income of the institutionalized spouse must be made available to the community spouse prior to determining whether the community spouse’s CSRA should be increased, in order to generate sufficient income
of the new law is the outgrowth of the agenda set by the long-term care insurance industry advocates. Many OBRA '93 provisions can be directly traced back to their polemics. Granted, the OBRA '93 Medicaid revisions were fostered by a variety of factors, including rocketing Medicaid expenditures at the state and federal levels, and overall budget and deficit reductions focused at the legislative level. Nevertheless, the long-term care insurance industry's characterization of the issues played a role in the development of this legislation. This note should be identified to assist in understanding the legislative objective of many OBRA '93 provisions.

clarify that states may impose a lien on the home of a community spouse (or other exempted relative) of an institutionalized Medicaid recipient, even though the state may not foreclose on the lien until the community spouse dies or sells the property. See id. at 27-31.

clarify that although term life insurance policies remain an exempt resource in most cases, certain term policies are not exempt. Specifically, resources used to purchase term life insurance policies within 30 months of Medicaid application that have a benefit-to-premium ratio in excess of a certain standard would be considered available, and not exempted. For example, a term life insurance policy with a death benefit of $100,000 purchased by an 89 year old man for the price of $97,000 would not be exempted. See BURWELL, supra note 12, at 22.

see infra note 48.

for example, the Medicaid budget for Florida for the year 2000 is projected to be between three and four billion dollars. See DUNLOP ET AL., supra note 14, at 1.

see supra note 18.

the enactment of OBRA '93 was not the culmination and conclusion of the efforts of the LTC insurance advocates. Following passage of OBRA '93, LTC Inc. published a report in which Moses, Director of Research, urged Medicaid state agencies to send representatives to attend the NAELA Third Annual Elder Law Institute because it focused on the interpretation of OBRA '93. LTC, INC. & STEPHEN A. MOSES, LONG-TERM CARE IN MONTANA: A BLUEPRINT FOR COST-EFFECTIVE REFORM 37 (1993). Moses recommended the implementation of an estate recovery program that employs third party contractors to operate on contingency fees, encourages competition among collectors and gives incentive awards to outstanding recovery specialists. Claiming that "Medicaid estate planning often shades into financial abuse of the elderly," he implored the states to relitigate expropriative divorce decrees, invade trusts, and "stop the theft of recipients' income by 'protective payees' by using private attorneys on contingency." Id. On April 21, 1994, Moses claimed that "[e]arly indicators from across the country on OBRA '93's potential effectiveness... are not good. It appears that prosperous people with access to the right legal and financial advice will continue to find ways to qualify for Medicaid nursing home benefits without spending down and without estate recovery liability." STEPHEN A. MOSES & LTC, INC., THE FLORIDA FULCRUM: A COST SAVING STRATEGY TO PAY FOR LONG TERM CARE 56 (1994). As ominous as this sounds, Moses conceded that such "planning is the practice of working within... rules to [legally] maximize eligibility for Medicaid benefits..." Id. at 13.
A. The Long-Term Care Insurance Industry Factor

Advocates of the long-term care insurance industry were perhaps the most vocal group expressing concern over the role of Medicaid in financing long-term care for the elderly. Motivated by a need to create a market for their products, the industry sought to foster the elderly’s perception that insurance represented the preferred vehicle for financing their long-term care needs.\(^{26}\) This would be accomplished by restricting Medicaid eligibility and strengthening estate recovery from what was retained. To achieve this goal, industry advocates set out to convince, or confirm to, lawmakers that existing Medicaid laws encouraged abuses and that the economic pressures they were confronting under the Medicaid program were resulting from these abuses. Legislative resolution would be achieved by establishing a comprehensive lien and estate recovery plan that would convince elders that they could not expect to leave their estates to their children\(^{27}\) and by back-stopping the recovery program to restrict eligibility at the front-end.\(^{28}\) Two of the more influential spokespersons for this industry are Stephen A. Moses and Brian Burwell.

1. Moses on Medicaid

*The Fallacy of Impoverishment*\(^{29}\) was published by Stephen A. Moses in 1990. The paper was based upon research conducted by Moses and others while he was a senior analyst for the Office of the Inspector General of the Department of Health and Human Services.\(^{30}\) The article was not

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26. According to Moses, “[w]e would also be sending a message to America’s senior citizens and their families . . . if they do not want to encumber their estate, then they or their heir[s] should purchase protection in the private marketplace.” Stephen A. Moses, *The Fallacy of Impoverishment*, 30 GERONTOLOGIST 24 (1990).

27. Id.

28. According to Moses:

   No one can recover an estate that does not exist. In the absence of front-end eligibility controls to prevent lawyer-assisted divestiture and recovery avoidance, little will remain in future estates to recover. Eligibility controls, liens and estate recoveries are inextricably linked and must be implemented in tandem to be effective.


30. The OIG research described by Moses was published in OFFICE OF ANALYSIS & INSPECTIONS, NO. OAI-09-88-01340, TRANSFER OF ASSETS IN THE MEDICAID PROGRAM: A CASE STUDY IN WASHINGTON STATE (May 1989) and OFFICE OF ANALYSIS & INSPECTIONS, NO. OAI-09-86-00078, MEDICAID ESTATE RECOVERIES (June 1988).
rested to his findings on state lien enforcement to recoup Medicaid payments, which was the principal focus of the study. Rather, Moses addressed primarily what he characterizes as manipulation of the transfer of assets rules by individuals who might otherwise consider purchasing long-term care insurance to fund nursing home costs. According to Moses, there was extensive anecdotal evidence that "people are jettisoning property before they apply for Medicaid nursing home care . . . ."

The problems that Moses described are repeated in the debate over the role of Medicaid in long-term care financing since MCCA. The abuses, while not supported with specific empirical verification, nevertheless magnify concerns that the system is being abused. To illustrate, one Medicaid eligibility member from Maryland noted that “[p]eople are starting to use a lot of fancy footwork to avoid losing the ‘family fortune.’” A staff member from Minnesota stated that “[t]here are lots of welfare specialists who help people avoid welfare resource limits.” “These people” described a network of private ‘elder law’ attorneys, [and] publicly funded legal services attorneys . . . who counsel families on how to qualify an infirm elder for Medicaid while preserving income and assets. . . . [such techniques include] interspousal and other legal transfers, trusts, purchase of exempt assets . . . and joint tenancy with right of survivorship.”

Claiming that most of the federal government work in the area had encouraged the development of private risk-sharing (i.e., insurance) solutions, Moses acknowledged that the development was slower than anticipated. Moses argued that “the elderly population perceives no urgent need to purchase insurance . . . [or] convert the equity in their home” so long as Medicaid is such an easily accessible program. This, in and of itself, could explain the lack of market demand for long-term care insurance. His solution to “this impasse between public and private long-term care financing options is quite simple[,] . . . give middle class elderly people a clear choice between access to [Medicaid] or preservation of their es-

31. Moses, supra note 26, at 23.
32. Id. at 22 (quoting a staff member from Maryland).
33. Id. (quoting a staff member from Minnesota).
34. These people were 32 interviewees of OIG queried on how, in one year, people who were initially denied but subsequently approved for Medicaid in Washington possessed $27.5 million at time of application. Id. at 22-23.
35. Id. at 23.
This goal could be accomplished by “closing the loopholes in transfer of assets restrictions, requiring legal encumbrances on property as a condition of eligibility, and mandating cost effective estate recoveries as a prerequisite for federal financial participation.” And so, the framework for OBRA '93 was forged.

2. Brian Burwell—Middle Class Welfare

In 1991, one of the more influential writings detailing the planning "abuses" fostered by the Medicaid provisions of MCCA was Brian Burwell's Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage. The paper was funded by the Health Insurance Association of America. The principal purpose of the study was to bolster a campaign against the spousal impoverishment and other protective aspects of Medicaid eligibility under MCCA. As Burwell frames the issue, "why should someone buy private long-term care insurance, if, for less money, they can hire an attorney, shelter their assets, and get 'nursing home insurance' through Medicaid?"

Burwell defined the term "Medicaid estate planning" to mean "the manipulation of Medicaid eligibility rules by non-poor elderly persons, their heirs, and their attorneys to obtain Medicaid coverage for nursing home care while protecting significant amounts of wealth." He described it as an abuse, the objective of the process being to "avoid using private wealth to pay for nursing home care, and letting taxpayers pay for it instead through the Medicaid program." In order to assess what he identified as "anecdotal accounts" of the dramatic increase in the volume of Medicaid estate planning, Burwell interviewed state and local Medicaid officials, and other unidentified relevant parties, concerning this phenomenon. In 1991, interviews were conducted over a four month period in six states: Connecticut, Maine, Minnesota, Florida, New York, and Maryland.

37. Id.
38. Id.
39. See BURWELL, supra note 12, at 1.
40. Id. at 7.
41. Id. at 1.
42. Id.
43. See id.; see also Moses, supra note 26, at 24; DUNLOP ET AL., supra note 14, at 1.
44. BURWELL, supra note 12, at 15 ("Most state and local Medicaid officials interviewed for this study felt that Medicaid estate planning strategies are rarely initiated by the elderly themselves. Rather, the initiators of Medicaid estate planning strategies are more usually the Medicaid applicant's children, who are trying to preserve their inheritances.").
While his findings lacked empirical validation, the conclusion drawn by Burwell is that “[s]tate Medicaid officials believe Medicaid estate planning is growing rapidly and has [from their perspective] become a serious policy problem.” Burwell acknowledged that determining whether there was a problem, and if so its extent, required “[m]ore rigorous research . . . to develop reliable estimates of the magnitude of Medicaid estate planning and its impact on Medicaid expenditures.” Nevertheless, his conclusions have held a predominant place in the conversation.

B. The State Medicaid Factor

The Medicaid revisions of OBRA '93 were certainly not the exclusive result of the lobbying efforts of the long-term care insurance industry. The states responsible for increasing Medicaid expenditures were confronting a situation which, from their perspectives, had to be curtailed. Restriction of eligibility, through the attractive vehicle of loophole closing, and budget

45. The conjectural, as opposed to empirical, approach is evidenced by a few of Burwell's observations: 1) “[T]rusts have evolved as popular financial instruments for retaining control of assets, and maintaining . . . income streams, while excluding the assets . . . for Medicaid. It's the classic case of having one's cake and eating it too.” BURWELL, supra note 12, at 22. 2) “Another type of trust is a supplemental needs trust. . . . Given the suspect intent of these kinds of trusts, some attorneys recommend also including a ‘fail-safe’ provision . . . which destroys the trust if it is invaded . . . [and is an] . . . effective mechanism[] for dissuading Medicaid agencies from invading trusts, because the Medicaid agency loses in either case.” Id. at 24 (emphasis omitted). 3) “Income cap’ States pose special problems for Medicaid estate planning attorneys. In general, it is easier to divest assets than it is to divest income.” Id. at 31. 4) “Miller trusts have thus become a potential Medicaid estate planning option for the heirs of Alzheimer's patients who have lost the capacity to manage their own financial affairs.” Id. at 32.

46. See id. at 1.

47. BURWELL, supra note 12, at 1.

48. A comparison should be made of the various “loopholes” Burwell identifies and addresses in the study and the points promulgated at the Waxman hearings. For example: 1) Cease assessing the penalty period from date of transfer but rather impose penalty from application for Medicaid; 2) Impose cumulative penalty periods for all assets transferred in [look-back period]; 3) Extend transfer of assets rules to elderly not in nursing homes; 4) Treat as exempt transfer for service only service done prospectively, not retrospectively; 5) Penalize transfers of income, such as inheritances; 6) Close loophole of claiming undue hardship; 7) Close loophole of investing in irrevocable annuities; 8) Close loophole of buying expensive term life insurance; 9) Eliminate Streimer and use of joint accounts; 10) Eliminate “MQT” opportunity with irrevocable, nondiscretionary trusts; 11) Eliminate “convertible” or “trigger” trusts; 12) Restrict “donor” trusts; and 13) Eliminate “shift assets before income” technique. See BURWELL, supra note 12, at 21.
replenishment through stronger estate recovery authority were the most sought results.

The most significant development from this perspective was a 1992 statement from the National Governors' Association. However, equally illustrative of the perception of the problems and their solutions were the proceedings at a meeting of the State Medicaid Directors’ Association in 1992.

1. The State Medicaid Directors’ Association

In January 1992, the State Medicaid Directors’ Association (“SMDA”), an affiliate of the American Public Welfare Association, held a meeting entitled “Managing Long-Term Care: State Strategies to Close Eligibility Loopholes and Recover Assets.” In his opening remarks, Bob Bairn, who was then the Minnesota Medicaid Director and Chairman of the SMDA Operations Committee, described how states, facing huge increases in Medicaid spending and shortfalls in state budgets, increasingly have to deal with “[t]he emerging legal practice of Medicaid estate planning.” “States feel that their eligibility workers are outnumbered and outgunned by estate planning attorneys who are looking for loopholes.”

At this meeting, Brian Burwell was in attendance and was reported to have counseled that elder law attorneys have greater resources than state Medicaid agencies “[t]o pursue their work and political agenda.” Burwell indicated that attorneys “[d]islike income caps because they find it difficult to transfer income” and “[t]heir fall back position is to require application of spousal impoverishment rules.” However, the meeting minutes report reflected that Burwell, perhaps out of character, described Medicaid planning as rational economic behavior and stated that

49. APWA STATE MEDICAID DIRECTORS’ ASS’N, SUMMARY OF THE STATE MEDICAID DIRECTORS’ ASSOCIATION MEETING ON MANAGING LONG-TERM CARE: STATE STRATEGIES TO CLOSE ELIGIBILITY LOOPHOLES AND RECOVER ASSETS 1 (1992) [hereinafter STATE STRATEGIES]. Information concerning this meeting was provided by William Overman, Esquire, of Atlanta, Georgia, who attended the meeting and presented the concerns of financing the chronic long-term care needs of the elderly from the perspective of elder law attorneys. Id.
50. Id. at 2.
51. Id.
52. Id. at 4.
54. Id. at 1.
there is nothing wrong or immoral about lawyers giving clients their best advice. 55

2. The National Governors’ Association

In July 1992, the National Governors’ Association (“NGA”) issued a public statement on Medicaid transfer of assets policies. 56 The states, particularly after the passage of MCCA, experienced rapid, and [from their perspectives] uncontrollable escalation of their state Medicaid expenditures. 57 In order to assess the factors contributing to this problem and develop strategies to cope, the national governors conducted their own study and issued their report.

The preface to the NGA statement took a highbrow approach, acknowledging that the absence of a national long-term care policy places the unacceptable burden of paying for the high costs of long-term chronic care on the shoulders of the individual and family. It stated that private long-term care insurance was not yet a viable option for the majority of the at-risk population, leaving Medicaid the only option shy of exhausting one’s entire life savings. The NGA acknowledged that while this was not the preferred option, in most cases it was the only option. Recognizing the need to develop a national strategy on long-term care, the statement concluded that the rising costs of long-term care for the chronically ill, coupled with the increasingly aging population, mandates a comprehensive solution.

Nevertheless, after identifying the problem in the context of comprehensive health care reform, the NGA statement echoes the previously voiced concern that “[a]necdotal evidence is now mounting that some non-poor elderly are using ‘estate planning’ techniques to shelter assets that otherwise would have kept them from becoming Medicaid eligible . . . .” 58 This abuse of the Medicaid program warranted a reexamination of the policy by which individuals become eligible for Medicaid long-term care services.

The NGA concluded that, in the context of Medicaid estate planning, two steps were required. Further information was necessary to ascertain the magnitude and impact of Medicaid estate planning. However, until a major overhaul to the nation’s system of financing long-term care services is undertaken, action was immediately required to address:

55. Compare id. with BURWELL, supra note 12, at 1.
56. PROPOSED POLICY ON MEDICAID TRANSFER OF ASSETS (Nat’l Governor’s Ass’n, Tallahassee, Fla.), July 1992, at 1 [hereinafter NGA POLICY].
57. See DUNLOP ET AL., supra note 14, at 1.
58. See NGA POLICY, supra note 56, at preface.
the growing concerns about Medicaid estate planning by the non-poor in order to clarify state responsibilities and ensure flexibility in Medicaid administration, to protect those individuals who are legitimately eligible for Medicaid long-term care coverage, and to help control escalating Medicaid spending for long-term care services.\(^5^9\)

Many of the NGA's recommendations for immediate change in the Medicaid eligibility rules can be traced to OBRA '93.\(^6^0\)

**III. OBRA '93—THE TRANSFER OF ASSETS RULES**

Having set the stage by perceptions and concerns, the structure for establishing financial eligibility for Medicaid assistance was ready for remedial overhaul. Motivated by budget reduction and perceived abuses, the ax was swift to fall. But like an ax, its precision left much to be desired. Difficulty and confusion interpreting and implementing the resulting statutory morass has been in direct proportion to the lack of preliminary debate by all affected interests.

**A. Computing the Period of Ineligibility**

1. Former Law

   Under former law, any transfer of resources made by an applicant or his or her spouse during the thirty month period preceding application for Medicaid, to the extent uncompensated, incurred a period of ineligibility.\(^5^9\) This period of ineligibility, computed from the date of the transfer, was

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\(^{59}\) Id. at 3.

\(^{60}\) Among the suggestions presented by the NGA for immediate relief from the misapplication of the Medicaid eligibility rules by well-off elders were:

1) Increasing the length of disqualification period for transfers at less than full consideration during the period preceding Medicaid application.

2) Providing that the initial date of the penalty period for pre-application transfers for less than full consideration predate the month of the transfer.

3) Eliminating or reducing certain exemptions from the transfer rules.

4) Extending the transfer of assets restrictions to those receiving community Medicaid assistance.

5) Curtailing the use of trusts to protect assets from exhaustion in the face of long-term care.

6) Clarifying and strengthening the law relating to liens and recoveries of estates. See id. at 4-5; see also OBRA '93 §§ 13611-13612, 107 Stat. at 622-29 (amending Social Security Act § 1917, 42 U.S.C. § 1396p).

\(^{61}\) Social Security Act § 1917(c)(1), 42 U.S.C. § 1396p(c)(1).
determined by dividing the uncompensated value of the transferred resource by the average monthly cost of nursing home care in the state.\textsuperscript{62} The maximum period of ineligibility for an uncompensated transfer was thirty months.\textsuperscript{63} In many states, separate transfers during the thirty month look-back period were each treated separately and were not aggregated.\textsuperscript{64}

2. OBRA '93

a. The "Look-Back" Period

Under OBRA '93,\textsuperscript{65} the look-back period for identifying uncompensated transfers of assets is thirty-six months, except in the case of certain payments from a trust or portions of a trust that are treated as assets disposed of by the individual. Those are subject to a sixty month look-back period.\textsuperscript{66} The look-back period for institutionalized individuals, begins on the first date the individual is an institutionalized individual who has applied for medical assistance under the state plan.\textsuperscript{67} In the case of a non-institu-

\textsuperscript{62.} Id.
\textsuperscript{63.} Id.
\textsuperscript{64.} Under prior law, the period of ineligibility for transfers during the look-back period commenced from the date of the transfer. The statute, however, did not appear to address the calculation of the period in the case of multiple transfers within the look-back period. The provision could therefore be interpreted as requiring that each separate transfer have its own penalty starting date. This could result in penalties for transfers made in the beginning of the look-back period expiring simultaneously with or prior to expiration of the penalty period for subsequent transfers. This concurrent calculation of the penalty period was considered "reasonable" under a HCFA Medicaid Letter No. 92-31 issued on June 12, 1992, from its Region III, but was found to have a potential for "gaming," that is, eliminating the connection between the amount of the transfer and the size of the penalty. See BURWELL, \textit{supra} note 12, at 17.

\textsuperscript{65.} The Health Care Financing Administration issued its policy and interpretations concerning the transfer of assets and trust provisions of OBRA '93 through Transmittal 64 in November 1994, which modified Part 3, Eligibility, of the State Medicaid Manual. As a result of the release of this Transmittal 64 during the publication of this article and the time necessary to fully analyze its impact on OBRA '93 implementation, only selected references to its content will be made. \textit{STATE MEDICAID MANUAL: PART 3—ELIGIBILITY} (Nov. 1994) [hereinafter Transmittal 64].

\textsuperscript{66.} The Senate Bill gave the states the option to extend the look-back period to four years. The American Public Welfare Association draft legislation provided for a five year optional look-back. \textit{See} OBRA '93 § 13611(a)(1), 107 Stat. at 622 (amending Social Security Act § 1917(c)(1)(B), 42 U.S.C. § 1396p(c)(1)(B)); \textit{see also} NGA POLICY, \textit{supra} note 56, at 4.

\textsuperscript{67.} OBRA '93 § 13611(a)(1), 107 Stat. at 622 (amending Social Security Act § 1917(c)(1)(A)-(B), 42 U.S.C. § 1396p(c)(1)(A)-(B)).
tionalized individual, the look-back begins on the date the individual applies for medical assistance under the state plan or, if later, the date on which the individual disposes of assets for less than fair market value.\textsuperscript{68} The term "institutionalized individual" is defined the same as it was under prior law, although the definition has been moved from section 1917(c)(3) to 1917(e)(3).\textsuperscript{69}

The term "non-institutionalized individual" is defined in 42 U.S.C. §1396p(e)(4) as "[a]n individual receiving any of the services specified in paragraphs 7 [home health care and personal care services], 22 [other medical care] or 24 [community supported living arrangements]."\textsuperscript{70}

b. The Services for Which Asset Transfers Trigger Ineligibility

For institutionalized individuals, the services for which the individual would incur a period of ineligibility for asset transfers include: 1) nursing facility services; 2) institutional services at nursing facility level of care; and 3) home or community-based services provided due to a waiver granted pursuant to section 1905(c) or 1905(d).\textsuperscript{71}

For non-institutionalized individuals, the services for which the individual would incur a period of ineligibility for asset transfers are as follows: 1) home health care and personal care services, other medical care, or community supported living arrangements pursuant to section 1905(a); and 2) at the option of the state, other long-term care services for which medical assistance is otherwise available under the state plan to individuals requiring long-term care.\textsuperscript{72}

\textsuperscript{68} Id.
\textsuperscript{69} Id. § 13611(c), 107 Stat. at 626 (amending Social Security Act § 1917(e)(3), 42 U.S.C. § 1396p(e)(3)).
\textsuperscript{70} Id. § 13611(a)(1), 107 Stat. at 622 (amending Social Security Act § 1917(c)(1)(C)(i), 42 U.S.C. § 1396p(c)(1)(C)(i)).
\textsuperscript{71} Id. § 13611(a)(1), 107 Stat. at 622 (amending Social Security Act § 1917(c)(1)(C)(ii), 42 U.S.C. § 1396p(c)(1)(C)(ii)). The Administration proposal, before adoption of Congressman Waxman's amendments, did not address an expansion of the medical assistance services to which the transfer of assets rules would apply. The Waxman Amendment delineated the nursing facility services, home and community-based services as defined in section 1915(d)(5)(C)(i), the services described in section 1905(a)(14) relating to services in an institution for mental diseases, the home and community care provided under § 1929, and the community supported living arrangements services provided under section 1930 of the Social Security Act, \textit{but only in the context of estate recoveries, not transfer of assets rules.} The Senate Bill mandated that the transfer of assets rules apply to the same three kinds of services following through to OBRA '93. It also provided that the state plan...
c. The Period of Ineligibility

Under OBRA '93, there is no longer a durational limitation on the
ineligibility period for uncompensated transfers. For institutionalized
individuals, the period of ineligibility is equal to, and in the case of a
noninstitutionalized individual, the period of ineligibility shall not be greater
than the period described below.

First, the total uncompensated value of all asset dispositions within the
look-back period are aggregated. Second, the total combined amount is
divided by the monthly cost of nursing facility services in the state
determined as of the date of application for benefits, not on the date(s) of
the transfer(s). Third, the period of ineligibility, determined under the
first two steps, begins on the first day of the first month during or after
which assets have been transferred for less than fair market value and which
does not occur in any other periods of ineligibility.

could apply the rules to long-term care services specified by the state provided to individuals
in addition to institutionalized individuals and approved by the Secretary and to long-term
care services otherwise available under the plan.

73. The calculation of the "look-back" period as well as the commencement point for
the period of ineligibility represented the most significant differences between the House and
Senate approaches. Under the Administration proposal, the look-back was 30 months
calculated from the first date as of which the individual was an institutionalized individual,
and had applied for or is receiving medical assistance under the state plan. Under the
Waxman Amendment, the look-back stretched to 36 months, from the same point of
reference. The Senate, however, took a harsher course. Under the Senate Bill, the general
look-back was 30 months but was required to begin with the first month in which the
individual was institutionalized, had applied for or was receiving assistance, or the state had
become aware that assets had been transferred and the individual was but for application of
the transfer of assets rules, eligible to have medical assistance paid. The practical impact of
this proposal was to commence the period of ineligibility for any transfers made within the
look-back period to the point in time when the individual's funds were otherwise inadequate
to pay for his or her medical care.

74. OBRA '93 § 13611, 107 Stat. at 622-27. The Senate Bill further provided a
limitation in the case of a state imposing a penalty for other than the specified services longer
than would have resulted if the individual had expended the assets transferred for the costs
of medical care furnished. In addition, the Senate Bill authorized the states to designate a
de minimis transfer amount if approved by the Secretary.

75. Id. § 13611(a)(1), 107 Stat. at 622-23 (amending Social Security Act § 1917(c)(1)-(E)(i)(l),
42 U.S.C. § 1396l(c)(1)(E)(i)(l)).

76. Id. § 13611(a)(1), 107 Stat. at 623 (amending Social Security Act § 1917(c)(1)(E)-
(i)(II), 42 U.S.C. § 1396l(c)(1)(E)(i)(II)).

77. Id. § 13611(a)(l), 107 Stat. at 622 (amending Social Security Act § 1917(c)(1)(D),
42 U.S.C. § 1396l(c)(1)(D)). While the provision most likely addresses consecutive transfer
issues, the treatment of the duration of the period of ineligibility had an interesting course.
An institutionalized individual's period of ineligibility is reduced by the number of months of ineligibility incurred by such individual as a non-institutionalized individual because of the same disposal of assets. Similarly, a non-institutionalized individual's period of ineligibility is reduced by the number of months of ineligibility incurred by such individual as an institutionalized individual because of such disposal of assets. 78

B. Exempt Transfers to/for Spouses and Disabled Individuals

1. Former Law

Under former law, section 1917(c)(2)(B) of the Social Security Act exempted transfers from spouses to another for the sole benefit of the individual's spouse, without limitation, as well as transfers to an individual's child who is blind or totally and permanently disabled.

2. New Law

The new law continues the exemption for transfers to the individual's spouse or to another for the sole benefit of the individual's spouse. 79 This

Initially, the Administration Proposal provided that the period of ineligibility included all months after the month of commencement during which the individual was institutionalized necessary to absorb the penalty. The months of ineligibility did not need to be consecutive, would include any months in a subsequent period of institutionalization, but would be tolled during any periods the individual was not institutionalized. The House Bill (pre-Waxman) and Senate continued the prior calculation of the ineligibility period and absent the application of the rule for calculating the penalty in the context of concurrent transfers, the Administration Proposal did not resurface. See Burwell, supra note 12, at 20-21.

78. OBRA '93 § 13611(a)(1), 107 Stat. at 623 (amending Social Security Act § 1917(c)(1)(E)(iii), 42 U.S.C. § 1396p(c)(1)(E)(iii)). The Waxman Amendment, by reverting to the time of transfer as the initiation point for the commencement of the period of ineligibility, addressed the consecutive transfer issue by providing that any transfers made in a period of ineligibility attributable to a preceding transfer would not commence until expiration of the period of ineligibility during which the transfer was made. The Senate, while adopting the more punitive penalty initiation point, did not incorporate the Administration formula. Id.

79. Id. § 13611(a)(2)(B), 107 Stat. at 623 (amending Social Security Act § 1917(c)-(2)(B)(ii), 42 U.S.C. § 1396p(c)(2)(B)(ii)). In the context of excluded transfers, the Administration proposal provided that both in the case of transfers to spouses as well as transfers to disabled children, the exclusion was limited to the excess of the recipient's resources over the level of assets allowed for the CSRA under § 1924(f)(2)(A). Not only was this a limitation, but its implementation was difficult to project because in many states the calculation of the CSRA was dependent on "snap shot" resource assessments which occur at a point in time far removed from the time of the transfer. In other words, in many
exemption is extended to transfers from the individual’s spouse to another for the sole benefit of the individual’s spouse. The exemption of a transfer directly to a disabled child is retained, and a further exemption is created for transfers to a trust established solely for the benefit of such disabled child. A new exemption is established for asset transfers to a trust established solely for the benefit of a disabled individual under the age of sixty-five, including a section 1917(d)(4)(A) trust.

instances it would be impossible to ascertain whether or not a disqualifying transfer was made, even after the fact. This interspousal and disabled child exclusion limitation was eliminated in the Waxman Amendment but resurfaced again in the Senate Bill. However, in the Senate Bill, the limitation did not apply to transfers to disabled children, only to transfers to the spouse or to another for the sole benefit of the spouse and to the new excluded transfer from the individual’s spouse to another for the sole benefit of the individual’s spouse. See BURWELL supra note 12, at 43.

80. OBRA '93 § 13611(a)(2)(B), 107 Stat. at 623 (amending Social Security Act § 1917(c)(2)(B)(ii), 42 U.S.C. § 1396p(c)(2)(B)(ii)). In Transmittal 64, detailed explanation was offered concerning the concept of “solely for” as used in the context of transfer exception both for spousal as well as blind or disabled child transfers. A transfer is solely for the benefit of an individual where no individual or entity except that spouse or child can benefit from the transferred assets in any way or at any time in the future. The same rule is applied to trusts established for protected individuals. Transmittal 64, supra note 65, § 3257(B)(6).

81. OBRA '93 § 13611(a)(2)(B), 107 Stat. at 623 (amending Social Security Act § 1917(c)(2)(B)(ii), 42 U.S.C. § 1396p(c)(2)(B)(ii)). In neither the House Bills nor the Senate Bills was the transfer to a trust for a disabled child included. The transfer to a trust for a disabled child exclusion is clear when it is the assets of the disabled child which are transferred to a section (d)(4)(A) trust, so that both the trust and the transfer receive favorable treatment. However, this exclusion also allows a parent to transfer assets to a trust for the benefit of a disabled child, which trust does not need to meet the qualification tests of a section (d)(4)(A) trust, without concern that the transfer will jeopardize the parents’ eligibility. Id.

82. Id. § 13611(a)(2)(B), 107 Stat. at 623 (amending Social Security Act § 1917(c)-(2)(B)(iv), 42 U.S.C. § 1396p(c)(2)(B)(iv)). Further note that while transfers to certain trusts are excluded from the new rules on treating trusts as available resources, the transfer provisions fail to exclude transfers to QITs for individuals in income cap states. This created the odd situation that the assets in a QITs are excluded from being considered available but transfers to the trust could result in a period of ineligibility. As explained in detail in section VII of this article, the application of the transfer penalty rules with respect to QITs required a complicated and to a great extent artificial set of criteria. The fourth exclusion for transfers to trusts, including section (d)(4)(A) trusts, for disabled individuals under age 65 has less logic to it than the third exclusion. First, a parental transfer to a trust, including a section (d)(4)(A) trust, is encompassed under the third exclusion. Apparently, it is intended to allow third parties who are not in the category of parent, grandparent or guardian to fund trusts for disabled individuals under section (d)(4)(A), even though such a trust if established with such third parties’ assets would not come under section (d)(4)(A) because it would not be the
C. **Elimination of Period of Ineligibility for Return of Assets/Hardship Waiver**\(^3\)

An individual will not be ineligible for medical assistance as a result of asset transfers if all assets transferred for less than fair market value have been returned to the individual.\(^4\) Otherwise the denial of eligibility would

beneficiary's assets that comprised the trust. Also, the provision would seem to exclude a transfer to a trust for the individual transferor's exclusive benefit.

83. OBRA '93 provides for waiver of the transfer rules in the situation where, "the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary." OBRA '93 § 13611(a)(2)(D), 107 Stat. at 623-24. The Administration proposal only addressed a hardship waiver in the context of trusts. The Waxman Amendment, in the provision eliminating the limitations on transfers to spouses and disabled children, proposed amending section 1917(c)(2)(D) to read: "the State agency determines, under procedures established by the State (in accordance with standards specified by the Secretary) that the denial of eligibility would work an undue hardship (in accordance criteria established by the Secretary)." It is also interesting to note that while the Senate required adoption of regulations for effective date purposes, the Waxman Amendment, not the Senate Bill, provided for an effective date regardless of adoption of regulations. It is also of interest to note that section 7422(3)(E) of the Senate Bill also provided for the states to ignore de minimis transfers but that provision was not incorporated within OBRA '93. Transmittal 64 defines "undue hardship" as deprivation of medical care such that the individual's health or life would be endangered or where the individual would be deprived of food, clothing, shelter or other necessities of life. Transmittal 64, supra note 65, § 3258.10(C)(5).

84. OBRA '93 § 13611(a)(2)(C)(iv), 107 Stat. at 623. Under prior rules, many states followed a policy which eliminated periods of ineligibility for uncompensated transfers which were returned to the applicant. The value of this option was significant in those cases where the monthly cost of nursing home care which was used as the divisor in calculating a period of ineligibility was less than the actual private pay cost of care. Since the "penalty" was durational, rather than directly related to the value of what was transferred, in those cases a period of ineligibility would not be coterminous with the period of private pay care for which the transferred amount would otherwise have paid. The benefit of the asset return was that the transferred funds alone, not augmented by additional funds needed to cover the portion of the ineligibility period remaining after use of the transferred funds at private rate, would be used and Medicaid assistance would in fact come earlier. The new law requires that all assets transferred for less than fair market value are returned, not just some of them. However, if only one asset were transferred at 40% of fair market value, would the entire asset have to be returned in order to take advantage of the waiver? If not, would 60% of the transfer date fair market value or the current fair market value have to be returned? Neither the Administration proposal nor the Waxman Amendment addressed this issue. The Senate Bill introduced the language appearing in OBRA '93. Transmittal 64 addressed this issue by confirming that all transferred assets must be returned, but authorizing the imposition of a reduced penalty where only part of an asset or its equivalent value is returned. It is still unclear as to the application of the penalty where some but not all assets are returned or
work an undue hardship under standards and on the basis of criteria established by the Secretary.

D. Treatment of Jointly Held Assets

1. Former Law

Under the former law, the establishment of a joint bank account, the addition of a child as a co-owner of a joint account, and in many states, the withdrawal of funds by the joint account owner, are not considered resource transfers by a Medicaid applicant. Under prior Social Security Administration/Health Care Financing Administration ("HCFA") interpretations, commonly referred to as the "Streimer" rule, joint bank account owners were considered as each owning 100% access to the account. If a Medicaid applicant applied for assistance, the entire account was considered available. Conversely, the withdrawal of account funds by a non-applicant, prior to application for benefits, was not considered a transfer by the Medicaid applicant because that individual was considered to own the entire account. In those states, the interpretation of 100% ownership also required the conclusion that the revocable creation of the joint account interest was not considered a transfer since the transferor still owned and controlled 100%.

2. OBRA '93

The new law provides that in the case of an asset held by an individual in common with another person or persons, whether held as joint tenancy, tenancy in common, or similar arrangement, any action by the Medicaid applicant, or by any other person that reduces or eliminates such individual's ownership or control of such asset, or the affected portion of the asset, shall be considered a transfer.

whether the fair value to be returned is determined as of the time of transfer or return. Transmittal 64, supra note 65, § 3258.10(C)(4).


86. Id. The Conference Agreement incorporated in the new law did not include the Senate provision limiting the impact of this provision to those dispositions inconsistent with the extent of the joint owners' interests. In addition, initial state interpretations have been made that the new joint ownership rules apply regardless of the "Streimer" type full accessibility by all joint owners. See, e.g., FLORIDA DEP'T OF HRS, POLICY STATEMENT SEPTEMBER 28, 1993, at 3 (1993). "When an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement (whether or not owner had unrestricted access to the asset) . . . ." Id. at 6 (emphasis added).
E. Allocation of Penalty Between Spouses

OBRA '93 expands the former law, which prohibited states from imposing transfer of assets penalties other than in accordance with the federal rules. OBRA now provides that:

In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, using reasonable methodology (as specified by the Secretary), a State shall apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan.

IV. OBRA '93—TREATMENT OF TRUSTS

A. Former Law

Prior to enactment of OBRA '93, section 1902(k) governed the treatment of self-settled trusts for Medicaid eligibility purposes. For Medicaid purposes, trusts were considered available if they were Medicaid Qualifying Trusts ("MQTs") and then only to the extent the fund was distributable in the discretion of the trustee. The amounts from the corpus of an MQT that were deemed available to a grantor were the maximum amount of payments that may be permitted to be distributed to the grantor under the terms of the trust, assuming the full exercise of discretion by the


88. Id. The initial interpretation of this provision by the State of Florida Department of HRS was as follows: "Divide any new or remaining penalty period by two and attribute to each spouse. Any odd months may be attributed to the spouse that caused the penalty or attributed according to the couple's (or their representatives') wishes." Transmittal 64 further "clarified" this issue by providing that when one spouse is no longer subject to his or her allocated penalty (i.e., the spouse dies), the remaining penalty "must be served by the remaining spouse." Transmittal 64, supra note 65, § 3258.5(J).

89. Under 42 U.S.C. § 1396a(k)(2) (1988), a MQT is a:
trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

Id.
trustee or trustees in the distribution of the maximum amount to the grantor. Case law had addressed issues such as identification of the trust settlor, the scope of the discretionary trustee authority, and limitations on that discretion.

B. New Law

Under OBRA '93, as borne out by each of the component House and Senate bills that contributed to the Conference Agreement, Congress identified "trusts" as the single most offensive Medicaid estate planning vehicle and tried, in almost every manner short of criminalization, to inhibit their use.

1. What is a Trust?

First, the MQT provisions of section 1902(k) have been eliminated. The new law requires the inclusion of assets that are in certain types of trusts which previously would not be classified as MQTs, such as non-discretionary trusts and trusts established by a court. The new law distinguishes revocable and irrevocable trusts and establishes rules regarding the availability and characterization of payments from each. Additionally, the term "trust" is defined to include any similar legal instrument or device, including annuities, but only so treated in the manner the Secretary specifies.

93. OBRA '93 § 13611(b), 107 Stat. at 624.
94. Id. § 13611(d)(1)(C), 107 Stat. at 627.
95. Id. § 13611(b), 107 Stat. at 624 (amending Social Security Act § 1917(d)(2)(C), 42 U.S.C. § 1396p(d)(2)(C)).
98. OBRA '93 § 13611(b), 107 Stat. at 626 (amending Social Security Act § 1917(d)(6), 42 U.S.C. § 1396p(d)(6)). Under OBRA '93, the term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies. Under the Administration proposal, annuities were dealt with in the transfer rules as specifically applied to annuities acquired in spousal context. The proposal would have provided that annuities established by an institutionalized spouse for a community spouse be considered an uncompensated transfer of resources; regardless of the actuarial value of the annuity. This provision appears to have been eliminated in the Waxman Amendment. It also included annuity in the parenthetical modifier to the term "trust" and without limitation to what the Secretary determined its treatment to be.
2. When is an Individual Considered to Have Established a Trust?

An individual is considered to have established a trust if assets of the individual (including assets of the individual’s spouse) were used to form all or part of the corpus of the trust and if certain individuals (described below) established the trust.\(^9\) The trust must be established, other than by will, by any of the following persons:

(i) The individual.
(ii) The individual’s spouse.
(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual’s spouse.
(iv) A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual’s spouse.\(^10\)


\(^10\) OBRA '93 § 13611(b), 107 Stat. at 624 (amending Social Security Act § 1917(d)-(2)(A)(i)-(iv), 42 U.S.C. § 1396p(d)(2)(A)(i)-(iv)). In addition, Burwell states:

More creative strategies are employed to create trusts which retain the flexibility of discretionary trusts, but which are still not counted for Medicaid purposes. One is a ‘donor trust’ in which an individual transfers assets to another individual (e.g. a child) who then establishes a trust for the benefit of the donor. Since the trust is not established by the individual (or the individual’s spouse) the trust does not meet the conditions for a ‘Medicaid qualifying trust’ as strictly defined in the legislation.

BURWELL, supra note 12, at 24 (citations omitted).
The trust rules apply without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of distributions from the trust. 101

3. Revocable Trusts

In the case of a revocable trust: 1) the corpus is considered resources available to the individual; 2) payments from the trust to, or for the benefit of the individual are considered income of the individual; and 3) other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rules. 102

4. Irrevocable Trusts

Under the new law, if there are any circumstances under which payments from the trust could be made to, or for the benefit of, the individual, then 1) the portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made is considered resources available to the individual; 2) payments from the corpus or income, to or for the benefit, of the individual are considered income of the individual; and 3) payments for any other purpose are considered a transfer of assets by the individual. 103

Any portion of the trust, or any income on the corpus, from which no payment could under any circumstance be made to the individual is considered, as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed), to be assets disposed by the individual for purposes of the asset transfer rules. 104 Further, the value of the trust is determined, for purposes of such rules, by including the amount of any payments made from such portion of the trust after such date. 105

101. OBRA '93 § 13611(b), 107 Stat. at 624 (amending Social Security Act § 1917(d)-(2)(C), 42 U.S.C. § 1396p(d)(2)(C)).
104. See infra text accompanying notes 106-29.
105. This was a new provision, contained in neither the House nor the Senate Bills. In the House Bill, once an asset transfer was assessed, payments from the trust after the date specified in clause (i) shall be disregarded. The Senate similarly provided that payments from such portion of the trust after such date shall be disregarded. The application of this
5. Significant Interpretation Issues Under OBRA '93

A number of significant issues presented themselves regarding the treatment of trusts under OBRA '93. Many of these questions have been explained through HCFA’s interpretations in Transmittal 64.

a. Application to Income Only Trusts

One of the more significant questions under OBRA '93 was the status of income only trusts. That is, irrevocable trusts from which only the income, not the principle, can be distributed. The issue is addressed in section 1917(d)(3)(B) of the Social Security Act which reads as follows:

In the case of an irrevocable trust—
(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income.\textsuperscript{106}

In the context of revocable trusts, there is no ambiguity: The trust principal is deemed available and payments are either considered income to the individual or disposed assets. In the context of irrevocable trusts, however, the determination of how much of the trust is to be considered available and under what circumstances is not fully ascertainable from the statutory language.

On the one hand, the provision could be reread to say: The portion of the corpus from which payment of income or corpus could be made shall be considered resources available to the individual. This interpretation would suggest that irrevocable income trusts would be considered available in their entirety, or at least that portion from which the income interest attached. From a statutory perspective, this interpretation is consistent with the characterization of the applicable portion of the corpus as an available provision is at best ambiguous. In what manner could post-establishment payments from a trust be added to its “value?” Should this increase the period of ineligibility? Would assets be counted twice for penalty purposes? See H.R. 5111, 103d Cong., 1st Sess. (1994); see also S. 7422, 103d Cong., 1st Sess. (1994).

Nevertheless, this interpretation poses difficulties. How could the right to access income only, as and when earned, make the underlying unavailable principal available to meet medical needs? The new trust rules deal not only with identification of the trust as resources of the individual, it established them as available. Contrasting this to prior law under the MQT rules, the definitional MQT established the resource nexus; the extent of accessibility through trustee discretion established availability. It appeared that Congress was equating the individual's accessibility to the trust, through income or principal, as a sufficient nexus to warrant consideration of the fund pool as available. The argument would be that if the individual's assets are structured in an arrangement by which they still provide economic benefit, they will be considered as if still available, regardless of the extent of that benefit. To that extent, they are not considered unavailable until all interest has been foreclosed.

108. See BURWELL, supra note 12, at 23 (describing the income only trust as a loophole).
109. Section 13611(b)(ii) amended 42 U.S.C. § 1396p(3)(B)(ii) to read:
   any portion of the trust from which, or any income on the corpus from which,
   no payment could . . . be made to the individual . . . shall be considered, as of
   the date of establishment of the trust (or, if later, the date on which payment to
   the individual was foreclosed) to be assets disposed by the individual for pur-
   poses of subsection (c) . . . .
OBRA '93 § 13611(b), 107 Stat. at 625 (amending 42 U.S.C. § 1396p(3)(B)(ii)). A clue to the possible meaning of this provision is found in the House Bill. There, a provision read that, in the case of an irrevocable trust, if there are any circumstances under which payment from the trust could be made to, or for the benefit of the individual, then the corpus of the trust (or that portion of the corpus from which the “increase whereof” payment could be made to the individual) shall be considered available resources to the individual. This provision would indicate, at least as far as the House was concerned, income only trusts could be considered available resources, even where principal itself is not available. This would be the case if the phrase “increase whereof” was considered equivalent to “income.” However, Congress knew the terms “income” and “increase” could be construed to refer to the appreciation in the transferred asset. The Senate Bill, like the OBRA '93 provision, is more ambiguous than the House version and could be argued to differentiate the available corpus from the available income. See OBRA '93 § 13611(b)(ii), 107 Stat. at 626 (amending Social Security Act § 1917(3)(B)(ii), 42 U.S.C. 1396p(3)(B)(ii)); see also S. 7422(a), 103d Cong., 1st Sess. (1994).
On the other hand, the provision could be read as: If there are any circumstances under which payment from the trust could be made to, or for the benefit of, the individual, the portion of the corpus from which payment could be made, or the portion of the income from which payment could be made, shall be considered resources available. This reading favors the interpretation that, in the case of income only trusts, the corpus itself is not considered available, only the income flow is considered available. However, the statutory difficulty is in identifying the income flow as an available resource. Would this require a present value calculation to determine how much is considered available? The same definitional and practical consideration would apply under subparagraph (ii) when the income interest terminates. What is to be valued? The future income flow brought back to present value?

111. On the one hand, Congress has retained the section 1612 definition of income; although for transfer purposes, income is coupled with resources for the definition of assets. See OBRA '93 § 13611(c), 107 Stat. at 626 (amending Social Security Act § 1917(e)(1), 42 U.S.C. § 1396p(e)(1)). On the other hand, Congress does not distinguish technical distinctions between trust income and corpus in the treatment of payments from trusts. See Social Security Act § 1917(d)(3)(A), 42 U.S.C. § 1396p(d)(3)(A)). This reading would indicate that in the trust context, Congress is willing to cast whatever characterization might be necessary to inhibit utilization.


113. The other avenue of exploring the issue is from the perspective of what happens when the tainting availability is terminated, as in clause (ii) of 42 U.S.C. § 1396p(d)(3)(B) which provides:

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could . . . be made to the individual . . . shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) . . . .

42 U.S.C. § 1396p(d)(3)(B) (1988). The House Bill provided that "any portion of the trust from which (or from the income whereof) no payment could under any circumstances be made . . . ." The Senate Bill provided that "any portion of the trust from which, or any income on the corpus from which, no payment could . . . ." The House Bill again seems to be focusing on the corpus (from which or the income from which payment could be made). When the transfer is deemed to occur, the House Bill further provides that "payments from such portion of the trust after such date shall be disregarded." In the case of the Senate Bill, which like OBRA '93 equated the treatment of income and resources for transfer purposes, one could still consistently argue that in the income only trust, only the income interest alone would be subject to the transfer rules and, therefore, could be considered available resources (although again strained definitionally). The valuation of the future income flow would again be an issue. See 42 U.S.C. § 1396p(3)(B)(ii) (1988 & Supp. V 1993); see also S. 7422, 103d Cong., 1st Sess. (1994).
The concern was resolved on December 23, 1993, in the first of a number of informal statements by the HCFA made in order to facilitate implementation of the new legislation.\footnote{Letter from Sally K. Richardson, Director, Medicaid Bureau, Health Care Financing Administration, to Ellice Fatoullah, Alzheimer's Association, New York City Chapter (Dec. 23, 1993) (on file with author).} In summary, if no portion of the trust corpus may be distributed to the individual (only income) then no portion of the principal of the trust is deemed a resource under the statute.\footnote{For an excellent explanation and analysis, see Ellice Fatoullah, "Income Only" Trusts and Trusts for the Disabled, NAELA Q. (Summer 1994).} This interpretation carried through in Transmittal 64.\footnote{Under the interpretation in Transmittal 64, the nexus of the individual to accessibility to the fund, however remote, was sufficient to establish availability. For example, if a trust can only pay to the grantor in the event the grantor needs a heart transplant, the full trust is available because payment could be made under some circumstance, however remote. Transmittal 64, supra note 65, § 3259.6(E). However, only the portion of the trust (income or principal) from which the disbursement could be made is considered the available portion. Where that portion is the income, Transmittal 64 is silent as to how the future income flow is to be valued. Id.}

b. Application of Sixty Month Look-Back

Another significant question under OBRA '93 was the application of the new sixty month look-back period to trusts. This issue presented itself in two situations: 1) application of the look-back to transfers from irrevocable trusts; and 2) application of the rule when a trust is established or an individual's interest is foreclosed.

c. Payments From Irrevocable Trusts as Transfers

In identifying which payments from trusts would incur a sixty month, as opposed to thirty-six month, look-back period, OBRA '93 provides:

(\textbf{B})(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d), 60 months).\footnote{OBRA '93 § 13611(a)(1), 107 Stat. at 622 (amending Social Security Act § 1917(c)(1)(B)(i), 42 U.S.C. § 1396p(c)(1)(B)(i)).}
Cited paragraph (3)(A)(iii) is the trust payment rule for revocable trusts\(^{118}\) which treats payments other than to, or for the benefit of, the individual as assets disposed of by the individual. However, the second cited clause, (3)(B)(ii),\(^{119}\) is not the corresponding provision\(^{120}\) for payments (other than to or for the benefit of the individual) in the case of irrevocable trusts. Rather, (3)(B)(ii) is the provision dealing with the asset transfer treatment when an individual’s interest in an irrevocable trust is foreclosed.

The problem with this statutory provision is that the sixty month look-back does not apply to payments from irrevocable trusts, other than, to or for the benefit of, the individual. Clearly, such payments from revocable trusts are subject to the sixty month look-back period. The foreclosure of an individual’s interest in an irrevocable trust is also subject to a sixty month look-back, at least under the statute as written. However, payments from an irrevocable trust are only subject to a thirty-six month look-back, at least under the statute as written. This reading was confirmed in Transmittal 64.\(^{121}\)

d. Application of Sixty Month Look-Back to No Interest Retained Trusts

A corollary issue is whether the establishment of a trust in which the individual retained no interest is subject to a sixty or thirty-six month look-back period.

Subparagraph (ii) provides that upon the establishment of the trust, if there is any portion of the trust from which no payment could be made, that portion of the trust is considered a transfer of assets. Further, asset disposition treatment (and hence the sixty month look-back period) applies to portions of a trust from which payments to the individual have been foreclosed.\(^{122}\) However, would that mean that the establishment of an irrevocable trust from which no benefit could ever be made to the individual is subject to a sixty month look-back? While the statute can be read in this fashion, an alternative interpretation could be made suggesting a contrary treatment.

\(^{118}\) Id. § 13611(a)(1), 107 Stat. at 622 (amending Social Security Act § 1917(c)(1)-(B)(i), 42 U.S.C. § 1396p(c)(1)(B)(i)).

\(^{119}\) Id.

\(^{120}\) See Fatoullah, supra note 114, at 15.

\(^{121}\) Transmittal 64, supra note 65, § 3258.4(E).

\(^{122}\) For a discussion of the trigger trust see BURWELL, supra note 12, at 23-24.
Paragraph (B) deals with irrevocable trusts, which should be considered available to the individual because of some retained benefit. The two provisions, (i) and (ii), should be read together. The way the statute is constructed, subparagraph (ii) seems dependent on (i). Paragraph (i) is triggered if "[t]here are any circumstance under which payment from the trust could be made," and then addresses the treatment of that portion of such a trust. Subparagraph (ii), rather than standing independently, continues by dealing with that portion of a clause in a trust from which no payment could be made. It does not appear to be dealing with a different trust. From this reading, the establishment of an irrevocable trust from which no benefit could ever have been made to the individual would not be assessed paragraph (B) asset transfer treatment and, just as in the case of an outright transfer, be subject to a thirty-six month look-back period.\textsuperscript{123} Transmittal 64 interprets the statute as requiring the sixty month look-back even in the case of the establishment of a no-interest retained irrevocable trust.\textsuperscript{124}

e. Hardship Waiver in the Trust Context

Under prior law, the states were allowed to waive application of the MQT provisions where the state determined such application would work an undue hardship.\textsuperscript{125} Under OBRA '93, state agencies are required to establish procedures, in accordance with standards specified by the Secretary, under which the agency waives the application of the trust

\begin{itemize}
\item \textsuperscript{123} This treatment is supported by the House Bill which provided that:
  In the case of an irrevocable trust, if no payment may be made from the trust under any circumstances to or for the benefit of the individual—
  (i) the corpus of the trust shall be considered, as of the establishment of the trust (or, if later, the date on which payment to the individual was foreclosed), a transfer of assets subject to section 1917(c), [which had no different treatment from outright transfers] and
  (ii) payments from the trust after the date specified in clause (i) shall be disregarded.
\item \textsuperscript{124} Transmittal 64, supra note 65, § 3258.4(E).
\item \textsuperscript{125} Under the Administration Proposal, the existing permissive waiver was continued. In the Waxman Amendment, as passed by the House, the State agency was required to establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes (under criteria established by the Secretary) that such application would work an undue hardship. The Senate Bill is for all intents and purposes the same as the House version. See supra note 112.
\end{itemize}
subsection with respect to any individual who establishes that application of such provision would work an undue hardship on the individual on the basis of criteria established by the Secretary of HCFA.\textsuperscript{126}

6. The “d4” Exempt Trusts

Under OBRA '93, three kinds of trusts are excluded from application of the new rules: 1) treatment as available assets; 2) non-traditional trust payment treatment; and 3) transfer of assets rules. The excepted trusts initially found their way into the law as a result of the Waxman Amendment, principally to ameliorate the harshness of the Administration proposal.

a. The d4ATrust: Under Age Sixty-Five Disabled Individuals\textsuperscript{127}

A trust containing the assets of a disabled individual under the age of sixty-five which was established for the benefit of such individual by the parent, grandparent, legal guardian of the individual, or a court, if the state receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual under a state plan, is exempted.\textsuperscript{128}

The essential elements are that the assets are those of the disabled individual; the trust was established for such individual’s benefit by the individual’s parent, grandparent, legal guardian, or a court, or the state receives repayment for medical assistance furnished such individual at the individual’s death. Additionally, the individual whose assets are in the trust must be under age sixty-five.\textsuperscript{129}

\textsuperscript{126} OBRA '93 § 13611(b), 107 Stat. at 626 (amending Social Security Act § 1917(d)-(5), 42 U.S.C. § 1396p(d)(5)). Transmittal 64 applies the same employs the same definitional “undue hardship” as used in the context of transfers of assets, but embellishes upon it by excluding circumstances that merely cause inconvenience or restrict lifestyle. Transmittal 64, supra note 65, § 3259.8(A). No examples are offered to explain this.

\textsuperscript{127} OBRA '93 § 13611(b), 107 Stat. at 625 (amending Social Security Act § 1917(d)-(4)(A), 42 U.S.C. § 1396p(d)(4)(A)).

\textsuperscript{128} Id.

\textsuperscript{129} Id.

Transmittal 64 clarifies that the trust must only be established when the individual is under 65, but retains its exemption after the individual attains that age as to asset placed in the trust before that time. The other concerns remain unaddressed. See Transmittal 64, supra note 65, at § 3259.7(A).
A number of issues affect this trust and its required components:

1) What is the status of the fund when the individual attains age sixty-five? Is it then "available" for Medicaid purposes? Will credit be given for the amount repayable to the state? Must payments out to or for the beneficiary first be paid to the state?

2) What is the status of the trust if the beneficiary ceases to be disabled?

3) Is the repayment obligation only for Medical assistance paid before age sixty-five?

4) Are there any limitations on the types of expenditures that can be made from the trust?

5) What impact will this measure have on nursing home litigation?

6) How will the age sixty-five limitation impact personal injury settlement trusts?

b. The d4b Trust: Qualified Income Trusts

A trust established for the benefit of an individual in a state which has a state plan imposing an income cap will be excluded from otherwise applicable trust treatment if:

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust), [and]
(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title.

130. The Waxman Amendment provided an exemption for: "trust[s] established for the benefit of a disabled individual (as determined under section 1614(a)(3)) by a parent, grandparent, or other representative payee of the individual." The Senate Bill counterpart had identical language to OBRA '93 with the exception of the under age 65 requirement. The under 65 requirement was added at the conference level to prevent institutionalized elderly, who, in many cases, would fit the definition of "disabled" under section 1614(a)(3), from taking advantage of the exception. The congressional intention appears to have been to protect Zebley trusts. See Sullivan v. Zebley, 493 U.S. 521 (1990).

131. OBRA '93 § 13611(b), 107 Stat. at 625 (amending Social Security Act § 1917(d)-(4)(B)), 42 U.S.C. § 1396p(d)(4)(B)).

132. Id.
Many of the issues presented by this attempt to establish qualified income trusts ("QITs") are explored in section VII of this article.\textsuperscript{133}

c. The d4C Trust: Pooled Asset Trusts

A trust containing the assets of a disabled individual will be considered exempt when:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1614(a)(3)) by the parent, grandparent, or legal guardian of [either the individual or a court] . . .

(iv) To the extent that amounts remaining in the beneficiary’s account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the [individual]. . . \textsuperscript{134}

\textsuperscript{133} The exception for the Miller Trust initially appeared in the Waxman Amendment. While the genesis of this provision was the treatment afforded trusts in jurisdictions such as Colorado as a result of the United States district court decision in Miller v. Ibarra, 746 F. Supp. 19 (D. Colo. 1990), the trusts contemplated in this provision are not restricted to the facts or the trust terms in that case. In its House form, the repayment requirement stated that: “the State will receive any amounts remaining in the trust upon the death of the individual. . . .” The Senate version engrafted the limitation on the repayment requirement to be “up to any amount equal to the total medical assistance received by the individual under a State plan under this title . . . .” In any case, the adoption of this provision has the potential to expand Medicaid eligibility to individuals in those states imposing an income cap but who, because of various restrictions in state law, were unable to rely on Miller. See SUSAN G. HAINES & JOHN T. COMBS, INCOME CAPS IN MEDICAID ELIGIBILITY, THE ELDERLAW REPORT (1991).

\textsuperscript{134} OBRA '93 § 13611(b), 107 Stat. at 625-26 (amending Social Security Act § 1917(d)(4)(C), 42 U.S.C. § 1396p(d)(4)(C)).
7. New Definition of Assets

One of the most critical definitional changes made under the new law relates to the definition of "asset" for transfer purposes. Under prior law there was a distinction between income and resource both for eligibility and transfer purposes.

The new law defines "asset" as including:

[A] income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse;

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including a court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

While there is considerable fleshing out of the meaning and application of this provision, it is here that Congress appears to have addressed the issues of the effect of a disclaimer, the "income" and transfer potential of lump sum receipts such as inheritances and personal injury settlements, and perhaps even the use of support orders.

135. OBRA '93 § 13611(c), 107 Stat. at 626 (amending Social Security Act § 1917(e)(1), 42 U.S.C. § 1396p(e)(1)). The Administration Proposal continued the transfer penalties for resource transfers only. The Administration Proposal's treatment of trusts was designed as an amendment to the Medicaid Qualifying Trust provisions of § 1902(k), 42 U.S.C. § 1396a(k). Paragraph (2)(B) of the amended provision defined "assets" as "all income or resources of the individual and of the individual's spouse . . . ," but only in the context of identifying whose assets comprised the trust corpus. The Waxman Amendment did not effect this provision. The change first appeared in the Senate Bill in virtually the same form as finally enacted.

136. OBRA '93 § 13611(c), 107 Stat. at 626 (amending Social Security Act § 1917(e)(1), 42 U.S.C. § 1396p(e)(1)).

137. BURWELL, supra note 12, at 1.
8. Effective Dates

Effective dates for payments in “calendar quarters beginning on or after October 1, 1993 without regard to whether or not final regulations to carry out the amendments have been promulgated.” The amendments will not apply to: benefits paid before October 1, 1993; assets disposed of on or before the date of enactment (August 10, 1993); or trusts established on or before the date of enactment (August 10, 1993). When a state plan requires state legislation in order for the plan to meet the additional requirements dealing with trusts, the state plan will not be deemed in noncompliance “solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment.”

V. MEDICAID ESTATE RECOVERIES

A. Former Law

Under former law, states were not required to establish estate recovery programs. Estate recovery could only occur after death and when there were no surviving children under age twenty-one. When a lien had been placed on the home of a nursing home resident, which was permitted under limited circumstances, it could not be foreclosed while certain siblings or adult children resided in the home.

B. OBRA '93

Under OBRA '93, states are now mandated to have “estate” recovery programs. The new law defines “estate” to include all real and

138. OBRA '93 § 13611(c), 107 Stat. at 626 (amending Social Security Act § 1917(e)-(1), 42 U.S.C. § 1396p(e)(1)).
139. Id. § 13611(e)(1)-(2), 107 Stat. at 627.
140. Id. § 13611(e)(3), 107 Stat. at 627.
141. OBRA '93 § 13611(e), 107 Stat. at 627.
142. Id. § 13611, 107 Stat. at 622-27 (amending Social Security Act § 1917(a), 42 U.S.C. § 1396p(a)).
143. Id. § 13612, 107 Stat. at 627-29 (amending Social Security Act § 1917(b)(1), 42 U.S.C. § 1396p(b)(1)).
144. Under the Administration proposal, the shift to mandatory recovery was introduced. The Waxman Amendment took a more intense approach to the estate recovery issue.
personal property and other assets included within the individual’s estate as defined for purposes of state probate law.145

The state, at its option, may include any other real or personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including property passing by joint tenancy, survivorship, life estate, living trust, or other arrangement.146

Apparently concerned with the abysmal cost recovery by the states as focused on by Burwell and Moses, Waxman’s Amendment sought to force the states to engage in aggressive recovery efforts as a means of recouping funds, and thus at the least stymieing the rate of growth in state Medicaid expenditures. Rather than merely mandating to the states that they seek recovery, but leaving to them any determination on how such a recovery program should be implemented, the Waxman Amendment tried to establish the requisites for an effective estate recovery program and make Federal Financial Participation conditional not only on implementing the required program, but proving ongoing compliance efforts.

145. The Waxman Amendment outlined its vision of an effective estate recovery program in the following manner:

(A) The program provides for identifying and tracking (and at the option of the State, preserving) resources (whether excluded or not) of individuals who are furnished any of the following long-term care services for which medical assistance is provided under this title . . . .

(B) The program provides for promptly ascertaining—

(i) when such an individual dies;

(ii) in the case of such an individual who was married at the time of death, when the surviving spouse dies; and

(iii) at the option of the State, cases in which adjustment or recovery may not be made at the time of death because of application of paragraph (3)(A) or paragraph (3)(B).

(C)(i) The program provides for the collection consistent with paragraph (3) of an amount not to exceed the amount [of medical assistance correctly paid for long-term care services on behalf of the individual] from—

(I) the estate of the individual;

(II) in the case of an individual [who was married at the time of death] from the estate of the surviving spouse; or

(III) at the option of the State, in a case described in subparagraph (B)(iii), from the appropriate person.


146. The Administration proposal redefined “estate” by amending 42 U.S.C. § 1396(b)(3) to read:

DEFINITION.—For purposes of this section, the term ‘estate,’ with respect to a deceased individual, includes all real [and] personal property and other assets in which the individual had any legally cognizable title or interest at the time of his death, including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, survivorship, life estate, living trust, or other arrangement.
This inclusion is mandatory for individuals who have received or who are entitled to receive benefits under a long-term care insurance policy in connection with which assets or resources are disregarded under a state plan amendment not approved as of May 14, 1993. In those situations where a lien was imposed under section 1396p(a)(1), recovery must be obtained when the property subject to the lien is sold.

In the case of individuals fifty-five years or older, recovery from the individual's estate is required for nursing facility services, home and community-based services, related hospital and prescription drug services, and at the state's option, other services provided under the state plan. The recovery does not apply to individuals who have received, or who are entitled to receive, benefits under a long-term care insurance policy in connection with which assets or resources are disregarded under a state plan amendment approved as of May 14, 1993.

This provision did not seem to be impacted by the Waxman Amendment. The Senate Bill retreated definitionally from the House Bill by restricting the mandatory recovery to an individual's estate for purposes of State law with respect to inheritance. Recovery against the more expansive category of assets was left optional. See 42 U.S.C. § 1396(b)(3) (1988 & Supp. V 1993).

The states became concerned that, with the House Bill, mandatory recovery and tracking, as required by the House, would place their Federal Financial Participation in jeopardy if they were either judicially or legislatively precluded from recovering against certain kinds of property included in the mandatory class (e.g., homestead property which is constitutionally exempt from creditor claims in Florida). The American Public Welfare Association actively sought relief through its legislative efforts which, at least in this area, found its way into the new law.

For a discussion of this issue see infra note 153.

Under OBRA '93, estate recovery is only mandated against individuals described in 42 U.S.C. § 1396p(a)(1)(B). That provision deals with recovery against a home of an individual who:

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and (ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home, except as provided in paragraph (2).

Under the OBRA '93 definition, it could be argued that only after a timely and relevant hearing effort can the state impose recovery. See OBRA '93 § 13612(c), 107 Stat. at 628 (amending Social Security Act § 1917(b), 42 U.S.C. §1396p(b)).
The state agency is required\textsuperscript{151} to establish procedures (in accordance with standards specified by the Secretary)\textsuperscript{152} under which the agency shall waive the application of the estate recovery (except to individuals who have received, or who are entitled to receive, benefits under a long-term care insurance policy in connection with which assets or resources are disregarded under a state plan amendment not approved as of May 14, 1993) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.\textsuperscript{153}

C. Effective Dates

The estate recovery provisions are effective for payments in calendar quarters beginning on or after October 1, 1993 without regard to whether or not final regulations to carry out the amendments have been promulgated. The amendments will not apply to individuals who died before October 1, 1993.

As in the case of the effective date\textsuperscript{154} for asset transfers and trusts, if the state plan requires state legislation in order for the plan to meet the new requirements, the state plan will not be deemed in noncompliance for Federal Financial Participation purposes solely on the basis of its failure to meet the additional requirements on of before the first day of the first quarter.

\textsuperscript{151} OBRA '93 § 13612(b), 107 Stat. at 628.

\textsuperscript{152} OBRA '93 requires that the state agency establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of the estate recovery provisions if their application would work an undue hardship as determined on the basis of criteria established by the Secretary. The Administration Proposal did not address this matter. The Waxman Amendment mirrors OBRA '93. The Senate Bill had a similar requirement. See S. 7422, 103d Cong., 1st Sess. (1994).

\textsuperscript{153} Under OBRA '93, state programs designed to encourage the purchase of long-term care insurance through waiver of asset transfer penalties, the so-called “public private partnership” have been effectively curtailed as of May 15, 1993. See UNIVERSITY OF MD., CTR. ON AGING, ROBERT WOOD JOHNSON FOUNDATION PROGRAM SUMMARY (1990). The elimination of this initiative which would have continued the promotion of long-term care insurance seems to run counter to the objectives of the industry advocates who sought adoption of many of the OBRA '93 provisions. As a component of this curtailment, the estate recovery provisions did not apply to individuals in states having previously approved plans which provided for the disregard of any assets or resources 1) to the extent that payments are made under a long-term care insurance policy or 2) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy. If the plan is either not approved of before May 15, 1993, or does not meet those requirements, recovery must be made and the hardship waiver is inapplicable. Id.

\textsuperscript{154} OBRA '93 § 13612(d), 107 Stat. at 628-29.
calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment.

VI. THE PROHIBITION ON FACILITY REQUIRED FINANCIAL DISCLOSURE

The Senate Bill\(^{155}\) contained a provision which was not related to the asset transfer/estate recovery focus of the other provisions of what became part II of OBRA '93. That provision, dealing with the issue of nursing facilities requiring financial disclosures (and indirectly financial guarantees) from prospective residents, was designed to prevent facilities from discriminating against Medicaid recipients in contravention of the Nursing Home Residents' Rights Bill of OBRA '87. The provision was deleted in the Conference Bill because it faced opposition\(^{156}\) as not being properly incorporated in the budget package, but the Committee Report, expending more attention to this matter than the whole of part two, stated:

> [a]bsent some limit on financial screening, the purpose of the existing statutory protection would be circumvented because nursing homes could effectively condition admission on financial information which indicates whether and when individuals are likely to receive or apply for Medicare or Medicaid benefits. Since this practice clearly violates these existing statutory rights, the Secretary may restrict financial screening in order to properly administer the existing statutory provisions assuring those rights.\(^{157}\)

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156. The Conference agreement does not include section 7422(c) of the Senate amendment relating to financial screening by nursing facilities. The conferees have been informed that a point of order could be raised in the Senate, under the so-called “Byrd Rule” (section 313 of the Congressional Budget Act of 1974) to the substance of this provision if included in the conference agreement. In order to avoid such a possible point of order, and because the conferees believe that the provision does nothing more than restate authority the Secretary has under current law, the provision has not been included. See id.

157. Id. This provision would have made explicit a prohibition on financial screening. The conferees believe that the existing provisions of Titles XVIII and XIX give broad authority to the Secretary to implement such a prohibition to the degree necessary to protect applicants’ rights to receive freely, or apply for, Medicare and Medicaid benefits.
VII. THE MILLER TRUST: OBRA '93 IMPLEMENTATION IN TURMOIL

From the perspective of Florida's experience in implementing OBRA '93, the most significant developments to date have focused on the trust authorized by the legislation to relieve the "income cap." Title XIX of the Social Security Act provides states the option to limit eligibility for nursing home care (that is, the vendor payment for room and board) to those applicants whose income does not exceed 300% of the current Supplemental Security Income ("SSI") benefit level. In an effort to contain their Medicaid cost base, Florida and a number of other states elected this option. The option creates what is often referred to as the "income cap" or the "Utah Gap.

The income cap operates by excluding nursing home assistance, an Institutional Care Program ("ICP") to individuals whose gross monthly income exceeds the cap by any amount. At this writing, the cap is $1338 per month. Income for these purposes is defined as income for SSI

158. As of this writing, Florida has not yet issued its Medicaid Manual changes fully implementing OBRA '93. It initially circulated an all district Policy Memorandum on September 28, 1993. A workshop to consider the Manual changes took place in June 1994, but final drafts have not yet been released. See Memorandum from Rob Lombardo, Bureau Chief, Aging and Adult Services, to 1-11 DPOAA (Sept. 28, 1993) (on file with author).

159. OBRA '93 § 13611(b), 107 Stat. at 625 (amending Social Security Act § 1917(d)-(4)(B), 42 U.S.C. § 1396p(d)(4)(B)).


161. Researchers have indicated that in Florida, there are 11,000 individuals falling into the gap. If a medically needy program was fully implemented, the state would experience a $45 million general revenue cost. See LARRY POLIVKA ET AL., LONG-TERM CARE IN FLORIDA: A FRAMEWORK FOR EXPANDING COMMUNITY PROGRAMS AND INCREASING ADMINISTRATIVE AND SERVICE DELIVERY EFFICIENCY 27 (1993).


163. Interestingly, the State of Utah, upon whose reputation the income cap is cast, does not employ the cap. The epithet is attributed to Virginia Fraser, Colorado's Nursing Home Ombudsman of the Legal Center in Denver, Colorado. She likened the predicament of people in this position to a gap in the Utah canyons with no way out. See id. at 4.

164. Under the medically needy program, by contrast, if individuals spend down their income on medical needs below a specified level (for example $384 per month in Maryland), they will receive Medicaid assistance. See Social Security Act § 1902(a)(iv)(C).
purposes and is therefore based on an individual’s gross income. Reductions for Medicare Part B premiums from social security or withholdings from pensions for taxes or other purposes are ignored for this computation, whether or not such deductions are voluntary or mandatory. The result is that individuals are considered as receiving income to which they do not actually have access. If this gross income calculation, determined on a monthly basis, exceeds the cap, they are denied ICP benefits.

The cruelty of the Utah Gap lies in its “catch 22” application. It establishes an artificial income eligibility level over which the ability to pay for care should be an inherent assumption, but which is less than sixty percent of the state’s average cost of care, and gives no credit for the portion of that income expended on such care. For example, the current state’s average cost of care as determined by the State of Florida is $2400. By application of the income cap, an individual having $1400 per month of income is both too poor to pay for his or her cost of nursing home care ($2400 plus) and too wealthy ($1338) to be entitled to assistance. This leaves those in need of care with no acceptable options.

Various provisions of the Medicare Catastrophic Coverage Act of 1988 which were intended to prevent spousal impoverishment are functions of the post-eligibility income budgeting process. In order to take advantage of these relief provisions, one must first be eligible. An institutionalized individual’s income which would ultimately be diverted to a community spouse, or other dependent, and reduce his or her income to

165. For Medicaid purposes, income is determined under the most closely related benefit program. 20 C.F.R. §§ 435.121, -.230, -.601 (1993). For SSI purposes, all income is considered available to the individual, including that not actually receipted. See also Himes v. Shalala, 999 F.2d 684 (2d Cir. 1993); Emerson v. Steffen, 959 F.2d 119 (8th Cir. 1992); Cervantes v. Sullivan, 963 F.2d 229 (9th Cir. 1992); Peura ex. rel. Herman v. Mala, 977 F.2d 484 (9th Cir. 1992).

166. The Florida Department of HRS employs a figure of $2400 as the state average cost of care although in many communities the cost of care ranges from $3200 to over $4500 per month.

167. Those who cannot afford the private cost of care stay at home with inadequate care, are placed in facilities unlicensed to provide the level of care they need, or try to relocate to other states. See Jill Quadagno et al., Falling Into the Medical Gap: The Hidden Long-Term Care Dilemma, 31 GERONTOLOGIST 521, 521-26 (1991).


169. Id.

an amount less than the cap, does not reduce it in order to initially obtain eligibility.

Obra ’93 attempted to address this problem through 42 U.S.C. § 1396p(d)(4)(B). The so-called “Miller Trust” or QIT, was better conceived in spirit than drafting. Congressional desire to relieve the impact of the income cap has proven so far, to be the most onerous provision of ObrA ’93 to implement.

Under section 1396p(d)(4), certain trusts were exempted from the various restrictions on the use and impact of trusts by Medicaid recipients. One such exemption was provided for certain trusts established for those caught in the Utah Gap. Under section 1396p(d)(4)(B), a trust will be exempt if:

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in that trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title, and

(iii) the State makes medical assistance available to individuals described in section 1902(a)(10)(A)(ii)(V), but does not make such assistance available to individuals for nursing facility services under section 1902(a)(10)(C).

The inspiration for, if not the substance of, section 1396p(d)(4)(B) was the federal district court case of Miller v. Ibarra. In that case, the district court approved Medicaid eligibility for four aged, infirm, and mentally incompetent individuals whose resources were below the eligibility level, but whose incomes were above the cap then in effect in Colorado. Under applicable Colorado law, the legal representatives petitioned the probate courts to establish the trusts to hold their income. The court ruled

171. OBRA ’93 § 13611(d), 107 Stat. at 626-27.
172. The Committee Report accompanying the Senate Bill described the second of two trusts exempted from its proposed treatment of trust as a trust known as “Miller Trusts” as a result of its similarity to the trusts being employed in Colorado and other states following the Miller decision.
173. OBRA ’93 § 13611(d), 107 Stat. at 626-27 (amending Social Security Act § 1917(d), 42 U.S.C. § 1396p(d)).
that the individuals’ rights to the incomes, upon which the judicial trusts were imposed, had been removed and transferred to the trustees.\textsuperscript{177} This made the income “not available” to the applicants for Medicaid purposes, since they had no access to the income before it was placed in the trust.\textsuperscript{178} HCFA indicated partial acquiescence to the \textit{Miller} decision,\textsuperscript{179} but neither the case nor HCFA’s approval could be relied upon by individuals in all states.\textsuperscript{180} This created an inequality of treatment amongst individuals which OBRA ’93 attempted to resolve.

Unfortunately, the correctness of the \textit{Miller} decision at the time of its rendition would not survive the changes in Medicaid law effected by OBRA ’93.\textsuperscript{181} How then is section 1396p(d)(4)(B) to be read? How could there be a Miller Trust when the foundation of \textit{Miller} no longer applied?

Florida’s experience in implementing the Miller Trust exemption in OBRA ’93 is illustrative of the clash between advocates seeking to achieve expedient implementation of the law and the state’s confusion and resistance to the federal directive. As one of the income states with the largest elderly population in the gap, Florida faced significant fiscal impact from wide-

\begin{itemize}
  \item \textsuperscript{177} \textit{Miller}, 746 F. Supp. at 27.
  \item \textsuperscript{178} The court further held that the transfer of resources provisions did not apply because 1) the amounts transferred were income under SSI rules and the penalties only applied to transfers of resources and 2) the trusts were not MQTs because they were established by the courts (through the guardians) and not the acts of applicants. Note that this latter point was contrary to Florida case law. \textit{See} Hatcher v. Department of HRS, 545 So. 2d 400 (Fla. 1st Dist. Ct. App. 1989).
  \item \textsuperscript{179} Letter from Gary Wilkes, Associate Regional Administrator, Division of Medicaid, Health Care Financing Administration, Region VIII, Denver, Co. to all State Medicaid Directors (Mar. 22, 1994) (on file with author). HCFA acquiesced to Colorado’s continued Federal Financial Participation for Medicaid paid to recipients establishing trusts under circumstances similar to the \textit{Miller} facts: for individuals whose income prevented eligibility, or incompetents for whom the trust were established, all monthly income directed into the trust and trustees having discretion to only distribute income in an amount less than the cap. HCFA did not agree, however, with the characterization of the trusts as not MQTs. Rather, it relied on its State Medicaid Manual Section 3215.1, holding that trusts established with an individual’s assets constituted a trust established by that individual even if effected by a guardian.
  \item \textsuperscript{180} Floridians were not able to take advantage of \textit{Miller} not only on the basis of \textit{Hatcher}, but the fact that Florida had not adopted the Uniform Guardianship Protective Proceedings Act (specifically section 2-308) that authorized the court to establish the trust to meet the needs of a protected person. Section 744.441(19) of the \textit{Florida Statutes} only provides for court approval of the trust established by the guardian.
  \item \textsuperscript{181} Under OBRA ’93, transfers of income, as well as resources, triggered a period of ineligibility. Trusts established by court are considered established by the individual. \textit{See also} BURWELL, supra note 12, at 20-22.
\end{itemize}
spread use of the Miller Trust by those needing its relief. It became the most vocal proponent for resolution.

OBRA'93 was designed to be implemented for trusts established on or before the date of enactment. For convenience of administration, Florida's Department of HRS chose to implement the new statute as to trusts effective October 1, 1993, and did so in its first pronouncement in an All District Policy Memorandum dated September 28, 1993. This Policy Memorandum primarily addressed effective dates and implementation of the transfer of asset rules.

Appendix 1 of the Memorandum dealt with income trusts for persons over the ICP income limit. In defining the criteria for the trust itself, the only significant amplification of the federal statute was the requirement that the trust be irrevocable. However, in addressing the criteria for dealing with the individual's income that was deposited to the trust, the stage was set for significant controversy.

The Policy Memorandum provided that where the trust was determined to meet the criteria for eligibility, the "income directly deposited into the trust will not be countable income. Income paid to the individual or a representative payee, other than the trust, will be counted as available income." There was a direction that "[c]ases experiencing problems in setting up direct deposits of their income into a trust must be referred [to the

182. In spite of estimates that full implementation of the Miller Trust would cost $45 million in general revenues, in Florida, where only the institutional care population is excluded for medically needy, the Florida Health Plan predicted that $13.1 million for fiscal year 1994-1995, and $19.8 million for fiscal year 1994-1995 would be experienced because of the limited use of the trust due to lack of publicity, cost, and delay in implementation. See AGENCY FOR HEALTH CARE ADMINISTRATION, THE FLORIDA HEALTH SECURITY PLAN: HEALTHY HOMES 1994, at 136 (Dec. 1993).

183. Telephone interview with Roy Trudell, Office of Medicaid Policy, & Stephen Blake, HCFA Region VIII. In conversations with Roy Trudell, Office of Medicaid Policy, HCFA, and Stephen Blake, HCFA Region VIII, it was described that while all of the income cap states had expressed concern that implementation of the Miller Trust would open the flood gate on expenditures, Florida (because of the pressure placed on it) had pressed the hardest. Id.

184. OBRA '93 § 13612(d), 107 Stat. at 628-29.

185. Memorandum from Rob Lombardo, Bureau Chief, Aging and Adult Services, to 1-I-I-DPOAA (Sept. 28, 1993) (on file with author).

186. While not in the actual legislation, the March 22, 1994 HCFA interpretation requires that the trust be irrevocable. See infra note 200. The letter makes the argument that if the trust were revocable under SSI rules, it would be counted as an available resource, even if it is exempt from section 1917(d) of the Social Security Act. This may not be correct since the specific Medicaid treatment of trusts overrides the general SSI treatment.
Program office in Tallahassee] for clearance and the case must be held pending until the clearance response is received.” In a similarly prophetic description of the treatment of the income paid out of the trust, the policy provided that the total amount of income which can be paid out of the trust (whether or not it is actually disbursed) will be considered available income to the client and will be budgeted to determine eligibility, to determine patient responsibility, and to apply spousal impoverishment policy, if applicable.

The HRS interpretation of the Miller Trust contained two major difficulties. Unlike the situation in the actual Miller trusts, amounts expendable for special needs of the trust beneficiary would be considered available whether or not disbursed. More importantly, it appeared that HRS had engrafted a requirement that the applicant’s income be directly deposited to the trust in order to be considered unavailable for eligibility purposes. Informal inquiries to HRS suggested that this policy was in response to verbal interpretations received from the Atlanta Regional Office of HCFA. Accordingly, with HCFA purportedly directing the state that income had to be directly receipted by the trust, Florida (which believed it would realize a potential $22 million dollar shortfall in unbudgeted Medicaid expenditures) took the stone wall approach.

In an attempt to convince the state to take a more liberal approach to these trusts, practitioners prompted the state to examine how other states were implementing the Miller Trust provisions of OBRA ‘93. Based on an internal HRS memorandum four states contacted all dealt with the income trust in different manners. Colorado reported that it was still relying on its state statute which required court direction of the income into the trust. Oregon allowed income over the income standard to be paid into the trust by the client or the representative. Administrative expenses and attorney’s fees were allowed as expenses of the trusts and the state provided a sample trust form. South Carolina indicated, according to the memo, that

187. For a discussion of post-eligibility of income see infra note 213.

188. In the trusts which were under consideration in Miller, the corpus of the trusts could be used for the beneficiaries’ need provided that in no month could distributions under the trustee’s discretion exceed an amount equal to the cap less $20. See Miller, 746 F. Supp. at 27.

189. Internal Memorandum from Martha Crabb, Program Administrator, for SSI Related Programs to Kimberly Tucker & Marshall E. Kelley (Dec. 9, 1993) (on file with author).

190. See COLO. REV. STAT. § 14-14-409.7 (1987 & Supp. 1994); see also id. §§ 15-14-409, 26-4-506.6.
income was direct deposited. At that time, Arkansas reported that it had not
done anything to implement OBRA '93.

With no resolution forthcoming, no Miller Trust applications being
approved, and the situation appearing bleak, advocates from the Elder Law
Section of the Florida Bar requested and were granted a meeting with a
number of high ranking officials and counsel from HRS and the State’s
Agency for Health Care Administration\(^\text{191}\) to explore ways of opening
utilization of the income trust. At the meeting, held in Tallahassee on
December 16, 1993, the issue of direct deposit, which had been acknowl-
ledged as imposing the impediment to implementation of the trust, became
a non-issue. HRS indicated that HCFA had advised \textit{that absent an irrevo-
cable assignment of the income} the QIT could not be used to obtain
eligibility. Whether the income was direct deposited or not, all of the
individual’s rights to the income had to be removed. Absent total divesti-
ture of rights in the income, it would be considered available wherever
deposited.

A copy of a draft HCFA manual statement\(^\text{192}\) was obtained which
confirmed the information relied upon by Florida. Under this interpreta-
tion, the issue of direct deposit became moot. According to the draft, income
belonging to the individual that was paid into the trust, still belonged to the
individual, even if the payment was made directly to the trust rather than to
the individual. Accordingly, income paid directly to the trust still belonged
to the individual and was counted as income to the individual when
determining eligibility. On the other hand, if the individual completely and
irrevocably divested himself of the income by irrevocably assigning the right
to that income to the trust, the income no longer belonged to the individual,
but instead legally belonged to the trust.

\(^{191}\) On December 16, 1993, Ira S. Wiesner, Chair and Charles F. Robinson, Vice Chair
of the Florida Bar Elder Law Section requested an opportunity to explain to the Department
of HRS and the Agency for Health Care Administration how the direct deposit requirement
could not be accommodated with the income items specifically identified in OBRA '93 as
the subject matter for the Miller Trust (social security, pension, and veterans benefits). The
meeting was also expected to result in a structure that would enable Florida to accept these
trusts but accommodate its concerns. For example, one of the concerns raised by HRS was
the ability to monitor whether the monthly income was placed in the trust and not expended
in violation of the trust terms.

\(^{192}\) A draft of the HCFA State Medicaid Manual dated November 23, 1993, was
presented at the meeting. The draft had been obtained from the HCFA Region IV Office.
In a conversation later with Roy Trudell, HCFA Office of Medicaid Policy, the author was
advised that it was a discussion piece only and did not represent HCFA policy. Telephone
Nevertheless, in a leap of logic matched in absurdity only by the catch
22 of the Utah Gap itself, not only would the transfer of assets193 then
apply, but also the requirement in section 1396p(d)(4)(B) that the income
belonged to the individual would be violated194 and the trust would be
disqualified. The draft acknowledged that "[w]hile it is possible to arrange
for the divestment via irrevocable reassignment, private pensions or other
similar income, federal pensions, such as social security benefits, federal
retiree pensions, VA benefits, etc., cannot be reassigned in this man-
ner."195 Thus, an individual with income from one of these sources, as
well as a private source, may still have countable income, even if some
income is reassigned to the trust.

At the conclusion of the meeting, HRS agreed to formally request
guidance from HCFA on the issues addressed at this meeting. On December
27, 1993, acting Assistant Secretary Lombardo forwarded a letter to HCFA
specifically inquiring whether a court ordered direction of income into the
trust would suffice to make that income unavailable for Medicaid eligibility
purposes. Secondarily, Lombardo inquired whether the state could mandate
distribution from the trust in an amount up to the ICP income limit for
application to patient responsibility.196

Response to the HRS request was not forthcoming. The issue was best
stated again by Lombardo, now Bureau Chief of Aging and Adult Services.
He described the various federal prohibitions on direct deposit by stating,

[t]he critical distinction here is the difference between a direct payment
and a direct deposit. Direct payment is required by HCFA, but not
allowable by SSA or ERISA qualified pensions plans. Direct deposit
does not irrevocably give up ownership in the income and therefore is

193. The transfer of assets exclusions contained in OBRA '93 section 13611(a)(2)(B)
do not exempt transfers to trusts under section 1917(d)(4)(B).
194. The actual Miller decision had been premised on a complete divestment of
the income and its unavailability. Miller, 746 F. Supp at 25.
payments); 42 U.S.C. § 401(a)(13) (Supp. V 1993) (dealing with the anti-alienation
provisions mandated for qualification of all qualified retirement plans); 42 U.S.C. § 407(a)
196. Under § 1396p(d)(4)(B), retained income must be repaid to the state to the extent
of Medicaid benefits received. However, there is no requirement in the statute that any
income be paid out. This created the concern from the Medicaid funding agency that individ-
uals would be able to place all of their income in the trust, pay nothing toward their cost of
care and then only repay at death without interest. This would have placed a significant
burden on the states to front end the cost of care, where as a pure medically needy program
contains full cost of care sharing at the front end.
not acceptable to HCFA, and therefore to HRS, on the basis of the irrevocability of the income trust. 197

Perhaps, prophetically, Lombardo suggested that, "[w]e believe changes in the federal law are needed and we are recommending that the Governor’s office pursue these changes." 198

Starting in January 1994, various members of the Florida Bar Elder Law Section began a concerted effort to force HCFA and Congress to resolve the impasse on implementing OBRA ’93 as concerns the Miller Trust. While dialogue continued with HRS, other more effective avenues became necessary. From the more political arena, all members of Florida’s Washington delegation were contacted for assistance in seeking resolution, as were other members of Congress, including Congressman Waxman. The most concerned attention came from Florida’s Senator Bob Graham and Congressman Michael Bilirakis. Each of these Florida representatives commenced a campaign of continued inquiry to and prodding of HCFA to respond, and respond positively, to Florida’s request for guidance in effecting congressional policy to authorize these trusts.

With political efforts and dialogue failing to attain results, a further type of pressure seemed inevitable. A notice of intent to file a class action suit in federal court was delivered to the Secretary of HRS on February 8, 1994. 199 William Hillman was the named plaintiff in the case which was ultimately filed. Hillman, an Alzheimer’s victim, had expended all his resources on nursing home care. His railroad retirement benefits and pension placed him $108.73 over the income cap. He established an income trust with his income directly deposited into the trust account. Mr. Hillman’s application for ICP Medicaid was denied.

As a result of growing Congressional pressure, and the likelihood of a potentially heavy class action liability prompting direct intervention of Florida’s governor, HCFA responded to the situation by issuing an all states Memorandum dated March 17, 1994. 200 Because HCFA and Congress viewed the ameliorative aspects of section 1396p(d)(4)(B) as analogous to

197. Interoffice Memorandum from Rob Lombardo, Bureau Chief of Aging and Adult Services, to John Slye, of the Office of General Counsel (Jan. 13, 1994).
198. Id.
199. Notice of Intent to File Class Action Suit in Federal Court, from Helen M.E. Stevens, Esq. & Nancy Penner, Esq. Florida Rural Legal Services, Inc. to James Towey, Secretary, Department of Health and Rehabilitative Services.
200. Memorandum from Sally K. Richardson, Director of Medicaid Bureau, HCFA to Regional Administrators, entitled Miller-Type Trust Exemption Under OBRA 93—INFORMATION (Mar. 17, 1994) [hereinafter Richardson Memorandum].
the Miller case,\textsuperscript{201} if not subject to its specific elements, responsibility for enunciating and clarifying the policy fell to Stephen Blake of the Denver Regional office. The all states policy memorandum was released March 17, 1994, and adopted by and transmitted under the pen of the various regions within a few days thereafter.\textsuperscript{202}

Analysis of this Memorandum illustrates the inconsistency within Medicaid policy and rule the Miller Trust created. This inconsistency and confusion resulted in an inability to implement the statute for more months than it had taken to pass it.\textsuperscript{203}

The Memorandum set out HCFA’s policy on Miller trusts issued in advance of a general State Medicaid Manual Instruction on Trusts. This was done because of “significant interest in this exemption . . . ”\textsuperscript{204} HCFA premised the Memorandum with an acknowledgement of Congressional intent to “help individuals living in so-called ‘cap’ states.”\textsuperscript{205} Interestingly, that intent is described as allowing to be sheltered only enough income so that such individuals to meet the state’s income standard. The inability to effect the use of such trusts was attributed to errors in drafting.

HCFA identified specific problems with the structure of section 1917(d)(4)(B) of the Social Security Act.

\textsuperscript{201} In describing the proposed exclusion, the Senate Finance Committee explanation to its Senate Bill 7422 described these as “Miller Trusts.” The House Committee explanation described the Utah Gap and the application of the trust, by stating that “[i]n the absence of these arrangements, people over the income cap stay at home or reside in board and care facilities, although they have been determined to need nursing home care. In neither location do they get the care and service they need.” John T. Combs & Ira S. Wiesner, Fourth Annual Elder Law Inst., The Miller Trust—Highlights Following OBRA ’93: Analysis and Forms 17 n.43 (1994).

\textsuperscript{202} HCFA policy, when interpreted and prepared for implementation, often takes the form of Regional Identical Letters. These letters are shared among the regions and with the Central HCFA Office. They are distributed to the public with the view that the policy announced in such letters will be utilized by the states in resolving controversies under the state plan. While not carrying the impact of regulations, they can be relied upon as statements of agency policy. See Fatoullah, supra note 115, at 15; see also Combs & Wiesner, supra note 201, at 1.

\textsuperscript{203} The first Congressional hearings on OBRA ’93 took place on April 1, 1993, and the law was enacted four months later on August 10, 1993. The statute became effective on October 1, 1993, but it was not until March 22, 1994, that clearance was obtained.

\textsuperscript{204} Richardson Memorandum, supra note 200.

\textsuperscript{205} Id.
1) The exemption from the OBRA '93 trust rules for Miller Trust did not exempt such trusts from the usual income and resource rules states apply under their state plans, generally the SSI rules.206

2) In Miller, the right to receive the income was transferred to the trust. As a result, using normal SSI rules, the income would not count as having ever been received by the individual. This created two distinct problems. First, the very income sources intended to be placed in the Miller Trust cannot, by law,207 be transferred to the trust. Further, under 1917-(d)(4)(B), only the individual’s income is exempted.208 Under SSI, once an individual transfers the right to receive income, payments are no longer income to the individual, and they belong to the trust. Under SSI rules, if an individual transfers the right to receive income, then it is no longer his or her income. The Miller Trust can contain only income that belongs to the individual. As a result, once the individual transfers his or her right to receive the income to the trust, it is no longer appropriate funding for a Miller Trust. On the other hand, if the income is not assigned, under SSI rules, the individual retains the right to the income and is then considered to receive it in the month it is placed in trust, even if the trust is irrevocable.209

3) Transfers of income or the rights to receive income into a Miller Trust would be subject to the transfer penalties in section 1917(c). Based on the specificity of section 1396p(d)(4)(B) over the general rules of SSI and Congress’ articulated purpose210 in enacting section 1917(d)(4)(B), to provide relief from the trust provisions for a very specific class of individuals, precedence is given to section 1917(d)(4)(B).

The Memorandum then enunciates its four rules to apply to Miller trusts, regardless of whether the individual retained the right to receive and then transfers the income into the trust or directly assigned the income into the trust:

1) If the trust meets the requirements of section 1917(d)(4)(B), the corpus of trust is exempt from being counted as available to the individual.

206. Here, the memorandum seems to be stating that a trust exempt from being considered available under the Medicaid rules for eligibility could still be considered available for SSI purposes.

207. See supra note 190.

208. OBRA '93 provides that “(i) the trust is composed only of pension, Social Security, and other income to the individual . . . .” OBRA '93 § 13611(b), 107 Stat. at 625 (amending Social Security Act § 1917(d)(4)(B)(i), 42 U.S.C. § 1396p(d)(4)(B)(i)).

209. Compare HCFA argument on November 23, 1993 with supra note 199 and accompanying text.

210. See supra note 201.
2) Income placed in a Miller Trust will not be considered as income to the individual.

3) The transfer of assets provisions of section 1917(c) apply to funds placed in the Miller Trust.

On the transfer of assets issue, an exception was created to the effect that it will not apply to the extent that income placed in the trust is paid out of the trust for nursing facility service, a level of care in any institution equivalent to that of nursing facility services or home or community based services provided under section 1915(c) or (d) of the Act.211

On June 2, 1994,212 a supplemental Memorandum was issued specifically detailing the impact of Miller Trust in the areas of transfer of assets, post-eligibility treatment of income and spousal impoverishment. The most significant expansion of the March 22, 1994 Memorandum was the explanation of the impact of Miller Trusts on post-eligibility issues.213

The Memorandum clarifies that HCFA was ignoring the SSI income rules for purposes of not counting income when first received by the individual and then placed in the Miller Trust. However, once the congressional purpose to make individuals who successfully get their income into the trust eligible for Medicaid is accomplished, the blinders are removed and SSI income rules again come into play. Since such income is income for SSI purposes, it is combined with all other countable income (i.e., income not placed in the trust) for determining the recipient's share of cost. After deducting for the personal needs allowance,214 family allowances (spousal215 and dependent216), home maintenance allowance,217

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211. Essentially, HCFA was trying to accommodate state concerns over nonpayment for cost of care and to bridge the gap to what would be the comparable situation in a medically needy context. In other words, in a medically needy state, an individual with significant monthly income would not likely receive Medicaid for nursing home costs because he or she would have to expend all of it to below its medically needy income amount before entitlement. There would be no ability to sequester the income as it appeared available with the Miller Trust from the statutory requirements.

212. As indicated earlier, initiating Regional Identical Letters on Miller Trusts came from Region VIII in Denver. On June 3, 1994, the Region VII office issued RIL#94-100. This amplified 94-075 of March 17, 1994. The letter from Region IV (Florida) was identified as MCD-33-94 and was dated June 3, 1994.

213. Under the post eligibility budgeting process, a Medicaid recipient is charged with a share of responsibility. Under 20 C.F.R. § 435.725 (1994), an individual's share of costs is determined by reference to all income, even income disregarded in the eligibility process, and after credit for certain allowance, establishes the amount of the nursing facility charge for which Medicaid will not be responsible.


215. Id. § 435.725(c)(2).
and medical expenses not subject to third party payment, the remainder is the amount by which the state reduces its payment to the institution and must be covered by the individual.

The memorandum also explains the application of the transfer of asset rules to the Miller Trust. In short, income placed into the trust will be subject to the transfer penalty computation to the extent not expended for the individual's post-eligibility responsibility, allowances or other expenditures not considered income distribution.

The result of months of effort and frustration at the federal and state governmental levels, as well as from providers, advocates and the public, is that all states now have the equivalent of a medically needy program for the institutional Medicaid applicant. While the income restrictions on the two programs are not identical, the net result is the same. The only difference in application is that access to care in the income cap states is a factor of the public, providers, and advisors being aware of the availability of the Miller Trust, being able to establish and operate the trust in the proper manner and overcoming the unwillingness to go to the cost, expense and inconvenience of its utilization. The equality of treatment Congress sought has been accomplished, albeit in a perverted and illogical manner.

Perhaps the absurdity of the current situation and the administrative costs will finally force states to abandon the income cap when its cost in human suffering is not an adequate incentive. Nevertheless, despite

216. Id. § 435.725(c)(3).
217. Id. § 435.725(c)(5). This is optional and not provided for in Florida. Id.
218. 20 C.F.R. § 435.725(c)(4) (1994). Under federal law, the allowance for amounts expended for incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare and other health insurance premiums, deductibles or coinsurance charges are not provided for in Florida. Since these are not provided for, as is the home maintenance allowance under 20 C.F.R. § 435.725(c)(5), Florida is currently in non-compliance with federal law. Id.
219. Under the transfer penalty application, since amounts expended for services or goods are at fair market value, no penalty is incurred. Payments for the expenses for nursing facility service, level of care services in an institution equivalent to that of nursing facility services, or home and community-based services are considered expended for fair value and are not subject to penalty. Likewise, amounts expended for items that are not food, shelter, or clothing are not considered "income" for SSI purposes. Therefore, they can be trust expenditures that do not incur the penalty. Further, distributions to the beneficiary's spouse are excluded from the transfer rules. As a result, if after payment of cost of care, all allowances, medical expenses, and distributions to community spouses totalling more than $2400 of income still remains in the trust, a penalty could be assessed. See COMBS & WIESNER, supra note 201. Transmittal 64 carried through the Memoranda interpretations without significant modification. Transmittal 64, supra note 65, § 3259.7(C).
expected criticism and skepticism, one of the few positive things to emerge from OBRA '93 has come to pass; how well the others fare is yet to be judged.

VIII. CONCLUSION

The dynamics of the development, adoption, and implementation of OBRA '93, as relates to Medicaid asset transfers, trusts, and estate recoveries, reflect the overall difficulties our society has in dealing with the ever increasing need for and cost of providing long-term health care. Private insurance interests found accessibility to government provided benefits too favorable, thereby restricting market pressure to purchase private long-term care insurance. Providers, faced with the gulf between private pay rates and Medicaid reimbursement widening while experiencing and increasing rate of Medicaid eligible residents, also sought relief. In an era of budget constriction, it was politically wiser to seek eligibility restrictions than higher reimbursement formulae. State Medicaid agencies faced more clients seeking assistance, often after obtaining planning advice from attorneys, than they had anticipated or were capable of serving. In turn they had to explain their experiences to state legislatures troubled by geometric increases in state Medicaid budgets.

The net result of all of this activity was legislation that attempted to shore up a defective system and ignore the underlying problem of an aging population expecting health care coverage whether they suffered an acute or chronic disability. Congressional concern with the increasing use of a "welfare" program to provide long-term care to the elderly required acknowledging that health care for seniors is not distinguishable whether it is a stroke, heart attack, or Alzheimer's disease. The net result of OBRA '93 is that cost containment won out over health care coverage, constriction over accessibility. The gauntlet of trying to implement the Miller Trust provision illustrates less willingness of its proponents to misaddress the problem. With the shift in the political balance of power between the parties, how this saga will yet play out may entail dealing with many more OBRAs.
Section 784.08 of the Florida Statutes: A Necessary Tool to Combat Elder Abuse and Victimization

I. INTRODUCTION

In an attempt to protect the elderly from crime, the Florida Legislature enacted section 784.08 of the Florida Statutes, which reclassifies an assault or battery as an offense of a higher degree when the victim is age sixty-five or older. Prosecutors, however, cannot completely effectuate the statute’s purpose because the statutory definition of elderly—someone age sixty-five or older—is arbitrary. Does a person become elderly on his sixty-fifth birthday? Is one age sixty-five or older at midnight on January 1 of any given year? And what about the elderly who born in February of the same year? The statutory definition fails to provide an answer.

birthday or is a person as old as they feel? Some people should be considered elderly even if they are younger than the statutory minimum age of sixty-five, particularly those who have serious health problems that have aged them beyond their years.

To aid in effectuating the purpose behind section 784.08 of the Florida Statutes, the prosecution is not required to prove that a defendant specifically intended to commit an assault or battery on a person over the age of sixty-five. The defendant needs only to intend to commit the assault or battery, not necessarily intend to commit the offense on a victim aged sixty-five or older. Requiring the defendant to have knowledge of the victim's age at the time of the attack would place a difficult burden on the prosecution.

3. Id. § 784.08(2).
4. Id. §§ 784.011, 784.03. Intent is a specific element of simple assault and simple battery which the state must prove. Generally, simple assault and simple battery require an act committed by the perpetrator, and intent, the perpetrator's mental state during the act. See BLACK'S LAW DICTIONARY 139 (5th ed. 1979). "An 'assault' is an intentional, unlawful threat by word or act to do violence to the person of another, coupled with an apparent ability to do so, and doing some act which creates a well-founded fear in such other person that such violence is imminent." FLA. STAT. § 784.011(1) (1993). A battery is committed if the perpetrator "[a]ctually and intentionally touches or strikes another person against the will of the other; or . . . [i]ntentionally causes bodily harm to an individual." Id. § 784.03.

An assault or battery may become an aggravated assault or aggravated battery when the circumstances of the offense are more serious. Id. §§ 784.021, 784.045. In most cases, the perpetrator must have inflicted "grievous bodily harm" on the victim, and the use of a weapon is not necessary. 6 AM. JUR. 2D Assault and Battery § 48 (1981) (whether grievous bodily harm has been committed is a jury question); 6A C.J.S. Assault and Battery § 72 (1975). This differs from common law assault and battery in which "the least touching of the [victim] in a rude, angry, or revengeful manner" is sufficient to constitute an offense. Id. Some factors which may make an assault aggravated include:

(1) the specific intent of the perpetrator, such as, for example, in the case of an assault with intent to commit murder, rape or robbery, or assault with intent to inflict great bodily injury, or assault with intent to commit a felony; (2) the means used by the perpetrator, as in assault with a dangerous or deadly weapon; (3) the kind of injury inflicted; (4) the fact that the nature of the assault is likely to inflict disgrace upon the victim; (5) the sex or age of the victim; (6) the sexual nature of the assault, or (7) the particular manner in which, or the particular circumstances under which, a sexual assault has been committed.


5. State v. Nelson, 577 So. 2d 971, 973 (Fla. 4th Dist. Ct. App. 1991). States may establish different degrees of punishment for a criminal offense based on the particular offense and the identity of the victim. See 21 AM. JUR. 2D Criminal Law § 594 (1981). The state derives its power to establish certain classifications from its police power. Id. As long as the state creates classifications which are "reasonable and not arbitrary," the constitutional
It is important to determine if statutes which give extra protection to the elderly, like section 784.08 of the Florida Statutes, are necessary. Old age often brings physical, emotional, and mental infirmities making an elderly person more vulnerable because the individual cannot defend him or herself from an attack, or does not recognize that abuse is occurring. Widespread abuse among the elderly has created a need for these statutes.

A growing trend to protect the elderly from abuse, neglect, and exploitation arose as a result of a heightened awareness of elder abuse. Society's recent acknowledgement of elder abuse stems from increases in the elder population; research involving child and spousal abuse; and the mere fact that "society... is more compassionate than it once was." Elder abuse occurs in various settings. Two members of the United States Senate Special Committee on Aging stated:

Elder abuse is a complex problem whose incidence, causes and remedies remain the subject of controversy among various advocates for the elderly. It is a phenomenon which encompasses different types of behavior—violence, neglect, exploitation—and occurs in a variety of settings including private homes, nursing homes, board and care facilities, and hospitals.

The typical victim of elder abuse is a woman over the age of seventy-five, who is dependent upon another person because of physical or mental incapacity. In most cases, the abuser is a relative, often the victim's child, to whom the victim provides housing and financial support. The abuse may appear in various forms: physical abuse, financial abuse,
violation of basic rights, or psychological abuse. Research shows most abusers witnessed violence in their homes as children, and the abuse was “transmitted from one generation to the next.”

In its effort to protect the elderly from abuse, neglect, and exploitation, the Florida Legislature also enacted sections 415.101 through 415.114 of the Florida Statutes, entitled the “Adult Protective Services Act.” The Act provides a mandatory reporting requirement of abuse; protective services investigations of cases of abuse; and penalties for abusers. Additionally, when the abuse or neglect constitutes an assault or battery, section 784.08, which reclassifies an assault or battery on a person sixty-five years of age or older as a crime of a higher degree, may apply. For example, a simple battery is ordinarily classified as a first degree misdemeanor. However, if the victim is over age sixty-five, the battery is reclassified as a felony of the third degree. Thus, an assault or battery on an elderly person is categorized as a more serious offense.

This paper will examine three issues. Part II will determine whether the Florida Legislature adequately defined the term “elderly.” If the statute excludes people who are elderly just because they are under sixty-five years of age, the statute’s purpose is not effectuated. Part III of this article will consider whether statutes, such as section 784.08 of the Florida Statutes, should require the prosecution to prove that defendant knew or should have known the victim’s age at the time the offense was committed. This should not be required in any statute which seeks to protect a vulnerable group of people because the purpose behind the statute would be thwarted by a difficult prosecutorial burden. Part IV will ascertain whether statutes, such as section 784.08, which protect a vulnerable group of people are necessary. Since elder abuse is widespread and must be deterred, enhanced penalties are necessary to punish elder abusers. Part V will suggest a solution to the problem of defining the term “elderly.”

13. Quinn, supra 9, at 203.
14. QUINN & TOMITA, supra note 8, at 76. However, in no way does this discussion infer that all elderly people are frail; this discussion considers elderly people as a group.
16. Id.
17. Id. § 784.08.
18. Id.
19. Id.
20. FLA. STAT. § 784.08 (1993).
21. SPECIAL COMM. ON AGING, supra note 7, at preface.
II. DEFINING THE TERM “ELDERLY”

A. National Trends

State elder abuse statutes across the country, including Florida’s, reveal there is a trend among state legislatures to make crimes committed against the elderly harsher offenses. This trend stems from the elderly’s vulnerability to crime as well as the effect crime has on them. Some states only make the crimes of assault or battery on an elderly person a higher offense. Others designate a laundry list of crimes, including assault, battery, robbery, theft, extortion, or fraud, which are categorized as higher offenses when committed against an elderly person. For example, instead of specifically listing which crimes require the imposition of a greater sentence when committed against an elderly person, Hawaii subjects a defendant to a mandatory minimum sentence of imprisonment if the defendant knowingly kills or seriously injures an elderly person in the course of committing a felony. Other states treat age as an aggravating circumstance, by increasing the defendant’s sentence when the crime involves an elderly victim.

Most of the states with statutes focusing on crimes against the elderly, as well as the American Association of Retired Persons and other federal regulations, define the term “elderly” by a minimum age. Yet, the minimum age differs from statute to statute. Some states classify a person as elderly at the age of sixty, while other states use the age of sixty-two or sixty-five. Similarly, the American Association of Retired Persons, the American Bar Association, and the American Society on Aging have recommended the use of a minimum age of sixty-five as a reasonable standard.

23. COLO. REV. STAT. § 18-3-209 (1990); ILL. REV. STAT. ch. 720, para. 5/12-4.6 (1992); TEX. CRIM. PROC. CODE ANN. § 22.04 (West 1989).
27. COLO. REV. STAT. § 18-3-209(a) (1990); D.C. CODE ANN. § 22-3901(a) (1989); HAW. REV. STAT. § 706-660.2(1) (1994); ILL. REV. STAT. ch. 720, para. 5/12-4.6(a) (1992).
29. ARIZ. REV. STAT. ANN. § 13-702(C)(12) (Supp. 1993); CAL. PENAL CODE § 368(d) (West 1988); NEV. REV. STAT. § 193.167(1)(h) (Supp. 1993); TEX. CRIM. PROC. CODE ANN.
Persons requires an individual to be age fifty-five to be a member. Eligibility for legal services under the Older Americans Act\textsuperscript{30} occurs at age sixty, and to receive some Social Security retirement benefits,\textsuperscript{31} one need be age sixty-two.\textsuperscript{32} These differences in minimum ages, exemplify the ambiguity surrounding the term elderly.

Differences within the class of elderly people as a whole creates this lack of uniformity among the various statutes. Physical and mental capabilities of older individuals may differ substantially among persons of the same age.\textsuperscript{33} This occurs because "[p]ersons age at different rates. Two sixty-five-year-olds, although chronologically the same, differ physically, mentally, and socially."\textsuperscript{34} In explaining the difference between aging and growing older, William Posner, a well-known social worker, stated:

\begin{quote}
[A] distinction \ldots must be made between getting older and "aging." The process of "aging" is not a universal one. This phase of life varies from human being to human being in all of its aspects. Commonly
\end{quote}

\footnotesize
\begin{itemize}
  \item § 22.04(c)(2) (West Supp. 1994).
  \item 30. The federal government and the states have the responsibility to assist in the achievement of the following objectives:
    \begin{enumerate}
      \item An adequate income in retirement in accordance with the American standard of living.
      \item The best possible physical and mental health which science can make available and without regard to economic status.
      \item Obtaining and maintaining suitable housing \ldots
      \item Full restorative services for those who require institutional care.
      \item Opportunity for employment with no discriminatory personnel practices because of age.
      \item Retirement in health, honor, dignity after years of contribution to the economy.
      \item Participating in and contributing to meaningful activity within the widest range of civic, cultural, educational and training and recreational opportunities.
      \item Efficient community services, including access to low-cost transportation \ldots
      \item Immediate benefit from proven research knowledge which can sustain and improve health and happiness.
      \item Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives.
    \end{enumerate}
  \item 31. The Social Security Act provides federal funding to states so that they may give financial assistance to aged needy individuals. 42 U.S.C. § 301 (1988).
  \item 32. William E. Adams & Rebecca C. Morgan, \textit{Representing the Client Who is Older in the Law Office and in the Courtroom}, 2 \textit{ELDER} L.J. 1, 5 n.21 (1994).
  \item 33. \textit{Id.} at 5 n.22.
  \item 34. \textit{Id.} at 6.
\end{itemize}

speaking, "aging" connotes gradual mental and physical disintegration. While each and everyone of us, by virtue of living, is getting older, not each and every one of us is "aging." We bring this concept to the foreground because we feel this to be the core of our ability to individualize elderly people and to help them accordingly.  

Individuals age at different rates as a result of "external factors, some of which are sociological in nature; research indicates that aging occurs earlier for members of the lower socioeconomic classes." Consequently, an older person's environment may cause a decline in both psychological and social well-being. Evaluating these factors reveals that specifying a minimum age is inadequate because an individual at a particular chronological age may not be similarly aged in terms of capabilities.

B. Florida's Approach

Section 784.08 of the Florida Statutes attempts to deter crimes against the elderly by imposing higher penalties upon the offenders. First, the statute imposes a mandatory minimum sentence for crimes of aggravated assault or aggravated battery committed against "a person 65 years of age or older . . . ." Second, it reclassifies a defendant's sentence if a crime of assault, aggravated assault, battery, or aggravated battery is committed upon a person sixty-five years of age or older. The statute sets out the normal penalty for each of the four offenses and then increases the penalty by one degree. For example, a felony of the second degree becomes a felony of the first degree.

C. Vagueness

As an alternative to designating a minimum age, some state legislatures have worded their criminal statutes to protect victims who are aged, decrepit, or elderly. However, these safeguards are insufficient be-

35. Id. at 6 (quoting Howard B. Gelt, Psychological Considerations in Representing the Aged Client, 17 ARIZ. L. REV. 293, 302 (1975)).
36. Id.
38. FLA. STAT. § 784.08(1) (1993).
39. Id. § 784.08(2).
40. Id. § 784.08(2)(a).
42. Id.
cause the terms “aged” and “elderly” are void for vagueness.\textsuperscript{44} The terms “elderly” and “aged” are synonymous since statutes using definitions of them can be analyzed together. \textit{Corpus Juris Secundum} defines elderly as “[s]omewhat old, advanced beyond middle age, or bordering on old age.”\textsuperscript{45} Similarly, \textit{Black’s Law Dictionary} defines an aged person as “one advanced in years.”\textsuperscript{46} In defining the term aged, both \textit{Ballentine’s Law Dictionary}\textsuperscript{47} and \textit{Corpus Juris Secundum}\textsuperscript{48} define the word aged as not “susceptible of precise definition,” finding it impractical to decide that a person becomes aged at a particular age. Therefore, the terms elderly and aged are void for vagueness because they are not readily definable.

Two state courts struck down statutes which protected the elderly from crime because the terms “aged” and “elderly” were vague.\textsuperscript{49} These states sought to protect the elderly differently from Florida by using the terms “elderly” and “aged” instead of a minimum age.\textsuperscript{50} Texas enacted a statute making an assault against an “aged or decrepit” person an aggravated offense.\textsuperscript{51} In \textit{Hallman v. State}, the charging document stated that the defendant, a “person of robust health and strength” at the time of the offense, committed an aggravated battery on an aged person.\textsuperscript{52} To prove the victim was aged, the prosecution provided evidence that the victim was sixty-six years old, five feet, eight inches tall, and weighed 124 pounds.\textsuperscript{53} In addition, the victim testified that although he needed an operation, he was “in good health” and could do “light work;” however, he could no longer

\textsuperscript{44} \textit{Hallman}, 18 S.W.2d at 653; \textit{White}, 395 A.2d at 1090. The void for vagueness doctrine is used to challenge a law’s constitutionality when one or more of its terms are not readily definable. \textit{See generally Laurence H. Tribe, American Constitutional Law} § 12-31 (2d ed. 1988). “As a matter of due process, a law is void on its face if it is so vague that persons ‘of common intelligence must necessarily guess at its meaning and differ as to its application.’” \textit{Id.} at 1033 (citing Connally v. General Constr. Co., 269 U.S. 385, 391 (1926)). The purpose of the doctrine is to ensure that people are given “fair notice” of what a law proscribes and to prevent “arbitrary and discriminatory” law enforcement. \textit{Id.}

\textsuperscript{45} 28 C.J.S. Elderly § 1051 (1941).

\textsuperscript{46} \textit{Black’s Law Dictionary} 57 (5th ed. 1979).

\textsuperscript{47} \textit{Ballentine’s Law Dictionary} 49 (3d ed. 1969) (citing Allen v. Pearce, 28 S.E. 859 (Ga. 1897)).

\textsuperscript{48} 2A C.J.S. 532 (1972) (citing Allen, 28 S.E. at 859).


\textsuperscript{50} \textit{Hallman}, 18 S.W.2d at 653; \textit{White}, 395 A.2d at 1090.

\textsuperscript{51} \textit{Hallman}, 18 S.W.2d at 653.

\textsuperscript{52} \textit{Id.}

\textsuperscript{53} \textit{Id.}
farm his land. In reversing the judgment in favor of the defense, the court declared the word “aged” as vague because the term aged is “quite indefinite,” and “[o]ne might be quite old, and yet not aged, within the meaning of the statute.” As a result of this vagueness, the state could not satisfy its burden of proving the victim was aged, consequently, the defendant was acquitted.

Similarly, a Delaware court struck down part of a death penalty statute which listed an “elderly” or “defenseless” victim as an aggravating circumstance. The case arose when the Delaware Superior Court certified six questions to the Delaware Supreme Court concerning the constitutionality of Delaware’s 1977 death penalty statute. The Delaware Supreme Court reasoned that the term “elderly,” without further definition, was vague because it had no “common and ordinary meaning sufficiently definite to meet [its] usage in the context of the [s]tatute.” The court also stated that there were no prior Delaware judicial interpretations, and that definitions from other jurisdictions and modern dictionaries were of little help. Furthermore, the court stated: “Manifestly, words such as ‘elderly’ and ‘defenseless,’ without legislative definition of scope and meaning, are susceptible of widely differing interpretations.”

D. Underinclusiveness

The current version of section 784.08 of the Florida Statutes is insufficient because the definition of an elderly person as one who is sixty-five years of age or older is too narrow. The statute is underinclusive

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54. Id. 55. Id. (citing Black v. State, 67 S.W. 113 (Tex. Crim. App. 1902)). But see Lewing v. State, 121 S.W.2d 599 (Tex. Crim. App. 1938) (interpreting a statute which stated that aggravated assault committed by person of robust health or strength upon one who is aged or decrepit as not unconstitutionally vague because the term decrepit made the statute definite).

56. Hallman, 18 S.W.2d at 653.
57. White, 395 A.2d at 1090.
58. Id. at 1084.
60. White, 395 A.2d at 1090.
61. Id.
62. Id. at 1091.
63. Id. “Underinclusive classifications do not include all who are similarly situated with respect to a rule, and thereby burden less than would be logical to achieve the intended government end.” TRIBE, supra note 44, § 16-4 at 1447. While legislatures should strive to avoid underinclusive legislation, the United States Supreme Court rarely invalidate...
because it does not include all of the people intended to be protected by the statute: all aged people who are not yet sixty-five years of age.\textsuperscript{64}

In the legislative history of section 784.08, a Senate Staff Analysis defined aged persons as "persons who are at least 60 years old and who suffer from the infirmities of aging such that they can not adequately provide for themselves."\textsuperscript{65} The Florida Legislature similarly chose the age of sixty in section 415.102 of the \textit{Florida Statutes}, the Adult Protective Services Act.\textsuperscript{66} Yet, the Florida Legislature chose to define the term elderly in section 784.08 of the \textit{Florida Statutes} as persons age sixty-five or older.\textsuperscript{67} The difficulty of defining the term "elderly" is not limited to the Florida Legislature; it plagues other states' legislatures as well.\textsuperscript{68} The age designated to define the term "elderly" differs depending on the state in which a person lives.\textsuperscript{69}

Texas has a statute which seeks to protect elderly individuals from physical abuse.\textsuperscript{70} Like section 784.08 of the \textit{Florida Statutes}, section 22.04 of the \textit{Texas Criminal Procedure Code} defines an elderly person as "an individual who is 65 years or older" at the time of the offense.\textsuperscript{71} By limiting the definition of "elderly" to a minimum age, the legislature added proof of the victim's age to the prosecution's burden. In \textit{Butler v. State},\textsuperscript{72} the defendant allegedly beat the victim, Agnes Harrel, with his fist and a board. The defendant appealed a guilty verdict on grounds that the prosecution failed to prove the victim was sixty-five years or older when the offense occurred.

The prosecution proffered four different pieces of evidence to prove the victim was sixty-five years old when the offense occurred.\textsuperscript{73} First, the

\begin{itemize}
\item \textsuperscript{64} \textit{FLA. STAT.} \textsection{} 784.08 (1993).
\item \textsuperscript{65} \textit{COMM. ON CRIMINAL JUSTICE, supra note 1, at 107.}
\item \textsuperscript{66} \textit{FLA. STAT.} \textsection{} 415.102(3) (1993); \textit{see supra text accompanying notes 15-17.}
\item \textsuperscript{67} \textit{Id.} \textsection{} 784.08.
\item \textsuperscript{68} \textit{See supra notes 23-29.}
\item \textsuperscript{69} \textit{See, e.g., ARIZ. REV. STAT. ANN.} \textsection{} 13-702(C)(12) (Supp. 1993); \textit{DEL. CODE ANN. tit. 11, \textsection{} 4209(e)(1)(r) (Supp. 1992); HAW. REV. STAT.} \textsection{} 706-660.2(1) (1994).
\item \textsuperscript{70} \textit{TEX. CRIM. PROC. CODE ANN.} \textsection{} 22.04 (1988).
\item \textsuperscript{71} \textit{Compare id. with FLA. STAT.} \textsection{} 784.08 (1993).
\item \textsuperscript{72} \textit{No. 01-87-00006-CR, 1988 WL 10848, at *1 (Tex. 1st Dist. Ct. App. Feb. 11, 1988).}
\item \textsuperscript{73} \textit{Id. at *2.}
\end{itemize}
prosecution presented evidence that Protective Services sent the victim to a foster home after the assault occurred. Second, the owner of the foster home testified that she only accepted residents that were at least sixty-five years of age. Third, an emergency room doctor testified that the victim was "elderly." Finally, the State introduced photographs of the victim taken by the hospital shortly after the offense occurred. The court concluded that the evidence provided did not prove the victim was sixty-five years of age or older at the time of the offense.\footnote{74}{Id.}

The court reasoned that just because the foster home did not take anyone who was not sixty-five years old did not prove that the victim was sixty-five.\footnote{75}{Id.} The court further explained that the State did not provide the date the victim began residing at the foster home or when she turned sixty-five. Additionally, the court remarked that neither the photographs nor the physician's testimony proved the victim was age sixty-five. The legislature failed to adequately define the term elderly; its definition was too narrow. As a result, the legislature frustrated the purpose of the law—the protection of elderly individuals—by placing an onerous burden on the prosecution.

III. FLORIDA'S LEGISLATIVE PURPOSE: PROTECTION OF A VULNERABLE GROUP

A. Elder Abuse Analogized to Juvenile Abuse

Although the exact reasons may differ, the public policy behind elder abuse statutes is similar: protection of a vulnerable group. Section 784.08 of the Florida Statutes was enacted to protect the elderly from crime. The elderly, like children, are in need of special protection from crime.\footnote{76}{Comm. On Criminal Justice, supra note 1, at 106.} Although the elderly are the least victimized age group in the country, crimes committed against the elderly are more serious.\footnote{77}{Id.}

Support in favor of heightened sentences for crimes involving the elderly is illustrated by the rationale behind statutes which protect juveniles from sexual battery. Abuse of juveniles is analogous to abuse of elders because both groups are vulnerable. Children are vulnerable because of their tender years.\footnote{78}{Michael M. v. Superior Court of Sonoma County, 450 U.S. 464, 469-70 (1981) (preventing teenage pregnancies, protecting young girls from physical injury or from loss of virginity, and advancing religious and moral attitudes regarding premarital sex constituted}
nor have the power to stop the abuse from occurring. Similarly, elders are vulnerable because of physical or mental infirmities. They too may not realize abuse is occurring or might be unable to prevent its occurrence. As a result, the Florida Legislature passed laws to protect children from physical, mental, and sexual abuse and to protect elders from abuse, exploitation, neglect, and criminal assault and battery.

Subsequent to the legislative amendment of section 784.08 of the Florida Statutes, there have been no challenges on the grounds that the defendant lacked knowledge that the victim was sixty-five years of age or older. However, if challenged, the courts may compare the legislative purpose of section 784.08 to the purpose of the two child sexual battery statutes, and conclude that the elder law statute is constitutional because the Florida Legislature enacted it to serve a similar purpose: to protect a vulnerable group of people.

First, both groups may be mentally incompetent. Children do not develop their mental faculties until they reach a certain age, while elders are susceptible to senility and Alzheimer’s Disease during their golden years. Second, children and elders may be physically incompetent. Children either do not know how to fight or are not strong enough to fend off an attacker, while elders may have physical problems due to aging that also make physical defense an impossibility. Regarding abuse and neglect, young children and elders can be a burden on their caregivers because they require constant attention due to their limited capacity. As a result, some caregivers may lash out at the child or elder in frustration.

The Florida Legislature intended to protect children when it drafted both of Florida’s sexual battery statutes. Children are vulnerable because

suspected legislative purposes for statutory rape law).

79. Florida has two statutes designed to protect juveniles from sexual battery. The first, section 794.011, criminalizes sex with a minor under the age of twelve. FLA. STAT. § 794.011 (1993). This statute requires a sexual battery or an attempted sexual battery which injures the sexual organs of the minor. Id. The second, section 794.05, prohibits sex with an unmarried person of chaste character under the age of eighteen. Id. § 794.05. The defendant’s lack of knowledge that the victim was under the age of twelve at the time of the offense is no defense under either sexual battery statute. Id. § 794.021.

80. See infra text accompanying notes 99-111.

81. Cf. State v. Nelson, 577 So. 2d 971 (Fla. 4th Dist. Ct. App. 1991) (holding that the statute’s language before amendment required the defendant’s knowledge of the victim’s age). The present version of the statute makes the defendant’s knowledge of the victim’s age irrelevant. See FLA. STAT. § 784.08(2) (1993).

82. See QUINN & TOMITA, supra note 8, at 76-77.

83. FLA. STAT. §§ 794.011, 794.05 (1993).
of their young age and lack of maturity, and as such, the legislature realized
that they needed special protection. The Florida Legislature enacted
section 794.05 prior to enacting section 794.011. In the interim, the
Florida Supreme Court held that the purpose of section 794.05 is "to protect
the virtuous young women of this State within the specified age from defile-
ment." Other states have agreed that children are vulnerable to sexual
advances because they may not understand the actions of the seducer or the
consequences of sexual intercourse. In addition, children may not have

§ 784.08 (1993)). In Senate Bill 138, which amended section 794.011 of the Florida
Statutes, the Florida Legislature stated that:

[justice redacted]

Id.

85. Fla. Stat. § 794.05 (1993). Section 794.05(1) provides:

Any person who has unlawful carnal intercourse with any unmarried person, of
previous chaste character, who at the time of such intercourse is under the age
of 18 years, shall be guilty of a felony of the second degree, punishable as
provided in s. 775.082, s. 775.083, or s. 775.084.

Id.

86. Id. § 794.011. Section 794.011(2) provides:

(a) A person 18 years of age or older who commits sexual battery upon, or
in an attempt to commit sexual battery injures the sexual organs of, a person less
than 12 years of age commits a capital felony, punishable as provided in ss.
775.082 and 921.141.

(b) A person less than 18 years of age who commits sexual battery upon, or
in an attempt to commit sexual battery injures the sexual organs of, a person less
than 12 years of age commits a life felony, punishable as provided in s. 775.082,
s. 775.083, or s. 775.084.

Id.

87. State v. Bowden, 18 So. 2d 478, 481 (Fla. 1944) (reversing a judgment which
quashed an information charging the defendant with unlawful carnal intercourse with an
unmarried female of previous chaste character under the age of eighteen).

88. Golden v. Commonwealth, 158 S.W.2d 967, 969 (Ky. 1942).
the strong will necessary to stop the sexual advances. Consequently, the law deems children incapable of consenting to sexual intercourse.

B. The Defendant’s Mens Rea

In a prosecution for the rape of a minor in Florida, as in the majority of jurisdictions, a defendant’s reasonable belief that the victim was above the statute’s specified age is not a defense to a charge of rape. This is true even if the victim misrepresented her age to the defendant before they became intimate, if the defendant actually tried to determine the victim’s age, or if the defendant had a reasonable belief that the victim was not a minor. This means that in most jurisdictions a defendant may be convicted of statutory rape even though the defendant did not intend to commit a crime. The defendant needs only to have intended to commit the sexual act.

As in statutory rape, lack of knowledge that an elderly victim is sixty-five years of age or older is no defense to a charge brought under section 89.

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89. Id.
90. See Caulder v. State, 500 So. 2d 1362, 1363 (Fla. 5th Dist. Ct. App. 1986) (holding a defendant cannot claim the child-victim consented to the sexual act because young children are deemed legally incapable of consenting); see also 75 C.J.S. Rape § 13 (stating sexual intercourse with a minor, both at common law and by statute, constitutes rape regardless of whether the victim consented to the act).
91. FLA. STAT. § 794.021 (1993); see also Simmons v. State, 10 So. 2d 436, 438 (Fla. 1942) (holding ignorance or mistake on part of defendant as to the age of the victim is no defense). But see People v. Hernandez, 393 P.2d 673 (Cal. 1964) (holding a statutory rape charge may be defended where the defendant lacked a criminal intent because of the defendant’s reasonable belief that the consenting female was beyond the age of consent).
93. Ransom, 942 F.2d at 776 (noting courts have rejected the “reasonable mistake of age defense” to statutory rape unless the governing statute states otherwise); see also FLA. STAT. § 794.021 (1993). Section 794.021 provides:

When, in this chapter, the criminality of conduct depends upon the victim’s being below a certain specified age, ignorance of the age is no defense. Neither shall misrepresentation of age by such person nor a bona fide belief that such person is over the specified age be a defense.

FLA. STAT. § 794.021 (1993).
94. Id. § 794.021.
95. McGillicuddy, supra note 92, at 700.
96. 15A FLA. JUR. 2D Criminal Law § 3803 (1993).
97. McGillicuddy, supra note 92, at 700.
98. 75 C.J.S. Rape § 9 (1975).
784.08 of the Florida Statutes.\textsuperscript{99} Prior to the statutory amendment eliminating a defendant’s knowledge of the victim’s age, a challenge was brought before a Florida court. In \textit{State v. Nelson},\textsuperscript{100} the defendant convicted under section 784.08, successfully appealed by arguing the statute required a defendant’s knowledge of the victim’s age.\textsuperscript{101}

On appeal, the court attempted to construe the statute by only applying the word “knowingly” to the mental state required to commit the crimes of assault or battery, not to the knowledge of the victim’s age.\textsuperscript{102} The court explained “it is doubtful that the legislature intended that the state would have to prove that the criminal knew the victim was at least sixty-five years old before the enhanced penalty could be invoked.”\textsuperscript{103} However, the court concluded such a construction was impossible, and held the word “knowingly” required the defendant to know the victim was sixty-five years of age or older at the time of the offense.\textsuperscript{104}

The court reasoned that the knowledge requirement was inappropriate for two reasons: 1) a defendant rarely knows a victim’s age;\textsuperscript{105} and 2) the statute was enacted to protect elderly individuals.\textsuperscript{106} Furthermore, the court compared the statute to other statutes which do not require the defendant to know the victim’s age or the criminality of the defendant’s conduct.\textsuperscript{107} The court noted that a person who rapes a child does not have to know the victim’s age,\textsuperscript{108} nor does a person who sells drugs within one thousand feet of a school need to know that he or she is within one thousand feet.\textsuperscript{109} The court stated that “the requirement of having to know whether someone is at least sixty-five years old places an intolerable burden of proof on the state, and we conclude that the statute, in its present form,
must be amended to be effective.” Representative Stafford, the main sponsor of the bill to amend section 784.08, stated the state should not have to prove the defendant’s knowledge of the victim’s age; the only factor determining whether an enhanced penalty applies is the victim’s age.

C. Illinois’ Similar Solution

Illinois’ aggravated battery statute is similar to that of Florida. Section 12-4.6(a) of the Illinois Revised Statutes states that “[a] person who, in committing battery, intentionally or knowingly causes great bodily harm or permanent disability or disfigurement to an individual of 60 years of age or older commits an aggravated battery of a senior citizen.”

Like section 784.08 of the Florida Statutes, the Illinois statute imposes a stiffer penalty upon conviction. Prior to enacting section 12-4.6(a), a similar provision, section 12-4(b)(10), made a simple battery committed upon a victim who was sixty years of age or older an aggravated battery. In People v. Jordan, the defendant attacked Eloise Lord, a sixty-six-year-old woman, when she went to a gas station with her daughter-in-law. The state charged Jordan with aggravated battery of a person aged sixty years or older under section 12-4(b)(10). Jordan appealed his conviction alleging the state failed to prove his knowledge of the victim’s age.

Upholding Jordan’s conviction, the court reasoned that the legislature did not intend to require the defendant’s knowledge of the victim’s age since it specifically rejected an amendment with such a requirement. The legislature enacted the statute to “protect senior citizens who were defenseless and often the prey of muggers.” Similarly, the “no knowledge”

110. Nelson, 577 So. 2d at 973.
111. HOUSE OF REPRESENTATIVES COMM. ON CRIMINAL JUSTICE, FINAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT, ch. 92-50, at 5 (1992), microformed on COMPILATION OF COMMITTEE STAFF ANALYSIS OF LEGISLATION PASSED BY THE LEGISLATURE OF THE STATE OF FLORIDA, h0115z.cj (Fla. Info. Assocs., Inc.).
112. ILL. REV. STAT. ch. 720, para. 5/12-4.6 (1992).
113. Id.
114. ILL. REV. STAT. ch. 720, para. 5/12-4.6(a) (1992); Witt, supra note 24, at 1164.
115. ILL. REV. STAT. ch. 720, para. 5/12-4.6 (1992).
117. Id. at 391.
118. Id.; see ILL. REV. STAT. ch. 720, para. 5/12-4.6 (1992).
120. Id. at 391.
121. Id.
requirement of section 784.08 of the Florida Statutes should be upheld if challenged because it was enacted for the same purpose as section 12-4.6(a) of the Illinois Statutes: to protect the elderly from physical attack.122

D. Should Elder Abuse Be a Strict Liability Offense?

Statutory rape was enacted as a strict liability offense because it is morally detestable.123 Strict liability is liability without fault and without regard to whether or not the defendant intended his acts.124 Usually, strict liability is imposed to punish people who commit crimes against the public welfare.125 In Simmons v. State,126 the state charged the defendant with assault with the intent to commit rape and with attempted statutory rape pursuant to section 794.021 of the Florida Statutes.127 The Simmons court categorized statutory rape as a felony "'in which, on [the] grounds of public policy, certain acts are made punishable without proof that the defendant understands the facts that give character to his act.'"128 As a result, most statutory rape statutes require the defendant’s intent to have sexual intercourse, but not the defendant’s intent to do so with a person below the age of consent.129

Similar to statutory rape, by not requiring the defendant to intend to hurt an elderly person by his or her actions, crimes against elders become strict liability offenses.130 These statutes make a defendant culpable of assault, battery, or rape, without requiring the defendant’s specific intent to commit the act on a person who is above or below a particular age.131

123. See Simmons v. State, 10 So. 2d 436 (Fla. 1942).
125. McGillicuddy, supra note 92, at 700.
126. 10 So. 2d at 436.
127. Id. at 437.
128. Id. at 438 (quoting Commonwealth v. Murphy, 42 N.E. 504, 505 (Mass. 1896)).
129. See, e.g., W.E. Shipley, Annotation, Mistake or Lack of Information as to Victim’s Age as Defense to Statutory Rape, 8 A.L.R.3d 1100 (Supp. 1994) (citing the following cases which held mistake of age is no defense in a charge of statutory rape: Nelson v. Moriarty, 484 F.2d 1034 (1st Cir. 1973); State v. Stiffler, 788 P.2d 220 (Idaho 1990); State v. Superior Court of Pima County, 454 P.2d 982 (Ariz. 1969); State v. Davis, 229 A.2d 842 (N.H. 1967), overruled by State v. Ayer, 612 A.2d 923 (N.H. 1992); Kelley v. State, 187 N.W.2d 810 (Wis. 1971)).
131. See id. Black’s Law Dictionary defines intent as it is used in the Restatement (Second) of Torts. BLACK’S LAW DICTIONARY 727 (5th ed. 1979). Intent "denote[s] that the actor desires to cause [the] consequences of his act, or that he believes that the consequences
There are additional justifications for alleviating the prosecution’s burden of proving the defendant intended to commit a crime on a person within a particular group. First, there is one less issue to litigate. Individuals charged with public welfare offenses usually refuse to take a plea; as a result, most of these cases go to trial. Since the defendant’s knowledge that the victim belonged to a protected class is not required, the legislature has effectively removed the prosecution’s burden of proving the defendant’s intent to commit the crime. Accordingly, there are fewer issues to resolve at trial. Second, courts reason that the defendant committed a moral wrong by carrying out the acts proscribed by the statute.

Offenses prosecuted under the elder statute justify the imposition of strict liability. Courts in Florida and Illinois have agreed that physical attacks on the elderly do not require knowledge of the victim’s age. The Florida court in *State v. Nelson* favored the “no knowledge” requirement because “the theory behind the statute [is] . . . that he or she who assaults elderly people does so at his or her peril.” Similarly, the Illinois court in *People v. Jordan* reasoned that “the person who sought to attack another did so at the risk that his victim would be 60 years old.”

The elder abuse statute, similar to Florida’s statutory rape provision, correctly imposes strict liability on offenders. Strict liability is appropriate in the interest of protecting elderly people from criminals who prey

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are substantially certain to result from it.” *Id.* An act becomes intentional when a danger ceases to be merely a foreseeable risk and becomes a substantial certainty. *Spivey v. Battaglia*, 258 So. 2d 815, 816-17 (Fla. 1972).

Both simple assault and simple battery require intent. *State Farm & Casualty Co. v. Saurazas*, 334 So. 2d 180, 181 (Fla. 4th Dist. Ct. App. 1976). Aggravated assault and aggravated battery require the same elements, including intent, as simple assault or battery. *See Parker v. State*, 482 So. 2d 576, 578 (Fla. 5th Dist. Ct. App. 1986); 6A C.J.S. *Assault and Battery* § 72 (1975). The difference between them is that an aggravated offense is more serious because of the identity of the victim or the type of injury sustained by the victim. *Id.*

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132. McGillicuddy, supra note 92, at 100.
133. See id.
134. See id.
135. Id.
136. Id. at 701.
137. FLA. STAT. § 784.08 (1993).
138. *Nelson*, 577 So. 2d at 972; *Jordan*, 430 N.E.2d at 391.
139. *Nelson*, 577 So. 2d at 972.
140. *Jordan*, 430 N.E.2d at 391.
141. FLA. STAT. § 784.08 (1993).
on their vulnerability. The elderly suffer greater injuries when they are attacked. According to the National Crime Survey\textsuperscript{142} conducted by the Bureau of Justice Statistics, nine percent of the violent crime victims aged sixty-five years or older experience serious injuries such as broken bones or loss of consciousness.\textsuperscript{143} In comparison, only five percent of younger victims suffer serious injuries.\textsuperscript{144}

Elderly victims take precautions in fifty-eight percent of their victimizations, while younger victims take protective steps in seventy-three percent.\textsuperscript{145} Usually, older victims do not respond to an attacker with physical action.\textsuperscript{146} Instead, the elderly victim “use[s] nonphysical action, including arguing or reasoning with the offender, screaming, or running away.”\textsuperscript{147} While the commission of any crime may be immoral in itself, victimizing people who are helpless, vulnerable, and likely to suffer serious injuries is intolerable.

IV. WHY THE ELDER LAW STATUTE IS NECESSARY

Statutes enhancing the penalties for crimes against the elderly are necessary because elderly people are vulnerable and need special protection. As people age, their physical, emotional, and psychological strength may wain so they are more susceptible to crime. Moreover, with age, reflexes diminish, and elders are less able to protect themselves or fight back against an attacker. Elderly victims, as opposed to younger victims, take fewer steps to protect themselves during an attack.\textsuperscript{148} “For the most part, they are frail and cannot speak for themselves or act on their own behalf.”\textsuperscript{149}

\begin{thebibliography}{9}
\bibitem{142} \textsc{Bureau of Justice Statistics, U.S. Dep’t of Justice, National Crime Victimization Survey: Elderly Crime Victims, NCJ-147186} (Mar. 1994) [hereinafter Elderly Crime Victims]. The Bureau of Justice Statistics publishes statistics based on interviews with approximately 100,000 people every six months about crimes they have experienced. “The [survey] includes the violent crimes of rape, robbery, and assault; personal theft; and the household crimes of burglary, household larceny, and motor vehicle theft.” \textit{Id.} at 1.
\bibitem{143} \textit{Id.} at 2.
\bibitem{144} \textit{Id.}
\bibitem{145} \textit{Id.} at 3.
\bibitem{146} Elderly Crime Victims, supra note 142, at 3.
\bibitem{147} \textit{Id.}
\bibitem{148} \textit{Id.}
\bibitem{149} Quinn & Tomita, supra note 8, at 6.
\end{thebibliography}
A. Vulnerability

The National Conference on Crime Against the Aging reported that the elderly are "eight times more vulnerable to crime than younger people, primarily because of their physical and financial limitations." An earlier study stated that the elderly make up one of the groups that are "especially vulnerable to crime," blaming "wealth (or perceived wealth) and physical weakness" for their susceptibility to crime. Perhaps this susceptibility contributes to the statistic that elderly people are almost twice as likely as young people to be raped, robbed, or assaulted at or near the home.

Other research studies reflect an elderly person's physical dependence upon another as a sign of vulnerability. A research study was conducted on 404 patients over the age of sixty admitted to the Cleveland Ohio Chronic Illness Center during a twelve-month period. The researchers found that these elderly people lived in the community and depended upon their families or other people for their needs. More than three-fourths of the abused elderly had at least one major physical or mental impairment. Fifty-one percent of the people were unable to walk without the aid of another person or a wheelchair, and ten percent had hearing problems. Forty-one percent "were either partially or totally confused or 'senile.'"

Another study was completed based on data from health and human service agencies and from elderly people living in the Washington, D.C.

150. Witt, supra note 22, at 1170 (citing Joan N. Scott, Senior Citizens Present a Special Case, Judges J., Summer 1982, at 19); see also Quinn & Tomita, supra note 8, at 21.
151. Id.
152. Id.
154. Quinn & Tomita, supra note 8, at 28.
155. Id.
156. Id.
157. Id.
158. Id.
The researchers found "94% of the abused elders were physically impaired (62% could not prepare their own food and 54% could not take their own medication), and 47% were moderately to severely mentally impaired." Under section 784.08 of the Florida Statutes, these people would not be a part of a protected class unless they were at least sixty-five years old.

B. Societal Attitudes

Legislation is necessary because societal attitudes such as ageism, greed, and negative attitudes towards the disabled promote abuse of the elderly. The elderly are viewed as people who have nothing to offer society. They are "shunned and avoided" and are sometimes removed from society by being placed into nursing homes or retirement communities upon reaching a certain age. Through ageism, younger people avoid the reality that they will get old. In the process, "the younger generations see older people as different from themselves; [and] thus they subtly cease to identify with their elders as human beings." This attitude may cause the elderly to be viewed as unimportant; consequently abuse is seen as less of a problem. The appearance and behavior of an elderly person "may be a stimulus for aggressive behavior on the part of others."

Negative attitudes toward the disabled may also contribute to elder abuse. Many elderly persons are disabled. Society views the disabled as unproductive and undesirable. These feelings have created a

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159. QUINN & TOMITA, supra note 8, at 28.
160. Id. at 29.
161. FLA. STAT. § 784.08 (1993).
162. Ageism is defined as "a process of systematic stereotyping of and discrimination against people because they are old." QUINN & TOMITA, supra note 8, at 82.
163. Id.; see also SPECIAL COMM. ON AGING, supra note 7, at 6.
164. QUINN & TOMITA, supra note 8, at 82.
165. Id.
166. Id.
167. Id.
168. Id.
169. QUINN & TOMITA, supra note 8, at 85.
170. Id.
171. Id.
172. Id.
"human propensity for hostility" towards handicapped people which may be based on "aversion and revulsion" as well as a fear of becoming disabled. 173

Greed is another societal attitude. 174 When a relative is caring for an elderly person, the caregiver may abuse the elder in hope that the elder will die, and the elder's inheritance will pass on to the caregiver. 175 This may also manifest itself if the caregiver misappropriates funds from the elder's accounts for the benefit of the caregiver. 176

C. Increased Victimization

In addition, legislation is necessary because elderly people are often the victims of crime and abuse. Most people expect perpetrators of crime to be strangers. 177 However, elder abuse by family members and caregivers has become widespread. 178 The Select Committee on Aging investigated the problem of elder abuse. 179 The Committee determined that the problem of elder abuse is "a full-scale, national epidemic which existed with a frequency few dared [to] imagine." 180 The Select Committee stated that elder abuse is "not limited to isolated cases of frail elders and their pathological offspring." 181 While abuse, neglect, and exploitation of the elderly may be prosecuted under the Adult Protective Services Act, it may also be prosecuted as a crime under section 784.08 if the abuse constitutes an assault or battery. 182

According to the National Crime Victimization Survey, elderly people, sixty-five years of age or older, are the "least likely of all age groups in the Nation to experience crime." 183 Younger people between the ages of

173. Id.
174. QUINN & TOMITA, supra note 8, at 89.
175. Id.
176. Id.
177. ELDERLY CRIME VICTIMS, supra note 142, at 2 (indicating that elderly violent crime victims are more likely than young victims to face attackers who are strangers to them).
178. QUINN & TOMITA, supra note 8, at ix.
179. SPECIAL COMM. ON AGING, supra note 7, at 4.
180. QUINN & TOMITA, supra note 8, at ix.
181. Quinn, supra note 9, at 202. "Abuse and neglect of the elderly are generally committed by those who are trusted by the elderly—family members mainly, but also lawyers, nurses, corner grocers, physicians, and bankers." Id.
182. FLA. STAT. §§ 415.111, 784.08 (1993).
183. ELDERLY CRIME VICTIMS, supra note 142, at 1.
twelve and twenty-four are most likely to be the victims of crime. In fact, the crime rates among the elderly have been declining over the years. However, these low figures are probably inaccurate because elderly people often do not report crimes committed against them. One study revealed forty-five percent of elderly crime victims did not report those crimes to the police. The Select Committee on Aging found that elder abuse is much less likely to be reported than child abuse, and eighty-two percent of all adult abuse cases which are reported annually involve an elderly victim.

Even though the statistics show the crime rate among elderly people is lower than other age groups, the statistics indicate the elderly fear crime the most. This belief has been called the "fear-victimization paradox." This fear of crime may cause elderly people to stay home where they are less likely to be the victims of crime. Thus, elders may be less victimized as a consequence of their fear.

In comparison to younger individuals, even though the elderly are less likely to be victims of violent crime, they still need special protection because the gravity of the consequences increases when they are victimized by violent crime. The National Crime Survey states that elderly victims are more likely than younger victims to sustain serious injuries from an attack. Older persons "suffer wounds, broken bones, and broken teeth less often than others, but they are more likely to receive internal injuries, to lose consciousness, and to suffer cuts and bruises." Elderly people, suffer more than just bruises from a fall because they usually are not in good physical shape; therefore, they need the special protection elder abuse statutes provide.

184. Id.
185. Id.
186. QUINN & TOMITA, supra note 8, at 10. Elder crime victims do not report crime committed against them because they do not want the public to know of their abuse, they are ashamed when the perpetrator is their child, and they may fear retaliation by the perpetrator in the form of increased abuse, while some believe they deserve the abuse. Id. at 10-11.
188. Quinn, supra note 9, at 203.
189. McGillicuddy, supra note 92, at 1171.
191. McGillicuddy, supra note 92, at 1172.
192. Quinn, supra note 9, at 155.
193. ELDERLY CRIME VICTIMS, supra note 142, at 2.
194. Quinn, supra note 9, at 155.
Increases in longevity and the elder population also illustrate the need for elder law statutes. In 1900, 895,000 people in the United States were age seventy-five and older. By 1980, there were 9,067,000 people over the age of seventy-four. In 1982, people aged seventy-five and older composed five percent of the population. By the year 2030, this percentage is expected to increase to ten percent. Accordingly, "[t]he incidence of elder abuse will increase given the rapidly growing numbers of frail old people in our society." 

V. MOVING TOWARD A SOLUTION

Legislatures need to devise adequate definitions of the terms "aged" and "elderly" to effectuate elder law statutes. This is evident by past holdings invalidating these statutes because they were void for vagueness. Specifying a minimum age alone is impracticable because it makes such a statute underinclusive. It excludes people who are under the minimum age, yet equally deserving of the law's protections. This applies particularly to people below age sixty-five who have aged beyond their years and are as vulnerable as people over sixty-five.

The Florida Legislature should not only specify a minimum age, such as sixty-five, but it should also allow the prosecution to show a victim under the age of sixty-five deserves special protection due to a disability or infirmity. Since the Florida Legislature passed section 784.08 with the purpose of protecting the elderly population from crime, the legislators should word the statute so that it protects the entire elder population.

The studies and statistics discussed in Part IV demonstrate that most abused elders are in poor physical or mental shape. Older people with bad health are more vulnerable to attack because they make easy targets. A person physically or mentally dependent on another, equivalent to that of a person sixty-five years or older, should receive the protections of section 784.08. Hence, the courts should decide whether a person under the statutory minimum age is similarly vulnerable to attack on a case by case basis. Physical and mental infirmities differ greatly from one person to the

195. QUINN & TOMITA, supra note 8, at 6.
196. Id.
197. Id.
198. Id.
199. Id.
200. QUINN & TOMITA, supra note 8, at 6.
201. See FLA. STAT. § 784.08 (1993).
202. Id.
next. Since people beneath the age of sixty-five may be as vulnerable to attack due to advanced aging, they too should be protected by the statute.

VI. CONCLUSION

The elderly need special protection against crime because they are vulnerable. As state legislatures draft laws giving the elderly special protection, the legislators must adequately define the terms “elderly” or “aged” so they are neither vague nor arbitrary. If this is not done, these laws, enacted to protect the elderly, will have no effect on crime. Statutes defining the elderly by a minimum age alone should not require the defendant to have knowledge of the victim’s age because an attack on such a vulnerable person is immoral and justifies the imposition of strict liability.

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I. INTRODUCTION

When you think about the famous comic strip, "Dennis the Menace" you quickly remember "poor old Mr. Wilson," the victim of constant torment by his young neighbor, Dennis Mitchell.1 Dennis always managed to do something to annoy his retired neighbor. But even grumpy old folks deserve peace and quiet every now and then, which is one reason why "adults-only" retirement communities have become so popular in America. The fictional Mr. Wilson is an ideal candidate for such a community because he would finally enjoy some peace and quiet. In fact, many older persons dream of retiring one day to a place where they can enjoy a more leisurely lifestyle, free from the worries of their younger days when they cared for their own children. As the large segment of the American

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1. Dennis Mitchell and Mr. Wilson are fictional cartoon characters created by Hank Ketcham. Dennis is a precocious child who is noted for constantly pestering his retired next door neighbor, Mr. Wilson.
population known as "baby boomers,"2 age, issues affecting the elderly will grab the attention of many people, including sociologists, politicians, and entrepreneurs. Catering to the needs of elders will not only be necessary due to the sheer number of baby boomers, but it also will become big business in America.3

One such elder need concerns housing; specifically, the issue of whether older persons can live in a community4 explicitly designed for them, exclusive of children. This is a heated issue because Congress eliminated “adults-only” communities when it passed the Fair Housing Amendments Act of 19885 (“FHA Act”). The United States Department of Housing and Urban Development (“HUD”) conducted public hearings across the country in the Fall of 1994 to solicit comments on their new proposals for redefining a segment of the FHA Act which deals with housing for older persons. The proposals are an effort to prohibit discrimination against families with children while preserving retirement communities.6

Under the FHA Act, condominium, mobile home and single family home owners and renters who prefer to live in an all-adult community may no longer legally do so unless the community qualifies as “housing for older persons” which is exempted under the FHA Act.7 Senator Orrin Hatch, one of three sponsors of the FHA Act, voiced his concern that many elderly

2. “Baby Boomer” is defined as “a person born as a result of the baby boom, a sharp increase in the birth rate which occurred in the US at the end of the Second World War and lasted until the mid sixties.” THE OXFORD DICTIONARY OF NEW WORDS 40 (1991).
3. As two writers observed, baby boomers are among the 72 million Americans born between 1946 and 1964. They wrote, “[t]he boomer group is so huge that it tends to define every era it passes through, forcing society to accommodate its moods and dimensions.” David M. Gross & Sophronia Scott, Proceeding With Caution; The Twentysomething Generation is Balking at Work, Marriage and Baby-Boomer Values. Why are Today’s Young Adults So Skeptical?, TIME, July 16, 1990, at 56, 57.
4. For the purposes of this note, the word “community” will sometimes be used to describe any of the following housing arrangements: condominiums, town homes, patio homes, cluster homes, single-family detached homes, manufactured homes, mobile homes, rental apartments, and rental homes.
6. The housing for older persons exemption requires the existence of significant facilities and services specifically designed for older persons if the housing is intended for persons 55 and older. The definition of “significant facilities” is being revised by HUD. See 59 Fed. Reg. 34,902 (1994) (to be codified at 24 C.F.R. § 100.304). This aspect of the housing for older persons exemption is the focus of this note. See discussion infra part II.
people may not realize this law allows families with children to move into communities formerly classified as adults-only communities. Although the exemption exists, it is rather narrow, and as many communities discover after engaging in costly litigation, the statute is also narrowly construed. Consequently, the exemption as applied may not be what it purports to be as written. Meeting the requirements of the exemption can be tricky, if not impossible.

There are three different ways a community may qualify for the exemption. Unless the community can meet the criteria established under one of these methods, it cannot discriminate against families with children. In other words, without a bona fide exemption, families with children must be allowed to rent or own in the housing community. Persons with children are called persons with "familial status" which simply means that they live with children under the age of eighteen. In addition to the familial status provisions, the FHA Act provides greater housing opportunities for handicapped persons by prohibiting discrimination against them. The FHA Act also adds stronger enforcement provisions which were absent from the 1968 Act. Furthermore, the FHA Act creates procedural choices that enable the aggrieved parties to be heard. For example, in addition to bringing suit in the state or federal district court, plaintiffs may

10. See discussion infra part II.
11. The language of the statute leaves little doubt about whether the adults-only housing is allowed. "[I]t shall be unlawful—(a) [t]o refuse to sell or rent... or otherwise make unavailable or deny, a dwelling to any person because of... familial status..." 42 U.S.C. § 3604(a) (1988); see also id. § 3604(b) (making it unlawful to discriminate against anyone based upon, inter alia, familial status).
12. "Familial status" is defined as:

[O]ne or more individuals (who have not attained the age of 18 years) being domiciled with — (1) a parent or another person having legal custody of such individual or individuals; or (2) the designee of such parent or other person having such custody, with the written permission of such parent or other person. Id. § 3602(k)(1)-(2) (1988).
seek relief from an Administrative Law Judge ("ALJ") through HUD.  

Decisions rendered by ALJs are often more helpful than those of district court judges because the Administrative Procedures Act, which created ALJs, requires the ALJ to support all findings and conclusions of law with detailed explanations. The judge's decision is reviewable by the Secretary of HUD or the appropriate federal court of appeals. An ALJ is bound by his or her agency's published rules, and the ALJ's decision could be overturned on appeal if there is no substantial evidence to support his or her ruling. The ALJ may grant relief by awarding actual damages, injunctive or equitable relief, and/or a civil penalty to "vindicate the public interest." When litigation costs are added to the damages and civil penalties, a community can easily be required to pay more than $50,000 to defend a challenge to its claimed exemption. As a result, any community that believes it qualifies for an exemption must be certain all of the requirements are met, otherwise it may face financial peril. Many communities, especially mobile home parks, do not have large cash reserves on hand to defend against such a challenge.

15. Id. at 6. The Administrative Procedures Act created essentially a "fourth branch" of government in order to ensure proper adjudication in administrative proceedings. Id. at 4. This note involves an analysis of the federal housing law; therefore, it will not discuss the various state fair housing laws.

16. Id. at 5.


19. Id. at 7 (citing 42 U.S.C. § 3612 (g)(3) (1988)).

20. See, e.g., Secretary, United States Dep't of HUD ex rel. Fallon v. Murphy, Fair Housing-Fair Lending (P-H) ¶¶ 25,002, nos. 02-89-0202-1, 02-89-0203-1, 02-89-0204-1, 02-89-0205-1, 02-89-0206-1, 02-89-0209-1, 02-89-0212-1, 02-89-0213-1, 02-89-0243-1, 1990 WL 456962, at *52 (H.U.D.A.L.J. July 13, 1990). In Murphy, the ALJ assessed a civil penalty of $2,000. Id. at *51. HUD was financially unsuccessful because it sought $362,976 in damages and civil penalties for the plaintiffs it represented, while the ALJ awarded them only $4338.00. Id. at *44-49. The ALJ's authority to impose the civil penalty is found at 42 U.S.C. § 3613(c) (1988).

21. In Washington, a jury awarded $2,000,000 in punitive damages and $415,000 in compensatory damages to one person and two fair housing organizations in a familial status discrimination case dealing with renters. See Schwemm, supra note 17, at 759.

22. For example, in a New Jersey case, a mobile home park was challenged under the FHA Act because of discrimination against persons with familial status. Murphy, 1990 WL 456962, at *1. The park charged $175 to $205.43 per month for rent for each of its 178 mobile home lots. It claimed to have operating expenses of $328,674.00 annually. The yearly expense per lot was $1846.48. Id. at *12. The park lost the lawsuit and paid damages of $7750, plus civil penalties of $2000. Id. at *47-49, *52. When attorneys' fees and costs
This note examines the housing for older persons exemption in the FHA Act. Specifically, it studies the “significant facilities and services incurred by the park are added to these figures it probably cost them more than $15,000 to defend one lawsuit. Additionally, the park was required to stop advertising as “adults only” and because it did not qualify for the housing for older persons exemption, it had to allow families with children to buy or rent in the park. Id. at *53-54. Imagine the problems this creates for the older residents living in the park. While here, the park may be able to fund its legal expenses from lot rents collected, if it cannot do so, it may have to create a special assessment for its residents. Also, if the by-laws make no provision for special assessments, the park would incur more legal fees to amend the by-laws to provide for special assessments. The end result is increased expenses for older persons who are probably on fixed incomes to begin with, as well as less money available to fund social and recreational facilities for residents.


(b)(1) Nothing in this subchapter limits the applicability of any reasonable local, State, or Federal restrictions regarding the maximum number of occupants permitted to occupy a dwelling. Nor does any provision in this subchapter regarding familial status apply with respect to housing for older persons.

(2) As used in this subsection, “housing for older persons” means housing —

(A) provided under any State or Federal program that the Secretary determines is specifically designed and operated to assist elderly persons (as defined in the State or Federal program); or

(B) intended for, and solely occupied by, persons 62 years of age or older; or

(C) intended and operated for occupancy by at least one person 55 years of age or older per unit. In determining whether housing qualifies as housing for older persons under this subsection, the Secretary shall develop regulations which require at least the following factors:

(i) the existence of significant facilities and services specifically designed to meet the physical or social needs of older persons, or if the provision of such facilities and services is not practicable, that such housing is necessary to provide important housing opportunities for older persons; and

(ii) that at least 80 percent of the units are occupied by at least one person 55 years of age or older per unit; and

(iii) the publication of, and adherence to, policies and procedures which demonstrate an intent by the owner or manager to provide housing for persons 55 years of age or older.

(3) Housing shall not fail to meet the requirements for housing for older persons by reason of:

(A) persons residing in such housing as of September 13, 1988, who do not meet the age requirements of subsections (2)(B) or (C): Provided, That new occupants of such housing meet the age requirements of subsection (2)(B) or (C); or
specifically designed to meet the . . . needs of older persons” requirement from the community’s viewpoint.24 This note attempts to answer the questions: What does this requirement mean? What does the court look for in order to determine that a community meets the exemption? What happens to a community that fails to qualify? Can a community qualify for the exemption if it was not originally designed to provide housing for older persons? Have the courts upheld the legislative intent of the exemption?25

The requirement of “significant facilities for older persons” set forth in the FHA Act is not clearly and specifically defined, and the examples provided by HUD in the Code of Federal Regulations are equally ambiguous.26 Additionally, the legislative history is not extensive, nor does it provide guidance with regard to legislative intent.27 As a result, communities must basically invite litigation in order to determine if they qualify for the exemption.28

(B) unoccupied units: Provided, That such units are reserved for occupancy by persons who meet the age requirements of subsection (2)(B) or (C).

Id. (emphasis added).

25. For example, in the Senate hearings on this legislation, one of its sponsors, Senator Edward M. Kennedy, specifically stated that the bill resolves the problems caused by discrimination against children, while at the same time protects the legitimate desire of older Americans to live in retirement oriented communities. 134 CONG. REC. at S 10,455 (daily ed. Aug. 1, 1988). During the Senate debate on the bill, Senator McCain said, “we must make absolutely sure that in our effort to provide such protection, we do not impinge upon the right of older Americans to enjoy peace and quiet in their retirement years within communities established for that purpose.” Id. at S10,551 (daily ed. Aug. 2, 1988).
26. The Secretary of Housing and Urban Development (“the Secretary”) defines “significant facilities” in the Code of Federal Regulations as including, but not limited to: [S]ocial and recreational programs, continuing education, information and counseling, recreational, homemaker, outside maintenance and referral services, an accessible physical environment, emergency and preventive health care of [sic] programs, congregate dining facilities, transportation to facilitate access to social services, and services designed to encourage and assist residents to use the services and facilities available to them . . . .
24 C.F.R. § 100.304(b)(1) (1993); see also Mark B. Schorr, The Federal Fair Housing Amendments Act of 1988 . . . And its Effect on “Adult-Only” Housing for Florida’s Older Residents, 63 FLA. B.J. 11, 13 (1989) (arguing that the term “significant facilities” is vague, and as a result causes needless litigation).
27. ROBERT G. SCHWEMM, HOUSING DISCRIMINATION LAW AND LITIGATION § 11.6(2)(a), at 11-67 (1993).
28. A Fort Lauderdale attorney, Mark B. Schorr, argued to the Court of Appeals for the Eleventh Circuit that the statute is unconstitutionally vague because the “significant facilities” provision is not clearly defined and there is no way a community can comply with the law.
The Court of Appeals for the Eleventh Circuit addressed the issue of vagueness regarding the interpretation of the exemption in *Seniors Civil Liberties Ass'n v. Kemp.* The court determined that the statute was not unconstitutionally void for vagueness because "a person of reasonable intelligence could easily derive the Act's core meaning and glean sufficient information to allow that reasonably intelligent person to conform to the statutory requirements." However, the decision in *Seniors* did not end the "significant facilities" debate. Some believe the requirement of services and facilities aimed at older persons set forth in the FHA Act could use more clarification. After examining the housing for older persons exemption, this note proposes a solution that should be efficient, inexpensive (compared to the costs of litigation), and fair to both sides, that is, families with children as well as older persons.

Part Two of this note describes the available exemptions pertaining to housing for older persons and briefly discusses the legislative intent behind the law. Part Three reviews South Florida cases, as well as cases from other states, focusing on the basis for the challenges, the arguments made, and the decisions which construe the exemption in order to examine how courts interpret the "significant facilities" requirement. Part Four examines the courts' main concern in familial status discrimination cases dealing with housing for older persons: using a pretext to qualify for the exemption. In other words, how can a community prove it is legitimately committed to providing housing for older persons? Part Four also provides a road map for communities to follow which should help them qualify for the exemption. Finally, this note concludes by suggesting that a certification procedure should be established by HUD to deal with the housing for older persons issue because the so-called flexible "significant facilities" definition

in good faith while seeking to qualify for the housing for older persons exemption; therefore, the statute violates the due process provision of the Fourteenth Amendment of the United States Constitution. *Seniors Civil Liberties Ass'n v. Kemp,* 761 F. Supp. 1528, 1551 (M.D. Fla. 1991), aff'd per curiam, 965 F.2d 1030 (11th Cir. 1992).

29. 965 F.2d 1030 (11th Cir. 1992).

30. Id. at 1036.

31. For example, the previous president of the Broward County Human Rights Board believes that the Human Rights Board should counsel communities to ensure the facilities provided are proper and sufficient to qualify for the exemption. However, his suggestion was not welcome by the board because the board perceives its role as the protector of persons with "familial status," not as the advisor to communities designed for older persons. Interview with Paul R Joseph, Esq., Professor of Law at Nova Southeastern University, Shepard Broad Law Center, in Ft. Lauderdale, Fla. (July 28, 1994).
is not workable. The recent hearings across the country held by HUD which involved discussing the proposed regulations is indicative of the inadequacy of the definition. A certification program should eliminate wasteful litigation for the plaintiffs, HUD, and the community over the interpretation of "significant facilities," while at the same time it will provide peace of mind for older persons and protect families from the trauma of litigation. Through the certification process, a community can form a partnership with HUD to ensure compliance and equal housing opportunities for everyone.

II. The Housing for Older Persons Exemption

Before discussing the housing for older persons exemption, it is important to briefly explain the purpose of the law to which it applies. The FHA Act came about because throughout the 1970s, families with children were finding it increasingly difficult, if not impossible, to find housing due to blatant discrimination against them. Beyond mere invidious discrimination against children, other factors contributed to the problem. One writer suggests that a combination of factors, such as marketplace demands for "singles-only" apartment complexes, rising interest rates for home mortgages, runaway inflation, and a decrease in the demand for larger units, brought

32. The new language of the definition will replace the word "especially" with the word "specifically" when describing significant facilities for older persons. See 59 Fed. Reg. 34,902 (1994) (to be codified at 24 C.F.R. § 100.304). HUD continues to support its vague definition of "significant facilities" by insisting that:

[A] single, precise, mathematical-like standard that fully implements the Act is not possible, nor may it be equitable.

As a result, the Department has concluded that a flexible standard is necessary in order to reflect regional variations in services and facilities that distinguish housing for older persons from other similar housing, as well variations determined by the geography of the site or by the differences in the nature or cost of the housing in question. To do otherwise could unnecessarily restrict housing opportunities for older persons by holding all housing to a single arbitrary standard that was not intended by the framers of the Act.

Id. at 34,903. HUD has not changed its tune since it first issued regulations defining "significant facilities." See, e.g., 54 Fed. Reg. 3256 (1989) (explaining that HUD believes geographic location plays a role in determining significant facilities).

33. See 59 Fed. Reg. 40,502 (1994). The first hearing was held August 15, 1994 in Fontana, California, and the second hearing was held August 25, 1994 in Tampa, Florida. The third hearing was held on September 29, 1994 in Phoenix, Arizona and the fourth was held on October 6, 1994 in Washington, D.C. Id.

about many of the problems families faced in obtaining housing in the 1970s. Eventually, families with children who could not afford to buy a home often found themselves homeless. They were unable to rent an apartment, mobile home, condominium, or single family home because such residences were located in "adults-only" communities. Members of Congress could not ignore demands for relief made by their constituents; consequently, Senators Edward M. Kennedy, Arlen Specter, and Orrin Hatch sponsored the Fair Housing Amendments Act of 1988 in an effort to resolve the crisis.

Congress found its authority for enacting this piece of legislation in the Commerce Clause of the United States Constitution. The Supreme Court noted Congress' broad authority under the Commerce Clause in *Heart of Atlanta Motel, Inc., v. United States*. The Court held it unlawful to refuse to accommodate non-white guests at a motel and such a refusal interfered with interstate commerce because most guests traveled from out-of-state to use the motel facilities. The Court reasoned that the Commerce Clause is the appropriate vehicle because "racial discrimination in public accommodations burdened interstate commerce by hindering the interstate mobility of the populace; such discrimination making transient accommodations unavailable discouraged certain persons from interstate travel." This same reasoning is applied to the FHA Act because the American population is mobile and the ability for people, especially families with children, to find housing is essential for commerce to continue unrestrained. As a result of this reasoning, Congress provided in the FHA Act of 1988 that it is unlawful to "discriminate against any person... because of... familial status...." The only exception is housing for older persons.

35. *Id.* at 395-96. Wolff's article posits that the FHA Act of 1988 misses the mark because the real cause of the housing shortage for families with children is economics, not discrimination. His article examines the economics of housing and concludes by stating the problem is that developers find it financially unrewarding to build units large enough for families and it is more lucrative to meet the housing demands for the singles market and childless couples of all ages. *Id.*


37. U.S. CONST. art. I, § 8, cl. 3.


39. Wolff, * supra* note 34, at 401-02 (citing *Heart of Atlanta*, 379 U.S. at 249-51).

40. *Id.* at 402 (citing *Heart of Atlanta*, 379 U.S. at 252-53).

41. See, e.g., *id.*

42. 42 U.S.C. § 3604(b) (1988).
Because older persons have special needs and many prefer to live their later years in peaceful surroundings without the distractions of children, Congress carved out an exception.\textsuperscript{43} It should be noted that the FHA Act is designed to promote housing opportunities for families and not to provide special protection for older persons' housing. This is important to remember when reviewing ALJ and court decisions regarding this exemption because the courts narrowly construe it, lest the exemption swallow the rule and put families back in the same place they were prior to 1988. Although provisions exist in the law for a housing community to qualify as housing for older persons and thus be exempt from the prohibition concerning familial status, meeting the requirements for the exemption is not easy.

The exemption for housing for older persons can be met three different ways: HUD housing,\textsuperscript{44} housing "intended for, and solely occupied by, persons 62 years of age or older,"\textsuperscript{45} or housing "intended and operated for occupancy by at least one person 55 years of age or older per unit."\textsuperscript{46} The statute provides that the Secretary of Housing and Urban Development ("the Secretary") shall determine what type of housing qualifies as housing for older persons.\textsuperscript{47} In order to do this, the Secretary developed regulations which require at least the following:

(i) the existence of significant facilities and services specifically designed to meet the physical or social needs of older persons, or if the provision of such facilities and services is not practicable, that such housing is necessary to provide important housing opportunities for older persons; and (ii) that at least 80 percent of the units are occupied by at least one person 55 years of age or older per unit; and (iii) the publication of, and adherence to, policies and procedures which demonstrate an intent by the owner or manager to provide housing for persons 55 years of age or older.\textsuperscript{48}

The statute also provides a grandfather clause for those residing in such facilities as of September 13, 1988 so that communities which had persons

\textsuperscript{44} 42 U.S.C. § 3607 (b)(2)(A) (1988 & Supp. IV 1992). This subsection provides: "[Housing] provided under any State or Federal program that the Secretary determines is specifically designed and operated to assist elderly persons (as defined in the State or Federal program) . . . ." Id.
\textsuperscript{45} Id. § 3607(b)(2)(B).
\textsuperscript{46} Id. § 3607(b)(2)(C).
\textsuperscript{47} Id.
younger than fifty-five or sixty-two years of age as of that date will not be disqualified, nor will younger persons be forced to relocate. Also, units unoccupied as of September 13, 1988 must be reserved for persons meeting the age requirements. The statute further provides that the Secretary shall create rules defining the term "significant facilities and services especially designed to meet the physical and social needs of older persons." The rules implemented by the Secretary are the basis for the judicial determination of whether the housing community qualifies for the exemption. Case law indicates many communities misinterpret the exemption requirements.

III. CONCERN OVER PRETEXT: A LOOK AT CASES AND CONTROVERSIES

A. An Overview

As mentioned in the introduction, aggrieved persons, HUD, the Attorney General, or senior citizen organizations may bring an action

49. Id. § 3607 (b)(3)(A).
50. Id. § 3607 (b)(3)(B).
51. 42 U.S.C.A. § 3607 note (West Supp. 1994) (Regulations Clarifying the Term "Housing for Older Persons"). The Secretary of HUD shall "make rules defining . . . significant facilities."
52. For clarification purposes, it is important to state what section of the law this note does not address. This note will not discuss HUD sponsored housing or the exemption for persons aged 62 or older. HUD sponsored housing could be an article in itself and is beyond the scope of this note. The housing for persons aged 62 and older is not in dispute: either all residents of the community are aged 62 or older, or the community is not exempt. If one person under aged 62 becomes a permanent resident of such a community, it loses its exemption. 134 CONG. REC. S10,456 (daily ed. Aug. 1, 1988) (memorandum of Sen. Kennedy and Sen. Specter describing modifications to the bill). These two provisions shall therefore not be discussed in this note. The third provision is the focus of this note because it causes most of the litigation: How can a community qualify as housing for older persons when 80% of the community is aged 55 or older? Many lay people serving on the various condominium, homeowner association, or mobile home community boards often misinterpret this provision of the statute to their own detriment. Although not all cases deal with familial status discrimination, HUD processed a total of 6104 cases in 1991. See Schwemm, supra note 17, at 768. Examination of case law can provide some insight.
53. 42 U.S.C. § 3613(a)(1)(A) (1988); see id. § 3602(f). An "aggrieved person" is, "any person who—(1) claims to have been injured by a discriminatory housing practice; or (2) believes that such person will be injured by a discriminatory housing practice that is about to occur." 42 U.S.C. § 3602(f) (1988).
54. Id. § 3612(a)-(p).
55. Id. § 3614(a)-(c).
56. See, e.g., Seniors, 761 F. Supp. at 1528.
in either the United States District Court or before a HUD ALJ. Most cases go to an ALJ because it is generally thought to be a more efficient resolution. The ALJ system is comparable to a bench trial. The money awards for tangible damages can amount to several thousand dollars. Other reimbursable expenses include alternative housing, emotional distress, embarrassment, humiliation, inconvenience, lost housing opportunity, and loss of civil rights. In assessing damages for emotional distress, the ALJ has broad discretion. For example, "humiliation can be inferred from the circumstances, as well as established by testimony." Lastly, the ALJ may award punitive damages in order to "vindicate the public interest." Thus, the exposure for communities far exceeds a few hundred dollars, and when defense costs are added to damage awards, the costs can run into hundreds of thousands of dollars. Many communities can ill-afford this. An ALJ recognized this problem in a recent case, stating that a civil penalty will not be imposed if the community could prove the penalty would cause it undue hardship.

B. HUD v. Nelson

The Nelson case is an ALJ decision from South Florida. In addition to paying actual damages to the plaintiff and compensating her for

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57. See Schwemm, supra note 17, at 749.
59. Id. at 6-7. The Federal Rules of Evidence apply in these proceedings and a full range of discovery tools are available to an aggrieved party. Additionally, punitive damages, injunctive, and other equitable relief can be ordered by the ALJ.
60. Id. at 9.
61. Id. at 12.
62. Id. at 17.
64. Id. at 25.
65. Id. at 26.
69. Id.
70. The defendant is a mobile home park located in Miami, Florida. The ALJ decisions are available in print through the Prentice-Hall publication, "Fair Housing-Fair Lending," Volume 2, and on-line through the WESTLAW "Fairhous" database.
emotional distress, the community also assessed a civil penalty of $5000.\textsuperscript{71} In Nelson, the ALJ found a mobile home park’s allegation that it qualified as housing for older persons to be a mere pretext for “adults-only” housing.\textsuperscript{72} The court said in order to qualify for the exemption under the FHA Act, the housing community must demonstrate, among other things, “that it provided significant facilities and services specifically designed to meet the physical or social needs of older persons.”\textsuperscript{73} Such facilities must demonstrate the housing community’s bona fide commitment to the “special needs of older persons.”\textsuperscript{74} In order to satisfy this requirement, a community must prove: it has significant number of facilities and services; the facilities and services are designed, built and adapted for easy use by infirm or handicapped; and older persons make significant use of such facilities.\textsuperscript{75} The judge also looked to the Code of Federal Regulations for guidance.\textsuperscript{76} The only facilities the housing community provided were a clubhouse and a

\begin{footnotes}
\item 72. Id. at *13.
\item 73. Id. at *6. (citing HUD. v. Murphy, 2 Fair Housing-Fair Lending (P-H) ¶ 25,002, at 25,043-44 (H.U.D.A.L.J. July 13, 1990)). The Nelson court correctly noted that once the charging party proves, by a preponderance of the evidence, that it has been discriminated against, the burden shifts to the respondent to prove, by a preponderance of the evidence, that it qualifies for the exemption for housing for older persons. Id. at *5.
\item 74. Id. at *6 (citing United States v. Keck, 2 Fair Housing-Fair Lending (P-H) ¶ 15,673, at 16,446 (W.D. Wash. Nov. 15, 1990)).
\item 75. Nelson, 1993 WL 498882, at *6. (citing Secretary, United States Dep’t of HUD ex rel. Lawson v. TEMS Ass’n, 2 Fair Housing-Fair Lending (P-H), ¶ 25,028, at 25,308-09 (H.U.D.A.L.J. Apr. 9, 1992). TEMS furnished many services and facilities such as: [A] pool, six shuffleboard courts, a horse shoe court and picnic area. The clubhouse included a card room, television, library, and restroom facility with handicap railings. Services included continuing education courses, guest speakers, weekly transportation to a shopping center, coordinated nursing services, arts and crafts, out-of-town trips, and a newsletter. Id. at n.15. Interestingly enough, they were not sufficient to satisfy the “significant facilities and services” test.
\item 76. The court cited 24 C.F.R. § 100.304(b)(1) (1993). This regulation provides that: “Significant facilities and services specifically designed to meet the physical or social needs of older persons” include, but are not limited to, social and recreational programs, continuing education, information and counseling, recreational, homemaker, outside maintenance and referral services, an accessible physical environment, emergency and preventive health care of . . . programs, congregate dining facilities, transportation to facilitate access to social services, and services designed to encourage and assist residents to use the services and facilities available to them (the housing facility need not have all of these features to qualify for the exemption under this subparagraph) . . .
\end{footnotes}
petanque court. The community sporadically sponsored social events, it
provided a 911 emergency hotline, and for a fee, residents could hire a
handyman for odd jobs. Also, the community assisted residents in
contacting the county “Meals on Wheels” program and the manager was
available twenty-four hours per day. But the community itself provided
no other services or facilities specifically designed for older persons.

More importantly, the judge highlighted what the community was
missing: recreational services, continuing education programs, and
informational services. Essentially, of all the examples of services and
facilities listed by HUD in the Code of Federal Regulations, none were
present in the Nelson Mobile Home Park community. The judge found
that no provisions for easy access for persons in wheelchairs existed, except
that the clubhouse was wheelchair accessible; however, it was not air-
conditioned. In fact, any other services the mobile home park provided
such as common area maintenance, and a community bulletin board, are
services any landlord would provide tenants and not services or facilities
specifically designed for older persons.

The ALJ also examined the FHA Act 1988 provision which states that,
where a community has been unable to satisfy the significant facilities test,
it may still legitimately claim the exemption for housing for older persons
if it meets the “practicability” and “important opportunity” tests. This
alternative is to be used in special circumstances and should be narrowly
applied. HUD outlined seven factors which satisfy this test:

(i) Whether the owner or manager of the housing facility has endeav-
ored to provide significant facilities and services designed to meet the
physical or social needs of older persons either by the owner or by
some other entity. Demonstrating that such services and facilities are
expensive to provide is not alone sufficient to demonstrate that the
provision of such services is not practicable.
(ii) The amount of rent charged, if the dwellings are rented, or the
price of the dwellings, if they are offered for sale.

77. Petanque is a form of lawn bowling.
79. Id.
80. Id.
81. Id.
82. Id.
(iii) The income range of the residents of the housing facility.
(iv) The demand for housing for older persons in the relevant geographic area.
(v) The range of housing choices for older persons within the relevant geographic area.
(vi) The availability of other similarly priced housing for older persons in the relevant geographic area. If similarly priced housing for older persons with significant facilities and services is reasonably available in the relevant geographic area then the housing facility does not meet the requirements of this paragraph (b)(2) of this section.
(vii) The vacancy rate of the housing facility.85

The judge applied each factor to the mobile home park, and concluded that it made no attempt to prove it could satisfy any of the seven factors listed.86 Furthermore, the park could not demonstrate by reliable, verified proof that eighty percent of its residents were fifty-five years of age or older.87

The third test, publication and adherence to policies and procedures, was also not met in this case. Six factors determine if this requirement is met:

(1) written rules and regulations; (2) the manner in which the housing is described to prospective residents; (3) the nature of the advertising; (4) age verification procedures; (5) lease provisions; and (6) the actual practices of the owner or manager in enforcing relevant lease provisions and relevant rules and regulations.88

The judge stated that the community demonstrated a commitment to excluding children but not a commitment to promoting itself as housing for older persons. The judge concluded that the housing community here violated the FHA Act by discriminating against persons with familial status because it refused to allow such persons to own or rent there.89 Additionally, the defendant housing community failed to demonstrate that it could qualify for the exemption because it provided housing for older persons. Because Ms. Hernandez, the plaintiff, demonstrated through testimony and medical records, that she suffered emotional distress from the incident, she

87. Id. at *9.
88. Id. (citing 24 C.F.R. § 100.304(c)(2) (1993)).
was awarded $30,000. Justifying the large damage award to Ms. Hernandez, the judge said she was an "eggshell plaintiff."

In order to "vindicate the public interest," the defendant was assessed a civil penalty which was significant due to its impudent violation of the law. The purpose of imposing such a penalty is to send the message to housing providers that they cannot assert a mere pretext and expect to get away with it. The maximum civil penalty is $10,000. Since the community had no prior violations of this nature, the judge set the civil penalty at $5000.

Finally, the ALJ enjoined the community from further discriminating against persons with familial status and/or harassing anyone because of his or her status as well as other injunctive and equitable relief available, such as removing "adults only" signs from the Park. In total, the community paid $35,000 in damages and penalties, plus its own attorneys' fees and other legal defense costs. This amount exceeds the monthly gross income from lot renters. A small mobile home park can ill-afford to fight challenges such as this one.

This case raises an interesting point: if a mobile home park cannot provide enough significant services and facilities to qualify for the exemption, perhaps it should reconsider its decision regarding families with children. After all, if the community cannot afford to provide facilities and services for older persons, it certainly cannot afford to pay attorney's fees, civil penalties, and large damage awards. On the other hand, a community should know up front whether or not it can qualify for the exemption without waiting to be sued. For example, in another South Florida case,

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90. Id. at *11, *13.
91. Id. at *13.
92. 42 U.S.C. § 3612(g)(3) (1988). The first offense can bring a $10,000 fine. Id. § 3612(g)(3)(A). The second offense within a five year period can trigger up to $25,000. Id. § 3612(g)(3)(B). If the housing community commits "[two] or more discriminatory housing practices during the 7-year period" a fine up to $50,000 may be imposed. Id. § 3612(g)-(3)(C).
94. Id. at *14.
97. Id.
98. Id. at *16.
99. Nelson Mobile Home Park has 149 lots which, if all rented for $170 each, would gross $25,330 per month. The park rented the lots in 1990 for $170 each. Id. at *8.
Massaro v. Mainlands Section 1 and 2 Civic Ass'n, the plaintiffs appealed to the Eleventh Circuit Court of Appeals concerning the publication requirement in the FHA Act.

C. Massaro v. Mainlands

The Mainlands is a community of 529 single family homes located in Tamarac, a city just north of Fort Lauderdale, Florida. The case arose in the United States District Court for the Southern District of Florida, where the judge decided the case in favor of the Mainlands. In overturning the district court, the United States Court of Appeals for the Eleventh Circuit reviewed the publication requirement of the statutory three-prong test to determine if the Mainlands properly met this requirement. For purposes of the appeal, the parties stipulated that the Mainlands met the significant facilities test.

The Mainlands attempted to amend its by-laws retroactively to limit residency to persons aged fifty-five or older. This attempt was done after the discriminatory action was commenced against the Massaros. The court specifically recognized that communities which had “adults only” policies prior to the effective date of the FHA Act could qualify for the exemption if they did so “in a manner [consistent] with the act.” But the Mainlands failed to correctly publish its policies and procedures in accordance with the FHA Act. This case is an example of “too little, too late” because, had the Mainlands properly amended its by-laws when the new law became effective, which was also prior to it taking action against the Massaros, the Mainlands would have had a stronger case and may have prevailed. Finding the trial court’s decision clearly erroneous, the Court of Appeals for the Eleventh Circuit reversed and remanded the case for further

101. 3 F.3d 1472 (11th Cir. 1993), cert. denied, 115 S. Ct. 56 (1994) (consolidating two cases, Massaro v. Mainlands and Mirabile v. Mainlands). The association attempted to amend its by-laws retroactively in a manner contra to the voting requirements provided in its by-laws. Id. at 1475.
102. Id. at 1474.
103. See Massaro v. Mainlands Section 1 and 2 Civic Ass'n, 796 F. Supp. 1499, 1500 (S.D. Fla. 1992), rev'd, 3 F.3d 1472 (11th Cir. 1993), cert. denied, 115 S. Ct. 56 (1994).
104. 42 U.S.C. § 3607(b)(2)(c)(iii) (1988) (providing that the community publish and adhere to “policies and procedures which demonstrate an intent by the owner or manager to provide housing for persons 55 years of age or older”).
105. Massaro, 3 F.3d at 1474 n.1.
106. Id. at 1479.
proceedings. The Mainlands asked the United States Supreme Court to hear its appeal, but, as the Massaro’s attorney correctly predicted, the Court denied certiorari.

D. United States v. Keck

In another mobile home park case, the United States District Court for the Western District of Washington heard a case where the defendant park attempted to evict a family because it provided housing for older persons and therefore believed it could force the family to leave. Like the court in Nelson, the court in Keck noted that the park failed to demonstrate that it provided significant facilities to meet the special needs of older persons and it failed to solicit outside organizations to provide services. The park also did not meet the eighty percent residency requirement for persons aged fifty-five or older. In examining the list of examples of significant facilities or services developed by HUD, the court commented that, “[a]lthough the examples in the regulations are not exclusive, a housing provider must offer its tenants a package of facilities and services that indicates a genuine commitment to serving the special needs of older persons.” In fact, the community presented “no objective evidence that [it] provides facilities or services tailored to meet these needs.” The only services it provided were those any landlord would provide any tenant: routine park maintenance, cable television, a newsletter, a laundry room, and so forth.

108. Id. at 1482.
109. Interview with Michael R. Masinter, Esq., Professor of Law at Nova Southeastern University, Shepard Broad Law Center, in Ft. Lauderdale, Fla. (July 14, 1994).
110. United States v. Keck, No. C89-1664C, 1990 U.S. Dist. LEXIS 19309 (W.D. Wash. Nov. 15, 1990). The list of significant facilities provided by HUD in the Code of Federal Regulations was reviewed here by the court and the park was found wanting because no sidewalks exist in the park and it provides no maintenance or repair services for its residents. Id. at *7. For the list of items provided in the Code of Federal Regulations see supra note 76.
113. Id. at *6-7.
114. Id. at *14; accord Park Place, 773 F. Supp. at 51.
116. Id. at *7; cf. Lanier v. Fairfield Communities, Inc., 776 F. Supp. 1533 (M.D. Fla. 1990) (holding that single family home community did not qualify as housing for older persons). The community in Lanier is called “Pointe Alexis” and is located in Pinellas County, Florida. The court did not address “significant” because no facilities were provided.
The community also alleged that it qualified for the exemption because it provided important housing opportunities for older persons and was exempt under the FHA Act. The community failed to convince the court it met this provision of the exemption, however, mainly because of two factors: there was no waiting list for the park and a high vacancy rate indicated low demand for such housing. Essentially, the park provided no independent and objective evidence that providing such facilities is impracticable as required by section 3607(b)(2)(C)(i) of the FHA Act of 1988.

Finally, due process, equal protection, and vagueness arguments were raised by the park and rejected by the court because no suspect class or fundamental right was involved. The judge ordered the park to pay the family $8032 compensation for financial loss and emotional distress, to institute a new policy allowing families with children to reside in the park, and to report to HUD on a regular basis. The Keck case stressed the requirement that the community provide "independent and objective evidence" to support its claim for the exemption. The Keck court reiterated that a community cannot merely label itself "housing for older persons;" it also bears the burden of demonstrating that it is really committed to providing housing opportunities for older persons. Once again, the court demonstrated its concern that the housing community was using the housing for older persons exemption as a pretext for the illegal "adults-only" housing.

Additionally, the court noted that the homes in Pointe Alexis had stairways inside and outside; there were no rear exits in the homes; the sidewalks were too narrow to accommodate wheelchairs; there were no benches provided except on the tennis courts; no handrails, ramps, or extra-wide doorways were provided in the common areas. Furthermore, Pointe Alexis is located two miles from the nearest shopping center, and medical, social, and recreational services. The community provided no congregate dining facility, no health facilities, no transportation, and no social events other than those provided ad hoc by the residents. Id. at 1536-37.

117. Keck, 1990 U.S. Dist. LEXIS 19309, at *15. See, e.g., 42 U.S.C. § 3607(b)-(2)(C)(i) (1988) (stating "if the provision of such facilities and services is not practicable, that such housing is necessary to provide important housing opportunities for older persons . . . ").
121. Id. at *16.
122. Id. at *10-11, *14.
E. Park Place Home Brokers v. P-K Mobile Home Park

In another mobile home park case, Park Place Home Brokers v. P-K Mobile Home Park, a mobile home park was charged with discrimination after attempting to evict a woman and her child. The United States District Court for the Northern District of Ohio made findings and determinations in accord with the Keck and Nelson cases. Park Place is interesting because the court stated a community cannot "piggy-back" off-site provisions and use them to satisfy the significant facilities test. In other words, the community must provide the services and facilities themselves. This contradicts the Keck court which indicated that outside solicitation may be considered.

Also, in order to successfully claim impracticability of providing facilities, the threshold factor is "whether the owner or manager of the facility has endeavored to provide significant facilities and services." Moreover, claiming that it is expensive to provide the services and facilities required for the exemption is insufficient. The community must provide bona fide cost estimates from an expert qualified to render such an opinion. In meeting the exemption requirement that the housing is necessary to provide important housing opportunities for older persons[,] the community must first satisfy the impracticability test.

The court rejected both the due process and the equal protection arguments raised by the defendant. The court explained that elderly citizens are not a protected class and therefore the level of scrutiny is weak; there need only exist a "rational relationship" between the legitimate governmental interest and the law being questioned. Since there is a rational relationship between the FHA Act of 1988 and the

124. Id. at 49. It is not necessary to repeat the arguments made by the defendant, P-K Mobile Home Park, because the arguments are either identical or substantially similar to those made in Nelson and Keck. See discussion supra parts III.B., III.D.
125. Park Place, 773 F. Supp. at 52.
127. Park Place, 773 F. Supp. at 53.
128. Id.
129. Id. Note that testimony from a handyman was held by the court to be insufficient to meet the expert opinion standard. Id.
130. Id. (citing 42 U.S.C. § 3607(b)(2)(C)(f) (1988)).
131. See Park Place, 773 F. Supp. at 54.
132. Id.
133. Id.
legitimate governmental interest of protecting families with children, the due process argument failed. The court added that in order to maintain "the balance Congress intended to strike between housing for older persons and the prohibition against familial status discrimination[,]" the exemption for the older persons housing must be narrowly construed.\textsuperscript{134}

F. \textit{HUD v. Ocean Parks}

A young couple planning to marry and start a family and an elderly couple with grandchildren joined together in a suit against a luxury high-rise condominium located in Jupiter, Florida for violations of the \textit{FHA} Act.\textsuperscript{135} Responding to the charge that it violated the law, the condominium association asserted that it qualified as housing for older persons pursuant to the exemption for persons aged fifty-five or older.\textsuperscript{136} Closer examination by the ALJ revealed that the results of the four surveys done by the association, two of which claimed that ninety-two percent of its residents were aged fifty-five or older, were either improperly tabulated or improperly verified.\textsuperscript{137}

In examining the "significant facilities" claim, the ALJ found that the association failed to provide any services of significance. For instance, while the community installed a wheelchair ramp to the clubhouse in November 1992, the bathrooms were neither equipped for, nor accessible by, handicapped individuals.\textsuperscript{138} To its credit, Ocean Parks Condominium is within walking distance of many stores and other services, but this appears merely fortuitous because the association did not provide sidewalks throughout the community so that its residents could access the neighboring stores, and the gravel paths that did exist were not lit at night.\textsuperscript{139} Even worse, because residents must traverse high door thresholds to enter their units, the individual units were not accessible by wheelchair.\textsuperscript{140} In examining the services and activities, the ALJ noted that the association employed no activity director and, in fact, unit owners themselves volunteered their time to plan and produce community events.\textsuperscript{141} Activities

\begin{itemize}
  \item \textsuperscript{134} Id. This reflects HUD's interpretation as well. \textit{See} 59 Fed. Reg. 34,903 (1994).
  \item \textsuperscript{135} \textit{See} \textit{Ocean Parks}, 1993 WL 316543, at *1.
  \item \textsuperscript{136} Id. at *9.
  \item \textsuperscript{137} Id. at *10.
  \item \textsuperscript{138} Id. at *11.
  \item \textsuperscript{139} Id.
  \item \textsuperscript{139} \textit{Ocean Parks}, 1993 WL 316543, at *12.
  \item \textsuperscript{140} Id.
  \item \textsuperscript{141} Id.
\end{itemize}
sponsored by these volunteers were sporadic and not elaborate.\textsuperscript{142} At the time of the trial, guest speakers had not visited the condominiums in over one year and any events at the clubhouse besides bingo, stitchery, or holiday parties were attended by less than twenty people.\textsuperscript{143} In her decision, the ALJ carefully reviewed the fact that the association designated certain units as housing for older persons while at the same time allowed families to live in other units. She reiterated that the burden is on the association to prove it qualifies for the housing for older persons exemption.\textsuperscript{144} The judge examined the verification procedures concerning age and occupancy at Ocean Parks and concluded that the community made no effort to verify ages in accordance with the law. Furthermore, the community failed to prove it published and followed policies and procedures which indicate an intent to provide housing for older persons consistent with the factors listed in the \textit{Code of Federal Regulations}.\textsuperscript{145} The community also did not properly describe and advertise the condominiums to prospective owners and tenants, and it often confused people as to whether the entire community is for older persons or whether only part of it is reserved as such.\textsuperscript{146} The absence of any facilities or services at the condominiums aimed at meeting the particular needs of older persons was an indication that the condominium association was really only interested in providing housing for "adults only." This is the type of discrimination that the FHA Act of 1988 was designed to prevent and the judge summed up the bottom line succinctly when she stated: "Simply that a facility is not specifically equipped for use by children does not mean that it automatically becomes a facility for persons 55 and older."\textsuperscript{147} The ALJ ordered the condominium association to pay damages to both plaintiffs in the aggregate of $20,500.\textsuperscript{148} Although the condominium association faced a $5000 civil penalty and although the ALJ would have assessed the penalty in this case, because of an administrative error by HUD, the judge found that a civil penalty would be inappropriate and therefore declined to assess one.\textsuperscript{149} The judge ordered the condomini-

\begin{enumerate}
\item Id.
\item Id. at *14.
\item Id. at *27.
\item Ocean Parks, 1993 WL 316543, at *28 (citing 24 C.F.R. § 100.304(c)(2) (1993)).
\item Id. at *29-30.
\item Id. at *31.
\item Id. at *42-43.
\item Id. at *41.
\end{enumerate}
um association to cease its discriminatory practices against families and institute appropriate procedures to ensure compliance with the law.\textsuperscript{150}

Through this brief examination of various cases dealing with the housing for older persons exemption, it is apparent that courts are most concerned with claims by communities which are nothing more than a pretext for "adults-only" housing. In creating the FHA Act, Congress intended to eliminate housing discrimination against families with children. To that end, the judges appear to consistently uphold the law. At the same time, however, Congress specifically intended to allow older persons to maintain their lifestyle and Congress acknowledged that the lives of millions of elderly Americans should not be disrupted by this law.\textsuperscript{151} To ensure that such communities can continue to exist and be developed in the future, the exemption was created. Unfortunately, because HUD deliberately chose to keep the definition of "significant facilities" flexible so as to accommodate the variety of housing communities throughout the United States, communities designed for older persons constantly face legal battles over the meaning of that term.\textsuperscript{152} Considering the stress many elderly Americans already face in the 1990s regarding issues such as health care and the economy, and considering the fact that so many elderly people exist on fixed incomes, losing a lawsuit involving several thousand dollars can be costly, if not devastating, to a retiree. What can communities do to protect themselves when the law is vaguely written and strictly construed? Part Four of this note will attempt to provide some guidance.

IV. SELF-PRESERVATION: THE BEST DEFENSE IS A STRONG OFFENSE

First, any housing community whether it currently exists or is still in the planning stages must accept the fact that "adults-only" housing is a relic of the 1970s and early 1980s, as popular today as another relic of the 1970s: men's leisure suits.\textsuperscript{153} A housing community that endeavors to create an "adults-only" environment will not remain such for very long. Someone, whether HUD, the Attorney General, or a person with "familial status" as

\textsuperscript{150} \textit{Ocean Parks}, 1993 WL 316543, at *43.


\textsuperscript{152} \textit{See 59 Fed. Reg. 34,903} (1994). HUD stated that "the Department has concluded that a flexible standard is necessary in order to reflect regional variations in services and facilities that distinguish housing for older persons from other similar housing . . ." \textit{Id.}

\textsuperscript{153} Leisure suits were popular men's apparel in the 1970s. They were two piece suits made of polyester in a variety of interesting colors such as lilac and mint green. No fashion-conscious man in the 1990s would be caught dead wearing one.
defined by law, will institute a challenge either in federal district court or through the HUD ALJ program. Unless the housing community is a truly bona fide community for older persons and can clearly demonstrate a commitment to providing housing for older persons, the community must allow children to reside within it according to the law. Furthermore, the seminal case, Seniors, stands for the proposition that constitutionally-based arguments made by the defendant community will fail.

In Seniors, an organization representing the interests of senior citizens brought suit in the United States District Court for the Middle District of Florida alleging that certain provisions of the FHA Act violated the United States Constitution. Specifically, the plaintiffs alleged their constitutional rights were abridged in the areas of freedom of association, privacy, equal protection, due process, taking of property without just compensation, and violation of contract or property rights. These arguments failed. The court noted that the plaintiffs had standing to bring suit because, “although a concrete injury has not yet occurred in the instant case, the case may still be ripe.” Because the organization, Seniors Civil Liberties Association Inc. (“SCLA”), brought suit itself and not on behalf of its members, the court decided that “even though the complaint is somewhat weak in its averments concerning the individual standing of SCLA, this Court finds that all named Plaintiffs have adequate standing to bring this lawsuit.” Perhaps the more persuasive argument made by the plaintiffs was that since HUD “refuses to tell anyone whether they qualify for an exemption until someone guesses wrong . . . it is virtually impossible for the Plaintiffs to know whether they qualify for an exemption until there is

154. See Massaro, 3 F.3d at 1474; Ocean Parks, 1993 WL 316543, at *1; Nelson, 1993 WL 498882, at *1.


156. 761 F. Supp. at 1528. On appeal, the United States Court of Appeals for the Eleventh Circuit upheld the United States District Court’s finding that the FHA Act of 1988 did not violate the plaintiffs’ constitutional rights to freedom of association, due process, privacy, and that there was no taking of property without just compensation. Seniors, 965 F.2d at 1035-36. Furthermore, the court found no violation of the Tenth Amendment to the United States Constitution. Id. at 1034. Finally, the court held that the language of the housing for older persons exemption was not unconstitutionally void for vagueness. Id. at 1036.


158. Id. at 1532-33.

159. Id. at 1545-60.

160. Id. at 1537.

161. Id. at 1539-40.
actually a case." The opinion is thorough and detailed but the court ultimately found that the FHA Act is not to be applied retroactively. The authority for Congress to create the FHA Act lies in the Commerce Clause of the United States Constitution, and the law does not violate the Tenth Amendment because the Supremacy Clause, found in Article VI of the United States Constitution, states that where state law and federal law conflict, federal law trumps state law.

The court further held that the FHA Act does not violate the plaintiffs’ right to privacy because that right involves more intimate relationships than just those between neighbors. Similarly, the freedom of association claim failed, according to the court, because the FHA Act of 1988 does not dictate with whom one must associate. Interestingly, the court’s opinion regarding vagueness spans nearly six pages and in the final analysis, the court determined that the plaintiffs’ due process rights were not violated because the law is not vague. The court reasoned that the language concerning the “55 and over exemption” must be flexible so that the services and facilities provided by the housing communities can best suit the community’s needs as dictated by its geographic location. Finally, the plaintiffs’ Fifth Amendment equal protection, due process, taking of liberty and property without just compensation, and freedom of contract arguments also failed. The court noted that the plaintiffs were not a suspect class and there was no fundamental right involved; additionally, the means chosen by Congress were rationally related to the legitimate governmental interest of eliminating housing discrimination against persons with children. Finally, the court said, “the Contract Clause of Article I, § 10 only applies to the states and not to Congress.” The court held that the plaintiffs’ claim that the government was taking property without just compensation was not ripe because the plaintiffs made no claim for compensation and have not presented a “concrete controversy concerning the Act’s economic

162. Seniors, 761 F. Supp. at 1539.
163. Id. at 1544.
164. Id. at 1546-47.
165. Id. at 1548.
166. Id. at 1548-49.
167. Seniors, 761 F. Supp. at 1551. The plaintiffs are free to ignore their neighbors, the court observed. Id.
168. Id. at 1551-56.
169. Id. at 1555.
170. Id. at 1556-59.
172. Id. at 1557.
effect” on plaintiffs’ land. The Seniors case is a strong opinion upholding the constitutionality of the FHA Act of 1988 and will most likely curtail similar challenges brought by defendant housing communities.

After reviewing the decisions from the federal courts and from the HUD ALJs, it is clearly evident that the housing for older persons exemption is not easy to obtain. A housing community must hold itself out as housing specifically for older persons in all of its advertising. The community must create rules and regulations as well as by-laws which clearly state its intention to provide housing for older persons. If the community seeks to qualify for the broader category of housing for persons aged fifty-five or older, it must ascertain that at least eighty percent of the units or homes in the community are occupied by residents over fifty-five years of age. This must be done precisely with clear and accurate records which include meticulous age verification procedures through the use of such items as driver’s licenses, birth certificates, passports or the like. All documentation must be kept accurate and up-to-date by the community. If the community cannot meet the eighty percent requirement, it cannot qualify for the housing for older persons exemption for persons aged fifty-five or older.

Next, the housing community must provide “significant services and facilities” aimed at meeting the needs of older persons. The community itself must provide the services and facilities and cannot latch on to services and facilities provided by others outside the community. For example, the “Meals on Wheels” program is independent of the housing community and is usually funded by the county. But if the community furnishes a bus which is owned and operated by the community and is used to squire around the residents of that community so they can access shopping, medical, or other professional assistance, and recreational or cultural events, it is considered a service designed to meet the needs of older persons.

173. Id. at 1558-59.
174. See supra part III.
175. See Murphy, 1990 WL 456962, at *12.
176. Id. at *39.
177. Id. at *33.
179. See id. at *29.
180. Murphy, 1990 WL 456962, at *33.
181. Id. at *36.
182. Id. at *4, *36.
183. See id. at *34-36. For example, in Murphy, the ALJ compared the community to another community owned by the same parent company: Fountain View Estates in Tampa,
Counseling for those affected by bereavement or Alzheimer's Disease is also considered a service. Other services include educational programs
designed specifically for the residents, such as courses on the nutritional needs of the elderly, aerobics, and woodworking, to name a few examples. The more services a community provides its older residents, the less likely it is to lose a lawsuit if challenged. For example, the ALJ in *Murphy* compared the defendant, a mobile home park, to a nearby condominium community, Original Leisure Village ("OLV"). The ALJ illustrated examples of "significant facilities" offered by OLV which appear to meet the requirements under the FHA Act.

OLV condominiums are located within ten miles of Friendly Village, the mobile home park in *Murphy*. There is no comparison between Friendly Village and OLV. While the facilities at Friendly Village are in a state of neglect and disrepair, OLV is an oasis for older persons, boasting two recreational halls, a woodworking shop, two pools, and a nine hole golf course. Boats are available for residents to use on the lake, and plots of land are set aside for residents so they may grow vegetables or flowers. The community provides a plethora of activities. While the regulations in HUD and the decisions by ALJs and federal courts do not explicitly state that a community must have elaborate facilities and services in place, the more a community can offer its older residents in this regard, the greater its chances for success when challenged. A good example of this is a case where a California condominium association, Huntington Landmark Adult Community Association, successfully met a familial status discrimination challenge. The basis for the plaintiff's claim rested upon both the FHA Act of 1988 and a similar California statute. The association used a gerontologist named Karen Adams as an expert witness. Ms. Adams explained to the court that when she visited the community, she noted many services and facilities in place designed to accommodate the needs of older

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186. *Id.* at *13-15.
187. *Id.* at *13.
188. *Id.* at *7-9 (stating warped pool cues; rest rooms which are not handicapped equipped; a community center kitchen with a stove that cannot be used; and a tattered putting green which had not been used in years).
189. *Id.* at *13.
190. *See Huntington*, 261 Cal. Rptr. at 875. In this case, the community sought to enforce its age restrictions against families with children and therefore, the community was the plaintiff. *Id.*
191. *Id.* at 876, 880; CAL. CIV. CODE § 51 (Deering 1990).
persons. More importantly, she stated that the community need not be "totally handicapped designed" because that effort is "largely unnecessary for senior citizens in the 55 to 65 age range." Ms. Adams added that the older population has a wide variety of needs and not all senior citizens are in ill health. Furthermore, she stated that requiring the community to be totally designed for the handicapped could be psychologically destructive because it would make the senior citizens feel "old and dependent."

The services and facilities provided by Huntington Landmark were not necessarily elaborate. For instance, the community offered the following: a pool, administrative offices, a wood shop, a ceramics room, and meeting rooms. Although the community provided a "large central facility that is used for dinner parties and other functions" there is no indication that this facility is a congregate dining facility that regularly prepares meals for the residents. Huntington Landmark also employed a general manager and staff of ten including a recreation director. The staff fully utilized the facilities available to them and provided many activities such as pool exercise classes, language classes, singing classes, and Friday night dances. Residents also could join special interest organizations such as the bingo, shuffleboard, or tennis clubs. The court did not appear concerned that the residents themselves volunteered in assisting other residents who were not ambulatory. In other words, the community itself did not necessarily have to provide the services to the residents. The court found that the community did not violate the California statute and quickly dismissed defendants' other claim that the community violated the FHA Act of 1988 because defendants "failed to sustain their burden of demonstrating a different result would be obtained if the federal law were applied."

As illustrated in the examples cited in Part Three of this note, most courts do not liberally construe the FHA Act like the court did in Huntington. Perhaps the use of an expert was one of the key factors in Huntington which helped the community prove that the facilities and services it offered

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192. Huntington, 261 Cal. Rptr. at 878.
193. Id.
194. Id.
195. Id. at 877.
196. Id.
197. Huntington, 261 Cal. Rptr. at 877.
198. Id.
199. See id.
200. Id. at 879-80.
were aimed at older persons. Still, if HUD would work with housing communities to ensure compliance with the FHA Act instead of ignoring their plight, the litigation created by the ambiguities of this law could be greatly reduced. To resolve the situation, HUD should create a certification procedure so communities for older persons could be certain they are acting within the law.

V. CONCLUSION: CERTIFICATION IS THE ANSWER

The problem of defining “significant facilities” in the housing for older persons exemption under the FHA Act of 1988 would be resolved if HUD would create a certification process. For example, a housing community endeavoring to provide housing for older persons could apply to HUD for certification. Once approved, the community would be presumed to meet the requirements for the exemption. Families with children would be on notice that the certified community complies with the FHA Act of 1988 and is specifically designed and used as housing for older persons. Certification would not be a mandate but could protect a community from frivolous claims and unnecessary litigation. Certification would not destroy the FHA Act of 1988 but in fact would enhance it because HUD would save money and, more importantly, families with children could avoid the emotional and stressful process of bringing a housing discrimination law suit against the community.

If designed properly, HUD could prevent false claims by communities seeking the exemption who are not really qualified. In other words, HUD can institute controls to prevent communities from falsely claiming to be exempt when in fact they are nothing more than an “adults-only” community. The certification process can contain built-in checks for pretext, such as the following proposals.

Under the proposed process, the housing community (“candidate”) applies for certification by completing a HUD certification application. The application solicits information from the candidate such as the size of the community, age of the residents, legal description of the community, and

201. See Huntington, 261 Cal. Rptr. at 878. Professor Joseph confirmed that communities should consider using experts to defend claims, assuming that the community also has provided legitimate services and facilities aimed at older persons. Interview with Paul R. Joseph, Esq., supra note 31.

202. HUD has considered this possibility. See Implementation of the Fair Housing Amendments Act of 1988, 54 Fed. Reg. 3254, 3256 (1989). HUD stated in 1989 that it was not yet apparent that a “pre-certification” procedure was necessary but if the Department believed certification was cost-effective, it would consider adding this in the future. Id.
services and facilities designed for older persons provided by the community. Attached to the application is a copy of the community's rules and regulations, by-laws, and any other relevant documentation such as the declaration of condominium. HUD charges the community a reasonable certification fee, for example $500, in order to offset administrative costs.

Once the application is reviewed by HUD, a field inspector visits the candidate community to meet with community representatives and tour the facilities and services intended by the community to qualify as "significant facilities." Satisfied that the community meets the requirements, the inspector recommends certification. To ensure that no favoritism or special agreements were made between the candidate community and the HUD inspector, HUD sends another inspector from a different region to perform a final check of the premises. Once HUD determines the community provides the proper services and facilities aimed at older persons appropriate for that geographic location, HUD grants the community certification.

Certification operates as prima facie evidence that the housing community meets the exemption requirements for housing for older persons according to the FHA Act of 1988. The certification is a rebuttable presumption for the community. If a certified community is challenged on the basis that the community either should not have been certified in the first place, or the community only maintained the services and facilities long enough to obtain certification, the community loses the presumption and the burden shifts to the community to prove otherwise. The standard of proof would be preponderance of the evidence. That is, once the aggrieved party proves by a preponderance of the evidence that the certified community really is not a community which legitimately provides housing for older persons in accordance with the law, the burden shifts to the certified community to prove by a preponderance of the evidence that it does indeed qualify for the exemption. With a certification process in place monitored by HUD on a regular basis, legal challenges should be significantly reduced.

Certification would not defeat the FHA Act of 1988. Because HUD controls the certification process, the certification would have built-in checks which would prevent communities from abusing the system. Obtaining certification would not be easy. A community seeking certification must prove it is a bona fide community for older persons within the scope of the law and that it is not an excuse for "adults-only" housing.

Finally, HUD reserves the right to revoke certification at any time, with proper notice to the community, if HUD is provided with evidence that the community is not maintaining its facilities in accordance with the law. The community then must serve a probationary period during which time it has
an opportunity to bring the community back into compliance or face revocation of its certification.

Details can be worked out through meetings between HUD, representatives from the communities, and organizations representing families with children. With certification, expensive litigation would be greatly curtailed and HUD would save money because as the system currently exists, HUD also incurs litigation costs.

Certification would provide a safe harbor for the older persons who legitimately desire to live in housing specifically designed for them. Additionally, families with children would be assured that they would not be “tricked” into buying or renting in a community that discriminates against them. If all parties are willing to cooperate with each other, the true purpose behind the FHA Act of 1988, equal housing opportunity for all persons, can be achieved with minimal litigation.

Elena R. Minicucci
Do the Crime, Do the Time: Should Elderly Criminals Receive Proportionate Sentences?

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I. INTRODUCTION

A number of elderly defendants have attempted to have their sentences vacated or reduced by arguing that the length of the sentences imposed upon them constitutes cruel and unusual punishment.¹ They have claimed that, given their ages and life expectancies, the sentences imposed amount to life imprisonment and are thus disproportionate to the crimes committed.² This article focuses on whether a sentence for a term of years upon an elderly offender, that for all practical purposes may amount to life imprisonment, constitutes cruel and unusual punishment.

Part II of this article discusses what is meant by cruel and unusual punishment. The discussion focuses on the Cruel and Unusual Punishment

¹. See United States v. Angiulo, 852 F. Supp. 54, 60 (D. Mass. 1994) (arguing that the remaining sentences of four defendants in their 70s amounted to life sentences without hope of parole); see also Alspaugh v. State, 133 So. 2d 587, 588 (Fla. 2d Dist. Ct. App. 1961) (complaining that the five year sentence imposed upon a 75 year old defendant violated the cruel and unusual punishment clause of the Florida Constitution), cert. denied, 139 So. 2d 693 (Fla. 1962).

². See Alspaugh, 133 So. 2d at 588.
Clause of the Eighth Amendment to the United States Constitution,\textsuperscript{3} the history of the Clause’s interpretation by the federal courts, and the states’ interpretation of their own constitutions’ cruel and unusual punishment clauses. Part III analyzes whether sentencing elderly offenders to a term of years that exceeds their life expectancies constitutes cruel and unusual punishment as defined in part II. The topics considered include age as a mitigating circumstance, the relevance of life expectancy in sentencing, public policy concerns, and the crimes committed by the elderly. This article concludes that sentencing elderly offenders to a term of years that, in proportion to their ages and life expectancies, amounts to life imprisonment, does not constitute cruel and unusual punishment.

II. CRUEL AND UNUSUAL PUNISHMENT

A. Background

The Eighth Amendment to the United States Constitution states that “[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”\textsuperscript{4} The Eighth Amendment was adopted directly from Article I, section 9 of the 1776 version of the Virginia Declaration of Rights,\textsuperscript{5} which in turn was adopted from the English Bill of Rights.\textsuperscript{6} Traditionally, the prohibition against cruel and unusual punishment referred to punishments such as torture,\textsuperscript{7} burning at the stake,\textsuperscript{8} or punishments that “involved unnecessary cruelty or shocked the mind of the community.”\textsuperscript{9}

B. History of Federal Interpretation

Those who believe the Eighth Amendment to the United States Constitution prohibits not only barbaric punishments, but also sentences that by their length or severity are disproportionate to the crime committed,\textsuperscript{10} disagree with those who believe the Eighth Amendment does not prohibit

\begin{itemize}
  \item \textsuperscript{3} U.S. CONST. amend. VIII.
  \item \textsuperscript{4} Id.
  \item \textsuperscript{5} Solem v. Helm, 463 U.S. 277, 286 n.10 (1983).
  \item \textsuperscript{6} Id.
  \item \textsuperscript{7} Austin v. Harris, 226 F. Supp. 304, 308 (W.D. Mo. 1964) (referring to Wilkerson v. Utah, 99 U.S. 130, 134-36 (1878)).
  \item \textsuperscript{8} Id.
  \item \textsuperscript{9} Id.
  \item \textsuperscript{10} See Solem, 463 U.S. at 284.
\end{itemize}
disproportionate sentences. The latter group, which believes that the Eighth Amendment only prohibits barbaric punishments, finds exception for a proportionality principle with regard to death sentences. Most of them also find exception with regard to other extreme cases of disproportionality.

This disagreement stems from the different interpretations given to Weems v. United States. Although the Supreme Court in Weems implied that disproportionality between the punishment inflicted and the crime committed might make the punishment cruel and unusual, it failed to put to rest the disagreement as to what constitutes cruel and unusual punishment. In Weems, the defendant public official was convicted of falsification of a public and official document and sentenced to fifteen years of cadena temporal. The Court held that this punishment was cruel and unusual, and was thus prohibited by the Eighth Amendment, even if the minimum penalty of cadena temporal had been imposed. Although the Court found the punishment to be cruel and unusual because of the method imposed, the Court also made reference to the fact that punishment for a crime should be in proportion to the offense.

12. See id. at 994 (stating that proportionality review is appropriate in cases involving the death penalty); see also Stanford v. Kentucky, 492 U.S. 361, 362 (1989) (stating that individualized consideration is a constitutional requirement in cases involving the death penalty).
13. See Rummel v. Estelle, 445 U.S. 263, 274 n.11 (1980) (stating that a proportionality principle would come into play in an extreme example such as the legislature making overtime parking a felony punishable by life); see also Harmelin, 501 U.S. at 1001, (Kennedy, J., concurring) (citing Solem, 463 U.S. at 288 (stating that "[t]he Eighth Amendment . . . forbids only extreme sentences that are 'grossly disproportionate' to the crime.").
14. 217 U.S. 349 (1910). In 1892, Justice Field stated that the Eighth Amendment prohibits punishments that are excessive in length or severity when proportioned to the crime. O'Neil v. Vermont, 144 U.S. 323, 339-40 (1892) (Field, J., dissenting). Eighteen years later, in Weems, the Supreme Court implied that the Eighth Amendment contained a proportionality guarantee. Weems, 217 U.S. at 366-67.
15. See Solem, 463 U.S. at 277 (holding that a criminal sentence must be proportionate to the crime for which a defendant has been convicted), overruled by Harmelin v. Michigan, 501 U.S. 957, 994-95 (1991) (plurality opinion) (holding that the Eighth Amendment contains no proportionality guarantee).
16. Weems, 217 U.S. at 381. Cadena temporal consists of hard and painful labor while carrying a chain at the ankle hanging from the wrist, and accessory penalties. Id.
17. Id. at 382.
18. Id. at 367.
Federal court decisions since *Weems* have been inconsistent.¹⁹ In *Perkins v. North Carolina*,²⁰ Perkins was convicted of committing a crime against nature²¹ and sentenced to a term of twenty to thirty years.²² The issue presented in *Perkins* was whether the duration of the sentence made the punishment cruel and unusual within the prohibition of the Eighth Amendment.²³ The United States District Court for the Western District of North Carolina found that because the sentence was within statutory limits and no exceptional circumstances were present, the sentence did not constitute cruel and unusual punishment within the meaning of the Eighth Amendment.²⁴

Similarly, in *United States v. Conley*,²⁵ the Eighth Circuit of the United States Court of Appeals held that a sentence imposed by a federal district judge was generally not subject to review if the sentence was within statutory limits.²⁶ Conley was sentenced to fifteen years in prison after being convicted of conspiring to distribute and distributing heroin.²⁷ The court held that a sentence imposed by a federal district judge is reviewable only if the judge has failed to use discretion, or in using discretion has grossly abused that discretion.²⁸

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²⁰. 234 F. Supp. 333 (W.D.N.C. 1964) (holding that if a sentence is prescribed within statutory limits, and no exceptional circumstances are present, the sentence does not constitute cruel and unusual punishment).

²¹. A crime against nature is defined as "[d]eviate sexual intercourse per os or per anum between human beings who are not husband and wife and any form of sexual intercourse with an animal." BLACK’S LAW DICTIONARY 371 (6th ed. 1990). In *Perkins*, the defendant was convicted of fellatio. 234 F. Supp. at 334.

²². *Id.*

²³. *Id.* at 337.

²⁴. *Id.* The court did not provide a definition for exceptional circumstances, but simply held that none were present in Perkins’ case. *Id.* at 337.


²⁷. *Conley*, 523 F.2d at 650.

²⁸. *Id.* at 656 (citing Woosley v. United States, 478 F.2d 139 (8th Cir. 1973); United States v. Nick, 503 F.2d 418 (8th Cir. 1974)).
Conversely, two years later in *Davis v. Zahradnick*, the United States District Court for the Western District of Virginia decided that the Eighth Amendment imposes an obligation on the judiciary to judge the constitutionality of a particular punishment. In addition, the court decided that simply because a sentence is legislatively approved does not mean that the sentence would not be prohibited by the Eighth Amendment. In this case, the court found that imposing forty years' imprisonment for an offense involving less than nine ounces of marijuana constituted cruel and unusual punishment because the punishment was grossly disproportionate to the severity of the crime.

In *Rummel v. Estelle*, a mandatory life sentence was imposed upon Rummel under a Texas recidivist statute following his third conviction, this time for obtaining $120.75 by false pretenses. Rummel had been previously convicted in Texas for the fraudulent use of credit cards to obtain goods or services, and for passing a forged check for $2836. The United States Supreme Court concluded that the length of sentences actually imposed for crimes punishable by terms of imprisonment in a state penitentiary is a legislative prerogative. The Court held that review of legislatively mandated terms of imprisonment is limited to the review of death sentences, and those extreme circumstances in which sentences are grossly disproportionate to the crime. Because the court did not find Rummel's sentence to be grossly disproportionate to the offense committed, the sentence was upheld.

In 1980, the Supreme Court vacated the judgment in *Davis v. Zahradnick* and remanded in light of *Rummel*. On remand, an equally
divided Court of Appeals affirmed the decision of the District Court\textsuperscript{40} and the United States Supreme Court ultimately granted certiorari.\textsuperscript{41} The Court held that a forty year sentence, within statutory limits, for the sale and possession of less than nine ounces of marijuana did not constitute cruel and unusual punishment as prohibited by the Eighth Amendment.\textsuperscript{42}

In 1983, the United States Supreme Court squarely addressed the proportionality issue in \textit{Solem v. Helm}\textsuperscript{43} and determined that the Eighth Amendment to the United States Constitution contains a proportionality guarantee.\textsuperscript{44} It reached this conclusion by reasoning that the Court's usual application of the proportionality principle in capital cases\textsuperscript{45} does not mean that a proportionality analysis is only applicable in capital cases.\textsuperscript{46} The Court developed a three-part test to aid courts in determining whether a sentence being reviewed under the Eighth Amendment constitutes cruel and unusual punishment.\textsuperscript{47} The first part of the test considers the gravity of the offense and the severity of the penalty.\textsuperscript{48} The second part compares the sentence imposed on the defendant with the sentences imposed on other criminals in the same jurisdiction,\textsuperscript{49} and the third part compares the sentences imposed for the conviction of the same offense in other jurisdictions.\textsuperscript{50} Applying this three-part test to Solem, the Court held that his sentence of life imprisonment without possibility of parole under South Dakota's recidivist statute for uttering a "no account" check for $100 along with six prior felony convictions, was significantly disproportionate to the crime committed and therefore constituted cruel and unusual punishment.\textsuperscript{51}

\begin{itemize}
\item \textsuperscript{40} Davis, 646 F.2d at 123. \\
\item \textsuperscript{41} Hutto, 454 U.S. at 370. \\
\item \textsuperscript{42} Id. \\
\item \textsuperscript{43} 463 U.S. at 277. \\
\item \textsuperscript{44} Id. at 290. \\
\item \textsuperscript{45} Id. at 289 (citing Gregg v. Georgia, 428 U.S. 153, 176 (1976) (holding that punishment of death for the crime of murder does not always violate the Eighth and Fourteenth Amendments. Where there is a separate trial to determine whether to impose the death penalty by considering aggravating and mitigating circumstances, and the decision is reviewable by the highest court of the state, there are sufficient proportionality safeguards)). \\
\item \textsuperscript{46} Id. at 290. \\
\item \textsuperscript{47} Id. \\
\item \textsuperscript{48} Solem, 463 U.S. at 290-91. \\
\item \textsuperscript{49} Id. at 291 (stating that excessive penalty may be indicated if more serious crimes are subject to the same or less penalties). \\
\item \textsuperscript{50} Id. \\
\item \textsuperscript{51} Id. at 303. The South Dakota recidivist statute enhances the penalty for a felony to life imprisonment if the defendant has at least three prior convictions. Id. at 281-82 (citing S.D. CODIFIED LAWS ANN. § 22-7-8 (1979) (amended 1981)).
\end{itemize}
The Court’s holding in *Solem* made it clear that the sentences imposed upon those convicted of a crime must be proportionate to the crime committed in order to withstand an Eighth Amendment challenge. Subsequent decisions, however, are not in conformity with *Solem*. For example, in *United States v. Harrington*, the Court of Appeals for the Eleventh Circuit construed the *Solem* holding to be synonymous with the Court’s holding in *Rummel* and held that a sentence constitutes cruel and unusual punishment only if it is grossly disproportionate to the crime committed. Then in *United States v. Rhodes*, the Fourth Circuit narrowly construed *Solem* as applying an extensive proportionality review only in capital cases and in those cases imposing a life sentence without possibility of parole. In *United States v. Freeman*, a federal district court in Arkansas applied the *Solem* test and found that a sentence of six years in a federal correctional institution for the sexual exploitation of a sixteen year old female in the production of a videotape was not so disproportionate as to constitute cruel and unusual punishment. The court found that because the sentence was within the statutory limits, and because the punishment imposed was not unprecedented in that and other jurisdictions, the harshness of the punishment was not disproportionate to the crime committed.

Eight years later, in *Harmelin v. Michigan*, the Supreme Court overruled its decision in *Solem*, finding that there is no proportionality guarantee in the Eighth Amendment. The Court disagreed with the interpretation *Solem* gave to the background of the Cruel and Unusual Punishment Clause of the Eighth Amendment.

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53. 761 F.2d 1482 (11th Cir. 1985) (holding that a 40 year sentence was not grossly disproportionate to the crime of engaging in a continuing criminal enterprise and therefore did not constitute cruel and unusual punishment without applying the *Solem* test).
54. *Id.* at 1485-86.
56. *Id.* at 1027. The court rationalized that because the Supreme Court reviewed a life sentence in *Solem*, and because the Court had never set aside a sentence for a term of years within statutory limits as cruel and unusual punishment, the Court’s holding in *Solem* was limited to those cases in which a sentence of life imprisonment without parole is imposed. *Id.*
58. *Id.* at 75.
59. *Id.*
60. 501 U.S. at 957.
61. *Id.* at 965.
62. *Id.*
pointed out that while the principle of proportionality was familiar to English law at the time of the drafting of the Declaration of Rights, the drafters did not explicitly prohibit disproportionate punishments, only cruel and unusual punishments.\textsuperscript{63} The Court also disagreed with \textit{Solem}'s interpretation of \textit{Weems}.\textsuperscript{64} It held that although \textit{Weems} did contain language suggesting that mere disproportionality might make a punishment cruel and unusual, "it is hard to view Weems as announcing a constitutional requirement of proportionality, given that it did not produce a decision implementing such a requirement, either here or in the lower federal courts, for six decades."\textsuperscript{65} Furthermore, the Court reasoned that the Cruel and Unusual Punishment Clause itself refers to the mode of punishment at issue and not the mode of punishment with reference to the crime committed.\textsuperscript{66}

In addition to overruling \textit{Solem}'s holding, the Court also abandoned the test set out in \textit{Solem}.\textsuperscript{67} The Court discarded the first part of the test because of the difficulty involved in assessing the inherent gravity of the offense and because this decision was better left to the respective states to determine what their communities consider grave.\textsuperscript{68} The second factor failed because it is impossible to compare sentences imposed by the same jurisdiction for offenses of equal or similar gravity when there is no objective standard of gravity.\textsuperscript{69} The third factor failed because "it has no conceivable relevance to the Eighth Amendment."\textsuperscript{70} The Court based its reasoning for this statement on the fact that states are allowed to make acts illegal that other states do not.\textsuperscript{71}

Overruling \textit{Solem} is of great significance in defining the Cruel and Unusual Punishment Clause of the Eighth Amendment and determining what it prohibits. As it stands, the Clause prohibits only those punishments that are inhumane or barbaric and those that are grossly disproportionate to the crime.\textsuperscript{72} The Court will only entertain a proportionality review in cases

\textsuperscript{63} Id. at 966.  
\textsuperscript{64} Id. at 993.  
\textsuperscript{65} \textit{Harmelin}, 501 U.S. at 992.  
\textsuperscript{66} Id. at 976.  
\textsuperscript{67} Id. at 962-63 (stating that the three-part test adopted in \textit{Solem} was explicitly rejected in \textit{Rummel} because of the complexities confronting any court that would attempt inter- and intra-jurisdictional analysis and because states always bear the distinction of treating some offenders more severely than they would be treated in another state).  
\textsuperscript{68} Id. at 988.  
\textsuperscript{69} Id.  
\textsuperscript{70} \textit{Harmelin}, 501 U.S. at 989.  
\textsuperscript{71} Id. at 989-90.  
\textsuperscript{72} See id. at 995-96.
involving the death penalty and in those cases in which the punishment imposed is grossly disproportionate to the crime committed.\textsuperscript{73}

C. State Interpretation

In \textit{Louisiana ex rel. Francis v. Resweber},\textsuperscript{74} the United States Supreme Court implied that the Cruel and Unusual Punishment Clause of the Eighth Amendment was applicable to the states through the Due Process Clause of the Fourteenth Amendment.\textsuperscript{75} Then in 1959, Justice Douglas, in a separate opinion, forthrightly stated that the Cruel and Unusual Punishment prohibition in the Eighth Amendment was applicable to states through the Fourteenth Amendment.\textsuperscript{76} Finally, in 1962, the Supreme Court held that the Eighth Amendment's prohibition against cruel and unusual punishment was applicable to the states through the Due Process Clause of the Fourteenth Amendment.\textsuperscript{77} This is significant because the states are bound by the meaning given to the Eighth Amendment by the United States Supreme Court.\textsuperscript{78} Hence, a state cannot impose a punishment that would violate the prohibitions of the Eighth Amendment.\textsuperscript{79} While some state constitutions only provide protection against cruel and unusual punishment,\textsuperscript{80} others provide more protection in prohibiting excessive or disproportionate punishments.\textsuperscript{81} The states must interpret their own similar clauses in line with the relevant United States Supreme Court cases when evaluating sentences.\textsuperscript{82}

\textsuperscript{73.} Id.
\textsuperscript{74.} 329 U.S. 459 (1947).
\textsuperscript{75.} Id. at 463.
\textsuperscript{77.} Robinson v. California, 370 U.S. 660, 675 (1962).
\textsuperscript{78.} Id.
\textsuperscript{79.} Id.
\textsuperscript{80.} See, e.g., ALA. CONST. art. I, § 15 (prohibiting the infliction of "cruel or unusual punishment"); see also CAL. CONST. art. I, § 17; FLA. CONST. art. I, § 17; NEV. CONST. art. I, § 6.
\textsuperscript{81.} See, e.g., ILL. CONST. art. I, § 11 (stating "[a]ll penalties shall be determined both according to the seriousness of the offense and with the objective of restoring the offender to useful citizenship"); see also IND. CONST. art. I, § 16 (stating that penalties shall be proportioned to the offense); ME. CONST. art. I, § 9 (stating that penalties and punishments shall be proportioned to the offense); R.I. CONST. art. I, § 8 (stating that all punishments should be proportioned to the offense).
\textsuperscript{82.} See Robinson, 370 U.S. at 660.
In *Grant v. State*, the defendant was convicted a second time for selling cocaine and was sentenced to a mandatory term of life imprisonment. The Georgia Supreme Court, relying on *Rummel*, held that the primary goals of a recidivist statute are to deter repeat offenders and to separate a person who repeatedly commits felonies from the rest of society. More important, the court relied on that part of the *Rummel* decision stating that the time to isolate the recidivist from the rest of society is "largely within the discretion of the punishing jurisdiction." The court thus concluded that the mandatory life sentence imposed upon Grant did not constitute cruel and unusual punishment under the Eighth Amendment.

Five years later, the Court of Appeals of Georgia, relying on *Harmelin*, found that a life sentence for selling crack cocaine to an undercover police officer did not constitute cruel and unusual punishment as prohibited by the Eighth Amendment.

In *State v. Montano*, the defendant was convicted of willfully fleeing from a law enforcement vehicle and was sentenced to four to five years in prison. The Court of Appeals of Arizona ruled that it had the power to reduce a sentence where it is clear that the sentence was excessive. "In determining whether there ha[d] been an abuse of discretion, [the court] look[ed] at the circumstances of the offense [along] with the moral character and past conduct of [Montano]." Because Montano had no prior felonies, and because his sentence resulted from the trial court's attempt to set an example to deter future similar offenses, the court believed that the sentence imposed was unnecessarily harsh and reduced the sentence to two to three years.

More recently, the Court of Appeals of Arizona held that consecutive sentences of ten years for one count of theft and ten years for one count of

83. 368 S.E.2d 737 (Ga. 1988) (holding that a statute mandating a life sentence upon a second conviction for selling cocaine did not violate the Eighth Amendment to the United States Constitution).
84. *Id.*
85. *Id.* at 738 (citing *Rummel*, 445 U.S. at 284-85).
86. *Id.*
87. *Id.*
90. *Id.*
91. *Id.* at 23.
92. *Id.* (citing State v. Killian, 370 P.2d 287 (Ariz. 1962)).
93. *Id.* at 23-24.
illegally conducting an enterprise not disproportionately severe. The defendant conducted a nationwide operation in which thousands of investors lost money. The defendant relied on *Solem* to argue that the sentences imposed were disproportionately severe and constituted cruel and unusual punishment. In addressing the defendant’s argument, the court held that although *Solem*’s vitality has been questioned, the Arizona Supreme Court had previously concluded that *Solem survives Harmelin*. However, even under a proportionality review, the defendant’s sentences were not excessive under the circumstances. The court stated that “[t]he critical inquiry is whether the sentence imposed is grossly disproportionate to the gravity of the offense.” The relevant factors in determining whether a sentence is grossly disproportionate are the harm to both the victims and society, and the culpability of the defendant. The court found that the lower court adequately considered the two factors and that neither demonstrated gross disproportionality. Moreover, the court was not required to go further because the Arizona Supreme Court interpreted *Harmelin* to require an inter-jurisdictional and intra-jurisdictional analysis only after the comparison of the crime committed and the sentence imposed has led to an inference of gross disproportionality.

In *Childers v. State*, the defendant pled guilty to possession of marijuana with intent to deliver and was placed on five years’ probation conditioned on paying a fine and costs, as well as a $10.00 per month supervision fee. Childers’ probation was revoked and he was sentenced to five years’ imprisonment because he had not reported to his probation officer in eight months and was eighteen months behind in paying the supervision fee. The defendant argued that the five year sentence imposed upon him was cruel, unusual, and excessive. The Court of

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95. *Id.*
96. *Id.* at 738.
97. *Id.* (citing *State v. Bartlett*, 830 P.2d 823, 826 (Ariz.), *cert. denied*, 113 S. Ct. 511 (1992)).
98. *Id.*
100. *Id.*
101. *Id.*
102. *Id.* (citing *Harmelin*, 501 U.S. at 1005).
104. *Id.*
105. *Id.*
106. *Id.*
Appeals of Arkansas concluded, however, that because the five year sentence was within the limits set by the legislature, the sentence was legal.\textsuperscript{107} The court further stated that any punishment authorized by statute is never cruel or unusual or disproportionate to the crime "unless it is a barbarous one unknown to the law or so wholly disproportionate to the nature of the offense as to shock the moral sense of the community."\textsuperscript{108} Applying this standard, the court held that a five year sentence for possession of marijuana with intent to deliver was not "wholly disproportionate to the nature of the offense."\textsuperscript{109}

In 1990, the Supreme Court of Arkansas held that the maximum six year statutory sentence and $10,000 fine for a second conviction for promoting obscene materials did not violate the Eighth Amendment.\textsuperscript{110} In previous cases, the Supreme Court of Arkansas had held that it would not reduce or compare sentences which are imposed within statutory limits.\textsuperscript{111} Furthermore, because the punishment was authorized by statute, it would not be deemed cruel or unusual unless the punishment was barbaric or so disproportionate to the crime that the moral sense of the community would be shocked.\textsuperscript{112}

The Supreme Court of Minnesota, in \textit{State v. Christie},\textsuperscript{113} interpreted its own cruel or unusual punishment clause and found its clause does not guarantee proportionality in sentencing.\textsuperscript{114} In \textit{Christie}, the defendant pled guilty to first degree burglary.\textsuperscript{115} After applying the patterned sex offender statute because the crime was sexually motivated, his sentence was increased to twenty years.\textsuperscript{116} The defendant contended that the patterned

\textsuperscript{107} Id. (citing Porter v. State, 663 S.W.2d 723 (Ark. 1984)).
\textsuperscript{108} Childers, 1989 WL 35019 at *1 (citing Parker v. State, 717 S.W.2d 197 (Ark. 1986)).
\textsuperscript{109} Id. at 924.
\textsuperscript{110} Dunlap v. State, 795 S.W.2d 920, 925 (Ark. 1990).
\textsuperscript{111} Id. at 924.
\textsuperscript{112} Id. at 924-25 (citing \textit{Parker}, 717 S.W.2d at 197).
\textsuperscript{113} 506 N.W.2d 293 (Minn. 1993), cert. denied, 114 S. Ct. 1316 (1994); \textit{see} MINN. CONST. art. I, § 5.
\textsuperscript{114} Christie, 506 N.W.2d at 299-300.
\textsuperscript{115} Id. at 295. The fact that the defendant carried only a condom into the house, coupled with the defendant's history of sexual offenses (a conviction for aggravated sodomy and rape, and admissions to other sex offenses such as rape and exposing himself to a woman), and a psychological determination that the defendant "had the quality of a fixated sex offender profile" led the court to believe that his crime was sexually motivated. \textit{Id}.
\textsuperscript{116} \textit{Id}.
sex offender statute denied him his right to proportionality in sentencing under the Minnesota Constitution. The court held that the prohibition against cruel or unusual punishment relates to mental or physical agony, or where a sentence's duration is out of all proportion to the offense committed. The court found that because the sentence Christie received reflected the seriousness of the burglary committed, as well as the odious intent with which it was carried out, the sentence was not cruel or unusual.

The Florida Supreme Court has found that the United States Constitution, as well as the Florida Constitution, guarantees judicial review of the proportionality of sentences. In Hale v. State, the court sentenced the defendant to two concurrent ten year minimum mandatory sentences and two concurrent twenty-five year maximum sentences for selling cocaine and possessing cocaine with intent to sell. This followed a previous violent felony conviction. The Florida Supreme Court found that the "United States Constitution provides a guarantee of proportionality and that such a guarantee acts as a minimum standard." The court disagreed with the district court's interpretation that in light of Harmelin, the United States Constitution does not guarantee a proportionality review. The court then interpreted Harmelin as upholding Solem. Because the court found Hale's sentence not clearly disproportionate to the crime he committed, it was unnecessary to define the cruel or unusual punishment clause of the

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117. Id. at 296-97 (citing MINN. STAT. § 609.1352 (1990)). The statute provides, in pertinent part, that if the crime was sexually motivated, if the offender is a danger to society, either because the crime involved an aggravating factor or because the offender previously committed a predatory crime (first-degree burglary), and if the offender needs long-term supervision or treatment, based on the assessment of an experienced professional, a court may sentence the offender to a term of imprisonment of not less than double the presumptive sentence under the sentencing guidelines and not more than the statutory maximum. Christie, 506 N.W.2d at 296-97.

118. Id. at 299.

119. Id. at 300 (citing State v. Anderson 159 N.W.2d 892 (Minn. 1968)).

120. Id. at 300.

121. See Hale v. State, 630 So. 2d 521, 525 (Fla. 1993) (holding that the United States Constitution has a proportionality guarantee); see also Williams v. State, 630 So. 2d 534 (Fla. 1993).

122. 630 So. 2d at 521.

123. Id.

124. Id.

125. Id. at 525.

126. Id.

127. Hale, 630 So. 2d at 521.
Florida Constitution. The court noted, however, that because the Florida Constitution prohibits punishments that are either cruel or unusual, and the United States Constitution prohibits only punishments that are both cruel and unusual, the Florida Constitution has a broader constitutional provision. Then in *Williams v. State*, the Supreme Court of Florida, in answering a certified question, held that proportionality review of a non-capital criminal penalty is available under the Florida Constitution.

In *State v. Dorthey*, the Louisiana Supreme Court decided that "[i]t is the Legislature's prerogative to determine the length of the sentence imposed for . . . felonies." The court stated that article I, section 20 of the Louisiana Constitution provides a basis for determining a sentence unconstitutional, even if not cruel or unusual, when the sentence is too severe for the offense committed. Hence, even if a sentence is within the statutory limits, it may violate a defendant's constitutional right against excessive punishment. The court stated that if the trial judge were to find that the punishment imposed makes "no measurable contribution to acceptable goals of punishment" or that the punishment was for "the purposeful imposition of pain and suffering and [was] grossly out of proportion to the severity of the crime," the trial judge must reduce the sentence to a constitutional one.

In 1972, the Supreme Court of California determined that California's cruel or unusual punishment clause may be violated by punishment that, although not cruel or unusual, is so disproportionate to the crime that it "shocks the conscience and offends fundamental notions of human dignity." In *In re Lynch*, the defendant contended that the court's imposition of an indeterminate sentence after his second conviction for indecent exposure was so disproportionate to the offense committed as to

128. *Id.*
129. *Id.*
130. 630 So. 2d at 534.
131. *Id.*
132. 623 So. 2d 1276 (La. 1993).
133. *Id.* at 1278 (citing *State v. Prestridge*, 399 So. 2d 564 (La. 1981) (holding that Louisiana's judiciary is responsible for reviewing the constitutionality of sentences imposed)).
134. *Id.* (citing *State v. Stetson*, 317 So. 2d 172 (La. 1975)).
135. *Id.* at 1280 (citing *State v. Sepulvado*, 367 So. 2d 762, 767 (La. 1979)).
136. *Id.* (citing *Sepulvado*, 367 So. 2d at 767).
137. *Dorthey*, 623 So. 2d at 1280-81.
violate the cruel or unusual punishment clause of the California Constitution. \textsuperscript{139} The court stated that while the function of the legislature is to define crimes and prescribe punishments, the legislature’s function remains circumscribed by the constitutional provision prohibiting cruel or unusual punishment. \textsuperscript{140} Furthermore, it is the duty of the judiciary to condemn any violation of the cruel and unusual punishment clause. \textsuperscript{141} The court found that greatly disproportionate punishments are also prohibited by the Eighth Amendment of the United States Constitution and by many states as well. \textsuperscript{142}

The Supreme Court of California developed a three-pronged test to aid in administering the rule of proportionality. \textsuperscript{143} The first part examines the nature of the offense and/or the offender, focusing on the danger posed to society; \textsuperscript{144} the second part compares punishments prescribed in the same jurisdiction for more serious offenses; \textsuperscript{145} and the third part compares punishments prescribed for the same offense in other jurisdictions. \textsuperscript{146}

In 1993, the First District Court of Appeal of California applied the tripartite test to determine whether requiring a defendant to register as a sex offender violated the Eighth Amendment. \textsuperscript{147} The court stated that if a disparity is found when comparing more serious offenses within the same jurisdiction and when comparing the same offense in other jurisdictions, it is only an indication that the punishment is an excessive one. \textsuperscript{148} The court further restated that the punishment will only be set aside if it so disproportionate to the offense that “it shocks the conscience and offends fundamental notions of human dignity.” \textsuperscript{149} The court found that while requiring the defendant to register as a sex offender was somewhat disproportionate to his culpability and therefore not unconstitutional. \textsuperscript{150}

\begin{itemize}
  \item \textsuperscript{139} \textit{Id.} at 923.
  \item \textsuperscript{140} \textit{Id.}
  \item \textsuperscript{141} \textit{Id.}
  \item \textsuperscript{142} \textit{Id.} at 927-30 (citing Furman v. Georgia, 408 U.S. 238 (1972); \textit{Weems}, 217 U.S. at 349)); \textit{see also} Workman v. Commonwealth, 429 S.W.2d 374 (Ky. 1968); People v. Lorentzen, 194 N.W.2d 827 (Mich. 1972); Canon v. Gladden, 281 P.2d 233 (Or. 1955).
  \item \textsuperscript{143} \textit{In re Lynch}, 503 P.2d at 930.
  \item \textsuperscript{144} \textit{Id.}
  \item \textsuperscript{145} \textit{Id.} at 931.
  \item \textsuperscript{146} \textit{Id.} at 932.
  \item \textsuperscript{147} People v. King, 20 Cal. Rptr. 2d 220, 222 (1st Dist. Ct. App. 1993).
  \item \textsuperscript{148} \textit{Id.} at 224.
  \item \textsuperscript{149} \textit{Id.} (citing \textit{In re Lynch}, 503 P.2d at 930).
  \item \textsuperscript{150} \textit{Id.} at 225.
\end{itemize}
III. SENTENCING THE ELDERLY AND THE CRUEL AND UNUSUAL PUNISHMENT CLAUSE

Imposing the same sentence upon an elderly criminal that would be imposed on a younger offender could effectively result in a life sentence.151 Many elderly defendants have thus attempted to have their sentences reduced or even vacated.152 They argue that the sentences imposed constitute cruel and unusual punishment because they are, for all practical purposes, life sentences, and are therefore grossly disproportionate to the crimes committed.153

A. Age as a Mitigating Factor

Elderly criminals face the same sentences as all other adults because sentences are prescribed according to the offense committed.154 While most states allow the courts to consider aggravating and mitigating circumstances, they are considered only in order to determine what sentence is appropriate within the prescribed punishment for the offense.155 In extreme cases, courts may depart from the prescribed punishment altogether.156 Whether advanced age is considered a mitigating circumstance, however, differs from state to state.157 While some states consider youth a mitigating circumstance,158 others allow age in general to be considered.159 A small number of states specifically refer to both the young and

151. See, e.g., Angiulo, 852 F. Supp. at 60-61.
152. See, e.g., id.
153. See, e.g., Watkins v. State, 225 S.E.2d 739, 740 (Ga. Ct. App. 1976) (holding that a five year sentence imposed on a 74 year old for aggravated assault was neither cruel or unusual punishment, nor excessive).
154. See, e.g., CAL. PENAL CODE § 1170 (Deering 1994); N.Y. PENAL LAW § 70.02 (Consol. 1994); S.D. CODIFIED LAWS ANN. § 22-22-1.2 (1994).
156. Id.
157. Compare Fla. STAT. § 921.0016 (1993) (specifying as a mitigating factor that at the time of the offense the defendant was too young to appreciate the consequences of the offense) with KAN. STAT. ANN. § 21-4626 (1992) (stating that the age of the defendant at the time of the crime is a mitigating circumstance).

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the elderly. However, even those states which consider age to be a mitigating circumstance treat it only as one factor to be weighed along with other aggravating and mitigating circumstances in determining which sentence within the statutory guidelines to impose on that particular individual.

B. Cases Involving Older Criminals

In Fisher v. State, the sixty-four year old defendant was convicted for the first-degree rape of a ten year old girl and was sentenced to twenty-five years in prison. The defendant argued that the twenty-five year sentence imposed upon him was comparatively excessive and therefore constituted cruel and unusual punishment. The Court of Criminal Appeals of Alabama stated that rape in the first degree was a felony punishable by a minimum of ten years and a maximum of life or not more than ninety-nine years, and that the gravity and seriousness of the offense involved merited harsh punishment. The court further found the argument so lacking in merit that it was rejected without further comment.

Similarly in Watkins v. State, the seventy-four year old defendant was convicted of aggravated assault for shooting an unarmed and non-threatening victim and was sentenced to five years’ imprisonment. The court noted that the jury had heard evidence of the defendant’s age, the fact that he was a diabetic with an amputated leg whose chronically ill wife was

160. See ALASKA STAT. § 12.55.155(d)(4)-(5) (1993) (stating that when a youthful offender’s conduct has been influenced by a mature person or when an older criminal’s behavior results from age-related physical or mental infirmities, it should be considered a mitigating factor); see also MASS. GEN. L. ch. 279, § 69(b)(5) (1994) (recognizing age as a mitigating circumstance in murder cases in which the state seeks the death penalty); TENN. CODE ANN. § 39-13-204(j)(7) (1993) (recognizing youth or advanced age of a defendant at the time of the crime as a mitigating circumstance).

161. See United States v. Bemal, 884 F.2d 1518, 1519 (1st Cir. 1989) (holding that the defendant’s being sentenced to the mandatory minimum instead of a harsher sentence for distributing cocaine was evidence that defendant’s age and health were taken into consideration).


163. Id. at 6.

164. Id. at 8.

165. Id. (citing ALA. CODE § 13A-5-6(a)(1) (1975)).

166. Id.

167. Fisher, 480 So. 2d at 8.

168. 225 S.E.2d at 739.

169. Id.
totally dependant on him, as well as evidence that Watkins had twice before been convicted of crimes involving the use of firearms.\textsuperscript{170} Despite the existing mitigating circumstances, the court held that the five year sentence imposed upon the defendant was well within the statutory limits for aggravated assault with a deadly weapon, and that such sentence did not constitute cruel and unusual punishment.\textsuperscript{171}

The United States Court of Appeals held that a thirty year sentence imposed upon a sixty-two year old defendant who was convicted of conspiracy to possess with intent to distribute cocaine, aiding and abetting the possession with intent to distribute cocaine, and distributing a controlled substance was not cruel and unusual punishment.\textsuperscript{172} The defendant argued that in light of his advanced age, a thirty year sentence was, in effect, a death sentence and thus constituted cruel and unusual punishment.\textsuperscript{173} The court found that the district court had considered the mitigating circumstances, including age, as evidenced by the minimum mandatory sentence imposed, rather than the even harsher punishment permitted by law.\textsuperscript{174} Because of the severity of the crime and the prevalence of drug-related societal problems, the court held that the sentence was not so excessive as to be unconstitutional.\textsuperscript{175}

The California Second District Court of Appeal also held in \textit{People v. Eshelman}\textsuperscript{176} that despite the defendant's age and other mitigating factors, the sentence imposed was not cruel and unusual punishment, considering the severity of the crime committed.\textsuperscript{177} The sixty-four year old defendant was convicted of second-degree murder and sentenced to seventeen years in prison.\textsuperscript{178} He contended that his sentence was disproportionate to the crime committed when his age and health, along with other mitigating factors, were considered.\textsuperscript{179} The court held that the mitigating factors did not outweigh the seriousness of the crime and that the seventeen year sentence was not out of proportion to the offense and therefore did not constitute cruel or unusual punishment.\textsuperscript{180}

\textsuperscript{170.} \textit{Id.}
\textsuperscript{171.} \textit{Id.}
\textsuperscript{172.} \textit{Bernal,} 884 F.2d at 1519.
\textsuperscript{173.} \textit{Id.} at 1520.
\textsuperscript{174.} \textit{Id.} at 1521.
\textsuperscript{175.} \textit{Id.}
\textsuperscript{177.} \textit{Id.}
\textsuperscript{178.} \textit{Id.}
\textsuperscript{179.} \textit{Id.} at 816.
\textsuperscript{180.} \textit{Id.}
In some cases age is considered irrelevant in sentencing determinations.\(^{181}\) Section 5H1.1 of the Federal Sentencing Guidelines states that "age (including youth) is not ordinarily relevant in determining whether a sentence should be outside the applicable guideline range. Age may be a reason to impose a sentence below the applicable guideline range when the defendant is elderly and infirm."\(^{182}\) In *United States v. Guajardo*,\(^{183}\) the United States Court of Appeals for the Fifth Circuit interpreted section 5H1.1 to mean that there may be extraordinary circumstances in which the age and health of a defendant may be relevant to the sentencing decision.\(^{184}\) Guajardo claimed that the mandatory sentences contained in the sentencing guidelines prohibit individualized sentencing and thus violate the Due Process and Equal Protection Clauses of the United States Constitution.\(^{185}\) He argued that his advanced age of fifty-five and poor health should have resulted in a downward departure from the Sentencing Guidelines range.\(^{186}\) The court found nothing about Guajardo's age or poor health, which included cancer in remission, high blood pressure, a fused right ankle, an amputated leg, and drug addiction, created an extraordinary circumstance to justify a downward departure from the sentencing guidelines range.\(^{187}\)

Similarly in *United States v. Cox*,\(^{188}\) the defendant argued that the district court erred in refusing to make a downward departure from the Federal Sentencing Guidelines on account of his advanced age.\(^{189}\) He argued that the guidelines violated his Due Process rights because the district court failed to consider his age.\(^{190}\) The Ninth Circuit found that the Sentencing Commission had addressed and rejected the use of age as a factor in determining sentences.\(^{191}\) The court further found that Cox had failed to show why age should be considered a factor under the requirements

\(^{181}\) See, e.g., Angiulo, 852 F. Supp. at 61 (stating that age plays little or no role in adjusting the fit between the crime committed and the sentence to be imposed).


\(^{184}\) Id. at 208.

\(^{185}\) Id. at 204.

\(^{186}\) Id. at 208.

\(^{187}\) Id.


\(^{189}\) Id. at *9.

\(^{190}\) Id.

\(^{191}\) Id. at *11.
of the Due Process Clause. The court concluded that "age is 'far less indicative of culpability than factors such as the offense itself, the defendant's criminal history, or the manner in which the offense is committed.'"

The United States District Court for the District of Massachusetts follows a general approach of age neutrality in sentencing. It focuses on the proportionate fit between the crime committed and the sentence to be imposed on the defendant. In Angiulo, four defendants contended that because they were all in their seventies, their remaining sentences amounted to life imprisonment without parole and were therefore excessive. The defendants were convicted of racketeering and racketeering conspiracy in 1986. The lower court sentenced Gennaro Angiulo to an aggregate of forty-five years in prison, Donato Angiulo to twenty years in prison, Francesco Angiulo to twenty-five years in prison, and Ilario Zannino to thirty years in prison. The court denied the defendants' motions to have their sentences reduced, stating that the sentences continued to be "justified and necessary to vindicate the important public policy concerns which undergird [the] criminal laws and ensure the domestic tranquility of . . . society."

C. The Irrelevance of Life Expectancy

Although age seems to be a relevant mitigating factor for sentencing purposes in state courts, and to a certain degree in federal courts, life expectancy of a defendant is considered wholly irrelevant in determining what sentence to impose. When elderly offenders claim that the sentence imposed upon them constitutes cruel and unusual punishment because the sentence amounts to life imprisonment, they are claiming that, in all probability, they will not outlive the sentence imposed upon them.

192. Id.
195. Id.
196. Id. at 59.
197. Id. at 55. One defendant, Ilario Zannino, was tried separately and convicted in 1987. Id.
199. Id. at 62.
201. See Alspaugh, 133 So. 2d at 587.
Therefore, life expectancy should be an important factor if elderly offenders are going to have a valid claim that the sentences imposed upon them constitute cruel and unusual punishment. However, as the following cases demonstrate, most courts are not inclined to consider life expectancy as a factor in their sentencing determinations.

The Florida Supreme Court has held that a defendant's life expectancy is irrelevant. In *Alvarez*, the defendant was convicted of robbery and sentenced to 125 years in prison. The defendant challenged the sentence on the ground that it exceeded the limit of "life" prescribed by the statute. The Florida Supreme Court rejected the notion that a defendant's life expectancy should be used to limit the longest term a defendant should serve. Justice England stated that because even a one day sentence may exceed the life of a defendant, mortality and life expectancy are irrelevant to the term that should be served by a particular defendant.

Eight years later, the Fifth District Court of Appeal of Florida, in *Powloski v. State*, reaffirmed that mortality and life expectancy are irrelevant to the sentence imposed. The defendant was convicted of second-degree murder and conspiracy to commit second-degree murder, and was sentenced to 300 years in prison. The defendant contended that her 300 year sentence was greater than that allowed by law because it exceeded her life expectancy and was therefore more severe than a life sentence. Following the supreme court's decision in *Alvarez*, the court rejected the notion that a defendant's life expectancy should be used to limit the length of sentence imposed on a defendant.

The Supreme Court of Colorado reached a similar conclusion in *Juarez v. State*. The defendant was convicted of two counts of attempted second-degree burglary of a dwelling. Based upon three prior felony convictions, the defendant was sentenced to life imprisonment with no

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202. 358 So. 2d at 10-11.
203. Id.
204. Id. at 12.
205. Id.
206. Id. at 14 (England, J., concurring in part and dissenting in part).
207. 467 So. 2d 334 (Fla. 5th Dist. Ct. App. 1985).
208. Id.
209. Id.
210. Id. at 335.
211. Id.
212. 855 P.2d 818 (Colo. 1993) (en banc).
213. Id. at 820.
possibility of parole for forty years.\textsuperscript{214} The defendant contended that his sentence should be vacated as disproportionate to his crimes, violating the cruel and unusual punishment clauses of both the United States and Colorado Constitutions.\textsuperscript{215} Juarez argued that with no possibility of parole for forty years, he was, for all practical purposes, sentenced to life imprisonment with no realistic possibility of parole because of his age and life expectancy.\textsuperscript{216} Although Juarez's life expectancy did not exceed forty years, the Supreme Court of Colorado concluded that the sentence did not constitute cruel and unusual punishment.\textsuperscript{217} Courts have also concluded that life expectancy is irrelevant in prescribing sentences upon defendants with terminal illnesses. In \textit{State v. Sherrill},\textsuperscript{218} the defendant was convicted of manslaughter and was sentenced to fifteen years of hard labor.\textsuperscript{219} The defendant contended that because he was infected with the AIDS virus, his sentence was excessive.\textsuperscript{220} The Court of Appeal of Louisiana concluded that the trial court was correct in declining to consider the defendant's illness, because his illness was not a sufficient mitigating circumstance.\textsuperscript{221} Similarly, in \textit{State v. Dixon},\textsuperscript{222} the Ohio Court of Appeals concluded that an indeterminate prison sentence for a defendant infected with the AIDS virus did not constitute cruel or unusual punishment.\textsuperscript{223} The defendant was convicted of one count of robbery and sentenced to a term of imprisonment of three to fifteen years.\textsuperscript{224} The court found it unnecessary to consider whether the term to be served was excessive under the circumstances, because the defendant had offered no proof that her medical needs would not be met in prison.\textsuperscript{225} Therefore, the court found the sentence imposed did not constitute cruel or unusual punishment.\textsuperscript{226}

\textsuperscript{214} Id. at 820 n.3 (citing \textsc{Colo. Rev. Stat.} § 16-13-101(2) (1986)) (stating that anyone convicted of a felony who has been convicted three times previously of a felony is a habitual offender and will be sentenced for “the term of his or her natural life”).

\textsuperscript{215} Id.

\textsuperscript{216} Id. at 820.

\textsuperscript{217} Juarez, 855 P.2d at 820-21.

\textsuperscript{218} 611 So. 2d 728 (La. 4th Cir. Ct. App. 1992).

\textsuperscript{219} Id. at 729.

\textsuperscript{220} Id. at 731.

\textsuperscript{221} Id.


\textsuperscript{223} Id. at *3.

\textsuperscript{224} Id. at *2.

\textsuperscript{225} Id.

\textsuperscript{226} Id.
While most cases have concluded that life expectancy is irrelevant to the sentencing process, the Court of Appeals of Michigan held in People v. Moore ("Moore I")\(^ {227} \) that an indeterminate sentence for a term of years must be for less than life and can only be imposed after considering the defendant's life expectancy at the time of sentencing.\(^ {228} \) In Moore I, the defendant had been convicted of one count of armed robbery, two counts of first-degree criminal sexual conduct, one count of assault with intent to do great bodily harm less than murder, and four counts of possession of a firearm in the commission of a felony, and was sentenced to 100 to 300 years' imprisonment.\(^ {229} \) The court concluded that "'life' and 'any term of years' are mutually exclusive concepts, . . . [and] 'any number of years' must mean 'any number of years less than life.'"\(^ {230} \) It also concluded that since "any term of years" means a number of years less than life, a sentence for a term of years should consider the defendant's life expectancy at the time of sentencing.\(^ {231} \) In 1989, however, the Michigan Supreme Court remanded People v. Moore\(^ {222} \) to the circuit court for resentencing in accordance with its decision in People v. Moore ("Moore II").\(^ {233} \) In Moore II, the defendant was convicted of second-degree murder and possession of a firearm during a felony and was sentenced to 100 to 200 years' imprisonment.\(^ {234} \) The defendant was thirty-four years old at the time he was sentenced.\(^ {235} \) The defendant urged the court to consider his life expectancy of 34.5 years on the day of sentencing in determining what sentence to impose.\(^ {236} \) The court held that a trial court was not required to make a factual determination of a defendant's actual life expectancy.\(^ {237} \) Were it otherwise, trial courts would be "reviewing the life expectancies of demographic subgroups, family health histories, and behavioral risks of acquiring certain illnesses, such as cancer and heart disease."\(^ {238} \)


\(^ {228} \) Id. at 514.

\(^ {229} \) Id. at 511.

\(^ {230} \) Id. at 514.

\(^ {231} \) Id.

\(^ {232} \) 442 N.W.2d 638 (Mich. 1989).

\(^ {233} \) 439 N.W.2d 684 (Mich. 1989).

\(^ {234} \) Id. at 684.

\(^ {235} \) Id. at 692.

\(^ {236} \) Id.

\(^ {237} \) Id. at 693.

\(^ {238} \) Moore II, 439 N.W.2d at 693.
Indeed, if life expectancy became a factor in the sentencing process, courts would have to consider many factors in order to determine a particular defendant’s life expectancy. According to the life tables published in the Vital Statistics of the United States, the life expectancy of women is longer than that of men, and men and women belonging to the white race live longer than men and women belonging to the black race. Thus, the courts would need to consider the sex and race of a defendant when calculating a particular defendant’s life expectancy. Determining race itself may present a problem when a defendant is bi-racial or multi-racial. Courts would also necessarily have to consider age in prescribing a punishment because a person’s life expectancy changes with each passing birthday. Making life expectancy a factor would therefore have the ironic effect of treating people differently in order to treat them equally. Without proof that this will in fact achieve the desired goal of equality, this concept may raise equal protection problems.

In addition to age, sex, race, and the factors mentioned in Moore II, one must question exactly how far a court would have to go in determining a particular defendant’s life expectancy. Would a court have to consider the fact that the defendant lives near a nuclear power plant? Or that the defendant resides in a dangerous neighborhood? What if the defendant has in all probability shortened his life span by abusing drugs or alcohol? More important, what if the defendant was adopted and there is no way of determining his family’s health history?

Furthermore, courts attempting to predict life expectancies would also face questions regarding the reliability of their predictions. For example, a person with a latent disease may not show symptoms at the time of sentencing. In essence, a person that seems to be healthy at the time of sentencing, yet dies earlier than predicted by the court, would have been sentenced more excessively than a person who lives as long, or even longer than the court predicts. Even less predictable than deaths attributable to poor health are accidental deaths. Speculation with regard to a defendant’s

239. Id.
241. Id.
242. Id.
244. 439 N.W.2d at 693.
life expectancy would result in a lack of uniformity in sentencing, and would therefore be contrary to the purpose of the sentencing guidelines. 245

D. Potential Effects on Deterrence

Many elderly defendants also argue that because of their advanced age, they no longer pose a threat to society. 246 While specific deterrence is one of the purposes of sentencing, it is not the only purpose. 247 Other important purposes include general deterrence and retribution. 248 In State v. Baker, 249 the defendant was found guilty of voluntary manslaughter and sentenced to a term not exceeding six years. 250 Baker argued that because he was sixty years old, had a declining physical condition, and lacked a prior criminal record, he presented no risk to society and should have been sentenced to probation rather than incarceration. 251 The Court of Appeals of Idaho agreed with the district court that “probation would not ‘measure up . . . to the gravity of the offense’ and that such a sentence ‘would be saying to the community that it is okay to take another’s life.’” 252 The court also acknowledged that general deterrence is a very important purpose of sentencing. 253

The issue of how deterrence would be affected is clearly an important one. If a penal sentence falls more harshly upon an older person, then it must also be true that a sentence proportioned to the person’s age and life expectancy will deter them as much as it would deter someone younger. The premise that a sentence falls more harshly upon an elderly offender, however, is “an untested conclusion, unsupported by any psychological or sociological analysis.” 254 The court in Angiulo stated that an equally persuasive argument could be made that a long prison sentence falls more harshly upon younger offenders because they will probably be unable to marry, be a parent, or launch a career while still young. 255

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245. See, e.g., ALASKA STAT. § 12.55.005 (1993); CAL. CODE ANN. § 1170 (Deering 1994).
246. See, e.g., Angiulo, 852 F. Supp. at 58.
248. Id.
249. Id.
250. Id. at 369.
251. Id.
253. Id.
255. Id.
While the elderly do not commit as many crimes as their younger counterparts, they did account for 0.7% of all arrests in 1992.\textsuperscript{256} There were 87,904 persons age sixty-five and older arrested in 1992, of which 4155 were for violent crimes,\textsuperscript{257} and 15,616 for property crimes.\textsuperscript{258} Elderly offenders were most often charged with driving under the influence, larceny-theft, drunkenness, disorderly conduct, and aggravated assault.\textsuperscript{259} The elderly also accounted for 212 of the arrests for murder and non-negligent manslaughter, 314 of the arrests for forcible rape, and 180 of the arrests for robbery.\textsuperscript{260} Because the elderly are committing crimes, there is an equally important need to deter them as there is for everyone else.

\textbf{IV. CONCLUSION}

The Eighth Amendment’s Cruel and Unusual Punishment Clause\textsuperscript{261} has been interpreted by the United States Supreme Court as not containing a proportionality guarantee.\textsuperscript{262} Some states, however, have interpreted the decision in \textit{Harmelin} as keeping with the precedent set in \textit{Solem}, thus finding that the Eighth Amendment does provide a proportionality guarantee.\textsuperscript{263} The states, for the most part, have interpreted their own constitutions as prohibiting excessive punishments as well as barbaric punishments.\textsuperscript{264} The states that have a proportionality guarantee provide that the punishment received for a particular crime will be proportioned to the severity of the crime committed.\textsuperscript{265}

\textsuperscript{256} See F.B.I., \textsc{Uniform Crime Reports for the United States} 228 (1992). The Uniform Crime Reports, published annually by the Federal Bureau of Investigation, tabulate arrest statistics based on all reporting agencies and estimates for unreported areas. \textit{Id.}

\textsuperscript{257} \textit{Id.} Violent crimes are the offenses of murder, forcible rape, robbery, and aggravated assault. \textit{Id.}

\textsuperscript{258} \textit{Id.} Property crimes are the offenses of burglary, larceny-theft, motor vehicle theft, and arson. F.B.I., \textsc{Uniform Crime Reports for the United States} 228 (1992).

\textsuperscript{259} \textit{Id.} For offenders aged 65 and older, there were 16,723 arrests for driving under the influence, 14,845 for larceny-theft, 10,138 for drunkenness, 3999 for disorderly conduct, and 3449 for aggravated assault. \textit{Id.}

\textsuperscript{260} \textit{Id.}

\textsuperscript{261} U.S. CONST. amend. VIII.

\textsuperscript{262} See Harmelin, 501 U.S. at 957.

\textsuperscript{263} See, \textit{e.g.}, Hale, 630 So. 2d at 521.

\textsuperscript{264} See, \textit{e.g.}, Montano, 589 P.2d at 21.

\textsuperscript{265} See, \textit{e.g.}, Dorthey, 623 So. 2d at 1276.
Most legislatures have provided by statute that the courts may consider age as a mitigating circumstance when sentencing.\(^{266}\) This only means however, that the courts are free to consider aggravating and mitigating circumstances within the guidelines prescribed by the legislature, or under extraordinary circumstances, to depart from the guidelines altogether.\(^{267}\) While most courts consider age as a mitigating factor when imposing a sentence upon a defendant, they have found that the life expectancy of a particular defendant is irrelevant for the purposes of sentencing.\(^{268}\)

The argument asserted by elderly offenders that identical sentencing of older and younger offenders constitutes cruel and unusual punishment is invalid because there is no proof that the sentences fall more harshly on the elderly than they do on younger offenders, and because there is only speculation that the sentences imposed upon elderly offenders essentially amount to life sentences. It is impossible to predict how long a particular individual will live. Any sentence, regardless of age, may exceed the life of the offender.\(^{269}\) Hence, elder status should not give rise to special treatment of elderly offenders.

\(\text{Cristina J. Pertierra}\)

\(266. \text{See, e.g., } \text{N.C. GEN. STAT. } \S \text{a-2000(e)(11)(17) (1993); see also TENN. CODE ANN. } \S \text{39-13-204(j)(7) (1993).}\)

\(267. \text{See, e.g., } \text{OR. REV. STAT. } \S \text{137.080 (1993); see also ARIZ. REV. STAT. ANN. } \S \text{13-702.01 (1993).}\)

\(268. \text{See, e.g., } \text{Juarez, 855 P.2d at 818.}\)

\(269. \text{Alvarez, 358 So. 2d at 14 (England, J., concurring in part and dissenting in part).}\)