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Multidisciplinary Practice and Ethics, Part I
Lawyers, Doctors, and Confidentiality
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I. INTRODUCTION

Medicare is the federal program that provides health insurance for the elderly and for younger persons with disabilities. Medicare coverage is secondary to coverage by private insurers in a number of situations, including liability cases. The Medicare as Secondary Payer (MSP) provisions of the statute are found at 42 U.S.C. § 1395y(b).1 This paper examines some widely held misconceptions about the collection powers of the Centers for Medicare & Medicaid Services (CMS) with respect to such liability insurers. Although the Medicare statute and regulations impose obligations on beneficiaries and their attorneys, they do not create a superlien or authorize imposition of penalties against attorneys who have disbursed proceeds to their clients. These misconceptions can cause hardship to Medicare beneficiaries as well as unnecessary work for personal injury attorneys.


1 The other kind of insurance which by statute is primary to Medicare is employer group health plans (EGHPs). 42 U.S.C. § 1395y(b)(1). They have not been included in the public attributions of “superlien” collection powers, and are not addressed in this paper.
II. Background

Liability insurers that are designated by Medicare as “primary plans” include “a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no fault insurance.” When a primary plan has not paid, and cannot be expected to pay, “promptly” for health services needed by an injured beneficiary, Medicare will make a “conditional” payment to the health care provider. Medicare regulations define “promptly” as being within 120 days after the earlier of hospital discharge or receipt of the claim.

When the responsibility for payment by a primary plan has been demonstrated by judgment, compromise, waiver, or release, Medicare must be reimbursed for its conditional payment. Medicare has contracted with private organizations, the Coordination of Benefits Contractor (COB), and the Medicare Secondary Payer Recovery Contractor (MSPRC) to gather information about the amounts of the conditional payments for various services and to collect the total claim from the personal injury attorney or beneficiary. However, reimbursement to Medicare is limited to the specific items or services related to the injury for which the primary plan was responsible; and reimbursement can be waived at the beneficiary’s request upon a showing of hardship, or in the interests of the Medicare program.

III. Common Assertions Regarding a Medicare Superlien

Neither the Medicare statute nor the formally adopted CMS regulations describe the MSP claim as a “lien,” but some of the agency’s informal materials assert powers and impose obligations that approach those of a lien. As will be seen below, there is no language in the Medicare statute or regulations that confers these powers on the agency or imposes these obligations on personal injury attorneys.

Such agency assertions include:
1. Immediately upon taking a case that involves a Medicare beneficiary, an attorney must inform the contractor about a potential liability lawsuit.
2. An attorney must contact the assigned lead contractor regarding Medicare’s interest in a liability lawsuit.
3. The attorney should not disburse settlement proceeds to his client/beneficiary until Medicare’s claim has been satisfied.
4. Medicare’s right to reimbursement should be asserted before the beneficiary has an opportunity to dispose of the funds; “This information is especially important if a future request of waiver or compromise is submitted.”

5. The attorney letter also states that Medicare can collect interest from the date of receipt on MSP claims which are not paid within 60 days, even if the beneficiary requests waiver or appeals unsuccessfully.

In addition to the foregoing assertions of power over attorneys by CMS, materials posted by or on behalf of the MSP collection contractors impose strict obligations and penalties on personal injury attorneys.

These contractor materials assert that:

1. “Medicare’s claim must be paid up front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days of receipt of proceeds from the third party.”

2. The attorney must obtain an authorization from his client to release Medicare data, which must be returned to the contractor even if a settlement has not been reached.

3. If the beneficiary neglects to pay Medicare after proceeds have been disbursed to her by her attorney, Medicare can recover from the attorney who received the proceeds.

In addition to publications by CMS and its contractors, many articles and educational materials prepared by or for the personal injury bar describe the Medicare claim for reimbursement of conditional payments as a “lien” or a “superlien.” The following statement is one example of the exaggerated assertions made concerning the nature of the MSP claim:

The Federal Medicare lien is a “Superlien.” The lien is automatic with no perfection of recording required. The lien applies to all injury settlements (first and third party, and uninsured and self-insured tortfeasors) and is enforceable against all parties involved (plaintiff, plaintiff attorney, insurance carrier, defendant). The lien clearly applies to all first-party, as well as third-party, settlements. The lien is enforceable against the tortfeasor, insurance company, plaintiff, and plaintiff’s attorneys. It is the most automatic, broad in scope, and enforceable lien that exists.

In addition, members of the bar often assume that CMS takes harsh enforcement action against attorneys who fail to honor the Medicare “lien.” But available information indicates that there has been little enforcement activity against attorneys. The one

11 Id. § 50.5, at 99.
12 Id. § 50.5.2.3.A.
14 Id. at 3.
15 www.msprc.info/index.cfm?content=includes/faq/faq, Go to FAQs, General Information, Liability/No Fault/Workers Compensation, and the question “What if a beneficiary disregards his/her obligation to repay Medicare after the proceeds of a settlement have been disbursed to him/her?”
reported case found by this author merely allowed Medicare to recover liability proceeds that had not been disbursed but were still in the possession of the attorney.  

IV. MEDICARE LAW DOES NOT CREATE A LIEN ON LIABILITY INSURANCE PROCEEDS

The federal statute and regulations impose a framework of obligations on Medicare beneficiaries, their attorneys, and insurers in order to implement the MSP system. However, the obligations of attorneys to Medicare have been exaggerated by CMS and its contractors, and have reached mythical proportions in descriptions by some commentators. The legal framework does not elevate the MSP claim to the status of a lien vis a vis attorneys, nor does it require a beneficiary’s personal injury attorney to notify Medicare of the client’s liability claim and withhold distribution until MSP recovery has been made, as a number of commentators assert.

A. Statutory and Regulatory Language

The statute confers specific MSP collection powers on the government, as follows:

**PRIMARY PLANS** 1862(b)(2)(B)(ii) A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service . . .

**ACTION BY UNITED STATES** 1862(b)(2)(B)(iii) In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.  

These amended provisions of the statute are the ones cited as support for the assertion that Medicare has lien or even superlien rights against attorneys handling liability recoveries. However, the term _lien_ does not appear in the MSP sections of the statute. Furthermore, it is noteworthy that no procedures are established for Medicare to record and give public notice of its claim, although such procedures are typically required for perfecting a medical lien. If Congress had intended to create a lien, particularly after the Zinman v. Shalala decision, _infra_ note 20, it surely would have used the term _lien_ in the statute and specified procedures for perfecting the lien. The CMS, itself, recognizes this

fact, since none of the regulations it has adopted over the years to implement the liability insurance portions of the MSP statute use the term "lien" in describing the obligations of the various affected parties.  

B. The Case Law Holds That No Lien Was Created

A decision in a federal class action lawsuit some years ago, Zinman v. Shalala, held that Medicare does not have a lien for recovery of its conditional payments. The nationwide class of plaintiffs in this case was defined as "Medicare beneficiaries injured in car accidents in which Medicare paid for medical expenses for which it was later determined that private insurance policies were liable to pay." In its decision, the court granted summary judgment for plaintiffs on their argument that the MSP demand notices given by Medicare violated due process in several ways. The court held that the claim Medicare made on its notices that it had a lien on liability proceeds was incorrect, because "the MSP statute does not state that Medicare has a lien" and "the MSP statute does not give the government a claim against property" but simply a right of action against the responsible party. Interestingly, in light of the persistent assertion by some that Medicare has a superlien, the court in Zinman v. Shalala also expressly rejected the Medicare agency’s further argument that "Medicare’s right is superior to a lien."

C. Statutory Changes in 2003 Did Not Create a Superlien

The proponents of the theory that Medicare has a “superlien” argue that 2003 legislative changes in the Medicare statute converted MSP reimbursement rights into lien rights enforceable against attorneys. The legislative history, as well as the language of the amended statute itself, shows that this is not the case. The Conference Agreement in 2003 stated that the MSP legislation made three clarifications:

1. Medicare could make conditional payments to be recovered later when primary payments would not be prompt;
2. Primary plans included self-insured employers; and
3. Medicare could recover from entities that had “received” payment from primary plans and could also bring actions to collect double damages against primary plans themselves.

No mention was made of creation of a Medicare lien.

The fact that the Medicare Prescription Drug, Improvement, and Modernization Act

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19 42 C.F.R. §§ 411.20-37, 411.50-54.
21 Zinman, 835 F.Supp. at 1163.
22 The Ninth Circuit affirmed the district court’s rejection of plaintiffs’ argument that MSP reimbursement should be limited to the portion of the liability proceeds attributable to medical expenses. Zinman, 67 F.3d. at 844-845. This part of the decision might be revisited based on the Supreme Court’s recent decision in Arkansas Dept. of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006).
23 Id. at 1171 (citing Thomas v. Shelton, 740 F.2d 478, 482 (7th Cir. 1984) (no lien created by right of action for recovery in the Medical Care Recovery Act)).
24 Id. at 1171.
of 2003 (MMA) did not impose lien powers on attorneys is also seen in the CMS commentary that accompanied its interim rule implementing the MMA, which summarized the MMA amendments without describing any new rights against attorneys. This CMS summary stated that the legislation expands the definition of a “primary plan” against which double damages can be recovered to include self-insurers, third-party administrators, and employers that sponsor or contribute to group health plans, while clarifying that simple recovery (e.g., without double damages) can be had against any entity (including attorneys) who have received payment from such a primary plan.

V. The Statutory MSP Collection Procedures Are Not Equivalent to Liens

In addition to the absence of explicit statutory language creating a lien, the bundle of rights and obligations created by the MSP statute and regulations do not amount to lien rights that must be protected by attorneys.

A. Private Medical Liens Impose Powerful Obligations

Medical liens are property interests in the rights of action (including claims and damages) of individuals who have received medical treatment on account of related personal injuries. They are created by statute, and these statutes provide that when clearly prescribed conditions are met a lien is perfected. In the absence of specific statutory language creating a lien, a medical provider has only an unperfected claim for payment of medical services.

The establishment of a lien confers a number of rights and obligations on the various parties, above and beyond the usual right to collect a claim for medical services against patients who recover tort damages. Thus, a liability insurer who has notice of the lien must assure that payment for the services for which it is liable is made to the medical provider.

Similarly, the establishment of a private medical lien imposes duties on personal injury attorneys, with adverse consequences should these duties be ignored. An attorney with notice of the lien may not disburse liability proceeds to a client until the lien has been satisfied. An attorney who disburses such funds to a client without satisfying the lien can be held liable to the hospital up to the amount disbursed.

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27 Id. at 9467-9468.
30 Viviani, at 332.
31 Bryan Mem’l Hosp. v. Allied Prop. & Cas. Ins., 163 F.Supp.2d 1059, 1066 (D.Neb. 2001) (insurer has a duty not to impair the hospital’s lien and is liable to pay the hospital if it settles directly with the injured party); Alegent Health v. American Family Ins., Inc., 656 N.W.2d 906 (Neb. 2003).
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protect funds upon which a third party has a lien may also be in violation of ethical rules and subject to disciplinary action. It is the fear of these duties and consequences that gives the characterization of the MSP claim as a lien such a disturbing impact on personal injury attorneys and their Medicare clients.

B. Medicare Has Limited Powers to Recover Its Conditional Payments

It is not clear that the Medicare statute or the MSP regulations give CMS the right to recover from a personal injury attorney funds that the attorney has already disbursed to a client, as would be the case with respect to a private medical lien. In fact, the MSP provisions of the statute never specifically identify attorneys as individuals against whom CMS recovery rights are created, although it lists worker compensation plans, automobile or liability insurance policies and plans (including a self-insured plan) and no fault insurance, and “an entity that has received payment from a primary plan.”

Significantly, the obligations of entities are clearly distinguished from, and significantly less than, the obligations imposed on primary payers. Under paragraph 42 U.S.C. § 1395y(b)(3)(A) of the MSP statute, Medicare is given a private cause of action to collect double damages against “a primary plan which fails to provide for primary payment (or appropriate reimbursement)” of a conditional payment as required. This clause, (3)(A), is expressly incorporated into the authorization of recovery from a primary plan in the preceding subsection of the statute. A primary plan for this purpose is defined as “a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including self-insured plan) or no fault insurance. . . [and] [a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.” Of central importance is the fact that the definition of a “primary plan” which is subject to double damages does not include attorneys who represent injured Medicare beneficiaries.

In contrast, the statute treats entities that have received payment from primary plans quite differently. While it authorizes Medicare to collect a penalty of double damages against primary plans, it merely authorizes Medicare to recover the amount of its claim from an “entity that has received payment from a primary plan,” with no reference to double dam-

34 The ABA Model Rules of Professional Conduct requires attorneys to protect third party claims against specific funds, such as “a lien against funds recovered in a personal injury action,” from “wrongful interference by the client.” ABA Model Rules of Professional Conduct – Center for Professional Responsibility, Rule 1.15(d), and Comment, http://www.abanet.org/cpr/mrpc/rule_1_15.html (last visited Aug. 30, 2009) Significantly, however, the attorney’s obligations under this ethical rule are limited to duties imposed by “applicable law.” Id. at Comment [4], http://www.abanet.org/cpr/mrpc/rule_1_15_comm.html (last visited Aug. 30, 2009).

35 42 U.S.C. §1395y(b)(2)(B)(ii). The absence of any mention of attorneys in this carefully drafted and extensive list of those subject to MSP recovery rights might support an argument that no obligations are imposed on attorneys, although regulations adopted by CMS do identify attorneys along with beneficiaries and others as “entities” subject to some limited MSP obligations. 42 C.F.R. § 411.24(g).


39 Id.
ages or to paragraph (3)(A) which authorizes such damages. The Medicare regulations simply require a beneficiary, provider, supplier, physician, attorney, or private insurer who has received a third-party payment to reimburse Medicare within 60 days of receipt.

This distinction between Medicare powers against primary payers and entities such as attorneys and beneficiaries who have received payment from primary payers is made clearly in the MSP regulations. While 42 C.F.R. §§ 411.24(c)(2) authorizes the collection of double damages against primary payers, 42 C.F.R. §§ 411.24(g) and (h) only authorize CMS to recover its payments from the entity that has received a primary payment. Most significantly, at 42 C.F.R. § 411.24(i)(1), the regulations provide that “[i]f Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.” The absence of any similar provision for reimbursement from an attorney who has disbursed proceeds to a client shows that Medicare has no authority to recover from attorneys who no longer have proceeds in their possession. The logic of these provisions is that, except for primary payers, recovery action should follow funds that are no longer in one entity’s possession to the new recipient. Thus, if funds received from a primary payer have been disbursed by the attorney to a client who is a Medicare beneficiary, the beneficiary becomes the entity from whom Medicare would recover them.

Surprisingly, CMS has brought few cases to assert Medicare recovery rights against personal injury attorneys. In the only reported decision entitled to precedential effect, CMS recovered its MSP claim from an attorney who still had the disputed funds in his possession. A second unreported MSP case also involved a contested claim against client funds that the attorney apparently still held “on her behalf.” The third case, also unreported, resulted in judgment against an attorney who failed to follow the administrative process for contesting an MSP claim before disbursing settlement proceeds to his client.

The strict delineation throughout the statute and regulations between primary payers and those who receive payments from primary payers shows that the same process was not intended to apply to both groups. The action Medicare may take with respect to entities receiving funds from primary plans is limited to recovering only such funds that have not been passed on to another responsible entity. This limited power is consistent with the omission of any reference in the statute to creation of a Medicare Secondary Payer lien.

41 42 C.F.R. § 411.24(g), (h).
42 42 C.F.R. § 411.24.
43 42 C.F.R. § 411.24(i). Furthermore, the extensive collection procedures set out in the MSP MANUAL, supra note 10, at §§ 50.5.3-4, focus on contractor actions to recover from liability insurers and beneficiaries rather than attorneys. The debt collection section of the manual states that when the most recently issued demand letter is sent to an attorney is in his capacity as representative of the beneficiary, rather than in his own right, the individual/entity being represented is the current debtor. Id. § 60.2.
47 42 C.F.R. §§ 411.24(g)-(h).
VI. HARMFUL EFFECTS ON MEDICARE BENEFICIARIES OF THE “LIEN” CHARACTERIZATION

A. Delays Disbursing Proceeds

One of the problems most complained about in the MSP collection process is delays in disbursing proceeds to beneficiaries after settlement of their liability claims. Resolution of a personal injury or workers’ compensation case may occur years after a Medicare beneficiary is injured. Thus, the imposition of further delays in disbursement of funds can be a genuine hardship for beneficiaries, as well as their attorneys. In a non-Medicare case, medical liens have been perfected by the time of settlement, so that the attorney already has been advised of the full amount of the liens and can quickly satisfy them. The balance of the settlement is immediately available for disbursement to the beneficiary and for payment of the attorney’s fee.

In the MSP process, however, personal injury attorneys cannot obtain the final amount of the Medicare claim from the contractor until some time after settlement. Because attorneys believe they must hold funds in their trust accounts until the Medicare contractor finally responds to their requests for a final recovery demand amount, injured beneficiaries are deprived of funds that they may need for living expenses or to obtain care. If the beneficiary requests waiver or appeals the amount of the claim, delays in distribution of the proceeds would be even longer. Since the characterization of the Medicare claim as a lien is incorrect, attorneys have no legal obligation to withhold settlements and should be able to distribute them to clients with appropriate advice and protections. After distribution, the beneficiaries are still, of course, required to reimburse Medicare for its actual claims in a timely manner, as stated in the Medicare statute and regulations.

B. Interferes with Right to Request Waiver or Appeal

The amount of the MSP claim determined by the Medicare contractor is frequently incorrect, including expenses for medical care unrelated to the beneficiary’s personal injury. As noted above, the exercise by Medicare beneficiaries of their rights to request waiver or to appeal the amount of recovery claimed by Medicare adds further delays to the distribution of settlement funds. This additional delay in payment creates financial incentives for both the beneficiary and the attorney to give up rights to request waiver or appeal, even when beneficiaries have good arguments for these rights. In addition, the insistence by Medicare that liability proceeds be retained by the attorney until Medicare claims have been resolved sometimes eliminates grounds for granting a hardship waiver, since the beneficiary is thereby prevented from using the proceeds for needed services.


49 Some personal injury attorneys help their clients in this situation by distributing a portion of the settlement while retaining an amount estimated to be sufficient to satisfy the MSP claim. Of course, the contractor’s form letter, supra note 2, states that no disbursement should be made until Medicare is satisfied.

50 The beneficiary should request reduction of MSP recovery by a proportionate share of the procurement costs, e.g. attorneys’ fees and costs of the litigation. MSP Manual, supra note 10, at §§ 50.2.2.
or living expenses. By interfering with beneficiaries’ rights to request hardship waivers or to appeal MSP claims, the incorrect characterization of MSP claims as liens obstructs beneficiaries’ statutory rights to these protections.

C. Ethical Implications Created for Attorneys

Finally, there are ethical implications regarding the willingness of attorneys to act as collection agents for Medicare recovery claims. The attorney who too readily hands over his client’s funds may breach an ethical obligation to the client. The Arizona Supreme Court disciplined an attorney for charging an excessive fee when he neglected to seek a compromise of a worker’s compensation recovery claim against his client’s insurance proceeds.

VII. Conclusion

The complexities of the MSP statute and regulations have caused confusion about the collection powers available against primary insurers and the more limited powers against attorneys, physicians, and other entities receiving payments from primary insurers. In addition, personal injury attorneys are accustomed to handling medical reimbursements from liability proceeds as liens, so it is natural and easy for them to handle Medicare reimbursements in the same way. A careful reading of the Medicare statute and regulations shows, however, that attorneys do not have obligations to identify potential MSP claims, or liability for double damages if they do not collect such claims for Medicare. The misunderstandings caused by the characterization of MSP claims as superliens should be cleared up for the protection of Medicare beneficiaries, as well as their attorneys.
FUTURE CHALLENGES FACING MEDICAID’S ROLE AS A PROVIDER OF LONG-TERM CARE

Molly O’Malley Watts, MPP, Judith Kasper, PhD, and Barbara Lyons, PhD

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I. Abstract

Medicaid’s role from its inception has been to ensure access to health care for low-income Americans. In fulfilling this role, Medicaid has become the major payer for long-term care services and supports to low-income individuals, and a safety-net for those who become impoverished as a result of long-term care needs. In addition to long-standing concerns about the high costs of long-term care, recent developments such as the shift of prescription drug coverage for dual eligibles from Medicaid to Medicare, initiatives allowing more flexibility in eligibility and benefit design, and growing concern about federal and state fiscal conditions have drawn attention to the challenges facing Medicaid as a provider of long-term care. This article describes these challenges and lays out issues facing the Medicaid program going forward.

II. Introduction

Over 10 million people need long-term care today to assist them in life’s daily activities. Most people with long-term care needs are over the age of 65 but many (42 percent) are under age 65. Over the next several decades, the aging of the population in the United States is expected to increase the demand for long-term care services. The number of elderly persons in the United States is projected to increase dramatically, both as a percentage of the population and in absolute numbers, due in large part to the aging of the baby boom generation and due to increased life expectancy. Further, long-term care services are vital to individuals with disabilities under the age of 65, who may require a lifetime of care. Thus, identifying ways to ensure access to needed services and providing adequate financing for long-term services and supports is an important policy concern.

A. Background on Long-Term Care

Long-term care refers to the supports and services needed when ability to care for oneself has been reduced by a chronic illness, disability, or aging. Core long-term care services are those that provide assistance in routine activities of daily living, such as bathing, dressing, getting around one’s home, taking medication, managing money, shopping for groceries and other necessities, and preparing meals. The need for long-term care can arise from various causes, including disease, disabling chronic conditions, injury, developmental disabilities, and severe mental illness. Some people need long-term care over a lifetime, such as children who are born with developmental disabilities or teenagers who incur traumatic brain injuries, while the elderly may need just a few hours a day due to decreasing mobility and cognitive functioning.

The vast majority of people with long-term care needs (86 percent) receive ser-

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3 Judith Feder et al., *Long-Term Care Financing: Policy Options for the Future*, (Health Policy Institute, Georgetown University) (June 2007), http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf.
4 Id.
vices in their community, including in their own homes. Only 14 percent live in nursing homes. Long-term care services and supports are usually provided by friends and family at home, through home and community-based services (HCBS) such as home health, personal care, and adult day care. Those with the most intensive needs reside in institutional settings, such as nursing homes or residential care facilities. Circumstances vary, both in terms of care needs and ability to pay for that care. Most care in the community (85 percent) is unpaid care provided by friends and family. Among people with long-term care needs living at home, fewer than 10 percent rely on formal paid care.

Although many people rely on unpaid help from family and friends, nearly $180 billion is spent annually on long-term care. Families run through large sums of money paying for long-term care because it is expensive. In 2009, the average annual cost of a nursing home stay was roughly $70,000 per year, which often exceeds individuals’ ability to pay for their care. The cost of nursing home stays vary among the states. For example, in New York the average annual rate is $81,000 per year, compared to $46,000 in Oklahoma. In 2009, home health care services averaged $46/hour and adult day care centers averaged $54/day, making community-based care costly too, depending upon an individual’s need for services.

Our country has a patchwork system in place for financing long-term care. As described below, most long-term care services are not covered by Medicare, and few people have private long-term care insurance to pay for nursing home stays. As a result, most people who require nursing home care eventually exhaust their savings and become eligible for Medicaid, the federal-state program that covers the costs of health and long-term care services for low-income individuals and individuals with disabilities. Medicaid pays for 40 percent of total long-term care spending, making it the primary payer for long-term care to such individuals. Medicare accounts for slightly less than 25 percent of long-term care spending; and direct, out-of-pocket spending by individuals and families accounts for 22 percent of spending. Because Medicaid is often the only source of coverage for these services, it plays a unique role in our health care system, helping to fill in the gaps in coverage and Medicare.

B. Medicaid’s Role Today

Medicaid plays a critical role for low-income people of all ages with long-term care needs. Nearly 3.4 million individuals, or seven percent of the total Medicaid population, rely on Medicaid long-term care services for a range of physical and mental health care needs. Over half of those who use Medicaid long-term care services and supports are individuals age 65 and older, but 34 percent are individuals under age 65 with a disability.

5 Id.
6 Id.
7 KAIser COM’N oN mEDICAId anD thE uNINSURED, mEDICAId aND lONG-TEmR mEadICAId SERvIcES & SUPPORTS FAcT SHEET, PUB. NO. 2186-06 (2009), http://www.kff.org/medicaid/upload/2186_06.pdf (estimates based on CMS National Health Accounts data).
9 Id.
10 Kaiser, supra note 7.
other 11 percent are adults and children who rely on Medicaid’s long-term care services and supports, but became eligible for Medicaid through pathways other than disability.\textsuperscript{11}

There is considerable diversity in the services used by, and the settings in which these services are provided to, those who rely on Medicaid to meet long-term care needs. Nursing home services are used predominantly by older people, while HCBS serve a broad age spectrum but are especially important for younger disabled people. The diversity of service and support needs also reflects varying causes of disability among Medicaid beneficiaries who receive long-term care services. These individuals include children with intellectual disabilities (such as mental retardation), developmental disabilities (such as autism), young adults with spinal cord and traumatic brain injuries, people with serious mental illness, and older people with Alzheimer’s disease and severely disabling chronic diseases such as diabetes and pulmonary disease.\textsuperscript{12}

Medicaid currently covers a wide range of long-term care services, in addition to such core services as personal care, which address a beneficiary’s limitations in performing routine activities of daily living. Medicaid pays for services ranging from a few hours per week in home and community settings, to 24-hour care in institutional settings such as nursing homes. Because of the diverse needs among disabled low-income beneficiaries, personal care alone, while often necessary, may not be sufficient to ensure community residence and integration. Medicaid has evolved to cover a broad spectrum of long-term care services and supports (in both community and institutional settings) that are often essential for individuals with disabilities. For example, persons with mental retardation and developmental disabilities may need supervision and cuing to prepare meals or manage finances. Those with mental illness may need supervised housing with onsite psychiatric care and medication management. Persons with spinal cord injuries and traumatic brain injuries may require modification of home environments to accommodate wheelchairs and assistive devices for bathing. Medical transportation is also a critical service for many individuals with severe disabilities.

States have considerable flexibility in which to structure their Medicaid long-term care programs. For example, there are two main ways a state can cover personal care services. One way is through the optional personal care benefit currently offered in 33 states, and another way is through HCBS waiver programs.\textsuperscript{13} Waiver programs are the primary mechanism for coverage of services other than personal care. Waiver programs can cover adult day care, homemaker/chore services, respite care, personal emergency response systems, case management, medical transportation, minor home repairs, social services, caregiver training, nutrition counseling, care in special residential facilities (for persons with mental illness for example), and services to persons in assisted living facilities. The

\textsuperscript{11} Anna Sommerset al., \textit{Medicaid’s Long-Term Care Beneficiaries: An Analysis of Spending Patterns}, Pub. No. 7576 (Kaiser Commission on Medicaid and the Uninsured) (Nov. 2006), http://www.kff.org/medicaid/7576.cfm.


\textsuperscript{13} Kaiser Family Foundation, Medicaid Benefits: Online Database, (Oct. 2006), http://www.kff.org/medicaid/benefits/index.jsp. All states offer at least one home and community-based waiver 1915(c) program with the exception of Arizona which operates home and community-based services through its comprehensive Section 1115 waiver.
standard 1915c waiver application, which states submit to the Centers for Medicare and Medicaid Services (CMS) for approval of waiver programs, lists these and many other services that might be included in designing a specific program. States also are permitted to propose additional services that are cost-effective and necessary to prevent institutionalization. Given this flexibility, there is variability from program to program in terms of eligibility for and receipt of services, and concerns have been raised about equity of access. Nonetheless, Medicaid provides the only means for low-income elderly and disabled Americans to obtain a broad spectrum of long-term care supports and services in both community and institutional settings.

III. Medicaid Long-Term Care Policy Challenges

A. Integrating Services for People with Long-Term Care Needs

People with long-term care needs also have substantial acute care needs, and often have needs beyond the traditional health care arena such as housing, social services, employment, and assistance in independent living skills. Medicaid’s capacity to meet effectively and efficiently the needs of low-income elderly and disabled Americans can be hampered by a lack of coordination across providers of acute and long-term care services and by an inability to address housing limitations or availability.

Over time, Medicaid has evolved as the primary safety net payer for long-term care and now meets a continuum of needs, especially for low-income disabled beneficiaries. The important role that Medicaid now fills in providing long-term care means engagement with many services and supports that are beyond the traditional health care arena. With efforts to increase use of community versus institutional services, including transitioning individuals from institutional to community care, the need for Medicaid programs to coordinate with other service sectors, such as housing, has increased. Difficulties in coordinating services for people with disabilities occur at many levels — among health and long-term care providers, and between health-related and other service sectors — potentially hampering the effectiveness of Medicaid in meeting needs and enabling community residence and integration.

Concerns about care coordination stemming from multiple providers and payers are not new. In the 1930s, the Chair of the Committee on the Costs of Medical Care expressed

concern about conflicting advice from specialists, duplicate tests, and lack of communication with patients.\textsuperscript{18} Recent articles on difficulties in coordinating care have focused on the consequences for persons with multiple chronic conditions.\textsuperscript{19} Many individuals with long-term care needs also require care for multiple or complex medical conditions. Heart or pulmonary diseases are major causes of disability among older people.\textsuperscript{20} Increased prevalence of diabetes, lung disease, and other co-morbid medical illnesses has been documented among adults with serious mental illness.\textsuperscript{21} Management of chronic medical conditions in people with disabilities has implications not only for patient well-being but for appropriate use of services and costs of care, given the high utilization rates of disabled individuals.\textsuperscript{22}

Although discussions of Medicaid’s role for persons with disabilities usually emphasize long-term care services and supports, Medicaid also provides coverage for physician care, skilled therapy (speech and physical therapy), and nursing services for these individuals. Coverage does not always ensure access, however. Among the consequences of poor care coordination is lack of access to needed services. Problems in coordinating medical and mental health services for persons with severe mental illness have been repeatedly documented. Medicaid enrollees with severe mental illness had 18 percent fewer claims for physical health care than Medicaid enrollees with similar physical health diagnoses but no mental illness.\textsuperscript{23} In a group of Medicaid patients with severe and persistent mental illness, despite high levels of use of outpatient services, use of primary and preventive services was quite low.\textsuperscript{24} Studies also indicate that people with disabilities are less

\textsuperscript{18} Ray Lyman Wilbur, \textit{The Economics of Public Health and Medical Care}, 83(4) The Milbank Quarterly 523-536 (1932, republished 2005).
\textsuperscript{20} United States Census Bureau, \textit{Survey of Income and Program Participation}, 2004 Panel, Wave 5, Table 2 (June–September 2005), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5816a2.htm.
\textsuperscript{21} Joseph Sokal et al., \textit{Comorbidity of Medical Illnesses Among Adults with Serious Mental Illness Who Are Receiving Community Psychiatric Services}, 192(6) J Nerv Ment Dis 421-427 (June 2004); Barbara Dickey et al., \textit{Medical Morbidity, Mental Illness and Substance Use Disorders}, 53(7) Psychiatr Serv 861-867 (July 2002).
likely to receive preventive services (e.g., mammography). The importance of a regular physician in access to medical care and routine preventive services is well established, as is the role of access to primary care in avoiding preventable hospitalizations. Data from a study of elderly dual enrollees in six states indicated a quarter of hospitalizations over a one-year period were ambulatory care sensitive (potentially preventable with appropriate primary care), and eight percent of enrollees experienced such a hospitalization.

Coordination of acute and long-term services also remains an ongoing concern. In one study of elderly dual enrollees, physicians were much less likely to refer individuals for long-term care services than for acute care. Among those needing a medical specialist, 87 percent received a physician referral; among those needing community services, home modifications, or transport services, around 50 percent received a referral. In addition, organizational barriers to care — inability to make appointments or arrangements for services, waiting lists, language or communication difficulties, conflicting treatment options — were experienced much more often than financial barriers.

There are also problems in coordinating services across Medicare and Medicaid, because Medicare is funded entirely at the federal level and Medicaid is administered by the states within federal guidelines but financed jointly by federal and state governments. Medicaid is a vital complement to coverage for poor and disabled Medicare beneficiaries. Dual eligibles — the nearly nine million low-income beneficiaries who are also covered by Medicaid — are among Medicare’s sickest, frailest, and poorest beneficiaries. Although the dual eligibles account for only 18 percent of Medicaid enrollment, 46 percent of all Medicaid expenditures for medical services are made on their behalf. Many suffer from cognitive impairments and chronic illnesses that require on-going help with activities of daily living. Medicaid provides the services to fill Medicare’s benefits gaps, enabling many to stay in their homes and helping to offset the cost of nursing home care for those in need of greater assistance.

The cost of dual eligibles has long been a difficult issue for states and the federal government. States often argue, particularly in tough economic times, that this group should be the responsibility of the federal government, and that the responsibility to fill in gaps in the Medicare benefit package for these individuals has been shifted inappropriately to states. The National Governors Association argues that dual eligibles should be a

25 Lisa I. Iezzoni et al., Mobility Impairments and Use of Screening and Preventive Services, 90(6) AJPH 955-61 (June 2000); Anthony Ramirez et al., Disability and Preventive Cancer Screening: Results from the 2001 California Health Interview Survey, 95(11) AJPH 2057-2064 (Nov. 2005).
26 Andrew B. Bindman et al., Preventable Hospitalizations and Access to Health Care, 274(4) JAMA 305-311 (July 26, 1995).
27 Marlene R. Niefeld, Johns Hopkins University, Ambulatory Care Sensitive Condition Hospitalizations among Elderly Medicare and Medicaid (Dual) Enrollees, Academy Health Annual Meeting Concurrent Sessions (June 8-9, 2004).
federal responsibility, and until a single program is responsible for the entire benefit array received by poor and disabled Medicare beneficiaries, care coordination and cost-shifting problems will lead to less than optimal care for the dual eligibles.30

A final challenge for Medicaid lies in coordinating with service sectors, like housing, that are outside the purview of the Medicaid program but are critical to goals such as transitioning individuals from institutional to community settings. Treatment of assisted living under Medicaid varies. Some states offer assisted living waiver programs that allow Medicaid to cover residential as well as care expenses, if persons are transitioning from nursing homes. In other states, Medicaid covers services but not the housing component of assisted living, severely restricting this option for most beneficiaries. The inability to secure affordable community housing, or to modify homes to accommodate the needs of persons with particular types of disabilities, can be major impediments to community residence. Some HCBS waiver programs cover home modifications, such as ramps or minor home repairs, although available funds are often capped. Recognition that expenses for re-establishing a community residence were a barrier to leaving a nursing home led the CMS in 2002 to allow payment for certain one-time expenses (such as security deposits and essential household furnishings) for individuals making a transition. Nonetheless, lack of stable affordable housing options for low-income elderly and disabled people can disrupt efforts to provide needed acute and long-term care services and supports in the least restrictive settings. Section 8 housing and housing for persons with special needs (e.g., housing with supervision for individuals with serious mental illness) is often limited and has substantial waiting lists; and Medicaid care planners are not typically able to assist in the housing application process.31

B. Impact of Varying Disability Criteria

Disability criteria for Medicaid coverage of long-term services and supports limit access to the most severely disabled and are not uniform, creating potential inequities across beneficiary groups and states. An option under the Deficit Reduction Act of 2005 (DRA’05) allows states to use less stringent criteria for HCBS eligibility, but also requires that eligibility criteria for institutional services be more restrictive.32 Many aspects of this option, such as allowances to cap enrollment and maintain waiting lists, make it uncertain whether its implementation by states will actually expand access to community services, but the ability to serve persons who do not require an institutional level of care potentially expands the population of disabled Medicaid beneficiaries eligible for community services. Currently, only Iowa and Colorado have taken up the HCBS state plan option, but

31 Wolff & Boult, supra note 19.
32 An option under the DRA allows states to use less stringent criteria for home and community-based services (HCBS) eligibility but also required that eligibility criteria for institutional services be more restrictive. Deficit Reduction Act of 2005, Pub. L. No. 109-171 § 6086 (2005).
an additional three states have plans to implement the option in state fiscal year 2009.\textsuperscript{34}

Approaches to screening and “need” criteria for long-term care services and supports vary across states and are driven by many factors, including a desire to control costs. Most states set functional eligibility criteria for HCBS at the same level that is used for care in a nursing facility. This limits access to services at earlier stages in the disabling process when it might be possible to shore up community supports. A recent survey found only seven waivers that used more restrictive functional eligibility criteria for institutional care.\textsuperscript{35} That said, each state interprets “need for institutional care” differently using state-administered assessment and eligibility systems to determine whether institutional level-of-care criteria are met. A study from the early 1990s, and one more recently, note that “the usual model” is to have multiple, separate screening and assessment tools that are applied to different programs and eligibility groups.\textsuperscript{36} A survey of states found that few had integrated their systems of assessment for community care on a statewide basis.\textsuperscript{37} In 2001, only three states coordinated screening and assessment across long-term care programs by “operating a single state administrative agency, using uniform need criteria and standard tools, and having automated databases.”\textsuperscript{38} Variability in “need” criteria allows states to tailor programs to their specific needs, but creates the potential for barriers to access because of the difficulties in obtaining information and negotiating the eligibility process across multiple programs.

Variation in who receives HCBS and whether this signals inequitable treatment of individuals with similar care needs is an ongoing concern.\textsuperscript{39} In many instances, existing variations appear arbitrary. One example is the implementation by states of a recommendation from the Advisory Panel on Alzheimer’s Disease that cueing and supervision in activities of daily living, and supervision for safety reasons (to protect against the consequences of impaired judgment), both be interpreted as meeting criteria for need for institutional care.\textsuperscript{40} Some states followed the recommendation, allowing individuals who met either criteria to be considered eligible for nursing home care and HCBS waivers. Other states, however, chose to base eligibility on only one of the two suggested criteria (making those who met the cueing/supervision criteria eligible in some states and those who met the safety criteria eligible in others), or to require that both criteria be met in

\begin{thebibliography}{99}
\bibitem{35} Terence Ng et al., Medicaid Home and Community-Based Service Programs: Data Update, Pub. No. 7720-02 (Kaiser Commission on Medicaid and the Uninsured) (Dec. 2008), http://www.kff.org/medicaid/upload/7720_02.pdf.
\bibitem{36} Walter Leutz et al., The Administration of Eligibility for Community Long-term Care, 33(1) The Gerontologist 92-104 (1993); M. Christine Tonner et al., State Long-term Care Screening and Assessment Programs, 19(3) Home Health Care Serv Q 57-85 (2001).
\bibitem{38} Tonner, supra note 36.
\bibitem{39} Summer, supra note 15; GAO, supra note 15.
\bibitem{40} Janet O’Keeffe, People with Dementia: Can They Meet Medicaid Level-of-Care Criteria for Admission to Nursing Homes and Home and Community-based Waiver Programs? #9912 (AARP Public Policy Institute) (Aug. 1, 1999), http://assets.aarp.org/rgcenter/health/9912_dementia.pdf.
\end{thebibliography}
order to qualify. Some states did not implement the recommendation, using other criteria altogether. The rationale for variations in eligibility criteria should continue to be scrutinized for its impact on equitable access to long-term care services and supports among low-income elderly and disabled people.

C. Means-Testing the Benefit

Individuals must meet financial qualifications for Medicaid coverage of long-term services and supports, in addition to meeting needs criteria. Studies show that the covered population consists of the very poor (many with incomes below the poverty line). Both income and asset standards ($2,000 for an individual and $3,000 for a couple, in most states) apply and are set at very low levels; but these vary across groups. For example, disabled adults of working age generally must have low incomes to qualify (eligibility for the personal care benefit is based on SSI eligibility — 74 percent of the poverty level; individuals who are in nursing homes may qualify at 300 percent of SSI).

A substantial proportion of users of Medicaid long-term care services and supports have been poor for long periods. People with disabilities are a large share of the working-age poverty population. In one study, among those who were poor over several years, about half were disabled individuals. Persons with significant disabilities and long-term care needs are often limited in work force participation and have difficulty accumulating assets. Onset of major health events (such as serious chronic disabling diseases) has been shown to reduce household income and result in substantial lost wealth and savings.

Medicaid’s safety net function also is vital, since most Americans do not have the economic resources to cope with permanently disabling illness or injury. Nonetheless, there has been particular concern that elderly individuals who enter nursing homes and qualify for Medicaid could have paid for their own care. An examination of assets among older people in the community indicates that two-thirds would be unable to pay for even one year of nursing home care.

Before 1981, when the Boren-Long Amendment was passed, Congress did not

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42 Id.


46 42 U.S.C.A. § 1382b(c) (Supp. 1975-1981). The Boren-Long Amendment alters section 1382b of the Social Security Act by adding a requirement that any transfer of assets for less than fair value within 24 months preceding the application for assistance shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under the Act. Assets so transferred shall be included in the applicant’s resources for the purpose of determining eligibility based on need.
penalize asset transfers in order to qualify for nursing home care. Over time, additional restrictions have been introduced, including liens on the property of living recipients and estate recovery of deceased recipients. Most recently, the DRA’05\(^\text{47}\) further tightened rules against asset transfer by including penalties for asset transfers prior to Medicaid eligibility, denying eligibility for persons whose home equity exceeds certain amounts, and imposing income-only rules which may reduce the amount of assets available to the community spouse.\(^\text{48}\)

Several studies find that asset transfer is less common than assumed and involves modest amounts that would cover very little of the cost of a nursing home stay. Early studies provided a range of estimates for the percentage of persons who spend-down to Medicaid coverage among nursing home patients (27 percent of elderly in Michigan,\(^\text{49}\) 10 percent from national data\(^\text{50}\)). A later study suggested that 44 percent of persons over age 65 who use nursing homes start and end as private payers, 27 percent start and end as recipients of Medicaid benefits, and only 14 percent spend down assets to become eligible for Medicaid.\(^\text{51}\)

One study found nine to 15 percent of new Medicaid-eligible nursing home residents had transferred assets, and the mean amount transferred was $4,000 (asset transfers were in fact more common among elderly people who did not enter a nursing home than among those who did).\(^\text{52}\) Another study found 18.5 percent of persons who eventually became Medicaid nursing home patients transferred assets in the two years prior to admission, in amounts averaging $8,202; 13.1 percent transferred assets in the four years prior to admission, transferring on average $5,380.\(^\text{53}\) A recent Government Accountability Office (GAO) study questioned whether DRA’05 provisions would have much effect on Medicaid eligibility among nursing home entrants because few applicants transferred assets or had home equity that exceeded DRA’05 limits.\(^\text{54}\)

The consequences of requiring impoverishment to qualify for Medicaid long-term care services are rarely addressed. The Family Opportunity Act (DRA’05) represents a departure in creating a new state option that offers Medicaid buy-in coverage to disabled children with family incomes up to 300 percent of the federal poverty level (states can cover eligible children at higher income levels with state-only funds). By providing a means for higher income families to buy in to Medicaid, this option recognizes that


\(^{48}\) Crowley, _supra_ note 33.


\(^{51}\) Brenda C. Spillman & Peter Kemper, _Lifetime Patterns of Payment for Nursing Home Care_, 33(3) Medical Care 280-96 (1995).

\(^{52}\) Jinkook Lee et al., _Medicaid and Family Wealth Transfer_, 46(1) Gerontologist 6-13 (Feb 2006).


requiring impoverishment to obtain coverage would not be in the interests of disabled children, their parents, or their siblings. Four states have taken up this option thus far. Legislation in the late 1990s (the Balanced Budget Amendment of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. No. 106-170) permitted state Medicaid “buy-in” programs for individuals with disabilities who would be able to work if they retained their health coverage. This program also appears to acknowledge that achieving the goals of community integration and residence for disabled individuals may mean reconsidering financial criteria for long-term care services and supports that require impoverishment. As of 2008, more than 90,000 individuals in 40 states were covered under this program.

D. Balancing Institutional and Community-Based Care

Medicaid covers a continuum of long-term care service settings from nursing homes to the community. Historically, differences in functional and financial eligibility criteria between nursing homes and community-based care steered low-income people with long-term care needs into institutional care settings. Over the past 20 years, greater parity in eligibility criteria, increased spending on community-based alternatives, and declines in nursing home beds have helped shift Medicaid long-term care spending away from nursing home care. Over the past two decades, the absolute number of nursing home residents ages 65 and older has actually declined. Medicaid beneficiaries have followed this trend. Between 1999 and 2003 the percentage of Medicaid beneficiaries ages 65 or older in nursing homes declined from 21.6 percent to 18.1 percent; the percentage of Medicaid beneficiaries ages 85 or older in nursing homes declined from 47.6 percent to 43.6 percent .

Many states now tie financial eligibility criteria for HCBS waiver programs to the nursing home standard. As of 2007, however, 24 percent of waiver programs still used stricter financial eligibility for HCBS waiver programs than for nursing facilities. The national percentage of Medicaid spending on HCBS more than doubled from 19 percent in 1995 to 41 percent in 2007. The number of nursing home beds also declined between 1990 and 2002 (from 66.7 to 61.4 per 10,000 population), although increases in assisted-living beds resulted in a modest increase in all types of long-term care beds over the same period (from 2.3 to 2.9 million).

States are employing a wide range of approaches to rebalance long-term care in

55 Smith, supra note 34. The states include Illinois, Iowa, Louisiana, and North Dakota.
57 Lisa Alexxih, Vice President, The Lewin Group, Nursing Home Use of “Oldest Old” Sharply Declines, National Press Club Presentation (Nov. 21, 2006).
59 Ng, supra note 35.
favor of community settings, such as nursing home diversion programs and nursing home transition programs. A review of nursing home diversion programs in eight states documents procedures that speed up the eligibility determination process, provide immediate payment to community providers (presumptive eligibility), and inform individuals about community options both prior to nursing home entry and, for those admitted, in the early part of a stay.62 Nursing home transition programs targeted at returning Medicaid-eligible nursing home residents to community settings, although serving relatively small numbers of individuals, represent another initiative to shift resources from institutional to community settings. Less reliance on institutional care is widely endorsed by disabled individuals, their families, and policymakers, and is legally mandated under Olmstead v. L. C.63 Concerns also have been raised, however, about wide variations in the availability of beds across states64 and possible future shortages, given the growth in population of persons at the oldest ages.65

Despite major shifts toward community care settings, the majority of Medicaid long-term care dollars still go toward nursing home care. Access to Medicaid coverage for community-based services, as opposed to nursing home care, remains more restricted, even when functional and financial criteria are the same. Individuals in nursing homes with incomes above the Medicaid qualifying limit can qualify based on spend-down criteria in many states, but community-resident individuals seeking services through waiver programs usually cannot.

Restrictions on income and assets for eligibility may inhibit goals to reduce institutional bias. Allowable resources for persons in the community (about $2,000) are very low and insufficient to maintain community residence without considerable family support. Family and friends provide high levels of assistance to disabled Medicaid beneficiaries, but caregivers who work or are elderly may have difficulty filling in the gap. In addition, individuals in the community face waiting lists for waiver services. Institutional care may prove the only alternative. Waiting lists can also block transitions from nursing homes. To avoid this, some states give preference for community services to such individuals. The number of waivers with waiting lists continues to grow and serve as a sign that access to HCBS programs is limited. In 2007, the figures show 332,000 individuals were on waiting lists for 106 waivers in 37 states; up from 280,000 in 2006.66

E. Flexible Benefit Design

Trends toward a more flexible benefit design hold both promise and peril. Flexibility provides the opportunity to individualize services and respond to consumer preferences, but poses challenges in maintaining equity and assuring that needs are being met. Provid-

64 Harrington, supra note 61.
66 Ng, supra note 35.
ing services and supports tailored to individual needs, rather than in a one-size-fits-all fashion, has been a long-standing goal in long-term care program design. Efforts to make Medicaid benefits more flexible and allow consumer involvement in determining and managing services could further expand service options, perhaps even allowing housing to be incorporated into benefit packages. The Cash and Counseling option under DRA’05 permits states to allow beneficiaries to manage an individual budget to purchase personal care assistance services (hiring caregivers and purchasing items that increase independence) that are part of a plan of care. While many consumers and their families desire more flexibility and control over services and providers, there is concern that states will be forced by restricted federal financing or constrained budgets to exercise flexibility over optional populations and services primarily to reduce access and coverage. The growing waiting lists for HCBS waivers indicate many states already feel unable to meet long-term care needs.

Other concerns relate to consumer protections and accountability. A study of Medicaid beneficiaries in California receiving services under agency-directed versus consumer-directed care models found beneficiaries in consumer-directed models reported more positive or similar outcomes for safety, unmet need, and satisfaction with services. Nonetheless, concerns remain. Key issues are the level and adequacy of budgets; differing levels of support across states in developing plans of care, managing budgets, and handling payroll functions; and the best way to monitor the adequacy of care provided. Experience with consumer-directed care models is still limited, and careful attention to implementation at the state level is warranted.

Greater flexibility in benefit design and qualifying populations will inevitably increase variability within and across states in terms of who is covered and the services received. This increases the importance of assessing and systematically monitoring individual-level outcomes including unmet needs and satisfaction with care. Studies of the relationship between state long-term care policies and programs with unmet needs are few. One case found that among elderly dual eligibles, receipt of paid in-home care substantially reduced levels of unmet need. Whether services and supports are adequate under an increasingly diverse set of programs aimed at different populations will require a focus on outcomes, and not solely on costs, as measures of system and program performance.

F. Maintaining and Monitoring Quality of Care

Quality of care is an ongoing concern in providing long-term services and supports to low-income elderly and disabled individuals. Identifying and remediying poor quality care requires mechanisms to monitor quality and incentives for implementing improvement. Most attention to quality of care has been on nursing homes. The quality of nursing homes has been a major focus since the early 1980s when the Institute of Medicine report Improving the Quality of Care in Nursing Homes led to the Nursing Home Reform Act (OBRA’87). A key element was the requirement that nursing homes conduct standardized patient-level assessments on all residents. Initially used as a care planning tool, these data now form the basis for evaluating quality of care. A well-developed literature on quality of care in nursing homes has examined how ownership, socioeconomic status, race, and a host of other facility and patient characteristics relate to quality of care. Although serious concerns about the quality of care in nursing homes remain, evidence suggests that the use of a comprehensive uniform assessment tool in nursing homes results in significant improvements in quality of care.

Unlike nursing homes, quality of care is not consistently or comprehensively evaluated in other residential long-term care settings, including assisted living facilities or in home and community-based care. As the Institute of Medicine (IOM) Report of 2003 noted, there is no core set of quality measures that applies across long-term care settings. The IOM Report also questioned the reliance on measures of satisfaction with care as an indicator of the quality of HCBS. The DRA’05 directed the Agency for Health Care Research and Quality to develop quality of care measures that can be used to assess Medicaid HCBS programs with regard to program performance, client functioning, and client satisfaction. These measures are intended for use in assessing the quality of HCBS and their outcomes. This effort represents a first step toward more comprehensive, standardized assessment of quality of care in Medicaid HCBS. The CMS also is developing a uniform patient assessment instrument to be used across nursing home and in-home care settings, which may begin to address the IOM goal of measures that apply across care settings. How these efforts will be coordinated is unclear, but they represent steps toward more rigorous and comprehensive standards for assessing quality in long-term care.

Many issues remain however, among them how to ensure state adoption of quality of

70 Ciaran O’Neill et al., Quality of Care in Nursing Homes: An Analysis of Relationships Among Profit, Quality, and Ownership, 41(12) Med Care 1318-30 (Dec. 2003).
71 Vincent Mor et al., Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care, 82(2) Milbank Q. 227-56 (2004).
75 GOOLOOS WUNDERLICH & PETER O. KOHLER, IMPROVING THE QUALITY OF LONG-TERM CARE (Committee on Improving Quality in Long-Term Care & Division of Health Care Services, eds., Institute of Medicine, The National Academies Press) (2001). FN #73. Should read: WUNDERLICH, supra note 73.
care assessment tools that will provide a basis for program evaluation. The DRA’05 calls for a comparative analysis of the system features of each state and dissemination of best practices information. If the decision to adopt quality of care measures and procedures for implementing quality of care assessment is left entirely to states, there will be widely varying information available, making it difficult to assess whether needs for long-term care services and supports are being met and whether variations in quality of care exist.

G. Financing Long-Term Services and Supports

The number of persons with long-term care needs is projected to grow, and the high costs of services mean a substantial proportion will turn to Medicaid. A recent report on the long-term care needs of the baby boomers indicates that the increasing size of the older population will result in a growing disabled older population. Furthermore, use of paid long-term care services will rise, more than doubling between the years 2000 and 2040. While boomers with long-term care needs will be better educated and have more income than current older disabled individuals, barring major changes in long-term care financing, Medicaid will play an essential role for those who are poor and of moderate incomes.

Disabled individuals under age 65 increasingly enjoy longer life expectancies. Medicaid is the largest single payer of direct medical services for adults and children with HIV/AIDS, who with modern drug regimens survive for substantially longer periods. Studies of persons with Downs Syndrome show average life expectancy has increased from about 30 years to about 60 years of age. Advances in treatments for people with chronic disabling conditions means that Medicaid long-term care services and supports for younger disabled people may be needed for increasingly longer periods.

Today, Medicaid pays for 40 percent of all long-term care expenditures and almost half of all nursing home care costs. The most commonly recommended alternatives to Medicaid financing of long-term services and supports are greater coverage by private long-term care insurance and use of home equity programs, such as reverse mortgages. The intended target for these is elderly individuals; younger disabled people are generally ineligible. A considerable body of research evidence shows that these options would have only a limited impact in reducing reliance on Medicaid among elderly low-income people with long-term care needs.

Purchase of long-term care insurance is closely tied to income and unaffordable for low-income elderly people. In 2002, national data on people ages 55 and older indicated that only three percent of older adults with incomes below $20,000 had long-term care insurance; over half of those who purchased this coverage had incomes exceeding $50,000.

Future Challenges Facing Medicaid’s Role

or assets exceeding $100,000.\textsuperscript{80} A GAO report in 2000 stated that while ability to afford these policies is a subjective judgment, estimates are that “long-term care insurance is affordable for only 10 to 20 percent of elderly individuals.”\textsuperscript{81} Younger disabled people are precluded from purchasing private long-term care insurance by pre-existing conditions, regardless of its affordability.

Other efforts to increase purchases of private long-term care insurance include tax subsidies (federal subsidies to employers who provide long-term care insurance and state subsidies to encourage individuals to purchase coverage)\textsuperscript{82} and state programs (such as Long-Term Care Partnership Programs) that allow individuals who purchase approved policies to protect assets and still qualify for Medicaid long-term care benefits.\textsuperscript{83} Neither can be expected to address the long-term care financing needs of lower income Americans. The value of tax deductions for long-term care insurance increases with income, and will most benefit those with higher incomes who currently are the primary purchasers of these policies. The expansion of Long-Term Care Partnership programs under DRA’05 is aimed at increasing coverage for people with modest economic resources who are at risk of spending down to become Medicaid-eligible. Evidence from the experience of the four early LTC Partnership states is limited, and it remains unclear whether these policies will primarily attract higher income people not truly at risk of spend-down, as opposed to those of moderate income who are the intended purchasers.\textsuperscript{84}

Reverse mortgages are also suggested as a mechanism for paying for long-term care expenses directly or for premiums for private long-term care insurance (reverse mortgages are available only to homeowners at age 62). Three-quarters of older households (single or couples 62 years of age or older) have some net home equity, but the number of individuals who could qualify for reverse mortgages, and the amounts that could be freed up, are estimated to be relatively small, and would “merely postpone, rather than obviate, the need for Medicaid assistance.”\textsuperscript{85}


\textsuperscript{83} Anne Tumlinson et al., Closing the Long-Term Care Funding Gap: The Challenges of Private Long-Term Care Insurance, Pub. No. 7879 (Kaiser Commission on Medicaid and the Uninsured) (June 2009), http://www.kff.org/insurance/7879.cfm.


\textsuperscript{85} Mark Merlis, Home Equity Conversion Mortgages and Long-Term Care (Health Policy Institute, Georgetown University) (Mar. 2005), http://ltc.georgetown.edu/pdfs/hecmfullreport.pdf.
For the foreseeable future, Medicaid will remain the major financing system for long-term care services and supports in our nation and the only mechanism addressing the needs of low-income Americans. Cost concerns drive much of the policy discussion concerning Medicaid’s role as a provider of long-term care, but as in other areas of health care there is increasing focus on quality and indicators that can be used to evaluate quality of care across providers and settings. Innovations in program design that allow coverage of a broad continuum of services and supports, more consumer involvement, and expansions in access are currently counterbalanced by a confusing array of eligibility criteria, inequities in access to services across and within states, and financial standards that require impoverishment to qualify. States are also facing a deepening fiscal crisis, which may force them to scale back the progress they have made in expanding HCBS programs in order to maintain the current level of services for all Medicaid beneficiaries. The needs for long-term services and supports that Medicaid addresses will not lessen in coming years; they will likely grow. The challenges for those who finance, design, and provide long-term care under the Medicaid program are to align incentives to ensure access, meet needs, and provide cost-effective high quality services and supports to low-income elderly and disabled Americans.
MULTIDISCIPLINARY PRACTICE AND ETHICS

PART I — LAWYERS, DOCTORS, AND CONFIDENTIALITY

By A. Frank Johns, JD, LLM, CELA

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I. INTRODUCTION

Many members of the medical and legal professions are serving older adults and their families. Each profession adheres to codes of ethics. Each profession’s code of ethics mandates confidentiality. Where are the confidentiality boundaries of each profession
when doctors and lawyers serve the same patients or clients? This two-part article examines those boundaries, assessing which definition is broader in scope. The article then questions which definition impedes or disrupts the application of the other when applied to the same patient or client. The first part of the article examines the black letter rules on confidentiality in each profession as they relate to privacy in the context of health care and to privacy in the context of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The second part of the article examines papers, opinions, and decisions in each profession, assessing several specific areas of confidentiality to determine if they clarify boundaries, showing differences between the professions that may be impediments to serving the same patient or client. The inquiry is prompted by the rising demographics of older adults in this society and by the increasing professional interplay between doctors and lawyers with the same elderly patients or clients.

II. THE MEDICAL PROFESSION AND CONFIDENTIALITY

Since its founding in 1847, the American Medical Association (AMA), which is considered the leading medical organization advocating for physicians and their patients, has had a code of ethics. Within the AMA, the responsibility and authority for developing its code of ethics has rested with the Council on Ethical and Judicial Affairs (CEJA) since 1873. Although the CEJA has judicial responsibilities, which includes “…appeal jurisdiction over physician members’ appeals of ethics-related decisions made by state and specialty medical societies,” individual ethical opinions and disciplinary decisions are determined on the local level. On its own, the CEJA issues no published opinions or disciplinary decisions concerning individual physician conduct thus leaving no way to ascertain how the AMA applies its ethics principles to medical practice, or how it mandates enforcement.

Much like lawyers, physicians must be licensed through their state’s medical board

2 History of AMA Ethics, original 1847 code of medical ethics, http://www.ama-assn.org/ama/pub/category/1930.html (last visited June 20, 2009). The current Code is comprised of nine Principles of Medical Ethics and a number of official “opinions” within nine separate categories. These categories are: Social Policy Issues; Inter-Professional Relations; Hospital Relations; Confidentiality, Advertising, and Communications Media Relations; Fees and Charges; Physician Records; Practice Matters; Professional Rights and Responsibilities; and the Patient-Physician Relationship. The AMA uses the term “opinions” to mean policy statements. The three opinions in the category of “Confidentiality, Advertising, and Communications Media Relations (5.00) that this article will examine are E-5.05: Confidentiality: E-5.059 Privacy in the Context of Health Care; and E-5.06: Confidentiality: Attorney-Physician Relation. AMA — Code of Medical Ethics, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml (last visited June 1, 2009) [hereinafter AMA Code of Medical Ethics].
3 (“The Council on Ethical and Judicial Affairs (CEJA) [which was originally called the AMA Judicial Council] develops ethics policy for the AMA. Composed of seven practicing physicians, a resident or fellow, and a medical student, the Council prepares reports that analyze and address timely ethical issues that confront physicians and the medical profession.”), AMA — About the Ethics Group, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/about-ethics-group.shtml (last visited June 20, 2009). The CEJA is one of three members of the AMA “Ethics Group,” which also includes the Ethics Resource Center and the Institute for Ethics. Id.
4 Id.
and each board carries statutory enforcement powers. However, unlike most state bar associations, the state medical boards do not publish their disciplinary decisions and ethics opinions. The lack of published decisions by the AMA and the state medical boards limits clear interpretation or understanding of just how the black letter of the code of medical ethics and the state disciplinary rules are applied. One source of information and analysis is the *Code of Medical Ethics: Current Opinions with Annotations*, which provides references to judicial decisions and published articles relating to the profession’s ethical principles. While this body of work, along with current codes, statutory revisions, and position statements provides non-medical professionals ample information for analysis, it lacks significantly in application. One medical ethicist opined recently that the intended secrecy of enforcement and discipline leaves the medical profession woefully behind in maintaining individual physician adherence to rules of ethics and in gaining higher standards of practice.

### A. Current Codes, Statutory Revisions, and Commentaries

1. The AMA Code of Medical Ethics — Confidentiality

The AMA ethical rule on confidentiality has been a part of its ethics code since its inception. Language of the time referred to keeping secrets:

…Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed; and the familiar and confidential intercourse to which physicians are admitted, in their professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honor.

The concept of confidentiality, or secrecy, in the early years was qualified to those times when “peculiar circumstances” required it. However, by 1903, the qualification was removed and the principle simply mandated that “…secrecy and delicacy should be

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5 *Compare* North Carolina Medical Board statutory authority §90-5.1, with Florida Board of Medicine statutory authority §458.311.
6 Catherine Carpenter, in-house attorney, North Carolina Medical Board, was most helpful in explaining how the ethics of the AMA and the North Carolina Medical Board are directed and enforced. She confirmed that the AMA and the North Carolina Medical Board (she could not say for other states) do not publish formal disciplines and opinions relating to the principles of medical ethics and confidentiality. She did, however, direct the writer to published Position Statements that will be mentioned in the paper. Telephone Interview with Catherine Carpenter, Attorney, North Carolina Medical Board (Oct. 11, 2007).
8 Comments to the author by Jonathan Evans, MD, geriatrician and medical director University of Virginia Medical School (Nov. 6, 2007).
10 *Id.*
strictly observed…” The current iteration of the confidentiality principle in the AMA Code of Ethics, as adopted by the AMA in 2001, is as follows:

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.12

Confidentiality within the medical profession becomes complicated due in part to the sophistication of medical practice; the societal issues patients present; and the technologies applied in the profession. The AMA has addressed these issues with written and detailed opinions in sub-components of the category of opinions that relate to confidentiality.13 This category is E-5.00: Opinions on Confidentiality, Advertising, and Communications Media Relations. Under this category, the AMA addresses eight specific areas,14 of which two, E-5.059 Privacy in the Context of Health Care and E-5.06 Confidentiality: Attorney Physician Relations, will be examined and discussed in the second part of this article.

2. State Medical Boards and Position Statements Related to Patient Confidentiality

The significant procedural variance among state medical boards when handling ethics issues is beyond the scope of this article. When narrowed to the specific reference of patient confidentiality, it was no less complicated. Finding any reference to patient confidentiality in many of the states’ medical board or the medical association or society Web sites proved daunting.15 Other than general information on medical confidentiality policy or ethics found at a few sites like the California Medical Society,16 patient confidentiality

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12 AMA Code of Medical Ethics, supra note 2.
13 Id.
14 Id. These include: E-5.051 Confidentiality of Medical Information Postmortem; E-5.055 Confidential Care for Minors; E-5.0591 Patient Privacy and Outside Observers to the Clinical Encounter; E-5.07 Confidentiality: Computers; E-5.075 Confidentiality: Disclosure of Records to Data Collection Companies; E-5.08 Confidentiality: Insurance Company Representatives; and E-5.09 Confidentiality: Industry-Employed Physicians and Independent Medical Examiners.
15 This author surveyed the Web sites of medical boards or societies in Missouri, New York, Massachusetts Illinois, and Colorado. No reference or link to patient confidentiality was provided. (All Web sites last visited June 29, 2009).
16 See California Medical Association, CMA ON-CALL: CMA online medical-legal library, citing Section 1110 Confidentiality of Sensitive Information: Physicians often ask about the proper way to protect particularly sensitive medical information. Certain information on drug or alcohol abuse, HIV disease, developmental disabilities, or mental health is covered by special confidentiality requirements. Questions also arise with respect to information provided to a physician in confidence by members of the patient’s family and others. The confidentiality of such records must be maintained even though it may be time-consuming to read the records to ensure that such information is not included when records are released to third parties. Rather than reviewing all the records each time a request is received, it would be far preferable to develop a filing system whereby this information is initially separated in some fashion from the rest of the medical record. Such a system will
was not found when the Web sites were searched.

However, the attorney for the North Carolina Medical Board directed attention to the North Carolina Board’s position statement that specifically addresses confidentiality and privacy:

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust — communication, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, appropriate care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board.17

3. Published Articles and Decisions

An annotation of the Code of Medical Ethics references published writings and court decisions that quote the principles in medical, ethical, and legal literature or cite the opinions in judicial rulings.18 This is the only source for examining the boundaries of the ethic of confidentiality within the medical profession. Even this source does not reference any opinions of any governing body of the medical profession that applies the principles of medical ethics to specific infractions by physicians.19 Many of the annotations reference the “harm or injury” exception to the confidentiality rule; including areas of child abuse,20

both save time and protect against inadvertent disclosure. The following discussion on maintaining the confidentiality of such records may provide helpful guidance. Because of the complexities of these laws, physicians uncertain of their obligations would be well advised to contact their professional liability carriers and/or personal attorneys if they receive a request for information protected by these special confidentiality requirements. In addition, there are special rules that apply to requests for these records by the patient, the patient’s attorney, a police officer, or pursuant to a subpoena. For further information on these requirements, see CMA ON-CALL document #1150, “Patient Requests,” #1127, “Attorney Pre-litigation Requests,” or #1147, “Law Enforcement Requests.” For further information on the rules applicable to HIV and AIDS, see CMA ON-CALL document #1112, “Confidentiality of HIV/AIDS Information.


18 See American Medical Association, supra note 7.

19 Id. Opinions on Social Policy Issues, § 2.02 Abuse of Spouses, Children, Elderly Persons, and Others at Risk, at 6-9.

20 Id. Opinions on Social Policy Issues, § 2.02 Abuse of Spouses, Children, Elderly Persons, and Others at Risk, at 6-9.
murder threats,21 HIV infection,22 and impaired driving.23 This seems to be as contentious an area in the medical profession as it is in the legal profession.24

B. Confidentiality: Privacy and HIPAA

In addition to the medical ethic of confidentiality, medical and health-care professionals are required to comply with the Health Insurance Portability & Accountability Act (HIPAA). The Health Insurance Portability & Accountability Act of 1996 was actually an amendment to the Internal Revenue Service Code of 1986.25 HIPAA includes Title II, euphemistically entitled Administrative Simplification, which contains provisions that were designed to improve the efficiency of the health care system by facilitating the electronic exchange of health care information. This portion of the statute also mandates that the Secretary of Health and Human Services promulgate rules to ensure confidentiality and privacy with respect to such health care information.26 This protection of confidentiality and security of health data through setting and enforcing standards was to include a privacy rule that “requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.”27

Affecting virtually all health care organizations28 and applying to and including all physicians, HIPAA’s privacy component had a compliance date of April 14, 2003. Coupled with the privacy rule were related rules with varying compliance dates, including the Security Rule (Compliance date: April 21, 2005); the Standard Unique Employer Identifier Rule (Compliance date: July 30, 2004); the National Provider Identifier (NPI) Rule (Compliance date: May 23, 2007 for most covered entities); and a final standard for a Health Plan Identifier yet to be published.29 Since enactment, HIPAA was found to be overly cumbersome. In an attempt to ease the difficulty, Congress passed the Administrative Simplification Compliance Act (ASCA) that amends HIPAA, requiring all claims

21 Id. (citing Tarasoff v. Regents of Univ. of Calif., 17 Cal. 3d 425, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27 (Cal. 1976); at xxxiii, citing Rocca v. Southern Hills Counselling Ctr., Inc., 671 N.E.2d 913, 916 (Ind. App. 1996); at xlv, citing Roth & Levin, Dilemma of Tarasoff: Must Physicians Protect the Public or Their Patients?, 11 Law, Medicine & Health Care 104, 106 (1983)).
22 Id. at xxxv (citing Estate of Behringer v. Medical Ctr., 249 N.J. Super. 597, 614, 633; 592 A.2d 1251, 1259, 1268 (N.J. Super. 1991)).
23 Id., at xxxvii (citing Utah Att’y Gen. Op. No. 77-294 (Utah Att’y Gen. 1978)).
24 See infra note 69, and accompanying text.
29 See supra note 25.
submitted to Medicare on or after October 16, 2003, to be done electronically except for certain circumstances.\textsuperscript{30}

HIPAA has severe civil and criminal penalties, supposedly making it more than just another paper tiger.\textsuperscript{31} HIPAA penalties include fines up to $25,000 for multiple violations of the same standard in a calendar year; and fines up to $250,000 and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information.\textsuperscript{32} As written, the penalties are straight-forward; to whom they apply may be the reason for so little enforcement.\textsuperscript{33} This has led to compliance resistance among medical and health-care professionals. More than that, many medical and health-care professionals and entities have revolted, declaring that they will ignore HIPAA.\textsuperscript{34}

To date, there has been minimum enforcement of HIPAA. Only one case, United States v. Ferrer,\textsuperscript{35} has been published, applying as one of the government’s causes of action the violation of the privacy section of the law. The case involved unusual and egregious facts. One newspaper article on the case\textsuperscript{36} reported that an “‘unwholesome criminal trilogy’ of identity theft, medical privacy violations and health-care fraud was committed by two cousins, stealing the personal information of more than 1,100 Cleveland Clinic patients and billed more than $2.8 million in Medicare charges.”\textsuperscript{37} The case was more about fraud and money than about privacy. One cousin, Ferrer, owned a medical claims business and used the stolen information to file fraudulent Medicare claims. Filing the claims unlawfully exposed the identity of patients which violated the privacy protection section of HIPAA.\textsuperscript{38}

\textbf{C. The Controversial Reporting Exception Should Do No Harm}

In both the medical and legal professions, there are significant differences of opinion on whether the rule of confidentiality should have an exception for harm or injury. This has been a long-standing issue in the medical profession with its position statement as articulated.\textsuperscript{39} It was also a primary and contentious issue when the ABA proposed and

\begin{itemize}
  \item \textsuperscript{30} \textit{Id.}
  \item \textsuperscript{31} In just a few more years, little may be heard of HIPAA enforcement. A good comparison may be found in what happened to the federal Patient Self Determination Act of 1990. See federal Patient Self Determination Act (PSDA), 42 U.S.C. 1395cc(a). After Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990), there was a flurry of regulations, trainings, lectures, seminars, and intensive education in the health care and medical professions. The hospitals and medical professionals were concerned with sanctions and enforcement of the new law. Little is heard regarding enforcement of PSDA 18 years later.
  \item \textsuperscript{32} \textit{See supra} note 25.
  \item \textsuperscript{33} \textit{See supra} note 25.
  \item \textsuperscript{34} \textit{See Joseph Granneman, Perspectives: Lack of enforcement undercuts HIPAA, Dec. 2006, http://searchsecurity.techtarget.com/magazineFeature/0,296894,sid14_gci1256974,00.html?src=SS_CLA_300002&psrc=CLT_14.}
  \item \textsuperscript{35} No. 06-60261 CR-COHN (S.D. Fla. Sept. 7, 2006).
  \item \textsuperscript{36} \textit{See Madeline Baro Diaz, Cousins face ID theft and fraud charges for stealing medical records in Florida, South Florida Sun-Sentinel, Sept. 9, 2006, http://www.patientprivacyrights.org/site/News2?page=NewsArticle&id=6483.}
  \item \textsuperscript{37} \textit{Id.}
  \item \textsuperscript{38} \textit{Id.}
  \item \textsuperscript{39} \textit{See supra} note 18, and accompanying text.
\end{itemize}
hotly debated the “harm or injury” exception to Model Rule 1.6 as a revision to the ABA Model Rules between 1998 and 2003. A more thorough analysis is not possible in this article; however, there are links and articles that provide such an analysis.  

### III. The Legal Profession and Confidentiality

Even conceding the weighed legal perspective of this article, analysis of legal ethics is easier to access because there are so many more sources. More importantly, the sources publish opinions and disciplinary decisions. The American Bar Association (ABA) publishes formal ethics opinions through the Center of Professional Responsibility, and each state bar organization publishes ethical violations and grievances annually or more often, depending upon the state. The numerous sources and the many decisions and opinions provide substantial clarity for lawyers who practice under these rules.

In its beginning in 1878, the purpose of the American Bar Association (ABA) was to advance “…the science of jurisprudence, the promotion of the administration of justice, and a uniformity of legislation throughout the country….“ The ABA acknowledges that “There was no national code of ethics; there was no national organization to serve as a forum for discussion of the increasingly intricate issues involved in legal practice.” It is noteworthy that the ABA did not begin the development of professional ethics until well into the 20th Century. As noteworthy, the ABA’s current stated mission still does not directly assert the primacy of its core values or its ethics, instead striving “…to be the

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42 This author has studied legal ethics for the past 20 years, maintaining membership in the ABA’s Center for Professional Responsibility; accumulating most if not all of the treatises, books, and significant articles on legal ethics; and lecturing for the ABA, NAELA, and the North Carolina Bar Association on the evolving nature of legal ethics as related to Elder Law.
47 Id.
national representative of the legal profession, serving the public and the profession by promoting justice, professional excellence, and respect for the law.”

As for ethics, the ABA formally addressed the ethics of the legal profession when it published the ABA Canons of Professional Ethics in 1908. In 1928, it adopted Canon 37 Confidences of a Client, which it amended in 1937. Ever since, the ABA has strongly and forcefully declared client confidences as one of its core values.

A. Current Codes, Statutory Revisions, and Commentaries

1. The ABA and State Bar Ethics Rules and Decisions

Compared to the medical profession, the legal profession is open and transparent with ethics opinions, legal decisions, and grievance and disciplinary decisions published and available to the public. The ABA publishes formal ethics opinions separately throughout the year, republishing a collection every few years in the Annotated ABA Model Rules of Professional Conduct.

On the state bar level, the ABA Center for Professional Responsibility reports that: “To date, California, Maine, and New York are the only states that do not have professional conduct rules that follow the format of the ABA Model Rules of Professional Conduct. New York follows the predecessor ABA Model Code of Professional Responsibility, and California and Maine developed their own rules.” In each state, the bar publishes its own opinions and grievance decisions throughout the year. Florida and North Carolina are typical examples of all state bars.

The Florida Bar has an extensive Web site, providing public access to searchable categories of ethics opinions dating back to 1959. It provides an annotated subject matter index, research references and assistance, frequently asked ethics questions, and the

50 See supra note 48.
51 Canon 37, supra note 48. The amended text of 1937:

It is the duty of a lawyer to preserve his client’s confidences. This duty outlasts the lawyer’s employment, and extends as well to his employees; and neither of them should accept employment which involves or may involve the disclosure or use of these confidences, either for private advantage of the lawyer or his employees or to the disadvantage of the client, without his knowledge and consent, and even tough [sic] there are other available sources of such information. A lawyer should not continue employment when he discovers that this obligation prevents the performance of his full duties to his former or to his new client. If a lawyer is accused by his client, he is not precluded from discharging the truth in respect to the accusation. The announced intention of a client to commit a crime is not included within the confidences which he is bound to respect. He may properly make such disclosures as may be necessary to prevent the act or protect those against whom it is threatened. Id.
52 See Thomas L. Shaffer, American Legal Ethics, Theology Today, Oct. 2002, available at http://findarticles.com/p/articles/mi_qa3664/is_200210/ai_n9126519/pg_1 (“... first, ‘undivided loyalty to the client’; second, ‘independent legal judgment for the benefit of the client’; third, ‘the lawyer’s duty to hold client confidences inviolate’; and fourth, ‘the lawyer’s duty to promote access to justice.’”) Id. at 8 (last visited Aug. 28, 2009).
53 See ABA Center for Professional Responsibility, supra note 43.
54 Id.
Ethics Update, a quarterly publication of the Florida Bar devoted solely to ethics.\(^{56}\)

Although not as extensive as Florida, the North Carolina Bar provides access to ethics opinions and grievance decisions through rule numbers and subject or title.\(^{57}\) North Carolina also publishes the annual State Bar Handbook that annotates all rules of professional responsibility with every proposed opinion or grievance decisions.\(^{58}\)

2. Legal Ethics Rule 1.6 Confidentiality of Client Information\(^{59}\)

\(a. \) The Mandatory Prohibition

Model Rule 1.6\(^{60}\) is direct and unequivocal. Attorneys are mandated not to disclose confidential client information. The mandate comes from the confidentiality rule of professional conduct published in similar form in every state.\(^{61}\) The Restatement of Law Governing Lawyers (hereinafter the “Law Governing Lawyers”) describes the mandate as, first, the duty of confidentiality, framed in the negative — that is, the duty not to dis-

\[^{56}\] The Florida Bar, Ethics Information, supra note 55.

\[^{57}\] See supra note 45.

\[^{58}\] Id.

\[^{59}\] This portion of the article (revised and edited) was presented at the 63rd Annual NYU Tax and Estate Planning Institute in 2004.

\[^{60}\] See ABA 2009 MRPC, supra note 43, Rule 1.6 Confidentiality of Information.

(a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).

(b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:

(1) to prevent reasonably certain death or substantial bodily harm;

(2) to prevent the client from committing a crime or fraud that is reasonably certain to result in substantial injury to the financial interests or property of another and in furtherance of which the client has used or is using the lawyer’s services;

(3) to prevent, mitigate, or rectify substantial injury to the financial interests or property of another that is reasonably certain to result or has resulted from the client’s commission of a crime or fraud in furtherance of which the client has used the lawyer’s services;

(4) to secure legal advice about the lawyer’s compliance with these Rules;

(5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer’s representation of the client; or

(6) to comply with other law or a court order.

\[^{61}\] Id.
close information. The second duty, framed in the positive, expressly modifies the first duty as it is related to safeguarding client information, and the third duty expressly directs client protections against a lawyer using confidential information for personal gain. The first duty is of such high social value that it is not modified and lawyers must obey it even to the detriment of others, and to the limitation on their own rights of free speech under the First Amendment.

b. Implied Authorization

The narrow exception to the mandate of Rule 1.6 is when disclosures are impliedly authorized. For example, a client may provide the Elder Law attorney with information so that it may be presented to other professionals, third parties, or tribunals in the furtherance of the client’s interests. While not specifically directing the Elder Law attorney to disclose the information, authorization to disclose will be implied by operation of law. However, the Elder Law attorney’s communications to others on behalf of the client must be in compliance with other rules. For example, if the lawyer misrepresented a situation or made false statements in violation of ABA Model Rule 4.1, then the disclosure would not be considered authorized by the client.

The Law Governing Lawyers sets out the exception differently, although appearing to end up at the same point. Section 61 of Law Governing Lawyers explains that the confidential client information may be used or disclosed when there is a reasonable belief that doing so will advance the interests of the client in the representation. When the lawyer’s reasonable anticipation of advantageous use or disclosure is not realized, the exception is not violated. As further explained in § 61, lawyers often contend with uncertainties, unexpected decisions, changes of facts, circumstances and relationships, all at times when immediate action is necessary. However, as long as the lawyer’s actions are intended to advance the client’s interests based on the lawyer’s reasonable calculations, then such action remains under scope of the section and is permissible.

The implied authorization is also impressed on those joint or multiple client representations where nothing has been orally or expressly written confirmed between the clients and the lawyer. It has been published in the ACTEC Commentaries that unless agreed otherwise in multiple client situations, a presumption of joint representation should attach and that confidential client information should be shared with the clients when it is received by the lawyer during the representation and it is regarding the subject of the representation.

62 See Restatement, supra note 43, § 60, at 461.
63 Id. at 462.
64 See Hazard & Hodes, supra note 43, at 9-59.
65 Id. at 9-60.
66 See Restatement, supra note 43, at 480.
67 Id.
68 American College of Trust and Estate Counsel (ACTEC), Commentaries on the Model Rules of Professional Conduct, 72 (ACTEC Foundation, 4th ed. 2006), available at http://www.actec.org/Documents/misc/ACTEC_Commentaries_4th_02_14_06.pdf. ACTEC is a national organization of approximately 2,600 lawyers elected to membership by demonstrating the highest level of integrity, commitment to the profession, competence and experience as trust and estate counselors. The ACTEC Commentaries have as
c. The Discretionary Exceptions Allowing Disclosure

Lawyers are given discretion to reveal or disclose information in those situations specifically expressed in the black letter of ABA Model Rule 1.6(b), including subsections (2) and (3), addressing potential or actual substantial injury resulting from crimes or fraud of, or those intended by the client.69

As explained in the extended comment to Model Rule 1.6, the 2002 amendment broadened the scope of the lawyer’s discretion to act when death or substantial injury are reasonably certain.70 It is noted that the amendment was in line with the published position of the Law Governing Lawyers.71 However, the Law Governing Lawyers went further to require that the lawyer must, if feasible, make a good faith effort to persuade the client not to act, or if the client already acted, to warn the victim or prevent further harm.72

The comment to Model Rule 1.6 went on to address when attorneys must reveal confidential information regarding the client’s commission, or intent to commit a crime or fraud while in a legal engagement.73 It is also addressed in Model Rule 1.0(d), defining fraud.74 There are several elements of the rule that must first be met before the lawyer may ethically exercise his or her discretion and reveal or disclose confidential client information. First, there must be an active legal relationship; second, the client must be using the lawyer’s services in furtherance of the crime or fraud; third, the lawyer must reasonably expect the crime or fraud to inflict substantial injury to finances or property of another, or believe that such injury may be prevented, or the damages and injury mitigated, or recouped; and fourth, relating to committed crimes and fraud, the lawyer may not reveal or disclose confidential client information if the client has already retained other defense counsel relating to the offense. Lawyers are given ways to ascertain just what to do in

their themes “(1) the relative freedom that lawyers and clients have to write their own charter with respect to a representation in the trusts and estates field; (2) the generally non-adversarial nature of the trusts and estates practice; (3) the utility and propriety, in this area of law, of representing multiple clients, whose interests may differ but are not necessarily adversarial; and (4) the opportunity, with full disclosure, to moderate or eliminate many problems that might otherwise arise under the Model Rules.” John R. Price, Reporter’s Note, ACTEC, id., at 1.


70 See ABA Center for Professional Responsibility, supra note 44. The legal profession was as conflicted as the medical profession as it struggled with the revision of Rule 1.6 that allowed exceptions to confidentiality. In 2001, there was a division between the House of Delegates of the ABA annual meeting and the revision proposed by the ABA Ethics 2000 Commission. The House of Delegates could not follow the Commission’s recommendation for substantial expansion of the grounds for permissive disclosure under Rule 1.6. Such significant erosion of the legal profession’s commitment to the core value of confidentiality was too high a price to pay in the Delegates’ opinion. The Commission asserted the overriding importance of human life and the integrity of the lawyer’s own role within the legal system, agreeing with critics that Rule 1.6 was out of step with public policy and the values of the legal profession. Regardless, the House voted not to change, embracing anew one of its primary core values. It was brought back before the House of Delegates in 2003 and adopted. Id.

71 See Restatement, supra note 43, § 66, at 496-503.

72 Id.

73 See ABA 2009 MRPC, supra note 43, Rule 1.6, subsections (b)(2) and (3).

74 Id. Rule 1.0(d) “Fraud” or “fraudulent” denotes conduct that is fraudulent under the substantive or procedural law of the applicable jurisdiction and has a purpose to deceive.
difficult ethical situations, or in those ethical situations in which the lawyer is ambivalent about exercising discretion.

Another exception to lawyer confidentiality is when complying with law or court order. When other laws may require that a lawyer disclose information about a client, the lawyer must confirm that such law supersedes Rule 1.6, and then discuss it with the client as may be required by other Rules. Even then, this exception permits the lawyer to make such disclosures as are necessary to comply with the law.

This exception also permits the lawyer to comply with a court order instructing the lawyer to disclose confidential client information. However, this exception does not allow an attorney to testify as a witness, revealing confidential client information without the client’s informed consent. The lawyer must declare attorney-client privilege or assert by other applicable law that the information sought is protected. The Comment to Model Rule 1.6 goes further, citing Model Rule 1.4, suggesting that even when ordered by a court to disclose, the lawyer must first decline, and in the event of an adverse ruling, the client must be consulted about the possibility of appeal. Without appeal, the exception permits the lawyer to comply with the court’s order.

B. Confidentiality: Privacy, Client-Attorney Relationship, and HIPAA

Primary information about HIPAA was discussed earlier in the physician section of the article. If HIPAA targets medical and health care professionals, how then does HIPAA reach attorneys and law firms? HIPAA covers entities if they have health plans that include self-insured plans and partially self-insured plans; health care clearinghouses; or health care providers transmitting any health information in electronic form. Attorneys, especially Elder Law attorneys, should consider the impact of HIPAA in two ways: 1. The impact on the business of the law firm; and 2. The impact on legal services and legal documents.

1. HIPAA and Firm Business

HIPAA may apply if the legal practice or law firm transmits health information to another entity. One way this happens is if there is a health plan that is administered by another entity. It may also occur if there is a partially self-insured plan, which includes

75 Id. Rule 1.6, subsection (b)(6).
76 Id. Rule 1.6, Comment.
77 Id.
78 Id.
79 Id.
80 This part of the article was previously presented by the author at the North Carolina Elder Law Section Symposium. See A. Frank Johns, Advance Directives: New Complexities with Capacity, Ethics and HIPAA, North Carolina Bar Elder Law Section, Eighth Annual Symposium (2004), citing Penny C. Wof ford, presenter on HIPAA Compliance (2003); see also Lewis A. Lefko and Kathleen T. Whitehead, Privacy Reigns: HIPAA Affects Access, Decision Making and Guardianship Practice, NAELE Elder Law Institute, Section 19 (Nov. 2003); see also Susan G. Haines, The HIPAA Privacy Rules: The Good, the Bad and the Ugly, XV ElderLaw Report 1 (Aspen, Feb. 2004).
81 See supra note 25, and accompanying text.
82 See supra note 25.
83 Id.
medical flexible spending accounts operated by the firm or practice.\textsuperscript{84}

As a covered entity, the practice or firm must initiate compliance procedures and processes.\textsuperscript{85} The firm must follow the HIPAA privacy rule by implementing standards and safeguards to protect individually identifiable health information (any employee health information in any form received as part of the health insurance function.\textsuperscript{86}) The standards require participating firms to assure that information received in health insurance functions will not be used to make employment decisions; that when sending or receiving a fax of health care information on public fax, someone stands at the fax machine and waits for it to go through or to be received; that attorneys and staff when working on health information at their desks must turn the information over when someone enters the room; that attorneys and staff not disclose health information to anyone except the employee, the employee’s representative (requires written consent) and routine disclosures (without consent).\textsuperscript{87} Routine disclosures are defined as health care treatments, health care payments (includes coordination of benefits, eligibility, coverage, billing, collections), or health care operations (includes activities necessary to carry out operation of health care plan). An example of a routine disclosure is when at reenrollment, the firm receives medical information from employees to disclose to insurance broker or company to make health insurance provider decisions.\textsuperscript{88} Non-routine disclosures require a written authorization which must contain the information being disclosed, for what purpose and to whom. If disclosure is for marketing, employment decisions, or non-health purposes, a record for each employee must be kept for all non-routine disclosures. If there is an incidental disclosure, one that occurs by accident, when all of the above safeguards are in place, then that will not be considered a violation of HIPAA.\textsuperscript{89}

HIPAA administrative requirements must be met if there is a self-insured or partially self-insured plan. All flex spending plans are considered partially self-insured and must follow HIPAA administrative requirements with the flex plan. If the practice or firm has to follow the HIPAA administrative requirements with the flex plan, it is recommended that the firm or practice go ahead and develop the broad administrative documents to cover the plan. If there is only a health plan in place, the practice or firm has the option to implement the HIPAA administrative requirements or not.\textsuperscript{90}

In addition to the rule and standards, the HIPAA administrative requirements must be maintained in a HIPAA compliance notebook, with a specific privacy notice, and a designated privacy officer.\textsuperscript{91} Coupled with the administrative requirements, there must also be HIPAA compliance training for those members of the firm or practice handling protected health information.\textsuperscript{92} The privacy notice to all employees and new enrollees must occur every three years that notice is available, and there must be documentation of

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{84} \textit{Id.}
  \item \textsuperscript{85} \textit{Id.; 45 C.F.R. § 160.103 Definitions – Health Plans.}
  \item \textsuperscript{86} \textit{Id. at (1)(viii).}
  \item \textsuperscript{87} \textit{Id. at § 164.520.}
  \item \textsuperscript{88} \textit{Id. at § 164.510-514.}
  \item \textsuperscript{89} \textit{Id.}
  \item \textsuperscript{90} \textit{See supra note 83.}
  \item \textsuperscript{91} \textit{45 C.F.R. § 160.310.}
  \item \textsuperscript{92} \textit{Id. at § 164.530(b)(1).}
\end{itemize}
\end{footnotesize}
any complaints. (This will oftentimes be the case when Elder Law attorneys work with
health care agents on behalf of the client.)\textsuperscript{93}

The HIPAA civil penalty of $100 per violation up to $25,000 per year for each
identical violation,\textsuperscript{94} And the criminal sanction of up to $50,000 in fines and one year
in prison,\textsuperscript{95} would apply to legal practices and firms no differently than when applied to
health care entities and medical practices.

2. HIPAA and Legal Services and Legal Documents

Consider HIPAA’s impact on legal services and the preparation of legal documents. An Elder Law practice or firm will have to address the impact of HIPAA if the services
or documents provided to clients are to be used to access health records of a person other
than the client, or by one other than the client needing to access health records of the cli-
ent. The most obvious application occurs with the preparation of advance directives for
clients. Elder Law attorneys and trust and estate counsel have created untold numbers of
powers of attorney that have been executed by their clients since the passage of HIPAA
in 1996. Many of those powers of attorney have no language allowing for access to con-
fidential information under HIPAA; neither the clients nor the attorneys will know about
it until it is absolutely necessary, and probably too late to correct.

In the legal profession, it is not clear whether attorneys and law firms acknowledge
HIPAA and comply with its requirements for implementation.\textsuperscript{96} As for enforcement —
who is checking? Where HIPAA creates issues and difficulties for attorneys is in the barri-
ers created for agents of powers of attorney and other fiduciaries representing the clients.
Elder Law and trust and estate attorneys may yet know the quagmire created when the
advance directives they have developed have no language authorizing the agent to have
access, specifically waiving the HIPAA privacy protection of the patient/client.

IV. Conclusion

This first part of the article examined the ethic of confidentiality as applied in the
medical and legal professions, focusing on the ethical boundaries and black letter rules
and analyzing their application. The second part of the article, which will appear in the
spring 2010 issue of \textit{NAELA Journal}, delves into articles, opinions, and decisions in each
profession, assessing whether they clarify boundaries to the extent that they show differ-
ences between the two professions that may be impediments to serving the same patient
or client.

\textsuperscript{93} \textit{Id.} at § 164.520.
\textsuperscript{94} \textit{See supra} note 32.
\textsuperscript{95} \textit{Id.}
\textsuperscript{96} No published articles or cases were found that shed any evidence on just how law firms and practices have
dealt with HIPAA.
THE WRONGFUL DISREGARD OF SSI COMPARABILITY BY SOME STATE MEDICAID AGENCIES AS IT RELATES TO SNTS

By Bridget O'Brien Swartz, CELA and Angela E. Canellos, CELA

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Part I of this article (written by Bridget O’Brien Swartz, CELA) and the Part II that follows (written by Angela E. Canellos, CELA) examine the varying treatment of SNTs by the states, despite attempts by federal law to create harmony between the Social Security Administration and Medicaid rules. Part I examines attempts by the states to restrict SNT distributions. Part II examines the wrongful disregard of SSI comparability by some state Medicaid agencies as it relates to SNTs.
PART I — THE MEDICAID CONSPIRACY AGAINST SPECIAL NEEDS TRUSTS

By Bridget O’Brien Swartz, CELA

I. INTRODUCTION

With the enactment of the Foster Care Independence Act (FCIA) in 1999,1 harmony finally existed between the Social Security Administration (SSA) and Medicaid with regard to the recognition and treatment of self-settled special needs trusts (SNTs) as exempt from the transfer penalty rules. As a result of FCIA, the SSA’s rules mirrored those of Medicaid insofar as trust exceptions are concerned.2 In fact, 42 U.S.C. § 1382b(c)(1)(C) (ii)(IV) explicitly references the Medicaid trust exceptions contained in 42 U.S.C. §§ 1396p(d)(4)(A) through (C). In brief, these exceptions include the following:

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2 Note, however, that for Supplemental Security Income (SSI) purposes, a SNT must also be irrevocable so as to satisfy POMS SI 01120.203.B.1.a and 01120.200.D.2, which require a beneficiary to have no ability to revoke the trust and make it available to meet his or her support needs, and POMS SI 01120.200.B.16, which requires a valid spendthrift clause. SOCIAL SECURITY ADMINISTRATION (SSA), SSA’S PROGRAM OPERATIONS MANUAL SYSTEM (POMS), SUPPLEMENTAL SECURITY INCOME (SI), (2009), available at https://secure.ssa.gov/apps10/poms.nsf/subchapterlist?openview&restricttocategory=05011 [hereinafter POMS SI].
(1) SNTs that are established by a parent,\(^3\) grandparent,\(^4\) guardian/conservator, or court\(^5\) for the benefit of an individual who is disabled and under age 65, and that include a provision directing repayment of Medicaid advancements upon termination of the trust.\(^6\)

(2) Trusts that hold only the income of a beneficiary and are designed to qualify the beneficiary for Medicaid despite the fact that the beneficiary’s income exceeds the state’s “income cap.”\(^7\) These trusts, popularly known as “Miller” trusts, are critically important for long-term care eligibility, but will not be discussed here.

(3) Trusts that are held as part of a pooled trust arrangement managed by a non-profit, and which provide that the beneficiary’s share of the pooled trust will repay the state “[t]o the extent that amounts remaining in the beneficiary’s account upon the death of the beneficiary are not retained by the beneficiary.”\(^8\)

Under the Omnibus Budget Reconciliation Act of 1993 (OBRA ’93) and the FCIA of 1999, individuals who are disabled and under the age of 65 can transfer assets that would otherwise disqualify them financially from SSI and Medicaid (and do so without penalty) to a trust for their benefit if, upon termination of the trust, Medicaid gets reimbursed the cost of medical services it has provided.\(^9\) Sounds simple, right? Not so fast! While federal law has seemingly eliminated the major discrepancy between SSI and Medicaid insofar as SNTs are concerned, the states have increasingly scrutinized the administration of such trusts and restricted the ability to make distributions for the benefit of the beneficiary.

II. “FOR THE BENEFIT OF” VS “FOR THE SOLE BENEFIT OF”

Pursuant to federal law, a trust established pursuant to 42 U.S.C. § 1396p(d)(4)(A) must be “for the benefit of a disabled beneficiary, as defined in 42 U.S.C. § 1382c(a)(3).” Beyond the foregoing, no statutory guidance exists as to what is meant by or what qualifies as “for the benefit of.” The Center for Medicare and Medicaid Services (CMS) goes a step further, however, and requires such trusts to be established “for the sole benefit of” the beneficiary who is disabled.\(^10\) Despite the absence of a statutory definition of “for the

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\(3\) The SSA, unlike Medicaid in many, if not most states, does not recognize SNTs established by a parent or grandparent of a competent adult unless initially funded by the parent or grandparent or state law allows for an empty or dry trust. In the former instance, the parent or grandparent will be treated as having acted in an agency capacity which is equivalent to the beneficiary establishing his own trust. See POMS SI 01120.200.B.2, 01120.201.B.7, and 01120.203.B.1.f. Note, funding SNTs with the assets of someone other than the beneficiary may run afoul of a state’s Medicaid rules, such as in Arizona. AHCCCS, ELIGIBILITY POLICY MANUAL, Ch. 800, at 804.00.B. (2009), available at http://www.azahcccs.gov/shared/EligibilityManual/EligibilityManual.aspx.

\(4\) Id.

\(5\) POMS SI 01120.203.B.1.a requires that the court in fact establish the trust and not merely approve its establishment.


\(7\) 42 U.S.C. § 1396p(d)(4)(B).

\(8\) 42 U.S.C. § 1396p(d)(4)(C).


benefit of,” CMS sees to it that “for the sole benefit of” is clearly understood and defines it as a transfer that is arranged in such a way that “no individual or entity except the . . . disabled individual can benefit from the assets in any way, whether at the time of the transfer or at any time in the future.” This serves as a springboard for the states to scrutinize trust distributions and use them as a basis to disqualify a beneficiary from Medicaid even when the beneficiary is SSI-eligible and, thus, categorically or automatically eligible for Medicaid.

A case in point, Arizona’s Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS), requires a d(4)(A) trust to be for the sole benefit of the beneficiary and has construed it strictly to mean that no person other than the disabled beneficiary can benefit, directly or indirectly, from distributions made from such a trust. In fact, Arizona delineates by statute what disbursements are allowable and it expressly disallows gifts to, payments for, or loans to other persons. Prior to September 2007, Arizona had also disallowed payments to a “financially responsible relative” for personal care services rendered to the beneficiary, as well as travel expenses for such a relative when a companion is required to enable the beneficiary to travel for non-medical reasons. In 2007, Arizona amended its statute to permit such payments if determined to be medically necessary by the beneficiary’s physician and provided by an individual who is registered by Medicaid to provide such services. Although living expenses can be paid out of SNTs, Arizona limits them to the pro rata share of the beneficiary. In the past, Arizona has also questioned the need to disburse funds for living expenses if the beneficiary is an SSI-recipient. Despite a court order requiring the beneficiary to pay alimony or child support, Arizona does not permit a SNT to make such payments as they are not “for the sole benefit of” the beneficiary. Most recently, AHCCCS has questioned the use of trust funds to modify the primary residence of the beneficiary if the beneficiary does not have an ownership interest in the property, despite express statutory authority to the contrary.

Several other states expressly require that SNTs be “for the sole benefit of” the beneficiary who is disabled. New Jersey requires the trust to specifically state that it is estab-

11 Id. § 3259.7.
12 This requirement, unlike others in Arizona, is the only one conspicuously absent from its statutes and regulations.
13 “Financially responsible relative” means the spouse of the beneficiary, or, if the beneficiary is under 18 years of age, the parent of the beneficiary. Ariz. Rev. Stat. § 36-2934.01.B.4(e) (2008). This is premised on federal regulations which prohibit Medicaid from paying a parent of a minor or a spouse for services “when the services are those that these persons are already legally obligated to provide.” The CMS State Medicaid Manual § 4442.3.B.1. Interestingly, Arizona had included in a § 1115 proposal to CMS which became effective in October 2007, a request for approval to initiate a demonstration project that would permit AHCCCS to pay a spouse for personal care services rendered in the home, which pilot project is ongoing. This request did not include the equivalent with respect to a parent of a minor child. Social Security Act § 115 or USC §1315.
15 AHCCCS, supra note 3, at 804.00.E.
16 Id.
lished for the sole benefit of the disabled individual. If a trust owns assets from which others benefit, then the others must pay their pro rata share of related expenses. For example, if the trust owns a house occupied by the beneficiary and three other individuals, the three others must pay three-quarters of related expenses. Conversely, if someone other than the beneficiary owns the house that serves as the beneficiary’s residence, the trust may only pay the beneficiary’s pro rata share of related expenses. Maryland requires that expenditures from the trust must be used for the sole benefit of the beneficiary and must be directly related to the beneficiary’s health care, education, comfort, or support. Like Arizona, Maryland also prohibits the use of trust assets to compensate family members of the beneficiary for serving the beneficiary in any way, including caring for the beneficiary, accompanying the beneficiary on travel, providing companionship to the beneficiary, and even serving as trustees or members of a trust advisory committee.

In July 2005, Pennsylvania enacted a statute requiring a SNT to provide that all distributions from the trust must be for the sole benefit of the beneficiary, and that any disbursement from the trust must have a reasonable relationship to the needs of the beneficiary (limiting the definition of “needs” to the “special needs” of the beneficiary). At a later date, Colorado’s Department of Health Care Policy and Financing implemented regulations requiring SNTs to be established solely for the benefit of the disabled individual under age 65, specifying that distributions from the trust may be made only to or for the benefit of the individual beneficiary. In the State of Washington, SNTs must be for the sole benefit of the beneficiary. This requirement is satisfied by providing that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred to such trust in any way. Interestingly, the statute permits individuals other than the beneficiary to benefit from the trust. In addition, Washington requires SNTs to provide for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound, based on the life expectancy of that individual or the term of the trust, whichever is less. It is unclear how the foregoing will impact the requirement that Medicaid be reimbursed the cost of medical services provided to the beneficiary upon termination of the trust.

Other states, although not going so far as to expressly require that SNTs be established for the sole benefit of the beneficiary, have certainly implied that is the case. Mississippi has “Guidelines” for payments and distributions from SNTs, which the trustee

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19 Id.
21 Id. § 10.09.24.08-2.C(9)(k) (2009).
22 62 Pa. Cons. Stat. § 1414(b)(3)(i)-(ii). Note, the constitutionality of this statute is being challenged in Lewis v. Richman, No. 06-3963 (E.D. Pa. 2006). This case is a class action and the class includes categorical recipients of MA for whom mandatory coverage as well as comparable coverage of non-categorical recipients is being argued.
must acknowledge in writing and agree to follow.\textsuperscript{26} The Guidelines prohibit SNTs from making gifts compensating a family member for services rendered as trustee or caregiver, and place limits on payments made for travel, recreation, family visits, visits to friends, and non-medical expenses. If a vehicle or residential real property are to be purchased by SNTs, then they must be specially equipped to meet the needs of the beneficiary, and residential real property must be owned by the trust. Based on reference to the parental duty to support a child in Schweiker v. Gray Panthers\textsuperscript{27} and the reasons cited by Arizona,\textsuperscript{28} New Mexico denied Medicaid eligibility to a child whose SNT was paying the mother for personal care services she rendered to him.\textsuperscript{29} New Mexico also argued that such payments are not for the sole benefit of the beneficiary, thereby rendering the trust invalid.

As is evident by the above, states have jumped on the CMS band wagon by requiring SNTs to be established and administered for the sole benefit of the beneficiary whether by statute, regulation, or whim. This requirement alone has made it increasingly difficult to administer SNTs in such a manner so as to ensure that there is no benefit to someone other than the beneficiary. Surely, when a disbursement is made to a family member or an independent third party, someone other than the beneficiary does indeed benefit. What is clearly objectionable to the states are disbursements to, or that may benefit, a family member or friend, regardless of its purpose or whether the beneficiary benefits.

\textbf{III. “Income” Distributions}

Most states are “SSI states”\textsuperscript{30} that is, they have agreed to extend Medicaid eligibility to those individuals who are determined eligible for and receiving SSI cash assistance.\textsuperscript{31} Moreover, these states have agreed in their respective State Plans to use methodologies for counting income and resources that are no more restrictive than those used by the SSI program in determining Medicaid eligibility for non-SSI recipients. In other words, an SSI state is generally required to use SSI criteria in determining Medicaid eligibility, whether or not the individual is eligible for and receiving SSI benefits.

So how does this apply to SNTs? If the trust principal is not a resource, as is presumably the case with respect to a trust established pursuant to 42 U.S.C. § 1396p(d)(4)(A), disbursements from the trust may be income to the beneficiary, depending on the nature

\textsuperscript{26} Richard Courtney, CELA, challenged the termination of Medicaid benefits of two SSI recipients who were beneficiaries of self-settled special needs trust on the basis that distributions ran afoul of Mississippi’s “Guidelines.” The state conceded that Medicaid does not have the authority to deny or terminate benefits to recipients of SSI benefits and reinstated the plaintiffs’ Medicaid benefits. See McDaniel v. Barbour, No. G200801256, Hinds County Chancery Court (First Judicial District 2008).

\textsuperscript{27} 453 U.S. 34 (1981).

\textsuperscript{28} See supra note 13.

\textsuperscript{29} Note, the child beneficiary had already been determined eligible for SSI benefits and should have been categorically eligible for Medicaid, yet Medicaid denied services due to distributions from the special needs trust. Hobbs v. Zenderman, 542 F.Supp.2d 1220 (D.N.M. 2008).

\textsuperscript{30} Thirty-nine states and the District of Columbia.

\textsuperscript{31} Most of the SSI states have entered into a § 1634 agreement with the SSA under the Social Security Act, 42 U.S.C. § 1383(c), whereby the SSA determines SSI eligibility thereby resulting in categorical or automatic eligibility for Medicaid. The few states that conduct their own Medicaid eligibility determinations still must adhere to SSI methodology in counting income and resource rules.
of the disbursements. Regular rules to determine when income is available apply. SSI defines “income” as food, shelter, cash, and anything that can be converted into such. Thus, payments out of a trust for such items constitute “income” to the beneficiary for SSI and Medicaid eligibility purposes. With respect to SSI, such payments would result in a reduction in the cash benefit; whereas for Medicaid purposes, such payments should be inconsequential unless they, along with the beneficiary’s other income, exceed the applicable income limit.

If a trust makes payment for food or shelter expenses directly to the vendor or provider, then the payment may constitute “in-kind support and maintenance” (ISM), which would result in a reduction of one-third or one-third plus $20, depending on the living arrangements of the SSI recipient. Most states have agreed in their respective State Plans to exempt unearned in-kind income from being counted as income for purposes of determining Medicaid eligibility. Thus, disbursements out of SNTs made directly to a vendor or provider for support and maintenance of the beneficiary should not be counted as income for Medicaid eligibility purposes.

Although relatively straightforward, several SSI states have deviated from SSI methodology in their treatment of disbursements out of SNTs. New Jersey, like Colorado, treats trust distributions for food or shelter as income for Medicaid eligibility purposes. In its Regulations, Colorado considers cash distributions from the trust, whether to the beneficiary or not, as income to the beneficiary, and considers distributions for food or shelter as in-kind income, both of which are countable toward income eligibility. Despite the discretion of the trustee of a SNT, Maryland treats as income any and all distributions, whether made directly to the beneficiary or to a third-party vendor. In its Guidelines, Mississippi takes the position that payments for maintenance and support are not for the beneficiary’s “special needs,” and, thus, such payments must not be made from SNTs.

New Mexico’s Regulations suggest that any (even one) distributions from SNTs, regardless of to whom the distribution is made or for what purpose, may constitute grounds for disqualifying the trust entirely. The Regulations state the following:

Only income and resources distributed directly to the applicant/recipient and/or to a third party on the applicant/recipient’s behalf by the trustee are considered available to the applicant/recipient in determining Medicaid eligibility if the applicant/recipient could use the payment for food, . . . or shelter for him/herself.

34 Known as the “One-Third Reduction” Rule or “VTR.” See POMS SI 00835.001.A.1.
35 Known as the “Presumed Maximum Value” Rule or “PMV.” See POMS SI 00835.001.A.2.
36 Each state’s respective State Plan may be found with its Secretary of State or Department of Health Services or the like, or is available through the CMS Regional Office with a public records request.
37 N.J. ADMIN. CODE § 10:71-4.11(g).
38 Colorado Department of Health Care Policy and Financing, 10 C.C.R. 2505-10 § 8.100.7.E.6.b.i.m.
40 N.M. ADMIN. CODE § 8.281.500.15.D.
In a letter dated July 20, 2000, New Mexico General Counsel stated that “OCG on behalf of the Department will not approve any language in SNTs which allows the trustee to make payments for shelter costs for the beneficiary’s benefit.”\(^{41}\) So, if there was any doubt as to whether New Mexico runs afoul of SSI criteria in its Regulations, its General Counsel has made it abundantly clear that that is the case and that it has done so arbitrarily.

Although some SSI states do not necessarily prohibit income distributions, whether in-kind or otherwise, from being made out of SNTs, they do require that such distributions not result in the beneficiary being disqualified from SSI or Medicaid benefits.\(^{42}\)

IV. PURCHASE OF OTHERWISE EXEMPT RESOURCES: THE HOME AND CAR

What about the SNT that purchases a home for the beneficiary? Real property that serves as the primary residence of the individual is an excluded resource for purposes of SSI and Medicaid eligibility purposes. If a SNT disburses funds to purchase a home to be owned by the beneficiary individually, SSI considers such disbursement to be “income” in the month made, thereby resulting in an overpayment in benefits for that month.\(^{43}\) Thereafter, the trust beneficiary would remain eligible for SSI despite his or her ownership of the home given its exclusion. When a SNT retains title to the home, SSI is not impacted due to the fact that the beneficiary retains a “beneficial interest” in the property.\(^{44}\)

Simple enough, right? Wrong yet again! In Arizona, SNTs may disburse funds to purchase a home for the beneficiary, but the trust must retain title to the home.\(^{45}\) The same is true in Mississippi under its Guidelines. New Mexico, however, prohibits SNTs from purchasing a home, or from making distributions for shelter costs at all. This rule is not the same for third-party SNTs, which may own the home of the beneficiary.\(^{46}\) Further, SNTs cannot purchase a home with trust funds and subsequently title it to the beneficiary individually so as to exempt the home for Medicaid eligibility purposes.\(^{47}\) In Arizona and New Mexico, then, a Medicaid recipient must purchase a home prior to funding SNTs if he or she is to hold title individually, let alone have a home in New Mexico.

New Jersey is a bit more generous. It allows SNTs to acquire property to provide shelter for the trust beneficiary on the condition that (1) the trust retains title to the property, (2) the trustee ensures that the acquisition does not create unintended problems (such as disqualifying someone from federal benefits), and (3) the parents are not relieved of their duty to support their minor child if they are financially able to do so.\(^{48}\)

Pennsylvania defines “special needs” as the following:

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\(^{41}\) Letter from the Office of the General Counsel in New Mexico (July 20, 2000) (on file with author).

\(^{42}\) See N.J. ADMIN CODE § 10.71-4.11(g)(1)(iii); see also MINN. STAT. § 501B.89.2(d), which applies only to third party settled special needs trust but is reportedly also applied to self settled special needs trusts.


\(^{44}\) See POMS SI 01120.200.F.1.

\(^{45}\) ARIZ. REV. STAT. § 36-2934.01.B.7(c). Arizona law also requires a vehicle purchased by the trust to be titled to the trust, or the trust to have a lien against the vehicle if owned by the beneficiary individually. See id. § 36-2934.01.B.4(b).

\(^{46}\) Letter, supra note 41.

\(^{47}\) Id.

\(^{48}\) N.J.ADM IN.CODE. § 10:71-4.11(g).
Those items, products or services not covered by the medical assistance program, insurance or other third-party liability source for which a beneficiary of a special needs trust or his parents are personally liable, and that can be provided to the beneficiary to increase the beneficiary’s quality of life, to assist in, and are related to, the treatment of the beneficiary’s disability.”

One can infer from the above that in Pennsylvania the purchase of a home by SNTs would not be permitted because the provision of shelter is the financial responsibility of the parents or because it is unrelated to the treatment of the beneficiary’s disability. An argument can be made, however, that a specially equipped vehicle is related to the treatment of the beneficiary’s disability since it is required to transport a beneficiary to and from medically necessary appointments.

Mississippi is similar to Pennsylvania in that it will allow SNTs to purchase residential real property and a vehicle, but only if they are specially equipped. If the beneficiary does not require a home or vehicle to be specially equipped, then the trust cannot purchase such items. If permitted to make such purchases, the trust must be the owner of the real property, as is the case in Arizona, but cannot be the owner of the vehicle. Payments to maintain and operate the vehicle are not considered “special needs,” and, thus, cannot be paid by the trust.

Maryland requires that purchases by SNTs exceeding $500 be made in the name of the trust, thus most vehicles purchased by the trust must be titled to the trust. Maryland also limits the investment in real property by such a trust to a single home property, which is used as the residence of the beneficiary and is titled to the trust. If a purchase of property is to be made by the trust in excess of $100,000, prior court approval is required. Similarly, New York requires notification in advance of any transactions tending to substantially deplete the principal of the trusts valued at more than $100,000, and specifies at what percentage of the value of the trust principal and accumulated income notification is required.

Underlying most of the above restrictions and conditions on SNTs disbursing funds to purchase exempt assets such as homes and cars, is likely the concerns of the states that families will not otherwise meet their financial obligation in providing for the basic support needs of a beneficiary who is a minor, and that there is a potential benefit to someone other than the beneficiary. Moreover, the purchase of a home and vehicle, and their modifications to meet the needs of the beneficiary, are likely the most substantial expenditures to be paid by SNTs. The states certainly have an interest in SNTs holding on to such assets, thereby subjecting them to the payback requirement upon the trust’s termination.

49 62 Pa. Cons. Stat. § 1414 (f) (emphasis added); see also note 22.
50 The Guidelines do provide for an undue hardship exception in the case of the purchase of a vehicle by a SNT.
52 Id. 10.09.24.08-2.C(9)(r) and (s) (2009).
53 18 N.Y. Codes R. & Regs. § 360-4.5(b) (2009).
V. Conclusion

In 1993, and again in 1999, Congress made clear its intent to allow “younger” persons who are disabled to set aside funds in trust without jeopardizing their eligibility for SSI and Medicaid. Public benefits and private sources of funding were to “marry” and leave no gap in the provision of necessary services to the disabled. Perceiving Medicaid as a program for the truly “indigent” and not one for those who by other means can provide for their care and necessities, the states have grown increasingly frustrated by the existence of SNTs. As a result, various states have imposed requirements and restrictions on SNTs that appear to have no legal basis. SSI states run afoul of their agreement with the SSA to (1) have it determine eligibility for the categorically needy (i.e., those who are eligible for SSI), and (2) to use rules no more restrictive than SSI in determining Medicaid eligibility for most others.

Unfortunately, this is no longer the case of an isolated incident, but has become a trend. We can try to defeat legislative attempts to control SNTs distributions and, if we fail, we can seek to repeal or amend the damage that has been done, or challenge the legislation judicially. We can monitor the public notices issued by Medicaid and submit comments, and attend hearings when it attempts to implement regulations imposing restrictions on SNTs.

What will you do? Will you advise clients to work within these undesirable parameters? Will you wait for the unlikely client who wants to challenge what is unfair and unjust at his own expense? Whatever you do, tread these waters lightly because precedent that is unfavorable will only provide momentum to the states. Do not go it alone, and be prepared to attack on all fronts, legislatively, administratively, and judicially. Collaborate with others, such as groups who advocate for the disabled and with whom you and your clients have a common objective, and attorneys whose practice complements yours and are able to bring skill and expertise you lack to the challenge.

PART II — COMPARABILITY BETWEEN SUPPLEMENTAL SECURITY INCOME AND MEDICAID IN RELATION TO SPECIAL NEEDS TRUSTS

By Angela E. Canellos, CELA

I. Introduction

In recent years, State Medicaid agencies have been more and more restrictive when evaluating SNTs. This gives rise to the question whether states must adhere to the same eligibility rules in their Medicaid programs that apply to the Federal SSI program. Some states are allowed to be more restrictive than federal law in certain respects. The majority of states, however, are required to follow the same rules as the Federal SSI program. Despite this fact, states are becoming increasingly more restrictive in their policies and statutes when it comes to SNTs. The attacks most frequently have been on self-settled SNTs. Such

trusts are established with the assets of the person who has a disability and is the beneficiary of the SNT. The receipt of assets often results from an inheritance or a court settlement. Third-party SNTs, which are established with the assets of an individual other than the beneficiary who is disabled (often the parent) are not generally under attack. No basis exists under federal law, however, for a distinction between the eligibility rules or trust distribution rules for self-settled versus third-party SNTs. The focus of this discussion will be on self-settled rather than third-party SNTs, thus when referring to SNTs in this discussion the assumption should be that the reference is to a self-settled SNT, except when otherwise noted.

II. BACKGROUND

The Medicaid program is a contractual program between the state and federal governments. Funding is derived from both entities. States are not required to participate in the Medicaid program, but if they do opt to participate, they must follow federal law.\(^55\)

If a state does not follow federal law, it may be subject to a loss of federal financial participation. While federal law effectively “pre-empts” state law, since the state is not required to participate, the legal issue is not strictly a matter of federal preemption. Instead, the states are statutorily required to be comparable in their methodology of determining eligibility under federal law.\(^56\)

The issue of comparability also comes up in several other contexts. One area of significant litigation currently concerns comparability in the provision of services among different groups of eligible Medicaid recipients. This type of comparability, which is set forth by federal statute, requires states to provide comparable services in “amount, duration, and scope” between categorically needy Medicaid recipients, such as SSI recipients, and medically needy (non-SSI) Medicaid recipients.\(^57\) In the last few years, this particular comparability requirement has eroded. States have been allowed leeway in requesting waivers of federal requirements and courts have often ruled in favor of states that did not provide comparable services. This type of comparability, however, is not relevant to the issue of comparability as between SSI and Medicaid in relation to SNTs, which is the subject of this article.

When the SSI program was created, states that did not want to extend Medicaid to all SSI recipients were given the option of limiting Medicaid eligibility to those individuals who would have been eligible on January 1, 1972, the effective date of the federal law that created the SSI program.\(^58\) Eleven states chose what is known as this “209(b)” option.\(^59\) All of them have at least one eligibility criterion that is more restrictive than the comparable one in the SSI program.

Of the remaining 39 states and the District of Columbia, eight of these (SSI states) make their own Medicaid determinations, but based on SSI, not state, criteria.\(^60\) The rest,


\(^{58}\) Section 209(b)(1) of Pub. L. No. 92-603 (codified as 42 U.S.C. § 1396a(f)).

\(^{59}\) Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia, POMS SI 01715.010(1).

\(^{60}\) The eight “SSI states” are: Alaska, Idaho, Kansas, Nebraska, Nevada, New Mexico, Oregon, and Utah. POMS SI 01715.010.2.
known as “1634 states,” elected to enter into agreements with the Secretary of the Department of Health and Social Services under § 1634 of the Social Security Act, pursuant to which a SSA determination of SSI eligibility also constitutes a determination of eligibility for Medicaid benefits.61

In all states, SSI recipients receive Medicaid benefits (subject to the differences in § 209(b) states). These Medicaid recipients are known as the “categorically needy.”62 Most states also cover the optionally categorically needy. These are individuals whose income is below 300 percent of the SSI level, or $2,022 a month in 2009.63 Some states also have a “medically needy” program, which provides coverage to non-SSI recipients who are either at least age 65 or disabled and, therefore, categorically related to the SSI program.64 Generally, the medically needy are individuals who have income over the applicable SSI level and, therefore, cannot qualify for SSI.65 For an institutionalized person or a waiver participant, the medically needy are those with income above the optionally categorically needy limit.66 The resource rules of both programs are the same with slight variances in burial exemptions, which are the subject of state law.

The original Medicaid statute included a provision that requires states to be no less restrictive in the income and resource Medicaid eligibility methodology than the SSI program.67 This statute originally applied only to medically needy individuals. Therefore, if a state provided Medicaid to the medically needy, the eligibility rules for this population had to be the same as those of the SSI program.

III. MEDICARE CATASTROPHIC COVERAGE ACT CHANGES

In the Medicare Catastrophic Coverage Act of 1988 (MCCA), the comparability statute was re-enacted and broadened in scope.68 This statute reads as follows:

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III),69 (a)(10)(A)(ii), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII),70 (a)(10)(A)(i)(V),71 (a)(10)(A)(i)(III),72 or (f)73 or under section 1905(p) [1396d(p)] may be less restrictive, and shall be no more restrictive, than the methodology-i) in the case of groups consisting of aged, blind, or disabled individ-

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65 POMS SI 01715.020 has a list of states that have medically needy programs.
68 42 U.S.C. § 1396a(a)(2).
69 Qualified pregnant women and children.
70 Low income families.
71 The optionally categorically needy including those that are institutionalized or in waiver programs.
72 The medically needy.
73 Individuals in § 209(b) states.
uals, under the supplemental security income program under title XVI [42 USCS §§1381 et seq.], or
ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be “no more restrictive” if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

This later statute is broader than the original statute in many ways. It applies to the optionally categorically needy, as well as the medically needy. Additionally, it applies to participants in Medicaid waiver programs and to Medicaid recipients in § 209(b) states except for the particular § 209(b) differences. The optionally categorically needy and waiver participants are those persons whose income is above the SSI level or the federal maximum benefit rate, which is $674 a month in 2009, but below 300 percent of the federal maximum benefit rate, which is $2,022 a month in 2009. These individuals are often getting long-term care services in a community waiver program.

Often, SNTs are most common and necessary for those in waiver programs. Individuals with disabilities who receive a personal injury settlement as a result of an accident or malpractice case that caused the disability are often in the community and qualify for a Medicaid waiver program. The SNTs could be funded with assets from another source, but often the referral to the SNT attorney comes from a personal injury attorney who has obtained a settlement or judgment for the person with a disability.

The later comparability statute mandates that the methodology used by the state to determine eligibility must be no more restrictive than that of the categorically related federal program. Furthermore, that state law would be considered no more restrictive if additional individuals may be eligible for Medicaid and no individuals who are otherwise eligible are made ineligible. The legislative history of this statute affirms Congress’s commitment to the concept of comparability. The statute was passed in reaction to the Health Care Financing Administration (HCFA) (now the CMS) interpretation of the original statute, which was that comparability meant “the same as” and did not include the “more liberal but not more restrictive” rule. Congress had earlier issued a moratorium on the enforcement of the HCFA regulations that contained this interpretation. That moratorium was codified in the Deficit Reduction Act of 1998.

Two parts of the MCCA legislation are relevant here: 1) the transfer of assets rule was passed for institutional Medicaid recipients, which meant a difference existed in the transfer of assets rule in the SSI and Medicaid programs; and 2) the later comparability statute was enacted, which was an apparent commitment to this requirement.

76 [The Deficit Reduction Act of 1998, Public Law 98-369, Sec.2373( c)] An excellent discussion of this legislative history is located at 58 Fed. Reg. 11, 4918-4939 (Jan. 19, 1993). Ironically, it appears as background to the enactment of the enabling regulations regarding comparability for the §209(b) states. Also, see Legislative History in H.R. Rep. No. 100-661, at 268 (1988).
IV. COMPARABILITY AND TRUSTS

As stated, the federal legislative history of the requirement of comparability is very strong. All exceptions to comparability have been to allow states to be more liberal, not more restrictive than the federal SSI program. As previously noted, the only exception is the § 209(b) exception. Even in that regard, this exception rarely poses a problem. For a § 209(b) state to be more restrictive in its Medicaid program, a more restrictive rule on a particular issue in 1972 had to have already existed. Some of these more restrictive rules had to do with disability determinations. Rarely, if ever, did a state have a more restrictive eligibility rule regarding a trust. The trusts currently under attack are self-settled trusts that are exempt under federal law, and such trusts were not even in existence in 1972.

In the New Hampshire case of Emily Huff, the state tried to restrict distributions from SNTs relying on its § 209(b) status. The New Hampshire Supreme Court noted that the state had not produced its state plan from 1972, and remanded the case on that very basis. The state was unable to produce the plan to prove it had SNTs restrictions in place in 1972. The landmark case regarding comparability and trusts in § 1634 states, which predated OBRA ’93, is the case of Ramey vs. Reinertson. This case involved three main plaintiffs — two of which were in a nursing home and one of which was a Medicaid waiver participant. All three plaintiffs had Medicaid Qualifying Trusts (MQTs).

Prior to the FCIA, the exception trusts applied to Medicaid only; however, a person could be otherwise eligible for SSI because until January 1, 2000, the SSI program did not penalize the transfer of assets. Therefore, a person could transfer assets to an irrevocable trust and qualify immediately for SSI and, therefore, Medicaid, as long as the trustee was someone other than the Grantor and the trust did not allow for distributions of principal. These trusts were the ones at issue in the Ramey case.

In Ramey, one nursing home resident and the waiver person were SSI recipients. One nursing home resident was not an SSI recipient, but was Medicaid eligible as option ally categorically needy. The opinion held that Medicaid coverage was mandated for the SSI recipients. Medicaid coverage is mandated for all “institutionalized” SSI recipients. However, coverage was not mandated and was denied for the non-SSI recipient. The state was allowed to make a separate determination of eligibility for the non-SSI recipient. Even though state law would have denied Medicaid because of the MQTs, the SSI recipients were found to be eligible because they were categorically needy and, therefore, their coverage was mandated.

V. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 TRUSTS

Individuals can financially qualify for benefits with a self-settled SNT that is exempt under OBRA ’93. OBRA ’93 identifies two types of exempt trusts relevant herein, —
the “payback” or d(4)(A) trust, and the “pooled” or d(4)(C) trust. The “payback” option requires any funds remaining in trust at the death of the beneficiary, who is the individual with a disability, to be paid back to any state that provided Medicaid to the individual during his lifetime. The “pooled” option requires that any funds retained by the trust be managed by a non-profit, most often for the benefit of other disabled persons. States vary on whether or not all of the funds may remain in the pool or if some funds may remain as long as a payback is also made with some percentage of the remaining finds.

The payback trust must be established by a parent, grandparent, guardian, or court. The pooled trust is established by a non-profit as a master trust and may be adopted by the individual who is disabled. The payback trust is only exempt for individuals under age 65. While individuals age 65 or older may participate in an exempt pooled trust, the transfer to the trust after age 65 is penalized in many states.

As noted, the self-settled trust exception is a result of OBRA ’93. This Medicaid exception was incorporated into the SSI program in 2000, as part of the FCIA of 1999. The SSI exception applies only to exempt trusts under 42 U.S.C. § 1396p(d)(4)(A) or (C), whereas the Medicaid exemption also applies to trusts under § 1396p(d)(4)(B). The latter trusts are used in income-cap states to reduce income and qualify individuals for Medicaid. The income-cap is a state option under federal law. The income-cap results from the fact that these states cover the optionally categorically needy in their Medicaid program, but they do not cover the medically needy. Therefore, individuals must have income below 300 percent of the federal benefit rate, which is $2,022 a month in 2009. Those with income higher than this amount cannot qualify by paying medical bills like they can in a spend-down state that covers the medically needy. The only option is the exempt trust. These so-called “Miller” trusts are not included in the SSI statute since they cannot be used to qualify a person for SSI.

Often, the OBRA ’93 self-settled exempt trusts are funded with money from a court settlement or an inheritance that was not directed to a third-party trust, i.e., SNTs set up and funded by the parent or other third party. Often the sums of money may be large. No payback or pooled requirement applies to third-party SNTs. The disabilities involved are often significant and, even though the sums involved may seem large, given the medical and custodial needs of these individuals, the trust is often necessary to maximize benefits and enable the individual to remain in the community, or provide for needs above and beyond what is covered by Medicaid. Many of these individuals are younger and competent, but have significant physical disabilities. Institutionalization would be detrimental to their emotional health and well-being. The combined resources of the Medicaid program and the SNT often allow these individuals to reach their maximum potential in the com-

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83 42 U.S.C. § 1396p(d)(4)(B) are the “Miller” trusts which are used in income-cap states to shift income and qualify individuals for Medicaid.
87 42 U.S.C. § 1382b(e)(5).
munity, and otherwise minimize the expense to Medicaid.

VI. RELATIONSHIP OF SSA AND MEDICAID AGENCIES

If the individual is on SSI, the State Medicaid agency should not get involved in the Medicaid determination. This is because of the previously mentioned fact that Medicaid is mandated for SSI recipients and many states have § 1634 agreements. However, if an individual applies for waiver services, then a functional assessment is necessary. At that point, some states get involved in re-evaluating Medicaid eligibility based on the existence of a SNT. Furthermore, provisions in the POMS of the SSA often direct the local SSA office to contact the State Medicaid agency when a SNT is involved. These provisions are found in numerous sections of the regional POMS. Since the criteria for qualifying for Medicaid, whether or not there is a SNT in existence, should be the same as the SSI criteria, the reason for a referral is questionable. In other words, if an individual with a self-settled SNT is eligible for SSI, then that individual should likewise be eligible for Medicaid despite the existence of a SNT. This argument becomes even more compelling in those states that have contracts with the federal government to determine Medicaid eligibility at the same time as the SSI eligibility determination is made, i.e., the § 1634 states. Therefore, the determination of whether or not the SNT is a resource and whether distributions are budgeted as income should be made by the Social Security Administration, not the State Medicaid Agency.

Despite the foregoing, the SI POMS does have numerous provisions that refer to whether or not the trust is revocable under state law. Referrals by SSA to the State Medicaid Office for this purpose are valid. However, the referral by SSA should be only for the purpose of determining whether the trust agreement is valid or whether the trust is revocable or irrevocable under applicable state law. Since the states have to be comparable to the SSI criteria in their Medicaid program, a determination of Medicaid eligibility should not occur due to the existence of the trust. Furthermore, The CMS State Medicaid Manual, which is CMS’ directive to the states in regards to the application of the federal statutes, directs the states to be the same as or less restrictive in their eligibility criteria than the SSI program in regard to trusts.

VII. MANDATED MEDICAID SERVICES

While all SSI recipients must receive Medicaid services from the state, not all Medicaid services are mandated. The mandated services include “medical card services” and nursing facility services. The medical card services include “payments for doctors and

90 Some of these provisions are as follows: POMS SI 01120.202.E; SI 01150.121C.4; SI 01730.48.E, and regional POMS provisions at SI DAL 01730.005 (Arkansas), SI DAL 01730.007 (Louisiana), SI DAL 01730.008.Q. (New Mexico), SI DAL 01730.009 (Texas), SI BOS 01730.048 (New England), SI NY 01730.105 (New York), and SI NY 1730.005 (New Jersey).
91 POMS SI BOS01120.200; SI CHI01120.200; SI DAL01120.200; SI NYO1120.200; SI ATL01120.201.
92 POMS SI 01120.200, but see POMS SI 1730.035B
93 The CMS State Medicaid Manual §§ 3257, para. 4- 5, and 3259.7. Note that these provisions were part of HCFA Transmittal No. 64, which was the policy of the HCFA, now known as the Center for Medicare and Medicaid Services (CMS).
94 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 U.S.C. § 1396d(a)(1)-(5), (17), (21); 42 C.F.R. § 435.120.
hospitals. Medicaid waiver services in the community are not mandated. If a state chooses to provide such services, however, the eligibility criteria should be the same as that of the SSI program, unless the state receives a “waiver.” States may request and be granted a waiver of SSI criteria in their Medicaid Waiver program. The waiver applies only to the “medically needy” class of waiver participants, and the purpose of the waiver is to expand benefits, not to be more restrictive. As previously discussed, the medically needy would be individuals whose income exceeds 300 percent of the federal maximum benefit rate for SSI, or $2,022 per month in 2009. Generally, medically needy waiver participants are children who are severely disabled and living with their parents. The parents’ income is then deemed or attributed to the child. This income often exceeds the applicable limit and, therefore, these children fall into the medically needy class of waiver participants. The reason for the federal granting of a waiver of SSI eligibility criteria to this group of Medicaid applicants is to allow states to provide benefits to severely disabled children without deeming the parental income to the children. Most states obtain this waiver for their child waiver programs. For example, states may have specific programs for children with autism or other groups of severely disabled children. None of the Medicaid waiver programs apply the SSI criteria of deeming parental income and resources to the children. Since this criteria is more liberal and not more restrictive than SSI criteria, the waiver is consistent with the comparability statute.

VIII. More Support for Comparability

One federal statute that has been used to argue against comparability with respect to SNTs actually supports it. This statute, 42 U.S.C. § 1396a(a)(10)(G), reads as follows:

(G) that, in applying eligibility criteria of the supplemental security income program under subchapter XVI of this chapter for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1382b of this title; (emphasis added).

Subsection (c) of § 1382b contains the SSI rules regarding transfers of assets and subsection (e) contains the SSI trust rules. This section applies only to non-SSI recipients, since coverage for SSI recipients is mandated.

However, the cross citation to § 1382b(e) exempts OBRA '93 (d)(4)(A) and (d)(4) (C) trusts. It reads as follows:

(e) Trusts
   (1) In determining the resources of an individual, paragraph (3) shall apply to a trust (other than a trust described in paragraph (5)) established by the individual.

95 42 U.S.C. § 1396n(c)(3); 42 U.S.C. § 1396n(d)(3) wherein it is stated that a waiver granted to a State may include a waiver of 42 U.S.C. § 1396a(a)(10)(C)(i)(III).
(5) This subsection shall not apply to a trust described in subparagraph (A) or (C) of section 1396p (d) (4) of this title.

It is important to note that this statute does not apply to SSI recipients. It applies to persons who are either optionally categorically needy or medically needy. In those cases, the states are directed to disregard two subsections of 42 U.S.C. § 1382b. The first disregarded subsection is (c), which contains the SSI rules regarding transfers of assets. In other words, states are allowed to disregard these SSI rules and have different rules in regards to Medicaid eligibility if a transfer of assets has occurred. As noted before, historically, differences in the transfer of assets rules existed between the SSI program and the Medicaid program, and some differences still remain. Therefore, disregarding comparability in this context makes sense and allows states to have transfer of asset rules that are either more liberal or more restrictive than those in the SSI program.

The other disregarded subsection, subsection (e), contains the SSI trust rules. Some states have interpreted the statutory authority to disregard SSI trust rules to mean that they can have more restrictive eligibility rules for trusts in their Medicaid program. However, § 1382b(e) exempts OBRA ’93 (d)(4)(A) and (C) trusts, as noted. Again, (d)(4)(B) trusts or “Miller” trusts are not referenced, since no SSI-Medicaid comparability exists in those situations.

The CMS provisions in The CMS State Medicaid Manual at §§ 3259, et seq., are the rules interpreting this statute for the self-settled non-OBRA ’93 trusts. These are trusts that are not exempt under the OBRA ’93 statute (i.e., trusts that are not payback, Miller, or pooled trusts). Remember that the OBRA ’93 trust rules are at §§ 3257 B(4) and (5). These provisions clearly state that OBRA ’93 (d)(4)(A) and (d)(4)(C) trusts are not subject to the restrictive provisions in § 3259.6, but are instead subject to the rules in § 1902 (f) (which is § 209b) or the more liberal rules under § 1902(r)(2) (which is the comparability statute discussed herein). Therefore, the so-called “non-comparability” statute and the related CMS rules apply only to non-exempt, self-settled trusts, such as MQTs, revocable trusts, or other non-exempt irrevocable self-settled trusts.

Another basis on which states are arguing against comparability is the U.S. Supreme Court case of Wisconsin Department of Health and Family Services v. Blumer. However, in the Blumer opinion, the Court specifically recognized that the issue of comparability was outside the scope of the decision in that case. The plaintiffs in Blumer were not SSI recipients. It was a spousal impoverishment case and no SSI situation exists when the rules are comparable to the Medicaid spousal impoverishment rules. Furthermore, the Court noted that there was no dispute in the case with respect to the definition of “income.” In that regard, the state was applying rules that were comparable to the SSI program in defining income. The issue in Blumer was whether the income of the institutionalized spouse could be attributed to the community spouse. Insofar as that issue was concerned, the Court held that the spousal impoverishment provisions of MCCA superseded any other provisions of the Medicaid statute.

In Blumer, 493, n.11, the Court stated as follows:

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97 42 U.S.C. § 1396a; § 1396a(r)(2)(B).
Blumer also contends that subsection (a)(3) of the MCCA forbids the income-first method because that provision expressly leaves in place the existing Supplemental Security Income (SSI) program rules for determining what constitutes income and resources, including the standards and methods used in such determinations. . . , however, the issue carved out by § 1396r-5(a)(3) — what qualifies as income or resources — is not implicated by this case…. At issue here is the different question, governed entirely by the MCCA, of whether money that is indisputably “income” may be attributed to the community spouse.

The decision in Blumer has led some states to believe that they can develop their own eligibility rules in the Medicaid program despite federal law. In this regard, the fact that Blumer did not negate the concept of comparability, but, in fact, upheld it, is critical. Furthermore, the Blumer Court relied heavily on the fact that the federal statute at issue in that case was ambiguous and the CMS State Medicaid Manual had provisions allowing the states to interpret the federal statute either as an income-first or resources-first statute. In regard to comparability on self-settled SNTs, specifically the OBRA ’93 d(4)(A) and (C) trusts, there is no ambiguity and the the CMS State Medicaid Manual requires states to follow the law of comparability.

Most recently the 10th Circuit Court of Appeals affirmed the District Court in the Hobbs case. However the court did not specifically rule on the issue of comparability in its decision, finding instead that there was no jurisdiction under 42 U.S.C. §1983. The court held that the States have discretion to exempt trust under d(4)(A) and d(4)(C) basing this conclusion on its prior holding in the Keith case. This reasoning is clearly faulty, however, since in Keith the trust at issue was a d(4)(B) trust and the comparability statute specifically excludes these trusts while not excluding the d(4)(A) and (C) trusts. The opinion is interesting for what it did not say particularly in regard to the fact that the court went out of its way to not rule on comparability, indicating this may have been the strongest argument. It is important to note that there was no admissible evidence in the record that the Social Security Administration had considered the trust a non-countable resource.

In a pending case in Pennsylvania the argument is being made that Keith was wrongly decided and that the comparability statute does apply to the d(4)(A) and (C) trusts for the reasons stated herein.

IX. Conclusion

Practitioners in states placing restrictions on self-settled SNTs beyond those found in federal law should challenge any such restrictions. States may attempt to place restrictions either by counting a trust as a resource, counting distributions from a trust as income to the beneficiary, or disallowing distributions for a particular purpose. If the restrictions are not comparable to the Federal SSI law, including the statutes, regulations and rules set

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98 See footnote 102.
100 Hobbs v. Zenderman, Case No. 08-2009, 10th Cir. Ct. of App. (Sept. 1, 2009)
101 Lewis V . Richman No. 06-3963 U.S. DC (E.D. Pa)
forth in POMS, they are illegal. Some cases are currently challenging these state restrictions and, hopefully, a favorable decision will be rendered.\textsuperscript{102}

\textsuperscript{102} See Appeal of Emily Huff, 154 N.H. 414 (2006), discussed earlier regarding “Comparability and Trusts”; see Hobbs v. Zenderman, 542 F.Supp.2d 1220 (D.N.M. 2008) in Bridget O’Brien Swartz’s discussion in section III of Part I: The Medicaid Conspiracy Against Special Needs Trusts regarding “Income Distributions”; see also McDaniel v. Barbour, No. G200801256, Hinds County Chancery Court (First Judicial District 2008), wherein the plaintiffs, two SSI recipients who were beneficiaries of self-settled special needs trusts, challenged Medicaid’s termination of their benefits on the basis that distributions ran afoul of Mississippi’s “Guidelines.” The State conceded that Medicaid does not have the authority to deny or terminate benefits to recipients of SSI benefits and reinstated the plaintiffs’ Medicaid benefits.
WHEN DISABLED HOMEOWNERS LOSE THEIR HOMES FOR A PITTANCE IN UNPAID PROPERTY TAXES: SOME LESSONS FROM IN RE MARY LOWE

By Robert F. Harris, Esq., Charles P. Golbert, Esq., and Barry Sullivan, Esq.

“[N]or shall any State deprive any person of life, liberty, or property, without due process of law . . . .”

—U.S. Constitution Amendment XIV, Sec. 1

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I. INTRODUCTION

Mary Lowe suffered from chronic schizophrenic disorder for most of her adult life. Over the years, she was hospitalized repeatedly. Nonetheless, Ms. Lowe was able to own and maintain her own home for 20 years until, at age 68, she lost her home at a forced tax sale triggered by an unpaid property tax bill in the amount of $347. It was because of her disabilities that Ms. Lowe failed to pay the tax bill and failed to receive notice of the tax deed proceeding. In fact, Ms. Lowe was hospitalized at a psychiatric facility when a deputy sheriff and letter carrier each attempted service at her home. Actual service was not effectuated. However, the letter carrier knew where Ms. Lowe was hospitalized and made an appropriate notation at the post office and on the notice returned to sender. According to medical experts, Ms. Lowe’s medical condition would have prevented her from understanding the significance of the notices even if she had received them.

This article describes the lengthy, complex, and ultimately unsuccessful litigation that sought recovery of Ms. Lowe’s home. Ms. Lowe’s case was litigated through the Illinois state court system; it was briefed and argued twice before the Illinois Supreme Court; and it was the subject of two petitions for writs of certiorari to the Supreme Court of the United States. One of those petitions was successful and resulted in a remand to the Illinois Supreme Court. Ms. Lowe (and, after her death, her estate) was represented by the Public Guardian of Cook County. The Public Guardian was eventually joined in the representation by the law firm of Jenner & Block, which provided assistance on a pro bono publico basis.

The facts of Ms. Lowe’s case suggest three distinct due process issues that may...
come into play when a homeowner stands to lose her home at a tax lien sale. First, when actual notice has been attempted, without success, at the person’s home, and there are strong clues as to the person’s whereabouts, does the Due Process Clause require that the party responsible for giving notice take reasonable steps to follow up on those clues? Second, when physical service is actually made, but the homeowner’s cognitive disability prevents her from understanding the significance of the notice, and the party required to give notice knows about the homeowner’s disability, is the physical act of service on the disabled homeowner sufficient to satisfy due process standards? Finally, what if the homeowner is disabled in a way that prevents her from appreciating the significance of the notice, but her disabilities are not known to the person responsible for giving notice?2

Section II will provide factual background and context to illustrate the nature and extent of the problems surrounding disabled homeowners. This section will discuss the cases of other disabled wards of the Public Guardian, in addition to Ms. Lowe, who lost their longtime homes at tax lien sales occasioned by their failure to pay very small property tax bills. Section III will discuss the factual circumstances of Mary Lowe’s case leading up to the litigation that sought recovery of her home.

Section IV will discuss the delinquent property tax sale procedures in Illinois and other jurisdictions.3 This section will suggest that the relevant state notice provisions may be sufficient in most cases to advise a homeowner that title to his home is in jeopardy, and that certain procedures must be followed if his property is to be redeemed, but that these notice provisions are of little value to a homeowner who does not receive the notice (despite the fact that his actual whereabouts are known or easily ascertainable) or who cannot understand or act on the notice due to a cognitive disability. In such circumstances, due process requires more. In addition, this section will argue that tax scavengers, who bid on and buy property at tax sales — but who are also charged with attempting to locate and provide notice to the homeowner — operate under an inherent conflict of interest. The scavenger’s interest is in obtaining title to the delinquent property at a windfall price, not in locating the homeowner and giving her notice of the proceeding or informing her about how to redeem her property.

Section V will analyze the applicable due process jurisprudence as it existed when Ms. Lowe’s case was at trial and on appeal in the Illinois state courts. This section will discuss the seminal cases from the United States Supreme Court addressing notice and due process, namely *Mullane v. Central Hanover Bank and Trust Co.*4 and its progeny,5 as well as *Covey v. Town of Somers,*6 which deals with the adequacy of notice given to

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2 When this article discusses disabled homeowners, it refers to persons with a cognitive disability, such as Alzheimer’s disease or other dementia, which renders the person unable to take care of financial or legal matters, to understand the significance of legal notices, or to take meaningful action with respect to such notices. The term is not used in this article to include persons with strictly physical disabilities. Of course, many persons with a cognitive disability, especially elderly persons, may also have physical disabilities.


persons with known disabilities. This section will then analyze the leading cases from Illinois and other jurisdictions that specifically address the kind of notice necessary to satisfy due process when the property interests of a disabled homeowner are at stake.

With this factual and legal background in place, Sections VI–VIII will discuss the litigation seeking recovery of Ms. Lowe’s home, as it proceeded through the Illinois trial and appellate courts, through the Supreme Court of Illinois and the Supreme Court of the United States, back again to the Supreme Court of Illinois, and finally culminating in the filing of a second, unsuccessful, petition for a writ of certiorari in the United States Supreme Court. These sections also will discuss Jones v. Flowers, an Arkansas tax sale case addressing the notice requirements of the Due Process Clause, in which the United States Supreme Court granted certiorari three weeks before the Illinois Supreme Court issued its decision in Mary Lowe I.

Section IX will discuss the inadequacy of alternative remedies, such as indemnity funds, for disabled homeowners who, due to lack of proper notice, have lost the homes in which they have lived for years, raised their families, and formed deep bonds. Section X will discuss legislative initiatives that the Public Guardian has proposed to ameliorate the circumstances of disabled homeowners who stand to lose their homes because of minimal unpaid property taxes and insufficient notice. In Section XI, the authors offer some concluding thoughts, including a call for remedial legislation.

II. BACKGROUND TO PROBLEM

The problem of homeowners with cognitive disabilities who stand to lose their homes because of the failure to pay a very small property tax bill is one that the Public Guardian’s Office sees with some frequency. The fact patterns tend to be similar. The delinquent taxpayer typically has owned his home for 20 to 30 years and has paid off all or most of the mortgage; the homeowner has substantial equity in the home with no liens or encumbrances; and the homeowner has regularly paid his taxes for decades. As the homeowner ages, he develops Alzheimer’s disease or some other infirmity that affects mental cognition. The normally diligent homeowner misses paying a small tax bill and faces the loss of her house at a forced tax lien sale.

Typically, the person’s home is her largest asset by far, and the value of the house greatly exceeds the paltry amount owed in unpaid taxes. For that reason, many of the stories have the same unhappy ending: a private scavenger buys the right to pursue the tax deed, makes the perfunctory efforts at giving notice that the relevant statute requires, and

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eventually exercises the right to redeem the property.\textsuperscript{12} As in Ms. Lowe’s case, there are often red flags suggesting that the homeowner is disabled, or that the homeowner did not receive or understand the significance of the notice. The law generally allows the scavenger to take the person’s home anyway.

The number of homes lost at tax sales is substantial. In Cook County, Illinois, 13,758 tax deeds were issued during the period from January 1, 2003, through July 31, 2007, for an annual average exceeding 3,000. In each case, title was conveyed to the scavenger.\textsuperscript{13}

This section will recount the stories of additional disabled wards of the Public Guardian’s Office who lost their longtime homes at tax lien sales due to small amounts of unpaid property taxes.

\textbf{A. Konstantina T.} \\

Konstantina T. lost her home of 15 years, valued at $470,000 to $490,000, at a tax lien sale. Ms. T., who had unpaid property taxes in the amount of $1,926, had immigrated to the United States from Greece in 1987, when she was 63 years old. She cannot speak or read English, and she cannot read or write Greek. Ms. T.’s husband died in January 2002, when he was 78 years old. Until he died, Ms. T.’s husband paid the bills and took care of the family’s financial matters. By the time of Mr. T.’s death, Ms. T. was suffering from mental illness, including delusional disorder.

Shortly before Ms. T.’s husband passed away, property taxes on the home became delinquent in the amount of $1,926. At a tax lien sale, BCS Services, Inc., a private tax scavenger, purchased the taxes and obtained a certificate of purchase for Ms. T.’s home. That certificate granted BCS the right to move the court for issuance of a tax deed following service of certain notices and the expiration of the statutory redemption period.

On January 7, 2004 — eight days after the expiration of the redemption period — the Probate Division of the Circuit Court of Cook County, Ill., appointed the Public Guardian as temporary guardian of Ms. T.’s estate, based on evidence of her disabilities and resultant inability to manage her financial affairs. Five days later, on January 12, 2004, the scavenger moved the court for issuance of a tax deed to Ms. T.’s home, and the Public Guardian filed objections. The Public Guardian was later appointed to serve as plenary guardian for Ms. T.

After lengthy, costly, and contentious litigation, the trial judge mediated a settlement. Although Ms. T. did not recover her home, BCS paid her a substantial monetary sum that the Public Guardian has used to provide for her care and comfort.\textsuperscript{14}

\textsuperscript{12} The tax sale procedures in Illinois, including the role of scavengers, are discussed in Section IV A, \textit{infra}.

\textsuperscript{13} This number was calculated by three advocacy organizations that moved for leave to file an \textit{amicus} brief in the Supreme Court of the United States in support of Mary Lowe: The Sargent Shriver National Center on Poverty Law, The Legal Assistance Foundation of Metropolitan Chicago, and The Lincoln Legal Foundation. The number is based on records obtained from the Office of the Cook County Clerk pursuant to a Freedom of Information Act request. The statistics are found on page 5 of the \textit{amicus} brief, which the advocates moved to file on August 17, 2007. The supporting documents are reproduced as an exhibit to the brief. The amount of money involved is also substantial. In the Chicago metropolitan area, the median home sale price was $262,500 during the third quarter of 2007. Mary Schaefer & Ann Lendrigan, Illinois Home Sales, Illinois Association of Realtors, Nov. 17, 2008, http://www.illinoisrealtor.org/iar/newsreleases/3Q08.html (last visited Dec. 26, 2008).

\textsuperscript{14} Estate of Konstantina T. v. Topalidis, No. 04 P 0118 (Cir. Ct. Cook County, Ill.), consolidated with \textit{In re
B. Elizabeth S.

Elizabeth S. is a former nun. After developing dementia and a seizure disorder, she lost her home of 26 years, valued at approximately $350,000, to a tax scavenger. She had unpaid taxes in the amount of $29.54. After accounting for a mortgage balance of approximately $100,000, Ms. S. had equity of approximately $250,000 in her home. The $29.54 in unpaid taxes was sold at a tax lien sale to a scavenger on April 3, 2000, when Ms. S. was 77. The time period for Ms. S. to redeem her taxes expired on January 21, 2003.

Ms. S. became disabled during the redemption period. In December 2002, Ms. S. was hospitalized after Fire Department officials observed her speaking incoherently; the diagnosis was viral encephalitis. A psychiatrist determined that Ms. S. could not make medical or financial decisions or take care of herself. Ms. S.’s condition worsened and she became more confused. Hospital staff determined that Ms. S. had a brain hemorrhage in the area of a previous cerebrovascular accident and diagnosed her condition as vascular dementia with psychosis.

Because Ms. S. could not manage her affairs, her case was referred to the Public Guardian, who filed a guardianship petition in the Probate Division of the Circuit Court of Cook County. The court appointed the Public Guardian as temporary guardian of Ms. S.’s estate on February 20, 2003, and as temporary guardian of her person on March 7, 2003. The Public Guardian was appointed plenary guardian on March 23, 2003.15

The scavenger filed a petition for a tax deed to secure title to Ms. S.’s home, and the Public Guardian filed objections. The case proceeded to a contested trial. Finding that the scavenger had complied with all of the requirements of the statute, the court denied the Public Guardian’s objections and granted the scavenger’s petition. On August 5, 2005, the Cook County Clerk issued a tax deed conveying title to Ms. S.’s home to the scavenger.16

The Public Guardian filed an indemnity lawsuit to recover the fair monetary value of Ms. S.’s home.17 The county treasurer filed objections. After lengthy litigation, the parties reached a settlement and a monetary sum was made available for Ms. S.’s care and comfort.18

The cases of Konstatina T. and Elizabeth S. are typical of the cases in which the Public Guardian becomes involved — cases of elderly people with substantial property who become disabled and have few human resources upon which to rely. Whether anything can be done to prevent the unjust loss of their homes often depends on how early in the process help can be made available to these elderly and infirm homeowners.

Application of the County Treasurer, 03 COTD 2231 (Cir. Ct. Cook County, Ill.).
15 Estate of Elizabeth S., No. 03 P 1442 (Cir. Ct. Cook County, Ill.).
16 Application of County Collector, No. 02 CD 4266 (Cir. Ct. Cook County, Ill.).
17 Illinois has an indemnity fund to compensate homeowners who wrongfully lose their homes through tax sale proceedings. See 35 Ill. Comp. Stat. 200/21-295. Claims against the fund are defended by the county treasurer, represented by the county state’s attorney, in adversarial proceedings. The subject of indemnity proceedings, including their inherent limitations as a means of making a disabled homeowner whole, is discussed in Section IX, infra.
18 Robert F. Harris as Guardian of the Estate of Elizabeth S. v. Papas, No. 05 COIN 000030 (Cir. Ct. Cook County, Ill.).
Mary Lowe was born on November 12, 1926. In the early 1960s, Ms. Lowe began experiencing symptoms of mental illness, including auditory hallucinations and delusional thinking. She was diagnosed with chronic schizophrenic disorder, and she was hospitalized for psychiatric care and treatment 27 times between 1964 and 1995. Ms. Lowe’s 26th hospitalization occurred in January 1995, after the Chicago police found her roaming naked in the streets on a cold winter night. When the police attempted to take Ms. Lowe home, they discovered the decomposing body of her companion, William Austin, who had died of natural causes some time previously, but who Ms. Lowe thought was still alive. In what was to be her final hospitalization, Ms. Lowe spent 16 months at the Tinley Park Mental Health Center, from August 26, 1995, until December 16, 1996, when she was released to the care of her son. Ms. Lowe died on November 15, 1998, two days after her 72d birthday.

In 1977, Ms. Lowe had purchased a single-family, split-level townhouse on the south side of Chicago. In 1993, she conveyed a partial interest in the property to her long-time companion, William Austin, and they held the property as joint tenants. When Mr. Austin died in 1994, Ms. Lowe became the sole owner.

Ms. Lowe’s mental illness was well-known in her neighborhood, and her schizophrenia became worse after periods of stress, such as that brought on by Mr. Austin’s death. Ms. Lowe frequently exhibited a variety of strange behaviors, including coming outside without clothing, shouting names and obscenities, moving her furniture to the curb, and screaming at passersby. She was often hospitalized at psychiatric facilities after such episodes.

Due to her disability, Ms. Lowe neglected to pay a property tax bill of $347. That failure led to a tax lien sale at which her home was sold. On March 3, 1993, Apex Tax Investments paid the outstanding tax bill (together with interest and fees) and obtained a certificate of purchase for Ms. Lowe’s home. On October 5, 1995, while Ms. Lowe was being treated at the Tinley Park Mental Health Center, Apex filed a petition for issuance of a tax deed. Ms. Lowe could redeem the property by paying the unpaid taxes, plus certain expenses, before the expiration of the redemption period on February 21, 1996.

Ms. Lowe remained hospitalized during the period in which a deputy sheriff and a letter carrier attempted service at her home. Personal service was attempted on Ms. Lowe, on Mr. Austin (her deceased companion), and on “occupant,” at the home. The deputy

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19 The facts regarding Mary Lowe’s case come primarily from the Illinois Supreme Court’s published opinions: the original opinion in Mary Lowe I and the opinion on remand from the United States Supreme Court, Mary Lowe II. Where appropriate, this article supplements the facts found in those opinions with facts from the consolidated record. In such instances, a citation to the consolidated record on appeal is provided. The consolidated record is available from the Clerk of the Circuit Court of Cook County.

20 SRII 25-26, EX 100, 130, 269.
22 Mary Lowe I at 914-15.
23 Mary Lowe II at 942.
24 Mary Lowe I at 914-15, SRII 26, 32, EX 261.
25 SRII 54-62, 82-87.
26 Mary Lowe I at 909-10.
sheriff was unable to effectuate service, and the notices were returned unserved. On each of the returns of service, the deputy sheriff wrote “House vacant per neighbors.” The deputy sheriff also placed a mark next to the word “MOVED” on the preprinted form to indicate why the notice was not served.  

Service was then attempted by Certified U.S. Mail. The letter carrier, Jewel Hightower, became concerned when she saw letters from the Sheriff that appeared to contain tax statements addressed to Ms. Lowe and Mr. Austin. Ms. Hightower knew that Mr. Austin had died; she therefore wrote “deceased” on the envelopes addressed to him. Ms. Hightower was also aware of Ms. Lowe’s mental illness, and she knew from a neighbor that Ms. Lowe was hospitalized at Tinley Park Mental Health Center. She noted this fact on a card maintained at the branch post office, and she wrote “person is hospitalized” on the envelopes addressed to Ms. Lowe. Ms. Hightower also wrote her initials (JHT) and route number (2719) on the envelopes. The envelopes were all returned to the clerk of the court, stamped “return to sender.”

Apex thus had knowledge that Ms. Lowe did not receive the notices. As returned, the notices also provided strong clues for anyone interested in determining Ms. Lowe’s whereabouts. The notices disclosed that Ms. Lowe was hospitalized, and they bore the initials and route number of a letter carrier who knew that fact and who might well have known (as she did) where Ms. Lowe was hospitalized. Moreover, the information was available, not just from Ms. Hightower, but also from the branch post office, where Ms. Hightower had made a note of it. Apex also knew that the matter was not inconsequential. The hospitalized homeowner faced the permanent loss of her valuable home for non-payment of $347 in taxes. Nonetheless, Apex made no further attempts to serve Ms. Lowe or to follow up on the letter carrier’s notations.

Apex’s petition for a tax deed proceeded to an ex parte prove-up, which occurred on May 20, 1996. At the hearing, Apex’s president, Fred Berke, testified in response to a series of questions put to him by Apex’s lawyer. Mr. Berke testified that he had visited the property. He received no response when he knocked on the door. He looked in the living-room window and saw no furniture. He spoke to the next-door neighbor, who told him that “the Lowes” owned the home but that no one was then living there. There is no indication from Mr. Berke’s testimony that he asked any obvious follow-up questions: “Do you know where Ms. Lowe is? Do you know how she can be reached?” Nor is there any indication that Mr. Berke disclosed the reason for his interest in Ms. Lowe or the purpose of his visit, or that he inquired as to whether anyone else might know about Ms. Lowe’s whereabouts or how to contact her. Likewise, there is no indication that Mr. Berke talked with anyone else in the neighborhood other than the next-door neighbor. The transcript of the entire prove-up consists of barely nine pages, including the title page.

27 Mary Lowe I at 910.
28 Id. at 910-11, 915, SRII 64-65, 72, 79-84.
29 Id. at 911.
30 R5-9.
31 Id.
32 Id.
33 R2-11.
Following the *ex parte* prove-up, the court granted Apex’s petition and entered an order directing the County Clerk to issue a deed vesting Apex with title to Ms. Lowe’s home. The Clerk issued the tax deed to Apex later that day.34

The returned envelopes containing the notations made by Jewel Hightower, the letter carrier, were included in the court file, but they were not called to the court’s attention. After retiring from judicial service, the judge who presided over the prove-up gave an affidavit stating that he would not have granted Apex’s application if he had been aware of those notations.35

On September 5, 1997, Bruce Lowe, a son living in California, filed a *pro se* petition seeking restoration of his mother’s title to the property. The court appointed the Public Guardian as Ms. Lowe’s attorney and *guardian ad litem*, and the Public Guardian subsequently filed original and amended petitions to set aside the tax deed.36 Ms. Lowe died on November 15, 1998, and the court substituted the Public Guardian, in his capacity as administrator for Ms. Lowe’s estate, as the plaintiff.37

IV. TAX SALE PROCEDURES

A. Illinois

Articles 21 and 22 of the Property Tax Code38 provide that the county may apply to the court for a judgment and order of sale when a homeowner has become delinquent in the payment of his property taxes. The county must provide publication notice at least 10 days before the application is filed.39 The county also must serve notice by certified or registered mail at least 15 days before the date of the application.40 The property owner may pay the delinquent taxes and costs at any time prior to the entry of judgment.41

If a judgment is entered against the property, the county may offer the property for sale to a private tax purchaser, known as a tax scavenger.42 The scavenger does not obtain title to the property at this time, but receives a certificate of purchase.43 The homeowner has the right to redeem the property by payment of the tax arrearage, penalties, and interest, until the expiration of a 30-month redemption period.44

Following his receipt of the certificate of purchase, the scavenger must deliver an initial notice to the county clerk for service on the homeowner. The notice must make clear that the property has been sold for delinquent taxes, that redemption may be made until a specified date, and that a petition for a tax deed will be filed if the property is not redeemed. The scavenger must deliver the notice to the county clerk within four months

34 Mary Lowe I at 912.
35 C541-42.
36 Mary Lowe I at 912-13.
37 Id. at 914.
38 35 ILL. COMP. STAT. 200/21-5 and 22-5.
40 35 ILL. COMP. STAT. 200/21-135.
41 35 ILL. COMP. STAT. 200/21-165.
42 35 ILL. COMP. STAT. 200/21-190.
43 35 ILL. COMP. STAT. 200/21-250.
44 Mary Lowe I at 909; 35 ILL. COMP. STAT. 200/21-345-21-355.
and 15 days after the tax sale, and the clerk must serve the notice by registered or certified mail within 10 days thereafter.\textsuperscript{45}

The scavenger must provide a second notice of the sale, which is to be served on the homeowner, occupants and interested parties not less than three months nor more than six months prior to the expiration of the redemption period. This second notice must include the redemption deadline.\textsuperscript{46} Unlike the initial notice, the second notice must provide the time and place at which the petition for a tax deed will be heard, so that the homeowner may appear and object at the proceeding.\textsuperscript{47} The scavenger must arrange for the sheriff to effect personal service, for the clerk of the court to make service by registered or certified mail return receipt requested, and for notice to be published three times in a newspaper.\textsuperscript{48}

During the same period — not less than three months nor more than six months prior to the expiration of the redemption period — the scavenger may file a petition for a tax deed to the property.\textsuperscript{49} The court may grant the petition if the scavenger demonstrates that the redemption period has expired without redemption taking place, and that the scavenger has complied with the statutory notice requirements, including the requirement that the scavenger make “diligent inquiry and effort” to locate and serve the homeowner.\textsuperscript{50}

There are several problems with the statutory scheme in Illinois and other jurisdictions. First, while the scheme may appear to require a number of acts on the part of the party responsible for giving notice, the scheme does not actually require any follow-up on the steps that are required. If letters are returned with any sort of notation, the statute does not require that any specific additional steps be taken. Moreover, the notices are of little value to disabled homeowners — such as Mary Lowe, Konstantina T. or Elizabeth S. — who cannot understand or act on them due to cognitive impairments; and the statute does not specifically require any special steps to be taken with respect to such persons, even if their cognitive disabilities are well known to the party required to give notice.

Most important, by making private tax scavengers responsible for locating and providing notice to an affected homeowner, the statutory scheme places legal responsibility for the giving of notice in the hands of actors with an inherent conflict of interest. In many cases, the homeowner’s whereabouts will be easy to verify: he will be living in the home that the scavenger is seeking to buy. In such cases, the homeowner will be easily located if the private scavenger minimally complies with his statutory obligations. When more is required, however, the scavenger’s inherent conflict of interest will come into play. The scavenger’s primary interest does not rest in locating the homeowner, but in obtaining the property at a bargain-basement price. His interest in locating the homeowner may be tepid at best. The Seventh Circuit has observed that property acquired at tax lien sales in Illinois “can often be sold at a significant profit over the amount paid for the lien.”\textsuperscript{51}

Similarly, the Illinois Supreme Court has noted that tax purchasers frequently “gain title

\textsuperscript{45} 35 ILL. COMP. STAT. 200/22-5.
\textsuperscript{46} 35 ILL. COMP. STAT. 200/22-10.
\textsuperscript{47} Id.; Mary Lowe I at 923.
\textsuperscript{48} 35 ILL. COMP. STAT. 200/22-15, 22-20, 22-25.
\textsuperscript{49} 35 ILL. COMP. STAT. 200/22-30.
\textsuperscript{50} 35 ILL. COMP. STAT. 200/22-40, 22-15.
to real estate for a fraction of its value.”52 Of course, the scavengers in the cases of Mary Lowe, Konstantina T. and Elizabeth S. all stood to acquire the properties for sums far below market value.

In the case of a missing homeowner, a scavenger is required by statute to exercise diligent inquiry and effort to locate the homeowner. The profit that a scavenger stands to gain from buying a home for a pittance and selling it at market value obviously provides an alternative incentive. Of course, the United States Constitution may require more than the statute, but even then, the real question is a practical one: what, really, does the law require of the scavenger, and how closely will an impartial third party inquire to see whether that has been done? In the absence of an effective adversarial proceeding, a hard look by an independent party is critical. But such a hard look will not occur if the statute does not require it and if the courts are too busy to provide it.

B. Other Jurisdictions

To provide context, this subsection will describe the tax lien procedures in several additional jurisdictions.

1. Arkansas

The Arkansas tax sale procedures were at issue in Jones v. Flowers,53 in which the United States Supreme Court granted certiorari three weeks before the Illinois Supreme Court released its decision in Mary Lowe I.

In Arkansas, property is forfeited to the state if taxes are past due for one year. The county collector transfers ownership of such property to the state by certifying that the taxes are past due. This certification vests title in the state in care of the Arkansas Commissioner of State Lands.54 Not less than 30 nor more than 40 days prior to the entry of the certification, the county collector is required to give publication notice to the owner of record that the land will be forfeited to the state unless redeemed within the prescribed period.55 The county collector also maintains a public record of delinquent lands, which is published annually.56

Once the county collector has provided the certification to the state, the homeowner has two years in which to redeem his property. At the beginning of this period, the Commissioner must notify the homeowner and interested parties by both certified mail and publication that the property will be sold if it is not redeemed.57 At the end of the redemp-
tion period, the property may be sold. However, the homeowner has an additional 30 days in which to redeem the property, and an additional notice to that effect must be served on the owner and interested parties by regular mail.\textsuperscript{58} This notice, like the prior notice, must be given by the Commissioner, rather than by the party purchasing the property.\textsuperscript{59} If the property is not redeemed within this 30-day period, the Commissioner will issue a tax deed.\textsuperscript{60}

Arkansas has special provisions addressing homeowners under disabilities. Property belonging to a minor, an insane person, or a person in confinement may be redeemed at any time within two years after the removal of the disability.\textsuperscript{61}

2. New York

Property taxes in New York are levied on December 31 of each year. The taxes become a lien against real property the next day (January 1), which is called the lien date.\textsuperscript{62} Ten months after the lien date, or as soon as practicable thereafter, the enforcing officer of the tax district will execute a list of all property with delinquent tax liens in that district.\textsuperscript{63} The list is maintained on file with the county clerk.\textsuperscript{64}

Twenty-one months after the lien date, or as soon thereafter as practicable, the enforcing officer may file a petition of foreclosure against those properties that still have delinquent tax liens.\textsuperscript{65} Notice of the petition is published for three non-consecutive weeks during a two-month period in at least two newspapers.\textsuperscript{66} The notice includes a description of the rights of redemption and the redemption deadline, which must be fixed at least three months after the first publication.\textsuperscript{67} The notice is also posted in the office of the enforcing officer and in the county court house.\textsuperscript{68}

On or before the date of the first publication notice, the enforcing officer serves notice on the owner and interested parties by certified and regular mail.\textsuperscript{69} If both mail notices are returned, the enforcing officer must attempt to obtain an alternative mailing address from the post office. If an alternative mailing address is secured, notice must be given at that address by certified and regular mail.\textsuperscript{70} If no alternative mailing address is found, the enforcing officer must post notice on the property.\textsuperscript{71}

If the owner does not redeem the property within the relevant period, the court con-

\textsuperscript{59} Id.
\textsuperscript{60} Id. § 26-37-203.
\textsuperscript{61} Id. §§ 26-37-305, 26-37-306, 26-37-203(b).
\textsuperscript{62} \textit{N.Y. Real Prop. Law} §§ 900, 902, 1102 (2008).
\textsuperscript{63} Id. § 1122.
\textsuperscript{64} Id.
\textsuperscript{65} Id. § 1123.
\textsuperscript{66} Id. § 1124.
\textsuperscript{67} Id.
\textsuperscript{68} Id.
\textsuperscript{69} Id. § 1125.
\textsuperscript{70} Id.
\textsuperscript{71} Id.
ducts a hearing and may award possession and title to the property to the tax district.\textsuperscript{72} The tax district is then able to sell or convey the property, with or without advertising for bids. However, the sale must be approved by a majority vote of the governing body of the tax district.\textsuperscript{73}

3. Florida

Property taxes in Florida are due on November 1 of each year and become delinquent on April 1 of the following year.\textsuperscript{74} The tax collecting authority mails a notice to delinquent homeowners by April 30.\textsuperscript{75} The notice includes a description of the property and informs the homeowner that a tax certificate will be sold for the unpaid taxes, with the property, itself, subject to sale at a future date. The notice advises the homeowner to “contact the tax collector’s office at once.”\textsuperscript{76}

On or before June 1, the tax collector is required to give publication notice once a week for a three-week period that it will sell tax certificates on all property with delinquent taxes.\textsuperscript{77} If the taxes are not redeemed, the tax collector will commence the sale of tax certificates by means of a bidding process.\textsuperscript{78} The successful bidder who obtains a tax certificate may not initiate contact with the owner of the property until two years have elapsed from April 1 of the year in which the tax certificate was issued.\textsuperscript{79}

After that two-year period has elapsed, the holder of the tax certificate may apply to the tax collector for issuance of a tax deed.\textsuperscript{80} The tax collector will then initiate an application in the county court.\textsuperscript{81} The clerk of the county court will give publication notice once a week for four consecutive weeks.\textsuperscript{82} The clerk also will give notice by certified mail return receipt requested to the owner and interested parties.\textsuperscript{83} Notice to the homeowner is also served personally by the sheriff. If the sheriff is unable to effectuate personal service, the sheriff will post the notice at the homeowner’s last known address.\textsuperscript{84} If the last known address is in a county other than the county in which the tax delinquent property is located, notice will be posted on the property to be sold. Those notices will indicate that the land will be sold at public auction unless the property is redeemed and will also include the date of the sale.\textsuperscript{85}

If the property is not redeemed, the clerk of the county court will offer the property to the highest bidder for cash at public outcry.\textsuperscript{86} If no bids exceed the amount needed to

\textsuperscript{72} Id. §§ 1130-1136.
\textsuperscript{73} Id. § 1166.
\textsuperscript{74} Fla. Stat. § 197.333 (2009).
\textsuperscript{75} Id. § 197.343.
\textsuperscript{76} Id.
\textsuperscript{77} Id. § 197.402.
\textsuperscript{78} Id. § 197.432.
\textsuperscript{79} Id.
\textsuperscript{80} Id. § 197.502.
\textsuperscript{81} Id.
\textsuperscript{82} Id. § 197.512.
\textsuperscript{83} Id. § 197.522.
\textsuperscript{84} Id.
\textsuperscript{85} Id.
\textsuperscript{86} Id. § 197.542.
re redeem the tax certificate and reimburse the certificate holder for all costs and interest incurred, a tax deed will be issued to the certificate holder.\textsuperscript{87} Otherwise, the property will be sold to the highest bidder.\textsuperscript{88} In such cases, the excess will be retained by the clerk for the benefit of the homeowner, lienholders, and certain interested parties.\textsuperscript{89}

V. The First Round of Illinois Litigation: Contemporaneous Legal Background

When the Public Guardian was litigating his petition to set aside the tax deed to Ms. Lowe’s home in the Illinois courts, he relied not only on the relevant Illinois statutory requirements but also on the United States Supreme Court case law addressing notice requirements under the Due Process Clause of the Fourteenth Amendment. The landmark cases are \textit{Mullane v. Central Hanover Bank and Trust Co.}\textsuperscript{90} and \textit{Covey v. Town of Somers}.\textsuperscript{91} In \textit{Mullane}, which addresses the adequacy of publication notice, the Supreme Court articulated its classic statement as to the type of notice that due process demands. The Court held that mere publication notice cannot satisfy constitutional due process when the names and addresses of interested parties are actually known or are available upon reasonable investigation. In later cases, the Supreme Court has reiterated that principle in various contexts.\textsuperscript{92} In \textit{Covey}, for example, the Court applied the principle articulated in \textit{Mullane} to vacate a tax lien sale because the responsible town officials knew that the homeowner was disabled.\textsuperscript{93} The Supreme Court’s due process jurisprudence, as it had developed at the time of the original state court litigation in Lowe, is discussed in subsection A, infra.

The Illinois Appellate Court also had decided a seminal case applying \textit{Mullane} and \textit{Covey} to a tax lien sale when the tax purchaser knew that the homeowner was disabled. In that case, \textit{In re Otsus},\textsuperscript{94} the court invalidated the tax sale on due process grounds even though all of the statutory notice requirements had been followed. \textit{In re Otsus} is discussed in subsection B, infra.

\textit{Covey} and \textit{In re Otsus} both involved situations in which the homeowner’s disabilities were known to the party responsible for providing notice. As discussed below, the Illinois trial court in \textit{Mary Lowe} found that Ms. Lowe’s mental illness was immaterial because Apex did not know that she suffered from mental illness. Of course, Apex easily could have discovered that fact if it had followed up on Ms. Hightower’s notations or contacted the post office for a new address. Moreover, courts in three other states – Pennsylvania, New York, and Oklahoma — have reached the opposite conclusion. In those states, courts have applied the \textit{Mullane} and \textit{Covey} standards to invalidate tax liens when the party responsible for giving notice did not know the homeowner was disabled.\textsuperscript{95} The

\textsuperscript{87} Id.
\textsuperscript{88} Id.
\textsuperscript{89} Id. §§ 197.582, 197.502(4), 197.473.
\textsuperscript{91} Covey v. Town of Somers, 351 U.S. 141 (1956).
\textsuperscript{93} Covey at 141.
\textsuperscript{94} In re Otsus.
\textsuperscript{95} In re Consolidated Return of Tax Claim Bureau of County of Del., 461 A.2d 1329 (Pa. Commw. Ct.
issue also was raised in a fourth state, Florida, which held that Mullane and Covey did not require the setting aside of a lien or sale when the party responsible for giving notice was not aware of the disability.96 These cases are discussed in subsection C, infra.

A. The Supreme Court’s Due Process Jurisprudence

1. Mullane v. Central Hanover Bank and Trust Co. and its Progeny — Publication Notice Violates Due Process When Person’s Location is Known or Ascertainable through Reasonable Inquiry

In 1950, the United States Supreme Court decided Mullane v. Central Hanover Bank and Trust Co.97 In Mullane, the Court considered what type of notice was constitutionally required to advise known trust beneficiaries of a proposed judicial settlement of accounts. Under New York law, only publication notice was required, even when the names and addresses of the beneficiaries were known. A court-appointed special guardian argued that publication notice was not constitutionally sufficient to afford due process to the known trust beneficiaries under the Fourteenth Amendment. The trial court held that publication notice was sufficient, overruled the special guardian’s objections, and entered a final decree settling the accounts.98 The appellate division of the New York Supreme Court, New York’s intermediate reviewing court, affirmed that decision without opinion, with one justice dissenting.99 The New York Court of Appeals, the state’s highest court, likewise affirmed.100

The United States Supreme Court reversed, holding that mere publication notice did not satisfy constitutional requirements in the case of known trust beneficiaries. In so holding, the Court articulated its now-classic statement of what due process requires:

An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections…. [W]hen notice is a person’s due, process which is a mere gesture is not due process. The means employed must be such as one desirous of actually informing the absentee might reasonably adopt to accomplish it.101

Over the years, the United States Supreme Court has reaffirmed the Mullane principle in various cases, including one in which the Court specifically addressed forced tax lien sales. In Mennonite Board of Missions v. Adams,102 the Court held that publication

96 Stubbs v. Cummings, 336 So. 2d 412 (Fla. App.1976).
98 Id. at 307-311.
100 In re Central Hanover Bank & Trust Co., 87 N.E.2d 73 (N.Y. 1949).
notice in a tax lien case will not satisfy due process if the interested party is reasonably identifiable. In *Mennonite Board*, notice of a tax sale was provided in accordance with an Indiana statute that required only posting in the county courthouse and publication once a week for three consecutive weeks.\(^{103}\) Finding that method of providing notice insufficient to satisfy due process, the Court explained:

> Because they are designed primarily to attract prospective purchasers to the tax sale, publication and posting are unlikely to reach those who, although they have an interest in the property, do not make special efforts to keep abreast of such notices.\(^{104}\)

In *Tulsa Professional Collection Services, Inc. v. Pope*,\(^{105}\) the Court further emphasized the limitations inherent in publication notice and the constitutional importance of efforts to provide actual notice. The issue in *Tulsa* was whether Oklahoma’s probate code, which allowed only publication notice to estate creditors and cut off most creditors’ claims not brought within two months of the publication, complied with the Due Process Clause.\(^{106}\) The Supreme Court held that it did not.\(^{107}\) Although Oklahoma had an interest in the expeditious conclusion of probate proceedings, the Court held that “a requirement of actual notice to known or reasonably ascertainable creditors is not so cumbersome as to unduly hinder the dispatch with which probate proceedings are conducted.”\(^{108}\)

2. *Covey v. Town of Somers* — Tax Lien Notice Was Constitutionally Inadequate When City Officials Knew Homeowner Was Disabled

Six years after *Mullane*, the Supreme Court applied the principles articulated in that case to invalidate a tax lien sale because town officials knew that the homeowner, Nora Brainard, was disabled. The Town of Somers, following the applicable New York statute, served Ms. Brainard by mail, by posting notice at the post office, and by publication in two local newspapers. When Ms. Brainard failed to respond, the court entered a judgment of foreclosure on September 8, 1952, and the deed to Ms. Brainard’s home was delivered to the town on October 24, 1952. Five days later, on October 29, 1952, the county court certified Ms. Brainard as a person of unsound mind in a separate proceeding, and she was committed to a state mental health hospital one week later.\(^{109}\)

The town later sought to sell the property for a minimum bid of $6,500. Ms. Brainard’s guardian, who was appointed only after the town had already obtained the deed to Ms. Brainard’s home, offered to pay the town $480, which represented the unpaid taxes, interest, penalties, costs of foreclosure, attorneys fees and maintenance costs on Ms. Brainard’s home. The town declined the offer.\(^{110}\)

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103 *Id.* at 791.
104 *Id.* at 799.
106 *Id.* at 480-81.
107 *Id.*
108 *Id.* at 490.
110 *Id.* at 144-45.
Ms. Brainard’s guardian then moved to set aside the default judgment and deed as repugnant to the Due Process Clause. The trial court denied the motion.111 The appellate division of the New York Supreme Court and the New York Court of Appeals both affirmed.112

The United States Supreme Court reversed, holding that when a homeowner had no guardian, and was known by municipal officials to lack the mental capacity to handle her affairs or understand the notice, service on the homeowner did not satisfy the requirements of due process. Referring to Mullane, the Court held:

Notice to a person known to be an incompetent who is without the protection of a guardian does not measure up to this requirement…. [Where] the taxpayer Nora Brainard was wholly unable to understand the nature of the proceedings against her property…and the town authorities knew her to be an unprotected incompetent, we must hold that compliance with the statute would not afford notice to the incompetent and that a taking under such circumstances would be without due process of law.113

B. In re Otsus – Seminal Illinois Case Addressing Notice to Known Incompetent Homeowner

In Illinois, In re Otsus114 is the seminal state case applying Covey and Mullane and addressing the adequacy of notice given in a tax deed proceeding to a disabled homeowner. Eleanor Otsus, whose mental illness was well known in her community, lost her home at a tax sale because she had not paid $8,600 in taxes. National Indemnity Corporation purchased Ms. Otsus’s delinquent taxes. Pursuant to the Illinois statute, National served Ms. Otsus personally and by publication. The return of service indicated that the deputy sheriff believed that Ms. Otsus did not speak English, when in fact she did.115 Significantly, National also provided notice to PLOWS Council on Aging.116 Ms. Otsus’s right to redeem the property expired on July 6, 1987, and she did not redeem before that date.117

On July 21, 1987, 15 days after the end of the redemption period, the Public Guardian of Cook County was appointed to act as Ms. Otsus’s guardian. The Public Guardian filed a petition for a declaratory judgment. The petition averred that the property was worth at least $100,000 and it set forth extensive facts about Ms. Otsus’s disability, confusion, paranoia, inability to care for herself, and inability to understand or act on any notices that were sent.118 The Public Guardian argued that the notice provisions of the

111 Id. at 145.
113 Covey, 351 U.S. at 146-47.
115 Id. at 145-46.
116 Id. at 146. Although the In re Otsus opinion contains no more information about PLOWS Council on Aging than its name and some excerpts from a PLOWS report concerning Ms. Otsus, it is apparent from context that PLOWS is an agency providing social services for elderly persons.
117 Id.
118 Id.
tax code were constitutionally insufficient, as applied to Ms. Otsus, because they “fail to take into account that persons living in a unique situation of disability cannot tell the difference between a piece of paper claiming to serve legal notice for the loss of property and a pizza advertisement.”\textsuperscript{119} The Public Guardian also argued that due process, in such circumstances, requires more than “mailing a notice to an incompetent, publishing notice to an incompetent in the Law Bulletin\textsuperscript{120} and having an untrained sheriff stick a piece of paper into the face of an incompetent woman.”\textsuperscript{121}

The trial court, finding compliance with all of the statutory requirements, including those relating to notice, dismissed the Public Guardian’s action.\textsuperscript{122} The Illinois Appellate Court reversed, finding that Covey was controlling and that the notice National gave to Ms. Otsus failed to comport with the Due Process Clause, even though it complied with Illinois statutory requirements:

\begin{quote}
We find that Covey controls our decision…. As in that case, Mrs. Otsus was known in her community as one lacking in competency, yet neither the authorities nor National made an attempt to have a guardian appointed to look after her interests. The record indicates that National became aware of PLOWS’ involvement with Mrs. Otsus as a result of its, National’s, conversations with the Village…; therefore, we can reasonably conclude that both National and the village knew of Mrs. Otsus’ diminished capacity….
\end{quote}

By serving PLOWS, National demonstrated that it was aware that Mrs. Otsus was in need of assistance and that its purchase of her property was neither routine nor of the ordinary sort. It now argues that technical compliance with the statutory notice requirements was sufficient to give her notice that her property had been sold; however, National knew or should have known that such notice was inadequate to inform Mrs. Otsus that her interest in her property was at risk.\textsuperscript{123}

C. State Tax Sale Cases Addressing Notice to Disabled Homeowner When Party Required to Give Notice was Unaware of Homeowner’s Disability

In Covey and In re Otsus, the homeowner’s disability was known to the party required to give notice. As discussed below, the trial court in Mary Lowe’s case found that Apex was unaware of Ms. Lowe’s disability, and that In re Otsus was applicable only to cases in which the homeowner’s disability was known.

Three state appellate courts and one state supreme court have addressed the validity of tax lien sales in circumstances in which it was not shown that the tax purchaser knew of the homeowner’s infirmities. In three of those cases, the courts applied Mullane

\footnotesize{\textsuperscript{119} Id. at 147.}
\footnotesize{\textsuperscript{120} The Chicago Daily Law Bulletin is a legal trade publication.}
\footnotesize{\textsuperscript{121} In re Otsus at 147.}
\footnotesize{\textsuperscript{122} Id. at 146-47.}
\footnotesize{\textsuperscript{123} Id. at 150.}
and Covey to invalidate the tax sale for want of due process.\textsuperscript{124} In the fourth case, a court reached the opposite result.\textsuperscript{125}


In \textit{In re Consolidated Return of the Tax Claim Bureau of the County of Delaware},\textsuperscript{126} the Commonwealth Court of Pennsylvania, an intermediate reviewing court, held that a tax sale could not be justified under the Due Process Clause when the tax deed petitioner had complied with all statutory notice requirements and was unaware that the homeowner was mentally incompetent. A tax scavenger, Glyder Realty Corporation, was the highest bidder at the tax sale. The sale was confirmed and a tax deed was issued to Glyder. When Glyder attempted to evict the homeowner, the homeowner’s competency was raised for the first time.\textsuperscript{127}

After an evidentiary hearing, the trial court found that the homeowner was incompetent, that she was incapable of understanding the meaning or significance of the notices of the tax sale, and that she was, therefore, incapable of taking action to prevent her home from being sold. The trial court ordered the tax sale to be set aside.\textsuperscript{128}

The appellate court affirmed. The court acknowledged that Covey was factually distinguishable because Glyder, unlike the town officials in Covey, was not aware of the homeowner’s disabilities. The court nonetheless applied Covey’s analysis, holding: “To give notice to a person who cannot comprehend it through no fault of that person is a ‘mere gesture’ which [does] not afford the notice required to satisfy the requirements of the United States Constitution, thus rendering a tax sale pursuant to such defective notice invalid.”\textsuperscript{129}

If the tax sale could be vacated due to the homeowner’s incompetence, the scavenger argued on appeal, all tax sales would be vulnerable to disruption and that would jeopardize the integrity of land titles.\textsuperscript{130} The appellate court rejected the scavenger’s position, and concluded with this observation: “We are here dealing not only with the integrity of real estate title but also with concepts of fundamental due process. In such a context…the rights of the individual to whom process is due must prevail.”\textsuperscript{131}


In \textit{Blum v. Stone},\textsuperscript{132} the appellate division of the New York Supreme Court reversed the trial court’s determination that a disabled homeowner had failed to prove a due process violation because the homeowner could not establish that the tax deed petitioner

\textsuperscript{125} Stubbs v. Cummings, 336 So. 2d 412 (Fla. App. 1976).
\textsuperscript{126} \textit{In re Consolidated}, 461 A.2d 1329.
\textsuperscript{127} \textit{Id.} at 1330.
\textsuperscript{128} \textit{Id.}
\textsuperscript{129} \textit{Id.} at 1332.
\textsuperscript{130} \textit{Id.} at 1332-33.
\textsuperscript{131} \textit{Id.} at 1333.
known that the homeowner was mentally incompetent. The homeowner, Naomi Blum, purchased her home in 1947. She regularly paid all the real estate taxes and other obligations for 32 years, until 1979, when she developed senile dementia. In 1980, when Ms. Blum was 93 years old, her taxes were sold to Shirley Stone. Ms. Blum did not redeem within the permissible time period, and Ms. Stone received a tax deed to Ms. Blum’s home.133

Ms. Blum died shortly thereafter and her son, Walter Blum, moved to invalidate the tax sale. Following an evidentiary hearing, the trial court found that Ms. Stone did not have actual or constructive notice of Ms. Blum’s reputed incompetency. Holding that Covey would warrant vacating a tax sale only if Ms. Stone or the county treasurer knew or should have known that Ms. Blum was incompetent, the trial court declined to receive evidence of Ms. Blum’s actual incompetence and rejected Mr. Blum’s due process challenge.134

The appellate court reversed, finding that Mr. Blum should have been permitted to present testimony regarding his mother’s lack of competency.135 The court expressly rejected the purchaser’s interpretation of Covey as requiring that the notifying party have actual or constructive knowledge of a homeowner’s incompetence: “Nowhere in the Covey case is there mention of a requirement that there must be proof that the party serving the notice…knew or should have known that the owner of [the] property was an unprotected incompetent.”136


In Vance v. Federal National Mortgage Ass’n,137 the Federal National Mortgage Association (FNMA) initiated a foreclosure action against Susan and Gary Vance, a married couple who jointly owned a home. Service was attempted on both owners, but personal service was made successfully only upon the wife. When Ms. Vance did not appear, FNMA secured a default judgment.138

The Vances initiated an action for vacatur. They alleged that Ms. Vance suffered from paranoid schizophrenia and was incapable of understanding the significance of the process served on her. That issue was not adjudicated, however. There were conflicting allegations as to whether FNMA knew of Ms. Vance’s schizophrenia, and that issue was likewise not adjudicated. FNMA moved for summary judgment only against Ms. Vance, which the trial court granted. The Oklahoma Court of Civil Appeals affirmed.139

The Oklahoma Supreme Court reversed the summary judgment due to unresolved issues of material fact. The Court held that the Due Process Clause requires more than mere compliance with procedural formalities; it guarantees that the procedure be fair in fact.140 The Court adopted a “totality of the circumstances” test to determine whether service is sufficient to impart the kind of notice that is constitutionally prescribed: “The

133 Id. at 550-51.
134 Id. at 551, 552-53.
135 Id. at 551-52.
136 Id. at 553.
138 Id. at 1277.
139 Id. at 1278-79.
140 Id. at 1280.
adopted test requires that under all the circumstances present in a case there be a reasonable probability the service of process employed apprises its recipient of the plaintiff’s pressed demands and the result attendant to default.”141

Not only was there no factual determination as to Ms. Vance’s level of capacity, there was no adjudication of FNMA’s knowledge of it. Under Covey, the Vance court held, FNMA’s knowledge of Ms. Vance’s incapacity is a material consideration. However, while the lender’s knowledge of Ms. Vance’s incompetence “can be a factor in deciding whether to vacate, proper analysis still requires the trial court’s primary focus in its ‘due process’ assessment to be on Susan’s capacity to understand the service of process.”142 The Court held that “if under the totality of the circumstances the trial court determines that Susan was so mentally challenged that she did not appreciate the notice imparted by service of process, the summary judgment…will be invalid…and subject to vacation.”143


While the In re Consolidated Return, Blum, and Vance cases teach that a forced sale may be vacated for want of due process even if the party required to give notice was not aware of the homeowner’s disability, a Florida appellate court reached the opposite result in Stubbs v Cummings.144 Bella Hicks inherited a home in 1958, but the property remained on the tax rolls under the name of a deceased relative, Nellie Reeves. Although the tax statements continued to be sent to the attention of Ms. Reeves, Ms. Hicks paid the taxes each year until 1968, when no payment was made. Edsel and Virginia McNeil purchased the taxes in 1970, and a tax deed issued to them in 1972.145

In 1968, Ms. Hicks was declared legally incompetent, but no guardian was appointed. Ms. Hicks died in 1972, and an executrix was appointed to administer Ms. Hicks’s estate. The tax deed issued after Ms. Hicks’s death but before the appointment of her executrix. Moreover, all notices relating to the delinquent taxes and the issuance of the tax deed had been addressed to Ms. Reeves, not Ms. Hicks. At the time, Ms. Reeves had been dead for more than 14 years. It was not shown that any of the officials involved in the tax deed proceeding had knowledge that the home belonged to Ms. Hicks or that Ms. Hicks had been adjudged incompetent.146

The executrix moved to set aside the tax deed based on Ms. Hicks’s adjudicated incapacity at all applicable times, and because the tax deed issued after her death and at a time when her estate was not yet represented. The trial court dismissed the complaint.147

The Florida district court of appeals affirmed. The court interpreted Covey as holding that due process is offended only if the party serving notice knows of the homeowner’s disability.148

141 Id. (emphasis in original).
142 Id. at 1281.
143 Id.
144 Stubbs v. Cummings, 336 So. 2d 412 (Fla. App. 1976).
145 Id. at 413.
146 Id.
147 Id.
148 Id. at 415.
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Stubbs was decided before Blum and Vance, but neither case mentioned Stubbs. Only In re Consolidated Return addressed Stubbs, and that court declined to follow the holding in Stubbs.149

VI. ILLINOIS TRIAL AND APPELLATE LITIGATION

This article will now discuss the litigation in the Illinois trial and appellate courts seeking recovery of Ms. Lowe’s home.

A. Trial Court Litigation

On November 10, 1997, shortly after the trial court appointed the Public Guardian as attorney and guardian ad litem for Ms. Lowe, the Public Guardian filed a petition to set aside the tax deed.150

1. Bona Fide Purchaser Issue

On August 12, 1998, John Herndon moved to dismiss the Public Guardian’s amended petition, claiming that he was a bona fide purchaser by virtue of a December 6, 1996, installment contract with Apex to purchase the property for $10,000. In April 1999, the Public Guardian moved for partial summary judgment, asking the court to find that Mr. Herndon was not a bona fide purchaser.151 The court granted the Public Guardian’s motion and denied Mr. Herndon’s. In doing so, the court charged Apex and Mr. Herndon with actual or constructive knowledge that Ms. Lowe was hospitalized and did not receive the notices:

Tax purchaser Apex ‘knew’ or ‘should have known’ that [Ms. Lowe] was in the hospital. It has either actual or constructive notice of the circumstances. Actual if it had exercised due diligence in reviewing the court file before prove-up, or constructive notice if it failed to exercise due diligence. Apex should have or would have noted the Post Office notation on the return envelope — and likely would not have filed an affidavit of complying with due diligence in its inquiry and service of notice as required by [the] Property Tax Code.152

2. Evidentiary Hearing

The Public Guardian’s amended petition proceeded to an evidentiary hearing on the remaining issues on February 20, 2002. The trial judge who had ruled on the bona fide purchaser issue had retired from the bench in July 1999, and a different judge therefore presided over the hearing.153 The Public Guardian presented evidence, but no other party chose to do so.154

150 Mary Lowe I at 912-13.
151 Mary Lowe I at 912, 913.
152 C340.
153 C541.
154 Mary Lowe I at 914.
The Public Guardian called Bernard Rubin, M.D., a practicing psychiatrist with 47 years’ experience who was stipulated as an expert. Dr. Rubin described Ms. Lowe’s chronic schizophrenic disorder and her 27 psychiatric hospitalizations from 1964 through 1996. Based on his review of the records, Dr. Rubin concluded that, from January 1995 to October 1996, Ms. Lowe was incompetent, unfit to handle any social or business necessities that arose in her life, and in need of a guardian. She would have been unable to understand or respond to legal documents served on her during this time. The court admitted Dr. Rubin’s expert report and the medical records from several of Ms. Lowe’s psychiatric hospitalizations.155

The Public Guardian then called Jewel Hightower, the letter carrier who had made notations on the envelopes that were sent to Ms. Lowe and returned to their sender. Ms. Hightower described Ms. Lowe’s strange behaviors, based on her own observations and those related to her by Ms. Lowe’s neighbors.156 Those behaviors included coming outside without dressing, shouting obscenities, moving furniture to the curb, and screaming at passersby.157 In August 1995, Ms. Hightower learned from one of Ms. Lowe’s neighbors that Ms. Lowe was hospitalized at Tinley Park Mental Health Center. Ms. Hightower noted this fact on a card maintained at the branch post office. She also testified as to how she marked and returned the letters addressed to Ms. Lowe, Mr. Austin, and “occupant.”158 According to Ms. Hightower, no one ever contacted her or anyone at the branch post office concerning the letters. If anyone had asked her, Ms. Hightower would have told them that Ms. Lowe was hospitalized at Tinley Park Mental Health Center. In addition, anyone could have discovered Ms. Lowe’s whereabouts by filling out a form at the branch post office. The returned certified letters were admitted in evidence.159

The Public Guardian rested. Apex and Mr. Herndon rested without presenting any evidence.160

3. Trial Court’s Ruling

On April 9, 2003, the trial court denied the Public Guardian’s petition to set aside the tax deed. The court found that Dr. Rubin was correct in his expert opinion that Ms. Lowe was incompetent.161 The court also found that, “given Ms. Lowe’s capacity, even if she had received notice, she wouldn’t have been able, in all likelihood, to understand or act upon it.”162

The court did not overturn the prior judge’s finding that Apex had actual or constructive knowledge that Ms. Lowe was hospitalized and failed to receive notice of the tax deed proceeding. However, the court found that Ms. Hightower’s notations were not sufficient to charge Apex with knowledge that Ms. Lowe was mentally ill. The court reasoned that Apex may have known that Ms. Lowe was hospitalized, but there was no

155 Mary Lowe I at 914-15, SRII 17-50, EX93-460.
156 Mary Lowe I at 915, SRII 57-61.
157 SRII 54-62, 82-87.
158 Mary Lowe I at 915, SRII 64-66, 70, 72, 76, 82-83.
159 Mary Lowe I at 915, SRII 80, 84.
160 SRII 145, 157-59.
161 Mary Lowe I at 915.
162 Id.
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reason for Apex to have known that Ms. Lowe was hospitalized for psychiatric reasons. Although the Public Guardian argued that the most rudimentary investigation of Ms. Hightower’s notations would have led to Apex’s actual knowledge of Ms. Lowe’s mental illness, the court found that Apex had no duty to do anything to follow up on the notations. In the trial court’s view, therefore, Ms. Lowe had not been denied due process.163

B. Illinois Appellate Court Affirms

A panel of the Illinois Appellate Court affirmed in an unpublished opinion.164 Like the trial court, the appellate court concluded that Apex’s knowledge of Ms. Lowe’s hospitalization was not a sufficient basis for presuming that Apex had knowledge of her mental illness. The court distinguished Covey and In re Otsus based on the trial court’s finding that Apex had not actually known that Ms. Lowe was mentally incompetent when it provided notice to her, whereas the fact of mental incompetence was actually known by the party required to give notice in Covey and In re Otsus.165 The appellate court did not consider whether Apex was required — based on its knowledge of Ms. Lowe’s hospitalization and the clues that Apex had as to Ms. Lowe’s actual whereabouts — to undertake any additional investigation.

The court declined to follow Consolidated Return and Blum, finding them inapplicable in light of In re Otsus.166 Since Consolidated Return and Blum were both decided before In re Otsus, but were not mentioned in the opinion in In re Otsus, the Illinois Appellate Court treated the rule stated in the two cases as having been implicitly rejected by the In re Otsus court.167 Of course, there was no need for the In re Otsus court to refer to these cases because the same issue was not presented in In re Otsus; it was uncontested that the party giving notice was aware of the homeowner’s disabilities. The appellate court also distinguished Vance on the ground that it “focused primarily on the propriety of summary judgment.”168 Finally, the court rejected the Public Guardian’s arguments that Apex had failed to exercise “due diligence” in locating and serving Ms. Lowe, or that its conduct constituted fraud or deception, under state law.169

C. Round One in the Illinois Supreme Court, Which Affirms the Decision of the Appellate Court

The Public Guardian filed a petition for leave to appeal, which the Illinois Supreme Court granted.170 After full briefing and oral argument, the Illinois Supreme Court affirmed the decisions of the trial and appellate courts on October 20, 2005.171 The Illinois Supreme Court’s decision was unanimous, with one Justice not participating.

The Illinois Supreme Court began by rejecting the Public Guardian’s state law argu-

163 Id. at 915-16.
164 Because the appellate court’s opinion is unpublished, citations are to the court’s slip opinion.
166 Id. at 13.
167 Id.
168 Id.
169 Id. at 14-20.
170 Petition of Apex Tax Invs., Inc. v. Lowe, 807 N.E.2d 975 (Ill. 2004).
171 Mary Lowe I.
ments that Apex had failed to show “due diligence” in its attempt to locate and serve Ms. Lowe and that its conduct constituted fraud or deception.\(^\text{172}\) The Court then addressed the Public Guardian’s federal due process claims. The Court observed that Ms. Lowe was hospitalized and received no notices from January 1995 through October 1996. According to the Court, however, it was significant that the record contained no information concerning Ms. Lowe’s mental competence in 1993, when the county collector filed an application for judgment and order of sale in the state trial court. At that stage, the collector was required to give notice to the homeowner by certified or registered mail and by publication. In addition, after the state trial court entered the order of sale, the statute required Apex to arrange for the county clerk to send a notice by registered or certified mail.\(^\text{173}\) The record was silent as to whether these earlier notices were sent or received. Significantly, the statute requires the giving of notice, but it does not require that the homeowner be advised of the time and place of the hearing on the petition for the tax deed, so that the homeowner can appear and object.\(^\text{174}\)

The relevance of the earlier notices (and Ms. Lowe’s mental competence at the time they were required to be given) was not an issue raised by Apex or Mr. Herndon, but the Illinois Supreme Court, itself, raised the question of whether these notices should be considered as part of the due process analysis.\(^\text{175}\) In any event, the Court concluded that it need not address the constitutional adequacy of the earlier notices because the notices challenged by the Public Guardian — \(i.e.,\) the notices of Apex’s petition for a tax deed and Ms. Lowe’s redemption rights that were returned unserved due to Ms. Lowe’s hospitalization — were, themselves, sufficient to satisfy the requirements of the Due Process Clause.\(^\text{176}\)

After summarizing the standards articulated in \textit{Mullane, Mennonite Board} and \textit{Tulsa Professional Collection}, the Court emphasized that the test is not whether the notice procedure actually succeeds in notifying the individual, but whether the procedure is reasonably calculated to do so.\(^\text{177}\) The Court found that that test was satisfied in Ms. Lowe’s case.

The Illinois Supreme Court agreed with the appellate court that the \textit{Covey} decision was not controlling because its holding was limited to cases in which the party responsible for giving notice was aware of the homeowner’s disabilities.\(^\text{178}\) The Illinois Supreme Court rejected reliance on \textit{Covey} for the additional reason that “the argument rests on the assertion that Apex did not conduct a diligent inquiry into ascertaining Mary Lowe’s whereabouts…. In this case, the circuit court…held that Apex had made a diligent inquiry to locate Mary Lowe.”\(^\text{179}\) The Court held, \textit{sua sponte}, that any federal constitutional challenge to the adequacy of the notice given to Ms. Lowe was barred by the trial court’s finding of diligent inquiry, even though that finding was based on Illinois state statutory and

\begin{itemize}
\item \textit{Id.} at 919-23.
\item \textit{Id.} at 923-24.
\item \textit{Id.} at 924.
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.} at 928.
\item \textit{Id.} at 927.
\item \textit{Id.}
\end{itemize}
constitutional standards (rather than on federal constitutional standards) and was entered following an *ex parte* hearing that was held without notice to Ms. Lowe.\footnote{Id.}

Finally, the Illinois Supreme Court addressed *In re Consolidated Return, Blum and Vance* in one paragraph. The Court noted that the appellate court had distinguished these cases on their facts, but, to the extent that these decisions supported the Public Guardian’s position and were not distinguishable, they were “not persuasive” because they rested on the assumption that due process requires actual notification, rather than reasonable notice procedures.\footnote{Id.} The Court also observed that Ms. Lowe did not lack a remedy, because she could seek relief from the indemnity fund.\footnote{Id. at 922-23. Indemnity fund proceedings, and the inherent limitations of such proceedings in making a disabled homeowner whole, are discussed in Section IX, *infra*.}

VII. **UNITED STATES SUPREME COURT DECIDES JONES V. FLOWERS, GRANTS CERTIORARI IN LOWE, AND VACATES THE ILLINOIS SUPREME COURT’S JUDGMENT**

A. *Public Guardian’s Petition for Certiorari*

On September 27, 2005, approximately three weeks before the Illinois Supreme Court ruled in *Mary Lowe I*, the United States Supreme Court granted certiorari in *Jones v. Flowers*.\footnote{Jones v. Flowers, 545 U.S. 1165 (2005).} In *Jones*, which is discussed in more detail in subsection B, *infra*, the Arkansas Supreme Court had affirmed the issuance of a tax deed when the party responsible for giving notice knew that the homeowner did not receive actual notice. The notices were sent via certified mail and returned with the notation “unclaimed.” One of the questions on which the United States Supreme Court granted certiorari was the following:

> When mailed notice of a tax sale or property forfeiture is returned undelivered, does due process require the government to make any additional effort to locate the owner before taking the property?

While *Jones* was being briefed in the United States Supreme Court, the Public Guardian filed a petition for a writ of certiorari on behalf of Ms. Lowe’s estate. In his petition, the Public Guardian presented three questions, the first of which was the same as that on which the Court granted certiorari in *Jones*. A second question, however, was predicated on a significant factual difference between the two cases: Whereas the *Jones* notices were returned with no clues or comments, the notations made by Ms. Hightower showed that Ms. Lowe was hospitalized and, by including Ms. Hightower’s initials and route number, indicated a source of additional information. Thus, the Public Guardian asked the Court to grant certiorari to determine whether the Due Process Clause, even absent a general duty to make additional efforts to locate a homeowner before her property is taken, nonetheless imposes such a duty when the returned, unserved notices contain information that is reasonably likely to lead to the discovery of the homeowner’s whereabouts or disability. Finally, the Public Guardian asked the Court to grant certiorari to de-
termine whether, consistent with the Due Process Clause, a finding of due diligence made as a matter of state law in an ex parte proceeding can foreclose a homeowner who did not receive notice of the proceeding from challenging, on federal constitutional grounds, the adequacy of the efforts made to determine her whereabouts.

B. United States Supreme Court Decides Jones and Holds That When Officials Know Homeowner Did Not Receive Notice, They Must Take Additional Reasonable Steps

The United States Supreme Court announced its decision in Jones v. Flowers on April 26, 2006. Speaking through the Chief Justice, a majority of the Court held that, when the state knows that a homeowner did not receive notice of a tax sale proceeding, the state must take reasonable additional steps to provide notice.

Gary Jones purchased his home in 1967. He lived there with his wife until they separated in 1993. Mr. Jones moved elsewhere and his wife continued to live in the family home. Mr. Jones paid the mortgage every month for 30 years, and the mortgage company paid the property taxes during that period. After Mr. Jones paid off the mortgage in 1997, the property taxes went unpaid and the property was certified as delinquent. In April 2000, the Commissioner of State Lands gave notice of the tax delinquency and redemption rights by certified mail sent to the address of the family home. Nobody was home to sign for the letter, and nobody appeared at the post office to claim the letter within 15 days. Thereafter, the letter was marked “unclaimed” and returned to the Commissioner. The Commissioner also gave publication notice. Linda Flowers submitted an offer to buy the property, and the Commissioner sent another notice to Mr. Jones by certified mail. That letter was likewise marked “unclaimed” and returned to the Commissioner. Ms. Flowers purchased the home, valued at $80,000, for $21,042.

Mr. Jones sued the Commissioner and Ms. Flowers in state court, alleging that notice was not sufficient under the Due Process Clause. The trial court granted summary judgment in favor of the Commissioner and Ms. Flowers, finding that the statutory procedures had been followed and that those procedures complied with due process. The Arkansas Supreme Court affirmed.

The United States Supreme Court granted certiorari and reversed. In the Supreme Court, the Commissioner argued that due process was satisfied once he provided notice reasonably calculated to apprise Mr. Jones of the impending tax sale by mailing him a certified letter. The Supreme Court held to the contrary. Although the notice sent to Mr. Jones was reasonably calculated to give notice to him at the time it was sent, the Court held that the Commissioner was obligated, when the notice was returned unclaimed, to take additional reasonable steps to attempt to provide actual notice to the homeowner, if practicable to do so. Citing Mullane, the Court observed that it did “not think that a

185 Id. at 223.
186 Id. at 223-24.
187 Id. at 224.
190 Id. at 226.
191 Id. at 225.
person who actually desired to inform a real property owner of an impending tax sale of a house he owns would do nothing when a certified letter sent to the owner is returned unclaimed.”192 On the contrary, the Court concluded that “such a person would take further reasonable steps if any were available.”193

The Court analogized the facts presented in Jones to a situation in which the Commissioner would hand a stack of notices to the letter carrier and then watch as the carrier accidentally dropped the letters down a storm drain. In such circumstances, “one would certainly expect the Commissioner’s office to prepare a new stack of letters and send them again.”194 The Court held that the Commissioner’s failure to follow up would be unreasonable in such circumstances, even though the letters were reasonably calculated to reach the recipients when delivered to the letter carrier.195

Finally, the Court identified several additional steps that the Commissioner reasonably could have taken to provide notice to Mr. Jones. Such steps included the use of regular mail so that the letter would be received at the address without the requirement of a signature, and the posting of notice on the front door of the home.196 On the other hand, the Court held that the Commissioner was not obligated to engage in an “open-ended search” such as phonebooks or governmental records such as income tax rolls.197 The Court concluded by observing that, “In this case, the State is exerting extraordinary power against a property owner — taking and selling a house he owns. It is not too much to insist that the State do a bit more to attempt to let him know about it when the notice letter addressed to him is returned unclaimed.”198

C. United States Supreme Court Grants Certiorari in Mary Lowe and Vacates Illinois Supreme Court’s Judgment

On May 22, 2006, less than a month after it released its opinion in Jones, the United States Supreme Court entered an order granting Ms. Lowe’s petition for a writ of certiorari, vacating the judgment of the Illinois Supreme Court, and remanding the case for further consideration in light of Jones.199

VIII. ROUND TWO IN THE ILLINOIS AND UNITED STATES SUPREME COURTS

A. Illinois Supreme Court Affirms for Second Time

On remand, following supplemental briefing and oral argument, a divided Illinois Supreme Court, with only five of seven justices participating, again affirmed the trial court’s denial of Ms. Lowe’s petition to set aside the tax deed.200 The Court distinguished Jones on the ground that the notice requirements under Illinois law are more comprehen-

192 Id. at 229.
193 Id.
194 Id.
195 Id.
196 Id. at 235.
197 Id. at 235-36.
198 Id. at 239.
200 Mary Lowe II.
sive than those contained in the Arkansas statute. The Court also distinguished Jones on the ground that Jones concerned the notice required before taking the property, whereas in Lowe the notice at issue that Apex was required to give was after it had received a certificate of sale entitling it to petition for a tax deed, and after the redemption period had expired.

According to the Illinois Supreme Court, Jones did not charge Apex with any duty to undertake further action or investigation based on the notations concerning Ms. Lowe’s hospitalization and Ms. Hightower’s initials and route number. According to the Court, requiring Apex to follow up on those notations would be akin to the “open-search” that Jones found not to be required by the Due Process Clause.

Finally, the Court declined to revisit its previous holding that Ms. Lowe’s federal constitutional challenge was barred by the due diligence finding that the trial court made as a matter of state law in the ex parte prove-up proceeding. The court reasoned that its “reconsideration of this case is limited to…whether Apex’s notice to Lowe satisfied due process under Jones.”

Justice Kilbride dissented. He agreed that Jones involved notice at an earlier stage of the process leading to the ultimate loss of a home, but found that this difference actually cut in favor of Ms. Lowe. In Justice Kilbride’s view, the need for muscular due process protections was even more acute when the proceeding was not the first step in the deprivation of a person’s property, but the last. As Justice Kilbride recognized, the proceeding at issue in Ms. Lowe’s case represented her last clear chance to protect her property interests from final and irrevocable extinction. “Due to the magnitude and imminence of the risk of complete forfeiture, I believe that due process mandates even more stringent notice requirements than those required before the sale of the property.”

B. United States Supreme Court Denies Certiorari

The Public Guardian filed a second petition for a writ of certiorari in the United States Supreme Court. Consistent with Justice Kilbride’s dissent, the Public Guardian asked the Court to grant certiorari to consider whether the Due Process Clause requires that a homeowner receive constitutionally-sufficient notice of the hearing at which title to her home may be fully and finally extinguished, rather than simply at the time that the certificate is granted. The Public Guardian also asked the Court to consider whether the

201 Id. at 225.

202 Id. at 226-27. The substantive difference between the statutory schemes is minimal and, in the view of the authors, immaterial. In Illinois, the taking of a homeowner’s property for delinquent taxes happens in two distinct steps: the tax sale, and the issuance of the tax deed. These steps are separated by a 30-month redemption period. In Arkansas, these steps are consolidated in a single event at the end of a two-year redemption period. See Section IV, supra.

203 Mary Lowe II at 227-30, citing Jones, 547 U.S. at 236.

204 Mary Lowe II at 232.

205 Id. at 234 (emphasis in original).

206 Id. at 235.
party required to provide constitutionally-sufficient notice may ignore an undelivered, returned notice that contains new information simply because that party took some reasonable steps to provide notice before the new information came to its attention. Finally, the Public Guardian asked the Court to decide whether a state statute may preclude a homeowner, who did not receive actual notice of the tax deed proceeding at which her property rights were extinguished, from challenging the sufficiency of the notice of that proceeding on federal constitutional grounds. The United States Supreme Court denied Ms. Lowe’s second petition for certiorari.207

IX. ALTERNATIVE REMEDIES

In affirming the Illinois trial and appellate courts’ denial of Ms. Lowe’s petition to set aside the tax deed, the Illinois Supreme Court opined that Ms. Lowe had a remedy in the form of recovery from an indemnity fund.208 This fund is financed from a nominal fee scavengers pay when they purchase a property at a tax sale.209 Recovery against the fund is by means of an action against the county treasurer, as trustee of the fund, brought in the court that ordered issuance of the tax deed.210

A homeowner who “sustains loss or damage by reason of issuance of a tax deed… and who is barred or… precluded from bringing an action for recovery of the property” may seek recovery of the loss sustained.211 Recovery is limited to the fair cash value of the property on the date the tax deed issued, less the value of any mortgages and liens.212 The homeowner must demonstrate exhaustion of remedies.213 In addition, the indemnity award may not exceed $99,000 unless the homeowner demonstrates that the loss was “without fault or negligence” on her part and that she “exercised ordinary reasonable diligence under all of the circumstances.”214

Recovery from the indemnity fund provides an incomplete remedy for several reasons. First, because the fund is financed by fees paid by scavengers, the level of available funds varies from year to year, and claims against the fund sometime exceed its resources. When that happens (or appears likely to happen), homeowners may not receive the full market value of their homes. Moreover, the amount of the award is left to the “broad discretion” of the court, which must take into account equitable principles, including the level of available funds.215 Such discretionary and uncertain relief clearly is not an adequate substitute for the property right extinguished with the forced sale of someone’s home.

Most important, perhaps, is the fact that the scheme takes no account of the “hedonic”

209 35 Ill. Comp. Stat. 200/21-295. The fee for properties purchased in Cook County, which includes Chicago and the surrounding suburbs, is $80 plus 5 percent of the amount of the taxes, interest and penalties. The fee for properties purchased in other counties is $20. Id.
211 Id.
212 Id.
value that the home has for its owners. Most people who have lost their homes because of faulty notice and a small amount of unpaid taxes do not want to be “made whole” in a purely financial sense. They do not want a sum of money. What they want is to continue to live in their homes, where they have lived their lives and raised their families.

X. LEGISLATIVE EFFORTS

Over the years, the Public Guardian has proposed to the Illinois General Assembly various remedial measures designed to address the problem of homeowners with cognitive disabilities who stand to lose their homes because of small amounts of unpaid taxes. Unfortunately, the forces opposed to such reform are well organized and influential. To date, all efforts to pass remedial legislation in Illinois have been unsuccessful.

A. SB 2409 (2004)

In 2004, the Public Guardian proposed legislation that would have required the tax purchaser to serve notice on the county public guardian or other designated person in all cases in which the homeowner has not redeemed the taxes within the redemption period.\(^\text{216}\) The Public Guardian would be required to make a determination as to the homeowner’s capacity within 60 days of receiving notice, with the possibility of securing one 60-day extension based upon a showing of good cause.\(^\text{217}\) If the Public Guardian concluded that the homeowner might be disabled and in need of a guardian, the Public Guardian would petition for guardianship. Notice would be served on the tax purchaser, who would be entitled to appear to object to a finding that the homeowner was disabled during any portion of the redemption period. Upon the filing of a guardianship petition, the tax deed proceeding would be stayed.\(^\text{218}\) If the court in the guardianship proceeding were to find that the homeowner was disabled and unable to manage her estate during any portion of the redemption period, redemption would be allowed for a period of six months after the entry of that finding.\(^\text{219}\)

SB 2409 received the support of many groups, including the editorial board of the Chicago Tribune.\(^\text{220}\) However, the bill was opposed by the scavenger lobby. The bill passed the Illinois Senate but died in committee in the House of Representatives.

B. SB 2007 (2007)

In 2007, the Public Guardian proposed an alternative approach. This legislation would have required that notices of tax sale proceedings be served by first-class mail in addition to certified or registered mail.\(^\text{221}\) In addition, the legislation would have altered the grounds on which a tax deed is contestable. Under current state law, a tax deed is contestable on only four narrow grounds: (1) showing that the taxes were paid prior to the sale; (2) showing that the property was exempt from taxation; (3) proving that the tax

\(^\text{216}\) Ill. Senate Bill 2409 §§ (a) and (b) (2004).
\(^\text{217}\) Id. § (c).
\(^\text{218}\) Id. § (d).
\(^\text{219}\) Id.
\(^\text{221}\) Ill. Senate Bill 2007 (2007).
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The deed was procured by fraud or deception, which must be shown by clear and convincing evidence; or (4) showing that the homeowner was not named in the publication notice and the tax purchaser did not make diligent effort to serve the homeowner. The bill proposed by the Public Guardian would have eliminated this limitation, allowing homeowners to seek vacation of a tax deed based on the same grounds provided by law for the vacating of any judgment. SB 2007 died in committee in the Illinois Senate.

C. Current Efforts

The Public Guardian is currently preparing language for a new legislative effort. This legislation would provide that a tax deed shall not issue for property in which a person with cognitive disabilities has an ownership interest, and that any order issuing such a tax deed will be void ab initio. The legislation also would provide that it is to be construed in light of equitable principles, particularly the public policy in favor of protecting the rights of the disabled.

XI. Conclusion

Ms. Lowe’s case suggests three distinct scenarios for analysis under the Due Process Clause: (1) where actual notice has been attempted without success at the person’s home, and there are strong clues as to the person’s actual whereabouts; (2) where physical service is made on the homeowner, but her cognitive disabilities prevent her from understanding the significance of the notice, and the party required to give notice knows about the homeowner’s disabilities; and (3) where physical service is made on a cognitively impaired homeowner, but the party required to give notice does not have reason to know or suspect of the homeowner’s disabilities.

As for the first situation, there is an excellent argument that the Due Process Clause requires the party serving notice to follow up on the clues. The argument is based on Jones, as well as the Supreme Court’s due process jurisprudence leading up to Jones. As Ms. Lowe’s case demonstrates, however, scavengers can attempt to distinguish Jones based on differences in the particular state statutory scheme at issue.

The United States Constitution is less likely than legislation to provide sure and certain relief in this area. For this reason, the authors believe that there is a strong need for remedial legislation along the following lines. First, the party charged with locating and serving the homeowner should be an impartial public official, not a private party with an interest in obtaining the property. In addition, remedial legislation should provide explicitly that the party responsible for giving notice must make reasonable efforts to follow up on information he or she gains that might reasonably lead to the whereabouts of the homeowner. The test for reasonableness should be simple: If a private party were owed the amount of equity in the homeowner’s house, would he or she think that additional steps reasonably should be taken before giving up on collecting the debt? The legislation

222 See 35 ILL. COMP. STAT. 200/22-45.
224 Making the order void ab initio, as opposed to voidable, would avoid the problem of a tax scavenger quickly turning around and selling the disabled person’s home to a subsequent buyer who then claims to be a bona fide purchaser, as occurred in Ms. Lowe’s case.
should also provide that the party required to give notice is charged with knowledge of readily available matters of public record containing information about the homeowner’s whereabouts, and that the party required to give notice must make reasonable efforts to follow up on such information. The same test of reasonableness would apply. If the party serving notice fails to undertake such efforts, he or she will be charged with knowledge of the facts that he or she would have discovered upon reasonable inquiry.

As for the second scenario, it is clear that notice to a known disabled homeowner is no notice at all, but a violation of the Due Process Clause. That has been clear since the Supreme Court’s decision in Covey v. Town of Somers, and state tax sale cases addressing disabled homeowners have consistently followed that precedent.

Finally, it is unclear, as a constitutional matter, whether service on a homeowner who is cognitively disabled and unable to understand the meaning and significance of the notice is sufficient when the party providing notice has no reason to know or suspect that the homeowner is disabled. The United States Supreme Court has not addressed that issue. So far, of the five states that have ruled on this question, three — Pennsylvania, New York and Oklahoma — have held that such a taking violates the Due Process Clause. The remaining two states — Florida and Illinois — hold that the property may be taken in such circumstances consistent with due process standards.

Given the law’s uncertainty with respect to the protection afforded by the Due Process Clause to cognitively impaired homeowners whose impairments may be unknown to those charged with giving notice, the need for remedial legislation is clear. One approach is that taken by Arkansas, which provides for equitable redemption. In Arkansas, property belonging to a minor, insane person or person in confinement may be redeemed up until two years after removal of the disability. Notably, two jurisdictions, New Jersey and the District of Columbia, allow the disabled homeowner a right of equitable redemption pursuant to case law.

Other possible approaches include those proposed by the Public Guardian and discussed above. In particular, the authors favor the Illinois SB 2409 (2004) approach involving appointment of an impartial public official, as opposed to a private scavenger operating under a conflict of interest, to investigate cases of non-redemption. This approach also allows for equitable redemption if it turns out that the homeowner is disabled. Also of value would be legislation along the lines of the Public Guardian’s current effort, providing that a tax deed issued for property in which a disabled person has an ownership interest would be void ab initio. If that proposal were to be adopted, scavengers would have a strong interest in making sure that non-redemption was not the result of a disabled homeowner’s failure to receive or understand the notice. By taking the additional steps that were not taken in Mary Lowe’s case, the scavenger would minimize any possibility that its title might later be held invalid.

Remedial legislation to protect cognitively disabled homeowners from loss of their homes at forced tax sales is consistent with the protections that disabled persons already enjoy in other areas of the law. For example, in Illinois, as in most states, statutes of limi-
tations are tolled while a person is under a disability,\textsuperscript{227} and a contract or note entered into by a disabled person is void as against that person.\textsuperscript{228} These special rules are consistent with the strong public policy in favor of protecting our most vulnerable citizens. Certainly, such protections are no less warranted when a cognitively disabled person stands to lose her home – probably the most valuable asset that she has, from both a financial and an emotional viewpoint.

The State has a legitimate and important interest in collecting property taxes and in attaching the property of property owners who could, but choose not to pay their taxes. The State also has a legitimate and important interest in encouraging persons to purchase properties when such property owners have chosen not to pay their taxes. But if homeowners have not paid their taxes or responded to notices because they did not receive them, or could not understand what they did receive because of a cognitive disability, the State has no legitimate interest in taking their homes, or in encouraging others to buy them. In such circumstances, equitable redemption or other protection should be afforded the homeowners before they lose their homes forever. That can be done, as the Public Guardian’s legislative proposals show, without causing harm to the State or to those with a legitimate interest in purchasing properties owned by deadbeat taxpayers. It can be done, and fundamental fairness requires that it be done.

\textsuperscript{227} 735 ILL. COMP. STAT. 5/13-211.
\textsuperscript{228} 755 ILL. COMP. STAT. 5/11a-22.