CROWDING OUT: ESTATE TAX REFORM AND THE ELDER LAW POLICY AGENDA

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The passage of the Economic Growth and Tax Relief Reconciliation Act (EGTRRA) in 2001 was a major triumph for the Bush administration, as it represented a victory for its anti-tax agenda. The passage of the EGTRRA, however, has had a number of effects both in terms of tax policy and in the larger elder law policy agenda. In this article, Professor Richard Kaplan, a noted scholar in both elder law and tax policy, takes those who advocate reducing the estate tax to task. Although the exemptions for the estate tax should, and ought to be raised to keep pace with inflation, the very issue, by dominating the elder law policy agenda, has distracted attention away from issues that are far more pressing for older Americans. Professor Kaplan goes on to question whether the estate tax is truly an elder law issue, noting that it does not affect the elderly, only their survivors. After examining the workings of the EGTRRA, Professor Kaplan then explores other elder law issues that are of more importance to elderly Americans, such as prescription drugs, long-term care insurance, advance health-care directives, Social Security’s earnings test, and employer-provided pensions, a field that is increasingly more important in the wake of the Enron disaster. Professor Kaplan concludes by calling for more attention to issues that relate directly to the medical and financial quality of elders’ lives, instead of the pecuniary interests of their survivors.

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In May 2001, Congress passed a major tax reduction law entitled the Economic Growth and Tax Relief Reconciliation Act (EGTRRA).\(^1\) This new statute was a triumph of political will that reflected then-newly elected President George W. Bush’s fixation with tax reduction as a major governmental priority. Among the more amazing aspects of EGTRRA is its extensive revision of the federal estate tax,\(^2\) including the complete repeal of this tax in 2010.\(^3\) Whether that particular provision takes effect as scheduled is highly conjectural at this point, but the indisputable point is that substantial congressional and presidential attention was focused on an issue that affects a very small minority of older Americans—namely, the federal tax on transfers of their wealth after they die.\(^4\)

The real impact of these provisions, however, is much broader. EGTRRA’s revision of the federal estate tax was characterized by the political actors who were involved in its enactment as a major benefit for older Americans.\(^5\) As a consequence, other legal problems that affect this age cohort have been shunted aside. Unfortunately, these issues affect many more older people than does the federal estate tax and in much more fundamental ways.

This article begins by examining EGTRRA’s estate tax changes from the perspective of elder law.\(^6\) In so doing, it is less interested in the specific details of these changes and more concerned with why estate tax reform has preoccupied policymakers and others who advocate on behalf of older Americans. The article then considers five current elder law issues of major significance and analyzes the legal consequences of EGTRRA’s displacing these issues onto the prover-
bial “back burner.” Finally, the article concludes with some recommendations for ensuring that elder law policy issues are not preempted by estate tax reform, which does nothing to improve the lives of older Americans.

I. Estate Tax Reform

As traditionally understood, “elder law” focuses on the legal consequences of extended life and the problems that older Americans face while they are alive. In this context, estate tax reform is a rather curious topic for elder law advocates, because estate taxes are never paid until after a person dies. Accordingly, they have no impact on how an older person pays for his or her health care, housing, or other basic needs. The simple reality is that the estate tax is imposed only on those assets that remain after all of a person’s needs have been financed. And if that person spends most of his or her financial resources on those needs, no estate tax is levied at all. In fact, the estate tax’s pre-EGTRRA exemption of $675,000 meant that only about 2% of decedents faced any estate tax liability. With EGTRRA raising this exemption amount to $1 million, the estate tax will affect even fewer Americans in the future. But even without this change, it is ridiculous to the point of fraudulent to label the estate tax a “death tax,” since forty-nine out of fifty people die without owing any estate tax. What are they? The undead?

In the context of elder law, the most significant point is that the economic burden of an estate tax is borne not by the person who died.

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7. See infra Part II.
8. See infra Part III.
10. See I.R.C. § 2002 (1994) (imposing liability for the estate tax on the executor of the estate); see also id. § 2203 (defining executor).
11. Id. § 2010(c), before amendment by EGTRRA, supra note 1.
but by that person's heirs. They are the ones whose finances are affected by the estate tax, because this tax reduces the size of their inheritances. But the decedent's lifestyle need never be affected by this levy, however onerous it may seem. Accordingly, it is fundamentally incorrect to characterize estate tax reform as an elder law issue. It is, instead, an issue for one's survivors, and only for survivors of the very well off at that.

Moreover, its impact is narrower still, because no estate tax is due on assets that pass to a decedent's surviving spouse. This so-called marital deduction has long been part of the estate tax, and since 1981, it has applied without regard to the amount of assets involved. So, when Bill Gates passes away, no estate tax will be due as long as his entire estate is bequeathed to his wife, Melinda. In other words, the estate tax is relevant only to survivors of the very well off other than the surviving spouse.

Nevertheless, older persons flock to seminars discussing the estate tax, and professional advisors often equate financial planning for older people with estate tax minimization. As a consequence, estate tax reform is often cast as an elders' issue, despite the fact that no one pays estate tax while he or she is alive, and neither does that person's surviving spouse.

To be sure, preserving inheritances for family members is a major concern for some older people. Indeed, preserving inheritances for

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17. Estates worth at least $5 million, representing only 6.1% of all taxable estates, paid over 51% of estate tax receipts. Computation by author using Asinof, supra note 14, at C1.


22. See KATHRYN G. HENKEL, ESTATE PLANNING AND WEALTH PRESERVATION § 1.02 (abr. student ed. 1998). Much of the planning to minimize federal estate taxes must be accomplished while the older person is still around to effectuate the transactions required. See generally id. § 1.02; RALPH GANO MILLER, ESTATE PLANNING PRIMER § 1-1 to 1-6 (8th ed. 1998). These transactions usually provide no tax savings, however, while the senior citizen is alive. See HENKEL, supra, § 1.02.
one’s heirs is a prominent reason why some people purchase long-term care insurance or seek Medicaid assistance with their long-term care expenses when they lack such insurance. The statistical reality, however, is that the federal estate tax is not a threat to the inheritances of most people.

Moreover, the steady increase in life expectancies has meant that the primary beneficiaries of estate tax reform are adult “children” who are often in their sixties. These folks are themselves approaching retirement, so their late-in-life inheritances provide little benefit in raising a family, starting a business, and the like. Such inheritances should certainly be permitted, but making sure that they are not unduly diminished by estate taxes is hardly a compelling social objective.

Why, then, is estate tax reform so popular among policymakers and their putative constituents? Several explanations are possible. First, to some people, all taxes are evil, and the estate tax is simply one more undifferentiated government exaction. Second, some older people feel that they have paid taxes throughout their lives—first, when they earn their income (income tax); then, when they spend (sales tax) or invest (capital gains tax) that income; and again, when they withdraw their savings (income tax). Having paid taxes at every step along the way, they genuinely resent the very idea of an additional imposition at their death, without regard to who really pays or its irrelevance to their actual financial situation.

28. Susan Wieler, Hardly an Heir-Tight Case—Supporters of Estate Tax Repeal Make a Poor Argument, NEWARK STAR-LEDGER, Mar. 8, 2001, at 17 (citing a Gallup Poll that found that 60% of the public favors estate tax repeal).
29. See, e.g., NPR: Talk of the Nation: Analysis: How the IRS Decides Who to Audit (NPR radio broadcast Apr. 9, 2001) (discussing negative public sentiment regarding the IRS).
30. See generally FROLIK & KAPLAN, supra note 9, at 354–59.
31. See, e.g., Edward J. McCaffery, Grave Robbers: The Moral Case Against the Estate Tax, 85 TAX NOTES 1429, 1439 (1999) (“people who have worked hard and
Third, many people attribute their relative affluence primarily to their own good habits and work ethic, and see no reason why the government should confiscate their hard-earned savings to subsidize those with less admirable traits. Moreover, many older Americans with substantial resources do not consider themselves wealthy, let alone rich, and cannot fathom being treated as if they were Rockefellers or Vanderbilts. Even the term “estate tax” itself, while legally descriptive, conjures up notions of a landed aristocracy that seems incongruent with the present level of exemption. When the federal estate tax was first imposed in 1916, the exemption amount was $50,000. If this amount were adjusted to reflect a similar proportion of the nation’s gross domestic product, the current exemption level would approach $9 million. The government’s failure to make this adjustment has aggravated the sense of duplicity and bad faith that surround the federal estate tax. Accordingly, a substantial and immediate adjustment of the estate tax exemption to $9 million is an appropriate policy decision.

Of course, to some Americans, the estate tax is hopelessly irredeemable. It must be repealed in its entirety, and merely augmenting the exemption level along the lines just suggested would not dissipate the deep-seated anger that they feel toward this particular tax. Whether there should be an estate tax at all is a question that has spawned a major debate in recent years, and entire forests have been decimated in the process. See generally McCaffery, supra note 31, at 1430–34.

32. See, e.g., Glendell Jones, Jr., Repeal the Estate Tax? Bad Move: The Transfer Tax System Paradigm, 89 TAX NOTES 793, 794 (2000); McCaffery, supra note 31, at 1439; Schlesinger & Kulish, supra note 4, at A1 (reporting a Gallup poll that found that 53% of Americans believe that riches are the result of “strong effort”).

33. See generally McCaffery, supra note 31, at 1430–34.


35. GARY ROBBINS & ALDONA ROBBINS, INST. FOR POLICY INNOVATION, THE CASE FOR BURYING THE ESTATE TAX 8 (1999) (the equivalent number in 1998 was $8,845,267).

36. Id. at 21.

37. See id. at 18–19; see also Bruce Bartlett, The End of the Estate Tax?, 76 TAX NOTES 105, 105 (1997); Charles O. Galvin, To Bury the Estate Tax, Not to Praise It, 52 TAX NOTES 1413, 1413 (1991); McCaffery, supra note 31, at 1430.


here, but if the estate tax were repealed in its entirety, one significant tax problem would remain: what would be the “basis” of property that is inherited from a decedent?  

Under current law, the new owner of inherited property is treated as having purchased the asset in question for its fair market value when the decedent died. This provision is known colloquially as the “step-up in basis” rule. In point of fact, the tax code does not utilize that phrase, and the basis of property that has gone down in value during a decedent’s lifetime is stepped down as well. In any case, the new owner receives a new tax basis equal to the property’s market value when the previous owner died.

For example, assume that Milton bought some land many years ago for $100,000 and that this property is worth $2 million at his death. When his daughter Anne inherits this land, she takes as her basis in this parcel the property’s market value at the time that Milton passed away—namely, $2 million. If she were to sell the property shortly thereafter, she would owe no income tax on the proceeds, because the amount she received at the sale should presumably equal her basis in the property of $2 million. Thus, Anne would never owe tax on the $1.9 million gain that she obtained when she sold this appreciated asset. Nor did Milton, by the way, because he did not sell the property during his lifetime. As a result, the appreciation in the


40. “Basis” is the tax term for measuring gain or loss; it can be cost or something else in the case of gifts, where there is no “cost” as such.


43. I.R.C. § 1014(a).

44. Id. Taxpayers may elect an alternative valuation date, which can be as much as six months after the date of the decedent’s death, but only if doing so reduces the amount of estate tax that would otherwise be due. I.R.C. §§ 1014(a)(2), 2032(a), (c). For treatment of property held jointly with a decedent, see FROLIK & KAPLAN, supra note 9, at 253–54.

45. See I.R.C. § 1001(a) (gain is the excess of the “amount realized” over the taxpayer’s “adjusted basis”).

46. Current value of $2 million - purchase price of $100,000 = $1.9 million of gain.

47. In general, an asset’s appreciation in value is not taxed until that asset is sold or exchanged. See I.R.C. § 1001(a). See generally BITTKER & McMahan, supra note 42, ¶ 3.2.
value of this asset that accrued over Milton’s lifetime is never sub-
tected to income tax—not to Milton, the owner, and not to Anne, his
successor.

This major revenue leakage, which in 2002 is expected to cost the
federal government more than $37 billion, is justified on one and
only one premise: the land’s value of $2 million was included in Mil-
ton’s estate when he died, and estate tax was imposed at that time on
the full amount of the property’s worth, including the unrealized
gain. Accordingly, some adjustment is needed to avoid taxing the
same gain twice—once in the estate tax, and again when it is realized
by the new owner, the legatee. The step-up in basis rule is this ad-
justment. But if the estate tax is repealed, the rationale for the step-
up in basis rule falls away as well.

For some seniors, such a trade-off would be acceptable: no
stepped-up basis on inherited property, but no estate tax owed when
the property’s owner dies. For most seniors, however, this trade-off is
much less appealing. At present, they owe no estate tax, but their
heirs are able to “step up” the basis of the assets that they inherit
nonetheless. Repealing the estate tax and its companion step-up in
basis rule represents a net loss to them. They would actually prefer
that the estate tax be retained, with an increased exemption to permit
even more assets to escape income tax on their appreciation.

And that is why EGTRRA retains the step-up in basis rule,
though in limited form, when the estate tax is repealed in the year
2010. At that time, inherited property will generally have the same
basis in the hands of the new owner as it had in the hands of the de-
cedent. Thus, in the earlier example, Anne’s basis in the land she in-

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48. JOINT COMM. ON TAXATION, ESTIMATES OF FEDERAL TAX EXPENDITURES
49. See BITTKE & McMahan, supra note 42, ¶ 29.4(1); see also I.R.C. § 2031(a).
50. Cf. I.R.C. § 1015(d)(6) (increasing the basis of property received as a gift by
the amount of gift tax paid that was attributable to the property’s unrealized ap-
preciation).
51. See Schlesinger & Kulish, supra note 4, at A1.
(2001). This provision is effective for “property acquired from a decedent dying
after December 31, 2009,” which is after the estate tax is repealed. I.R.C.
§§ 1022(a)(1), 2210(a). See generally Joseph M. Dodge, What’s Wrong with Carryover
53. I.R.C. § 1022(a)(2)(A). But if the property is worth less than its adjusted
basis in the hands of the decedent, its value is stepped down to the property’s fair
market value when the decedent died. Id. § 1022(a)(2)(B). This is essentially the
same rule that applies to such assets currently.
herited from her father would be $100,000; his basis carried over to his heir. But to avoid making the heirs of most decedents worse off under this no-estate-tax regime, the step-up in basis rule is retained, though it is limited to $1.3 million of appreciation.\textsuperscript{54} In other words, some inherited property will receive a step-up in basis, while other assets will have a carryover basis, depending upon the size of the estate in question. Moreover, even assets within the same estate may be treated differentially if they have more than $1.3 million of unrealized appreciation as a group, because the executor of an estate can allocate the $1.3 million step-up in value among those assets however he or she chooses.\textsuperscript{55} In that situation, some assets will get a step-up in basis, others will not, and still others may have only a portion of their unrealized appreciation included in their basis.\textsuperscript{56} But the point remains that retaining some vestige of the step-up in basis rule was deemed politically necessary because, for most decedents,\textsuperscript{57} the estate tax is not as important as what happens to the basis of the property that their heirs inherit.

To summarize, estate tax reform is of financial consequence to a small and diminishing segment of the older population. For most older people, other issues have much more relevance to their health and financial security. By focusing on estate tax reform, policymakers allowed a relatively unimportant issue to preempt these more significant concerns.

\section*{II. Elder Law Policy Agenda}

This section examines five elder law issues that have lingered without action for several years and affect older Americans much more fundamentally than does estate tax reform. This modest agenda does not purport to be comprehensive, but it does try to restore some balance and proportionality in the formulation of public policy toward older Americans. In so doing, this agenda provides a sense of the misplaced policy priorities that the current focus on estate tax reform has produced.

\textsuperscript{54} \textit{Id.} § 1022(b)(2)(B). Property received by a surviving spouse is eligible for an additional step up in value of up to $3 million. \textit{Id.} §§ 1022(c)(1), (2)(B). In any case, a property’s basis cannot exceed the property’s fair market value on the day the decedent died. \textit{Id.} § 1022(d)(2).

\textsuperscript{55} \textit{Id.} § 1022(d)(3)(A).

\textsuperscript{56} \textit{Id.} § 1022.

\textsuperscript{57} Schlesinger & Kulish, supra note 4, at A1.
A. Prescription Drugs

When Medicare was created in 1965, it was intended to be a comprehensive health care program for older Americans, regardless of their medical profile or particular needs. To that end, it covers almost all hospitalization costs incurred by persons age sixty-five years and older, along with most doctors’ bills, medical equipment costs, and laboratory fees. Since 1965, medicine has made major progress in the treatment of various diseases and chronic illnesses. Some of these developments have been reflected in changes to the Medicare program, but many others have not.

Of these, the single most significant development is undoubtedly the increasing use and rising cost of pharmaceutical drugs. Prescription medications now treat conditions on an outpatient basis that previously required hospitalization or could not be treated at all. While this phenomenon is global in its dimensions, Medicare is the only major national health care program that provides no general coverage of outpatient prescription medications. Moreover, most private health care arrangements in the United States reflect the new

60. See generally Marmor, supra note 58.
61. Id.
64. See Deborah A. Freund et al., Outpatient Pharmaceuticals and the Elderly: Policies in Seven Nations, Health Aff., May/June 2000, at 259. Canada’s national health insurance program does not include prescription medications, but each province has some program that covers these costs. Id. at 260. In some limited circumstances, Medicare does cover these costs; e.g., immunosuppressive agents for organ transplant recipients, clotting factors for hemophiliacs. See Iglehart, supra note 62, at 1010.
reality of pharmaceutical treatment and provide some coverage of prescription drug costs.65

In the absence of such coverage, Medicare enrollees have turned to three principal means of obtaining their medications,66 but each has significant deficiencies and programmatic drawbacks.67 The first of these is enrollment in a Medicare health maintenance organization (HMO).68 Such arrangements almost always cover pharmaceutical expenses,69 and this feature is one of their most effective selling points.70 But Medicare HMOs often have limited formularies, which means that only certain pharmaceuticals are included.71 The cost of any drug that is not in a plan’s formulary is the financial responsibility of the enrollee alone. Furthermore, 87% of Medicare HMOs impose annual caps, some of which are only $600.72 In any case, these HMOs face a variety of cost pressures that have resulted in waves of nonrenewals,73 leaving thousands of former enrollees to scramble for

65. Iglehart, supra note 62, at 1010; see also CYNTHIA COSTELLO, OLDER WOMEN’S LEAGUE, 2000 MOTHER’S DAY REPORT, PRESCRIPTION FOR CHANGE: WHY WOMEN NEED A MEDICARE DRUG BENEFIT 5 (2000).

66. Some Medicare enrollees who meet the stringent financial need criteria of Medicaid can obtain pharmaceutical coverage through that program. Soumerai & Ross-Degnan, supra note 62, at 724 (reporting that only fourteen state Medicaid programs have such coverage and that “the majority of low-income Medicare enrollees do not live in [those] states”). As to Medicaid eligibility generally, see FROLIK & KAPLAN, supra note 9, at 104–10.

Some twenty-nine states have prescription drug programs for their older residents, but these programs are also restricted to low-income populations. See AARP PUBLIC POLICY INST., STATE PHARMACY ASSISTANCE PROGRAMS 2001: AN ARRAY OF APPROACHES 10 (2001), http://research.aarp.org/health/ib50_spap.html. Moreover, the scope of these programs varies widely. Id. The most current information about such programs can be obtained at the National Conference of State Legislatures, State Pharmaceutical Assistance Programs’ Website, http://www.ncsl.org/programs/health/drugaid.htm.


69. Margaret Davis et al., Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries, HEALTH AFF., Jan./Feb. 1999, at 231 (95% of Medicare HMOs cover drugs).

70. Nancy Ann Jeffrey, Seniors in Medicare HMOs Should Know the Drugs That Prescription Plans Cover, WALL ST. J., May 16, 1997, at C1 (coverage of pharmaceuticals is “a magnet that has helped membership in Medicare managed-care plans explode”); see also Wilcox, supra note 68, at 73.

71. See Jeffrey, supra note 70, at C1.


73. Iglehart, supra note 62, at 1011 (reporting that 120 of 266 Medicare HMOs have chosen to discontinue their participation in Medicare).
alternative arrangements. As a result, the proportion of Medicare enrollees in Medicare HMOs, never more than about one-sixth,\(^74\) has been declining in recent years\(^75\) and represents a shrinking response to Medicare's lack of prescription drug coverage.

A second alternative that some Medicare enrollees have enjoyed is drug coverage plans provided by their former employers.\(^76\) These plans are similar to those offered by Medicare HMOs in many ways. For example, they typically have restricted formularies, impose co-payment obligations on each prescription, and have annual caps on covered costs.\(^77\) More generally, retiree health benefits have been targeted in recent years for corporate cost cutting,\(^78\) and many employers have reduced or eliminated their plans' drug benefits as part of these efforts. Employer-provided retiree drug benefits, therefore, are also a shrinking response to Medicare's noncoverage of these costs.

The third alternative that some Medicare enrollees have undertaken is supplemental health care insurance called "Medigap" insurance.\(^79\) Medigap policies plug some of the gaps in Medicare's health care package, one of which is the noncoverage of prescription medication.\(^80\) Of the ten standardized Medigap packages, however, only three cover prescription drugs.\(^81\) These three plans, by the way, are

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75. See John Thomas, H.M.O.'s to Drop Many Elderly and Disabled People: Health Experts Predict Most Severe Consequences Will Be Loss of Prescription Drug Benefits, N.Y. TIMES, Dec. 31, 2000, at A14 (reporting the loss of Medicare HMO coverage by one-sixth of all Medicare HMO enrollees on January 1, 2001); see also John K. Iglehart, The Centers for Medicare and Medicaid Services, 345 NEW ENG. J. MED. 1920, 1923 (2001) (only 14% of Medicare beneficiaries are in managed care arrangements).
76. See Gluck, supra note 63, at 3 (28% of Medicare enrollees have such coverage).
77. See id. at 2, 3.
78. See MERCER/FOSTER HIGGINS, NATIONAL SURVEY OF EMPLOYER-SUPPORTED HEALTH PLANS 2000 44 (2001) ("While employer-sponsored medical coverage for retirees has slowly eroded throughout the 1990s, the process appears to have accelerated in 2000."); see also PAUL FRONSTIN, RETIREE HEALTH BENEFITS: TRENDS AND OUTLOOK 9 (2001); HEWITT ASSOC., RETIREE HEALTH COVERAGE: RECENT TRENDS AND EMPLOYER PERSPECTIVES 3 (1999); U.S. GEN. ACCOUNTING OFFICE, RETIREE HEALTH BENEFITS: EMPLOYER-SUPPORTED BENEFITS MAY BE VULNERABLE TO FURTHER EROSION 2, 9, 12 (GAO-01-374, 2001).
80. See FROLIK & KAPLAN, supra note 9, at 94–95.
81. See id. at 94.
the most expensive of the ten Medigap packages available, which may explain why only 29% of Medigap policy owners have prescription drug coverage.

In any case, Medigap insurance is not a complete solution to Medicare’s noncoverage of drug costs. Two of the three Medigap packages that cover such costs have an annual limit of only $1,250, and the third package has a limit of $3,000 per year. Moreover, all three plans have an annual deductible of $250 per insured, and a copayment obligation of 50%. Thus, if Rebecca fills a prescription that costs $170, her Medigap policy pays only $85 (one-half of the $170 cost), assuming that Rebecca already paid $250 for drugs this year and has not yet hit her annual limit. In other words, Medigap’s drug coverage has significant limitations and in some cases, may not be cost-effective. That is, the additional cost of purchasing a Medigap package that includes a drug benefit may exceed the cost savings anticipated from that benefit.

As a result of the restrictions described above, adding prescription drug coverage to the Medicare program is vitally important to the health and finances of most older Americans. And that is why this elder law issue was featured so prominently in the last presidential election campaign. Both major political parties recognized that the current situation was inadequate and proposed solutions for the voters’ consideration. These proposals differed in terms of their scope of coverage, eligibility of prospective enrollees, costs to the enrollees, and the extent to which they worked with or supplanted existing arrangements. These are all legitimate components for debate and

84 FROLIK & KAPLAN, supra note 9, at 94.
85 Id.
87 Calmes & McGinley, supra note 86, at A28; Murray, supra note 86, at A20; see also Laurie McGinley & Shailagh Murray, Lawmakers Sweeten Drug-Benefit Plans to Gain Edge with Voters, WALL ST. J., June 26, 2000, at A48.
programmatic design, but the point remains that both political parties recognized that there was a problem. Nevertheless, no solution has been adopted thus far.89

In part, this inaction reflects the considerable lobbying efforts by the pharmaceutical industry to forestall any legislative action.90 Although Medicare coverage of prescription drugs would increase sales of such medicines, the drug makers apparently believe that with such coverage would come restrictions on how much they could charge for these drugs.91 This fear of conjectural “price controls” has so galvanized the drug industry that it resists mightily every form of governmental pharmaceutical coverage—be it state or federal.92 To be fair, this fear of pricing limits is completely rational, given Medicare’s sorry efforts to restrict hospital charges via diagnostic range groupings93 and its heavy-handed reductions in allowable charges by physicians and other health care providers.94 As a result, the drug industry fights virtually every proposed drug benefit for Medicare enrollees.

But their efforts would not be so effective if Medicare enrollees were unified in seeking a drug benefit. The availability of the alternatives described above have atomized the market for prescription drug coverage and dissipated the political will necessary to undertake this structural change.95 To some degree, therefore, current prescription drug arrangements, though limited in their availability and often inadequate in their implementation, have become barriers to genuine programmatic improvement.96

95. Harris, supra note 90, at R5.
96. See Thomas Rice & Jill Bernstein, Supplemental Health Insurance for Medicare Beneficiaries, NAT’L ACADEMY OF SOCIAL INSURANCE, MEDICARE BRIEF, Nov. 1999, at 11–12,
Consequently, the issue remains: how can a program that is charged with providing for the medical needs of older Americans not cover prescription medication, when such medication is an increasingly significant part of their medical regimen?

B. Long-Term Care Insurance

Financing the cost of long-term care is one of the major issues facing older Americans and their families today. As I have explained elsewhere, most older people do not realize that long-term care expenses are essentially their own responsibility. In fact, a recent national survey of Americans aged forty-five years and older revealed that most people believe that long-term care costs are covered by existing governmental programs. Unfortunately, that is not the case.

Medicare’s coverage of long-term care is riddled with restrictions and limitations. For example, it covers nursing home expenses only if the care provided is “skilled nursing care.” Moreover, that care must be needed to treat a condition that was first treated in a hospital stay that preceded the nursing home admission, and that hospital stay must have lasted at least three days. Even if these conditions are met, Medicare pays for only twenty days within a “spell of illness.” After that, it covers only those costs that exceed a daily deductible and only for the next eighty days. That deductible is adjusted annually for inflation, and in 2002 was $101.50 per day.


97. Kaplan, supra note 24, at 65.
98. Id.
102. 42 U.S.C. § 1395x(i).
103. Id. §§ 1395d(a)(2)(A), 1395e(a)(3).
104. “an illness” begins with the nursing home admission and ends when the patient has been out of a hospital, nursing home, or rehabilitative facility for sixty consecutive days. 42 U.S.C. § 1395x(a)(2); 42 C.F.R. § 409.60(b).
Little wonder then that Medicare pays only 13% of older Americans’ nursing home costs.\(^{107}\)

Outside the nursing home context, Medicare’s long-term care limitations are even more severe. Care in assisted living facilities\(^{108}\) is not covered at all\(^{109}\) even though 41% of respondents in the survey mentioned earlier believed otherwise.\(^{110}\) Nor do Medigap insurance policies provide any coverage of these costs.\(^{111}\)

Medicare does cover long-term care within a person’s home, but again there are serious restrictions. Such “home health care” must be provided or supervised by a registered professional nurse, pursuant to a written plan of care.\(^{112}\) This care plan must be established by a physician\(^{113}\) who reviews the plan at least once every two months.\(^{114}\) Moreover, only those persons who cannot leave their home without assistance are eligible for Medicare’s home health care benefits.\(^{115}\) Even then, these benefits are limited to no more than four hours per day on average.\(^{116}\) And once again, Medigap policies provide no additional coverage, even though 49% of respondents in the survey mentioned earlier believe otherwise.\(^{117}\)

A very different picture is presented by Medicaid, the government’s health care program for poor people.\(^{118}\) Medicaid does cover nursing home care, even at care levels below “skilled nursing care.”\(^{119}\) It also provides home health services, even to patients who are not confined to their homes.\(^{120}\) Moreover, Medicaid’s coverage can include home health aides and personal care services;\(^{121}\) some state pro-

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108. See generally Frolik & Kaplan, supra note 9, at 176–78.
109. See Lawrence A. Frolik, Residence Options for Older or Disabled Clients ¶ 9.08[1], at 9–17 (2001).
110. See AARP, supra note 99, at 36.
113. Id. § 1395x(m).
114. 42 C.F.R. § 484.18(b) (2001).
116. See id. § 1395x(m) (penultimate sentence) (general limit of twenty-eight hours per week, divided by seven days).
117. See AARP, supra note 99, at 44.
118. See generally Frolik & Kaplan, supra note 9, at 101–29.
121. 42 U.S.C. § 1396d(a)(1), (3).
grams even cover adult daycare and respite care for family caregivers.

But Medicaid has two significant drawbacks. First, it is restricted to persons “whose income and resources are insufficient to meet the costs of necessary medical services.” Thus, a qualifying applicant’s financial resources are limited to $2,000, an automobile worth less than $4,500, a burial plot, and similar items. A person can own a home, but only if that person “expects to return” to that home. Additional allowances are permitted when a person’s spouse lives in the community at large, but even then, Medicaid imposes liens and takes other measures to secure reimbursement of its outlays after the Medicaid recipient has died. The details of these provisions need not be considered further here, because the point is that Medicaid eligibility is not an appealing prospect for most older Americans.

Then, there is Medicaid’s second major drawback: limited access to long-term care providers. Due to various budgetary pressures over the years, Medicaid has developed a pattern of paying below-market rates, in some cases below even the cost of providing the care services in question. As a result, some nursing homes no longer accept patients on Medicaid, and other facilities limit sharply the number of

122. Id. § 1396t(a)(7).
123. Id. § 1396t(a)(5).
124. Id. § 1396.
125. Id. § 1382(b)(3).
126. Id. § 1382(b)(1)(A).
127. Id. § 1382(b)(1)(B).
128. See id. § 1382b(a), (d) (life insurance with a face amount of no more than $1,500; burial expense fund of no more than $1,500).
129. Id. § 1382b(a)(1).
130. 20 C.F.R. § 416.1212(c) (2001).
131. See generally FROLIK & KAPLAN, supra note 9, at 116–21.
Medicaid recipients that they do accept. As a consequence, obtaining long-term care via Medicaid usually means having fewer provider options. In light of the intensively personal nature of long-term care services, this reality can be very unsettling.

In my article entitled *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, I propose that the continuum of long-term care be bifurcated for purposes of policy analysis into nursing homes on the one hand and all other long-term care facilities on the other. Care in nursing homes should then be covered by Medicare as a natural extension of that program’s comprehensive coverage of hospitalization costs. Accordingly, the current limitations on Medicare’s coverage of nursing home costs should be revised and in some cases simply repealed outright. Long-term care in facilities other than nursing homes, however, should remain a family’s responsibility, because such care is more in the nature of comfort care than medical services. Within this demarcation of responsibility, some elders and their families might decide to shift the financial risk via the mechanism of long-term care insurance.

Whether this approach is adopted or rejected, the federal government should act immediately to regulate the terms of long-term care insurance policies, as it did with Medigap insurance in 1990. That earlier effort established a core package of basic benefits and standardized the content and possible combinations of the various optional features. It also created various consumer protections, such as guaranteed renewability, and a limited open enrollment period.

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138. *Id.* (manuscript at 38–41); see also FROLIK & KAPLAN, supra note 9, at 66–67.

139. *See Cracking the Conundrum, supra note 137* (manuscript at 41–43) (explaining why Medicare coverage should not be extended beyond nursing homes).

140. *See generally FROLIK & KAPLAN, supra note 9, at 131–43.*


142. *See HEALTH CARE FIN. ADMIN., supra note 79, at 15, 27–28; see also FROLIK & KAPLAN, supra note 9, at 92–95.*

143. 42 U.S.C. § 1395ss(q)(1).
Pricing was left largely to the marketplace on the presumption that consumers are accustomed to comparing prices for comparable products. But those products must indeed be comparable, and an appropriate role of government is to ensure such comparability. Unfortunately, no such comparability exists today.

In 1996, Congress made a token effort in this regard by imposing some basic requirements\(^\text{145}\) in exchange for making premiums for long-term care insurance tax-deductible as medical expenses.\(^\text{146}\) For example, long-term care insurance policies must be guaranteed renewable,\(^\text{147}\) they cannot be cancelled except for nonpayment of premiums. Moreover, they may not condition long-term care benefits upon a patient’s being hospitalized before needing long-term care.\(^\text{148}\) In addition, the policies must provide some mechanism to avoid “unintentional lapse,” which happens when a policy terminates due to inadvertent nonpayment of premiums.\(^\text{149}\) Certain disclosures and policy features are mandated as well.\(^\text{150}\) But all of these requirements apply only to “tax-qualified” policies.\(^\text{151}\) Long-term care insurance policies that are not tax-qualified are unaffected by these provisions.

In any case, the central problem of noncomparability remains, with no fixed levels of coverage or even standardized options. To take the simplest example, one company may offer a policy that pays long-term care costs for three years, six years, or life.\(^\text{152}\) Another com-

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144. *Id.* § 1395ss(s)(2)(A). In addition, insurers may not duplicate coverage that a person already has. *Id.* § 1395ss(d)(3).


146. I.R.C. § 213(d)(1)(D) (Supp. V 1999). The tax benefits are subject to numerous structural limitations, especially their treatment as medical expenses, that effectively minimize their utility. FROLIK & KAPLAN, supra note 9, at 145–46. As a result, the impact of this legislation has been muted. Joshua M. Wiener et al., *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L.J. 57, 96 (2000).


150. See, e.g., I.R.C. § 7702B(g)(2)(A)(i)(X) (referring to inflation protection); *id.* § 7702B(g)(3) (discussing disclosures); *id.* § 7702B(g)(4) (requiring nonforfeiture of benefits).

151. *Id.* §§ 213(d)(10), 7702B(b)(1).

152. NORTHWESTERN LONG TERM CARE INS. CO., NORTHWESTERN MUTUAL LIFE INS. CO., QUIETCARE: A TAX-QUALIFIED COMPREHENSIVE LONG-TERM CARE INSURANCE POLICY 9 (1999) (on file with author) [hereinafter QUIETCARE].
pany policy covers terms of two years or four years. How can one easily compare which policy is cost-effective when one offers apples and the other has oranges? The confusion then escalates with different possible elimination periods (comparable to a deductible), daily benefit amounts, inflation adjustment formulae, coverage of home care costs, refund provisions, and so on ad nauseam. The result of these multiple and noncomparable features is serious consumer confusion. Little wonder, then, that less than 10% of older Americans have long-term care insurance.

The need to reform this product is critical even if, as I have proposed elsewhere, such insurance covers care only in assisted living facilities, continuing care retirement communities, and the like. But if private long-term care insurance is also expected to finance nursing home costs, as is the case currently, some serious standardization of this product must occur immediately. The model for such action already exists in the form of the Medigap insurance reform undertaken a decade ago. Government should act now!

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154. Compare QUIETCARE, supra note 152, with Your Needs, supra note 153 (comparing Northwestern’s periods of 90 or 180 days to John Hancock’s periods of 20 or 100 days).

155. Compare QUIETCARE, supra note 152, with Your Needs, supra note 153 (comparing Northwestern’s daily benefit amounts beginning at $50 per day to John Hancock’s beginning at $100 per day).


157. Compare QUIETCARE, supra note 151, with GE CAPITAL ASSURANCE, PRIVILEGED CARE SELECT (1996) (on file with author) (comparing Northwestern’s 50% coverage of home care costs with GE’s 80% coverage).


159. Id. at 36–37, 45 (describing different options that can apply if premiums are discontinued after a number of years and describing options regarding worldwide coverage and medical alert systems).


162. See Cracking the Conundrum, supra note 137 (manuscript at 38–44) (calling for the extension of Medicare to cover nursing home costs).

C. Advance Health Care Directives

Every state within the United States has authorized some form of advance health care directive. Some directives are “living wills,” relatively simple declarations that the maker of the instrument does not want life-extending medical procedures performed, if he or she has a terminal illness and death is otherwise imminent. The specific language varies from state to state, but the essence of these documents is largely the same.

An alternative type of advance health care directive is the health care proxy or “durable power of attorney for health care.” This form typically makes no explicit declaration about medical preferences, but simply designates someone to make health care decisions in the event that the maker of this instrument cannot do so. These forms developed more recently than did living wills, but they respond to the same basic desire—namely, to control one’s medical destiny when a person either cannot understand the nature of the decision required or cannot communicate the decision itself. In these circumstances, the person is said to lack decision-making “capacity,” and the advance health care directive fills the void.

Health care directives are not exclusively an elder law issue, of course. Indeed, the celebrated court cases that spawned the development of health care directives involved young women in their twen-


165. See LIEBERSON, supra note 164, §§ 5:1–7:15.

166. See FROLIK & KAPLAN, supra note 9, at 29–41 (detailing the factors common to living wills that transcend state boundaries); see also B.D. COLEN, THE ESSENTIAL GUIDE TO A LIVING WILL 31–114 (1991) (modeling living wills for the forty-one states that had passed living will legislation as of 1990).


170. See LIEBERSON, supra note 164, §§ 20:1–11; see also ROBERT B. FLEMING, ELDER LAW ANSWER BOOK 17-8 to 17-9 (2000) (discussing difference between a living will and health care proxy).

ties. Moreover, a federal statute known as the Patient Self-Determination Act of 1990 requires that “all adult individuals” who are admitted into a hospital or nursing home, or who arrange services with a home health agency be informed about their right to prepare such a directive and be given the appropriate forms. Nonetheless, older people have a significantly greater awareness of, and interest in, advance health care directives. For example, one study found that 35% of persons over age seventy-five have some form of advance directive, compared with only 9% of persons under age thirty. Consequently, advance health care directives and their effectiveness are important matters to older Americans.

There are a variety of intriguing legal and medical issues with such directives, but one that is uniquely capable of governmental resolution is portability. That is, each state has its own form, and state laws vary as to whether out-of-state forms will be honored. Elders who spend any part of their lives in more than one state must be concerned with the state-to-state acceptance of their advance health care directives. While elders with homes in two states are often advised to execute health care directives in both states, few do so. The growing number of older people who travel out-of-state to see relatives and to take extended vacations are also at risk. But what should they do? Load up their luggage with advance directives for

172. See generally Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261 (1990) (Nancy Cruzan was twenty-five years old); In re Quinlan, 355 A.2d 647 (N.J. 1976) (Karen Ann Quinlan was twenty-two years old).
177. See, e.g., 755 ILL. COMP. STAT. 35/9(h) (1993) (Illinois will recognize a living will that is “in compliance with the law of [another] state”).
179. See, e.g., Frolik & Kaplan, supra note 9, at 39; Lieberson, supra note 164, § 18:25.
180. See generally Carlisle, supra note 178.
181. See generally id.
every state through which they plan to travel? This solution is as pre-
posterous as it is unrealistic.

The better solution is interstate recognition of out-of-state ad-
vance health care directives. This approach was proposed in 1999 as
part of the Advance Planning and Compassionate Care Act.182 That
legislation included certain safeguards to ensure appropriate respect
for state-specific policies; for example, state laws regarding the with-
holding or withdrawal of health care would not be abrogated by an
out-of-state directive.183 Moreover, state laws that provide “greater
portability, more deference to a patient’s wishes, or more latitude in
determining a patient’s wishes” would be honored.184 In other words,
the proposed legislation could only enhance a patient’s existing rights;
it could not contract them. Nevertheless, neither this Bill nor any
other dealing with this issue185 has emerged out of committee for con-
sideration by the full Congress.

As a result, older Americans who want to ensure that their
medical care decisions are implemented have no such assurance once
they leave the borders of their home state. This problem is easily fix-
able and should be addressed forthwith.

D. Social Security Earnings Test

No government program is as important to older Americans as
Social Security.186 For two out of three retirees, it provides the major
part of their retirement income, and for almost a third of retirees, it
provides 90% or more.187 But Social Security was never intended to be
the principal source of retirement income, and its benefits are not
computed with this goal in mind.188 As a result, many older Ameri-
cans supplement their Social Security retirement benefits with em-

182. S. 628, 106th Cong. § 5(a), (b) (1999); see also H.R. 1149, 106th Cong. § 5(a),
(b) (1999) (companion proposal).
183. S. 628, 106th Cong. § 5(a) (proposing 42 U.S.C. § 1395cc(f)(5)(B)); S. 628,
106th Cong. § 5(b) (proposing 42 U.S.C. § 1396a(w)(6)(B)).
184. S. 628, 106th Cong. § 5(a) (proposing 42 U.S.C. § 1395cc(f)(5)(C)); S. 628,
106th Cong. § 5(b) (proposing 42 U.S.C. § 1396a(w)(6)(C)).
(ii) (2001) (directing the Secretary of Health and Human Services to “develop a
national advance directive form” that would “be honored by all health care pro-
viders”).
186. SOCIAL SECURITY ADMIN., FAST FACTS & FIGURES 7 (2001).
187. Id.
188. See FROLIK & KAPLAN, supra note 9, at 282–87 (explaining how Social Secu-
rity benefits are calculated).
ployer-provided pensions, individual savings and investments, and even employment.\textsuperscript{189} It is this latter category that demands immediate attention, more specifically the so-called retirement earnings test of Social Security.\textsuperscript{190}

This innocent-sounding provision reduces a Social Security recipient’s retirement benefit by 50% of every dollar earned over a certain limit that is adjusted annually for inflation.\textsuperscript{191} In 2002, that limit is $11,280.\textsuperscript{192} For example, assume that Peter is otherwise entitled to Social Security benefits of $12,000 per year, but he takes a job at Wal-Mart that pays an annual salary of $17,280. Because that amount exceeds Social Security’s retirement earnings limit of $11,280 by $6,000, Peter’s Social Security benefit is reduced by half of this excess—namely, $3,000. As a result, Peter receives Social Security retirement benefits of only $9,000 ($12,000 minus $3,000). In effect, the $6,000 that Peter earned above Social Security’s annual limit bore an implicit tax of 50%.

To make matters worse, those earnings are subject to a federal income tax of 15% (or more),\textsuperscript{193} as well as Social Security’s own payroll tax of 15.3%, counting the employer’s share.\textsuperscript{194} The combined tax rate on Peter’s income above Social Security’s retirement earnings limit, therefore, exceeds 80%.\textsuperscript{195} This computation, incidentally, does not even consider any state income taxes that might apply to these earnings.

In fact, Peter’s situation could be even worse. If he has a modest pension or some investment income, his Wal-Mart earnings might take his “adjusted gross income”\textsuperscript{196} above $25,000. At that point, the Social Security benefits themselves become subject to federal income tax.\textsuperscript{197} By taking the job at Wal-Mart, in other words, Peter exposes as

\textsuperscript{191} Id. § 403(f)(3).
\textsuperscript{193} I.R.C. § 1(c) (1989). The amount of the earnings test’s threshold would move Peter out of the 10% tax bracket in most circumstances.
\textsuperscript{194} I.R.C. §§ 3101(a), (b), 3111(a), (b) (1989).
\textsuperscript{195} 50% implicit tax + 15% income tax + 15.3% Social Security tax = 80.3%.
\textsuperscript{196} I.R.C. § 62(a). See generally BITTKER & MCMAHON, supra note 42, ¶ 2.1[3].
\textsuperscript{197} I.R.C. § 86(a), (c)(1)(A).
much as 85% of his Social Security benefits to tax,\textsuperscript{198} the exact proportion depending upon Peter’s income from all other sources.\textsuperscript{199} And if his income exceeds $28,000 (in 2002),\textsuperscript{200} Peter has entered the 27% tax bracket.\textsuperscript{201} The combined impact of the retirement earnings test (50%), the federal income tax (27%), Social Security’s payroll tax (15.3%), and the income tax on the Social Security benefits themselves (as much as 23%)\textsuperscript{202} is an effective tax rate that can exceed 100%!

Why older Americans should face such confiscatory levels of taxation is by no means clear. Many older Americans want to remain in the workforce and to stay active for reasons other than money.\textsuperscript{203} For example, Peter’s job at Wal-Mart provides a daily regimen, interaction with people of varying ages, employee discounts on essential products, and supplemental health care benefits, perhaps even prescription drugs. As Americans live longer,\textsuperscript{204} this trend should be encouraged, not penalized.

For these reasons, Congress repealed a less severe version of Social Security’s retirement earnings test in 2000.\textsuperscript{205} But that repeal applies only to Social Security recipients who have reached “full retirement age,” which generally is sixty-five years, but is rising gradually, depending on one’s year of birth.\textsuperscript{206} So, for someone born in 1940, “full retirement age” is sixty-five years and six months.\textsuperscript{207} In any case, the retirement earnings test for Social Security recipients below this age was not touched. As a result, those individuals who receive Social Security retirement benefits between “early retirement age” of sixty-

\textsuperscript{198} Id. § 86(a)(2).
\textsuperscript{199} See FROLIK & KAPLAN, supra note 9, at 306–10. See generally Nathan Oestreich, Taxability of Social Security Benefits After the Repeal of the Earnings Test, 89 TAX NOTES 543 (2000).
\textsuperscript{201} I.R.C. § 1(c).
\textsuperscript{202} If 85% of one’s Social Security benefits are subject to a 27% income tax, the effective tax rate on these benefits is 22.95%.
\textsuperscript{204} It’s Official: Life Expectancy in U.S. Hits New High at 76.9, BIOMEDICAL MKT. NEWSL., Oct. 26, 2001, at 1.
\textsuperscript{206} 42 U.S.C. § 416(j)(1)–(3).
\textsuperscript{207} See FROLIK & KAPLAN, supra note 9, at 279.
two years\textsuperscript{208} and their applicable “full retirement age” face the retirement earnings test that was examined above.\textsuperscript{209} Moreover, the application of this test is especially painful in light of the actuarial reduction of Social Security benefits that these people have already suffered. When someone begins receiving Social Security benefits prior to reaching “full retirement age,” those benefits are reduced according to a formula that considers the precise age at which those benefits begin.\textsuperscript{210} The younger that recipient is, the larger the benefit reduction, with the largest reduction being when benefits begin at age sixty-two years.\textsuperscript{211} For example, in 2002 when the “full retirement age” is sixty-five years and six months, starting benefits at age sixty-two entails a reduction based of forty-two months,\textsuperscript{212} which translates into a 22.5\% reduction.\textsuperscript{213} And as Social Security’s “full retirement age” increases in the future,\textsuperscript{214} the maximum benefit reduction will increase to 30\%.\textsuperscript{215} This reduction, moreover, is a permanent loss of benefits that continues throughout the recipient’s life. It is not eliminated when the person reaches “full retirement age.”\textsuperscript{216} Given this reality, it seems particularly misguided, if not downright cruel, to impose the “retirement earnings test” in these circumstances. Accordingly, Congress should complete what it started in 2000 and repeal the Social Security retirement earnings test in its entirety.

To be sure, Social Security is currently on the policy horizon, but not in this regard. Widely differing proposals call for a complete restructuring of Social Security’s benefit formula, substituting predictable and guaranteed benefit levels\textsuperscript{217} for the prospect—and only the prospect—of potentially higher benefits resulting from individual

\begin{itemize}
\item \textsuperscript{208} 42 U.S.C. § 416(l)(2).
\item \textsuperscript{209} See id. § 403(b)(1).
\item \textsuperscript{210} Id. § 402(q).
\item \textsuperscript{211} See FROLIK & KAPLAN, supra note 9, at 279–81.
\item \textsuperscript{212} Three years + six months = forty-two months.
\item \textsuperscript{213} Thirty-six months x 5/9\% per month + 6 months x 5/12\% per month = 20\% + 2.5\% = 22.5\%.
\item \textsuperscript{214} 42 U.S.C. § 416(l)(1)–(3).
\item \textsuperscript{215} Thirty-six months x 5/9\% per month + 24 months x 5/12\% per month = 20\% + 10\% = 30\%.
\item \textsuperscript{216} To the extent that the retirement earnings test reduces a person’s Social Security benefits, the “early” retirement benefit reduction may be recalculated when the recipient reaches “full retirement age.” FROLIK & KAPLAN, supra note 9, at 305.
\item \textsuperscript{217} Richard L. Kaplan, Top Ten Myths of Social Security, 3 ELDER L.J. 191, 205–07 (1995).
\end{itemize}
control over a portion of that person’s payroll taxes. These ideas may—or may not—be beneficial to retirees in some distant tomorrow, but they have little relevance to current retirees or those retiring anytime soon. Indeed, President Bush has announced that his first principle in reforming Social Security is that “[m]oderization must not change Social Security benefits for retirees or near-retirees.” A similar commitment was expressed in a Concurrent Resolution that passed the House of Representatives by a nearly unanimous vote. Repeal of Social Security’s retirement earnings test, therefore, should be considered independent of any reappraisal of the overall Social Security program that might happen.

E. Employer-Provided Pensions

Almost half of today’s retirees have some sort of employer-provided pension plan that supplements their Social Security benefits. Historically, most of these were defined-benefit plans; that is, the plan defined what benefits a retiree would receive, and the employer

218. The literature on Social Security reform proposals is far too vast for a mere footnote. For the most recent “official” proposal, see REPORT OF THE PRESIDENT’S COMMISSION, STRENGTHENING SOCIAL SECURITY AND CREATING PERSONAL WEALTH FOR ALL AMERICANS (2001), http://csss.gov/reports/Final_report.pdf (last visited Jan. 11, 2002) [hereinafter STRENGTHENING].


220. STRENGTHENING, supra note 218, at 10.


223. See FROLIK & KAPLAN, supra note 9, at 344.
was financially responsible for making sure that the pension plan provided those benefits. More recently, however, employers have either substituted or supplemented these arrangements with defined-contribution plans. Under a defined-contribution plan, the employer provides a specified sum that the employee then invests at his or her discretion. Investment successes and failures are those of the employee/prospective retiree alone.

A variation on the defined-contribution theme is the 401(k) plan, so named for the authorizing section of the Internal Revenue Code. Under a 401(k) plan, an employee directs that a portion of his or her salary be invested on a tax-deferred basis in the plan, and the employer usually matches that portion according to some predetermined schedule. But the basic arrangement is the same: the employee invests the funds in question as he or she chooses, and any investment gains—or losses—are entirely that person’s concern.

Most 401(k) arrangements have a limited number of investment options. A typical plan might offer a fixed-income contract and an array of mutual funds, some investing in bonds, some in stock, with the exact number and variety of the offerings varying by employer. There are no federal requirements regarding the mix of investments that must be offered by the employer, even though the employee bears all of the investment risk.

In recent years, many prospective retirees have invested most of their section 401(k) account in the stock of their corporate employer. While 401(k) plans usually offer other alternatives, certain financial incentives, such as employer matching of employee contributions and

224. See generally id. at 346–49.
226. See generally FROLIK & KAPLAN, supra note 9, at 349–51.
230. EMJAY CORP., supra note 227, § 1-8.
231. See id. § 6-1.
232. See id.
233. Id. §§ 6-27 to 6-28.
special discounts, often apply exclusively to investments in the employer’s corporate stock.235 Such arrangements often produce very high concentrations of employer stock in these plans,236 sometimes in excess of 80%.237 Moreover, most such 401(k) plans place restrictions on when their holdings of employer stock can be sold.238 Thus, when the stock in these plans starts to decline in value, the accountholder is unable to stem his or her loss by liquidating the shares.

The resulting lack of diversification seriously jeopardizes a retiree’s financial security. After all, if the stock’s value drops in response to company-specific conditions, rather than general market conditions, the company may be facing serious economic problems. In such circumstances, the employee may soon be out of a job. And because pre-Medicare health insurance is usually obtained from one’s employer as a fringe benefit,239 the loss of employment is followed shortly thereafter by the loss of health insurance—or at least affordable health insurance.240 What a terrible time to discover that one’s retirement account has suffered a significant reduction in its value! Rarely

237. See Ellen E. Schultz, Employers Fight Limits on Firm’s Stock in 401(k)s, WALL ST. J., Dec. 21, 2001, at C1 (reporting concentrations of 94.7% at Proctor & Gamble, 90.2% at Abbott Laboratories, 88.2% at Dell Computer, 85.5% at Pfizer, 81.6% at Anheuser-Busch, and 81.5% at Coca-Cola) [hereinafter Employers Fight Limits on 401(K)s].
238. Schultz & Francis, supra note 235, at A1 (85% of companies with their own stock in 401(k) plans restrict the sale of such stock).
240. When an employee is terminated, that person may continue coverage for up to eighteen months under the former employer’s health insurance plan, but that person will pay the full cost of the premiums for that insurance. 29 U.S.C. §§ 1162(1), (2)(A)(i), (3)(A), 1164(1) (1994). The eighteen-month limitation does not apply if the employer files for bankruptcy. Id. §§ 1162(2)(A)(iii), 1163(6). In any case, the former employee’s out-of-pocket cost for this insurance might be as much as ten times its pre-termination expense. See INSURE.COM, KNOW YOUR COBRA RIGHTS, http://www.insure.com/health/cobra.html (last modified Nov. 29, 2001).
As a result, only one in five eligible individuals actually obtains COBRA insurance. KAISER COMM’N ON MEDICAID & THE UNINSURED, COBRA COVERAGE FOR LOW-INCOME UNEMPLOYED WORKERS 1 (2001), http://www.kff.org/content/2001/10252001/4021.pdf (last visited Feb. 11, 2002).
The elder law journal

Vol. 10

has the adage “don’t put all your eggs in one basket” been more flagrantly violated. 241

The compelled concentration of one’s retirement assets in a single stock should simply be prohibited. But when a statutory amendment was proposed in 1996 to do so, a coalition of major corporations effectively eviscerated the measure. 243 Since that time, the stock market has sustained a major decline, and some particular stocks have lost much of their value. 244 The impact on the 401(k) plans of these companies has been catastrophic, with the nearly complete wipeout of the Enron Corporation plan being only the worst example. 247 In other words, the very calamity that the 1996 proposal was designed to prevent has now occurred.

It is now time to reconsider the concentration of retirement fund assets in corporate employer stock. 248 Even if employees should be allowed to allocate some portion of their retirement accounts to such stock, current levels of concentration should not be permitted. Corporate match incentives should be rethought to ensure that such policies do not encourage future retirees to compromise their prospects for a secure retirement by loading up on employer stock. In addition, 401(k) account holders must be allowed to diversify out of any company stock that they receive, without excessive time and age-based restrictions. 249

Any new legislation, moreover, should prohibit any grandfathering of existing plans. Instead, it should provide some reasonable

242. 401(k) Pension Protection Act of 1996, S. 1837, 104th Cong., § 2(a) (1996) (limiting the amount of employer stock in a company’s 401(k) plan to 10% of the plan’s assets).
243. See Schultz, supra note 234, at C1; see also Daniel Kadlec, Time Bomb: 401(k)s Stuffed with Employer Stock are a National Calamity, TIME, Mar. 5, 2001, at 84.
246. See Schultz & Francis, supra note 235, at A1; see also Schultz, supra note 237, at C11.
247. See, e.g., Pension Protection and Diversification Act of 2001, S. 1838, 107th Cong., § 2(a) (2001) (limiting the amount of employer stock to 20% of the plan’s assets); Pension Protection Act, H.R. 3463, 107th Cong., § 2(a) (2001) (10%).
248. See S. 1838, 107th Cong., § 2(a) (2001) (permitting sale of company stock in a 401(k) plan ninety days after its receipt).
schedule for bolstering the financial integrity of any 401(k) plans that do not meet whatever new standard is adopted for investment diversification. Otherwise, these retirement accounts, which often constitute their owners’ single largest nonresidential asset, may be unable to provide the retirement security that older Americans have been led to expect.

III. Conclusion

As the preceding section has shown, the elder law policy agenda has many issues of great importance to older Americans. A prescription drug benefit should be added to the Medicare program, so that enrollees are able to obtain the medication they need without relying on inadequate and undependable arrangements. Long-term care insurance policies should be regularized, so that older people can compare different packages and optional features and make informed choices. Advance health care directives should be accepted across state lines, so that the expectations of the older people making these directives are honored outside their home state. Social Security’s retirement earnings test should be repealed in its entirety, so that older people who continue to work are not penalized by confiscatory taxes. And finally, 401(k) plans should have strict limits on how much employer stock they can hold, so that retirees can receive the retirement security that these accounts were intended to provide.

This list is by no means exhaustive. But it does convey a sense of some vital concerns that relate directly to the medical and financial quality of elders’ lives, in contrast to reform of the federal estate tax, which affects only the finances of their nonspouse survivors. Advocates for elders and the policymakers who care about their needs (or at least their votes) must refocus their attention on elder law issues of genuine consequence. They must not allow general disdain for the government’s means of raising revenue to divert them to essentially

251. See supra Part II.A.
252. See supra Part II.B.
253. See supra Part II.C.
254. See supra Part II.D.
255. See supra Part II.E.
peripheral concerns. Seniors also must resist pandering efforts on matters that, in reality, are relevant only to the wealthiest among them.

Elder law issues involving health care and retirement security have enormous significance to older Americans, and this policy agenda must not be crowded out by estate tax reform.