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Government, Law and Policy Journal

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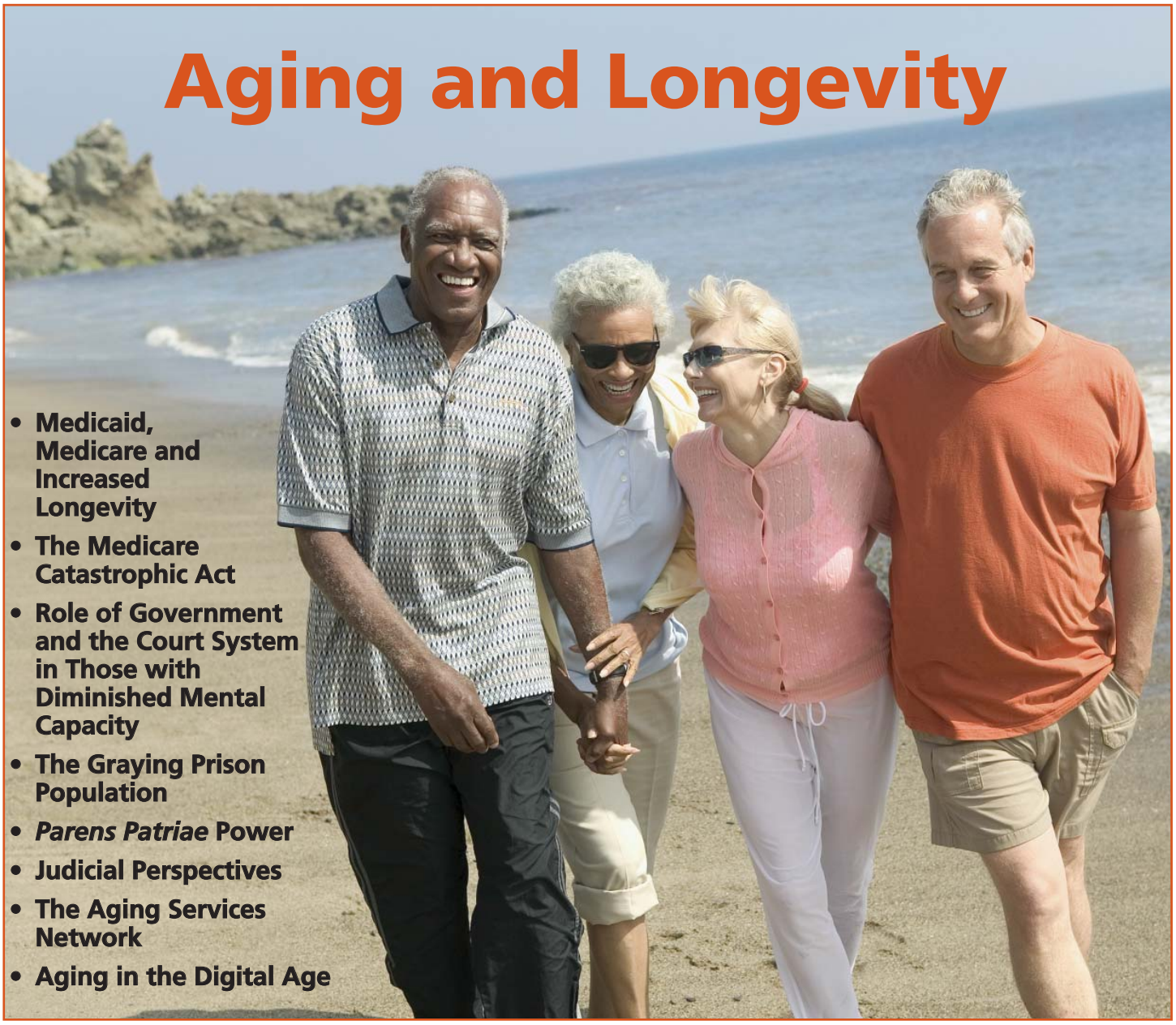
Aging and Longevity



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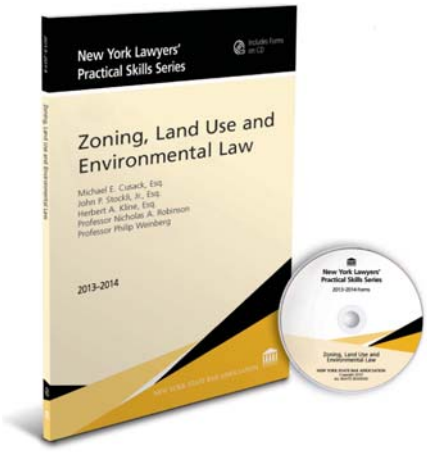

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Editor's Foreword

By Rose Mary Bailly

"Old is always fifteen years from now."

—Bill Cosby

Even if we think we are not old yet, the United States Administration on Aging may. It has adopted age 65 as a milestone in aging and reports that in 2012, the population of Americans 65 years or older numbered 43.1 million, representing about 13.7% of the population and that within this older population the number of people aged 85 and older is rising.[1] In New York, the population of individuals 65 or older in 2012 represented 14.1% of the population.[2] New York ranks in the top four states with the highest number of older adults, tying Texas with 2.7 million people age 65 and older.[3]

The longevity of the citizens of this state and nation presents significant public policy choices as well as individual concerns about health care, housing, retirement, support services, and long-term care, to name just a few of the issues facing older adults and their families. Robert "Bob" Abrams, Esq., co-founder and an executive partner at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP, is a nationally recognized expert in Health and Elder Law, and is passionate about the opportunities, challenges and consequences which face our aging population. Bob enthusiastically agreed to be the Guest Editor for this issue of the *Journal,* devoted to the topic of aging and longevity, in order to start us thinking about these choices and concerns. We are grateful to Bob and the authors he brought together to help us understand what is on the horizon for all of us, Millennials, GenXers, and Baby Boomers, all together.

Bob Abrams introduces us to the subject of aging and longevity with a history lesson. Beginning with visions of health care for our nation's older citizens articulated by Presidents Harry S. Truman and Lyndon Johnson, Bob's article, *Medicaid, Medicare and Increased Longevity* examines how Medicare and Medicaid, two programs which provide assistance with health care costs, fall short in addressing the long-term care needs of older adults. He questions what the future of health care should be. Hoping that we will learn from past public policy decisions, Richard Alterbaum reviews how public policy can be developed and then undone in his article, *The Rise and Fall of the Medicare Catastrophic Coverage Act*, which traces the rise and rapid demise of this federal legislation.

In *Aging Up the River: Law and Policy Challenges Facing America's Graying Prison Population*, Benjamin Pomerance examines the multifaceted policy problem engaging states across the country of how to treat a population that society has condemned to live out their older years behind bars.

"The longevity of the citizens of this state and nation presents significant public policy choices as well as individual concerns about health care, housing, retirement, support services, and long-term care, to name just a few of the issues facing older adults and their families."

Adults are generally presumed to be competent under the law with the legal right to make decisions on all matters affecting their personal well-being. Everyone values their autonomy—just ask the holder of a newly minted driver's license if he or she is ready to drive. Unfortunately and inevitably, many individuals will face issues regarding the exercise of their autonomy as they age. If an individual's decision-making capacity is impaired by some physical or mental condition, a question arises as to whether the individual's autonomy must be curbed, to protect either the older individual or others. Robert Cannon and Lauren Numeroff show us how New York is addressing that potential loss of autonomy in their respective articles, *Perspectives on the Role of Government and the Court System in Addressing the Legal Needs of Individuals with Diminished Mental Capacity*, and *Parens Patriae Power: the Court's Role in Addressing the Fragility of Capacity*. From the Bench, Judges Tanya R. Kennedy and Arthur M. Diamond offer their perspectives on diminished capacity.

Greg Olsen bridges the divide between policy and personal issues in his article *The Valuable Role of the Aging Services Network,* which examines how New York's State Office for the Aging serves older adults in New York through its public and private partnerships.

Finally, Christine Julien reminds us in *Aging in the Digital Age* that as people are living longer, new, innovative technologies are putting things at their fingertips in ways never before imagined and describes how these technologies can serve and support older adults.

I would like to especially thank our Executive Editor for 2013-2014, Kathleen Rivers, Albany Law School, Class of 2014, for her professionalism, enthusiasm and patience. She and her Albany Law School colleagues, Cameron Betterley, Kelly Hendricken, Sean Moran, Jamie VanDenburgh, and Christopher Scoville, Class of 2014, and Alexander Cooper and Benjamin Novogroski, Class of 2015, also deserve thanks for their forbearance in putting this issue together. My thanks also to the staff of the New York State Bar Association, Dan McMahon, Pat Wood, Megan O'Toole, Wendy Harbour, and Lyn Curtis, for their help, expertise and most especially their patience. My thanks to the Government Law Center's new Executive Director, Ray Brescia, and last, my thanks to Patty Salkin, now Dean of Touro Law Center, for her continuing inspiration.

Finally, I take full responsibility for any flaws, mistakes, oversights or shortcomings in these pages. The errors are entirely my own. Your comments and suggestions are always welcome at rbail@albanylaw.edu or at Government Law Center, 80 New Scotland Avenue, Albany, New York 12208.

Endnotes

1. The Older Population (The Administration in Aging), available at http://www.aoa.gov/Aging_Statistics/Profile/2013/3.aspx; Why Population Aging Matters: A Global Perspective (National Institute on Aging), available at http://www.nia.nih.gov/health/publication/why-population-aging-matters-global-perspective/trend-3-rising-numbers-oldest-old.
2. New York State and County Quick Facts, available at http://quickfacts.census.gov/qfd/states/36000.html.
3. A Profile of Older Americans 2012 6 (Administration on Aging), available at http://www.aoa.gov/Aging_Statistics/Profile/2012/docs/2012profile.pdf.

Medicaid, Medicare and Increased Longevity

By Robert Abrams

We Americans think of ourselves as a nation that cares about our fellow human beings, especially our family members, other loved ones and our neighbors. We claim to be particularly concerned with our older relatives: our parents, grandparents, aunts, uncles and—as we all get older and live longer—ourselves and our children.

"Although a half century has passed since the initial passage and implementation of the Medicare and Medicaid programs,… we have done little to plan for the increased longevity of older Americans and the personal, familial, health care and financial challenges that accompany increased longevity."

Our concern for older Americans was eloquently articulated almost fifty years ago when President Lyndon Baines Johnson announced the passage of Medicare and former President Harry S. Truman discussed the need for Medicaid:

President Lyndon Baines Johnson:

> No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their late years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this prosperous country.[1]

President Harry S. Truman:

> Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection.[2]

There were approximately 18 million Americans over the age of 65 when President Johnson introduced Medicare;[3] today there are over 40 million Americans who are at least 65 years of age[4] and more than 100 million Americans who are 50 years of age and older.[5]

When President Harry S. Truman made the above remarks, he probably did not consider increased longevity and the number of older citizens who would require Medicaid protection, nor could he have foreseen the significant impact of the *Olmstead* decision[6] regarding the way in which we provide for the health care, shelter, and personal needs of the elderly and individuals with disabilities.

Moreover, life expectancy in 1965 was 67 years for men and 73 years for women, which meant that male Medicare beneficiaries would require approximately 2 years of coverage and female Medicare beneficiaries would require approximately 8 years of coverage.[7] Today, Americans who are 65 years of age or older can expect to live until age 85 and, accordingly, many may be entitled to approximately 20 years of Medicare benefits.[8]

Although a half century has passed since the initial passage and implementation of the Medicare and Medicaid programs, and notwithstanding our individual and collective love for the "elders" among us, we have done little to plan for the increased longevity of older Americans and the personal, familial, health care and financial challenges that accompany increased longevity. Our leaders in state and federal governments have failed to establish a sound and sustainable long-term care policy and such procrastination has and will continue to have disastrous individual and societal consequences.

Some, for example, argue that Medicaid, a program designed to provide health care coverage for individuals with minimal income and assets, has become, by default, our nation's *de facto* long-term care program. By circumstance or design, many older persons attempt to comply with Medicaid's stringent financial eligibility requirements[9] to ensure that they can access, and have Medicaid pay for, the costly medical and personal care they require (or may require in the future). With increased age often comes three or more chronic health care conditions,[10] reliance on five or more prescription medications,[11] multiple visits to the hospital emergency room,[12] hospital admissions due to acute health care episodes[13] and short or

long-term placement in a rehabilitation facility or nursing home.[14]

Medicaid, a joint federal and state program, covers the above referenced services for eligible individuals. Unfortunately, due to the absence of a viable long-term care plan, Medicaid has been a particular drain on our nation's economy, and on state budgets in particular.

Moreover, due to a variety of reasons, including the absence of a national long-term care plan, informed Americans, whose income and assets may minimally and, in some cases, significantly exceed the Medicaid eligibility requirements, engage in "Medicaid planning" to accelerate their Medicaid eligibility.[15] Such planning is legal[16] and may involve the transfer of assets, creation of Medicaid-approved trusts, spousal refusals, the use of promissory notes and/or other sophisticated strategies.[17] Such planning options often require the assistance of a knowledgeable and experienced attorney and can be quite expensive. It is indeed ironic that potential Medicaid beneficiaries must spend thousands of dollars to qualify for a program designed for individuals with minimal financial resources and income.

Unlike Medicaid, almost all of America's seniors are eligible for Medicare. However, notwithstanding President Johnson's vision that Medicare would pay for home care and nursing home care, Medicare's administrators have spent the last five decades attempting to limit such coverage. In recognition of the lack of Medicare coverage for long-term care, several attempts have been made to pass laws that would expand Medicare coverage. Unfortunately, most such attempts have ultimately failed, including the Medicare Catastrophic Coverage Act in 1990.[18]

While legislative attempts have generally been unsuccessful, advocates have commenced and successfully litigated cases against the federal government to clarify the scope of Medicare services. As a result, over the past several years, there has been an increase in Medicare coverage for home care, nursing home and therapeutic services. Needless to say, however, further expansion and clarification is necessary.

Regardless of the original intent of the Medicare and Medicaid programs, it is clear that tens of millions of older Americans rely on one or both of these programs. Such reliance has resulted in significant public expenditures. The following statistics illustrate some of the costs associated with Medicare and Medicaid:

- The total health care-related costs for individuals who are 65 years of age or older is approximately One Trillion One Hundred Eighty-Six Billion Dollars ($1,186,000,000,000).[19] Medicare, which provides at least partial health care coverage for almost all American citizens who are 65 years of age or older, pays approximately 45% of these costs, a total of Five Hundred Twenty-Nine Billion Dollars ($529,000,000,000).[20]
- Medicare beneficiaries receive significant benefits but must make certain premiums, co-insurance and/or deductible payments. The average Medicare beneficiary contributes approximately $4,500 toward the cost of his or her Medicare coverage.[21]
- The greatest expenditure on health care costs is during the last six months of life when approximately $22,407 is spent per Medicare beneficiary.[22]
- The total current health care expenditures for individuals 85 years of age or older is One Hundred Ninety Billion Four Hundred Sixty-Five Million Dollars ($190,465,000,000).[23]
- Medicaid contributes approximately One Hundred Thirty-One Billion Dollars ($131,000,000,000) toward the health care costs incurred by Medicaid beneficiaries.[24]
- Approximately five million Americans have Alzheimer's type dementia.[25] According to a recent RAND corporation study, each case of dementia costs $41,000 to $56,000 a year and the total costs of dementia in 2010 were between $159 billion dollars and $215 billion. The Alzheimer's Association estimates that the total cost of dementia cases may exceed one trillion dollars by the year 2050.[26]
- Given that there are currently 5,700,000 Americans who are at least 85 years of age[27] and this demographic is expected to more than double over the next 20 years,[28] we can expect health care costs for this group to experience a corresponding increase.
- The Department of Health and Human Services predicts that America's total health care expenditures for individuals 65 years of age and older will increase by 33% in the next two decades.[29] In other words, the health care costs incurred by older Americans places a heavy burden on America's current and future fiscal stability.

Suffice it to say, that our federal and state governments, through both the Medicare and Medicaid programs, have and will continue to commit substantial money and resources to providing varying levels of health care and personal care to older Americans.

With at least hundreds of billions of dollars at stake, as well as the future of America, it's clearly time for our nation to evaluate if these funds would be better invested in a coordinated long-term care delivery system, rather than to rely principally on two fifty-year-old programs that were not designed to address the unprecedented and accelerated longevity of our older—but not necessarily

old—citizens. Maybe it is also time to revisit each citizen's responsibility to participate in long-term care planning, rather than face the responsibility of paying thousands of dollars toward Medicare premiums, co-payments and deductibles and other out-of-pocket expenses at a time when they may no longer be working and, therefore, have less income.

In closing, there is something bizarre, unsavory and inefficient about our current long-term care system; maybe we should celebrate the 50th anniversary of Medicare and Medicaid by creating an appropriate and efficient long-term care program.

Endnotes

1. Public Papers of the Presidents of the United States: Lyndon B. Johnson, 1965. Vol. II, entry 394, pp. 811-815. Washington, D.C.: Government Printing Office, 1966.
2. *Id.*
3. *Id.*
4. A Profile of Older Americans: 2012, Administration on Aging of the U.S. Department of Health and Human Services, at p. 2.
5. United States Census Bureau, 2012 National Projections, Middle Series.
6. *Olmstead v. L.C. ex re. Zimring*, 527 U.S. 581,604 (1999) (holding that the state could take into account available resources in determining whether patients, who qualified for community-based treatment, were entitled to immediate community placement). The *Olmstead* ruling stimulated federal guidelines for how states should comply with the Americans with Disabilities Act and spawned numerous lawsuits and complaints to the Department of Justice.
7. Committee on Ways and Means, 1998 Green Book, May 19, 1998, p. 1044.
8. Social Security Administration, Actuarial Life Table (2009).
9. Seniors & Medicare and Medicaid Enrollees (available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html).
10. Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, Congressional Budget Office (June 2013).
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*
15. *Matter of Shah*, 257 A.D.2d 275, 282-83, 694 N.Y.S.2d 82 (2d Dep't 1999) ("The complexities of the Medicaid eligibility rules, not to mention the complexities of State and Federal law concerning gift and estate taxation which often come in to play as hapless middle class Americans seek to save themselves from financial ruin as the result of astronomical nursing home costs, should never be allowed to blind us to the essential proposition that a man or a woman should normally have the absolute right to do anything that he or she wants to do with his or her assets, a right which includes the right to give those assets away to someone else for any reason or for no reason.").
16. *New York State Bar Association v. Reno*, No. 97-CV-1760 (N.D.N.Y., April 7, 1998).
17. *Matter of Shah*, 257 A.D.2d 275, 282-83, 694 N.Y.S.2d 82 (2d Dep't 1999).
18. T Rice, K Desmond and J Gabel, The Medicare Catastrophic Coverage Act: a post-mortem, *Health Affairs*, 9, no.3 (1990):75-87.
19. The hidden costs of U.S. health care: Consumer discretionary health care spending, Deloitte Center for Health Solutions (2012).
20. *Id.*
21. Kaiser Family Foundation, Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households: An Updated Analysis of Health Care Spending as a Share of Total Household Spending (Washington: The Kaiser Family Foundation, March 2012).
22. Amy S. Kelley, Susan L. Ettner, R. Sean Morrison, Qingling Du, Neil S. Wenger, and Catherine A. Sarkisian. Determinants of Medical Expenditures in the Last 6 Months of Life. *Ann Intern Med*, February 15, 2011.
23. Total Personal Health Care Spending by Gender and Age Group, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
24. Katherine Young, Rachel Garfield, MaryBeth Musumeci, Lisa Clemans-Cope, and Emily Lawton, Medicaid's Role for Dual Eligible Beneficiaries, The Kaiser Commission on Medicaid and the Uninsured (August 2013).
25. Hebert LE, Weuve J, Scherr PA, Evans DA, Alzheimer's disease in the United States (2010-2050), Neurology (2013).
26. Monetary Costs of Dementia in the United States, The New England Journal of Medicine, v. 368, no. 14, Apr. 2013, p. 1326-1334.
27. A Profile of Older Americans: 2012, Administration on Aging of the U.S. Department of Health and Human Services, at p. 2.
28. *Id.*
29. *Id.*

Robert Abrams (Bob) is the co-founder and an executive partner at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP, a law firm located in Lake Success, New York, with locations in Brooklyn, Manhattan and Rochester. He created the Aging and Longevity Law Institute ("ALLI") for the Touro Law Center. Bob served as the chair of the Health Law and Elder Law sections of the New York State Bar Association. Michael Zacharias, Summer Clerk from the Touro Law Center, assisted in the preparation of this article.

The Rise and Fall of the Medicare Catastrophic Coverage Act

By Richard Alterbaum

The Medicare Catastrophic Coverage Act (MCCA) was the most major expansion of Medicare, the federal government-run health insurance program designed for Americans over age 65, since the passage of Medicare Parts A and B in 1965. Among other things, the MCCA sought to place a cap on out-of-pocket spending for hospital and physician services and cover prescription drugs for seniors. The MCCA was passed by a margin of 328 to 72 in the U.S. House of Representatives and 86 to 11 in the Senate with sweeping bipartisan majorities and on July 1, 1988, was signed into law by President Ronald Reagan. Yet on December 13, 1989, President George H.W. Bush, Reagan's successor, formally repealed the law after the Senate and House voted overwhelmingly in opposition to its provisions.

This report will utilize a polity-centered analysis to describe how such a dramatic shift occurred over a relatively short period of time. This approach takes into consideration every factor that may shape or influence a major change in a policy, including the impact of prior policies, the role of political actors and institutions, democratic and electoral processes, administrative capacity, and the effect of interest groups and lobbies. The polity-based framework will be used first to examine in detail all of the forces that led to the passage of the MCCA and helped shape its structure, with emphasis on the influence of Medicare Parts A and B, individuals such as Otis Bowen and Ronald Reagan, Congressional debates on the matter, and interest groups such as the American Association for Retired Persons (AARP). Then, in a similar fashion, it will account for why the MCCA was repealed, highlighting in particular the structural flaws in the law such as its controversial financing mechanism and the role of organizations like the National Committee to Preserve Social Security and Medicare. Finally, based on this analysis, this report will assess the legacy of the MCCA and relate it to policies that arose after its repeal, including Medicare Part D as well as the Patient Protection and Affordable Care Act (PPACA).

A Polity-Centered Analysis of the Passage of the Medicare Catastrophic Coverage Act (MCCA)

Prior Policies: To gain a full understanding of the MCCA utilizing a polity-centered approach, one must first grasp the nature of the policy environment when the MCCA was passed. In particular, the origins of the MCCA date back to the passage of Medicare Parts A and B in 1965. Prior to 1965, health insurance had become unaffordable to most seniors due in large part to the increasing prevalence of experience rating, whereby private insurers would discriminate against beneficiaries and calculate premiums on the basis of their relative risk and characteristics such as age and health status, as opposed to community rating, in which all policyholders in a certain group or region pay the same rate. As a result, by the mid-1960s, only around one half of seniors, who were generally sicker than the rest of the population, had any form of health insurance to help them cover the cost of their medical bills.

"The MCCA was passed…with sweeping bipartisan majorities and on July 1, 1988, was signed into a law by President Ronald Reagan. Yet on December 13, 1989, President George H.W. Bush,… formally repealed the law after the Senate and House voted overwhelmingly in opposition to its provisions."

After years of debate and deliberation, two key proposals developed to aid this uninsured group: the King-Anderson bill, a politically liberal piece of legislation which covered the costs of hospitalization for the elderly and was financed as a universal social insurance program, and a conservative counterproposal resembling private insurance, in which policyholders pay voluntary premiums in return for physician services and, originally, prescription drugs. With the support of President Lyndon Johnson, Representative Wilbur Mills (D-AK), Chairman of the House Ways and Means Committee, combined the two ideas into one bill, HR 6675, and they would ultimately serve as the bases for Medicare Parts A and B, respectively. However, Mills and the Congress dropped Part B prescription drug coverage on the grounds that

such care was too expensive and suspect to unpredictable costs, especially in addition to hospital inpatient cost coverage, which was the main focus of the bill for lawmakers and was the central priority at the time for seniors. Nor did HR 6675 include catastrophic coverage or a cap on out-of-pocket costs.

Over the next several decades, successive Congresses and presidential administrations made a number of significant changes to the Medicare program. Among these included the creation by the Carter Administration of the Health Care Financing Administration (HCFA) to administer the Medicare and Medicaid programs, a task previously performed by the Social Security Administration. This organizational shift served as an acknowledgement of the growing enrollment in Medicare and Medicaid and their increasing importance and impact on the health care landscape. Indeed, by 1985, there were approximately 31 million Medicare beneficiaries in America. Therefore, HCFA was established as the need arose for an independent, stand-alone agency to administer and manage health insurance and benefits for millions of Americans. Also, the change was implemented as a means to reduce the administrative costs of Medicare and Medicaid. During the MCCA debate itself, the HCFA helped estimate the costs that the new law imposed and recommended the amount of premium increases necessary for its financing.

Other alterations to Medicare during this time included coverage expansions to include individuals below 65 with permanent disabilities and such ailments as end-stage renal disease; the establishment of the Medicare prospective hospital payment system based on case-based diagnosis-related groups as opposed to cost-based reimbursement; and numerous efforts at Medicare cost containment as government health care spending rapidly rose. However, despite a 1969 task force advocating for the measure, Medicare still did not cover outpatient prescription drugs, nor did it feature a limit on patients' out-of-pocket spending or catastrophic coverage protection. Instead, Medigap supplemental insurance policies arose in response to coverage gaps pertaining to service and cost-sharing. They began to receive federal oversight in 1980 with the passage of the Social Security Disability Amendments of 1980, also known as the "Baucus Amendments." These amendments mandated that Medigap policies return 75% of aggregate premiums to beneficiaries of group insurance policies in the form of benefits and 60% to beneficiaries of individual policies. They also created a voluntary certification option for Medigap insurer. This was the state of Medicare when the MCCA episode occurred in the late 1980s.

Key Political Actors: One of the major actors involved in developing the MCCA was Otis Bowen (R-ID), a physician and Governor from Indiana from 1973-1981 who, in November 1985, was appointed by President Ronald Reagan as secretary for Health and Human Services (HHS), a position that entailed overseeing the HCFA and the administration of Medicare. In 1986, a commission headed by Bowen released a report that detailed solutions to close gaps pertaining to Medicare acute care coverage, the most notable of which was a lack of a benefit to aid seniors who faced catastrophic medical expenses. With assistance from his chief of staff, Thomas Burke, Bowen crafted a proposal to set a $2,000 out-of-pocket limit on Medicare beneficiaries per year financed by a rise in the Medicare Part B premium by $4.92 per month, or $59 per year. Medicare would only pay for 20 percent of approved physician bills and would require a $500 beneficiary deductible for up to two hospitalizations until the cap was reached, after which this program would cover all hospital and physician-related costs. Bowen had a personal stake in this matter—in 1981, his wife, Beth, faced a catastrophic illness, bone marrow cancer, and passed away. Furthermore, out-of-pocket costs were rising dramatically; from 1980-1985, they had increased for seniors by 49% for hospital care and 31% for outpatient and physician services. This was a result, in part, of skyrocketing health care costs for the economy as a whole, increasingly expensive treatments, technology, and health care administration, and a lack of government regulation following the erosion of the Nixon administration's wage and price controls during the 1970s. Also, the aforementioned Medigap supplemental policies were often inadequate or contained high administrative costs, and in real terms the elderly were paying as much out-of-pocket in 1985 as they had in 1965, when Medicare was enacted. For personal and policy-related reasons then, Bowen became an impassioned advocate for catastrophic coverage as HHS Secretary and Reagan's point person on this policy.

The second major political actor involved in the passage of the MCCA was President Reagan himself. In 1961, Reagan, once a New Deal-supporting Democrat who shifted over time to become a conservative small-government Republican, had recorded an LP on behalf of the American Medical Association (AMA) in which he dramatically lambasted what would later become Medicare as a stepping stone toward socialized medicine and the extinction of individual freedom and liberty. And yet by his second-term in office, Reagan had changed his perspective and supported the Bowen proposal under the condition that it would be self-financed by Medicare beneficiaries, as opposed to an increase in general taxes for the greater public, and not raise the budget deficit. The federal debt had swelled since the start of his tenure as president—by 1988, it stood at $2.8 trillion. In a radio address to the nation on February 14, 1987, Reagan argued that Medicare catastrophic coverage would provide "peace of mind for some 30 million older Americans" and "financial security" for the elderly. Reagan had genuinely come to recognize the importance of Medicare and viewed it

as an essential program worth saving, no less expanding, upon which millions depended for their health and well-being. Other more political factors also played into Reagan's change of heart. Reagan sought to use Medicare expansion as an issue to deflect attention away from the deepening Iran-Contra scandal, which was eroding his administration's integrity and appeal and even provoking calls for impeachment of the President. Indeed, from October 1986 to March 1987, Reagan's approval ratings had sunk from 63 percent to 43 percent, a 20 percent dive, according to Gallup. Additionally, Democrats had effectively criticized Reagan in the 1986 midterm elections for proposing a delay in the cost-of-living increases of Social Security. The President, as well as his vice president who was running to succeed him, George H.W. Bush, viewed the MCCA as a way to win favor amongst seniors and to display compassion, as opposed to the image of heartless cutters of programs for the needy and aged. Therefore, on May 19, 1987, Reagan introduced Secretary Bowen's initiative to the Congress.

Political Institutions—the Influence of Congress: The modest Bowen proposal underwent drastic changes as it was debated in Congress from the time of its introduction to its ultimate passage in July 1988. In particular, the size and scope of the policy expanded greatly, in large part owing to Congressional Democrats. Although they were not keen on its self-financing mechanism and were more preferential toward social insurance schemes, most Democrats supported any enlargement of the Medicare program. Furthermore, the party was newly empowered as a result of the 1986 midterm elections, in which it gained eight seats in the Senate and five additional seats in the House to add to its overwhelming majority. As a result, the Democrats sought to use their strengthened leverage to negotiate with President Reagan and shape domestic policy in a liberal fashion and pave the way for a greater government role in the provision of social services. At the same time, Republicans, who were weary of antagonizing politically active seniors, were willing to cooperate on this matter in a bipartisan fashion and were eager to support the President in acquiring a much-needed political victory.

The initial catalyst for changes to the Reagan bill was Congressman Claude Pepper (D-FL), then the chairman of the House Select Committee on Aging. At the time that the MCCA debate started, Pepper, along with Congressman Henry Waxman (D-CA), were attempting to enact long-term care legislation. Pepper threatened to attach his bill to the Reagan and Bowen proposal and would only be mollified if its benefit package, which he perceived as being too narrow, was expanded. However, Reagan would likely have vetoed a long-term care benefit, which would have amounted to approximately $20 billion per year. Instead, to appease Pepper, Congressmen Pete Stark (D-CA) and Bill Gradison (R-OH) reduced the out-of-pocket threshold in Reagan's bill from $2,000 to $1,700, made it cover services provided in skilled nursing facilities, and reduced the copayments and deductibles it required. During a Ways and Means Subcommittee Hearing, House liberals urged Stark and Gradison to make further expansions to the legislation, leading them to double its Medicare home health benefit and to add a requirement that states pay for all Medicare deductibles and copayments for seniors eligible for Medicaid. A similar debate in the House Energy and Commerce Committee's subcommittee on health and the environment culminated in further benefits for mammograms, respite care, and prevention of spousal impoverishment if the husband or wife of the Medicare beneficiary was institutionalized in a nursing home. The Congress eliminated the two hospitalizations requirement and used the bill to cover hospice care and home health care. It also created the Qualified Medicare Beneficiary (QMB) program, which expanded Medicaid's role in covering Medicare Part A and B premiums for seniors who were at a low income threshold and were consequently dual eligible. Finally, Speaker of the House Jim Wright (D-TX) endorsed a prescription drug benefit, despite the reservations of many Congressmen about the cost of doing so. The Senate, with the leadership of Finance Committee Chair Lloyd Bentsen (D-TX), agreed under the condition that this drug coverage would be used for catastrophic, not routine care. Pursuant to the new benefit, Medicare would cover 80% of all costs relating to the purchase and acquisition of drugs once the beneficiary met a $600 deductible. This was a recognition of the prevalence and importance of prescription drugs—from 1982 to 1993, usage of them increased from 4.7% to 5.6% of total health care spending in the United States.

The result of the myriad additions was a dramatic increase in the cost of the new Medicare benefit, estimated at $31 billion over the course of four years. As a result, the Reagan Administration's initial suggestion of an increase in the Part B Premium by $4.92 per month alone was insufficient to finance the bill. Congress altered the premium increase such that beneficiaries would initially pay an additional $4 per month in 1989, but this figure would progressively rise to $10.20 in 1993. Most controversially, wealthy seniors would face a progressive income-based surtax, which was capped at $800 for individuals who made around $45,000 per year and $1,600 for couples per year with a joint income of approximately $75,000 per year. Republicans in Congress were supportive of making Medicare means-tested and income-related on the grounds that Medicare crowded out private insurance for those who could afford it, so that benefits should be limited only to the neediest because it was inequitable for poorer individuals and the young to subsidize the elderly and affluent. Conversely, Democrats feared that these measures would weaken Medicare's universal benefit nature and financing structure and were also not

pleased with the scope of the additional costs. Indeed, the surtax and premium increases were placed on top of the numerous other expenses that the bill already imposed on seniors to access its new benefits, including a $560 hospital care deductible, a $75 Part B deductible with a 20% coinsurance until the established cap of $1,370 per year was reached, and a $600 deductible for the purchase of prescription drugs, with a 20% coinsurance for the purchase of all subsequent drugs. Nonetheless, Democrats would not let their concerns over greater cost-sharing prevent the most dramatic expansion of Medicare since its inception from occurring.

The Influence of Interest Groups: Another key reason for why the MCCA passed with such overwhelming support was that initially, the vast majority of interest groups and stakeholders in the debate over the MCCA were supportive or at least neutral toward the legislation. The American Hospital Association (AHA) encouraged the passage of the MCCA so long as its members would be adequately reimbursed under the new benefits. The AHA hoped that the bill would expand hospital coverage and consequently, the utilization of inpatient services under Medicare Part A. The AMA, which represented physicians and was adamantly against the passage of Medicare in 1965, did not vocally oppose the MCCA under the condition that the bill would not threaten the professional autonomy of the physician nor alter the traditional fee-for-service payment model. The Health Insurance Association of America, advocating for the insurance industry, remained neutral on the bill if it would not seriously threaten its provision of Medigap policies or introduce new regulations on its members. The National Association of Manufacturers supported the MCCA because it was self-financed, as opposed to being funded by an increase in payroll taxes, and that it could assist businesses that were providing Medicare supplementary health insurance to retirees. The pharmaceutical manufacturing industry was opposed to the legislation and launched a $3 million advertising campaign against it that only intensified after it was signed into law. This lobby feared that the new prescription drug benefit would begin with government purchase of drugs but culminate in cost control and pricing standards, which would erode its members' profits. However, other players involved in the provision of prescription drugs, such as the American Pharmaceutical Association and the Generic Pharmaceutical Industry Association, disagreed and took a less adversarial stance, recognizing that the new benefit would enhance the ability of seniors to purchase their products.

The final key interest group was the elderly, represented by such organizations as the National Council of Senior Citizens and particularly the American Association of Retired Persons (AARP). According to Horace Deets, then the executive director of the organization, the AARP strongly supported the gaps in coverage that the MCCA closed, the possibility of a reduction in out-of-pocket costs for seniors, and the new benefits that the legislation provided, including those relating to prescription drugs and spousal impoverishment. However, Deets believed that the bill should have had a broader funding base and not have been financed solely by seniors and that it ought to have possessed a long-term nursing home care benefit. The latter claim was also echoed by advocacy groups like the Villers Foundation, which in later years became known as Families USA. Despite its reservations, the AARP proved a constructive force and played a particularly prominent role in lobbying for the prescription drug benefit. Indeed, AARP representatives helped convince Speaker Wright to endorse this coverage expansion, an event that proved crucial to the bill's eventual enactment. Some organizations representing seniors, such as the Grey Panthers, were ambivalent about the MCCA due to the lack of structural changes it made to health care financing and that it would not lead to a single-payer health insurance system. Overall, however, the preponderance of lobbying groups ranging from AARP to hospitals to doctors to even insurers were initially supportive of the MCCA and the new benefits it guaranteed or neutral toward it, and did not represent major obstacles to the legislation's passage.

On July 1, 1988, in a Rose Garden ceremony, President Reagan signed the MCCA into law after it was passed by overwhelming bipartisan majorities in both houses of Congress. At the event, Reagan touted the MCCA for replacing "worry and fear with peace of mind," since a jump in expenses for the elderly could be "more than a budget problem; it could be a tragedy." With such overwhelming support and powerful reasoning on Reagan's side, why, only barely a year later, was the MCCA repealed? What were the forces that led to this dramatic reversal? Using once more a polity-centered approach, the next segment of this paper will answer these questions.

A Polity-Centered Analysis of the Repeal of the Medicare Catastrophic Coverage Act (MCCA)

Past Policies: The MCCA Repeal Act of 1989 was approved by the Congress with veto-proof majorities in both houses of Congress and was signed into law by President George H.W. Bush on December 13, 1989. It completely nullified the MCCA of 1988 with the exception of the aforementioned QMB benefit to expand Medicaid coverage for dual eligibles, the spousal impoverishment benefit, and several other minor provisions. To understand why this occurred it is necessary to acquire a comprehensive understanding of the MCCA itself, which was passed the year prior. On balance, the MCCA seemed to have a highly positive impact, providing Medicare beneficiaries with a set of very valuable benefits. Pursuant to the law, Medicare would cover additional time spent at hospitals, limit the amount of out-of-pocket expenses for doctor's

visits, establish an out-of-pocket cap of $1,370, pay expenses relating to the purchase of outpatient prescription drugs, eliminate the possibility of financial ruin as the result of a catastrophic illness or prolonged hospitalization, and help cover additional services ranging from respite care to mammograms, skilled nursing care, home health care, and hospice care. In short, the MCCA's essential purpose was to strengthen the Medicare program and would ensure that millions of seniors across the country could afford a greater array of important services and not fear the costs that could result from a severe illness or ailment.

Yet underneath the MCCA's appealing exterior of new benefits and expanded coverage lay serious flaws. Firstly, the MCCA failed to make structural reforms to the Medicare program.

One particularly notable omission was the lack of fundamental changes to the fee-for-service (FFS) payment model used by Medicare. FFS, which reimburses providers for each service they perform, has and continues to reward quantity over quality, incentivizes overutilization and provision of care, and does not improve the efficiency, integration, or delivery of care but rather only contributes to its fragmentation. The latter point is especially important, considering that seniors are prone to chronic conditions that, depending upon their status, require the services of multiple providers potentially for both acute and post-acute care in a number of inpatient or outpatient settings.

Secondly, the bill lacked a critical benefit that, while very expensive, was passionately sought by seniors—long-term nursing home care and the custodial and personal services surrounding it. In 1988, Medicare paid for less than two percent of the cost of nursing home care, something the MCCA did little to change. This was despite the fact that long-term care represented one of the largest contributors to the catastrophic medical expenses that were the focus of the MCCA.

Thirdly, a relatively small proportion of the Medicare-eligible population would utilize the key benefits that the MCCA did feature. According to a 1988 Congressional Budget Office (CBO) projection, only 3.8% of beneficiaries, or 1.3 million people, would use the new hospital care benefit under Part A, 7%, or 2.1 million people, would take advantage of the cap on out-of-pocket costs under Part B, and 16.8%, or 5.6 million people, would benefit from new prescription drug coverage under Part B.

Fourthly, and most importantly, while only around 27% of Medicare beneficiaries would greatly benefit from the MCCA based on the above estimates, nearly all of them would be subject to either higher Part B premiums or the progressive income surtax, which would have impacted approximately 40% of seniors. In many cases, the elderly would need to pay more than they would have to pay to purchase Medigap supplemental plans, the main substitute for the MCCA's catastrophic coverage along with employer-sponsored wraparound retirement plans that, depending on the policy, may have even covered some of the same services that the MCCA did. Also, the revenues that the MCCA brought in were projected by the CBO to initially exceed costs, feeding the perception that the federal deficit was being reduced on the backs of seniors. As was discussed, this financing scheme traces back to President Reagan's vow that, due to budgetary and fiscal concerns, the MCCA would have to be funded by Medicare recipients. As a result, the MCCA departed from traditional social insurance structures, such as those featured in Social Security or Medicare Part A, which incorporated broad funding bases in return for guaranteed universal benefits. Reagan's stipulation ultimately led the Congress to craft a bill that would ultimately benefit few at the expense of many. This dilemma in particular was at the root of the movement to repeal the MCCA.

The Influence of Interest Groups: As was examined previously, most of the major interest and lobby groups that had a stake in the MCCA debate, including the AARP, physicians, insurers, and hospitals, were initially either neutral toward the legislation or were supportive toward it. Yet after the bill was signed into law on July 1, 1988, this generally positive attitude proved irrelevant in the wake of a growing backlash movement against the MCCA by Medicare beneficiaries. Indeed, there was a fundamental disconnect between elite groups who stood to benefit from or were left alone by the MCCA and a grassroots campaign led by politically active seniors who feared the costs relating to the law but were not entirely cognizant of its benefits. The first signs of discontent amongst seniors were heard in November 1988 at town meetings in California and Florida, retirement communities in states such as Arizona, and at campaign forums in Nevada. The revolt against the MCCA arguably climaxed on September 17, 1989, as crowds of elderly people surrounded and accosted Congressman Dan Rostenkowski (D-IL), the longtime Chairman of the House Ways and Means Committee, holding wooden signs and yelling, "Liar! Coward! Impeach!"

No other group contributed more to this backlash against the MCCA than the National Committee to Preserve Social Security and Medicare (NCPSSM). The NCPSSM was formed in 1982 by former Congressman James Roosevelt (D-CA), the son of President Franklin D. Roosevelt, who signed into law the Social Security Act. The mission of the NCPSSM was and continues to be to strengthen and protect Medicare and Social Security and to prevent cuts or a reduction of benefits to these and other programs upon which the elderly depend. It remains a self-funded not-for-profit organization that coordinates grassroots support amongst politically active seniors to advocate for its priorities.

One of the NCPSSM's first major campaigns was to repeal the MCCA. To this end, once the MCCA was passed, the NCPSSM flooded Congressional offices with upwards of two million postcards and a countless number of phone calls, launched petition drives, television and radio advertisements, and organized demonstrations that were specifically set in the home districts of select Congressmen who depended upon the support of the committee's members. One television spot featured prominent members of Congress, including Claude Pepper (D-FL), Andrew Jacobs (D-IN), and Senator Mark Hatfield (R-OR), as well as actor Lome Greene, and urged viewers to take "immediate action" against the MCCA. In its efforts, the NCPSSM exaggerated the costs that the legislation would impose on Medicare beneficiaries while minimizing its benefits, as well as attacking the bill for lacking long-term care coverage. The NCPSSM claimed that nearly all seniors would be faced with the additional $800 surtax when in fact this new charge was primarily limited to individuals in higher-income brackets. It also asserted that AIDS patients would disproportionally benefit from the prescription drug coverage, even though most who suffered from this ailment unfortunately died before they could access Medicare benefits. As the NCPSSM pressed on, membership in the organization grew to nearly five million and it raised millions of dollars to fund its efforts. The NCPSSM was joined by the aforementioned pharmaceutical manufacturing industry, which feared that the MCCA would lead Medicare to institute price controls on prescription drugs and heavily invested in advertisements to repeal the law. Its efforts were also complemented by groups such as the Seniors Coalition Against Catastrophic Act, whose members passionately testified against the bill before the Senate Finance Committee, as well as the National Association for Retired Federal Employees and the Retired Officers Administration.

As the efforts of the NCPSSM intensified, public support for the MCCA plummeted from a high of 91 percent to 65 percent by December 1988 to 46 percent in March 1989. Organizations such as the AARP tried to defend the law and the new benefits that it would provide to seniors, but to no avail. The swelling anger over the MCCA and its financing mechanism propelled the Congress to act.

Political Institutions—The Congress: Initially, Congress did not seek to entirely repeal the law. Instead, the debate revolved around what new benefits could be retained if the surtax were reduced or eliminated without a corresponding increase in revenue from other sources (Moon, 1990). In the U.S. Senate, Senators John McCain (R-AZ) and Orrin Hatch (R-UT) sponsored a bill to delay the MCCA's benefits and collection of the supplemental premiums but this was narrowly defeated by an up-or-down vote. Senator George Mitchell (D-ME) and Robert Dole (R-KS) similarly tried to prevent the MCCA from being dismantled. Meanwhile, in the House, the Ways and Means and Committee produced a compromise between Committee Chair Dan Rostenkowski (D-IL) and Bill Gradison (R-OH) to halve the supplemental premium and permit Medicare beneficiaries to drop the MCCA coverage on the condition that they also opt out of Part B Coverage. Another plan produced by William Archer (R-TX) and Brian Donnelly (D-MA) would have only kept the provision of the law expanding Medicaid coverage to assist low-income Medicare recipients. An additional bill proposed by Peter Stark (D-CA), Henry Waxman (D-CA), and Gradison would have cut supplemental premiums and most benefits with the exception of prescription drugs and mammograms.

Ultimately, on October 4, 1989, the House voted 360-66 for the Archer-Donnelly legislation to repeal most of the MCCA. Two days later, the Senate voted 99-0 to pass a plan crafted by Senator McCain that would have abolished the supplemental premium and most of the new benefits with the exception of the unlimited hospital coverage as well as the home health and respite care benefits. However, after six weeks of deliberation, the Senate realized that anything short of the MCCA's complete dissolution would be politically untenable considering the overwhelming opposition to the law. On November 17, during a meeting amongst members of both chambers, Senator Bentsen persuaded his colleagues to accept repeal. On November 21, Senators McCain and Dole (R-KS) tried once more to avert this fate, but their efforts proved futile and on November 22, the Senate voted by unanimous consent to repeal the MCCA.

Political Institutions—The Executive: President Reagan's Vice President, George H.W. Bush, succeeded him to become the 41st President of the United States on January 20, 1989. Originally, Bush, who was in the midst of his 1988 Presidential campaign and needed the support of seniors especially after Reagan attempted to reduce Social Security benefits, had urged President Reagan to sign the MCCA into law. Yet as the opposition to the MCCA deepened, Bush ambivalence toward it grew. As repeal was being debated in Congress, President Bush remained mildly supportive of the MCCA as long as it did not contribute to the budget deficit. Then in September 1989, Louis Sullivan, the HHS Secretary, stated that while the administration preferred no changes to the law, if change had to occur it would have to lead to "good health policy, [be] revenue neutral, [and be] politically stable." As the weeks progressed, the President attempted to cater to both sides of the debate, emphasizing the benefits of the act while acknowledging the grievances related to how it was financed. Yet ultimately, his administration, not wishing to entangle itself further in controversy, did not offer the MCCA the support it needed for it to remain politically viable. Furthermore, White House officials became increasingly skeptical of the MCCA not just because of its costs but also that it constituted a major expansion of the

federal government, possibly at the expense of the private insurance companies which were offering Medigap supplemental policies. Additionally, Bush took no real ownership of the MCCA, which he and his staff perceived as the initiative of President Reagan, and he lacked the same political stake that his predecessor had in the success of the law. Therefore, Bush acquiesced to the growing anger that was directed at the bill and, following the passage of its repeal in both chambers of Congress, formally repealed the MCCA on December 13, 1989. This ends the saga of what for the time could have been the largest expansion of Medicare since 1965.

The analysis above reveals a plethora of reasons for why the MCCA failed. These included a coercive and narrow self-funding mechanism that imposed potentially substantial costs on a targeted, concentrated, and politically active population; a lack of information and clarity concerning the range and scope of the coverage additions that were provided by the new law; an absence in the MCCA of key benefits like long-term nursing home care; a passionate, well-funded, and highly organized opposition movement that was able to steer public opinion against the act and cowed Congress into moving toward repeal; and a lack of enthusiasm and effort by the advocates for the MCCA, including by the George H.W. Bush administration, which exerted little political capital to salvage the law. The final section will discuss the aftermath and the policy legacy of the MCCA as well as its relevance regarding contemporary health care policy debates and the fate of the PPACA.

The Aftermath of the MCCA Episode

After the failure of the MCCA, Congress never passed an out-of-pocket cap on Medicare enrollees, instead opting for the continued usage of Medigap supplemental insurance policies. Nor, despite Claude Pepper's wishes, did it ever enact comprehensive long-term care. Instead, Medicare only helps cover part of the costs associated with the first 100 days of a stay in a hospice care, home health care, or in a skilled nursing facility. However, to do so, it requires that the beneficiary have had a recent prior hospital stay of at least three days, have been admitted to a Medicare-certified nursing facility prior to that hospital stay, and that the beneficiary has established a need for skilled care, such as nursing services or therapy. In addition to Medigap, Medicaid can also fill in the long-term care gap to an extent but only if the individual requiring those services meets certain income and asset requirements to become dual eligible. However, thanks to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which culminated in the creation of Medicare Part D, Medicare does cover outpatient prescription drugs, one of the most major benefits that was supposed to be provided by the MCCA. Unlike the MCCA, Medicare Part D is a voluntary program, allows seniors to opt out, and is not self-financed—thus it does not provoke the same degree of resistance that the MCCA faced. Instead, there was ultimately a lack of revenue to make the program budget-neutral. This fact, combined with an arbitrary cost limit set by President George W. Bush for the program of $400 billion over ten years, led Part D to feature a coverage gap known as the "donut hole." That is, Medicare will not pay for annual drug expenses ranging from $2,250 to $5,100. However, the Patient Protection and Affordable Care Act (PPACA) will phase out this gap by 2020. Additionally, Medicare Part D is administered by private insurers that offer either standalone prescription drug plans or Medicare Advantage prescription drug plans with basic coverage requirements. Currently, Medicare Part D has enjoyed relative popularity, with 39 million seniors enrolled in outpatient prescription drug coverage plans under the program.

Finally, some have argued that the repeal of the MCCA bears relevance toward the debate regarding the fate of the PPACA. Indeed, both constitute major expansions of the federal government's role in the health care sector and both have engendered great controversy and opposition due in large part to a lack of awareness of the benefits that both laws grant, as opposed to the costs that they impose. Based on the analysis and research that this report entailed, however, currently the PPACA does not seem like it will be repealed in the same fashion that the MCCA was and there are major differences between the two. The PPACA is more firmly established than the MCCA and is backed by a Supreme Court ruling affirming the constitutionality of the individual mandate, President Obama, who has made the success of the PPACA a top priority for his administration, and a Democratic majority in the U.S. Senate. These actors are in turn joined by a myriad of liberal advocacy organizations as well as a lack of sustained opposition from major interest groups in the health care industry. For these forces, the progressive goal of establishing universal health insurance to cover the sick and needy—which had previously been deferred for nearly a century in America since former President Theodore Roosevelt's call for it in his 1912 presidential campaign—is something that is worth passionately fighting for, arguably more than, say, only some new Medicare benefits.

However, regarding the PPACA, circumstances can change, especially with a possible shift in the balance of power between the Congress and the White House in the Republican Party's favor; the mass cancellation of insurance policies in the non-group market and possibly the group and employer-based markets due to a lack of compliance with the law's minimum coverage requirements; the possibility of adverse selection if young people opt out of the insurance exchanges, leading to, with the possibility of a less advantageous risk pool, higher and increasingly

unaffordable premiums; as well as more intense backlash regarding any of the other controversial provisions in the law, ranging from the costs associated with the individual and employer mandates to the cuts that the PPACA makes to providers to the new taxes it imposes to fund expanded coverage. The PPACA does still possess many positive features such as a ban on discrimination based on preexisting conditions with the guaranteed issue regulation; the granting of insurance coverage to millions through the insurance exchanges with accompanying subsidies as well as the enlargement of Medicaid; and pilot programs run by the Center for Medicare and Medicaid Services, the most recent title for what was previously the Healthcare Financing Administration, to lower medical costs and reform the health care payment and delivery system away from fee-for-service and toward a more coordinated, integrated, and cost-effective system of care that rewards value over volume. Regardless, despite what may have been the best of intentions, major changes or policy shifts regarding the health care system can ultimately backfire, as the MCCA episode proved.

Works Cited:

- Historical Debt Outstanding—Annual 1950-1999. (August 18, 2008). *Treasury Direct.* Retrieved from http://www.treasurydirect.gov/govt/reports/pd/histdebt/histdebt_histo4.htm.
- Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance. (March 2013).
- *Center for Medicare and Medicaid Services.* Retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.
- Medicare: A Timeline of Key Developments. (2005). *Kaiser Family Foundation.* Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2005/06/5-02-13-medicare-timeline.pdf.
- Medicare Prescription Drug Benefit Fact Sheet. (November 19, 2013). *Kaiser Family Foundation.* Retrieved from http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/.
- New Law Curbs Cost to Patients Under Medicare. (July 2, 1988). *Orlando Sentinel.* Retrieved from http://articles.orlandosentinel.com/1988-07-02/news/0050170218_1_medicare-beneficiaries-medicare-coverage-doctor-bills.
- Our History. (2013). *National Committee to Preserve Social Security and Medicare.* Retrieved from http://www.ncpssm.org/AboutUs/HistoryofNCPSSM.
- Presidential Job Approval Center. (2013). *Gallup.* Retrieved from http://www.gallup.com/poll/124922/presidential-approval-center.aspx.
- Who Pays for Long Term Care? (2013). *U.S. Department of Health and Human Services.* Retrieved from http://longtermcare.gov/the-basics/who-pays-for-long-term-care/.
- Altman, S. H., & Schactman, D. (2011). Power, Politics, and Universal Health Care: The Inside Story of a Century-Long Battle. Amherst, New York: Prometheus Books.
- Deets, Horace. (October 7, 1989). AARP Position is Clarified on Catastrophic Health Act.
- *The Schenectady Gazette.* Retrieved from http://news.google.com/newspapers?nid=1917&dat=19891007&id=NXkhAAAAIBAJ&sjid=0IkFAAAAIBAJ&pg=2689,1951541.
- Capretta, James. (April 2013). The Role of Medicare FFS in Inefficient Healthcare Delivery.
- *American Enterprise Institute/Robert Wood Johnson Foundation.* Retrieved from http://www.aei.org/files/2013/04/15/-the-role-of-medicare-feeforservice-in-inefficient-health-care-delivery_141413376272.pdf.
- Flynn, James. (December 1997). Fiscal Policy Implications of the 1988 Medicare Catastrophic Coverage Act. *Naval Postgraduate School.* Retrieved from www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA343410.
- Hulse, Carl. (November 17, 2013). Lesson is Seen in Failure of Law on Medicare in 1989.
- *NYTimes.com.* Retrieved from http://www.nytimes.com/2013/11/18/us/politics/lesson-is-seen-in-failure-of-1989-law-on-medicare.html.
- Kronenfeld, Jennie Jacobs. (2011). Medicare. United States: Greenwood.
- Moon, Marilyn. (September 1990). The Rise and Fall of the Medicare Catastrophic Coverage Act. *National Tax Journal,* Vol. 43, No. 3*:* 371-381. Retrieved from http://ntj.tax.org/wwtax%5Cntjrec.nsf/D88B11320D364E638525686C00686DDA/$FILE/v43n3371.pdf.
- Oliver, Thomas, Lee, P.R., & Lipton, H.L. (June 2004). A Political History of Medicare and Prescription Drug Coverage. *The Milbank Quarterly,* 82(2)*:* 283-354. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690175/.

- Rapaort, Carol. (September 19, 2012). Medigap: A Primer. *Congressional Research Service.* Retrieved from http://www.fas.org/sgp/crs/misc/R42745.pdf.
- Reagan, Ronald. (February 14, 1987). Radio Address to the Nation on Proposed Catastrophic Health Insurance Legislation. *The American Presidency Project.* Retrieved from http://www.presidency.ucsb.edu/ws/index.php?pid=33745#ixzz1yLIT9yg7.
- Rice, Thomas, Desmond, K, & Gabel, J. (1990). The Medicare Catastrophic Coverage Act: A Post-Mortem. *Health Affairs,* Vol. 9, No. 3, 75-87. Retrieved from http://content.healthaffairs.org/content/9/3/75.full.pdf+html.
- Tolchin, Martin. (October 9, 1989). Retreat in Congress; The Catastrophic-Care Debacle—A Special Report: How the New Medicare Law Fell on Hard Times in a Hurry. *NYTimes.com.* Retrieved from http://www.nytimes.com/1989/10/09/us/retreat-congress-catastrophic-care-debacle-special-report-new-medicare-law-fell.html?pagewanted=all&src=pm.
- Street, Debra. (November 1993). Maintaining the Status Quo: The Impact of Old-Age Interest Groups on the Medicare Catastrophic Coverage Act of 1988. *Social Problems,* Vol. 40, No. 4*:* 431-444. Retrieved from http://www.jstor.org.resources.library.brandeis.edu/stable/3096860?seq=1.
- Thompson, Carolyn. (Presidential Transition and Public Policy: The Repeal of Medicare Catastrophic Coverage. In R. Himmelfarb and R. Perotti (Eds.), *Prince Over Politics?*
- *The Domestic Policy of the George H.W. Bush Presidency.* Retrieved from Google Books.
- Yardley, William. (May 7, 2013). Otis R. Bowen, Governor and Health Secretary, Dies at 95.
- *NYTimes.com.* Retrieved from http://www.nytimes.com/2013/05/08/us/politics/otis-r-bowen-ex-governor-of-indiana-dies-at-95.html?_r=0.

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Aging Up the River: Law and Policy Challenges Facing America's Graying Prison Population

By Benjamin Pomerance

"The degree of civilization in a society can be judged by entering its prisons."

—Russian author Fyodor Dostoyevsky

John H. Bunz will celebrate his ninety-third birthday in November.[1] Described by observers as "feeble-looking" after the death of his wife in 2010, he requires a wheelchair to travel any distance of significant length.[2] Yet he still is in better health than George Sanges, age 73, who suffers from cerebral palsy, takes multiple medications twice a day, and recently was rushed to the emergency room for heart problems.[3] And both of them are more alert than Leon Baham, a 71-year-old man with dementia who goes into delusional bouts of yearning for his deceased wife.[4]

On the surface, these elderly, ailing men have extremely sympathetic profiles. All three appear to be the "grandfatherly" figures to whom our society is historically taught to show compassion and concern. Yet they also have a huge component of their lives which would tend to turn thoughts of sympathy and care upside-down: They are all prisoners.[5] The wife for whom Baham plaintively pines was also his murder victim.[6] Similarly, Bunz, at age 90, beat his 89-year-old wife with a hammer until she was dead.[7] Sanges is imprisoned in Georgia for aggravated assault against his wife of 48 years.[8]

From this scenario, a tension of opposites emerges: Three old, sick men, individuals in great need of care, yet also people who committed some of the worst violent crimes known to humankind. Today, this paradox confronts American lawmakers more often than ever before. From 1995 to the present day, the number of elderly inmates in United States prisons rose by more than 280%.[9] The number of state and federal prisoners age 65 and over increased by 63% from 2007 to 2010.[10] To compound the issue, the graying trend behind bars is virtually guaranteed to continue, spurred by the aging of the Baby Boomer population and the large number of inmates serving lengthy sentences. Experts estimate that *one-third of all prisoners* in American correctional facilities will be age 55 and older by 2030.[11]

As elderly individuals continue to occupy a larger proportion of the nation's prison profile, correctional systems must develop new methods to deal with the unique needs of an aging population. Constitutional standards demand a particular level of care administered within the prison system,[12] a threshold which becomes more challenging to meet as an individual grows older. And in an era when state and federal budgets already face substantial challenges and pressures, the basic care of an elderly inmate leaves a tremendous additional financial imprint—as much as nine times greater than the daily health care costs for a younger prisoner.[13] Blueprints for early release of elderly inmates who seemingly pose no further societal threat exist in many states and on the federal level, but implementing these plans also provokes more questions, ranging from strenuous objections by victims' advocates groups to concerns about where these elderly and ill people will go when released from the prison environment.[14]

"[T]he graying trend behind bars is virtually guaranteed to continue, spurred by the aging of the Baby Boomer population and the large number of inmates serving lengthy sentences. Experts estimate that one-third of all prisoners *in American correctional facilities will be age 55 and older by 2030."*

The answers to these questions are not easy. Yet they are vital concerns that New York, like all other states, must grapple with today and in upcoming years. This article briefly examines some of these tough decisions and the alternatives facing policymakers at this time.

I. Defining "Elderly" in the Prison Context

Even a basic definition of the word "elderly" presents problems in prisons. Inmates over age 50 often have the body and mind of a person 11.5 years older than his or her chronological age.[15] Consequently, only a few states requires an inmate to reach age 65 before attaining "elderly status."[16] Fifteen states use age 50 as a benchmark.[17] Others use age 55, the threshold that is also used by the National Commission on Correctional Health Care.[18] Some states avoid using a chronological age at all, instead relying on the degree to which the inmate is disabled and unable to provide personal care to himself or herself.[19]

Given the lack of homogeneity among elderly prisoners, this last option might be the most attractive. States

could structure new legislation such that an inmate of any age with certain disabilities or other medical issues would be considered "elderly" for care purposes, but that all inmates age 55 and older would automatically be considered elderly, regardless of disability status. Since a 55-year-old inmate has, on average, the physiological age of a 66-year-old individual, this would be a reasonable way to structure this elusive definition.

II. Questions on the Inside: Concerns for Elderly Inmates in Daily Prison Life

A. Medical Questions

Inmates older than age 55 have an average of three chronic medical conditions.[20] Approximately 20% suffer from at least one mental illness.[21] Older prisoners frequently become more isolated and anxious than younger prisoners and are considerably more vulnerable to contracting contagious diseases.[22] To avoid these health problems, elderly inmates require closer medical monitoring than what prisons typically offer to a younger population. Elderly prisoners also need age-appropriate "active treatment"—programs involving older inmates in meaningful activities to prevent physical, mental, and emotional decline.

Given that the Eighth Amendment to the United States Constitution prohibits inadequate health care behind bars[23]—defined through case law as "deliberate indifference" by prison medical staff,[24] including disregarding a known substantial risk of harm[25]—correctional facilities are legally bound to develop physical and mental health solutions for elderly inmates. In New York, part of this plan includes advanced "preventative maintenance," with inmates receiving full health assessments from prison doctors every two years after turning 50.[26] Notably, though, the overall scarcity of prison health care personnel leaves these elderly inmates to be examined by general practitioners rather than geriatrics specialists.[27] This would seem to increase the likelihood of early symptoms of aging-related diseases remaining unnoticed in these assessments. However, with corrections budgets tight, elderly prisoners are unlikely to see gerontologists frequently in their facilities anytime soon.

For prisoners with Alzheimer's disease and other severe conditions, New York State's Department of Corrections and Community Supervision utilizes its Unit for the Cognitively Impaired at the Fishkill Correctional Facility.[28] This unit accepts inmates of all security classifications and provides a less rigorous, more care-intensive environment than the rest of the prison system.[29] Many other states have developed similar "geriatric units" for elderly inmates with debilitating medical problems.[30] Most of these units are presently filled to capacity, at a high financial cost, with some states looking for ways to accommodate more sick elderly inmates.[31] In New York, for instance, an expansion at the Walsh Medical Center in Rome is scheduled to add 38 more skilled nursing beds by 2014.[32]

Several prison systems even involve younger inmates in the care of elderly prisoners, a concept that seems to boost the morale of older inmates while making the younger prisoners feel worthwhile and productive. For instance, the "Gold Coat" program at the California Men's Colony, recently profiled in *The New York Times*, trains carefully screened young prisoners to fulfill certain daily duties for older inmates with dementia.[33] New York's "prison hospice" initiatives integrate healthy inmates into facility palliative care efforts, helping prisoners pass away in an atmosphere of dignity and respect.[34] Other states have similar end-of-life programs in their correctional facilities.[35] Of course, these inmates-caring-for-inmates programs require vigilant selection and training procedures monitored closely by facility staff.

The area most frequently overlooked in correctional health care for the elderly is "active treatment," or working to ensure that healthy elderly inmates remain healthy. A recent Human Rights Watch report observed that many older inmates "have little to do besides read, watch television, or talk to each other."[36] While this hardly seems cruel and unusual at first glance, mental and physical stagnation can produce grave consequences for elderly individuals.[37]

Perhaps the greatest strides toward a viable "active treatment" model are currently occurring at Northern Nevada Correctional Center. There, Mary Harrison's "True Grit" program welcomes more than 200 elderly prisoners in activities from drama groups to animal therapy to fixing wheelchairs for other inmates in the "chop shop."[38] Proper hygiene and grooming—no "scruffy beards" allowed—is a must.[39] Appropriate behavior is expected at all times, and the inmates are required to keep their unit clean in order to continue in the program.[40]

So far, the process seems to work. Prisoners taking psychotropic medications when they join True Grit often can stop taking the strong drugs after a period of time.[41] No True Grit inmate achieving parole has ever recidivated.[42] Perhaps most impressive, though, is the cost to the state: nothing.[43] The volunteer-driven initiative does not require one cent of taxpayer dollars.[44]

New York does not have a comparable active treatment program in its prison system. With so many elderly inmates in the state's prisons, creating some sort of sustainable active treatment plan should become a vital component of prison health care. Doing otherwise seems to fall into the category of disregarding a known risk of medical harm, a practice forbidden in prisons by the Eighth Amendment[45] and, more importantly, by basic humanity.

B. Housing Questions

One of the most exasperating issues regarding elderly inmates is where to put them. As already noted, several states are building separate units or facilities for older prisoners, particularly elderly inmates with serious physical or mental health concerns.[46] These congregate housing arrangements concentrate the older prisoners in one area, where they can receive increased attention and specialized care for their unique needs.[47] Additionally, removing elderly inmates from general population takes them away from younger, stronger inmates who can—and far too often do—exploit them.[48]

However, separating the elderly from the young is not the automatic panacea that it may appear to be at first glance. To begin with, Title II of the Americans with Disabilities Act (ADA) applies to all federal and state prisons, requiring that correctional facilities provide reasonable accommodations to all prisoners with disabilities.[49] While discrepancies among the circuits exist on the extent of the ADA's protections in prisons,[50] the general concept is this: Prisons should deliver services, including living arrangements and programs, in the "most integrated setting appropriate to the needs of qualified individuals with disabilities."[51] Segregated housing and programming for the elderly may fall well short of this legal standard. Furthermore, many elderly prisoners truly do not want their environment to consist solely of "old codgers living with other old codgers,"[52] instead preferring to live among the general population around younger, more lively individuals.[53]

Some elderly inmates with disabilities simply cannot be adequately and safely programmed in a mainstream population environment.[54] This is particularly true for inmates who have significant cognitive impairments, such as dementia.[55] Importantly, though, geriatric units must not become "death houses."[56] A proper age-appropriate active treatment program, as discussed in the preceding section, would go a long way toward providing a more integrated setting for elderly prisoners, preventing the geriatric wing from becoming "the place where people go to die."

C. Training Questions

Prisons are necessarily designed around regimented scheduling and uniform treatment. However, there are times when these standards should be relaxed when dealing with elderly and ill prisoners. Keith Davis, Warden of Deerfield Correctional Facility in Virginia, a prison with a high concentration of elderly inmates, listed patience, communication, and compassion as key attributes when dealing with older prisoners.[57] Unfortunately, a 2012 Human Rights Watch report noted that these attributes were too often absent, stating that "[e]ven in prisons with high proportions of older prisoners, staff do not consistently treat them (or any others) with respect."[58] It went on to describe situations where corrections officers taunted elderly inmates for certain medical conditions and where guards grew extremely impatient with slower older prisoners.[59]

Often, these problems occur from a lack of understanding about the unique needs of the elderly.[60] Therefore, proper training of prison personnel about dealing with elderly individuals is essential.[61] These trainings should not be a one-time experience, either, but should occur on a regular basis to reinforce the principles of proper and effective conduct with regard to elderly individuals. Also, this training should not be delivered by a corrections official, as some states are currently doing, but rather by an outside geriatric specialist who also has knowledge about the corrections system and its goals.[62] This diligent training, coupled with proper monitoring, will hopefully help correctional systems avoid the adverse legal ramifications that could arise when facility personnel do not understand how to strike the balance between security objectives and proper treatment of elderly individuals within their care.

III. Questions on the Outside: When Elderly Inmates Should Stop Being Inmates

In the late 1980s, at the height of the AIDS epidemic in American prisons, some states enacted laws allowing inmates dying from AIDS to receive an early conditional release from prison.[63] These "compassionate parole" programs eased the high cost impact that AIDS-suffering inmates left on state corrections budgets, lessened the overcrowded conditions of prisons, permitted terminally ill prisoners to die among family members rather than behind bars, and allowed these individuals who now posed little threat in free society.[64]

Today, many commentators offer these same rationales in advocating for the early release of certain elderly inmates.[65] Many states, including New York, have passed laws allowing conditional release of elderly inmates who are terminally or severely ill.[66] The federal government also has a compassionate release program, expanded substantially in August 2013, for "elderly and infirm federal prisoners who have served a significant part of their sentence and pose no danger."[67]

Advocates of "compassionate release" point out that the risk of repeat offenses drops dramatically as people age[68]—a recidivism rate of just 4% for individuals age 65 and above in New York, for instance, compared with a 16% recidivism rate for parolees age 49 and younger.[69] They note that early release would shift the elderly inmate's high costs from the state government, significantly cutting taxpayer costs of providing for that person.[70] They show that overcrowding remains a nationwide crisis in prisons, and argue that releasing elderly inmates early helps reduce this problem.[71]

To opponents of early release, however, particularly crime victims' advocates, an inmate's age and poor health should not excuse him or her from serving a full sentence.[72] They also note that even a very sick man or woman can still potentially commit other crimes, including violent crimes, and that society should not take this risk.

Also problematic is the fact that elderly inmates often have no place to go if released from prison. Frequently, family support is non-existent for these individuals, and many nursing homes and assisted-living facilities will not admit somebody with a criminal record.[73] In a 2010 interview, Lester Wright—serving as New York's Chief Medical Officer at that time—attributed the state's poor medical parole statistics in part to the difficulty of finding nursing home placements.[74] "The problem is, when we start trying to put people out, there are others in the community who are sure we're trying to make more crime in the community," Wright said in that interview. "We're also competing for beds. Some people think my patients aren't as valuable as other people in society."[75]

A growing number of states, however, are looking to integrate nursing homes and assisted-living facilities into their early release programs.[76] New York, for instance, is apparently seeking to establish a working relationship with nursing homes willing to accept conditionally released elderly inmates.[77] Success in this area would be an important piece to a sustainable compassionate release program for elderly prisoners in New York and elsewhere.

Another key issue in this area is efficiency. In New York, for example, more than 950 inmates have died while waiting for release since the state adopted medical parole in 1992—nearly three times the number of inmates who actually were granted medical parole during that same time period.[78] In 2011 alone, New York received 106 new requests for compassionate release, granting seven of them and denying 11.[79] It is unclear what happened to the remaining 88 applications from that year. Other states, such as Texas[80] and Oklahoma,[81] have experienced similar problems with delays in their compassionate release processes.

Obviously, a thorough vetting mechanism before releasing any inmate from prison is essential. However, states with compassionate release laws should make all reasonable efforts to streamline these procedures, given that time is of the essence for individuals who are elderly and infirm. These states, including New York, should consider following the lead of Louisiana, which in 2011 instituted one of the first parole boards dedicated specifically to elderly prisoners.[82] Given that procedural delays can prove fatal—literally—for aged and sick inmates, providing expedited review is certainly appropriate.

There is no doubt that compassionate release programs are controversial. However, when operated properly, they provide a way to ease the huge cost burdens borne by prison systems—and, by extension, taxpayers—in a humanitarian way, releasing only those prisoners who are dangerously sick and extremely unlikely to re-offend. If operated using a strict set of criteria for conditional release, and if community partners like nursing homes and assisted-living facilities agree to house elderly and ill prisoners who have no place else to go, compassionate release initiatives could continue to play an increasingly large role in the discussion about America's aging population behind bars.

IV. Final Thoughts

The unprecedented rate at which America's prison population is aging presents multiple challenges and concerns. The good news is that the federal government and the states are already taking action on many of these issues, from increasing the frequency of check-ups for elderly inmates to constructing specialized geriatric prison units, and from creating prison hospice programs that make an inmate's last days more dignified to utilizing inmate-to-inmate care services that benefit both the older and younger prisoner. Additional improvement, however, is needed in other areas, such as the current lack of active treatment programs at many facilities and the need for better staff training regarding working with the elderly.

Outside the prison gates, the growth of compassionate release programs for high-cost, low-risk elderly inmates appears to be another important means of dealing with the rising elderly prison population and should continue to evolve. However, these programs will succeed only with proper controls to ensure that the right people are released and that they have an appropriate place to go. Efficient processing systems are also pivotal to the effectiveness of these early conditional release initiatives.

In the end, there is no single best set of policies for addressing all of these issues. Determining the most manageable framework for New York, and for any state, will be resolved only by bringing multiple stakeholders to the table, from corrections officials to medical professionals, and from judges and attorneys to victims' advocates to the elderly prisoners themselves. In this still-new discussion, all of these voices must be heard.

"The degree of civilization in a society can be judged by entering its prisons," wrote Fyodor Dostoyevsky more than a century ago. Today, and for at least the next two decades, anyone entering America's prisons will find more elderly individuals than ever before. The way we treat them will determine the way that our society is judged for years to come.

Endnotes

1. *See* Stephen T. Watson & Matt Gryta, *At 90, What Does 17 Years in Prison Mean?*, Buffalo News, Sept. 9, 2010, http://www.buffalonews.com/city/police-courts/courts/article185122.ece.
2. *Id.*
3. *See* Stephanie Chen, *Prison Health-Care Costs Rise As Inmates Grow Older and Sicker*, cnn, Nov. 13, 2009, http://articles.cnn.com/2009-11-13/justice/aging.inmates_1_prison-inmate-largest-prison-systems-medical-costs?_s=PM:CRIME.
4. *See* Pam Belluck, *Life, With Dementia*, N.Y. Times, Feb. 28, 2012, http://www.nytimes.com/2012/02/26/health/dealing-with-dementia-among-aging-criminals.html?pagewanted=all.
5. Watson & Gryta, *supra* note 1; Chen, *supra* note 3; Belluck, *supra* note 4.
6. *See* Belluck, *supra* note 4.
7. *Id.*
8. *See* Chen, *supra* note 3.
9. Human Rights Watch, Old Behind Bars: The Aging Prison Population in the United States 20 (2012).
10. *Id.* at 18.
11. Israel Issi Doron & Helene Love, *Aging Prisoners: A Brief Report of Key Legal and Policy Dilemmas*, 2 Int'l J. Criminology & Sociology 322 (2013).
12. *See* Part IA, *infra*.
13. Timothy Williams, *Number of Older Inmates Grows, Stressing Prisons*, N.Y. Times, Jan. 26, 2012, http://www.nytimes.com/2012/01/27/us/older-prisoners-mean-rising-health-costs-study-finds.html.
14. *See* Part III, *infra*.
15. Jaime Shimkus, *Corrections Copes with Care for the Aged*, Nat'l Comm'n on Correctional Health Care, Summer 2004, *available at* http://www.ncchc.org/pubs/CC/aging_inmates.html.
16. *See* Vera Inst. of Justice, It's About Time: Aging Prisoners, Increasing Costs and Geriatric Release 4 (2010) (noting the wide range of definitions of "elderly" utilized by the individual states); Aging Out In Prison: Age Distribution of the Colorado Prison System 2 (2011) (describing the different definitions that states use when determining whether an inmate is "elderly").
17. It's About Time, *supra* note 16, at 4.
18. *Id.; see also* Shimkus, *supra* note 15.
19. Correctional Healthcare: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates 10 (Jayne Anno, Camelia Graham, James E. Lawrence, Ronald Shansky, eds., U.S. Dep't of Justice 2004).
20. Mike Mitka, *Aging Prisoners Stressing Health Care System*, 292 J. Am. Med. Ass'n 423 (2004).
21. *Id.*
22. *See* Correctional Healthcare, *supra* note 19, at 10 ("Elderly inmates experience a reduction in human interaction and tend to withdraw owing to a lack of privacy and a loss of self-esteem. They are frightened, anxious, and dependent, especially on prison staff."). However, it is also important to note that there can actually be certain medical benefits for particular prisoners. A study by the Florida Department of Corrections in 2000 revealed that two-thirds of the inmates in their state's correctional facilities received their first significant health care experience while in prison. Carrie Abner, *Graying Prisons: States Face Challenges of an Aging Inmate Population*, State News, Nov./Dec. 2006, at 9.
23. *See* Estelle v. Gamble, 429 U.S. 97 (1976); *see also* Timothy Curtin, *The Continuing Problem of America's Aging Prison Population and the Search for a Cost-Effective and Socially Acceptable Means of Addressing It*, 15 Elder L.J. 473, 475 (2007) ("[P]risoners are the only people in the United States who have a constitutional right to health care.").
24. *Estelle*, 429 U.S. at 104 (citing Greg v. Georgia, 428 U.S. 153, 173 (1976)); *see also* Whitley v. Albers, 475 U.S. 312, 319 (1986) ("It is obduracy and wantonness, not inadvertence or error in good faith, that characterize the conduct prohibited by the Cruel and Unusual Punishments Clause").
25. *See, e.g.*, Helling v. McKinney, 509 U.S. 25 (1993) (citing Hutto v. Finley, 437 U.S. 678, 682 (1978)); Brown v. Johnson, 387 F.3d 1344, 1350–52 (11th Cir. 2004); Hathaway v. Coughlin, 37 F.3d 63, 66 (2d Cir. 1994).
26. Telephone Interview with Dr. Carl J. Koenigsmann, Deputy Commissioner and Chief Medical Officer for the New York State Dep't of Corrections and Community Supervision (July 3, 2012).
27. *See* Interview with Brian Fischer, Commissioner of the New York State Dep't of Corrections and Community Supervisions (June 25, 2012).
28. *See* Kevin E. McCarthy & Carrie Rose, State Initiatives to Address Aging Prisoners (Mar. 4, 2013), *available at* http://www.cga.ct.gov/2013/rpt/2013-R-0166.htm.
29. *Id.*
30. *Id.* (discussing similar units in California, Florida, Louisiana, Nevada, Pennsylvania, Virginia, and Washington).
31. *See, e.g.*, Telephone Interview with Justin Jones, Director of the Oklahoma Dep't of Corrections, ("If we opened another [geriatric] facility, we could fill it right away").
32. McCarthy & Rose, *supra* note 28.
33. Belluck, *supra* note 4.
34. *See* John Leland, *Fellow Inmates Ease Pain of Dying in Jail*, N.Y. Times, Oct. 17, 2009, http://www.nytimes.com/2009/10/18/health/18hospice.html.
35. *See generally* Nat'l Inst. Of Corr., hospice and palliative care in corrections (1998).
36. Old Behind Bars, *supra* note 9, at 68.
37. *See* Shimkus, *supra* note 15.
38. Telephone Interview with Mary Harrison, Founder and Director of the "True Grit" program at Northern Nevada Correctional Center (June 21, 2012).
39. *Id.*
40. *Id.*
41. *Id.*
42. Steve Milne, *National Award for Nevada's True Grit Inmate Program*, capitol public radio, Oct. 7, 2011, *available at* http://www.capradio.org/articles/2011/10/07/national-award-for-nevada%27s-true-grit-inmate-program.
43. Interview with Mary Harrison, *supra* note 38.
44. *Id.*
45. *See* notes 23–25, *supra*.
46. *See* notes 28–31, *supra*.
47. This system received particularly high praise from Commissioner Fischer. *See* Interview with Brian Fischer, *supra* note 27.
48. Jeremy L. Williams, The Aging Inmate Population: Southern States Outlook 6–7 (2006).
49. *See* 42 U.S.C. §§ 12131–12165 (2013). The Office of Fair Housing and Equal Opportunity is charged with enforcing this provision of the ADA.
50. *Compare* Amos v. Md. Dep't of Pub. Safety, 126 F.3d 589, 594–95 (4th Cir. 1997) (holding that Title II should not apply to prisons at all), *with* Onishea v. Hopper, 171 F.3d 1289 (11th Cir. 1999) (applying

a balancing test to decide whether the integration interests of the inmate outweigh penological goals of the facility).

51. *See* Pa. Dep't of Corrections v. Yeskey, 524 U.S. 206, 213 (1998); U.S. v. Georgia, 546 U.S. 151, 159 (2006) (both specifically applying Title II of the ADA to state prisons).

52. Telephone Interview with Jamie Fellner, Senior Advisor in the U.S. Program at Human Rights Watch and author of *Old Behind Bars* (Apr. 12, 2012).

53. *Id.*

54. *See* OLD BEHIND BARS, *supra* note 9, at 57 ("[T]here is little doubt that ensuring elderly offenders are incarcerated in a manner that respects their human dignity may require transfer from general population units at some point during their incarceration.").

55. *See id.* at 53 ("At some point, cognitive problems can grow so severe that remaining in the general population is no longer an option.")

56. This was the phrase which Oklahoma Department of Corrections Director Justin Jones said that many inmates used regarding the geriatric facility at the Joseph Harp complex. *See* note 31, *supra*.

57. Telephone Interview with Keith Davis, Warden of Deerfield Correctional Facility in Virginia (July 11, 2012).

58. OLD BEHIND BARS, *supra* note 9, at 64.

59. *Id.*

60. *Id.* at 63 (describing the challenging experiences of a California corrections officer who works in a unit with inmates who have dementia. The officer "came to the unit with no understanding of dementia, or even any training in how to communicate with those who have it." This left the officer in the difficult situation of "learning it as (he goes) along."). *See also* FLA. CORR. MED. AUTH., INCARCERATING ELDERLY AND AGING INMATES: MEDICAL AND MENTAL HEALTH IMPLICATIONS 8 (2000) ("A lack of adequately trained prison staff is a barrier in responding fully to the special needs of the aging inmate."); Belluck, *supra* note 4 ("Corrections officers are used to punishing aggressive inmates, not evaluating them for Alzheimer's.").

61. *See id.* at 66 ("Having become used to thinking that 'violence is just around the corner' and that a big, firm hand is necessary to avert the ever-present potential for danger, it is a big change for (corrections officers) to develop a more 'caring' approach for the aged and infirm.").

62. It is true that this will cost money, and that corrections budgets are already stretched thin. However, as America's incarcerated population ages, corrections officials have an obligation to train their staff to interact appropriately with these older prisoners. It would seem that there are better ways for the budget to be trimmed, such as the proper use of early release policies with low-risk, high-cost elderly inmates. *See* Part III, *infra*.

63. William B. Aldenberg, *Bursting at the Seams: An Analysis of Compassionate-Release Statutes and the Current Problem of HIV and AIDS in U.S. Prisons and Jails*, 24 N.E. J. ON CRIM. & CON. 541, 548–51 (1998).

64. *Id.*

65. *See generally* AT AMERICA'S EXPENSE: THE MASS INCARCERATION OF THE ELDERLY (ACLU 2012); Jason S. Ornduff, *Releasing the Elderly Inmate: A Solution to Prison Overcrowding*, 4 ELDER L.J. 173, 188 (1996); IT'S ABOUT TIME, *supra* note 16, at 10–12; OLD BEHIND BARS, *supra* note 9, at 80–82.

66. For New York's governing law in this area, see N.Y. EXEC. LAW § 259-s (2013).

67. Jamie Fellner, *Graying Prisoners*, N.Y. TIMES, Aug. 18, 2013, http://www.nytimes.com/2013/08/19/opinion/graying-prisoners.html.

68. *See*, *e.g.*, AT AMERICA'S EXPENSE, *supra* note 65, at vi, vii ("Research has conclusively shown that by age 50 most people have outlived the years in which they are most likely to commit crimes. For example, arrest rates drop to just over 2% at age 50 and are almost 0% at age 65.… There is also overwhelming evidence that prisoners age 50 and older are far less likely to return to prison for new crimes than their younger cohorts.").

69. *Id.* at 23.

70. *Id.* at 26–41.

71. *See*, *e.g.*, NPR: *Aging Prison Population Poses Unique Challenges* (NPR radio broadcast, Oct. 26, 2010) (statement by Project for Older Prisoners Founder Jonathan Turley saying, in part, "The Constitution requires that [some group of prisoners] be released unless we do a massive expansion of our prison system. The question is who.").

72. *See id.*

73. OLD BEHIND BARS, *supra* note 9, at 80 ("One of the biggest obstacles [corrections officials] face is finding nursing home care for the former prisoners who need it.").

74. Katherine Mieszkowski, *When the Nursing Home Resident in the Next Room is a Convicted Criminal*, N.Y TIMES, Jan. 19, 2012, http://www.nytimes.com/2012/01/20/us/prisoners-on-medical-parole-housed-in-california-nursing-homes.html?pagewanted=all.

75. *Id.*

76. *See*, *e.g.*, Arielle Levin Baker, *State Seeking Nursing Home to Take Sick, Disabled Prisoners*, CT MIRROR, Feb. 27, 2012, http://ctmirror.org/story/15565/state-seeking-nursing-home-take-sick-disabled-prisoners.

77. Interview with Carl J. Koenigsmann, *supra* note 26.

78. Cara Buckley, *Law Has Little Effect on Early Release for Inmates*, N.Y. TIMES, Jan 30, 2010, http://www.nytimes.com/2010/01/30parole.html?pagewanted=print.

79. N.Y. DEP'T OF CORRECTIONS AND COMMUNITY SUPERVISION, MEDICAL PAROLE REPORTS 2008-2011 (sent to the author by Commissioner Brian Fischer on June 26, 2012).

80. Emily Ramshaw, *Few Texas Inmates Get Released on Medical Parole*, TEXAS TRIBUNE, June 3, 2010, http://www.texastribune.org/texas-dept-criminal-justice/texas-department-of-criminal-justice/few-texas-inmates-get-released-on-medical-parole.

81. Interview with Justin Jones, *supra* note 31.

82. *See* H.B. 138, 2011 Leg. Reg. Sess. (La. 2011).

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Perspectives on the Role of Government and the Court System in Addressing the Legal Needs of Individuals with Diminished Mental Capacity

By Robert Cannon

Introduction

On October 7, 2013, Touro Law Center launched the nation's first Aging and Longevity Law Institute by hosting its First Annual Conference on Developments in Aging and Longevity Law (the "Conference"). The Conference, titled "The Capacity Crisis: What Lawyers Need to Know and Do for Their Clients, the Public and Themselves," addressed the role the legal profession must play in recognizing and addressing America's capacity crisis. Many of the Conference's esteemed interdisciplinary faculty recounted their own personal experiences dealing with a loved one with diminished mental capacity. Their passionate and thought-provoking presentations inspired this article.

The Conference analyzed the pivotal role that New York's government and court system play in addressing the legal needs of individuals with diminished mental capacity. Touro Law Center was honored to welcome three outstanding keynote speakers, each of whom demonstrates an unwavering commitment to addressing the complex issues facing America's aging population.

The Hon. A. Gail Prudenti, Chief Administrative Judge, New York State Unified Court System, discussed the essential role the courts play in dealing with the needs of older individuals and individuals with diminished mental capacity. She emphasized that "the courts often become the critical safety net for the most vulnerable members of our society."[1]

The Hon. Kathleen Rice, Nassau County District Attorney, provided valuable insight into the mechanisms and policies in place within the criminal justice system. Such policies enable the Nassau County District Attorney's Office to handle situations in which those with diminished mental capacity are accused, convicted and/or victims of a crime. District Attorney Rice commented "the same capacity issues that make it more complicated for prosecutions against older defendants also make too many of our older neighbors easy targets for scammers looking to take advantage of them."[2] She concluded her presentation by outlining how New York State District Attorneys combat elder financial abuse, in particular, the recommendations made within the *Report of the New York State White Collar Crime Task Force,* an initiative of the District Attorneys Association of New York.[3]

Greg Olsen, New York State Office for the Aging, addressed how New York State Government protects older individuals with diminished mental capacity. Mr. Olsen outlined his office's commitment "to try and help older adults remain as independent as possible"[4] by ensuring the proper implementation of programs such as the Legal Services Initiative.

By utilizing the informative and thought-provoking presentations of the aforementioned individuals as a starting point, this article provides an overview of how court systems throughout the United States, the Nassau County District Attorney's Office, and the New York State Office for the Aging protect society's most vulnerable individuals.

The Court System

National

Throughout the United States, court systems have established special initiatives, such as model courts for the aging, to address the unique needs of older persons. The initiatives discussed in this article include court programs in Illinois and Florida.

In August 2012, the Circuit Court of Cook County in Chicago, Illinois, established the Elder Law and Miscellaneous Remedies Division ("ELMRD"), a model court for elderly adults. The Hon. Patricia Banks is the Presiding Judge of the ELMRD.[5] Her article, "A New Age and a New Court for Older Litigants," discusses the formation of the ELMRD and the benefits of developing a model court for elderly adults.[6]

> A specifically designated court will offer more expertise in these matters, as well as more time to handle them. Moreover, elder law attorneys seeking to serve their clients often walk an ethical tightrope, given competing pressures to preserve client confidentiality and to share concerns about clients with family members. A court system equipped with a social service component geared to the needs of

> the elderly can provide opportunities to share concerns with nonfamily members who are experts in the field of aging. Ultimately, hearing cases in courts specially equipped to handle the multiplicity of aging issues will improve access and fairness in the court system as a whole.[7]

In conjunction with ELMRD, Cook County founded the Cook County Elder Justice Center that provides services to persons sixty (60) years of age or older involved in legal proceedings.

The Elder Justice Center ("EJC"), a court-based program in Florida's Thirteenth Judicial District, Hillsborough County, Tampa, assists individuals sixty (60) or older in navigating the court system.[8] The goals of the EJC, as outlined on its website, include providing "a designated elder-friendly facility for seniors, assistance to senior victims of abuse and/or exploitation and short term case management services."[9]

In 2008, recognizing a dearth of resources available to judges and the courts on aging issues, the National Center for State Courts established the Center for Elders and the Courts ("CEC").[10] The CEC "strives to increase judicial awareness of issues related to aging, provide training tools and resources to improve court responses to elder abuse and adult guardianships, and develop a collaborative community of judges, court staff, and aging experts."[11] For information on how courts across the nation address the complexities inherent in legal matters involving older persons and individuals with diminished mental capacity, visit the CEC website at www.eldersandcourts.org.

New York State Unified Court System

Under the leadership of Chief Judge Jonathan Lippman, Chief Administrative Judge A. Gail Prudenti, and their predecessors, New York has established numerous initiatives to address the needs of individuals with diminished mental capacity. Most notable are the Court's initiatives with respect to Mental Hygiene Law, Article 81 guardianships. During the Hon. A. Gail Prudenti's presentation at the Conference, she discussed some of these innovative approaches, including:

1. The Model Guardianship Part in Suffolk County;
2. The Special Landlord/Tenant Initiative in New York City; and
3. The Guardian Assistance Network.

Suffolk County Model Guardianship Part

In 2005, utilizing the Hon. H. Patrick Leis III's experience and expertise, and recognizing the successes of New York State's Integrated Domestic Violence Court, Chief Judge Judith Kaye announced the establishment of the Model Guardianship Part in Suffolk County. This model court integrated all pending litigations, i.e., foreclosure actions, matrimonial actions and criminal proceedings, involving an alleged incapacitated person ("AIP"). By assigning all pending litigations to one judge familiar with the underlying guardianship proceeding and well-versed in dealing with individuals with diminished mental capacity, the guardianship process is "tailored to the individual needs" of the AIP, a key objective of Mental Hygiene Law, Article 81.[12]

During her presentation at the Conference, the Hon. A. Gail Prudenti paid tribute to the Model Guardianship Part, describing it as a "one family, one judge approach that really promotes a sensitive, comprehensive decision making process…and provides a warm and comforting environment."[13]

This Model Guardianship Part is an exemplary court. An article by the AARP Public Policy Institute and the ABA Commission on Law and Aging, "Guarding the Guardians: Promising Practices for Court Monitoring"[14] and an article written by Judge Leis in the June 2006 edition of the New York State Bar Association's *Journal*[15] discuss the Model Guardianship Part with high regard.

Special Landlord/Tenant Initiative in New York City

In 2008, the New York State Office of Court Administration established an innovative new Part in New York County Housing Court.[16] This Part ("Part I" or the "Integrated Part") was designed to deal with situations in which a New York County resident is simultaneously an AIP in a Supreme Court, Mental Hygiene Law Article 81 guardianship matter and the subject of a Civil Court housing case. Both cases are integrated and adjudicated by one judge.[17] In his article, "Innovative Part Integrates Guardianship and Housing Matters," published in 2011, the Hon. Shlomo S. Hagler, Justice, Supreme Court, New York County, Civil Term, praises the innovative part and believes it has "succeeded in protecting and empowering vulnerable tenants."[18] Additionally, he outlines some of the Part's other achievements:

> The Part offers unique solutions to real problems. In open court and with consent of the parties the court coaxes [the Department of Social Services], charities, and family members to pay rental arrears. The court reaches out to housing specialists both in government and the private sector to provide affordable housing. The court counsels tenants to clean up their apartments, allow access to the landlord to make repairs and to remove hazardous conditions.[19]

The Guardian Assistance Network

The Guardian Assistance Network ("GAN") assists family members and friends appointed to serve as guardians pursuant to Article 81 of the New York Mental Hygiene Law.[20] Originally aimed at lay Guardians appointed in Kings County, the Office of Court Administration expanded the program statewide in 2006, with funding from the State Justice Institute.[21] "GAN offers support, practical advice and training (for lay guardians) in carrying out guardianship responsibilities."[22]

GAN developed a training manual[23] for lay guardians and offers regular training courses that satisfy the court-ordered training requirements.[24] In addition to the in-person training programs, GAN also offers a three-part online training video for lay guardians which also satisfies training requirements.[25]

Although GAN does not offer legal services, it provides free assistance to lay guardians in completing the following tasks:

- Setting up a guardian bank account;
- Writing reports and accountings required by the court;
- Finding services and helping apply for government benefits;
- Making a plan for the [incapacitated person] that allows as much independence as possible; and
- Locating resources that will help care for the [incapacitated person].[26]

Looking Forward

The courts play an integral part in not only addressing the needs of individuals with diminished mental capacity but also addressing the concerns of family members. In recounting her own experiences presiding over cases involving individuals with diminished mental capacity, the Hon. A. Gail Prudenti remarked:

> I have seen court officers comfort distraught family members. I have seen judges mediate deeply rooted family problems that started far before the incident that brings them to the Court and I have seen the Court play such an important role that extends far and wide. [27]

Throughout the country, as the aforementioned initiatives evolve and new initiatives are established, the courts must continue to balance the state's *parens patriae* power and the legal rights of individuals with diminished mental capacity. In her article titled, "*Parens Patriae Power: The Court's Role in Addressing the Fragility of Capacity*," Lauren J. Numeroff, Esq., captures this legal tension and the delicate balance the courts must strike.[28]

How New York State Addresses the Legal Needs of Aging Individuals with Diminished Mental Capacity

According to *New York State's Resource Guide for Older New Yorkers*, published by the New York State Office for the Aging in 2012, the Office for the Aging "serves as an advocate for over 3.7 million New Yorkers age 60+… [and] for older persons at all levels of government and the private sector with the cooperation of concerned organizations and older New Yorkers."[29] The New York State Office for the Aging's overall mission is

> to help older New Yorkers be as independent as possible for as long as possible through advocacy, development and delivery of person-centered, consumer-oriented, and cost-effective policies, programs and services which support and empower older adults and their families, in partnership with the network of public and private organizations which serve them.[30]

Pursuant to this mission, Greg Olsen of the New York State Office for the Aging, alongside New York State Governor Andrew Cuomo, the New York State Bar Association, the New York Office of Court Administration, and Robert Abrams, Esq., created the Legal Services Initiative ("LSI"). LSI aims to increase access to affordable legal assistance to three primary target groups: (1) New York's older adults, (2) individuals with disabilities and (3) caregivers of these individuals.[31] The press release for LSI issued by New York State Governor Andrew Cuomo states:

> The collaborative effort will identify the legal needs and barriers to justice faced by older adults and individuals with disabilities. The partners involved in the effort will develop a strategic plan to more effectively use existing resources, including attorney pro bono programs, to target areas of greatest need.…
>
> The partnership is expected to yield a variety of educational programs and tools, including an interactive website, a series of community forums to raise awareness about the legal issues often faced by the targeted populations, an elder preparedness self-assessment tool, an elder law treatise for attorneys and other professionals, and strategies for increasing the availability of free and low-cost legal services.[32]

In 2014, the LSI formed an interdisciplinary "Think Group" with approximately 100 experts throughout New York, to, *inter alia*, implement the findings of legal surveys

which the New York State Office for the Aging will have conducted. During Mr. Olsen's presentation at the Conference, he outlined the five distinct groups of individuals that have or will be surveyed:

1. Area agencies on aging;
2. Legal service contractors who contact with area agencies;
3. A statewide survey of consumers (conducted through a contract with Siena College);
4. New York State attorneys; and
5. Members of the Judiciary.[33]

According to Mr. Olsen, the "Think Group" of dedicated professionals will "develop strategies and recommendations regarding the gaps uncovered" and how New York can best meet the needs of vulnerable and underserved older persons, many of whom have diminished mental capacity.[34]

In addition to the LSI, the New York State Office for the Aging has established a wide range of services designed to address the needs of New York State's aging population, including the Long Term Care Ombudsman Program,[35] the New York Elder Caregiver Support Program,[36] and the Livable New York Initiative.[37]

When Older Individuals Are Victims of a Crime

According to a 2011 MetLife study, "the annual loss by victims of elder financial abuse is estimated to be at least $2.9 billion, a 12% increase from the $2.6 billion estimated in 2006."[38] With New York State containing the third largest older adult population in the country, behind California and Florida,[39] New York State District Attorneys and legislators will play a critical role over the coming years in tackling the growing problem of elder financial abuse.

As outlined by District Attorney Rice during her presentation at the Conference and as described in the *Report of the New York State White Collar Crime Task Force*, the older adult population is particularly susceptible to financial exploitation "due to physical or mental infirmities" and present "an attractive target: as a group they hold the largest percentage of the nation's wealth."[40] District Attorney Rice provided the following example of elder abuse:

> Right now we are also hearing anecdotal evidence of an Obamacare card scam… Senior citizens are getting called and told that they have to give up their credit card and other information and buy an actual Obamacare card or else they are going to lose their insurance. Of course none of that is true but to someone who is vulnerable that sounds like something that is reasonable.

In response to the prevalence of elder abuse, New York government offices provide many useful resources including, *inter alia*:

- New York County District Attorney's Office, Resources for Victims of Elder Abuse: http://manhattanda.org/resources-victims-elder-abuse.
- Nassau County Office for the Aging: http://www.nassaucountyny.gov/agencies/Seniors/index.html.
- Suffolk County's Elder Abuse Unit: http://www.suffolkcountyny.gov/da/AbouttheDAsOffice.aspx.
- New York State Office of Children and Adult Services, Bureau of Adult Services: http://ocfs.ny.gov/main/psa/.

In 2012, Cyrus R. Vance, Jr., then President of the District Attorneys Association of the State of New York, established the New York State White Collar Crime Task Force (the "Task Force") to examine the legal tools available to prosecutors to fight crimes that were not imaginable even just twenty years ago.[41] The Task Force concluded that more needed to be done to combat the financial exploitation of elders and it formed an Elder Abuse Working Group ("The Group").[42] The Group provided the following five recommendations:

- Amend the Criminal Procedure Law to allow for the conditional examination of victims who are 75 years old or older.
- Incorporate the holding of *People v. Camiola* into the definition of Larceny so that purported consent by a victim with diminished mental capacity is not a defense to Larceny.
- Amend the Criminal Procedure Law to permit a caregiver to accompany a vulnerable victim into the grand jury. The definition of "caregiver" would include both informal caregivers and professional social workers.
- Allow prosecutors to obtain medical records of mentally impaired victims of financial exploitation, without requiring a waiver from those very victims.
- Amend the crime of Larceny by false promise to make clear that partial performance, standing alone, does not defeat a prosecution that is otherwise legally sufficient. This aims to clarify the rulings of some courts, in reliance on *People v. Churchill*.[43]

Many local district attorneys, including District Attorney Rice, believe that a District Attorney's role is to not only prosecute crime, but also to educate the public on how to better protect itself. In 2010, District Attorney Rice launched an educational campaign to teach older persons how to protect themselves from scams that target their vulnerabilities.[44]

When Older Individuals Are Accused of a Crime

When older individuals with diminished mental capacity are arrested and charged with a crime, the lawyers and judges involved in court proceedings must ultimately address whether the older individuals had the capacity to form the required mental state, i.e., intent,[45] knowledge,[46] recklessness,[47] to commit the crime. Proof of a mental defect may not be a complete statutory defense but "it may in a particular case negate a specific intent necessary to establish guilt."[48] However, as the following quotation emphasizes, more has to be done to understand the consequences of diminished mental capacity:

> Alzheimer's disease patients, too demented by illness to remember their own names, have gone to jail for slapping their caregivers during an agitated fit. Seniors caught shoplifting have confessed they did so because they were lonely and craved attention, not because they needed what they took. Elders have missed court appearances because they were frightened and confused.[49]

When Older Individuals Are Convicted of a Crime

According to a 2012 American Civil Liberties Union report, "At America's Expense: The Mass Incarceration of the Elderly," there are 246,600 prisoners over the age of fifty (50) incarcerated in the United States.[50] The report also found that "it costs $34,135 per year to house an average prisoner, but it costs $68,270 per year to house a prisoner age 50 and older."[51]

Some prisons have become *de facto* or *de jure* nursing homes. This phenomenon has been the subject of many articles including *America's Prisons Have Turned Into Really Awful Nursing Homes*[52] featured on www.businessinsider.com. Most experts agree that prisons are not equipped to meet the medical and personal care needs of older persons, especially those who suffer with Alzheimer's disease and/or other forms of diminished mental capacity.

It is for this reason that many advocates believe that prisons must consider the compassionate release of their older and sicker inmates. The Justice Department's Inspector General agrees. The Inspector General has called on United States prisons to release, as appropriate, more prisoners who are sick and/or have serious terminal illnesses.[53] In light of recent cases, such as the early release from prison of Brooke Astor's son, Anthony D. Marshall, who was incarcerated for his conviction of stealing millions of dollars from Ms. Astor,[54] the public has and will continue to debate how society should deal with older prisoners.

Conclusion

Robert Abrams, Esq., Co-Founder and Of Counsel to Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Einiger, LLP, Chair of Touro Law Center's Aging and Longevity Law Advisory Board, and guest editor of this special edition of the *Government, Law and Policy Journal* said "the statistics prove that the situation is getting worse not better and that these changing demographics of society demand a response from the legal, professional and academic communities."[55] As the nation's population continues to age, it is vital that our government and court systems address the issues facing society's most vulnerable individuals. By guaranteeing the successful implementation of initiatives such as the Legal Services Initiative, by continuing to address the deficiencies in the criminal justice system through reports such as the Report of the New York State White Collar Crime Task Force and by ensuring that the Courts continue to provide a critical safety net, we can appropriately care for society's most vulnerable individuals.

Endnotes

1. Video Recording: The Capacity Crisis: What Lawyers Need to Know and Do for Their Clients, the Public and Themselves, held by Touro Law Center (Oct. 7, 2013) (on file with author).
2. *Id*.
3. The District Attorneys Ass'n of the State of New York, Report of the New York State White Collar Crime Task Force (2013).
4. *Supra* note 1.
5. State of Illinois, Circuit Court of Cook County, Elder Law & Miscellaneous Remedies Division, http://www.cookcountycourt.org/ABOUTTHECOURT/CountyDepartment/ElderLawMiscellaneousRemediesDivision.aspx.
6. Judge Patricia Banks, *A New Age and A New Court for Older Litigants*, Experience, Vol 22. No. 2 (2012).
7. *Id.* at 13.
8. The Elder Justice Center, http://www.fljud13.org/CourtPrograms/ElderJusticeCenter.aspx (last visited Oct. 25, 2013).
9. The Elder Justice Center, http://www.fljud13.org/CourtPrograms/ElderJusticeCenter/FAQs.aspx (last visited Oct. 25, 2013).
10. About CEC, http://www.eldersandcourts.org/About-CEC.aspx (last visited Oct. 25, 2013).
11. *Id.*
12. N.Y. Mental Hyg. Law § 81.01.
13. *Supra* note 1.
14. Naomi Karp, AARP Public Policy Institute, & Erica Wood, ABA Commission on Aging, *Guarding the Guardians: Promising Practices for Court Monitoring*, Dec. 2007, available at http://assets.aarp.org/rgcenter/il/2007_21_guardians.pdf.
15. H. Patrick Leis, III, *The Model Guardianship Part: A Novel Approach*, N.Y.S.B.A. Journal (June 2006).
16. Shlomo S. Hagler, *Innovative Part Integrates Guardianship and Housing Matters*, 245 N.Y.L.J. 119 (2011).

17. *Id.*
18. *Id.*
19. *Id.*
20. The Guardian Assistance Network, Welcome, http://www.nycourts.gov/ip/gan/ (last visited Oct. 25, 2013).
21. *Id.*
22. The Guardianship Assistance Network, About Us, http://www.nycourts.gov/ip/gan/aboutus.shtml (last visited Oct. 25, 2013).
23. State Justice Institute, Guide to Guardianship for Lay Guardians Appointed Under Article 81 of the New York State Mental Hygiene Law (4th ed. 2011).
24. N.Y. Mental Hyg. Law § 81.39 (b).
25. The Guardianship Assistance Network, Online Training Video, http://www.nycourts.gov/ip/gan/training.shtml (last visited Oct. 25, 2013).
26. The Guardianship Assistance Network, How Can GAN Help? http://www.nycourts.gov/ip/gan/howcanganhelp.shtml (last visited Oct. 25, 2013).
27. *Supra* note 1.
28. Lauren J. Numeroff, *Parens Patriae*: The Court's Role in Addressing the Frailty of Capacity, 16 Gov't, L. & Pol'y J. Summer 2014 at 28.
29. New York State's Resource Guide for Older New Yorkers.
30. New York State Office for the Aging, Our Mission, http://www.aging.ny.gov/index.cfm.
31. *Description of the Initiative*, http://www.aging.ny.gov/LivableNY/LegalServices/DescriptionOfInitiative.pdf.
32. Press Release, Governor Andrew M. Cuomo, Governor Cuomo Announces Statewide Partnership to Improve Access to Legal Services for Vulnerable New Yorkers (Sept. 12, 2012), available at http://www.aging.ny.gov/LivableNY/LegalServices/PressRelease.pdf.
33. *Supra* note 1.
34. *Id.*
35. New York State Office for the Aging, http://www.aging.ny.gov/NYSOFA/Services/Index.cfm?id=LTCOP,#LTCOP.
36. New York State Office for the Aging, http://www.aging.ny.gov/NYSOFA/Programs/CaregiverSvcs/OAA-IIIE.cfm.
37. New York State Office for the Aging, http://www.aging.ny.gov/livableny/index.cfm.
38. MetLife Mature Market Institute, The MetLife Study of Elder Financial Abuse, Crimes of Occasion, Desperation, and Predation Against America's Elders at 2 (2011), available at https://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-elder-financial-abuse.pdf.
39. U.S. Dep't of Health & Human Services, Admin. On Aging, A Profile of Older Americans: 2011 at 9 (2011), available at http://www.aoa.gov/aoaroot/aging_statistics/profile/2011/docs/2011profile.pdf .
40. The District Attorneys Ass'n of the State of New York, *supra* note 3, at 62.
41. *Id.* at 2.
42. *Id.* at 62.
43. *Id.* at 9 (Internal citations omitted).
44. Press Release, Nassau County District Attorney's Office, *DA Rice Launches Educational Campaign to Help Senior Citizens Learn How to Protect Themselves From Scams,* (Nov. 30, 2010), available at http://www.nassaucountyny.gov/agencies/DA/NewsReleases/2010/113010seniorscams.htm; *see also,* District Attorney's Office, DA Rice: Senior Citizens Can Avoid Being Scammed by Following a Few Simple Safety Tips and Recognizing Red Flags, available at http://www.nassaucountyny.gov/agencies/DA/SeniorScams.htm.
45. A person intentionally commits a crime "when his conscious objective is to cause such result or to engage in such conduct." N.Y. Penal Law §15.05(1).
46. A person "knowingly" commits a crime "when he is aware that his conduct is of such nature or that such circumstance exists." N.Y. Penal Law §15.05(2).
47. A person "recklessly" commits a crime "when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists." N.Y. Penal Law §15.05(3).
48. *People v. Segal*, 54 N.Y.2d 58, 66, 429 N.E.2d 107, 110, 444 N.Y.S.2d 588, 591 (1981).
49. Diane C. Lade, *Advocates Ask Special Courts for the Elderly*, Sun Sentinel, July 19, 1999, available at http://articles.sun-sentinel.com/1999-07-19/news/9907190212_1_seniors-court-staff-task-force.
50. American Civil Liberties Union, *At America's Expense: The Mass Incarceration of the Elderly*, June 2012, available at https://www.aclu.org/criminal-law-reform/americas-expense-mass-incarceration-elderly.
51. *Id.* at 27-28.
52. Erin Fuchs, *America's Prisons Have Turned Into Really Awful Nursing Homes*, Business Insider, August 7, 2013, available at http://www.businessinsider.com/americas-prisons-have-too-many-old-people-2013-8.
53. U.S. Department of Justice, Office of the Inspector General, *The Federal Bureau of Prisons' Compassionate Release Program*, April 2013, available at http://www.justice.gov/oig/reports/2013/e1306.pdf.
54. Russ Buettner, *Brooke Astor's Son Is Paroled,* N.Y. Times, August 22, 2013, available at http://www.nytimes.com/2013/08/23/nyregion/brooke-astors-son-to-be-paroled.html.
55. *Supra* note 1.

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Parens Patriae Power: The Court's Role in Addressing the Fragility of Capacity

By Lauren J. Numeroff

> There is no doubt that the State may have a compelling interest, under its *parens patriae* power, in providing care to its citizens who are unable to care for themselves.… Such a determination is uniquely a judicial, not a medical function.[1]

As members of a society in which autonomy is valued at a premium, and considered "unalienable,"[2] restrictions on such autonomy may only be exercised when countered by a compelling state interest.[3] The protection of those who are unable to care for themselves is a doctrine with a rich history in this country's laws, and those of societies far older than ours.[4]

Much of the scholarly discourse regarding the court's role pursuant to the states' *parens patriae* [5] power with respect to the aging population has focused primarily on the deprivation of civil liberties and ageism.[6] However, as important as it is for society not to violate the individual liberties of our older citizens, nor to assume that advanced age is a proxy for incompetency, it is equally important that courts, in whose jurisdiction the statutes which invoke the *parens patriae* power generally fall, remain vigilant in their task of effectively identifying incapacity, and protecting those who lack the capacity to protect themselves.

The New York Supreme Court, as a court of general jurisdiction at law and in equity, includes the care, custody, and control of incompetents in its inherent powers.[7] While this is not an exhaustive list, the courts in New York have jurisdiction over cases in which an individual's right to self-determination may be infringed upon due to the individual's inability to make decisions on his or her own behalf under Mental Hygiene Law (MHL) Articles 9 and 81, the Civil Practice Law and Procedure Rule (CPLR) 1201, and the Surrogate's Court Procedure Act (SCPA) Article 17-A. These laws, which are summarized below in the context of the *parens patriae* power, entrust the courts with the grave responsibility of making the critical determination as to whether an individual has capacity—a determination that cuts off an individual's most basic and primal civil right, as well as one that has the potential to save that individual's life.

However, it is not only in civil commitment or guardianship proceedings when the courts, in an exercise of the state's *parens patriae* power, are entrusted with making determinations regarding capacity. Rather, the issue of capacity presents itself in nearly every type of case that could come before a court of law or equity, including but not limited to landlord/tenant actions, estate litigation, contract litigation, complex commercial litigation, real estate law, matrimonial actions, and criminal cases.

Most remarkable about the *parens patriae* power, with which the courts have been entrusted, is that *capacity* is not a "yes/no" issue. For example, there are different standards for testamentary capacity, capacity to make a gift or conveyance, capacity to contract, the need for a guardian of the estate, the need for a guardian of the person, capacity to commit a crime, capacity to stand trial for a crime, involuntary civil commitment to a mental institution, capacity to consent to sexual conduct, capacity to marry, eligibility for Social Security benefits by reason of mental impairment, and eligibility for relief under the Americans with Disabilities Act of 1990.[8] Moreover, there are individuals whose capacity fluctuates, such that on certain days, or at certain times of day, they may lack capacity, but be perfectly capable on other days or times.[9] Capacity is therefore a fragile concept, bending and fluctuating depending on the task at hand, and one that, subject to the pressures of a yes/no inquiry, can irreparably fall apart. This fragility renders the courts' task of determining whether capacity exists—a determination with grave consequences—a substantial one.

Treatment of the Mentally Ill

Article 9 of the MHL (entitled, Hospitalization of the Mentally Ill) provides three mechanisms by which a mentally ill person's rights may be suppressed pursuant to both the state's *parens patriae* and police powers.[10]

Pursuant to MHL § 9.27, a director of a hospital may, upon the application for involuntary admission, admit and retain a person alleged to be mentally ill and in need of involuntary care and treatment, upon the certificates of two examining physicians.[11] "Mental illness" is defined as "an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation."[12] Similarly, MHL § 9.39 permits a director of a hospital to admit and retain for a maximum of fifteen (15) days, an individual alleged to have a mental illness, for which immediate observation, care, and hospital treatment is appropriate, and which is likely to result in serious harm to himself or others. Because the statute allows

for notice and a hearing, periodic reassessment of the patient's status, and the appointment of counsel, involuntary commitment under §§ 9.27 and 9.39 is not considered to be violative of due process.[13]

While such involuntary commitment may come before the courts on review of an appeal, the determination of whether the person alleged to be mentally ill and in need of involuntary care and treatment is made at the hospital, without the involvement of the courts.

However, pursuant to MHL § 9.60 ("Kendra's Law"),[14] a court order may be obtained that authorizes assisted outpatient treatment for an individual eighteen years or older who is suffering from a mental illness, is unlikely to survive safely in the community without supervision, has a history of noncompliance with treatment, is unlikely to voluntarily participate in such outpatient treatment, and is likely to benefit from such treatment.[15] At a hearing, the petitioner must present clear and convincing evidence, through the testimony of an examining physician, that the subject of the petition meets the criteria for assisted outpatient treatment.[16]

While these provisions expose the broad authority granted to the state regarding the treatment of mentally ill individuals, the Court of Appeals has held that neither *parens patriae* nor the state's police power provides sufficient bases for forcibly administering antipsychotic medication without a judicial determination as to that individual's capacity to make a reasoned decision with respect to the proposed treatment.[17] In contrast to MHL §§ 9.27, 9.39, and 9.60's requirements that an individual is suffering from mental illness and in need of treatment, *Rivers v. Katz* established that upon an exhaustion of the administrative review procedures that allow a[n alleged] mentally ill person to appeal decisions regarding any form of care and treatment,[18] the State "bear[s] the burden of demonstrating by clear and convincing evidence the patient's incapacity to make a treatment decision."[19] The Court of Appeals further safeguarded against the involuntary administration of medication by stating that if a court finds that the patient does not have the capacity to make such decisions, that court would have to make a determination as to "whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment, and any less intrusive alternative treatments."[20]

Accordingly, the *Rivers* decision curbed the state's broad *parens patriae* power by prohibiting its employment when a patient is, despite his or her mental illness, capable of comprehending the consequences of the decision to refuse medication that poses a significant risk to his or her well-being. While MHL §§ 9.27, 9.39, and 9.60 require a medical determination before an individual can be involuntarily admitted to a hospital or ordered to participate in an assisted outpatient treatment program, the courts must inquire into an individual's ability to understand and appreciate the consequences of his or her actions in order to allow medical professionals to administer psychiatric treatment against a patient's wishes.

Guardianships

Article 81 of the MHL allows for a guardian to be appointed for an individual who has been adjudicated to lack capacity. The powers granted to Article 81 guardians, while varied based on the individual's functional limitations, can be quite vast,[21] such that guardianships constitute a significant curtailment of wards' individual liberties. Accordingly, there are multiple procedural and substantive safeguards in Article 81 that assist judges in making determinations regarding an individual's incapacity under the statute. At the forefront of these protections is the concept that any compromise of individuals' rights should constitute the "least restrictive form of intervention which assists them in meeting their needs but, at the same time, permits them to exercise the independence and self-determination of which they are capable."[22]

In addition to the standard protective provisions of notice, opportunity to be heard,[23] and the right to counsel,[24] a court evaluator is typically appointed in guardianship proceedings to serve as the eyes and ears of the court, by investigating the allegations in the petition, the condition of the person alleged to be incapacitated, the resources of the person alleged to be incapacitated, and the person(s) nominated as guardian, and making recommendations to the court upon such investigation.[25]

In order to make a finding of incapacity, the court must determine, based on clear and convincing evidence,[26] that: the individual has functional limitations[27] which impair that individual's ability to provide for his or her personal needs and/or property management; the individual lacks understanding and appreciation of the nature and consequences of his or her functional limitations; there is a likelihood that the individual will suffer harm because of his or her functional limitations and inability to adequately understand and appreciate the nature and consequences of such functional limitations, and, the individual needs a guardian to be appointed in order to prevent such harm.[28] In addition to ordering a guardianship that constitutes the "least restrictive form of intervention" guardianship judges are tasked with taking an already vulnerable individual and stripping that individual of his or her rights of self-determination, in essence, creating a further layer of vulnerability[29] that must be accounted for by the appointment of a qualified guardian[30] to care for that individual, and a diligent court examiner[31] to attentively monitor the guardian's acts with respect to the ward.[32] The guardian and court examiner appointed are then fiduciaries to the state's ward, which provide even further safeguards.

In practice, the guardianship proceeding is an essential tool to protect an individual who lacks the ability to protect him or herself from abuse (physical, emotional, or financial) and self-neglect. As our aging population grows—an inevitable side effect of modern medicine's advances—the potential for a larger population of individuals living with dementia and Alzheimer's disease increases. This is not ageism, but a fact.[33] In addition, the statistics on abuse among the aging population are dismal,[34] making vital the state's great power of being able to intervene and protect those who cannot protect themselves.

Outside the context of a guardianship proceeding, however, the state's *parens patriae* power actually creates a burden for judges to at least look into the matter of an individual's capacity, and address the issue of whether the individual before the court is capable of adequately prosecuting or defending his or her rights. When a party has not been adjudicated as lacking capacity, but is not functionally able to prosecute or defend his or her rights, CPLR § 1201 requires that that person appear through a guardian *ad litem*, such that the court must appoint a guardian *ad litem* for that individual. A guardian *ad litem* is defined as a "guardian, [usually] a lawyer, appointed by the court to appear in a lawsuit on behalf of an incompetent or minor party."[35]

Similar to Article 81, a guardianship under Article 17-A of the SCPA is established for an individual with compromised mental capacity. However, unlike MHL Article 81, Article 17-A guardianships are for individuals who never had capacity in the first place. Until the age of eighteen, our parents are our natural guardians.[36] However, because an individual with significant intellectual disability will not outgrow his or her need for a guardian, the state has an interest in protecting such people throughout their lives by having a guardian appointed. Therefore, the process of appointing a guardian for an individual who is adjudicated as a "mentally retarded person"[37] or a developmentally disabled person is much simpler than an Article 81 guardianship. Upon the court's finding that the individual has an intellectual disability, "the court is authorized to appoint a guardian of the person or of the property or of both if such appointment of a guardian or guardians is in the best interest of the mentally retarded person."[38]

As intellectually disabled individuals are just as vulnerable as the individuals who were once capacitated, the 17-A guardianship is an indispensable tool that the state provides to protect them.

"Independence and Self-Determination"[39]

Even when the broad *parens patriae* power of the state is exercised in Article 81 guardianship matters, the individual who is the subject of a guardianship maintains all powers and rights not granted to the guardian[40] and, above all, has her right to independence and self-determination respected by the fact that such guardianships must "take in account the personal wishes, preferences and desires of the person, and [] afford[] the person the greatest amount of independence and self-determination and participation in all decisions affecting such person's life."[41]

The harm to the individual whose right to direct her own life is trespassed upon or superseded by the court's *parens patriae* power is one that is on even footing with the great harm to society that is caused by a loss of faith in the courts. When courts fail to truly acknowledge an individual's right to independence and self-determination, we are all at risk. For example, in connection with several guardianship actions in New York's Nassau County, individuals have become so dismayed by what they perceived to be a miscarriage of justice to their family members that they have taken to electronic media to publicize their stories.[42] While these stories are undoubtedly, and heavily, one-sided, and unsettled, contested guardianships will inevitably leave at least one party unhappy; these stories do reflect the grave risk to society of the appearance of impropriety created when courts exercise their *parens patriae* power without being extremely sensitive to each individual's personal wishes and desires.

In the child custody *Matter of Lincoln v. Lincoln*, the Court of Appeals discussed "[t]he burden on a Judge when he acts as *parens patriae* [being] perhaps the most demanding which he must confront in the course of his judicial duties" and laid out a framework for assisting judges in ferreting out the best interests of the child in contentious custody litigations.[43] Specifically, the Court acknowledged that there is no deprivation to the parents' rights when a judge speaks in confidence with the child whose custody is at issue, without the consent of the parents.

New York Guardianship judges, including Judge Laura Visitación-Lewis, in New York County, have applied these principles by conducting *Lincoln* hearings to determine the alleged incapacitated person's preferences. Arguably, holding these hearing more often can provide judges with greater insight into the personal wishes, preferences, and desires of the alleged incapacitated person, and instill in the public a greater sense of confidence in the courts' ability to effectively and impartially adjudicate guardianship matters.

Conclusions

The state's *parens patriae* power enables the state to have tremendous control over the lives of individuals within its borders when such individuals suffer from disability that prevents them from being able to care for themselves, and causes a lack of understanding and appreciation of how their disability affects their ability to care for themselves. With such vast power comes tremen-

dous responsibility not to tread too heavily on such individuals' liberties by ensuring that they are afforded the greatest amount of autonomy within the confines of the courts' orders, and to carefully assess each individual's capacity.

Moreover, the courts play the primary role in monitoring the thousands of Article 81 guardianships in the state. The many protections in Article 81 in conjunction with Part 36 of the Rules of the Chief Judge,[44] provide an elaborate scheme through which wards of the state are meant to be protected by the courts. The statutory framework of oversight, though, does not contemplate judicial involvement until an application is filed regarding noncompliance with the reporting requirements and fiduciary obligations of guardians or other court appointees. This, combined with a lack of sufficient resources, presents the courts with unique challenges as to how to reap vigilance from its appointees.

Finally, all of the courts in this state have a duty to ensure that when a litigant presents with diminished capacity, or allegations are made with respect to a party's diminished capacity, that the courts are sensitive to the fragility of capacity, and act upon the state's *parens patriae* power to protect such parties and their respective postures in the litigation before the courts. To the extent that it is reasonable to do so, judges should consider the value of holding *Lincoln* hearings as a means of fulfilling that duty.

Endnotes

1. *Rivers v. Katz*, 67 N.Y.2d 485, 496-97, 495 N.E.2d 337, 343, 504 N.Y.S.2d 74, 80 (1986) (internal citations omitted).
2. *See* The Declaration of Independence para. 2 (U.S. 1776).
3. *Rivers*, 67 N.Y.2d at 493, 496.
4. *See Moore v. Flagg*, 137 A.D. 338, 341–46, 122 N.Y.S. 174 (1st Dep't 1910) (regarding jurisdiction over such matters); Neil B. Posner, *The End of* Parens Patriae *in New York: Guardianship under the New Mental Hygiene Law Article 81*, 79 Marq. L. Rev. 603, 604–05 (1996) (*citing* Peter M. Horstman, *Protective Services for the Elderly: The Limits of* Parens Patriae, 40 Mo. L. Rev. 215, 218 (1975), and discussing the statute Praerogativa Regis in the time of Cicero, and the "English concept of the king as father of his subjects" which, in combination with a set of fiduciary obligations entrusted to the heir of an incompetent person, was "carried over into the United States after the American Revolution").
5. Latin for "parent of his or her country," and the legal doctrine by which the state is regarded as "sovereign…in its capacity as provider of protection to those unable to care for themselves." Black's Law Dictionary 520 (9th ed. 2009).
6. *See*, *e.g.*, Jennifer Beth Glick, Note, *Protecting and Respecting Our Elders: Revising Mandatory Elder Abuse Reporting Statutes to Increase Efficacy and Preserve Autonomy*, 12 Va. J. Soc. Pol'y & l. 714, 729–30 (2005) (regarding elderly abuse victims and how mandatory reporting of abuse pursuant to the state's *parens patriae* power is inappropriate when the victim is not adjudicated incompetent); Carolyn L. Dessin, *Financial Abuse of the Elderly: Is the Solution a Problem?*, 34 McGeorge L. Rev. 267, 307–08 (2003) (arguing that older citizens are not *per se* vulnerable to abuse, such that older citizens, generally, require protection under the *parens patriae* power, but that physical or mental impairments create such vulnerability); Christy Holmes, Comment, *Surrogate Decisionmaking in the 90's: Learning to Respect Our Elders*, 28 U. Tol. L. Rev. 605, 624 (1997) ("Statutory recognition of the right to make bad decisions would significantly increase the protection of the elderly's autonomy.… Reform efforts should focus on a separation of 'unwise' and 'incompetent' decisions."); Jan Ellen Rein, *Preserving Dignity and Self-Determination of the Elderly in the Face of Competing Interests and Grim Alternatives: A Proposal for Statutory Refocus and Reform*, 60 Geo. Wash. L. Rev. 1818, 1838 (1992) ("Evidently, the line between helpful protection and harmful authoritarian imposition is thin and wavering.").
7. *See Moore*, 137 A.D. at 42, 122 N.Y.S. 174; *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (2nd Dep't 1980), order modified on other grounds, *Matter of Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).
8. Thomas R. Kellogg, *Proof of Incompetency*, 62 Am. Jur. Proof of Facts 3d 197 (2001).
9. *See*, *e.g.*, *In re Martin's Will*, 82 Misc. 574, 144 N.Y.S. 174 (N.Y. Sup. Ct. N.Y. Cty. 1913).
10. Whereas the *parens patriae* power gives the state jurisdiction to prevent an individual from harm that may come to him or herself, the police power is used to protect the community from harm. *In re K.L.*, 1 N.Y.3d 362, 370, 806 N.E.2d 480, 485, 774 N.Y.S.2d 472, 477 (2004).
11. N.Y. MHL § 9.27.
12. MHL § 1.03(20).
13. *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983); *Fisk v. Letterman*, 501 F. Supp. 2d 505 (S.D.N.Y. 2007).
14. MHL § 9.60.
15. *Id*.
16. *Id.*
17. *Rivers*, 67 N.Y.2d at 497, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.
18. 14 N.Y.C.R.R. 27.8.
19. *Rivers*, 67 N.Y.2d at 497, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.
20. *Id.* at 497-498, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.
21. See MHL §§ 81.21 and 81.22 for the powers with which a property management and/or personal needs guardian may be appointed.
22. MHL § 81.01.
23. MHL § 81.07.
24. MHL § 81.10.
25. *See* MHL § 81.09.
26. MHL § 81.12(a).
27. "Functional limitations" are defined as "behavior or conditions of a person which impair ability to provide for personal needs and/or property management. MHL § 81.03(c).
28. MHL § 81.15(b) and (c).
29. *But cf.* MHL § 81.29 (reserving for the ward all powers not granted to the guardian and establishing, generally, that a guardianship order is not a *per se* declaration of incapacity in all respects).
30. MHL § 81.39.
31. MHL § 81.41.
32. *See*, *generally*, MHL §§ 81.30–36.
33. In 2002, the prevalence of individuals over age 71 was 13.9% (1 in 7), and in 2007, the elderly population was expected to grow to 70 million by 2030. B.L. Plaaman, et al., *Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study*, 29 Neuroepidemiology 125, 126 (2007). In 2013, it is estimated that 5 million people over the age of 65 have Alzheimer's disease (compared to 200,000 under the age of 65), and that in 2030, 13.8 million people over the age of 65 will suffer from Alzheimer's.

Alzheimer's Association, *2013 Alzheimer's Disease: Facts and Figures*, 9 ALZHEIMER'S & DEMENTIA, 2013, at 15, 20.

34. In 2011, the New York State Elder Abuse Prevalence Study reported that "141 out of 1,000 older New Yorkers have experienced an elder abuse event since turning age 60." UNDER THE RADAR: NEW YORK STATE ELDER ABUSE PREVALENCE STUDY, http://ocfs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf.

35. BLACK'S LAW DICTIONARY 320 (9th ed. 2009).

36. N.Y. DRL § 81.

37. "For the purposes of [Article 17-A of the SCPA], a mentally retarded person is a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with mental retardation, having qualifications to make such certification, as being incapable to manage him or herself and/or his or her affairs by reason of mental retardation and that such condition is permanent in nature or likely to continue indefinitely." N.Y. SCPA § 1750.

"[A] developmentally disabled person is a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with developmental disabilities, having qualifications to make such certification, as having an impaired ability to understand and appreciate the nature and consequences of decisions which result in such person being incapable of managing himself or herself and/or his or her affairs by reason of developmental disability and that such condition is permanent in nature or likely to continue indefinitely, and whose disability: (a) is attributable to cerebral palsy, epilepsy, neurological impairment, autism or traumatic head injury; (b) is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons; or (c) is attributable to dyslexia resulting from a disability described in subdivision one or two of this section or from mental retardation; and (d) originates before such person attains age twenty-two, provided, however, that no such age of origination shall apply for the purposes of this article to a person with traumatic head injury." N.Y. SCPA § 1750-a.

38. N.Y. SCPA §§ 1750, 1750-a.

39. MHL § 81.01.

40. MHL § 81.29.

41. MHL § 81.01.

42. See the stories of Dorothy Wilson, Richard Maas, and Joan Pezzolo on Diane Wilson's blog, judicialdestructionofdorothy.wordpress.com, where she writes about how the late Justice Asarch appointed Mary Giordano, Esq. as guardian for her mother, Dorothy Wilson, which resulted in her move to a nursing home against her wishes. See also nasga-stopguardianabuse.blogspot.com for stories from around the country in which so-called "professional guardians" entrusted with caring for wards of the state fail to properly do so.

43. *Matter of Lincoln v. Lincoln*, 24 N.Y.2d 270, 272, 247 N.E.2d 659, 660, 299 N.Y.S.2d 842, 843-844 (1969).

44. 22 N.Y.C.R.R. § 36.

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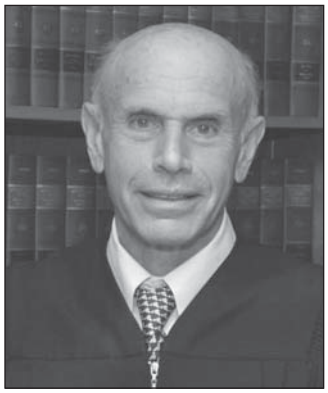
Judicial Perspectives

By Hon. Arthur M. Diamond



"Judge Diamond, I won't leave my house. Please, please, don't make me. I won't."

Mrs. Doe spoke these words to me while her counsel stood next to her at the podium in my courtroom at the conclusion of an Article 81 hearing that had taken us all morning to complete. Her adult daughters had brought the petition, stating in it that while their mother was mentally quite fit, they believed that it was unsafe for their mother to continue living alone. "Our mother will not accept live-in assistance and she will not discuss any type of alternate living arrangements. Her eyesight is poor and we believe that it is only a matter of time that she will end up in a hospital."

At the hearing, I met Mrs. Doe. By that time she had accepted several hours a day of assistance in the form of a person who did shopping, bill paying, and doctor appointments. But she still refused to allow anyone to sleep at her home. Her daughters, seeking personal needs guardianship, pressed their case that their mother refused to acknowledge her functional limitations and that she would suffer harm and danger if they were not appointed and given authority to put in place a plan that they believed would provide adequate safeguards for her.

Mrs. Doe and I proceeded to have a lively, frank and sometimes difficult conversation.

"If I listened to you and you go home and tomorrow at three o'clock in the morning, you fall, I will be responsible for that, Mrs. Doe and I can't have that." I told her.

"Don't worry," she told me. "I haven't fallen yet and I will be careful. Why should I pay someone to sleep in my home when I don't need them or want them? This is my home. I am not disabled. I am not incapacitated. I don't need guardians. It's crazy." Her counsel smiled at no one particular and gazed up at the ceiling.

At the end, Mrs. Doe and I came to an agreement and she convinced me that she could stay alone in her home at night. But she agreed to wear an alert type necklace that would let her call for help if she needed it. Pursuant to my oath, this was—I believed—the least intrusive method of relief that I thought would protect her, honor her wishes and maintain her dignity.

I hear from the court evaluator from time to time. Mrs. Doe is doing fine. She hasn't fallen yet.

The Hon. Arthur M. Diamond has been a Supreme Court justice in Nassau County since 2004 and hears Article 81 cases weekly.

By Hon. Tanya R. Kennedy

I preside over the Integrated Article 81 Mental Hygiene Law Guardianship/Landlord-Tenant Part in Supreme Court, New York County. Each day, I conduct hearings to determine whether persons are incapacitated and require the appointment of a personal needs and/or property management guardian. Earlier this year, I conducted a hearing to determine whether a person who previously consented to the appointment of a guardian was now incapacitated, which necessitated the extension of the guardianship past its expiration. The guardian filed a petition for an expansion of powers to sell the ward's cooperative apartment, alleging that the ward was incapacitated. The ward opposed the application and I appointed Mental Hygiene Legal Service as counsel. Following the hearing, I denied the guardian's application and dismissed the petition since there was no clear and convincing evidence that the appointment was necessary.

The ward who was the subject of the hearing previously enjoyed a comfortable standard of living while married to her wealthy spouse. The former spouse was ordered to pay lifetime monthly maintenance to the ward, which allowed her to remain in her cooperative residence. Due to the former spouse's failure to make payments, the ward was facing a pending nonpayment eviction proceeding at the time of this hearing. Since the ward opposed the relief requested, the guardian was required to prove by clear and convincing evidence that there was a need for the guardianship prior to this Court's determination of incapacity. While the ward's expectations regarding her ability to remain at the cooperative were unrealistic, it did not mean that the ward did not appreciate the consequences of her situation and the differences between her marital and post-divorce standards of living. This Court did not substitute its judgment regarding the ward's lifestyle choices and arbitrarily exercise its *parens patriae* power.

While I am cognizant of this Court's *parens patriae* power to appoint a guardian, I am also sensitive to the delicate balance between such power and a person's right to exercise his or her independence and self-determination. The balancing of these competing interests requires that a judge exercise compassion to impart individualized justice in guardianship proceedings. However, when a court exercises its discretion to appoint a guardian, the guardian's authorized powers must constitute the least

restrictive form of intervention which is narrowly tailored to address only those personal needs and/or property management the incapacitated person is unable to exercise due to his or her lack of capacity. Although judges bring their own personal experiences and lifestyle choices to the bench, the determination of incapacity and the level of required intervention must be based upon an objective examination of the person's ability to manage their personal needs and/or property management.

The Honorable Tanya R. Kennedy, an Acting Supreme Court Justice and Supervising Judge of Civil Court, New York County, previously presided in the integrated guardianship/landlord-tenant part in Supreme Court, New York County. Since 2006, Justice Kennedy has served as an adjunct professor at Fordham University School of Law where she teaches a juvenile justice seminar course. Justice Kennedy is a graduate of the Benjamin N. Cardozo School of Law and is a member of various judicial and bar associations, including the National Association of Women Judges, where she serves on the Executive Board.

The Valuable Role of the Aging Services Network

By Greg Olsen

It is common knowledge that in 1965 both Medicare and Medicaid were passed to provide comprehensive health insurance for older Americans and to provide a financing mechanism for skilled nursing care. A companion piece of legislation was also passed in 1965 that was designed to be a countervailing force to both Medicare and Medicaid. That legislation, the Older Americans Act, was designed to prevent emergency room visits, and hospitalization as well as nursing home placement by providing a comprehensive package of non-medical community-based long-term services and supports. Equally important was the need to have a locally based system to assure that those being discharged from the hospital or rehabilitation would succeed back in their homes and communities.

The dynamics of population change are vitally important to planning and preparing to create an efficient, successful system of services and supports for older New Yorkers. Demographic change and the evolution in our population characteristics over time have important implications. While there are many challenges in the coming years related to the growth of the older population, the role of the State Office of Aging, the county-based area agencies on aging, and the network of contracted partners have never been so important.

The New York State Office for the Aging's (NYSOFA's) home and community-based programs provide frail older persons access to a well-planned, coordinated package of in-home and other supportive services designed to support and supplement informal care. NYSOFA's overall goal is to improve access to, and availability of, appropriate and cost-effective non-medical support services for functionally impaired older individuals to maximize their ability to age in their community and avoid higher levels of care and publicly financed care. Our broad-based affiliations and partnerships are helping us to plan, develop and implement innovative programs and services, strengthen our core programs and develop strategies to support caregivers, promote volunteerism and civic engagement, and help communities plan for their unique drivers of demographic change.

It is our mission as the State Office for the Aging, in partnership with the network of public and private organizations that serve our older population, to assist older New Yorkers to be as independent as possible for as long as possible through delivery of high quality, person- and family-centered, cost-effective programs and services. Our efforts to address the challenges presented by a growing older population are rooted in the deepest principle of our aging services philosophy: to promote the independence of older adults by serving them—where they want to be served and where it is most cost-effective to serve them—in their homes and communities. NYSOFA takes this mission very seriously and we will continue to work at the community, county, State and federal levels to ensure that the voices of our constituents and their families are integral to our program and policy development.

"It is our mission as the State Office for the Aging…to assist older New Yorkers to be as independent as possible for as long as possible through delivery of high quality, person- and family-centered, cost-effective programs and services."

The area agencies on aging and network of aging service providers have done a tremendous job over time in leveraging resources, stretching their dollars, developing innovative ways to provide services and developing and strengthening community partnerships to help them carry out their work. The longstanding history of the network to provide cost-effective and quality services that help older adults remain independent is becoming more and more recognized for its value. Over the past few years, the Administration on Aging (AoA), in partnership with the Centers for Medicare and Medicaid Services (CMS) has empowered the aging network across the country to test new models of care and strengthen partnerships with the medical community. We have developed programs that prevent Medicaid spend-down and nursing home placement, reduce preventable hospital readmissions, strengthen caregiver and respite services, teach older adults how to manage chronic conditions, provide services to our veterans, combat Medicare fraud, provide intensive options in counseling for long-term care and strengthen our NY Connects: *Choices for Long Term Care Program* (New York's federally recognized Aging and Disability Resource Center {ADRC}). The recognition of the role of the aging network in health and long-term care is becoming more evident by the innovative work we are being asked to pilot and the requirement of broad-based partnerships.

Services provided by the county offices for the aging and their partners target those at risk of Medicaid spend-down and nursing home placement due to their functional limitations and/or cognitive impairments and their caregivers. Services include:

- Case Management
- Personal Care Level I and II (non-Medicaid)
- Ancillary services such as PERS, those that maintain or promote the individual's independence such as:
  - (i) purchasing/renting of equipment or assistive devices
  - (ii) purchasing/renting, maintaining and repair of appliances
  - (iii) personal and household items
- social adult day services
- transportation to needed medical appointments, community services and activities
- those that maintain, repair or modify the individual's home so that it is a safe and adequate living environment, such as:
  - (i) home maintenance and chores
  - (ii heavy house cleaning
  - (iii) removal of physical barriers
- those that address everyday tasks, such as:
  - (i) house cleaning
  - (ii) laundry
  - (iii) grocery shopping, shopping for other needed items and other essential errands
  - (iv) bill paying and other essential activities
- Home delivered meals
- Congregate meals
- Nutrition counseling and education
- Long-term Care Ombudsman
- HIICAP
- Employment
- Medicare prevention, screening and wellness
- Options counseling, benefits and application assistance
- Senior center programming
- Evidence Based Interventions such as Chronic Disease Self-Management and fall prevention
- Volunteer opportunities
- No wrong door information and assistance to access a broad array of long-term services and supports
- Caregiver support services
  - Support groups
  - Training
  - Respite, and
- Legal Services

One exciting new partnership is the "Legal Services Initiative (LSI)," an Initiative designed to increase access to justice for older adults, persons of all ages with disabilities and caregivers. The LSI partnership was launched in September 2012 by NYSOFA, the Office of Court Administration, the New York State Bar Association, the Office of Persons with Developmental Disabilities and Long Island Attorney Robert Abrams.

NYSOFA administers a statewide legal services program, and it continues to be clear that access to affordable legal services can be a critical factor in an older person's ability to continue to live in his or her home and community of choice. Many anecdotal comments from across our State indicate that there is a gap in available, affordable legal assistance among various vulnerable population groups and in many cases there is a lack of access to whatever legal assistance does exist.

The intent of the LSI is to measure and document this gap and the need for legal services and to develop steps and strategies to address this need and reduce the gap. We are initiating this project at this time because of a variety of changing trends.

All population groups are living longer.

Increasing numbers of people are living alone at all stages in their lives. Our health and long-term care policies stress keeping people at home and providing services and care in their homes.

Resources are limited and often housed in different "silos," dictating a need for public and private organizations to rethink the way they do business and better coordinate existing resources and efforts to improve outcomes.

Those trends and others have resulted in older adults, people of all ages with disabilities, and growing numbers of their caregivers encountering more issues and more types of issues that have a legal basis for their solutions. However, in the face of this growing need, the gap in availability and in access is growing. In addition, the issues faced by these population groups are becoming much more complex, more often requiring specialized knowledge and professional help for resolution. Issues such as housing, health, employment and finances, long-

term care, family relationships, marriage and custody, exploitation and abuse, public benefits and discrimination oftentimes require legal advice/intervention for resolution.

The Initiative is also important because too often, residents lack awareness of what their legal rights are and they may not even consider seeking legal help. Or, if they end up in the court system, they are often not represented by a lawyer. Individuals might not seek legal assistance because they find it to be unaffordable and are not aware of attorneys' pro bono work or of the various agencies that provide legal services for individuals who cannot afford legal help.

We also find that residents' interactions and communication with attorneys and members of the court system can often be hampered by language, communication, mobility, hearing, and vision problems experienced by many individuals. Members of the legal field are not trained about, and may be unaware of, the impact of such conditions or of how the effect of such problems are intensified by different types of disabilities or the aging process.

And, often, members of the legal field are not knowledgeable about issue areas that are of specific or distinct concern to older adults or individuals with disabilities.

In order to turn anecdote into fact, the partnership is conducting 5 statewide surveys to 1) measure the gap in access to affordable legal assistance by New York's older adults, individuals of all ages with disabilities, and family caregivers; 2) identify which areas of the State have the greatest gap; 3) measure the extent to which people are using legal assistance to resolve problems; and 4) understand which legal issues are most important to the State's residents.

The partnership will also convene a group of knowledgeable and motivated individuals who will use the survey findings and information from their own professional and personal experiences to develop a blueprint of steps, priorities, activities, and training events to enhance access to affordable legal services by the targeted populations and their caregivers.

The aims of the initiative are to promote awareness among individuals of their legal rights, increase access to affordable legal services and the availability of legal assistance, increase the understanding among members of the legal field of the needs and the characteristics of older adults, individuals with disabilities, and caregivers and, thereby, increase access to justice by these individuals.

The aging network is a great partner in this Initiative because of its ability to develop public-private partnerships, plan and develop innovative programming and leverage additional resources. This innovative and unique Initiative will be a model for the country and will help focus limited resources to where they are most needed.

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Aging in the Digital Age: How Seniors Can Use Technology to Access Needed Government Benefits and How Government Can Play an Important Role in Helping to Bridge the Technology Gap for Older Adults

By Christine Julien

Today, post-recession, everyone is looking for ways to maximize resources and cut cost. One solution that is being looked to is technology. Technology is being embraced by businesses and government entities to streamline processes and develop more efficient ways to do business and reduce waste. The phrase "doing more with less" has become the permanent way of life. Particularly in government, technology is playing an increasing role in the delivery of benefits and services to the public. Arguments for incorporating technology in the service delivery model in government include better and greater access to benefits, reaching potentially a wider group of eligible individuals, streamlined processes and lower cost, which also promotes more transparency and accountability in the use of taxpayers' funds. Efficiency in the delivery of government benefits and services, especially in current fragile economic climate, is a goal recognized by the highest level of government to the lowest. For example, in April 27, 2011, Executive Order 13571 (Streamlining Service Delivery and Improving Customer Service),[1] issued by President Barack Obama, outlined the need for the Federal government to streamline and make more efficient its service delivery to better serve the public. Executive Order 13571 states in relevant part that:

> …with advances in technology and service delivery systems in other sectors, the public's expectation of the Government have continued to rise.… Government managers must learn from what is working in the private sector and apply these best practices to deliver services better, faster, and at a lower cost. Such best practices include increasingly popular lower-cost, self-service options accessed by the Internet or mobile phone and improved processes that deliver services faster and more responsively, reducing the overall need for customer inquiries and complaints. The Federal Government has a responsibility to streamline and make more efficient its service delivery to better serve the public.[2]

Thus, it is not surprising that in many areas of state and local government throughout the country technology is being used to promote efficiency in the delivery of services to the public in order to streamline processes, maximize resources and reduce cost. These technological innovations include more self-service options accessed by the Internet which is changing how government interacts with the public. While younger people generally welcome new technologies and are quick to adopt it in their daily lives, some older people are a little more reluctant and are not yet comfortable with using technology. Particularly, there are many reasons why the elderly (age 60 and older) are reluctant to embrace new technologies, and it is important for government to identify and understand those concerns and develop solutions that can help bridge the technology gap among that population and get everyone onboard.

Some of the more common reasons given for why the elderly avoid new technologies include lack of knowledge, usability, inability to see the benefits of using the technology, and privacy concerns. I submit that each of these concerns, if properly addressed, can help ease the discomfort that the elderly experience with technology.

Let us explore those concerns in greater detail. First, the idea that many older people avoid technology because they do not know how to access or use the technology and don't actually think that they can learn is quite true. You often hear older people say "I can't learn this at my age" or "I am too old to get it," and while none of this may actually be true, this lack of confidence can translate into fear and, consequently, avoidance of the technology altogether. However, for some older adults the difficulty with technology is not due to lack of knowledge, but the fact that the design itself does not take into account age-related motor and cognitive abilities which are so essential to accessibility. According to an article entitled *Designing a Familiar Technology For Elderly People*, the idea that age-related "technophobia" is the main obstacle to elders' technology usage is progressively disappearing. "On the contrary, one of the main reasons for elderly users being neglected by technology is that hardware and software design, and in particular interfaces, have simply not been conceived to suit them."[3] The article further elaborated that "designing technologies for older adults means, first

of all, to carefully take modifications in perceptual, motor and cognitive capabilities into account."[4] Thus, when adopting new technology, government should not only incorporate education and training to help older adults willing to learn take full advantage of the benefits of the technology, but in designing new technology should also bear in mind the limitations of the elderly and disabled.

Research has also shown that the reluctance of older adults to adopt new technologies is also due to their inability to see the benefit of the technology and its perceived relevance to day-to-day life.[5] In general, most people will not devote the energy to learn something new if they cannot see the benefit or relevance to day-to-day life. Yet, for some it may simply be resistance to change and the preference of sticking to what is familiar. For instance, I know many people who prefer receiving paper checks rather than sign up for electronic direct deposits despite the advantages and convenience and others still can't see the benefits and relevance of using a smart phone and continue to prefer the land line. Government may never be able to get that group of people to abandon their old ways of doing things and replace it with new technology. However, for older adults willing to adopt new technology, government can play an important role by encouraging its usage through education on how to use the technology, designing technology that suits their needs, and helping them to recognize the benefits, especially in the areas that can actually impact their lives such as accessing government benefits.

As to privacy concerns being a reason for why older people avoid technology, those concerns are very real and should not be ignored. Rightfully, privacy should be in the back of everyone's mind when entering personally identifiable information online (i.e., name, date of birth, social security number). In some ways, it is a Catch-22 because in order to take advantage of the convenience of applying for or purchasing an item on the electronic commerce market, you are required to provide certain personal information to either verify identity, assessed eligibility, or to process payment, etc.; however, there is a real potential threat of unauthorized access and use of this personal data. For example, the Federal Trade Commission (FTC) estimates that as many as 9 million people living in the United States have their identities stolen each year.[6] Particularly, studies have shown that older people are more likely to be targeted in identify theft and fraud schemes and are more susceptible to victimization, fraud and scams on the Internet. Therefore, it is important for seniors to be able to authenticate whether a particular government website or communication is secure and legitimate. Government, on the other hand, has an obligation to implement data protection safeguards and ensure that private information collected is secured and being used for its intended purpose. For the elderly, confidence that their privacy and security is protected online will contribute to more participation in government programs and acceptance of new technologies.

As we move toward a more digital age, many state and local government agencies have embarked on comprehensive overhaul of their service delivery model by incorporating more technology to streamline government processes. The goal is to emphasize more self-service options accessed by the Internet or mobile phone and improved processes that deliver services faster, cheaper and more responsively to the public. Thus, it is important for the elderly to develop some level of comfort using new technology. For example, in New York State, individuals are able to determine eligibility for and apply for certain government benefits online such as Unemployment Insurance benefits, Social Security benefits and some Social Services benefits and work supports. The myBenefits site[7] is a website launched by the New York State Office of Temporary and Disability Assistance (OTDA) which allows New Yorkers to go online and find out if they qualifiy for work support and other programs designed to help low-income working families and individuals make ends meet. According to a press release at the launching of the myBenefits website, "accelerating the use of state e-government services like myBenefits is one of the primary goals of the New York State universal broadband access initiative designed to close the digital divide gaps throughout our state. Greater access to online government resources like myBenefits enables individuals and communities to participate more fully in society and the digital economy."[8] I submit that in order to truly achieve this goal and get older people to also participate more fully and close the digital divide gap among that population, some of the concerns and discomfort that they experience with technology must be addressed.

Additionally, NYC residents can visit the ACCESS NYC website[9] to find out if they may qualify for over 30 city, state and federal benefit programs such as Medicaid and Supplemental Nutrition Assistance Program (SNAP) formerly Food Stamp. Further, a perfect example of how technology has been incorporated in the delivery of government benefits is the use of the Electronic Benefit Transfer (EBT) in the SNAP program.[10] SNAP benefits are provided through an electronic benefit card, similar to a debit or credit card. Once an individual is determined eligible and an EBT card is issued, an account will automatically be set up for the individual, and every month the benefits will automatically be deposited on the card.

Technology is also revolutionizing the United States Health Care system. For example, as part of the Patient Protection and Affordable Care Act[11] (Affordable Care Act) and the Health Care and Education Reconciliation Act,[12] which together make up the federal health care reform legislation, major changes are occurring in the delivery of health services in the United States. For instance, in New York under the Affordable Care Act (ACA), individuals are able to shop for and purchase health insurance online through what is known as an "Exchange." The exchange is supposed to provide more people with access to affordable health insurance coverage and set up mecha-

nisms for consumers to shop knowledgeably for insurance.[13] The Federal government is operating an exchange in the States which have opted not to set up their own exchange under the ACA. Unfortunately, the federal government's launch of the federal health insurance marketplace has received a lot of criticism for its many technical glitches. Reportedly, the site Healthcare.gov[14] is performing slowly and users have experienced countless glitches such as difficulty logging in, the site displaying incorrect plan information and users receiving erroneous reports. The troubled rollout has prevented many people from viewing available coverage options and enrolling in a health insurance plan. Some in the media have compared the Obama administration's troubled rollout of the health care exchanges to those of the Medicare Prescription Drug benefit rollout in 2005 and 2006 under President Bush's administration. Rather than point fingers and draw comparisons as to which administration's rollout was more smooth, I think what the rollout of both Medicare Part D and the Affordable Care Act truly demonstrates is the fact that technology is not perfect. The Medicare Part D system was an online prescription drug plan finder which allowed seniors to browse through coverage options and enroll in the program. I would imagine that designing such complex systems to accommodate so much information and activities will experience some glitches and have many flaws to be worked out in the early stages. Perhaps some of those glitches and issues could have been predicted and resolved prior to the official launch. However, no matter how imperfect technology is, the reality is that technology is still a good thing and government must continue to improve and find better, faster, and cheaper ways to do things using technology. I have incredible faith that once those glitches and problems have been resolved, the ACA online infrastructure will function as it should and the benefits will have outweigh the setbacks.

Worthy of mention is how technology is also changing the way health care providers deliver services and interact with patients through the use of Electronic Health Record (EHR), sometimes referred to as Electronic Medical Record (EMR) systems. EHRs are defined as a "digital collection of electronic patient health information generated by one or more encounters in any care delivery setting," and typically include patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.[15] EHRs have essentially transformed the health care system from a mostly paper-based industry to a more computerized system. Particularly, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 ("the Act"), signed into law as part of the American Recovery and Reinvestment Act (ARRA) of 2009, more commonly referred to as a "stimulus package," encourages the use of EHR technology in ways that can positively improve patient care. The Act provides financial incentives to eligible professionals (including eligible Medicare and Medicaid health care providers), eligible hospitals and critical access hospitals (CAHs)[16] to adopt, implement, upgrade and demonstrate "meaningful" use of EHR technology.[17] Some of the benefits cited for adopting EHR systems include improvement in the quality of patient care, reduction in medical errors and reduced costs such as those associated with supplies needed to maintain paper files and reduction in billing errors.[18]

Physicians are not necessarily best known for having the most legible handwriting and sometimes an illegible handwriting can result in serious consequences for the patient such as delay in treatment and lead to unnecessary tests and inappropriate medication doses.[19] Therefore, EHRs seem to be a great solution for resolving some of these issues and that alone suggests that EHRs are here to stay. One governmental agency that has developed and has begun using an EHR system is the U.S. Department of Veterans Affairs (VA). The VA has adopted an online personal health record (PHR) system known as My Health*e*Vet.[20] My Health*e*Vet enables veterans to "create and maintain a PHR that includes access to health education information, personal health journals, copies of key portions of VA patients' electronic health records and electronic services such as online VA prescription refill request, Secure Messaging and more."[21] This is a great benefit to veterans by helping them to manage and make informed decisions about their health care needs and promotes better coordination of care among multiple service providers.

The Elder Law Section of the New York State Bar Association (NYSBA) recently published a pamphlet entitled "17 Benefits for Older New Yorkers,"[22] which highlights some of the major benefits available to older New Yorkers, and not surprising most of these benefits are accessible online. The seventeen major benefits discussed in the pamphlet are: (1) Social Security, (2) Medicare, (3) Medicare Buy-In, (4) Medicaid, (5) Supplemental Security Income (SSI), (6) Temporary Assistance, (7) Veterans Benefits, (8) Elder Pharmaceutical Insurance Coverage (EPIC), (9) Food Stamps, (10) Home Energy Assistance Program (HEAP), (11) Weatherization Referral and Packaging Program (WRAP), (12) Senior Citizen Rent Increase (SCRIE), (13) Senior Citizen Homeowners Exemption (SCHE), (14) Real Property Tax Credit, (15) Reduced Fare, (16) New York State School Tax Relief Program (STAR) and (17) Live Line Telephone Service.

Even if an individual is unable to apply directly for some of these benefits online due to state and federal program rules and guidelines, he or she may still be able to obtain valuable information such as reviewing eligibility criteria and downloading the application online, avoiding multiple trips to the local government office. Given that mobility often deters older people from seeking or applying for benefits to which they may be entitled, the convenience of applying from one's own home is a huge

benefit worth exploring. For more detailed information on these 17 benefits for older New Yorkers, please refer to the NYSBA pamphlet; however, below is a brief summary and information on how to access and obtain valuable information on these benefits by telephone or online:

Social Security—provides income for insured workers, certain spouses, divorced spouses, children, grandchildren and surviving parents. To apply call (800) 772-1213 to find your local office, or visit the website: www.ssa.gov. Further, the Social Security Administration offers individuals the ability to apply for Social Security retirement online from the convenience of own home or any computer. Their slogan is "Retire Online—It's So Easy!"[23]

Supplemental Security Income (SSI)—provides monthly payments to limited income individuals who are aged (65 or older), blind or disabled, in addition to other income they may be receiving such as Social Security. To apply, contact the Social Security Administration (800) 772-1213 or visit www.ssa.gov.

Temporary Assistance—provides cash benefits for limited-income persons for essential food, clothing, shelter and one-shot deals. To apply, contact your local Department of Social Services which information is available at: (800) 342-3009. In NYC, residents can contact the Human Resources Administration at (877) 472-8411 for information and an application. For additional information, see also www.otda.ny.gov/programs/temporary-assistance.

Medicaid—to apply for Medicaid, you can use the "Fill and Print" ACCESS NY Health Care application at: (https://apps.health.ny.gov/doh2/applinks/accessny/). Fill out the application on your screen and print the completed form from the convenience of your home. Once printed, you can either mail or bring the application to your local DSS/HRA office.

Medicare—to apply, contact the Social Security Administration/Medicare: (800) 772-1213 or visit www.medicare.gov.

Medicare Savings Program—information may be obtained by searching for "Medicare Savings Program" through the NYS Department of Health (DOH) website: http://www.health.state.ny.us/. You can also search through: www.medicare.gov.

Elder Pharmaceutical Insurance Coverage Program (EPIC)—covers more than one-half the cost of most prescription drugs after income-eligible beneficiary pays Medicare Part D premium or deductible. For more information, call (800) 332-3742/ (518) 862-9936, or visit the website: www.health.ny.gov/health_care/epic.

SNAP/Food Stamp—provides food support to low-income New Yorkers including working families, the elderly and the disabled to increase their ability to purchase food. SNAP Centers are located in all five boroughs and you can go online to locate a SNAP Center near you.[24] Alternatively, you can take advantage of the option to apply for SNAP online including recertification and phone interviews options by filing an electronic application using the ACCESS NYC or myBenefits websites.

Home Energy Assistance Program—a federally funded program that assists eligible households with cash or credit for heating costs and heat-related emergency grants. Questions regarding the HEAP program should be directed to your local Department of Social Services Office, the NYS HEAP Hotline at (800) 342-3009 or visit website: www.otda.ny.gov/programs/heap.

Transportation—The Reduced-Fare MetroCard program subsidizes subway or bus fare for seniors (65 years of age or older) and individuals with qualifying disabilities. Fare is half the base fare. For more info contact the New York State Office of the Aging: http://www.aging.ny.gov/ResourceGuide/Transportation.cfm.

To apply by mail, you may also download the application online: http://www.mta.info/nyct/fare/rfindex.htm., and mail completed application with a 2″x2 ½″ photograph, and photocopy of acceptable proof of age such as Driver's License, Medicare Card or Birth Certificate, or proof of qualifying disability to:

MTA New York City Transit
Attn: Reduced Fare Program
130 Livingston Street
Brooklyn, New York

Veterans Benefits—The U.S. Department of Veterans Affairs administers benefits to veterans such as pensions for low income and disabled veterans, health care, education and training, life insurance, and burial and memorial benefits. Dependents and survivor benefits may also be available for certain benefits. To apply contact the NYS Division of Veterans Affairs at (888) 838-7697; U.S. Department of Veterans Affairs (800) 827-1000; or visit: http://www.va.gov; www.veterans.ny.gov. Additionally, as mentioned earlier veterans may also manage their health care needs by accessing the VA's My Health**e**Vet, https://myhealth.va.gov, personal health record (PHR) website.

Weatherization Assistance Program (WAP)—assists income-eligible families and individuals by reducing their heating/cooling costs and improving safety of their homes through energy efficiency measures. Ac-

cording to the NYSBA manual on 17 benefits for older New Yorkers. Funds are limited but applications by the elderly and disabled receive a priority. To apply, contact your local Office for Aging, the New York State Division of Housing & Community Renewal or New York City HRA for more information.

Internet Websites:

New York State Division of Housing & Community Renewal: http://www.dhcr.state.ny.us/programs/weatherizationassistance/.

New York City HRA: http://www.nyc.gov/html/hra/html/directory/heap.shtml.

Senior Citizen Rent Increase Exemption (SCRIE)—exempts rent-controlled/rent stabilized, Division of Housing and Community Renewal (DHCR) housing and rent-regulated hotel tenants from certain rent increases. To apply, in NYC contact the Department of Finance (DOF) and outside NYC, contact the New York State Division of Housing and Community Renewal (DHCR).

Internet Website:

http://www.dhcr.state.ny.us/Rent/about.htm#seniors.

New York City Department of Finance: http://www.nyc.gov/html/dof/html/property/property_tax_reduc_drie_sc_te.shtml.

Senior Citizen Homeowners Exemption (SCHE)—provides partial tax exemption up to 50% on real property owned by qualified senior citizens. For more info visit New York State Exemption Applications website: http://www.tax.ny.gov/pit/property/exemption/seniorexempt.htm.

NYC Tax Reductions for Residential Property: http://www.nyc.gov/html/dof/html/property/property_tax_reduc_individual.shtml#sche.

Real Property Tax Credit (IT 214)—provides tax credit or cash payment for part of rent or property taxes paid during the year. Apply by submitting Form IT-214 with tax return, or, if no return, anytime during the year. For assistance from New York State Department of Taxation and Finance call (800) 225-5829.

Internet Websites:

New York State Department of Taxation and Finance: http://www.tax.ny.gov/pit/credits/real_property_tax_credit.htm.

New York State IT-214 Form: http://www.tax.ny.gov/pdf/current_forms/it/it214_fill_in.pdf.

New York State School Tax Relief Program (STAR)—provides an exemption from the school portion of property taxes for owner-occupied primary residences. All New Yorkers who own their own one- two- or three-family homes, condominiums, or cooperative apartments, mobile homes or farms are eligible for the STAR tax exemption. Apply by contacting local assessor's office or by accessing the necessary STAR Reimbursement Application Form available online at http://www.orps.state.ny.us/ref/forms/index.htm.

New York City residents should call the New York City Department of Finance at 311 or (212) 504-4080 or the website at: http://www.nyc.gov/html/dof/html/property/property_tax_reduc_individual.shtml.

Life Line Telephone Service—reduces the cost of basic telephone service and connection charges for limited-income persons. To apply, contact your local telephone company business office.

Internet Websites:

New York State Public Service Commission: www.askpsc.com/. From that homepage, follow the links for Telephone to the "Life-Line Discounted Telephone Services" or call for information at (888) Ask-PSC1 (888) 275-7721.

National Association of State Utility Consumer Advocates: Lifeline Across America: http://www.lifeline.gov/lifeline_Consumers.html.

Conclusion

We know that government benefits are extremely important to improving the health and well-being of the elderly, and we also know that the elderly are least likely to know for which benefits they qualify or how to apply. For example, according to the Food Research and Action Center, older Americans who are eligible for SNAP are significantly less likely to participate in the program than other demographic groups. Reportedly, factors contributing to this low participation rate range from barriers related to mobility, technology and stigma, to widespread myths about how the program works and who can qualify.[25] Technology has the potential to improve the lives of older adults by providing greater access to needed government benefits; therefore, encouraging the use of technology among older people to learn about programs to which they may be entitled and how to apply online for such benefits is a good opportunity to increase enrollment rates so that the elderly can maximize their benefits. With the rapid growth of the Internet and the increasing role of technology in our daily lives including in the delivery of government benefits and services, it's important not to leave the elderly population behind. Government should

incorporate training to help the elderly take full advantage of the benefits and convenience of technology. While also bearing in mind that for some, due to physical limitations or cognitive impairments, reasonable accommodations must be provided including accommodations in the design of new technologies, so as not to discriminate against those individuals and comply with the requirements of the Americans with Disabilities Act. Government should encourage older people to take advantage of technology to access these very important benefits which can make a huge difference in healthy aging and longevity.

Endnotes

1. http://www.whitehouse.gov/the-press-office/2011/04/27/executive-order-streamlining-service-delivery-and-improving-customer-ser.
2. *Id.*
3. C. Leonardi, C. Mennecozzi, E. Not, F. Pianesi and M. Zancanora, "Designing a Familiar Technology for Elderly People" April 30, 2008, available at http://www.gerontechnology.info/Journal/Proceedings/ISG08/papers/095.pdf.
4. *Id.*
5. Neil Selwyn, "The information aged: A qualitative study of older adults' use of information and communication technology," 18 Journal of Aging Studies 369-384 (2004).
6. The FTC developed a guide to help attorneys and victim service providers resolve legal problems that pro-bono clients may have following the theft of their identity. To access the guide and obtain more information visit http://www.consumer.ftc.gov/articles/pdf-0119-guide-assisting-id-theft-victims.pdf/docs/i.%20Table%20of%20Contents.pdf.
7. www.myBenefits.ny.gov.
8. *Struggling to Get By? New Website Helps Determine If You May Qualify for Supports. State Unveils myBenefits.ny.gov, a Quick, Easy, Interactive Tool,* available at http://www.labor.state.ny.us/agencyinfo/mybenefits.htm.
9. https://a858-ihss.nyc.gov/ihss1/en_US/IHSS_homePage.do.
10. Pub. L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of August 22, 1996 "mandated that States implement EBT systems before October 1, 2002, unless USDA waived the requirement because a State faced unusual barriers to implementation." At the time, legislative history for implementing the EBT system indicated that it was intended eliminate "the cumbersome processes required by the paper food stamp system. By eliminating paper coupons which could be lost, sold or stolen, EBT may help cut back on food stamp fraud. EBT creates an electronic record of each food stamp transaction, making it easier to identify and document instances where food benefits are exchanged for cash, drugs, or other illegal goods." *See A Short History of SNAP*, available at http://origin.www.fns.usda.gov/snap/rules/Legislation/about.htm.
11. Pub.L. 111-148, signed into law by President Barack Obama, March 23, 2010.
12. Pub.L. 111–152, 124 Stat. 1029, amending the Patient Protection and Affordable Care Act (Pub.L. 111–148), signed into law by President Barack Obama on March 30, 2010.
13. https://www.healthcare.gov/what-is-the-health-insurance-marketplace/.
14. https://www.healthcare.gov/.
15. *Electronic Health Care Record Defined*, Health Care IT News, available at http://www.healthcareitnews.com/directory/electronic-health-record-ehr.
16. A Critical Access Hospital (CAH) "is a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital.…" The characteristics of a CAH are -that it offers 24-hour, 7-day-a-week emergency care; is located in a rural area and is limited in size and has an average length of 96 hours for acute care. *What are critical access hospitals (CAH)?*, http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/critical.html.
17. Center for Medicare and Medicaid Services, MEANINGFUL USE, HTTPS://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/LEGISLATION/EHRINCENTIVEPROGRAMS/MEANINGFULUSE.HTML.
18. Nir Menachemi and Taleah H. Collum, Benefits and drawbacks of electronic health record systems, 4 Risk Management and Healthcare Policy 47-55 (2011), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3270933/.
19. Daniel K. Sokol and Samantha Hettige, "Poor handwriting remains a significant problem in medicine," 99 Journal of the Royal Society of Medicine 645-646 (December 2006), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1676338/.
20. https://www.myhealth.va.gov.
21. https://www.myhealth.va.gov/mhv-portal web/anonymous.portal?_nfpb=true&_nfto=false&_pageLabel=termsAndConditions.
22. This NYSBA publication is available at https://www.nysba.org/Sections/Elder/17_Benefits_for_Older_New_Yorkers/17_Benefits_for_Older_New_Yorkers_Pamphlet_(2013).html.
23. www.socialsecurity.gov.
24. Visit http://www.nyc.gov/html/hra/html/directory/food_stamp_centers.shtml.
25. Food Research and Action Center, SNAP/Food Stamp Challenges, SENIORS AND SNAP/FOOD STAMPS, http://frac.org/initiatives/addressing-senior-hunger/seniors-and-snapfood-stamps/.

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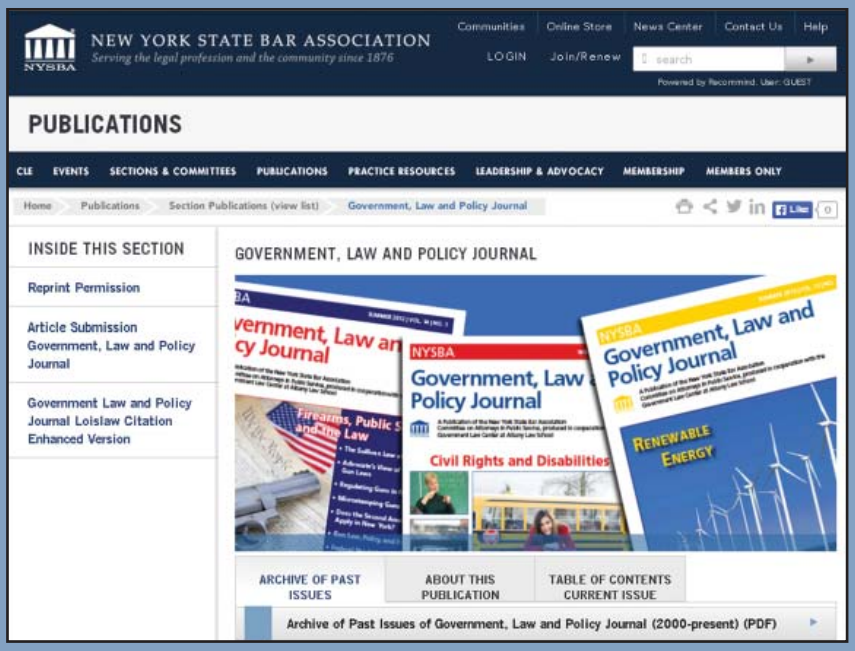

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