XV. Social Security and Public Welfare

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This inaugural Survey Article recognizes the substantial and increasing importance of Indiana law and of the relationship between state and federal law in the frequently litigated area of social security and public welfare. As is typical of the area, the relevant law has changed rapidly on several fronts during the past survey period. If any underlying theme emerges, it is that of an increased tension between the laudable goals of welfare-oriented policies and perceived budgetary constraints. A generally positive result of this unfortunate clash of priorities has been an enhanced concern for program fiscal integrity.

A. Indiana Medicaid Law

1. Medicaid Co-Payments and Injunctive Relief.—In *Claus v. Smith,*[1] the plaintiff Medicaid recipients sought to preliminarily enjoin the Indiana Department of Public Welfare from requiring, in its discretion, nominal payments by a recipient for certain nonmandatory Medicaid services.[2] The district court ordered the injunction based on findings of a substantial likelihood of plaintiffs' success on the merits and of irreparable harm to the plaintiffs were the co-payment scheme to be effected.[3]

Of interest in this case was the unusually generous irreparable harm determination. The court found that such harm was "certain to result in this case"[4] but went on to elaborate that:

> The plaintiffs . . . *may not* be able to afford the nominal co-payment. Thus, the imposition of a co-payment requirement *may* result in their failure to obtain certain non-mandatory Medicaid services. Failure to obtain medical services *can* result

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[1]519 F. Supp. 829 (N.D. Ind. 1981).

[2]The Indiana statutory authority for imposing these charges is Ind. Code § 12-1-7-16(c), (d) (Supp. 1981) (amended 1982 to exempt additional nonmandatory services from being subject to co-payment). Ind. Code § 12-1-7-14.9 (Supp. 1981) (amended 1982), referred to in statutory subsection (c) above, was construed in Wilson v. Stanton, 424 N.E.2d 1042 (Ind. Ct. App. 1981).

[3]519 F. Supp. at 831. *Contra* Crane v. Mathews, 417 F. Supp. 532, 539-40 (N.D. Ga. 1976). Experimental co-payment requirements have been upheld under Medi-Cal in California Welfare Rights Org. v. Richardson, 348 F. Supp. 491 (N.D. Cal. 1972).

[4]519 F. Supp. at 831. The court in *Crane v. Mathews* found the threatened harm too speculative. 417 F. Supp. at 540. The court in *Claus* may have considered *Crane* irrelevant in view of the temporary nature of the co-payment program in *Crane.*

> in medical problems becoming worse or even untreatable. Implementation of the co-payment scheme *would* result in irreparable harm to the plaintiffs.[5]

Given this language and the absence of a finding that the plaintiffs would require nonexempt, nonmandatory Medicaid services, and particularly in light of the Department's statutory discretion to waive co-payment requirements in cases of undue hardship,[6] any irreparable harm threatened in this case would, in the court's own implicit admission, seem highly contingent and speculative rather than "certain."

Elsewhere, a court has held that "[a]llegations of mere speculative or contingent injury, with nothing to show in fact that it will occur, are insufficient to support a prayer for injunctive relief."[7] This restrictive approach to injunctive relief is grounded in the traditional cautious reluctance to grant such an extraordinary remedy.[8] It may be argued, though, that the court in *Claus* did no more than extend the kind of interest-balancing undertaken in a due process context by the Supreme Court in *Goldberg v. Kelly*[9] to the context of a preliminary injunction request.

2. Medicaid Reimbursement and Subrogation Rights.—In *State v. Cowdell,*[10] the State of Indiana and the Department of Public Welfare appealed a circuit court judgment awarding them only a one-fifth reimbursement of Medicaid funds expended by them from the proceeds of a litigation settlement between the Medicaid recipient and the injuring party. On appeal, no abuse of discretion was found.[11]

The plaintiffs in this case relied on a state administrative regulation allowing state subrogation to the claims of Medicaid recipients "to the extent of Medicaid benefits received by the recipients . . . ."[12] On appeal, the court found this language consistent with the nature of subrogation as an equitable doctrine, the extent of its application, therefore, being subject to the equities of the particular case.[13] In this

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[5]519 F. Supp. at 831 (emphasis added).

[6]IND. CODE § 12-1-7-16(d) (1982).

[7]Stephens v. Bacon Park Comm'rs, 212 Ga. 426, 428, 93 S.E.2d 351, 351-52 (1956). *See also* Powell v. Garmany, 208 Ga. 550, 67 S.E.2d 781 (1951).

[8]*See, e.g.,* Barcelo v. Brown, 478 F. Supp. 646 (D.P.R. 1979); Orion Broadcasting, Inc. v. Forsythe, 477 F. Supp. 198 (W.D. Ky. 1979); Rivera v. Blum, 98 Misc. 2d 1002, 420 N.Y.S.2d 304 (Sup. Ct. 1978).

[9]397 U.S. 254, 261 (1970) (balancing "brutal need" against possible additional public expense in passing on the need for a pretermination hearing for welfare recipients).

[10]421 N.E.2d 667 (Ind. Ct. App. 1981).

[11]*Id.* at 672.

[12]470 IND. ADMIN. CODE § 5-1-11 (1979). County departments of public welfare are now accorded subrogation rights under IND. CODE § 12-5-6-9 (1982). The federal statute and regulation mandating this subrogation action were discussed in another context in 81 Op. Att'y Gen. 15 (May 15, 1981).

[13]421 N.E.2d at 671.

instance, however, the only unaccounted-for equity was the plaintiffs' failure to pay their pro rata share of the Medicaid recipient's attorney fees in obtaining the tort settlement. Although the court cited an analogous New Mexico case[14] involving an almost equally serious disparity between the subrogation award and extent of the subrogee's payment to the subrogor, the court failed to give guidance as to its reasoning in finding no abuse of discretion in the trial court award. Examples of more explicitly justified and more generous subrogation awards, however, can be found in Indiana and elsewhere.[15]

3. Deemed Availability of Noninstitutionalized Spouse's Funds for Medicaid Eligibility Purposes.—Brown v. Smith[16] was the result of the Supreme Court's memorandum decision in *Stanton v. Brown*[17] to vacate the Seventh Circuit's judgment in *Brown v. Stanton*[18] and to remand the case in light of the Supreme Court case of *Schweiker v. Gray Panthers.*[19]

In *Gray Panthers,* the Court had held that, for Medicaid entitlement and benefit amount determinations, Congress had authorized[20] the states, under appropriate circumstances, to impute to an institutionalized spouse the income or resources of a noninstitutionalized spouse.[21] The Court stated that:

> "Available" resources are different from those *in hand.* We think that the requirement of availability refers to resources left to a *couple* after the spouse has deducted a sum on which to live. It does not, as respondent argues, permit the State only to consider the resources actually paid by the spouse to the applicant.[22]

The Court cited Judge Pell's opinion, concurring in part and dissenting in part in *Brown v. Stanton,* for the impracticality of requiring states to first adjust upwards the institutionalized spouse's Medicaid

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[14]White v. Sutherland, 92 N.M. 187, 585 P.2d 331 (1978).

[15]*See, e.g.,* Home Owners' Loan Corp. v. Henson, 217 Ind. 554, 29 N.E.2d 873 (1940); Reserve Loan Life Ins. Co. v. Dulin, 69 Ind. App. 363, 122 N.E. 3 (1919). *See also* Stanford v. Aulick, 124 Ariz. 487, 605 P.2d 465 (1979); Colonial Penn Ins. Co. v. Ford, 172 N.J. Super. 242, 411 A.2d 736 (Law Div. 1979); Columbia County v. Randall, 49 Or. App. 643, 620 P.2d 937 (1980). If the Department acts before final settlement, the *Cowdell* subrogation problem may now be avoidable under a new provision of the Indiana Code. IND. CODE § 12-1-7-24.6 (1982).

[16]662 F.2d 464 (7th Cir. 1981).

[17]453 U.S. 97 (1981).

[18]617 F.2d 1224 (7th Cir. 1980).

[19]453 U.S. 34 (1981).

[20]*See* 42 U.S.C. § 1396a(a)(17)(B), (D) (1976). The provision is discussed in another context in 81 Op. Att'y Gen. 15 (May 11, 1981).

[21]453 U.S. at 48.

[22]*Id.* (emphasis in the original).

benefits and then proceed under a state spousal support statute to attempt to obtain reimbursement from a recalcitrant noninstitutionalized spouse.[23]

On remand, the court in *Brown v. Smith* held that although *Gray Panthers* had sanctioned, in the abstract, Medicaid deeming or the imputation of spousal income, the Court had left untouched the requirement of an "individualized factual determination of the noninstitutionalized spouse's needs in computing the potentially available funds subject to deeming."[24] This requirement seems administratively manageable as long as the burden of showing unavailability of the apparently available funds is shouldered by the claimant's spouse with some verification of expenses required. The cost of individualized determinations would further seem worth paying if such a procedure obviated any necessity for a divorce or for a reduction in part-time work effort based on the press of financial necessity.

4. Medicaid Benefit Termination and the Exhaustion Requirement.—In *Evans v. Stanton,*[25] the court of appeals upheld the dismissal of the plaintiff's complaint against the Indiana and Marion County Departments of Public Welfare. The plaintiff's Medicaid benefits had been terminated without a prior hearing because of the plaintiff's failure to timely file for appeal. The plaintiff sought reinstatement, damages for medical expenses and due process violations, attorney fees, class action certification, and declaratory and injunctive relief.

The court of appeals, in this case, required exhaustion of administrative remedies on the grounds that the plaintiff's constitutional claims were pressed not alone but in conjunction with unresolved factual claims regarding his continuing eligibility and on the grounds that "expedient administrative procedures" were available.[26] An additional consideration was the Public Welfare Departments' relative expertise in administering the challenged regulations.[27]

Waiver of administrative exhaustion requirements has been recommended under similar circumstances.[28] The appellate court referred

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[23]*Id.* at 46. Judge Pell's language has been further quoted by Chief Justice Burger, dissenting in Herweg v. Ray, 102 S. Ct. 1059, 1069 (1982). *Gray Panthers* is discussed briefly in Note, 20 J. FAM. L. 369 (1982).

[24]662 F.2d at 468 (citing Schweiker v. Gray Panthers, 453 U.S. 34, 49 n.21 (1981)). The Seventh Circuit's prior discussion of this requirement is in Brown v. Stanton, 617 F.2d 1224, 1227-28 (7th Cir. 1980).

[25]419 N.E.2d 253 (Ind. Ct. App. 1981).

[26]*Id.* at 255. *Compare id.* (no finding of such severe or imminent harm as would justify waiver of exhaustion) *with* Claus v. Smith, 519 F. Supp. 829, 831 (N.D. Ind. 1981) (finding irreparable harm substantial enough to justify preliminary injunction). *See supra* text accompanying notes 4-6.

[27]419 N.E.2d at 255 (discussing 470 IND. ADMIN. CODE § 9-7-3 (1979)).

[28]*See* Rosenberg, *Overseeing the Poor: A Legal-Administrative Analysis of the Indiana Township Assistance System,* 6 IND. L. REV. 385, 393-94 (1973).

to several Indiana exhaustion cases[29] without discussing the occasionally illuminating and generally more liberal federal authority. The holding in *Evans* may be instructively contrasted with that of the Supreme Court in the well-known case of *Mathews v. Eldridge,*[30] as acutely expounded by Professor Davis:

> The holding [of *Eldridge*] is, in precise terms, that a reviewing court may decide a question not raised before the agency and may decide a constitutional issue when the moving party has not exhausted administrative remedies on nonconstitutional issues . . . even when "the only avenue for judicial review" is a statute which requires exhaustion "*as a jurisdictional prerequisite,*" . . . even when the party seeking review is entitled to apply for a reconsideration, including a hearing, and does not do so, . . . even when the agency on reconsideration might reach a favorable decision which would make a determination of the constitutional question unnecessary . . . .[31]

In sum, while the result in *Evans* seems sound, it is to be hoped that in an appropriate case, specifically, one involving impending significant irreparable medical harm to the plaintiff, each of the numerous considerations recognized in *Evans*[32] militating against waiving exhaustion, including the presence of unresolved factual issues, will be seen to be outweighed.

5. State Participation in Medicaid and Preventive Health Care for Children.—Bond v. Stanton[33] involved a class action civil rights suit contending that Indiana failed to implement an appropriate preventive health care program for children as required[34] of all states participating in the Medicaid program. On appeal, the plaintiffs maintained, and the Seventh Circuit held, that Indiana's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program did not minimally specify what particular tests were required, that Indiana had not identified those Medicaid providers willing and able to perform EPSDT tests, and that the state had not monitored the tests given or required appropriate diagnosis and follow up treatment of examinees.[35]

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[29]Most notably, to Wilson v. Board of Ind. Employment Sec. Div., 385 N.E.2d 438 (Ind.), *cert. denied,* 444 U.S. 874 (1979).

[30]424 U.S. 319 (1976).

[31]K. DAVIS, ADMINISTRATIVE LAW TREATISE § 20.16, at 292-93 (Supp. 1982). *See also* Carter v. Stanton, 405 U.S. 669 (1972) (per curiam) (Indiana welfare regulation case brought in federal court as a section 1983 action; administrative exhaustion not required).

[32]419 N.E.2d at 255 (quoting Indiana Dep't of Welfare v. Stagner, 410 N.E.2d 1348, 1351 (Ind. Ct. App. 1980)).

[33]655 F.2d 766 (7th Cir. 1981).

[34]42 U.S.C. § 1396d(a)(4)(B) (1976).

[35]655 F.2d at 769.

The court reasoned that "[w]ithout a thorough screening, including for example appropriate laboratory tests and a nutritional assessment, two diseases known to be among the leading health problems of poor children—malnutrition and lead poisoning—may well go undetected or unprevented."[36] This analysis compares quite favorably with that of the court in *Wisconsin Welfare Rights Organization v. Newgent.*[37] In *Newgent,* the court correctly noted that the regulatory authority for requiring the extensive testing approved of in *Bond* was of a non-binding interpretive rule character,[38] but the *Newgent* court departed from the spirit of *Bond* in finding that evidence that only 1.5 percent of those examined had received a sickle cell test, or that only 9.3 percent had received a lead poisoning test, did not indicate, without other evidence, a lack of aggressive EPSDT implementation in Wisconsin.[39] Thus, the court in *Bond* was more aggressive than the *Newgent* court with respect to monitoring the administration of the EPSDT program.[40]

B. Uncompensated Hill-Burton Costs as Reimbursable Medicare Costs

In *Johnson County Memorial Hospital v. Schweiker,*[41] the plaintiffs were fifty-one Indiana hospitals that had participated both in the federal Medicare program and in the Hill-Burton Act grant program. Under the latter program, grants for hospital construction or improvement are tied to providing a certain measure of free hospital care not reimbursed under Hill-Burton.[42] Judge Dillin determined that the policy aim of having the costs of treating Medicare beneficiaries borne by the Medicare program and of having Medicare not bear the costs of serving non-Medicare patients was served by interpreting the Hill-Burton free care costs as an imposed legal duty of the hospitals and a proportionately reimbursable indirect cost under the Medicare program.[43] "The Medicare patients benefit from the improved physical plant which results from Hill-Burton grants as they benefit from other . . . 'necessary and proper costs' such as heating and lighting."[44] The cost

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[36]*Id.*

[37]433 F. Supp. 204 (E.D. Wis. 1977) (decided, however, on plaintiff's motion for summary judgment for declaratory and injunctive relief).

[38]*Id.* at 213. *See also* Smith v. Miller, 665 F.2d 172, 179 n.7 (7th Cir. 1981).

[39]433 F. Supp. at 214-15.

[40]*Compare* 655 F.2d at 770 *with* 433 F. Supp. at 211-12, 215. *See also* Rosenbaum, *The Medicaid Early and Periodic Screening Diagnosis and Treatment Program: HEW's New Regulations,* 13 CLEARINGHOUSE REV. 742, 742 (1980) (discussing the need for aggressive EPSDT implementation).

[41]527 F. Supp. 1134 (S.D. Ind. 1981).

[42]42 U.S.C. § 291 (1976 & Supp. IV 1980).

[43]527 F. Supp. at 1139.

[44]*Id.* (citing 42 C.F.R. § 405.451(b)(2) (1980)).

of the free care obligation was found to be so similar to interest payments on building loans that not to classify such free care cost along with the expressly reimbursable interest on borrowed funds would be arbitrary and capricious.[45] Finally, the cost of free care was found not to be excluded from reimbursement as charity because the free care obligation was legally enforceable.[46]

Roughly one month after the decision in *Johnson County Memorial Hospital* was issued, the District Court for the Northern District of Illinois reached a contrary result in *Saint Mary of Nazareth Hospital Center v. Department of HHS.*[47] The court in *Saint Mary of Nazareth Hospital Center* saw the free care costs as excluded charity[48] and found the connection between Hill-Burton construction or modernization and Medicare recipients, in particular, as too attenuated to qualify for reimbursement.[49] The court concluded that "it would be illogical" and in the nature of double-dipping "to obligate hospitals to provide a certain amount of free health care to indigents as compensation for receiving federal funds and then reimburse the hospital, again with federal funds, for the obligation incurred through the initial receipt of federal monies."[50]

This latter contention was recently addressed in *Metropolitan Medical Center v. Harris.*[51] Looking to the legislative history of the Hill-Burton Act, the District Court of Minnesota found "no evidence of any intent to require a hospital to pay for rendering the free care, only that the facilities be made available to all people,"[52] without regard to the hospitalized person's financial position. By itself, however, this policy would not dictate that the participating hospital be technically overcompensated for such free care provision.

C. Tightening of Welfare Benefit Standards

The persistent theme of the impingement of practical budgetary constraints on questions of statutory and regulatory interpretation was manifested in *Foster v. Center Township.*[53] On cross motions for summary judgment, the court in *Foster* found that while a federal

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[45]527 F. Supp. at 1140. Characterizing a failure to classify free care costs with interest payments as "contrary to law" would technically seem a more suitable ground for reversal; it is hardly arbitrary to distinguish the two.

[46]*Id.*

[47]531 F. Supp. 419 (N.D. Ill. 1982).

[48]*Id.* at 422. *Contra* St. James Hosp. v. Harris, 535 F. Supp. 751 (N.D. Ill. 1981).

[49]531 F. Supp. at 421.

[50]*Id.* at 422.

[51]524 F. Supp. 630 (D. Minn. 1981).

[52]*Id.* at 633. *See also* Iredell Memorial Hosp. v. Schweiker, 535 F. Supp. 795, 799 (W.D.N.C. 1982).

[53]527 F. Supp. 377 (N.D. Ind.), *aff'd mem.*, 673 F.2d 1334 (7th Cir. 1981).

statute[54] prevents a state from lowering its guaranteed income level for welfare recipients to take food stamps into account, it is permissible for a state to lower its guaranteed level for other reasons, such as to prevent the insolvency of its welfare benefit system.[55] Because a genuine issue of material fact remained as to Center Township's reason for decreasing the guaranteed income level, the court held that summary judgment was inappropriate.[56]

Authority is available to support the court's determination that congressional intent "was to guarantee that food stamps would be available not in substitution for, but in addition to, any welfare payments already provided by states."[57] The crucial practical problem appears to be the evidentiary one of distinguishing a proscribed indirect linkage of benefit levels to food stamp availability from reduction of or failure to increase benefit levels because of perceived budget constraints. To a certain extent, these two justifications may not even be conceptually distinct.

In *Stanton v. Smith,*[58] the action of the Indiana State Welfare Board in ratably reducing, by twenty-five percent, the financial standards measure used to determine minimum essential needs for Aid to Families With Dependent Children (AFDC) recipients was challenged on the typically unavailing grounds of improper legislative delegation. The legislature had specified simply that such reduction was to be carried out and could not exceed thirty-five percent.[59] The Welfare Board, thereupon, held hearings to select a suitable reduction percentage. The Attorney General and the Governor were privy to the hearings and, with the Department of HEW, approved the Welfare Board's twenty-five percent reduction figure.[60] The supreme court held that the delegation was not improper in view of the existence of legislative standards designed to guide the exercise of the Welfare Board's discretion.[61]

It is clear that one of the Welfare Board's guidelines was the state's statutory obligation "to provide minimum standards of assistance which would provide reasonable subsistence to the most

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[54]7 U.S.C. § 2017(b) (Supp. IV 1980).

[55]527 F. Supp. at 379.

[56]*Id.*

[57]*Id. See, e.g.,* Dupler v. City of Portland, 421 F. Supp. 1314 (D. Me. 1976). For a discussion of some of the tenth amendment issues inherent in this type of statute, see State v. Schweiker, 655 F.2d 401, 411-14 (D.C. Cir. 1981).

[58]429 N.E.2d 224 (Ind. 1981). For further discussion of this case, see Smith, *Administrative Law, 1982 Survey of Recent Developments in Indiana Law,* 16 IND. L. REV. 1, 22 (1983).

[59]429 N.E.2d at 225.

[60]*Id.* at 228.

[61]*Id.*

needy children."[62] What is not indicated by the opinion is how the selected reduction figure relates to this standard, or more generally, how this figure relates to any policy or evidentiary basis for choosing the twenty-five percent reduction as opposed to any other particular figure between zero and thirty-five. While the reasoning process of the Welfare Board was not called into question on review, it does not seem appropriate to conclude, as the supreme court did, that "the action taken [by the Welfare Board] was subject to sufficient input and control to prevent arbitrary action."[63] Arbitrariness is most directly controllable through a required statement of reasons or grounds for the administrative rule promulgated, rather than through official participation.[64]

D. Local Welfare Assistance

The legal relationship between the township trustee and the county board of commissioners was at issue in *Perry Township v. Hedrick.*[65] In *Hedrick*, the court of appeals affirmed the trial court's grant of a writ of mandamus to compel the trustee to comply with the board of commissioners' order to pay the plaintiff's delinquent utility bill.[66] The commissioners had reversed the trustee's initial denial of assistance to the plaintiff, Hedrick, and the court of appeals held that from that point, "the trustee was under a clear legal duty to comply with the order by performing the ministerial act of paying Hedrick's delinquent electric bill."[67] The court noted that "[n]o provision in the general assistance statute is made for the trustee to appeal the Commissioners' decision."[68]

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[62]*Id.*

[63]*Id.*

[64]*See generally* 5 U.S.C. § 553(c) (1976); 1 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 6:12 (1978 & Supp. 1980). Indiana statutory provisions on Welfare Board administrative rulemaking impose no comparable "statement of purpose" requirement. *See* IND. CODE §§ 4-22-2-4, -5 (1982); IND. CODE §§ 12-1-2-2, -3 (1982). *But see* Greenberg, *Administrative Law, 1980 Survey of Recent Developments in Indiana Law,* 14 IND. L. REV. 65, 68-69 (1981). The value of a statement of reasons requirement even in the absence of statutory mandate is extolled in Tri-State Generation and Transmission Ass'n v. Environmental Quality Council, 590 P.2d 1324, 1330-31 (Wyo. 1979), and a statutory mandate itself is endorsed in the 1981 MODEL STATE ADMIN. PROCEDURE ACT § 3-110, 14 U.L.A. 66 (Supp. 1982).

[65]429 N.E.2d 313 (Ind. Ct. App. 1981).

[66]*Id.* at 318.

[67]*Id.* at 317. *See* Rosenberg, *Overseeing the Poor: A Legal-Administrative Analysis of the Indiana Township Assistance System,* 6 IND. L. REV. 385, 393 (1973).

[68]429 N.E.2d at 317. A somewhat similar issue was determined in accord with the *Hedrick* result in Smythe v. Lavine, 76 Misc. 2d 751, 351 N.Y.S.2d 568 (Sup. Ct. 1974) (county social service commissioner not empowered to seek judicial review of immediate supervisor's aid determination). In Attorney General v. Board of Pub. Welfare,

The lack of symmetry between the individual claimant's right to appeal[69] and that of the trustee should not be disturbing, especially in view of the trustee's ability to make subsequent eligibility determinations with respect to the claimant.[70] If the Indiana statutory characterization of the trustee as the "overseer of the poor"[71] is to be meaningful in this context, it must imply a diminished sense of legal adversariness on the part of the trustee.[72] The smooth functioning of county government also weighs in this direction, and the burden of administrative and judicial appellate delay on potential welfare recipients[73] is obviously substantial.[74]

E. Social Security Disability Claims

The manipulability and occasional harshness of substantial evidence review were successively manifested in two significant disability benefit decisions handed down by the Seventh Circuit.

In *Cassiday v. Schweiker,*[75] the Court of Appeals for the Seventh Circuit reversed a denial of Social Security disability benefits by Chief Judge Eschbach of the Northern District of Indiana.[76] The case

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328 Mass. 446, 104 N.E.2d 496 (1952), mandamus was held to lie to compel a local board of public welfare to make payments in accordance with a determination by the state department of public welfare.

[69]*See* IND. CODE § 12-2-1-18 (1982). Appeal of general assistance aid denials in Indiana is discussed in Note, *General Assistance Programs: Review and Remedy of Administrative Actions in Indiana,* 47 IND. L.J. 393 (1972).

[70]*See* IND. CODE § 12-2-1-6.3 (1982).

[71]*Id.* § 12-2-1-18.

[72]It might be said that the trustee owes a divided quasi-fiduciary duty to both current claimants and to future claimants, with the latter embodying the value of the integrity of funding. In an analogous setting, the Secretary is not afforded an appeal of administrative decisions in favor of Social Security Supplementary Security Income claimants beyond that provided for in 20 C.F.R. § 416.1455 (1981).

[73]*See* Goldberg v. Kelly, 397 U.S. 254, 261 (1970) (discussing termination, as opposed to the initial granting, of benefits).

[74]While *Hedrick* was the most significant state welfare system case decided on appeal during the past survey period, several cases merit at least brief mention. In Vanderburgh County Dep't of Pub. Welfare v. Prindle, 419 N.E.2d 239 (Ind. Ct. App. 1981), the court of appeals located the responsibility for medical and hospital care of Indiana resident indigents injured out of state but treated in state with the county of the indigent's residence. This result has not been changed by the repeal of the statute involved nor by enactment, effective January 1, 1982, of the new governing statute, IND. CODE §§ 12-5-6-1 to -11 (1982). The problem in Trustees of Indiana Univ. v. County Dep't of Pub. Welfare, 426 N.E.2d 74 (Ind. Ct. App. 1981) of eligibility standards for hospital assistance is now resolved by section 12-5-6-2(c) of the Indiana Code and by regulations promulgated thereunder. *See* 470 IND. ADMIN. CODE § 11-1-1 (Supp. 1982).

[75]663 F.2d 745 (7th Cir. 1981).

[76]Chief Judge Eschbach joined the Seventh Circuit on December 12, 1981, some five weeks after the Seventh Circuit's decision in *Cassiday.*

developed from a decision by Indiana Rehabilitation Services[77] to discontinue Mrs. Cassiday's benefits on the grounds that her symptoms[78] no longer prevented her from engaging in substantial gainful employment.[79]

On appeal, the Seventh Circuit conceded the difficulty in evaluating the claim in question but found the Administrative Law Judge's (ALJ) approach to the evidence to be "highly selective"[80] and arbitrary, not in any particular instance, but in cumulative effect.[81] Neither the decision to terminate benefits nor the ALJ's determination that the claimant had willfully refused prescribed treatment was found to be based on substantial evidence in the record.[82]

Substantial evidence in the record, as a whole, has been classically described as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion"[83] or as "enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury."[84] In this case, nine physicians[85] either treated, examined, or reviewed the claimant or her medical records during the relevant period. The treating physicians apparently tended to view the claimant's condition as more severely disabling than the majority of the examining physicians or the evenly split reviewing physicians. The Seventh Circuit was willing to "direct a verdict," despite this obvious equivocality, in view of case law according the opinion of a treating physician

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[77]In accordance with the national pattern, Indiana Rehabilitation Services acts under contract with the Social Security Administration. 663 F.2d at 746.

[78]*Id.* (the symptoms included "pain, numbness, tingling, and weakness in her arms and hands" and chest pain, brought on by occlusion of blood vessels and nerve root compression).

[79]*Id. See* 42 U.S.C. § 423 (1976 & Supp. IV 1980); 20 C.F.R. §§ 404.1501 to -.1574 & app. 2 (1981).

[80]663 F.2d at 749.

[81]*Id.* at 748.

[82]*Id.* at 750.

[83]Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938), *quoted in* NLRB v. Columbian Enameling & Stamping Co., 306 U.S. 292, 300 (1939). *See also* Richardson v. Perales, 402 U.S. 389, 401 (1971); Universal Camera Corp. v. NLRB, 340 U.S. 474, 477-87 (1951).

[84]NLRB v. Columbian Enameling & Stamping Co., 306 U.S. 292, 300 (1939).

[85]Inefficient over-utilization of expensive physician time in the disability adjudication process is common. *See* Richardson v. Perales, 402 U.S. 389 (1971) (six examining physicians and one reviewing physician relied upon); Oldham v. Schweiker, 660 F.2d 1078 (5th Cir. 1981) (eight examining physicians and one examining psychologist involved); Anderson v. Schweiker, 651 F.2d 306 (5th Cir. 1981) (ten examining physicians involved); Roy v. Secretary of HHS, 512 F. Supp. 1245 (C.D. Ill. 1981) (six examining physicians); Schlabach v. Secretary of HEW, 469 F. Supp. 304 (N.D. Ind. 1978) (six physicians involved).

greater weight than that of a physician who has examined the claimant only once.[86]

Ideally, this case would have been remanded for vocational expert testimony. What should be sought from physicians is their opinion as to a claimant's physical or medical condition, not whether the claimant falls into the legal category of "disabled," or even whether the claimant's relationship to the relevant job market is such that she is capable of "sedentary light work" or "light sedentary work."[87] Each of the latter quoted expressions is legally meaningless under the applicable disability regulations.[88]

The Seventh Circuit also found insufficient evidence to sustain the ALJ's determination that the claimant's case fell under the regulation barring disability status to one who willfully refuses prescribed treatment.[89] The appellate court declared its willingness to hang the weight of a disability determination on the distinction between a physician's "prescribing" surgery—an unidiomatic usage in itself—and "recommending" surgery. The claimant's reasons for declining treatment may be frivolous or amount to sheer opportunism as long as the latter characterization, and not the former, is applied to the physician's remedy.

In the second disability benefits case, Judge Posner of the Seventh Circuit applied the substantial evidence standard far more deferentially. In *Cummins v. Schweiker,*[90] the court of appeals upheld the denial of disability benefits by the District Court for the Northern District of Indiana, relying in part on the controversial new medical-vocational guidelines or grid regulations.[91]

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[86]*See* Allen v. Weinberger, 552 F.2d 781, 786 (7th Cir. 1977). *Cf.* Cummins v. Schweiker, 670 F.2d 81, 84 (7th Cir. 1982) (refusing to accord decisive weight to the opinion of a long-time family physician).

[87]663 F.2d at 747. Increased use of vocational expert testimony would also mitigate any perceived battles between government-employed physicians and sympathetic family physicians. *Compare* Cummins v. Schweiker, 670 F.2d 81, 84 (7th Cir. 1982) *with* Richardson v. Perales, 402 U.S. 389, 414 (1971) (Douglas, J., dissenting).

[88]*See* 20 C.F.R. § 404.1567 (1981).

[89]*See id.* § 404.1518 (1980).

[90]670 F.2d 81 (7th Cir. 1982).

[91]20 C.F.R. §§ 404.1501 to -.1569 & app. 2 (1981). Under these regulations, a severely impaired claimant prevented from doing his past work and not currently doing significant work is categorized based on the level of work exertion he is capable of, his age, education, and nature of work experience, and the transferability of any acquired job skills to other job settings. The individual findings are then simply programmed into the appropriate Appendix 2 Grid. Nonexertional limitations aside, if the precise combination of findings in a given case is explicitly provided for in one of the grids, the claimant is determined by the grid to be disabled or not disabled. Administrative notice has been taken in the rules themselves of the number of unskilled jobs at various exertional levels that exist throughout the national economy. 20 C.F.R. app. 2 § 200.00 (1981); Decker v. Harris, 647 F.2d 291, 297 (2d Cir. 1981). The regulations discuss the

The claimant in *Cummins* was forty-nine years old, of limited education, arthritic in his knees and right shoulder, mildly weakened in his right side due to an automobile accident, and had suffered, outside the record on appeal, a recent heart attack. A potentially significant nonexertional limitation was his blindness in one eye. By implication, the claimant would have been found disabled had he been fifty years old, had unimpaired binocular vision, and suffered no heart attack.

While Judge Posner recognized in *Cummins* that the statutory criteria for disability are quite strict and that disability is not synonymous with unemployment or even unemployability,[92] the *Cummins* decision left uncertain the status of other undiscussed, recent Seventh Circuit cases of a more liberal bent. Where Judge Posner writes of the claimant in *Cummins* that "[p]ossibly his prospects of obtaining substantial gainful employment of any kind . . . have never been more than theoretical,"[93] the Seventh Circuit has previously held that "[t]he mere theoretical ability to engage in substantial, gainful activity is insufficient to defeat an applicant's claim for disability benefits."[94]

Judge Posner's opinion upholds the grid regulations[95] against a challenge to the effect that the regulations attempt, contrary to statute, to dispense with the need for evidence of the existence, in substantial numbers, of suitable jobs. The difficulty inherent in cross-examining a grid as to whether particular unspecified sorts of jobs are genuinely suitable for the claimant has rendered the grid regulations controversial,[96] despite their laudable aim of streamlining the

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claimant's right to rebuttal only in the context of the various factual determinations programmed into the grid, and not in the context of linking specific existing job types with the claimant's capacities. 20 C.F.R. app. 2 § 200.00 (1981); Geoffroy v. Secretary of HHS, 663 F.2d 315, 318 (1st Cir. 1981).

[92]*See* 20 C.F.R. § 404.1566(c) (1981).

[93]670 F.2d at 84.

[94]Smith v. Secretary of HEW, 587 F.2d 857, 861 (7th Cir. 1978) (per curiam). *See also* Stark v. Weinberger, 497 F.2d 1092 (7th Cir. 1974); Schlabach v. Secretary of HEW, 469 F. Supp. 304, 316 (N.D. Ind. 1978) (focusing on the unrealism of supposing that an employer would actually hire anyone with the impairments of the claimant).

[95]670 F.2d at 83-84. *See supra* note 91 and accompanying text.

[96]*See, e.g.*, Chapman v. Schweiker, No. 81-1025 (10th Cir. Feb. 26, 1982) (available June 28, 1982, on LEXIS, Genfed library, Newer file); Kirk v. Secretary of HHS, 667 F.2d 524 (6th Cir. 1981) (upholding the regulations against several statutory and constitutional objections); Salinas v. Schweiker, 662 F.2d 345, 349 (5th Cir. 1981) (allowing the use of administrative notice of jobs which claimant could perform in lieu of calling a vocational expert to testify) (citing Frady v. Harris, 646 F.2d 143, 144-45 (4th Cir. 1981)). *But see* Davis v. Schweiker, 536 F. Supp. 90 (N.D. Cal. 1982); Santise v. Harris, 501 F. Supp. 274, 277 (D.N.J. 1980) (discussed in *Cummins*), *rev'd sub nom.* Santise v. Schweiker, 676 F.2d 925, 935 (3d Cir. 1982) (favorably citing Judge Posner's opinion in *Cummins*). *See also* Desedare v. Secretary of HEW, 534 F. Supp. 21 (W.D. Ark.

disability adjudication process and increasing the uniformity of result.[97]

F. Statutory Developments

In addition to the legislative enactments mentioned in connection with particular cases above, the past survey period was marked by numerous potentially significant statutory developments.

The legislature, in one enactment, defined Community Action Agencies and community action programs aimed at poverty reduction.[98] The legislature charged such agencies to be broadly representative in composition and emphasized utilizing private sector resources in closing social service gaps, coordinating the variety of social service programs available, and focusing available resources on the most needy persons.[99]

Similarly, the legislature established a department on aging and community services and a state commission on the aging and the aged thereunder.[100] The legislative emphasis is on service coordination and research, as well as advocacy, in areas such as health and nutrition, transportation, and housing and employment counseling. Also, the role of senior volunteer programs and the value of participation by the aged in community life is noted.[101]

Attorneys will note the absence, in the statute, of any explicit recognition of the need of older citizens for the provision of legal services.[102] In this area, as in others, the availability and stability of

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1981); Stewart v. Harris, 508 F. Supp. 345 (D.N.J. 1981). Probably the most trenchant criticism of the regulations relied upon in *Cummins* is to be found in Campbell v. Secretary of HHS, 665 F.2d 48, 53-54 (2d Cir. 1981); Decker v. Harris, 647 F.2d 291, 298-99 (2d Cir. 1981); and Fisher v. Schweiker, 514 F. Supp. 119, 121 (W.D. Mo. 1981). In turn, *Decker* has been criticized in Torres v. Secretary of HHS, 677 F.2d 167, 169 (1st Cir. 1982). The most recent case on point is Broz v. Schweiker, 677 F.2d 1351, 1360 (11th Cir. 1982) (striking down the grid's conclusive determination that persons age 49 are able to adjust to new unskilled sedentary work as improperly ignoring the distinction between legislative and adjudicative facts).

[97]*See* 670 F.2d at 83.

[98]IND. CODE §§ 12-1-21-1 to -9 (1982).

[99]*Id.*

[100]*Id.* §§ 4-27-1-1 to -4-3.

[101]*Id.* § 4-27-3-1. The State of California provides an interesting contrast in more explictly recognizing the role of older citizens as a collective social resource. "Older persons constitute a fundamental resource of the state which previously has been undervalued and poorly utilized, and . . . ways must be found to enable older people to apply their competence, wisdom, and experience for the benefit of all . . . ." CAL. WELF. & INST. CODE § 9001(a) (West Supp. 1982). California thus approaches an explicit distinction between older citizens as a productive community resource and older citizens as social service consumers. It is arguable that the retired person seeking part-time paid employment has less of an immediate community of interest with the chronically impaired aged than with the active workforce.

[102]In contrast, see CAL. WELF. & INST. CODE § 9002(f)(8) (West Supp. 1982).

state funding is of perhaps greater concern than coordination and efficient utilization of programs, and Indiana has declined to follow emulable models in this respect.[103]

In a related welfare area, an Indiana rehabilitation services agency was established to receive gifts and bequests, to initiate and operate programs related to the vocational rehabilitation of blind, visually impaired, and handicapped persons, and to operate, with federal government approval, a disability determination division for the purpose of adjudicating disability insurance and supplemental security income claims under Social Security.[104]

Under another act,[105] "health facilities" was defined[106] and an Indiana health facilities council established, with the latter being empowered to adopt rules to protect patient health, safety, rights, and welfare, along with the authority to conduct unannounced inspections[107] of health care facilities and to recommend to the State Board of Health with respect to the issuance and revocation of licenses. Provision is made for investigation and confidentiality of complaints, and for imposition of appropriate sanctions for rule violations. The most serious and unmitigated violations may result, after June 30, 1983, in the state health commissioner's ordering immediate corrective action and imposing a fine of up to $10,000,[108] along with license revocation by the health facilities council on the commissioner's recommendation.

Also, a nursing home prescreening program was established[109] that generally requires prior screening and approval for placement in a nursing home by a multidisciplinary screening team "if the person is currently or will within two (2) years be financially eligible for assistance under the Federal Medicaid Program . . . for the payment of any part of the cost of care provided in a health facility."[110] The

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[103]*See, e.g.*, N.Y. EXEC. LAW §§ 536-a4(b), 541 (McKinney 1972 & Supp. 1972-1981) (providing for at least partial or limited state reimbursement of approved local expenditures for community services to the elderly).

[104]IND. CODE §§ 16-7-17-1 to -15 (1982).

[105]*Id.* §§ 16-10-4-1 to -29.

[106]*Id.* § 16-10-4-2(a). Significant exclusions are made with respect to the scope of "health facility." *See id.* § 16-10-4-2(b).

[107]*Id.* § 16-10-4-7(b). For an excellent discussion of the fourth amendment constitutionality of unannounced warrantless inspections of health care facilities limited by statute to reasonable times, see People v. Firstenberg, 92 Cal. App. 3d 570, 155 Cal. Rptr. 80 (1979), *cert. denied*, 444 U.S. 1012 (1980).

[108]IND. CODE § 16-10-4-15(c)(1)(A) (1982). For a thorough discussion of several issues involved in the imposition of substantial civil fines by administrative agencies, see Lloyd A. Fry Roofing Co. v. Pollution Control Bd., 46 Ill. App. 3d 412, 361 N.E.2d 23 (1977).

[109]IND. CODE §§ 12-1-22-1 to -6 (1982).

[110]*Id.* § 12-1-22-2(a). *Cf.* ARIZ. REV. STAT. ANN. § 11-293 (Supp. 1981) (conditioning eligibility for nursing home placement on preadmission screening of the individual indigent).

screening process involves an assessment of whether placement in a nursing home is appropriate in light of the applicant's medical needs and the availability and cost-effectiveness of alternatives to nursing home care. Nonparticipation by the applicant in the preadmission screening program bars the person's eligibility for Medicaid assistance in connection with services provided by the nursing home for two years after admission.[111]

Finally, the legislature established a State Medicaid Fraud Control Unit[112] under applicable federal statutory authority.[113] Provision is made for the referral of unresolved cases of suspected overpayments or improper payments to Medicaid providers to the Medicaid Fraud Control Unit, which may in turn refer the matter to the appropriate prosecutor.[114]

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[111]This provision is probably defensible against an equal protection or due process challenge in light of the federal statutory mandate of 42 U.S.C. § 1396(a)(26)(A) (Supp. IV 1980) and the "broad discretion" conferred on the states in adopting standards with respect to eligibility for Medicaid assistance. *See* Beal v. Doe, 432 U.S. 438, 444 (1977). *See also* Blum v. Yaretsky, 102 S. Ct. 2777 (1982). The Medicaid "freedom of choice" policy of section 1396(a)(23) would not seem to be literally implicated, though conscientious, religiously based objections to the preadmission screening would raise constitutional questions.

[112]IND. CODE §§ 4-6-10-1 to -2 (1982).

[113]42 U.S.C. § 1396b(q) (Supp. IV 1980). For a discussion of the Federal Medicare-Medicaid Anti-Fraud and Abuse Amendments, see H. MCCORMICK, MEDICARE AND MEDICAID CLAIMS AND PROCEDURES 9-15 (Supp. 1981).

[114]IND. CODE §§ 12-1-7-15.8 to -15.9 (1982).