ARTICLES

ELDER LAW AS PROACTIVE PLANNING AND INFORMED EMPOWERMENT DURING EXTENDED LIFE

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I. INTRODUCTION

Like most people, I did not plan my initial involvement in Elder Law. I had taught Federal Income Taxation and related subjects for nearly eleven years when my mother began needing assistance following a series of health incidents. She passed away after six months and, as I reflected on that period, I realized that I had acquired a voluminous amount of knowledge regarding various discrete legal regimes, and that much of this knowledge would be very valuable for students to learn in a structured context.

About this time, I received one of those occasional mailers from the American Bar Association touting an upcoming seminar on something called "Elder Law." As I reviewed the contents of what was to be covered at that seminar, I realized that what I had spent the preceding half-year doing fit within this rubric and that I could create an experimental course under this title. I have taught this course continuously since that time to anywhere from twenty-five to one hundred students each time, depending upon the vagaries of the academic calendar and competing curricular alternatives. This Article explains the current content of this course and some of the pedagogical decisions involved in determining its scope.

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I begin the course by explaining what I consider to be the nature of Elder Law and why anyone should care about it. Some preliminary statistics suffice to show that the number of Americans over age sixty-five is rising and is expected to increase even further as the Baby Boom generation reaches this milestone.[1] As the prominent psychologist and gerontologist Ken Dychtwald has observed, "two-thirds of all the men and women who have ever lived past [sixty-five] in the entire history of the world are alive today."[2] Moreover, in the United States, someone who reaches age sixty-five can expect to live another 17.4 years if male or 20.3 years if female.[3]

More importantly, the number of Americans reaching advanced age is increasing. In fact, the age cohort of Americans age eighty-five and over increased by approximately thirty-eight percent in the 2000 Census[4] and is expected to increase another thirty-seven percent in the 2010 Census that is currently underway.[5] The needs of this group are very different from "senior citizens" who are twenty years younger,[6] which demonstrates rather vividly the potential breadth of Elder Law. The main point, however, is that the phenomenon of significant numbers of Americans living to older ages is relatively recent, and the law has only recently begun to consider the increasing legal concerns of these older Americans.

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1. Administration on Aging & U.S. Dept. of Health & Human Servs., *A Profile of Older Americans: 2008*, at 3, http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2008/docs/2008profile.pdf (accessed Sept. 21, 2010) [hereinafter *Profile*]. The United States Census Bureau considers those "born between 1946 and 1964" as belonging to the Baby Boom generation. U.S. Census Bureau, *Selected Characteristics of Baby Boomers 42 to 60 Years Old in 2006*, at 2, http://www.census.gov/population/www/socdemo/age/2006%20Baby%20Boomers.pdf (accessed Oct. 29, 2010).

2. Nicholas Varchaver, *Pitchman for the Gray Revolution*, Fortune 63, 63 (July 11, 2005) (available at http://money.cnn.com/magazines/fortune/fortune_archive/2005/07/11/8265244/index.htm) (quoting Ken Dychtwald).

3. *Profile*, *supra* n. 1, at 2. Note that these numbers represent the apex of the age distribution curves; thus, the vast majority of older persons will live either shorter or longer lives than these specific data points suggest.

4. Lisa Hetzel & Annetta Smith, *The 65 Years and Over Population: 2000, Census 2000 Brief* 2 (U.S. Dept. of Com. 2001) (available at http://www.census.gov/prod/2001pubs/c2kbr01-10.pdf).

5. *Profile*, *supra* n. 1, at 3 (stating that the eighty-five and over population is projected to total 5.8 million in 2010).

6. *See* Lawrence A. Frolik & Alison P. Barnes, *An Aging Population: A Challenge to the Law*, 42 Hastings L.J. 683, 690–691 (1991) (distinguishing diverse sub-groups within the age sixty-five and over population, including "the young old," "the old," and "the old old").

In this regard, Elder Law is very different from the law's multi-century concern with the property of older people as they pass away. A succinct distinction between Elder Law and more traditional law school courses pitched at "older" clients, such as Estate Planning, Trusts and Estates, and the like is that Elder Law concerns itself with the needs of people as they live longer, while those other courses deal with what happens to their property after they are gone. At the same time, Elder Law is rather special in that it consists not of a distinct body of law as such, but rather as a potpourri of different statutes that affect older people primarily or at least disproportionately. In other words, Elder Law is defined by the clients it serves rather than by specific laws.

Furthermore, the laws that primarily affect older people are already numerous and likely to become more so over time. After all, older Americans are well organized, and the membership organization AARP (formerly known as the American Association of Retired Persons) is a major player in any policy debate that affects citizens age fifty and above.[7] Additionally, older Americans have historically voted in greater percentages than their younger counterparts.[8] As a result, political leaders and policymakers pay particular attention to the needs of older Americans.[9]

Two related but independent sociological trends have further spurred the growth of Elder Law: first, the dramatic increase of women in the compensated workforce;[10] and second, the tendency of families to disperse geographically.[11] The confluence of these phenomena means that much of the day-to-day care that families historically provided to their elders is now being outsourced, so to

7. Robert H. Binstock, *Older People and Political Engagement: From Avid Voters to 'Cooled-Out Marks'*, 30 Generations 24, 28 (Winter 2006–2007).

8. *Id.* at 24–25.

9. *Id.* at 28–29. As an example of government officials catering to the older-American demographic, President George W. Bush made a major push in 2003 to add an expensive prescription drug benefit to the Medicare program with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003), despite his general emphasis on reducing the size and scope of government. *E.g.* Lynn Sweet, *Bush Wants Medicare Drug Deal: President Visiting Chicago Today to Push Prescription Benefit*, Chi. Sun Times 8 (June 11, 2003) (available at WL, 6/11/03 CHISUN 8).

10. U.S. Dept. of Labor & U.S. Bureau of Labor Statistics, *Women in the Labor Force: A Databook,* at 1 (Report 1018, U.S. Dept. of Labor 2009) (available at http://www.bls.gov/cps/wlf-databook-2009.pdf).

11. Frolik & Barnes, *supra* n. 6, at 703.

speak, to institutions, agencies, and other third parties—some private, some public.[12] These new arrangements and programs involve rules and regulations concerning eligibility, benefit entitlements and limitations, payment structures, and provider responsibilities—the natural grist of lawyers' work.

The scope of what can be subsumed under Elder Law, in other words, is both growing and seemingly endless. Consequently, some judicious selections must be made to limit what can be covered in an Elder Law course. I claim no ultimate answers in divining what such a course should consider, and I imagine that there is greater variation among Elder Law courses than among many, if not most, other law school courses. Such variety undoubtedly reflects the preferences and comfort zones of individual instructors, in large part.

II. PRELIMINARY TOPICS

I devote the first three weeks of my course to three somewhat unrelated but relatively non-technical subjects: ethical considerations, advance directives, and elder abuse. To be sure, questions of legal capacity and dependency run through each of these three topics, but they are useful beginning points primarily because they are more accessible to many students and often resonate with those who have dealt with older people in their own lives.

A. Ethical Considerations

The week on ethical considerations introduces two major concerns that recur throughout the course in different contexts. The first is the perennial question, Who is the client? Determining the answer to that question involves related issues of diligent representation, communication, confidentiality, and conflict of interests, because those legal imperatives relate to duties owed to

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12. *See e.g.* Sen. Spec. Comm. on Aging, *Assisted Living in the 21st Century: Examining its Role in the Continuum of Care*, 107th Cong. 1 (Apr. 26, 2001) (available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_senate_hearings&docid=f:73340.pdf) (discussing the dramatic increase in the size of the assisted living industry); Sy Moskowitz, *Still Part of the Clan: Representing Elders in the Family Law Practice*, 38 Fam. L.Q. 213, 231 (2004) [hereinafter Moskowitz, *Clan*] (stating that more than 1.7 million Americans reside in nursing homes).

one's client.[13] Consequently, it is essential to identify this person.[14] To set the stage for an open-ended discussion of possibilities, concerns, and professional imperatives I begin with a few hypotheticals from Professor John Donaldson's insightful 1991 article, *Ethical Considerations in Advising and Representing the Elderly*.[15] These hypotheticals involve intergenerational conflicts, attorney-client obligations, and related questions that are often difficult or uncomfortable to resolve, but which permeate much of Elder Law.

The second major concern considered in this unit is whether the client, now identified, is competent. The guidelines set forth in the American Bar Association's (ABA) Model Rules of Professional Conduct are a useful beginning point,[16] but the practical realities of determining competency make those guidelines some-

13. Model R. Prof. Conduct 1.3, 1.4, 1.6, 1.7, 1.8 (ABA 2009).

14. The Elder Law literature devoted to this question is large and rich. *E.g.* Patricia M. Batt, Student Author, *The Family Unit as Client: A Means to Address the Ethical Dilemmas Confronting Elder Law Attorneys*, 6 Geo. J. Leg. Ethics 319, 324 (1992) (suggesting changes to the American Bar Association's (ABA) Model Rules of Professional Conduct to accommodate an older client's need or desire to enlist "family unit representation"); Carolyn L. Dessin, *Protecting the Older Client in Multi-Generation Representations*, 38 Fam. L.Q. 247 (2004) (reviewing how to navigate representation of clients from multiple generations of the same family without marginalizing the elderly or compromising ethical and legal requirements); Moskowitz, *Clan*, *supra* n. 12, at 243–245 (discussing the role of family members in directing the financial and legal affairs of older relatives); Special Issue, *Ethical Issues in Representing Older Clients*, 62 Fordham L. Rev. 961 (1994) (addressing how various challenges associated with representing elderly clients, including concerns about client capacity and potential conflicts of interest between clients and third parties, complicate the identification of the "client").

15. John E. Donaldson, *Ethical Considerations in Advising and Representing the Elderly* 173 (ALI-ABA Course of Study Materials, Course No. C682 May 30, 1991) (available at WL, C682 ALI-ABA 173). For example, one hypothetical introduces a man who asks his attorney for assistance in estate planning on behalf of his elderly, absent-minded father. The father does not see the need for asset-protection measures that the son has encouraged him to take (such as gifting his money and signing a power of attorney); however, he is willing to do whatever the son suggests if the attorney endorses it. *Id.* at 184–185.

Another hypothetical explores how an attorney should navigate representation of a husband and wife, by presenting a conflict of interest between the two parties. The husband, who is losing his mental capacity, is in control of the couple's money; the wife wants a power of attorney so she can handle their finances instead. If the attorney believes the wife has a better ability to handle the couple's money but knows that the husband's ideas about how to handle the mortgage and other bills differ significantly from the wife's, does the attorney have the duty to pressure the husband to sign a power-of-attorney? *Id.* at 187–188.

16. *See e.g.* Model R. Prof. Conduct 1.14 (setting forth guidelines for dealing with clients with diminished capacity).

what difficult to apply in particular circumstances.[17] Would-be practitioners need to understand the imprecise nature of many competency determinations. There is no blood test or other medical metric that delineates competency from incompetency, and the determination itself may produce different results in different contexts, depending on the nature of the legal task at hand. Moreover, the ABA recommends that a lawyer "may seek guidance from an appropriate diagnostician,"[18] but this recommendation assumes a degree of medical precision that is often not extant.[19]

B. Advance Medical Directives

The unit on advance directives is styled "Controlling One's Medical Destiny" and concerns questions of medical care decisionmaking when a patient is unable to make those decisions. This general topic is not exclusively an older person's issue, of course, and the relevant statutory regimes typically apply to anyone over the age of majority, often eighteen years. In fact, the most famous cases that mark this area actually dealt with young people in their twenties who fell into a coma or vegetative state, and were thus incapable of making their own decisions about end-of-life issues.[20] Nevertheless, this topic seems to have evolved as a

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17. Robert B. Fleming & Rebecca C. Morgan, *Lawyers' Ethical Dilemmas: A "Normal" Relationship When Representing Demented Clients and Their Families*, 35 Ga. L. Rev. 735, 740 (2001).

18. Model R. Prof. Conduct 1.14 cmt. 6.

19. An eye-opening study in *The New England Journal of Medicine* involved 1,879 subjects age sixty-five and older who were examined by the same clinicians using six commonly used diagnostic classification systems for dementia. Timo Erkinjuntti et al., *The Effect of Different Diagnostic Criteria on the Prevalence of Dementia*, 337 New Eng. J. Med. 1667 (1997). Depending upon which specific diagnostic tool was used, the proportion of patients in this study who were determined to be suffering from dementia ranged from 3.1% to 29.1%, a variance of more than nine-fold, and only twenty subjects were so classified according to all six methodologies. *Id.* at 1670–1671. To be sure, dementia is a medical diagnosis that is not co-terminus with the legal assessment of incompetency, Warren F. Gorman, *Testamentary Capacity in Alzheimer's Disease*, 4 Elder L.J. 225, 226 (1996), but the results of this experiment are fascinating nonetheless.

20. *E.g. Cruzan v. Dir. Mo. Dept. of Health*, 497 U.S. 261 (1990) (age twenty-five); *In re Guardianship of Schiavo*, 851 So. 2d 182 (Fla. 2d Dist. App. 2003) (age twenty-seven); *Matter of Quinlan*, 355 A.2d 647 (N.J. 1976) (age twenty-two). The Terry Schiavo case, which is the most recent, captivated not only the nation but also the United States Congress, which held a rare Sunday session that resulted in Pub. L. No. 109-3, 119 Stat. 15 (2005). George J. Annas, *"Culture of Life" Politics at the Bedside—The Case of Terri Schiavo*, 352 New Eng. J. Med. 1710, 1710 (2005).

component of Elder Law, perhaps because older people generally are more willing to address it and often have fairly well developed ideas about what they want if they are unable to make their wishes known.[21]

The vast majority of Americans, however, do not have an advance medical directive.[22] Interestingly, the general distastefulness of the subject is typically not the reason for this predicament.[23] Rather, reasons that are more commonly provided include: (a) lack of awareness that such documents exist; (b) reluctance of many physicians to bring up the subject; and (c) widespread misunderstanding that these directives are primarily for older people or persons who are in poor health.[24]

Accordingly, I begin with the default option that has been provided by forty-four jurisdictions—namely, healthcare-surrogacy statutes.[25] In effect, these laws provide an advance directive for those who have not prepared one on their own, so it is useful to examine the contours of this directive in some detail. To do so, however, presents the pedagogical question of whether to generalize for a national audience or to particularize by focusing on one state's law. It is certainly possible to discuss these laws in general outline, but for state-specific legal regimes, such as healthcare-surrogacy statutes, I use a specific state's law (typically Illinois)[26] for greater realism and pertinence. In any case, the differences among the states are less substantial than the similarities (except for those states without surrogacy statutes, of course).

Examining when the healthcare-surrogacy statute applies, and what it provides when it does, opens up a range of concerns

21. *See* U.S. Gen. Acctg. Off., *Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain* 9 (Pub. No. GAO/HEHS-95-135, 1995) (available at http://www.gao.gov/archive/1995/he95135.pdf) (reporting that a study of hospital patients showed that older patients were more likely to have advanced directives than younger patients).

22. *Id.* at 2 (stating that "only [ten] to [twenty-five] percent of Americans have documented their end-of-life choices or appointed a healthcare agent").

23. *Id.* at 8.

24. *Id.* at 8, 10–12.

25. A compilation of these statutes by the ABA's Commission on Law & Aging can be accessed on the ABA's Website. ABA Commn. on Law & Aging, *Default Surrogate Consent Statutes as of September 1, 2008*, http://www.abanet.org/aging/legislativeupdates/pdfs/Famcon_Chart.pdf (accessed Sept. 21, 2010).

26. 755 Ill. Comp. Stat. Ann. 40/1 to 40/65 (West, WL current through P.A. 96-955 of the 2010 Reg. Sess.).

and complaints about the statute as enacted. One response might be to propose various statutory amendments; but, for many clients and their lawyers, a more immediately satisfying response may be to execute a living will or a healthcare proxy (or power of attorney).[27] Doing so enables the parties to address specifically the problems they have with the surrogacy statute's provisions. Once again, examining state-specific laws involving these very different forms of an advance medical directive enables future practitioners to add to their professional "toolboxes" in terms of the mechanisms that will be at their disposal when they counsel clients.

I do not contend, however, that every dilemma has a satisfying resolution. For example, one issue of perennial concern is accessibility; that is, Where should an executed directive be kept to ensure that it is available when needed?[28] A federal statute enacted in 1990, the Patient Self-Determination Act,[29] provides that an adult patient entering a hospital, nursing home, or home-health agency that is covered by either Medicare or Medicaid must be informed of his or her right to make an advance medical directive, but this law does not specify where that directive should be maintained once it has been made. In this context, I examine private registries that purport to store these documents,[30] along with legislative proposals to create government-administered facilities for this purpose.[31]

27. A compilation of these statutes by the ABA's Commission on Law & Aging can be accessed on the ABA's Website. ABA Commn. on Law & Aging, *Health Care Power of Attorney and Combined Advance Directive Legislation as of September 1, 2008*, http://www.abanet.org/aging/legislativeupdates/pdfs/HCPA-CHT.pdf (accessed Sept. 21, 2010).

28. *See* R. Sean Morrison et al., *The Inaccessibility of Advance Directives on Transfer From Ambulatory to Acute Care Settings*, 274 J. Am. Med. Assn. 478 (1995) (citing evidence that advance directives may be ineffective if the documents are not readily accessible to emergency medical personnel—and may not be honored even when they are available).

29. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101–508, §§ 4206, 4751, 104 Stat. 1388, 1388-115, 1388-204 (1990).

30. *See e.g.* DocuBank, *Home*, http://www.docubank.com (accessed Oct. 29, 2010) (advertising, "Immediate Access to Healthcare Directives & Emergency Medical Information—Anywhere, Anytime, 24/7/365"); MedicAlert Found., *Home*, *Advance Directive*, https://www.medicalert.org/join/DNRDetail.htm (accessed Oct. 29, 2010) (offering twenty-four-hour access to stored documents by fax); U.S. Living Will Registry, http://www.uslivingwillregistry.com/default.asp (accessed Sept. 21, 2010) (encouraging consumers to purchase lifetime registration for their loved ones).

31. *E.g.* Advance Planning and Compassionate Care Act of 2009, Sen. 1150, 111th

Another common concern is portability; that is, Will an advance medical directive that has been validly executed in one state be honored in another state in which the client happens to find him or herself at any given moment?[32] Related to this concern is enforceability more generally; that is, Will any directive be followed by the healthcare providers to whom it is presented? The scope of civil and criminal penalties for failure to follow medical directives is entirely a product of state law, one that is very appropriate to examine in this context.[33]

One particular curricular innovation that I employ at this point perhaps bears mention. During the sessions dealing with healthcare-surrogacy statutes and advance medical directives, my Elder Law class is joined by medical students who receive the same materials and participate along with the law students. It is important for future practitioners of both law and medicine to observe in a neutral classroom setting how their counterparts view these documents and the alternative treatments that they authorize. The questions asked by the two groups of students are invariably very different, and that exposure sensitizes them to these differing professional perspectives.

The final topic in this unit is physician-assisted suicide. Because most states (including Illinois) do not sanction this practice,[34] this discussion necessarily involves some other state's law, and Oregon's Death with Dignity Act[35] is the oldest such statute currently in force. Once again, having law and medical students examine this issue together heightens the interest in the discussion that ensues regarding patient eligibility, rights of doctors

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Cong. § 133(a) (May 21, 2009) (available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1150is.pdf) (authorizing a study of the feasibility of such a registry).

32. *See id.* at § 131 (proposing to authorize state-to-state portability of advance medical directives).

33. *See generally* Patrick Webster, Student Author, *Enforcement Problems Arising from Conflicting Views of Living Wills in the Legal, Medical and Patient Communities*, 62 U. Pitt. L. Rev. 793 (2001) (discussing the frequent failure of medical personnel to comply with living wills, and the civil and criminal penalties—or lack thereof—under which a physician can be cited or prosecuted for such failure).

34. 755 Ill. Comp. Stat. Ann. 40/50 (West, WL current through P.A. 96-955 of the 2010 Reg. Sess.).

35. Or. Rev. Stat. Ann. §§ 127.800–127.995 (West, WL current through 2009 Reg. Sess.) (originally enacted in 1994).

who disapprove of the practice, protections for depressed or infirm elders, notification of family members, and the like.[36]

C. Elder Abuse

Few topics are as fraught with emotional concerns as the issue of Elder Abuse. Such abuse can range from sad but discrete acts like financial exploitation to heart-wrenching and stomach-turning instances of physical, psychological, or even sexual abuse.[37] For some students, the issue is merely academic and they want to consider it at length; for others, it is beyond gruesome and they would like to move through it as quickly as possible. Most acts of elder abuse, of course, are crimes in and of themselves. While the presence of an older and often infirm victim certainly makes these episodes more tragic, the underlying law is largely the same. I find it useful nonetheless to discuss the duties and responsibilities that state laws impose in terms of who must report cases of suspected elder abuse and the legal consequences for everyone involved.[38] How these laws apply, or should apply, to lawyers, bankers,[39] and clergy[40] in particular is often of special interest. Some familiarity with the various federal, state, and local agencies that make up what is loosely described as the

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36. *See generally* Russell Korobkin, *Physician-Assisted Suicide Legislation: Issues and Preliminary Responses*, 12 Notre Dame J.L. Ethics & Pub. Policy 449 (1998) (outlining the implementation issues that must be examined when creating physician-assisted-suicide statutes, including how to identify qualifying patients, define physician roles, and create appropriate policies to guide the process).

37. *See generally* Seymour Moskowitz, *Golden Age in the Golden State: Contemporary Legal Developments in Elder Abuse and Neglect*, 36 Loy. L.A. L. Rev. 589 (2003) (citing examples of elder abuse and its impact on the victims, as well as discussing civil and criminal remedies).

38. *See generally* Seymour Moskowitz, *Saving Granny from the Wolf: Elder Abuse and Neglect—The Legal Framework*, 31 Conn. L. Rev. 77, 168–169, 185–192 (1998) (providing a compilation of elder abuse reporting statutes).

39. *See generally* Sandra L. Hughes, *Can Bank Tellers Tell? Legal Issues Relating to Banks Reporting Financial Abuse of the Elderly* (ABA 2003) (available at http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/publication/bank_reporting_long_final_52703.pdf (accessed Sept. 21, 2010) (presenting results of research conducted between 2001 and 2002 on the role banks could play in the fight against financial elder abuse).

40. *See generally* Seymour Moskowitz & Michael J. DeBoer, *When Silence Resounds: Clergy and the Requirement to Report Elder Abuse and Neglect*, 49 DePaul L. Rev. 1 (1999) (analyzing the conflict between elder abuse reporting laws and the tradition of confidentiality in clergy-parishioner communications, and discussing the complex legal issues raised by that intersection).

"aging network" is also appropriate for coverage in this context.[41] As elder abuse is often the result of suboptimal caregiving arrangements, this subject can serve as a launching point for examining the role of geriatric care managers in creating more advantageous care plans at the outset.[42]

III. THREE MAJOR ISSUES

The core of the Elder Law course constitutes the rest of the semester and focuses on three major, and to some extent overlapping, issues: (a) what financial resources will be available to finance the client's life; (b) where will the client live; and (c) how will the client pay for his or her medical care. In rough terms, the time devoted to these topics is three weeks, two weeks, and five weeks, respectively.

A. What to Live on

The general issue of "what to live on" examines three separate subjects, although the first two have significant interactions with each other. The three subjects are: (a) Social Security; (b) private pensions; and (c) control over one's assets. These subjects are rather technical in nature and involve a fair amount of arithmetic; however, a mastery of key concepts and an understanding of variable interrelationships do not require unusual mathematical facility.

1. Social Security

The federal government's Old-Age, Survivors, and Disability Insurance program, known colloquially as Social Security, was created in 1935 and remains the most common source of post-employment income.[43] The importance of this program for Ameri-

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41. *See e.g.* Administration on Aging, U.S. Dept. of Health & Human Servs., *National Aging Network*, http://www.aoa.gov/AoARoot/AoA_Programs/OAA/Aging_Network/Index.aspx (last modified Jul. 16, 2009, 8:53:58 a.m.) (indicating that the Administration on Aging coordinates a network of agencies in providing services for older citizens).

42. *See generally* Mary Lynn Pannen, *A Win-Win Partnership: The Elder Law Attorney & Geriatric Care Manager*, 13 NAELA Q. 25 (Spring 2000) (detailing the role of a geriatric-care manager in handling complex issues in elder care).

43. In 2006, about 86.4% of Americans over the age of sixty-five had income from Social Security benefits, while only about 30.7% "had income from pensions and retirement

ca's seniors cannot be overstated. Fully 89% of older Americans receive a monthly benefit from this program,[44] accounting for 37% of their total income.[45] The proportion of a retiree's income that comes from this program, moreover, varies across the income distribution and ranges from 83.1% for the lowest quintile to 18.2% for the highest quintile.[46] Indeed, it represents 50% or more of a retiree's income for 64% of all beneficiaries and 90% or more of a person's income for 32% of all beneficiaries.[47] These percentages are higher for unmarried beneficiaries than for married recipients,[48] but the point remains that Social Security is a major component of older Americans' retirement income.

From a client-counseling standpoint, probably the most significant concern, and easily the most frequently discussed issue, is when should a client begin receiving Social Security benefits. This inquiry necessarily requires the future practitioner to have a working knowledge of the program's options and how certain actions by a retiree can affect that person's benefit amount.[49]

Social Security allows persons to commence benefits at ninety-six monthly points beginning when a person reaches age sixty-two and continuing through his or her seventieth birthday.[50] Thus, the Elder Law attorney should understand the operation of Social Security's "early retirement penalty" and its permanent duration,[51] as well as the delayed retirement bonuses that are available to clients who start their benefits after their "full

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savings." Ke Bin Wu, *Sources of Income for Older Persons*, *2006* at 1 (AARP Public Policy Inst. Fact Sheet FS 143, Apr. 2008) (emphasis omitted) (available at http://assets.aarp.org/rgcenter/econ/fs143_income.pdf).

44. U.S. Soc. Sec. Administration et al., *Fast Facts & Figures about Social Security, 2008*, at 5 (SSA Publication No. 13-11785, Aug. 2008) (available at http://www.ssa.gov/policy/docs/chartbooks/fast_facts/2008/fast_facts08.pdf).

45. *Id.* at 6.

46. Wu, *supra* n. 43, at 7.

47. U.S. Soc. Sec. Administration et al., *supra* n. 44, at 7.

48. *Id.*

49. *See generally* Lawrence A. Frolik & Richard L. Kaplan, *Elder Law in a Nutshell* 290–318 (5th ed., Thompson/West 2010) (explaining the factors that affect the amount of Social Security retirement benefits workers are entitled to, including getting married and working past retirement age).

50. 42 U.S.C. § 402(q) (2006); Richard L. Kaplan, *A Guide to Starting Social Security Benefits*, 11 J. Retirement Plan. 34 (July–Aug. 2008) [hereinafter Kaplan, *Guide*].

51. *See* 42 U.S.C. § 402(q) (prescribing the method for computing the early retirement penalty and dictating that the penalty deduction will apply to each monthly insurance benefit payment).

retirement age."[52] Similarly, how Social Security benefits are computed is critical, even though the precise mathematics can be left to online calculators[53] and the annual statements that are sent to all Americans starting when they reach age twenty-five.[54] Of relevance in this context is the foundational concept of the "primary insurance amount"[55] and its relationship to a client's work history via that person's "average indexed monthly earnings" computation.[56]

But Social Security benefits go far beyond the monthly payments that are made to the retirees themselves, and effective advisors must understand the range of so-called derivative benefits.[57] Depending upon a specific client's situation, some of these benefits may be pivotal or irrelevant. They include benefits paid to the following persons:

- current spouse if that person's own work record benefit is lower;[58]
- divorced spouse if their marriage lasted at least ten years;[59]

52. *Id.* at §§ 402(w), 416(l)(1).

53. *E.g.* U.S. Soc. Sec. Administration, *Social Security Online*, *Benefit Calculators*, http://www.socialsecurity.gov/estimator (last reviewed or modified Sept. 23, 2010) (providing retirement "estimates based on [a visitor's] actual Social Security earnings record").

54. U.S. Soc. Sec. Administration, *Social Security Online*, *Find an Answer to Your Question*, *The Social Security Statement*, http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/129 (updated Oct. 1, 2010, 8:06 a.m.) (explaining that Social Security statements are automatically mailed annually to workers over the age of twenty-five).

55. "Primary insurance amount" refers to the "benefit . . . a person would receive if he/she elects to begin receiving retirement benefits at his/her normal retirement age." U.S. Soc. Sec. Administration, *Social Security Online*, *Automatic Increases, Primary Insurance Amount*, http://www.ssa.gov/OACT/COLA/piaformula.html (last reviewed or modified Oct. 15, 2010). For a brief explanation of how the "primary insurance amount" is calculated, see *id.* For a list of the "bend points" or dollar amounts used to calculate the "primary insurance amount," see United States Social Security Administration, *Social Security Online*, *Automatic Increases, Benefit Formula Bend Points*, http://www.ssa.gov/OACT/COLA/bendpoints.html (last reviewed or modified Oct. 15, 2010).

56. Using the national average wage indexing series when computing a person's retirement benefit "ensures that a worker's future benefits reflect the general rise in the standard of living that occurred during his or her working lifetime." U.S. Soc. Sec. Administration, *Social Security Online*, *Automatic Increases, National Average Wage Index*, http://www.ssa.gov/OACT/COLA/AWI.html#Series (last reviewed or modified Oct. 15, 2009).

57. Frolik & Kaplan, *supra* n. 49, at 302–313 (outlining the range of derivative Social Security benefits that can be paid to a retiree's family).

58. 42 U.S.C. § 402(b)(2).

59. *Id.* at §§ 402(b)(1), 416(d)(1), (4).

- children under eighteen years of age and certain others;[60]
- survivors, including the current and former spouse(s) and children;[61] and
- parents who received at least half of their support from a deceased child.[62]

Some of these benefits have their own reduction formulae depending on the age of the beneficiary when the benefit is claimed, and all of them are increased annually by a cost of living adjustment.[63]

Future Elder Law attorneys also need to understand Social Security's "retirement earnings" test. This test reduces current benefits[64] when a recipient who is younger than "full retirement age" has income from employment in excess of certain thresholds that are adjusted annually for inflation.[65] Finally, the federal income taxation of Social Security benefits,[66] and state income taxation as well,[67] necessarily impacts a client's investment planning and related financial decisionmaking.

For these reasons, someone advising older clients about starting Social Security benefits needs to know a fair amount about the client.[68] Many clients take benefits earlier than they should and live to regret that decision.[69] Among the key facts that the attorney should determine are the following:

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60. *Id.* at § 402(d)(1), 416(e).

61. *See generally id.* at § 402 (prescribing under what circumstances persons become entitled to old-age or survivors insurance benefit payments).

62. *Id.* at § 402(h).

63. *Id.* at § 402(c)(2).

64. *Id.* at § 403.

65. For an explanation of how the earnings test works for people below normal retirement age, see United States Social Security Administration, *Social Security Online*, *Automatic Increases, Exempt Amounts under the Earnings Test*, http://www.ssa.gov/OACT/COLA/rtea.html (last reviewed or modified Oct. 15, 2010).

66. *See* I.R.C. § 86 (2006) (prescribing the taxation of Social Security benefits).

67. *See* David Baer, *Issue Brief: State Taxation of Social Security and Pensions in 2006* (AARP Public Policy Inst. Nov. 2007) (available at http://assets.aarp.org/rgcenter/econ/ib84_taxation.pdf) (discussing the state income tax treatment of Social Security benefits, state by state).

68. *See generally* Kaplan, *Guide*, *supra* n. 50, at 33 (discussing the many factors that must be considered when determining the optimal time for an individual to begin receiving Social Security benefits).

69. *See e.g. id.* (noting that the penalty for taking early retirement at age sixty-two is a *permanent* twenty-five percent decrease in the benefit amount, which can significantly impact a retiree's economic well-being).

- current health status and longevity prospects of the putative claimant and that person's spouse;
- work history (i.e., fewer than thirty-five years; less than maximum earnings);
- marital history;
- plans for future employment;
- availability of other sources of income such as a spouse's pension;
- investment expertise and temperament;
- tax bracket, both state and federal;
- access to health insurance prior to Medicare's eligibility age of sixty-five; and
- presence and age of minor children.[70]

Certainly, it would help to know the precise month in which the potential claimant and his spouse will pass away, but rarely are such data available with any degree of reliability. Nevertheless, appreciating Social Security's range of benefits and determining the facts listed above makes an informed decision more likely.

Finally, it might be worth confronting some popular myths concerning Social Security and examining what elements of truth they contain.[71] Of course, the future is ultimately unknowable and long-term government forecasting is notoriously unreliable, especially concerning politically sensitive issues like immigration and medically uncertain prospects for continued advances in longevity.[72] Certain issues, moreover, require some familiarity with

70. 42 U.S.C. § 402; Kaplan, *Guide*, *supra* n. 50, at 34–37.

71. *See generally* Richard L. Kaplan, *Top Ten Myths of Social Security*, 3 Elder L.J. 191 (1995) (contesting several enduring but inaccurate myths about Social Security, including the myth that Social Security is or will soon be insolvent); Mark Weisbrot, *Demographic Tidal Waves and Other Myths: Social Security and Medicare*, 9 Elder L.J. 1, 2–12 (2001) (debunking, among others, the myth that Social Security needs "fixing," and humorously exposing the political and academic characters who have perpetrated that myth).

72. *See* S. Jay Olshansky et al., *A Potential Decline in Life Expectancy in the United States in the 21st Century*, 352 New Eng. J. Med. 1138, 1143 (2005) (stating, "Dire predictions about the impending bankruptcy of Social Security based on the SSA's projections of large increases in survival past [sixty-five] years of age appear to be premature.").

the intricacies of government budget accounting and similar arcana.[73] These circumstances notwithstanding, potential advisors should understand enough about the program's prospects to effectively counsel clients who fear that Social Security is running out of money and might act on that fear by commencing benefits earlier than those individuals should.

2. Private Pensions

Employer-provided pensions are the second "leg" of the proverbial three-legged stool of retirement funding, but their variability is far greater than the benefits available under Social Security. Only about forty-three percent of current retirees have any employer-provided pension,[74] and the nature of these pensions is currently undergoing a seismic shift in both composition and dependability.[75] Even students who have taken a law school course on Pensions (or Deferred Compensation) typically spend very little time examining the issue from the perspective of an employee who has retired and is now ready to draw benefits from the pension plan. Thus, it falls to the Elder Law course to examine what options are available to the prospective retiree.

Fortunately, an attorney counseling potential pension claimants need not become a closet actuary, because many of the pivotal issues are not terribly complex. For example, many employer pension plans *integrate* the pension benefits with the employee's anticipated Social Security benefits.[76] In this situation, an employer may estimate what the employee will receive from

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73. For a discussion of some of these intricacies, including: the Social Security "trust fund"; the management of Social Security revenue; suggestions for filing a projected future shortfall in funds; and alternatives to traditional Social Security benefits, such as "individual accounts" and IRAs, see Richard L. Kaplan, *The Security of Social Security Benefits and the President's Proposal*, 16 ElderLaw Rpt. 1 (Apr. 2005).

74. U.S. Soc. Sec. Administration et al., *supra* n. 44, at 5.

75. *See* Donald L. Bartlett & James B. Steele, *The Broken Promise*, TIME 32 (Oct. 23, 2005) (available at http://www.time.com/time/magazine/article/0,9171,1122017,00.html) (illustrating how in recent years, many companies have frozen or revoked pension plans, devastating retirees who relied on the income); Roger Lowenstein, *The End of Pensions* N.Y. Times Mag. § 6, 56 (Oct. 30, 2005) (available at http://www.nytimes.com/2005/10/30/magazine/30pensions.html?scp=1&sq=&st=nyt) (discussing how changing demographics and corporate strategies are threatening pension funds).

76. Ellen E. Schultz, *To See If Your Pension Is on the Money, Double Check Your Firm's Calculations*, Wall St. J. C1 (Mar. 12, 1997) (available in LEXIS, News & Business library, *Wall Street Journal* file).

Social Security based upon that employee's work history with that employer. Depending upon the employee's actual earnings history, the employer may end up subtracting more Social Security benefits from the pension benefits than the employee will actually receive. As a result, the employee will receive a smaller pension than he or she is entitled to under the employer's pension plan. An attorney can insist that the employer calculate the employee's pension payments using the employee's actual earnings history.[77] Lawyers can also advocate for a class of retirees when major pension-plan changes are being proposed, as happened when some employers adopted so-called cash-balance plans.[78]

At a minimum, future practitioners must understand the critical differences between "defined benefit" and "defined contribution" plans.[79] Although the "defined benefit" plan model has been in rapid retreat the last few decades, many current retirees are still covered by such plans, and some employers—especially

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77. *See* Mary Williams Walsh, *Pensions: Big Holes in the Net*, N.Y. Times G1 (Apr. 12, 2005) (available at http://www.nytimes.com/2005/04/12/business/retirement/12walsh.html?_r=1&scp=1&sq=&st=nyt) (describing how an attorney won a judgment against a pension plan that refused to honor time worked before a mid-career employment gap, and thereby increased the client's benefit nearly fourfold).

78. *See e.g.* Daniel Eisenberg & Sally B. Donnelly, *The Big Pension Swap*, TIME 36 (Apr. 19, 1999) (available at http://www.time.com/time/magazine/article/0,9171,990749,00.html) (stating that "close to two-thirds of workers fare better under the [cash-balance] plans"); *but see* Ellen E. Schultz & Elizabeth MacDonald, *Retirement Wrinkle: Employers Win Big with a Pension Shift; Employees Often Lose*, Wall St. J. A1 (Dec. 4, 1998) (available in LEXIS, News & Business library, *Wall Street Journal* file) (discussing the "dark side" of cash-balance plans, which may significantly cut the pensions of many older workers); *see generally* Alvin D. Lurie, *Cash Balance Plans: Enigma Variations*, 85 Tax Notes 503, 503–504 (1999) (comparing cash-balance and "defined benefit" plans and rejecting the argument that cash-balance plans inherently discriminate against older workers); Joshua A. Rodine, Student Author, *Does the Cash Ever Balance after Conversion?: An Examination of Cash Balance Pension Plan Conversions and ADEA Claims*, 9 Elder L.J. 285 (2001) (analyzing cash-balance plans in the context of the Age Discrimination in Employment Act); Edward A. Zelinsky, *The Cash Balance Controversy Revisited: Age Discrimination and Fidelity to Statutory Text*, 20 Va. Tax Rev. 557, 558 (2001) (stating, "As a matter of psychology, the resentment against cash balance conversions, deeply and sincerely held, largely stems from psychological expectations in the continuation of the *status quo*, rather than from any legal or logical entitlement to the perpetuation of existing pension coverage.").

79. *See generally* Richard L. Kaplan, *Enron, Pension Policy, and Social Security Privatization*, 46 Ariz. L. Rev. 53, 54–63 (2004) [hereinafter Kaplan, *Enron*] (comparing the "defined benefit" plan, a pre-determined retirement benefit under which the employer assumes most of the investment risk, and the "defined contribution" plan, under which the employee has control over investment decisions).

governmental units—continue to sponsor such plans as their primary pension benefit.[80] A "defined benefit" plan delineates how much an employee will receive at retirement, typically depending on that person's tenure with the employer and his or her salary history for the immediately preceding three to five years.[81]

The exact details vary from plan to plan, but the essential point is that the plan *defines* the *benefit*; that is, it determines the amount to be paid without regard to the investment success or failure of the pension plan's assets.[82] Employers assume all of the investment risk, and if an employer is unable to pay the specified amount, the federal government provides limited insurance of these payments through an entity called the Pension Benefit Guaranty Corporation.[83] This system is similar to the federal government's coverage of bank deposits under the Federal Deposit Insurance Corporation and operates to isolate retirees from most of the market vicissitudes that might affect their pensions.[84] To some extent, "defined benefit" plans parallel Social Security's retirement benefit but with two extremely important differences: first, most nongovernmental plans pay an amount that is fixed at retirement and does not increase for post-employment inflation, unlike Social Security's annual cost-of-living increases; and second, no benefits are paid to a retiree's spouse or other beneficiary while the retiree is alive, again unlike Social Security's panoply of pre-death benefits for certain dependents of the claiming client.

"Defined contribution" plans differ in virtually every aspect from "defined benefit" plans. These plans, the most ubiquitous format being the 401(k) plan, provide that a defined amount is contributed into the plan by the employee and often—though not necessarily—by the employer as well.[85] After that contribution is

80. *Id.* at 61–62.
81. *Id.* at 56.
82. *Id.* at 55, 57.
83. *See* 29 U.S.C. § 1305 (2006) (establishing four revolving funds to be used by the Pension Benefit Guaranty Corporation to pay various benefits guaranteed by sections 1322 and 1322a of title 29); *see generally* Jill L. Uylaki, Student Author, *Promises Made, Promises Broken: Securing Defined Benefit Pension Plan Income in the Wake of Employer Bankruptcy: Should We Rethink Priority Status for the Pension Benefit Guaranty Corporation?* 6 Elder L.J. 77 (1998) (proposing changes in the role of the Pension Benefit Guaranty Corporation, which insures employee pensions in the wake of corporate bankruptcy).
84. Kaplan, *Enron*, *supra* n. 79, at 57.
85. *Id.* at 67.

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made, the employer's obligations largely cease.[86] The amounts contributed are then invested by the employee according to the options that are available in the plan, and the contributions produce a total that depends entirely on the investments selected and their market performance.[87] There are no promises of future-benefit levels and no federal guarantees.[88] The result is that the amount ultimately accumulated may, in fact, be less than the amount originally contributed, even without considering the impact of inflation during the investment period.[89] Plan investments in the sponsoring employer's stock can be especially problematic,[90] as the Enron debacle demonstrated so painfully, particularly if there are certain restrictions on the disposition of such stock.[91]

In any case, many current and most future retirees have "defined contribution" plans as their principal—and often only—source of employer-provided pension.[92] As a result, this replacement of "defined benefit" plans with "defined contribution" plans means that there has been a wholesale shifting of investment risk from employers and the federal government to individual retirees. These retirees also bear the risk that they might outlive their resources (other than Social Security), unless they skillfully manage the withdrawal phase of these retirement plans or find someone else who is willing to assume that risk.[93]

Attorneys need to be familiar, therefore, with the options that are available to retirees under these plans. One option is to *roll*

86. *Id.*

87. *Id.*

88. *Id.* at 59.

89. *Id.* at 67.

90. *Id.* at 70–81; *see generally* Maureen B. Cavanaugh, *Tax as Gatekeeper: Why Company Stock is Not Worth the Money*, 23 Va. Tax Rev. 365 (2003) (analyzing the risk to pension benefits caused by defined contribution plans with a high concentration of company stock, and reviewing some notorious examples of pension-fund disasters caused by such unbalanced asset allocations).

91. *See* Cavanaugh, *supra* n. 90, at 371 (noting, "By plan design, individuals whose plans hold restricted company stock are subject to all down-side risk without even the potential to benefit from its current appreciation.").

92. Age Wave & Harris Interactive, *Retirement at the Tipping Point: The Year That Changed Everything* 5 fig. 4, http://www.agewave.com/RetirementTippingPoint.pdf (May 2009).

93. *See* Kaplan, *Enron*, *supra* n. 79, at 67 (emphasizing that employees with "defined contribution" plans are not guaranteed any minimum benefit and may even "end up with less than [their] actual contributions to the plan").

over the funds into an Individual Retirement Account (IRA) that the retiree would then manage.[94] Virtually every financial institution offers such accounts, thereby providing a literally stupefying range of investment alternatives to suit any particular retiree's goals and risk preferences.[95] Certain financial services companies have developed so-called target-date funds that attempt to produce reliable income over the lifetime of a retiree, but their investment history is much too short to derive any assessment of their viability.[96] Alternatively, retirees might take their plan balance as a lump-sum distribution and invest or spend it however they see fit.[97] Some retirees might prefer to shift the risk of extended longevity to an insurance company that will pay a specified amount over the life of the retiree and possibly his or her surviving spouse as well.[98] Such annuity contracts carry their own

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94. *See* Jeff D. Opdyke, *Where to Roll the Nest Egg: IRAs May Offer More Options, But Moving out of 401(k) Plans Isn't Right for All Retirees*, Wall St. J. B1 (Oct. 7, 2006) (available in LEXIS, News & Business library, *Wall Street Journal* file) [hereinafter Opdyke, *Nest Egg*] (stating that rolling one's 401(k) plan into an IRA may be the most important retirement decision an employee can make); *but see* Richard L. Kaplan, *Retirement Funding and the Curious Evolution of Individual Retirement Accounts*, 7 Elder L.J. 283, 292–302 (1999) (discussing the many allowable pre-retirement uses of IRAs and their potential detriment to retirement plans). A related option converts an IRA into a so-called "Roth IRA" to avoid income taxation of future withdrawals in exchange for current taxation of the amount converted. For an examination of the advantages and disadvantages of this strategy, see Richard L. Kaplan, *To Roth or Not to Roth: Analyzing the Conversion Opportunity for 2010 and Beyond*, 9 Bureau Natl. Affairs Daily Tax Rpt. J-1 (Sept. 22, 2009) (available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1476976, *select* "One-Click Download").

95. Opdyke, *Nest Egg*, *supra* n. 94.

96. *See generally* Tom Lauricella, *For Retirement, 'One Size' Isn't Always a Good Fit—Target-Date Funds Are Easy to Select, But Have Posted Big Losses*, Wall St. J. R1 (Mar. 2, 2009) (available at LEXIS, News & Business library, *Wall Street Journal* file) (discussing the mixed success of target-date funds, which increased in popularity from 2000 to 2002).

97. *See* Theo Francis, *Pension Tension: Figuring Out When to Lump It*, Wall St. J. D1 (Mar. 13, 2007) (available in LEXIS, News & Business library, *Wall Street Journal* file) (suggesting that retirees "be wary" when deciding whether to take their pension as a lump sum); Ellen E. Schultz, *Frittered Away: Offered a Lump Sum, Many Retirees Blow It and Risk Their Future*, Wall St. J. A1 (July 31, 1995) (available in LEXIS, News & Business library, *Wall Street Journal* file) (stating that many retirees who take their pensions in lump sums spend the money too quickly and must return to work or scrape by with no retirement income).

98. *See* Kelly Greene, *Do-It-Yourself Pensions: New Products Are Helping People Turn Part of Their 401(k)s into a Steady Paycheck in Retirement*, Wall St. J. R1 (July 14, 2007) (available in LEXIS, News & Business library, *Wall Street Journal* file) (discussing the benefits and potential drawbacks of retirees directing portions of their 401(k) investment into purchasing an annuity); Anne Tergesen & Leslie Scism, *Getting Smart about Annuities: These Products Can Be Loaded with Traps and Fees*, Wall St. J. R1 (Apr. 18, 2009) (available in LEXIS, News & Business library, *Wall Street Journal* file) (observing, "In recent months, sales of plain-vanilla immediate annuities . . . have hit an all-time high.");

risks, of course, including: (a) the risk of erosion due to inflation, since very few of these contracts provide any increase once annuitization begins;[99] and (b) the risk of instability, as the contract is only as sound as the insurance company providing the annuity, as supplemented, to some degree, by guaranty funds created under state law.[100] With respect to all of these alternatives, the eligibility requirements and the relevant tax consequences—including penalties for premature or delayed distributions[101]—are very important.

3. Control of One's Financial Assets

The final set of issues within the general question of "What will the person live on?" concerns that person's investment assets other than retirement-savings vehicles or employer-provided pension plans. The question addressed here is not how to manage those assets for maximum return or safety, an issue that resides more comfortably in the domain of financial advisors, but rather who will *control* those assets when a client is either unable or unwilling to do so. This issue can arise, for example, when a person's capacity for making financial decisions is impaired to the extent required for the specific task at hand. Alternatively, a client might be the surviving spouse of the spouse who handled the couple's finances. At this point in the survivor spouse's life, learning about personal financial management may not hold

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see also Jeffrey R. Brown, *A Paycheck for Life: The Role of Annuities in Your Retirement Portfolio*, Trends and Issues 1 (June 2008) (available at http://www.tiaa-crefinstitute.org/pdf/research/trends_issues/TrendsIssues_0608Brown_01.pdf) (explaining how annuities can be used to guarantee a stream of retirement income for the rest of a retiree's life); Jerry Hyman, *Live Long and Prosper (with Annuities?)*, 15 ElderLaw Rpt. 1 (2004) (discussing how to avoid outliving one's assets by carefully evaluating financial risks and using annuities as part of an overall investment portfolio).

99. *See* Nancy Ann Jeffrey, *Safe but Sorry: Insurers Push 'Immediate' Annuities*, Wall St. J. C1 (Mar. 29, 1996) (available in LEXIS, News & Business library, *Wall Street Journal* file) (stating that buying immediate, fixed annuities locks the investor into current low rates and does not "guard against inflation").

100. *See* Jeff D. Opdyke, *Should You Drop Your Insurer?—Investors Flee As Concern Grows about Whether Some Companies Will Survive*, Wall St. J. D1 (Nov. 20, 2002) (available in LEXIS, News & Business library, *Wall Street Journal* file) (citing the financial woes of insurers to point out the potential vulnerability of annuities).

101. I.R.C. §§ 72(t), 4974(a) (2006); *see generally* Frolik & Kaplan, *supra* n. 49, at 374–381 (explaining these penalties and their exceptions).

much appeal. Regardless of the issue's genesis, the question is, Who will handle that person's finances from this point forward?

The scope of this issue necessarily depends upon the range and sophistication of the client's financial holdings. A simple checking account is one thing; a diversified portfolio of mutual funds, stocks, bonds, exchange-traded securities, commercial real estate, commodity investments, and the like is quite another.

There is a range of devices for sharing management of financial assets that differ in terms of cost, comprehensiveness, flexibility, and tax consequences. The simplest is the joint account; the most complicated is the revocable or living trust; and a mid-range mechanism is the durable power of attorney (DPOA) for financial matters. Moreover, these devices are not mutually exclusive, and can be combined for optimal effectiveness. Thus, a person might have a joint bank account with his or her son for day-to-day expenses, a DPOA with his or her daughter to cover specified investments, and a living trust with his or her realtor-niece as trustee to handle the client's apartment buildings.

Of these three devices, a joint account is the simplest to create, often only requiring the signing of a signature card at the bank of choice.[102] On the other hand, creating a DPOA is typically much more complex, requiring completion of a several-page form, the details of which are often specified by state law but are permitted to be personalized in varying degrees depending on the controlling statute.[103] At a minimum, a client can designate which assets are to be covered by the DPOA.[104] Some state forms allow the maker, or "principal," of the DPOA to add specific powers that are not customarily included in such a document, such as the

102. *See Elder Law Institute 1992: Representing the Elderly Client of Modest Means* (PLI Course Handbook Series No. D4-5233, 1992) (available at WL, 215 PLI/Est 247) (identifying joint accounts as simple to create and requiring signatures of all persons on the account); *see generally* Richard V. Wellman, *Joint Accounts: Dangers and Alternatives*, in *Estate Planning Strategies: A Lawyer's Guide to Retirement and Lifetime Planning* 263, 263–269 (Jay A. Soled ed., ABA 2002) (discussing the simple nature of joint accounts but also noting potential legal complexities of such accounts and outlining some safer alternatives).

103. *See generally* Karen E. Boxx, *The Durable Power of Attorney's Place in the Family of Fiduciary Relationships*, 36 Ga. L. Rev. 1 (2001) (discussing various legal issues involved in the creation of a durable power of attorney).

104. *See generally* Andrew H. Hook, *Durable Powers of Attorney and Advance Directives*, in *Estate Planning Strategies: A Lawyer's Guide to Retirement and Lifetime Planning*, *supra* n. 102, at 221–235 (explaining how durable powers of attorney can be broadly drafted to allow clients to manage and control their assets to fit their needs).

power to make gifts of the maker's property in certain amounts to certain individuals,[105] and to restrict other standard powers, such as the ability to sell securities.[106] The degree of personalization desired will affect the cost of preparing the DPOA[107] and the difficulty of actually using it.[108] Although some financial institutions insist on using their own forms for accounts held with them, state law often sets forth the extent to which parties within the state must honor a DPOA that uses some other format.[109] As was the case with advance medical directives, using a specific state's DPOA form (in my case, the Illinois form[110]) focuses the discussion of the options that a client might or might not want to exercise with respect to this control mechanism.

As mentioned above, the most complicated device for controlling an elder person's assets is a revocable trust. Revocable trusts are usually individualized documents that cover whichever assets were legally transferred to the trusts.[111] A benefit of this device is

105. *See* Kate Mewhinney, *Gifts with Powers of Attorney: Are We Giving the Public What It Wants*, 16 Experience 37, 37–38 (Spring 2006) (discussing the dangers of using the statutory "short form" DPOA that may not give the agent "gift-giving" authority versus drafting a DPOA that does). This ability to "gift" the maker's assets is a particularly important tool when it comes to preserving the maker's assets and also when it comes to ensuring they qualify for Medicaid. *Id.* at 37. In fact, Professor Mewhinney suggests that when drafting DPOAs attorneys include the following provision: "I authorize my agent to transfer my property for the purpose of qualifying me for governmental medical assistance." *Id.* at 38.

106. *See e.g.* 755 Ill. Comp. Stat. Ann. 45/3-3 (West, WL current through P.A. 96-926 of the 2010 Reg. Sess.) (allowing for the withholding of various standard powers, including those over "stock and bond transactions," by crossing out the power to be withheld on the Illinois statutory durable power of attorney form).

107. *See* Jesse J. Richardson et al., *Virginia Cooperative Extension*, *Managing Prosperity: Estate and Retirement Planning for All Ages: Powers of Attorney*, "Practical Considerations," http://pubs.ext.vt.edu/448/448-064/448-064.html (May 1, 2009) (discouraging the use of form DPOAs, and encouraging the use of customized DPOAs drafted by attorneys despite their initial increased cost).

108. *Contra id.* (stating that although many lawyers have told the author they use the statutory DPOA form because many third parties will not accept customized DPOAs, the author has never experienced this problem, and that, in fact, in his experience third parties prefer DPOAs that specify the scope of the agent's authority).

109. *See generally* William J. Brisk & Mary C. Cretella, *How Enforceable are Durable Powers of Attorney?* 9 NAELA Q. 13 (Winter 1996) (discussing how the use of durable powers of attorney can often be thwarted by third parties, and states are implementing stronger statutes in an effort to enforce acceptance).

110. 755 Ill. Comp. Stat. Ann. 45/3-3 (West, WL current through P.A. 96-926 of the 2010 Reg. Sess.).

111. *See generally* John P. Huggard, *Advising Clients about Revocable Living Trusts*, 3 J. Retirement Plan. 35 (July–Aug. 2000) (reviewing and debunking several "myths" associated with revocable trusts, including the common misconceptions that living trusts avoid

that a revocable trust can direct that assets be used in ways that do not necessarily satisfy fiduciary standards.[112] For example, a trust instrument might indicate that funds should be used to pay for a private room in a hospital or nursing facility, even if the client's medical condition does not require such an arrangement. Similarly, it might authorize care for a pet, even though the client is no longer at home with the animal.[113] In short, a living trust can direct that money be spent in any manner the client would want it spent, regardless of that expenditure's apparent extravagance.[114]

Despite the differences discussed above, two inescapable features apply to all three of these devices for handling a person's financial affairs. First, a reliable person must be available and willing to be the designated decisionmaker, whether that person is the joint accountholder, the agent under a DPOA,[115] or the trustee under the living trust. Of course, a client might designate different people on different devices to limit the amount of damage that any one person might cause; but the point remains—there is no substitute for having a dependable representative who will look after a client's assets as if they were his or her own.

Second, all three devices must be created while the client has sufficient legal capacity to do so. Moreover, if property must be transferred to effect the device, whatever capacity is required to accomplish that task must be present as well.[116] In other words, the plan must be in place *before* it is needed. By the time it is

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probate and creditors, protect buyers' privacy, and reduced postmortem costs).

112. *But see id.* (describing potential shortcomings of revocable living trusts that can lead to diminishment of assets).

113. *See* Cynthia L. Barrett, *Protecting Pets in Your Clients' Estate Plans*, 11 NAELA News 1, 1, 2, 5 (Nov.–Dec. 1999) (explaining the steps a pet owner can take to attempt to provide for his or her pets should the owner become ill or die).

114. Living trusts can also operate as will substitutes and avoid the probate process by including instructions for distributing assets following the death of the settlor. Frolik & Kaplan, *supra* n. 49, at 278–281. But the primary focus on living trusts in Elder Law is on their potential for handling a client's assets while the client is still alive. *Id.* at 273–278.

115. *See generally* Nina A. Kohn, *Elder Empowerment as a Strategy for Curbing the Hidden Abuses of Durable Powers of Attorney*, 59 Rutgers L. Rev. 1 (2006) (describing how DPOAs can facilitate financial exploitation of the principal by agents who overreach their fiduciary duties); Jennifer L. Rhein, Student Author, *No One in Charge: Durable Powers of Attorney and the Failure to Protect Incapacitated Principals*, 17 Elder L.J. 165 (2009) (discussing the inherent conflict and potential for abuse created because DPOAs presume incapacity of the principal, leading to insufficient guidance and supervision by the agent).

116. *See generally* Frolik & Kaplan, *supra* n. 49, at 260–262 (noting the importance of the client being legally competent to be able to make such decisions at that earlier time).

necessary, it may be too late. As the expression goes, few people plan to fail but many fail to plan. Thus, the issue of client competency becomes paramount once again.

When no arrangements have been made for handling a person's financial assets, the legal process of guardianship must be sought.[117] This default procedure is specified by state law in terms of cost, who can serve as guardian (or "conservator" in some jurisdictions), the extent to which a court will supervise the guardian, that person's powers, and what notice must be provided to the putative ward's relatives before certain actions are taken.[118] Guardianship is generally a public process and can be especially convoluted if the petition for guardianship is contested and a trial becomes necessary to determine the client's competency.[119] While most people undoubtedly would opt for some other approach, guardianship remains an option for those who did not make alternative arrangements when they had the capacity to do so.[120] In any case, guardianship is an important component of Elder Law, because attorneys often serve as guardians under court appointment,[121] and certain law student clinics and other non-profit entities take on these responsibilities as well, especially when the assets involved fall below some specified threshold.[122]

B. Where to Live

Fewer issues are more fundamental to a person's well-being in older age than where that person will live. At first, the answer

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117. An excellent Baedeker to the world of guardianship can be found in Frolik & Kaplan, *supra* n. 49, at 236–259. I can make this apparently unseemly boast because the referenced pages are entirely the work of Professor Frolik.

118. *See id.* at 243–259 (explaining the procedural steps required to create a guardianship, the costs involved, and the powers provided to the guardian).

119. *See id.* at 246 (discussing the legal complexities that may arise when the guardianship is contested).

120. *See generally* Lawrence A. Frolik, *Is a Guardian the Alter Ego of the Ward?* 37 Stetson L. Rev. 53, 83 (2007) (describing the shift of court-appointed guardians from merely a party answerable to the court that appointed it to a representative of the party that is similar to the relationship created by a DPOA).

121. *See* Edward D. Spurgeon & Mary Jane Ciccarello, *Lawyers Acting as Guardians: Policy and Ethical Considerations*, 31 Stetson L. Rev. 791, 831–839 (2002) (indicating that lawyers are allowed to be appointed guardians and in some situations may be the best person for the job).

122. *See generally id.* at 832–839 (noting that most jurisdictions permit courts to appoint any qualified person to be the guardian of incapacitated person).

is obvious—wherever that person lives presently. Indeed, a survey by AARP found that seventy-one percent of Americans age forty-five and over want to live in their current home until the end of their lives.[123] Moreover, this sentiment actually increases as people age, so that ninety-five percent of Americans over age seventy-five hold this objective.[124] But this objective may not be realistic or even desirable, depending on a variety of social, family, and financial considerations.

Far too many people assume that the only alternative to an older person's current residence is the dreaded nursing home, when the reality is actually quite different. In fact, only 4.4% of the population age sixty-five and over reside in nursing facilities, and only 15.1% of those age eighty-five and above do so.[125] Accordingly, there is an entire continuum of residential options between the two alternatives of personal residence and nursing home, including independent retirement centers, assisted living facilities, and continuing care retirement communities.[126] There are other options currently in development as well, as major hospitality companies anticipate the arrival of aging Baby Boomers.[127] Thus, this portion of the course proceeds by examining three related issues: (a) why the current home does not work; (b) how to manage disposition of that residence; and (c) which alternative housing arrangement is most appropriate.

123. Ada-Helen Bayer & Leon Harper, *Fixing to Stay: A National Survey of Housing and Home Modification Issues* 24 (AARP 2000) (available at http://assets.aarp.org/rgcenter/il/home_mod.pdf).

124. *Id.* at 25.

125. *Profile*, *supra* n. 1, at 5.

126. *See generally* Lawrence A. Frolik, *Residence Options for Older and Disabled Clients* (ABA 2008) (discussing many of the residential options available to seniors who may no longer be able to live on their own).

127. *See e.g.* Mike Buzalka, *What Does the Future Hold for CCRCs? Forget the Boomers—They're a Couple Decades Away—But that Doesn't Mean Today's Seniors Aren't Forcing Changes*, Food Mgt. (Aug. 1 2005) (available at 2005 WLNR 26127934) (describing continuing care retirement communities (CCRCs) that offer flexibility to residents, including independent apartments, townhouses, or cottages and the ability to move into on-site assisted living if necessary); Graham Lanktree, *Checking in to a New Home Front: Done Right, Condo Hotels Going up across Canada Can Add Density to Downtown Cores and Vibrancy to the Streetscape*, Globe and Mail (Toronto, Can.) B11 (Apr. 27, 2010) (available at 2010 WLNR 8655176) (informing readers of new luxury hotel residences designed for aging Baby Boomers with more services available).

1. Viability of the Present Residence

A useful exercise at the outset is to inquire why the older person, or more likely his or her family, believes that it is no longer feasible for the older person to remain in the current residential setting.[128] There can be a whole host of reasons why housing circumstances may have changed, including the following non-exclusive list:

- property taxes have risen beyond what the older person can afford;
- utility costs have risen—particularly if the home's heating and cooling systems have not been upgraded to current efficiency standards;
- the older person is no longer willing or able to prepare meals safely and on a regular basis;
- the older person's medication regimen has been expanded and requires careful monitoring;
- the older person needs assistance with basic functions such as bathing, toileting, or dressing;
- the older person needs regular exercise or other therapies that require the supervision or assistance of trained personnel;
- the home itself has structural impediments, such as stairs, or has safety hazards, such as slippery or uneven floors;
- appliances and other features of the home are inaccessible or require a degree of dexterity that the older person no longer possesses;
- maintenance of the home or yard present ongoing difficulties and increasing costs;

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128. *See* Lawrence A. Frolik, *The Client's Desire to Age in Place: Our Role as Elder Law Attorneys*, 15 NAELA Q. 6, 7 (Summer 2002) [hereinafter Frolik, *Client's Desire*] (stating that determining why the family believes the older person must leave the residence is necessary to resolve the potential conflicts and to ultimately allow the person to remain in the home).

- living alone, perhaps for the first time in many decades, may cause the older person to feel socially isolated and disengaged;
- transportation difficulties (due to a loss of driving privileges, for example) create problems in handling ordinary tasks, such as grocery shopping, as well as attending religious services and getting to doctors' appointments.[129]

Other issues might be involved as well, but the foregoing list is representative of the concerns that can arise as a homeowner ages. But the fundamental question remains: Do these issues require the older person to leave his or her home?

Being able to answer this question in the negative requires Elder Law attorneys to have a fairly comprehensive toolbox so that every problem does not look like a nail simply because they only have a hammer. In this context, as the metaphor suggests, there are a variety of planning strategies that may enable older people to remain in their current residences. Indeed, each of the problems set forth above has a solution short of leaving the residence. Some examples include the following:

- Some states offer property tax relief to lower-income seniors in the form of property tax freezes or other programs.[130]
- Home-health services provide in-home therapies, assistance with activities of daily living, and more medically complicated procedures by trained personnel.[131]
- Telemedicine and computer-based methodologies enable long-distance monitoring of certain key medical metrics.[132]

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129. *See generally* Lawrence A. Frolik, *The Special Housing Needs of Older Persons: An Essay*, 26 Stetson L. Rev. 647 (1996) (discussing numerous factors that play a role in an older person's decision of whether to remain in the home or move to a facility providing more assistance for the elderly).

130. David Baer, *State Programs and Practices for Reducing Residential Property Taxes* (AARP 2003) (available at http://assets.aarp.org/rgcenter/econ/2003_04_taxes.pdf).

131. Frolik, *Client's Desire*, *supra* n. 128, at 7–8 (noting that a number of options are available to alleviate older persons' health concerns).

132. Sue Shellenbarger, *Taking Care of Parents: New High-Tech Links Can Offer Some Relief*, Wall St. J. B1 (Mar. 8, 2000) (available in LEXIS, News & Business library, *Wall Street Journal* file).

- Homemaker services provide meal preparation, companionship, and light house cleaning.[133]
- Adult day care centers provide transportation, personal hygiene services, and mental stimulation appropriate to a person's condition and tastes.[134]
- Many religious organizations arrange transportation for members to and from services.[135]
- Mass transit companies may provide accommodation for disabled persons on their regular routes.[136]

There are other workarounds as well, and more are being developed every day with the goal of enabling people to "age in place" rather than abandoning their current residence. With respect to affordability, some services are subsidized, others are provided by aging network organizations on a sliding scale, and still others offer quantity discounts.[137] In some cases, family members might contribute to the cost of these services.[138]

For structural problems with the home itself, there is an entire industry devoted to retrofitting existing residences and making them suitable for aging owners.[139] Constructing bath-

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133. Simona Covel, *Taking Care of Business: Why In-Home Health Care Is One of the Hottest Concepts in Franchising Today*, Wall St. J. R9 (Mar. 17, 2008) (available in LEXIS, News & Business library, *Wall Street Journal* file).

134. *E.g.* Jeff D. Opdyke, *Finding Day Care—For Your Parents—Choices Grow for Increasing Number of Baby Boomers Who Have Frail Parents They Are Reluctant to Leave*, Wall St. J. D1 (Jan. 10, 2008) (available in LEXIS, News & Business library, *Wall Street Journal* file).

135. *See* M. L. Reig, Student Author, *The Unspoken Poor: Single Elderly Women Surviving in Rural America*, 9 Elder L.J. 257, 282–283 (2001) (suggesting that churches are in a position to provide the elderly with transportation to and from social events).

136. A number of mass transit providers allow senior citizens or disabled persons to ride free. *E.g.* St. of Ill., *Seniors Ride Free*, http://www2.illinois.gov/ridefree/Pages/default.aspx (accessed Sept. 24, 2010) (allowing senior citizens age sixty-five and older and people with disabilities to ride buses and trains for free throughout Illinois).

137. *See generally* Jon Pynoos et al., *Aging in Place, Housing, and the Law*, 16 Elder L.J. 77 (2008) (discussing programs being implemented to develop financing systems in an effort to help older persons remain in their homes and suggesting policies that will foster this objective).

138. Frolik, *Client's Desire*, *supra* n. 128, at 7.

139. *E.g.* Rebuilding Together, http://www.rebuildingtogether.org (accessed Sept. 26, 2010); *see generally* Pynoos, *supra* n. 137, (arguing that further major policy changes are required to ensure the availability of modifications to homes and the construction of accessible and supportive housing).

rooms and bedrooms on the first floor to obviate the need to negotiate stairs is an alternative to staircase escalators and elevators, depending upon zoning allowances.[140] Replacing kitchen appliances, fixtures, bathroom fittings, and installing safety features such as carbon-monoxide detectors and fire alarms are other possibilities.[141] Some of these changes are not inexpensive, but they pale in comparison to the cost of most residential care facilities.[142]

Paying for these one-time expenditures or the ongoing costs of the in-home service options described previously may pose a serious financial problem for many older persons. In this context, Elder Law attorneys need to be familiar with reverse mortgages. These financial instruments provide cash to an older homeowner and do not require repayment until the homeowner leaves the home—unlike the more typical home improvement loan that has a regular repayment schedule.[143] The amount available is a function of the home's value minus outstanding debts, prevailing interest rates, and the age(s) of the homeowner(s).[144] Reverse

140. Mobility in homes can be such a challenge for the elderly that there is a movement termed "visitability" that advocates for building codes that require all homes to be built with "a zero step entrance, wide entry-door, and a full or half bath on the first floor" so that the elderly or disabled can access the homes of family and friends. Pynoos, *supra* n. 137, at 95.

141. *See e.g.* June Fletcher, *The Home Front: For Boomers, the House of the Future*, Wall St. J. W8 (Mar. 9, 2007) (available in LEXIS, News & Business library, *Wall Street Journal* file) (discussing universal design features to allow greater accessibility to older persons); June Fletcher, *The House of the Future—Yours—Elder-Friendly Touches Gain Ground with Homeowners*, Wall St. J. W12 (Feb. 14, 2003) (available in LEXIS, News & Business library, *Wall Street Journal* file) (describing home products for the aging including doorways providing easier wheelchair access, stacked closets that can handle elevators, and other home features allowing easier access for seniors).

142. Robin Paul Malloy, *Inclusion by Design: Accessible Housing and Mobility Impairment*, 60 Hastings L.J. 699, 736 (2008–2009) (discussing how implementing accessibility modifications in homes can save a great deal of money by preventing elderly people from moving into residential care units before they actually need to).

143. Kelly Greene & Valerie Bauerlein, *Reverse Mortgages: The Choices Expand*, Wall St. J. D1 (Nov. 13, 2007) (available in LEXIS, News & Business library, *Wall Street Journal* file) (explaining how reverse mortgages operate to allow older homeowners more options to use the equity they have built in their homes).

144. *Id.*; *see generally* Celeste M. Hammond, *Reverse Mortgages: A Financial Planning Device for the Elderly*, 1 Elder L.J. 75 (1993) (discussing the benefits of allowing the elderly to remain in their homes while tapping into the equity through reverse mortgages); Richard L. Kaplan, *Tapping the Equity of Older Homeowners with Reverse Mortgages*, 175 J. Accountancy 36 (Feb. 1993) (listing and discussing variables and considerations involved in the reverse mortgage system); Jean Reilly, Student Author, *Reverse Mortgages: Backing into the Future*, 5 Elder L.J. 17 (1997) (specifying the factors used to determine reverse-mortgage-maximum-loan amounts and additionally discussing the range of services available, the tax complexities, and the legislative developments to regulate the

mortgages can be obtained with a line of credit that is suitable for major construction initiatives or as a stream of monthly payments that can pay for ongoing costs.[145] To be sure, reverse mortgages may have legal implications regarding taxation at the home's eventual disposition or eligibility for certain public benefits,[146] but they remain an important means by which an older person can stay in his or her home. The larger point here is that Elder Law attorneys can help older homeowners make their existing residence work—an especially important objective given older persons' strongly expressed preferences.

That is not to say, however, that all older persons will be able to stay in their home until the very end. For various reasons, the need to move out of the home may become inevitable. But most older people prefer to defer that inevitability as long as possible, and the holistic approach to an elder's housing concerns described above can accomplish that goal.

2. Disposition of the Home

When a move must be undertaken, selling the home is fraught with considerable emotional baggage and no small amount of tax implications as well. Although the tax code's exclusion of gains on the sale of a principal residence is usually covered in the Income Taxation course, some students may not have taken that class, while others may have forgotten this particular provision.[147] Accordingly, a serious re-examination of this issue is appropriate with a specific focus on sales by long-time homeowners. Among the key aspects worthy of attention in this context are the following:

industry).

145. Greene & Bauerlein, *supra* n. 143 (indicating that homeowners age sixty-two or older using reverse mortgages are able to sell back the equity in their homes in exchange for either a lump sum, monthly payments, or a line of credit).

146. Frolik & Kaplan, *supra* n. 49, at 219–222; *see generally* U.S. Govt. Accountability Off., *Reverse Mortgages: Product Complexity and Consumer Protection Issues Underscore Need for Improved Controls over Counseling for Borrowers* (Pub. No. GAO-09-606, 2009) (available at http://www.gao.gov/new.items/d09606.pdf) (asserting that many older persons seeking reverse mortgages are in a vulnerable position and that there are no institutional controls to ensure that those making such decisions are fully informed of the financial consequences of their decision).

147. I.R.C. § 121 (2006 & Supp. 2009).

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- Many homes of older persons produce no gain at all upon their disposition due to changes in the neighborhood's desirability or the residence's outdated electrical systems and other features.
- *Gains* from, as opposed to sales prices of, older residences are typically less than the tax code's exclusion of $250,000 (or $500,000 for married couples),[148] even though those parameters have not been increased since they were enacted in 1997.[149]
- Joint ownership of a residence, regardless of the marital status of the owners, may interact with the tax code's step-up-in-basis rule[150] if one of the joint tenants died before the home was sold.
- Inter vivos gifts of a residence to an older person's younger relative might have less than optimal tax consequences.[151]
- Reverse mortgages can upset an older homeowner's tax planning if the as-yet unrealized gain on the residence exceeds the tax code's applicable exclusion.[152]

A final option is moving out of the residence but retaining it for a future testamentary transfer. In the overwhelming majority of cases, there are no negative tax consequences of this strategy,[153] but most older people have the bulk of their financial net worth tied up in their residence.[154] As a result, they typically need

148. *Id.* at §§ 121(b)(1), (2)(A).

149. Taxpayer Relief Act of 1997, Pub. L. No. 105-34, § 312(a), 111 Stat. 788, 836–841 (1997) (amending I.R.C. § 121).

150. I.R.C. § 1014(a) (2006).

151. *See* Frolik & Kaplan, *supra* n. 49, at 207–210 (explaining that the donor's standard $250,000 gain exclusion will not apply if the donee does not use the home as a "principal residence" and that gain will then carry over to the donee for taxation purposes).

152. *Id.* at 219–221.

153. *See id.* at 210–212 (explaining that a decedent's adult child can take the home with a basis of the fair market value, rather than the parent's adjusted basis, so long as there is no oral or written contractual agreement to give the home in exchange for the child's services).

154. *See* Alicia H. Munnell & Mauricio Soto, *The Housing Bubble and Retirement Security* 1 (Trustees of Bos. College, Ctr. for Ret. Research 2008) (available at http://crr.bc.edu/images/stories/Briefs/ib_8-12.pdf) (indicating that a house comprises at least half of a typical household's wealth).

to dispose of their home to finance whatever housing arrangement comes next.

3. Alternative Housing Arrangements

Once the home has been sold the question remains: Where will the older person live? One alternative that has deep historical antecedents is moving into the residence of one of the older person's adult children on either a temporary or permanent basis.[155] In this situation, the family member may provide shelter and other benefits such as meals and room cleaning. In other situations, however, the family member may take on a more extensive caregiving role. This latter option involves a range of legal issues, especially if the arrangement is formalized in a family caregiving agreement.[156] Some of the applicable concerns include federal and state income tax withholdings, Social Security obligations, unemployment taxes, workers' compensation, and employee benefits.[157] These agreements should clearly set forth the responsibilities that the family caregiver is assuming, as well as expectations concerning: the cost of special accommodations that the older person might require; vacation plans; cost of living adjustments; and the like.[158] Such agreements are becoming more common as fami-

155. *See* Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 Va. Tax Rev. 509, 511 (2005) [hereinafter Kaplan, *Tax Policy*] (noting that most long-term care of older adults is provided by family and friends); U.S. Dept. of Health and Human Servs., *Family Caregivers: Our Heroes on the Frontlines of Long-Term Care*, http://aspe.hhs.gov/daltcp/CaregiverEvent/factsheet.pdf (Dec. 16, 2003) (commenting that family caregivers are the "backbone" of care for elderly adults).

156. *See generally* Kaplan, *Tax Policy*, *supra* n. 155, at 526–534 (describing family caregiving agreements as a form of contract specifying what "compensation" the caregiver will receive for providing care for the elder parent and the related inheritance and taxation issues).

157. *See id.* at 516–517 (itemizing necessary withholdings when transfers are treated as compensation rather than as gifts); Scott M. Solkoff, *Personal Service Contracts for the Elderly Revisited* (pts. 1 & 2), 18 ElderLaw Rpt. 1 (Nov. 2006), 18 ElderLaw Rpt. 3 (Dec. 2006) (noting the tax implications a caregiver must consider when entering into a compensation contract).

158. *See* Donna S. Harkness, *Life Care Agreements: A Contractual Jekyll and Hyde?* 5 Marq. Elder's Advisor 39, 48–51 (2003) (suggesting that long-term care agreements specifically enumerate the services expected so as to prevent exploitation or disputes later); Richard L. Kaplan, *Formalizing the Informal: Family Care Agreements in Canada and the United States*, 1 Can. J. Elder L. 52, 77–85 (2008) (noting that many elderly and their families will be resistant to formally detailing the arrangement in a legal contract but that the practice is advisable nonetheless).

lies recognize the importance of these caregiving arrangements to both parties.[159]

An alternative to family caregiving is employment of nonrelatives to provide this important function, whether it is provided in the older person's home or in a relative's residence. All of the issues mentioned above apply with equal force in this situation, and some additional concerns, such as immigration status and liability insurance, might be important as well.[160] Some families outsource these concerns by engaging home-caregiver agencies, but due diligence is still required regarding which home-care agency to employ.[161]

If a residential home setting is not appropriate, a range of congregate care settings[162] exists currently and is likely to expand over time. Each presents its own set of legal issues, including:

- cost and scope of services provided;
- coverage of these costs via public programs like Medicaid or private insurance;
- upfront expenditures ("buy-ins") and their refundability versus ongoing expenses;
- access to healthcare and the cost thereof; and
- the extent of federal versus state regulation and accessibility of inspection reports.[163]

In addition to these issues, certain housing alternatives present specific legal concerns unique to their arrangements, and

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159. *See* Kaplan, *Tax Policy*, *supra* n. 155, at 512–516 (citing a study finding that the number of households acting as caregivers to the elderly tripled between 1997 and 2007 and such numbers will continue to grow).

160. *See* Natalie A. Simon, *Legal Considerations in Hiring In-Home Caregivers*, 7 ElderLaw Rpt. 1, 1 (May 1996) (noting the "tax, labor law, and tort obligations of employers who hire caregivers").

161. Julia Y. Capozzi, Student Author, *Chapter 2: Criminal Background Checks for Recipients of In-Home Supportive Services*, 40 McGeorge L. Rev. 591, 594–595 (2009).

162. Congregate care settings often refer to group residences that provide for private living arrangements, such as apartments and condominiums, but also provide some support services such as common areas, daily meals, and social interaction. Lawrence A. Frolik & Melissa C. Brown, *Advising the Elderly or Disabled Client*, § 16.06, 16-33 to 16-34 (2d ed., Thompson Reuters 2010).

163. *See* Frolik & Kaplan, *supra* n. 49, at 228–235 (discussing various legal complexities involved with congregate-care settings).

these concerns often involve familiar doctrines from contract law or exercises in statutory interpretation. For example, admission contracts for independent retirement centers often require that residents be able to live without assistance or may restrict the use of walkers or wheelchairs.[164] Assisted living facilities often employ so-called negotiated risk contracts that release the facility from liability for inadequate care.[165] Continuing care retirement communities usually guarantee access to the community's nursing home if a resident requires that level of attention, but what happens if that particular facility is full?[166]

Nursing homes represent the most medically intensive option across the housing spectrum and present their own set of legal issues. For example, most of these agreements ask that a relative of the older person be listed as that person's "responsible party," but does this designation refer to a contact person in case of emergencies or does it incorporate an open-ended obligation to cover the resident's cost of care?[167] Similarly, federal law limits a

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164. *See* Erin Ziaja, Student Author, *Do Independent and Assisted Living Communities Violate the Fair Housing Amendments Act and the Americans with Disabilities Act?* 9 Elder L.J. 313, 315 (2001) (reporting that phone calls to several senior communities ascertained that, for example, seniors requiring wheelchairs or seeing-eye dogs would not be allowed to live in those communities); *see also* Michael Allen et al., *Fair Housing Protections for Older Clients*, 17 NAELA Q. 37 (Spring 2004) (outlining the legal authority that exists to prevent discrimination against the elderly and handicapped); Carol Wessels, *The "Independent Living" Eviction in Subsidized Housing*, 15 NAELA Q. 9, 9 (Summer 2002) (relaying the story of an elderly person being evicted from her apartment because the landlord did not believe she could live independently anymore).

165. *See* Eric Carlson, *Advocacy for Assisted Living Residents*, 14 ElderLaw Rpt. 1, 3–4 (June 2003) (advising elderly residents in assisted living facilities against agreeing to "negotiated risk" waivers); *see also* Stephanie Edelstein, *Resident Rights in Assisted Living: Sources and Resources*, 16 ElderLaw Rpt. 1, 4 (Mar. 2005) (suggesting that there is no good reason for negotiated risk agreements, and noting that several states have prohibited such agreements); *see generally* Eric M. Carlson, *Long-Term Care Advocacy* § 5.07(2) (Matthew Bender 2005) [hereinafter Carlson, *Long-Term Care*] (discussing assisted living contracts and the enforceability of negotiated risk agreements therein).

166. Ideally, this issue should be addressed in detail in the continuing care retirement community contract. Charles P. Sabatino, *Continuing Care Facilities: Guidelines for Evaluating Contracts*, 3 ElderLaw Rpt. 1, 4 (June 1992). One solution is to give residents priority to the on-site nursing facilities, but provide that they can be sent off-site if necessary. Carlson, *Long-Term Care*, *supra* n. 165, at § 6.09(3).

167. *See Podolsky v. First Healthcare Corp.*, 50 Cal. App. 4th 632, 646, 656–657 (Cal. App. 2d Dist. 1996) (holding that, while third-party-guarantee agreements are allowable under federal and state laws, sufficient notification and explanation of such an agreement must be disclosed and such an agreement cannot be required for admission); Eric M. Carlson, *A Nursing Home Cannot Force a Resident's Family Member or Friend to Become Financially Responsible for Nursing Home Expenses*, 9 NAELA Q. 19, 19 (Fall 1996) (indicating that even though federal law prohibits third-party-guarantor agreements from

nursing home to six specified grounds for involuntarily discharging residents,[168] but what happens to a resident whose expenses are being covered by Medicaid if the facility stops participating in that program?[169] Other issues arise when admissions agreements mandate arbitration of disputes[170] or limit a facility's liability for negligent or inadequate care.[171] The applicability and enforceability of these provisions may depend on evolving caselaw in the relevant jurisdiction.

C. How to Pay for Medical Care

Healthcare costs are a major concern of older Americans and one that actually increases as they age. Since the enactment of Medicare in 1965, most acute care costs for this age cohort have

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being required for admission, nursing homes continue to ignore and evade the law); *see also* Katherine C. Pearson, *The Responsible Thing to Do about "Responsible Party" Provisions in Nursing Home Agreements: A Proposal for Change on Three Fronts*, 37 U. Mich. J.L. Reform 757 (2004) (arguing that family members or other third parties should not be forced to volunteer to assume personal debt obligations for the care of the resident).

168. 42 U.S.C. §§ 1395i-3(c)(2)(A), 1396r(c)(2)(A) (2006) (Medicare-certified facilities and Medicaid-certified facilities, respectively); *see also* 42 C.F.R. § 483.12(a)(2) (2009) (listing reasons why facilities may transfer or discharge patients).

169. *See* Nursing Home Resident Protection Amendments of 1999, Pub. L. No. 106-4, 113 Stat. 7 (1999) (amending 42 U.S.C. § 1396r(c)(2)(F) (1994)) (providing continuing rights to those who were residents of the facility before the facility's voluntary withdrawal from Medicaid participation); *see generally* Cori F. Brown, Student Author, *Nursing Homes: Status-Based Evictions and the Medicaid Crisis*, 12 Elder L.J. 355 (2004) (contending that a loophole in the Nursing Home Resident Protection Amendments allows nursing homes to evict Medicaid residents).

170. *See Woebse v. Health Care & Ret. Corp.*, 977 So. 2d 630, 633–635 (Fla. 2d Dist. App. 2008) (holding a mandatory arbitration agreement unconscionable after the signer was told to sign the lengthy agreement without being given an opportunity to read or subsequently review the numerous documents); *see generally* Suzanne Gallagher, *Mandatory Arbitration Clauses in Nursing Home Admission Agreements: The Rights of Elders*, 3 NAELA J. 187 (2007) (arguing that nursing home agreements should not contain mandatory arbitration clauses that waive the resident's constitutional rights to trial by jury and due process); Ann E. Krasuski, Student Author, *Mandatory Arbitration Agreements Do Not Belong in Nursing Home Contracts with Residents*, 8 DePaul J. Health Care L. 263 (2004) (recommending that Congress prohibit mandatory arbitration clauses that are usually signed in haste during admission and can bind residents and families to such agreements); Katherine Palm, Student Author, *Arbitration Clauses in Nursing Home Admission Agreements: Framing the Debate*, 14 Elder L.J. 453 (2006) (proposing a model admission agreement allowing for arbitration that would encourage and enhance consumer knowledge about such cost-saving agreements, while allowing nursing home residents to be treated respectfully and with care).

171. *See* Carlson, *Long-Term Care*, *supra* n. 165, at § 3.06(2)(e) (explaining that waivers included in admission agreements that purport to waive a facility's liability are illegal).

been covered by the federal government.[172] Nevertheless, from its inception, Medicare's coverages have been subject to restrictions and limitations that owe more to historical accident than programmatic coherence.[173] Indeed coverage of prescription drugs, a key element of most health insurance plans, was not added to Medicare until 2003.[174] Even now, less than half of older Americans' healthcare expenses are covered by Medicare.[175] Some gaps in this program's coverage are filled by private, so-called Medigap insurance policies or via managed care arrangements.[176] But the single largest gap in Medicare concerns long-term care.[177] Older persons whose income is low enough to qualify for Medicaid benefits receive coverage for many types of long-term care through that separate governmental program, while others must either purchase private long-term care insurance or pay those costs themselves.[178] In sum, the answer to the question of "how to pay for medical care" is a convoluted and uncoordinated maze consisting of Medicare, long-term care insurance, and Medicaid.

1. Medicare

This federal program is financed through a combination of payroll taxes paid throughout the course of an employee's work history, monthly premiums paid for optional coverages while retired, and general tax revenues.[179] Medicare itself consists of four distinct components, labeled Parts A through D, and Elder Law attorneys must understand the contours of each Part, the

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172. Frolik & Kaplan, *supra* n. 49, at 56.

173. *See generally id.* at 56–109 (discussing the implementation and eligibility requirements of the various Medicare coverages).

174. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

175. Henry J. Kaiser Fam. Found., *Fact Sheet: Medicare: Medicare Spending and Financing* 1, http://www.kff.org/medicare/upload/7305-04-2.pdf (May 2009).

176. *See generally* Frolik & Kaplan, *supra* n. 49, at 97–109 (discussing these two options, which provide additional coverage beyond benefits received through Medicare). Medigap policies are an optional means for older persons to limit their exposure to unexpected medical bills that are not covered fully by Medicare. *See generally id.* at 97–103 (explaining protection provisions and policy benefits of Medigap plans).

177. Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 Lewis & Clark L. Rev. 407, 409–410 (2007) [hereinafter Kaplan, *Retirement*].

178. *See generally id.* at 422–448 (discussing the qualification requirements, benefits, and drawbacks of both Medicaid and private long-term care insurance policies).

179. Kaplan, *Retirement*, *supra* n. 177, at 416–417.

File: Kaplan.Galley.PublicationCopy.docx Created on: 12/28/2010 3:09:00 PM Last Printed: 1/17/2011 9:18:00 PM

applicable limitations, and the nature of the options that exist within these components.[180] For students who have not interacted with the United States healthcare system to any significant degree, traversing the world of Medicare is one strange and often depressing journey, but it is a path that simply must be navigated.

Medicare Part A is the one component that virtually every older American has because enrollees who worked approximately ten years[181] (or whose current[182] or divorced spouse[183] did so) can obtain its coverage with no additional cost. Part A covers hospital costs, some expenses of "skilled nursing facilities," home healthcare, and hospice care.[184] Part A coverage has deductibles, medical eligibility restrictions, durational limits in terms of days of coverage, and other qualifiers that can easily overwhelm seniors and their advisors.[185] For example, Medicare covers virtually all costs in a hospital but only during the first sixty days of a "spell of illness," subject to a deductible that is adjusted annually for inflation.[186] Similarly, Medicare covers the cost of "skilled care" in a nursing home only if the stay was preceded by a hospital admission within the preceding thirty days for treatment of the same or a medically related condition.[187] There are many such provisions, and it is incumbent on the Elder Law attorney to have a working knowledge of them.

Such knowledge is necessary in the first instance to evaluate whether a client should consider obtaining a Medigap policy. Medigap policies are issued exclusively by private companies and an enrollee pays all of the associated costs, though some employers provide such coverage as a retiree health benefit.[188] Medigap

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180. *See generally* Frolik & Kaplan, *supra* n. 49, at ch. 4 (explaining the four primary Medicare parts).

181. 42 U.S.C. §§ 414(a)(2), 426(a)(2)(A), 1395c.

182. *Id.* at §§ 402(b)(1), (c)(1).

183. *Id.* at § 416(d)(1).

184. *Id.* at §§ 1395c, 1395d; *see generally 2010 Medicare Handbook*, chs. 2–5 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., Aspen Publishers 2010) [hereinafter *Medicare Handbook*] (detailing how Medicare Part A applies in each of the different settings).

185. *Medicare Handbook*, *supra* n. 184, at chs. 2–5.

186. *Id.* at § 2.04(A), at 2-8 to 2-9.

187. 42 U.S.C. § 1395x(i)(A); 42 C.F.R. § 409.30(b)(1).

188. *But see* Richard L. Kaplan et al., *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 Yale J. Health Policy L. & Ethics 287, 292–300 (2009) (analyzing the diminishing scope and declining availability of such benefits).

policies come in twelve different but standardized bundles of coverages.[189] Premiums vary by company and the comprehensiveness of the benefits package selected. No one is required to buy Medigap insurance, so a critical question is whether such a policy makes sense for a particular client in terms of the client's expected healthcare utilization, ability to afford the premiums, future insurability, and general attitude toward assuming insurable risks.[190] Apart from this very practical determination, the regulation of Medigap insurance represents an interesting policy question regarding the role of government—namely, should government expand Medicare's package of benefits, or should government leave to individuals the decision to augment this coverage by purchasing supplementary insurance? If the latter, should government facilitate that process by regulating the contents of such policies[191] and thereby enable cost comparison by prospective purchasers?

Medicare Part B covers doctors' fees, ambulance charges, some home healthcare, medical supplies, and outpatient therapy.[192] It is optional coverage, but most older people choose to obtain it, primarily because the federal government subsidizes up to seventy-five percent of its cost from general tax revenues.[193] That is, the monthly premium assessed for Medicare Part B is calculated to cover twenty-five percent of the program's projected expenses for the year.[194] Certain high-income enrollees, however, pay higher premiums that are based on their income for federal

189. *See generally* Ctrs. for Medicare & Medicaid Servs., *2010 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* 11 (CMS Product No. 02110, 2010) [hereinafter *Guide*] (available at http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf) (listing the available Medigap policies).

190. *See generally Medicare Handbook*, *supra* n. 184, at ch. 8 (detailing the aspects of the different policies and encouraging attorneys to help their clients choose the plan best suited to their needs).

191. For an example of Medicare supplemental insurance regulation, see Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4353(a), 104 Stat. 1388, 1388-129 to 1388-130 (1990) (codified at 42 U.S.C. § 1395ss(a)) (prohibiting the issuance of such policies unless the state in which it is issued has a program in place to set and enforce standards).

192. 42 U.S.C. §§ 1395k, 1395x.

193. Kaplan, *Retirement*, *supra* n. 177, at 417 (explaining how "[g]eneral tax revenues provide [seventy-five percent]" of the funding for Part B, while the remaining twenty-five percent is provided by premiums paid by the enrollees); *Medicare Handbook*, *supra* n. 184, § 1.05(B), at 1-19 to 1-22 (describing Medicare Part B and noting that the coverage is optional).

194. *Medicare Handbook*, *supra* n. 184, § 6.02(C)(1), at 6-10.

tax purposes from a prior year.[195] In effect, there is a sliding scale for the cost of this coverage, but even the wealthiest Medicare enrollee receives an effective subsidy of twenty percent for his or her Medicare Part B coverage.[196] Part B has its own deductibles and limitations,[197] some of which can be covered by specific Medigap policies.[198] Thus, key client decisions in this context are: first, whether to purchase Medicare Part B (which is generally advisable);[199] second, whether to purchase a Medigap policy; and third, what particular benefits that Medigap policy should contain.

Medicare Part D covers pharmaceutical medicines[200] and differs from Medicare Parts A and B in that there is no specific coverage package set forth in the statute.[201] Instead of a one-size-fits-all orientation that applies across the country, Part D plans vary by state and by individual provider.[202] The animating philosophy of the legislation that created Part D was to rely on private companies rather than fashion a standardized benefit package.[203] As a result, at least forty-one and as many as fifty-five different benefit packages were available in each state in 2010,[204] and they often change annually in important respects. Monthly premiums can vary dramatically depending upon the particular plan selected—from under ten dollars in one plan to more than one hundred twenty dollars in another, in 2010.[205]

Although the plans' coverages are subject to federal "actuarial equivalence" parameters, they have substantial variability within

195. *See generally* Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, 9 J. Retirement Plan. 22 (May–June 2006) (explaining the "means-testing" provision implemented in 2007 that reduces the federal subsidy for Medicare Part B based on higher levels of income).

196. *Id.* at 28.

197. For an explanation of what copayments and deductibles beneficiaries under Part B are responsible for, see *Medicare Handbook*, *supra* note 184, at § 6.02(D), at 6-21 to 6-22.

198. For a list of Medigap policies and information on what each policy covers, see *Guide*, *supra* note 189, at 13.

199. *See* 42 U.S.C. § 1395r(b) (prescribing a permanent penalty for late enrollment).

200. *Id.* at §§ 1395w-101 to 1395w-152.

201. *See* Frolik & Kaplan, *supra* n. 49, at 86–93 (describing the varying scopes of coverage and premium costs available for beneficiaries to select from).

202. *See generally Medicare Handbook*, *supra* n. 184, at ch. 11 (discussing how the Part D prescription program works through private company offerings throughout the states).

203. *Id.* at 11-3.

204. Henry J. Kaiser Fam. Found., *Fact Sheet: Medicare: Medicare Part D Prescription Drug Plan (PDP) Availability in 2010*, at 1, http://www.kff.org/medicare/upload/7426-06.pdf (Feb. 2010).

205. *Id.*

those constraints.[206] Thus, some plans cover only generic drugs, while others cover certain brand-name drugs and not others. Further, plans may cover the same medication at some dosages but not others. For example, a plan might cover a medication that is taken at a dose of one-thousand milligrams once per day but not five-hundred milligrams twice per day.[207] Many plans follow the statutory prototype of an annual deductible, followed by coverage of seventy-five percent for drug costs up to a specified limit, followed by a coverage gap known colloquially as the "donut hole," and then ninety-five percent of drug costs in excess of this coverage gap.[208] Meanwhile, some plans eliminate the annual deductible entirely,[209] and other plans eliminate the coverage gap mainly for generic medications.[210]

Enrollees are directed to Medicare's website to make their annual plan selections based on the ever-changing scope of the plans' approved drug formularies and premium costs.[211] All plans receive substantial federal subsidies, and lower-income Medicare beneficiaries receive additional financial assistance depending upon the level of their annual income and assets.[212] There is no

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206. *See generally CMS Guidance on the Actuarial Equivalence Standard for the Retiree Drug Subsidy*, http://www.eric.org/forms/uploadFiles/35F100000005.filename.Actuarial_Equivalence_Guidance.pdf (Apr. 7, 2005) (discussing the actuarial equivalence standard and the methodology behind it).

207. *See generally* Ctrs. For Medicare and Medicaid Servs., *How Medicare Drug Plans Use Pharmacies, Formularies, and Common Coverage Rules*, http://www.medicare.gov/Publications/Pubs/pdf/11136.pdf (revised October 2009) (discussing drug plan coverage logistics).

208. *See* Frolik & Kaplan, *supra* n. 49, at 89–90 (describing the prototype plan and the applicable parameters in 2010). For an explanation of the political imperatives that spawned the coverage gap concept, see Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAELA J. 167, 171–172 (2005).

209. *See* Henry J. Kaiser Fam. Found., *Medicare Part D 2010 Data Spotlight: Benefit Design and Cost Sharing* 1, http://www.kff.org/medicare/upload/8033.pdf (Dec. 2009) (reporting that forty percent of plans have no annual deductible).

210. *See* Henry J. Kaiser Fam. Found., *Medicare Part D 2010 Data Spotlight: The Coverage Gap* 1, http://www.kff.org/medicare/upload/8008.pdf (Nov. 2009) (finding, "In 2010, as in previous years, the vast majority of . . . plans that offer gap coverage cover generic drugs but not brand-name drugs."). The recently enacted health care reform legislation will reduce, but not completely close, this coverage gap gradually over ten years beginning in 2011. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1101(b)(3), 124 Stat. 1029, 1037–1039 (2010) (adding 42 U.S.C. §§ 1395w-102(b)(2)(C)(ii), (D)(i)(I), (ii) (lowering an enrollee's co-payment obligation on generic and brand-name drugs, respectively)).

211. U.S. Dept. of Health & Human Servs., *Medicare.gov*, *Medicare Plan Finder*, http://www.medicare.gov/find-a-plan/questions/home.aspx (accessed Sept. 25, 2010).

212. 42 U.S.C. § 1395w-114.

requirement that a client participate in Medicare Part D, but if a person chooses not to do so when he or she is first eligible, any subsequent enrollment is subject to a delayed enrollment penalty,[213] the amount of which depends upon how long that person was without "creditable prescription drug coverage."[214] Once again, there are numerous decision points that clients must consider, including: first, whether to purchase a Part D plan at all; and second, which plan to buy—a decision that might need to be revisited as plan parameters and a client's pharmaceutical needs change.

Finally, Medicare Part C provides an alternative to the conglomeration of benefit coverages just described. This component refers to various Medicare managed care arrangements, including health maintenance organizations, which are collectively denominated "Medicare Advantage" plans.[215] These plans typically provide all of the coverages of Medicare Parts A and B and include some drug coverage as well.[216] That coverage is typically based on a restricted formulary of approved medications and may have annual caps and other limitations. On the other hand, Medicare Advantage plans generally cover the standard deductibles and co-payment obligations of Medicare Parts A and B, thereby obviating the need for any Medigap policy.[217] Like managed care arrangements, generally, these plans usually limit enrollees to specified physicians, hospitals, pharmacies, and other healthcare providers, and impose costly charges for services from providers who are outside the organization's approved network.[218] Only approximately one-fifth of Medicare enrollees obtain their Medicare coverage through this program,[219] but it remains an

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213. *Id.* at § 1395w-113(b).

214. *Id.* at § 1395w-113(b)(3).

215. *Id.* at § 1395w-21(referring to such plans as "Medicare+Choice plans").

216. *See generally* Marsha Gold & Maria Cupples Hudson, *Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It Provide, and Should Standards Apply?* (AARP 2009) (available at http://assets.aarp.org/rgcenter/health/2009_03_medicare.pdf) (discussing the benefits provided through Medicare Advantage).

217. *Medicare Handbook*, *supra* n. 184, § 7.02(A), at 7-7.

218. *Id.* § 7.02(B), at 7-8; *see generally* U.S. Govt. Accountability Off., *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs* (Pub. No. GAO-08-359, 2008) (available at http://www.gao.gov/new.items/d08359.pdf) (examining the financial aspects of Medicare Advantage Plans).

219. Henry J. Kaiser Fam. Found., *Fact Sheet: Medicare: Medicare Advantage* 1, http://www.kff.org/medicare/upload/2052-12.pdf (Apr. 2009).

important option for those who appreciate the simplicity of this integrated approach.

Beyond the bewildering array of choices and differing arrangements, Medicare can serve as the basis for wide-ranging classroom discussions about healthcare generally and the role that government should play in this vital function.[220] After all, Medicare is the closest version of universal health insurance that the United States has adopted thus far. Within the category of Americans age sixty-five and over, the problem of the uninsured is largely absent. But this achievement has its costs and detractors.[221] For example, does the prospect of universal coverage incentivize people to disregard common wellness admonitions regarding smoking, diet, and regular exercise? Alternatively, what does the experience of Medicare regarding exploding programmatic costs imply for government healthcare programs generally? Should Medicare's means-testing provisions be extended and made more severe, or would such changes erode the sense of communal solidarity that undergirds this program's widespread popularity? If budgetary pressures cause the government to reduce its payment rates to healthcare providers, will those providers decline to participate in the Medicare program or limit the number of Medicare beneficiaries they are willing to see?[222] If Medicare is to maintain its foundational role in the financing of healthcare for older Americans, these questions are extremely critical.[223] It does a client little good, after all, to have

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220. *See e.g*. Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. Ill. L. Rev. 777, 787–788 (discussing and criticizing Professor Richard Epstein's attack on the Medicare system and examining then current Medicare reforms).

221. *E.g.* Richard A. Epstein, *Mortal Peril: Our Inalienable Right to Health Care?* ch. 7 (Addison-Wesley Publg. Co. 1997) (discussing the unsustainability of Medicare due to its increasingly out of control costs); David A. Hyman, *Medicare Meets Mephistopheles*, 60 Wash. & Lee L. Rev. 1165 (2003) (examining Medicare in the context of the "Seven Deadly Sins").

222. *See* Physicians' Found., *The Physicians' Perspective: Medical Practice in 2008* at 9 (Physicians' Found. 2008) (available at http://www.mendocinohre.org/rhic/200811/PF_Report_Final.pdf) (reporting that 11.70% of physicians surveyed had "closed their practices to Medicare patients").

223. *See generally* Cent. Found. Task Force on Medicare Reform, *Medicare Tomorrow: The Report of the Century Foundation Task Force on Medicare Reform* (Lisa Potetz & Thomas Rice eds., Cent. Found. Press 2002) (discussing then recent changes in Medicare and evaluating how those changes affect the parties involved); Marilyn Moon, *Medicare: A Policy Primer* (Urb. Inst. Press 2006) (explaining what Medicare is, describing how the program works, and examining the possibility of future reform); Daniel Shaviro, *Who Should Pay for Medicare?* (U. of Chi. Press 2004) (examining the Medicare program and its

Medicare coverage for treatment of macular degeneration if no ophthalmologist will accept a Medicare patient.

2. Long-Term Care Insurance

As people age, their risk of needing long-term care increases, and America's aging population has made this issue more prominent than it was when people did not live long enough to succumb to various age-related diseases. Medicare was created when this concern was less significant, and its coverages reflect that historical reality. As a result, Medicare's coverage of home healthcare is extremely limited, its coverage of nursing home care is restricted to short periods of acute treatment rather than chronic need, and its coverage of assisted-living facilities is nil.[224] Unless an older person's financial resources are low enough to qualify for Medicaid's long-term care benefits, the burden of paying for long-term care rests with the older person or perhaps the older person's family if they are so inclined. If that person, or his or her family, does not want to bear the risk of paying for such care, long-term care insurance might be worth considering.

Generally, such insurance is issued by private companies with no direct federal subsidy for buyers.[225] Premiums for such insurance are deductible as medical expenses,[226] but this deduction is subject to age-based dollar limits,[227] which are adjusted annually for inflation,[228] as well as a more general requirement that medical expenses exceed 7.5% of a person's "adjusted gross income."[229] In 2000 it was estimated that only about ten percent of

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resulting costs); Symposium, *The Future of Medicare, Post Great Society and Post Plus-Choice: Legal and Policy Issues*, 60 Wash. & Lee L. Rev. 1087 (2003) (examining Medicare from a variety of perspectives); Symposium, *Future of Medicare*, 18 Health Aff. 1 (Jan.–Feb. 1999) (discussing Medicare and the policies behind the program as well as statistics and ideas for reform).

224. *See* Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. Ill. L. Rev. 47, 58–64 (discussing the financing options available to those needing or interested in purchasing long-term care).

225. *See* Elder Law Answers, *Long-Term Care Insurance*, http://www.elderlawanswers.com/Elder_Info/Elder_Article.asp?id=2595 (accessed Sept. 26, 2010) (explaining the logistics of long-term care insurance).

226. I.R.C. § 213(d)(1)(D) (2009).

227. *Id.* § 213(d)(10)(A).

228. *Id.* § 213(d)(10)(B); *see* Rev. Proc. 2009-50, § 3.21, 2009-45 I.R.B. 617, 623 (providing inflation-adjusted amounts for 2010).

229. I.R.C. § 213(a).

Americans age sixty-five and over had long-term care insurance,[230] though that number may increase over time.

A useful exercise at the outset is to inquire why the vast majority of older persons have not secured long-term care insurance. Some general explanations of this phenomenon include the following:

- People (mistakenly) believe that Medicare covers most forms of long-term care. A survey by AARP in 2006 of 1,456 persons age forty-five and older found that more than fifty-eight percent believed that Medicare covered nursing home care[231] and fifty-two percent thought that it covered assisted-living facilities.[232]
- People do not expect to live long enough to develop the sort of maladies that require long-term care.
- Needing long-term care is not a certainty.[233]
- People assume that their spouse or children will be willing and able to provide such care if the need arises.[234]

Some people may have actually considered such insurance in the past and decided not to purchase it. They too have their reasons for this decision, including some or all of the following:

- Their application was rejected because of pre-existing medical conditions or family history.[235]
- The insurance was too expensive in light of personal expectations of never needing care. In fact, an important

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230. U.S. Gen. Acctg. Off., *Long-Term Care Insurance: Better Information Critical to Prospective Purchasers* 3 (Pub. No. GAO/T-HEHS-00-196, 2000) (available at http://www.gao.gov/archive/2000/he00196t.pdf).

231. AARP, *The Costs of Long-Term Care: Public Perceptions Versus Reality in 2006*, at 3, 30 (AARP 2007) (available at http://assets.aarp.org/rgcenter/health/ltc_costs_2006.pdf).

232. *Id.* at 43.

233. *See* LifePlans, Inc., *Who Buys Long-Term Care Insurance? A 15-Year Study of Buyers and Non-Buyers 1990-2005*, at 44, http://www.ahipresearch.org/PDFs/LTC_Buyers_Guide.pdf (Apr. 2007) (stating that for some older persons, "a lack of understanding about the risk of needing [long-term care]" is a reason they do not buy such insurance).

234. *Id.* at 46 tbl. 12.

235. *See* Christopher M. Murtaugh et al., *Risky Business: Long-Term Care Insurance Underwriting*, 32 Inquiry 271, 277 (Fall 1995) (finding that approximately one in four Americans age sixty-five would probably have been rejected in 1995).

study found that "[c]ost was cited most frequently as a very important reason for deciding not to buy."[236]

- Substantial rate increases on existing policies raise questions about whether the insurance will remain affordable when it is most likely needed.[237]
- The solvency of the insurers is backed by state, rather than federal, guaranty funds and only up to specified limits per insured.[238]
- Policy options are confusing and not standardized among insurers, making price comparisons very difficult if not impossible.[239]

These concerns notwithstanding, Elder Law attorneys need to be familiar with long-term care insurance and some of the more fundamental options that are available.[240] The lack of such insurance, after all, might expose a client to considerable financial risk. The average cost of a private room in a nursing home is currently $75,190 per year,[241] with significant price variation across the nation,[242] and the cost is likely to increase in the future. Few clients can afford five or possibly ten years of such expense with-

236. LifePlans, Inc., *supra* n. 233, at 44.

237. *See* Jennifer Levitz & Kelly Greene, *States Draw Fire for Pitching Citizens on Private Long-Term Care Insurance*, Wall St. J. A1 (Feb. 26, 2008) (available in LEXIS, News & Business library, *Wall Street Journal* file) (reporting that one individual's policy was subjected to a rate increase of 260% in only three years).

238. *See* M.P. McQueen, *Insurer Casts Off Long-Term Care Policies*, Wall St. J. D1 (Dec. 3, 2008) (available in LEXIS, News & Business library, *Wall Street Journal* file) (discussing Conseco Inc.'s transfer of many of their long-term care policies to a state supervised trust).

239. *See* LifePlans, Inc., *supra* n. 233, at 44 (finding that in 2005, fourteen percent of those who considered purchasing long-term care insurance did not do so because they were confused about "which policy was right for them").

240. *See generally* Lawrence A. Frolik, *Long Term Care Insurance: Deal or No Deal?* 43 U. Miami Heckerling Inst. Est. Plan. ch. 17 (U. Miami 2009) (discussing aspects of long-term care insurance); Robert D. Hayes et al., *What Attorneys Should Know about Long-Term Care Insurance*, 7 Elder L.J. 1 (1999) (educating attorneys on long-term coverage insurance policies).

241. Genworth Fin., *Genworth 2010 Cost of Care Survey* 5 (Genworth Fin. & Natl. Eldercare Referral Sys. 2010) (available at http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.14625.File.dat/2010_Cost_of_Care_Survey_Full_Report.pdf).

242. For a comprehensive survey of the cost of private rooms in nursing homes across America organized by states and regions within states, see *id.* at 20–86.

out seriously affecting their financial well-being or their testamentary intentions regarding family members or charitable institutions.[243]

Fortunately, Elder Law practitioners need not become experts in every aspect of this ever-changing product. At a minimum, however, they should understand the five building blocks of any long-term care insurance policy.[244] They are as follows:

- Daily-insured amount: the maximum payment per day for care in a nursing home or other long-term care facility.[245]
- Length of coverage: how many days, usually calibrated in annual increments, the policy will pay.[246]
- Elimination period: the number of days of care before the policy's benefits begin, comparable to a deductible in more familiar insurance settings.[247]
- Home care coverage: usually a percentage of the daily-insured amount to cover healthcare services that enable the policyholder to stay at home.[248]
- Inflation protection: an adjustment of the daily-insured amount, typically expressed as five percent per year, possibly compounded annually.[249]

It is critical to understand how these variables affect premium charges. For example, inflation protection is the single most expensive option[250] and can easily double or triple the cost of a policy, depending upon the age of the insured when the policy is first acquired and the specific formula used to determine the

243. *See generally* Frolik, *supra* n. 240, at ¶¶ 1703.1, 1703.2 (stating that most elderly couples do not have sufficient income or savings to pay for the cost of long-term care).

244. Kaplan, *Retirement*, *supra* n. 177, at 430–436.

245. *Id.* at 430–431.

246. *Id.* at 431.

247. *Id.*

248. *Id.* at 432.

249. *Id.* at 432–433.

250. *See generally* Marc A. Cohen et al., *Inflation Protection and Long-Term Care Insurance: Finding the Gold Standard of Adequacy* (AARP 2002) (available at http://assets.aarp.org/rgcenter/health/2002_09_inflation.pdf) (discussing inflation riders and their effects on insurance benefits).

adjusted amount.[251] Home care coverage is also a very expensive addition, and it typically covers only eight hours of care per day.[252] If family members or friends are not willing and able to provide care for the other times that a client will need attention, then long-term care insurance is probably of less value than the prospective buyer imagines.

Numerous other policy options or "riders" are available as well. Some waive future premiums once a client receives benefits under the policy. Others refund some or all of the premiums paid if no long-term care benefits are ever paid.[253] Some policies treat the total insured amount as a "pool of benefits" that the client can use according to whatever schedule is appropriate, up to the insurance limit.[254] Special provisions may enable married couples to share unused benefits under their respective policies.[255] Of course, all these features increase the cost of the policy and further confuse the purchasing process.

As noted already, the lack of standardization of policy terms makes price comparison among companies a frustrating process.[256] To take the simplest example, the elimination period[257] that one company offers may be available as fifty, seventy-five, or one hundred days, while another company offers thirty, sixty, and

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251. Anne Tumlinson et al., *Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance* 6–9, http://www.kff.org/insurance/upload/Closing-the-Long-Term-Care-Funding-Gap-The-Challenge-of-Private-Long-Term-Care-Insurance-Report.pdf (June 2009).

252. *Cf.* Ctrs. for Medicare & Medicaid Servs., *Medicare and Home Health Care* 6 (CMS Product No. 10969, 2010) (available at http://www.medicare.gov/publications/pubs/pdf/10969.pdf) (stating that Medicare provides home health care only if the person needs *less* than eight hours each day of skilled nursing care).

253. *See e.g.* AXA Equitable, *Beyond the Basics: Disability Income Insurance Riders*, http://www.axa-equitable.com/insurance/disability-income/insurance-riders.html (accessed Sept. 26, 2010) (explaining the most common types of riders available for purchase, including future increase option riders, cost-of-living riders, Social Security riders, hospital income riders, lifetime extension riders, waiver-of-premium riders, accidental death and dismemberment riders, automatic benefits increase riders, partial disability benefits riders, and return-of-premium riders).

254. Bonnie Burns, *Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers* 7 (AARP 2006) (available at http://assets.aarp.org/rgcenter/il/2006_13_ltci.pdf).

255. *Id.* at 6.

256. *See generally id.* at 19–21 (examining the difficulties in comparing long-term care insurance policies and providing recommendations).

257. The elimination period is the period of time between the onset of a disability and the time the person is eligible for benefits. Some plans refer to this period as a "waiting period" or "deductible." *Id.* at 8.

ninety day options. The general lack of interactive websites for long-term care insurance, as are common for life and automobile insurance, makes informed decisionmaking unnecessarily difficult, particularly for those increasingly web-savvy seniors who can and would use such services. An interesting policy question is whether governmental regulation of key policy components, like the standardization of Medigap policies, would encourage more clients to buy long-term care insurance.

Into this already confused mix comes a new federal government initiative to provide some coverage of long-term care. Enacted as part of the major healthcare reform initiative of President Barack Obama,[258] this program is styled Community Living Assistance Services and Support, or CLASS.[259] This program begins in 2011 but will not pay any benefits until 2016 at the earliest because it requires five years of enrollment before someone can receive benefits.[260] Moreover, it is financed by payroll contributions made while a person is employed,[261] so it will not apply to any currently retired Americans. When effective, the CLASS program will pay daily cash benefits that vary with a claimant's degree of impairment,[262] but which must average at least fifty dollars per day.[263] Accordingly, its significance is greater for home healthcare and adult day care arrangements than for the costlier institutional care settings that long-term care insurance generally targets.[264]

3. Medicaid

Although Medicare is the primary source of financing for the healthcare needs of older Americans, Medicaid often comes into play regarding long-term care.[265] Its coverage of nursing homes, in

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258. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

259. *Id.* at § 8002(a)(1).

260. *Id.* (adding 42 U.S.C. § 3202(6)(A)(i) to The Public Health Service Act).

261. *Id.* (adding 42 U.S.C. §§ 3204(a)(1), (2) to The Public Health Service Act).

262. *Id.* (adding 42 U.S.C. § 3203(a)(1)(D)(ii) to The Public Health Service Act).

263. *Id.* (adding 42 U.S.C. § 3203(a)(1)(D)(i) to The Public Health Service Act).

264. *See generally* Richard L. Kaplan, *Financing Long-Term Care After Health Care Reform*, 13 J. Retirement Plan. 7 (July–Aug. 2010) (analyzing the CLASS program and comparing its benefits to those available from long-term care insurance).

265. *See* U.S. Dept. of Health & Human Servs., *Medicare.gov*, *Long-Term Care*, *What is Long-Term Care?*, http://www.medicare.gov/longtermcare/static/home.asp (updated Mar.

particular, is far less restrictive than Medicare's coverage and generally includes extended stays for chronic conditions, like Alzheimer's disease, that are not expected to ameliorate over time.[266] For some Elder Law attorneys, in fact, Medicaid planning forms a major portion of their professional practice, particularly with clients who lack long-term care insurance. Moreover, even clients with such insurance might exhaust their policy's benefits and then turn to Medicaid to pay for long-term care from that point forward. As a result, Medicaid eligibility determination is a pivotal component of Elder Law.

Medicaid differs from Medicare in many significant respects. Medicaid is a means-tested healthcare program for lower income persons of any age,[267] rather than an age-based entitlement like Medicare.[268] In fact, the majority of Medicaid beneficiaries are under the age of sixty-five, although older beneficiaries account for a disproportionately high share of Medicaid's expenditures.[269] Furthermore, Medicaid is a joint undertaking of the federal and state governments, so both levels of government finance its costs, set qualifications for benefits, and administer the program.[270] Therefore, although federal law delineates many of the important standards that applicants must satisfy, the laws of individual states are also very important in determining whether a specific client will qualify for Medicaid benefits.[271] Many state parameters

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25, 2009) (stating, "Generally, Medicare doesn't pay for long-term care.").

266. *See* 42 U.S.C. § 1396a(a)(4)(A) (providing for methods to implement the plan); 42 U.S.C. § 1396d(f) (defining nursing facility services).

267. *See generally* A. Kimberley Dayton et al., *Advising the Elderly Client* § 29:36–47 (West 2010) (discussing the elements considered when determining financial eligibility for Medicaid); Lawrence A. Frolik & Melissa C. Brown, *Advising the Elderly or Disabled Client* § 14.03 (2d ed., Thomson Reuters/WG&L 2010) (discussing issues related to Medicaid); Jerry A. Hyman, *Elder Law and Financial Strategies: Planning for Later Life* § 20.02, at 20-11 to 20-13 (L. J. Press 2010) (discussing financial eligibility for Medicaid); John J. Regan et al., *Tax, Estate & Financial Planning for the Elderly* § 10.07, at 10-28 to 10-39 (Matthew Bender 2009) (discussing financial-need criteria for Medicaid eligibility).

268. For more information on the conditions that must be met in order to qualify for Medicare, see *supra* notes 181–183, 193–196 and accompanying text.

269. *See* Howard Gleckman, *Medicaid and Long-Term Care: How Will Rising Costs Affect Services for an Aging Population?* 3 (Trustees of Bos. College, Ctr. for Retirement Research 2007) (available at http://crr.bc.edu/images/stories/Briefs/ib_2007-4.pdf) (exploring trends in Medicaid spending on long-term care and discussing the implication of its rapid growth).

270. April Grady, *CRS Report for Congress: Medicaid Financing* 1 (CRS Report RS22849, 2008) (available at http://aging.senate.gov/crs/medicaid5.pdf).

271. *Id.* at 3–4.

fall within ranges that are specified by the federal government, but some fairly dramatic differences persist across the country.[272] Consequently, focusing on a single state's administration of Medicaid is often the most sensible pedagogical approach, but understanding key state variations is also useful. After all, states with more generous eligibility criteria may alter these criteria in the future as budgetary concerns dictate.

At the outset, one must recognize that qualifying as a Medicaid beneficiary is not without its drawbacks for the older client. Apart from the program's rather strict financial eligibility criteria, it is an open secret that healthcare providers generally—and nursing homes especially—monitor their census to limit the number of Medicaid patients that they accept.[273] This circumstance is the result of perennial efforts to reduce government spending, which translate into below-market (and often below-cost) rates being paid for the services that are provided to Medicaid patients.[274] As a result, Medicaid patients often have limited options when selecting a nursing home, which means that they might have to settle for facilities that are less pleasant or farther away from their families. Location is critical because a client's spouse and other family members might not be able to visit a distant facility as regularly, which in turn might affect the quality of care that the client receives and perhaps his or her health and general disposition as well.[275] Moreover, if the quality of care in

272. There are websites available to compare Medicaid details between states. *E.g.* Henry J. Kaiser Fam. Found., *Statehealthfacts.org*, *State Medicaid Fact Sheets*, http://www.statehealthfacts.org/medicaid.jsp (accessed Sept. 25, 2010).

273. *See* Joshua M. Wiener, *Long-Term Care and Devolution*, in *Medicaid and Devolution: A View from the States* 185, 203 (Frank J. Thompson & John J. DiIulio, Jr. eds., Brookings Inst. Press 1998) (stating that "nursing homes prefer private-pay to Medicaid patients"); James D. Reschovsky, *Demand for and Access to Institutional Long-Term Care: The Role of Medicaid in Nursing Home Markets*, 33 Inquiry 15, 16 (Spring 1996) (recognizing "strong evidence that Medicaid eligibles face substantially lower access to nursing home services than private payers").

274. *See generally* Eljay, LLC, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care* (Eljay, LLC 2009) (http://www.ahcancal.org/research_data/funding/Documents/2009%20Medicaid%20Shortfall%20Report.pdf) (identifying shortfalls when comparing Medicaid reimbursement and allowable Medicaid costs in different states for 2007, and projecting Medicaid shortfalls for 2009).

275. *See* Christine A. Price, *Ohio State University Extension, Senior Series: Tips When Visiting a Nursing Home*, http://ohioline.osu.edu/ss-fact/0188.html (accessed Sept. 26, 2010) (discussing the importance of maintaining familial relationships with elders living in nursing homes).

the nursing home declines, a Medicaid patient may find it difficult to move to some other facility that could provide better care.

For clients who are not in immediate need of long-term care, a related consideration is the future viability of Medicaid. Periodic Medicaid reform measures are enacted, the most recent being in 2006,[276] all of which make eligibility for Medicaid benefits *more* difficult to obtain. These legislative modifications, it should be noted, often take effect upon enactment, thereby jeopardizing any arrangements that were premised upon existing Medicaid policies remaining in effect. In this context, some clients might want to consider, or possibly reconsider, whether long-term care insurance makes sense in light of the political realities that confront this program.[277]

Be that as it may, even a cursory examination of Medicaid can quickly become rather technical. To maintain some perspective, therefore, it may be appropriate to focus on four foundational concepts that can be stated briefly as follows:

- An applicant's income may be limited to a specific sum or directed in its entirety (minus a very small personal allowance) to the nursing home, depending on state law.[278] For Medicaid purposes, income is defined very broadly without the numerous exceptions and exclusions that are endemic to the federal income tax. For example, gifts from relatives, including bequests from siblings, are counted as income by Medicaid, even though they would not be considered income to the recipient for tax purposes to the recipient.[279]

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276. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).

277. Brian E. Barreira, *Long-Term Care Insurance—A Necessary Option to Consider*, NAELA News 1 (July 1995). In fact, former president of the Massachusetts Chapter of the National Academy of Elder Law Attorneys, Brian Barreira, has suggested that Elder Law attorneys who fail to advise their clients of Medicaid's financial situation may be committing legal malpractice. *Id.* at 1–2. Barreira advises that instead of counseling their clients to transfer their assets and drop their health insurance to qualify for Medicaid, attorneys should counsel their clients to obtain long-term care insurance. *Id.*

278. For a list of sources providing information on this topic, see *supra* note 267.

279. *See* I.R.C. § 102(a) (2009) (explaining that gifts and inheritances are excluded from "gross income").

- Most of an applicant's assets must be used for his or her medical care, other than an exemption amount of $2,000.[280] Certain assets are not considered for this purpose, including wedding rings,[281] an automobile,[282] prepaid burial plans,[283] and a principal residence[284] if the owner "expects to return" to it.[285] The amount of the principal residence exemption is limited according to an applicant's equity in the property,[286] the exact amount being set by state law. All other financial resources, be they securities, retirement savings accounts, real estate, et cetera, must be "spent down" to the $2,000 level.
- If the client has a spouse who will be living in the community at large, this "community spouse" may keep additional assets up to an amount set by the state from a range that the federal government adjusts annually.[287]
- This "community spouse," moreover, is entitled to a minimum monthly income allowance from the client,[288] with the exact amount determined, once again, by the state from a range that the federal government adjusts annually.[289]

When clients learn of these restrictions, many are dismayed and some want to give away their "excess" assets to family members and other favored recipients. But Medicaid imposes a major penalty on any such "uncompensated transfer" of property[290] that takes place during a specified number of years (currently, five) prior to a person's qualifying for Medicaid benefits.[291] The length

280. 42 U.S.C. § 1382(a)(3)(B).
281. 20 C.F.R. § 416.1216(b)(2) (2006).
282. *Id.* at § 416.1218(b)(1).
283. 42 U.S.C. § 1382b(d); 20 C.F.R. § 416.1231(b).
284. 42 U.S.C. § 1382b(a)(1).
285. 20 C.F.R. § 416.1212(c) (first sentence).
286. 42 U.S.C. § 1396p(f)(1).
287. *Id.* at § 1396r-5(f)(2); U.S. Dept. of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Medicaid Eligibility: Spousal Impoverishment*, http://www.cms.hhs.gov/MedicaidEligibility/09_SpousalImpoverishment.asp#TopOfPage (last modified July 22, 2010) [hereinafter *Spousal Impoverishment*].
288. 42 U.S.C. § 1396r-5(d)(2).
289. *Spousal Impoverishment*, *supra* n. 287.
290. 42 U.S.C. § 1396p(c)(1)(A).
291. *Id.* at § 1396p(c)(1)(B)(i).

of this "look-back" period is a factor that Congress uses to limit Medicaid eligibility, and every change ever enacted has *lengthened* this time period.[292] To compute the penalty, the "uncompensated value" of the assets transferred is divided by a number that represents the average cost of a nursing home room for the state or county in which the applicant resides.[293] Once computed, this penalty determines the number of months during which Medicaid will not pay long-term care benefits for a patient who otherwise qualifies for such benefits.[294]

One final feature of Medicaid merits attention: estate recovery of benefits provided. That is, the state agency administering Medicaid is required by federal law to recover any amounts paid for a client's care from that person's estate.[295] This provision makes Medicaid benefits resemble a loan more than an entitlement, although no interest is imposed on the benefits received. Payback is deferred until after the death of a client's community spouse,[296] but it is then implemented without any *de minimis* limits or other exceptions. In fact, some states have expanded their definition of a person's estate for purposes of Medicaid recovery,[297] often going far beyond what their probate laws encompass.

In a broader context, Medicaid's requirements can stimulate a classroom discussion regarding the proper allocation of responsibility for the cost of long-term care, similar to that suggested above with respect to Medicare.[298] That is, should this expense be

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292. *E.g.* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (amending 42 U.S.C. 1396p(c)(1)(B)(i) to extend the look-back period to sixty months).

293. 42 U.S.C. § 1396p(c)(1)(E)(i).

294. *Id.* at § 1396p(c)(1)(D). Certain transfers are not penalized; for example, assets conveyed to a client's blind or disabled child or to a trust established to benefit such a child are not penalized. *Id.* at § 1396p(c)(2)(A)(i)–(iv).

295. *Id.* at § 1396p(b)(1); *see generally* Jon M. Zieger, Student Author, *The State Giveth and the State Taketh Away: In Pursuit of a Practical Approach to Medicaid Estate Recovery*, 5 Elder L.J. 359 (1997) (discussing the different aspects of estate recovery programs in place to recoup Medicaid funds, and suggesting alternatives to those programs).

296. 42 U.S.C. § 1396p(b)(2).

297. Such expansions are authorized by statutory provision. *Id.* at § 1396p(b)(4)(B); *see* Ian S. Oppenheim & Alex L. Moschella, *National Perspective on Expanded Estate Recovery: Case Law Analysis, Emerging Legislative Trends and Responsive Strategies for the Elder Law Attorney*, 1 NAELA J. 7, 24–30 (2005) (discussing the present and future of estate recovery programs); *see generally* Naomi Karp et al., *Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices* 19–23 (AARP 2005) (available at http://assets.aarp.org/rgcenter/il/2005_06_recovery.pdf) (discussing estate recovery programs operated by different states).

298. *See* Richard L. Kaplan, *Financing Long-Term Care in the United States: Who*

File: Kaplan.Galley.PublicationCopy.docx Created on: 12/28/2010 3:09:00 PM Last Printed: 1/17/2011 9:18:00 PM

borne primarily by the older patient, his or her family, local agencies, or government at various levels?[299] The contrast between Medicare's coverage of acute care expenditures and Medicaid's coverage of long-term care costs is particularly anomalous. With respect to hospital care, for example, Medicare imposes no eligibility restrictions based on a patient's income or assets. Nor is there any obligation to repay these costs when a patient dies. On the other hand, Medicaid's estate recovery provisions have no *de minimis* allowances, in contrast to the multi-million dollar exemption in the federal estate tax.[300] More specifically, one might examine the appropriateness of planning to secure Medicaid coverage for an unmarried client versus a client who has a community spouse, or whether such planning is basically inheritance insurance for surviving heirs.[301] In the latter case, perhaps the client's likely heirs should obtain and pay for long-term care insurance on the client. Finally, ever-increasing outlays for Medicaid have budgetary implications for other state obligations, including public education at all levels, police protection, maintenance of roads, and administration of justice, including prison

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Should Pay for Mom and Dad? in *Aging: Caring for Our Elders* (David N. Weisstub et al. eds., Kluwer Academic Publishers 2001) (available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=294056) (discussing long-term care and financing this care in terms of Medicaid); *see generally* Seymour Moskowitz, *Adult Children and Indigent Parents: Intergenerational Responsibilities in International Perspective*, 86 Marq. L. Rev. 401 (2002) (discussing elderly caretaking responsibilities within families); Allison E. Ross, Student Author, *Taking Care of Our Caretakers: Using Filial Responsibility Laws to Support the Elderly beyond the Government's Assistance*, 16 Elder L.J. 167 (2008) (discussing both domestic and international civil and criminal filial responsibility laws and their enforcement).

299. *See* Richard L. Kaplan, *Honoring Our Parents: Applying the Biblical Imperative in the Context of Long-Term Care*, 21 Notre Dame J.L. Ethics & Pub. Policy 493, 509–515 (2007) (proposing that long-term care provided in nursing homes be covered by Medicare but such care provided in less medically intensive settings be the responsibility of patients and their families).

300. The amount of the exclusion allowed varies depending upon the year the taxpayer dies. I.R.C. § 2010(c).

301. *See* Alison Barnes, *An Assessment of Medicaid Planning*, 3 Hous. J. Health L. & Policy 265, 289–292 (2003) (discussing Medicaid eligibility planning and spousal impoverishment); *see generally* Eleanor M. Crosby & Ira M. Leff, *Ethical Considerations in Medicaid Estate Planning: An Analysis of the ABA Model Rules of Professional Conduct*, 62 Fordham L. Rev. 1503 (1994) (discussing ethical issues related to the practice of Medicaid estate planning); Leslie Curry et al., *Medicaid Estate Planning: Perceptions of Morality and Necessity*, 41 Gerontologist 34 (2001) (examining individual behaviors in Medicaid estate planning); Jan Ellen Rein, *Misinformation and Self-Deception in Recent Long-Term Care Policy Trends*, 12 J.L. & Policy 195 (1996) (addressing policy issues concerning long-term care financing in the 1990s).

operations.[302] What should the role of government be in this context?

IV. CONCLUDING THOUGHTS

The Elder Law course described above has a deliberate focus on planning rather than reacting. For that reason, much more time is spent on elements of retirement security than on responses to criminal abuse of the elderly, for example. The key is empowerment of the older citizen so that person can exercise maximum control over his or her assets and autonomy. Not every subject will be pertinent to every client, to be sure, and more-detailed coverage of some subjects is probably better left to practitioners who specialize further within Elder Law. While current policy debates form an integral component of particular topics, the course's clear emphasis is on the laws and practices that affect older Americans *today*. After all, there is little reason to expect that older Americans forty years from now will confront the same legal regimes that today's elders must negotiate.

On the other hand, an emerging theme in Elder Law more generally is the increasing ethnic diversity of America's older population. At present, America's elders represent the most Caucasian of any age cohort, but that characteristic is changing over time.[303] This phenomenon will affect every topic in the Elder Law course to some degree. Whether the "client" may or must include younger family members is often a cultural construct, and responses to basic questions regarding the sharing of medical information vary among ethnic groups.[304] Definitions of what constitutes elder abuse and assessments of what should be done also vary significantly among different ethnicities.[305] Attitudes toward

302. *See generally* James Marton & David E. Wildasin, *Medicaid Expenditures and State Budgets: Past, Present, and Future*, 60 Natl. Tax J. 279 (June 2007) (examining and discussing how existing and prospective Medicaid reforms would affect the current assignment of responsibilities between state and federal governments in light of state spending pressures).

303. *See Profile*, *supra* n. 1, at 1 (reporting that in 2007 almost twenty percent of those over age sixty-five were minorities).

304. Marty Richards, *Ethical, Spiritual and Cross Cultural Implications: Some Considerations For Elder Law Attorneys*, 8 NAELA Q. 4, 7 (Fall 1995).

305. For a study based on thirteen scenarios used to measure these differences, see Ailee Moon & Oliver Williams, *Perceptions of Elder Abuse and Help-Seeking Patterns among African-American, Caucasian American, and Korean-American Elderly Women*, 33

the home, the extent of family obligations to provide elder care, and the acceptability of nursing homes, assisted-living facilities, and other non-familial arrangements are very different among different groups, and statutes written for a more homogenous population may simply be inappropriate as America's older population becomes more diverse.[306] Thus, the Elder Law course of tomorrow is likely to be even more variegated and interesting than its present configuration.

Gerontologist 386 (1993). The study showed that Korean-American women were the least likely to consider a given scenario abusive. *Id.* at 389.

306. *See* Lynette Clemetson, *U.S. Muslims Confront Taboo on Nursing Homes*, N.Y. Times A1 (June 13, 2006) (available at http://www.nytimes.com/2006/06/13/us/13muslim.html?_r=1&scp=1&sq=&st=nyt) (discussing Muslim views on elder care in the expanding market for nursing homes); *but see* Sarah Kershaw, *Many Immigrants Decide to Embrace Homes for Elderly*, N.Y. Times A1 (Oct. 20, 2003) (available at http://www.nytimes.com/2003/10/20/us/many-immigrants-decide-to-embrace-homes-for-eldely.html?scp=1&sq=Many+Immigrants+Decide+to+Embrace+Homes+for+the+Elderly&st=nyt) (noting changing attitudes toward the institutionalization of elders among some ethnic groups that have historically frowned on the practice).