ELDER LAW HAWAII

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I. Overview[2]

Elder Law has been part of the Hawaii legal landscape for over a quarter of a century, yet many members of the bar and the community do not have a clear sense of this unique field of practice. This article intends to provide a brief introduction to "Elder Law," including some insight as to what it means to be an Elder Law attorney, the Elder Law experience at the University of Hawaii, and a few updates or reviews on select areas of the law impacting on the practice of Elder Law.[3]

II. The Aging Population

To truly understand the meaning and importance of Elder Law, one must understand some basics of the aging population. It is common knowledge that the population of older persons in Hawaii and throughout the United States is growing.[4] This article does not discuss the various arguments about what one should call an older person (various terms have been used over the years, including "elderly," "senior" and "senior citizens," "aged," "*Kupuna*," among others) or at what age a person becomes an 'older person".[5]). Perhaps the most salient points relating to an aging population can be derived from observing

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[2] A short version of this article was published in the April 2009 issue of the *Hawaii Bar Journal*.

[3] The overview of the practice field of Elder Law relies heavily on information provided by the National Academy of Elder Law Attorneys ("NAELA"). See the National Academy of Elder Law Attorneys website at <www.naela.org>. The NAELA membership is comprised of attorneys in the private and public sectors dealing with legal issues affecting the elderly and disabled. Members also include judges, professors of law, and students. NAELA's vision is to be the recognized leader for inspiring and empowering attorneys to enhance the quality of life for the elderly. See, http://www.naela.org/About_WhatIsNaela.aspx?Internal=true, last visited February 20, 2009.

[4] About 20% of Hawaii's population is over the age of 60. See, <http://www.uhfamily.hawaii.edu/publications/brochures/OlderAdults_DemographicProfil>, last visited February 20, 2009.

[5] The definition of "old age" seems to be highly dependent on the scenario for which it is needed. Examples include: 50 is the minimum age for AARP membership; 60 is used in the Older Americans Act (Public Law 109-365 (2006); and 62, 65, or 67 can be used for purposes of Medicare and certain Medicaid benefits. For additional insight regarding definitions of "old age" as well as insights into aging and legal issues pertaining to the elderly, see *Legal Aspects of Elder Care* by Marshall B. Kapp published by Jones and Bartlett Publishers (2009), *Elder Law Cases and Materials* by Lawrence A. Frolik and Alison McChrystal Barnes, fourth edition published by LexisNexis (2007), *Aging Concepts and Controversies*, third edition by Harry Moody, published by Pine Forge Press (2000) and *The Elder Law Hawaii Handbook* by James H. Pietsch and Lenora Lee, published by the University of Hawaii Press (1998—update forthcoming).

the life expectancy and disability of a population. As has been documented, both life expectancy and disability rates are increasing throughout the population – creating the need to care for people over a longer period of time. Although not inevitable, incidence of physical and mental disabilities increase with age and it is not always possible to know when disability may set in or how it will impact an individual. Many older persons lead active lives well into their 80s, 90s and 100s. While our aging population is diverse, their longevity and the pressing need for health care and legal advocacy is summarized by a sobering Administration on Aging report:[6]

The Administration on Aging report demonstrates that, in the immediate future, the number of disabled persons, at all levels of disability, will increase rapidly. The number of people with severe to moderate disabilities will more than triple between the years 1986 and 2040. The implications of long life expectancies and incidence of disability on society in general could be catastrophic. Perhaps the most salient point one may infer from this report is that with longer life expectancies and increasing disability rates, society must determine how to care for people over a longer period of time. The frightening specter of Alzheimer's Disease and related disorders of the brain disorders clearly evidences such an inference.[7]

In a large sense, the rapidly changing demographic of the State has driven development of a unique practice of law, known as "Elder Law."

III. Elder Law

No matter what age is used to categorize "old age," legal problems affecting the elderly are growing in number. Laws and regulations are becoming more complex for all segments of the population, and this includes laws, which have a particular effect on older persons. Further, legal actions taken by older people (often with the assistance of an attorney) may result in unintended legal consequences. As a quick example, the simple transfer of a piece of property may result in the disqualification of an individual for Medicaid benefits for long-term care.[8] Over the past quarter century, Elder Law has emerged as a unique practice of law to meet the diverse needs of an aging population.

Elder Law is a unique field of practice because it is not defined by any particular technical legal distinctions but rather by the client to be served. The attorney who practices Elder Law may handle a range of issues, but has a specific category of clients—older persons, or their representatives or their caregivers. Elder Law attorneys focus on the legal needs of the elderly and work with a variety of tools and techniques to meet the goals and objectives of the older client. Elder law attorneys often work closely with others who commonly work with older persons, including doctors, nurses, social workers, case mangers,

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[6] See <http://www.aoa.dhhs.gov/aoa/stats/aging21/health.html>, last visited February 20, 2009.

[7] See *id.* The report goes on to state:

> Among those included in the severely disabled category are those with clinically diagnosed Alzheimer's disease. A team of researchers (Evans et. at., 1992) has compiled a set of projections of persons with this condition. These analysts expect 10.2 million cases (middle series) at ages 65 and over by 2050, and possibly 14.3 million cases (high series) by 2040, as compared with about 3.8 million (both middle and high series) in 1990. There is the expected progression in numbers of cases with increasing age, a pattern that intensifies with the passage of time. By 2040, most of these cases, some 70 percent, occur among ages 85 and over. The number of cases at these ages will increase by over 300 percent, as compared with 25 to 50 percent for ages 65 to 74. This change reflects the entry of the baby-boom cohorts into the highest ages by 2040.

[8] Medicaid, as well as Medicare issues will be discussed later in this paper.

financial planners, insurance agents and other lawyers who may have a specialized legal skill needed by the older client, representative or caregiver. Obviously, the challenges of an Elder Law attorney are often greater than in a practice that is limited to a single technical area of the law as the practice of Elder Law encompasses many different fields of law. As indicated on the NAELA web site[9], some of these include:

- Preservation/transfer of assets seeking to avoid spousal impoverishment when a spouse enters a nursing home;
- Medicaid;
- Medicare claims and appeals;
- Social security and disability claims and appeals;
- Supplemental and long term health insurance issues;
- Disability planning, including use of durable powers of attorney, living trusts, "living wills," for financial management and health care decisions, and other means of delegating management and decision-making to another in case of incompetency or incapacity;
- Conservatorships and guardianships;
- Estate planning, including planning for the management of one's estate during life and its disposition on death through the use of trusts, wills and other planning documents;
- Probate;
- Administration and management of trusts and estates;

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[9] See <http://www.naela.org/About_QandA.aspx?Internal=true>, last visited February 20, 2009. That site further explains more about the Elder Law attorney:

> Most Elder Law attorneys do not specialize in every one of these areas. So when an attorney says he/she practices Elder Law, find out which of these matters he/she handles. You will want to hire the attorney who regularly handles matters in the area of concern in your particular case and who will know enough about the other fields to question whether the action being taken might be affected by laws in any of the other areas of law on the list. For example, if you are going to rewrite your will and your spouse is ill, the estate planner needs to know enough about Medicaid to know whether it is an issue with regard to your spouse's inheritance.
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> Attorneys who primarily work with the elderly bring more to their practice than an expertise in the appropriate area of law. They bring to their practice a knowledge of the elderly that allows them and their staff to ignore the myths relating to aging and the competence of the elderly. At the same time, they will take into account and empathize with some of the true physical and mental difficulties that often accompany the aging process. Their understanding of the afflictions of the aged allows them to determine more easily the difference between the physical versus the mental disability of a client. They are more aware of real life problems, health and otherwise, that tend to crop up as persons age. They are tied into a formal or informal system of social workers, psychologists and other elder care professionals who may be of assistance to you. All of these things will hopefully make you more comfortable when dealing with them and ease your way as you try to resolve your legal problem.

- Long-term care placements in nursing home and life care communities;
- Nursing home issues including questions of patients' rights and nursing home quality;
- Elder abuse and fraud recovery cases;
- Housing issues, including discrimination and home equity conversions;
- Age discrimination in employment;
- Retirement, including public and private retirement benefits, survivor benefits and pension benefits;
- Health law; and
- Mental health law.

There is a danger in attempting to have such a multi-faceted practice. The laws affecting the elderly are broad in their scope, and frequently change based on statutes, regulations, and program operations. Understanding, following, and keeping up with such changes is challenging, to say the least. In addition to being knowledgeable about legal theories and being able to spot legal issues unique to the aging population, the Elder Law attorney should also be able to assist the client with, or make appropriate referrals for what are traditionally non-legal services, such as planning for possible long-term care needs, including seeking nursing home care. Locating the appropriate type of care, coordinating private and public resources to finance the cost of care, and working to ensure the client's right to quality care are all part of the Elder Law practice.[10] In providing such services to clients, it is also important to note that many of the clients will have limited means, as their resources may be directed to paying long-term care costs. Further, there may be a sense of urgency with many cases, as many clients do not have the luxury of time.

Most Elder Law attorneys will find great satisfaction with their jobs. The stress of keeping up with the rapidly changing, broad areas of law, and managing a high-paced practice, however, is not without its consequences.

IV. Elder Law at the University of Hawaii[11]

Elder Law has been an integral part of the William S. Richardson School of Law at the University of Hawaii at Manoa for nearly twenty years. The University of Hawaii Elder Law Program (UHELP) consists of three interrelated components designed to train future Elder Law attorneys and to provide quality legal services to traditionally underserved populations: substantive legal education, clinical legal education, and direct legal services.

Substantive legal education at the UHELP consists of three primary courses offered to law students and certain graduate students. These courses are "Law, Aging and Medicine" (formerly known as the "Elder Law" course), "Health Law," and "Health Law and Ethics: Bioethics." The substantive legal courses provide a basic foundation for legal practice with the elderly. Substantive topics covered include: Social Security and Supplemental Security Income, Supplemental Nutrition Assistance Program (formerly "food stamps"), Medicare, Medicaid, the Older Americans Act, the delivery of legal services to the elderly,

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[10] *Id.*

[11] See <www.hawaii.edu/uhelp>.

guardianship and conservatorship, long term care, elder abuse and neglect, adult protective services, medical treatment decisions, financial planning, estate planning, consumer protection, housing, and age discrimination in employment. Geriatric Fellows and Psychiatry Fellows from the John A. Burns School of Medicine are also offered courses of instruction to help them understand the medical-legal issues affecting older persons. The substantive areas of education help to prepare students for the clinical aspect of the Elder Law experience at the University of Hawaii.

Law students and certain graduate students who have completed the substantive requirements are eligible to participate in the Elder Law Clinic (including an Advanced Elder Law Clinic). The goal of the Elder Law Clinic is to provide students with "real-life" experiences representing older clients with a variety of Elder Law issues. The Clinic combines traditional classroom education with the opportunity to provide direct legal services under the close supervision of a professor who is also licensed to practice law in Hawaii. The Elder Law Clinic allows students to serve socially and economically needy older persons (60+) on Oahu with problems involving public entitlements, guardianship/conservatorship and their alternatives, landlord-tenant, elder abuse, age discrimination, planning for incapacity and death, consumer protection, healthcare and medical treatment decisions. While the services that the Clinic provides to the community are free, the Clinic only operates during the fall and spring semesters. The direct legal services component of UHELP provides the logistics and legal support for the Elder Law Clinic, and it provides direct legal services year-round to qualified older persons and caregivers on Oahu.

UHELP has been responsible for the direct delivery of legal services to the elderly since 1991. The program had its origin at the Legal Aid Society of Hawaii, which remains a valued partner in addressing legal issues of older persons. UHELP operates throughout the calendar year as a direct legal services provider. Its goal is to enhance, protect and preserve the autonomy and independence of older persons through education, training and direct legal services. UHELP places particular emphasis on assisting socially and economically needy older persons and their caregivers.[12] UHELP is directed by a professor/attorney (the author) who has the primary responsibilities for operating the law firm and the educational components of the program. UHELP also has a practicing attorney in the community who volunteers to assist the program on a part-time basis, two law clerks, and a law office administrator/legal assistant. UHELP is also fortunate to have the inspiration and namesake of the law school, former Chief Justice William S. Richardson in residence in the UHELP office. UHELP has a case load of approximately 400 cases a year and conducts extensive community outreach services, such as providing educational seminars for the elderly, caregivers, and service providers.

While UHELP is able to assist numerous people each year through its legal services and community outreach endeavors, the scope of services is limited. UHELP is not permitted to assist with business or criminal law matters, or with personal injury or other fee-generating cases. Individuals may qualify for services if they are 60 years or older and are socially or economically needy or if the individual is

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[12] Funding for UHELP is provided by the University of Hawai'i William S. Richardson School of Law, the Elderly Affairs Division of the City and County of Honolulu (under Title III of the Older Americans Act), the State of Hawai'i Indigent Legal Assistance Fund managed through the State of Hawaii Judiciary, the Hawai'i Justice Foundation and through donations. There are no fees charged for services, but donations are welcome. Because of limited staff and resources, services are limited, and priority is given to the most needy of clients. To find out more about UHELP, please call (808) 956-6544 (FAX (808) 956-9439) or write to: University of Hawai'i Elder Law Program, 2515 Dole Street, Honolulu, HI 96822.

a caregiver of an older person and needs legal assistance on behalf of the older person. Each case is evaluated according to its own merits and in accordance with staff capabilities.[13]

By providing students with the opportunity to learn many of the substantive laws relating to the practice of Elder Law and invaluable experiences serving the community, UHELP hopes to elevate the future practice of Elder Law to new heights.

V. Update on Select Elder Law Issues

As previously mentioned, Elder Law encompasses a broad range of technical legal subjects. In this update, an overview of just a few subjects is provided, namely health care decision-making, including end-of-life decisions, protective services, including "elder abuse," and an overview of emerging Medicare and Medicaid issues.

A. Health Care Decision-Making

Understanding key legal issues relating to health care is a central focus of Elder Law. Health care decisions are made every day in Hawaii by patients or their authorized representatives, along with their physicians or other health care providers. It has become increasingly important for Elder Law Attorneys to have an understanding of the laws pertaining to health care decision-making. It is important for Elder Law attorneys to understand how decisions are made and enforced when the patient is unable personally to make informed decisions. As in other states, a combination of laws impact health care decision-making in Hawaii.

B. Informed Consent

The process for making medical treatment decisions revolves around the concepts of informed consent and a person's constitutional right to accept or refuse unwanted medical treatment. In general and with few exceptions, the United States Constitution and the common law provide that an individual with decision-making capacity has the right to consent to or refuse any suggested medical treatment, even if refusal may result in death.[14] To ensure that the patient's consent to treatment is informed, the Hawaii

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[13] UHELP services include:

- Advance Healthcare Directives-healthcare instructions (similar to the old "living will") and healthcare powers of attorney
- Simple wills-restricted to certain estate values
- General durable powers of attorney
- Planning for incapacity and death
- Counseling on end-of-life decision-making
- Information about public benefits
- Counseling on legal issues relating to elder abuse, care giving and guardianship/conservatorship
- General legal information and referrals

Some types of cases UHELP does not handle are:

- Criminal Law (including traffic violations)
- Commercial or Income Producing Matters
- Personal Injury Matters

[14] *See, e.g.,* U.S. CONST. amend. XIV; *Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261 (1990).

State Legislature has provided the Board of Medicine the option, within certain boundaries, to establish standards for health care providers to follow in giving information to a patient, or to a patient's guardian or "surrogate" if the patient is not competent.[15] These standards may include the substantive content of the information to be given, the manner in which the information is to be given by the health care provider, and the manner in which consent is to be given by the patient or guardian.[16] The concept of informed consent essentially revolves around a patient's right to have the opportunity to be an informed participant in his or her healthcare decisions. Discussions regarding the treatment or procedures normally include information regarding the patient's diagnosis, the nature and purpose of a proposed treatment or procedure, their attendant risks and benefits, alternative treatments or procedures and their attendant risks and benefits and the risks and benefits of not receiving or undergoing a treatment or procedure.[17]

The doctrine of informed consent to treatment includes the right to informed refusal of treatment. A competent adult patient has the right to refuse all forms of medical intervention, including life-saving or life-prolonging treatment.[18]

Hawaii has adopted a patient-oriented standard applicable to the duty to disclose risk information prior to treatment.[19] The patient-oriented standard of informed consent focuses on what reasonable patients objectively need to hear from the physician to allow them to make informed and intelligent decisions regarding proposed medical treatment.[20]

C. Hawaii's Uniform Health Care Decisions Act (Modified) and Advance Directives

There have not been many changes to Hawaii's Uniform Health Care Decisions Act (Modified)[21] (" UHCDA"), but this article will provide a short background for those attorneys who may not be familiar with it. Anecdotal evidence gathered by UHELP suggests that many lawyers and doctors still do not know anything about this law. This often creates difficulties when uninformed doctors and lawyers deal with decisions being made for individuals who lack capacity.

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[15] *See* HAW. REV. STAT. § 671-3 (1983). On January 1, 2004, Hawaii Laws Act 114 (H.B. 651) (2003) became effective. The Act amends HAW. REV. STAT. § 671-3 substantially by recognizing "legal surrogates" for the purposes of making healthcare decisions. For the purposes of the Act, a "legal surrogate" is "an agent designated in a power of attorney for health care or a surrogate designated or selected in accordance with Chapter 327E."

[16] *See* HAW. REV. STAT. § 671-3 (1983).

[17] H.B. 651, 2003 Leg., 23rd Sess. (Haw. 2003) and S.B. 624, 2003 Leg., 23rd Sess (Haw. 2003) were introduced in the 2003 legislative session to update Hawaii's informed consent laws. A compromise bill was passed and signed into law as Act 114 (HAW. SESS. LAWS 114, 2003). In brief, the changes to the law, effective January 2004, include changes to update Hawaii law to make it more consistent with other laws and extending the right to consent to or refuse medical treatment to legal guardians or surrogates.

[18] *See Cruzan v. Director, Miss. Dep't of Health*, 497 U.S. 261, 278-79, (1990) (assuming, and strongly suggesting, that the Fourteenth Amendment Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment).

[19] *Carr v. Strode*, 904 P.2d 489 (Haw. 1995).

[20] *Id.* This case overruled the prior standard as expressed in *Nishi v. Hartwell*, 473 P.2d 116 (Haw. 1970).

[21] *See* HAW. REV. STAT., Chapter 327E (1999).

The UHCDA places the so-called "living will,"[22] the durable power of attorney for health care, and a surrogate consent law together in one statute. An "individual instruction," which takes the place of what is commonly called the "living will," applies to a wide range of health care decisions, not just end-of-life decisions. The residual decision-making portion of the Act is somewhat like family consent statutes that have been adopted in a majority of States. This section of the Act applies only if there is no applicable individual instruction, guardian, or appointed agent. Hawaii has established a unique framework for appointing or selecting surrogates. In Hawaii, there is no established hierarchy for surrogates.

The use of advance directives in legal planning is an integral part of the elder law practice even though their effectiveness may continue to be questioned and compliance to patients' desires may still be inconsistent.[23] Under Hawaii law, an adult or emancipated minor may make advance health care directives[24] by giving an "individual instruction"[25] orally or in writing and/or by executing a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider,[26] but an individual may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.[27] The law even provides an optional sample form (and explanation), which may be duplicated or modified to suit the needs of the person. Alternately, one may use a completely different form that contains the substance of the sample form found in the statute.[28]

Under the UHCDA, a surrogate may make a health care decision for a patient if the patient lacks capacity and no agent or guardian has been appointed or neither the agent nor guardian is available.[29] A patient may designate or disqualify any individual to act as a surrogate by personally informing the supervising health care provider.[30] In the absence of such a designation, or if the designee is not reasonably

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[22] Nowhere in HAW. REV. STAT., Chapter 327E is the term "living will" used.

[23] In 2008, the U.S. Secretary of Health and Human Services provided a comprehensive report to Congress entitled "Advance Directives and Advance Care Planning." The report focused on (1) the best ways to promote the use of advance directives and advance care planning among competent adults as a way to specify their wishes about end-of-life care; and (2) addressing the needs of persons with disabilities with respect to advance directives. See http://aspe.hhs.gov/daltcp/reports/2008/ADCongRpt.htm, last visited July 15, 2009.

[24] HAW. REV. STAT. § 327E-3 (1999).

[25] *Id.* § 327E-2. (defining an "Individual Instruction" as an individual's direction concerning a health care decision for the individual).

[26] *Id.* § 327E-34(a).

[27] *Id.* § 327E-4(b).

[28] *Id.* § 327E-16.

[29] *Id.* § 327E-2 (defines "capacity" as an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision). It defines "surrogate" as an individual, other than the patient's agent or guardian, authorized under this chapter to make a health-care decision for the patient.

[30] *Id.* § 327E-5(a).

available, a surrogate may be appointed to make a health care decision for the patient.[31] Unlike the Uniform Act approved by the NCCUSL, Hawaii's modified version of the UHCDA does not provide for the more common approach of a hierarchy of decision makers for a decisionally incapacitated patient, but instead provides for decision making by surrogates selected from a group of "interested persons."[32]

Under the Hawaii statute, "interested persons" means the patient's spouse, unless legally separated or estranged, a reciprocal beneficiary, any adult child, either parent of the patient, an adult sibling or adult grandchild of the patient, or any adult who has exhibited special care and concern for the patient and is familiar with the patient's personal values.[33] As explained above, the patient can designate or disqualify a surrogate. Accordingly, interested persons can be "trumped" by an orally designated surrogate. In the same manner, a patient may orally disqualify someone who otherwise might be entitled to make decisions on behalf of the patient.

Hawaii's version of the UHCDA places restrictions on decisions by "non-designated surrogates."[34] For example, the statute provides that "artificial nutrition and hydration may be withheld or withdrawn upon a decision by the surrogate only when the primary physician and a second independent physician certify in the patient's medical records that the provision of artificial nutrition or hydration is merely prolonging the act of dying and that the patient is highly unlikely to have any neurological response in the future."[35]

D. Out-of-Hospital Resuscitation Codes and Physician Orders for Life Sustaining Treatment (POLST)

Advance healthcare directives under the UHCDA often are not very useful when a patient suffers cardiac or respiratory arrest or is being transported from home or a health care facility to another health care facility. In a hospital or other healthcare facility setting, a patient who suffers an arrest is routinely resuscitated, unless there is a written do-not-resuscitate ("DNR") order in the medical record. The DNR order is only an instruction to withhold the otherwise automatic initiation of cardiopulmonary resuscitation and it should not affect other forms of treatment. Outside of a healthcare facility, emergency response personnel normally attempt to resuscitate an individual who suffers a cardiac or respiratory arrest. This may or may not be the course of action that the individual would request if he or she still could make and express a choice. Since 1995, Hawai'i law has provided for so-called out-of-hospital do-not-resuscitate protocols.[36]

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[31] *Id.* § 327E-5(b).

[32] *Id.*

[33] *Id.* § 327E-2.

[34] *Id.* § 327E-5 (e) (mentions a "surrogate who has not been designated").

[35] *Id.* § 327E-5 (g). This particular provision has been the source of some confusion. There are several unanswered questions. Does "any neurological response" equate to something less than brain death and if so, what? Could it mean "irreversible coma" or "persistent vegetative state?" Must tube feeding be applied or continued for every patient who has a "non-designated" surrogate selected to make health care decisions if no definition of "any neurological response" can be agreed on by the medical community? Would seeking guardianship rather than selecting a "non-designated" surrogate be an effective means of circumventing the limitations? UHELP has suggested several proposals to clarify this matter.

[36] *See* HAW. REV. STAT. §321 23.6 (1994). Rapid Identification Documents.

Under a 2006 statute that modified the 1995 law,[37] the Department of Health was to adopt new rules for emergency medical services which include uniform methods of rapidly identifying an adult person who has certified, or for whom has been certified, in a written "comfort care only" document that the person (or, consistent with the UHCDA , the person's guardian, agent, or surrogate) directs emergency medical services personnel, first responder personnel, and healthcare providers not to administer chest compressions, rescue breathing, electric shocks, or medication, or all of these, given to restart the heart if the person's breathing or heart stops, and directs that the person is to receive care for comfort only, including oxygen, airway suctioning, splinting of fractures, pain medicine, and other measures required for comfort.[38] As of the date this article was drafted, no rules have been adopted. However, a new law has been enacted that implements a system to recognize "Physician Orders for Life Sustaining Treatment" ("POLST").[39] Until the Department of Health adopts new rules, the Elder Law attorney may have a hard

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[37] Act 46 signed by the governor on April 27, 2006 amending HAW. REV. STAT. §321 23.6.

[38] *Id.* The written document containing the certification shall be signed by the patient or, consistent with chapter 327E (UHCDA), the person's guardian, agent, or surrogate and by any two other adult persons who personally know the patient; and the original document containing the certification and all three signatures shall be maintained by the patient, the patient's Physician, Attorney, Guardian, Surrogate, or any other person who may lawfully act on the patient's behalf.

Two copies of the document shall be given to the patient, or the patient's guardian, agent, or surrogate.

The rules also shall provide for the following:

(1) The patient, or the patient's guardian, agent, or surrogate, may verbally revoke the "comfort care only" document at any time, including during the emergency situation;

(2) An anonymous tracking system shall be developed to assess the success or failure of the procedures and to ensure that abuse is not occurring; and

(3) If an emergency medical services person, first responder, or any other health care provider believes in good faith that the provider's safety, the safety of the family or immediate bystanders, or the provider's own conscience requires the patient be resuscitated despite the presence of a "comfort care only" document, then that provider may attempt to resuscitate that patient, and neither the provider, the ambulance service, nor any other person or entity shall be liable for attempting to resuscitate the patient against the patient's will.

Other states have addressed the issue of out-of-hospital DNRs and, while Hawai'i has taken a unique approach to its statute, several states have similar documents to identify patients who do not want CPR. The documents have varying names but increasingly they are called "Physician Orders for Life-Sustaining Treatment" or POLST. See note 39, *infra.*

[39] Act 186 (HB 1379, H.D.2, S. D. 2, C.D. 1) 2009 Hawaii State Legislature, Relating to Physician Orders for Life Sustaining Treatment (POLST). The legislature sent the proposed Act to Governor Linda Lingle on May 8, 2009. The Governor put the bill on her proposed veto list, however, in the end, she decided to neither sign nor veto, and Act 186 became law by default on July 15, 2009. It may be hard to understand how the new law will work until seeing administrative rules, which "may" be adopted by the Department of Health in accordance with § -4. POLST is not an advance directive in the conventional sense, but it is an advance care planning tool that reflects the patient's goals for medical decisions that could confront the patient in the immediate future. See the national POLST website at http://www.polst.org and the website of Kokua Mau, which has led the Hawaii effort to pass the POLST law, http://www.kokuamau.org. To add to the difficulty, the law was not crafted with clarity. For example, as seen below, a surrogate is given authority to act for an incapacitated person, but the definition of surrogate does not include a guardian or an agent. The Department of Health has approved the POLST Form developed by Kokua Mau but, as of the date of this article, the form contains several areas of confusion, essentially surrounding the problematic definition of "surrogate." The form is being widely distributed in hospitals. You can find the latest approved POLST Form on the Kokua Mau website. The Elder Law Attorney should know the issues and terminology and be aware of the likelihood of change to the statute to make it clearer.

time providing counsel and advice on all aspects of this particular area of the law since, up to now, the existing laws affecting end-of-life decisions do not fit together very well and the new POLST law is no exception. Unfortunately, it may be that most doctors do not know what to tell their patients either. What seems to be clear, however, is that attorneys and doctors should encourage their clients and patients to consider executing advance directives to ensure that their individual instructions are clear and that there will be someone who is legally authorized to carry out their wishes should they become incapacitated.

E. "Elder Abuse" and Protective Services

Nearly two hundred years ago, King Kamehameha I [40] gave Hawaii its first law. Known as the Law of the Splintered Paddle, or *Mamala-hoe Kanawai*, [41] Hawaii's first law establishes a history and tradition

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§ -1 Definitions, defines "Physician orders for life-sustaining treatment form" as "a form signed by a patient, or if incapacitated, by the patient's surrogate and the patient's physician, that records the patient's wishes and that directs a health care provider regarding the provision of resuscitative and life-sustaining measures. A physician orders (sic) for life-sustaining treatment form is not an advance health-care directive."

"Surrogate" "shall have the same meaning as in section 327E-2. See note 29, *supra*.

§ -2 Physician orders for life-sustaining treatment form; execution; explanation; compliance; revocation (a) The following may execute a form:

(1) The patient;
(2) The patient's physician; and
(3) The surrogate, but only if the patient:
    a. Lacks capacity; or
    b. Has designated that the surrogate is authorized to execute the form.

The patient's physician may medically evaluate the patient and, based upon the evaluation, may recommend new orders consistent with the most current information available about the individual's health status and goals of care. The patient's physician shall consult with the patient or the patient's surrogate before issuing any new orders on a form. The patient or the patient's surrogate may choose to execute or not execute any new form. If a patient is incapacitated, the patient's surrogate shall consult with the patient's physician before requesting the patient's physician to modify treatment orders on the form. To be valid, a form shall be signed by the patient's physician and the patient, or the patient's physician and the patient's surrogate. At any time, a patient, or, if incapacitated, the patient's surrogate, may request alternative treatment that differs from the treatment indicated on the form.

(b) The patient's physician or a health care provider shall explain to the patient the nature and content of the form, including any medical intervention or procedures, and shall also explain the difference between an advance health-care directive and the form. The form shall be prepared by the patient's physician or a health care provider based on the patient's preferences and medical indications.

(c) Any health care provider, including the patient's physician, emergency medical services personnel, and emergency physicians shall comply with a properly executed and signed form and treat the patient according to the orders on the form; provided that compliance shall not be required if the orders on the form request medically ineffective care or health care that is contrary to generally accepted health care standards.

(d) A patient having capacity, or, if the patient is incapacitated, the patient's surrogate, may revoke a form at any time and in any manner that communicates intent to revoke.

[40] King Kamehameha I (Born: between 1740 and 1758; Died: May 8, 1819) eventually united all of the islands of Hawaii during his reign.

[41] The first edict declared by Kamehameha was the Law of the Splintered Paddle--based on his own experience on a fateful

of protecting older persons. The initial edict of the King required that the aged, women, and children should be protected from harm while they slept by the roadside, under the most severe of penalties. The Law of the Splintered Paddle continues to be a part of the current State Constitution,[42] but now only serves as a "symbol of the State's concern for public safety."[43]

Protective services can be broadly defined as intervention by the state, or sanctioned by the state to provide protections to individuals who are not capable of protecting themselves. Guardianship and conservatorship are examples of such intervention.[44]

Protective services also include protections against "elder abuse." Unfortunately, two centuries since the time of King Kamehameha the Great, elder abuse in Hawaii has essentially taken the same form as in other states. The National Center on Elder Abuse (NCEA) defines the major types of elder abuse as physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, financial or material exploitation, and self-neglect.[45] Hawaii has adopted a number of laws to address these abuses.

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day which taught him that human life was precious and deserved respect..."

The Law of the Splintered Paddle
"O my people,
Honor thy god;
Respect alike (the rights of) men great and humble;
See to it that our aged, our women, and our children
Lie down to sleep by the roadside
Without fear of harm.
Disobey and die."

From *The Law of The Splintered Paddle*, Hawaii Legal Auxiliary (1998).

[42] HAW. CONST. art. IX, § 10 (1978).

[43] *Id.* ("The law of the splintered paddle, *mamala-hoe kanawai*, decreed by Kamehameha I – Let every elderly person, woman and child lie by the roadside in safety–shall be a unique and living symbol of the State's concern for public safety.")

[44] Who qualifies or is subject to protections is subject to change. For example, a new law signed by the Governor in 2009 changes the "threshold" for undertaking conservatorship in Hawaii. Section 1, Act 21 Haw. Sess. Laws 2009, codified at HAW. REV. STAT § 560:5-401 Protective Proceeding now reads (changes are underscored): Upon petition and after notice and hearing, the court may appoint a limited or unlimited conservator or make any other protective order provided in this part in relation to the estate and affairs of:

(2) Any individual, including a minor, if the court determines that, for reasons other than age:

(A) By clear and convincing evidence, the individual is unable to manage property and business affairs *effectively* because of an impairment in the ability to receive and evaluate information or to make or communicate decisions, even with the use of appropriate and reasonably available technological assistance[;] *or because of another physical, mental, or health impairment*, or because the individual is missing, detained, or unable to return to the United States; and....

[45] *See* National Center on Elder Abuse, *Major Types of Abuse*, http://ncea.aoa.gov/NCEAroot/Main_Site/FAQ/Basics/Types_Of_Abuse.aspx (last visited August 7, 2008). The NCEA defines these major types of abuse as follows:

> **Physical abuse** is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.
>
> **Sexual abuse** is defined as non-consensual sexual contact of any kind with an elderly person. Sexual contact with any

In 1989, the Hawaii State Legislature enacted the Dependent Adult Protective Services Act (DAPSA).[46] The originally proposed legislation included specific reference to older persons[47] but that provision was deleted by the legislature in the final version that ultimately became law.[48] Despite the

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person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

Emotional or psychological abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation are examples of emotional/psychological abuse.

Neglect is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.

Abandonment is defined as the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney.

Self-neglect is characterized as the behavior of an elderly person that threatens his/her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice.

[46] *See* Act 189 Haw. Sess. Laws 1989, codified at HAW. REV. STAT. Part X, Chapter 346.

[47] DEPENDENT ADULT PROTECTIVE SERVICES, 346 HAW. REV. STAT. § 221 (1989).The original proposal was entitled, Elder and Dependent Adult Protective Services Act which would have included under its scope both older persons (60 years of age or above--original draft 1988 draft proposal on file with author) and "dependent adults" between the ages of 18 and 59. *See, also* Note 98, *infra.* Although the statute provides protections to all persons who are 18 years of age or over, HAW. REV. STAT. § 346-221 emphasizes "The legislature recognizes that citizens of the State who are elders and mentally or physically impaired constitute a significant and identifiable segment of the population and are particularly subject to risks of abuse, neglect and exploitation."

[48] Other measures were also changed from the original draft, e.g., the provision that the protections of the law would be available if a victim has been abused or was at risk of imminent abuse was changed to a stricter requirement that the victim must have been abused and was threatened with imminent abuse before intervention by the State would be permitted. Vestiges of the original draft can still be seen in the existing law. For example, coroners are still mandated reporters under HAW. REV. STAT. § 346-224 (1993) even though it is unlikely that in their official duties they would be in a position to that a victim would be threatened with imminent abuse. Also HAW. REV. STAT. § 346-224 provides that "An individual shall not be involuntarily subjected to the provisions of this part solely based on advanced age." Further HAW. REV. STAT. § 346-224 (d) has a more inclusive reporting standard for discretionary reporters (actual abuse or threatened imminent abuse), while HAW. REV. STAT.

protests of those who question the constitutionality of laws to afford greater protections to older persons, the original DAPSA recognized the State's interest in protecting elders.[49] While the new version of this statute still does not include any protections based on age, it will be discussed later in detail as an example of a legal tool utilized to address elder abuse in Hawaii.

F. Laws Protecting Elders

While neither DAPSA nor the new Adult Protective Services law provide specific protections for older persons, as outlined below, the Hawaii State legislature has passed several laws that provide additional protections specifically for older persons. These protections exist in several areas of the law.

Most acts of elder abuse are offenses under the Hawaii Penal Code[50] ("HPC") that provides criminal penalties for crimes against all persons in Hawaii. Much of the abuse directed against the elderly can be prosecuted under the HPC. The HPC enumerates several enhanced penalties for certain crimes directed against older or disabled individuals.[51] These penal provisions provide the backbone for the City and County of Honolulu establishment of an Elder Abuse/Justice Unit within the Office of the Prosecuting Attorney.[52]

Civilly, the Department of Commerce and Consumer Affairs investigates reports of consumer fraud and imposes penalties, including enhanced penalties for fraud directed against elders.[53] The Department of the Attorney General is also authorized under the Elder Justice Act, which took effect in

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§ 346-227 uses reporting criteria for mandated reporters that abuse has occurred and is imminent.

[49] *See* HAW. REV. STAT. § 346-221.

[50] *See* Disposition of Convicted Defendants, Chapter 706, Haw.Rev.Stat. (1986).

[51] HAW. REV. STAT. § 706-620 (2003) prohibits sentencing a defendant to a term of probation if the crime involved the death of or infliction of serious or substantial bodily injury upon a child, an elder person, or a handicapped person. HAW. REV. STAT. § 706-660.2(2003) provides for mandatory minimum terms of imprisonment for persons who, in the course of committing or attempting to commit a felony, causes death or inflicts serious or substantial bodily injury upon a person who is sixty years of age or older, or blind, paraplegic of quadriplegic or eight years of age or younger. HAW. REV. STAT. § 706-662(2003) provides criteria for extended terms of imprisonment for a defendant who is an offender against the elder, handicapped, or minor under the age of eight.

[52] In its inaugural pamphlet, the Office of the Prosecuting Attorney stated that it "is committed to fighting elder abuse and improving the quality of life for all seniors in the State of Hawaii. To accomplish this goal, the Elder Abuse/Justice Unit was created." Message from Prosecuting Attorney Peter B. Carlisle in "Abuse Is Getting Old" pamphlet (2008) "To enhance awareness, prevention, and prosecution of crimes affecting the elderly."

[53] HAW. REV. STAT. § 480-13.5 (1998) provides:

(a) Additional civil penalties for consumer frauds committed against elders.
If a person commits a violation under section 480-2 which is directed toward, targets, or injures an elder, a court, in addition to any other civil penalty, may impose a civil penalty not to exceed $10,000 for each violation.
(b) In determining the amount, if any, of civil penalty under subsection (a), the court shall consider the following:
(1) Whether the person's conduct was in willful disregard of the rights of the elder;
(2) Whether the person knew or should have known that the person's conduct was directed toward or targeted an elder;
(3) Whether the elder was more vulnerable to the person's conduct than other consumers because of age, poor health, infirmity, impaired understanding, restricted mobility, or disability;
(4) The extent of injury, loss, or damages suffered by the elder; and
(5) Any other factors the court deems appropriate.
(c) As used in this chapter, "elder" means a consumer who is sixty-two years of age or older.

2003, to pursue a civil action on behalf of the state against certain caregivers who have been found guilty of abusing[54] a dependent elder.[55] The action can be for the purposes of prevention, restraint, or remedy.[56] The statute defines neglect as "the reckless disregard for the health, safety or welfare of a dependent elder ... that results in injury[.]"[57] To illustrate the range of actions that constitute neglect, the statute reads: " 'Neglect' includes, but is not limited to ... [f]ailure to provide or arrange for necessary ... health care; except when such failure is in accordance with the dependent elder's [health care] directive[.]"[58] If a dependent elder lacks sufficient capacity to communicate a responsible decision, abuse occurs when the individual is "exposed to a situation or condition which poses an imminent risk of death or risk of serious physical harm[.]"[59]

In the event that abuse or negligence is found, a mandatory civil penalty will be ordered in an amount "not less than $500 nor more than $1,000 for each day that the abuse occurred ... [plus] costs of investigation."[60] The statute does not specify a maximum amount.[61] The law provides limited protection and to qualify, an offense must be committed against a resident who is 62 years of age or older, has a mental or physical impairment, and is dependent upon another for personal health, safety, or welfare due to the impairment.[62] Those who can be held liable as caregivers include "any person who has undertaken the care, custody, or physical control of, or who has a legal or contractual duty to care for the health, safety, and welfare of a dependent elder, including ... owners, operators, employees, or staff of ... [l]ong-term care facilities[.]"[63] There is a significant limitation imposed under the law, or, more accurately, perhaps carved out of the original proposed legislation. As originally drafted, the proposed legislation would have covered individual caregivers in addition to institutional caregivers. However, a significant advantage to claims brought by the attorney general is the statutory exemption that excludes actions brought by the State from a statute of limitation.[64]

Hawaii laws pertaining to condominiums include provisions relating to "aging in place" and provide limitations on the liability of associations, directors, unit owners, or residents, or their agents and

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[54] HAW. REV. STAT. § 28-94(a)(2003). The statute defines abuse as "actual or imminent physical injury, psychological abuse or neglect, sexual abuse, financial exploitation, negligent treatment, or maltreatment." *Id.*

[55] HAW. REV. STAT. § 28-94(a) (2003).

[56] *Id.*

[57] *Id.*

[58] HAW. REV. STAT. § 28-94(b) (2003).

[59] HAW. REV. STAT. § 28-94(b)(5) (2003).

[60] HAW. REV. STAT. § 28-94(a) (2003).

[61] *Id.*

[62] HAW. REV. STAT. § 28-94(b) (2003).

[63] *Id.*

[64] HAW. REV. STAT. § 657-1.5 (1993).

tenants acting through the board for certain actions taken regarding elderly (defined as age 62 or older) or disabled unit owners or residents.[65]

During the 2007 legislative session, the Hawaii State Legislature enacted a number of age-specific laws, while declining to adopt age-specific language into an Adult Protective Services measure.

Under Act 94–Relating to Financial Abuse, financial institutions in Hawaii are required to report any suspected financial abuse committed against a senior citizen aged 62 or older to the Department of Human Services (DHS) or a local law enforcement agency. The new law imposes a mandatory duty on any financial institution to report any such suspected incident of financial abuse immediately by telephone to DHS, followed by a written report within five business days.[66]

Under Act 95–Relating to Enhanced Penalties for Securities Violations Against Elders, the Commissioner of Securities is allowed to impose an extra $50,000 fine per violation to be added to any existing civil or administrative fine levied for securities violations against a person 62 years or older.[67]

Under Act 50—Relating to Sanctions for Violations by Mortgage Brokers and Solicitors Committed Against Elders, the State may impose fines of up to $10,000 for each violation by mortgage brokers and solicitors committed against elders, defined as consumers 62 years or older.[68]

G. Non-Age-Based Protective Laws

In addition to the previously mentioned laws providing protections to older persons in a few specified areas, there are several non-age-based laws that have been used to protect abused older persons or to punish or sanction abusers.

The State of Hawaii Office of the Long-Term Care Ombudsman has the power to investigate incidents of alleged abuse in long term care facilities such as nursing homes and care homes. Most individuals in long-term-care facilities are older persons by almost any definition of "older person." Accordingly, this statute has a direct effect on many older persons in such facilities. As part of the statewide elderly services network, the program's main purpose is to facilitate assessment and prevention of elder abuse in long-term care facilities,[69] and to advocate improvement of the quality of care received.[70] In cases of institutional mistreatment, defined by the statute as "acts which may adversely affect the health, safety, welfare, and rights of residents[,]" complaints can be made to the State Ombudsman (investigator).[71] Those entitled to assistance under the program include all elderly residents of long-term care facilities, intermediate care facilities, nursing homes, or similar adult care facilities.[72] A report of mistreatment can

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[65] HAW. REV. STAT. § 514B-142 (2009) The aging in place provisions had been in effect since 2004, and provisions regarding disabled were enacted in 2009.

[66] Incorporated into Hawaii Revised Statutes as HAW. REV. STAT. § 412: 3-114.

[67] Incorporated into Hawaii Revised Statutes as HAW. REV. STAT. § 486-27.

[68] Incorporated into Hawaii Revised Statutes as HAW. REV. STAT. § 454-4.5.

[69] HAW. REV. STAT. § 349-3 (1993).

[70] HAW. REV. STAT. § 349-12 (1993).

[71] HAW. REV. STAT. § 349-12(b)(2) (1993).

[72] HAW. REV. STAT. § 349-12(a) (1993).

be filed by a victim, or by any other person on behalf of the victim,[73] and can be made to an area agency on aging, by phone, in writing, or in person.[74]

Investigators making unannounced visits to nursing homes and certified Long-Term Care Ombudsman volunteers that meet regularly with residents are also able to take complaints.[75] In addition, volunteers are available to advise interested parties about issues such as resident rights, informal and formal remedies, and can refer a resident to appropriate services and agencies.[76]

All complaints received are immediately investigated by the Long-Term Care Ombudsman.[77] With the written consent of the victim or victim's representative, the ombudsman can access all patient records and files.[78] All reports are kept confidential.[79] Where an individual lacks sufficient capacity, a court may order disclosure.[80] If abuse or neglect is found, the ombudsman will advise the victim of possible options, but consent is required before the findings can be forwarded to appropriate agencies (including law enforcement) capable of taking corrective action.[81] Any act of retaliation by a facility or its employees is a misdemeanor.[82] Each act of retaliation is considered a separate incident and each day that an act continues constitutes a separate offense.[83]

The Medicaid Investigations Division of the Department of the Attorney General of the State of Hawaii has the power to investigate and prosecute alleged incidents of abuse in health care facilities that receive Medicaid funding.[84] Under state law, the Division is conferred with the power to investigate alleged abuses occurring in any State nursing facility.[85] When findings of abuse, neglect, or exploitation of a

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[73] HAW. REV. STAT. § 349-12(b)(2) (1993).

[74] *See* EXECUTIVE OFFICE ON AGING, 2003 ANN. REP. 6-7 (Oct. 2003), *available at* <http://www2.state.hi.us/eoa/pdf/2003_Annual_ Report.pdf> (August 7, 2008).

[75] *See id.*

[76] *See id.* See also, *Long-Term Care Ombudsman Volunteer Representative Program*, http://hawaii.gov/health/eoa/LTCO.html, last visited August 20, 2008. According to the Hawaii State Department of Health description, the Long-Term Care Ombudsman Volunteer program was created to enhance the LTCO program goals in assuring the rights and well being of residents. Volunteers act as representatives of the Long-Term Care Ombudsman Program by providing advocacy to residents during weekly confidential face-to-face visits. These visits are for the purpose of promoting the quality of life and care that residents are entitled to under federal and state laws.

[77] HAW. REV. STAT. § 349-12(b)(7) (1993).

[78] *Id.*

[79] HAW. REV. STAT. § 349-12(b)(7) (1993); HAW. REV. STAT. § 349-12(b)(8) (1993).

[80] HAW. REV. STAT. § 349-12(b)(12) (1993).

[81] HAW. REV. STAT. § 349-3(7) (1993).

[82] HAW. REV. STAT. § 349-14(b) (1993).

[83] HAW. REV. STAT. § 349-14 (1993).

[84] *See* HAW. REV. STAT. § 28-91 (1993). This office is called the Medicaid Fraud Control Unit in many other jurisdictions.

[85] *Id.*

dependent adult are made, the Division may criminally prosecute the nursing facility involved.[86] Claims pursued by the Division must prove that conduct rises to the level of criminal intent. This is an extremely high standard that is rarely met in dependent elder abuse cases.[87] As mandated reporters under the Dependent Adult Protective Services Act, however, even when conduct does not reach criminal levels, investigators are required to forward the report to the Department of Human Services.[88]

The Department of Health and the Department of Commerce and Consumer Affairs helps assure the safety of many older persons in nursing facilities through their regulatory powers even though, much like the Long-Term Care Ombudsman,[89] the authorizing statute does not include an age component. All nursing facilities in Hawaii must be licensed by the State Department of Health ("DOH").[90] If a facility fails to "substantially . . . conform to the required [licensing] standards[,]" the license may be revoked or suspended.[91] Currently, standards require all facilities to have a written policy prohibiting the mistreatment, neglect, or abuse of a resident.[92] Thus, intervention may also be initiated by filing a complaint with the Department of Commerce and Consumer Affairs.[93] The Department investigates all complaints and takes appropriate action where violations of standards are found.[94] Any person found in violation of the licensing standards is fined "not more than $500 for a first offense[,]" and "not more than $1000, or imprisonment not more than one year, or both," for subsequent offenses.[95] Remedies or penalties are cumulative to those available under other state laws, unless otherwise provided.[96]

H. Dependent Adult Protective Services Act

Until July 1, 2009, the most comprehensive law providing protection was the Dependent Adult Protective Services Act ("DAPSA")[97] which recognized that the elderly and the mentally or physically impaired form a significant and identifiable segment of the population that is particularly subject to risks of abuse, neglect, and exploitation.[98]

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[86] *Id.*

[87] Mike Gordon, Elder abuse bills take spotlight, Honolulu Advertiser at B8 (Feb. 27, 2003).

[88] HAW. REV. STAT. § 346-224 (1993).

[89] *See* note 48, *supra.*

[90] HAW. REV. STAT. § 457B-3 (1993).

[91] HAW. REV. STAT. § 457B-6(3) (1993).

[92] *See* 11 H.A.R. § 11-94-15(c)(5) (1985).

[93] HAW. REV. STAT. § 457B-6(5) (1993).

[94] *Id.*

[95] HAW. REV. STAT. § 457B-12 (1993).

[96] HAW. REV. STAT. § 457B-13 (1993).

[97] HAW. REV. STAT. Chapter 346 Part X,

[98] HAW. REV. STAT. § 346-221.(1993).

The stated purpose of DAPSA was to protect adults who are at a high risk of abuse, neglect, and financial exploitation due to their dependency on others.[99] To be entitled to protection under this law, individuals had to be "dependent adults" defined as persons who are at least 18 years old, who have a mental or physical impairment, and who are "dependent upon another person, a care organization, or a care facility for personal health, safety, or welfare," due to the impairment.[100]

Intervention was initiated by a report to the Department of Human Services' (DHS) Adult Intake,101 usually by a mandated reporter[102] or any other person who has reason to believe that a dependent adult has been abused and is threatened with imminent abuse.[103] If the "abuse" criteria were met, the report was sent to Adult Protective Services ("APS") for investigation.[104] However, APS had to have the consent of the victim, or the representative of the victim, before an investigation or protective action can commence.[105]

I. Act 154—A New Adult Protective Services Law

Key provisions of the Dependent Adult Protective Services law were amended, and the term "dependent" is no longer part of the title of the law, effective July 1, 2009.[106] The overall law has not been repealed but Act 154 has made significant changes to the then existing Dependent Adult Protective Services Law and the multitude of these changes became effective July 1, 2009.

The new provisions of the law deletes "dependent" from its title and is called "Adult Protective Services."[107] Changes include deleting the term "dependent," adding the more inclusive term

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[99] HAW. REV. STAT. § 346-221 (1993).

[100] HAW. REV. STAT. § 346-222 (1993).

[101] HAW. REV. STAT. § 346-224 (1993.

[102] See HAW. REV. STAT. § 346-224 (2008). Mandated reporters include licensed or registered professionals of healing arts, physicians, nurses, pharmacists, employees or officers of any public or private agency or institution providing medical services, law enforcement, employees or officers of any adult residential care home or similar institution and (effective 2009) licensed Social Workers and unlicensed individuals who are employed as social workers.

[103] HAW. REV. STAT. § 346-224 (1993).

[104] HAW. REV. STAT. § 346-227 (1993).

[105] HAW. REV. STAT. § 346-230 (1993). In the author's opinion, this may be the most critical feature of any proposal to afford protections to mentally capacitated adults, including older persons. The author has witnessed how effective Adult Protective Services (APS) personnel can be in stopping abuse, just by investigating suspected cases. The knowledge that somebody in the government is watching over victims also seemed to help avoid future abuse. The author has also witnessed victims who decline services and the respect shown by APS in honoring the wishes of the mentally capacitated adult, yet offering services in the event the individual changes his or her mind.

[106] *See* Act 154, S.B. No. 2150, S.D. 2, H.D. 2, C.D. 1 Hawaii State Legislature (2008) Section I. modifying HAW. REV. STAT. § 346-221:

While advanced age alone is not sufficient reason to intervene in a person's life, the legislature finds that many elders have become subjects of abuse, neglect, and exploitation. Substantial public interest exists to ensure that this segment of the population receives protection.

[107] *Id*, Sec., 5 modifying HAW. REV. STAT. § 346-223.

"vulnerable," and giving the Department of Human Services the jurisdiction to investigate cases of abuse of a vulnerable adult who has suffered abuse or is in danger of abuse if immediate action is not taken.

Under the new provisions of the law, mandated reporters are required to report cases of abuse of a vulnerable adult who has incurred abuse or is in danger of abuse if immediate action is not taken and the department is required to investigate.[108]

Under the new provisions of the law, a "vulnerable adult" means a person 18 years of age or older who, because of mental, developmental, or physical impairment, is unable to:

- Communicate or make responsible decisions to manage the person's own care or resources;
- Carry out or arrange for essential activities of daily living; or
- Protect oneself from abuse.[109]

Under the new provisions of the law, "abuse" means any of the following, separately or in combination:

- Physical abuse,
- Psychological abuse,
- Sexual abuse,
- Financial exploitation,
- Caregiver neglect, or
- Self-neglect.[110]

"Caregiver neglect" means the failure of a caregiver to exercise that degree of care for a vulnerable adult that a reasonable person with the responsibility of a caregiver would exercise within the scope of the caregiver's assumed, legal, or contractual duties, including but not limited to the failure to:

- Assist with personal hygiene,
- Protect the vulnerable adult from abandonment,
- Provide, in a timely manner, necessary food, shelter, or clothing,
- Provide, in a timely manner, necessary health care, access to health care, prescribed medication, psychological care, physical care, or supervision,
- Protect the vulnerable adult from dangerous, harmful, or detrimental drugs,
- Protect the vulnerable adult from health and safety hazards, or
- Protect the vulnerable adult from abuse by third parties.[111]

"Self-neglect" means:

- A vulnerable adult's inability or failure, due to physical or mental impairment, or both, to perform tasks essential to caring for oneself, including but not limited to:

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[108] *Id.*

[109] *Id*, Sec., 6 modifying HAW. REV. STAT. § 346-224.

[110] *Id*, Sec. 4., modifying HAW. REV. STAT. § 346-222 Definitions.

[111] *Id.*

- Obtaining essential food, clothing, shelter, and medical care,
- Obtaining goods and services reasonably necessary to maintain minimum standards of physical health, mental health, emotional well-being, and general safety, management of one's financial assets, and

- The vulnerable adult appears to lack sufficient understanding or capacity to make or communicate responsible decisions and appears to be exposed to a situation or condition that poses an immediate risk of death or serious physical harm.[112]

As before, a person mandated to make a report who knowingly fails to do so, or willfully prevents another from reporting the abuse, will be guilty of a petty misdemeanor.[113]

APS may undertake informal resolution with the facility, seek an order for immediate protection, seek a temporary restraining order, or file a petition with the court seeking any protective or remedial actions authorized by law.[114] If there is probable cause[115] to believe that the dependent adult lacks the capacity to make such decisions and has no designated representative, a court may issue a protective order[116] and may appoint a guardian *ad litem* to represent the victim's interests.[117] Under the statute, "abuse" is demonstrated by a preponderance of the evidence.[118] If the court determines that abuse has taken place, a protective order will be issued.[119] In addition, "[t]he court may . . . order the appropriate parties to pay or reimburse reasonable costs and fees of the guardian ad litem and counsel appointed for the dependent adult." [120] Protective proceedings do not preclude use of any other criminal, civil, or administrative remedies. [121]

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[112] *Id.*

[113] HAW. REV. STAT. § 346-224(e) (1993).

[114] HAW. REV. STAT. § 346-228 (1993). Where injury is imminent, an order for immediate protection may be obtained orally or in writing by the department, without notice to the defendant and without a hearing. HAW. REV. STAT. § 346-231(a) (2009). If an order is issued orally, it must be reduced to writing within 24 hours, and the department must file a petition with the court within 24 hours. HAW. REV. STAT. § 346-231(e) (2009). A hearing to show cause why an order should be continued will take place within 72 hours of the issuance of a written order. HAW. REV. STAT. § 346-231(f) (1993). If cause is shown, the court is required to schedule an adjudicatory hearing "as soon as it is practical." HAW. REV. STAT. § 346-232(c) (2009).

[115] HAW. REV. STAT. § 346-231(b)(1993). The statute provides that a finding of probable cause may be based in whole or in part upon hearsay evidence when direct testimony is unavailable.

[116] HAW. REV. STAT. § 346-231 (1993).

[117] HAW. REV. STAT. § 346-234 (2009).

[118] HAW. REV. STAT. § 346-240(b) (2009).

[119] HAW. REV. STAT. § 346-241 (2009). The statute provides that if the defendant fails to comply with the protective order, "[t]he court may apply contempt of court provisions and all other provisions available under the law[.]"

[120] HAW. REV. STAT. § 346-234 (1993).

[121] HAW. REV. STAT. § 346-223 (2009).

VI. Medicare and Medicaid and Long-Term Care

Traditional financial and estate planning resources and techniques may no longer meet the needs of the elderly, disabled and vulnerable populations, especially when addressing long-term care financing options. The three most common means of financing long-term care are: (1) direct payment by patients or their families; (2) long-term care insurance; or (3) the Medicaid program. Most persons over 65 are Medicare beneficiaries. Medicare can provide some coverage for care in a nursing home but only under limited circumstances and not for extended periods of time. Most persons over 65 are not eligible for Medicaid, due to restrictions on income and assets, but it is advisable to research Medicaid requirements to determine eligibility and alternatives.[122]

Attorneys in this area of law face a changing society and changing legal guidelines. As the role of government benefit programs increases in the lives of greater numbers of moderate income families, attorneys must be aware of programs and benefits that may impact a person's well-being and wealth. Awareness of these programs widens available financial and estate planning options for clients. This article cannot provide the depth of knowledge that an Elder Law attorney needs, but it may signal some issues that a lawyer may need to examine in advising an older client, representative or caregiver.[123] Note that, especially with government benefit programs, laws, regulations and policies may change often and sometimes without much notice.

The general population commonly confuses Medicare and Medicaid because of their similar sounding names and the fact that both programs were adopted in 1965. These programs, however, are quite distinct in purpose and tradition, and their journey through history has long been the focus of national debate.

A. Medicare

The Medicare program is a federal health insurance program for the "aged" and certain disabled people. The Medicare program offers several "Parts" to cover various medical expenses. The Centers for Medicare and Medicaid Services[124] ("CMS") is the agency under the United States Department of Health and Human Services responsible for administering Medicare.[125] The government aligns Medicare eligibility with Social Security eligibility. Importantly, Social Security – not CMS – will make the final decision on eligibility and enrollment. Persons already receiving Social Security will automatically be

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[122] There are other programs for special populations that an elder law attorney should research depending on the situation of his or her client. For example, "Aid and Attendance" is an underutilized special monthly pension benefit offered by the Veterans Administration for veterans and surviving spouses who require in-home care or live in nursing homes. To qualify, the veteran must have served at least 90 days of active military service, one day of which is during a period of war and must have been discharged under conditions other than dishonorable. Additional information and assistance in applying for the Aid and Attendance benefit may be obtained by calling

1-800-827-1000. Applications may be submitted on-line at http://vabenefits.vba.va.gov/vonapp/main.asp. Information is also available on the Internet at www.va.gov or from any local veterans service organization.

[123] The author prepared an update to the Medicare and Medicaid chapter of the Hawaii State Bar Association's *Encyclopedia of Estate Planning* which is available through the Hawaii State Bar Association. It contains the new administrative rules for Hawaii's Medicaid Program which will be discussed later in this article.

[124] Formerly called the Health Care Financing Administration ("HCFA").

[125] Official website for Medicare, available at <www.medicare.gov> (last visited February 20, 2009).

enrolled in Part A and Part B unless they opt out of Part B. Persons not receiving Social Security retirement but who want to enroll must initiate the process three months before date of eligibility.[126] Being "retired" is not important; eligibility is tied to age 65 and working years. If a person lacks the requisite working year requirement for Social Security that person can purchase Part A at a monthly premium. Disability is not tied to age but time. Persons disabled for at least 24 months or who have end-stage renal disease are likewise eligible.[127] It is important to note that Medicare is an "insurance" program and does not have resource or income limitations for eligibility. Part A is funded by payroll deductions under the Federal Insurance Contributions Act ("FICA"). Part B is funded by a combination of General Tax Revenues (75%) and by premiums paid by participants (25%). Eligible persons can apply online[128] or at their local Social Security Administration office.

There were two original parts to the Medicare program. Part A, commonly known as "Hospital Insurance," helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health services, and hospice care, and blood supply. Part B, commonly known as "Medical Insurance," is a voluntary health insurance program that helps pay for medically necessary doctors' services and other medical expenses not covered by Part A. Medicare Part A will pay for skilled nursing facility ("SNF") services only if the patient required and received skilled care on a daily basis which, as a practical matter, could only be provided in a skilled nursing facility on an inpatient basis.[129] "Skilled care" are those services that are so inherently complex they can only be safely and effectively handled by or under the supervision of professional or technical personnel.[130] Part A thus excludes coverage for custodial or personal levels of care. Examples of custodial care would include care for the convenience of the patient or the patient's family such as the giving of routine oral medications, assistance in dressing, eating, and going to the toilet, or periodic turning and positioning in bed. To receive SNF care under Part A, the beneficiary must have been hospitalized for at least three consecutive days (not including the day of discharge) and, at the time of discharge, must have been over 65 years of age, entitled to Part A benefits based on disability, or entitled to Part A benefits based on end-stage renal disease.[131] Other threshold requirements include:

- The beneficiary must be in need of SNF care, admitted to the facility, and receive the needed care within thirty days after he or she is discharged from the hospital.[132] An exception may apply.[133]
- The patient must be in a Medicare-certified facility.[134]

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[126] Social Security Electronic Booklet, *available at* <http://www.ssa.gov/pubs/10043.html#part5> (last visited February 20, 2009).

[127] Persons with end-stage renal disease (ESRD) must require dialysis treatment or kidney transplant.

[128] For online application go to <https://secure.ssa.gov/apps6z/iRRet/rib> (last visited Feb 20, 2009).

[129] 42 U.S.C. § 1395f(a)(2)(B) (2009).

[130] 42 C.F.R. § 409.32(a)(2009).

[131] 42 C.F.R. § 409.30(a)(1), (2) (2009).

[132] 42 C.F.R. § 409.30(b) (2009).

[133] 42 C.F.R. § 409.30(b)(2) (2009).

[134] 42 U.S.C. § 1395f(a)(2009).

- The SNF care must have been ordered by a physician, require the skills of technical or professional personnel, and are furnished directly by, or under the supervision of, such personnel.[135]
- The beneficiary must require SNF care on a daily basis.[136]
- The SNF care must be related to the condition that required hospitalization.[137]

If a beneficiary meets the above criteria, Part A covers up to 100 days of SNF care per benefit period. Part A pays for all covered services for the first twenty days.[138] From the twenty-first day to 100th day, the beneficiary must pay a daily co-insurance charge.[139] If a beneficiary is discharged from a SNF care facility after receiving SNF care, he or she is not entitled to additional SNF care in the same benefit period unless he or she is readmitted to the same facility within thirty days of discharge or hospitalized again for at least three consecutive days.[140]

Medicare pays for covered home health services supplied by participating home health agencies.[141] Part A covers home health services if the beneficiary is housebound, is under the care of a physician, needs skilled services, and is under a plan of care.[142] Skilled services include intermittent skilled nursing services, physical therapy, speech-language pathology services, continuing occupational therapy services, and medical social services.[143] A beneficiary is not required to pay deductibles or co-insurance payments.[144] Home health services must be furnished in either the beneficiary's home or in an outpatient setting such as a hospital, skilled nursing facility, or a rehabilitation center.[145]

Home health services are covered under both Parts A and B. Payments for home health services, however, are always made under Part A except in cases where the beneficiary is enrolled under Part B, but is not entitled to Part A. In those cases, payment is made under Part B.

Hospice services rendered by a Medicare participating program for terminally ill beneficiaries are covered by Part A. The beneficiary's doctor must certify that the beneficiary is terminally ill, i.e., that the beneficiary has a life expectancy of six months or less.[146] A beneficiary who is terminally ill may elect to

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[135] 42 C.F.R. § 409.31(a)(1)-(3) (2009).

[136] 42 C.F.R. § 409.31(b) (2009).

[137] 42 C.F.R. § 409.31(b)(2)(i)-(iii) (2009).

[138] 42 C.F.R. § 409.61(b) (2009).

[139] 42 C.F.R. § 409.36(b) (2009).

[140] 42 C.F.R. § 409.36 (2009).

[141] 42 C.F.R. § 409.42(e) (2009).

[142] 42 C.F.R. § 409.42(a)-(d) (2009); 42 C.F.R. § 409.43 (2009).

[143] 42 C.F.R. § 409.42(c)(1)-(4) (2009); 42 C.F.R. § 409.45(c) (2009).

[144] 42 C.F.R. § 409.61(d) (2009).

[145] 42 C.F.R. § 409.47 (2009).

[146] 42 U.S.C. § 1395x(cc)(3)(A) (2009).

receive hospice services from a particular hospice program for two ninety-day periods and an unlimited number of subsequent sixty-day periods during the beneficiary's lifetime.[147] A beneficiary who makes this election gives up certain Medicare benefits during the election period.[148] However, he or she may revoke the election at any time during the election period and make a new election.[149] There is a co-insurance charge of five percent for inpatient respite care.

Medicare now includes Part C, which is called Medicare Advantage. It provides options for enrollment to beneficiaries. Its plans include:

- Medicare managed care plans;
- Medicare preferred provider organization (PPO) plans;
- Medicare private fee-for-service plans; and
- Medicare specialty plans.

Medicare Part D provides prescription drug plans.[150]

B. Medicaid

The hottest topic in Elder Law seems to be Medicaid for a number of reasons: The cost of long-term care is extremely expensive and increasing; Medicare does not provide coverage for most people; and somewhat ironically, Medicaid often can provide coverage, especially with advanced legal planning. Medicaid is a program designed to help people with low income and limited resources pay for certain health care services. For attorneys helping clients plan for the future, including possible long-term care placement, it is essential to understand Medicaid. As this article will explain, Medicare does not cover the cost of long-term care for most individuals but Medicaid can do so based on sometimes complex qualification criteria. Most people do not have long-term care insurance and, with costs for basic custodial care in a nursing home approaching $100,000 per year, most people want to know their options.

Medicaid, or Title XIX (of the Social Security Act), is financed jointly by the federal government and the state and is administered by the state. Therefore, the rules and regulations governing Medicaid vary from state to state. It is not unusual to confuse Medicaid and Medicare programs as both were started about the same time, deal with health care, and sound similar. The programs, however, are very different. Two basic differences are that Medicaid is for needy people only and is run by the state.

Broad national guidelines govern Medicaid. Federal statutes, regulations, and policies direct states as they (1) establish their own eligibility standards; (2) determine the type, amount, duration, and scope of services; (3) set the rate of payment for services; and (4) administer their own programs. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, state legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.[151]

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[147] 42 U.S.C. § 1395(d)(1) (2009).

[148] 42 U.S.C. § 1395(d)(1), (2) (2009).

[149] 42 U.S.C. § 1395(d)(2)(B) (2009).

[150] An overview of Medicare can be found at <www.medicare.gov> or <http://www.ssa.gov/pubs/10043.html>.

[151] Medicaid Program - General Information, Technical Summary, available at http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp (last assessed Feb. 20, 2009).

Medicaid is Hawaii's Medical Assistance Program for needy individuals and families authorized under Title XIX of the Social Security Act. Medicaid funding is a partnership between the state and the federal government, with each sharing the program costs. Because of this partnership, the Medicaid program is subject to change from amendments to federal regulations and state statutes. Medicaid is administered by the Med-QUEST Division of the Department of Human Services under Hawaii Administrative Rules Title 17, Subtitle 12.

Medical assistance is provided to eligible Hawaii residents through the QUEST Expanded (QEx) Medicaid Section 1115 Demonstration, which allows Hawaii to provide coverage of more residents and services that would be allowed under the provisions of the Title XIX Medicaid State Plan. The Hawaii QUEST program was established in 1993 as a Medicaid demonstration under the provisions of Section 1115(a) of the Social Security Act to provide managed care medical coverage to residents who were not aged, blind, or disabled. The State built on the success of the Hawaii QUEST program to expand managed care coverage for all fully subsidized Medicaid recipients. The most recent extension of the QEx Demonstration was approved by the Centers for Medicare and Medicare Services for the period February 1, 2008 until June 30, 2013, and authorized managed care coverage for aged, blind and disabled residents.

The QEx Demonstration will provide Medicaid coverage through a managed care system through four distinct programs instead of the traditional fee-for-service model:

- The Quest Expanded Access (QExA) program covers individuals who are sixty-five years and older, blind or disabled (ABD).
- The Hawaii QUEST (QUEST) program covers individuals and family members who are not ABD.
- The QUEST-Net program provides a limited coverage safety net for QUEST or QExA recipients who become ineligible for assistance due to excess assets or income.
- The QUEST-Adult Coverage Expansion (ACE) program covers uninsured adult who do not qualify for QUEST or QExA.

Medicaid eligibility is determined under the requirements of one of the QEx Demonstration programs, and coverage of benefits will be provided by the providers in the health plan's provider network. DHS will pay a premium to the health plan, and the plan is responsible to reimburse providers in their network for services rendered to the enrollees. The health plans are not responsible to pay for dental services, transplant services, and certain behavioral health services, which will continue to be provided on a fee-for-service basis. In 2009, HMSA, AlohaCare, and Kaiser are the contracted health plans for the QUEST, QUEST-Net and QUEST-ACE programs, and Ohana Health Plan and Evercare are the QExA health plans.

Medicaid is the payer of last resort. All other medical coverage, which an individual has from third parties, must be the primary payer of an individual's medical expenses. Thus, individuals who are eligible for Medicaid and who are eligible for medical insurance (Medicare, for example) will receive Medicaid coverage to pay the portion of costs which the insurance does not pay. Thus, the payments to the health plans are adjusted if the individual has other medical insurance.

Individuals who qualify for fully subsidized Medicaid generally are not responsible to share in the cost of Medicaid covered services. The exceptions are for certain recipients who must share in the cost of their long-term care expenses, and for certain QUEST-Net adult recipients who must pay a portion of the QUEST-Net premium. Individuals who qualify for supplemental medical assistance through the Medically Needy program are responsible for the portion of their medical bills used to spend down their excess income. In the QExA program, the cost share for long-term care expenses and the spend down amounts for Medically Needy individuals are considered as enrollment fees that are payable to the QExA health plan.

C. Deficit Reduction Act of 2005

Because eligibility for Medicaid is tied to the amount of an individual's assets, some people attempt to transfer their assets, usually for less than fair market value, in an effort to qualify for medical assistance under Medicaid. New provisions required by the Deficit Reduction Act of 2005 (DRA) address many of the loopholes individuals or their representatives have exploited in Medicaid rules to transfer certain assets without incurring a penalty. Hearings to implement the DRA were held in the summer of 2009. These amendments form the heart of Medicaid planning. Final rules went into effect in October 2009.

The following is a summary of the provisions of the Deficit Reduction Act and new rules of the Department of Human Services;[152]

A penalty period in which Medicaid will not provide long-term care coverage will be assessed if the individual or the individual's spouse transferred an asset for less than fair market value within the applicable look-back period prior to the request for long-term care coverage. Under the new rules, the look-back period is: thirty-six months for an asset transferred prior to February 8, 2006; sixty months for an asset transferred on or after February 8, 2006; or sixty months for an asset transferred to an irrevocable trust prior to February 8, 2006. A penalty period will also be assessed if an individual transfers an asset after being determined eligible for long-term care coverage. A penalty will not be assessed, however, if the transfer of an asset owned by the community spouse was made after the individual has been determined eligible.

Annuities established on or after February 8, 2006 that fail to meet certain requirements will be considered transferred assets, although certain annuities are exempt if they were established by retirement accounts and IRAs that meet specified Internal Revenue Code requirements. Promissory notes, loans, and mortgages established on or after February 8, 2006 are considered transferred assets unless it is actuarially sound, makes equal payments, and is not cancelled upon the individual's death.

A penalty period will not be assessed when:

- The asset transferred was the individual's home and title was transferred to the individual's spouse, child under age twenty-one or a blind or disabled child, a sibling who has equity interest in the home and has lived in the home at least one year immediately before the individual requested Medicaid payment of long-term care services, or an adult child who has lived in the home for at least two years immediately before the individual became institutionalized and was a caregiver to the individual.
- The asset, other than a home, was transferred: to the individual's community spouse, from the community spouse to another for the sole benefit of the community spouse, to the individual's child who is under age twenty-one or a blind or disabled child, to a trust established solely for the benefit of an individual under age sixty-five and who is disabled.
- The individual can verify that he or she intended to transfer the asset at fair market value or for other valuable consideration, or that the asset was transferred solely for a purpose other than to qualify for Medicaid.
- The asset transferred for less than fair market value has been returned.

The period of ineligibility is the value of the transferred asset, divided by the monthly statewide average cost of private care in a long-term facility (currently $8,850). A penalty would begin when the individual is eligible for Medicaid and requires long-term care services coverage. The department may

[152] See http://hawaii.gov/dhs/main/har/ As previously indicated, an update to the chapter on Medicare and Medicaid in the Hawaii State Bar Association's *Encyclopedia on Estate Planning* is now available.

waive the penalty period if it determines that imposing the penalty would cause undue hardship for the individual.

Individuals with over $750,000 equity in their home are not eligible for long-term care services Medicaid coverage, unless the individual's spouse or dependent child lives in the home. Individuals may reduce their equity in the home through a reverse mortgage or home equity loan without penalty, and an individual has the right to file for a waiver if he or she cannot legally reduce their home equity.

D. Spousal Impoverishment Provisions

Congress established provisions under the Medicare Catastrophic Coverage Act (MCCA) to address the financial hardship faced by married couples when one spouse is placed in a long-term care facility and the other spouse remains in the community. Prior to the enactment of the MCCA, the couple had to reduce their assets to Medicaid asset allowance in order to qualify for Medicaid payment for the care for the institutionalized spouse., In addition, the community spouse could only receive financial support from the institutionalized spouse up to the Medicaid income standards. Thus, before an institutionalized spouse could qualify for Medicaid, the couple needed to virtually deplete their life savings, leaving the community spouse a minimal financial safety net, and with income that was often below the poverty level on which to survive. This circumstance was referred to as "spousal impoverishment".

The MCCA amended the Social Security Act by adding section 1924, which affected the treatment of the married couple's assets and income in determining the Medicaid eligibility of the spouse who needed assistance to pay for long-term care in a nursing home or other medical facility. Under the provisions of section 1924, only the income of the institutionalized spouse was considered in the Medicaid eligibility determination, and the community spouse could receive allowances to retain portions of the couple's assets and a portion of the institutionalized spouse's income. The new regulations established a minimum and a maximum amount for the asset and income allowances, and allowed the States to establish the amount of the allowances for their State. The allowances were subject to annual increases and increases due to court orders or fair hearing decrees. Hawaii chose to use the maximum amount for both asset and income allowances. In 1989, the maximum asset allowance was $60,000 and the maximum income allowance was $1,500. In 2009, after ten years of annual increases, the maximum asset and income allowances had increased to $109,560 and $2,739, respectively.

In the month the Medicaid application for the institutionalized spouse is filed, all non-exempt assets owned by a couple is evaluated and totaled. The community spouse is allowed to retain the amount allowed by law. Any excess is applied to the institutional spouse's $2000 assets limit. Once Medicaid eligibility is established, assets owned by the institutional spouse that are part of the asset allowance must be transferred to the community spouse. If this is not accomplished, the non-transferred asset will count toward the institutionalized spouse's asset retention limit of $2,000. After Medicaid eligibility is established, the assets owned by the community spouse will not affect the eligibility of the institutionalized spouse, so the community spouse is free to accumulate assets over the community spouse asset allowance.

Prior to MCCA, after an institutionalized spouse established Medicaid eligibility, the institutionalized spouse's income was essentially applied to the cost of his or her care. A monthly maintenance allowance for the community spouse was allowed. However, the amount of the allowance was tied to the Medicaid income standards, so the allowance could not exceed the SSI payment standard or the Medically Needy Standard for an individual residing in the community. Under the provisions of the MCCA, the income of the community spouse is not considered available to the institutionalized spouse.[153]

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[153] 42 U.S.C. § 1396r-5 (2008).

If a source of income is in the name of both spouses, then one-half of the amounts will be considered available to each spouse.[154] The monthly maintenance allowance for the community spouse was no longer tied to the Medicaid income standards. The new monthly maintenance allowance is based on the difference between the maximum income allowance ($2,739 for 2009) and the gross income of the community spouse. Thus, the income of the community spouse can be supplemented by a contribution from the income of the institutionalized spouse up to the amount of the monthly maintenance allowance. Since the contribution to supplement the income of the community spouse is voluntary, the institutionalized spouse must agree to provide the contribution.

E. Recovery of Medicaid Funds

Under the provisions of the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"),[155] states were required to establish Medicaid recovery programs, which included mandatory recovery of medical assistance payments for nursing home care. Prior to 1993, Hawaii had a voluntary Medicaid recovery program that pursued recovery only if a recipient was over age sixty five and had no heirs. Presently, Hawaii will seek recovery of Medicaid payments from the estates of deceased individuals who received assistance while in a nursing facility or other medical institution at any age, and from individuals not in nursing facilities who received benefits from age fifty-five.[156] Recovery will not be pursued if the deceased recipient had a surviving spouse or surviving dependent child. Recovery of medical assistance paid in error due to the complicity of an individual are made directly from the individual or the individual's estate.

The home property of an individual in a nursing facility is exempted as an asset if there is a stated intention to return to the property. In the 1994 state legislative session, Haw. Rev. Stat. § 346-29.5 was amended to require the placement of liens on the home property of Medicaid recipients in nursing homes under certain conditions. If the state has made a determination, pursuant to notice and hearing requirements, that the individual cannot reasonably be expected to leave the nursing facility and return to the home property, a lien may be placed on the home property unless the individual's spouse, dependent child or sibling with an equity interest is currently residing legally on the property.

Recovery from the lien on the home property cannot be made when a sibling who has resided in the home for at least a year before the individual's institutionalization or an adult child who has lived at the home at least two years before the institutionalization and provided care to the individual at the home are legally living on the home property and have continuously lived on the property since the institutionalization of the individual. The state also cannot recover funds from the lien if the individual has a surviving spouse or dependent child.

As a reminder, all federal and state health care financing laws and regulations are subject to amendment due to economic, judicial, and social pressures, so the Medicaid program is constantly evolving. Attention must be paid to changes in the federal regulations and state statutes and administrative rules that occur after Congressional and legislative sessions.

VII. Conclusion

Although it has been in existence for nearly a quarter century, Elder Law continues to be an ever-growing and expanding field of practice. Elder Law attorneys typically face multi-faceted challenges on

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[154] 42 U.S.C. § 1396r-5 (2008).

[155] *See generally* 42 U.S.C. § 1396p

[156] H.R.S. Section 346-37 (2008).

behalf of their clients. This article addressed the demographics driving the need for Elder Law and just a few of the areas Elder Law attorneys may find themselves looking for answers and strategies. Although many attorneys do not consider themselves to be Elder Law attorneys, the changing demographics of the state will inevitably require them to learn about this field. Practicing Elder Law attorneys are encouraged to share their knowledge and enthusiasm with others to help assure that people who are aging in Hawaii will continue to receive quality legal services.