FOREWORD
NAELA’S STUDENT JOURNAL

Rebecca C. Morgan, Esq.
Edwin M. Boyer, Esq. ................................................................. 1

ARTICLES
REVISITING THE INDIAN HEALTH CARE IMPROVEMENT ACT: A VOTE TO INCREASE LONG TERM
CARE SERVICES FOR RURAL NATIVE AMERICANS
Jacqueline A. Olexy ............................................................... 3

ARE NURSING HOMES NURSING THE NEEDS OF THE INDIAN AMERICAN IMMIGRANTS?
Shilpa M. Gokare ................................................................. 19

KELO AND THE SENIOR HOUSING CRISIS: HOW AN EMINENT DOMAIN–SENIOR HOUSING
PARTNERSHIP COULD BE BOTH ADVANTAGEOUS AND DESTRUCTIVE
Michael Nonaka ................................................................. 39

RELIANCE ON INADEQUATE GOVERNMENT PROGRAMS AND THE STRUGGLE FOR LONG-TERM
CARE
Todd A. Marquardt ............................................................. 61

I CAN STAY OR I CAN GO: IMPROVING CURRENT ASSISTANCE PROGRAMS TO INCREASE
CHOICES IN LOW-INCOME ELDERLY HOUSING
Lauren R. Sturm ................................................................. 91

THE SOLVENCY SOLUTION: HOW A “QUICK FIX” WILL ENSURE MEDICARE’S SOLVENCY
Jerry Carleton ................................................................. 113

LOST IN TRANSLATION? HOW CULTURALLY-SPECIFIC ADULT DAY CARE CENTERS CAN
IMPROVE THE LIVES AND HEALTH OF KOREAN ELDERLY LIVING IN NEW YORK CITY
Irene S. Kang ................................................................. 139

THE LEGACY OF MULTI-GENERATIONAL HOUSING—
ANSWERING THE PROBLEM OF THE GENERATION GAP
Junlin Ho ........................................................................ 147

ALZHEIMER’S DISEASE: MEDICARE’S DIRTY LITTLE SECRET
Meredith Leigh ................................................................. 155
It has been our privilege to see the completion of the first NAELA Student Journal Writing Contest and the first publication of the NAELA Student Journal. This year’s contest helped law students find greater interest in, and understanding of, diversity issues related to the field of Elder Law. The idea for the Journal came from NAELA president Lawrence Davidow, who described the Journal’s purpose as: “the goal of the NAELA Student Journal is to acquaint more students with elder law while creating an annual publication which addresses important diversity and minority related issues.”

The Committee creating this project included Ed Boyer, Doris Hawks, Becky Morgan, Barbara Hughes, Craig Reaves, Ruth Phelps, Bridget Jurich and Jonathan Boyle.

The winning article, Revisiting the Indian Health Care Improvement Act: An Important Step in Improving Access to Long Term Care Services for Rural Native Americans, was written by Penn State Dickinson Law School student Jacqueline A. Olexy. President Lawrence Davidow honored her at the Spring 2006 NAELA Symposium in Washington D.C., where she was presented with a $1,500 cash prize and funding for travel and meeting related expenses. The second place winner, Shilpa M. Gokare, a law student at Georgia State University College of Law wrote the article, Are Nursing Homes Nursing the Needs of the Indian American Immigrants? and received $1000 cash. The third place winner, Michael Nonaka, a law student at the University of Pennsylvania, received $500 cash for his article Kelo and the Senior Housing Crisis: How an Eminent Domain–Senior Housing Partnership Could Be Both Advantageous and Destructive. All the authors published in this volume received a complimentary one-year membership to NAELA. The articles for this year’s contest
were required to specifically address any topic related to one or more of the following three issues in an elder law practice: 1) diversity in senior housing, 2) diversity in access to health care, and 3) diversity in capacity and guardianship. Articles were judged on originality, accuracy, research, conciseness, analysis, and clarity of style and the winners were selected by a committee of Allan D. Bogutz, Ed Boyer, William J. Browning, and Becky Morgan.

This competition is open to all students in good standing who attend a law school full- or part-time within the United States. All articles must be original and previously unpublished. For more information about the writing contest, contact Bridget Jurich, NAELA Account Manager, at 520-881-4005 or bjurich@naela.com. We hope that you enjoy this first issue of the *NAELA Student Journal*. 
REVISITING THE INDIAN HEALTH CARE IMPROVEMENT ACT: A VOTE TO INCREASE LONG TERM CARE SERVICES FOR RURAL NATIVE AMERICANS

Jacqueline A. Olexy*

TABLE OF CONTENTS

INTRODUCTION ............................................................................................................... 4
I. LTC SERVICES & ELDERLY RURAL NATIVE AMERICANS ........................................... 5
   A. Factors impacting access to LTC .............................................................................. 6
   B. Who shoulders the responsibility to provide rural LTC? ........................................ 8
II. CURRENT PROVISIONS FOR FORMAL HEALTH CARE SERVICES ............................. 9
   Option 1: The primary provider, Indian Health Services (IHS) .................................. 9
   Option 2: Accessing services through outside contractors ...................................... 11
   Option 3: Self-governing compacts ........................................................................... 12
III. APPLYING THE INDIAN HEALTH CARE IMPROVEMENT ACT TO RURAL LTC ...... 13
   A. The most recent version of the IHCIA ................................................................. 15
   B. Proposed IHCIA provisions for LTC ................................................................. 15
IV. IHCIA REAUTHORIZATION - AN IMPERATIVE FOR RURAL LTC SERVICES .......... 16
CLOSING NOTES ............................................................................................................. 17

* Jacqueline A. Olexy, the winner of the 2006 NAELA Student Journal Writing Competition, is a 2006 graduate of The Pennsylvania State University Dickinson School of Law. She would like to extend a note of gratitude to Professor Katherine Pearson for her enthusiasm and motivation in encouraging the study of Elder Law.
“Policies that have been of most benefit to minority elderly in the contemporary era are those that have focused on raising the level of the floor in access and quality of medical care for all older persons.”

INTRODUCTION

Nearly twenty years ago, the federal government acknowledged that Indian Health Services (IHS) was remiss in its provision of geriatric health care and that older Native Americans lacked comprehensive long-term care (LTC) services. Shortly thereafter, the National Indian Council on Aging (NICOA) identified long-term care as the most pressing health-related issue facing elderly Native Americans. Time has passed, and research regarding Native American LTC frameworks, particularly for those living in rural areas, is still an underdeveloped area of study. Further, the federal government has yet to effectively address this pressing concern. Rather, it can be argued that Congress has taken a less than progressive approach by consistently appropriating inadequate funds for IHS and by failing to reauthorize the Indian Health Care Improvement Act (IHCIA).

Perhaps most concerning about the current lack of LTC services for rural Native Americans – only 6.5% of those living in Indian country currently receive such care - is that the magnitude of this need is only going to increase in coming years. In

3. National Indian Council on Aging, National Indian Aging Agenda for the Future (1995). The term “elder” in Native American communities is often a term used to denote a person holding a position of leadership independent of age. Within this paper, it simply refers to someone of older age and does not reference any political or leadership status.
5. Jodi Rave, Indian Health Needs Outlined, TheBismarckTribune.com, www.bismarcktribune.com/articles/2005/07/15/news/state/sta01.txt (July 15, 2005). Dr. Charles Grim, Former Interim Director of Indian Health Services, stated that Indian health programs are underfunded by about 40%.
6. 18 U.S.C. § 1151 (2006). Congress has recognized three categories of Indian country: reservations, Indian allotments, and dependent Indian communities. In this note, the term is used as one of general applicability as lands on which Native Americans govern and reside.
general, Native Americans are the fastest-growing minoritypopulation for which growth is not dependent on immigration, and at least half of elderly Native Americans reside in rural areas where few LTC service options operate. Average life expectancies may reach 82.5 years by 2025, thus fueling an increased need for LTC services. By 2030, there will be a 51% increase in the number of elderly Native Americans who experience functional limitations of moderate or severe levels. The number of those aged 60 and over will at least double, and in some age groups, such as the 85-plus, the number of men and women will increase four-fold.

In general, delivery of rural health care is more difficult to tackle systemically, for both Native and non-Native Americans alike, than the delivery of care in more populated areas. Rural health care is typically less accessible, narrower in scope, and less able to offer service alternatives compared to more urban counterparts. To develop accessible, comprehensive LTC services requires accurate needs assessments, flexible infrastructures, and, most importantly, funding.

I. LTC SERVICES & ELDERLY RURAL NATIVE AMERICANS

LTC means far more than traditional nursing home care. It encompasses an array of ongoing health and social services that support elders in need of help with basic daily activities of living because of physical or mental infirmity. LTC services can augment and help streamline the care that families provide.

For instance, LTC can include personal care services, homemakers, chore services, home health aide services, respite care, case management, transportation,
home modification, assisted living, and rehabilitation therapy. The most consistently used services among elderly rural Native Americans include transportation services, meal programs, public health nurses, and community health representatives (health paraprofessionals). Older Native Americans have reported preferences for services that include assistance with home renovations (e.g., creating handicap accessible homes and installing heating, electricity, and plumbing systems), dental and eye care treatments, monetary assistance for weekly therapies, costs for transportation to therapies, personal assistance for homecare (e.g., housework, meal prep assistance), and medical equipment (e.g., wheelchairs, beds, bathing chairs, walkers).

A. Factors impacting access to LTC

For many elderly rural Native Americans, issues of geographic isolation, poverty, and transportation further complicate access to LTC services. Almost three-fifths of elderly Native Americans live at an economic level 200% below that of the poverty rate. Their health status as a whole ranks among the worst of any U.S. minority population; additionally, elderly rural Native Americans suffer from physical disabilities at a rate 50% higher than that of other elderly Americans. They have a higher prevalence of most chronic diseases (excepting colorectal cancer and cataracts) than the rest of the population aged 55 and older. In particular, elderly Native


21. National Indian Council on Aging Advocacy Agenda, Remarks presented at the “Listening Session” of the White House Conference on Aging, (Sept. 9, 2004) (statement of William F. Benson, former Acting Assistant Secretary for Aging at the Administration of Aging) [hereinafter Benson] Of frontier elders (the most rural type of elders), 36% had an annual income below five thousand per year, while 40% of rural elders had annual incomes between seven and $14,000 per year.

22. Id.

23. Moulton et al., supra n. 19. Moulton and her colleagues examined the rates of hypertension, diabetes, cataracts, arthritis, and specific cancers, and how each is associated with additional co-morbidities.
American experience significantly higher rates of hypertension, arthritis, stroke, and diabetes than non-Native counterparts.24 Even life expectancy is considerably shorter – nearly 5.8 years less - than the general population.25

Coupled with these grim health statistics are projections for greater overall numbers of Native elderly, many of whom will need LTC services.26 The overwhelming bulk - upwards of 90% - of current LTC services are provided through unpaid intrafamilial care.27 While women in the home have historically been primary caregivers, the advent of more women entering the workforce creates less certainty that caregiving in the home can remain the norm.28 Further, while the majority of elderly continue to live on or near tribal lands, younger generations often leave the reservation to pursue educational and economic opportunities, thus leaving the “old to care for the old.”29

Availability to LTC services means that elders can independently access the services or that the services can be brought to them.30 In rural areas, the necessity of traveling long distances to receive or deliver services makes service delivery expensive and often impractical.31 For the elderly living in rural areas, a common problem is a lack of transportation to the service areas offering LTC assistance.32 Although an ideal LTC service plan would deliver directly to the elder’s doorstep, many of the larger care providers are often found in more populated urban communities, primarily because economies of scale do not favor smaller, more geographically scattered operations.33 Therefore, means of transportation can be a vital component to ensure availability of LTC services.34

Further, cultural factors also impact how LTC services are delivered and received among older Native Americans. Although health beliefs and cultural values can vary

24. Id.
25. Id. Life expectancy rates can vary dramatically among Native Americans living in different IHS service areas. For example, the life expectancy in the California IHS service area is 76.3 years compared to 64.3 years in the Aberdeen, South Dakota IHS service area.
27. See Chapleski, supra n. 4. The bulk of LTC care in our county, particularly in Native American families, is delivered through intrafamilial care.
28. Indian Health Service Oversight Hearing on Native American Elder Health Issues Before the Senate Committee on Indian Affairs, 107th Cong. (2002) (statement of Kathleen Annette, Area Director of Bemidji Area Indian Health Service) [hereinafter Annette].
29. Id.
30. See Redford, supra n. 2, at 10.
31. Id.
32. Id. at 10. Over 60% of Native Americans live in tribal areas that are at least 50 miles from a city of 50,000 people. The likelihood of rural elders getting to an urban area for services is even more remote than delivery of services to them. A 1995 Tribal Transit study found that only 13% of respondents indicated that their current transit system met the needs of their respective communities.
34. Id.
significantly among tribal groups\textsuperscript{35} which implies that LTC services should not be culturally neutral\textsuperscript{36} - Native Americans have traditionally placed a high value on according great respect to older tribal members.\textsuperscript{37} It can be critically important to shape services able to preserve and protect the respected position of an elder.\textsuperscript{38} Provision of LTC should also take into account strong family preferences for support care to be delivered in the elder’s home, a holistic approach in the delivery of the care (i.e., physical, mental, and social-well-being), and an appreciation for the community’s respect of the elder.\textsuperscript{39}

B. Who shoulders the responsibility to provide rural LTC?

Responsibility for providing LTC service options for the more than 560 federally recognized tribes\textsuperscript{40} should fall squarely on the federal government. It is well established through treaties, Supreme Court decisions, and legislation\textsuperscript{41} that the federal government shares a “trust relationship”\textsuperscript{42} with Native peoples whereby the federal government incurred the obligation to provide health care in exchange for millions of acres of ceded land.\textsuperscript{43}

Congressional oversight of Native American health care primarily began with the Snyder Act of 1921.\textsuperscript{44} It was the first major legislation to authorize funding for Native American health care.\textsuperscript{45} The Act authorized the Bureau of Indian Affairs (BIA) to “direct, supervise, and expend such moneys as Congress may from time to time

\begin{itemize}
\item \textsuperscript{35} Chapleski, supra n. 4, at 386-387.
\item \textsuperscript{36} Annette, supra n. 28.
\item \textsuperscript{37} Chapleski, supra n. 4, at 384-85.
\item \textsuperscript{38} See J. Neil Henderson, \textit{How Do We Understand and Incorporate Elders’ Teaching and Tribal Values in Planning a Long Term Care System?}, in American Indian & Alaska Native Roundtable on Long Term Care in Developing Long Term Care Service: Final Report 2002, Discussion Paper #4, http://www.ishhs.gov/PublicInfo/PublicAffairs/PressReleases/Press_Release_2002/Final_LTC_Report_ALL.pdf#search='Native%20American%20Roundtable%202002' (2002). To properly respect cultural values, several things must be kept in mind: 1) Have a serious intent to respect cultural beliefs, 2) Use appropriate experts in forming culturally appropriate programs, and 3) Genuinely appreciate the differences within seniors of different generations (Id. at 27).
\item \textsuperscript{39} Dave Baldridge, et al., \textit{Tribal Guide for Elder Care: A Primer on Long-Term Care Services & Financing for Indian Elders}, 4, http://www.nsclc.org/news/04/dec/rrf_tribalguide.pdf (2004). Two fundamental problems are associated with developing LTC services. First, LTC is not a standard package set; rather, it is a variety of services. Second, funding options and availability are often “limited, fragmented, and difficult to assess.” (Id. at 4).
\item \textsuperscript{40} Indian Health Services, \textit{Fact Sheet}, http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/ThisFacts.asp. (accessed April 10, 2006) [hereinafter IHS].
\item \textsuperscript{41} Id.
\item \textsuperscript{42} John & Baldridge, supra n. 9, at 14-16.
\item \textsuperscript{43} See Id. at 12-15.
\end{itemize}
appropriate, for the benefit, care, and assistance of the Indians throughout the United States for purposes including . . . for the relief of distress and conservation of health.”

Responsibility for the provision of Native health care has encountered many organizational transfers, although it is now under the auspices of the Indian Health Service of the Department of Health and Human Services. Although different pieces of legislation regarding the provision of Native American health care have been passed throughout the years, the Snyder Act is still used today as a means of authorizing funding for Native health services.

II. CURRENT PROVISIONS FOR FORMAL HEALTH CARE SERVICES

Direct health care services are considered to be services provided at an IHS facility. Native, and primarily rural, tribes generally have three options for receiving IHS-funded health care: 1) Receiving health care directly from IHS hospitals, clinics, and small health centers, 2) Contracting with IHS for health services to be provided by a third party, or 3) Compacting with IHS for the funding and control to be transferred to the tribal government, with the tribe then becoming responsible for the provision of health services (compacting essentially acts as a block grant process allowing for tribal autonomy on how money is spent). If IHS is unable to provide direct health care in a region, then option two and three may be utilized. Regardless of which option structures the care, eligible Native American patients are not required to pay for services provided, or approved through, IHS contract provisions. However, IHS is a payor of last resort, meaning that when a recipient is also eligible for coverage under the Veteran’s Administration, Medicare, or Medicaid, the recipient must exhaust all alternate resources before IHS is required to pay. Further, under the Indian Self-Determination Act, Native Americans are to have maximum participation in the management and delivery of their federal service programs.

Option 1: The primary provider, Indian Health Services (IHS)

IHS is the arm of the Department of Health and Human Services (HHS) responsible for the delivery and provision of health services to an estimated 2.7 million
Native Americans. The majority of IHS services are provided in hospital and clinic settings, most of which are limited to acute and preventive care. The IHS budget, although the largest source of federal spending for Native American health, constitutes just .5% of the entire HHS budget.

IHS traces its roots to the Snyder Act of 1921. Unfortunately, IHS inherited a system that historically had been deprived of the resources necessary to provide health care equitable to that provided to most other Americans. Perhaps more unfortunate is the fact that this statement still rings true. Congressionally appropriated funds currently only cover an estimated 60% of the health care needs of eligible Native Americans.

IHS subsists on appropriated funding, which means that services must be planned within the budget, rather than the budget funding exact plans of care. IHS is neither an entitlement program (as compared to Medicare or Medicaid), nor an insurance program with an established benefits package. It does not provide the same services in every IHS service area, and service availability within IHS service areas may vary from year to year because of funding limitations. IHS, often regarded as a system of “universal eligibility but limited availability,” has long been recognized as unable to meet all of the health needs facing Native Americans.

While IHS has made significant progress in combating infectious and acute disease, other necessary services continue to be “underfunded, inadequately staffed, or

56. Id.
57. John & Balridge, supra n. 9, at 67.
58. Broken Promises, supra n. 45, at 88. Beyond the Bureau of Indian Affairs and IHS, a wide variety of federal agencies administer health programs that provide assistance, albeit piecemeal, to Native Americans.
60. See Broken Promises, supra n. 45. See also Indian Health Service, Transitions 2002: A 5-Year Initiative to Restructure Indian Health, 9 (October 2002). A Native American born in 2002 has a life expectancy of 70.6 years compared to 76.5 years for non-Native Americans.
61. A Neglected Obligation, Editorial, Wash. Post, August 30, 2005, at A22. IHS spends an average of $1914 on health services per Native American per year; comparatively, the U.S. government spends annually, on average, $3800 per year per prisoner, and $5065 per person in the general population.
62. IHS, supra n. 40. IHS consists of 33 hospitals, 59 health centers, and 50 health stations.
63. Broken Promises, supra n. 45, at 47.
64. Id.
65. Id.
66. Id. at 47, n. 13.
67. Rose Pfefferbaum et al., Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices, 21 Am. Indian L. Rev. 211, 220 (1997). Furthermore, questions as to the responsibility for delivery of services continue to be raised, even though such questions have been asked and answered. This questioning of authority may be due to organizational budget constraints and an inability to meet established responsibilities.
2006] INDIAN HEALTH CARE IMPROVEMENT ACT 11

completely unaddressed."68 This statement would be directly applicable to IHS provision, or the lack thereof, of LTC services.

IHS, by statute, lacks authority to build or operate nursing homes or other long term, custodial care facilities.69 The National Indian Council on Aging (NICOA) points out that this restriction does not "preclude the IHS from providing technical assistance and medical support to tribal home and community care programs and facilities, including SNFs [skilled nursing facilities]. Nor is the IHS prevented from providing formal home health care programs or geriatric training for its staff."70 The result is that rural elder Native Americans receive, if any, long-term care services through a spotty patchwork of payors and providers. The Administration on Aging (AOA), IHS, the BIA, Medicare, and Medicaid may all provide funding for rural elder care,71 but there is a distinct lack of coordination among these providers.72 Further, while many smaller tribes lack resources and expertise to provide or manage care on their own, the complexity of navigating through various funding sources can be daunting and burdensome.73

Option 2: Accessing services through outside contractors

Option two, in many instances, results when IHS contracts with local, non-IHS health care providers.74 Known as contract health services (CHS), the services are typically ones that IHS is unable to provide through its own facilities.75 Payments for CHS are authorized based on strict guidelines and are subject to availability of funds.76 Of course, IHS cannot guarantee availability of funding. Because of limited resources, CHS services are prioritized first to the most life-threatening illnesses or injuries.77 Important to note is that unless care recipients reside within the specifically contracted

68. John & Baldridge, supra n. 9, at 9. Other problematic areas include environmental health efforts, maintenance and construction of facilities, and public education regarding substance and alcohol abuse.
70. John & Baldridge, supra n. 9, at 10.
71. Id.
72. See Redford, supra n. 2.
73. Id. See also 25 U.S.C. § 1641(a) (2006) (Medicare); 1642(b) (Medicaid) Medicare/Medicaid reimbursemments are not considered in determining a tribe’s allocation of IHS services or funding. See also, Benson, supra n. 21 at 19. Medicaid is the principal source of public long term care financing, but Medicare more often pays for some home health services (so long as the home health provider is state certified, which may be difficult for some tribes if state regulations require occupational or physical therapies).
74. Baldridge, et al., supra n. 39, at 8.
75. Broken Promises, supra n. 45, at 52-53.
77. Id.
CHS delivery area, eligibility for services purchased from the private sector with IHS contract funding is waived.\(^7\)

**Option 3: Self-governing compacts**

Option three evolved out of the Indian Self-Determination and Education Assistance Act of 1975.\(^7\)\(^9\) The legislation reflected the sentiment that federal domination of Native American service programs stalled Native autonomy and socio-economic progress.\(^8\) The Act intended to ensure Native participation, control, and decision-making in program development and delivery,\(^8\) however, where tribes opt out of contract programs, IHS is still responsible for continuing to provide services.\(^8\) Opposition to the Act was based on concerns that it was yet another escape hatch for the federal government to avoid its obligation in providing health care to Native peoples.\(^8\)

Self-governing compacts allow tribes to contract or compact with the federal government to plan, conduct and administer programs tailored to tribal needs.\(^8\) Some programs have been very successful with building extensive LTC service programs.\(^8\) More than a dozen tribes have built their own nursing homes – the first being established in 1969.\(^8\) Funding for the nursing homes has come from a variety of sources and a few tribes have been able to reinvest gaming revenues.\(^8\) Tribes choosing to build their own facilities do so, in part, because of a lack of other service options, and more importantly, to be able to provide culturally-appropriate care.\(^8\) Housing a LTC facility on a reservation can be a source of pride and show of respect

---

\(^7\) Broken Promises, *supra* n. 45, at 62. In particular, this situation creates a problem for Native Americans moving to and/or living in urban areas.


\(^8\) Trombino, *supra* n. 52, at 149.

\(^8\) Id. at 151-52.

\(^8\) Id. at 149.

\(^8\) Id. at 133.

\(^8\) Broken Promises, *supra* n. 45, at 56-57. Under a Title I contract, a tribal organization contracts to conduct and administer certain portions of a health program operated by IHS. Under a Title V compact, a tribal government compacts to take over the operation of a health program.

\(^8\) Redford, *supra* n. 2, at 8.

\(^8\) John & Baldridge, *supra* n. 9, at 70.


\(^8\) John & Baldridge, *supra* n. 9, at 70. A lack of cultural sensitivity and isolation from family and friends are major sources of resident and family dissatisfaction with care provided in off-reservation nursing homes.
A few examples illustrate the success of tribal implementation of residential LTC services:

- American Indian [Arizona, Tohono O’Odham - Pima] (built 1969)
- Chinle [Navajo] (Arizona, built 1971)
- Blackfeet Health Department (Montana, built 1974)
- Choctaw Residential center - Mississippi Band of Choctaws (built 1987)

However, lack of funding and staffing shortages are difficult barriers for many tribal communities to overcome. For some tribes that made the decision to shoulder health service responsibilities, compact funding is often insufficient to meet associated expenses. This is particularly true for tribes that were experiencing financial difficulties prior to implementing the services. Therefore, Native American self-determination in developing and implementing health and LTC services is good in theory, but without adequate funding, little headway in health status or access can be gained.

III. APPLYING THE INDIAN HEALTH CARE IMPROVEMENT ACT TO RURAL LTC

The Indian Health Care Improvement Act of 1976 (IHCIA), represented the first legislative statement of Native American health goals. Organized in eight titles, it adopted health objectives meant to lessen health disparities. The IHCIA acknowledged that, because of the “unique legal relationship” between the federal government and Native Americans, the government had a responsibility to improve and maintain Native health. The Act stated that it was a “major national goal” to provide services capable of raising the health status of Native peoples to the “highest possible level.”

The IHCIA has since provided the statutory framework for the governmental provision of Native American health care. Among other things, it has sought to

89. Chapleski, supra n. 4, at 382.
90. John & Baldrige, supra n. 9, at 71.
91. Redford, supra n. 2 at 8. Studies of American Indian elders and their family caregivers have consistently shown that elders do not want to be cared for in a nursing home and families only use nursing homes only as a last resort; therefore tribe-specific homes likely ease the discomfort associated with typical institutional care.
92. See Baldrige, et al., supra n. 39, at 8.
93. Id.
97. Id.
98. Id.
recruit health professionals, provide scholarships for Native Americans working in health professions, and upgrade health facilities. When first passed, the IHCIA exceeded the scope of the Snyder Act in providing guidance and funding for health improvement. It was implemented as authorizing legislation whereby it could be changed as needed. Initial legislation specified dollar amounts for specific provisions for the first four years, and then appropriated monies thereafter (meaning later funding was not guaranteed). Unlike the Snyder Act, which has no sunset date, IHCIA provisions for authorized funding expired in 2001. All subsequent reauthorization attempts have thus far failed to pass both Houses of Congress.

After its initial passage, the IHCIA was amended and reauthorized four times. In 1992, Congress reauthorized it for an additional ten years. In 1999, IHS and tribal leaders began preparing for its 2002 reauthorization. IHS convened a National Steering Committee (NSC) to develop a report on IHCIA recommendations. The NSC was composed of one elected tribal representative and one alternate from each of the twelve IHS Areas, a representative from the National Indian Health Board, a representative from the National Council on Urban Indian Health, and a delegate from the Tribal Self-Governance Advisory Committee. The NSC invested a lot of time and energy in crafting reauthorization legislation, but, unfortunately, the NSC efforts were not able to procure a favorable result. A U.S. Commission on Civil Rights draft report speculated that the 2002 reauthorization failure may have been the result of Congress’ preoccupation with national security matters. That may be true,

103. Trombino, supra n. 52, at 141.
109. Id.
110. Ibid.
111. Id.
112. See generally, A Bill to Reauthorize the Indian Health Care Improvement Act: Hearing on S. 556 Before the S. Comm. on Indian Affairs, 108th Cong. 10 (2003) (statement of Rachel Joseph, Co-Chair, National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act.)
114. Broken Promises, supra n. 45 at 25, n.127.
but as the IHCIA funding provisions continues to go unauthorized, the original purpose of the act is lost.

A. The most recent version of the IHCIA

During the 106th and 107th legislative sessions, revised versions of the IHCIA were introduced into Congress, but neither passed the full Senate. In 2003, the 108th Congress introduced S. 556, a reauthorizing bill that didn’t make it off of the Senate floor. During the 109th Congress, Senate Indian Affairs Committee chairman John McCain introduced a new version of the IHCIA, Senate bill 1057, entitled a Bill to Amend the Indian Healthcare Improvement Act to Revise and Extend that Act. This bill aims to “revise and extend” the IHCIA, reauthorize funding provisions, and raise the health status of Native Americans to at least the levels set forth in Healthy People 2010. Further, it continues the example of earlier versions and encourages Native American participation in establishing health care priorities and goals. The latest version of the IHCIA takes into account recent NSC comments and recommendations.

B. Proposed IHCIA provisions for LTC

The most recent adaptation of the IHCIA retained the previous structure of its earlier versions, but it now includes specific provisions for LTC options. Under proposed Title II, “Health Services,” the Secretary of Health and Human Services (Secretary) would have the authority, either directly or through the Indian Self-Determination and Education Assistance Act, to augment IHS long-term care

119. Id.
120. S. 1057 § 3(2), 109th Cong. (2005).
122. S. 1057 (Sen. McCain’s opening remarks); See also, National Indian Health Board, IHCIA Reauthorization Introduced, at www.nihb.org/article.php?story=20050518131605244#comments (May 18, 2005). Included with the proposed S. 1057 were many of the National Steering Committee’s concerns, requests and recommendations for the IHCIA.
services,\textsuperscript{125} enhance home health care,\textsuperscript{126} and capitalize on the use of community health representatives.\textsuperscript{127}

“Shared Services for Long-Term Care,” section 205(a), would authorize the Secretary to either directly provide for the delivery of LTC and similar services or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act for tribes owning and operating their own LTC or like facility. Agreements for care would require sharing of staff (or other services) between IHS or a Tribal Health Program, and the facility.\textsuperscript{128} Expenses relating to shared services (e.g., salaries) would be allocated proportionately between IHS and the tribal organization.\textsuperscript{129} Contracts or compacts could authorize for tribal construction, renovation, or expansion of long-term care or other similar facilities.\textsuperscript{130} Funding authorization for these provisions is for “such sums as may be necessary for each fiscal year through . . . year 2015 to carry out this title.”\textsuperscript{131}

IV. IHCIA REAUTHORIZED – AN IMPERATIVETIVE FOR RURAL LTC SERVICES

In the years since the IHCIA was last reauthorized, mainstream health care delivery systems have been updated, while the framework for Native health care delivery has not.\textsuperscript{132} For example, modern trends have increasingly emphasized home health care and a heavier focus on preventive services.\textsuperscript{133} Reauthorization is a necessity for Native health care systems to parallel modern changes in delivery programs.\textsuperscript{134} Reauthorization would update service methods and the range of programs, while at the same time, allow Native communities the opportunity to create culturally appropriate programs, including LTC services.\textsuperscript{135}

The IHCIA is the “backbone of IHS,”\textsuperscript{136} but without funding, it has no muscle. Congress has done an “abysmal job” at funding Native health programs,\textsuperscript{137} and as

\begin{itemize}
  \item \textsuperscript{125} S. 1057 § 201(a)(5)(A), 109th Cong. (2005).
  \item \textsuperscript{126} S. 1057 § 201(a)(5)(H), 109th Cong. (2005). Home health care can avoid, or help to delay, the need for hospitalizations and nursing home placement and thus reduce Medicaid/Medicare spending. It can also allow older persons to stay within their communities, a factor usually associated with a higher quality of life.
  \item \textsuperscript{127} S. 1057 § 201(a)(5)(I), 109th Cong. (2005) A community health representative trains health paraprofessionals and applies such services to the provision of health care, health promotion, and disease prevention services.
  \item \textsuperscript{128} S. 1057 § 205(a), 109th Cong. (2005).
  \item \textsuperscript{129} S. 1057 § 205(b)(2), 109th Cong. (2005).
  \item \textsuperscript{130} S. 1057 § 205(b)(3), 109th Cong. (2005).
  \item \textsuperscript{131} S. 1057 § 225, 109th Cong. (2005).
  \item \textsuperscript{134} \textit{Id.}
  \item \textsuperscript{135} Rave, \textit{supra n. 5}.
  \item \textsuperscript{136} Indian Health Care Improvement Act: S. 1057 before the Committee on Senate Health, Education, Labor and Pensions Committee on Senate Indian Affairs, 109th Cong. (2005) (statement of Charles Grim, Director, IHS).
\end{itemize}
recent history indicates, reauthorization is far from guaranteed. Economic concerns will likely continue to hinder reauthorization. In 2001, the Congressional Budget Office estimated that the cost of reauthorization would be 6.9 billion dollars over 10 years. Additionally, the current climate of federal budget cuts of social services offers little assurance for IHCIA funding. President Bush’s proposed budget plan for 2007 has outlined a $36 billion dollar reduction in Medicare spending over next five years; last year, Medicaid experienced $4.7 billion in cuts, only half of what the administration requested.

CLOSING NOTES

Like much of the U.S. population, rural Native American communities will face an increasing demand for LTC in coming years. For a variety of reasons, many Native American communities are ill-prepared to deal with this pending “explosion” of need. Native families will continue to be a vital part of a long-term care service system, but the federal government has the responsibility to alleviate that burden through funding, coordination of providers, and delivery of services. The latest version of the IHCIA establishes a beginning framework for improving rural access to LTC services. Further, it contains funding provisions for proposed services. Yet before any good can come of this proposed legislation, Congress must provide its stamp of approval.

Congress’ apathy with the IHCIA may be attributable to having more pressing, immediate issues to which it must focus its attentions. But after so many years of inaction, it can neither be the whole story nor a compelling enough explanation. Further, lobbying efforts are often less than fruitful if parties bring little bargaining power to the table. Perhaps passage of the IHCIA simply needs more attention drawn to its cause.

For example, the 2003 legislation reauthorizing the IHCIA was introduced in both chambers of the 108th Congress. A few Congressional hearings on the respective bills were held, but little further was accomplished. However, seemingly timed with the opening of the Smithsonian’s National Museum of the American Indian, both the Senate and the House versions of the IHCIA were “quickly and unanimously approved.” The media attention focused on the new museum, coupled with the

137. A Neglected Obligation, supra n. 61.
138. Broken Promises, supra n. 45 at, 126.
141. Benson, supra n. 21.
142. See Redford, supra n. 2, at 10.
144. Id.
presence of 20,000 Native peoples visiting Washington D.C. to celebrate the opening,\(^{145}\) drew attention to the languishing IHCIA.\(^{146}\) Of course, this level of demonstration and attention is expensive and requires large-scale organization, a feat not likely to occur again in this Congressional year, or even in the near future.

Even so, members of Congress can easily be reminded of Native presence by simply looking out their windows facing the National Mall. The image of the National Museum of the American Indian should be readily visible. Hopefully, it will serve as a reminder that memorializing Native American history in an expensive museum\(^{147}\) is more than just a bricks-and-mortar symbol of the government’s commitment to this heritage. A convincing commitment to contemporary Native Americans would be better demonstrated by reauthorizing the IHCIA and enabling development of comprehensive LTC services for rural elderly.


\(^{146}\) Pallone, *supra* n. 143.

\(^{147}\) National Museum, *supra* n. 144. The cost of constructing the museum was $199 million, half of which came from private donors.
ARE NURSING HOMES NURSING THE NEEDS OF THE INDIAN AMERICAN IMMIGRANTS?

Shilpa M. Gokare*

TABLE OF CONTENTS

I. HISTORY OF IMMIGRATION LAWS AND THE TREND OF MIGRATION OF INDIAN AMERICANS TO THE UNITED STATES OF AMERICA ........................................... 20
   A. The Old Immigrants ................................................................. 20
   B. A Major Milestone .................................................................. 21
   C. The New Wave ....................................................................... 22
   D. The New Indian Immigrants .................................................. 22

II. DEMOGRAPHICS OF THE NEW INDIAN IMMIGRANTS .................................................. 23

III. UNIQUE BELIEFS AND NEEDS OF THE HINDU COMMUNITY .................................. 24
   A. Diet ..................................................................................... 24
   B. Health Beliefs ...................................................................... 25
   C. Religious Beliefs ................................................................. 25
   D. End-of-Life Procedures ....................................................... 26
   E. Dress .................................................................................. 26
   F. Language ............................................................................. 27
   G. Family Structure ............................................................... 27
   H. Gender Roles ...................................................................... 27
   I. Wealth Possession ............................................................... 27

IV. CURRENT NURSING HOME FACILITIES AND THE SERVICES THEY OFFER ............ 28
   A. Relevant Sections of the Dietary Regulations ........................ 28
   B. Relevant Sections of the Safety Regulations ............................ 29
   C. Relevant Sections of the Recreation Regulations ....................... 29

V. BRIDGING THE GAP BETWEEN CURRENT SERVICES AVAILABLE AND THE UNIQUE NEEDS OF THE HINDU COMMUNITY ........................................... 30
   A. Dietary Requirements .......................................................... 30
   B. Health Beliefs ...................................................................... 31
   C. Religious Beliefs ................................................................. 32
   D. End-of-Life Beliefs and Practices .......................................... 33
   E. Language ............................................................................. 33
   F. Clothing Requirements ....................................................... 34

* Shilpa M. Gokare is the second place winner of the 2006 NAELA Student Journal Writing Competition. She graduated from Georgia State University-College of Law in June 2006.
SPECIAL FOCUS ON HINDU IMMIGRANTS

There are currently 1,678,765 Indian Americans living in the United States\(^1\). Many of these Indian Americans face the prospect of spending the last years of their lives in nursing homes that neither understand nor respect their culture or their religion. This paper examines this problem, with a special focus on the fate of the Hindu immigrants in the state of Georgia.

I. HISTORY OF IMMIGRATION LAWS AND THE TREND OF MIGRATION OF INDIAN AMERICANS TO THE UNITED STATES OF AMERICA

Indian Americans are those who originate from the southern part of the Asian continent. Although per the 2000 census, there are 1,678,765 Indian Americans in the United States,\(^2\) Indians have not always been welcomed in the United States.

A. The Old Immigrants

The history of the first Indian Americans (hereinafter known as “Indians”) in this country dates back to the time period between 1899-1913.\(^3\) During this time period, approximately 7000 Indians immigrated to the United States, largely as indentured and unskilled laborers, to work either in the railroad and steamship companies, or as farmers in the agricultural fields.\(^4\) Around this time, the prevailing sentiments of the local population toward these immigrants were very negative. In 1907, the Asian Exclusion League (AEL) of San Francisco opposed the immigration of Indians into the United States,\(^5\) through staging anti-South Asian riots. In 1913, California eventually enacted the Alien Land Law that restricted the ability of non-citizens to buy or lease land. The continued influence and lobbying of AEL in Congress by Democratic Representative John Raker and Immigration Commissioner Anthony Caminetti, to restrict immigration of Indians,\(^6\) ultimately led to the enactment of the Immigration

---

2. Id.
4. Id.
5. Id.
Act of 1917, which placed a “Barred Zone” on immigration from South Asia that included India.\(^7\) Furthermore, the Supreme Court decision in *United States v. Thind*, 261 U.S. 204 (1923) held that although Asian Indians belonging to the “Aryan” race were Caucasian\(^8\), they were not “white,”\(^9\) and therefore could not be citizens of the United States.\(^10\) The term “white person” was defined as a common man’s understanding of the term.\(^11\) The repercussions of this ruling sent huge waves through the Indian immigrant community, as this ruling not only denied future Indian petitions for citizenship, but also annulled previous naturalizations\(^12\) of people of Indian origin.

### B. A Major Milestone

The tensions surrounding immigration and naturalization continued to exist with Indians on one side, constantly trying to have these provisions repealed, and the AEL, and the American Federation of Labor on the other, constantly trying to tighten the immigration laws. The Magnuson Act of 1943\(^13\) lifted the barriers placed on citizenships for most of the Asian immigrants except Indians. At this time, the Indians argued for similar rights and, after intense lobbying, the Indians were able to gain support of a few prominent Congressmen and also of President Franklin D. Roosevelt. This eventually led to the enactment of American Asian Citizenship Act of 1946,\(^14\)

\(^7\) Immigration Act, ch. 29, 39 Stat. 874 (1917). The Immigration Act of 1917 codified all previously enacted exclusion provisions. The Act specifically denied entry to people from a “barred zone” that included South Asia through Southeast Asia and islands in the Indian and Pacific Oceans. It established a literacy test and excluded illiterate aliens from entry. It further expanded the list of aliens excluded for mental health and other reasons, considerably broadened the classes of aliens deportable from the United States, and introduced the requirement of deportation without a statute of limitations in certain more serious cases. *Id.*

\(^8\) A remote common ancestry found in the ‘Aryan’ race that the ethnologists considered being “Caucasian.” *US v. Thind*, 261 U.S. 204 (1923). Thind, an immigrant from Northern India, argued that he was a “Caucasian.” The Court ruled that although he belonged to the Aryan race, he was not eligible for citizenship as he did not fit the common man’s definition of “white person,” which referred to Caucasians from Northwestern Europe. *Id.* at 213.

\(^9\) *US v. Thind*, 261 U.S. 204 (1923). The *Thind* Court, held that “the term ‘Aryan’ has to do with linguistic and not at all with physical characteristics, and it would seem reasonably clear that mere resemblance in language, indicating a common linguistic root buried in remotely ancient soil, is altogether inadequate to prove common racial origin.” *Id.* at 210.

\(^10\) The *Third* Court, defined the meaning of white person within the meaning of U.S. Rev. Stat. § 2169. The statute provided that the provisions of the Naturalization Act would apply to ‘aliens being free white persons, and to aliens of African nativity and to persons of African descent’. The *Third* Court while quoting the *Ozawa v. The United States* 260 U.S. at 214 (1922), stated that the words “free white persons” as per the U.S. Rev. Stat. § 2169 were to be used as words of common speech, to be interpreted in accordance with the understanding of the common man, and were synonymous with the word “Caucasian” only as that word is popularly understood. Thus the *Ozawa* court defined “white” as “Caucasian.”


\(^12\) India Abroad Ctr. For Pol. Awareness, *supra* n. 3.


which was signed by President Truman. This was considered to be a huge victory and a major milestone in immigration reform, as the Act not only reversed the *Thind* decision, but also abolished the “Barred Zone” established by the Immigration Act of 1917, thereby allowing naturalizations by Indians, and also setting an immigration quota (based on ethnic origins) for Indian immigrants at 100 per year.\(^{15}\) In 1952, Congress enacted the Immigration and Nationality Act of 1952\(^ {16}\), also known as the McCarran-Walter Act, which further established the basic laws of U.S. citizenship and naturalization.\(^ {17}\)

C. The New Wave

The Immigration Reform Act of 1965\(^ {18}\) was framed as an amendment to the 1952 Act and lifted the nationality criteria, thus eliminating the national quota and putting all people on an equal footing, irrespective of their nationality.\(^ {19}\) This legislative action opened the doors of America to the world. This had a tremendous impact and changed the demographics of the American population. The number of Indians coming to The United States until 1965 had remained in the hundreds. However, following the elimination of the nationality quotas in 1965, tens of thousands of Indians came to The United States. Thus began the era of the new Indian immigrants in the United States.

D. The New Indian Immigrants

With the ban on national quotas lifted, Indians started immigrating in huge numbers. These foreigners, termed “new Indian immigrants,” were distinguishable from the “old Indian immigrants” of the late nineteenth and early twentieth century in many ways. While the old immigrants were unskilled laborers and farmers, most of the new immigrants were extremely well educated and well-qualified professionals. According to the 1990 U.S. Census department, over 85% of Indians in the United States had graduated from high school and 58% had college degrees or higher professionals degrees.\(^ {20}\) These educational levels were the highest of any group in the United States (including whites and other Asian groups). The Indian family’s median

\(^{15}\) India Abroad Ctr. For Pol. Awareness, *supra* n. 3.
\(^{16}\) McCarran-Walter Act, Pub. L. No. 82-414, 66 Stat. 163.
\(^{17}\) Wikimedia Found. Inc., http://en.wikipedia.org/wiki/McCarran-Walter_Act (Nov. 14, 2005). The 1952 Act abolished the racial restrictions which previously existed, but retained a national quota system and permitted an annual quota of 2,000 for Asian Pacific immigrants. The Act also gave preference to foreigners with education or skills.
income of $60,093\textsuperscript{21} was the highest in the country as well,\textsuperscript{22} as compared to whites and other Asian groups.

II. DEMOGRAPHICS OF THE NEW INDIAN IMMIGRANTS

While there were only five thousand Indian Americans living in the United States in the 1960s, by the mid 1970s, over 350,000 Indian Americans had emigrated from India.\textsuperscript{23} Between 1980-1990, the Indian population in the United States was said to have grown 103%.\textsuperscript{24} The 2000 U.S. census records the number of Indian Americans in the United States at 1,678,765, with an annual growth rate of 7.6%. Indian Americans constitute 0.6% of the United States population and are the third largest constituency in the Asian American community after the Chinese American and the Filipino American communities.\textsuperscript{25} Indian Americans make up 16.4% of the Asian American population, and the Asian American population as a whole is 3.6% of the United States population.\textsuperscript{26}

In Georgia, according to the 2000 census, the Indian American population stood at 46,132, out of which approximately 37,162 people lived in the metro Atlanta area.\textsuperscript{27} The vast majority of these Indian Americans practice the Hindu religion.\textsuperscript{28} There are nearly 1.5 million Hindus in the United States, forming the fifth largest religious group after Christianity, Judaism, Islam, and Buddhism.\textsuperscript{29} In Georgia, the Hindu population stands at a mere 0.2% of the population.\textsuperscript{30}

The new group of Hindu immigrants that immigrated in the 1960s-70s is now gradually reaching retirement age and entering the elder age group. As the elderly Hindus are entering nursing homes, they will place unique burdens on existing facilities. Issues regarding differences in religious practices; health care decisions; and end of life procedures, practices and rituals will reach the forefront, and as such, must be understood in the religious and cultural context of this population.

\textsuperscript{23} Embassy of India, *supra* n. 20.
\textsuperscript{24} Id. (quoting the Population Reference Bureau).
\textsuperscript{25} Out Of India, *supra* n. 1.
\textsuperscript{26} Id.
\textsuperscript{27} Indian American Center For Political Awareness, *Georgia-A Profile from the U.S. Census 2000*, http://www.iacfpa.org/census2k/data/ga.htm (accessed Nov 27, 2005).
\textsuperscript{28} Khushwant Singh, *This Above All, Indian Religions in America*, The Tribune Online Edition, (Saturday Plus), http://www.tribuneindia.com/1999/99jan02/saturday/aboveall.htm (Jan. 2, 1999). Some of the other religions practiced by Indian Americans are Sikhism, Islamism, Christianity, Jainism, Buddhism, Zoroastrianism, and Judaism. Id.
The next two sections will examine how the regulations that govern nursing homes in one state (Georgia) may impose requirements that are inconsistent with, and in some cases, in stark contrast to the religious and cultural needs of Hindu residents of these homes.

III. UNIQUE BELIEFS AND NEEDS OF THE HINDU COMMUNITY

A. Diet

The dietary needs of Hindu elderly will vary significantly from those of the general population. Many Hindus are vegetarians, as they believe that every living being has a soul that has entered into it by reincarnation. Even those who may eat meat will most definitely shun beef, as the cow is worshipped as a revered figure in Hindu mythology.

Food preparation also must follow strict rules, as Hindus believe that some foods are inherently “cool,” while others are inherently “hot” (as per the Ayurvedic medical beliefs). As such, certain foods can be eaten only during certain seasons and not in certain combinations. Moreover, Indian cuisine involves a blend of many spices such as garlic, ginger, cumin, fennel, turmeric, and mustard seeds. Not only do these spices have their own therapeutic properties but they also add a strong aroma and flavor to the food.

A typical Hindu meal consists of rice, flat bread, a variety of vegetables, lentils (cooked in a curry sauce with a blend of various spices), and salads, and ends with yoghurt and sweets. Even though a Hindu family may appear outwardly westernized, it will have a traditional meal at home on a daily basis. According to Ms. Neena Joglekar, a Clinical Dietician who provides consultation to nursing home residents in the metro Atlanta area, Hindu elderly entering the nursing home may find the food served in the nursing homes to be unfamiliar and bland.

32. Religion & Ethics Newsweekly, supra n. 29.
34. Id. Some of the incompatible food combinations are as follows: Milk or yoghurt should not be combined with sour or citrus fruits; melons and grains should not be combined; honey should not be cooked; milk protein and meat protein should not be combined because meat contains the “heating” element whereas milk contains the “cooling element.” Id.
36. Telephone Interview with Neena Joglekar, Clinical Dietician, Private Consultant in Alpharetta, Ga. (Nov. 23, 2005). According to Ms. Neena Joglekar, a Clinical Dietician, who provides consultation to nursing home residents in the metro Atlanta area, a typical breakfast served in a nursing home consists of toast, scrambled eggs, sausage, bacon, or oatmeal and banana with milk, orange juice, and decaffeinated coffee. A lunch and dinner meal typically consists of side salad, with either pasta, spaghetti, or lasagna, chicken, or fish, or beef, or pork chops, served with either
Fasting is also a common ritual in Hinduism. Hindu elderly women often fast because they believe that it improves the well being of their families and especially because it increases the longevity of their husbands.37

B. Health Beliefs

Many elderly Hindus believe in the science of “Ayurvedic” medicine that aims at healing and curing the mind, body and the soul, rather than just the physical symptoms.38 It is a holistic approach of medicine that aims at treating the individual physically, mentally and spiritually. According to Ayurveda, each individual is made up of three doshas (energy force) -kapha, pitta, and vata.39 It is believed that maintaining a balance among the three represents health and well-being, and any imbalance represents illness that can be treated by eating the right foods which supplement these doshas. As noted above, each food is said to have a cooling or a heating effect.40 Hence, different foods are associated with the maintenance of different doshas. As such, Hindu elderly may avoid foods in certain combination, to avoid further imbalance of doshas. Given the basic belief in Ayurveda and holistic medicine, the dietary needs of Hindu Americans would be significantly different.

C. Religious Beliefs

The basic goal in Hinduism is to achieve “moksha,” or salvation, by gaining freedom of the soul from ‘endless reincarnation and the suffering inherent in existence that results from bad karma.’41 The basic premise in Hinduism is that our actions and the behaviors of our past lives affect our current lives. This is known as “Karma”. Thus, Hindus may attribute their illnesses to “karma” even though they may be highly educated, and as such have a complete understanding of the biological causes of illnesses.42 Moreover, since Hindus believe in reincarnations, they perceive death as merely a phase that will enable them to transit on to the next life. Hence, most Hindu elderly would focus on preparing their souls for a new life after death43 and as such, their health care decisions nearing end of life would differ significantly from the Judeo-Christian values.

38. Id.
39. Id.
40. Lad, supra n. 33.
41. Alagiakrishnan & Chopra, supra n. 37.
42. Id.
D. End-of-Life Procedures

Hindus believe that cremation is the most spiritual way of disposing of bodily remains, as it is the quickest way to free the soul from any physical attachments. The common belief is that as long as the physical body remains visible the soul will linger on and not proceed on to its journey beyond death.44

Hindus believe that after death, the soul leaves the body and either follows the path of the sun—the brighter path never to return again thus having achieved “moksha,” or the path of the moon—the darker side, from which it will return over and over. Whether the soul of an individual will take the brighter or the darker path will depend on many factors45 such as:

i. His previous deeds: the more evil deeds he has committed during his life, the lower the worlds his soul would go to and the better the deeds, the higher the worlds his soul would go to.

ii. His thoughts and state of mind at death: if he is thinking of God and the divine power, then the soul would go to the highest world; if he is thinking of his family, then it will go back to his ancestors’ family and be reborn into that family; if he is thinking bad thoughts, then it would go to the lowest worlds.

iii. The time of death: if one dies on an auspicious holiday or while engaged in a religious activity, then his soul will travel to heaven, irrespective of his past deeds.

iv. Funeral practices and rituals: it is believed that if the funeral rites were not performed properly, then it would delay the journey of the soul towards its respective world.

These beliefs will play a significant role when it comes to decision-making regarding components of the Living Wills such as resuscitation, hydration, and nutrition.

E. Dress

There are glaring differences between the way Hindu women dress and the way Western women dress. Even though they may have been working women all their adult lives and have complied with the dress codes at their respective workplaces, Hindu women may have continued to wear the traditional Indian attire, such as sarees and salwar-kurtas, and dress up with the traditional jewelry while at home, or on special occasions and holidays. They often wear the bindi (dot) on their foreheads and mangalasutra (necklace) around their necks, signifying protection for their marriage and their husbands.46

45. Id.
F. Language

There are more than 300 different languages and dialects spoken within the Indian community, although English is now becoming a popular second language. However, the new immigrants from the post 1960s period, although well educated, may not be very fluent in English.

G. Family Structure

Family support and ties play a major role in this community. Many Hindu Indian families may include grandparents as well in the family unit. Thus, many of the new immigrants may have moved to be closer to their children or to live with their children, who are the “second generation Indian Americans”. These “second generation” children, having been born and raised in the United States, often feel like they are the “in-betweens,” and often compartmentalize their lives. At home, they are governed by the Indian lifestyle, and while outside, they are governed by the mainstream community. Thus, they may feel torn between their duty to care for their parents on one hand, and their desire to live independently on the other. There is a strong emphasis in values and traditions on caring for the elderly family members. As a result, there may be feelings of guilt and disappointment in placing the elderly in nursing homes and as such, many families are reluctant to place their elderly family members into nursing homes. Even when elder Hindu family members are placed in nursing homes, typically any decision related to their healthcare is taken only after a consultation with the entire family.

H. Gender Roles

Gender roles are clearly demarcated for Hindus, with that of the husband generally being more dominant than the wife, irrespective of the education and income-earning capacity of the parties involved. Thus, the role of men is more authoritative and the women generally take a more passive role, even when it comes to their own health care decision-making. Moreover, since direct eye contact between women and men may be limited, elderly Hindus may prefer to have a same-sex health care provider.

I. Wealth Possession

Most of the new Hindu immigrants are the first generation immigrants into the United States and do not possess much inherited or passed-on wealth. Even though they are skilled and educated professionals with a higher median income than other Americans, the Hindu Indian immigrants do not possess substantial accumulated wealth.
wealth. Their wealth and savings will generally have been invested for their children’s education and retirement, with perhaps little set aside for end-of-life nursing care and treatment.

In order to address the specific needs of the Hindu immigrant population, the major differences in terms of language, religion, diet, and cultural practices and belief systems have to be evaluated against the backdrop of the current nursing home facilities and the types of services they offer. Only then will we be able to recommend strategies and programs that will address and honor the differing religious and cultural traditions of the Hindu elderly population.

IV. CURRENT NURSING HOME FACILITIES AND THE SERVICES THEY OFFER

According to the official U.S Government site for people with Medicare, there are 363 nursing homes in Georgia. The regulations that govern nursing homes in Georgia appear at Official Compilation Rules and Regulations of the State of Georgia. The regulations address the functioning of the nursing homes in general in the areas of administration, record keeping, professional services provided, environmental sanitation and housekeeping, dietary, safety, and recreation needs. There is no specific regulation that addresses the differences among the needs of different aging populations.

A. Relevant Sections of the Dietary Regulations

Ga. Comp. R. & Regs. r. 290-5-8-.06 (3) (2005), which regulates the dietary services and needs of the residents in a nursing home states that nutritionally adequate diet must be provided to all patients based on their age, sex, activity levels, and physical condition, and that any nutrient concentrates and supplements shall be given only upon a written order of a physician. This regulation does not consider the patient’s ethnic background or religious beliefs when it comes to adjusting a nutritionally adequate diet. It only mentions age, sex, activity and physical condition.

Similarly, Ga. Comp. R. & Regs. r. 290-5-8-.06 (5) (2005) states that a physician or a dentist must approve any modification in diets in writing. This regulation thus addresses the need for a modified diet only due to illness or any other

---

physical condition, and not due to purely religious or cultural beliefs. Thus, the nursing homes may not offer non-meat or ethnic food service. They may not even have cooks to prepare foods required by the Hindus.

B. Relevant Sections of the Safety Regulations

The safety regulation, Ga. Comp. R. & Regs. r. 290-5-8-.13 (8) (2005), states that smoking or open flames of any kind in areas where oxygen is in use or stored will be prohibited and warning signs will be posted accordingly. This regulation clearly prohibits the use of any open flames, such as candles, lamps, or incense sticks. However, many Hindus believe that lighting an oil lamp at sunset is auspicious and a sign of welcoming Lakshmi, the Goddess of Wealth, into their homes. Lamps give light, which is a symbol of righteous knowledge. Lakshmi (wealth personified) increases only in the environment of knowledge and light, where the intentions and motives are clear and full of wisdom. Hence, Hindus light lamps to bow down to ‘knowledge’, which they consider to be the greatest of all forms of wealth. Lighting incense sticks daily at time of praying and meditation is also part of the religious ritual. These rituals thus seem to be in direct conflict with the nursing home safety regulations.

Furthermore, the regulations do not address the religious needs of the nursing home residents. Hindu priests may not be on the list of people who are invited to conduct religious services by the nursing homes. Typically, nursing homes may employ the services of a Christian minister and/or a Jewish Rabbi. The Sunday school services offered may be heavily geared towards people of Christian faith thereby excluding Hindus. There may be no emphasis on non-Christian holiday observances. Hindus have numerous holidays and festivals and observing those festivals is an important component of their culture.

C. Relevant Sections of the Recreation Regulations

Ga. Comp. R. & Regs. r. 290-5-8-.16 (2) (2005) requires that suitable recreational and entertainment activities be arranged for the residents of the nursing home according to their needs and interests. The nursing homes recognize that such activities are an important adjunct to daily living and enable restoration to self-care and resumption of normal activities. Many nursing homes arrange for ‘Bingo Nights’, and other activities, such as holiday parties and birthday parties, which may not be culturally appropriate for the Hindus. Elder Hindus generally do not celebrate birthdays or may prefer to keep any celebration small and within the family, and may even feel uncomfortable with the attention they receive on their birthdays. Most of the

entertainment, such as television, may be in English with no provision for ethnic channels on Dish television. The Hindu differences in gender roles also tend to segregate men from women, and elderly Hindu women may feel uncomfortable socializing with men who are not their husbands.\(^{67}\)

The regulation further requires that nursing home facilities make available a variety of supplies and equipment adequate to satisfy the individual interests of residents. Thus, this regulation enables nursing homes to carry local community newspapers, newsletters, and magazines, and may even allow local community channels via Dish network and cable.

V. BRIDGING THE GAP BETWEEN CURRENT SERVICES AVAILABLE AND THE UNIQUE NEEDS OF THE HINDU COMMUNITY

An effort to bridge the gap between the needs of elderly Hindus and the current services available is feasible but it is one that would require a change in societal views and a willingness on the part of nursing homes and their staffs to change their attitudes. In order to make the nursing homes a welcoming place to the ethnic minority, the nursing home staff should undergo training in cultural sensitivity. The staff should familiarize themselves with different religious and cultural norms and respect the uniqueness of different cultural practices, such as dietary practices, gender roles, and marital status.\(^{68}\) The top-management level staff and administrators should also set an example by their own behavior while also supervising the behavior and relations between the other employees and the ethnic residents and between the residents themselves.\(^{69}\) The other residents also should be made aware of the cultural differences and practices. Thus, the staff should encourage and help residents develop positive relationships with each other.\(^{70}\)

A. Dietary Requirements

This is by far the most important issue for Hindus in nursing homes. Nursing homes do not provide ethnic foods and diets. Hindus are set apart from the rest of the American community because of their unique dietary requirements and restrictions. Hindus will most definitely not consume any beef whatsoever as they perceive the cow to be a sacred animal. Most Hindus are also vegetarians and do not eat any meat, including eggs, white meat, and/or seafood. There are also strict restrictions on food preparations.\(^{71}\) Hindus will not eat food that is prepared in the same pots and pans that were used to cook dishes containing meat. Additionally, certain food combinations are

\(^{67}\) Bhungalia et al., supra n. 31.

\(^{68}\) Gretchen Schafft, Nursing Home Care and the Minority Elderly, 8 J. Long-Term Care Admin. 1, 6 (1980).


\(^{70}\) Schafft, supra n. 68.

\(^{71}\) Bhungalia et al., supra n. 31.
avoided due to their beliefs in “ayurvedic” medicine.\(^{72}\) This leaves them with very little choice given the additional restrictions imposed on them due to illnesses or physical conditions.

The challenge then remains of being able to provide not only a healthy and nutritionally appropriate diet, but also one that is appetizing and adequately meets the requirements of Hindus in such circumstances. Vegetarian foods prepared at nursing homes typically do not use the same spices that are used in Indian cuisine and as such will taste bland\(^{73}\) and will not cater to the taste buds of Hindus. The key issue then is to provide Hindus with those foods that they are comfortable eating, as well as are accustomed to eating in their own homes. Hindus also prefer to eat with their hands, especially their right hands\(^{74}\) and do not use the same hand by which they are eating to serve themselves or others. One way to bridge this need is by employing the services of an Indian nutritionist and an Indian chef at the nursing homes. The Indian chef would be required to comply by the dietary regimens recommended by the Indian nutritionist to the physician. The physician’s approval of the modified diet\(^{75}\) will ensure that the Hindu resident’s dietary needs are also being catered to in terms of health and nutrition.\(^{76}\)

Fasting by Hindu women on specific days of the week is also very common to ensure the family’s well being. There are additional restrictions on types of food that could be consumed on such days, such as fruits, nuts, and dairy products only. In addition to this, there are some festive foods that must be consumed on certain holidays and festivals. Employing an Indian chef to cook these special dishes or foods will enable the Hindu residents to celebrate their festivals and holidays without compromising on their religious practices and beliefs and yet being able to satisfy their dietary requirements. Thus, such beliefs must be considered while planning and preparing a dietary regimen for Hindus, and such practices must be respected as long as their medical condition can tolerate it.\(^{77}\)

**B. Health Beliefs**

Dr. Deepak Chopra, Founder of The Chopra Center for Wellbeing in southern California,\(^{78}\) has popularized ‘ayurveda’ and its holistic approach to a healthy living through his numerous discourses all over the country. Although the principles of ‘Ayurvedic’ medicine and its holistic approach are now gaining momentum in the United States, it is still not a universally recognized field of alternative medicine. However, as mentioned before, many Hindus believe in this traditional system of medicine and also follow certain ayurvedic practices, such as herbal medicinal

\(^{72}\) Lad, supra n. 33.

\(^{73}\) Alagiakrishnan & Chopra, supra n. 37.

\(^{74}\) Bhungalia et al., supra n. 31.

\(^{75}\) Ga. Comp. R. & Regs. r. 290-5-8-.06(5)(2005).


\(^{77}\) Alagiakrishnan & Chopra, supra n. 37.

treatment and following a certain food regimen. Ayurveda is a science that offers a logical and scientific approach for determining a correct diet based upon an individual’s constitution or ‘dosha’. This approach is quite different from the “traditional” view of a balanced diet consisting of appropriate portions from all the five food groups. According to Ayurvedic literature, such a regimen is insufficient to lead us to the path of good health. It is believed that eating the right combination of food enables good health, and certain combinations of food must be avoided to avoid any imbalance. Such beliefs and practices influence the attitudes towards health care for the Hindu nursing home resident and may tend to interfere with his health care and treatment, as he may first choose to use home remedies and herbal medicines for minor illnesses. It is therefore of utmost significance that the health care provider be familiar with these practices and also be aware of any herbal medications that the resident may be prescribing to himself and its effects on pharmacological medications.

Modesty is valued as a virtue among the Hindus and as such the Hindu residents in a nursing home may expect the doctors to be authoritative and to make all the decisions regarding their own health care. They tend to take a passive role and generally accept medical advice without questioning or challenging the health care professional’s expert opinion. In circumstances requiring them to take a more active role, they usually consult and discuss with their family, and decisions are made by the family as a whole.

Mental illness continues to be a stigma and it is often concealed behind other physical symptoms, and hence a mental health provider must always be on the lookout for any symptoms that indicate mental illness.

C. Religious Beliefs

As mentioned above, Hindus believe in the “karma” theory thereby attributing their illnesses as a consequence of their past actions and life. This leads to a sense of hopelessness and helplessness as they may sense a loss of control over their own health. This should be of particular importance when treating some of the psychiatric problems, such as depression and anxiety, which are associated with old age. Hindus also perceive death as just a transitional phase that enables them to move on to their next life, and as such is not a major calamity.

It will be very beneficial for physicians and psychiatrists to have a basic understanding of the nursing home resident’s religious beliefs and how he or she “practices and lives out his faith.” The nursing homes could employ the services of

79. Lad, supra n. 33.
80. Alagiakrishnan & Chopra, supra n. 37.
81. Id.
82. Bhungalia et al., supra n. 31.
83. Alagiakrishnan & Chopra, supra n. 37.
84. Id.
85. Id.
86. The Global Oneness Commitment, supra n. 43.
87. Bhungalia et al., supra n. 31.
Indian doctors as consultants. Furthermore, allowing Hindus to conduct certain religious activities and celebrate certain religious holidays in their traditional manner will also make their stay in the nursing home less intimidating. These religious activities will also address important psychological needs, such as social interaction, spiritual enhancement and connecting with self and others.88

D. End-of-Life Beliefs and Practices

Hindus believe that cremation is the most spiritual way of disposing of bodily remains as it is the quickest way to free the soul from any physical attachments. Chanting, praying, and use of incense sticks are a large part of the end-of-life rituals.89 Hindu family members of the same sex as the deceased must wash and bathe the body of the deceased. It is also important to note that, from that point on, healthcare staff should take care to touch the body as little as possible.90 It is commonly believed by Hindus that, once dead, the body must be moved to the ground so as to be as close to the earth as possible.91 Embalming and autopsy is believed to injure the “astral body”92 and also be felt by the soul. This is of particular importance especially when obtaining permission for organ donation.93 In the event that the cremation has to be postponed so as to allow time for relatives to arrive, “it is recommended that dry ice surround the body and that the coffin be kept closed.”94

E. Language

Although the new Hindu immigrants may know how to speak English, they may not be as fluent in the language or typically may speak English with a strong Indian accent, thereby making them difficult to understand. Furthermore, Mr. Bill Colter, a Manager of Nikkei Concerns, a Seattle-based ethnic Assisted Living community for the Japanese observes that “many people with dementia often revert to their primary language.”95 The second-generation children of the residents may also not be fluent in the primary language of their parents.96 These issues pose communication problems thereby requiring the services of an interpreter97 in order for the residents to be able to communicate their needs to the staff and the health care provider at the nursing home.

89. Bhungalia et al., supra n. 31.
90. Id.
91. Alagiakrishnan & Chopra, supra n. 37.
92. The Global Oneness Commitment, supra n. 44.
93. Alagiakrishnan & Chopra, supra n. 37.
94. The Global Oneness Commitment, supra n. 44.
96. Id.
97. Alagiakrishnan & Chopra, supra n. 37.
F. Clothing Requirements

Some Hindu men wear a sacred and holy thread across their chest symbolizing that they belong to the ‘Brahmin’ caste. It is a common customary practice to pray and worship by holding this thread at the auspicious time so as to derive great strength and power.98 ‘Married’ Hindu women wear a necklace around their neck made of sacred black beads, (called the ‘mangalasutra’) which should not be removed or cut without their permission99 as it has significant religious implications. The ‘mangalasutra’ is a sign of marriage and married women are required to wear it at all times in order to protect their marriage and the life of the husband. It is a customary belief that the necklace should be removed only if the woman becomes a widow.100 Similarly, married Hindu women also wear a “bindi” (dot) on their forehead as a protection for their marriage and their husbands.101

Furthermore, Hindu women who are comfortable wearing the traditional Indian clothes such as sarees and salwar-kurtas may find nursing home gowns to be too revealing or too short102 and may prefer to wear their own clothes brought from their homes.

G. Family Structure and Gender Roles

The Hindu community is a very close-knit community often relying on family help to care for the elderly. However, the new immigrants do not have much family support as they are the first generation of immigrants in the United States. The only family they may have is their children, who may be living elsewhere in the United States and thus unable to extend their help and support. The new Hindu immigrant is left with no choice but to return back to India during old age (which is a common practice), or seek the services of nursing homes. Placing a family member in a nursing homes is perceived to be shameful and disgraceful and a failure on part of the family for their lack of ability to care for their loved ones. Nursing home staff must be sensitive to these sentiments of the Hindu family when the family visits the nursing home resident. Moreover, because Hindu families are so closely-knit, visitors will be many and often.

The new immigrant generation holds conservative views with regards to gender roles, and each gender performs his or her traditional roles within the family. Women often assume a passive role in the family and the men are the decision makers and breadwinners. The men are the ones who interact with people in the community and thus serve as the primary link between society and family.103 Women and men both tend to prefer and feel secure with same sex health care providers, and may feel

98. Sri Swami Sivananda, supra n. 65.
99. Punditravi, supra n. 46.
100. Id.
101. Id.
102. Alagiakrishnan & Chopra, supra n. 37.
103. Bhungalia et al., supra n. 31.
uncomfortable with any physical contact made by the opposite sex. Health care providers must bear this in mind while examining the Hindu nursing home resident.

VI. CONCLUSIONS AND RECOMMENDATIONS

The apprehensions, anxieties and the hesitation of the Hindu elderly to even consider nursing homes or long term care services as an option is comprehensible, given the barriers to long-term healthcare services and the lack of current appropriate services and facilities available for Hindus. Hindus pose a unique set of issues because of their religious and other cultural differences. Hence it becomes critical that facilities providing health care services be also uniquely tailored to provide such services to meet the demands and needs of the varied demographic population. This can be achieved by:

- Conducting cultural sensitivity training to all the staff in nursing homes, including administrators, healthcare providers and support staff (at least in those geographical areas where there is a huge Hindu immigrant population). The cultural sensitivity training should include sessions on differences in religious practices, health care beliefs, food, clothing, family structure and differences in gender roles.
- The staff in nursing homes should include an Indian doctor or physician, an Indian nutritionist or dietician, an Indian chef, and also an interpreter for language barriers.
- Nursing homes could provide a small place of worship for Hindu residents where it would be safe to light incense sticks while praying, or have group religious activities such as “Bhagavad-Gita” study for the Hindu residents (along the lines of “Bible study”). This is a highly valued activity in old age as one prepares for death.
- The Hindu community must be encouraged to visit and participate in the activities of nursing homes and their efforts to open up their doors and welcome the Hindu immigrant community.

Hindu immigrants who arrived in the 1960s-70s will soon be arriving at the threshold of old age and bringing with them a myriad of health care and long term care needs. The American mainstream society has to be ready for them when they avail themselves of such services. Only when the nursing homes are ready to provide such facilities and services can they truly open up their doors to this minority ethnic group.

However, this change has to be two-sided. Hindu immigrants too, have to open up their minds and widen their perspective to consider that nursing homes and other long term care facilities may be not only a feasible option, but also in many circumstances their only option (besides returning to India). There is no doubt that there is an immense feeling of guilt and shame faced by the family in placing their loved ones in a nursing home. However, the Hindu families also have to accept the reality that many of them will continue to live and face old age in the United States, given that their children and family are residing here.

One of the way that nursing homes can open up and welcome Hindus is to advertise in the local Hindu community magazines and newspapers and educate the Hindu community about the services provided that are tailored to the ethnic minority group. Another option, though highly controversial, is to “cluster” different ethnic groups together in different wings of the nursing home. By doing this, the nursing home is diversely populated and yet is able to cater to the specific needs of each community. The different groups also continue to be part of the mainstream community and interact with them. The Mid America Convalescent Center in Chicago, which has a huge ethnic community, has been successful in implementing this approach. This nursing home groups residents by ethnicity. Each group lives on a different floor with their own traditional food served to them and with staff who speak their language and who conduct culturally appropriate activities. So far, the Center has tried this approach only with the Hispanic and Chinese communities. However, there are other nursing homes in Chicago that have also used this approach with Koreans, Poles, Russians and even Indians.

The efforts made by these communities prove that this is a feasible option. By broadening their client base, the nursing homes are also increasing their businesses. However, the key is to be able to convince the Hindus that by placing their loved ones in nursing homes, they are not abandoning them. On the other hand, it is also a relief to the Hindu family if they are convinced that nursing homes will be sensitive and will cater to their needs and beliefs. Thus, it is a win-win situation on both sides.

This approach, however, also has its own drawbacks. The nursing homes in Georgia are highly understaffed. State inspectors found that since 1999, nearly one in every three nursing homes had staffing problems that left thousands of nursing home residents without enough aides or nurses to care for them. Under such circumstances, when the nursing homes are struggling to barely keep their staff from resigning, it would be highly unrealistic to expect nursing homes to employ additional services of Indian chefs, nutritionists or physicians who will cater to the needs of only a small number of minorities in nursing homes. The differences between Hindus and the rest of the American population are so varied that it makes practical sense for the Hindu community itself to come together and to consider other options and alternatives to such an arrangement.

105. Aeschleman, supra n. 69.
106. Id.
108. Id.
109. Id.
110. Id.
AN ALTERNATE PLAN

The new Indian immigrants who arrived in the 1960s took about a decade to settle down, and once they saw that their children were also settled in schools and colleges, they started funneling some of their income towards building Hindu temples,112 to ensure the preservation of their culture and religion. As a high-income earning group, Hindus in America have earned considerably and have also invested considerably in building religious institutions and temples.113 Hindus have invested nearly $1.5 billion in approximately 200 Hindu temples in the United States in the past three decades.114 This evidences the fact that there is a considerable amount of wealth in the Hindu community as a whole. The Hindu community, many of whom will soon be reaching old age, should now focus on redirecting their wealth from temples to instead investing their wealth in assisted living, long-term care and nursing home care facilities that would address their unique differences and needs.115 This would be a more feasible solution as these facilities could employ the services of Indian chefs, nutritionists, male and female physicians to deal with the nursing home residents of the same sex. Social and religious activities and holiday celebrations will be more aligned with the cultural requirements. Only then will the Hindu community be more receptive and comfortable with placing their elderly in such a facility that will be familiar to them and more like a ‘home’.

115. Basler, supra n. 95. A Seattle based Japanese nursing home, Nikkei Manor, supports this concept of an ethnic assisted living community that caters solely to the needs of that community. Nikkei Manor caters to the people of Japanese descent and provides services such as Japanese food and music, and activities such as haiku, ikebana, and calligraphy. The residents can even watch sumo wrestling via satellite television. Id.
KELO AND THE SENIOR HOUSING CRISIS: HOW AN EMINENT DOMAIN—SENIOR HOUSING PARTNERSHIP COULD BE BOTH ADVANTAGEOUS AND DESTRUCTIVE

Michael Nonaka*

TABLE OF CONTENTS

INTRODUCTION ............................................................................................................. 39

I. KELO, ITS PREDECESSORS, AND PUBLIC REACTION ................................................ 41
   A. Kelo’s Predecessors .......................................................................................... 41
   B. Kelo v. City of New London ....................................................................... 43
   C. The Public and Legislative Response .......................................................... 45

II. THE SENIOR HOUSING CRISIS................................................................................. 48
   A. The Quiet Crisis ........................................................................................... 48
   B. The Legislative Response ............................................................................ 50

III. THE BENEFITS TO AN EMINENT DOMAIN - SENIOR HOUSING PARTNERSHIP........ 52
   A. How Proponents of Eminent Domain can Benefit from the Partnership..... 52
   B. How Seniors in Need of Housing can Benefit from the Partnership ........... 54

IV. WORDS OF CAUTION ABOUT THE PARTNERSHIP................................................... 56

CONCLUSION ................................................................................................................ 60

INTRODUCTION

KeLo v. City of New London,1 is the latest Supreme Court case in eminent domain jurisprudence that has been fiercely debated in the media, political and academic circles.2 The case made bare “economic development” an acceptable public purpose to legitimize government takings of private property. “Economic development” can refer to any one or more of a whole package of public benefits – tax revenue, jobs, or production. The media has provided an unending supply of doomsday predictions

* Michael Nonaka is the third place winner of the NAELA Student Journal Writing Competition. He studies law at the University of Pennsylvania.

driven by Justice O’Connor’s dissent, which focus on the state’s “new found ability” to arbitrarily take a person’s house if the result is to bolster economic development.

One oft-mentioned component of economic development packages is the construction of affordable senior housing. Eminent domain and its attendant benefits and burdens are being discussed at a time when senior housing is altogether lacking. The baby boomer generation will reach retirement age and there will simply not be enough affordable and quality housing to accommodate its needs. Quantity, moreover, is not the only deficiency. Reports of seniors living in decrepit conditions are common, and restoration and rehabilitation are essentials to any plan addressing senior housing needs.

Eminent domain, far from being the unitary solution to the senior housing crisis, presents a unique opportunity for seniors. Proponents of eminent domain – namely, city council members and planning commissions – and seniors in need of housing each have something to gain by squaring themselves in the other’s corner. Senior housing is a politically popular cause that could lend legitimacy and approval to city councils looking to use eminent domain to secure economic benefits. On the other hand, including plans for senior housing in the overall scheme of urban planning secures for seniors a place in the forefront of new and exciting development.

But to suggest that the holding in Kelo serendipitously paves the way for a senior housing solution is to casually ignore eminent domain’s effects on minority communities. This paper examines the extent to which eminent domain could be a sensible complement to a senior housing solution by looking at the benefits and burdens of such a partnership.

Part I gives a brief history of eminent domain, Kelo’s role in the doctrine’s evolution, and public and legislative reaction to the Supreme Court decision. Part II examines the senior housing crisis from a variety of perspectives. Part III analyzes how an eminent domain – senior housing partnership could be mutually advantageous.

3. Kelo, 125 S. Ct. at 2677 (O’Connor, J., dissenting) (stating “Today nearly all property is susceptible to condemnation . . .”).
4. See e.g., Hands off our homes, Economist 21 (Aug. 20, 2005).
5. See City Officials Demonstrate Positive Impacts of Eminent Domain, League of Minnesota Cities Press Release ( Jan. 18, 2006) (“There are certain components of quality of life that all of us consider essential to our health and vitality as communities and as a state. Sometimes these goals – jobs, affordable housing, senior housing, environmental clean up and protection, strong neighborhoods – cannot be fully realized without the use of eminent domain.”)(emphasis added). Senior housing needs construction of new facilities and also a long term commitment to restoring and rehabilitating housing that are currently in a state of disrepair. See Federal Programs and Local Organizations: Meeting the Housing Needs of Rural Seniors, Housing Assistance Council (2001) available at http://www.ruralhome.org/pubs/hsganalysis/elderly/carteret.htm. (outlining Carteret County, NC’s collaborative efforts “which greatly accentuate the provision of elderly housing services. . .and the concerted effort of these groups greatly assists elderly homeowners to receive repairs and rehabilitations of their homes”).
6. See e.g., Folly to Mix Seniors and Addicts, Chicago Tribune 20 (Jan. 21, 1995).
7. For an introduction to this issue, see Justice Thomas’ dissent in Kelo, 125 S. Ct. at 2677 (explaining how urban renewal programs often target minorities).
Finally, Part IV discusses the reservations of such a partnership, namely the possibility of displacing many senior minorities from their homes.

I. KELO, ITS PREDECESSORS, AND PUBLIC REACTION

Eminent domain does not have a lengthy history in the courts. Before turning to Susette Kelo and her story, it is useful to look at the two principal cases—Berman and Midkiff—that informed the Kelo majority and dissenting opinions. This will not only put the case in its proper historical context, but will also reveal how momentous (or un-momentous) Kelo was in terms of eminent domain jurisprudence. After a discussion of Kelo, the public and legislative response is outlined.

A. Kelo’s Predecessors

In Berman v. Parker,8 the District of Columbia Redevelopment Land Agency was given authority by the District of Columbia Redevelopment Act of 1954,9 to “acquire and assemble, by eminent domain and otherwise, real property for the redevelopment of blighted territory in the District of Columbia and the prevention, reduction, or elimination of blighting factors or causes of blight.”10 Blighted land would be taken by the Agency and turned over to private redevelopment agencies for improvement. In Project Area B, the area targeted for redevelopment, 64.3% of the dwellings were beyond repair, 17.3% were satisfactory, 57.8% had outside toilets, and 82.2% had no wash basins or laundry tubs.11 A plan was proposed for the area by the Agency and subsequently approved by the district commissioner. Samuel Berman owned a department store in Area B that was not blighted. He challenged the constitutionality of the taking on the basis that his property was being taken for a private, not public use and that his property was not blighted.12

The Court disagreed with Berman’s contentions. The Court considered the slum-like qualities of the area to be important and spent considerable time decrying the negative effects of a broken down, ailing community. The Court relied exclusively on the “public purpose”13 test to validate the council’s redevelopment. Simplistically, because ridding the area of blight was a valid public purpose, the council’s use of eminent domain was valid. After establishing that judicial scrutiny of a legislative determination of public purpose is limited, the Court found that Congress’s pursuit of the public welfare as an end validated any means it chose to accomplish that end.14 The fact that Congress could conclude that enhanced public welfare could be

10. Berman, 348 U.S. at 29 (citing 60 U.S.C. 790, § 5(a)).
11. Id. at 30.
12. Id. at 31.
14. Id. at 33 (stating that “Once the object is within the authority of Congress, the means by which it will be attained is also for Congress to determine.”).
accomplished “through an agency of private enterprise,” did not affect the legitimacy of the public purpose underlying the taking. Furthermore, even though Berman’s department store was not blighted, the Court gave considerable deference to the legislative determination that solving Plan B’s urban problems required “planning the area as a whole.” Berman reaffirmed the Court’s commitment to the “public purpose” test as opposed to the “public use” test.

In Hawaii Housing Authority v. Midkiff, the Hawaii legislature enacted the Land Reform Act of 1967, which “created a land condemnation scheme whereby title in real property is taken from lessors and transferred to lessees in order to reduce the concentration of land ownership.” Lessees on single-family residential lots could petition the Hawaii Housing Authority (HHA) to condemn the property on which they live. The HHA then held a hearing to determine if state acquisition of the property would “effectuate the public purposes” of the Act. If the HHA so found, the State could acquire the land by paying the owner a price and then sell the land to the lessee. The Midkiffs were one of 72 private landowners that owned 47% of the State’s land, a member of the so-called Hawaiian oligopoly. They promptly brought suit after their land was evaluated at one of the HHA’s hearings on the ground that their land was being taken and converted directly into private use, in contravention of the “public use” requirement of the 5th Amendment.

The Court again looked for the public purpose cited by the Hawaii legislature. It stated that as long as an exercise of eminent domain was rationally related to a conceivable public purpose, a compensated taking would never be proscribed by the public use clause. Analogizing to Berman, the Court found that “[r]egulating oligopoly and the evils associated with it is a classic exercise of a State’s police powers.” The taking could pass directly to private hands and remain valid as long as the taking served a valid public purpose.

In both Berman and Midkiff, the individual properties targeted were not blighted or problematic in any way. Rather, the surrounding property or ownership scheme was the ill that generated the public purpose for remedial legislation. Property passed from one private owner to another private owner in both cases. The Court was considerably deferent to Congress and the Hawaii Legislature. Considering this trend of deference towards a legislature’s judgment of what is a public purpose, the result in Kelo was not

15. Id. at 34.
16. Id. (stating that “It was believed that the piecemeal approach, the removal of individual structures that were offensive, would be only a palliative.”).
17. The “public use” test is taken directly from the U.S. Constitution and requires that property after the taking be used by the public. Roads, community centers, and public parks are common examples.
19. Id.
20. Id.
21. Id. at 239.
22. Id. at 241.
23. Id.
exactly surprising. The central question Kelo addressed was how far a legislature could go in defining a public purpose.

B. *Kelo v. City of New London*

Susette Kelo purchased her Victorian style house in 1997 and has made substantial improvements over the period of her ownership. Wilhelmina Dery was born in her house in 1918, her family having owned the home since 1901. Kelo and Dery were two of seven plaintiffs bringing suit to enjoin destruction of their homes by the New London Development Corporation.

New London is located in southeastern Connecticut. Once the sight of the Naval Undersea Warfare Center, the city in 1998 was home to an unemployment rate that was more than double that of the state. The New London Development Corporation (NLDC) is a private, nonprofit organization created several years prior to assist with economic redevelopment. New London authorized a bond issue to construct a state park in Fort Trumbell, the site that previously hosted the Warfare Center. In addition, Pfizer Inc. announced plans to construct a $300 million dollar research facility next to Fort Trumbell, which was also the area in New London where Susette Kelo and the other plaintiffs resided. The NLDC regarded Pfizer’s plans as an anchor and impetus for economic rejuvenation in the area and based its own plans around accommodating Pfizer and the jobs that would bring new people into the city. The NLDC intended for the plan, “in addition to creating jobs, generating tax revenue, and helping to build momentum for the revitalization of downtown New London, the plan was also designed to make the City more attractive and to create leisure and recreational opportunities on the waterfront and in the park.”

In order to accomplish this plan, the NLDC, who was made the city council’s development agent, was given power by the city council to purchase and acquire property by exercising eminent domain in the city’s name. The NLDC found that a 90 acre plot of land was necessary for redevelopment and successfully negotiated the purchase of this land with the exception of the plaintiff’s property. The NLDC initiated condemnation proceedings and the plaintiffs responded by bringing suit, claiming that the taking violated the “public use” requirement of the Fifth Amendment.

The New London Superior Court granted a permanent restraining order prohibiting the taking of 11 of the 15 properties but upheld the taking as to the other 4 properties. Both sides appealed to the Connecticut Supreme Court, which held that all of the proposed takings were valid. Relying on a Connecticut statute that expressed

---

26. *Id.*
27. *Id.*
28. *Id.* at 2660.
29. *Id.*
a legislative determination that the taking of developed land as part of an economic redevelopment project was a “public use” and in the “public interest,” the court held that economic development qualified as a valid public use under the state and Federal constitution. The Supreme Court granted certiorari to determine “whether a city’s decision to take property for the purpose of economic development satisfied the ‘public use’ requirement of the Fifth Amendment.”

Justice Stevens wrote the majority opinion for the Court, joined by Justices Kennedy, Souter, Ginsburg, and Breyer. The opinion reaffirmed the Court’s deference to legislative determinations of public purpose. Economic development, the Court found, was not unlike the public purposes affirmed in \textit{Berman} and \textit{Midkiff}, and therefore the taking of the plaintiff’s property was constitutional. The fact that the property was passing to a private entity did not matter, just as it did not matter in \textit{Midkiff}, because public purposes could be served through agencies of private enterprise.

The concern raised by the plaintiffs that the Court’s logic could seemingly allow one-to-one forcible transfers between private parties was dismissed as not representative of the facts. The Court also rejected heightened scrutiny for eminent domain takings for economic development on the grounds that such an exacting review would delay many construction projects, and because second-guessing was not consistent with the considerable amount of deference given to the legislature.

In sum, the Court took the same position as the Supreme Court of Connecticut, looking only for a valid public purpose, giving the legislature considerable deference in deciding what that purpose was, and ending the analysis. Justice Stevens made clear that the Court’s opinion only interpreted the United States Constitution requirements and left the issue of further restrictions on the takings power to the states.

Justice O’Connor’s dissent, joined by Chief Justice Rehnquist, Justice Scalia, and Justice Thomas, focused on the fact that past precedents had never gone so far as to allow economic development alone to serve as the public purpose. In \textit{Berman} and \textit{Midkiff}, the takings were of such a character that the destruction of the property by itself served a valid public purpose. In \textit{Berman}, eliminating blight was a legitimate public purpose and in \textit{Midkiff}, dismantling a land oligopoly was equally legitimate. O’Connor emphasized the fact that the taking of property in New London was a purely private taking because the plaintiff’s property, by itself, did not constitute a harmful

\begin{enumerate}
\item \textit{Id.} at 2661.
\item \textit{Id.} at 2664 (stating that “For more than a century, our public use jurisprudence has wisely eschewed rigid formulas and intrusive scrutiny in favor of affording legislatures broad latitude in determining what public needs justify the use of the takings power.”).
\item \textit{See Midkiff}, 467 U.S. at 243.
\item \textit{Kelo}, 125 S. Ct. at 2668. The idea of heightened scrutiny for some eminent domain takings found favor with Justice Kennedy, who, in his concurrence, reserved the idea for takings where the risk of impermissible favoritism was so acute. \textit{Id.} at 2670 (Kennedy, J., concurring).
\item \textit{Id.} (stating that “We emphasize that nothing in our opinion precludes any State from placing further restrictions on its exercise of the takings power.”).
\end{enumerate}
character whose eradication could form the basis of a public purpose. Her final words would later become a battle cry for opponents of eminent domain: “Any property may now be taken for the benefit of another private party. . .The beneficiaries are likely to be those citizens with disproportionate influence and power in the political process. . .As for the victims, the government now has license to transfer property from those with fewer resources to those with more.”

Justice Thomas wrote a separate dissent to suggest how unworkable the public purpose standard had become and how simple the “public use” test would be to apply. Justice Thomas’s parting words were equally, if not more chilling than Justice O’Connor’s. Thomas recognized that predominantly racial minorities would be subjected to eminent domain. In Berman, 97% of the individuals removed due to the blighted area were black and in another instance in Detroit, MI, referred to as Poletown, eminent domain was used to displace a black community to make way for a General Motors plant. Indeed, urban renewal resulted in widespread displacement of minority communities. “Of all the families displaced by urban renewal from 1949 through 1963, 63 percent of those whose race was known were nonwhite, and of these families, 56 percent of nonwhites and 38 percent of whites had incomes low enough to qualify for public housing, which, however, was seldom available to them.”

The Kelo majority opinion did little to allay concerns that the government was free to initiate purely private transfers. All of the opinions utilized what little precedent there was in eminent domain case law and because of that shortage, the Justices had more freedom to emphasize the importance of certain facts and minimize the importance of others. The public and legislative response was inflammatory in part because of the ease with which the Kelo majority shaped past precedent.

C. The Public and Legislative Response

The public and legislative response was swift, as public groups decried the end of property rights and federal, state, and local legislatures started working on bills that would limit the effects of the Court’s ruling.

Kelo galvanized many concerned citizens groups to advocate for eminent domain reform, ranging from citizens organized by state, ideology, and race. The Minnesotans

38. Id. at 2675 (stating that “New London does not claim that Susette Kelo’s and Wilhelmina Dery’s well-maintained homes are the source of any social harm.”).
39. Id.
40. Id. at 2679 (Thomas, J., dissenting) (stating that “The most natural reading of the Clause is that it allows the government to take property only if the government owns, or the public has a legal right to use, the property, as opposed to taking it for any public purpose or necessity whatsoever.”).
for Eminent Domain Reform (MNEDR) is a coalition of civil rights groups, religious
groups, concerned citizens and city officials trying to push eminent domain legislation
through the Senate. The Virginia Farm Bureau has been similarly active in pushing
legislation in Virginia restricting right of entry of government condemners and
ensuring just compensation. The Castle Coalition is the Institute for Justice’s
property rights group that provides interested citizens with resources, including an
“eminent domain abuse survival guide” that outlines steps to take to defend against
eminent domain. The Cato Institute weighed in by emphasizing that the Court had
not committed to strong property rights since the New Deal. Project 21 is a group
created to promote the views of African-Americans whose “entrepreneurial spirit,
dedication to family and commitment to individual responsibility” has been
underrepresented in civil rights groups. The Virginia arm of Project 21 has protested
the Court’s decision, picking up on Justice O’Connor’s admonitions. Horace Cooper,
a member of Project 21 and law professor at George Mason University School of Law
stated that Kelo, “places nearly all private property in peril. As Justice Sandra Day
O’Connor wrote in her dissent...’The specter of condemnation hangs over all
property.’ Nothing is to prevent the State from replacing any Motel 6 with a Ritz-
Carlton, any home with a shopping mall, or any farm with a factory.” It is important
to note that not all citizens believe Kelo was as momentously destructive as the groups
mentioned above. One common reply, albeit not responsive, to opponents of eminent
domain is that Kelo did not make any major jurisprudential move that Berman had not
already made. Regardless, after the Kelo decision was announced, a Quinnipiac
University poll showed that 89% of Connecticut citizens favored laws limiting
eminent domain. 68% of all registered voters nationwide favor such laws.

44. Press Release, Minnesotans for Eminent Domain Reform, Historic & Diverse Coalition Calls for
45. Press Release, Virginia Farm Bureau Federation, Farm Bureau calls for eminent domain reform,
American Farm Bureau states that “[A]gricultural land is the livelihood of our farmers and ranchers
and important for U.S. food and feed production, but land used this way is not the highest income
generator for government bodies. Tax revenue cannot be the basis for seizing private property.”).
index.html (accessed April 21, 2006).
47. See James W. Ely Jr., Property Rights and the Takings Clause: “Poor Relation” Once more: The
(“[T]he justices have been unwilling to break free of the New Deal constitutional hegemony that
radically weakened traditional judicial solicitude for economic rights.”).
49. Project 21, Press Release, Black Activists in Virginia Call for Eminent Domain Reform,
51. Quinnipiac Polling Inst. 1, Connecticut Voters Say 11 - 1 Stop Eminent Domain, Quinnipiac
The legislative response was swift and organized as well, fueled by groups like the MNEDR. On the state level, 45 states have passed or proposed laws that restrict eminent domain in some fashion. These bills range from expressing displeasure with *Kelo*,\(^53\) to specifically prohibiting eminent domain for economic reasons,\(^54\) to constitutional amendments relating to eminent domain.\(^55\) Most of these bills will pass to the state senates in the upcoming months and their treatment as the *Kelo* frenzy subsides will largely determine the future of eminent domain in the states. The United States Congress has been more cautious. The Senate has introduced three bills; the most notable one is the Protection of Homes, Small Businesses, and Private Property Act of 2005 sponsored by Senator Cornyn (R-Texas).\(^56\) The bill states that eminent domain is only available for public uses and that economic development is not a public use.\(^57\) The Act is currently making its way through the Senate Judiciary Committee and a hearing was held where property law professors, the NAACP, and Susette Kelo got a chance to tell the Senate about the evils of eminent domain. The House has been slightly more prolific, introducing and passing a bill in Congress that prevented any moneys from a Treasury, Transportation, and Housing and Urban Development Appropriations bill from going to the enforcement of the *Kelo* decision.\(^58\) The House also passed a bill by a 365-33 vote on June 30, 2005, one week after the decision was announced, which expressed disagreement with the majority opinion.\(^59\) In sum, taking up Justice Stevens’ invitation, eminent domain legislation has been much more prevalent in the state legislatures, although Congress has taken a small step in restricting federal moneys to enforce *Kelo*. 2006 will be a key year, in both state legislatures and Congress, in meting out competing interests that make eminent domain so debatable.

*Kelo* gave opponents of eminent domain the momentum necessary to introduce legislation at state and federal levels of government. Although the decision is hardly momentous in its legal reasoning, the decision has become momentous for all of the fear it has engendered over property rights. At the same time eminent domain is being debated in Congress and the media, the senior housing crisis is another housing issue

\(^53\) See H.R. 49A (Al. 2005) (“expressing grave disapproval. . .”)
\(^54\) See S.B. 2939, 1st Sess., at § 46 (Haw. 2006) (prohibiting “Eminent domain for economic development purposes.”); H.B. 27, 2nd Sess., at 1 (N.M. 2006) (“The state or a local public body shall not condemn private property if the taking is to promote private or commercial development and title to the property is transferred to another private entity.”); H.B. 2438, 1st Sess., at § 1 (Tenn. 2006); H.B. 2427, 1st Sess., at § 2 (Wash. 2006).
\(^57\) S. 1313 § 3, 109th Cong. (2005).
that the public and legislatures must address. Unlike eminent domain, which only poses a problem to the extent city councils exercise it, the senior housing crisis is an inevitable problem.

II. THE SENIOR HOUSING CRISIS

A. The Quiet Crisis

The Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (the “Commission”) was established by a 2000 appropriations bill to provide, “an estimate of the future needs of seniors for affordable housing and assisted living and health care facilities.…” The Commission had 14 commissioners in charge of the study, including members of several housing authorities, private developers, and members of church housing. After conducting field hearings across the United States and creating task forces to gather a vast sum of data, the Commission delivered its final report to Congress on June 28, 2002. The findings were anything but positive.

The Commission noted that the number of seniors (age 65 or older) was set to increase dramatically by the year 2020. In 2002, seniors accounted for 12.4% of the U.S population. By 2020, that number will rise to 20% and 53 million Americans (1 in 6 residents) will be 65 or older. The Commission found that one-third of all seniors would have housing needs and that the current production of affordable housing would not “even begin to meet demand.” Compounding the problem is the fact that nearly half of seniors have an income of less than 50% of the regional median. Seniors use more than 50% of their income on housing. In terms of pure demand, by 2020, an additional 730,000 rent-assisted units will be needed to maintain the rate of senior accommodation that exists today. In the present, there are long waiting lists for senior housing. Rent-assisted housing is truly unavailable. For every senior served

62. The co-chairs were Ellen Feingold, the president of Jewish Community Housing for the Elderly, and Nancy Hooks, Regional Vice President for the American Association of Homes and Services for the Aging (AAHSA).
63. Report, supra n. 60.
64. Id. at 1.
65. See id. at 13.
66. Id. at 14. See also Housing for the Elderly: Hearing Before the Subcomm. on Housing and Community Opportunity, House Comm. on Financial Services, 107th Cong. (July 17, 2001) (statement of Thomas Slemmer, President, National Church Residencies) (“Unfortunately, low income elderly people seeking housing are faced with multi-year waiting lists exacerbated by the shrinking supply of suitable, affordable housing as some owners convert existing units to market rate housing.”).
67. Report, supra n. 60 at 22.
by rent-assisted housing, there are six with unmet housing needs. This steadily rising senior population paired with an uncoordinated policy toward senior housing is what the Commission refers to as the “quiet crisis.” Elocuently stated, “The housing and healthcare services shortfall of today will turn into the housing and healthcare services crisis of tomorrow if our policymakers fail to anticipate and act on the arrival of baby boomers that are of modest means.”

As the report indicates, the problem is not one of sheer supply and demand. Affordability and habitability are part of the problem as well. As mentioned, nearly half of seniors have income amounting to less than 50% of the regional median. Section 202 Housing for the Elderly grants, as a part of the Department of Housing and Urban Development, help take the sting off of housing in two ways. The first is to provide grants to nonprofit organizations to construct affordable rental housing for seniors. The second is to make partial rental payments to the organizations to lower rental prices to seniors. Unfortunately, the HUD grant and rental payment application is a bureaucratic nightmare with long delays that financially threaten the non-profits that are planned in anticipation of receipt of this money. Many of the homes that seniors live in are increasingly old and badly in need of repair. A study conducted by the Illinois Institute for Rural Affairs showed that 20% of seniors live in houses that are more than 73 years old. Furthermore, the study found that certain severe problems, such as inadequate heat or lack of indoor plumbing, were typical in many areas. A different study found that seniors in urban areas nationwide suffered from many of the

---

68. Id. at 5.
69. Id. at 1.
70. Housing and Service Needs for Seniors: Hearing Before the Senate Banking, Housing and Urban Affairs Comm., 109th Cong. (June 16, 2005) (statement of Nelda Barnett, Member Board of Directors, AARP).
71. Although for sure, the most pressing issue is inadequate supply. According to co-chair Ellen Feingold, in 2020, 9.5 million very low income seniors will have high priority housing problems. Assuming that one-quarter (the current proportion) of these seniors want to live in rent-assisted housing, 2.4 million units need to be produced by 2020. If production had started in 2003, 140,000 units a year would satisfy the need. See Seniors Housing and Health Care: Hearing Before the Senate Comm. on Banking, Housing and Urban Affairs, 107th Cong. (2002) (statement of Ellen Feingold, co-chair, Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century).
72. E.g., Section 202 Housing: Hearing Before the Senate Special Comm. on Aging, 108th Cong. (2003) (statement of Larry Craig, Member, Senate Committee on Aging). A year before, the Commission recommended that the process be simplified. Just three years before, The Section 202 housing program was hailed as “widely recognized to be one of the federal government’s most successful housing programs. . .[and] the “crown jewel” of HUD assistance to elderly Americans. It has well served the elderly, local communities and our nation for over four decades. It continues to prove its value.” The Affordable Housing for Seniors and Families Act: Hearing on S. 2733 Before the Senate Subcomm. on Transportation, Comm. on Banking, Housing and Urban Affairs, 106th Cong. (2000) (prepared testimony of Laverne R. Joseph, Chief Executive Officer, the Retirement Housing Foundation). Regardless of their past success, Section 202 grants are undoubtedly a part of the future solution.
73. See Jane Adler, Rural, urban seniors share in housing woes, Chicago Tribune A6 (Dec. 19, 2004).
same conditions. Facilities constructed in the 1960s and 70s desperately need modernization to maintain the level of care provided. 20% of the 45,000 federally-assisted housing units built in that time period do not have capital reserves to meet repair needs. Facilities in poor financial condition have every incentive to convert their units into market-rent apartments after their 30 or 40 year contract period. 83,000 units are currently at risk of conversion and another 15,000 units have already converted to market rents.

Another factor that complicates the housing crisis is one of senior preference. In a May 2000 AARP Study of people aged 45 or older, 82% said they would rather not move from their current home if they were to become dependent on someone else for day to day care. This preference, called “aging in place,” is supported by dozens of interest groups including the National Aging in Place Council, National Association of Home Builders, Aging in Place Initiative, and the NeighborWorks Campaign for Home Ownership. Taking hold of the fact that a majority of seniors want to remain in their homes, these organizations aim to make seniors aware of home-based services that make independent living possible. Critics claim that aging in place only encourages seniors to remain in houses with substandard conditions but without the money for repair. Because of the overwhelming number of baby boomers and seniors alike who desire to remain in their homes, aging in place initiatives will be an integral consideration in any long term solution. State legislatures and Congress has paid increasing attention over the past five years to the housing crisis.

B. The Legislative Response

After the 2002 Commission declared a “quiet crisis,” the national government took notice of the problem. In December of 2005, the President convened the White House Conference on Aging, held every decade, to develop recommendations for a coordinated policy on senior issues. This past year’s conference rightly focused on the “78 million baby boomers turning 60 in January of 2006.” Although the final

---

74. Id.
76. In accepting federal funds for construction of facilities, organizations must usually make a commitment to being in the business of providing senior housing for 30 or 40 years.
77. E.g., American Association of Homes and Services for the Aging, supra n. 75.
79. See Adler, supra n. 73 (asserting that one university professor believes that “public policy should encourage seniors to sell their homes and move to more appropriate and safer housing” and that there has not been “a careful assessment if aging in place is a desirable approach”).
report will not be presented by statute to Congress until June of this year, certain resolutions called for immediate action. The first recommendation was the immediate reauthorization of the Older Americans Act of 1965, which is set to expire at the end of 2005. One of the act’s objectives concerns a commitment to “suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.” The 2000 amendments to the Act ensure that a future Commission meets to assess the success of past initiatives. Several of the resolutions of the White House Conference concerned housing specifically. Resolution 14 advised “expand[ing] opportunities for developing innovative housing designs for seniors’ needs.” Resolutions 23 and 24 flatly advised to enhance the availability and affordability of senior housing. Several of the resolutions focused on the need for a coordinated effort from state and Federal agencies, all levels of government, and local communities. At the same time, a bill for such a coordinated agency is making its way through the House.

Senator Paul Sarbanes introduced the Meeting the Housing and Service Needs of Seniors Act of 2005, which was subsequently passed in the Senate by unanimous consent. The Senate found that programs established to provide senior services were fragmented and spread across many different agencies, making access difficult. Reacting to the 2002 Commission’s finding that “the most striking characteristic of seniors’ housing and health care in this country is the disconnection of one field from another,” Senator Sarbanes asserted that fragmentation of services had “real consequences.” “The disconnect of housing from services places an enormous burden on seniors and their families in making decisions about long-term care. Families must not only worry about the affordability of housing, but they must piece together health care, transportation, physical assistance and other services.” The bill establishes the “Interagency Council on Meeting the Housing Needs of Seniors,” comprised of the President’s cabinet and the heads of several federal agencies. The agency’s purpose is to streamline services for seniors in such a way as to minimize the administrative burden and bureaucratic delays, and maximize cooperation across the state and federal levels of government. The core programs that need to be coordinated are those administered by the Department of Housing and Urban Development. Some of these programs include payments to non-profit organizations constructing senior housing, to convert regular senior housing programs into assisted living facilities, and to facilitate reverse mortgages for seniors. The statements at the Congressional hearings stress how difficult it is for seniors and non-profit organizations to access these programs. The legislative response has largely centered on centralizing administration of services

86. Id. at § 2(6).
87. Report, supra n. 60 at 7.
and the real question of how much money will be spent to further those services will be debated in state and federal legislatures in the near future.

III. THE BENEFITS TO AN EMINENT DOMAIN - SENIOR HOUSING PARTNERSHIP

The purpose of this section is to examine how eminent domain can be used to help assuage the senior housing crisis, and to explain what eminent domain proponents stand to gain by including seniors in economic development plans. Before this discussion is elaborated however, it is necessary to elucidate the role each plays in current public policy. Eminent domain is an implementation of a particular belief in the way society is ordered, with private property rights subordinate to the will of the State, as long as that will is pursuing the greater public interest. This belief represents the vision the founders had for the United States as reflected in the Fifth Amendment. The restraints on eminent domain have developed over the course of a century through Supreme Court cases addressing the public use test and the ensuing public purpose test. Therefore, while some minimum amount of eminent domain is safely guarded in the Bill of Rights, the expansive reading of the power in Kelo is, has been, and will continue to be contested. Eminent domain is only a vehicle, a means to an end and the extent to which it should be available to city councils is a matter of debate. The senior housing crisis is not. It is an empirically verifiable set of circumstances. The only debatable part about the crisis is how it will be addressed. It could be natural to suggest that eminent domain, a means, and the senior housing crisis, an end to be abated, are joined pieces of the same puzzle. Part III certainly looks at some of the features of each that could lead to this notion. But where Part III paints a picture of a relationship of mutual benefit, Part IV is a resounding warning for such a partnership. Now that their potential relationship is explained, the possible benefits for each can be examined.

A. How Proponents of Eminent Domain can Benefit from the Partnership

As Part I illustrates, opponents of eminent domain are a mobilized, highly charged group of concerned politicians, lawyers, community groups, and media outlets. Few Supreme Court cases in the 20th Century have engendered as much rage and response as Kelo. Indeed, because Kelo is not revolutionary in terms of prior precedent, the debate will take place largely in the media and political stages. Local

90. Although the United States Constitution imposes more restrictions on the eminent domain power, such as just compensation and the public use requirement, the core of the power is predicated on a judgment that private individuals can never know the public good as well as the State. See Hugo Grotius, The Law of War and Peace 402 (1625).

91. It is important to note that this paper does not attempt to establish the validity of the current eminent domain jurisprudence. The paper’s position is merely that, if a person can come to the conclusion that eminent domain is desirable and legally justified in its current form, the power has interesting benefits for senior citizens and vice versa. Part IV goes on to examine concerns raised by the relationship.

organizations across the United States have sprung up in response to the Court’s holding and politicians have taken firm stances on the issue to satisfy constituents.\(^{93}\) The senior housing crisis is also a hot button issue that many baby boomers have an interest in seeing resolved as quickly and efficiently as possible. By tying the use of eminent domain to the construction of senior housing, proponents of the power mitigate some of the political backlash \textit{Kelo} has caused. This would be a devious proposition if it was not indicative of the purposes eminent domain proponents cite in defense of the power. By far, one of the most common uses of land when proponents of eminent domain outline their proposals is senior housing. In Chicago, eminent domain has been used to take land that used to be occupied by a former railyard and adult bookstore to build “senior housing, a Target store, movie theaters and other businesses.”\(^{94}\) In Worcester, eminent domain was used to take land that used to house a shoe-manufacturing plant to build either “affordable senior housing or assisted living.”\(^{95}\) In Lodi, NJ, officials are trying to use eminent domain to uproot a trailer park community to build a “gated senior community with 250 housing units and 112,000 square feet of retail.”\(^{96}\) In rehabilitation of parts of Louisiana affected by Hurricane Katrina, “judicious use of eminent domain” is seen as a necessary component of development of senior housing.\(^{97}\) This is not to suggest that legislatures did not already have senior housing in mind when areas for redevelopment were targeted. Legislatures are not deciding to use eminent domain without first recognizing needs of the senior community. The fact still remains that senior housing is a politically popular cause that helps to fight the “one man’s home is another man’s Home Depot” picture that eminent domain opponents try to paint. Constructing senior housing on sites acquired through eminent domain reminds the public that greedy developers are not the only stakeholders served by an exercise of the power. In this way, redevelopment councils can benefit by building senior housing on eminent domain property because it gives the public less of a reason to react.

\footnotesize{93. E.g., Press Release, Office of Connecticut State Senator Judith G. Freedman, \textit{Sen. Freedman Disappointed with U.S. Supreme Court Decision in New London Eminent Domain Case}, http://www.senaterepublicans.ct.gov/press/freedman/062405.htm (June 24, 2005) (“Senator Judith G. Freedman (R-26) said she agrees with the many constituents who have contacted her to express their disappointment regarding this week’s U.S. Supreme Court decision in \textit{Kelo et al vs. New London}...[She is] quickly losing count of the phone calls and e-mails from constituents who are shocked by the U.S. Supreme Court decision...[and] wants to reassure [her] constituents that, like them, [she believes] that eminent domain is a tool to be used in only the most extraordinary circumstances, not for commercial development.”).}

\footnotesize{94. Crystal Yednak, \textit{Eminent domain now big business; Lawmakers, owners confront land grabs}, Chicago Tribune 1 (Jan. 3, 2006).}

\footnotesize{95. Patricia J. James, \textit{Frye Property may get assisted living home}, Telegram & Gazette (Worcester, MA) B3 (Jan. 24, 2006).}


Another way that eminent domain proponents can benefit by constructing senior housing on targeted land is the cost savings due to government subsidies available for developers who choose to build senior housing for low-income seniors. Although developers used to be reluctant to build senior housing because of the prohibitive administrative and legal costs associated with qualification, the Housing for Older Persons Act of 1995 simplified qualification for senior communities. Now that the initial hurdle is lowered, redevelopment agencies can consider senior housing as they would any other real estate venture with the added benefit of section 202 HUD grants. Section 202 grants can come in two forms. The first is a capital outlay intended to defray construction costs that does not have to be repaid if the facility is operated as senior housing for 40 years. The second is a rental payment subsidy intended to defray operating costs, which in turn defray senior tenant’s rental costs. With the first type of assistance, redevelopment boards should have a much easier time finding a willing buyer for lands acquired through eminent domain if the buyer knows that his initial capital outlay is significantly lower. Redevelopment councils can safely rely on being able to sell land for senior housing as long as HUD grants are accessible. With the second type of assistance, rental assistance payments minimize some of the risk incumbent to managing housing. Tenants only have to pay a small percentage of their rent, with the federal government paying the rest. Consequently, the risk of defaulting tenants is lowered. Additionally, with the sizable waiting list for rent-assisted housing, there is no shortage of seniors looking to live in such property. A redevelopment council’s funding depends on its ability to increase property values. This creates a strong incentive for a fast turnaround from acquisition to sale, to which the demand for rent-assisted senior housing and its federal funding are conducive.

Eminent domain proponents stand to benefit from senior housing’s political popularity and government subsidies. Although senior housing is certainly not meant for all land acquired through eminent domain, developers gain a substantial amount of political leverage by including senior housing in a redevelopment plan. On top of this, the economics of the overall transaction are also beneficial. The benefits that facilities constructed through eminent domain can bring to seniors are also substantial.

B. How Seniors in Need of Housing can Benefit from the Partnership

The most obvious benefit to seniors from exercises of eminent domain is the increased availability of housing. As the previous section demonstrates, senior housing is frequently constructed on land acquired through eminent domain.

99. Id. at 184.
100. Importantly, § 202 grants are only available for senior housing for low-income elderly.
103. See Yednak, supra n. 94.
Waitlists are burdensomely long. Although any amount of additional senior housing will ultimately help with the shortage, to truly stem the oncoming tide of seniors who will expand these waitlists, a sound national policy dedicated to building senior housing must be the core of any solution. The quantity of senior housing needed is overwhelming and construction cannot depend in any part on a blight determination. In terms of the overall housing crisis, therefore, eminent domain provides only a small benefit to seniors.

For individual seniors who move into newly constructed property acquired and developed through eminent domain, the benefits are much greater. These seniors will be fortunate to reside in an area that has been thoroughly and thoughtfully planned under intense scrutiny. Because of this, seniors can expect a plethora of services at their disposal and an infrastructure cognizant of senior needs. This helps greatly with the service fragmentation problem, discussed in Part II, because the land is developed with senior needs in mind. For example, because seniors make roughly 90% of all of their trips in a private car, the need for accessible and durable roads must be part and parcel to a senior housing community. Fortunately, to take California as an example, redevelopment agencies typically spend two-thirds of their money on “improving streets, streetlights, landscaping, sidewalks, parking lots, sewer and water systems and other public infrastructure.” Seniors that depend on updated and reliable infrastructure for their daily needs benefit by living in areas developed through eminent domain.

Because any eminent domain development will be closely monitored by community groups, there is a greater premium placed on intelligent and collaborative planning. Getting the entire community involved in the redevelopment plan unifies the community toward a common goal, which includes quality senior care, if they so choose. As the American Planning Association states, in response to Kelo, “the Court specifically noted that communities are granted deference in the determination of public use based primarily on the fact that an open, participatory, and comprehensive planning process was involved. Planning is the appropriate forum for public debate and decision making. Good plans outline the collective vision of a community.”

---

104. See generally, Memorandum from Elaine Costello, Community development director of Mountain View, CA and Linda Lauzze, Administrative and neighborhood services manager, to the Mountain View, CA City council 12 (Oct. 13, 2005) available at http://www.ci.mtnview.ca.us/citygov/council/agendas/pdf/101805_6.pdf (stating that there are over 700 households on a waiting list for senior and special needs housing).

105. Although this is not the holding in Kelo, many states are in the process of adopting statutes that require such a finding in order invoke eminent domain. See e.g., H.R. 331, 126th Leg., 1st Reg. Sess. (Oh. 2005).


107. E.g., City of West Sacramento Website, Answers to 10 Common Questions about Redevelopment, http://www.ci.west-sacramento.ca.us/cityhall/departments/redev/about/faq.cfm (accessed April 24, 2006).

redevelopment plans are the product of community input and include provisions for senior housing, seniors can look forward to being welcomed into the community. Eminent domain, pursuant to a collaborative community plan, can benefit seniors by ensuring that everyone in the community wants the seniors to be there.

Benefits for seniors in terms of eminent domain is, for all practical purposes, limited to the select few who eventually live on property acquired through the power. For these seniors, their new homes entail a sense of community and newly updated infrastructure. But these seniors are only one side of the coin. The other side is the people uprooted by eminent domain. For these people, the picture is not nearly as bright. Only after this important group is evaluated can a true picture of the eminent domain – senior housing relationship be painted.

IV. WORDS OF CAUTION ABOUT THE PARTNERSHIP

Up to this point, the focus has been on the benefits that eminent domain can provide to seniors and the advantages eminent domain proponents gain by including seniors in their redevelopment plans. Critics, discussed in Part I, point out numerous ills often associated with eminent domain, including the diminution of property rights, the undemocratic nature of its exercise, and its discriminatory impact on minority groups. This last ill, the disproportionate negative impact on minority groups is discussed in this part. Despite numerous protests from minority communities, it is not a generally accepted principal that eminent domain affects minority groups. Mayor Eddie Perez, mayor of Hartford, CT, in praising the Kelo decision, stated “For urban America and communities of color, in particular, homeownership is the ticket to the American dream. . . .If Congress were to pass legislation to hamstring state and local governments from using eminent domain in some of our poorest communities, I believe that we would have fewer people becoming homeowners.” This myopic focus on homeownership callously disregards the economic reality that many low income individuals are more concerned with making rent payments than stashing away money for a down payment. As it stands right now, 49.1% of African Americans own their own home while 76.0% of Whites own their own home. The disparity is not the result of restrictions on eminent domain but a reflection of the socioeconomic conditions that attend race. Using eminent domain to level an apartment building could give one minority family home ownership and leave 99 homeless. In this Part, the argument and data supporting Justice Thomas’ contention is briefly examined before closer attention is paid to eminent domain’s possible effects on senior minorities.

[109] Project 21, supra n. 49 (stating that minorities without much weight in the political process are more often the targets of eminent domain).


A. Eminent Domain’s Disproportionate Effect on Racial Minorities

Justice Thomas’s final paragraph warns about the potential for disproportionate amounts of burden to fall on minority groups when local communities try their hands at urban renewal or eminent domain:

Of all the families displaced by urban renewal from 1949 through 1963, 63 percent of those whose race was known were nonwhite, and of these families, 56 percent of nonwhites and 38 percent of whites had incomes low enough to qualify for public housing, which, however, was seldom available to them. Public works projects in the 1950’s and 1960’s destroyed predominantly minority communities in St. Paul, Minnesota, and Baltimore, Maryland. In 1981, urban planners in Detroit, Michigan, uprooted the largely “lower-income and elderly” Poletown neighborhood for the benefit of the General Motors Corporation. Urban renewal projects have long been associated with the displacement of blacks; ‘in cities across the country, urban renewal came to be known as ‘Negro removal.’ Over 97 percent of the individuals forcibly removed from their homes by the “slum-clearance” project upheld by this Court in Berman were black. Regrettably, the predictable consequence of the Court’s decision will be to exacerbate these effects.\(^{112}\)

Areas typically targeted by eminent domain are “not only systematically less likely to put their lands to the highest and best social use, but are also the least politically powerful.”\(^{113}\) Eminent domain is often used to accomplish urban renewal – economic development localized to traditionally poorer neighborhoods. Professor Wendell Pritchett asserts that urban renewal programs have generally been associated with targeting slums, thereby disproportionately affecting minority residents.\(^{114}\) In fact, Professor Pritchett asserts and Justice Thomas agrees, “slum clearance and negro clearance” were often used interchangeably.\(^{115}\) Minorities in urban areas typically live in poorer neighborhoods that redevelopment councils favor because of their low property values and potential for tax revenue. Furthermore, there is no evidence that minority communities uprooted through eminent domain benefit in some way because of the taking.\(^{116}\) The fact that the Southwest D.C. neighborhood targeted in Berman was 97% black before eminent domain and a majority white after is evidence that eminent domain can be used to shape the racial demographics of a city.\(^{117}\)

112. *Kelo*, 125 S. Ct. at 2687 (Thomas, J., dissenting) (internal citations omitted).
113. *Id.*
115. *Id.* at 34.
116. “Just compensation” for a slum will be a small amount of money and cannot be presumed to cover the cost of securing new housing.
117. *See Pritchett*, supra n. 114, at 47. *See also The Kelo Decision: Investigating Takings of Homes and other Private Property: Hearing Before the Sen. Comm. on the Judiciary, 109th Cong. (2005) [hereinafter Hearing] (statement of Hilary O. Shelton, Director, Washington Bureau NAACP) (“A 2004 study estimated that 1,600 African American neighborhoods were destroyed by municipal projects in Los Angeles . In San Jose, California, 95% of the properties targeted for economic redevelopment are Hispanic or Asian-owned, despite the fact that only 30% of businesses in that area are owned by racial or ethnic minorities. In Mt. Holly Township, New Jersey, officials have...*)
Shelton, director of the Washington Bureau of the NAACP, eloquently sums up the effect by stating that, “racial and ethnic minorities are not just affected more often by the exercise of eminent domain power, but they are almost always affected differently and more profoundly. . . . [T]he very threat of such takings will also hinder the development of stronger ethnic and racial minority communities.”

Eminent domain can wreck a minority community and the demographic that suffers the most is seniors.

**B. Eminent Domain’s Negative Impact on Senior Minorities**

Senior minorities uprooted through the eminent domain process suffer more than non-senior minorities and Caucasian seniors because senior minorities are 1) worse off financially, 2) extensively rooted in the community, and 3) underserved by social service programs.

Although Mr. Shelton’s statement to the Senate Judiciary Committee establishes that any person whose land is targeted for eminent domain will not be able to afford to live on the land post-development, senior minorities suffer from the lack of wage income due to their age and from “cumulative disadvantage as a consequence of powerlessness, subordination, prejudice, and discrimination.” In other words, senior minorities, namely blacks, struggled through times in the early to mid 20th Century when there was no semblance of economic equality between the races. “[T]he situation of the minority aged represents a compounding of the disadvantages of an ethnic stratification and an age stratification system.”

30% of elderly blacks receive public assistance payments compared to 7% of elderly whites and only 13% of elderly blacks receive income from personal assets compared to 53% of elderly whites. Trends in home ownership, an important source of income through Reverse Annuity Mortgages, show that homes owned by minority seniors are generally lower in value and in more dilapidated condition than non-minority seniors. Senior minorities simply have less money than other seniors and other minorities, and will have more difficulty securing living arrangements after being uprooted. With all of the recent attention on rent-assisted senior housing, one might suggest that senior minorities uprooted through eminent domain live in senior housing constructed on their old land. This assumes that senior housing is indeed built on the newly acquired land and that there is no waiting list for this housing. The first assumption might be valid but the

---

118. Id.
119. Id.
121. Id.
second is surely untenable. As discussed, there are long waiting lists for rent-assisted housing, especially in major metropolitan areas. The effect of this housing dynamic will be to uproot many minority communities, including seniors, and to implant a group of seniors who have been patiently waiting for rent-assisted housing on the waiting list. The senior demographic in the new community will be as diverse or as homogenous as the waiting list for rent-assisted housing. The point is that, in abating the senior housing crisis by constructing rent-assisted housing, senior minorities uprooted through eminent domain cannot expect to receive any of the benefits.124

Senior minorities also tend to be more rooted in their respective communities because their children tend to live closer. In a study of a New York City neighborhood, 71% of black seniors’ families lived either with them or within the metropolitan area, compared to only 49% of white seniors’ families.125 Additionally, in an emergency, 82% of black seniors felt they could depend on their children, their spouses, or their friends to help them, whereas only 59% of white seniors felt the same way.126 Seniors living in central city neighborhoods tend to be a social group, closely tied with many of their neighbors.127 The presence of their family causes senior minorities to have more of an interest in remaining in their current living arrangements because they have less options should their housing be taken through eminent domain. A senior who depends on her children for support, or in the case of an emergency, cannot readily move outside the metropolitan area if uprooted. Senior minorities remain geographically close to their families for many reasons and have more of a vested interest in housing stability. One of the reasons senior minorities stay close to family is the unresponsiveness of social programs.

Although there has been steadfast improvement over the past two or three decades, senior minorities are nonetheless underserved by social service programs. Outreach, information and referral programs are deficient in educating senior minorities about available services.128 Because of their isolation in high crime and poor transportation neighborhoods, Hispanic and black elderly often do not get as much interaction with other senior minorities and do not receive word of mouth information concerning services.129 Elderly minorities are underrepresented in mental health programs because of “lack of bilingual, bicultural professional and paraprofessional staff; inaccessibility because of lack of transportation and segregated

124. One plausible idea is to require that economic redevelopment plans include “relocation” housing to temporarily house uprooted residents while they search for new housing. This would certainly take the initial sting out of eminent domain but would not negate the long term demographical shifts that can result.
126. Id. at 32.
128. See Vladimir Einisman, Long-Term Care and the Minority Elderly, Trends and Status of Minority Aging 91, 95 (E. Percil Stanford & Shirley A. Lockery eds., 1982).
129. Id.
Many senior minorities feel strongly about self-reliance and do not want to admit that they have psychological problems. The problem eminent domain poses for senior minorities is that the impediments they face in securing services from the government are only exacerbated after being uprooted. Distrust and phobia are fueled when senior minorities have their homes taken. “The minority elderly have great attachment to their homes and to the barrio and its subculture. They are fearful of being removed from their cultural surroundings. . . .” There are considerations unique to senior minorities that reflect a lifetime of discrimination and disenchantment in the social system. Using eminent domain to acquire property that seniors have lived on for decades forces alienation in a way that other demographics can avoid, due to secure finances, or a good faith reliance on the social services system.

CONCLUSION

*Kelo* transformed a tool for urban renewal into a wrecking ball for private gain, at least in the minds of many public interest groups. The holding was announced little over six months ago and state political machines sprung to life in an attempt to convince residents that their homes were not in jeopardy. Nonetheless, eminent domain remains a common practice, not necessarily because resistance has been overcome but because precedent for its legality and utility is well known. Because local communities remain sensitive to eminent domain, constructing senior housing frames the power in terms of its capability to solve rather than cause problems. The benefits for seniors who move into newly constructed senior housing, whether it is rent-assisted or not, can count on a carefully planned community and easy access to social services. For those who are forced to make way for newly constructed senior housing, the benefits are few and far between. Senior minorities have the most trouble readjusting after being uprooted and minorities in general tend to be more often affected by local eminent domain actions. For this reason, if eminent domain is to be used to help the senior housing crisis, it must be mindful of the idea that the preservation of minority communities and senior minority trust can trump the short term need for senior housing. The senior housing crisis has no timer. It exists at the present and will continue to worsen over time if nothing is done. The eminency of this threat, however, cannot be used to justify complete disruption of senior minority communities.

130. Id. at 94.
132. Einsman, supra n. 128.
RELIANCE ON INADEQUATE GOVERNMENT PROGRAMS AND THE STRUGGLE FOR LONG-TERM CARE

Todd A. Marquardt

TABLE OF CONTENTS

INTRODUCTION............................................................................................................. 62
I. GOVERNMENT ASSUMING RESPONSIBILITY OF SUPPORT........................................ 63
II. RELIANCE ON INADEQUATE GOVERNMENT PROGRAMS........................................ 66
   A. Income Replacement .............................................................................................. 66
   B. Health Care ........................................................................................................... 69
      1. Medicare Basics .................................................................................................. 69
      2. Medicare Part D – Prescription Drugs ................................................................. 71
      3. Diversity’s Effect on Health Care ....................................................................... 73
   C. Long-Term Care .................................................................................................... 75
      1. High Cost of Long-Term Care ............................................................................ 75
      2. Medicaid Planning for Long-Term Care .............................................................. 76
      3. Medicare Catastrophic Coverage Act Congressional Intent ......................... 79
III. THE DEFICIT REDUCTION ACT OF 2005 (“DRA”)....................................................... 80
   A. 3 Year Look-Back Changed to 5 Year Look-Back and Changes in the Application of Any Resulting Penalty Period......................................................... 81
   B. Application of “Income-First” Rule in Applying Community Spouse’s Income before Assets in Providing Support of Community Spouse............ 82
IV. ILL-PREPARED AND ILL-EQUIPPED FAMILIES ............................................................... 85
   A. Changing Family Dynamics ................................................................................ 86
   B. Diversity of Elderly and their Care-Receivers ...................................................... 87
CONCLUSION ................................................................................................................ 89

* Dedicated to June Lavone Marquardt, my grandmother.
** Todd A. Marquardt graduated from St. Mary’s University School of Law in May 2006. The author thanks his loving and supportive wife, Kris Marquardt, for her understanding and encouragement. The author also thanks Brian Stork, a mentor and friend, and Patricia Sitchler for her insight and encouragement.
INTRODUCTION

In 2003 there were nearly 36 million elderly individuals in the United States. These elderly Americans are most concerned about income replacement, health and medical care, and long-term care. Securing income, health, and long-term care satisfy the underlying desire for “control of their resources and maximum independence” in addition to meeting basic human needs. These concerns grow more important as we live longer lives. People are living longer because increased knowledge about health and medical advances in science and technology. Knowledge about health has helped more Americans develop healthy living patterns, and medical advances in technology have helped physicians provide better medical care. The disadvantage to living longer is that “longevity has also increased the number of elderly who have chronic illnesses, multiple medical problems, functional limitations, and disabilities.” Living longer with comfortable amenities, however, is expensive.

The overriding issue in recent history has been how to allocate the costs of securing income, health care, and long-term care for the elderly when elderly individuals cannot provide for themselves. Should the government pay to support the

---

1. The author defines “elderly” as individuals who are 65 years of age or older.
3. The author notes that long-term care encompasses all types of long-term care including nursing home care, private care at home, and others. This article will discuss long-term care in general and the effect of paying for nursing home care specifically.
4. Burton Fretz, Fighting Poverty Among the Elderly Poor, 1 Geo. J. on Fighting Poverty 63 (1993) (stating that “adequate income, adequate health care, decent housing, and proper nutrition” are problems confronting the elderly poor).
7. Smith, supra n. 6 at 356-57 (citing Demographic Perspectives on Gender and Family Caregiving, in Gender, Families, and Eldercare 20 (Jeffrey W. Dwyer & Raymond T. Coward eds., 1992)).
elderly population through social programs, or should families bear the costs? The United States has, for the most part, chosen to finance care for the elderly through government social programs. In response, the United States population has relied on the government and those programs for the past seventy years.

I. GOVERNMENT ASSUMING RESPONSIBILITY OF SUPPORT

The United States formally took on the responsibility of reducing poverty after the Great Depression. The point is not that social programs began because of the collapse of the economy; rather, the point is that the United States government took on the responsibility of helping those who couldn’t work. “With the S.S.A. (and other New Deal programs), which introduced the idea of entitlement into national policy, the federal government assumed responsibility for the welfare of most, if not all, of its citizens...” President Franklin Delano Roosevelt signed the Old Age Pension Act (hereafter “Social Security”) on August 14, 1935. “Social Security’s main objectives were to “provide a system of income maintenance for the aging through social insurance,” and “provide a floor of protection for the most needy segment of the older population.” In addition to income insurance, several presidential administrations advocated for national health insurance, starting with President Theodore Roosevelt.

The American Association for Labor Legislation and the Progressives advocated for national health insurance with FDR’s cousin. President Theodore

8. Lee Anne Fennell, Relative Burdens: Family Ties and the Safety Net, 45 Wm. & Mary L. Rev. 1453, 1469 (2004) (explaining that people agree on supporting dependent elderly, but disagree on whether government or families should pay for that support).

9. One of the author’s principle arguments is that the United States government committed to and took on the responsibility of supporting the elderly with the enactment of social programs like Social Security, Medicare, and Medicaid.

10. Dilley, supra n. 5, at 295 (stating that the middle and working class based their culture on the certainty of Social Security and pensions).


12. Walter I. Trattner, From Poor Law to Welfare State at 277 (6th ed. 1999) (emphasis original, quoting Michael Katz, Walter H. Annenberg Professor of History and a Research Associate in the Population Studies Center at the University of Pennsylvania. He is quoted because he is a well known historian on American education; urban social structure and family organization; and the history of social welfare and poverty).


Roosevelt. The movement stalled, however, because of President Theodore Roosevelt’s defeat in 1912 and the anti-German sentiment of World War I.

President Franklin D. Roosevelt was not as successful on his push for a national health care policy either. The American Medical Association (hereafter “AMA”) resisted a national health insurance policy because they claimed it would lead the United States to Socialism. The campaign for national health insurance did accomplish two things: it sparked the private health insurance industry to market more heavily, and it encouraged the AMA to agree to a compromise. The compromise would come almost 30 years after Social Security with the enactment of Old-Age, Survivors, and Disability Insurance (“OASDI”) during President Lyndon Johnson’s administration.

President Lyndon B. Johnson’s “War on Poverty” resulted in a health care program for the elderly: Medicare. President Lyndon Johnson’s success in signing the Medicare program into law was due in large part to the AMA’s compromise, a new Congress, and a new initiative toward impoverished elderly. President Johnson’s purpose for Medicare was that, “no longer will older Americans be denied the healing powers of modern medicine. No longer will illness crush and destroy savings that they

---


20. Stiehm, *supra* n. 15.

21. *Id.* (explaining that the national health insurance movement was based on social insurance in Germany in the 1800’s. World War I’s anti-German sentiment, therefore, resulted in rejection of the movement).


23. *Id.*

24. *Id.* (explaining that insurance started paying doctors directly and selling products to employers to offer as a benefit).

25. *Id* at 217.


27. Frolik & Barnes, *supra* n. 22 at 217.
have so carefully put away over a lifetime so that they might enjoy dignity in later years.\textsuperscript{28} This purpose is still relevant today, especially regarding long-term care.

The enactment and growth of Medicare is another example of how the United States government has assumed the responsibility for providing health care for the elderly. But, there are no “Medicare” or “Social Security” type government programs for long-term care. In fact, “long-term care services generally could be defined as the services the government health benefits did not cover, except as a last resort option for the poor.”\textsuperscript{29} Medicare will cover limited long-term care to effect rehabilitation following hospitalization,\textsuperscript{30} and Medicaid will generally cover the elderly poor,\textsuperscript{31} but these modest programs for catastrophic medical crisis and the poor have given the elderly a false sense of security for long-term care. The middle class is generally left out, but for those who can afford it, long-term care is provided or financed through personal wealth, by families, or long-term care insurance.\textsuperscript{32}

Elderly immigrants and minorities are probably the least able to afford long-term care, but that is not their only problem. The diversity of the United States’ elderly population raises more questions about inadequate government programs for the elderly. Foreign born immigrants and minorities face the same concerns with income replacement, health care, and housing as U.S. born citizens, but they also face unique barriers as well.

In 2000, there were 35 million elderly people in the United States, of which there were 3.1 million elderly foreign born individuals.\textsuperscript{33} Many immigrants will be retiring with the baby boom generation and will be referred to as immigrant baby boomers.\textsuperscript{34} Immigrant baby boomers will face an insolvent Social Security program, a decrepit Medicare plan, and uncertain long-term care along with U.S. baby boomers. Immigrant baby boomers, however, will also face added barriers to even get these inadequate government programs. Added barriers are usually due to legal status, inability to speak or understand English, and other cultural differences.\textsuperscript{35}

\begin{thebibliography}{10}

\bibitem{28} Eleanor D. Kinney, \textit{Medicare Managed Care from the Beneficiary’s Perspective}, 26 Seton Hall L. Rev. 1163, 1164 (1996).

\bibitem{29} Frolik & Barnes, \textit{supra} n. 22, at 313.

\bibitem{30} 42 USC 1395d(a)(2) (2006)(providing for the scope of post-hospital extended care services); 42 CFR 409.5 (2006)(providing a general description of Medicare Part A benefits); 42 CFR 409.20 (2006)(providing for coverage of post-hospital skilled nursing facility (SNF) care); Frolik & Barnes, \textit{supra} n. 22, at 313. (stating that Medicare Part A will cover the costs of care in a skilled nursing facility including “room and board; nursing care; physical, speech, and occupational therapy; and drugs;” but will not cover “custodial care and convenience items”).

\bibitem{31} Id.

\bibitem{32} Id.


\bibitem{34} Donald E. Gelfand, Aging and Ethnicity: Knowledge and Services 47 (1994) (stating that many immigrants become “aged” at the same time as U.S. born baby boomers).

\bibitem{35} Id. at 47 (stating that illegal immigrants have the most age related problems. Elderly people born in the U.S., however, generally have “superior resources and functional status.” Superior resources
In addition to foreign born or immigrant elderly, there is significant diversity within the U.S. natural born elderly population. “At the same time that the overall population becomes more diverse, a greater proportion of the elderly will become more racially and ethnically diverse.”

This article will focus on elderly concerns generally and with minority problems specifically, and how government programs are changing the extent to which families will care for and support the elderly. The five sections in this article will focus on problems the elderly face as a whole and also address racial, ethnic, and cultural elderly concerns and obstacles. Section I introduced the background of the United States’ major government programs. The author argued in section I that the United States has taken on the responsibility of supporting the elderly’s needs for income replacement, health care, and long-term care. Section II describes the inadequacy of government programs addressing income replacement, health care, and long-term care and Americans’ reliance and dependence on those programs. Section III addresses changes set out in the Deficit Reduction Act of 2005 (hereafter “DRA”). Section IV explains the inability of American families to respond to inadequate and shrinking government programs, and section V concludes with the possible effects if families are less able or less willing to care for the elderly.

II. RELIANCE ON INADEQUATE GOVERNMENT PROGRAMS

A. Income Replacement

The vast majority of elderly people tend to be retired or otherwise not working. In fact, only 13.8 percent of U.S. born elderly and 12.4 percent of foreign born elderly were working in March 2000. Most elderly need to replace income earned from work or from a working spouse. Historically, families, including adult children, supported the elderly. The prevalence of children supporting their elderly parents, however, has declined remarkably over time. Industrialization, mobility, and working women were a major cause in the reduction in children supporting parents. Society’s dependence on government programs such as Social Security, Medicare, and Medicaid may also have contributed to the decline in familial support. Now, income replacement usually comes from a combination of savings, pensions, investments, government benefits, with less emphasis on familial support.

The purposes of Social Security have changed through the years. One objective in 1935 was “to provide a system of income maintenance for the aging through

include education, income, and insurance. Functional status includes communication ability, ease of transportation, and access to information).

37. He, supra n. 33, at 11.
38. Frolik & Barnes, supra n. 22, at 153.
39. Id. at 153 (stating a reduction in elder reliance on children).
40. Id. (stating that the primary sources of income are “earnings, personal savings, employment-related pension plans, and public benefits”).
individual insurance,” also referred to as the safety net.\footnote{Lammers, \textit{supra} n. 14.} The objective changed by the 1970’s to be “sufficient retirement income regardless of other sources. . .”\footnote{Id. at 91(citing Colin Campbell, Financing Social Security, American Enterprise Institute for Public Policy Research (1979)).} Today the question is again asked: “Should Social Security benefits constitute an adequate income without other sources?”\footnote{Id. at 90.}

Social Security is largely inadequate because income from Social Security is not enough to sustain seniors for all their retirement needs. But regardless of the amount payable, the current Social Security trust fund is predicted to be depleted in the future. Social Security never \textit{adequately} provided enough money for someone to live on for the duration of his or her retirement. It is often said that a comfortable retirement is based on a “three-legged stool” of (1) Social Security, (2) pensions and (3) savings.\footnote{Dilley, \textit{supra} n. 5, at 252; Social Security Online, \textit{Frequently Asked Questions About Social Security’s Future}, http://www.socialsecurity.gov/qa.htm (last visited January 27, 2006).} Unfortunately, the Social Security program has evolved from the safety net FDR envisioned into a retirement plan for those unwilling or unable to save retirement by alternative means.

The elderly poor cannot afford to fund the other two legs of the three-legged retirement stool – pensions and savings. “In 1999, 32 million individuals, representing 34% of all older persons, reported an income of less than $10,000; only 23% earned $25,000 or more.”\footnote{Seymour Moskowitz, \textit{Filial Responsibility Statutes: Legal and Policy Considerations}, 9 J.L. \\& Pol’y 709, 718 (2001) (citing Administration on Aging, Dep’t of Health and Human Services, A Profile of Older Americans (2000), available at http://www.aoa.gov/aoa/stats/profile/profile2000.html).} In 2002, Social Security income – a benefit intended to be only a safety net – accounted for over eighty percent of aggregate income for the poorest two-fifths of the elderly.\footnote{Federal Interagency Forum On Aging-Related Statistics, \textit{supra} n. 2, at 15.}

The Social Security Administration acknowledges that future Social Security income for retirees will be cut unless changes are made in the law. “Unless changes are made, when you reach age 62 in 2041, benefits for all retirees could be cut by 26 percent and could continue to be reduced every year thereafter.”51 “If Social Security’s projections are correct and if no tax increases, benefit cuts or other changes have been adopted, 2017 is the year when the cash surpluses will end.”52 The Social Security Administration’s projections for the solvency of the trust fund are more conservative than the Congressional Budget Office projections. The Congressional Budget Office projects the Social Security trust fund to start depleting in 2052.53 Elderly minorities and immigrants are more likely to rely on Social Security income because many are more likely to have low skilled jobs, low income, and low savings and retirement. “Hispanic workers are far less likely than Whites or Blacks to participate in employer-sponsored retirement plans.”54 The Employee Benefit Research Institute found that of workers aged twenty-one to sixty-four – 29 percent of Hispanics, 45 percent of Blacks, and 53 percent of Whites – participated in retirement plans.55 Instead of employer retirement plans, Hispanics rely on Social Security for income more than any other population. “Fifty-one percent of elderly Hispanic beneficiaries rely on their Social Security checks for 90 percent or more of their income.”56

African Americans face unique obstacles as well. The effects of segregation and racism of the past continue to impact elderly African Americans today. Racism excluded African Americans from unions, higher paid crafts/trades, and professional positions.57 Exclusion from job opportunity has resulted in inadequate income and retirement, poor health, no health insurance, and minimal education. It is no surprise then that African Americans are part of a group that relies on Social Security the most.58

Most elderly face hard times when solely relying on Social Security income for retirement. Minorities are even more likely to totally rely on Social Security and their needs are probably greater. The amount paid to each individual is too small to pay for

53. Id.; In accord, Social Security to Start Losing Money in 2020, Pittsburgh Post A6 (February 1, 2005).
55. Id. at http://www.cbpp.org/6-28-05socsec3.pdf.
56. Id.
57. Gelfand, supra n. 33, at 66.
58. Id. at 100 (arguing that women, African Americans, and Latinos rely solely on Social Security Income more than others).
necessities like food, clothing, and shelter. The Social Security trust fund will not remain solvent because of the enormous demands of the baby boom generation. Government health care benefits, like Medicare, relieve some of the costs that Social Security once paid for, but are still inadequate to meet the growing needs of today’s elderly populations.

B. Health Care

Elderly people today face the challenges of living with disabilities and paying high health care costs. Because people in America are generally living longer than before, there is a greater likelihood of “chronic and disabling health conditions.” The elderly generally spend more on health care than younger people, and medical care costs for treating chronic and disabling health conditions is especially expensive. “After adjusting for inflation, health care costs increased significantly among older Americans from 1992 to 2001.” In 2001, elderly people without chronic medical conditions only spent an average of $3,837 on health care, while elderly people with five or more chronic conditions spent an average $15,784 on health care.

1. Medicare Basics

The United States government has responded to increasing health care costs through the enactment of Medicare programs. Medicare consists of Part A, Part B, Part C, and now Part D. Medicare Supplemental Policies, or Medigap policies, are optional programs used to cover deductibles and co-payments. Lastly, some employers provide health care benefits as part of a retirement package, but the main costs of health care for the elderly are paid for by Medicare.

Retired persons who are age 65 and have paid into the Social Security system are entitled to Medicare Part A. Medicare Part A generally provides an “entitlement to payment for inpatient hospital services, post-hospital extended care services, home health services, and hospice care.” Medicare Part A provides a good base emergency

59. Federal Interagency Forum On Aging-Related Statistics, supra n. 2, at 22 (showing that life expectancy for ages 65 and 85 has increased between 1900 and 2001).
60. John C. Cavanaugh & Susan Krauss Whitbourne, Gerontology: An Interdisciplinary Perspective 331 (1999); Jacobson, supra n. 11 (arguing that elderly have an increased life expectancy).
62. Id.
63. Frolik & Barnes, supra n. 22, at 284.
64. Arlene Luu & Bryan A. Liang, Case Management: Lessons from Integrated Delivery to Promote Quality Care to the Elderly, 9 Mich. St. J. Med. & Law 257, 261-62 (2005) (“Those eligible for Medicare Part A include: all individuals over age sixty-five who have paid the mandatory payroll taxes for a minimum number of quarters; individuals who have been disabled for at least 24 months; individuals with end-stage renal disease who require dialysis treatment or kidney transplant; or those over 65 ineligible for Social Security benefits but who elect to purchase Part A at a monthly premium.”); Timothy Stolzfus Jost, Anniversary Essay: The Most Important Health Care Legislation of the Millennium (So Far): The Medicare Modernization Act, 5 Yale J. Health Pol’y L. & Ethics 437 (2005) (stating that “Medicare is an entitlement program”).
health care plan for the elderly, but plan co-payments and deductibles make it inadequate for those seniors who cannot purchase supplemental health insurance. Those entitled to Part A may also enroll in Medicare Part B.

“Medicare Part B or Supplemental Medical Insurance (SMI) covers such services as physicians and other individual provider services, emergency room visits, diagnostic and therapeutic services, certain preventive screening tests and durable medical supplies and equipment,”66 again with required deductibles and co-payments. While a beneficiary can opt out of Part B, most beneficiaries end up paying the monthly premium,67 along with a yearly deductible, and a percentage owed as a co-payment or co-insurance. Medicare parts A and B and Medigap cover most health care costs. The disadvantage is the large amount of paperwork that is involved with these two plans.

The 1997 Balanced Budget Act established Medicare Part C (“Medicare + Choice”).68 “Medicare + Choice plans were required to cover all of the services covered by traditional Medicare,” but operated differently than Medicare Part A and B.69 Medicare + Choice operated like a managed care plan.70 Managed care means “a system of health care payment and service utilization intended to contain costs by shifting some of the risk of high cost services to the provider as an incentive to select less expensive care.”71 The Medicare Modernization Act of 2003 changed Medicare + Choice to “Medicare Advantage” or “MA” eliminating the various forms of Medicare + Choice except for the managed care part.72 Medicare Advantage as an HMO is attractive because of its low costs and limited paperwork. Problems arise, however, because of limited choice of primary care physician and cost containment measures.73

Some employers offer benefits like retirement health insurance. The advantages of employer-provided health care are lower costs. Retirees with employer provided health care and prescription drug insurance “are being advised not to sign up for the Medicare [Part D] benefit.”74 The disadvantages are more paperwork and the possibility of losing the health benefit. Unlike pensions, employer provided health insurance is exempt from ERISA’s vesting regulations.75 Employers may, therefore, revoke health care benefits so long as the employer has provided in the employment

---

66. Luu & Liang, supra n. 64, at 262 (citing Frolik & Barnes, supra n. 22, at 218).
67. Pear, supra n. 49 (stating the Medicare Part B monthly premium is $88.50 for 2006).
68. 42 U.S.C.A. § 1395w-21 et seq. (2005); Jost, supra n. 64, at 440.
69. Jost, supra n. 64, at 440.
70. Id.
71. Frolik & Barnes, supra n. 22, at 226.
73. See Judith Feder and Marilyn Moon, Managed Care for the Elderly: A Threat or a Promise?, 22 Generations No. 2, 6-8 (Summer 1998); Dian Archer, From a Medicare Rights Advocate: Problems and Solutions in Medicare Managed Care, 22 Generations No. 2, 77-78 (Summer 1998) (both reproduced in Frolik & Barnes, supra n. 22, at 226.
74. Paul Krugman, The Deadly Doughnut, N.Y. Times A23 (November 11, 2005) (arguing that employer drug benefits cover more than Part D).
75. Sprague v. General Motors Corp., 133 F.3d 388, 400 (6th Cir. 1998).
contract a right to modify or terminate those benefits. An employer may provide for a vesting health insurance policy for the life of an employee, but that likelihood is very small.

While private insurance and Medicare cover the majority of the elder population, those persons who are disabled, elderly, or who have end stage renal disease and who fall below the poverty rate receive Medicaid benefits. President Lyndon B. Johnson signed title XIX of the Social Security Act, Grants to the States for Medical Assistance Programs, on July 30, 1965. This was an extension of the Kerr-Mills Medical Assistance Program already in place. Medicaid’s purpose is “to provide medical assistance to those whose resources are insufficient to meet the costs of necessary medical care.” Medicaid was once a major government program providing the elderly poor with no cost prescription drugs. Now, Medicare Part D provides the government prescription drug program.

2. Medicare Part D – Prescription Drugs


“With the Medicare Act of 2003, our government is finally bringing prescription drug coverage to the seniors of America. With this law, we’re giving older Americans better choices and more control over their health care, so they can receive the modern medical care they deserve...Our nation has the best health care system in the world. And we want our seniors to share in the benefits of that system. Our nation has made a promise, a solemn promise to America’s seniors. We have pledged to help our citizens find affordable medical care in the later years of life. Lyndon Johnson established that commitment by signing the Medicare Act of 1965. And today, by

76. Id.
77. Id. (stating that an employer may vest).
78. The author believes that the likelihood is small because many corporations will cut employee benefits when profits are low.
79. The Medicaid program is generally beyond the scope of this article. The author only introduces it to point out that there is a program for the extreme poor. Medicaid will be discussed only in relation to Medicaid planning for long-term care housing.
reforming and modernizing this vital program, we are honoring the commitments of Medicare to all our seniors.84

President Bush and Congress enacted the MMA in response to “soaring” prescription drug prices. In 2000, the average prescription drug cost was $1,340.85 The elderly paid forty-two percent of the costs of prescription drugs, insurance paid thirty-five percent and public programs paid the remaining twenty-three percent.86 Because Medicare did not cover prescription drugs prior to the act, many low income and middle class seniors were forced to pay out-of-pocket for their prescriptions.87 Those elderly who relied exclusively on Social Security income were especially hurt by high prescription drug prices.

Medicare Part D, the new Medicare Drug benefit, may help some seniors with the cost of prescription drugs, but will be largely inadequate for low income and middle class seniors.88 Part D will cost most seniors a “$250 deductible, a $35 monthly premium,” and twenty-five percent co-payments on their medicine.89 Medicare Part D will pay for seventy-five percent of drug costs for the first $2,250.90 Enrollees of Part D will also face the “doughnut hole”91 — 100 percent payment of costs for drug expenses that exceed $2,250 but are less than $5,100.92 Medicare Part D will then pay for ninety-five percent of the costs exceeding $5,100.93 Before the MMA, Medicaid covered the cost of prescription drugs for low income elderly.94

Elderly Americans with Medicare and Medicaid are known as “dual eligibles.”95 Dual eligibles received basic health care services under Medicare, and Medicaid paid for Medicare premiums, “outpatient prescription drugs, routine and preventive care, and dental care.”96 The MMA provided that on January 1, 2006 Medicaid would no

---

86. Id.
88. Id. at 402 (arguing that elderly relying on Social Security income will not have enough money to pay out-of-pocket costs).
91. Krugman, supra n. 74; Jost, supra n. 64, at 440; Wieghaus, supra n. 83.
92. Krugman, supra n. 74.
95. Id.
96. Id.
longer pay for prescription drugs. 97 Instead, dual eligibles could pick a prescription drug plan or one would be chosen for them. 98 The problems low income seniors face is that Medicare Part D may not cover all drugs and does not cover the entire cost of prescription drugs that are covered unless the person is a resident of a nursing home. 99

The MMA excludes drugs once covered by Medicaid, including: widely used drugs for management of acute anxiety and panic attacks, seizures, and to treat weight loss due to cancer or AIDS. 100 Even though “duals are automatically eligible for the Part D subsidy that helps low-income seniors pay for their premium and cost-sharing fees. . .CMS notes that in some cases the lowest monthly premium available may be higher than the premium level subsidized by Medicare for dual eligibles.” 101 Some low income seniors may discontinue medication because of increased co-payments. 102 Many in the diverse elderly population cannot afford any extra costs, but those are not the only health care problems United States’ minorities and immigrants face.

3. Diversity’s Effect on Health Care

Two major obstacles elderly immigrants and minorities face in obtaining adequate health care are lack of health insurance and access to medical care during their non-elderly life. “Forty-five percent of the older population with no health insurance is foreign born.” 103 Foreign born immigrants face two possible barriers to health insurance: jobs that employ undocumented workers and part-time jobs do not offer health insurance. 104 Even if health insurance is available, it is likely to be too expensive for immigrants to afford. 105 Minorities are also more likely to be without health insurance than Whites. Thirty-two and 6/10 percent of Hispanics, 29 percent of American Indians and Alaska Natives, 21.8 percent of Native Hawaiian and other Pacific Islanders, and 19.8 percent of Blacks lack health insurance. 106 Only 14.6 percent of Whites lack health insurance.

97. 42 U.S.C.A. § 1395w-114 (West 2005); Cody, supra n. 94.
98. Cody, supra n. 94.
99. Id. at 29 (stating that the MMA excludes some drugs).
100. Id. (describing the drugs used to treat those symptoms) (citing 42 C.F.R. § 423.100 (2004)); John J. Campbell, Bad Moon Rising: The Dark Side of Medicare Part D and Medigap, 34-Oct. Colo. Law. 71 (October, 2005) (stating that some drugs are not covered).
101. Some Duals Could Face Partial Premium Costs under Part D Program, 8 Inside CMS 4 (February 24, 2005).
103. He, supra n. 33.
104. Gelfand, supra n. 33, at 49.
105. Id.
In 2003, African Americans comprised eight percent of elders.\textsuperscript{107} Inner-city African Americans who survive to old age may face chronic medical problems. African American elderly face greater likelihood of stroke, coronary heart disease, and acute myocardial infarction.\textsuperscript{108} African Americans are also more likely to suffer from conditions related to occupational hazards or poor living conditions.\textsuperscript{109}

While American Indians do not live in urban areas, they do traditionally live on reservations or in rural areas. American Indians make up 5.6 percent of the elderly population.\textsuperscript{110} American Indians also face unique challenges that affect their need for health care later in life. A United States Government Accountability Office study\textsuperscript{111} found that American Indians suffered more from chronic liver disease and cirrhosis, diabetes, nephritis, pneumonia and influenza, tuberculosis, unintentional injuries, suicide, and homicide than the general U.S. population.\textsuperscript{112} Government benefits may help, but there are barriers to qualifying in the first place. The complexity of Social Security and Medicare confuses some Native American elders.\textsuperscript{113} Elders who do succeed at applying for government benefits, but who are denied benefits the first time, generally don’t apply again.\textsuperscript{114}

After 70 years of Social Security and 40 years of Medicare, minorities are still left behind. Race and ethnicity, in itself, is not primarily a barrier to healthcare. Ethnic or cultural differences... “level of acculturation or integration into ‘American’ life,” ability to speak and proficiency in English, education level, educational level of one’s parents, distrust of Western medicine, unfamiliarity with the means to obtain health care, and fears of being deported all present difficulties to access to healthcare.\textsuperscript{115} Additionally, elders who lived without insurance or adequate access to health care services continue to face challenges with disabling conditions and high medical costs. Securing adequate income replacement and access to healthcare are continuing challenges for elders. Another hurdle associated with health care is continued safe housing\textsuperscript{116} for elders facing debilitating and disabling conditions.

\begin{itemize}
\item 108. Gelfand, \textit{supra} n. 33, at 68-69.
\item 109. \textit{Id.} at 70.
\item 111. United States Government Accountability Office, \textit{Indian Health Service: Health Care Services Are Not Always Available to Native Americans}, Report to the Committee on Indian Affairs, U.S. Senate, GAO-05-789 (August 2005), \textit{available at} http://www.gao.gov/new.items/d05789.pdf (The study focused on the effectiveness of the Indian Health Service (HIS), a government program to increase accessibility to Native Americans).
\item 112. \textit{Id.} at 6-7.
\item 114. \textit{Id.}
\item 115. Stiehm, \textit{supra} n. 15.
\item 116. Elder housing is a subject in itself and is beyond the scope of this article. This article is limited to the long-term care nursing home component of housing and long-term costs.
\end{itemize}
C. Long-Term Care

The United States government took on the responsibility of providing income replacement for the elderly upon retirement with its Social Security program. The main problems with this program are that the American people relied on Social Security as their sole retirement program, but Social Security does not provide enough income for retirees to pay for food, clothing, healthcare premiums, deductibles, and co-payments. Likewise, the government assumed responsibility for providing medical care for the elderly with the Medicare program.

“Long-term care services generally could be defined as the services the government health benefits did not cover, except as a last resort option for the poor.” 117 Medicare pays for only limited care in a skilled nursing facility, but not long-term care.118 Medicaid covers the costs of long-term care only if elderly individuals are sick and poor enough. The long-term care issue is even more complex than income and health care issues because the elderly expected government programs to cover these costs, but there is no government program designed for long-term care.

Some elderly face a point when health care is not enough to cover all their needs. Once one’s health deteriorates, he or she begins to require help with “activities of daily living,” (“ADL”) and “instrumental activities of daily living” (“IADL”). ADL’s are described as “eating, bathing, dressing, using the toilet, getting in and out of bed, and getting around the house,” and IADL’s include “preparing meals, shopping for groceries, and getting around outside.”119 Long-term care serves to meet activity and instrumental activity needs of daily living.

1. High Cost of Long-Term Care

Long-term care – nursing home care and custodial home care – is expensive. “A nursing home typically cost more than $50,000 per year.”120 Nursing home costs range from $33,600 to $55,200 per year for a semi-private room and $60,000 to $90,000 for a private room.121 Custodial home care ranges from $70,080 to $131,400 per year.122 While in-home care is preferred by most, if not all, only independently wealthy elders can afford to pay these costs out-of-pocket. Total spending for long-

---

117. Frolik & Barnes, supra n. 22, at 313.
119. United States General Accounting Office, Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage, GAO-05-968, n. 3 at 1 (September 2005).
122. Id.
term care in 2003 was $183 billion. Spending on long-term care consists of: Medicaid 48%, out-of-pocket 20%, Medicare 18%, private insurance 9%, and other 6%. Because private-pay is not an option for most people, long-term care insurance has become a more affordable alternative.

Less than ten percent of elderly individuals had purchased a long-term care insurance policy in 2000. Many people who do not buy long-term care insurance question the affordability and value of coverage of such policies. “Some studies estimate that long-term care insurance is affordable for only 10 to 20 percent of the elderly.” “Individuals should consider purchasing long term care insurance only if their annual income after retirement is greater than $30,000 and the value of their assets exceeds $100,000 (not counting the value of their home).” Absent wealth or long-term care insurance, an individual needing substantial assistance of nursing home care may qualify for the Medicaid program to cover the costs.

2. Medicaid Planning for Long-Term Care

Eligibility for Medicaid is based on whether one is medically needy or categorically needy. “To qualify as medically needy, individuals must meet the SSI resource test, have income insufficient to pay for their medical care, and meet the other basic Medicaid requirements. . .The extraordinary cost of long-term care usually creates medically needy eligibility.” The need for care component of Medicaid eligibility is referred to as functional eligibility criteria and includes analysis of activities of daily living and instrumental activities of daily living. Medicaid benefits are funded through federal and state cost sharing. As a result, states promulgate rules that are supposed to conform to broad federal guidelines. Some

123. United States General Accounting Office, Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage, supra n. 119, at 4.
124. Funding Sources for Long-Term Care, 2003 at United States General Accounting Office, Long-Term Care Financing: Growing Demand and Cost of Services are Straining Federal and State Budgets GAO-05-564T, p. 5 (April 2005) (See Figure 1).
125. Sitchler, supra n. 121.
126. Scanlon, supra n. 118, at 10.
127. Id.
129. Sitchler, supra n. 121 (citing Stan Hinden, Taking Cover From High Nursing Home Costs, Washington Post H1 (July 13, 1997)).
130. The Veteran’s Affairs may provide benefit also, but VA benefits are highly regulated by the federal government and are outside the scope of this article.
131. The scope of this article is limited to the medically needy.
132. Frolik & Barnes, supra n. 22, at 330 (explaining the distinction between categorically and medically needy).
133. Id. at 330 (explaining the distinction between categorically and medically needy).
134. United States General Accounting Office, Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage, supra n. 119 (defining ADL’s and IADL’s).
states use the “spend-down” income test and other states use the “income cap” income
test to determine eligibility for Medicaid.135

In income cap states, medically needy individuals must not have an income that
exceeds “300 percent of the SSI monthly benefit for a single person.”136 A major
disadvantage of income cap states is the rule that income of $1 above the cap mandates
Medicaid ineligibility.137 Elderly individuals in income cap states may increase their
chances for Medicaid eligibility by creating a Qualified Income Trust (“QIT”)138 or
moving to a spend-down state.139 Creating a QIT is so simple that moving to another
state is often not chosen. Medicaid eligibility in a spend-down state requires one to
spend his or her income on medical expenses.140 Once income is below a state-
determined amount, and therefore eligible, Medicaid would then cover the remaining
cost.141

A Medicaid applicant receiving income over the eligibility cap may use the QIT
to reduce the applicant’s income below the state cap.142 Using a QIT properly will not
cause disqualification of Medicaid.143 “The use of a QIT with a payback is meant to
create eligibility for individuals in income cap states whose income is greater than the
cap and so ineligible for Medicaid.”144 The trust will not cause ineligibility if the trust
is composed of pension, Social Security, and other income. Once in the trust, the
assets are paid out in the form of (1) a minimal allowance to the applicant, (2) a
spousal allowance, (3) unreimbursed medical expenses, and (4) a payment to the
nursing home. The federal government and Medicaid allow use of the QIT because
the state receives remaining assets in the trust when the applicant dies.145 While
frequently misused as a trust to “shelter” assets, a QIT is only a receptacle for income
as is used solely to overcome the income cap requirement.

Another important consideration when Medicaid planning for long-term care is
determining how the community spouse146 will support himself or herself when the
other spouse moves into the nursing home. The community spouse’s allowed income

135. Frolik & Barnes, supra n. 22, at 331.
136. Id. at 332.
137. Id.
is often referred to as a “Miller Trust” because it arises from Miller v. Ibarra, 746 F.Supp 19 (D.
Colo. 1990).
139. Frolik & Barnes, supra n. 22 at 332.
140. Id. at 331.
141. Id.
143. Frolik & Barnes, supra n. 22 at 346.
144. Id.
145. 42 U.S.C. § 1396p(d)(4)(B) (Lexis 2006); see also Frolik & Barnes, supra n. 22 at 346; and
Sitchler, supra n. 121.
146. 42 U.S.C.S. § 1396r-5(h) (Lexis 2006) (defining community spouse as the spouse of an
institutionalized spouse and defining an institutionalized spouse as an individual who is in a
medical institution or nursing facility or who is married to a spouse who is not in a medical
institution or nursing facility.).
will be determined by scrutinizing the couple’s assets and the institutionalized spouse’s income.\textsuperscript{147} During the application process for Medicaid benefits, Medicaid workers must look at the total assets owned by the applicant spouse and the community spouse. Calculating the applicant couple’s assets is important because a portion of the couple’s assets may be reserved for the benefit of the community spouse.\textsuperscript{148} “To determine that reserved amount (the Community Spouse Protected Allowance ‘CSRA’), the total of all of the couple’s resources (whether owned jointly or separately) is calculated as of the time the spouse’s institutionalization commenced; half of that total is then allocated to each spouse (the “spousal share”).”\textsuperscript{149}

A spouse living in the community who is married to an institutionalized Medicaid applicant with resources exceeding the $2,000 SSI resource test will take advantage of the “spousal impoverishment provisions” of the Medicare Catastrophic Coverage Act of 1988 (“MCCA”).\textsuperscript{150} The spousal impoverishment provisions allow the community spouse to set aside and reserve sufficient income and assets to provide for the community spouse’s own needs.\textsuperscript{151} The calculation is complex and begins with scrutinizing the community spouse’s income. Under the rule,

The Act’s income allocation rules direct that, in any month in which one spouse is institutionalized, ‘no income of the community spouse shall be deemed available to the institutionalized spouse,’ § 1396r-5(b)(1); require States to set for the community spouse a ‘minimum monthly maintenance needs allowance’ (MMMNA), § 1396r-5(d)(3); and prescribe that, if the community spouse’s posteligibility income is insufficient to yield income equal to or above the MMMNA, the shortfall-called the ‘community spouse monthly income allowance’ (CSMIA)—may be deducted from the institutionalized spouse’s income and paid to the community spouse, § 1396r-5(d)(1)(B).\textsuperscript{152}

If the diversion of the institutionalized spouse’s income (CSMIA) is insufficient to raise the community spouse’s gross income up to the MMMNA, then the community spouse will be able to set aside sufficient joint resources to generate the income shortfall.\textsuperscript{153} State law provides a minimum and a maximum amount that can be set aside for the community spouse generally referred to as the “protected resource amount” (“PRA”) or “community spouse protected allowance” (“CSRA”). For example, in Texas, the minimum amount one can set aside in 2006 is one-half of the total assets belonging to the family with a minimum of $19,908 and a maximum is $99,540.\textsuperscript{154} But if the amount of assets necessary to generate income (MMMNA) for the CP is greater that the maximum amount, a greater amount of assets will be

\textsuperscript{147} 42 U.S.C.S. § 1396r-5(d) (Lexis 2006).
\textsuperscript{148} Id.
\textsuperscript{150} 42 U.S.C. § 1396r-5 (Lexis 2006).
\textsuperscript{151} Blumer, supra n. 149 at 478.
\textsuperscript{152} Id at 478.
\textsuperscript{153} Id at 473-74.
\textsuperscript{154} Sitchler, supra n. 121 at 14.
protected for the community spouse – ergo preventing the impoverishment of the community spouse. The purpose of this rule is only to overcome the cap on non-exempt resources for Medicaid eligibility.

The MCCA’s resource allocation rules provide, inter alia, that, in determining the institutionalized spouse’s Medicaid eligibility, a portion of the couple’s resources-called the “community spouse resource allowance” (CSRA)-shall be reserved for the benefit of the community spouse, § 1396r-5(c)(2).

To calculate the CSRA, the couple’s jointly and separately owned resources are added together as of the time the institutionalized spouse’s institutionalization commenced; half of that total, subject to certain limits, is then allocated to the community spouse, §§ 1396r-5(c)(1)(A), (2)(B), (f)(2)(A), (g). The CSRA is deemed unavailable to the institutionalized spouse in the eligibility determination, but all resources above the CSRA (excluding a $2,000 personal allowance reserved for the institutionalized spouse under federal regulations) must be spent before eligibility can be achieved, § 1396r-5(c)(2).

Using this spousal impoverishment provision will not benefit wealthy individuals because there is a cap on the maximum amount one can set aside. Wealthy individuals would not benefit from purging their fortunes just to qualify for Medicaid; there would be no money left for extravagant long-term care living. There are a wide variety of state specific strategies that can be used as Medicaid planning for long-term care, but this article will only address the spousal impoverishment provision.

3. Medicare Catastrophic Coverage Act Congressional Intent

In 1988, Congress passed the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act (MCCA), 42 U.S.C.A. § 1396r-5, which outlined Medicaid Eligibility standards to be adopted by the states to ensure that the community spouse had a necessary, but not excessive, amount of income and resources protected from inclusion in the institutionalized spouse’s eligibility for Medicaid, and as such these resources did not need to be spent down for the institutionalized spouse’s care.

The spousal impoverishment provisions of the MCCA were intended to prevent an institutionalized spouse’s decent into poverty. Penalizing elderly who transfer

---

155. Id.
156. Id.
158. Id.
159. Beyond the scope of this article.
assets to family as compensation for informal care discourages family and friends from caring for their frail elderly family members.\textsuperscript{161}

Government programs that encourage families to care for and support one another would benefit the elderly population and help offset the effects of shrinking entitlements. “Many baby boomers continue to assume they will never need such coverage or mistakenly believe that Medicare or their own private health insurance will provide comprehensive coverage for the services they need.”\textsuperscript{162} Because of the widespread misperception that Medicare covered long-term care for all individuals, many middle class retirees suddenly found themselves spending their life savings for long-term care.\textsuperscript{163} Estate attorneys responded by helping their clients plan to qualify for Medicaid to cover long-term care expenses. “Eligibility for Medicaid nursing home care has been extended to a significant portion of those in need with middle class retirement incomes.”\textsuperscript{164} Instead of strengthening family incentives and government programs to ensure a reasonable level of replacement income, health care, and long-term care, Congress passed and the President signed a law penalizing Medicaid planning for long-term care.

III. THE DEFICIT REDUCTION ACT OF 2005 (“DRA”)

The fear of “apocalyptic demography” was a driving factor in passage of DRA.\textsuperscript{165} Apocalyptic demography is “the fear that the growing older population will place catastrophic burdens on society and deplete health care resources.”\textsuperscript{166} The White House hopes the DRA will save $71 billion total with $5 billion cut from Medicaid alone.\textsuperscript{167} In 2003, 35.6 million people were covered by Medicaid, and in 2004 there were 37.5 million.\textsuperscript{168} A White House Press Release illustrates the fear:

\begin{quote}
\end{quote}

\begin{quote}
162. \textit{United States General Accounting Office, Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage}, supra n. 119, at 15.
\end{quote}

\begin{quote}
163. \textit{Pear, supra} n. 49, at A26 (quoting Lawrence E. Davidow, President of the National Academy of Elder Law Attorneys: “I’m horrified and surprised that Congress would turn its back on middle-class senior citizens who look to Medicaid as a safety net to pay for long-term care. It’s more likely that people who need long-term care will lose their homes and everything they have worked a lifetime to acquire, because they’ll have to use their assets to pay for nursing home care.”).
\end{quote}

\begin{quote}
164. \textit{Frolik & Barnes, supra} n. 22, at 313-314.
\end{quote}

\begin{quote}
165. \textit{Social Policy & Aging, supra} n.36.
\end{quote}

\begin{quote}
166. \textit{Id}.
\end{quote}

\begin{quote}
\end{quote}

\begin{quote}
\end{quote}
In the long run, the biggest challenge to the budget is mandatory spending – or entitlement programs like Medicare, Medicaid, and Social Security. Together, these programs are now growing faster than the economy and the population – and nearly three times the rate of inflation. By 2030, spending for Medicare, Medicaid, and Social Security alone will be almost 60 percent of the entire Federal Budget. The annual growth of entitlement programs needs to be slowed to affordable levels.\textsuperscript{169}

The DRA’s changes for the elderly are going to make qualifying for Medicaid more difficult for the middle class.\textsuperscript{170}

\textit{A. 3 Year Look-Back Changed to 5 Year Look-Back and Changes in the Application of Any Resulting Penalty Period}\textsuperscript{171}

A Medicaid applicant who transfers assets for less than fair market value for the purpose of qualifying for Medicaid during the look-back period\textsuperscript{172} is ineligible for Medicaid for a calculated period of time known as the “penalty period.”\textsuperscript{173} These transfers are typically gifts to family members or other informal caretakers, meant to reward or induce family and friends for care and support or to set aside assets that might be used to provide for the supplemental care and comfort of the elderly nursing home resident.\textsuperscript{174} The look-back period before the DRA was 36 months.\textsuperscript{175} The amendment provided in the DRA changes the 36 month look-back period to 60 months.\textsuperscript{176} The effect of the lengthening of the look-back period is minimal compared to the effect of the change of the start date of the penalty period.

There is a penalty of ineligibility for those who transfer assets below market value within this look-back period when the transfer is for the purpose of qualifying for Medicaid.\textsuperscript{177} The old law started the penalty period from the first day of the month when the transfer occurred.\textsuperscript{178} Now, the penalty period starts from the date of the transfer or the date one would otherwise be eligible, whichever is later.\textsuperscript{179}

\begin{itemize}
  \item \textsuperscript{169} The White House Office of the Press Secretary, \textit{supra} n. 167.
  \item \textsuperscript{170} See Susan Jaffe, \textit{House-Passed Bill Would Make it harder to get Medicaid to Pay for Nursing Home}, Plain Dealer B10 (February 2, 2006).
  \item \textsuperscript{171} There are differences in application of the rules between an institutionalized applicant and a non-institutionalized applicant. For purposes of this section the author assumes the applicant is already institutionalized.
  \item \textsuperscript{172} \textit{Mertz ex rel. Mertz v. Houston}, 155 F. Supp. 2d 415, 421 n. 7 (E.D. Pa., 2001) (defining the look-back as, “in most cases, 36 months prior to the day that the institutionalized individual applies for Medicaid.”).
  \item \textsuperscript{173} 42 U.S.C.A. § 1396p(c)(1)(A) (West 2005).
  \item \textsuperscript{174} Pantaleo & Freedman, \textit{supra} n. 161, at 18-19 (Fall 1994) (explaining transfers made to compensate informal care-takers).
  \item \textsuperscript{175} 42 U.S.C.A. § 1396p(c)(1)(B)(ii) (West 2005).
  \item \textsuperscript{177} 42 U.S.C.A. § 1396p(c)(1)(A) (2005).
  \item \textsuperscript{178} 42 U.S.C.A. § 1396p(c)(1)(B)(ii) (West 2005).
\end{itemize}
The effect of this change is enormous. Applicants before the DRA often found it unnecessary to challenge the presumption that a transfer was made for the purpose of qualifying for Medicaid. The penalty period had often run out by the time the applicant applied for Medicaid. Now, applicants will be more likely to challenge a finding that the transfer was made for the purpose of Medicaid eligibility. Because the date on which the penalty period starts is potentially the date of eligibility, applicants will already be in need of care and impoverished at the time the penalty period begins. A significant problem occurs, however, when the applicant develops a memory or mental impairment. A lot can happen in five years. An elderly person may not anticipate an incapacitating event like a heart attack or stroke or foresee the aggravation of Parkinson’s or dementia occurring within five years of a gift. Some applicant’s will fail to prove a finding of ineligibility simply because the applicant is mentally incompetent and cannot explain the conditions of the transfer.

An elderly person penalized by these provisions is disqualified from receiving Medicaid benefits based on a complicated formula taking the value of the gift divided by the average monthly cost of nursing home care. Surprisingly, the wealthy will still be able to benefit from Medicaid planning if desired because only wealthy families can care for their elderly parent during the period of ineligibility and then reapply for Medicaid.

B. Application of “Income-First” Rule in Applying Community Spouse’s Income before Assets in Providing Support of Community Spouse.

Elderly people facing the huge costs of long-term care have been able to use the Medicare Catastrophic Coverage Act of 1988 (“MCCA”) to qualify for Medicaid and reduce their liability for the cost of care. The spousal impoverishment provisions of the MCCA allow elderly Medicaid applicants looking for a nursing home (“institutionalized spouse”) and their spouses living in the community (“community spouse”) to reserve assets and income. If a community spouse is unable to support himself or herself, the MCCA allows the community spouse to show that he or she is below a statutorily defined minimum income. The MCCA provides:

Revision of community spouse resource allowance. If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse’s income to a the minimum

---

180. 42 U.S.C.A. § 1396p(c)(2)(C) (West 2005) (providing that an applicant would not be ineligible for transferring an asset if the applicant could show (i) he or she intended to transfer at fair market value or other valuable consideration, (ii) transfer was made for a purpose other than to qualify for Medicaid, or (iii) assets transferred for less than market value were returned to the applicant).

181. See Jaffe, supra n. 170 (quoting United States House of Representative Steven LaTourette as saying, “Five years was punitive and could create big gaps in coverage for people who worked hard, paid their taxes, maybe saved a little bit of money, helped their kids with their education and then, through no planning of their own, all of a sudden are stricken with Alzheimers or had a stroke.”).


183. 42 U.S.C.A. § 1396r-5(e)(2)(C); Blumer, supra n. 149 at 478.
monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.184

The MCCA allows the community spouse to keep assets up to a calculated amount to generate income as part of his or her MMMNA. Whether a State uses income-first or resource-first rules determines how much a community spouse’s CSRA could be. The income-first rule or the resource-first rule is applied when the community spouse has gross income that is less than the State’s MMMNA. The purpose of the MCCA revision of the CSRA is to divert income to the community spouse to attempt to raise the community spouse’s income up to the minimum amount.185 For example, in Texas the MMMNA is $2,488.50.186 If the community spouse’s pension gross income is less than $2,488.50, then he or she will need to obtain income from some other source: the resources (under the resource first rule) or from the institutionalized spouse’s income (under the income first-rule). The income-first rule requires the institutionalized spouse to divert available income to the spouse in an amount sufficient to raise the community spouse’s income up to the MMMNA.187 If the community spouse’s gross income plus the institutionalized spouse’s available income is still insufficient, then the CSRA can be increased.188 Recall, that a community spouse is allowed to protect resources equal to one-half of both spouses combined countable resources or $99,540 under Texas law, whichever is smaller.189 The resource-first rule allowed the community spouse to raise the CSRA to a sufficient amount to generate any shortfall in income from the MMMNA before any diversion of income from the institutionalized spouse.190

The resources-first method, by contrast, excludes the CSMIA from consideration. ‘Community spouse’s income’ under that approach includes only income actually received by the community spouse at the time of the fair hearing, not any anticipated posteligibility income transfer from the institutionalized spouse pursuant to § 1396r-5(d)(1)(B). If the community spouse’s income so defined will fall below the MMMNA, the CSRA will be raised to reserve additional assets sufficient to generate income meeting the shortfall, whether or not the CSMIA could also accomplish that task.191

The DRA amends the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act192 and now requires use of the “Income-First” rule when

185. Sitchler, supra n. 121 at 8.
186. Id.
187. Id.
188. Id.
189. Id. at 7.
190. Blumer, supra n. 149 at 484.
191. Id.
determining revision of the community spouse’s resource allowance.\textsuperscript{193} The question prior to the DRA was whether the State would use the institutionalized spouse’s income or reserved assets to raise the community spouse’s income to adequately provide for a minimum maintenance needs allowance (MMNMA). When a party shows that the community spouse’s gross income is less than the “minimum monthly maintenance needs allowance” (MMNMA) the community spouse is entitled to increase his or her CSRA.\textsuperscript{194} Additionally, the community spouse may be eligible for an “excess shelter allowance.”\textsuperscript{195} If the community spouse’s MMNMA is below 150\% of federal poverty or if the community spouse has an extraordinarily high rent or mortgage payment, Medicaid will increase the community spouse’s MMNMA.\textsuperscript{196}

Most states, including Wisconsin,\textsuperscript{197} use the “income-first rule,” and the United States Supreme Court has upheld the rule.\textsuperscript{198} Under the “income-first” rule, “the State considers first whether potential income transfers from the institutionalized spouse, which the MCCA expressly permits, will suffice to enable the community spouse to meet monthly needs once the institutionalized spouse qualifies for Medicaid.”\textsuperscript{199} An institutionalized spouse’s potential transfers may include Social Security income, Supplemental Security Income, retirement, pensions, income generated by assets,\textsuperscript{200} (usually exempt assets since the applicant has no more than $2000 in countable assets) and the like.

Under the income-first method, ‘community spouse’s income’ is defined to include not only the community spouse’s actual income at the time of the fair hearing, but also a potential posteligibility income transfer from the institutionalized spouse. Thus, only if the community spouse’s preeligibility income plus the CSMIA will fall below the MMNMA may the couple reserve a greater portion of assets through an enhanced CSRA.\textsuperscript{201}

In short, the income-first rule requires that the institutionalized spouse contribute a portion of whatever income he or she may be receiving to the community spouse in order to raise the community spouse’s minimum income.

There are two disadvantages to using the “income-first” rule.\textsuperscript{202} First, when combined income is greater than about $2,225 and a community spouse is not left with

\begin{footnotes}
194. Blumer, supra n. 149 at 478. This calculation is state specific but must be at least 150\% of the federal poverty level.
198. Blumer, supra n. 149 at 473.
199. Id. at 478.
200. See Id. at 486 (explaining Burnett’s (the institutionalized spouse) income sources).
201. Id. at 484
202. See Sitchler, supra n. 121 at 7 (providing an example of the effects of changing Texas law from resource-first to income-first).
\end{footnotes}
survivor income benefits after the institutionalized spouse’s death, then the community spouse may have fewer assets to generate income than under the resource-first rules. Remember, that in order for the institutionalized spouse to qualify for Medicaid, the community (both spouses) must spend down its resources. Additionally, the community spouse receives a lower monthly income after his or her institutionalized spouse passes away. The community spouse is significantly worse off with no survivor benefits, no income from her institutionalized spouse less monthly income, half the community assets, and is therefore, left without a safety-net. Second, States will spend more money on Medicaid under the income-first method for the institutionalized spouse’s long-term care than under the resource-first method. The elderly couple’s resources have been spent down, so the community spouse cannot rely on interest from those assets for his or her monthly allowance. Instead, the community spouse siphons off the institutionalized spouse’s income for support. This leaves the institutionalized spouse short on money to pay for nursing home care, and State Medicaid must pay the difference. States using the income-first rule will see increased Medicaid costs because community spouses rely more on institutionalized spouses’ income which leads to less income for the institutionalized spouse.

Changes in asset transfer penalty period rules and use of income-first rules will eliminate an elderly parent’s tools of inducing his or her children to ensure care, support, and a reasonable standard of living. The White House claims that the DRA “tightens the loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits.” These “loopholes” cannot be explained in such simplistic terms. In fact, Medicaid planning did two things. First, Medicaid planning was a tool for the elderly to induce their children to take care of them. Second, Medicaid planning helped ensure a reasonable quality of life while incapacitated or functionally dependent.

IV. ILL-PREPARED AND ILL-EQUIPPED FAMILIES

“Research on family care giving clearly has demonstrated that the responsibility for the care of impaired older adults, is most often assumed by one family member, referred to as the primary care giver.” A spouse is usually the primary caregiver with adult children being the secondary caregivers. When there is no spouse, adult children are typically the primary caregiver. Blackstone famously characterized children’s responsibility to their parents.

203. Retirement pensions often have the option of high monthly income or lower monthly income and a survivor benefit. A spouse is without a survivor benefit when the institutionalized spouse opts for higher monthly income rather than survivor benefits.


206. Id.

207. Id.
There is a moral responsibility, even higher than the legal, for children to help their needy parents. The forces tending toward the disintegration of strong family bonds are already too numerous; for the state deliberately to add to them by removing any filial obligations would be to weaken still further the most basic and revered of all our social institutions.208

The duties of children to their parents arise from a principal of natural justice and retribution. For those who gave us existence, we naturally owe subjection and obedience during our minority, and honour and reverence ever after: they, who protected the weakness of our infancy, are entitled to our protection in the infirmity of their age; they who by sustenance and education have enabled their offspring to prosper, ought in return to be supported by that offspring, in case they stand in need of assistance.209

A. Changing Family Dynamics

Changing family dynamics and reliance on the government’s assumption of the responsibility to provide for the elderly has left families ill prepared to care for the elderly. Families are increasingly expected to care for their elderly, especially when government programs are cut. Families are small, more fragile, and spend more money on extended family support today than in the past.210 Children who would care for their elderly parents may face difficulties because fewer children mean a greater proportional share of responsibility.211 Because families are facing obstacles to supporting their extended family, the government should offer incentives to families who financially or physically support their elder parents.

Families have seen increased urbanization and geographic mobility of their children.212 The shift away from geographic stability started with industrialization213

208. Jacobson, supra n. 11, at 542-43 (citing Our Needy Aged 200 (Floyd A. Bond, et al., eds., 1954)).
209. Id. at 543-44 (citing 1 Blackstone, Commentaries, 446-459).
211. Moskowitz, supra n. 45, at 725.
212. Cavanaugh & Whitboune, supra n. 60, at 330.
213. Proclamation of Senior Citizens Month, 1965 U.S.C.C.A.N. 4297 (April 16, 1965) (Lyndon Johnson noted that the rising elderly population was due to industrialization, urbanization, and advancing medical science and technology).
because of the need to leave the family farm to move to cities.214 Because there are fewer mom and pop businesses and fewer family farms, there is less need for families to stay in close proximity.215 “One important outgrowth of these economic and geographic changes for later-life families is that parent-child relationships have become far more voluntary and less obligatory.”216 Often aging parents want to stay where they are, and children often want to move to new places or find better work in other areas.217 The government could provide incentives like the tax deduction for moving expenses when relocating for a job and reinstate the legislative intent of the MCCA so that families would be encouraged to compromise on the best domicile for both the adult children and their elderly parents.

Women who used to stay home and care for the children and elderly are now working. Working women who care for both children and an elderly relative are often referred to as “women in the middle.”218 “Women provide approximately 70 percent of all elder care.”219 The general pattern of caretakers today starts with the elderly wife, then to a daughter, next to a daughter-in-law.220 Two-thirds of women who care for an elderly relative hold full-time employment.221 Family members who work and care for their elderly relatives face personal, professional, emotional, and financial challenges.222 A 1992 study showed that “almost one-forth of those surveyed changed their employment drastically as a result of their elder-care responsibilities.”223

B. Diversity of Elderly and their Care- Receivers

Elderly immigrants are more likely to live in family settings than elderly born in the United States.224 “Older foreign born” are more likely to be in poverty than elderly born in the U.S.225 Because foreign elderly are more likely to be in poverty, they are also more likely to participate in means tested government programs.226 In fact, over

214. Narayanan, supra n. 210, at 371 (explaining that “industrialization supplanted a social system based on family networks and developed social systems based on geographical and social mobility”); Jacobson, supra n. 11, at 528.
215. Cavanaugh & Whitboune, supra n. 60, at 331.
216. Id.
218. Cavanaugh & Whitboune, supra n. 60, at 331; cf. Gail Hunt, Carol Levine, & Linda Naiditch, Young Caregivers in the U.S. 1 (2005) (arguing that surveys show men, women, young, middle-aged, old, etc. care for the elderly).
219. Smith, supra n. 6 (explaining the women’s movement away from the home and toward the workplace).
220. Id. at 360-61.
221. Id. at 364 (citing Jaine Carter & James Carter, Sandwich Generation in a Pickle, Scripps Howard News Service (July 11, 2002)).
222. Id. at 364.
223. Narayanan, supra n. 210, at 400.
224. He, supra n. 33, at 7.
225. Id. at 9 (citing 13.8 percent of the older foreign born were in poverty in 1999 compared to 9.3 percent of native born elderly).
226. Id. at 10.
three times as many foreign born elderly households received cash assistance than native citizens.\textsuperscript{227} Twice as many foreign born elderly households received non-cash assistance.\textsuperscript{228} It would seem then that foreign elderly suffer more than natives when family support and government programs are inadequate.

Minorities tend to expand their “circle” or “network” to include relatives beyond the traditional nuclear family. “People of color…” tend to rely more heavily on extended kin networks for physical, emotional, and economic support relative to whites.\textsuperscript{229} Elderly Koreans expect their daughters-in-law to take care of them.\textsuperscript{230} The government needs to address and construct programs responding to the struggles of minority extended families.

Average ages of family caregivers categorized by ethnicity are: Whites age 50, Blacks age 41, and Hispanics age 37.\textsuperscript{231} More Blacks work and provide care to elderly family members than Whites or Hispanics.\textsuperscript{232} Elderly Whites tend to be older when they need care than do Blacks and Hispanics.\textsuperscript{233} If a family does provide care for their elderly relatives, the family is often over worked. “Over 70% of caregivers had no help from formal caregivers, even though over 80% had been providing care for at least one year, and 40% had been providing this care for 20 or more hours per week.”\textsuperscript{234} In short, minority families need government assistance in providing care for their elderly family members, especially when Social Security, Medicare, and Medicaid are not adequately addressing elderly needs.

Some elder advocates have suggested the U.S. government provide tax benefits, housing opportunities, and expansion of the Family Medical Leave Act to encourage adult children to primarily support their aging parents.\textsuperscript{235} It has also been suggested that companies, corporations, and employers provide benefits and programs for adult children who provide for elderly parents.\textsuperscript{236} Other proponents of government incentives point to expanding the Dependent Care Deduction, the Dependent Care Assistance Plan, the Family and Medical Leave Act, the Older Americans Act, and

\textsuperscript{227} Id. at 10 (citing five percent of households in 1999 with an elderly native received means-tested cash benefits; and 16.5 percent of foreign born households received means-tested cash benefits).

\textsuperscript{228} Id. at 10 (citing 29.1 percent of foreign born households received noncash means tested assistance while only 14.1 percent of native households did).

\textsuperscript{229} Smith, supra n. 6 (citing Colleen Johnson & Barbara Barer, Families and Networks Among Older Inner-City Blacks, 30 Gerontologist 726 (1990)).


\textsuperscript{231} Maryam Navaie-Waliser, et al., The Experiences and Challenges of Informal Caregivers: Common Themes and Differences Among Whites, Blacks, and Hispanics, 41 Gerontologist 733, 735 (2001).

\textsuperscript{232} Id.

\textsuperscript{233} Id. at 736-37.

\textsuperscript{234} Id. at 737.

\textsuperscript{235} Narayanan, supra n. 210, at 396-97.

\textsuperscript{236} Id. at 396-97 (illustrating programs initiated by Stride Rite, US Sprint Communications Company, American Express).
National Family Caregiver Support Program. Incentives could also be as creative as a Japanese program that provides loans to families supporting elderly parents.

**CONCLUSION**

Elderly Americans must start focusing on how to replace their income once retired or otherwise disabled, how to pay for health care when they are sick, and how to protect their loved ones when they are disabled and incapacitated. The debate as to who will bear the cost of supporting the elderly is an age-old question that is still debated today. Presidents Roosevelt and Johnson and others intended for the United States government to help bear these costs.

The United States government assumed responsibility for support of the elderly population when it enacted Social Security, Medicare, and Medicaid. The elderly relied on these programs and expected these programs to adequately provide for them upon retirement. These programs have, however, become less than adequate through time and legislative cutbacks, especially for elderly immigrants and minorities. This is especially true in the case of immigrants or minorities who are often overlooked because they do not understand social welfare system.

Families also relied on government programs to support their parents and grandparents. The inadequacy of current government programs contradict President Roosevelt’s and President Johnson’s purpose for Social Security and Medicare, respectively. Likewise, the changes to Medicaid planning in the Deficit Reduction Act of 2005 contradict the Congressional intent of the Medicare Catastrophic Coverage Act of 1988. As a result, families will be ill-equipped to care for the elderly.

Ill prepared families who do not or can not care for their elderly may still be forced to provide such support. State governments have started enforcing filial responsibility laws to require families to care for the elderly. The consequences of under-preparedness and forced care will be a lower quality of life for the elderly upon retirement, except for the wealthy. One need only look back to pre-Social Security times to see that a lack of adequate government programs for the elderly means only retirement for the rich. Americans should resolve not to repeat history and demand a reasonable quality of life for the elderly – including immigrants, minorities, and poor.

---


240. Filial responsibility issues are beyond the scope of this article. Filial responsibility laws are an interesting topic that must be explored in-depth. Here, the topic is merely mentioned as a possible response to meeting elderly needs.

INTRODUCTION

Nobody wants to be told where they must live, or to be made to feel they have no options in their living arrangements. However, there are always barriers to perfect choice. Economists talk about the “choice process” as a series of eliminations. The choice set is partitioned into two or more subgroups, then one subgroup is chosen, and the objects in the other subgroup are dropped from consideration. A “constrained choice” occurs when situational or extrinsic factors dictate a specific set of partitions.1

---

1 Lauren R. Sturm is an Elder Law LL.M. Candidate at the University of Kansas School of Law. She earned her J.D. from the University of Kansas School of Law in May of 2004.

Constrained choice of appropriate housing will be affected by barriers such as level of income, higher demand for a certain kind of dwelling, family size, and availability of transportation. But as one ages, the barriers increase. Retirement leads to fixed incomes. Proximity to family and needed medical services becomes more crucial. Individual mobility in and around the home may be limited. Unexpected illnesses or deaths create new expenses. There are innumerable circumstances that make older people feel insecure about their housing arrangements. If they are already living on a lower income, that insecurity substantially increases. Too many older Americans face a too-constrained choice in housing due to limited economic resources.

Assistant Secretary for the Department of Health and Human Services Josefina G. Carbonell laid out a vision for older Americans in 2005:

In July the Older Americans Act will celebrate its 40th anniversary. As we move forward with plans for the reauthorization of the Act, it provides a great opportunity to prepare for this coming wave of older adults and make AoA’s vision for an aging society a reality. I believe that by continuing to forge ahead on our strategic priorities though both this budget and the reauthorization process, we can develop a comprehensive, coordinated and cost-effective system of care that ensures that elderly individuals can maintain their independence and dignity in their homes and communities.²

However, the reality is falling short of this vision. The Minority Report of the recently formed Seniors Commission succinctly laid out what is at stake for the nation’s low-income elderly:

The present and growing gap between the supply of affordable housing for poor seniors and the documented need constitutes a crisis for hundreds of thousands of them. The numbers of very elderly and frail people are rising dramatically, yet the numbers of units of appropriate housing are not. Affordable and decent housing linked with supportive services is crucial to preserving the health and dignity of these elders.³

Senior citizens now represent 12.4% of the population, but by 2030, that population will increase to 20%.⁴ Therefore, one should consider all current statistics on the housing needs of lower income elderly individuals in the light that if current trends continue, existing problems would be exacerbated dramatically. With that in mind, according to the U.S. Department of Housing and Urban Development, almost 1.2 million households with worst case housing needs consist of single elderly individuals or elderly couples with no children present in the household.⁵ Elderly households overwhelmingly receive Social Security, yet more than one-half of them have incomes below the poverty line, and 74% have incomes below 30% of their

5. U.S. Dept. of Housing and Urban Development, Section 8 Tenant –Based Housing Assistance: A Look Back After 30 Years 14 (Washington, D.C., March 2000).
area’s mean income. Older renters are also more vulnerable to physical problems as they age when compared to homeowners. In 1995, 22% of renters age 62 and older reported difficulty with one or more physical activity, versus 16% of homeowners 62 and older.

In order to address this worst-case need, the particular challenges of housing older persons must be carefully considered within the most widespread model of housing assistance in the United States, the Section 8 Housing Choice Voucher program, as well as the two other programs that serve the most older Americans, the Section 202 Elderly Housing Program and Public Housing. These three housing programs most frequently interact with the Home and Community-Based Services Waiver Program under Medicaid, and service provision and/or case management is frequently coordinated by Area Agencies on Aging. To make affordable, appropriate housing available for all low-income, older Americans, we have to not only make that housing more available to all low-income Americans, but do so in an extremely consumer-friendly way.

Right now the indication is that this is not happening. The current administration has proposed cutting by nearly $200 million the federal program that provides for both construction and rent subsidies for low-income elderly. Without affordable housing options and service provision mechanisms in the community, seniors with modest incomes will continually be housed in institutional settings that are not always appropriate for them.

Recommendations will include appropriations for capital improvements to public housing so that it can be suitable for aging tenants, increasing the number of Medicaid HCBS waivers and Section 8 vouchers, passing the Medicaid Community Attendant Services and Supports Act (MiCASSA), adding “source of income” to the Fair Housing Act and/or passing more state laws that address source of income discrimination, and increasing the linkages between service provision and locating appropriate housing.

6. Id.
I. WHAT IS AGING IN PLACE?

Remaining in one’s current dwelling well into old age is the norm for the vast majority of seniors in the U.S. As of 1997, only 4.5% of U.S. elders resided in nursing homes, and as of 1999, 80.27% were owners of their dwellings.\(^1\)

The Assisted Living Federation of America defines “Aging in Place” as, “a resident’s choice to remain in their living environment regardless of the physical or mental changes that may occur as they age.”\(^1\)\(^3\) To accomplish this, Aging in Place “requires the coordination of health and housing programs to deliver a customized level of care in an individual’s current environment.”\(^1\)\(^4\) According to an AARP nationwide telephone survey taken in 2004, an overwhelming 76% of survey participants (all over age 50) wished to stay in their homes as they aged.\(^1\)\(^5\) Among respondents who were earning less than $20,000 per year, that percentage goes up to 85%.\(^1\)\(^6\) It is no wonder that aging policy today is significantly, if not primarily, concerned with keeping older Americans out of nursing homes.\(^1\)\(^7\)

The most successful “Aging in Place” programs will minimize the provision of inappropriate care, and in theory, the costs of that care, by offering a range of flexible services and tailoring those services to fit the needs of the individual.\(^1\)\(^8\) “Aging in Place” creates both health-care and housing options that provide support at the margin of need as defined by the older person’s desire and efforts to live independently.\(^1\)\(^9\) It also focuses on maintaining social networks within the individual’s community.\(^1\)\(^0\) The AARP’s “Beyond 50.05” survey report explained the advantages of Aging in Place best:

It is easy to understand why most people age 50 and older prefer to age in place. Over time, people form attachments to their homes and communities for personal and practical reasons. Their homes and communities can form the basis for positive life experiences and memories, sentiments that remain strong even if the home and community no longer meet the needs of the person living there. In addition, over time people become familiar with what their communities have to offer in terms of shopping, recreation, social


\(^{15}\) Andrew Kochera, Audrey Straight & Thomas Guterbock, Beyond 50.05: A Report to the Nation in Livable Communities: Creating Environments for Successful Aging, AARP Public Policy Institute (2005).

\(^{16}\) Id. at 58.

\(^{17}\) Lawler, supra n. 14.

\(^{18}\) Id.

\(^{19}\) Id.

\(^{20}\) Id.
services, and opportunities for social interaction. This knowledge is important for independence. Therefore, enabling the majority of older persons who prefer to remain in their homes to do so is a major goal, or, if this is not desired or practical, providing alternative housing options in the same community is an important priority.  

II. SECTION 8

A. What Is It Generally?

The Federal Section 8 program began in 1975 as a way to assist low-income families, elderly people and people with disabilities to rent decent, safe and affordable housing in the community. There are four types of Section 8 assistance: tenant-based rental assistance, project-based rental assistance, homeownership assistance and down-payment assistance. This article will focus on tenant-based assistance.

To be eligible for Section 8 assistance, a household (which can consist of one person) must be at or below 50% of the area-wide median income as determined and disseminated by HUD on a yearly basis. All household members must be a citizen or legal permanent resident of the United States, and they must be in good standing with all federal housing programs, meaning, one cannot have been evicted from public housing, been terminated from another Section 8 program for cause, committed fraud or criminal acts in connection with a federal housing program or failed to reimburse a Public Housing Authority (PHA) for unpaid rent or damages, or currently owe money to a PHA.

The Section 8 subsidy will pay the difference between 30% of the household’s income and a predefined limit based on the size of the unit (usually based on the number of bedrooms). When the renter takes the voucher with him or her to the property and the lease is signed, the landlord enters into a contract with the local Public Housing Authority (PHA) for the duration of the lease and also promises to meet certain program requirements, such as minimum rental unit quality standards. When a voucher is issued, it must be used within 60 days, or an extension needs to be granted.

23. Id.
24. Id.
25. Id.
26. This is called the Fair Market Rent (FMR). It is based on the 40th percentile of the rental cost of conventional, standard quality units, and can go up to the 50th percentile in high-price markets. Calculations are based on telephone surveys, the most recent census, and the HUD American Housing Survey. See also Kochera, supra n. 7.
27. Id.
28. Id.
B. Section 8 and the Older American Population

One should carefully consider the following three elements when comparing the utilization of HUD Section 8 Housing Choice Vouchers by older renters to that of renters as a whole: The population of older persons in the U.S. is growing rapidly, their housing needs tend to merge with their high-cost long-term care needs, and their difficulties with Section 8 are a heightened representation of the low-income renters’ difficulties with the Section 8 program in general.30

In 2004, 330,475 Section 8 Housing Choice Vouchers were used by households with a member age 62 or older.31 This program assists more seniors than any other housing assistance program; yet, as a percentage of all Section 8 program participants, seniors reap the fewest vouchers, at only 16%.32 It would therefore appear that while vouchers have proved their utility to seniors, seniors may not be utilizing Section 8 up to the level that their demographic cohort would warrant. Health, physical mobility, stamina, competency and even impending mortality may be legitimate barriers to successful navigation of housing assistance programs. But the program also has inherent barriers.

What are the difficulties of all low-income renters with Section 8 and other demand-driven mechanisms? One hurdle is obtaining a voucher in a climate of decreasing expenditures on housing assistance. When the pool of vouchers dry up, Public Housing Authorities (PHAs) will not let waiting lists get too long and therefore, for much of the year, a waiting list for a housing voucher is closed off to new applicants, only to be announced reopened in a small newspaper announcement.33 Another hurdle is the ability to locate appropriate rental housing once a voucher is secured due to the resistance of landlords who do not wish to participate in a federal program with regulatory mandates. More frequently than it should happen, tenants and PHA workers must convince and cajole landlords into accepting vouchers.34

However, there is a positive side to Section 8 Vouchers for the older American population, which is the variety of housing options that it can be used for. The regulations controlling the Section 8 Housing Choice Voucher Program expressly allow PHAs to permit elderly occupation of congregate housing and group homes.35 If an elderly person is considered disabled under the Fair Housing Act, it is required that the PHA permit use of the voucher in one of these housing types as a reasonable

32. Id.
accommodation. These types of housing include independent living units within Continuing Care Retirement Communities as well as Assisted Living Units and units in group homes geared toward elderly residents, as well as typical apartments and other rental units. So, there is flexibility for the older voucher user as housing and service needs change, as long as the voucher is not being used for skilled nursing care.

C. Putting Together Section 8 and In-Home Services: HOPE IV

The Housing Opportunities for People Everywhere Elderly Independence (HOPE IV) pilot program was authorized by Section 803 of the National Affordable Housing Act as a tenant-based program, administered by PHAs for older persons who were not previously receiving HUD assistance. Running from 1993 to 1998, the program provided Section 8 housing assistance, case management and non-medical support services, usually through Area Agencies on Aging (AAAs).

Area Agencies on Aging (AAAs) were established under Title II of the Older Americans Act (OAA) in 1973 to respond to the needs of Americans aged 60 and over in every local community. AAAs must contract with outside entities for service provision if it is more economical to do that rather than the AAA carrying out all service provision themselves. The services available through AAA and Title VI agencies fall into five broad categories: information and access services, community-based services, in-home services, housing and elder rights. Within each category a range of programs is available. AAAs often serve as portals to care. They assess multiple service needs, determining eligibility, authorizing or purchasing services and monitoring the appropriateness and cost-effectiveness of services. AAAs provides direct services and contract with local providers to furnish other services in the community, and in many cases are the only options for low-income elderly persons who would otherwise navigate the matrix of services and benefit programs with little to no assistance, making their eventual institutional placement much more likely.

HOPE IV allowed applicants to remain in their homes as long as it was in the PHA area and met HUD’s Section 8 quality standards. To understand the effects of the program, HOPE IV elderly were compared to a similar population receiving Section 8 assistance only. A key feature of HOPE IV was the establishment of a Service Coordinator position within the PHA with responsibilities for the design and

36. Id.
implementation of an integrated system of case management, personal care, and home management services for frail elderly Section 8 tenants. Of particular importance was the coordination of traditional Section 8 staff activities with the new case management and services components of HOPE IV. In addition, the Service Coordinator was responsible for forging relationships with other agencies and organization in the community with resources and responsibilities for programs on aging, including purchase-of-services arrangements with existing providers. Supporting the Service Coordinator was a Professional Assessment Committee (PAC) responsible for screening applicants for frailty and documenting need for services, in accordance with the HUD HOPE IV regulations. The PAC had to include at least one medical professional and at least two other members with various health or social services backgrounds.\(^\text{43}\)

It was unfortunate that this program did not continue past the prescribed funding timeframes because HOPE IV showed a significant correlation between receipt of services in the Section 8 unit with a range of positive outcomes for the older adult participants, across multiple domains of functioning.\(^\text{44}\) This included a higher measure of contact with family members when compared to the baseline group as well as the Congregate Housing Services Program, a project-based pilot program.\(^\text{45}\) Where there was inadequate coordination between PHAs and service providers (usually AAAs) or where otherwise viable participants were turned away due to lack of frailty (they had to be unable to perform at least two Activities of Daily Living or ADLs), the program did falter, but otherwise, there were foundations laid for great success.\(^\text{46}\)

While the Majority Members of the Commission on Affordable Housing and Health Facility Needs in the 21st Century declined to recommend specific funding authorizations, the Minority Report recommended reauthorization of the program as part of a larger push for more housing assistance for the expected 3.2 million very low- and extremely low-income renters with priority housing problems that will exist by 2020.\(^\text{47}\) The HOPE IV evaluation showed that prior to the program’s implementation, existing Section 8 policies and procedures often discouraged application and participation by eligible frail elderly persons. In-person application requirements, the need for assistance in locating accessible rental housing for persons with disabilities, the absence of linkages with care providers, and the steering of aging tenants to more congregate options, like skilled nursing facilities, often excluded frail elderly persons from Section 8 altogether. These barriers affected not only new frail elderly applicants, but also existing Section 8 tenants who had aged in place.\(^\text{48}\)

\(^{43}\) \text{Id.}
\(^{44}\) \text{Id. at 6.}
\(^{47}\) Submitted to the Committee on Financial Services, \textit{supra} n. 3.
\(^{48}\) Cremin, \textit{supra} n. 8.
D. Section 8, Source of Income Discrimination and Older Americans

The final evaluation of the HOPE IV program made the following important observation:

Even if a suitable residence could be found in a desired location, the landlord might refuse or be reluctant to rent to elderly Section 8 tenants. Six grantees reported having a hard time convincing landlords to accept HOPE IV participants. Three of these grantees emphasized that very tight housing markets in their communities made Section 8 rents unappealing to most landlords. Another grantee, initially spared from having to deal with this problem, anticipated difficulties with landlords in the future, as the vacancy rates for one-bedroom market in the community fell and rents continued to rise.49

As previously stated, landlord aversion to voucher holders are a major barrier to the all-around success of the Section 8 housing voucher program.50 While there are significant protections for landlords in the Section 8 program and subsidized tenants are no more costly to landlords than unsubsidized tenants,51 in a tight housing market, landlords will naturally be as choosy as they are able to be with potential tenants within the confines of the law, or even, outside those confines.52 This difficulty places new voucher funding in jeopardy because PHAs must meet a 97% placement rate of eligible applicants in order to apply for additional funding.53 Therefore, the incentive is to not expend time and effort convincing landlords who normally don’t take vouchers to take them (those in more desirable middle income neighborhoods) but instead, to overly rely on landlords who take vouchers, even if to do so reinforces cycles of poverty. It is logical that PHAs will do what secures the most funding for their area of service.

From an efficiency standpoint, mandating that landlords not turn away a tenant because that tenant wishes to partially pay rent with a voucher would eliminate the above perverse incentive. The incentive would then be to litigate whenever possible illegal actions by landlords so as to safeguard a jurisdiction’s funding, especially if there is institutional support for litigation through state Legal Aid Societies, Attorney General’s offices, state Human Rights Commissions and/or any other willing legal advocate. Several Federal laws protect Section 8 voucher users and/or applicants in certain situations where the landlord benefits from some federal or HUD assistance. For example, owners of low-income housing tax credit projects must certify, at least annually, that they have in place an “extended low-income housing commitment” that prohibits, “the refusal to lease to a holder of a [Section 8] voucher or certificate...
because of the status of the prospective tenant as such a holder." 54  Source of income has been seen as a pretext for protected classes under the Fair Housing Act. 55  Additionally, under § 1437f(t)’s “take one, take all” mandate on landlords who have accepted any Section 8 voucher holder, if a landlord has accepted one voucher holder, they are mandated not to turn down another voucher holder, and failure to do so would be considered discrimination. 56  Though this law was temporarily suspended by the Congress for fiscal years 1996 and 1997, the statute itself was not repealed, and it may therefore become available once again in the future. 57

But outside of these incremental directives, the federal government has refused to mandate that landlords treat a Section 8 voucher like a cash payment, that is, to mandate program participation. Academics have advocated the addition of “status with regard to rental assistance” to the Fair Housing Act, citing as legislative precedent the Equal Credit Opportunity Act of 1974. 58  So far, that recommendation has gone nowhere. 59

However, some states, acutely aware of a lack of affordable housing, have been leaders in passing “Source of Income Discrimination” laws. 60  Once these laws are passed, landlord organizations frequently want to litigate whether the statutes apply to housing vouchers, rather than other forms of assistance, since the voluntariness of the federal program may create a Federal preemption issue. 61  Such was the case in the

56. Knapp v. Eagle Property Management Corp., 54 F.3d 1272, 1276-79 (7th Cir. 1995)
58. 15 U.S.C. § 1691(a)(2) (1995) (“It shall be unlawful for any creditor to discriminate against any applicant, with respect to any aspect of a credit transaction . . . because all or part of the applicant’s income derives from any public assistance program . . .”), Supra, Note 51.
59. It is the fervent wish of the author that in light of Hurricane Katrina and the significant amount of displaced individuals and families struggling to find appropriate housing with emergency vouchers that this recommendation be seriously considered.
flagship Section 8 Source of Income Discrimination Case, Franklin Tower One, L.L.C. v. N.M. Many organizations and legal scholars have noted the importance of this New Jersey Supreme Court case for the viability of state source of income laws generally.

What is more notable from a senior housing perspective is that the plaintiff in the case was a senior citizen who was attempting to “Lease in Place” (a play on “Age in Place”). The case involves a 65-year-old widow, not named, who tried to use her federal Section 8 voucher to pay for a portion of her rent in an apartment that she had lived in for several leasing cycles. The landlord at the time, Sava Holding Corp., refused to participate, claiming participation in the program was voluntary and it did not want to get entangled in “bureaucracy.” The landlord later filed a complaint against the tenant, claiming non-payment of rent. The property had been sold to Franklin Tower One, which inherited the court action.

The trial court ruled that N.J.S.A. 2A:18-61(a), which prohibited discrimination by landlords against people who have children or who are “on Public Assistance, or receive alimony or child support,” did not apply to Section 8 vouchers and that the statute was also preempted by the Constitution’s Supremacy Clause. But the Appellate Court reversed, and the New Jersey Supreme Court affirmed the Appellate Court, saying that this was not a situation where Congress left no room for state regulation in the area of housing assistance; rather, states may impose greater restrictions than those imposed by federal law. The court further ruled that the legislative history of New Jersey’s source of income protections indicates that the court should err on the side of protecting the tenant due to a “critical shortage of rental housing space in New Jersey.” They did point out that the landlord has the full right to screen and review the tenant’s references, background, employment and rental history to verify that the tenant is otherwise qualified to reside in the landlord’s building.

So, where there is Source of Income protection, there is actually quite a bit of flexibility for a lower-income senior with a housing voucher who is trying to remain in his or her rental unit and/or move to a more appropriate apartment, perhaps even in a Continuing Care Retirement Community (CCRC). Where there is a lack of litigation and/or guidance thus far in the states that have these laws is in the area of congregate housing, including assisted living. While congregate housing is a valid dwelling for

64. Cremin, supra n. 8.
65. Franklin Tower One, L.L.C., supra n. 60.
66. Id. at 1107 (citing Salute v. Stratford Greens Garden Apartments, 136 F. 3d 293, 296 (2nd Cir. 1998)); Knapp v. Eagle Property Management Corp., 54 F. 3d 1272, 1282 (7th Cir. 1995).
67. Id. at 1111 (citing N.J.S.A. 2A:18-61.1).
68. Id. at 1110-1111.
Section 8 housing voucher purposes, each state would have to decide if its source of income laws extend into housing that is usually regulated separately from normal rental housing units. Perhaps test cases in the states with these protections is warranted in order to cement older voucher holders’ right to enter into a monthly lease with any allowable Section 8 dwelling, including congregate housing/assisted living, without worry that the facility administrator will turn down the voucher. To assure that all eligible dwellings under Section 8 receive source of income protection, Congress should add source of income language to the federal Fair Housing Act, where it can stand alongside age and disability as significant protection for older Americans looking to remain independent and integrated in their communities for as long as possible. Source of income protection can both help an older person age in place and make sure that the money truly does follow the person.

III. PROJECT-BASED PUBLIC HOUSING FOR OLDER AMERICANS

A. HUD Section 202 Elderly Housing: An Overview

The Housing Act of 1959 created the Section 202 HUD Elderly and Handicapped Supportive Housing Program to develop housing for the elderly. It did this by providing direct loans at below market rates to not-for-profit organizations, for-profit limited partnerships and local governments for new construction of housing for the elderly and disabled. Like Section 8, unit rents cannot constitute more than 30% of the tenant’s income, and subsidies are given to tenants to satisfy this provision. In 1990, the original Section 202 program was divided into Section 202 for the elderly and Section 811 for disabled individuals. In these units, landlords can specify to whom they would like to rent; for example, if they would like to focus on elderly individuals with Alzheimer’s, and turn down other otherwise eligible tenants, they may do so. In general, Section 202 serves a population of frailer and more vulnerable elderly. The average resident is 80 years old and 90% of the residents are women that live alone. In 2004, 221,753 elderly residents lived in Section 202 housing units.

---

71. The author actually advised a friend’s lower-income grandfather who lives in Oklahoma, a state with a source of income law, to get on a Section 8 waiting list as soon as possible because they anticipated that assisted living would be necessary in 3-5 years.
72. See Lauren R. Sturm, Fair Housing Issues in Continuing Care Retirement Communities: Can Residents be Transferred Without their Consent? 6 New York City L. Rev. 119 (Fall 2003).
74. Id.
77. Beckert v. Our Lady of Angels Apartments, Inc. 192 F. 3d 601 (6th Cir. 1999).
78. Cremin, supra n. 8.
B. Public Housing: An Overview

Almost one million seniors live in public housing, which represents one-third of the 1.4 million units operated by public housing authorities (PHAs). Public housing is the country’s largest federal housing program for seniors. Public Housing for senior citizens is defined by the Housing Research Foundation as developments in which at least two-thirds of the units have fewer than two bedrooms and half of all households qualify as either elderly or younger disabled.

Originally, public housing was not targeted to older Americans at all—the elderly were usually admitted only as members of an extended family. As recently as 1952, elderly households accounted for only 6 percent of the public housing population. The situation began to change in 1956, when Congress made seniors explicitly eligible for admission and authorized public housing authorities to develop housing specifically for their use. Many low-income seniors have since put down roots in their public housing communities, especially in urban areas. Almost one-fourth of elderly public housing households have lived in their units for nine years or longer, but almost half have moved within the past three years.

C. Making Public Housing Work for Seniors: HOPE VI and Elderly Plus

After the end of the HOPE IV program in 1997-8, HUD subsequently devoted $21 million of its HOPE VI allocation to a different elderly demonstration program. The program provided grants to five public housing authorities for the development, rehabilitation, and reconfiguration of facilities specifically targeted for the elderly. In three of the demonstration sites (Cambridge, Massachusetts; Miami, Florida; and Mobile, Alabama), the public housing authority (PHA) is coordinating onsite assisted living services for all or part of the sites’ resident elderly population. In the other developments (in Allegheny County, Pennsylvania and New Bedford, Massachusetts), the PHA either has developed or is developing facilities that will enable local health and social service providers to serve residents onsite.

Building on the lessons of the HOPE VI program, The Council on Large Public Housing Authorities (CLPHA) proposed the “Elderly Plus” initiative in 2000. It would make capital improvements and allow for essential services in elderly public housing by adding $250 million to a minimum annual Capital Fund appropriation of

---


82. Id.

83. Id.

84. Id.

85. Sean Zielenbach, The HOPE VI Elderly Demonstration Program after Five Years, 13 Fall J. Affordable Housing & Community Dev. L. 81 (Fall 2003).
$3 billion, in each of the next five years. This initiative builds on programs authorized in the Quality Housing and Work Responsibility Act of 1998 (QHWRA) for a Capital Fund and for Supportive and Congregate Housing Services. The focus would be on upgrading the aging stock of apartments for the elderly and, in some cases, of buildings occupied by both elderly and disabled households. As with the QHWRA Capital Fund, a grantee could use a portion of its grant for non-capital purposes; in Elderly Plus, such uses would include service coordinators and various supportive and congregate housing services best suited to the needs of a PHA’s residents.86

The earmarked Elderly Plus funds would be awarded competitively based upon a PHA’s demonstrated capacity to carry out its proposal, the potential for linking to local healthcare, social services, and other resources, and the quality of the assistance to be afforded to the frail elderly or the disabled, as the case may be, or to both groups in buildings jointly-occupied. As envisioned by the new QHWRA, PHAs would be given significant flexibility to develop and implement the initiative.87 In a way, Elderly Plus would, de facto, make public housing more similar to Section 202 housing, where service provision by local agencies is already common.

Harry Thomas, a member of the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, testified in favor of Elderly Plus, observing:

The inventory of public housing for the elderly and disabled is an extremely valuable asset which we cannot afford to neglect or abandon. Dramatic cuts to the Public Housing Capital Fund, like those currently proposed, would place our stock of housing for elderly and disabled residents in serious jeopardy. Instead, we need more resources and flexibility, as outlined in the “Elderly Plus” proposal, to enable seniors and disabled residents to age more comfortably in their own homes. Using the successes we have already experienced in public housing for seniors as models, we need to continue to look for ways to wrap needed services into our facilities and programs, so that our elders are not displaced as their needs increase. I am convinced that we can do this if we apply unflagging commitment and the right resources to this problem.88

Scarcity of housing resources compels policy-makers to maximize the utilization of all available units that could be made appropriate for elderly individuals with lower incomes. This means opening up tenant-based vouchers with source of income protection as well as modernizing public housing units so that those older Americans who wish to age in place in these units can do so safely and happily. It also means that a full commitment must be made by Medicaid to provide social and medical services in non-institutional settings.

87. Id.
88. Testimony of Harry Thomas, Executive Director, Housing Authority of the City of Seattle and Member of the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century before the U.S. House of Representatives, Committee on Financial Services, Subcommittee on Housing and Community Opportunity (July 17, 2001.)
IV. MEDICAID HOME AND COMMUNITY BASED SERVICES: GENERAL OVERVIEW

In 1981, Former President Ronald Reagan signed into law P.L. 97-35, which established within the Social Security Act a Medicaid Home and Community Based Services (HCBS) Waiver Program. This law states, in pertinent part, that:

The Secretary may by waiver provide that a State plan approved under this title may include as 'medical assistance' under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility... (Emphasis mine.)

Under this legislation, States were authorized to request and provide, with the Secretary of Health and Human Services’ approval, homemaker or home health aide services, personal care services, adult day health, recuperative, respite care and other services, case management, partial hospitalization services, psychosocial rehabilitation services and clinic services for individuals with chronic mental illness, all within the consumer’s home or community. Additionally, under President Bush’s “New Freedom Initiative,” HCBS now may also fund one-time, set-up expenses for individuals who are making the transition from an institution to their own home or apartment in the community. This can include a security deposit, but not rent.

Currently, all states participate in the waiver program, but some states delayed while others aggressively sought waivers. For example, the state of Maryland only began offering a HCBS waiver program in 2001. Though the services offered from state to state are mostly similar, some states slightly deviate from the norm. Florida offers pest control and financial counseling for their waiver consumers. Oklahoma offers in-home occupational therapy and speech therapy.

Medicaid is the nation’s primary payer of Long-Term Care services, paying 44% of such costs in 2000. Though funding for HCBS has doubled in the ten-year period between 1987 and 1997, as of 1999, HCBS was still only 26% percent of total

---

92. Dennis G. Smith, “Center for Medicaid and State Operations Letter Summary #02-008” (May 9, 2002).
93. Id.
95. Department of Health and Human Services, Center for Medicare and Medicaid Services, Overview of State Home and Community-Based Services (HCBS) Waivers (2002).
96. Id.
97. Randy Desonia, Is Community Care a Civil Right? The Unfolding Saga of The Olmstead Decision, National Health Policy Forum Background Paper, at 3 (March 12, 2003).
Medicaid spending for Long-Term Care. Seventy Four percent of this spending purchased institutional care. HCBS, even with its yearly growth, does not hold parity with nursing homes under Medicaid. Demand for HCBS among Medicaid participants does exceed supply, so under the Medicaid Act, states are authorized to limit enrollment and maintain waiting lists, which they frequently do.  

Because HCBS is a part of Medicaid, a state-federal partnership, eligibility varies somewhat among the states and among the types of waiver programs. In Kansas, for example, to be eligible for the HCBS program for the Frail Elderly (HCBS/FE), one has to be over age 65, financially eligible for Medicaid and must meet the Medicaid threshold for needing Long-Term Care (LTC). This threshold is generally more difficult to meet than the definition under the 1956 Social Security Act to determine Social Security Disability Insurance eligibility, which restricts compensable disabilities to those who have a “medically determinable physical or mental impairment.”

A. “Most Integrative Setting”: The Olmstead Decision and Subsequent Cases

The Americans with Disabilities Act (ADA) states that state and local governments must:

Make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity.

The ADA now pervades all spheres; from work to transportation to building construction and starting with the Supreme Court case Olmstead v. L.C. ex.rel. Zimring, Medicaid HCBS. In this case, which has been compared to no less than Brown v. Board of Education in its scope and importance, the Supreme Court ruled that a Long-Term Care system that primarily funds institutional care (such as long-term care nursing facilities) when community care is appropriate deliberately segregates people with disabilities. Where a state’s treatment professionals determine that a disabled individual can be served in a community program and the person would prefer community treatment, the state is obligated to serve that person in

100. Id.
the community unless doing so would cause a fundamental alteration to the community program. \textsuperscript{106} The programs and services offered by a public entity must be in the “most integrated setting appropriate (emphasis mine) to the needs of qualified individuals with disabilities.” \textsuperscript{107}

\textit{Olmstead} allows the affirmative defense of “fundamental alteration to a program” only if the defendant first shows the following: (1) the state has a comprehensive, effectively working plan for placing qualified persons with disabilities in community settings, (2) the waiting list for community services moves at a reasonable pace, and (3) the movement of the waiting list is not controlled by the state’s desire to keep its institutions fully populated. \textsuperscript{108} Once the defendant has met this test, it may make arguments regarding Plaintiff’s remedy causing a “fundamental alteration.” \textit{Olmstead} states that “fundamental alterations” can include situations when an eligibility criteria is not met by a plaintiff who may be otherwise medically fit for community integration, or when Plaintiff’s remedy would change the “program’s integrity” or its “essential purpose.” \textsuperscript{109} This is a major snag for potential \textit{Olmstead} plaintiffs and interpretation of this affirmative defense has varied widely amongst the different Appellate Circuits.

The movement of the waiting list can be influenced by the amount of resources available to the state and the needs for other individuals with disabilities. \textsuperscript{110} However, in \textit{Helen L. v. Didario} \textsuperscript{111}, the court ruled for the plaintiff under \textit{Olmstead} and took it one step further by stating that a lack of funding or other funding constrains would not excuse a state from compliance with the requirements of the ADA. \textsuperscript{112} In \textit{Boulet v. Cellucci}, \textsuperscript{113} the 3\textsuperscript{rd} Circuit took \textit{Olmstead} even further, granting full HCBS waiver services to plaintiffs who were on a waiting list for certain services but were receiving other services under Medicaid. \textsuperscript{114} Once one begins receiving any Medicaid HCBS services, providing the full compliment of services under their care plan within “reasonable promptness” is an entitlement under the Medicaid Act and that if the applicant is eligible, the services are feasible and settings are available for the delivery of those services, the entitlement must be received within 90 days. \textsuperscript{115}

To illustrate how varied outcomes can be in \textit{Olmstead} cases, we will look within the 10\textsuperscript{th} Circuit, where two cases would seem to be at odds with each other regarding how funding issues would impact Medicaid-eligible consumers from receiving HCBS services.

\begin{itemize}
  \item \textsuperscript{106} \textit{Id.} at 607.
  \item \textsuperscript{107} 28 C.F.R. § 35.130(d) (2001).
  \item \textsuperscript{108} \textit{Id.} at 605-606.
  \item \textsuperscript{109} Smith and Calandrillo, \textit{supra} n. 102.
  \item \textsuperscript{110} 28 C.F.R. § 35.130(d) (2001).
  \item \textsuperscript{111} 46 F. 3d 325 (3rd Cir. 1995). A plaintiff who was in a nursing home and determined eligible for Pennsylvania’s HCBS program was placed on a wait list due to lack of available state funding.
  \item \textsuperscript{112} \textit{Id.} at 337-338.
  \item \textsuperscript{113} 107 F. Supp. 2d 61 (D. Mass. 2000).
  \item \textsuperscript{114} \textit{Id.} at 79. They first state that the “cap” on waiver services is one of many eligibility requirements, and that until one is within that population cap, he or she is not eligible for HCBS.
  \item \textsuperscript{115} \textit{Id.} at 77, 79-80.
\end{itemize}
services. The first, *Lewis v. New Mexico Department of Health*\(^{116}\), agreed with *Olmstead* that, “unjustified isolation of persons with disabilities is a form of disability discrimination prohibited by the ADA.”\(^{117}\) But it also held that “states are not required to provide community-based services to all those who request them regardless of the cost. . . The right to integrated placements is a limited one.”\(^{118}\) The court endorsed a cost-benefit analysis that balances the individual’s right to integrated placements with the State’s available resources and its obligations to provide other programs and services for the public to determine the appropriate remedy in each case.\(^{119}\)

But a more recent Appellate court case, *Fisher v. Oklahoma Health Care Authority*\(^{120}\), reversed and remanded a lower court ruling for summary judgment in the Appellee’s favor; stating that there was an issue of material fact as to whether the State of Oklahoma’s decision to cease providing unlimited, medically-necessary prescription drug benefits under a HCBS waiver program but continuing such funding for non-elderly disabled persons who were institutionalized would put Appellants at high risk for premature entry into a nursing home, thus violating the Medicaid Statute. Upon remand, assuming the trial court rules that Appellants are put at too high a risk for institutionalization; it is unclear whether they would then employ *Lewis*’ cost-benefit analysis in determining the parameters of Appellants’ entitlement to the HCBS prescription service.\(^{121}\)

Older adults who would be potential consumers of HCBS waivers can assert *Olmstead* as readily as the non-elderly disabled. The ADA has adopted Section 504 of the Rehabilitation Act of 1974’s definition, which states that an individual have either a physical or mental impairment, that the impairment limits a major life activity, and that the limitation be substantial to qualify as a disability for purposes of the ADA.\(^{122}\) Thus, the target older adult population that *Olmstead* wanted to reach would include institutionalized older adults who want to be in the community or those soon to become institutionalized without the HCBS services that want to remain in the community.\(^{123}\)

In *Pennsylvania Protection & Advocacy, Inc. v. Department of Public Welfare*\(^{124}\), a case brought to assert the rights of residents of a specialized nursing facility for older Pennsylvanians, the district court, ruling on cross-motions for summary judgment,

\(^{117}\) Id. at 1288.
\(^{118}\) Id. at 1239.
\(^{119}\) Id. at 1238-9.
\(^{120}\) 335 F. 3d 1175 (10th Cir. 2003).
\(^{121}\) It is unclear how the Medicare Modernization Act (MMA) Part D Drug Benefit would alter circumstances in this case. See *California Foundation for Independent Living Centers Sample Letter on Olmstead and Medicare Part D*, http://www.cfilc.org/site/apps/nl/content2.asp?c=ghKRI0PDIoE&b=1038165&ct=1719087 (accessed April 30, 2006).
\(^{123}\) For *Olmstead* cases involving older adults, see e.g. *Fisher v. Oklahoma Health Care Authority*, 335 F. 3d 1175 (10th Cir. 2003), *Townsend v. Quasim*, 328 F. 3d 511 (9th Cir. 2003).
held that the defendants had shown that the development of community services for facility residents would constitute a “fundamental alteration” of the state’s program. Therefore, defendants were not mandated to facilitate community placement. The court reached this conclusion based on a detailed cost analysis submitted by both parties comparing the cost of community placement with the cost of keeping residents at the facility. The court interpreted Olmstead’s admonition to compare the cost of community placement with “the resources available to the state” to mean that the point of comparison should be the state’s “mental health” budget, not its overall budget,\textsuperscript{125} and held that community placement of all facility residents who could be placed would represent a “fundamental alteration.”

Although it may be inappropriate for a court to order defendants to pursue a specific source of federal funds, for example, to request additional slots for the state’s home- and community-based waiver, the availability of additional federal reimbursement is a factor that the court should consider when determining whether the state’s waiting lists move at a reasonable pace. If the evidence shows that the defendants have unreasonably declined to avail themselves of readily available federal funding for home- and community-based services, the court may properly reject their claims that the relief requested would represent a “fundamental alteration.”\textsuperscript{126} Therefore, one can discern how critical sufficient federal funding of Medicaid is to the “teeth” of the Olmstead mandate.

B. Codifying Olmstead: The MiCASSA Bill

The Medicaid Community-Based Attendant Services and Supports Act (MiCASSA)\textsuperscript{127} seeks to amend Title XIX (Medicaid) of the Social Security Act by offering individuals who are eligible for Nursing Facility Services to choose where their services will be provided either in the institutional setting or in the community and administered by community-based attendants. The term community attendant services and supports means help with accomplishing activities of daily living (eating, toileting, grooming, dressing, bathing, and transferring), instrumental activities of daily living (meal preparation, managing finances, shopping, household chores, phoning, and participating in the community), and health-related functions (which can be delegated or assigned as allowed by state law). These can be done through hands-on assistance and/or supervision. They also include help with learning, keeping and enhancing skills to accomplish such activities. These services would be provided based on a functional needs assessment and agreed to by the individual receiving the services. The bill outlines a variety of service delivery models such as vouchers, direct cash payments or via the use of a fiscal agent or the current state or nonprofit agency delivering the services.\textsuperscript{128} The key component of MiCASSA is that all services must be provided in the most integrated setting possible and appropriate to the needs of the

\textsuperscript{125} Id. at 31.
\textsuperscript{126} Halderman v. Pennhurst State School and Hospital, 555 F. Supp. 1144, 1162 (E.D. Pa. 1983)
\textsuperscript{128} Id.
individual. The proposal has been heavily lobbied against by the nursing home industry, which receives the vast majority of Medicaid long-term care dollars.\(^{129}\)

MiCASSA advocates like to use the phrase “the money follows the person” to describe what the bill does. Though the bill will likely go through significant revision to assure its eventual passage, essentially, it would allow consumers to choose among various service delivery models including vouchers, direct cash payments, fiscal agents and agency providers, designed to empower the consumer to acquire the services he or she needs in the setting that is most desirable. In a way, MiCASSA would make Medicaid more like the HUD Housing Choice Vouc her Program in its implementation.

C. Olmstead and Housing: A Logical Overlap

After the \textit{Olmstead} case, the Department of Health and Human Services began publishing guidance letters for states on how to become \textit{Olmstead}-compliant, starting in January of 2000, and states were expected to respond with their own plans.\(^{130}\) Despite the “less restrictive setting” language in the case, the implicit housing issues received scant attention. At the end of 2000, none of the 22 \textit{Olmstead}-related plans submitted by states mentioned housing.\(^{131}\) But last year, as part of the President’s “New Freedom Initiative,” HUD recognized its integral part in the successful implementation of \textit{Olmstead} policies, and issued important implementation suggestions.\(^{132}\) These included being more generous with voucher search periods for holders with disabilities, making referrals to Independent Living Centers, Protection and Advocacy Organizations and other helpful non-profits who are well versed in navigating the web of low-income housing and service provision in the home, and having PHAs provide special searching assistance, which is likely similar to roles that PHA workers played in the HOPE IV program.\(^{133}\) While these steps are encouraging, one must ask when the \textit{Olmstead} case will come home to housing; that is, when will a plaintiff emerge whose only barrier to community integration is not service provision, but the lack of housing assistance?

\(^{129}\) Harriet McBryde Johnson, Civil Rights And Long-Term Care: Advocacy In the Wake of \textit{Olmstead} V.L.C. Ex Rel. Zimring, 10 Elder L. J. 453, 457 (2002).


\(^{133}\) \textit{Id.} at 2-3.
CONCLUSION

Ideally, older adults would like to minimize moves to higher and higher care levels that are more shut off from the human connections they have made and instead, stay where they have high levels of familiarity, service options and established community ties. Most often, their ability to do this is controlled by their health, the proximity of family, friends and community resources, and most importantly, their income. When consumers of health and housing public benefits, including older Americans, advocate for more ideal service provision, they value community integration and flexibility in the public benefits they receive. What they currently have is a patchwork of benefits that are complicated to maneuver, slow to respond and limited in resources. Committing significant resources into housing and service provision, adding Source of Income protection to the Fair Housing Act and passing the Medicaid Community Attendant Act (MiCASSA) into law is a very tall order, especially in the current political climate. But demographics do not lie; the housing crisis facing older Americans is here and it will only get worse. We must honor our elders and all the work they have done for the betterment of this country. In doing so, we show the next generation how we might like to be honored as we age.
THE SOLVENCY SOLUTION: HOW A “QUICK FIX” WILL ENSURE MEDICARE’S SOLVENCY

Jerry Carleton*

INTRODUCTION

I. INCEPTION OF MEDICARE
   A. Program Content
   B. Population
   C. Budgets and Trust Fund
      1. The Trustees
      2. The Trust Funds
      3. How the Trust Funds are Financed

II. FUTURE PROSPECTS
   A. Demography
   B. Healthcare
      1. Technology
      2. Nursing
      3. Managed Care
         a. The 1997 Balanced Budget Act
         b. The Medicare Modernization Act
   C. Budgetary Prospects
      1. How the Estimates are Made of Trust Fund Future
      2. Current Projections for the HI
      3. The SMI is Covered Indefinitely
      4. The Need for Reform
         a. The Board of Trustees
         b. Message from the Public Trustees
         c. Congressional Budget Office and Outside Perspectives

III. ASSURING SOLVENCY
   A. Cost
      1. Eliminate Fraud
      2. Eliminate Big Ticket Care
      3. Support Privatization
      4. Lose Some Privileges
      5. Private Insurance

* Jerry Carleton studies law at Lewis & Clark Law School in Portland, Oregon.
INTRODUCTION

The topic of the funding and viability of the Medicare system is under considerable debate, and one of the most important aspects of that debate is the solvency of the current system. The scope of this inquiry will not cover all of the Centers for Medicare and Medicaid Services (CMMS), or even include Medicaid, but focus solely on the Medicare system as it exists today and has operated in the past. The main question is, will the system survive?

The Medicare system has been in existence for more than thirty years as part of the social security retirement program of the United States, and is an integral part of how US citizens view healthcare. Working citizens have money withheld from their paychecks to fund this program, making its solvency important to the current working generation who would, presumably, rather keep that money if the program will not be around to benefit them when they retire.

There are several key issues to address such as demographics, the actual funding, controls proposed, and the benefits offered, but the most important aspect to explore is the solvency of the system. Demographics will be a key part of this inquiry, especially with the aging generation of “baby-boomers” which will have a profound impact on the number of people eligible for Medicare. Whether that shift in population will actually devastate the solvency of the program will be an area of exploration, trying to separate political doomsday messages from actual fiscal realities of the program. Ultimately that will put emphasis on the funding and current costs of the program, and past proposals to “fix” the program will be critiqued with the benefit of hindsight. With recent pushes towards managed healthcare, they will be the primary focus of past proposals, looking to whether or not such an approach would be appropriate for the Medicare system in a cost-benefit analysis, which will segue into policy discussions beyond just the financial aspects of the system.

Policy issues will be important in the coverage of this topic, the main issues being the amount of benefits offered and choice built in to the current system, should they be maintained status quo or changed? The managed care discussion must be viewed with these policy questions in mind, as well as the more basic discussion of solvency. The approach in this inquiry to the solvency of the program will very much be influenced by policy, because it seems irresponsible to talk about the costs and services of a system without taking into consideration the actual people the services are designed for and delivered to, and who actually pay for the system. Medicare is part of our
Government which claims to be by the people and for the people, so the financials of the program will not be considered in a vacuum.1

I. INCEPTION OF MEDICARE

Before diving into the actual funding of the system and the policy issues behind it, a brief overview of the program itself will provide context.

A. Program Content

The Almanac of Policy Issues credits Medicare as both “one of the nation’s primary health insurance programs and, in many ways... one of the federal government’s most significant success stories.”2 The program is credited as such a great success due to the services it provides to such a great number of people. As will be discussed in greater detail below, the services are provided through two separate parts of Medicare, each with its own financing structures.

The Congressional Budget Office (CBO) gives a simplified explanation of what those two parts and the services they provide are: “Hospital Insurance, or Part A, helps pay for inpatient hospital care, home health care, skilled nursing, and hospice care for the aged and disabled.” It continues: “Supplementary Medical Insurance, or Part B, helps pay for physicians’ services, outpatient hospital care, and other services.”3

Finally, Medicare is managed by the Centers for Medicare and Medicaid Services, or CMMS (and commonly referred to as CMS), which is a division of the U.S. Department of Health and Human Services.


B. Population

The Medicare program is a financial giant, with annual expenditures of over $400 billion and over 40 million people enrolled and active.\(^4\) The Almanac of Policy Issues reports that Medicare provides coverage to nearly 39 million people, about 14 percent of Americans, and nearly every senior aged 65 or older. As a comparison point, before Medicare was enacted in 1965 just 56 percent of seniors had hospital insurance. Finally, accounting for Part B, the Policy Almanac reports that in fiscal year 1999, 32.3 million seniors and 4.6 million people with disabilities were enrolled in Part B.\(^5\)

HME News reports that CMMS pays more than 1 billion fee-for-service claims each year, and provides oversight to state payments for services provided by healthcare professionals under Medicaid and the State Children’s Health Insurance Program (SCHIP) as well.\(^6\) Reporting the numbers for 2005, HME News adds that Medicare also made monthly payments to more than 450 Medicare health plans across the US.\(^7\)

C. Budgets and Trust Fund

The actual budgets for funding the Medicare programs come from two trust funds, which are by law managed by a Board of Trustees. A more in-depth introduction to the trusts, the trustees, and how it operates is needed to explore solvency, which follow.

1. The Trustees

The Medicare Board of Trustees was established under the Social Security Act, as amended, to oversee the financial operations of the Medicare trust funds.\(^8\) Several officers and two members appointed by the President and confirmed by the Senate to represent the public constitute the make up of the Board. As of the 2005 Annual Report, the current 6 members of the Board are: John W. Snow, Secretary of the Treasury, and Managing Trustee; Elaine L. Chao, Secretary of Labor, and Trustee; Michael O. Leavitt, Secretary of Health and Human Services, and Trustee; Jo Anne B. Barnhart, Commissioner of Social Security, and Trustee; John L. Palmer, University Professor and Dean Emeritus of the Maxwell School of Citizenship and Public Affairs at Syracuse University, Trustee; and Thomas R. Saving, Director of the Private Enterprise Research Center and Professor of Economics at Texas A & M University, Trustee.\(^9\)

---

5. Almanac of Policy Issues, supra n. 2.
7. Id.
2. The Trust Funds

As summarized in the 2005 Annual Report, there are two applicable trust funds to the Medicare program: the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. They were created in the U.S. Treasury to account for all program income and disbursements, and benefit payments and program administrative costs are the only purposes for which disbursements from the funds can be made. Regarding the funds themselves, program revenues not needed in the current year to pay benefits and administrative costs are invested in special non-negotiable securities of the Federal Government, receiving credit for a market rate of interest. Thus the trust funds represent the accumulated value of all prior annual surpluses, including interest, and provide automatic authority to pay benefits.10

Federal law also dictates the reports to be generated on the status of the trust funds. 42 U.S.C. 1395i requires the Medicare Trustees to submit an annual report on the HI, and 42 U.S.C. 1395t requires the Trustees to submit an annual report on the SMI Trust Fund.11 In a letter to then CMMS Administrator Scully, Linda Calbom, the Director of Financial Management and Assurance for the United States General Accounting Office, stresses the importance of the annual report. “A wide spectrum of users relies on these projections for a variety of purposes. These include the Congress, which need reliable information about the Medicare trust funds to make informed decisions about future HI and SMI program funding and benefits.”12

3. How the Trust Funds are Financed

The HI is financed by payroll taxes on earnings by employees, employers, and the self-employed. The tax is taken on total earnings, and in 2004 the HI received $160 billion from this tax.13 Taxable payroll for the HI side of Medicare in 2003 was $5.4 trillion.14 HI taxes are levied on all earnings, whereas Social Security taxes are levied on earnings up to a maximum level each year. That maximum as reported by the Congressional Budget Office in 2003 was $87,000, and that lead to a taxable payroll for Social Security in 2003 of $4.4 trillion, $1 trillion less than the HI payroll tax has access to. One more additional source of tax revenue over Social Security, HI taxes are paid by certain members of the federal workforce and some state and local government workers who do not participate in the Social Security program.15

As for the actual percentages, employers and employees each pay 1.45% in taxes on all earnings for the HI. The self-employed are charged the equivalent of both sides, the combined employer and employee tax rates, which is 2.9 percent.16 A relevant

10. Id.
11. Calbom, supra n. 8.
12. Id.
14. Congressional Budget Office, supra n. 3.
15. Id.
point for later analysis, the HI has relied on the same contribution formula for 20 years. The matching payroll tax shared by employers and employees which finance the trust fund have not been increased since 1985.\textsuperscript{17}

The SMI, comprised of both Part B and Part D, is funded very differently than the HI. Seventy-five percent of the SMI funding comes from Federal General Revenues, and is supplemented by monthly premiums from the beneficiaries, which equates to about twenty-five percent. The premium has been $78.20 in 2005 for Part B.\textsuperscript{18} When the Part D benefit begins January 1, 2006, the Part D account in the SMI trust fund will receive additional payments from states. This is because the federal government will assume Medicaid responsibilities for premium and cost-sharing subsidies for individuals eligible for both Medicare and Medicaid.\textsuperscript{19}

The total income to each side of funding from 2004 is reported in the 2005 Annual report. The HI received $183.9 billion, and the SMI received $133.8 billion. Administrative expenses to each in 2004, as a percentage of total expenditures, were 1.8% for the HI, and 2.1% for the SMI.\textsuperscript{20} If expenditures are in fact higher than income, which is discussed below, there is considerable overhead to this program. While the administrative expenses look small as a percentage, the 1.8% of expenditures for HI equals over $3.31 billion in overhead cost for the HI trust fund. The SMI administrative expenses calculate out to more than $2.8 billion.

Knowing the program content and the population that the system serves shows the importance of solvency, and knowing the financing of the system on an annual basis in dollars can be staggering. Questions arise as to why the HI and SMI are financed differently, and why over $6 billion is spent each year in overhead for the two trust funds. Most significantly, it seems a restructuring could cure the solvency problem.

II. FUTURE PROSPECTS

The future prospects of the Medicare system will depend heavily on several factors. These factors include the demography of the United States, dictating who the Medicare program will serve, and the state of healthcare in general, as rising costs, new technologies and new reforms all play into what the program must and can afford to provide. Finally the budget of the program, and its budgetary prospects, factor heavily into Medicare’s solvency. Understanding these elements is key to the solvency question.

A. Demography

According to the 2005 Annual Trustee Report, demography is a huge challenge to the solvency of Medicare. Factors playing into a difficult demography for the system

\textsuperscript{17} Center for Medicare Advocacy, Inc., \textit{Medicare’s Solvency: Helped or Harmed by the Medicare Act of 2003?}, http://www.medicareadvocacy.org/Reform_MedSolvencyAndAct (March 29, 2005).

\textsuperscript{18} Actuarial Publications, \textit{supra} n. 9.

\textsuperscript{19} National Committee to Preserve Social Security and Medicare, \textit{supra} n. 16.

\textsuperscript{20} Actuarial Publications, \textit{supra} n. 9.
to work within are the age of the nation’s population, the increasing number of veterans today, and fewer workers funding the system through their payroll taxes.

The primary trends driving the growth of the health care industry are a longer life expectancy and a rise in the percent of the population aged 65 and older. According to CMMS, Medicare enrollment is expected to almost double from approximately 40 million in 2003 to over 70 million by the year 2030. In addition, in the year 2000, the segment of the population over age 65 accounted for approximately 40 percent of the total health care expenditures, although it represented only about 12.4 percent of the total population.21

Not only is the make-up of the population aging, the number of Veterans is increasing and changing the demographics of the United States as well. Currently there are 24.5 million military veterans in the United States. Only 9.5 million of those veterans are age 65 or over, showing the substantial amount of younger veterans in the US. From a dollar perspective, the aggregate amount of money received annually by the 2.6 million veterans compensated for service-connected disabilities is $22.4 billion, and the total spending by the federal government for veterans’ benefits programs in fiscal year 2004 was $59.6 billion.22 Disabled veterans in particular add to the number of people receiving disability compensation, and at least to some extent, decrease the number of people working and paying into Medicare through payroll taxes.

Finally, fewer workers are a concern for the Medicare program, bringing less revenue into the HI for Part A and leading to Medicare shortfalls. Today there are approximately four workers for every Medicare beneficiary, but by 2079, there will be only about two workers for every beneficiary.23 As the program already had cost exceed tax income in 2004 (discussed below), even having four workers for every beneficiary today is insufficient to fund the program in its current form. The worker-to-beneficiary ratio is headed in the wrong direction.

B. Healthcare

The healthcare to be delivered, and how efficiently it can be delivered, ultimately dictate how much the Medicare program will cost. Changing the face of healthcare, and all interrelated, are technology, nursing, and managed care.

1. Technology

Former HHS Secretary Thompson focused on technology as a way to combat rising healthcare costs. “Efforts to improve technology and integrate new technology into the health care system will help lower costs by reducing medical errors and improving the efficiency of health care delivery.”24 Another benefit from new

21. US Department of Health and Human Services, supra n. 4.
technology is less invasive surgery, leading to shorter hospital stays and lower cost. On the other hand, many see the increased technology in healthcare as leading to increases in cost, not only from longer-life expectancies but in just the price tags paid for the new equipment and devices available. Secretary of the Treasury Snow quite bluntly puts one cause above all others for the solvency problems of Medicare: “the principal culprit here is the rising cost of health care. . .Controlling health care costs is the real key to the long run fiscal sustainability of both Medicare and the federal budget.”

An article titled “Nursing Shortage Threatens Health Care” attributes the shortage of nurses today in the US to advancements in technology, showing the increase in expense that technology has effectuated. “Since the 1990s, there have been dramatic technological improvements in health care. There are more diagnostic tests to run, more medications to administer and more machines to monitor.” The article adds: “Care is becoming more specialized, requiring a greater number of nurses and nurses with more comprehensive training.” All of these factors lead to increased costs, a result of technological advances.

2. Nursing

The Nursing profession has become an ingrained element of how healthcare is offered today. There are 2.7 million nurses today in the United States. According to a 2004 report by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), there are about 126,000 unfilled nursing positions in the United States, and the lack of staff is putting patients’ health in danger. The report found that 19 percent of medical errors resulting in death or serious injury were due to nursing shortages, and that more than 90 percent of nursing homes lack a sufficient number of healthcare workers to provide even the most basic care. The American Hospital Association reports that 13 percent of nursing positions nationwide are vacant currently and that 20 percent are likely to be vacant by the year 2015.

These nursing shortages are being blamed on pervasive changes to the medical industry over the past decade. Technological advances discussed above have lead to an increased need for nurses, and consequently, according to the Department of Labor nursing has become one of the five fastest-growing professions in the US. In response, JCAHO is recommending that the federal government provide hospitals with funding directly for more nurses.

Even with this demonstrated need for nurses, and even with that need for nurses growing exponentially, many hospitals are making staffing cuts. Some attribute this to the push for managed care. Dr. Linda Aiken, director for the Center for Health

25. Id.
27. Id.
28. Id.
29. Id.
30. Id.
Outcomes and Policy Research at the University of Pennsylvania School of Nursing, points to the rise of HMO’s for this shift. “In response to reduced hospital stays mandated by HMOs, hospitals thought they could reduce the number of nurses they employed. . . . They started cutting their nursing staffs just when they needed to increase them.” In order to save money, hospitals not only let nurses go, but also replaced registered nurses with less-qualified, lower-paid licensed practical nurses and nursing aids. Remaining registered nurses were thus left with the heavier workloads discussed above, and the cost-savings attempt has arguably led to substantially lower quality of care.

A nursing shortage is affecting the delivery of healthcare negatively, which has become dependent on nurses. Fixing medical error increases cost. Whether or not the shortage is to be blamed on the managed care-push for cost-savings or on advances in technology, the shortage is resulting in increased medical mistakes and a lower standard of care.

3. Managed Care.

The solvency question for Medicare, coupled with rising healthcare costs, has led to significant past-attempts to curb costs and help solvency of the program. There have been a few significant federal attempts at implementing cost savings through managed care, this inquiry will look at some of the more recent attempts. Managed care implementation takes the focus from the traditional “choice of care” to cost savings. An initial federal attempt turned into a disaster, which has then led to a restructuring with several components of the initial attempt. While the restructuring is still too fresh to fully judge its effectiveness, it may be on the right track.

a. The 1997 Balanced Budget Act

A significant, and ultimately failed, attempt to curb Medicare costs came as part of the 1997 Balanced Budget Act, signed into law by President Bill Clinton. The legislation’s primary goal was to balance the federal budget by 2002, which was operating in deficit at that time, but included several provisions relevant to Medicare. Provisions included “language trimming growth in Medicare spending by $116.4 billion over five years, most of which was due to reductions in payments to health care providers (hospitals and doctors).” The legislation also increased the Medicare Part B premiums expected from the beneficiaries, established new “Medicare+Choice” managed care plans, and created a bipartisan commission to study Medicare’s long-term finances and report to Congress.

The commission established was known as the National Bipartisan Commission on the Future of Medicare, but unfortunately: “In March of 1999 the commission disbanded, unable to achieve sufficient unity to forward an official recommendation to

31. Id.
32. Id.
33. Almanac of Policy Issues, supra n. 2.
Congress. The commission came close to an official proposal on a plan endorsed by Senator Breaux. With several controversial changes to the Medicare system of the time, the plan proposed the transformation of Medicare into a premium support system, where instead of Medicare directly covering beneficiaries or underwriting the beneficiaries’ participation in HMO’s, they would receive a fixed amount of money to purchase private health insurance. Also significant, the plan would have raised the age of eligibility from 65 to 67 (which has already been done for Social Security), and provided a prescription drug plan for low income individuals.

Clinton ended up releasing another plan in 1999, with the central feature being a budget surplus transfer into the Medicare program. $794 billion in surplus general tax revenues were to be transferred to the Medicare program from 2000 through 2014, which would have the effect of extending the program’s insolvency date. Other aspects included a prescription drug benefit and the elimination of co-payments and deductibles for preventative care.

This major impasse, coupled with major pressure from health care providers, prompted back-peddling by Congress, ultimately undoing any remaining changes from the 1997 Balanced Budget Act regarding Medicare. Congress began to reverse some of the spending cuts from the Act in late 1999, with legislation restoring $35 billion in Medicare and Medicaid funding to hospitals, nursing homes and health plans over five years. In 2000 Congress restored another $16 billion in Medicare funding to various health care providers. Significant structural reforms were put off until the coming session of Congress, and Medicare reform became substantial fodder for the 2000 presidential campaigns. The next major piece of legislation to pass came as the fruition of a campaign promise by George W. Bush, fulfilled three years after his election.

b. The Medicare Modernization Act

The Medicare Modernization Act of 2003 (MMA) is the latest sweeping attempt at using managed care to curb costs. As it is very new and still being implemented, it is difficult to see whether this legislation will help to control costs and improve solvency.

Following the release of the Annual Trustees’ Report in 2004, to help explain how the passage of MMA will ultimately improve the solvency of the Medicare program, then HHS Secretary Thompson stated in a release: “The reforms built into the new Medicare law often get overshadowed by the new prescription drug benefit, but these reforms provide more tools to use to improve the solvency of the program.” He goes on: “Medicare provides America’s seniors and persons with disabilities with

34. Id.
35. Id.
36. Id.
37. Id.
38. Id.
access to the highest quality health care, and we made the program even better by adding coverage for prescription drugs and more preventive care.”

While there are less hard facts about the new programs, there is no lack of opinions about what the legislation will do and whether or not it will be a success. The National Committee to Preserve Social Security and Medicare focuses on what they perceive to be failures of the Part D program in particular. They believe the new drug program will not save money, but cost seniors an incredible amount more. “Seniors will continue to face ever-increasing premiums because the prescription drug law fails to provide meaningful mechanisms to contain health care costs.” Actually keying in on a particular policy issue, they emphasize that the lack of cost savings mechanisms is because the new law “does not effectively permit the importation of low-cost prescription drugs from other industrialized countries.” Ignoring the health benefits of the FDA, they point out that “Drugs that are manufactured in the United States or in FDA-approved plants are often sold for much less in other industrialized nations.”

Another policy disagreement noted, which arguably could save money for the Medicare program, is that the prescription drug law prohibits HHS from using the bulk purchasing power of the federal government to negotiate lower prices on the prescription drugs to be provided. Pointing to effective use of this tool by other governmental units (and making a very strong point), the Special Report states: “Price negotiation is a tool that has been used effectively by the Department of Veteran’s Affairs and many state governments to deliver lower drug prices and could deliver similar positive results to Medicare beneficiaries.” In addition, the cap from general revenue financing introduced with the legislation, in their opinion: “represents an arbitrary measure of the program’s health and prohibits the consideration of all solutions to the program’s long-term shortfall.” The “Financial Trigger” in the MMA legislation requires the Medicare Trustees’ annual report on the financial solvency of Medicare to include a new section monitoring the rate of Medicare spending growth and the use of general revenues.

The trigger system begins with the trustee requirement to project the point at which general revenues will finance at least 45 percent of Medicare’s outlays. If then the trustees project in two consecutive reports that the 45 percent cap will be reached in the next 6 years, it will “trigger” (hence the name) Presidential action and Congressional review. The Special Report notes that the Presidential action will be a proposal likely requiring “severe Medicare cuts to reduce general revenue financing.”

Because the Medicare program was set up to rely on general financing for 75 percent of Part B and Part D, the cap is seen as ignoring the financing structure and prohibiting “the use of increased revenues to address problems facing both the

40. Id.
41. Granted, some would argue there are none.
42. National Committee to Preserve Social Security and Medicare, supra n. 16.
43. Id.
44. United States Department of Health & Human Services, supra n. 24.
45. National Committee to Preserve Social Security and Medicare, supra n. 42.
Medicare program and the U.S. health care system.” Projections based on the trustees’ report find the cap will be reached in 2012, triggering Presidential action in 2007.\textsuperscript{46} The Center for Medicare Advocacy, Inc. is similarly critical of the new insolvency trigger formula. Calling the formula “arbitrary,” they note that it is unlike any formula “applied to other services funded by general revenues such as defense and education.”\textsuperscript{47} They agree that this new definitive threshold will be met soon. “The extraordinary payments to managed care, the unrestricted drug costs to be paid under Medicare Part D, and the aging of our population make it all but inevitable that this definition will be met.”\textsuperscript{48}

Unsurprisingly, HHS does not feel the new trigger is negative. While they do not commit to “severe cuts” as suggested by the National Committee to Preserve Social Security and Medicare should the trigger happen, they do report that the Presidential proposal to address the problem will “be given special fast-track consideration in the Congress under the new law.”\textsuperscript{49} A Medicare Report from The Bureau of National Affairs quotes Secretary Leavitt on the subject: “It’s the best foundation on which to build for future benefits. . .I would do nothing to minimize the Medicare problems, but we’re beginning to establish a different culture among providers.” That different culture is said to be due to MMA’s focus on prevention, improved drug benefits, and a pay-for-performance system.\textsuperscript{50}

The Senior Journal highlights reforms and initiatives designed to address Medicare’s financial condition.\textsuperscript{51} One reform involves preventative benefits, for example a new “Welcome to Medicare” physical, which should help new beneficiaries to Medicare become aware of and address health problems before they become costly.\textsuperscript{52} There is a new “Medicare Health Support” initiative designed to help chronically ill beneficiaries reduce their health risks. This is significant because chronic illnesses such as diabetes and congestive heart failure account for a large percentage of Medicare’s costs every year.\textsuperscript{53} The MMA includes a stronger “Medicare Advantage” program, which the Senior Journal states will help “beneficiaries get even more options to better manage chronic conditions and where health plans have stronger financial incentives to help improve coordination and reduce costs for chronically ill beneficiaries.”\textsuperscript{54}

CMMS Administrator McClellan agrees with Secretary Leavitt, crediting the passage of MMA as a step in the right direction. McClellan, a Board of Trustees secretary, states: “with implementation of MMA, Medicare is beginning to provide benefits that are in line with modern medicine and its emphasis on preventative

\textsuperscript{46} Id.
\textsuperscript{47} Center for Medicare Advocacy, Inc., \textit{supra} n. 17.
\textsuperscript{48} Id.
\textsuperscript{49} United States Department of Health & Human Services, \textit{supra} n. 24.
\textsuperscript{50} Id.
\textsuperscript{51} SeniorJournal.com, \textit{supra} n. 23.
\textsuperscript{52} Id.
\textsuperscript{53} Id.
\textsuperscript{54} Id.
care...We expect that Medicare’s new steps to improve care coordination, prevent
disease complications, and reward better performance will help avoid unnecessary
Medicare costs.” Regarding Part B cost and coverage he states: “We are looking
closely at the reasons for the Part B cost increases, and we will work with physicians
and other health professionals to make sure we are getting the most for rising Medicare
spending.”

Even with all of the literature already circulating as to the success or failure of the
MMA, the real test will be time, a test that the Medicare system as a whole has faired
well at thus far.

C. Budgetary Prospects

The final major piece of understanding the future prospects of the system is
understanding the budget and how it is projected. How the estimates are made, and
what those projections currently are for both HI and SMI are important, as well as
understanding how the current Board of Trustees for Medicare views the program’s
solventcy.

1. How the Estimates are Made of Trust Fund Future

The Board of Trustees for Medicare make two main projections for the solvency
of Medicare in their annual report: “short range” which looks 10 years down the road,
and “long range” which projects out 75 years. These projections are made based on
current law and assumptions about all of the factors that affect the income and outgo of
each trust fund. Assumptions include: Economic growth, Wage growth, Inflation,
Unemployment, Fertility, Immigration, Mortality, and other factors relating to
disability incidence and the cost of hospital, medical and prescription drug services.

As the future is uncertain, three sets of economic and demographic assumptions
are used to give three results of the short and long range projections. The assumptions
are reexamined each year and revised as warranted. The trustees note: “In general,
greater confidence can be placed in the assumptions and estimates for earlier
projections than for later years.” Alternative I is the low cost alternative, more
optimistic, and using more favorable economic and demographic conditions for trust
fund financing than the “best estimate.” Alternative II is based on the intermediate
assumptions, and is called the best estimate by the trustees. Alternative III is the high-
cost alternative, more pessimistic for trust fund financing, and using less favorable
economic and demographic conditions for trust fund financing than Alternative II.

2. Current Projections for the HI

Beginning with the short-range outlook, from 2005-2014, the trustees report that
the HI does not meet the test of financial solvency beginning in 2014. That test of
solventcy measures the adequacy of HI by comparing its assets at the beginning of a
year to projected costs for that year. This measure becomes the “trust fund ratio.” A trust fund ratio of 100 percent or more, where the assets are at least equal to projected benefit payments for a year, is considered a good indicator. It is considered good because even if expenditures exceed income, the trust fund reserves combined with annual tax revenues, “would be sufficient to pay full benefits for several years, allowing time for legislative action to restore financial adequacy.” Under the Alternative II assumptions, its assets fall below the 100 percent level of one year’s outgo during 2014.58

The long-range outlook, spanning 2005-2079, is similarly negative. Costs increase steeply between 2010 and 2030 because of baby-boom retirement. Medicare costs continue to grow rapidly as well due to expected continued increases in use and cost of healthcare. Specifically, the continued development of new technology is expected by the trustees to cause per capita health care expenditures to continue to grow faster in the long term than the economy as a whole, which they note has happened historically.59

With all of those projections in mind, the trustees report a series of “Key Dates” for HI funding. When costs exceed the tax income to the program, use of trust fund assets occurs, and it does so in stages. The first stage, labeled as the first year outgo exceeds income excluding interest, has already has happened. In 2004 the interest earnings had to be used to help pay HI benefits. The second stage, the first year outgo exceeds income including interest, is projected to occur in 2012, when assets will have to be redeemed to pay benefits. This will continue to occur each year until stage three, the year the trust fund is exhausted, currently projected to happen in 2020. In 2020, tax income is estimated at 79 percent sufficiency in paying all HI costs, and is further projected to only pay 27 percent by 2079.60

A report from The Bureau of National Affairs, Inc. highlights that the projected 2020 insolvency date for the HI is actually one year later than the projection from 2004. It then highlights a solution, calling for an immediate 107% increase in the current Medicare payroll tax rate or a 48% cut in benefits.61 Other alternatives are discussed below.

3. The SMI is Covered Indefinitely

Short-range outlook and long-range outlook have a less stringent “annual contingency reserve” asset test applied to Part B and Part D, because of how the SMI is financed. The financing for each is provided in part by beneficiary premiums, and federal general fund revenue payments automatically adjust each year to meet the remainder of the expected cost. Therefore, both Part B and Part D accounts in SMI are fully financed through the 75 years, no matter what costs are actually incurred under

58. Id.
60. Id.
current law. The CBO specifically criticizes this practice, stating “The Medicare trustees project no long-range imbalance for SMI, even though premiums paid by beneficiaries cover only one-fourth of the program’s cost.” They continue that current law requires the government to cover the remaining costs with credits from the Treasury’s general fund, “a practice that effectively precludes an adverse conclusion from the trustees.”

Rather than leave the analysis there, the Senior Journal notes that the Part B assets in the SMI declined by $4.5 billion in 2004. Part B premiums are reported to rise over 30 percent, from $87.70 per month in 2006 to $114.70 per month in 2014, and that the Part B annual deductible will increase over 30 percent, from $123 in 2006 to $161 in 2014. Looking just at 2006, the Part B premium is on track to see one of the largest premium increases in the Medicare program’s history. Estimates from CMMS indicate a Part B premium increase of an additional $1.50, 14 percent ($11.00) from the $78.20 per month in 2005 to $89.20 per month in 2006. Moving to Part D projections, the numbers show that premiums will rise 72 percent from $37.37 a month in 2006 to $64.26 a month in 2014. The Part D annual deductible is projected to increase nearly 75 percent from $250 in 2006 to $437 in 2014. The trustees do not ignore these concerns and just remain content with SMI being solvent according to their formulas. They discuss the changing sources of Medicare financing in some detail, and lump the HI and SMI back together to cover the concern more fully. They admit that as costs grow, general revenues and beneficiary premiums will play a larger role in financing the entire program. Looking to expenditures and current law non-interest revenue sources for HI and SMI combined as a percentage of GDP, the program will be 13.6 percent of GDP by 2079, while revenue from taxes will still be only 1.4 percent of GDP. Further, Federal general fund revenue contributions are projected to rise from one percent of GDP in 2006 to 6.2 percent of GDP in 2079, and beneficiary premiums are projected to jump from .3 percent to 1.7 percent.

Keeping the current law constant, revenues from taxes thus fall substantially as a share of total non-interest Medicare income, from 53 percent to 15 percent, while Federal general fund revenues, from 35 percent to 64 percent, and premiums, from 12 percent to 18 percent, will rise. The gap between total non-interest income and expenditures is projected to steadily widen because of growing annual HI deficits, and are projected to reach four percent of GDP by 2079. Running the new financial trigger from MMA, that threshold is projected to happen in 2012.
Seeing the budgetary prospects for both HI and SMI, including how the estimates are made and what the current projections are, the next question before addressing how to ensure solvency is whether or not there is a need for reform.

4. The Need for Reform

The need for reform of the current Medicare program is a near consensus, with most groups believing at least something must be done. Exactly what that something is leads to debate though, even within the Board of Trustees. Some of these competing views are taken into consideration, including the position of the Board, the Public Trustees in particular, and other outside views such as the Congressional Budget Office.

a. The Board of Trustees

The Board of Trustees points out that public concern focuses on HI trust fund exhaustion dates, when benefits under current law cannot be paid in full any more. The Trustees see more immediate and fundamental reasons for reform of Medicare financing, noting greater demands will be placed on federal general fund revenues long before trust fund exhaustion. They add that exhaustion of trust funds for the HI should begin in 15 years, and conclude: “The sooner these problems are addressed, the more varied and less disruptive will be their solutions.”

b. Message from the Public Trustees

The Public Trustees also felt reform was necessary, but took even a broader view of the situation to support their call to reform, and stressed the immediacy of the problem. Most noteworthy, they weigh in on the major sources of uncertainties in the long-term projections for Medicare, and how all of those uncertainties create a problem with the three alternative projections based on low cost, intermediate and high cost assumptions. “The low and high cost alternatives assume that these factors vary individually, as well as collectively, in a direction resulting in an outcome that is either less or more costly, than the intermediate assumptions.”

c. Congressional Budget Office and Outside Perspectives

The CBO view of the outlook for Medicare differs from the outlook presented by Trust Fund Measures. Quite bluntly, the CBO does not find the Trustee methods of projecting adequate, and would instead use only GDP-based projections, which they note is the one conventionally used for the federal budget as a whole. The concepts used for the trustee assessment, for example trust fund reserves and actuarial balance, shed light on the program’s accounting in the CBO’s opinion, but not the real economic resources required by them. The CBO cites several reasons, but primarily points to one: the assessments are based on measures of income and spending that are averaged effectively over 75 years, and because of this they do not “reveal the

70. Actuarial Publications, supra n. 9.
71. Id.
magnitude of the program’s rising resource requirements.” The focus on the 75 year imbalance of total income and spending does not shed light on the long-range draw on workers’ earnings that may be required to cover future benefits.72

EPI has come out against the 75-year projection system, stating: “Despite everyone’s best efforts, it is essentially impossible to make even ballpark estimates 75 years into the future.” They feel too much emphasis is placed on those projections: “They were designed to be, and for most of their existence have been, pay-as-you-go systems. The notion that their strength and continued existence rests upon the demonstration of a 75-year funding stream is quite recent.”73

The National Committee to Preserve Social Security and Medicare not only finds fault with the 75-year projection, they also speak against the gage of Medicare against an “Infinite Horizon.” The infinite horizon projections extend the forecast period from beyond the traditional 75 years out to infinity. Several factors make both uncertain, including: “the rate of scientific breakthroughs; the frequency of release of ‘blockbuster’ drugs; new diseases or recurrence of older ones; and new medical treatment techniques that improve the quality of or prolong life.”74

Back to the CBO’s analysis of the Trustees’ 75 year forecast, the averaging to make the 75 year projection allows the computing to be done on the basis of “totals” which imply that surpluses projected to occur early in the period will offset later deficits. The CBO points out:

Crediting surpluses to trust funds is simply a paper transaction. When funds are needed to pay benefits, resources will have to be drawn from the economy. Crediting surpluses to the trust funds will not necessarily create those resources because the surpluses may be used to boost spending on other federal programs or allow other revenues to be lower. If the surpluses do not raise national savings and, thus, increase the size of the economy, the rate of tax on workers’ earnings will have to rise to a much higher level than what is shown by the overall imbalance for the 75-year period.75

They further make the distinction that transfers from the general fund and trust fund reserves are just the result of credits exchanged between accounts in the Treasury, and therefore just reflect a commitment by the government to pay the benefits, not necessarily the means to pay those benefits. The CBO wraps up: “From a budgetary perspective, those gaps between what the government receives and spends for...Medicare can only be filled by increased borrowing, higher taxes, reduced spending, or some combination thereof.”76

All of the CBO analysis leads them to the same overall conclusion they started with, that GDP reporting should be used by the Trustees. As seen in the 2005 Annual

---

72. Congressional Budget Office, supra n. 3.
74. National Committee to Preserve Social Security and Medicare, supra n. 16.
75. Congressional Budget Office, supra n. 3.
76. Id.
Report, the same traditional measures are still being used, although more methods are being incorporated into the report. Varying results from the CBO and other outside groups, as made apparent above, will continue to happen until everyone involved can agree on using the same method.

III. ASSURING SOLVENCY

In their 2005 Annual Report, the Trustees say the system is not solvent as currently structured, and is actually worse off than Social Security. They do not downplay the problems to face, but the Annual Report also makes no concrete suggestions for a path forward. The report does give the numbers needing to be changed though, saying that a 107 percent increase in income, or a 48 percent reduction in outlays, will equate to an actuarial balance over next 75 years.\(^77\) As this demonstrates, looking for a solution to a solvency problem, the problem can be approached from the cost side, the income side, a combination of both, or a complete restructuring. The one thing that all sides can agree on is that some action must be taken.

A. Cost

A logical way to address the problem is to spend less money, and a 48 percent reduction in outlays will suffice. Cutting the expenditures of the program in half seems severe, but eliminating fraud ensures the dollars go to the right place. Several options follow.

1. Eliminate Fraud

The Medicare and Medicaid system loses tens of billions per year to fraud and abuse of the system.\(^78\) Studies estimate that fraud and abuse adds 10 percent to total healthcare spending. A 2002 estimate from the HHS Office of Inspector General reported $13.3 billion in improper fee-for-service payments by Medicare that year. That number equals eight percent of its fee-for-service reimbursement.\(^79\) More recently, in his testimony regarding the 2004 Medicare Trust Fund Report, Secretary of the Treasury Snow reports that reductions in fraud and abuse are expected to save $35 billion.\(^80\) Thus eliminating this can cut costs incredibly.

HME News reports that eliminating fraud has been largely successful over the past year. “Aggressive oversight and new improvement efforts have cut the number of improper fee-for-service Medicare claims by half in one year, from 10.1% in 2004 to 5.2% in 2005, a $9.5 billion reduction in improper payments.”\(^81\) Quoting CMMS

\(^77\) Actuarial Publications, supra n. 9.
\(^81\) HME News, supra n. 6.
Administrator McClellan: “The unprecedented $9.5 billion reduction...reflects our commitment to careful measurement and targeted oversight, and we intend to keep building on these efforts.” Dr. McClellan further explains: “We are measuring the accuracy of payments more closely, and that enables us to target our efforts more effectively with Medicare contractors and providers.” This shows that there is another $9.5 billion improperly paid, a substantial amount of resources for the program.

Comparing the error rate farther back than 2004, the Medicare fee-for-service error rate has decreased from 14.2 percent in 1996 to the current 5.2 percent. 1996 is a significant year as this was the first year that the Medicare improper payment rate was reported. Other factors credited for the dramatic change from 2004 to 2005 include the marked improvement in the “no documentation” and the “insufficient documentation” error rates, as well as provider education, which CMMS has committed significant time and resources to and is credited in reducing insufficient documentation to just over 1 percent.82

Fraud is still happening. But as demonstrated above, the fraud and abuse trend is one area of the Medicare program heading the right direction.

2. Eliminate Big Ticket Care

This option, which may seem appealing because it can have immediate cost-savings effects, is not justified. The concept of “big ticket care” is broad, and while some groups advocate for eliminating it, there is no real definition of which type of care constitutes “big ticket.” It would seem that the term suggests eliminating more expensive procedures from coverage in the Medicare system, but grouping procedures by expense alone falls inadequately short of logic. Granted, there are controversial (and expensive) procedures covered by Medicare, for example bariatric surgery, which could be eliminated. But the cost of a treatment should not be the key factor in eliminating it, and this method of dealing with solvency seems off course.

The proper way to approach big ticket care is through the new focus from the passage of MMA, preventative medicine. Costly care can be mitigated by ensuring that health problems do not progress wherever possible, and early detection and prevention is a practical way to do this. Flat out elimination of expensive treatments may save some immediate dollars, but it will leave people in need of medical attention in serious trouble. Eliminating big ticket care as a solution to Medicare’s solvency should be equated with using a Band-aid when surgery is necessary.

3. Support Privatization

Privatization has received considerable attention, but it seems the privatization already in motion is costing more money than it is saving. In an article for the Center for American Progress, Terri Shaw and Christian Walker come out against the privatization of Medicare because “Private health insurers are providing fewer benefits at greater costs.” In their view, one of the reasons Medicare is in financial trouble is due to the move towards greater privatization of Medicare through MMA. Contrary to

82. Id.
the original rationale for privatizing Medicare, they report that privatization increases rather than decreases Medicare costs, thus worsening the financial outlook rather than improving it. They state: ‘That privatization costs money, and lots of it, is not a secret. Private companies want to make a profit for offering health insurance.’ 83

Ultimately, privatization has yet to prove successful, from its 1997 failure to the current restructuring by the MMA. If the goal of privatization really is to reduce cost, there is no proven reason to favor this method as it costs more money. If the goal regarding privatization is to provide better care or even more choices in care, the evaluation of its effectiveness would be different. Again, maybe the MMA approach will prove successful once the transition is made, and it should be given the opportunity to succeed, but based on past attempts at privatization it seems there should be more attention on other ways to cut costs.

4. Lose Some Privileges

Losing privileges is another possibility, but it should be grouped in the same category of options as eliminating big ticket care. A proactive approach of preventative medicine seems a better answer, and to fully implement the approach, even further privileges may need to be added. The prescription drug coverage incurred substantial new costs to the Medicare program as a whole, but if preventative drugs can substitute for costly procedures down the road, it is a logical addition to the continuum of care. Adding privileges for preventative reasons seems a better approach, rather than taking away services that beneficiaries are dependent upon.

There could be a comprehensive review of all treatments and services covered by Medicare, and through evaluating the importance and actual usage of treatments, the evaluation may highlight procedures that serve little purpose. To conduct such a review though would require substantial overhead cost and time, and assumes to a certain degree that all beneficiaries are the same in their treatment needs. A benefit not useful to one beneficiary may be a crucial benefit to another, and because healthcare and health needs are so unique, the notion of a “comprehensive” review and evaluation of benefits seems flawed. This method has the potential to create more conflicts and overhead costs than ability to save dollars for the system. Medicare coverage is not seen as “high-end” insurance, but closer to the necessities for healthcare. Cutting the base-level of benefits is the wrong focus for cost-savings. Focusing instead on providing preventative treatments to save on future costs in a more holistic and healthy approach.

5. Private Insurance

As discussed above, Senator Breaux’s plan proposed the transformation of Medicare into a premium support system, where beneficiaries would receive a fixed

amount of money to purchase private health insurance. This option may run into the
same theoretical problems as privatization, that private insurance will not be able
to provide the same standard of care on the funds given through Medicare. If
beneficiaries are not given enough money to purchase private insurance of the same
caliber as their Medicare coverage, this option likens to cutting big ticket care and
losing privileges, it is a bad idea.

Should privatization through MMA be successful, this option should be revisited.
But until there is a positive showing from MMA implementations, there are more
logical ways to cut costs without losing quality of care. Again, Medicare is seen as a
base-level of healthcare coverage, and any solvency suggestions should not go below
that base level. If private insurance companies cannot deliver that base level on the
Medicare funding now used, this will not be a cost-savings measure. The only clear
cost-saving method which does not detract from the coverage currently is the
elimination of fraud, which should continue to be a priority. Before detracting from
care to save money though, the income-side of the equation should be visited.

B. Income

According to the 2005 Report, a 107 percent increase in income will achieve
solvency for the current Medicare system. More than doubling income can be done in
several ways, each of which could see resistance from the party asked to pay.

1. Expand the Worker Pool

As the Senior Journal reports, there are approximately four workers for every
Medicare beneficiary today, and that number is declining, with projections that by
2079, there will be only about two workers for every beneficiary. A simplistic
solution is to expand the worker pool, knowing that every year hundreds of thousands
of immigrants are turned away from the United States. Several European countries are
now seeing the need for more laborers, and are relaxing their immigration policies
accordingly. While the US has taken recent steps to increase the number of “Worker
Visa’s” issued each year, much more could be allowed. The ramifications on the
United States infrastructure would need to be considered, but with the proper research,
this may be a viable option.

This option is much more positive than several of the cost-saving methods,
because it provides at least the same standard of care currently being received, and the
immigrants allowed in to the country to work are also willing and eager to come. The
new workers arguably receive an opportunity for a better quality of life (for their
family as well), and the beneficiaries of Medicare are still taken care of. Again,
research is needed on the impacts to US infrastructure before all is known about this
method, and an “open-border” with restriction-free immigration is not being promoted.
With that said, this could result in increased revenues to the Medicare system with the
least resistance from the population being asked to pay.

84. Almanac of Policy Issues, supra n. 2.
85. SeniorJournal.com, supra n.23.
2. Tax More

The Center for Medicare Advocacy, Inc. sees this as the obvious answer, citing to the fact that HI funding for Medicare has not changed in 20 years. They state: “Clearly, if the Medicare Fund is to remain solvent, the revenue formula must be increased from the formula set in 1985.” Taxing more is another good possibility, but it has the potential for strong political backlash for whichever politicians attempt to put it in place. While the percentage of income taxed for the Part A benefit has not changed for two decades, and therefore is arguably due for an update, this method largely ignores the Part B and Part D benefits.

Keep in mind, the SMI funding Part B and Part D is technically solvent, but it does face the same challenge of rising healthcare costs. Increasing the tax to employers and employees would only add revenues to the HI funding the Part A benefit, and is thus only a partial solution. And as this suggestion requires the current workforce to take-home less money from their paychecks and current employers to pay additional taxes as well, there will need to be considerable support from the public for this option to work. People are intimately affected when it comes to their money, and will need to keep the big picture in mind that they will receive benefits when they retire. Opening up immigration may be an easier sell to the public.

3. Keep Beneficiaries Working Longer

With Congress involvement, the age of eligibility could be raised, and beneficiaries could be encouraged to work longer, therefore pulling less from the system and adding more to it. The Senator Breaux plan would have raised the age of eligibility from 65 to 67. Longer life expectancies and advanced technologies mean people are staying in the work force longer, and because this option helps both income and cost, it seems even more beneficial. With no new taxes or immigration policy, it may also be the least disruptive.

If this method were shown to have broad support from citizens close to the eligibility age, it shares the benefit of being supported by those it calls upon to make the sacrifice. Just as immigration brings in willing workers, this method would be strong if workers between the ages of 65 and 67 proved supportive. As this population block tends to vote in high percentages, the option could easily be presented for their approval, along with the rest of the nation which would ultimately be affected.


An option completely separate from income and expenditures is to restructure the system. For example, the technical solvency of Medicare can be achieved by structuring Part A like Part B and D, by law to automatically meet the next year’s expected costs. While the CBO and several groups would disagree with this method as irresponsible and ultimately just ignoring the problem, it would create instant solvency

86. Id.

87. Almanac of Policy Issues, supra n. 2.
as defined by the Trustees. Less time and energy would be wasted worrying about
the solvency of the system because it would be linked to premiums and general
revenue.

Beyond achieving technical solvency by changing how the Part A is financed, a
real opportunity exists to improve the continuum of care and cut costs in the process.
Part A should be combined with Parts B and D during the restructuring, so that the
entire system flows together. Parts B and D would need to become mandatory to
benefit from the Part A income stream, and ultimately for this model to work. As
currently structured, all emphasis is on hospital care (with limited skilled nursing
possibilities), because Part A is the one portion of Medicare guaranteed to all
beneficiaries.

Hospital care is exponentially more costly than skilled nursing facility care,
which is more expensive than assisted living, and finally more expensive than home
care. If all parts of the system were mandatory, rather than optional, a beneficiary
would be encouraged to graduate into a less-expensive care setting, rather than staying
in the hospital longer (because the hospital is the only place covered by Part A, and
often the only coverage a beneficiary has). With cost savings from shorter hospital
stays, funds will be available to bridge the current gap between hospital and home
care, providing for an assisted living benefit and ensuring a beneficiary is cared for
even without an “illness” allowing for hospital care.

Besides improving the continuum of care, other benefits will come from
combining Medicare Parts A, B and D and making them all mandatory. For example,
the current optional structure of Part B (which will also affect Part D once it is fully
operational) leads to a phenomenon called “adverse selection.” Beneficiaries choosing
to opt in for Part B coverage pay a monthly premium, whereas all beneficiaries receive
Part A without additional payments. Because it costs extra out-of-pocket money, only
beneficiaries who need the extra coverage due to health considerations actually opt in.
Thus Part B ends up with more of an unhealthy population, because the healthy
eligible beneficiaries decide not to join.

If any private insurance company insured only unhealthy people, it would not
survive and certainly would not profit. Private insurers need to sign up healthy
individuals to offset unhealthy ones, and will charge different monthly premiums to
people depending on their health risk. Medicare Part B cannot charge different
premiums based on health, and largely misses the healthy population due to its
optional yet universally available nature. Its hands are tied, and its costs are rising
because of it.

An initial financial restructuring of the Part A funding would equate to solvency,
and has the potential to save in overhead general administrative costs because the
annual solvency debate would be automatically resolved, negating the need for the
Annual Trustees Report. Parts A, B and D would all be general revenue and premium
financed (with payroll taxes formerly funding the HI being added to general revenues),

88. This would of course require a repeal of the new MMA “Financial Trigger” regarding general
revenues, but the remainder of MMA should remain as its effectiveness is either proven or
disproved.
adjusted each year to meet expected costs. In addition, the three parts should be
combined together and offered as a mandatory package to beneficiaries, creating a
continuum of available care rather than a hospital-focused model. Cost savings, and
improved healthcare, would result from such a synergy.

CONCLUSION

All sides agree that Medicare is currently insolvent, but as this financial giant
cycles billions of dollars every year and most everyone can agree to the importance of
the program, finding solvency should not be impossible. Several expenditures jumped
out in particular during such a comprehensive view of the topic, and curbing those
expenses alone could get the system well on its way.

Fraud continues to be a large drain on resources, and even with remarkable
progress made in the last year, there is still about $9.5 billion wasted annually. While
this viewpoint is extremely idealistic, curbing fraud only hurts criminals, and it should
be pursued before any necessary services to beneficiaries are cut. There has also been
a major shift in focus under MMA, and before another major shift is made the MMA
should be given a chance to perform. The focus on preventative care could not be
better, and while initially more expenditures may be made to put the system in place,
providing better care in the hopes of eliminating more costly care later on is right on
target.

Regarding care, chronic care is on the rise, representing some 61 percent of
healthcare expenditures. A groundswell in homecare is just hitting the industry, and
should it continue, the cost of care at home over a hospital is exponentially less
without the overhead that healthcare facilities represent. And finally, there is
considerable overhead to the Medicare program. Administrative expenses this year for
HI and SMI will equal over $6.11 billion.

With that in mind, a first step to solvency should be to restructure the HI to make
it a general revenue and premiums problem, like the SMI, and cut overhead. All sides
of the debate get hung up on this “solvency problem.” Billions of dollars are being
wasted every year with the current system, so there must be an effort to continue
fighting fraud, push prevention through MMA, and cut the administrative costs to the
HI and all of its projections required by law.

The same sources of income to the HI now should be kept in place, but diverted
into general revenues. Income can be increased to the system by allowing for more
workers, having people work longer, and maybe even by trying to increase taxes, but
because of the importance of Medicare it should be linked to general revenues to keep
its funding on par with defense, education, and other important federal systems. Strip
away the technicalities of surpluses and credits to these trust funds, which are really
only record keeping entries within the Treasury. This is everyone’s problem, and
should be treated as such.

Finally, combine all three Parts of Medicare into a comprehensive coverage
package, available to each beneficiary (but from which they cannot opt out). This will
fill gaps in the available care, remove the hospital focus to Medicare, and eliminate
adverse selection happening from the optional nature of Parts B and D. With the
potential to reduce costs from more efficient care, increase income from the larger user pool paying premiums, and ultimately deliver a better continuum of care for beneficiaries, all sides benefit. Moreover, solvency will still be automatic each year, and the Medicare system will be available through the year 2038 and beyond.
LOST IN TRANSLATION?  HOW CULTURALLY-SPECIFIC ADULT DAY CARE CENTERS CAN IMPROVE THE LIVES AND HEALTH OF KOREAN ELDERLY LIVING IN NEW YORK CITY

Irene S. Kang

TABLE OF CONTENTS

SUMMARY .................................................................................................................. 139
INTRODUCTION........................................................................................................... 140
I. DIFFERENCES BETWEEN ADULT DAY CARE AND ADULT DAY HEALTH CARE .... 140
II. ASIAN AMERICAN ELDERLY LIVING IN NEW YORK CITY: SPOTLIGHT ON KOREAN ELDERLY ........................................................................................... 141
III. REVISED HHS LEP GUIDANCE ............................................................................ 142
IV. THE ADMINISTRATION ON AGING GUIDELINES .................................................. 145
CONCLUSION .............................................................................................................. 145

SUMMARY

This paper briefly examines the influence of Executive Order No. 13166 of 2000,1 and its implications for Limited English Proficient (LEP) elderly, particularly, the LEP Korean elderly in New York City participating in Adult Day Health Care (ADHC) programs. The guidelines set forth by the Administration on Aging for Culturally and/or Linguistically Competent Agencies, as well as the guidance issued by the Department of Health and Human Services pursuant to Executive Order 13166 are explored, leading to the conclusion that the needs of the LEP Korean elderly are not being met, and would greatly benefit from culturally – specific services to enable them to experience higher quality health care.

* Irene S. Kang graduated from the Dickinson School of Law of the Pennsylvania State University in May, 2006. In 2005, she received the NAELA Minority Student Summer Fellowship. In May 2006, she presented the video documentary component to this paper at the NAELA Symposium in Washington, D.C. She would like to thank Professor Katherine C. Pearson for her continuous encouragement throughout the Elder Law Clinic and Workshop experiences.

1. 65 C.F.R. 50121 (2000); see also, 42 U.S.C. § 2000d-7 (2000) (stating that “Prohibition against exclusion from participation in, denial of benefits of, and discrimination under federally assisted programs on ground of race, color, or national origin.”).
INTRODUCTION

On August 11, 2000, President Clinton issued Executive Order No. 13166, which reiterates the principles of Title VI of the 1964 Civil Rights Act with respect to LEP persons.2 The Executive Order states that recipients of federal financial assistance must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.3 The Department of Justice was responsible for providing LEP guidance to other federal agencies and for ensuring consistency within each agency-specific guidance. To assist programs receiving federal financial assistance determine the extent of its obligation to provide LEP services, the Department of Justice provided four factors to consider: 1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; 2) the frequency with which LEP individuals come in contact with the program; 3) the nature and importance of the program, activity, or service provided by the program to people’s lives; and 4) the resources available to the grantee/recipient and costs.

As will be explored in this paper, the obligation recognized under this Executive Order to provide services to persons of limited English-language ability is particularly important in the context of health care services, and “adult day care” is an important access point for health care services for the elderly, specifically, the LEP elderly.

I. DIFFERENCES BETWEEN ADULT DAY CARE AND ADULT DAY HEALTH CARE

Many people have seen day care programming for adults and may believe that such programs are little more than recreation centers. In fact, two categories of Adult Day Care programs exist: the social model, and the medical model. The social model, commonly known as senior centers, offers only community-based social programs. The medical model, on the other hand, offers comprehensive health care in addition to community-based social programs.4 The purpose of Adult Day Health Care or “ADHC” programs is to help “registrants with functional impairment to maintain their health status and enable them to remain in the community.”5 A physician must recommend the ADHC program to the potential registrant, and the potential registrant must not require continuous 24-hour impatient care and services, but still require supervision, monitoring, preventive, diagnostic, therapeutic, rehabilitative or palliative

2. 65 C.F.R. 50121 (2000); see also, 42 U.S.C. § 2000d-7 (2000) (stating that “Prohibition against exclusion from participation in, denial of benefits of, and discrimination under federally assisted programs on ground of race, color, or national origin.”).
3. 65 C.F.R. 50121, (2000) (stating that “First, we must ensure that Federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English. This is of particular importance because, in many cases, LEP individuals form a substantial portion of those encountered in federally assisted programs.”) (emphasis added).
5. Id.
Public funding is limited for adult day services. Most of the public funding is obtained from state Medicaid home and community-based waiver programs. These waiver programs allow states to develop alternatives to nursing home care for Medicaid-eligible individuals.

In New York, the average ADHC program is reimbursed $103.00 per registrant per day by Medicaid. Since nursing home care Medicaid reimbursement amounts to more than $250.00 per day, ADHC is a cost-effective method for the government to provide services to the elderly, including services often provided in a full-time residential nursing facility.

II. ASIAN AMERICAN ELDERLY LIVING IN NEW YORK CITY: SPOTLIGHT ON KOREAN ELDERLY

According to a landmark study by the Asian American Federation of New York, Elderly Asian American New Yorkers experience poverty and depression at a higher rate than the general elderly population. More than one in four elderly Koreans living in New York City (28% or 1,716) exist below the poverty line, markedly surpassing the city’s overall elderly poverty rate of 18%. From 1990 to 2000, the number of Asian senior citizens grew by 91 percent, from 33,214 to 63,312. Furthermore, almost three-quarters of elderly Asians (73%) possessed limited English-speaking skills. Approximately 40% (29,454) of the Korean adult population in New York City spoke English “not well” or “not at all,” while only 13% of the overall adult New York City population experienced LEP. Immigrants comprised the vast majority of

8. Telephone Interview with Christine Fitzpatrick, Executive Director, Adult Day Health Care Counsel, (November, 2005).
9. Id.
10. The Asian American Federation of New York, a nonprofit organization that strives to advance the civic voice and quality of life of Asian Americans in the New York metropolitan area, was founded in 1990. The Federation supports and collaborates with 39 member agencies focusing on Asian American programming to strengthen services within the community, http://www. aafny.org (last visited Sept. 4, 2006)
11. Harris Interactive, Inc., Asian American Elders in New York City: A Study of Health, Social Needs, Quality of Life and Quality of Care, http://www.aafny.org/research/default.asp (last visited Feb. 25, 2006). This is the first comprehensive examination of the demographics, living conditions, social supports and overall life satisfaction of elderly Asian Americans. The Federation, a public policy leadership organization, collaborated with the Brookdale Center on Aging at Hunter College to produce the study, which provides an in-depth portrait of older Asian Americans, identifies critical unmet needs, and recommends action steps to fill service gaps. The study is based on a regionally representative survey of more than 400 New York City residents age 65 and older, and belonging to the city’s six largest Asian American ethnic groups: Chinese, Korean, Indian, Filipino, Vietnamese and Japanese-Americans.
12. Id.
13. Id.
the Korean population in NYC in 2000, which may be why Koreans have a higher occurrence of LEP than the general population.\(^{14}\)

Few programs and services exist to meet the growing demand for culturally- and linguistically-appropriate health care and social services in New York City. As a result, “Asian American seniors endure disproportionate poverty and depression, with related health and social consequences [comparable to the overall elderly population of New York City].\(^{15}\)” Almost all Asian-American elderly who participated in the study immigrated to the United States when they were middle to late-middle age, an aspect that helps explain their high level of LEP, dependence on children, and also why many do not qualify for Social Security benefits, as there was little time to accrue them.\(^{16}\) In addition, 41% of Asian American seniors receive Medicaid benefits.\(^{17}\)

It is also important to recognize the traditional cultural beliefs to which—most Korean elderly cling. The Korean elderly generally expect their children, particularly the eldest son, to provide long-term care. Since it is usually necessary for newly immigrated adults to work, the Korean elderly cannot receive the care and attention they need. Although Korean elders are held in high esteem within their families, many elders who find themselves in a new country, without a working understanding of the English language, often feel dependent and isolated. Many Korean-American families experience a sense of shame in sending their elders to nursing homes, because traditionally, it was unheard of. Some Korean families even feel the same way when considering sending their elder family members to ADHC programs as well because they believe that only the family should take care of their elderly. Hopefully this stigma can be mended with the growth of culturally-specific health care programs. Unfortunately the available Guidances introduced by the Department of Health and Human Services and the Administration on Aging, along with the New York Health Code, offer mixed messages as to whether culturally-specific programs are recognized, let alone, encouraged.

III. REVISED HHS LEP GUIDANCE

On August 8, 2003, the Department of Health and Human Services (HHS) released a Guidance to Federal Financial Assistance Recipients Regarding LEP Persons pursuant to Executive Order 13166.\(^{18}\) The purpose of the policy guidance was to “assist recipients in fulfilling their responsibilities to provide meaningful access to LEP persons under existing law.”\(^{19}\) Potential recipients of HHS assistance may include: state, county and local health agencies; state Medicaid agencies, hospitals, nursing homes, home health agencies, and managed care organizations. ADHC

\(^{14}\) Id.

\(^{15}\) Id.

\(^{16}\) Id. 37 percent of older Asian Americans receive Supplemental Security Income (SSI), and about half receive Social Security benefits.

\(^{17}\) Id.


\(^{19}\) Id.
programs, both public and private, would be considered recipients because many receive state and federal Medicaid reimbursement. The Guidance also noted that when planning for the needs of LEP persons seeking health and health-related services, community members seeking to participate in health promotion or awareness activities should be considered. ADHC programs are an ideal fit, because they attempt to improve the quality of life for the LEP elderly, as well as promote health and awareness.

The providing notice section is extremely helpful, as it encourages recipients to inform LEP persons that services are available by “working with community-based organizations, [providing] notices in local newspapers in languages other than English, providing notices on non-English language radio and television stations, presentations at schools and religious organizations.” Providing notice in the LEP’s primary language is especially important for the elderly, because they need to know that there are beneficial programs, such as ADHCs, where they can actively participate in and benefit from exist in their primary language.

The Guidance also utilizes the Department of Justice’s 4-Factor Test in assessing the extent of services the programs receiving federal assistance should offer to the LEP: 1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; 2) the frequency with which LEP individuals come in contact with the program; 3) the nature and importance of the program, activity, or service provided by the program to people’s lives; and 4) the resources available to the grantee/recipient and costs. The following application of each of the four factors to culturally-specific ADHC programs catering to the LEP elderly illustrates how relevant and beneficial these programs can be.

Applying the 4-Factor Test:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee. The Guidance asks that the reader look to community agencies, religious organizations, legal aid entities, and others who may help identify populations which may be underserved because of existing language barriers and who would benefit from the recipient’s program, activity or service, were language services provided. There are many Asian American elderly, not only Korean elderly, who would benefit from ADHC programs where language services are provided. In a 2003 study conducted by the Asian American Federation of New York, 40% of the Asian American elderly surveyed in New York reported symptoms of depression varying from mild to

20. Id.
21. Id.
22. Id.
23. Id.
24. Id.
Given the high level of depression and poverty among the Asian American elderly, the social activities, as well as the skilled nursing care provided at ADHCs, a significant number of LEP persons would be served.

2. The frequency with which LEP individuals come in contact with the program. In New York City, one can reasonably expect to come in contact with LEP elder. The Guidance provides, “the more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed.” From a 2000 Census report, it was reported that 1,716 Korean elderly were living in poverty. It is necessary to support this substantial number of LEP elderly with language-specific programming.

3. The nature and importance of the program, activity, or service provided by the program to people’s lives. The Guidance suggests that the recipient (of federal funding) consider the importance and urgency of its program, activity, or service. The services ADHC programs provide for the Korean LEP elderly are extremely important because they foster a sense of community where they interact with their peers. Since registrants for ADHC programs are not in fine health, they are provided with assistance and supervision with the activities of daily living, pharmaceutical services, social services, and nursing services. Since many Asian American elderly are more likely to experience symptoms of depression when they cannot understand English, and when they encounter cultural disparities with their children, ADHC programs that can address and help alleviate these uniquely culturally specific problems these participants face. It is important to note that ADHC programs not only provides a safe, productive atmosphere for the LEP elderly, they also give primary caretakers the opportunity to rest during the program hours.

4. The Resources Available to the Recipient and Costs. Instead of hiring interpreters and translators to run multicultural programs, for the LEP

27. Id.
elderly, it would be more economical to create programs that cater to their specific needs. The familiarity of language, ethnic-specific activities and familiar cuisine will help foster a sense of community for many LEP elderly who feel isolated. The LEP elderly would also receive better health care, as they will be able to communicate their symptoms and needs to the nursing staff.

IV. THE ADMINISTRATION ON AGING GUIDELINES

The Administration on Aging website for Culturally and/or Linguistically Competent Agencies declare, “Providing culturally competent service is not only the right thing to do, it is good business.” The guidelines set forth by the Administration on Aging for Culturally and/or Linguistically Competent Agencies are vague and difficult to apply for programs serving LEP elderly. Some suggestions included: mutual respect, recognizing that acculturation occurs differently for everyone; being open, honest and respectful; being willing to listen and learn. These guidelines apply best for a multicultural ADHC program with registrants possessing a working knowledge of English. Considering three out of four Asian American elderly are LEP, these guidelines are unconstructive. The guidelines also suggest that hiring staff that reflects the client population and being creative in finding ways to communicate with population groups that have limited English-speaking proficiency. It is important to hire bilingual staff who reflects the client population, and being creative in finding ways to communicate with frail elderly registrants seems risky. For frail LEP elderly registrants, communication is paramount. There is no creative substitute that can match the level of care that fluency in the LEP elder’s language provides.

CONCLUSION

In the last decade, there have been several attempts to combine different ethnic minority elderly together to participate in ADHC programs in New York City, however, the directors of these programs experienced great difficulty fostering a connection between the registrants. The lack of understanding, and the cultural differences between the groups made it challenging to provide effective health care, as well as provide social activities that they all can participate in. Both Mrs. Fitzpatrick, Executive Director of the Adult Health Care Council, and Mrs. Kang

33. Id.
34. Id.
35. Interview with Susie Kang, Director, Adult Day Health Care at Queens Boulevard Extended Care Facility (February 24, 2006).
36. Id.
predict that culturally-specific ADHC programs, and even culturally-specific nursing homes are a growing trend that will flourish due to sheer demand.\(^{37}\)

Only two ADHC programs that are conducted in Korean by bilingual nursing staffs exist in New York City. One of these ADHC programs runs at full capacity, where each registrant receives Medicaid, and has a long waiting list, even though it does not advertise.\(^{38}\) More programs like these are needed, and perhaps ADHC programs and other long term care programs are slow to meet the demand because of the mixed messages sent by the Guidance by HHS, as it attempted to implement Executive Order 13166, and the guidelines set forth by the Administration on Aging for Culturally and/or Linguistically Competent Agencies. Neither the HHS Guidance, nor the Administration on Aging unambiguously suggests conducting health care programs in a language other than English. Rather than spending funds to hire interpreters to translate multicultural ADHC programs for LEP elderly, as the HHS Guidance and the Administration on Aging suggests, it would be more economical for recipients of federal funding to create programs that cater to culturally-specific needs of a single LEP elderly minority group.\(^{39}\) More importantly, since communication would no longer be an issue, the LEP elderly would experience much-needed access to meaningful and effective health care.

\(^{37}\) Telephone Interview with Christine Fitzpatrick, Executive Director, Adult Day Health Care Counsel (November, 2005); Interview with Susie Kang, Director, Adult Day Health Care at Queens Boulevard Extended Care Facility (February 24, 2006).

\(^{38}\) Interview with Susie Kang, Director, Adult Day Health Care at Queens Boulevard Extended Care Facility (February 24, 2006).

\(^{39}\) Adult Day Health Care at Queens Boulevard Extended Care Facility in Woodside, NY, is a bilingual program that is conducted in Korean and English.
THE LEGACY OF MULTI-GENERATIONAL HOUSING—
ANSWERING THE PROBLEM OF THE GENERATION GAP

Junlin Ho*

TABLE OF CONTENTS
INTRODUCTION ........................................................................................................... 147
I. THE FAIR HOUSING ACT’S SENIOR HOUSING EXEMPTION .................................... 148
II. THE LEGACY ACT .............................................................................................. 149
III. MULTI-GENERATIONAL HOUSING INITIATIVES .................................................. 151
CONCLUSION .............................................................................................................. 153

INTRODUCTION

Across America, grandparents, many of whom are retired, are finding themselves called back to work as primary caregivers for their grandchildren. According to the U.S. Census 2000, 4.5 million children live in grandparent-headed households, a 30 percent increase from the U.S. Census 1990 statistics.1 This number indicates that over 6 percent of children under the age of eighteen in the United States are living with their grandparents. Perhaps the most telling sign is the fact that policymakers only felt the necessity to add one new question to the U.S. Census questionnaire in 2000—if a grandparent did have grandchildren living in the same household, was the grandparent responsible for most of the basic needs of the grandchildren?2 Over 2.4 million grandparents answered the question with a resounding yes.

Many of these grandparents are finding life with their grandchildren more difficult than they had bargained for. Aside from the many financial and legal issues that elderly caregivers face, including the need for support services, grandparents are discovering an additional burden: the lack of housing. This problem was painfully reinforced for Chaz Cope and his grandparents. Chaz moved in with his grandparents to escape his stepfather’s abuse. Although his grandparents welcomed Chaz into their home, the retirement community his grandparents lived in, aptly named Youngtown, posed a significant dilemma. The Phoenix suburb of 2,500 had a local ordinance that

* Junlin Ho is a J.D. candidate, Class of 2007, at the University of Chicago Law School.
1. AARP, Lean on Me: Support and Minority Outreach for Grandparents Raising Grandchildren 7 (AARP 2003).
2. Id. at 8.
required each household to have at least one person who was fifty-five years or older. In addition, the ordinance limited children eighteen years of age and younger from staying longer than three months. After a year had passed, the town threatened to evict Chaz. Media coverage and public outrage alerted the State Attorney General to Chaz’s plight. Through a last minute discovery by the AG’s office that Youngtown’s ordinance violated state law, Chaz and his grandparents were saved from being forced to move.

As more grandparents take in their grandchildren, families are discovering themselves in a similar predicament as the one Chaz and his grandparents faced. Housing options for multi-generational families are often limited due to a senior housing exemption in the Fair Housing Act, which allows for the exclusion of families with children from senior-designated housing. This paper first discusses the senior housing exemption and the policy reasons behind why the exemption was included in the Fair Housing Act. Next, it discusses the legislative response to the needs of seniors in multi-generational families. Finally, the paper highlights successful intergenerational housing initiatives and the road ahead for grandparents who are raising their grandchildren.

I. THE FAIR HOUSING ACT’S SENIOR HOUSING EXEMPTION

In order to understand how the senior housing exemption came to be included in the Fair Housing Act, we must first look at the history behind the Act. In an effort to end housing discrimination during the civil rights movement, Congress enacted the Fair Housing Act in 1968. In this first incarnation, the Act provided protection against discrimination on the basis of race, color, religion, and national origin. Unfortunately, the Act did not achieve the results that many civil rights activists had hoped for. The next two decades saw the dawning of a new practice—the conversion of housing complexes into adults-only communities. As families were prohibited from living in these communities, the practice led to the exclusion of many minorities with children. Courts also found that all-adult conversion policies had a “substantially greater adverse impact on minority tenants.” Betsey v. Turtle Creek Associates, 736 F.2d 983, 988 (4th Cir. 1984). This phenomenon is also applicable to intergenerational families. The U.S. Census 2000 statistics indicate that over 13 percent of all African American children live in grandparent-headed households while only 4 percent of Caucasian children are similarly situated. See AARP, supra n. 1, at 7.
communities that provided special services for the aging. In response, Congress enacted the Fair Housing Amendments Act (“FHAA”) in 1988. The FHAA provided protection to families by prohibiting discrimination on the basis of familial status. However the FHAA provided a specific exclusion to this ban: the senior housing exemption.

The Fair Housing Act currently prohibits discrimination in the sale or rental of housing “against any person . . . because of race, color, religion, sex, familial status, or national origin.” The familial status provision does not apply though “with respect to housing for older persons”. There are several ways a development can become classified as housing for older persons, but the most common way to qualify is to have “at least 80 percent of the occupied units . . . occupied by at least one person who is 55 years of age or older”. If a complex meets the requirements laid out in the Fair Housing Act senior housing exemption, it can exclude families with children.

Given Congress’ tacit support for discrimination against families, at least in the context of senior housing, the next question that follows is whether the FHAA senior housing exemption is constitutional. Shortly after the FHAA was enacted, many family activists proceeded to challenge the senior housing exemption’s constitutionality under the Equal Protection clause. The response they received from the courts though was no different than what Congress had provided. The exemption prevailed since courts held that it was rationally related to legitimate state interests. Specifically, “[t]he housing-for-older-persons exemption as amended bears a rational relationship to the government’s legitimate interest in preserving and promoting housing for older persons.” With the Congressionally provided exemption in place and no further judicial remedies, seniors in multi-generational families have found housing options very limited. The senior housing exemption, a law designed to protect the interests of elders, has negatively impacted seniors responsible for the care of their grandchildren. These grandparents, many of whom would otherwise qualify for senior housing, need to find alternative housing in order to keep their families intact.

II. THE LEGACY ACT

Multi-generational families are a unique population who present special challenges. In many ways, the families are comprised of two groups with competing diametric desires. Just when seniors are thinking of downsizing, they must find larger apartments with more bedrooms. Seniors who might have already been under a tight budget often find themselves in a precarious financial situation as they try to stretch their resources to support themselves and their grandchildren. The children often need
playgrounds and after school activities while seniors want solitude to rest and the ability to socialize with other similarly situated people. Multi-generational housing must meet the needs of both populations. Unfortunately, subsidized multi-generational housing has rarely been a policy priority. This has resulted in much fewer housing options for families since they cannot rent smaller units that do not have enough bedrooms, and they are completely banned from subsidized elder units where children are excluded.14 Grandparents have responded by foregoing senior housing they might otherwise be eligible for and assuming the additional burdens that come with raising children. But the process has not been easy.

Examples of the difficult process include Avonne Johnson, a 64 year-old grandmother, whose daughter has been in and out of jail for the last decade. When her daughter went to jail, leaving a generational gap in the family, Ms. Johnson assumed the role of caregiver to her granddaughter. She has been unable to move into senior subsidized housing because of her granddaughter and is waiting for a Section 8 voucher in hopes of moving to a safer neighborhood where her granddaughter can play outside. The most difficult part though has been the isolation and lack of support she initially experienced during the process of second-time parenting.15 Grandparent frustration has sparked the growth of support groups and counseling programs for multi-generational families. Ms. Johnson found her emotional support from a grandparents’ counseling program she joined, which provides her with classes that teach her second-time parenting skills, help her manage her stress levels, and understand the family’s financial situation.16

With the release of the U.S. Census 2000 statistics and the added boost of successful counseling and support programs for grandparents, Congress has finally begun to focus on the dearth in multi-generational housing. In response, U.S. Representative Michael Capuano (D-MA) introduced legislation to provide Congressional funding for an intergenerational housing demonstration program.17 On December 16, 2003, Congress and the President enacted the Living Equitably: Grandparents Aiding Children and Youth Act, otherwise referred to as the LEGACY Act.18

The LEGACY Act specifically targets intergenerational families that would otherwise be excluded from subsidized elderly housing, such as Section 202 developments. The Act covers families with children eighteen years of age or younger (or nineteen years of age if the child is attending school).19 The head of household must be a grandparent or relative who qualifies as an elderly person pursuant to

---

15. Violet Law, *No Retirement Home Here: More Black Women are Raising Their Grandchildren— Even as They Struggle to Find Housing*, Colorlines Mag. 27 (Sept. 22, 2005).
16. *Id.*
19. *Id.* at § 202(1).
2006]  

MULTI-GENERATIONAL HOUSING  

Section 202 regulations. The LEGACY Act’s language is suitably vague to allow for flexibility, but the statute does address the essence of multi-generational housing. It provides that the funded intergenerational housing must be “equipped with design features appropriate to meet the special physical needs of elderly persons, as needed” as well as “features appropriate to meet the special physical needs of young children, as needed.” In addition to the design elements, the units must also provide “a range of services that are tailored to meet the needs of elderly persons, children, and intergenerational families.” The housing is to be created by retrofitting existing units in Section 202 developments, by building an annex or addition to existing Section 202 projects, or by developing new buildings solely for intergenerational housing.

When enacted at the end of 2003, the LEGACY Act called for the creation of a demonstration program that would provide $10 million in funding over the course of five years. Much to the chagrin of policymakers though, Congress did not appropriate any funds to the demonstration program for nearly two years. But the good news finally came in the fourth quarter of 2005, when the program received its first congressional appropriation, in the amount of $4 million.

III. MULTI-GENERATIONAL HOUSING INITIATIVES

The challenges posed by intergenerational families are not merely due to the countervailing needs of two populations; often, families are still haunted by the generation gap in the family unit. The missing generation exists for many reasons including the AIDS epidemic, substance abuse, incarceration, family abuse and neglect, poverty, death, and mental health problems. Regardless of the reason for the generation gap, many children in intergenerational families end up harboring feelings of abandonment and resentment, while grandparents are twice as likely to be clinically depressed as their counterparts who are not primary caregivers. Given the difficulties that intergenerational families face, in order to be successful, multigenerational housing must address both the physical and emotional needs of the populations it serves.

GrandFamilies House (“GrandFamilies”) is a success story in large part because it has balanced the needs of the intergenerational families living within the confines of

20. See id. at § 202(2), 202(3), 202(6).
21. Id. at § 202(8).
22. Id. at § 203(c)(3)(A).
23. Id. at § 203(b).
24. Id. at § 203(f), 203(g).
27. See Llana, supra n. 26.
its walls. When it opened in Boston in 1998, it represented a huge step forward for multi-generational housing. Even today, over seven years after it first opened its doors, GrandFamilies is still considered a revolutionary housing initiative and is used as a model and benchmark for new multi-generational housing projects. It was the first subsidized housing development designed specifically for grandparents who are primary caregivers for their grandchildren.\(^\text{29}\) Local non-profits created twenty-six units of housing by rehabbing a shuttered nursing home. Throughout the construction process, features that protected both children and seniors were incorporated into the design. All units are handicapped accessible and physical elements include electrical outlet-covers and grab bars in the bathrooms.\(^\text{30}\) In addition, the project provides substantial common space for services.

Services are an integral component of GrandFamilies. The project’s services are provided on-site by the YWCA Boston and include preschool and after-school programs for the children, exercise classes, and medical screening. In addition, GrandFamilies hires staff members, including a resident services coordinator, and a youth coordinator to ensure residents have a full slate of programs. The project also arranges for a social worker to come every week to provide information to grandparents on their rights in the foster care, juvenile court, and social security systems.\(^\text{31}\) Other features include vans that take residents around town.

These services have allowed residents greater flexibility and have allowed the project to adapt with time. Although it has had growing pains including inadequate space for teen activities, GrandFamilies strives to provide as many on-site services to grandparents as possible in hopes of delaying the day when seniors will be forced to enter an assisted living or nursing home facility where their grandchildren will no longer be able to live with them.\(^\text{32}\) Nearly eight years out, it is clear that GrandFamilies’ success has come from its longevity—its ability to provide for its residents as the population begins to grow up and age.

GrandFamilies continues to represent unique circumstances that are not easily replicable. Like any other service-intensive affordable housing, the $4 million development was built using a variety of sources including HOME funds and low-income housing tax credits and relies on annual subsidies to cover operating costs. Although project-based Section 8 vouchers were not available at the time, the non-profit developers convinced the Massachusetts Department of Housing and Community Development and the Boston Housing Authority to each provide fifty tenant-based Section 8 vouchers specifically for low-income grandparents raising their grandchildren.\(^\text{33}\)

\(^{29}\) Butts, supra n. 26.

\(^{30}\) See Kanders, supra n. 28, at 5.

\(^{31}\) Id. at 6.

\(^{32}\) Llana, supra n. 26.

Given the well-documented success of GrandFamilies and the difficulties of creating intergenerational housing, it is not surprising that the politician behind the LEGACY Act, Representative Capuano, is from Massachusetts, the home of GrandFamilies. Policymakers have witnessed firsthand the challenges in creating intergenerational housing as seen by the length in time between GrandFamilies and the next multi-generational housing development to be completed, the GrandParent Family Apartments. GrandParent Family Apartments is a fifty-unit project built in the Bronx that is touted as “a national demonstration model offering affordable, safe housing with an array of support services for both the grandparents and their grandchildren.” The housing is available to grandparent-headed households where the senior earns less than $17,000 annually. The two projects share more than just a similarity in name; services at GrandParent Family Apartments also include a tailored program for both grandparents and grandchildren including tutoring programs, visiting nurses, and communal recreation space. Perhaps the most telling sign though is the fact that the grand opening for GrandParent Family Apartments took place on October 14, 2005. It took over seven years to create a second multi-generational housing development.

The growing need for intergenerational family housing, coupled with the first congressional appropriation of $4 million for the LEGACY Act, has piqued the interest of many non-profits nationally. According to Generations United, an intergenerational family advocacy group, there are at least twenty communities interested in creating housing similar to GrandFamilies or GrandParent Family Apartments. Indeed, the LEGACY Act goes a long way to funding the two to four projects included in the Act’s demonstration program. But the question remains: what about the rest? Two to four projects, although not insignificant given the fact that only two subsidized intergenerational housing developments have been created in over seven years, will only represent a drop in the bucket.

CONCLUSION

Although the LEGACY Act represents a major improvement to affordable housing options for seniors responsible for the care of their grandchildren, it can only represent the first step. The Act’s funding is not nearly enough to address the needs of the 2.4 million grandparents who are responsible for most of the basic needs of their grandchildren, or the 4.5 million children who find themselves living in grandparent-headed households. They remain excluded from elder housing and often lack the resources to access the information and services necessary to help them survive as a family unit. These two groups represent truly different populations who are often suddenly forced to coexist in an environment neither expected to live in.

35. Garcia, supra n. 25.
The statistics only indicate a substantial increase in seniors who are primary caregivers for their grandchildren; these numbers do not provide us with a clear reason for the trend. What is clear though is the dearth in housing options currently available to these elders. Although many with adequate resources can survive in standard housing by foregoing the services they would receive in senior housing, they should not be forced to make this choice. In addition, low-income grandparents have even fewer housing options. We can only hope that the LEGACY Act represents the first step in a process that will provide elders responsible for raising their grandchildren with better access to subsidized multi-generational family housing. The Act’s demonstration program will help create innovative developments that ultimately may lead to similar initiatives being undertaken in the market housing industry. This long overdue program represents the start to providing better housing options to the 2.4 million grandparents caring for their grandchildren. The process needs to move forward at a faster rate though, since waiting another seven years for new housing is simply too long.
ALZHEIMER’S DISEASE: MEDICARE’S DIRTY LITTLE SECRET

Meredith Leigh*

My grandfather suffered from dementia before his death in 2005. When my sister and I walked into his room at the nursing home, my aunt, his caretaker, asked if he knew who we were. His response was, “No, but they sure are pretty girls.” Our pictures were all over that room, but our only importance to him was that we were pretty girls who had come for a visit. As the window on his life closed, the only person he recognized was his daughter who took care of him daily; he confused my mother with her, primarily because she was a female of about the same age, rather than because of any resemblance.

My grandfather’s condition is far from unique, and, as far as dementia goes, not all that severe. There are many books published about Alzheimer’s disease, but there remains a basic lack of understanding about the illness. Researchers know that healthy brain tissue degenerates, but they haven’t really figured out why this happens and know of no way to stop it.1 A patient diagnosed with Alzheimer’s Disease faces a hugely different battle from that of a cancer patient. Not only are treatments vastly more advanced for the cancer sufferer, there is the potential for a cure. In addition, Medicare and private insurance will cover the bulk of the cancer patient’s care.2 In Iowa, Medicare Part A covers 80% of inpatient chemotherapy.3 The Alzheimer’s patient is not as fortunate.

Alzheimer’s sufferers can look forward to a descent into darkness and probable poverty, as the most hope available to them is a slowdown of the disease’s ravages with no prospect of a cure. As their need for supplemental care grows, their family members are often left without options; in-home care is prohibitively expensive and nursing-home care even more so. The diversity in access to healthcare for people suffering from diseases with accepted treatment programs compared with sufferers of incurable but treatable diseases such as dementia is a problem that has been largely ignored in this country. Cancer patients receive substantially superior treatment than Alzheimer’s patients do from within our health-care system, largely because we have a better understanding of their disease.4

* Meredith Leigh studies law at Drake University Law School.
3. Id.
4. Id.
Elder Law Attorneys and other advocates for the elderly need to push for reforms of insurance and Medicare to provide ample coverage for dementia sufferers. Insurance and Medicare must be forced to appropriately re-structure the system to provide comparable and adequate care to Alzheimer’s patients, as it does for cancer patients.

Alzheimer’s disease is considered treatable incurable. While there are a variety of methods available to stem the progress of the disease, there is, at present, no way to stop the progression.5 In the United States, $100 billion dollars are spent per year in medical and custodial expenses on Alzheimer’s patients.6 The average annual cost of caring for an Alzheimer’s patient is between $27,000 and $47,000.7 Considering that two to four million people are afflicted, the amount of money being spent on Alzheimer’s per year is staggering.8 And it’s only going to get worse.

As people age, the likelihood of developing Alzheimer’s disease increases dramatically.9 For every five years after age sixty-five, the prevalence of Alzheimer’s disease doubles and Americans’ life expectancy only continues to grow.10 In the year 2000, it was projected that 72,000 people would live into their second century.11 By 2010, that number will rise to 131,000.12 By 2050, almost a million people — 834,000 — will live to be over 100 years old.13

These statistics mean that Alzheimer’s disease is only going to become more prevalent. As the baby boomer generation ages, the number of elderly in America will grow exponentially. With an increase in the geriatric population, there will be a coinciding increase in the cases of Alzheimer’s.14 The American people are heading straight into an Alzheimer’s health-care crisis.

Although Alzheimer’s is eventually fatal, death occurs an average of eight to ten years after diagnosis.15 That means the caregiver for an Alzheimer’s patient who spends the minimum average of $27,000 for the low-end estimation of eight years will run a tab for that disease of $216,000.16 Using the higher end numbers, the total nears a half-million dollars. The median income of households in the U.S. in the year 2000

---

5. Interview with Carol Sipfle, Executive Director, Greater Iowa Chapter Alzheimer’s Association (Nov. 16, 2005).
7. Mayo Clinic Health Information, Mayo Clinic on Alzheimer’s Disease 7 (2002).
8. Id. at 6.
9. Id.
10. Id.
11. Id.
12. Id.
13. Id.
14. Id. at 7.
15. Id. at 27.
16. Id.
was $41,990.  

If a family member of one of these median households got an Alzheimer’s diagnosis, the family could expect to spend more than half of its annual income on the care and treatment of that one individual.

Perhaps even more problematic, this money is being spent with no prospect for a cure.  The treatments costing so much money are utilized to either minimize symptoms of the disease, slow down the onset of those symptoms, or merely keep the Alzheimer’s patient functioning at the highest level still available to them. Few people envision, nor are they prepared for, bankrupting themselves in their later years to pay someone to take care of the daily tasks once done so easily.

The money numbers shouldn’t necessarily be shocking, because we are led to believe that the government has programs in place to deal with the myriad health issues of the elderly; that’s what Medicare is for and we expect it to fulfill its promises. A caregiver can theoretically use the elderly patient’s Social Security to supplement costs associated with their care. If the patient is lucky enough to have private insurance, then the financial problem should be virtually nonexistent.

It’s not. Treatments associated with Alzheimer’s don’t fall into the neat categories the government authorizes Medicare to cover. Since there is no cure for Alzheimer’s, its patients can’t capitalize on constructive treatments like chemotherapy or radiation that Medicare covers the bulk of the cost of for cancer patients. There are a handful of prescription drugs associated with the treatment of Alzheimer’s, but the bulk of the expense comes from monitoring an Alzheimer’s patient twenty-four hours a day, seven days a week.

The bills from in-home nursing care, or a full-time nursing home, are not within the financial reach of most American families, and yet Medicare covers none of these treatments. By the year 2020, there will be an estimated 12.3 million people over the age of sixty-five, who are “mildly to severely” disabled, and require some assistance to perform regular, day-to-day activities. However, assistance is not provided under Medicare for those who are only “mildly to severely” disabled. The simple day-to-day supervision that is required by Alzheimer’s patients is left to friends and family members to manage by themselves, when these friends and family are, quite often, elderly and disabled themselves.

20. Medicare, supra n. 2.
21. Interview with Carol Sipfle, Executive Director, Greater Iowa Chapter Alzheimer’s Association (November 16, 2005).
22. Id. at 228.
23. Alzheimer’s Disease Education & Referral (ADEAR) Center, supra n. 17.
Healthcare continues to be a huge campaign issue in this country, mostly because everyone knows there is a problem, but no one has a feasible solution. Former president Bill Clinton relied on healthcare reform as his platform for two successful presidential campaigns. And yet in 2000, at the end of his presidency, we were arguably no closer to a solution to the health-care crisis than we were at the beginning of it. If anything, we were even further from a solution because of all of the funds that had been mismanaged in an attempt to pass significant healthcare reform.

While there aren’t any perfect solutions, better solutions than the one currently in place do exist. Elder Law attorneys have it within their power to find a way and advocate for adequate coverage for the millions of Alzheimer’s sufferers and their caretakers. The legal community cannot continue to allow the disparate treatment of degenerative diseases to continue; financial ruin should not be yet another side effect of Alzheimer’s.

Most Americans are on a first-name basis with Alzheimer’s Disease. Plaques and tangles form in the brain, resulting first in memory loss. Many people mistakenly identify the early symptoms of Alzheimer’s as simple side effects of aging. However, the memory loss is merely the first step in a long downward spiral. Eventually, as the plaques and tangles overtake the brain, the Alzheimer’s sufferer’s personality changes: the patient becomes hostile where before they were passive; they fail to recognize those that were once most dear to them; they become increasingly disoriented by their surroundings and grow unable to recognize where they are.

While no genetic link has been isolated as the cause of Alzheimer’s, the ApoE4 gene is linked to 60% of late-onset Alzheimer’s cases. In addition, a variety of hormones and vitamins have been associated with the onset and progression of Alzheimer’s. Estrogen was promoted in 1997 as a possible hormonal therapy that could delay the onset of Alzheimer’s, but further research demonstrated that no definitive link could be ascertained. Vitamin E was shown to delay progression of the disease in a study published in the *New England Journal of Medicine*. Ginkgo, the Asian memory-loss preventative has also been shown to have small effects on Alzheimer’s patients.

Symptoms may vary from person to person, but common side effects associated with dementia include: severe memory loss, confusion, inability to form abstract thoughts, inability to concentrate, struggling with complex or routine tasks, personality

25. *Id.* at 12.
28. Mayo Clinic Health Information, *supra* n. 6, at 35.
29. Dean, *supra* n.1, at 27.
30. Mayo Clinic Health Information, *supra* n. 6 at 27.
31. *Id.* at 84.
32. *Id.* at 85.
changes, and paranoia. These changes tend to increase in severity as the plaques and tangles take over more and more brain space.

As the disease progresses, the physical side effects become increasingly pronounced. If the Alzheimer’s patient has not already succumbed to a different disease, muscle stiffness, incontinence, labored breathing and eventual inability to walk will set in as the disease runs its full course.

Although there is no cure, one can hardly fault the researchers. A variety of treatments are being explored, including a vaccine. News about a promising vaccine tested on monkeys was published in the 2004 issue of *Alzheimer’s Disease and Associated Disorders*. Unfortunately, the first human trials led to brain inflammation, causing researchers to stop the study, but the discovery that monkey brains are substantially similar to human brains and can be used to test positive treatments was, in and of itself, a promising sign.

While all of these alternative treatments are being posited and tested, the two to four million Alzheimer’s sufferers in the U.S. continue to deteriorate and die with inadequate coverage from Medicare and private insurance because their illness does not fall into the conventional disease paradigm created by society. Until the early nineties, Medicare and Medicaid were allowed not only to neglect treatment of Alzheimer’s patients, but also to disregard the associated side effects. In other words, if a patient was depressed because of their diagnosis of Alzheimer’s, Medicare did not cover the care of the Alzheimer’s patient and did not cover the treatment required for the depression because it stemmed from the uncovered disease.

In 1993, the Superior Court of New Jersey held that it was impermissible to deny coverage of psychiatric care if the origin of the psychiatric problem was another disease, such as Alzheimer’s. Previously, the state health commission had been able to deny coverage for care on the basis of causation of the problem. Thus, since Alzheimer’s was an incurable disease, money spent on a “cure” would not be covered since no cure had been approved. This antiquated approach failed to account for the myriad other afflictions that accompany Alzheimer’s disease and allowed insurance companies and government health care programs to deny legitimate claims for accepted treatments on the basis that the true root of the problem was incurable.

Heaton effectively changed New Jersey’s status quo by mandating that health care coverage must be comprehensive, regardless of whether another origin existed for the problem. Unfortunately, this ruling had limited effect as many Medicare service

33. Mayo Clinic Health Information, *supra* n. 6 at 27.
34. *Id.*
35. Consumer Health Interactive, *supra* n. 18, at 221.
37. *Id.*
39. *Id.*
40. *Id.*
41. *Id.*
providers continue to believe that it is legal to deny individuals who are “chronic and stable,” such as Alzheimer’s patients, because the individuals will not recover. Until the accurate understanding of the holding is more widely known, the law will not be used to its full potential. Considering that over 70% of people with Alzheimer’s have at least one other medical condition, this ruling was a huge step towards bridging the financial chasm between expenses associated with Alzheimer’s and what the average American can actually afford. The Medicare community needs to be informed so that the ruling can be fully put into effect.

The ruling in Heaton was undeniably progress, but it remains a far cry from solving the financial woes of the Alzheimer’s community. The astronomical costs associated with caring for an Alzheimer’s patient are still a very present reality for the average caretaker.

Carol Sipfle, executive director of the Greater Iowa Chapter of the Alzheimer’s Association, says that as it is now, Medicare isn’t much use to Alzheimer’s sufferers in providing coverage for their Alzheimer’s because there are so few accepted treatments. Rather, the bulk of the costs that are associated with the disease come from the non-stop treatment that is required near the end stages. Even if the patient is functioning lucidly the bulk of the time, that is of little practical good, because it is impossible to predict when a spell will happen. While on Sunday the patient might be eating, dressed, and ready to go when their ride comes for church, the next day may be an entirely different story. It is true that the patient will remain within a certain range of behavior, but it is impossible to know when they will fall one more step behind, or when the descent will go even further.

This unpredictability leads to the need for constant monitoring. An Alzheimer’s patient cannot be left alone for days on end, because it is impossible to tell if they’ll be all right. For those patients without a family member willing to sacrifice a significant amount of their free time, the patient is in desperate need of a home health aide; a home health aide that Medicare won’t provide for unless a doctor prescribes skilled nursing, or you qualify as “homebound” and need skilled nursing care. A doctor is unlikely to prescribe nursing care for someone who simply needs some help with cooking or a reminder that they need to change their shirt, and yet that is exactly the

42. Medicare Advocacy, Medicare for People with Alzheimer’s Disease and Other Chronic Conditions, http://www.medicareadvocacy.org/ArchivedPages/Chronic_Alzheimers.htm (March 28, 2005).
44. Interview with Carol Sipfle, Executive Director, Greater Iowa Chapter Alzheimer’s Association (November 16, 2005).
45. Id.
kind of help that would keep an Alzheimer’s patient out of full-time nursing care longer.

In “Alzheimer’s and the Medicare Mirage,” Chris Woolston writes that the current Medicare rules fail when they refuse to acknowledge that most Alzheimer’s patients in the early stages of the disease don’t need full-time nursing care, but rather a home health aide who can help them with the day-to-day tasks that are becoming more difficult as the disease takes hold of their body.47 “Homebound” is a state not usually achieved until the very end stages of the disease, leaving the patients who are just beginning their struggles out in the cold.48 Alzheimer’s patients receive coverage for their doctors’ visits, physical therapy, if that is found to be “reasonable and necessary,” and little else.49

The author of “Choosing the Right Long-Term Health Insurance,” Ben Lipson, says:

“Many people grossly overestimate the benefits of Medicare until they have access to it. We have 27 million informal caregivers in this country.”50 We have that many informal caregivers because Alzheimer’s patients have not budgeted for the overwhelming expense in their later years, and informal caregiving is pretty much the only option available to people too poor to afford round-the-clock care.51 “Poor” in this instance includes most of America’s working middle-class.

Alzheimer’s disease was found in a 1994 report to be the third most expensive disease in the United States, trailing only heart disease and cancer.52 By 2010, Medicare will be spending $49.3 billion on treatment for patients with Alzheimer’s disease, but their level of care will still significantly trail that of cancer patients because the Alzheimer’s patients won’t be getting the treatment they require.53 It is not the fault of the Alzheimer’s patient that their care is unquantifiable; they still deserve treatment and access to care that can help ease their burden, and that of their caretakers.

In 2004, $72.1 billion was spent on cancer care.54 Medicare spent an average of $24,200 for a colorectal cancer patient’s first-year of treatment.55 If screening for colorectal cancer were performed as recommended, that expense could be greatly reduced.56 Medicare already provides coverage for the screening test, so the solution lies in advocating that the target population actually have the screening done.57

47. Consumer Health Interactive, supra n. 18.
48. Id.
49. Id.
50. Id.
51. Id.
52. Dean, supra n. 1, at 27.
53. Id.
55. Id.
56. Id.
57. Id.
It is doubtful that a reduction in spending on only one type of cancer will free up enough excess funds in Medicare to make better Alzheimer’s treatment a reality. However, it is this sort of change that can help bring about the financial means for better Alzheimer’s treatment. “The treatment of elderly cancer patients places a substantial financing burden on Medicare,” say the authors of a study on the rising costs of cancer care as America’s population ages.58 Alleviating some of that burden by encouraging the elderly to get the screens that can catch cancer in its early stages and reduce the cost of treatment is one step in the right direction.

In addition, we must advocate increased awareness of Alzheimer’s symptoms, resulting in earlier diagnosis of the disease. Allowing the elderly to brush off forgetfulness as merely aging is a luxury we can’t afford; it is much easier to obtain a diagnosis and fight from there than it is to fight the diagnosis and then fight the disease. Discovering Alzheimer’s a mere six months earlier would mean a 65% decline in months of avoidable nursing home care, and a 48% decrease in unnecessary drug treatment.59 It would be a decided benefit to avoid that time and those treatments, and it would also translate to significant savings.

What can Elder Law attorneys do to bridge the gap between where Alzheimer’s care should be and where it is now? While it is up to the doctors to discover a cure, and up to lobbyists to procure more funding, it is up to lawyers to ensure that all geriatric diseases receive equal treatment under the law. The cancer patient is not entitled to better treatment simply because his or her disease has an accepted course of treatment with a more formalized payment plan.

At present, diseases with conventional treatment plans receive allocated funds from Medicare. A doctor makes the diagnosis, the appropriate treatment is prescribed, and Medicare or private insurance agrees to cover the bulk of the treatment cost because it is an approved method of treating an understood disease. While it is true that cure rates for cancer are far from 100%, they are vastly better than the current 0% for Alzheimer’s disease.

The news that care for Alzheimer’s isn’t going to be completely covered is news to many elderly. “Many seniors are surprised that, despite their Medicaid or Medicare coverage and/or Medicare supplement policies, they have virtually no nursing home or long-term care coverage,” says Bruce Radke in a 1993 article.60

The baby boomer generation grew up believing that Social Security and Medicare were well-established programs that would provide coverage in their advanced years. Instead, these programs are quickly approaching bankruptcy, or at the very least severe financial trouble. With that trouble can only come a corresponding drawback in services that are already scarce. In 1989, Medicare paid less than 2 percent of nursing-

59. Dean, supra n. 1, at 35.
home costs. In fact, according to Dr. David Himmelstein, “Unless you’re Bill Gates, you’re just one serious illness away from bankruptcy.”

Medicare and Medicaid are already falling far short of the demand for health care for the elderly in this country, especially in terms of chronic, degenerative diseases such as Alzheimer’s. Radke’s proposal says the solution lies in long-term-care insurance. Unfortunately, long-term-care insurance is a costly endeavor requiring not only anticipation of a chronic disease in the later years, but also expectation of one. While perhaps it is reasonable to expect people to enroll in these programs now, in the day and age of declining health-care coverage by the government, it is not likely to solve the problems of the current and upcoming populations of the elderly.

Long-term care insurance is certainly a possible future solution, but the concept wasn’t even introduced to the general public until the late 1970s. People in their seventies now were already in their mid-forties in the 1970s; the expensive option came too late for them. Additionally, it is nearly impossible to get a policy in place after an Alzheimer’s diagnosis; no insurance company is going to sign up to pay the bills after they’re sure you’re going to incur them. Radke’s proposal is a feasible future solution but does nothing to combat the current health care crisis facing America.

What should be happening with American healthcare is that a diagnosis of a degenerative terminal illness, such as Alzheimer’s, should be accompanied by a lump-sum payout from Medicare into a secure health-care account. This is not a perfect solution, either, but it would put the decision-making power back in the hands of the patient, rather than in the paperwork zoo associated with attempting to get medical expenses reimbursed. And while Medicare does not have the funds to pay out an amount that would adequately cover all of the costs of care associated with Alzheimer’s, the patient would be aware of what their financial limitation was from the very beginning, rather than erroneously relying on it for care and finding that the coverage comes up short in their dying days.

When a patient is diagnosed with Alzheimer’s, the doctor should be able to enter that diagnosis into a central software program. The patient’s name would come up along with a diagnosis and the associated budget. For ease of numbers, hypothetically there would be a cap of $1000 per month or a general cap of $12,000 annually, terminating upon death, but limited to no more than $100,000 over the course of the disease. The Alzheimer’s patient would then be in control of choosing what type of treatments they wish to finance. The difference between Alzheimer’s and a more straightforward disease is that there is no clear treatment program in place for the Alzheimer’s patient. The patient has a variety of treatment options available to them,

61. Id. at 229.
63. Radke, supra n. 59.
64. Id.
65. Id.
66. Dean, supra n. 1, at 221.
ranging from clinical studies to herbal remedies. Without the worry of which treatments Medicare will cover, the decision-making power would be wholly in the hands of the patient.

At what point a patient receives a diagnosis of Alzheimer’s greatly affects the course of the disease in the patient and how far along in the process they are. Many people receive their diagnosis and still have many good years left before the disease begins to ravage their brains. Others may start to decline noticeably after they receive their diagnosis; although they were declining before, their condition now has a label and cannot be denied. Regardless of the path the disease takes in the individual, all sufferers are entitled to a certain level of care that they currently aren’t receiving.

Because personal preferences are so varied, treatments that feel right for individuals also span a huge range. Some patients take herbal remedies, like ginkgo biloba and vitamin E. Others try the few prescription drugs available on the market. Still others might want to merely save their funds until the end and use the money for home hospice care or a full-time nursing home, both of which can erode financial stability with alarming speed.

Of course, this proposed solution is not without its flaws. Conservatives would likely be worried that the accountability is too lax, that allowing for a lump sum payment would lead to government fraud. In addition, Medicare is not free of financial problems as is; however, simply because Medicare is short on funds does not mean that patients who require care should be neglected. Alzheimer’s patients are being ignored under the present government set-up. We cannot allow that atrocity to continue with a weak argument that the government doesn’t have enough money to fix the situation; instead we must do a fiscal reconfiguring to find the extra funds to make it a possibility.

In addition, a lump-sum payment would allow capitalism to take hold in the healthcare market. Medicare patients would shop around for economical treatments and health-care if they were aware that their funds were limited. The market would respond to this newly aware consumer and some prices would be forced down through competition. Bringing the free market into a system currently plagued by expensive treatments can only be a good thing.

The lump sum payment would not simply be an amount of money without strings attached. Rather, the database would keep track of all patients diagnosed with Alzheimer’s. When a medical expense associated with the disease arose, the caregiver would be able to pay the bill from that account. The money would be required to go to a certified health organization: a full-time caregiver, nursing home, hospital, pharmacy, etc.

Liberals would likely argue that the establishment of a centralized database is too “Big Brother,” overly intrusive monitoring by the government. However, the sea of paperwork senior citizens must already wade through to get their Medicare benefits is no less a burden than this proposed plan. If Americans expect the government to help us with our problems then we must also provide them with the information necessary to step in and be of service. Simply writing a check upon diagnosis would be an open invitation to fraud; there must be some constraints involved and a centralized database would be the best way to alleviate the most concerns.
People will always find a way to circumvent the rules, but it is preferable that coverage for Alzheimer’s patients is provided with some funds slipping through the cracks rather than allowing all Alzheimer’s patients to be ignored by government healthcare programs which are still hemorrhaging funds. In addition, in 1998 Medicare lost approximately $12 billion, or $.07 on the dollar, to fraud. The system that we have in place is failing.

While it is true that an open funding system wouldn’t eliminate Medicare fraud, it would encourage the Medicare consumer to increase vigilance over their bills. A patient or a patient’s caretaker who knew they had a limited allotment for treatment would be much more likely to spot-check the bills for overpayment than one who was confident in his or her belief that the government would pick up the tab regardless of the cost. Until we force it to be a priority, it won’t be.

Despite Alzheimer’s near-epidemic proportions among the elderly and the tragedy of the disease, Americans should not be without hope. While researchers are still years or even decades away from finding a cure for Alzheimer’s disease, there does not have to be a continuing legacy of bankruptcy intertwined with its physical ravages. Instead, Americans should be confident that the government will help to provide significant healthcare for them in their twilight years. With strong advocates arguing for and effecting health-care reform, their confidence won’t be misplaced.