September 2010

The Costs of Early-Onset Alzheimer's Disease and the Federal Benefits Dilemma

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THE COSTS OF EARLY-ONSET ALZHEIMER'S DISEASE AND THE FEDERAL BENEFITS DILEMMA

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I. INTRODUCTION

Alzheimer's disease (AD), first described by Dr. Alois Alzheimer in 1906, is a condition with which most Americans are familiar.1 Approximately 5.3 million Americans currently live with AD.2 AD is usually thought of as a disease that afflicts the elderly, people older than sixty-five years, and is generally described by its two most noticeable characteristics: memory loss and death. What many people may not know about AD is that it can affect any age group. When people over sixty-five develop AD, the condition is labeled Later-Onset Alzheimer's disease (LOAD), and when people sixty-five or younger develop AD, the condition is labeled Early-Onset Alzheimer's disease

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2 Id.
Although most people who develop AD do so after reaching sixty-five, it's estimated that at least 220,000 people currently have EOAD.4

Most government initiatives intended to help families cope financially with the costs associated with severe disabilities are not designed for people with EOAD. Instead, these benefits programs are primarily designed to assist the elderly. As a result, people with EOAD are often unable to obtain adequate short-term and long-term benefits and care, and are unable to properly provide for their families. Our federal government has taken some steps to address the disparity in benefits available for people with EOAD, but these measures are thus far inadequate. Our government is legally and equitably obligated to take larger, swifter legislative steps toward ensuring that people with EOAD receive the respect, assistance, and care they deserve.

This Note begins by discussing the basic pathology of EOAD. This information sets the foundation for the discussion that follows regarding the especially catastrophic physical and financial effects of EOAD. Next, the Note evaluates the primary government programs in place intended to assist persons disabled by EOAD and considers the positive and negative aspects of these programs. Then, the Note explores various legal and equitable arguments that support the proposition that the government is obligated to provide those with EOAD with adequate financial resources, specifically Social Security and Medicare benefits. Next, the Note evaluates the government's recent actions that address the inadequacy of current health care benefits programs and the possible impact of proposed solutions. Finally, the Note closes by summarizing the main points of this Note and the impact of the conclusions made throughout on America's health care and disability programs.

II. THE PHYSICAL AND FINANCIAL EFFECTS OF EOAD

EOAD is a physically devastating condition. The disease is progressive, and those who develop it waste away from the inside out. As their brain tissue gradually deteriorates, their cognitive and motor functions decline, and they become unable to care for themselves properly. In addition to other difficulties faced by those with EOAD, reliance on others for income and care can be extremely costly. This Part of the Note examines the intricacies of the pathology of EOAD, the difficulties often faced by those with the disease, and, finally, the financial burden the disease places on those who develop it.

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A. EOAD Pathology

When a person experiences significant loss of cognitive ability, such as memory loss or persistent disorientation, that person suffers from dementia. Alzheimer’s disease is one of many conditions that cause dementia. With AD, dementia results from the progressive neurodegeneration of brain tissue. Scientists believe that the accumulation of proteins within the neurons, glia, or the extracellular space in the brain causes neurofibrillary tangles and neuronal loss which may contribute to the degeneration of brain tissue and the development of AD. Brain degeneration caused by AD generally affects the whole brain symmetrically, and it reduces brain mass. The progressive degeneration of brain tissue in people with AD is terminal; thus, there is no effective medical treatment to stop or reverse the damage to the brain. There are also no known treatments that delay the onset of the disease.

AD is the seventh leading cause of death in the United States, and death from AD occurs on average eight years after the first symptoms of the disease appear. There are two main types of AD: EOAD and LOAD. These two types are usually distinguished by age; EOAD refers to the development of AD at or before the age of sixty-five, and LOAD refers to the development of AD after age sixty-five. Within the EOAD type, there are two recognized sub-types: familial EOAD and sporadic EOAD. Familial EOAD refers to a predisposition for development of EOAD if one or more first-degree blood relatives have also developed the disease. Sporadic EOAD occurs when there is no apparent fam-
ily history of AD. Pathologically, sporadic and familial EOAD are almost identical; each is evidenced by similar effects on the brain and similar symptoms.

The onset of EOAD is usually gradual and is not characterized by sudden and significant cognitive impairment. Instead, the first noticeable symptoms of the disease are minor, and the disease then progresses in predictable stages. By far, the first symptom normally noticed is memory loss. Memory loss is initially episodic, which then may progress to semantic memory loss. In addition to memory loss, other symptoms of EOAD include problems maintaining focus, the inability to properly process and interpret visual images, apathy, depression, aggression and agitation, wandering, and delusions. Less frequently, EOAD may also cause hallucinations, both visual and auditory, and seizures.

Obtaining a diagnosis of EOAD can be difficult for many reasons. First, because the disease is uncommon in adults under sixty-five, doctors may look to other causes for the cognitive decline. Second, multiple conditions which cause dementia present symptoms identical to those of EOAD. Third, one parent has the autosomal dominant trait for AD and the other parent does not, their children have a fifty-fifty chance of developing AD. See id. If both parents have the autosomal dominant trait for AD, the children will likely also develop AD. See id. It is possible for people to carry genes associated with AD without ever developing the condition. Early-Onset Alzheimer’s: When Symptoms Begin Before 65, MAYOCLINIC.COM (Nov. 4, 2007), http://www.mayoclinic.com/health/alzheimers/AZ0009. The majority of people who develop EOAD contain a genetic defect on chromosome 14. Living With Early-Onset Alzheimer’s Disease, CLEVELANDCLINIC.COM, http://my.clevelandclinic.org/disorders/alzheimers-disease/hic_living_with_early-onset_alzheimers_disease.aspx (last visited Sept. 8, 2010). This chromosome defect is not associated with LOAD. Id.

EARLY-ONSET DEMENTIA, supra note 7, at 264. Some researchers suggest that all forms of EOAD are familial, despite a lack of family history of the disease. Id. Under this theory, family members with the autosomal dominant trait for AD may not develop the disease because of an intervening circumstance such as death. Id.

EARLY-ONSET DEMENTIA, supra note 7, at 276.

Id. at 269.

Id.

Id. at 270–71. Episodic memory involves specific events and details, such as the “who’s” and “when’s” of previous experiences. Human Memory, http://www.cc.gatech.edu/classes/cs6751_97_winter/Topics/human-cap/memory.html (last visited Sept. 8, 2010). People who have episodic memory loss may be unable to remember, for example, when or where their high school reunions took place. Id. Semantic memory, however, involves concepts and skills. Id. Person suffering semantic memory loss may be unable to perform certain tasks because they cannot remember all of the steps necessary to complete the tasks. Id.

EARLY-ONSET DEMENTIA, supra note 7, at 271–74. The two most common delusions experienced by people with AD are the Capgras delusion—the belief that a relative or friend has been replaced by an imposter—and paranoid delusions involving theft. Id. at 273–74.

Id.

NATIONAL CHALLENGE, supra note 4.

See DIAGNOSTIC AND STATISTICAL MANUAL, supra note 3, at 156–57.
there is no established pathological means for consistently and correctly diagnosing EOAD; presence of the disease can only be positively verified by post-mortem brain autopsy. To make a diagnosis of EOAD during a person’s life, a series of tests that measure cognitive function are administered. The first step toward diagnosis is to establish that the person is suffering from dementia. There is no one test that can be used to determine whether a person has dementia. Therefore, a battery of tests must be administered to determine whether dementia is present. Testing should include neurological, psychiatric, and neuropsychological evaluations. Dementia is established when testing shows that the person’s memory loss and cognitive problems are “sufficiently severe to cause impairment in occupational or social functioning” and “represent a decline from a previously higher level of functioning.” Once dementia is confirmed, testing should focus on excluding all other possible causes of dementia. EOAD can be confidently diagnosed when all other possible causes of dementia are eliminated.

The Alzheimer’s Association has estimated that at least 220,000 people in the United States today have EOAD. However, because many people with EOAD may still not have received a proper diagnosis, this figure may be an underestimate. The majority of people who develop EOAD are between the ages of sixty and sixty-five. The frequency of EOAD halves every five years between the ages of sixty and forty-five. Although EOAD is very rare in people under age forty-five, some cases have been documented. Some population groups are at greater risk for developing EOAD. People with Down’s syn-

25 EARLY-ONSET DEMENTIA, supra note 7, at 276.
26 Id. at 263.
27 Id. at 2.
28 Id. at 45.
29 DIAGNOSTIC AND STATISTICAL MANUAL, supra note 3, at 157. The four major types of cognitive problems recognized by the DSM-IV, a manual used by doctors to diagnose various disorders, are aphasia, apraxia, agnosia, and disturbances in executive functioning. Id. Aphasia is the loss of the ability to communicate through language or understand the linguistic communication of others. Id. Apraxia is the inability to engage in a physical activity despite having the strength for and knowledge of the task at hand. Id. Agnosia is the loss of ability to recognize objects despite having adequate visual acuity. Id. Executive functions are behaviors that involve planning or abstracting, such as handling finances. Id.
30 EARLY-ONSET DEMENTIA, supra note 7, at 263.
31 Id.
32 NATIONAL CHALLENGE, supra note 4.
33 The Alzheimer’s Association has combined data from numerous studies, and it has concluded that up to 640,000 people may currently be living with EOAD. NATIONAL CHALLENGE, supra note 4.
34 See EARLY-ONSET DEMENTIA, supra note 7, at 8.
35 Id.
36 Id.
drome, people who have experienced severe head injuries, and Latinos and African-Americans have shown a greater likelihood for developing EOAD than other population groups.37

B. Problems Faced by Those With EOAD

As described above, the effects of EOAD are physically and emotionally devastating. The disease also takes a financial toll on the people it afflicts. It is estimated that slightly less than one-third of those who develop EOAD do not have health insurance when their symptoms appear.38 For many of these people, dementia is a disqualifying, preexisting condition that prevents them from obtaining private health insurance.39 Without health insurance, some people may not have enough money saved to pay for necessary medical services.40 This problem is compounded when uninsured people with EOAD have or develop another serious condition that necessitates medical treatment.41 The accrual of medical debts that exceed income may eventually lead to bankruptcy.42

The income of people with EOAD may substantially decline when those people can no longer work because of the disease.43 Some people may be forced to leave work before acquiring a diagnosis and thus may be ineligible for

37 EARLY-ONSET DEMENTIA, supra note 7, at 84; DIAGNOSTIC AND STATISTICAL MANUAL, supra note 3, at 141; BASICS OF ALZHEIMER’S DISEASE, supra note 6, at 13. In the 1960s and 1970s, researchers linked exposure to aluminum to an increased risk of developing AD. BASICS OF ALZHEIMER’S DISEASE, supra note 6, at 12. However, studies conducted since that time have not supported a connection between aluminum and AD. Id.
38 NATIONAL CHALLENGE, supra note 4.
39 Id.
40 Id.

Many Americans burdened with medical debt, however, choose not to file for bankruptcy because to do so would cut them off from access to the health-care providers they depend on. [footnote omitted] Rather, they attempt to pay their medical bills, often using high-interest credit cards or mortgaging their homes and property. As they become overwhelmed by these obligations, they often face loss of employment because of repeated garnishments, as well as humiliating harassment from aggressive collection agencies.

41 NATIONAL CHALLENGE, supra note 4. “Many with early onset Alzheimer’s and other dementias are in poor health, have higher rates of serious medical conditions, are much more likely to be hospitalized, and have higher out-of-pocket expenditures for prescription drugs.” Id.
42 “Medical expenses are one of the leading causes of bankruptcy in the United States.” DISENTITLEMENT, supra note 40, at 2.
43 NATIONAL CHALLENGE, supra note 4. “Many people with early onset Alzheimer’s and other dementia are still working when their symptoms emerge. Due to the nature of the condition, changes in their job performance or behavior may not be understood or addressed. The workplace can become a difficult environment.” Id.
some forms of employer assistance.\textsuperscript{44} Some people may be capable of retiring early and drawing retirement benefits, but others may not have saved money for retirement.\textsuperscript{45} Without retirement benefits, or employer assistance, it is unlikely that a person with EOAD can maintain an income similar to that enjoyed before developing the disease.\textsuperscript{46} Loss of income can affect more than just the people who develop EOAD; people with EOAD are much more likely than those with LOAD to have dependent children for whom they are responsible.\textsuperscript{47} Parents with EOAD may not be able to maintain an income that allows them to provide for their children’s needs.\textsuperscript{48} In addition to children, some people with EOAD may also be responsible for the care of ill relatives.\textsuperscript{49} Family income may also take a drastic hit if a family member must quit employment to care for a person with EOAD.\textsuperscript{50}

Acquiring and maintaining adequate long term care is a struggle for many people with EOAD.\textsuperscript{51} Those with more advanced forms of EOAD may require nursing home care.\textsuperscript{52} However, nursing homes are generally intended for the elderly, and so it may be difficult to find a nursing home appropriate for someone with EOAD.\textsuperscript{53} Private insurance may provide for nursing home care for some individuals, but for those who do not have insurance, nursing home costs can be prohibitive.\textsuperscript{54}

Although the financial pressures created by the disease may be intimidating, there are federal programs that may provide some financial assistance to people with EOAD. The next section of this Note discusses three of these programs and how they might alleviate the financial burden of EOAD.

III. FEDERAL BENEFITS PROGRAMS

There are three major federal benefits programs that provide assistance for people with qualifying disabilities: Social Security, which encompasses

\begin{quote}
\textsuperscript{44} \textit{Id.}
\textsuperscript{46} NATIONAL CHALLENGE, supra note 4. “Losing one’s job has a huge financial impact. The HRS data shows that average annual income is much lower for people age 55–64 with disabling cognitive impairment than for people of the same age with normal cognitive status . . . .” Id.
\textsuperscript{47} See Commenter 4 From Oklahoma, supra note 45.
\textsuperscript{48} See id.
\textsuperscript{49} See generally id.
\textsuperscript{50} Seventy percent of people with AD live at home and receive care in their homes. BASICS OF ALZHEIMER’S DISEASE, supra note 6, at 8.
\textsuperscript{51} See NATIONAL CHALLENGE, supra note 4.
\textsuperscript{52} Id.
\textsuperscript{53} Id.
\textsuperscript{54} Id. “In 2005, the average annual cost of nursing home care was $64,240 . . . .” Id.
\end{quote}
Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI), Medicare, and Medicaid. These three programs can assist people with EOAD in different areas of their lives. Social Security provides financial benefits in place of lost wages, Medicare pays for some medical care, and Medicaid covers some of the costs of long-term care. The following three subsections describe the creation and operation of these programs, the assistance these programs can offer to those with EOAD, and the ways these programs must be improved to adequately assist those with EAOAD.

A. Social Security

Initially signed into law in 1935 as the Social Security Act, the Social Security program was created as part of then President Franklin D. Roosevelt’s New Deal system intended to help the United States cope with the Great Depression. Since its creation, Social Security has evolved into a program that today provides financial benefits to qualifying disabled persons, including some people with EOAD. Of the twenty-one titles now codified as part of the Social Security Act, Title II and Title XVI provide the statutory basis for the creation and maintenance of SSDI and SSI. These are the two programs that disburse Social Security benefits to qualifying disabled persons, including those afflicted with EOAD. The programs are administered by the Social Security Administration.

SSDI is intended to aid people who are unable to work for a significant period of time because of a disability. The program is funded by the Federal Disability Insurance Trust Fund, which is funded by the Social Security tax on employment wages. Qualifying disabled persons receive SSDI benefits according to their age and the amount of Social Security taxes they have paid; the type of disability and extent of disability are not used to determine the amount of SSDI benefits that are awarded. A person applying for SSDI benefits must

56 See id.
60 42 U.S.C. § 401.
61 Disability Benefits, supra note 59. There are two tests used to evaluate whether a person meets the earning requirements for SSDI benefits. Id. The “recent work” test uses the age at which a person becomes disabled to determine whether that person has been employed for enough time during specified years to receive benefits. Id. The “duration of work” test uses the age at which a person becomes disabled to determine whether the person has been employed long enough to receive benefits, but the work to satisfy this test does not need to occur within any
be disabled for at least six months before he or she becomes eligible to receive benefits. Disability benefits awards are retroactive to the date six months after becoming disabled regardless of the intervening time period between disability onset and a finding of disability by Disability Determination Services (DDS) or a judge. Family members of disabled persons may also qualify for benefits under this program.

SSI is a need-based program that can provide additional assistance to disabled persons below a certain income and resource threshold. Unlike SSDI, SSI is funded by the United States Treasury. Also unlike SSDI, a person may receive SSI benefits without ever having paid Social Security taxes, and SSI does not require that a person have worked for any length of time before becoming disabled. Both SSDI and SSI require that for persons with EOAD to receive Social Security benefits, they must show that they are legally disabled when they apply for benefits.

The Social Security Act dictates that a person is disabled for purposes of the Act if he or she is unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months" or suffers from blindness. The meanings of "impairment" and "disability" are not the same as used within the statute. Impairment is any physical or psychological condition that can be diagnosed by a doctor or other health expert. As described in the Act, impairment is only one aspect of the disability determination. To be disabled, a person must have an impairment and be unable to work in any field for at least one year. Thus, a person may be impaired, but may not be disabled, and so may not be eligible for Social Security benefits.

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specific timeframe. Id. To be eligible for SSDI benefits, Social Security taxes must be paid during the years worked. Id.


See id. Applicants should apply for benefits as soon as they become disabled so that if they are approved to receive benefits, they may receive benefits payments sooner. Disability Benefits, supra note 59.

Disability Benefits, supra note 59.


Id.

Id.; see supra text accompanying note 61.

42 U.S.C. § 416(i).

GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT 3 (Linda Cocchiarella & Gunnar B.J. Andersson eds., 2000) [hereinafter GUIDES].

42 U.S.C. § 416(i).
Whether a person can engage in "substantial gainful activity" is determined by examining the severity of that person's medical condition. For a condition to be considered severe, it must "significantly limit" the ability to engage in simple activities necessary for work. Other factors taken into consideration when evaluating ability to work are the person’s education, background, work experience, age, and acquired skills. The ability to work is not gauged solely in terms of an applicant’s ability to engage in substantial gainful activity in the field in which the person is trained to work. If an applicant is found to reasonably have the ability to work in any field, the applicant is not considered disabled.

Disability determinations are made by state DDS offices; an applicant’s personal physician does not determine disability. DDS creates teams that evaluate applications, and these teams may consist of physicians, clinical psychologists, analysts, and other DDS staff members. Although personal physicians do not decide whether a person is disabled for Social Security benefit purposes, they can play an important role as witnesses to help prove that a disability exists. DDS uses standards prescribed by the Social Security Administration to determine whether an applicant is disabled. If an applicant is found to be disabled, that applicant is referred to the Social Security Administration for the disbursement of the appropriate benefits.

Both SSDI and SSI provide a financial “safety net” for people who become significantly disabled. Social Security programs can prevent financial ruin for people who cannot earn an income because of a disabling medical condition. In this way, SSDI and SSI act as “public insurance.” The financial

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1 Id.; Disability Benefits, supra note 59.
2 Disability Benefits, supra note 59. The Social Security Administration has recognized “remembering” as an example of a simple activity necessary for work. Id.
3 GUIDES, supra note 69, at 8.
4 Disability Benefits, supra note 59.
5 Id.
8 See Disability Benefits, supra note 59. See also Disability Determination Under Social Security, SOCIAL SECURITY ONLINE, http://www.socialsecurity.gov/disability/professionals/bluebook/12.00MentalDisordersAdult.htm#12.01%20Category%20of%20Impairments,%20Mental (last visited Sept. 8, 2010) (the Social Security Administration’s description of what constitutes a disabling mental impairment for use by medical professionals).
9 See Disability Benefits, supra note 59; see supra text accompanying note 61.
10 See JOEL S. WEISSMAN & ARNOLD M. EPSTEIN, FALLING THROUGH THE SAFETY NET 1 (1994) [hereinafter SAFETY NET].
11 See GROWTH IN DISABILITY BENEFITS: EXPLANATIONS AND POLICY IMPLICATIONS 178 (Kalman Rupp & David C. Stapleton eds., 1998) [hereinafter GROWTH IN DISABILITY BENEFITS].
12 Id.
assistance provided by these programs is especially important for people with EOAD because their conditions will not improve and they thus have no hope to resume employment and earn an income.

The family members of individuals disabled by EOAD may also receive some disability benefits.83 EOAD sufferers with dependent children are eligible to receive some help from SSDI, but not SSI, in providing for their children. Dependent children under the age of eighteen are eligible to receive benefits which may continue after the age of eighteen if the child is a student.84 Neither SSDI nor SSI awards benefits equitably to spouses. Despite the often intensive role spouses play in supporting and caring for husbands or wives with EOAD, spouses may collect SSDI only if they are over the age of sixty-two or are caring for a child under the age of sixteen.85 Many people develop EOAD before they or their spouses reach the age of sixty-two, and the spouses may not have access to SSDI benefits that may allow them to afford to care adequately for their families. Benefits for spouses may be especially important for those spouses who may need to quit careers to care for a husband or wife with EOAD. Another serious problem with Social Security is that it does not offer any benefits to children, siblings, other relatives or friends that may care full-time for an EOAD sufferer.86

Concerns about the number of people receiving Social Security benefits and the availability of funds for benefit payouts have led to reluctance by evaluators to find that a person is disabled and deserving of benefits.87 The evaluation process currently rejects approximately seven of every ten applicants.88 For individuals with EOAD, this attitude has been a significant obstacle, especially when taking into account the difficulty people with EOAD face in proving disability. The individual must show that he or she has a condition serious enough

84 Id.
85 Id.
86 Id.
87 GROWTH IN DISABILITY BENEFITS, supra note 81, at 7. “Social Security Disability Insurance and Medicare . . . have been more restrictive with respect to eligibility.” A.E. Benjamin, Trends among Younger Persons with Disability or Chronic Disease, in THE FUTURE OF LONG-TERM CARE: SOCIAL AND POLICY ISSUES 75, 86 (Robert H. Binstock, Leighton E. Cluff, & Otto von Mering eds., 1996).
88 See ELDERLAWANSWERS, supra note 62. In 2004, the Office of Disability Programs compiled data related to the success of benefits applicants. Filing for Disability in West Virginia, DISABILITYSECRETS.COM, http://www.disabilitysecrets.com/disability-resources-west-virginia.html (last visited Sept. 14, 2010). According to the data, 63.3% of applicants are rejected by DDS, and only 36.7% are approved. Id. Of the applicants that are reconsidered, 84.9% are rejected again with only 15.1% being awarded benefits. Id. There is currently no data collected that tracks how many applicants with EOAD are rejected from receiving disability benefits. National Challenge, supra note 4.
to be precluded from the workforce and eligible for benefits. Until very recently, this has been a significant obstacle for people with EOAD. If the person did not have a strong diagnosis of EOAD from a physician, it could be hard to prove that a disability existed. Furthermore, EOAD sufferers, in the initial and middle stages of the disease, can look young and healthy and can be able to constructively participate in the disability evaluation. Because it could be difficult to prove that an individual who appeared to look and function normally could be significantly disabled, deserving people with EOAD were unfairly denied benefits.

The Social Security Administration has created a list of debilitating conditions that are intended to qualify an applicant for disability benefits with only a minimal showing of medical information related to the condition. A person with a condition on the list who receives benefits despite making a minimal showing of disability is said to receive a "Compassionate Allowance." The screening process for Compassionate Allowances is conducted using a Predictive Model to single out particular applicants who are likely disabled, whose claims of disability are likely to be easily established, and whose claims are likely to be processed quickly. This procedure streamlines benefit disburse-

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89 See ELDERLAwANSWERS, supra note 62.
91 NATIONAL CHALLENGE, supra note 4.
92 Id. In a testimonial given by Jay Jones, a man diagnosed with EOAD, and his wife, Laura Jones, Ms. Jones stated:

After Jay was removed from his first job, in 2007, he had no benefits at all, and we filed for disability benefits. I filled out the paperwork for Jay and went to the Social Security office. I will say that this was one of the most challenging times for me. Our world had been turned upside down, I had to plan to return to work to support us, we had a four-year-old daughter to raise . . . . But I still felt like we presented a strong enough case. Even the person from Social Security who helped me with the paperwork thought we did it right . . . . Imagine our surprise, when 6 months later, we got Jay’s denial letter.

94 Id.
ment by allowing pre-screened applicants to forgo a potentially lengthy approval process. 96

The list of Compassionate Allowances was created in response to information gained from public hearings, the Social Security service community, and medical and scientific experts. 97 This information showed that there are many conditions that are completely debilitating, and that requiring drawn out approval processes before benefits may be disbursed is unnecessarily costly and potentially harmful to those who need the benefits. 98 On July 29, 2009, the Social Security Administration held an outreach hearing specifically to address whether EOAD is a condition that deserved to be added to the list of conditions that receive Compassionate Allowances. 99 On February 12, 2010, EOAD was added to the list of Compassionate Allowances, effective March 1, 2010. 100

Ideally, the inclusion of EOAD on the list will improve access to benefits for people with EOAD. It should decrease costs for the Social Security Administration and the federal court system because less time and manpower will be needed for evaluation of benefits applications, and resources will not be consumed through appeals. People with EOAD should need to spend less time and money pursuing disability claims and appeals. They should also be able to allocate more of their own funds for health care and family maintenance, which may in turn result in better overall health, despite the condition, and less dependence on government funds.

Those who are initially denied Social Security disability benefits may appeal within sixty days of receipt of the denial. 101 This process may involve a review of the claim, a hearing conducted by an administrative law judge, review by the Social Security's Appeals Council, or review by a federal district court. 102 Appellants have the right to be represented by counsel should they so choose. 103 However, persons with EOAD may not be able to afford an attorney because of the financial pressures presented by the disease.

As the Medicare system stands now, the sooner Social Security disability benefits are awarded, the sooner a person with EOAD can receive Medicare

97 Compassionate Allowances, supra note 93.
98 See id.
102 Id.
103 Id.
benefits. Similarly, a person who qualifies for SSI automatically qualifies for Medicaid in most states. The next two sections of this Note discuss the general operation of Medicare and Medicaid and how these programs mesh with Social Security.

B. Medicare

Medicare was established in 1965. The statutory basis for its creation is found in Title XVIII, Health Insurance for the Aged and Disabled, of the Social Security Act of 1965. Medicare is a federally operated, health insurance-like program, which provides financial benefits for beneficiaries' medical treatment and care needs. Medicare is only intended to provide some financial help to those who qualify; Medicare does not cover the costs of all medical services or long-term care. Known as “the health program for the elderly,” Medicare was originally designed to assist only the elderly in affording health care resources. In 1973, the program was expanded to provide assistance to people under the age of sixty-five with qualifying disabilities.

Medicare distributes benefits from a fund that is supplied by a tax on employment wages and from Social Security premiums. Most Americans over sixty-five are eligible for Medicare, but those under sixty-five, particularly people with EOAD, must be eligible for SSDI before they are covered by Medicare. For disabled persons, coverage under Medicare begins automati-
cally two years after becoming eligible to receive SSDI benefits. Medicare coverage persists as long as the qualifying disability.

Like SSDI and SSI, Medicare acts as a safety net by preventing the financial ruin of Americans who require medical treatment. Although Medicare does not pay all medical expenses, it provides essential financial assistance for people who cannot earn employment wages. This is especially true for people with EOAD. Because of the age at which the disease strikes, and because it renders the afflicted unable to work, EOAD sufferers may not have the financial resources to support both daily family living expenses and medical treatment. Medicare ensures that qualifying Americans with EOAD do not have to sacrifice proper medical treatment so that they can afford to care for their families.

There is, however, one major disadvantage to Medicare—the two-year waiting period. The two-year period between the date SSDI benefits begin and the date of Medicare eligibility may place a significant economic burden on some people with EOAD. As discussed above, many people may sacrifice medical treatment to afford being able to support a family. Some legislators have recently moved to eliminate the two-year wait. Other legislators have begun taking steps toward instituting a national health care plan that would extend Medicare coverage to all people without any waiting period.

C. Medicaid

Medicaid, like Medicare, was established in 1965. The statutory basis for its creation is found in Title XIX, Grants to States for Medical Assistance Programs, of the Social Security Act of 1965. Medicaid is a health insurance program that operates by assisting people in paying for medical care and long term care, including nursing home care. Medicaid is a joint project between

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116 Id.
117 See id.
118 Economic and Clinical Realities, supra note 110, at 17 ("Medicare . . . tends to focus cost-containment attention on those who are elderly.").
119 Medicare, supra note 109. See also Economic and Clinical Realities, supra note 110, at 18 ("Medicare . . . only pays 40 percent of older persons' health care costs . . . . Older persons themselves finance just under 42 percent of their aggregate care.").
120 See discussion infra Part V.A.
121 See id.
122 See id.
the federal government and each state. Each state operates its own Medicaid program, but these programs must meet standards set by the federal government. However, states do have some flexibility in determining eligibility for Medicaid.

In most states, those who are eligible for SSI are also eligible for Medicaid. In all states, eligibility is largely dependent on a person’s income and the value of that person’s assets, only those with a low income and asset level can qualify for Medicaid. Each state sets its own threshold for income and assets. In all states, the income and asset threshold is extremely low. If a person’s income level is too high and initially disqualifies him or her from Medicaid, that person may meet the “medically needy” requirement that allows him or her to “spend down” income to qualify. The spend-down amount is similar to a deductible; after paying the spend-down amount—in general, any income

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128 Id.
130 Those under the age of sixty-five must meet additional eligibility requirements, such as disability. Your Guide to Medicaid, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, http://www.wvdhhr.org/bms/oMedPolicyCor/YourGuideMedicaid.pdf (last visited Sept. 14, 2010). As of 2010, for a person to qualify in West Virginia if that person does not qualify for SSI, the value of countable assets must not exceed $2,000 for one person (a person’s home is typically not a countable asset), and that person’s monthly income after spend down must not exceed $2,022. Family Assistance: Medicaid, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, http://www.wvdhhr.org/bcf/family_assistance/medicaid.asp (last visited Sept. 14, 2010). In California, countable assets must not exceed $2,000 for one person, and monthly income after spend down must not exceed $1,133. Medi-Cal (for People with Medicare), CALIFORNIA HEALTH ADVOCATES, http://www.cahealthadvocates.org/low-income/medi-cal.html (last visited Sept. 14, 2010). In New York, countable assets must not exceed a value of $13,800 for one person, and monthly income must not exceed $767 for one person. Medicaid in New York State, NEW YORK STATE DEPARTMENT OF HEALTH, http://www.health.state.ny.us/health_care/medicaid/ (last visited Sept. 14, 2010).
131 Overview Medicaid Eligibility, supra note 125.
132 Mandatory Eligibility Groups, supra note 127.
133 As of 2010, for a person to qualify in West Virginia if that person does not qualify for SSI, the value of countable assets must not exceed $2,000 for one person (a person’s home is typically not a countable asset), and that person’s monthly income after spend down must not exceed $2,022. Family Assistance: Medicaid, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, http://www.wvdhhr.org/bcf/family_assistance/medicaid.asp (last visited Sept. 14, 2010). In California, countable assets must not exceed $2,000 for one person, and monthly income after spend down must not exceed $1,133. Medi-Cal (for People with Medicare), CALIFORNIA HEALTH ADVOCATES, http://www.cahealthadvocates.org/low-income/medi-cal.html (last visited Sept. 14, 2010). In New York, countable assets must not exceed a value of $13,800 for one person, and monthly income must not exceed $767 for one person. Medicaid in New York State, NEW YORK STATE DEPARTMENT OF HEALTH, http://www.health.state.ny.us/health_care/medicaid/ (last visited Sept. 14, 2010).
you have that is in excess of that which is necessary to meet daily needs—Medicaid will cover any further care costs.

Medicaid is a program that can substantially benefit people with EOAD by providing the financial means of obtaining long-term care, such as care in a nursing home. However, meeting the low income and asset requirement can be extremely difficult for people with EOAD, especially if those people have families. So that one spouse may qualify for Medicaid while the other spouse may preserve some of the family’s savings, couples have turned to drastic measures and even divorce. Our government has an obligation to bridge the gap between Medicare, which does not pay for nursing home care and other long-term care, and Medicaid. The government has a duty to ensure access to proper medical treatment for people with EOAD and to prevent families from becoming destitute.

IV. EQUAL PROTECTION CHALLENGES TO THE RATIONING OF BENEFITS

Advances in medical technology have resulted in Americans living longer, healthier lives despite the onset of disease or disability. As the number of elderly Americans increases, the expected cost of supporting these citizens is also expected to rise. The cost of health care in the United States is

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136 See id.

137 See supra text accompanying note 54.


Christine Crawford of Aurora, Ohio, started divorce proceedings after her husband’s care for dementia consumed more than $100,000 of their savings. Crawford said she didn’t want to divorce her husband, with whom she’d raised three children, but it was the only way to preserve what was left of their life savings. “All along I kept saying, ‘Absolutely not. I won’t do that,’” said Crawford . . . . “I was so proud of the fact we’d been married for 42 years.”

Id.

139 A.E. Benjamin, supra note 87, at 76. “As early as the year 2030, fully 20 percent of Americans are likely to be aged 65 and over.” Economic and Clinical Realities, supra note 110, at 20 (citation omitted).

enormous, and one-third of the federal budget is directed towards assisting the elderly in accessing health care.\textsuperscript{141} As an age group, the elderly require and use more health care resources than any other age group.\textsuperscript{142} Many analysts predict that the rising elderly population will play a primary role in the eventual depletion of Social Security and Medicare resources.\textsuperscript{143}

National health care costs continue to swell and federal resource availability dwindles at an inversely proportional rate.\textsuperscript{144} To contain the costs associated with supporting America's elderly, diseased, and disabled persons, the United States has developed different means for determining who is most deserving of federal resources.\textsuperscript{145} Undoubtedly, some methods of differentiating between those who are worthy of federal assistance and those who are not is necessary to maintain federal financial stability; the government cannot reasonably give away money to everyone who asks for it.\textsuperscript{146} Creating criteria used to determine who is deserving of benefits is called "rationing."\textsuperscript{147} One possible means that could be used to contain costs would include rationing benefits to target specifically delineated age groups.\textsuperscript{148} Because of large-scale and effective advocacy over the last half-century, the elderly have obtained significant recognition by our government in the form of easier access to Social Security and Medicare benefits.\textsuperscript{149} By choosing to provide the elderly with easier access to benefits, the federal government has rationed its resources to favor the elderly.\textsuperscript{150} As a result, non-elderly individuals are disadvantaged.

\textsuperscript{141} ETHICS, supra note 140, at 5. "Indeed, one can argue that in America we have something resembling a welfare state for the elderly but for no other age group." Id. at 6.

\textsuperscript{142} Economic and Clinical Realities, supra note 110, at 20.

\textsuperscript{143} See ETHICS, supra note 140, at 5. "[H]ealth care costs for older persons have been depicted as . . . 'a great fiscal black hole' that will absorb an unlimited amount of our national resources." Binstock & Post, supra note 140, at 4–5 (citation omitted).

\textsuperscript{144} See Binstock & Post, supra note 140, at 5.

\textsuperscript{145} See id.

\textsuperscript{146} See id.

\textsuperscript{147} "Rationing" refers to the denial of federal resources because of expensive, cost concerns and is not related to the allocation of scarce medical resources. See Nancy Neveloff Dubler & Charles P. Sabatino, Age-based Rationing and the Law: An Exploration, in TOO OLD FOR HEALTH CARE: CONTROVERSIES IN MEDICINE, LAW, ECONOMICS, AND ETHICS 92, 114 (Robert H. Binstock & Stephen G. Post eds., 1991).

\textsuperscript{148} See id. at 92.

\textsuperscript{149} See Binstock & Post, supra note 140, at 1–2. An applicant sixty-five or older needs only show that he or she has paid Social Security or Medicare taxes to receive benefits, whereas a non-elderly applicant must additionally prove disability. Disability Benefits, supra note 59; Medicare, supra note 109.

\textsuperscript{150} See Dubler & Sabatino, supra note 147, at 96–97.
Many critics of rationing argue that age alone is an insufficient factor for determining who is worthy of federal benefits. Rationing by age encroaches upon fundamental "Western humanistic thought" and morality by violating the ideal of "human equality." By distinguishing members of the population by a particular personal characteristic, separating those groups based on that characteristic and then supplying members of only one group with benefits, equality between groups is destroyed. The concept of equality is entrenched in the history of the United States; it appears in both the Declaration of Independence and the United States Constitution. As part of the Constitution, equality is also ingrained in the American legal system. By taking on the responsibility of providing benefits to its citizens, the United States government is legally bound by the Fourteenth and Fifth Amendment to distribute these benefits among its citizens while maintaining equality among the people.

Rationing has a significant impact on people with EOAD. It can be much harder for a person with EOAD to obtain benefits than it is for a person with LOAD or many other disabilities. Although Social Security, Medicare and Medicaid were not designed to discriminate against people with EOAD, they do have discriminatory effects.

Whether rationing access to benefits in a way that disadvantages people with EOAD violates the constitutional concept of equality has not been addressed by American courts. However, there is a constitutional basis for many arguments that may be used to challenge the legality of rationing benefits to the disadvantage of people with EOAD. The basis of these arguments is the Equal Protection Clause of the Fourteenth Amendment which states that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." Although the Fourteenth Amendment alone does not apply to the federal government, the United States Supreme Court has held that the concept of "liberty" within the Fifth Amendment—which does apply to the federal gov-

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151 See Binstock & Post, supra note 140, at 9. "[T]he very notion of age-based social support is morally suspicious, since even the very wealthiest of those over age sixty-five receive public assistance through Medicare." DOUGHERTY, supra note 108, at 167.

152 Binstock & Post, supra note 140, at 9.

153 THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776) ("We hold these truths to be self-evident, that all men are created equal . . . ."); U.S. CONST. amend. XIV, § 1 ("[N]or shall any State . . . deny to any person within its jurisdiction the equal protection of the laws."); U.S. CONST. amend. XIII, § 1 ("Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction."); U.S. CONST. amend. XV, § 1 ("The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of race, color, or previous condition of servitude.").

154 See Binstock & Post, supra note 140, at 9.


156 See Disability Benefits, supra note 59; Medicare, supra note 109.

157 U.S. CONST. amend. XIV, § 1.
ernment—and the Fourteenth Amendment are not "mutually exclusive." According to the Court, classifications that would violate equal protection if made by the States violate due process if conducted by the federal government.

The class of people with EOAD is not receiving equal protection of the laws as compared to the class of people with LOAD or as compared to the class of disabled Americans. There are three main tests used to determine whether a class is not receiving equal protection of the laws: the "rational basis" test, the "intermediate scrutiny" test, and the "strict scrutiny" test. The rational basis test is the most commonly used of the three tests and requires that the classification only be "rationally related" to a state interest. The intermediate scrutiny test demands that the classification serve a compelling government interest and that the classification is substantially related to serving that government interest. The strict scrutiny test is the most stringent of the three and requires that the classification be necessary to further a compelling government interest.

In deciding what test to use, the specific characteristic that distinguishes the classes in question becomes important. Below is a discussion of some of the various avenues that may be explored when analyzing the constitutionality of rationing benefits to the disadvantage of people with EOAD.

A. Rationing By Age

The first and most obvious characteristic separating people with EOAD from people with LOAD is age. As described above, the two conditions are alike except for the age at which they strike. The Court has spoken on the legality of classifications based on age. In *Massachusetts Board of Retirement v. Murgia*, which involved a mandatory retirement age for police officers, the Supreme Court decided that classifications based on age are not "suspect" and that the rational basis test should apply to age based classifications. The Court distinguished age from other characteristics, such as race and national origin, which are subject to strict scrutiny. Classifications based on race and national origin are evaluated using the strict scrutiny test because these traits are immutable and often easily visible; people cannot change their heritage or

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159 *Bolling*, 347 U.S. at 499–500.


161 Dubler & Sabatino, *supra* note 147, at 98.


163 Dubler & Sabatino, *supra* note 147, at 98.

164 *Diagnostic and Statistical Manual*, *supra* note 3, at 140.


166 Id. at 313–14.

skin color. Age is different—although people have no control over aging, people’s ages change constantly. In this sense, despite being an easily visible trait upon which bias may be rooted, age is not an immutable characteristic. In *Murgia*, the Court described age as a number which “marks a stage that each of us will reach if we live out our normal span.”168 Because all people who live normal life spans will go through a particular age, age is not a suspect classification.169

Following *Murgia*, because classifications by age are not suspect, a challenge to the constitutionality of rationing benefits based on age to the disadvantage of people with EOAD must be conducted using the rational basis test. To pass the rational basis test, the AD age classifications must be rationally related to the interests served by Social Security and Medicare.170 In practice, almost all legislation passes the rational basis test.171 As to the creation of programs that ration benefits by age, the government has a small hurdle in showing a rational basis for rationing. It should be able to easily produce data indicating that federal resources are limited and that the elderly require these resources at a higher rate than the non-elderly.172 However, an EOAD party challenging age rationing may have some success in court by showing that the classification arbitrarily burdens people with EOAD and must, therefore, be deemed unconstitutional.173

B. Rationing By Medical Condition

There is another legal approach that may garner some success for those with EOAD. Instead of viewing the creation of classes by age, it may be argued that the classes are separated by medical condition. The success of this argument rests in the premise that EOAD and LOAD are separate conditions apart from the age of onset. This approach can be buttressed by producing evidence that EOAD and LOAD are pathologically different.174 Unlike the argument regarding age, there is no explicit delineation in either the Social Security or Medicare legislation between people with EOAD and people with LOAD. However, as administered, the programs distinguish between LOAD and EOAD.

The Supreme Court has never ruled on whether classifications by medical condition are subject to low, intermediate, or strict scrutiny under the Fourteenth Amendment. It is possible that in addressing the scrutiny due to the

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169 *Id.*
170 *See Dubler & Sabatino, supra* note 147, at 98.
171 *Id.*
172 *See Binstock & Post, supra* note 140, at 4–5.
173 *See Nowak & Rotunda, supra* note 160, at 634.
174 *See supra* text accompanying note 15.
EOAD class, the Court would analogize EOAD to mental retardation. Both
EOAD and mental retardation affect cognitive ability, and the Court has ad-
dressed classifications based on mental retardation. In City of Cleburne v.
Cleburne Living Center, Inc., the Court held that individuals with mental retar-
dation are not members of a suspect class. If people with EOAD are not con-
sidered members of a suspect class, the rational basis test would apply. Again,
the government’s hurdle would be small—the government can easily show that
denying easier access to benefits for people with EOAD is policy that ensures
the preservation of the federal benefits reservoir. An EOAD party attacking
the government’s position might have success arguing that cost differences do
not justify the potential harms caused to those with EOAD.

C. Rationing by Ability to Acquire Adequate Health Care

Although the United States Constitution guarantees equality, it does not
expressly guarantee a right to health care or health security. The right to
health care has been recognized by the laws of other countries. It is not sur-
prising that the U.S. Constitution does not discuss health care, given that the
primary purpose behind the creation of the document was to provide for a li-
mited federal government. There is, however, a constitutional basis for ar-
guing that rationing federal benefits denies people with EOAD a fundamental
“right to life.” Denying adequate access to federal benefits denies people
with EOAD the financial means to acquire health care that preserves life.
Applying equal protection analysis, those with EOAD and LOAD are distin-
guished by their ability to acquire adequate health care through access to federal
benefits. The Supreme Court recognized in Webster v. Reproductive Health
Services that there is a “state[] interest in [protecting] potential human life.”
When also considering the existence of laws against murder, it follows that the
government has an interest in existing life. Therefore, according to principles
of equal protection, by developing a benefits system that denies equal access to

176 Id.
177 Binstock & Post, supra note 140, at 4–5.
178 Although health care is not addressed in the Constitution, both the States and federal gov-
ernment have instituted programs to benefit public health. DISENTITLEMENT, supra note 40, at 25.
179 Id. at 24–25.
180 Id. at 25.
181 Dubler & Sabatino, supra note 147, at 102.
182 Id.
183 See id.
185 See Dubler & Sabatino, supra note 147, at 102.
federal benefits, and in turn, adequate health care, the government has violated a fundamental right of people with EOAD.\(^\text{186}\)

If the right to life-preserving benefits is considered fundamental, then under equal protection analysis, the classification would be subject to the strict scrutiny test. The majority of classifications that involve fundamental rights are found to be unconstitutional.\(^\text{187}\) This is because the strict scrutiny test creates a high hurdle for the government to overcome; the government must show that the classification is absolutely necessary to meet a compelling interest.\(^\text{188}\) It is unlikely that the government could show that denying easier access to federal benefits to individuals with EOAD is the only option for controlling costs associated with the benefits programs. The government could raise taxes to offset costs, or could reorganize benefits payment plans to preserve resources. Thus, if the right to care is fundamental, the Social Security, Medicare, and Medicaid programs must be expanded to adequately cover people with EOAD to be constitutional.

There is one hiccup associated with this fundamental right analysis. Language in the *Webster* case directly opposes the conclusion that there is a fundamental right to care.\(^\text{189}\) Specifically, *Webster* states that “the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests . . . .”\(^\text{190}\) Despite this decree, the Fifth and Fourteenth Amendments, in addition to other Amendments, have been used to justify the right to governmental aid. For example, the government must provide appointed counsel to indigent criminal defendants to represent them.\(^\text{191}\) It may be possible to convince a court that the “right to life” is a fundamental right that entitles a person to receipt of federal benefits.

D. Rationing by Wealth

As discussed above,\(^\text{192}\) before an applicant can qualify for Medicaid, that person must be extremely poor.\(^\text{193}\) Because a spouse’s income and assets are also taken into account when determining Medicaid eligibility, both the applicant and spouse are forced into poverty before the applicant can qualify for Medicaid.\(^\text{194}\) To prevent families from becoming practically penniless, some

\(^\text{186}\) See id.

\(^\text{187}\) Id. at 98.

\(^\text{188}\) Id.

\(^\text{189}\) *Webster*, 492 U.S. at 507.

\(^\text{190}\) Id.


\(^\text{192}\) See supra Part III.C.

\(^\text{193}\) See supra text accompanying note 133.

\(^\text{194}\) See Weston, supra note 138.
spouses have turned to divorce as the only practical solution to their financial dilemma.\textsuperscript{195} By creating a program that essentially forces people into divorce so that they may receive benefits, the government's approach in rationing Medicaid benefits to only the extremely poor, particularly those with families, arbitrarily burdens the recognized fundamental right to marriage.\textsuperscript{196}

The Equal Protection analysis of the inequitable dispensing of Medicaid benefits begins with defining the classes at issue. Here, the two classes are those persons who have such a low income that they meet Medicaid requirements, and those who have incomes that are high enough to disqualify them from Medicaid benefits. Although not all people with EOAD have problems affording long-term care, and although some people with EOAD do easily qualify for Medicaid, this analysis is still tremendously relevant to those with EOAD who cannot afford long-term care, but do not qualify for Medicaid. This analysis may also be applied to persons with disabilities similar to EOAD.

The Supreme Court declared that wealth is not a suspect classification.\textsuperscript{197} In \textit{Dandridge v. Williams}, the Court upheld a Maryland law that contained a provision denying the distribution of benefits proportional to family size.\textsuperscript{198} Effectively, larger families received a smaller share of benefits per person than smaller families.\textsuperscript{199} The Court stated that it was enough that the Maryland law had a rational basis and that it was "free from invidious discrimination."\textsuperscript{200} The Court then continued:

\begin{quote}
We do not decide today that the Maryland regulation is wise, that it best fulfills the relevant social and economic objectives that Maryland might ideally espouse, or that a more just and humane system could not be devised. Conflicting claims of morality and intelligence are raised by opponents and proponents of almost every measure, certainly including the one before us. But the intractable economic, social, and even philosophical problems presented by public welfare assistance programs are not the business of this Court. The Constitution may impose certain procedural safeguards upon systems of welfare administration. But the Constitution does not empower this court to second-guess state officials charged with the difficult
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\textsuperscript{195} Id.
\textsuperscript{196} Loving v. Virginia, 388 U.S. 1 (1967).
\textsuperscript{197} Dandridge v. Williams, 397 U.S. 471 (1970).
\textsuperscript{198} Id. at 480.
\textsuperscript{199} Id.
\textsuperscript{200} Id. at 487.
responsibility of allocating limited public welfare funds among the myriad of potential recipients.201

There are many parallels between the Maryland law in Dandridge and the current Medicaid quandary. A court evaluating the Medicaid qualification requirements could find that they do not best fulfill their intended purpose and that states may not be implementing the Medicaid program in the most effective manner. However, the Dandridge conclusion deviates from the logical Medicaid conclusion. The administration of Medicaid has led reasonable Americans to choose to divorce so that they, or their former spouses, may qualify for coverage. The Medicaid program is being administered in such a way that it effectively infringes on the fundamental right to marriage. Therefore, as directed by the Constitution, the judiciary must impose measures on the system of Medicaid administration to protect families.

This argument and the three arguments presented above provide some legal bases for attacking the constitutionality of benefits rationing. Rationing, particularly in a way that disadvantages people with EOAD offends both legal and moral notions of equality. Every justification for providing easy access to benefits to people with LOAD applies to people with EOAD; distinguishing the conditions does not diminish the equally devastating effects of AD. Although our Constitution does not explicitly delineate a fundamental right to care, it does contain language that supports the conclusion that there exists a fundamental right to care. Furthermore, our government has a duty to provide this care in a way that does not arbitrarily burden certain classes of citizens, including those with EOAD. When viewed in conjunction with each other, and the equitable reasons for extending benefits, these constitutional arguments provide a compelling basis for extending the access to benefits, enjoyed by those with LOAD and people with similar disabilities, to those with EOAD.

V. THE FUTURE OF FEDERAL BENEFITS

The United States is the only fully industrialized Western nation that does not guarantee health care benefits to its citizens.202 Furthermore, the United States spends more money on health care than any other country.203 In the last one hundred years, the United States government has made repeated efforts to expand its control over the health care system to provide health care coverage to more of its citizens.204 The failure of these efforts has been attributed to nu-

201 Id. (citations omitted).
202 SAFETY NET, supra note 80, at 1.
204 Across the entire span of the twentieth century, all attempts to enact a health care reform plan that would guarantee universal coverage have been defeated.
numerous causes including anti-statist sentiments, weak labor movement, racism, and established state policies. The greatest achievement for legislators in the twentieth century regarding health care was the introduction of Medicare in 1965.

Instead of a federally provided health care plan to cover all Americans, a “welfare safety net [made up of] a collection of programs and facilities loosely strung together,” provides care for select groups of people. This “safety net” includes programs such as Social Security, Medicare, and Medicaid. The programs are designed primarily to aid low income and elderly individuals. The safety net also includes federally mandated state programs that provide health care benefits for some pregnant women, children and families living in poverty, and elderly and disabled persons receiving Supplemental Security Income. Federal law also requires that hospital emergency rooms stabilize patients before they may seek compensation.

While no severely ill or injured person may be turned away from a hospital, and while some Americans receive benefits from federal programs, many Americans are falling through holes in the health care safety net and are not receiving the benefits they need and deserve. This is especially true for people with EOAD; they do not qualify for some benefits, such as Medicare within the first two years of disability, Supplemental Security Income, and other programs that are based on income. Furthermore, they may have a difficult time proving eligibility for disability benefits. This inability to access federal benefits may result in people with EOAD plunging into dire financial straits, particularly those who are middle income or those who did not have private insurance before receiving an EOAD diagnosis.

Below is a discussion of some of the steps being taken by the federal government to address the disparities in our health care system. First, a narrow

The AALL compulsory state health insurance plan in the 1910s, Roosevelt’s proposal for national health insurance in the New Deal, Truman’s plan in the post-World War II era, Nixon’s National Health Insurance Partnership and Kennedy’s Health Care for All Americans Act in the 1970s, and Clinton’s Health Security plan in the 1990s met the same ignominious fate.

JILL QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE 201 (2005). “[T]he ironic outcome in each instance was federal action that entrenched a private alternative to a public program.” Id.

205 Id. at 202–07.
206 Id. at 202.
207 SAFETY NET, supra note 80, at 1.
208 Id.
209 Id.
210 QUADAGNO, supra note 204, at 208.
211 DISENTITLEMENT, supra note 40, at 11.
212 See supra Part III.
213 See supra Part II.B.
look at one aspect of our health care system is undertaken: an evaluation of the Medicare two-year wait. Second, the scope expands to evaluate the broader implications of the health care system with an emphasis on access to insurance.

A. Medicare and the Two-Year Wait

As noted above,214 people with EOAD are not eligible for Medicare until two years after they become eligible for SSDI.215 During this time frame, even with SSDI benefits, the costs of supporting a family and obtaining adequate health care can result in huge out-of-pocket expenses.216 Therefore, removing this wait period would provide people with EOAD the financial support they need to care for themselves and their families. It may also prevent persons from becoming so poor during the two-year wait that they require more government assistance than they would without the wait.

On March 25, 2009, Senator Jeffrey Bingaman and Representative Gene Green reintroduced bills to the Senate and House of Representatives, respectively, that would phase out the two-year wait period after the receipt of SSDI benefits for people who have not yet reached the age of sixty-five.217 The Ending the Medicare Disability Waiting Period Act of 2009 is intended to relieve some of the financial pressure placed on disabled individuals, many of whom lose their job-related health insurance when they must quit, or are fired from, their jobs.218 This legislation would allow people with EOAD much-needed access to the financial resources that Medicare provides concurrently with receipt of SSDI benefits.219

B. Increased Access to Health Insurance and Other Federal Measures

The focus of the American health care system is on commercially available private insurance acquired by individuals, independently or through employers.220 However, because classes of people, such as those with EOAD, have not acquired, cannot acquire, or cannot afford to maintain private insurance, and

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214 See supra Part III.B.
215 Medicare, supra note 109.
218 H.R. 1708, supra note 217; S. 700, supra note 217; Two-Year Wait, supra note 216.
219 Two-Year Wait, supra note 216.
220 DOUGHERTY, supra note 108, at 164.
because these people fall through the safety net, the federal government has an obligation to adjust its insurance and health care systems to fairly accommodate these Americans. As one critic has noted:

[T]he health care marketplace ... fails to satisfy the important public duty of achieving some decent level of health care for all Americans as a matter of right, and that in light of this failure, there is a public, hence ultimately governmental, responsibility to create an alternative system for financing or delivering care.  

Throughout 2009, President Barack Obama, in an effort to fulfill a campaign promise to extend health care benefits to all Americans, pushed Congress to address the failures of America’s health care system. On September 9, 2009, President Obama addressed a joint session of Congress and proposed changes to the health care system in an effort to spur Congress into action. Congress responded by proposing the Affordable Health Care for America Act bill and the Patient Protection and Affordable Care Act bill in the House of Representatives and the Senate, respectively.

The Affordable Health Care for America Act bill was sponsored by Representative John D. Dingell and introduced in the House on October 29, 2009. The bill proposed that no private or federal insurance program may deny or rescind coverage because of a pre-existing condition. Furthermore, it supported the creation of a public option health insurance program to compete with private insurance providers and drive down insurance costs. The bill also provided for the creation of a federal health insurance exchange program. According to the bill, the changes to the existing health care structure would be funded by increased taxes for wealthier individuals and families, and the public

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221 Id.
225 Affordable Health Care for America Act, supra note 224.
226 Id.
227 Id.
228 Id. “There is established ... a Health Insurance Exchange in order to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.” Id.
option health insurance would be funded entirely by premiums. On November 7, 2009, the House passed the Affordable Health Care for America Act bill, which was then placed on the Senate calendar.

On September 17, 2009, Representative Charles B. Rangel sponsored the introduction of the Service Members Home Ownership Tax Act of 2009 bill in the House. This bill passed the House and was received by the Senate on October 8, 2009. When it reached the Senate, the bill was not intended by the House to address health care. However, because any bills relating to revenue must originate in the House, the Senate decided to amend the Service Members Home Ownership Tax Act bill to incorporate health care reform proposals. As part of the amendment process, the bill was renamed the Patient Protection and Affordable Care Act.

Substantively, the Senate’s amended bill had some similarities to, and differences from, the House’s Affordable Health Care for America Act bill. First, neither would allow any private or federal insurance program to deny or rescind coverage because of a pre-existing condition. Second, both would create health insurance exchange programs; however, the Senate’s bill provided that the exchange be created and administered by the States. Third, the Senate bill did not mandate the creation of public-option health insurance. Fourth, both incorporated a tax increase for wealthier Americans to help fund the benefits programs, but they differed on how this change would take effect.

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229 Id.
232 Id.
233 See id.
234 U.S. CONST. art. I, § 7 ("All Bills for raising Revenue shall originate in the House of Representatives; but the Senate may propose or concur with Amendments as on other Bills.").
235 H.R. 3590, supra note 231.
236 Id.
237 H.R. 3962, supra note 230; H.R. 3590, supra note 231. According to the legislation, insurers would be able to deny and rescind coverage until a health insurance exchange program came into effect, either in 2013 if the House’s date was adopted, or 2014 if the Senate’s date was adopted. Jordan Rau et al., A Consumer’s Guide to Health Reform, NPR (Dec. 24, 2009), http://www.npr.org/templates/story/story.php?storyId=121857029&ft=1&f=1001. Until effective date of a health insurance exchange program, “both bills would create a temporary high-risk pool for people who’ve been rejected for coverage or have pre-existing medical conditions.” Id.
238 H.R. 3962, supra note 230; H.R. 3590, supra note 231.
239 H.R. 3962, supra note 230.

Both bills hit up the wealthy, but in different ways. The House would impose a 5.4 percent income tax surtax on individuals who earn more than $500,000 a
The Patient Protection and Affordable Care Act bill was passed by the Senate on December 24, 2009. Before the bill became law, it achieved resolution by the Joint Conference Committee. Then, upon a passing vote by both the House and the Senate, the President signed the Patient Protection and Affordable Care Act into law on March 23, 2010. The Patient Protection and Affordable Care Act introduces multiple changes to our health care system that may assist individuals with EOAD.

A major problem for people with EOAD has been lack of access to private insurance, either acquired independently or through employment. Upon diagnosis of EOAD, it has been nearly impossible for people with EOAD to acquire private insurance because of the pre-existing, terminal condition, and those with insurance could lose coverage because of their diagnosis. The Act eliminates the ability of private insurance companies to deny coverage to people because of an EOAD diagnosis.

Because private insurance companies will not be able to deny coverage to terminally ill people such as those with EOAD, private insurance premiums may become cost prohibitive for some Americans. However, the legislation provides a potential solution to this problem by providing for the creation of health insurance exchange programs. These programs, administered by either

Jordan Rau et al., supra note 237.

H.R. 3590, supra note 231.

U.S. Const. art. I, § 7. The 2010 election of Republican Scott Brown to the United States Senate appeared to diminish the likelihood that the health care legislation will reach President Obama's desk. See Michael Cooper, G.O.P. Surges to Senate Victory in Massachusetts, N.Y. Times, Jan. 20, 2010, at A1. Brown stated that he would oppose this legislation. Id. With Brown’s election, the Democratic Party no longer had the sixty votes necessary to overcome Republican filibusters. Id. However, using the Health Care and Education Reconciliation Act of 2010, the Patient Protection and Affordable Health Care Act was approved by only fifty-one votes in the Senate according to budget reconciliation rules. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).


NATIONAL CHALLENGE, supra note 4.

federal or state governments, may create competition within the health insurance market and help to drive costs down.\textsuperscript{248} Another method originally conceived in the bill to help contain costs involved the creation of a public option health insurance program.\textsuperscript{249} With the public option, the federal government would have the ability to provide lower cost health insurance to people with EOAD.\textsuperscript{250} In addition, a federally administered public option health insurance program may increase competition within the insurance market which may in turn result in more affordable private insurance for people with EOAD.\textsuperscript{251} However, the creation of a public option was highly opposed by many Republican members of Congress, so it was eventually scrapped.\textsuperscript{252} As an alternative to a public option, the government could reallocate funds already at its disposal.

People with EOAD who live in poverty may already have access to some benefits including Supplemental Security Income and Medicaid.\textsuperscript{253} The cut-off income for these programs is very low; many poorer Americans with EOAD who are above the bar cannot qualify for these programs, but may still need financial assistance.\textsuperscript{254} The Patient Protection and Affordable Care Act expands Medicaid to include people with incomes up to 133\% of the poverty line, which is $14,404 for individuals.\textsuperscript{255}

There are still multiple problems facing those with EOAD that are not addressed by Congress’s health care plan. First, the legislation does not provide benefits that would increase access to nursing home facilities for younger Americans who need full-time assistance and care.\textsuperscript{256} Second, the legislation does not address the non-health care problems experienced by people with EOAD such as the financial hardships that may occur as the result of job loss. Thus, SSDI will still play the most significant role in supporting those with EOAD.

\begin{itemize}
  \item \textsuperscript{248} See H.R. 3962, supra note 230; H.R. 3590, supra note 231.
  \item \textsuperscript{249} H.R. 3962, supra note 230.
  \item \textsuperscript{250} See H.R. 3962, supra note 230.
  \item \textsuperscript{251} See id. If the public option health insurance program is made up predominately of high-risk individuals, including people with EOAD, the program may be unable to provide complete coverage for all program members while simultaneously providing premiums low enough to be affordable.
  \item \textsuperscript{253} Jordan Rau et al., supra note 237. See supra Part III.A.
  \item \textsuperscript{254} See supra Part II.B.
  \item \textsuperscript{255} § 2001, 124 Stat. at 271. See Jordan Rau et al., supra note 237.
  \item \textsuperscript{256} See supra Part II.B.
\end{itemize}
VI. CONCLUSION

AD is a disease that can affect people of any age. Depending on the age at which it strikes, it may produce hardships different from those that may be experienced by other age groups. Specifically, those with EOAD are much more likely than those with LOAD to have responsibilities such as caring for dependent children, and they may lose the ability to fulfill these responsibilities if they become unemployed or lose health insurance coverage because of their illness. In addition, people who develop EOAD may be forced to retire early and may need to liquidate retirement benefits to support families and cover health care needs.

There are currently three programs that provide the majority of federal financial assistance to individuals with EOAD: Social Security, Medicare and Medicaid. Social Security disability benefits can play a large role in preventing families with EOAD from descending into financial ruin. Although the addition of EOAD to the list of Compassionate Allowances should potentially reduce the number of deserving people with EOAD being denied SSDI benefits, it is too soon to tell whether the Social Security program has been adequately adjusted to meet the needs of people with EOAD. Medicare may be available to those with EOAD, but only after waiting two years from the date SSDI benefits begin. Medicaid can provide funds needed for nursing home care, but eligibility requirements are so difficult to meet that families are choosing to divorce so that a spouse can receive the care he or she needs.

The United States health care and benefits systems are designed to target aid to specific groups of people deemed worthy of receiving benefits. Particularly, the benefits programs are designed to help both the elderly and the extremely poor. Medicare, for instance, is much more accessible to the elderly than to people with EOAD. Because the federal government has taken the initiative to provide benefits to the people, it has a constitutional responsibility to provide those benefits fairly to all classes of people. This responsibility is rooted in both the Fourteenth Amendment's Equal Protection Clause and the Fifth Amendment's Due Process Clause.

There are multiple challenges that can be made to the constitutionality of the current health care and disability programs and their methods of benefits distribution. Specifically, these programs may be unconstitutional because they unfairly classify individuals with LOAD as worthy of receiving benefits that are denied to, or harder to obtain for, people with EOAD. While the United States Supreme Court has already addressed and rejected many of the elements of these constitutional challenges, the specific challenges in this note have yet to be made to, and considered by, the Court. Furthermore, the challenges illustrate the effective discrimination against people with EOAD in regard to the distribution of benefits.

The federal government has taken steps to provide greater access to benefits for citizens who need them. The two-year wait for Medicare has also been opposed in the legislature. By eliminating the wait, the government would
help increase family stability and prevent some families from falling into debt. In 2009, President Obama spurred members of Congress to create legislation that would provide most Americans with easier access to health insurance. In March of 2010, the Patient Protection and Affordable Care Act was approved by Congress and signed into law by the President. Of particular importance to people with EOAD, is that this legislation forbids insurance companies from denying insurance coverage to people with pre-existing conditions. Under this new legislation, individuals with EOAD who want health insurance will have access to it.

Although the federal government has taken great strides toward providing adequate benefits to disabled persons, including those with EOAD, many important needs of people with EOAD have not been addressed. The government has a Constitutional duty to provide benefits fairly, and thus, it must engage in further reform to adequately provide benefits for individuals with EOAD.

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