

LONG-TERM CARE AND THE TAX CODE: A FEMINIST PERSPECTIVE ON ELDER CARE

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ABSTRACT

Elder care is an increasingly important sector in the comprehensive health care matrix in the United States. It is a realm of particular import to women: women live longer, develop degenerative conditions at higher rates than men, and are more likely to receive and provide care. Women earn less income, possess less net wealth, and are far more likely to live in poverty. Public policies regarding elder care add to the increasing strain on women by systematically rejecting home-based caregiving labor as “legitimate” economic activity, rendering it unworthy of subsidized support. As a result, a secondary policy bias develops, favoring institutional (market) elder care over home-based options, which creates demonstrably poor health and life-quality results and adds substantial monetary costs to both affected individuals and taxpayers. This Article examines the state of elder care—especially in the long-term context—and its impact on the lives of women as both care recipients and caregivers. Employing various strains of feminist thought, this Article establishes elder care as an integral component of feminist concern and examines current policy approaches that incorporate tax-based and non-tax-based reforms to stimulate improvements to the elder care industry, raise life quality outcomes, expand elder care choices, and encourage higher participation in caregiving labors in an area of vital need.

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I. INTRODUCTION

Throughout human history, and across cultures, women have assumed the role of primary care providers.¹ This nurturing focus has been principally directed at childcare activities,² but in recent times has expanded to encompass the increasing care needs of an aging population which, ironically, is also mostly comprised of women. Women live longer than men and have higher rates of degenerative physical and mental ailments that require supervised and concentrated care. Old age has often been coined “the second childhood,” but in the context of women’s cultural role as caregivers, this term describes a specific type of dilemma: women need greater care for longer and women bear a massive preponderance of the caregiving responsibilities.³

1. See generally Wendy Wood & Alice H. Eagly, A Cross-Cultural Analysis of the Behavior of Women and Men: Implications for the Origins of Sex Differences, 128 *PSYCHOL. BULLETIN* 699 (2002).

2. Gretchen Livingston, *Opting Out? About 10% of Highly Educated Moms are Staying at Home*, PEW RES. CTR. (May 7, 2014), <http://www.pewresearch.org/fact-tank/2014/05/07/opting-out-about-10-of-highly-educated-moms-are-staying-at-home>. According to Pew Research, approximately ten percent of women with a master’s degree or higher are dropping out of the workforce to care for their children. According to the Social Security administration, females spend twelve years out of work. *Women and Caregiving: Facts and Figures*, NATIONAL CTR. ON CAREGIVING, (Dec. 31, 2003), <https://www.caregiver.org/women-and-caregiving-facts-and-figures> [hereinafter *Women and Caregiving*].

3. Unfortunately, the caring of older women by younger women, either unpaid or lowly paid, ends up perpetuating the feminization of poverty. See Maria Shriver, *The Female Face of Poverty*, THE ATLANTIC (Jan. 8, 2014), <http://www.theatlantic.com/business/archive/2014/01/the-female-face-of-poverty/282892/>; Riane Eisler & Kimberly Otis, *Unpaid and Undervalued Care Keeps Women on the Brink*, SHRIVER REP. (Jan. 22, 2014), <http://shrivereport.org/unpaid-and-undervalued-care-work-keeps-women-on-the-brink/>; Joan Entmacher et al., *Insecure & Unequal: Poverty and Income Among Women and Families 2000-2013*, NAT’L. WOMEN’S L. CTR. (Sept. 2014), http://www.nwlc.org/sites/default/files/pdfs/final_2014_nwlc_poverty_report.pdf; Alexandra Cawthome, *The Straight Facts on Women in Poverty*, CTR. FOR AM. PROGRESS (Oct. 2008), https://www.in.gov/icw/files/women_poverty.pdf.

Elder care⁴ is a feminist issue. Several strains of feminist thought affirm this statement, including the “ethic of care”⁵ associated with Carol Gilligan,⁶ the persistent and increasing feminization of poverty explored in sociological feminist literature,⁷ and the “derivative care” theory of Martha Fineman.⁸ Elder care is also fertile ground for application of the “double bind,” first written about in the feminist context by Martha Chamallas.⁹ We see the manifestation of this in the frequent instances where the interests of those requiring care stand in opposition to those administering the care. These perspectives reveal a critical and damaging divergence between the welfare needs of the truly dependent elder woman (the “care-receiver”) and the unpaid family member or poorly-compensated caregiver (the “care-provider”).

The public policy matrix systemically ignores caregiving labors as “economic” activity on par with the labor produced in the capitalist marketplace.¹⁰ By

4. See I.R.C. § 7702B(c)(1) (2012) (called into question by *Dragovich v. U.S. Dep’t of Treasury*, 872 F. Supp. 2d 944) (N.D. Cal. 2012); see also Peggie R. Smith, *Who Will Care for the Elderly?: The Future of Home Care*, 61 BUFF. L. REV. 323, 326 (2013) [hereinafter Smith, *Who Cares for the Elderly*]. Broadly understood, long-term care services are “services that assist the elderly with daily activities, such as dressing, bathing, toileting, eating, shopping, cooking, cleaning, taking medications, and visiting healthcare providers.” Peggie R. Smith, *The Future of Family Caregiving*, in *WOMEN WHO OPT OUT: THE DEBATE OVER WORKING MOTHERS AND WORK-FAMILY BALANCE* 119, 121 (Bernie D. Jones, ed., 2012).

5. See Rebecca Korzec, *A Feminist View of American Elder Law*, 28 U. TOL. L. REV. 547, 549 (1997). I do not reject the traditional concepts of “autonomy, personal responsibility, rationality, and individualism” in favor of “solidarity, empathy, and community responsibility.” *Id.*

6. See generally Carol Gilligan, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN’S DEVELOPMENT* (1993) (arguing that women, like men, are able to think and act in a just manner, but that women act more with elements associated with the value of care); Maureen Sander-Staudt, *Care Ethics*, INTERNET ENCYCLOPEDIA OF PHIL., <http://www.iep.utm.edu/care-eth/> (last visited Sep. 6, 2018).

7. Marjorie E. Starrells, Sally Bould, & Leon J. Nicholas, *The Feminization of Poverty in the United States—Gender, Race Ethnicity, and Family Factors*, 15 J. OF FAM. ISSUES 590 (1994) <http://journals.sagepub.com/toc/jfia/15/4>.

8. See generally Martha Albertson Fineman, *THE NEUTERED MOTHER, THE SEXUAL FAMILY, AND OTHER TWENTIETH CENTURY TRAGEDIES* (1995) (looking at definitions of family and arguing against social policies that do not support caregiving and dependency); Martha Albertson Fineman, *THE ILLUSION OF EQUALITY* (1991) (arguing that divorce reform harms rather than protects women and children).

9. Martha Chamallas, *INTRODUCTION TO FEMINIST LEGAL THEORY* 10 (3d Ed. 2013) (“Being caught in a double bind or ‘catch-22’ . . . not only can low income women not take advantage of the credit due to their low taxability, but they often cannot afford the market price of the very childcare the credit was ostensibly designed to help them obtain.”). See Marilyn Frye, *THE POLITICS OF REALITY: ESSAYS IN FEMINIST THEORY* 2 (1983) (Double binds are “situations in which options are reduced to very few and all of them expose one to penalty, censure or deprivation” and one of the “most characteristic and ubiquitous features of the world as experienced by oppressed people.”). For a recent article discussing the double bind, see Nancy E. Shurtz, *Seeking Citizenship in the Shadow of Domestic Violence: The Double Bind of Proving “Good Moral Character,”* 62 ST. LOUIS L. REV. 237 (2018); see also Nancy E. Shurtz, *Gender Equity and Tax Policy: The Theory of “Taxing Men,”* 6 S. CAL. REV. L. & WOMEN’S STUD. 485, 520 (1997) (describing the double bind low-wage women workers face when paying for childcare expenses).

10. Feminist literature has often discussed the devaluation of household and childcare labor. See Nancy C. Staudt, *Taxing Housework*, 84 GEO. L.J. 1571, 1573 (1996) (arguing that non-market

refusing to recognize caregiving labor, these policies—or lack thereof—limit participation in vital caregiving opportunities and restrict care recipients from achieving best-outcome health and cost results. Moreover, such policy regimes counter widely-accepted views that government should actively promote classical “liberal” virtues of autonomy,¹¹ independence, choice, and power—all important factors when elderly women express an overwhelming preference for home or home-like environments over hierarchical institutional settings.¹² The closely related liberal values of rationality and personal responsibility are important drivers to encourage individuals to take an active hand in their own care.¹³

The acute nature of the care crisis for women should not lead one to conclude that men are not affected by these same issues. This is, indeed, a crisis for all of society.¹⁴ Approximately 65.7 million people in the United States, or one in four adults, identified themselves as family caregivers in 2009.¹⁵ The thesis of this

household labor should be included in the tax base, which would increase access to public retirement benefits and signal to society the importance of this work); Susan B. Boyd & Claire F.L. Young, *Feminism, Law, and Public Policy: Family Feuds and Taxing Times*, 42 OSGOODE HALL L.J. 545, 553 (2004) (offers a retrospective analysis of feminist research on tax and family law since the early 1980’s and focuses, in part, on women’s economic insecurity related to their familial and caregiving roles as unpaid laborers in the home).

11. “There are different concepts of autonomy. One is autonomy as free action—living completely independently, free of coercion and limitation. This kind of freedom is a common battle cry. But it is . . . a fantasy. Our lives are inherently dependent on others and subject to forces and circumstances well beyond our control. Having more freedom seems better than having less. But to what end? The amount of freedom you have in your life is not the measure of the worth of your life. Just as safety is an empty and even self-defeating goal to live for, so ultimately is autonomy.” Atul Gawande, *BEING MORTAL: MEDICINE AND WHAT MATTERS IN THE END* 140 (2014).

12. *Id.* at 193. “By 2011, 45% of Americans died in hospice” and “[m]ore than half of them received hospice care at home, and the remainder received it in an institution, usually an inpatient hospice facility for the dying or a nursing home.” *Id.* In his book, Gawande discusses “how to face mortality and preserve the fiber of a meaningful life.” *Id.* Gawande cites sociologist, Erving Goffman, who in his 1961 book, *Asylums*, compared nursing homes to prisons. *Id.* at 73, citing Erving Goffman, *ASYLUMS* (1961). See also Erving Goffman, *The Characteristics of Total Institutions*, in *ORGANIZATION AND SOCIETY* 312, 314 (1961) (*First*, all aspects of life are conducted in the same place and under the same single authority. *Second*, each phase of the member’s daily activity will be carried out in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. *Third*, all phases of the day’s activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole circle of activities being imposed from above by a system of explicit formal rulings and a body of officials. *Finally*, the contents of the various enforced activities are brought together as parts of a single overall rational plan purportedly designed to fulfill the official aims of the institution.).

13. Policies that promote savings or the purchase of long-term care insurance indirectly benefit the less affluent, those more likely to be using (and dependent upon) social insurance. Debate exists, however, as to whether mandates or tax incentives are the better mechanism to change behavior patterns, such as purchasing of long-term care insurance. See Nancy E. Shurtz, *Eco-Friendly Building From the Ground Up: Environmental Initiatives and the Case of Portland Oregon*, 27 J. OF ENVNTL. L. & LITIG., 237, 296-297 (2012) (setting forth seven criteria to help policy makers decide on mandates over market mechanisms).

14. See generally *THE NEUTERED MOTHER*, *supra* note 8.

15. *Who Will Provide Your Care?*, U.S. DEP’T OF HEALTH & HUM. SERV. (last modified Oct. 10, 2017), <http://longtermcare.gov/the-basics/who-will-provide-your-care.html/>. See also, *Caregiving: The Impact on the Workplace*, HEALTH ADVOCATE, <http://www.healthadvocate.com/downloads/webinars/caregiving.pdf> (about 87% of caregivers provide care for those over 50, 15% provide care to someone

Article is that our amalgamated citizenry benefits most when it cares for its most vulnerable citizens in a way that respects their independence and autonomy,¹⁶ while providing more support to the family members and the low-paid workers who care for them.¹⁷

As currently written, numerous provisions in the Internal Revenue Code (tax code) provide benefits for long-term care.¹⁸ The tax code favors nursing home care, particularly when it is financed through Medicaid or Medicare. It provides a limited below-the-line itemized medical deduction for long-term care services and long-term care insurance—a provision that was strengthened by the Tax Cuts and Jobs Act of 2017 (TCJA).¹⁹ TCJA also added a new employer credit for a portion of salary paid to qualifying employees who take paid family and medical leave.²⁰ Despite these new changes, the tax code minimally subsidizes adult day care and continuing community care, fails to adequately support the low-wage care worker, and devalues the unpaid caregiving services of family members. It also fails to provide the necessary funds to expand a public commitment to support the care and maintenance of the rapidly growing elder population in America.²¹

Thus, this Article suggests further tax changes, in combination with other legal reforms to improve the quality of elder care and honor the wishes of the care-receiver, while also improving the circumstances of care-providers. In addition to tax reform, this Article recommends the following policy changes: (1) Modify the 2015 regulations under the Fair Labor Standards Act (FLSA) as to employee coverage; (2) Expand the Family Medical Leave Act (FMLA) to allow for paid leave and extended periods of aggregate sanctioned leave; (3) Restore and fund core elements of the repealed Community Living Assistance Support and Services Act (CLASS) (involving employer-provided long-term care insurance); and (4) Modify Medicaid and Medicare to subsidize expanded home care services for the impaired patients who are not classified as “chronically ill,” and adopt a single-payer comprehensive long-term care health program. It is past the time to

who lives more than an hour away, more than 33% have a child or grandchild under 18 in their home, and one in 10 families have a child under 18 with a disability).

16. See John Rawls, *A THEORY OF JUSTICE* (1971) (arguing that social and economic inequalities are to be adjusted so that they have the greatest benefit to the least-advantaged members of the society).

17. See *THE NEUTERED MOTHER*, *supra* note 8, at 161–64.

18. In this Article, tax code references are to the current code. However, when a provision of the code has been changed by the Tax Cuts and Jobs Act of 2017, Pub. L. 115-97, 131 Stat. 2054, reference is made to that act.

19. Pub. L. 115-97 (§ 11027), 131 Stat. 2054, 2077 (the TCJA lowers the floor from 10% to 7.5% for all taxpayers until January 1, 2019.) See discussion *infra* Part II(B)(2)(a) notes 406-431 and accompanying text.

20. Pub. L. 115-97, (§ 13403), 131 Stat. 2054, 2135. See discussion *infra* Part II(B)(2)(c) notes 503-510 and accompanying text.

21. Diane Calmus, *The Long-Term Care Financing Crisis*, THE HERITAGE FOUNDATION (Feb. 6, 2013), <http://www.heritage.org/research/reports/2013/02/the-long-term-care-financing-crisis>.

begin reflecting on this crisis of the aged, a crisis most egregiously visited upon women, who comprise the majority of those affected.²²

Part I of this Article discusses the components that define the long-term care crisis and its outside impact on women. It examines the two general categories of care-providers—unpaid informal caregivers and formal paid care workers—and explores the formidable personal and financial challenges they face. What they share in common is that they are overwhelmingly populated by women. Part II discusses the different models of elder care, their respective merits and demerits and how they are subsidized. It concludes that the cheapest and best model is often the one involving care in the home, despite the fact that the tax system favors institutional care, the tax system fails to value unpaid home care, and the tax code does not adequately subsidize low-paid caregivers. Part III suggests several tax and non-tax measures to address the most acute shortcomings attached to the growing long-term care crisis. Part IV offers some conclusory remarks.

II. LONG-TERM CARE IS A FEMINIST ISSUE

Long-term care is a uniquely feminist issue. First, women comprise the significant majority of those likely to require long-term care. Second, women are more likely to provide long-term care, whether on an informal unpaid basis or as a formal paid worker. Third, women earn less income, possess less net wealth, are far more likely to live in poverty than men, and thus are less able to financially provide for their long-term needs, increasing the likelihood they will be institutionalized at some point. As a contributing factor, the tax code and the insurance industry employ a definition of long-term care that is excessively narrow and does not provide substantive support for the growing needs of elder care patients. This segment of the Article will examine current policy definitions of “long-term care” and propose a more inclusive and utilitarian alternative. It will then discuss the aforementioned trio of factors that most significantly impact women in the long-term care context.

A. THE DEFINITION OF LONG-TERM CARE

The term “long-term care” may, depending on the context, be given either a technical and restrictive definition or a broad and inclusive meaning. The tax code (to establish related income tax exclusions and deductions)²³ and insurance

22. Ten million uninsured people were enrolled in ObamaCare by the beginning of 2015. Barack Obama, State of the Union Address (Jan. 20, 2015) (transcript available at <https://www.whitehouse.gov/the-press-office/2015/01/20/remarks-president-state-union-address-january-20-2015>). Now the number is 10.3 million. *ObamaCare Enrollment Numbers*, OBAMACARE FACTS (last visited Sep. 9, 2018). See also The Tax Cuts and Jobs Act, Pub. L. 115-97 (§ 11081), 131 Stat. 2054, 2092 (2017) (recently repealed the individual mandate requiring taxpayers to obtain and maintain health insurance).

23. I.R.C. § 7702B(c) (2012).

companies (to determine eligibility for benefits)²⁴ employ a “narrow” definition. Here, long-term care refers to only “qualified long-term care services”²⁵ required for “chronically ill”²⁶ individuals who are unable to perform two or more “activities of daily living.”²⁷ This definition is excessively technical and restrictive.

“Qualified long-term care services” are defined under Section 7702B of the tax code as including “necessary diagnostic, preventive, therapeutic, curing, treating, mitigating” (so called “medical care”), and “rehabilitative services,” (hereinafter “rehabilitative care”). It also covers “maintenance or personal care services” (hereinafter “personal” or “custodial care”).²⁸ According to Peggy Hollander, qualified long-term care services can include “skilled care,” “intermediate care,” or “custodial care.”²⁹ Skilled care often involves “24-hour nursing and rehabilitative care, performed by skilled medical personnel under the supervision of a doctor.”³⁰ This type of assistance also includes care from a visiting nurse or physical therapist in the home or alternative care facility.³¹ Intermediate care involves “occasional nursing and rehabilitative care by skilled medical personnel under the supervision of a doctor.”³² Custodial care often does not involve the assistance of a nurse or doctor, but involves help with “bathing, dressing, . . . eating,” and other activities of daily living.³³ The “activities of daily living” is a standard term in the health care field and refers to “[b]asic actions that independently functioning individuals perform on a daily basis”³⁴ including eating, using the restroom, transferring (mobility such as moving from a bed to a chair), bathing, and dressing.³⁵

24. *Receiving Long-Term Care Insurance Benefits*, U.S. DEP’T OF HEALTH & HUM. SERV., <https://longtermcare.acl.gov/costs-how-to-pay/what-is-long-term-care-insurance/receiving-long-term-care-insurance-benefits.htm> (last modified Oct. 10, 2017).

25. I.R.C. § 7702B(c)(1) (2018).

26. I.R.C. § 7702B(c)(1)(A) (2018).

27. I.R.C. § 7702B(c)(2)(A)(i), (B) (2018).

28. I.R.C. § 7702B(c)(3) (2018). These are defined as “any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).” *Id.*

29. Peggy M. Hollander, *Long-Term Care Insurance and Estate Preservation*, ALI-ABA EST. PLAN. COURSE MATERIALS J. (Apr. 2000), http://files.ali-cle.org/thumbs/datastorage/lacidoirep/articles/EPCMJ_HollanderEPCMJ0004_thumb.pdf.

30. *Id.*

31. *Id.* I argue later that family members can (and do) perform this type of care. See Elizabeth Shell, *Value of Voluntary Long Term Care for Family Reaches Staggering Amounts*, PBS (Apr. 8, 2014), <http://www.pbs.org/newshour/runtdown/what-working-a-part-time-job-for-five-years-for-free-looks-like/>.

32. See Hollander, *supra* note 29, at 6.

33. *Id.*

34. *Glossary: Activities of Daily Living (ADLs)*, U.S. DEP’T HEALTH & HUM. SERV., <http://longtermcare.gov/the-basics/glossary/> [hereinafter *Glossary*].

35. I.R.C. § 7702B(c)(2)(B)(i)-(vi) (2018). See also Nathalie D. Martin, *Funding Long-Term Care: Some Risk-Spreaders Create More Risks Than They Cure*, 16 J. CONTEMP. HEALTH L. & POL’Y 355, 357 (2000).

In order to qualify under the Section 7702B definition of “long-term care,” the patient must have a “plan of care prescribed by a licensed health care practitioner.”³⁶ In addition, this brand of assistance must address a set of disabilities that cause an individual to be deemed “chronically ill.” According to the tax code a “chronically ill” individual is “one who has been certified by a licensed health care practitioner within the previous twelve months,” as either (i) “an individual who, for at least ninety days, is unable to perform at least two activities of daily living without substantial assistance due to loss of functional capacity,” or (ii) “an individual who requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.”³⁷ A chronically ill person is not an individual who is acutely ill.³⁸

This definition is too narrow and hinders an individual’s access to care. First, skilled, intermediate, and custodial care can be and often are performed by family members or paid home providers.³⁹ Second, many elder adults are not so seriously ill as to need help with two activities of daily living. More likely they are unable to perform one of the “Independent Activities of Daily Living,” a list of everyday functions that define the ability to live on one’s own.⁴⁰ Thus, they may benefit from what I term *practical* care, which may include light housekeeping, transportation to and from the doctor, grocery or other shopping, bill paying, phone calling or letter writing.⁴¹ They may also benefit from what I call *companion* care, interactions which may include conversation, recreational activities, and mealtime engagement.⁴² Although practical and companion care do not fit within the prevailing definition of the long-term care genre, they are important therapeutic components of care. These types of care provide emotional and psychological support of elder patients as well as their family members. If a person lacks these abilities, they lose their “capacity to live safely”—a critical threshold in

36. I.R.C. § 7702B(c)(1)(B) (2012) (2018); I.R.S. Pub. No. 525, *Taxable and Nontaxable Income*, at 18 (2017).

37. I.R.S. Pub. No. 554, *Tax Guide for Seniors*, at 24 (2017). See I.R.C. § 7702B(c)(2)(A) (2018); see also National Care Planning Council, *Putting Home Care in Perspective* (June 25, 2009), <https://www.longtermcarelink.net/article-2009-6-25.htm> (discussing statistics on home care for those with cognitive impairment, although not severe cognitive impairment); Family Caregiver Alliance, *Caring for Adults with Cognitive and Memory Impairment*, <https://www.caregiver.org/caring-adults-cognitive-and-memory-impairment> (setting forth ten steps to take in the care of those with a cognitive impairment and stating that severe cognitive impairment requires caregiving and supervision, at least in some form).

38. *Glossary*, *supra* note 34 (explaining that acute care is usually short-term care and distinguishable from personal or custodial care).

39. See Shell, *supra* note 31.

40. These eight activities include the following: (1) shopping for oneself, (2) preparing one’s own food, (3) maintaining one’s house, (4) doing one’s own laundry, (5) managing one’s medications, (6) making phone calls, (7) traveling on one’s own, and (8) handling one’s own finances. Gawande, *supra* note 11, at 15.

41. See Sarah H. Matthews, *Gender Roles and Filial Responsibility*, in *GENDER ROLES THROUGH THE LIFESPAN: A MULTIDISCIPLINARY PERSPECTIVE* 245, 252 (Michael R. Stevenson ed., 1994).

42. See discussion of Congressional definition and other definitions of care, *infra* note 71 and accompanying text.

determining the need for heightened levels of elder care and resource support.⁴³ A more comprehensive definition of elder care should include skilled, personal or custodial, practical, and companion care components.

Under the tax code, this narrow definition determines whether payments made to the elderly are excluded from gross income or whether amounts paid under insurance policies are deductible. The tax code thus piggybacks upon the definition used by the insurance industry in their long-term care policies and this narrow definition often limits tax benefits.

However, this technical definition of care is not the definition that is used in other health-related tax code provisions. Two crucial provisions offer broader definitions of elder care: the medical deduction provision and the new family leave employer credit. First, the medical deduction provision, Section 213 of the tax code, sets forth an itemized deduction for “medical care” and encompasses a definition broader than the above definition of long-term care. Here the tax code states that medical care expenses are those that include the cost of “diagnosis, cure, mitigation, treatment, or prevention of disease, or . . . [any treatment that affects a part] . . . or function of the body.”⁴⁴ Except for the last phrase, this definition seems to mirror the Section 7702B definition of qualified long-term care services. In fact, medical care, in the context of long-term care, has been interpreted in the same way as under Section 7702. Thus, skilled care, “rehabilitative care,” and “maintenance or personal care services” of the chronically ill are all considered medical care.

Second, the new family leave employer credit, Section 45S of the tax code (added by the TCJA), allows an employer a general business credit for a portion of wages paid to a qualifying employee who takes qualified “family and medical leave” under the FMLA.⁴⁵ FMLA defines long-term care differently than the traditional tax code provisions and insurance companies. First, it specifically covers informal unpaid care-providers and allows them to take unpaid leave from their work to care for the elderly.⁴⁶ Second, it covers those with a “serious health condition.”⁴⁷ FMLA defines “serious health condition” as “an illness, injury, impairment, or physical or mental condition that involves inpatient care in a

43. Gawande, *supra* note 11, at 93 (talking about Abraham Maslow’s book, *A Theory of Human Motivation*, which famously described people as having a hierarchy of needs. It is often depicted as a pyramid. At the bottom are our basic needs—the essentials of physiological survival (such as food, water, and air) and of safety (such as law, order, and stability). Up one level are the needs for love and for belonging. Above that is our desire for growth. . . . Finally, at the top is the desire for what Maslow termed “self-actualization”—self-fulfillment through pursuit of moral ideals and creativity for their own sake).

44. I.R.C. § 213(d)(1)(A) (2018). This provision is discussed *infra* notes 406-431 and accompanying text.

45. This provision is discussed *infra* notes 503-510 and accompanying text.

46. 29 U.S.C. § 2612(a)(1)(C) (2018). The unpaid leave allowed by the FMLA is limited to caring for a parent with a serious health condition. *Id.* The statute says nothing about extended family taking on that role as caregiver.

47. 29 U.S.C. § 2612(a)(1)(D) (2018).

hospital, hospice, or residential medical care facility, or continuing treatment by a health care provider.”⁴⁸ Other age-related candidates for the “serious health condition” designation are the various forms of dementia, Parkinson’s disease, or complications from accidents, such as from a fall.⁴⁹

By these standards, those who are chronically ill under the above definition of long-term care would also have a “serious health condition.”⁵⁰ However, those suffering acute conditions would also qualify. The FMLA defines “residential medical care” to include in-house care of the elderly and even recognizes the importance of “physical care” and “psychological support.”⁵¹ Physical care includes care with “basic medical, hygienic, or nutritional needs or safety, or . . . transport . . . to the doctor.”⁵² Psychological care means providing “comfort and reassurance which would be beneficial to a . . . parent with a serious health condition who is receiving inpatient or home care.”⁵³ Thus, companion care would qualify. The FMLA provisions also allow for supportive care in “situations where the employee may be needed to substitute for others who normally care for the family member or covered service member, or to make arrangements for changes in care, such as transfer to a nursing home.”⁵⁴

Non-medical or practical-type care, such as housework, help with finances, etc., would not qualify under the FMLA.⁵⁵ *Pang v. Beverly Hospital*, a California case, illustrates this limitation.⁵⁶ Here, a daughter’s leave to assist her elderly mother’s move to a single-level apartment was denied under the California Family Rights Act (CalFRA).⁵⁷ The Court of Appeals held that even though the mother had a “serious medical condition,” the daughter’s support with her mother’s move did not “directly, or even indirectly, provide or participate in medical

48. 29 U.S.C. § 2611(11) (2018). *See also* 29 C.F.R. § 825.113(a) (2018). Examples would include “heart attacks, heart conditions requiring heart bypass or valve operations, most cancers, back conditions requiring extensive therapy or surgical procedures, [and] strokes” but would not include “the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraines, routine dental or orthodontia problems [and] periodontal disease.” *Id.*

49. Peggie R. Smith, *Elder Care, Gender, and Work: The Work-Family Issue of the 21st Century*, 25 BERK. J. EMP. & LAB. L. 351, 385 (2004).

50. Chronically ill is narrower than serious medical condition because it specifically deals with not being able to deal with two of the activities of daily living. *See* Glossary, *supra* note 34 (compare “chronically ill” with “serious medical condition”).

51. 29 C.F.R. §§ 825.102, 124a, 124b (2018). *See also* Sec. 2 Title 1 Sec. 101(11)—Serious Health Conditions.

52. 29 C.F.R. § 825.124(a) (2018).

53. *Id.*

54. 29 C.F.R. § 825.124(b) (2018).

55. Jennifer L. Morris, *Explaining the Elderly Feminization of Poverty: An Analysis of Retirement Benefits, Health Care Benefits, and Elder Care-Giving*, 21 NOTRE DAME J. L. ETHICS & PUB. POL’Y 571, 597 (2007) (stating these requirements suggest “a vision of the elderly as being hidden, bed-ridden individuals who only venture outside the home for medical care,” and “perpetuates the stereotype of the elderly as dependent, passive, and unproductive”).

56. *Pang v. Beverly Hosp., Inc.*, 94 Cal. Rptr. 2d 643, 650 (Ct. App. 2000).

57. *Id.* at 651. CalFRA refers to the Moore-Brown-Roberti Family Rights Act in California. *See* CAL. GOV. CODE § 12945.1 (West 2015).

care for her mother,” concluding that CalFRA did not contemplate such practical care.⁵⁸ However, if the daughter had moved her mother to a nursing home, her leave would qualify under FMLA.⁵⁹ The decision in *Pang* is problematic in that the court failed to consider that the mother’s medical condition was the factor that precluded her from moving to a therapeutically more beneficial dwelling, and ignored the copious medical evidence supporting home residence over imposed institutionalization.⁶⁰ The court’s judgment that the move to a nursing home represented the only valid “medical” basis for sanctioning the daughter’s leave displays an arbitrary exercise of authority and a lack of common sense, evidenced by the fact that the type of support care offered by the daughter is covered under the FMLA.⁶¹ A broader and more flexible evaluative framework should be employed in lieu of default processes that mandate institutional outcomes.

The definition of care under the Fair Labor Standards Act is an interesting study in evolution of elder care: it guarantees minimum wages⁶² and overtime pay⁶³ for certain categories of elder care-providers,⁶⁴ but defines labor performed by informal hires as “companionship care” and exempts this type of work from both the minimum wage requirement and overtime regulation.⁶⁵ In 2007, the Supreme Court, in *Long Island Care at Home, Ltd. v. Coke*, held that whether to include home-care workers paid by third parties as covered under the FLSA was a detail best worked out by the Department of Labor—and that home-care workers should thus remain exempt from the FLSA protections.⁶⁶ In 2015, however, the Department of Labor essentially reversed this decision by expanding the definition of covered workers to include caregivers hired by home health care agencies. It also expanded its definition to include workers considered “certified nursing assistants, home health aides, personal care aides,” or workers who lived-in the household of the care-receiver.⁶⁷ The *Coke* case—when viewed under this broader canopy that directly connects the diminished capacity to perform daily

58. *Pang*, 94 Cal. Rptr. 2d at 649.

59. *Id.* at 648. See also The Family and Medical Leave Act of 1993, 29 C.F.R. § 825.12(b) (2018).

60. Chris Orestis, *Life Expectancy Compression: The Impact of Moving into a Long Term Care Facility on Length of Life*, LIFE CARE FUNDING (Feb. 12, 2013), <http://www.lifecarefunding.com/white-papers/moving-into-long-term-care-facility/> (“The mortality rate of individuals moving into skilled nursing facility is death within the first 12 months by as much as 50%-60%.”).

61. See generally 29 C.F.R. § 825.124 (support-type care includes helping with basic medical, hygienic, or nutritional needs or safety).

62. See 29 U.S.C. § 206(f) (2012).

63. See 29 U.S.C. § 207(a)(1) (2012).

64. See 29 U.S.C. § 202 (2012).

65. See 29 C.F.R. § 552.6 (2015). This statute has been preempted by 29 C.F.R. § 552.2(b) (2015). Direct care workers, such as certified nursing assistants, home health aides, personal care aides, and other caregivers are protected along with key domestic service workers. See *Domestic Service Final Rule Frequently Asked Questions*, U.S. DEP’T. OF LAB., <https://www.dol.gov/whd/homecare/faq.htm> (last visited Oct. 17, 2018).

66. 551 U.S. 158, 167–71 (2007).

67. See *infra* note 182 and accompanying text.

activities with underlying medical conditions—represents a misguided decision. This case is revisited later in this Article.

In feminist literature focusing on class and race, care-related labor has been traditionally categorized as either “spiritual” or “menial” labor.⁶⁸ First, domestic work performed by women is considered “spiritual” by virtue of its performance without financial compensation, a sacrifice for the good of the family. Second, paid domestic labor possesses no “higher” motivation behind it—it is essentially “dirty work” of low station and deserving of commensurately meager compensation. Herein lies the justification for employing (and herding) minority and immigrant women into domestic labor. In this literature, “white homes, family members—usually wives, mothers and daughters—perform spiritual caregiving,” whereas “[m]enial caregiving is typically assigned to devalued and underpaid minority and immigrant women.”⁶⁹ In this Article, I argue that we benefit from and must explicitly value both brands of care.

The reality is that elder adults benefit from a full spectrum of supportive care—from skilled to simple companionship. Studies reveal that individual patients require a wide array of individualized assistance, suggesting the need for a restatement of the general definition of long-term care.⁷⁰ One instructive “model definition” actually emanated from the halls of Congress, an official report stated that long-term care “refers to a broad range of medical, social, and personal care, and supportive services needed by individuals who have lost some capacity for self-care because of a chronic illness or disability.”⁷¹ This more inclusive definition of long-term care encompasses the concept in a comprehensive dimension and includes what I consider practical and companion care. Unfortunately, the lack of agreement on the terms of discussion constructs a barrier to thorough understanding of pertinent research in the field, as it is difficult to know if the literature is using the narrow or the more inclusive definition of long-term care. Furthermore, this confusion can handicap the policy process when legal and other authorities employ multiple and (often) divergent definitions.

68. Dorothy E. Roberts, *Spiritual and Menial Housework*, 9 YALE J. L. & FEMINISM 51, 55–56 (1997).

69. Dorothy E. Roberts, *Race, Care Work, and the Private Law of Inheritance*, 40 L. & SOC. INQUIRY 511, 516 (2015). See also Gerald F. Seib, *How Immigration Could Affect Grandma’s Care*, WALL ST. J., Jan. 22, 2018, at A4 [hereinafter Seib, *Immigration*] (“A recent study by PHI, an organization that works with the long-term and home care industry, found that one in four ‘direct care’ workers is an immigrant.”).

70. See National Care Planning Council, *supra* note 37 (42% of elder adults need help with bathing; 37% need help with dressing; 32% need help with transferring; 22% need help with doing light housework; 19% need help with medication reminders; 6% need help with shopping; 2% need help with using the phone; and 1% need help managing money).

71. S. REP. NO. 108-265, vol. 1, at 11 (2004). See also Anja Eleveld, *Claiming Care Rights as a Performative Act*, 26 L. CRITIQUE 83, 83 (2015) (giving a similar definition for long-term care as “all activities and relations involved in meeting the physical and emotional requirements of dependent [elderly] adults”).

B. WOMEN ARE MORE LIKELY TO NEED ELDER CARE

More than two-thirds of elder adults—age sixty-five and older—will require some kind of long-term care.⁷² The majority of these will be women. According to the *New England Journal of Medicine*, “for a man over age 65, the odds are one in three (33 percent) that he will need long-term care,” whereas “for a woman over age 65, the odds are one in two (50 percent) that she will need long-term care in her life.”⁷³

Women have an increased need for long-term care because of their increased life expectancy⁷⁴ and their increased risk of developing chronic illnesses and ailments like Alzheimer’s disease.⁷⁵ Women generally outlive men by five or more years.⁷⁶ Women age sixty-five today can expect to live about twenty more years and require an average of 3.7 years of extended long-term care support.⁷⁷ As a result of this increased need for assistance, nearly two-thirds of home care users and institutionalized care recipients are women.⁷⁸

This increased need leads to a higher financial burden for women because women need care for longer, are less likely to have help from a spouse or partner, and are more likely to develop illnesses requiring formal care. A woman’s stay in a nursing home is typically much longer than that of a man: while roughly half of all men in nursing homes are discharged within three months, some sixty-four percent of women remain longer.⁷⁹ Medicare imposes a 100-day maximum on its payment coverage per qualifying episode, leaving the burden of additional

72. Leslie Scism, *Long-Term-Care Insurance: Is it Worth it?*, WALL ST. J. (May 1, 2015, 9:58AM), <http://www.wsj.com/articles/long-term-care-insurance-is-it-worth-it-1430488733>; see also, *Who Needs Care?*, U.S. DEP’T OF HEALTH & HUM. SERV., <https://longtermcare.acl.gov/costs-how-to-pay/what-is-long-term-care-insurance/receiving-long-term-care-insurance-benefits.html> (“most Americans turning age 65 will need long-term care services at some point in their lives”).

73. See Robert N. Butler, *On Behalf of Older Women: Another Reason to Protect Medicare and Medicaid*, 334 NEW ENGLAND J. MED. 794, 794 (1996), noted in THE ADVISOR’S GUIDE TO LONG-TERM CARE 5 (R. David Watros & Erik T. Reynolds eds., 2013) [hereinafter ADVISOR’S GUIDE].

74. *Long-Term Care Insurance: Fact Sheet*, NAT’L ASSOC. OF INS. COMM’RS. (May 2018), http://www.naic.org/documents/consumer_alert_ltc.htm. See also *Women and Long-Term Care: Fact Sheet*, AARP (Apr. 2007), https://assets.aarp.org/rgcenter/il/fs77r_ltc.pdf.

75. *2018 Alzheimer’s Disease Facts and Figures*, ALZHEIMER’S ASS’N 18 (2018), <https://www.alz.org/media/HomeOffice/Facts%20and%20Figures/facts-and-figures.pdf>; see also Alice Park, *New Hope for the Treatment and Prevention of Alzheimer’s*, TIME 38 (Nov. 23, 2015) (“by 2050, an estimated 160 million people worldwide will be diagnosed with Alzheimer’s”).

76. See Debora MacKenzie, *Women Live Longer than Men but Suffer More Years of Poor Health*, NEW SCIENTIST 34, 34 (Mar. 17, 2016), <https://www.newscientist.com/article/2081497-women-live-longer-than-men-but-suffer-more-years-of-poor-health/>.

77. *How Much Care Will You Need?*, U.S. DEP’T OF HEALTH & HUM. SERVS., <http://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html> (last visited Oct. 17, 2018).

78. Lauren Harris-Kojetin et al., *Long-Term Care Services in the United States: 2013 Overview* 33, U.S. DEPT. OF HEALTH AND HUM. SERVS. (December 2013), http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf (As of 2012, women composed seventy-two percent of the people in residential care homes and composed almost sixty-eight percent of the individuals living in nursing homes.).

79. Scism, *supra* note 72 (only thirty-six percent of women stay in a nursing home for less than three months).

personal expenditures principally on the leaner pocketbooks of women.⁸⁰ Because women are more likely to incur these kinds of residential healthcare-related expenses, they are more likely to exhaust their personal assets and require aid through Medicaid⁸¹ and other forms of public assistance.

Women are also less likely to have live-in care from a spouse or partner. They often live alone in later life, as one in three baby boomer women are either divorced or have never been married.⁸² According to the U.S. Census Bureau, an estimated 800,000 Americans lose their spouse every year.⁸³ The majority of these—some eighty percent—are women.⁸⁴ Today, an elderly woman who is sixty-five years old “can expect to live nearly fifteen years past the death of her spouse.”⁸⁵

Further, women are more likely to develop illnesses that will require formal long-term care. According to the National Center for Health Statistics, “[o]lder women are more likely than older men to have a health problem that requires special equipment such as a cane, a wheelchair, a special bed, or a special telephone,”⁸⁶ all of which can be precursors of the need for long-term support.⁸⁷ Also, “ten million baby boomers will develop Alzheimer’s”⁸⁸ and “[a]lmost two-thirds of Americans with Alzheimer’s are women.” Women also comprise the majority population for all categories of dementia.⁸⁹ Since a high proportion of those diagnosed will spend a substantial portion of their remaining lives in

80. See Lawrence A. Frolik, *Elder Law and Later-Life Legal Planning*, AMERICAN BAR ASSOCIATION 76 (2017) [hereinafter Frolik].

81. See Russ Banham, *Facing the Future: When it Comes to Accepting the Need for Long-Term Care Down the Road, Many Opt for Denial*, WALL ST. J. (2010), <http://online.wsj.com/ad/article/longtermcare-future>.

82. Haley Sweetland Edwards, *Inside the Next Social Security Crisis*, TIME (June 23, 2015), <http://time.com/3969233/inside-the-next-social-security-crisis>.

83. Carolyn Kortge, *91-year-old Draws on Well of Adaptability to Redefine Life*, REGISTER GUARD (July 19, 2015), at E2.

84. *Id.*

85. Janie S. Steckenrider, *Long-Term Care: A Woman’s World*, 22 J. HEALTH & HUM. SERVS. ADMIN. 452, 457 (2000).

86. Kristen Robinson, *Trends in Health Status and Health Care Use Among Older Women*, 5 CTR. FOR DISEASE CONTROL (Mar. 2007), <http://www.cdc.gov/nchs/data/ahcd/agingtrends/07olderwomen.pdf> (stating specifically that “[i]n 2004-2005, 19 percent of women aged 65 years and over (age adjusted) had a health problem that required special equipment compared with 15 percent of men (11)”).

87. *Medicare’s Role for Older Women*, HENRY J. KAISER FAM. FOUND. (May 16, 2013), <http://kff.org/womens-health-policy/fact-sheet/medicares-role-for-older-women> (“Women live longer than men, on average, and a greater share of older women than older men face health and functional problems. Older women experience some multiple chronic conditions (such as arthritis, osteoporosis, and hypertension) at higher rates than older men, and this gender gap persists as they age.”).

88. *Generation Alzheimer’s: The Defining Disease of the Baby Boomers*, ALZHEIMER’S ASS’N 1, 1 (2011), http://act.alz.org/site/DocServer/ALZ_BoomersReport.pdf?docID=521.

89. Alzheimer’s Disease Facts and Figures, *supra* note 75, at 215.

institutional care settings,⁹⁰ the users of long-term care services and resources are—and will be—predominantly women.⁹¹

C. WOMEN ARE MORE LIKELY TO BE THE CARE-PROVIDER AND MAKE SACRIFICES

Women are more likely to be the care-provider—both unpaid and paid.⁹² Informal caregivers are usually unpaid family members and friends of the person requiring care⁹³ and formal care workers are paid. These formal workers range from highly-paid registered nurses (RNs), licensed practical nurses (LPNs) or licensed vocational nurses (LVNs), to the less well-paid certified nursing assistants (CNAs), home health aides (HHA), social workers, and lowly-paid personal aids or helpers in the home.⁹⁴ The paid care-provider can work independently or for a care facility or care agency.⁹⁵

Both informal and formal caregiving duties have been traditionally performed by women.⁹⁶ Women represent over two thirds of family caregivers,⁹⁷ and over ninety percent of direct care workers.⁹⁸ Unpaid care is usually not valued as

90. *Id.* at 27. It is possible this care will overwhelm the government system—as well as caregivers. *Id.* at 50.

91. Harris-Kojetin, *supra* note 78, at 33.

92. The well-being of the care-receiver is inexorably tied to the quality and character of the actions of the care-provider. See Jan Oyeboode, *Assessment of Carer's Psychological Needs*, 9 *ADVANCES IN PSYCHIATRIC TREATMENT* 45, 45 (2003), <https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/assessment-of-carers-psychological-needs/1B83902EB1E1EAB929CDE76D9EFF3401/core-reader>; see e.g., Gawande, *supra* note 11, at 99-100 (“Although none of Ivan Ilyich’s family or friends or doctors grasp his needs, his servant Gerasim does. Gerasim sees that Ivan Ilyich is a suffering, frightened and lonely man and takes pity on him, aware that some day he himself would share his master’s fate.”).

93. Wan He et al., *An Aging World: 2015*, U.S. CENSUS BUREAU 1, 79, (Mar. 2016), <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p95-16-1.pdf>.

94. See Harris-Kojetin, *supra* note 78, at 14; see also Galina Khatutsky et al., *Understanding Direct Care Workers: A Snapshot of Two of America’s Most Important Jobs*, U.S. DEP’T OF HEALTH & HUM. SERVS. 1, 19-24, (Mar. 2011), http://www.ahcancal.org/quality_improvement/Documents/Understanding_DirectCareWorkers.pdf; Robyn I. Stone, *Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century*, MILBANK MEM’L FUND 1, 10-12 (Aug. 2000), http://www.milbank.org/uploads/documents/0008stone/LongTermCare_Mech5.pdf.

95. Stone, *supra* note 94, at 10-12. “[N]ursing homes or other extended care facilities employed 170,856 (RNs) or 8.1 percent of all RNs.” *Id.* at 10. “112,217 RNs were employed by home health agencies.” *Id.* at 11. “182,110 licensed practical nurses (LPNs) worked in nursing homes . . . and another 39,774 LPNs worked in home health care.” Most paid providers of long-term care are paraprofessional workers—certified nursing assistants in the nursing home, or home care workers, deliver the largest share of the primarily low-tech personal care and the assistance with managing daily life. After unpaid caregivers, these workers are the key to helping elders with disabilities maintain their independence and quality of life. . . . [A]n estimated 643,080 nursing assistants were employed in nursing homes. *Id.* “Approximately 697,000 . . . home health aids were employed by home health agencies, hospitals, and others.” *Id.* “[T]he majority of paraprofessionals are women . . . an estimated 89.4 percent of nursing aids were female . . . [and a] . . . survey of home care workers reported that 96 percent [were women] . . . employed by agencies, and 100 percent of the self-employed, were female.” *Id.*

96. *Id.*

97. *Id.* at 10.

98. Robyn I. Stone & Joshua M. Weiner, *Who Will Care for Us: Addressing the Long-Term Care Workforce Crisis*, THE URBAN INST. 1, 11-12, <http://www.urban.org/sites/default/files/alfresco/>

“economic” activity,⁹⁹ and paid caregiving is compensated poorly,¹⁰⁰ even when there is a documented shortage of available workers in the field.¹⁰¹ Friends or family typically provide unpaid care, with two-thirds of these labors performed by “wives or daughters.”¹⁰²

Female caregivers—both unpaid and paid—make significant financial, personal, and health sacrifices to accommodate caregiving responsibilities.¹⁰³ Paid caregivers choose to earn their living in an intensely personal caring profession, but often do not have favorable worker benefits or opportunities for advancement, not to mention long-term care benefits of their own.¹⁰⁴ Unpaid care-givers, because of their career sacrifices, whether the sacrifice involves quitting a job to take care of an ill family member or accepting low wages in return for providing direct care for others, women are two-and-a-half times more likely than men to end up in poverty and five times more likely than men to depend on Social Security.¹⁰⁵ Elderly women tend to rely on younger women for their care and these women, in turn, often sacrifice their careers and future financial security in order to act in service to the elderly.¹⁰⁶ Thus, this syndrome that combines economically undervalued labor with pernicious long-term effects on future financial stability helps to perpetuate and exacerbate the feminization of poverty.

publication-pdfs/310304-Who-Will-Care-For-Us-Addressing-the-Long-Term-Care-Workforce-Crisis.PDF.; see also *The Direct Care Workforce: An Integral Part of Long-Term Services and Supports*, U. S. DEP'T OF HEALTH & HUM. SERVS. 1, 1 (Apr. 2013), <https://aspe.hhs.gov/sites/default/files/pdf/177271/dcwIB.pdf> [hereinafter *Direct Care Workforce*].

99. See Staudt, *supra* note 10, at 1598–99 (“[B]y refusing to count unpaid household labor in the calculation of retirement benefits and by tying such benefits only to wages, Congress has almost guaranteed that women will live in poverty at higher rates than men.”).

100. Stone & Weiner, *supra* note 98, at 3.; see also Judith Graham, *A Shortage of Caregivers*, N.Y. TIMES (Feb. 26, 2014), <http://newoldage.blogs.nytimes.com/2014/02/26/a-shortage-of-caregivers/> (“these are low-paid, demanding jobs”); Sarah Jane Glynn, *The Gender Wage Gap Double Whammy*, CTR. FOR AM. PROGRESS (Apr. 16, 2012), <https://www.americanprogress.org/issues/women/news/2012/04/16/11428/the-gender-wage-gap-double-whammy/>.

101. See generally Seib, *supra* note 69.

102. Stone, *supra* note 94, at 9.

103. *Caregiving*, FAMILY CAREGIVER ALLIANCE: NAT’L CTR. ON CAREGIVING, <https://www.caregiver.org/caregiving> [hereinafter *Caregiving*].

104. See Glynn, *supra* note 100 (for example, these workers do not have family leave because they are not covered by the FMLA); 29 U.S.C. § 2612(a)(1)(C) (2018); see also *infra* note 139 and accompanying text.

105. See Margaret B. Neal & Donna L. Wagner, *Working Caregivers: Issues, Challenges, and Opportunities for the Aging Network* 8, <http://www.caregiverslibrary.org/Portals/0/Working%20Caregivers%20-%20Issues%20for%20the%20Aging%20Network%20Fin-Neal-Wagner.pdf>; *Long-Term Care—Important Information for Women*, AM. ASS’N FOR LONG-TERM CARE INS., <http://www.aaltci.org/long-term-care-insurance/learning-center/for-women.php> [hereinafter *Important Information for Women*].

106. Morris, *supra* note 55, at 606.

1. *The Unpaid Family/Friend Caregiver*

Most elder care assistance is provided by informal, unpaid care from family members and friends.¹⁰⁷ As this Article has discussed, the burden often falls on women to provide this informal care.¹⁰⁸ Yet the toll on these care givers, not only in terms of lost wage income, but health consequences, is significant. Yet the value of this care, not only to the taxpayer but to the care receiver, are not considered in setting policy.

Approximately 65.7 million people in the United States, or one in four adults, identified themselves as family caregivers in 2009.¹⁰⁹ Family caregivers provide around eighty percent of long-term care in America,¹¹⁰ with most caregivers operating as the *sole* caregiver.¹¹¹ Forty percent of all women eighteen and older provide elder care.¹¹² While men are becoming more involved in caregiving for the elderly,¹¹³ with thirty-seven percent of men eighteen and older provide elder care,¹¹⁴ women generally invest an average of “50 percent more time giving care than men do.”¹¹⁵ According to the Bureau of Labor Statistics, “more than 22 million American women spend more than three hours a day providing unpaid care for an elderly person.”¹¹⁶ The typical unpaid caregiver is a “46-year-old woman who spends 20 hours a week providing care to her mother.”¹¹⁷

Elder care given by the family or a friend can be simple or extensive—and range, as discussed earlier, from skilled to companionship care.¹¹⁸ Often these caregivers require assistance from formal care workers.¹¹⁹ However, less than ten percent of those in need of long-term care rely solely on paid care services.¹²⁰

107. *Id.* at 588.

108. *See Who Will Provide Your Care?*, *supra* note 15.

109. *Id.*

110. S. Rep. No. 107-74, at 9, 13 (2002). *See also* Barbara Coleman & Sheel M. Pandya, *Fact Sheet: Family Caregiving and Long-term Care 1*, AARP PUB. POL’Y INST.

(Nov. 2003), http://assets.aarp.org/rgcenter/il/fs91_ltc.pdf; K. Nicole Harms, *Caring for Mom and Dad: The Importance of Family-Provided Eldercare and the Positive Implications of California’s Paid Family Leave Law*, 10 WM. & MARY J. WOMEN & L. 69, 82 (2003) (“Family caregiver are currently responsible for providing approximately eighty percent of the long-term care in America, and the cost of replacing family caregivers who are unpaid with professional paid caregivers would be nearly \$200 billion dollars annually.”).

111. ADVISOR’S GUIDE, *supra* note 73, at 4 (emphasis added).

112. *See generally* Shell, *supra* note 31.

113. *See* ADVISOR’S GUIDE, *supra*, note 73, at 13 (referencing 2008, 2009, and 2011 studies conducted by the MetLife Mature Market Institute that showed from 34% to 51% of men are considered primary caregivers).

114. *See generally* Shell, *supra* note 31.

115. *Important Information for Women*, *supra* note 105.

116. Haley Sweetland Edwards, *The Next Social Security Crisis: Why American Women are Bearing the Brunt of the Retirement Crunch*, TIME (Aug. 2, 2015) at 50.

117. *Important Information for Women*, *supra* note 105.

118. *See* discussion *infra* Part II and accompanying footnotes.

119. *See* Smith, *Who Cares for the Elderly*, *supra* note NOTEREF_Ref323486087\h 4, at 327.

120. Lynn Feinberg, *Populations in Need of LTSS and Service Delivery Issues*, Testimony Before the Commission on Long-Term Care, AARP PUB. POL’Y INST. (July 17, 2013), http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Feinberg-Testimony_Commission-on-Long-Term-Care.pdf.

Only seven percent of the elderly who have a family caregiver live in an institution.¹²¹ Half of these unpaid caregivers perform tasks once limited to trained nurses.¹²² Many state laws, however, limit the administration of some medically skilled care in the home to licensed professionals.¹²³ Such rules and restrictions can often result in the institutionalization of the elder, often contrary to their wishes.

Families in higher socioeconomic groups tend not to provide physical care themselves, but instead “purchase elder care services, provide financial gifts, buy alternative lodging, and remodel homes to accommodate an elder.”¹²⁴ The working poor and working-class families are more likely to provide direct care themselves, as they cannot afford to hire professional care-providers. When low-income families do purchase formal services, they use them “only for short periods of time;” whereas, “middle-class and higher-income caregivers hire elder care assistance for longer periods.”¹²⁵

Because of smaller families and other demographic shifts, the number of family members able and willing to care for the elderly has shrunk.¹²⁶ Often children do not even live in the same location as their parent.¹²⁷ With the absence of unpaid care workers, a strain is placed on paid direct care workers as well as institutions, such as nursing homes.¹²⁸

Women are more likely than men to be informal caregivers for two reasons. First, the female member in the marital unit will often take care of her older husband.¹²⁹ Second, in the absence of a partner, the primary caregiver for the elderly parent is a daughter, daughter-in-law, or niece.¹³⁰ Since married women often provide end-of-life care for their husbands, this can delay or even prevent the

121. See Frolik, *supra* note 80, at 167.

122. Adina Wingate, *More Americans Serving As Home Caregivers*, ARIZONA DAILY STAR (Jan. 25, 2015), https://tucson.com/news/local/more-americans-serving-as-home-caregivers/article_7096b74d-956b-510f-a086-8b18878d1dd0.html.

123. See generally Karl Polzer, *Assisted Living State Regulatory Review*, NAT'L CTR. FOR ASSISTED LIVING (2011), https://www.ahcancal.org/ncal/advocacy/regs/Documents/2011_reg_review.pdf.

124. Ann Bookman & Delia Kimbrel, *Families and Elder Care in the Twenty-First Century*, 21 FUTURE OF CHILDREN 117, 126 (2011), <https://files.eric.ed.gov/fulltext/EJ944934.pdf>.

125. *Id.*

126. See generally Scism, *supra* note 72.

127. Francine Russo, *Caring for Aging Parents: Should there be a Law?*, TIME (July 22, 2013), <http://healthland.time.com/2013/07/22/caring-for-aging-parents-should-there-be-a-law/>.

128. Lynn Feinberg et al., *Valuing the Invaluable 2011 Update: The Growing Contributions and Costs of Family Caregiving*, AARP PUB. POLICY INST. 10 (2011), <https://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf>.

129. Elizabeth O'Brien, *Women Face A New Long-Term Care Dilemma*, MARKETWATCH.COM (March 7, 2013), <http://www.marketwatch.com/story/women-face-a-new-long-term-care-dilemma-2013-03-07>.

130. Mathews, *supra* note 41, at 249. See also *Important Information for Women*, *supra* note 105; Steckenrider, *supra* note 85, at 453.

woman from receiving formal long-term care herself.¹³¹ When the husband is in need of long-term care, family resources are often spent on his care, leaving the wife with fewer funds for her own care.¹³² Even women who bring more assets into the marriage are considered as one economic unit with their husbands for purposes of Medicaid eligibility, and the wife's property can be used for the husband's care, even after her death.¹³³ In addition, women may be less likely to secure family caregivers and as a result tend to require more formal long-term care as they age.¹³⁴ Consequently, they also exhaust their personal resources faster, ultimately hastening reliance on public assistance programs, notably Medicaid.¹³⁵

When there is no spouse, the typical care-provider juggles the demands of professional life and childcare with the responsibilities of elder care. A majority of unpaid family caregivers are employed full-time in market labor, while an additional eleven percent are employed part time.¹³⁶ These conditions often require care-providers to make sacrifices in their formal employment for the sake of the caregiving commitments. The caregiver may need to leave work early, take extended lunch breaks, stay at work late, cut back on hours, make up for missed time, and in severe cases, choose to work part time, pass up promotions, or leave the workforce entirely.¹³⁷ The impacts of family caregiving on the professional and financial stability of caregivers can be dramatic and significant.¹³⁸

Some care-providers may be able to use sick days or family leave to care for the elderly. In the short term, the FMLA is unpaid and is not available to most workers (and definitely not available to the low-paid elder care workers in the

131. *Women and Caregiving*, *supra* note 2 (“A common scenario is an older woman who cares for her husband and who discovers that there are few resources—financial or otherwise—to meet her own needs for assistance.”).

132. Rick L. Law & Diana M. Law, *A Woman's Nightmare: Long-Term Care—Two Elder Law Attorneys' Perspectives*, THE CATALYST (2008), <https://www.isba.org/committees/women/newsletter/2008/06/awomansnightmarelongtermcaretwoelde>.

133. Thomas E. Simmons, *Medicaid as Coverture*, 26 HASTINGS WOMEN'S L. J. 275, 278–79 (2015). Simmons tells two relevant stories here. One of a later life marriage (with no prenuptial) in which the husband needed to go to a nursing home and the wife's assets had to be spent down for his care, even though she brought more assets to the marriage and the couple's agreement was to keep those assets separate. *Id.* at 291–93. The other story involved a wife who died before her husband but an elective share was asserted against her estate to pay for her husband's care. *Id.* at 293–95.

134. Steckenrider, *supra* note 85, at 453.

135. *Id.* at 465.

136. See ADVISOR'S GUIDE, *supra* note 73, at 13; see also *Selected Caregiver Statistics*, National Ctr. on Caregiving, FAMILY CAREGIVER ALLIANCE: NAT'L CTR. ON CAREGIVING, <http://caregiver.org/node/44>.

137. See ADVISOR'S GUIDE, *supra* note 73, at 12–13; Harms, *supra* note 110, at 75–76.

138. Studies show that over “60% of female caregivers make career sacrifices to accommodate caregiving responsibilities.” ADVISOR'S GUIDE, *supra* note 73, at 12. Sixty-seven percent of caregivers adjust work schedules to care for a parent and thirty percent of employees miss work to care for the parent, losing “up to 16 hours of work per month due to caregiver responsibilities.” *Id.* at 13. Further, “[t]hirty-one percent quit work due to providing care for a loved one.” See Harms, *supra* note 110, at 76 (citing the Dep't of Labor “future work,” 50% had to make changes at work, such as leaving early, going in late, changing to part time taking time off during the day and 6% had to quit work).

home)—so taking off time to care for a family member often results in lost wages.¹³⁹ Women in more highly-paid professional and managerial positions are better able to afford the unpaid family leave guarantee under FMLA, and they may have jobs that accrue sick leave that can be used for such care.¹⁴⁰ These women “are also more likely to enjoy paid parental leave, sick leave, vacation time, and scheduling flexibility.”¹⁴¹ Even women who qualify for FMLA leave are limited: the FMLA is limited to twelve weeks per year and elder care is often a year-round job. Furthermore, studies show that even those wanting to take family leave hesitate to use it because of the feared impact on their jobs.¹⁴²

Balancing the care of a family member with a full-time job can exert serious financial pressures on the care-provider, and adversely affect her employer as well.¹⁴³ The *total* estimated lifetime costs comprised of “lost wages, pension, and Social Security benefits of caregivers of parents [both women and men] are nearly \$3 trillion.”¹⁴⁴ The individual impacts of lost and foregone financial resources on caregivers is dramatic across-the-board,¹⁴⁵ but is especially harmful for women. For women, the caregiver’s lost wages is \$142,693, lost social security benefits is \$131,351, impact on pensions \$50,000, totaling an overall financial impact of \$324,044.¹⁴⁶ For men, the financial impact is \$283,716.¹⁴⁷ On the employer side of the ledger, U.S. businesses are expected to lose in excess of “\$33 billion annually from absenteeism, decline in productivity, interruptions . . . decreased morale and motivation, unwillingness of the employee to travel, and inability to relocate.”¹⁴⁸

The financial problems can be exacerbated by the tax code, which further disincentivizes home-based care by taxing any income received by the family care-provider. Family care-providers can be paid for their labors, but compensation

139. ADVISOR’S GUIDE, *supra* note 73, at 12. See discussion of new code Section 45S, *infra* Part II(B) (2)(c) notes 503-510 and accompanying text.

140. Nancy Folbre, *Reforming Care*, 36 POL. & SOC’Y 373, 379 (2008).

141. *Id.*

142. See Harms, *supra* note 110, at 71 n.14 (citing David Cantor et al., *Balancing the Needs of Families and Employers: The Family and Medical Leave Surveys 2000 Update* 2-16, U.S. DEP’T OF LABOR, <http://www.dol.gov/asp/fmla/chapter2.pdf>).

143. See ADVISOR’S GUIDE, *supra* note 73, at 13.

144. *Id.*

145. *Family Caregivers Cost Survey: What They Spend & What They Sacrifice*, AARP (Nov. 2016), <https://www.aarp.org/research/topics/care/info-2016/family-caregivers-cost-survey.html>. (The Report’s key findings include: (1) 78% of caregivers incur out-of-pocket expenses, averaging around \$7,000 for close caregivers and \$12,000 for long-distance caregivers; (2) caregivers spending nearly 20% of their income on caregiving; (3) household expenses garner the largest share of expenses, with 41% of total spending; and (4) 56% of employed caregivers experience one work-related strain, such as working different hours, fewer/more hours, and taking time off.)

146. See ADVISOR’S GUIDE, *supra* note 73, at 13.

147. *Id.*

148. See *id.* at 14; see also Harms, *supra* note 110, at 86 (“This issue is important to employers as the impact of caregiver issues costs an estimated \$29 to \$31 billion annually.”).

for these services results in taxable income.¹⁴⁹ In addition, the care-provider is obligated to pay self-employment taxes on these earnings.¹⁵⁰ The care-receiver might also promise an inheritance share to a family caregiver, but litigation in such circumstances has most often resulted with the will provisions taking precedent over any implied care contracts.¹⁵¹ Under Medicaid rules, parents can enter into personal care contracts with their children or a friend (or others) and still comply with eligibility requirements.¹⁵² Medicaid rules also permit children who live with their parents and have provided care for at least two years to retain the house.¹⁵³

Beyond pure financial losses, informal caregiving can also have a negative physical, mental, and emotional impact on the caregiver.¹⁵⁴ Nearly “four out of five primary family caregiver [sic] who report that caregiving is stressful are women, and roughly three-quarters of primary caregivers who report feeling ‘very strained’ physically, emotionally, or financially as a result of providing care are female.”¹⁵⁵ Part of this added stress comes as a result of its frequent character as “second shift” work—duties layered on top of the caregiver’s market-labor job and own domestic responsibilities.¹⁵⁶ The burdens of such extended care “can hinder the caregiver’s ability to provide care, lead to higher health care costs, and adversely affect the quality of life of both the caregiver and care receivers.”¹⁵⁷ This “all-consuming” aspect has resulted in reports of measurable decline in the caregiver’s general state of health,¹⁵⁸ with heightened risk of premature death.¹⁵⁹

149. I.R.C. § 61(a)(1) (2016) (“Gross income means all income from whatever source derived, including . . . [c]ompensation for services.”).

150. *Family Caregivers and Self-Employment Tax*, IRS.GOV (Feb. 26, 2015), <https://www.irs.gov/businesses/small-businesses-self-employed/family-caregivers-and-self-employment-tax>.

151. See Marshall B. Kapp, *For Love, Legacy, or Pay: Legal and Pecuniary Aspects of Family Caregiving*, CTR. FOR INNOVATIVE COLLABORATION IN MED. & L. 1, 5 (2012), <http://diginole.lib.fsu.edu/islandora/object/fsu:209892/datastream/PDF/view>.

152. See David L. Rice, *Elder Law and the Tax Practitioner: How to Navigate the Murky Waters*, ABA TAX SECTION 13 (Jan. 11, 2011); Shenna J. Knox, *Eldercare for the Baby-Boom Generation: Are Caregiver Agreements Valid?*, 45 SUFFOLK U. L. REV. 1271 (2012).

153. *Medicaid Treatment of the Home: Determining Eligibility and Repayment for Long-Term Care*, U.S. DEP’T OF HEALTH & HUM. SERVS. (Apr. 1, 2005), <https://aspe.hhs.gov/basic-report/medicaid-treatment-home-determining-eligibility-and-repayment-long-term-care> (“Adult children must have lived in the home for at least 2 years immediately before the deceased Medicaid recipient was institutionalized and have provided care that may have delayed the recipients admission to a nursing home or other medical institution.”). Here, the issue is whether it is best to inherit the property and get a step-up in basis, see I.R.C. § 1014 (2016).

154. See *Caregiver Health*, FAMILY CAREGIVER ALLIANCE: NAT’L CTR. ON CAREGIVING, <https://www.caregiver.org/caregiver-health> [hereinafter *Caregiver Health*].

155. *How Do Family Caregivers Fare?: Caregivers of Older Persons Data Profile*, CTR. ON AN AGING SOC’Y AT GEORGETOWN UNIVERSITY (June 2005), <http://ihcrp.georgetown.edu/agingsociety/pdfs/CAREGIVERS3.pdf>.

156. Arlie Hochschild and Anne Machung, *THE SECOND SHIFT* (Avon Books: New York, 1990).

157. ADVISOR’S GUIDE, *supra* note 73, at 12.

158. ADVISOR’S GUIDE, *supra* note 73, at 10.; see also *Caregiver Health*, *supra* note 154.

159. ADVISOR’S GUIDE, *supra* note 73, at 12 (citing Elissa S. Epel et al., *Accelerated Telomere Shortening in Response to Life Stress*, 101 PROCEEDINGS OF THE NATIONAL ACADEMY OF SCIENCES No. 49, 17312 at 17315 (Dec. 4, 2004)).

In the case of a married couple, the non-institutionalized caregiver spouse “has a significant risk of death as a result of [the other] spouse’s hospitalization.¹⁶⁰ These adverse stress effects are emotional and mental as well as physical. Many suffer from depression¹⁶¹ at a rate much higher than those not engaged in caregiving activities.¹⁶² As a consequence of these increased risks or the actual deterioration of a caregivers’ emotional, mental, and physical health, many informal caregivers ultimately have to make the decision to place their impaired relative in a long-term care facility, often contrary to the care-receiver’s wishes.¹⁶³

The impact of unpaid family care is profound on the care-receiver and the caregiver. Long-term care is mostly provided through freely given and loving labor.¹⁶⁴ It often allows the care-receiver to remain at home with quality care, avoid the devastating costs of institutional care and personal financial ruin, and save taxpayer billions of dollars. The estimated value of replacing family caregivers with professional paid caregivers is over \$500 billion annually.¹⁶⁵ Thus, it is imperative that tax and other policy be changed to support this unpaid care.

2. *The Paid Direct Care Worker*

Direct care workers, over ninety percent of whom are women, are the primary providers of paid hands-on care for more than thirteen million elderly and disabled Americans.¹⁶⁶ These direct care-providers can be independent contractors or work as employees for a business or care agency.¹⁶⁷ Direct care workers are generally poorly paid, with such jobs “offering few benefits and few incentives to increase skills, experience or tenure.”¹⁶⁸ According to the *National Center for Health Statistics*, approximately 1.5 million people in the United States were employed as formal direct care workers in 2012.¹⁶⁹ These care-providers are on average forty years of age or older.¹⁷⁰ Often, they have children.¹⁷¹ About thirty

160. ADVISOR’S GUIDE, *supra* note 73, at 12 (citing Nicholas A. Christakis & Paul D. Allison, *Mortality After the Hospitalization of a Spouse*, 354 NEW ENGLAND J. MED. 719, 726 (2006)).

161. *Id.*

162. Shell, *supra* note 31 (“20 percent of these employed women caregivers over [fifty] suffer report symptoms of depression, compared to 8 percent of their non-caregiving peers.”).

163. Gwendolen T. Buhr et al., *Caregivers’ Reasons for Nursing Home Placement: Cures for Improving Discussions with Families Prior to the Transition*, 46 THE GERONTOLOGIST 52, 57 (2006).

164. It may be possible, however, that some children are giving care out of the expectation of an inheritance. See Thomas E. Simmons, *Medicaid as Coverture*, 26 HASTINGS WOMEN’S L. J. 275 (2015).

165. *Cost of Informal Caregiving for U.S. Elderly is \$522 Billion Annually*, RAND CORPORATION (2014), <https://www.rand.org/news/press/2014/10/27.html>.

166. Khatutsky, *supra* note 94, at 1. Over 7.6 million elderly Americans receive formal home care by paid caregivers. The estimate would be much greater if one includes informal care. ADVISOR’S GUIDE, *supra* note 73, at 28.

167. Stone, *supra* note 94, at 10–12.

168. Folbre, *supra* note 140, at 378. Skilled nursing jobs carry a higher salary than other paid caregiving work. See *CNA Careers & Salary Outlook by State*, NURSE JOURNAL, <http://nursejournal.org/certified-nursing-assistant/cna-careers-salary-outlook/>.

169. Harris-Kojetin, *supra* note 78, at 14.

170. Khatutsky, *supra* note 94, at 4.

171. *Id.* at 11.

percent are women of color.¹⁷² Twenty-five percent are immigrant.¹⁷³ Many live in poverty.¹⁷⁴ On average, direct care workers make around ten dollars per hour in 2018.¹⁷⁵ The median earnings for direct care workers were less than \$19,500 per year in 2017.¹⁷⁶ This places many in this population beneath the official poverty line: “28 percent of personal care aides and 20 percent of home health aides in 2010.”¹⁷⁷ Nearly “a quarter report having received cash welfare benefits for families and children . . . and about 42% have been on food stamps in the past.”¹⁷⁸ Often these workers are “sandwiched,” balancing non-work-related demands, such as providing care to children or sick family members, with the demands of work.¹⁷⁹

Just over one-half of direct care workers “work for organizations that offer benefits such as paid sick leave and holidays, health insurance, and retirement/pension plans.”¹⁸⁰ A U.S. Department of Health and Human Services report found that of those direct care workers who were offered health insurance by their employer, most did not enroll in the coverage offered—usually reporting that health insurance was still too expensive.¹⁸¹

In 2007, the Supreme Court, in *Long Island Care at Home, Ltd. v. Coke*, ruled that elder care workers in the home were not covered under the Fair Labor

172. See Smith, *Who Cares for the Elderly*, *supra* note NOTEREF_Ref323486087\h 4, at 329 n.29.

173. See Seib, *supra* note 69 (Referring to a recent study by PHI, an organization that works with the long-term and home care industry, indicating that the number of immigrant direct caregivers has been rising—from 20% in 2005 to 24% in 2015. In some states, like New York, California, New Jersey, and Florida, 40% of elder care workers are immigrants.).

174. *U.S. Federal Poverty Guidelines*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://aspe.hhs.gov/poverty-guidelines> [hereinafter *Poverty Guidelines*] (for 2018 poverty is \$12,140 for a single person, \$16,460 for a household of two, and \$25,100 for a household of four).

175. *Average Direct Care Worker (DCW) Hourly Pay*, PAY SCALE, [https://www.payscale.com/research/US/Job=Direct_Care_Worker_\(DCW\)/Hourly_Rate](https://www.payscale.com/research/US/Job=Direct_Care_Worker_(DCW)/Hourly_Rate) (last visited Oct. 18, 2018). See also Khatutsky, *supra* note 94, at 25.

176. *Direct Care Worker Salaries*, GLASSDOOR.COM, https://www.glassdoor.com/Salaries/direct-care-worker-salary-SRCH_KO0,18.htm; Nancy Folbre, *The Business of Home Care*, N.Y. TIMES: ECONOMIX (Sept. 13, 2013), <http://economix.blogs.nytimes.com/2013/09/23/the-business-of-home-care/>.

177. Folbre, *supra* note 176.

178. Khatutsky, *supra* note 94, at 6.

179. *Id.* at 11. See also Folbre, *supra* note 176 (“About half are able to support their families only by recourse to public assistance”).

180. Khatutsky, *supra* note 94, at 29.

181. *Id.* at 31. It will be helpful to have new studies as to the effect of the ACA on these workers. It is possible that the price subsidies on the exchange and the tax subsidies will change this aspect of low-paid elder care workers’ situation. See Matthew Ozga, *Supreme Court Ruling Means More Direct-Care Workers Will have Health Coverage*, PARAPROFESSIONAL HEALTH CARE INST. (June 25, 2015), <http://phinational.org/blogs/supreme-court-ruling-means-more-direct-care-workers-will-have-health-coverage>; Abby Marquand, *Too Sick to Care: Direct-Care Workers, Medicaid Expansion, and the Coverage Gap*, PARAPROFESSIONAL HEALTH CARE INST. (July 2015), <http://phinational.org/sites/phinational.org/files/research-report/toosicktocare-phi-20150727.pdf> (Finding that “despite their critical role as care providers, roughly 400,000 direct-care workers live without health insurance in states that have opted not to expand Medicaid. By contrast, 650,000 direct-care workers are now eligible for health coverage because of their state’s decision to expand this vital program.”).

Standards Act (FLSA).¹⁸² Thus, they did not have to be paid minimum wage or overtime compensation.¹⁸³ Ms. Coke worked as a home care worker for a home care agency and often slept in her clients' homes and worked twenty-four hour shifts.¹⁸⁴ Ms. Coke claimed that her agency failed to pay her a minimum wage and overtime in violation of the FLSA.¹⁸⁵ A unanimous court held that the FLSA did not cover Ms. Coke, because the FLSA specifically did not cover casual babysitters or persons who "provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves."¹⁸⁶ The court held, in the absence of clear Congressional authority to the contrary, the intent of the FLSA was not to cover these types of workers.¹⁸⁷ Subsequent to this case, the Department of Labor adopted new regulations interpreting FMLA to cover care-providers working for a third-party agency, such as a home care agency, and specialized home workers, including those living with the care-receiver.¹⁸⁸

The view that elder caregivers are "babysitters" degrades a class of labor that has traditionally been labeled "women's work" and perpetuates discrimination against those performing these labors—particularly women of color.¹⁸⁹ This form of discrimination has a long history. Legislators during the New Deal Era relied upon "notions of family privacy" to insulate employers of domestic workers from adhering to laws guaranteeing fair wages and the protection of the federal labor statutes.¹⁹⁰ Racially-tinted politics were in play when President Roosevelt agreed to exempt domestic labor and agriculture from the New Deal protections in order to secure vital political support from the Southern congressional contingent.¹⁹¹ In the modern context, such laws expand these discriminatory practices that assume cheap—and subservient—care-providers to the elderly.

182. See *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 167–171 (2007).

183. *Id.* at 168.

184. *Id.* at 164.

185. *Id.*

186. 29 U.S.C. § 213(a)(15); *Long Island Care at Home, Ltd.*, 551 U.S. at 169.

187. *Long Island Care at Home, Ltd.*, 551 U.S. at 166–68.

188. See *Long Island Care at Home, Ltd.*, 551 U.S. at 169–70; 29 C.F.R. §§ 552.6, 552.109(a); discussion, *supra* note 66 (covering certified nursing assistants, home health aides, personal care aides, or live-in the household).

189. See Peggie R. Smith, *Regulating Paid Household Work: Class, Gender, Race, and Agendas of Reform*, 48 AM. U. L. REV. 851, 866–67 (1999) (discussing how discrimination limited the employment opportunities for ethnic women during the late nineteenth and early twentieth centuries); Seib, *supra* note 69 (indicating that the combination of new immigration restrictions with increasing demand for direct-care workers could adversely "affect grandma's care").

190. Roberts, *supra* note 69, at 516 ("They treated domestic service as private and not a form of 'real work' that merited inclusion in labor legislation. Household employers argued that regulating domestic service would jeopardize family life in their homes and that legal protections were unnecessary because of employers' 'assumed magnanimity.'").

191. See Larry DeWitt, *The Decision to Exclude Agricultural and Domestic Workers from the 1935 Social Security Act*, 70 SOC. SECURITY BULL. 4 (2010), <https://www.ssa.gov/policy/docs/ssb/v70n4/v70n4p49.html>.

The situation in *Coke* graphically illustrates the “double bind” phenomenon.¹⁹² Here, the interests of the financially-strapped care-receiver diverge from the interests of the poorly-paid care-provider.¹⁹³ On the one hand, many elderly women are poor and want to stay in their homes (the alternative being institutionalization), but can only accomplish this by spending the minimum on care assistance. On the other hand, the low-paid care workers often perform skilled and personal care duties covering all aspects of daily living, yet are not being paid on par with their performance or expertise. Consequently, these care-providers diminish their future personal and financial stability because they are unable to save, afford insurance, or otherwise provide for the basic maintenance of their families. Often, these same poorly-compensated workers are also providing unpaid care to other family members—husbands, children, and parents. Many younger women—particularly women of color—are similarly “sandwiched” and will face the same bleak dilemmas later in life. Hence, the systematized perpetuation of poverty for women continues.

This structure has created a new set of problems. Due in large part to low wages, limited benefits and lack of opportunities for advancement, fewer women are choosing to enter or remain in the elder care field.¹⁹⁴ Worker turnover is high.¹⁹⁵ Yet, demand for elder caregivers is increasing at a rapid rate, creating a “a documented critical and growing shortage of these workers.”¹⁹⁶ With the aging of the American population,¹⁹⁷ demand is expected to increase by about half over the next decade, requiring 1.6 million new positions by 2020.¹⁹⁸ An AARP Public Policy Institute report underscores this problematic “care gap.” Whereas in 2013 there were seven caregiver candidates per prospective care-receiver, by 2030 this ratio will drop to four-to-one; and by 2050 projected to fall beneath three-to-one.¹⁹⁹ This shortage can also directly result in the increased

192. MARILYN FRYE, *THE POLITICS OF REALITY: ESSAYS IN FEMINIST THEORY* 2, 49 (1983) (“Situations in which options are reduced to a very few and all of them expose one to penalty, censure or deprivation.”).

193. See generally Smith, *Who Cares for the Elderly*, *supra* notes NOTEREF_Ref323486087 \h 4 and 49, for legislative solutions and policy arguments for why the FLSA regulations should be changed. I argue for an expanded Earned Income Credit. See discussion *infra* note 636 and accompanying text.

194. See Smith, *Who Cares for the Elderly*, *supra* notes NOTEREF_Ref323486087 \h 4 and 49.

195. *Id.*

196. See Khatutsky, *supra* note 94, at 1; Seib, *supra* note 69 (“There already is a shortage of such workers.”).

197. See Seib, *supra* note 69 (“By 2050, a fifth of the U.S. population will be age 65 or older.”; “As Americans get older[, they] live longer. . . The rate of disability and chronic conditions is increasing.”)

198. Dorie Seavey, *Investing in Home Care Workers* (Jan. 24, 2014), <http://baileypark55.com/2014/01/investing-in-home-care-workers>.

199. Donald Redfoot et al., *The Aging of the Baby Boom Generation and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers*, 85 AARP PUB. POL’Y INST. 1 (Aug. 2013), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/lrc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-lrc.pdf.

institutionalization of women where the paid caregiver tends to have higher wages and benefits.²⁰⁰

D. WOMEN ARE LESS LIKELY TO BE ABLE TO AFFORD LONG-TERM CARE

Women are less likely to be able to afford long-term care because long-term care services are expensive, and women have fewer direct financial resources available to pay the expensive costs of any necessary long-term care. Thus, women are more likely to use long-term care insurance (if they have it), spend down their savings, and be institutionalized.²⁰¹

Consequently, the potential that the government may not be able to adequately meet the future demands of its social insurance programs is of grave concern to care-receivers. The congressional efforts to severely slash Medicaid funding²⁰² and the overall federal budgetary hit from the Tax Cuts and Jobs Act of 2017²⁰³ are two examples of current federal government policies that raise concerns about the adequacy of future funding for long-term care. Growing national debt and budget deficits, decaying infrastructure, and other competing demands on the budget, also raise serious concern about the government's ability to adequately meet Medicaid demands.²⁰⁴

Long-term care services are expensive and are often out of reach for the average person. According to the Genworth Cost of Care Survey, the annual cost of a private room in a nursing home in 2017 was more than \$85,000.²⁰⁵ Homemaker

200. See *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boomer Generation*, U.S. DEP'T OF HEALTH & HUM. SERVS. (2003), <https://aspe.hhs.gov/sites/default/files/pdf/72961/ltcwork.pdf>. Studies show that many of those institutionalized need not be institutionalized. See *Aging in Place: Facilitating Choice and Independence*, U.S. DEP'T OF HOUS. & URBAN POLICY (Fall 2013), <https://www.huduser.gov/portal/periodicals/em/fall13/highlight1.html>.

201. See *Spouses of Medicaid Long-Term Care Recipient*, U.S. DEP'T OF HEALTH & HUM. SERVS. (2005), <https://aspe.hhs.gov/sites/default/files/pdf/74086/spouses.pdf>.

202. See Addy Baird, *Republican Budget Would Decimate Medicare and Medicaid*, THINK PROGRESS (Oct. 4, 2017), <https://thinkprogress.org/senate-gop-budget-would-cut-more-than-1-trillion-from-medicaid-and-medicare-965ee50ee262/>; see also Michael Hiltzik, *Fiscal Idiocy: What States Refusing Medicaid Will Cost Their Citizens*, L.A. TIMES (Dec. 6, 2013), <http://www.latimes.com/business/hiltzik/la-fi-mh-citizens-20131206,0,7229746.story#axzz2veTIEN8W> (reporting that twenty-five states have opted not to extend this coverage).

203. Alan S. Blinder, *Why Now Is the Wrong Time to Increase the Deficit*, WALL ST. J. (Jan. 31, 2018), A15 (In light of the Tax Cuts and Jobs Act: "The economy doesn't need fiscal stimulus. Further, as we look to the future, we see an aging population putting great pressure on government budgets, especially for health care and pensions.").

204. See ADVISOR'S GUIDE, *supra* note 73, at 7; see also John D. Rockefeller, *The Pepper Commission Report on Comprehensive Health Care*, 323 NEW ENGLAND J. OF MED. 1005, 1005 (1990), <http://www.nejm.org/doi/full/10.1056/NEJM199010043231429> (On long-term care, the political gains in taking a stand are substantial and the costs are relatively small. Most Americans—rich and poor, old and young—see themselves at risk of impoverishment if they or their family members need long-term care. They support government action to ensure their protection. At the same time, no entrenched system of private insurance is threatened by government expansion, and providers stand to gain considerably from broader public support. Finally, the elderly and their families are politically organized and active in demanding government help.).

205. *Genworth 2017 Cost of Care Survey*, GENWORTH FIN. 5 (Nov. 2017), <https://pro.genworth.com/riiproweb/productinfo/pdf/179703.pdf> (national medium price was \$85,775 for semi-private room and

services averaged \$131 a day and home health aides averaged \$135 per day.²⁰⁶ On an annual basis, these expenses can exceed those for assisted living, which average \$45,000 per year in 2017.²⁰⁷

First, long-term care insurance, which was supposed to help pay for these expenses, does not offer a solution because the industry is undergoing a crisis,²⁰⁸ only a dozen or so insurers are even selling coverage and their rates are rising dramatically.²⁰⁹ Long-term care insurance is expensive and even more expensive for women.²¹⁰ For example, an insurance premium for a single woman is higher than the cost for a married woman of a joint long-term care insurance purchase with her husband.²¹¹ Spousal discounts exist because insurance companies “expect couples will care for each other if one becomes ill.”²¹² However, as this Article discusses, this applies less to women.

Second, women have fewer direct financial resources available to pay the expensive costs of long-term care insurance or any necessary long-term care. Women suffer economic disadvantages from lower lifetime wages, lower pensions, work disruptions for childbirth and childcare, as well as disruptions for elder care.²¹³ Although seventy-four percent of women participate in the U.S. workforce and over half of all households have a female breadwinner, women are not doing the type of work that contributes to their own financial security.²¹⁴

\$97,445 for private room in 2017); see also Emily Mullin, *How to Pay for Nursing Home Costs: Medicare, Medicaid, and other Resources Can Help Minimize the Cost of Long-Term Care*, U.S. NEWS & WORLD REP. (Nov. 16, 2016),

<https://health.usnews.com/wellness/articles/2016-11-16/how-to-pay-for-nursing-home-costs>.

206. *Id.*

207. *Id.*

208. Leslie Scism, *Millions Bought Insurance to Cover Retirement Health Costs. Now They Face an Awful Choice*, WALL ST. J. (Jan. 17, 2018), <https://www.wsj.com/articles/millions-bought-insurance-to-cover-retirement-health-costs-now-they-face-an-awful-choice-1516206708>.

209. *Id.* (Fewer than 100,000 policies were sold in 2016 and sales fell to about 34,000 in the first half of 2017.).

210. Long-Term Care Insurance Rates and How to Find the Best Costs, AM. ASS’N FOR LONG-TERM CARE INS., <http://www.aaltci.org/long-term-care-insurance-rates/> (in 2015, according to the American Association for Long-Term Care Insurance, the average annual premium for a sixty-year-old couple buying a fairly typical policy was around \$2,500 (combined), whereas a single woman’s policy would cost only a few hundred dollars less); see also *Long-Term Care Insurance Tax Deduction Information*, AM. ASS’N FOR LONG-TERM CARE INS., <http://www.aaltci.org/long-term-care-insurance/learning-center/tax-for-business.php/>; C. Andrew Lafond et al., *The Tax Implications of Long-Term Care Insurance*, 95 PRACTICAL TAX STRATEGIES 159, 161 (2015) (a policy that would pay a daily \$200 benefit for 3 years with a 3% compound inflation option—is now between \$3,549 and \$4,746).

211. See O’Brien, *supra* note 129.

212. Lafond, *supra* note 210.

213. Korzec, *supra* note 5, at 555 n.67 (“stating that a woman with a 40 year career who interrupts it for seven years, will receive half the pension she would have received from continuous employment” (quoting Kerry Hannon, *A Woman’s Special Dilemma*, U.S. NEWS & WORLD REP. 93 (June 13, 1994))).

214. Edwards, *supra* note 116, at 50 (“[T]he problem facing single, retirement-age women today is not that they haven’t worked hard enough in their younger years, says Heidi Hartman, president of the Institute for Women’s Policy Research. It’s that they’re not doing the type of work that contributes to security in old age.”).

Additionally, women are likely to experience financial hardships due to their caregiving responsibilities to children, partners, and older parents.²¹⁵ Caring for children in particular has an adverse impact on women's earnings and ability to save.²¹⁶ Women often directly bear the costs for children,²¹⁷ including large expenditures, such as college tuition.²¹⁸ According to the Pew Research Center, over ten million American women drop out of the workforce to care for children full time.²¹⁹ They repeat this pattern when it comes to caring for their parents.²²⁰ According to one Social Security Administration study, women averaged some twelve years out of the workforce caring for children, older relatives and friends.²²¹

Many women face financial hardship by virtue of being single, either through divorce or widowhood, and by never having married.²²² Over one-third of baby boomer women are single.²²³ Marriage rates continue to drop, resulting in less pooling of assets—often with more affluent partners. According to Pew Research Center, in 2011, just fifty percent of Americans were married, and twenty percent had never married, a record number.²²⁴ This growing number of single women, in concert with their relatively lower aggregate levels of income and wealth, make this population “overwhelmingly more vulnerable than men” in their later lives.²²⁵

215. Mathews, *supra* note 41, at 250.

216. NAT'L EQUAL PAY TASK FORCE, *Fifty Years after the Equal Pay Act* 4 (2013), https://obamawhitehouse.archives.gov/sites/default/files/equalspay/equal_pay_task_force_progress_report_june_2013_new.pdf.

217. Cawthorne, *supra* note 3.; see also Marjorie E. Kornhauser, *Love, Money, and the IRS: Family, Income Sharing and the Joint Income Tax Return*, 45 HASTINGS L. J. 63, 110 (1993).

218. Marjorie Kornhauser, *Theory Versus Reality: The Partnership Model of Marriage in Family Income and Tax Law*, 69 TEMP. L. REV. 1413, 1430-31 (1996).

219. See Livingston, *supra* note 2.

220. John Schall, *Caregiving is Forcing Women 50+ to Leave the Work Force*, FORBES (Oct. 10, 2016), <https://www.forbes.com/sites/nextavenue/2016/10/10/caregiving-is-forcing-women-50-to-leave-the-workforce/#865b3dc138dd> (women over 50 are dropping out of the workforce at increasing numbers to care for their parents and the number of children caring for adults tripled over the fifteen-year period 2001-2016).

221. *Women and Caregiving*, *supra* note 2.

222. Purvi Sevak et al., *Perspectives: The Economic Consequences of a Husband's Death*, 65 SOC. SECURITY BULL. 3 (2003), <https://www.ssa.gov/policy/docs/ssb/v65n3/v65n3p31.html>.

223. I-Fen Lin & Susan L. Brown, *Unmarried Boomers Confront Old Age: A National Portrait*, 65 THE GERONTOLOGIST 153, 153 (2012); Lori M. Hunter, *Unmarried Baby Boomers Face Disadvantages as they Grow Older*, POPULATION REFERENCE BUREAU (Feb. 2014), <https://www.prb.org/baby-boomers-and-disability/>.

224. Wendy Wang & Kim Parker, *Record Share of Americans Have Never Married*, PEW RES. CTR. (Sept. 24, 2014), <http://www.pewsocialtrends.org/2014/09/24/record-share-of-americans-have-never-married/>; D'Vera Cohn et al., *Barely Half of U.S. Adults are Married—A Record Low*, PEW RES. CTR. (Dec. 14, 2011), <http://www.pewsocialtrends.org/files/2011/12/Marriage-Decline.pdf>.

225. Edwards, *supra* note 116, at 48; Richard L. Kaplan, *Top Ten Myths of Social Security*, 3 ELDER L. J. 191 (1995); CTR. FOR COMTY. CHANGE & OLDER WOMEN'S ECON. SEC. TASK FORCE, *Expanding Social Security Benefits for Financially Vulnerable Populations* 3-6 (Oct. 2013).

Women collect less in Social Security benefits.²²⁶ They pay less into the system over their lifetimes as their wages are lower and they tend to take breaks for child-care responsibilities. Yet more than half of elderly women depend on Social Security for over half of their income.²²⁷ On average, older women's income is three-fifths of older men's income—and less than half the income of that of an older couple.²²⁸ Thus, elderly women are often not as wealthy as their male counterparts.²²⁹

Women tend to fare much better financially when connected to a partner.²³⁰ Married women can share in their partner's higher incomes and Social Security benefits, as well as inherit money from their spouses.²³¹ In addition, divorced women who had been married for at least ten years can access a former spouse's Social Security benefits and widows may also be able to tap their former partner's pensions.²³² On the other hand, taking care of a sick husband or spending down for Medicaid for their spouse could have the opposite result. It is estimated that almost eighty percent of widows who end up in poverty were not poor prior to their husband's deaths.²³³

Third, all of these factors translate into lost wages, lower pensions,²³⁴ and fewer funds available for savings and long-term care needs.²³⁵ Women tend to inadequately save and plan for future long-term care needs because they assume multiple caregiving roles for their family's welfare, while placing their own prospective needs on the sidelines.²³⁶ Yet what is of prime importance to women are

226. See Morris, *supra* note 55, at 606.

227. Selena Caldera, *Social Security: Who's Counting on it?*, AARP 2 (Mar. 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2012/Social-Security-Whos-Counting-on-It-fs-252-AARP-ppi-econ-sec.pdf; Edwards, *supra* note 116, at 50 (this contrasts to “fewer than a fourth of married couples” who depend on Social Security as their only source of income.)

228. INST. FOR WOMEN'S POL'Y RES., *The Economic Security of Older Women and Men in the United States 2* (Oct. 31, 2007), <https://iwpr.org/wp-content/uploads/wpallimport/files/iwpr-export/publications/BPD480.pdf>.

229. See *id.*

230. Edwards, *supra* note 116, at 48 (“The idea that marriage allays poverty has been a powerful conceit in Washington for decades, spanning both sides of the aisle.”); see also Melanie Hicken, *Why Many Retired Women Live in Poverty*, CNN MONEY (May 13, 2014), <http://money.cnn.com/2014/05/13/retirement/retirement-women/>.

231. David A. Weaver, *Widows and Social Security*, 70 SOC. SECURITY BULL. 3 (2010), <https://www.ssa.gov/policy/docs/ssb/v70n3/v70n3p89.html>.

232. Edwards, *supra* note 116, at 50.

233. Carol Moseley-Braun, *Women's Retirement Security*, 4 ELDER L. J. 493, 495 (1996). Please note that the studies focus on married couples and not those who are unmarried with partners. Neither is there data on gay and lesbian marriages. In no way does this author want to appear to be discriminatory.

234. See Morris, *supra* note 55, at 573 (three reasons exist for women's inadequate retirement: (1) exclusive reliance on spouse (and upon divorce or death, often lose this benefit), (2) preoccupation with current immediate expenses, and (3) tendency to be risk adverse, perhaps not saving in investments that have good returns).

235. Korzec, *supra* note 5, at 555 n.67 (stating that a woman with a 40-year career who interrupts it for seven years will receive half the pension she would have received from continuous employment (citing Kerry Hannon, *A Woman's Special Dilemma*, U.S. NEWS & WORLD REP., 93 (June 13, 1994))).

236. Morris, *supra* note 55, at 582–83.

the financial and emotional strains the requirements of long-term care exerts on their families.²³⁷ Failure to prepare for the costs of long-term care is the major cause of impoverishment among elderly women.²³⁸ Across the board, poverty rates for widows far outpace poverty rates for men in similar circumstances,²³⁹ and these factors are amplified for women of color²⁴⁰ and those living in rural settings.²⁴¹

With more women living in poverty, women outnumber men in Medicare and Medicaid enrollments.²⁴² Both programs are biased towards institutional care.²⁴³ Among dual enrollees in both Medicare and Medicaid programs, the preponderance of women was just over sixty percent in 2015.²⁴⁴ Many people believe—incorrectly—that Medicare or private health insurance (obtained under the

237. BMO WEALTH INST., *Financial Concerns of Women* 42 (Mar. 2015), <https://www.bmo.com/privatebank/pdf/Q1-2015-Wealth-Institute-Report-Financial-Concerns-of-Women.pdf>.

238. *The Economic Impact of Long-Term Care on the Elderly*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Oct. 1994), <https://aspe.hhs.gov/basic-report/economic-impact-long-term-care-individuals>; Tate Blahnik, *The Elderly Become a New Export*, https://web.stanford.edu/class/e297c/poverty_prejudice/citypoverty/theelderlybecome.htm (“the cost of long-term care is extending far beyond the financial capability of most elderly individuals”); Barbranda Lumpkins Walls, *Aging Conference Reveals Poverty's Impact on Older Adults* (March 24, 2016), <https://www.aarp.org/politics-society/advocacy/info-2016/effect-of-poverty-on-older-adults.html> (“Women in particular are subject to fall into poverty because of widowhood, withdrawing from the labor force to care for children or other family members and decline in health.”).

239. Youngae Lee and Jinkook Lee, *Widows: How do they become the poor?* <http://paa2006.princeton.edu/papers/61592>; Alicia H. Munnell, Geoffrey T. Sanzenbacher, and Alice Zulkarnain, *What Factors Explain the Decline in Widows' Poverty*, <http://crr.bc.edu/working-papers/what-factors-explain-the-decline-in-widows-poverty/> (marriage has become “less common among those with lower socioeconomic status”).

240. According to 2013 census data, the poverty rate for white, single women age sixty-five and older is one in six, for an African-American woman of the same age, one in three, but fifty percent, or one in two for a Hispanic woman. See Carmen DeNavas-Walt & Bernadette D. Proctor, *Income and Poverty in the United States*, U.S. CENSUS BUREAU 12–15 (Sept. 2015), <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>; Sophia Kerby, *State of Women of Color in the United States* (July 17, 2012), CTR. FOR AM. PROGRESS, <https://www.americanprogress.org/issues/race/reports/2012/07/17/11923/the-state-of-women-of-color-in-the-united-states/> (women of color more likely to have bad health and be uninsured); Monique Morrissey, *Women Over 65 are More Likely to be Poor than Men, Regardless of Race, Educational Background or Marital Status*, ECON. POL'Y INST. (March 8, 2016), <https://www.epi.org/publication/women-over-65-are-more-likely-to-in-poverty-than-men/> (stating that “older, minority, and unmarried women are at the greatest risk” of poverty).

241. See generally M. L. Reig, *The Unspoken Poor: Single Elderly Women Surviving in Rural America*, 9 ELDER L. J. 257 (2001).

242. Beth H. Tracton-Bishop, *Women and Aging Fact Sheet*, SOCIOLOGISTS FOR WOMEN IN SOCIETY 3, https://socwomen.org/wp-content/uploads/2018/03/fact_win2006-aging.pdf.

243. Joanna K. Weinberg, *The Past, Present, and Future of Long-Term Care—a Women's Issue?*, 25 J. HEALTH POL. POL'Y & L. 565, 568 (2000).

244. *Data Analysis Brief: Medicare-Medicaid Dual Enrolment From 2006 Through 2015*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2016), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual-Enrollment_2006-2015.pdf.

Affordable Care Act) will pay for long-term care.²⁴⁵ While Medicare and private health insurance cover “short-term needs,” a large percentage of the costs associated with long-term care are paid out of personal savings,²⁴⁶ including unpaid family care.

In order to afford the increasing costs of long-term care, many middle class women are forced to become poor by spending down their assets to qualify for Medicaid.²⁴⁷ Medicaid ultimately leaves women with fewer options for their long-term care.²⁴⁸ Given that the long-term care subsidies in both Medicaid and Medicare are biased toward institutional care,²⁴⁹ women are concerned about the shortage of informal caregivers and affordable health care aides/nurses available to them in their communities in the short term²⁵⁰ and the long-term care that they’ll need access to in the future.²⁵¹ Unfortunately, federal and state spending on Medicaid competes for public dollars with other government programs.²⁵²

III. MODELS OF ELDER CARE AND THEIR RELEVANCE TO WOMEN

Thanks to advanced medical knowledge, development of public health policies and infrastructure, and improved availability and quality of foodstuffs, we are living longer than ever before. At the turn of the twentieth century people over the

245. See William Galston, *Live Long and Pay for it: America’s Real Long-Term Cost Crisis*, THE ATLANTIC (Sept. 12, 2012), <http://www.theatlantic.com/business/archive/2012/09/live-long-and-pay-for-it-americas-real-long-term-cost-crisis/262247/>; Will Medicaid or Medicare Help Pay for My Mother’s Long-Term Care?, CARING.COM, <https://www.caring.com/questions/medicaid-or-medicare-long-term-care>.

246. *Costs & How to Pay*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://longtermcare.gov/costs-how-to-pay/> (savings can include annuities, retirement funds, reverse mortgages on homes, etc.). See *infra* notes 294 and 335.

247. *Nursing Home Bills are Swamping Medicaid*, MONEY <http://time.com/money/4427532/long-term-care-medicaid-costs/> (“[M]iddle-class Americans..often must spend down or transfer their assets to qualify for Medicaid coverage.”); Tomas G. Donian, *Middle-Class Medicaid*, (July 1, 2017), <https://www.barrons.com/articles/middle-class-medicaid-1498887732>; Weinberg, *supra* note 243, at 568.

248. See Andrew Melnyk & Harh Sharma, *Who Will Pay for Our Long-Term Care* 1 (Nov. 2014), https://www.acli.com/-/media/ACLI/Public/Files/PDFs-PUBLIC-SITE/Public-Consumer-Info/LTC-insurance/LTC_Report.ashx

249. *Long Term Care Facilities*, <https://quizlet.com/98924637/long-term-care-facilities-flash-cards/> (“America’s long-term care system is heavily biased toward institutional care, mostly nursing-home care.”); AARP, *Why Long-Term Care Is A Women’s Issue*, AARP.ORG (Sept. 2010), http://www.aarp.org/relationships/caregiving/info-10-2009/boomer_women.html.

250. Darla Mercado, *Women Are Losing Sleep over this Retirement Savings Fear*, CNBC (Sept. 29, 2018), <https://www.cnbc.com/2018/09/28/women-are-losing-sleep-over-this-retirement-savings-fear.html> (stating that 7 in 10 women are “very concerned” about their long-term care); Folbre, *supra* note 140, at 374 (“The upsurge in interest in work/family policies has been accompanied by intensified concerns about the scandalously poor quality of nursing-home care, the shortage of home health care aids and nurses, the conspicuous inefficiencies of our health care system. . .”).

251. Melnyk & Sharma, *supra* note 248, at 5.

252. *Policy Basics: Where do Our Federal Tax Dollars Go?*, CTR. ON BUDGET & POL’Y PRIORITIES (Mar. 4, 2016), <http://www.cbpp.org/research/federal-budget/policy-basics-where-do-our-federal-tax-dollars-go>.

age of sixty-five constituted just 4.1% of the population.²⁵³ Now, that percentage has more than trebled, and this cohort exceeded 46 million.²⁵⁴ By 2045, “there will be as many people over eighty as there are under five.”²⁵⁵ By 2050, a fifth of our population will be sixty-five or older.²⁵⁶

As this population gets older and lives longer, the availability of long-term care will need to expand commensurately. The Department of Health and Human Services has estimated that “52% of Americans turning 65 today will develop a disability requiring long-term care services.”²⁵⁷ As the aging population has increased, we have seen a growth in social safety net programs for our older citizens. Until 1965 there was no Medicare or Medicaid,²⁵⁸ and elder citizens in physical and/or financial distress were either taken care of by their families or were committed to the “poorhouse.”²⁵⁹ Today, government sponsored programs provide around seventy percent of long-term-care financing.²⁶⁰ Even with these tools in place, certain perspectives remained constant: Seniors (1) want to age in place, either in their homes or home-like environments; (2) desire care that delivers high quality service that respects their dignity; (3) when possible, prefer to be cared for by their loved ones; and (4) want to secure needed care in the most financially affordable manner.²⁶¹

As the aforementioned demographic data illustrate, a large and growing population of seniors, many of whom will require a high degree of late-life care assistance, poses fresh questions about our individual and collective orientations to relationship of care and dependency.

Feminist literature has focused considerable attention to these issues. A wing of thought known as Ethical Feminism²⁶² builds from the premise that our

253. ADMIN. ON AGING, *A Profile of Older Americans: 2011 2* (2011), <https://www.aarp.org/content/dam/aarp/livable-communities/learn/demographics/a-profile-of-older-americans-2011-aarp.pdf>.

254. Wan He, Daniel Goodkind, & Paul Kowal *An Aging World: 2015: International Population Reports*, U.S. CENSUS BUREAU (March 2016), <http://cdn.census.gov/ipeds/data/c2k15/tables/2015/00000000000.pdf>.

255. Gawande, *supra* note 11, at 36.

256. See Seib, *Immigration*, *supra* note 69, at A4.

257. *Id.*

258. *Id.*

259. *Id.* at 35–36.

260. Diane R. Calmus, *The Long-Term Care Financing Crisis*, CTR. FOR POL’Y INNOVATION 7 (Feb. 6, 2013), http://s3.amazonaws.com/thf_media/2013/pdf/CPI_DP_07.pdf.

261. Jennifer Levitz, *Communities Struggle to Care for Elderly, Alone at Home*, WALL ST. J. (Sept. 25, 2015), <http://www.wsj.com/articles/communities-struggle-to-care-for-elderly-alone-at-home-1443193481>.

262. Gilligan, *supra* note 6 (Gilligan’s research focused on how men and women make moral choices and solve moral dilemmas. She named the approach of the female as an “ethic of care” and distinguished it from the male approach—as a “different voice.”); see also Mary Jo Frug, *Progressive Feminist Legal Scholarship: Can We Claim “A Different Voice”?*, 15 HARV. WOMEN’S L.J. 37, 50 (1992) (uses the word “crude Gilliganism” to describe how some commentators argued that the origin of the difference was biological rather than environmental.); Nel Noddings, *Caring: A Feminist Approach to Ethics and Moral Education* (1984) (a descriptive analysis of the philosophy of care, the caring relation, and ethics); see generally *Feminist Ethics*, QUIZLET, <https://quizlet.com/110712781/feminist-ethics-flash-cards/>.

relationships of interdependence form the foundations of human morality and strength. There is considerable disagreement in the academy as to whether these priorities are innately tied to gender or are products of social role assignment. Regardless of source, women are widely acknowledged to have adopted a basic human orientation as existing in relationships to others. As this translates to the present discussion: women care about caring.

A second perspective in the feminist pantheon takes the view that society functions not only as a web of interconnected relationships, but that the foundational relationships of the human network are, by nature, ties defined by dependency. This viewpoint most prominently promoted by Martha Fineman,²⁶³ points to the mother-child “unit” as the primal social component in cultures across the world. The lengthy developmental period required of the human species builds into societal function the *necessity* of dependency relationships as part of the natural order. This means that, to some degree, those who provide care for the wholly dependent are, in turn, dependent upon others to sustain all. This defines the train of thought known as “Derivative Care” theory. One of the principal elements is that contemporary institutions in the United States are based significantly on denial of relationship of dependency in favor of structures founded on presumptions of universal individual autonomy and free association between sovereign actors. Put simply, society functions because we depend on others, but modern institutions are built around the individual. As we observe in the present study, the dramatic change in the make-up of our citizenry will require us to rethink these presumptions and reshape our social institutions and public policies to reflect acknowledgment of the primacy of dependency relationships.

This section will examine the five principal models of elder care: (1) nursing home care, (2) home care, (3) continuing-care retirement communities (or assisted living), (4) residential home care, and (5) adult day care.²⁶⁴ It will compare them based on the criteria considered important by women—quality of care, patient fit, and monetary cost.²⁶⁵ This part will also analyze the means of finance and subsidy of this care, by unpaid or paid caregiving, or through the tax system. I conclude that both direct and indirect tax subsidies favor institutional care and that the tax system does not adequately value or support home-based care. Ample evidence exists, however, to indicate that this model of care provides the best combination of care quality, patient comfort, and cost effectiveness.

263. Fineman, *supra* note 8, at 51 (arguing that regardless of any woman’s individual choice to bear or raise a child, “women will be treated as mothers (or potential mothers)” because “social constructions and its legal ramifications operate independent of individual choice”).

264. *Your Guide to Choosing a Nursing Home or Other Long-Term Care*, CTRS. FOR MEDICARE & MEDICAID SERVS. 11-16 (Aug. 2015), <https://www.medicare.gov/Pubs/pdf/02174-Nursing-Home-Other-Long-Term-Services.pdf>; *What Are My Other Long-Term Care Choices?*, U.S. CENTERS FOR MEDICARE & MEDICAID SERVS., <http://www.medicare.gov/what-medicare-covers/part-a/other-long-term-care/choices.html> (listing eight types of care) [hereinafter *Long-Term Care Choices*].

265. See Harms, *supra* note 110, at 80 n.93 (women want freedom of choice and want to delay institutionalization (citing Deborah M. Merrill, CARING FOR ELDERLY PARENTS: JUGGLING WORK, FAMILY, AND CAREGIVING IN MIDDLE AND WORKING CLASS FAMILIES 167 (1997))).

A. NURSING HOMES

Nursing homes, also known as skilled nursing facilities, are designed for those who need twenty-four-hour medical care and need significant help with their activities of daily living.²⁶⁶ Most “[n]ursing facilities are licensed to provide custodial care; rehabilitative care, such as physical, occupational or speech therapy; or specialized care for Alzheimer’s patients.”²⁶⁷ In another words, this is “skilled care.”²⁶⁸ Nursing homes are a compelling option to some because they have the capability to provide most any medical need a resident might require. Usually a licensed physician supervises the care of each resident and nurse or other qualified medical personnel are available on site twenty-four-hours a day.²⁶⁹ Having these medical professionals on-site “allows the delivery of medical procedures and therapies . . . that would not be possible in other” types of care.²⁷⁰

Nursing home patients are primarily women,²⁷¹ although women generally prefer home-based or community care.²⁷² This is particularly true among advanced-age populations. For example, of those patients in nursing homes over eighty-four years of age, seventy-four percent are women.²⁷³ There is strong evidence to suggest that, based on established medical criteria to determine appropriate assignment of patients to nursing homes, many of these women should not be there. A significant number of nursing home residents do not need assistance with two activities of daily living,²⁷⁴ meaning that these persons do not meet the threshold levels of degraded function to qualify as “chronically ill,” but are classified as such simply because they are already institutionalized.²⁷⁵

There are two main drawbacks to nursing homes: the low levels of satisfaction among residents and the high cost. First, the Nursing Home Reform Act (NHRA) of 1987 was enacted to remedy the bleak findings of a study commissioned by Congress revealing widespread abuse and poor treatment of residents in these facilities.²⁷⁶ One of the outcomes of the NHRA was the establishment of the residents’ “bill of rights” that entitles them to visitations, grievance procedures,

266. ADVISOR’S GUIDE, *supra* note 73, at 31.

267. *Glossary*, MCKINGHTS.COM, <http://www.mcknights.com/glossary/n/> (defining “Nursing Facility”).

268. *See also Skilled Nursing Facility (SNF) Care*, MEDICARE.GOV, <https://www.medicare.gov/coverage/skilled-nursing-facility-care.html>. Most residents, with the average age of 84, require help with at least three activities of daily living. Kevan H. Namazi & Paul Chafetz, ASSISTED LIVING: CURRENT ISSUES IN FACILITY MANAGEMENT AND RESIDENT CARE 16 (2001).

269. ADVISOR’S GUIDE, *supra* note 73, at 31.

270. *Id.* *See also* Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, U. ILL. L. REV. 47, 56–57 (2004).

271. *See* Ari Houser, NURSING HOMES (2007), https://assets.aarp.org/rgcenter/il/fs10r_homes.pdf.

272. *See* Cadance Howes, *Who Will Care for the Women?*, in WOMEN AND RETIREMENT SECURITY 3 (Heidi Hartmann & Sun-hwa Lee eds, 2007).

273. *Resident Profile*, NAT’L CTR. FOR ASSISTED LIVING, <https://seniorpath.com/senior-living-resident-profile/>.

274. *Id.*

275. *Id.*

276. 42 U.S.C. § 1395 i-3.

notification of particulars of medical treatment, and so on.²⁷⁷ In addition, many nursing facilities offer residents a wide variety of planned social, recreational, and spiritual activities.²⁷⁸ The intention of such operational features is to provide environments that offer a degree of stimulation and social interaction that can counter feelings of isolation that many individuals experience in the institutional care setting.²⁷⁹ On the other hand, many nursing home patients express low satisfaction with these facilities.²⁸⁰ The most common complaints of nursing home residents have been coined the “Three Plagues:” boredom, loneliness, and helplessness.²⁸¹ Operational shortcomings are also common sources of displeasure, including inadequate resources to meet individual needs²⁸² and chronic understaffing, which results in non-responsiveness to the patient call button—

277. Nursing Home Residents’ Bill of Rights should include the following: (1) the right to be informed of your rights and the policies of the home, (2) the right to be informed about the facility’s services and charges, (3) the right to be informed about your medical condition and treatment, (4) the right to participate in planning your care and medical treatment, (5) the right to choose your own physician, (6) the right to manage your own personal finance, (7) the right to privacy, dignity, and respect, (8) the right to personal possessions, (9) the right to be free from abuse and restraints, (10) the right to voice grievance without retaliation, and (11) the right to be discharged or transferred only for medical reasons. See 42 U.S.C. §§ 1395 i-3, 1396r (2000).

278. Anthony Cirillo, *Activities for Nursing Homes and Assisted Living*, VERY WELL HEALTH (Dec. 5, 2017), <https://www.verywellhealth.com/activities-for-nursing-homes-and-assisted-living-197773>.

279. Gawande, *supra* note 11, at 116. Gawande tells the story of Bill Thomas who accepted a job as director of Chase Memorial Nursing Home in New York, with 80 severely disabled elderly residents. Thomas added dogs, cats, birds, plants and children to liven up the place and increase the satisfaction of the residents. “In place of boredom, they offer spontaneity. In place of loneliness, they offer companionship. In place of helplessness, they offer a chance to take care of another being.” *Id.* Relying on Josiah Royce, a Harvard philosopher who wrote *The Philosophy of Loyalty*, Gawande says “we all seek a cause beyond ourselves. . . . The cause could be large (family, country, principle) or small (a building project, the care of a pet). The important thing was that, in ascribing value to the cause and seeing it as worth making sacrifices for, we give our lives meaning.” *Id.* at 126.

280. See NATIONAL ACADEMIES OF SCIENCE, ENGINEERING, MEDICINE, *Satisfaction as Measure of Quality* (Sept. 17, 2014), <http://www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>; Nicolas Castle et al., *Use of Resident Satisfaction Surveys in New Jersey Nursing Homes and Assisted Living Facilities*, J. OF APPLIED GERONTOLOGY (June 1, 2004), <http://journals.sagepub.com/doi/abs/10.1177/0733464804265584>; Genevieve N. Thompson, Susan E. McClement, & Harvy M. Chochinov, *Understanding Bereaved Family Member’s Dissatisfaction with End-of Life Care in Nursing Facilities*, 38 J. OF GERONTOLOGICAL NURSING 49 (2012), https://www.researchgate.net/publication/234064508_Understanding_Bereaved_Family_Members’_Dissatisfaction_with_End-of-Life_Care_in_Nursing_Homes (complaints included receiving confusing and inadequate information from nursing staff about medical treatment of patients and feeling that end-of life care different than expected); THE NATIONAL INSTITUTE OF NURSING RESEARCH, *Changing Practice, Changing Lives: Ten Landmark Nursing Research Studies*, <https://www.ninr.nih.gov/sites/files/docs/10-landmark-nursing-research-studies.pdf>.

281. Gawande, *supra* note 11, at 116.

282. See Georg Bollig et al., *Nothing to Complain About?: Residents’ and Relatives’ Views on a “Good Life” and Ethical Challenges in Nursing Homes*, 23 NURSING ETHICS 143 (2014), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4786778/pdf/10.1177_0969733014557719.pdf.

particularly for toileting needs.²⁸³ Food quality and delivery also receive a high incidence of negative commentary.²⁸⁴

Perhaps the single biggest drawback of nursing home care is its expense. Estimates vary by region, but most reputable surveys set the annual cost per patient at between \$70,000 and \$100,000.²⁸⁵ According to Genworth Financial, in 2014 the annual median cost was \$87,600 for a private room and around \$77,380 for a shared room.²⁸⁶ In states like Connecticut, the care can be double this amount.²⁸⁷ It is sadly ironic that while women generally prefer a low-intrusive style of medical care,²⁸⁸ they often end up in facilities that employ expensive measures and procedures that many elder patients do not desire nor garner benefit.²⁸⁹ These include expensive tests for routine symptoms and ineffective therapies for terminal conditions.²⁹⁰ Even at this, these facilities are generally deemed “more cost effective than hospitals.”²⁹¹

As part of the tax and social safety net benefits, many seniors will end up in nursing homes whether they want to or not. Seniors in poverty will qualify for nursing home care because they are eligible for Medicaid. Middle class individuals and couples, after spending down their assets to the requisite level of depletion, can also receive this public subsidy. Wealthy seniors will likely be able to afford nursing care for a considerable period of time, but despite the comprehensive medical care in such facilities, most care-receivers wish to reside at home.

283. See Huey-Ming Tzeng, *Perspectives of Staff Nurses of the Reasons for and the Nature of Patient-Initiated Call Lights: An Exploratory Survey Study in Four US Hospitals* 1 (2010), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2841165/pdf/1472-6963-10-52.pdf>.

284. See generally Sandra F. Simmons et al., *Resident Complaints about the Nursing Home Food Service: Relationship to Cognitive Status* (2009), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2670252/pdf/gbp007.pdf>.

285. ADVISOR'S GUIDE, *supra* note 73, at 34 (nursing homes can cost an average of \$239 per day); Kirsten J. Colello et al., *Long-Term Services and Supports: Overview and Financing* 5 (Feb. 8, 2011), <https://www.hsd.org/?view&did=707282> (In 2011, the annual median cost of nursing home care was “\$70,445 for a semi-private room, and over \$77,000 for a private room.”).

286. GENWORTH, *supra* note 205, at 18. See also Matthew Craft, *Families Face Tough Decisions as Cost of Elder Care Soars*, ASSOCIATED PRESS (July 21, 2014), <https://www.usatoday.com/story/money/personalfinance/2015/07/24/families-face-tough-decisions-cost-elder-care-soars/30587503/>.

287. GENWORTH, *supra* note 205, at 25.

288. See Gawande, *supra* note 11, at 100 (arguing simple needs at the end of life).

289. See generally Penelope Wang, *Cutting the High Cost of End-of-Life Care*, TIME (Dec. 12, 2012), <http://time.com/money/2793643/cutting-the-high-cost-of-end-of-life-care/>.

290. The primary mission of a nursing home is to provide medical and nursing care, including preparing a written plan, updating that plan once a year and essentially being under the supervision of a physician who is aware of his or her legal obligations of care. This nursing home model results in lots of tests and an emphasis on prolonging life and not life quality. Cf. Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK LAW REV. 407, 415–16 (2007).

291. *Id.* The primary mission of a hospital is to deal with acute illness on a temporary basis. Thus, hospital stays are shorter, but more expensive, than nursing home stays.

1. *Government and Other Financing*

Medicaid pays for just over half of all nursing home stays.²⁹² Medicare, which was never intended as a long-term care option, also provides significant funding for some long-term care expenses.²⁹³ Few seniors use purely private savings and even fewer carry long-term insurance.²⁹⁴ Family assistance helps with all of this financing as well as providing personal, practical and companion care.

a. Medicaid. Medicaid is the largest single source of payment for long-term care, financing six-in-ten nursing home residents.²⁹⁵ Nursing home residents accounted for nine percent of Medicaid enrollees, but twenty-one percent of all program spending.²⁹⁶ In 2016, Medicaid paid over \$48.9 billion in long-term care for more than 1.5 million recipients of those services.²⁹⁷ That is an average expenditure of \$32,153 per nursing home beneficiary recipient for that year.²⁹⁸ The amount received per recipient depended on the length and amount of care needed; individual benefits could vary greatly, especially if recipients only needed care for a small portion of the year or only needed coverage for doctor's visits.²⁹⁹

Medicaid is a federally funded but state-administered program. Within broad national guidelines, states create their own eligibility requirements and some variability in the "type, amount, duration, and scope of services."³⁰⁰ For example, in some states a nursing home stay might include services for patients in their own homes with skilled home care.³⁰¹ However, other states have sought to limit their aggregate Medicaid expenditures by rejecting the expansion of Medicaid

292. Julia Paradise, *10 Things to Know About Medicaid: Setting the Facts Straight*, THE HENRY J. KAISER FAMILY FOUND. 1, 8 (June 9, 2017), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/> (sixty-four percent of nursing home residents depend upon Medicaid. Nursing home residents account for 6% of Medicaid enrollees but 42% of all program spending). See also *Spectrum of Available Care: Other Options to Consider* (Jan. 2001), [www.CONSUMERREPORTS.COM](http://www.consumerreports.com).

293. Consumer Reports, *Spectrum of Available Care: Other Options to Consider* (Jan. 2001), [www.CONSUMERREPORTS.COM](http://www.consumerreports.com); see also U.S. CENSUS BUREAU, *Health Insurance Detailed Table: 2000* (Sept. 2001), <https://www.census.gov/hhes/www/hlthins/data/incpovhlth/2000/hi00t1.html>.

294. *Id.* (17% out of pocket, 11% private insurance, 53% Medicaid, and 20% from Medicare). See Hollander, *supra* note 29, at 594.

295. Paradise, *supra* note 292.

296. Paradise, *supra* note 292 Figure 1 (children made up 43% of the enrollees and the disabled took 40% of expenditures).

297. CTRS. FOR MEDICARE & MEDICAID SERVS., *Brief Summaries of Medicare and Medicaid: Title XVIII and Title XIX of The Social Security Act 31* (Nov. 20, 2017), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2017.pdf>.

298. CTRS. FOR MEDICARE & MEDICAID SERVS., *Brief Summaries of Medicare and Medicaid: Title XVIII and Title XIX of The Social Security Act 29* (Nov. 1, 2013), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2013.pdf> (this total excludes costs for intensive care facilities).

299. *Id.*

300. *Brief Summaries*, *supra* note 297, at 22.

301. ADVISOR'S GUIDE, *supra* note 73, at 48.

eligibility thresholds under the Affordable Care Act.³⁰² Many states have instituted programs that promote the purchase of long-term care insurance in the hope that purchases of such policies will forestall exhausting all their liquid assets that eventually will lead to publicly-subsidized institutionalization.

The highest profile initiative of this sort is a thirty-nine state cooperative with the federal government known as the Partnership for Long-Term Care (PLTC).³⁰³ The PLTC program started as a four-state consortium under a precursor program in 1989, but was expanded by a congressional push to lower the deficit by trimming Medicaid spending and allowing states to impose “cost-sharing” and premiums for recipients on a variable basis depending on income as a percentage of the Federal Poverty Level (FPL).³⁰⁴ The idea of the PLTC is to incentivize the purchase of long-term care insurance policies that meet state coverage standards. The programs essentially waive some or all of the Medicaid asset depletion requirements for purchasers of qualified policies, allowing the purchaser to retain more of their assets and still qualify for Medicaid.³⁰⁵ Otherwise the Omnibus Budget Reconciliation Act of 1993,³⁰⁶ which amended the Social Security Act, mandates recovery of the value of long-term care benefits from the estate of decedents who received Medicaid.³⁰⁷ Essentially the states guarantee that they will not deplete all assets for long-term care before the purchaser qualifies for Medicaid coverage.³⁰⁸

302. Some states are even requiring work for eligibility, not an issue with those in nursing homes. See also Michael Hiltzik, *Fiscal Idiocy: What States Refusing Medicaid Will Cost Their Citizens*, LATIMES.COM (Dec. 6, 2013), <http://www.latimes.com/business/hiltzik/la-fi-mh-citizens-20131206,0,7229746.story#axzz2veTIEN8W>.

303. Jamie P. Hopkins, Theodore T. Kurlowicz, Christopher P. Woehrie, *Leveraging Filian Support Laws Under the State Partnership Programs to Encourage Long-Term Care Insurance*, 20 WIDENER L. REV. 165, 186, n. 318 (2014) [hereinafter Hopkins]. States without such plans include Alaska, Delaware, Hawaii, Illinois, Massachusetts, Michigan, Mississippi, New Mexico, Utah, Vermont, and Washington. See AM. ASSOC. FOR LONG-TERM CARE INSURANCE, *Long Term Care Insurance Partnership Plans*, <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#faq>; see generally Joanie Rothstein, *Long-Term Care Partnership Expansion: A New Opportunity for States*, CTR. FOR HEALTH CARE STRATEGIES, INC. (May 2007), https://www.chcs.org/media/Long-Term_Care_Partnership_Expansion.pdf.

304. *The Deficit Reduction Act: Important Facts for State Government Officials, Medicare and Medicaid Services* DEP'T OF HEALTH & HUM. SERVS. 2 (2006), <https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/Guide.pdf>. See Poverty Guidelines, *supra* note 174.

305. See Hopkins, *supra* note 303, at 185 (“purchasing a qualified long-term care insurance policy in a state with a qualified State Partnership Program could help protect an individual’s assets, requiring the individual to spend down less in order to qualify for Medicaid coverage”).

306. Pub. L. No. 103-66, 107 Stat. 312 (1993) (codified at 42 U.S.C. § 1396p (West, Westlaw through P.L. 115-223)).

307. *Id.* at § 1396p(b)(1)(B). (“In the case of an individual who was fifty-five years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual’s estate.”).

308. Alexis Ahlstrom, Emily Clements, Anne Tumlinson, *Long-Term Care Partnership Program: Issues and Options*, GEORGE WASHINGTON UNIV. SCH. OF PUB. HEALTH AND HEALTH SERVS. 4.

People who purchase such a qualified plan benefit³⁰⁹ because, regardless of the type of care they require in the future, they will receive the appropriate service and not have to spend down assets to qualify for Medicaid.³¹⁰ This will avoid the possibility of losing all their assets, which could be a very powerful incentive. An additional incentive is the fact that these state plans act as qualified long-term care contracts,³¹¹ which means payments are tax deductible under not only state tax law but also under the medical expense deduction in federal tax law.³¹² In theory, all of these could be powerful inducements to purchase long-term care insurance.

The PTLTC program, however, seems to be unsuccessful for three reasons.³¹³ First, asset protection is not a driving force for the purchase of insurance. Second, essentially these programs give easier access to Medicaid, which is not perceived as desirable by people looking to purchase long-term care insurance.³¹⁴ Third, premiums on long-term care policies are rising rapidly, especially for women, who have the greatest apparent incentive to purchase them.³¹⁵ States have hoped to encourage individuals to purchase long-term care insurance in these programs as a means to promote personal responsibility.³¹⁶ Further, states want to expand the market for private long-term care insurance to make it accessible to the middle class.³¹⁷ Unfortunately, like the state tax incentive initiatives, the PLTC has had only “modest success.”³¹⁸ In one study of seventeen states, only 165,000

309. See Hopkins, *supra* note 303, at 183-185 (the insurance contract must satisfy seven specific statutory requirements of the Deficit Reduction Act of 2005 plus five other requirements, such as portability, inflation protection, and constrained ability of insurers to raise future premiums).

310. See Hopkins, *supra* note 303, at 185.

311. I.R.C. § 7702B(f)(1) (West, Westlaw through P.L. 115-223) (“If (A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and (B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract, such plan shall be treated as a qualified long-term care insurance contract for purposes of this title. . . (2) For purposes of paragraph (1). . . “State long-term care plan” means any plan (A) which is established and maintained by a State or an instrumentality of a State, (B) which provides coverage only for qualified long-term care services, and (C) under which such coverage is provided only to (i) employees and former employees of a State, (ii) the spouses of employees, and (iii) individuals with a relationship to employees or spouses described in any of paragraphs (A) – (G) of §152(d)(2).”).

312. I.R.C. § 213 (West, Westlaw through P.L. 115-223). See *supra* note 44 and *infra* notes 345-351 and accompanying text.

313. Joshua M. Wiener, Jane Tilly, & Susan M. Goldenson, *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 ELDER L. J. 57, 88 (2000); see Ahlstrom, *supra* note 308 (they point to different problems: (1) maintaining and expanding consumer protections, (2) enhancing the Medicaid component, and (3) education of the public as to the benefits of the program).

314. Given that people want to remain in their homes, institutionalization is not the preferred option.

315. Eleanor Laise, *Long-Term Care Coverage Costlier for Women*, KIPLINGERS RETIREMENT REP. (2013).; see also Scism, *supra* note 208.

316. *Id.* at 84.

317. *Id.*

318. See Howard Gleckman, *Healthcare and the Long-Term Fiscal Outlook*, 65 TAX L. REV. 835, 855 (2012) [hereinafter Gleckman].

policies were sold over a ten-year period.³¹⁹

While Medicaid can help to provide care to people who need it, the program has its limits. One of the vagaries of Medicaid is that it is not universally accepted by top-level nursing homes, while other homes restrict the numbers of Medicaid residents to a limited percentage.³²⁰ Moreover, Medicaid does not cover recreational activities or other forms of non-medical care.³²¹ Because Medicaid requires enrollees to spend down their financial assets, even special rules that allow community spouses (the ones remaining at home) to retain some of their collective income and assets cannot prevent both spouses from living in poverty.³²² In an income test state, a married Medicaid applicant is eligible only when all the couple's resources are reduced to a level of a prescribed allowance for the community spouse, the applicants' resource allowance amount, and exempt resources.³²³ The balance of the resources must be spent down or protected before they qualify for Medicaid. Generally, it is necessary for both the infirm individual and spouse to live in poverty to qualify for Medicaid assistance. As a practical financial survival strategy, divorce is sometimes recommended.³²⁴

b. Medicare. Medicare, which was never designed to provide for long-term care, provides almost twenty percent of long-term care costs³²⁵ and, with certain

319. *Id.* at n. 150.; see also Robert Crum, *Creating Long-Term-Care Insurance Options for Elderly People*, ROBERT WOOD JOHNSON FOUND., 3-4 (2011) <http://www.rwjf.org/content/dam/web-assets/2011/10/creating-long-term-care-insurance-options-for-elderly-people>.

320. See *Medicaid and Nursing Homes: Medicaid Facts as they Relate to Nursing Homes, SkilledNursingFacilities.org*, <https://www.skillednursingfacilities.org/resources/medicaid-and-nursing-homes/> (last visited Sept. 7, 2018).

321. ADVISOR'S GUIDE, *supra* note 73, at 48.

322. *Id.* at 48-49.

323. Janice E. Hatton & John C. Urness, *Basics of Medicaid Law*, OREGON EST. PLANNING AND ADMIN. SEC. NEWSL., Vol. XVII, No. 2, 4 (April 2000), http://oregonestateplanning.homestead.com/April_2000.pdf (In order to receive Medicaid LTC health services in Oregon, the applicant must either receive Supplemental Security Income, Aid to Dependent Children, or meet both an income and a resource test. The 2000 income cap limit was \$1,536 per month. The applicant is not eligible for Medicaid if his income is over unless he can transfer or eliminate enough income to get under the cap. The income cap amount is three times the SSI amount and is adjusted annually. Only the income of the applicant is counted for Medicaid-qualifying purposes; Spousal income is not. Available income includes social security, pension benefits, annuity payments, and alimony. If the applicant's monthly income is over \$1,536 it is necessary to shift income from the applicant to another. Otherwise, the applicant may establish an Income Cap Trust to meet the income test. Once established, all the recipient's monthly income goes into the Trust bank account. Allowable monthly distributions from the Trust include a personal needs allowance, fees associated with the administration of the Trust, health insurance premiums, medical care costs, the purchase of an irrevocable burial plan, and possibly payments to the spouse. After payment of all allowable deductions, the balance must be paid to the long-term care facility.).

324. *Id.* at 11.

325. Paradise, *supra* note 292; *Id.* at 595 (In 1996, Congress passed the Balance Budget Act and the Health Insurance Portability and Accountability Act which reaffirmed the government's intent not to cover chronic, long-term home care. Medicare only covers rehabilitation, acute care); see also ADVISOR'S GUIDE, *supra* note 73, at 46.

restrictions, will pay some nursing home costs.³²⁶ Like Medicaid, Medicare has its limits. For example, Medicare will only cover services “from a Medicare certified skilled nursing home after a qualifying hospital stay.”³²⁷ Medicare will not cover custodial care in the absence of a skilled care plan that consists of assistance with bathing, dressing, ambulating, toileting, incontinence, feeding, and administering medication.³²⁸ After the annual deductible (\$1,316 in 2017) has been paid, Medicare pays for up to ninety days of care, but only after a three-day hospitalization. The first sixty days are covered in full, but the last thirty days are subject to a daily co-pay (\$329 in 2017).³²⁹ Medicare often stops paying after the first 100 days following a hospital stay if a given medical condition is not improving.³³⁰ Despite these restrictions, Medicare remains a valued option because it is available to everyone who qualifies, whether they are wealthy or poor.

Medicare Part A covers both nursing home care and hospice care³³¹ and is financed by the Federal Insurance Contribution Act (FICA), which imposes a mandatory payroll tax on the wages of employees and the self-employed.³³² Employees pay a 1.45% tax on all wage income and the employer matches this 1.45% amount.³³³ Self-employed individuals pay a tax of 2.9% as well—on their employment income. An additional 0.9% tax is paid by higher income-earners, on wages and self-employment income that exceed \$200,000 for a single taxpayer (\$250,000 for a married couple filing joint).³³⁴

c. Savings and Insurance. Savings and long-term care insurance represent a small amount of the financing for nursing homes. With regard to savings, nearly seventeen percent of long-term care costs are paid for out-of-pocket or financed

326. See FROLIK, *supra* note 80, at 74 (“Medicare pays for semiprivate rooms,” but the annual deductible in 2017 was \$1,316).

327. The Medicare definition of a SNF requires a registered nurse to be on duty 14 hours a day, a physician to be on call at all times, and an ambulance service be available to a local hospital.

328. *Id.* (“Prior to 1997, Medicare reimbursements to nursing homes were based on actual costs submitted on each patient.” After the Balanced Budget Act of 1996, however, payment is “based on a pricing formula determined by the intensity of care needed as well as the number of anticipated days of care multiplied by a rate factor derived from 1998 historic costs in the geographic area” of the skilled nursing facility. Since this is a prospective payment, the nursing homes have claimed they are losing money from the current reimbursement system.). See *Brief Summaries of Medicare and Medicaid: Title XVIII and Title XIX of The Social Security Act*, U.S. DEP’T OF HEALTH & HUM. SERVS. 11, Nov. 1, 2013, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2013.pdf>.

329. After the first 90 days, days 91-150 are covered by the 60 lifetime reserve days. The lifetime reserve days have a daily co-pay of \$658 in 2017. See FROLIK, *supra* note 80, at 74.

330. ADVISOR’S GUIDE, *supra* note 73, at 45.

331. This is end-of life care that focuses on pain relief. “Medicare A provides hospice care for two 90-day periods followed by an unlimited number of 60-day periods.” See FROLIK, *supra* note 80, at 75.

332. See generally I.R.C. §§ 3101-3201.

333. *Fact Sheet: 2017 Social Security Changes*, SOC. SECURITY ADMIN., <https://www.ssa.gov/news/press/factsheets/colafacts2017.pdf> (last visited Sept. 8, 2018).

334. *Id.*

by private savings accounts.³³⁵ With regard to insurance, long-term care insurance represents slightly over seven percent of the costs.³³⁶

Wealthy taxpayers are often better off financially if they self-insure. First, they can adopt a “wait and see” approach, hedging their bets that they may never need long-term care. Second, if they do need care, they benefit from bunching all the long-term care expenses into one year. This is definitely a perverse policy as it runs counter to the very rationale of purchasing long-term care insurance to begin with. Sometimes, when the elderly parent has not saved enough to pay for long-term care, their children will pay in their stead.³³⁷

2. Tax Subsidies

The tax system provides several generous tax subsidies for nursing home care but does not incentivize home-based care in the same way. First, the tax code allows individuals to completely exclude from their gross income the value of any benefits received under Medicare and Medicaid, including meals and lodging provided in nursing facilities. Second, the tax code allows for a partial exclusion of nursing home care if it is paid through long-term care insurance. Third, for taxpayers who itemize their deductions (rather than taking the standard deduction), the tax code allows a deduction for medical care expenses that could include the value of meals and lodging, as well as the purchase of long-term care insurance.

a. Exclusion of Medicare and Medicaid Benefits Received for Long-Term Care. If an individual receives benefits through social insurance, such as Medicare and Medicaid, they can exclude those benefits from their gross income. The welfare exception in the tax area would preclude the taxability of benefits received based on need, but they would also exclude entitlements from income under federal subsidy programs.³³⁸ Thus, this tax benefit can be extremely valuable. For example, if the value of a shared nursing home room is around \$100,000 and if that value were included in the senior’s taxable income, under the 2018

335. See Paradise, *supra* note 292. Private savings options for long-term care include traditional savings, and other techniques, such as home-equity loans, reverse mortgages, annuities, trusts, or life settlements. All of the details of these savings mechanisms are beyond the scope of this Article. Many advisors believe that a client with assets exceeding \$2 million will not need long-term care insurance, at least if there is sufficient income flow and liquidity of assets. See Joan M. Krauskopf, et al., *Elderlaw: Advocacy for the Aging 2d* §12.62 (1999). According to the Center for Retirement Research at Boston College, less than 15% of households have accumulated that much in total financial assets. Anthony Webb & Natalia Zhivan, *What Is the Distribution of Lifetime Health Care Costs from Age 65?*, CTR. FOR RETIREMENT RESEARCH AT B.C., No. 10-4, March 2010.

336. See Paradise, *supra* note 292.; see also ADVISOR’S GUIDE, *supra* note 73 (life insurance, annuities and other “hybrid” products have been popular for use for long-term care.).

337. See *infra* Part II(B)(2)(a).

338. See Theodore P. Seto and Sande L. Buhai, *Tax and Disability: Ability to Pay and the Taxation of Difference*, 154 U. OF PENN. L. REV. 1053, 1106 (2006) (“Perhaps the single most important tax rule of particular relevance to people with disabilities, a set of ruling known collectively as the “general welfare doctrine,” excludes most safety net payments from income—an issue of vital importance to people with disabilities.”).

federal income tax system the marginal tax rate would be around twenty-four percent.³³⁹ Thus, the benefit of this exclusion includes the value of the room as well as the board (including other services received by the patient), and thus could be significant. Although most of the beneficiaries of this exclusion are poor, when Medicare pays the bill, the wealthy also benefit. In the last section of this Article I propose that a part of this amount be taxed.

b. Exclusion of Long-Term Care Insurance Benefits Received. When long-term care insurance covers the cost of nursing home care, the recipient can partially exclude the amount.³⁴⁰ Long-term care policies that pay a set daily amount without regard to actual expenses incurred are not taxable up to a per diem amount (\$360 in 2018).³⁴¹ This per diem exclusion amount is very reasonable since the average private room costs \$267 and a semi-private room \$235.³⁴² However, long-term care policies that pay or reimburse actual expenses are not taxable.³⁴³ Any payments that represent dividends or refunds are taxed.³⁴⁴

c. Itemized Deduction for Medical Care Expense. When paid for by the taxpayer, the costs of nursing homes, including the costs of meals and lodging, can be deductible as an itemized deduction. The tax code requires that these payments exceed a floor amount and qualify as unreimbursed qualified medical expenses.³⁴⁵ This deduction is an itemized deduction, which means that it is only available to

339. *Id.* at 1108. *See* I.R.C. § 1 (showing that a single taxpayer with taxable incomes between \$82,500 and \$157,500 pay taxes at the marginal rates of 24%. Starting in 2018 no personal exemption is available. Instead, a standard deduction of \$12,000 is available to the single taxpayer plus an additional “old age” amount.).

340. Amounts received for nursing home care are generally excludable from income as amounts received for personal injury or sickness. INTERNAL REVENUE SERV., PUB. NO. 525, *Taxable and Nontaxable Income* 42 (2018). 26 USC § 7702B(a)(2) amounts received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (defined in § 213(d)). The excludable amount is figured by subtracting any reimbursement received for the cost of qualified long-term care services from the larger of the following amounts: The cost of qualified long-term care services; or the dollar amount for the period (\$200 per day in 2001). *Id.*

341. *2018 Tax Implications of Long-Term Care Insurance (LTCi) for Individuals and Businesses*, MASS. MUTUAL LIFE INS. CO., <https://www.massmutual.com/efiles/ltc/pdfs/ltc1419.pdf>. The per diem limit must be allocated among all policyholders who own contracts of the same insured. The taxpayer should receive Form 1099-LTC showing any payments from the insurance contract. Box 3 will indicate if the payments were made on a per diem basis or were reimbursements of actual long-term care expenses. “Per diem payments and reimbursements must be reported on Form 8853 to determine if any of the per diem payments are taxable.” *See* J.K. Lasser’s, *YOUR INCOME TAX 2017 TAX GUIDE* 393 (2017).

342. *See* GENWORTH, *supra* note 205.

343. *See* Lafond, *supra* note 210.

344. *See* Lafond, *supra* note 210, at 161 (“LTC benefit payors must report the benefits paid by January 31 of the year following the benefit payments. The report must include the name, address, and Social Security number of the individual receiving the benefits. In addition, the payor must state how the benefits were paid (either whole or in part on a per diem basis) on an annual basis.”).

345. *See* I.R.C. § 213 (West, Westlaw through P.L. 115-223).

those taxpayers who do not take the standard deduction.³⁴⁶ Most elderly women have no tax liability and thus will receive little or no benefit from this provision.³⁴⁷ With the increase in the standard deductions under the TCJA most taxpayers are likely to forgo taking the itemized deductions altogether. The Tax Policy Center estimates that “about 11% of house-holds are projected to itemize deductions” as a result of the TCJA, “down from 26% under the prior” tax law.³⁴⁸ Under the TCJA, the standard deduction for 2018 (which will be adjusted for inflation thereafter) is \$24,000 for married couples filing jointly, \$18,000 for head of households, and \$12,000 for single taxpayers.³⁴⁹ If the taxpayer making these payments is 65 or older they may receive an additional standard deduction (\$1,300 if married or \$1,600 if single for 2018), making them even less likely to itemize.³⁵⁰ That means for a single woman over sixty-five, medical expenses in 2018 would have to be greater than \$13,600 to receive any tax benefit at all.

In addition to the itemized deduction hurdle, the medical care deduction must be over a floor amount. Under the TCJA, the overall AGI percentage limit will be 7.5% (for the next two years), regardless of whether the taxpayer paying for the care is under the age of sixty-five.³⁵¹ For example, if a taxpayer pays nursing home expenses of \$30,000 and has an AGI of \$100,000, then \$30,000 less \$7,500 (or \$22,500) will be deductible as an itemized deduction.

The last hurdle is that the definition of unreimbursed qualified medical expenses must be met to obtain this itemized deduction. Unreimbursed qualified

346. In fact, most taxpayer do not pay federal income tax. Brad Plumer, *Who Doesn't Pay Taxes in Eight Charts*, WASH. POST, (Sept. 18, 2012), https://www.washingtonpost.com/news/wonk/wp/2012/09/18/who-doesnt-pay-taxes-in-charts/?noredirect=on&utm_term=.8f5142785cb0. See also Roberton Williams, *Why Nearly Half of Americans Pay No Federal Income Tax*, TAX NOTES (June 7, 2010). Under the tax code deductions can be above-the-line or deduction in reaching adjusted gross income, I. R.C. § 62 (a)(1)-(21) (West, Westlaw through P.L. 115-223) (which lists those deductions specifically), or deductions can be below-the-line deductions I.R.C. § 63(d)(1) (West, Westlaw through P.L. 115-223). The medical deduction of §213 is not listed above-the line so it is an itemized deduction. That deduction (plus others, such as mortgage interest, taxes and charitable) will constitute below-the-line deductions and will result in the taxpayer itemizing their deductions. Thus, the taxpayer will either take the basis standard deduction (plus “old age additional amount) or will use form Schedule A and itemize their deductions.

347. I.R.C. § 63(b)(1), (3); *Itemizing or Standard Deduction: Six Tips to Help You Choose*, INTERNAL REVENUE SERV. (MAR. 10, 2014), <https://www.irs.gov/newsroom/itemizing-vs-standard-deduction-six-tips-to-help-you-choose>.

348. See Richard Rubin, *Tax Law Spurred a Rush to Charitable-Giving Funds*, WALL ST. J., Feb. 2, 2018, at A2.

349. I.R.C. § 63(c)(7)

350. I.R.C. § 63(c)(3), (f). One-half of Americans who are 65 or older have no tax liability, which means deductions for medical expenses are of no value. Of the remaining, many have paid off their home mortgage so will have no deduction for that. Even if itemized deductions exceed the basic standard and the “old-age” additional amount, the tax benefit is only an excess amount. See Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care*, 25 VIR. TAX REV. 509 at 544 nn. 229-30 (2005).

351. I.R.C. § 213(f)(2). In two years the percentage goes back to 10% for taxpayer who have not attained the age of 65. In that year, a recalculation under the alternative minimum tax of 2.5% will need to be made. See I.R.C. § 56(b)(1)(B).

medical expenses include certain long-term care services for the chronically ill. These services provide “necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services,” as well as “maintenance or personal care services.”³⁵² If medical services are not the primary reason for admission to the facility, then a deduction is not allowed for meals and lodging. If the patient entered the nursing home on a recommendation from the doctor, the treatment at the facility had a direct therapeutic effect on the patient, and the attendance was for a specific ailment rather than for a “general” health condition, then the deduction for the total nursing home costs (including all meals and lodging) will be allowed.³⁵³

The premiums on any qualified long-term care insurance may also be a qualified medical expense. The maximum allowed as a deduction is based on the taxpayer’s age at the end of the year.³⁵⁴ Thus, for 2018, (1) \$420 is allowed for a taxpayer forty years old or under at year-end, (2) \$780 for a taxpayer forty-one through fifty; (3) \$1,560 for a taxpayer fifty-one through sixty; (4) \$4,160 for a taxpayer sixty-one through seventy, and (5) \$5,200 for a taxpayer over seventy years old.³⁵⁵ Since most long-term care policies have an elimination period, the taxpayer can combine the medical expenses during that year, with the premiums paid on the insurance, and they may be able to exceed the 7.5% limit. Thus, the insurance premiums may not eliminate completely this itemized deduction, as those premiums, plus other medical expenses, could be greater than these 2018 amounts.

B. HOME CARE

Home Care is long-term care furnished to recipients in their homes by a family member, friend, or by a paid caregiver, such as a nurse, therapist, home care aide or helper.³⁵⁶ This type of care can range from specialized skilled care to simple companion duties.

The principal benefit of home care is one of physical and mental comfort; most people prefer the familial environments of everyday life and, especially among older Americans, there is more dignity aging in place. Seniors generally play a more proactive role in selecting the types of services they receive in the home setting.³⁵⁷ Staying in one’s house can provide a “feeling of personal control” and

352. I.R.C. §§ 213(d) & 7702B(c)(1) (2006).

353. See Lasser, *supra* note 341, at 389; see also Rev. Proc. 2017-58, 2017-45 I.R.B. 489, at Section 1.26.

354. *IRS Issues Long-Term Care Premium Deductibility Limits for 2017*, ELDER LAW ANSWERS (Feb. 24, 2017), <https://www.elderlawanswers.com/irs-issues-long-term-care-premium-deductibility-limits-for-2017-15826>.

355. Rev. Proc. 2017-58, 2017-45 I.R. B. 489.

356. Thomas Day, *About Long Term Care at Home*, https://www.longtermcarelink.net/eldercare/long_term_care_at_home.htm (care in home is provided by both paid and non-paid providers).; see also ADMIN. ON AGING U.S. DEP’T OF HEALTH & HUM. SERVS., *Where Can You Receive Care?*, <http://longtermcare.gov/the-basics/where-can-you-receive-care/>.

357. See ADVISOR’S GUIDE, *supra* note 73, at 8.

added sense of autonomy,³⁵⁸ particularly crucial factors since more than “half of home care recipients are cognitively impaired” and many of them require around-the-clock supervision.³⁵⁹

By avoiding institutionalization, elder patients better retain powers of engagement and exercise of choice, both of which contribute to an improved quality of life. This preference for home-based elder care is increasing,³⁶⁰ while the percentage of this population residing in nursing homes has declined somewhat over time.³⁶¹ This decline has occurred as the number of elderly citizens requiring long-term care is reaching new highs.³⁶² These phenomena attest to the high level of desire among the elderly to remain in their homes for their care needs.

The growing trend of long-term care insurance claims for home care further demonstrates this increasing desire for home-care. According to the American Association for Long-Term Care Insurance, in 2012, “roughly half of newly opened claims were for home-based care,” thirty-one percent were for nursing homes, and nineteen percent for assisted-living facilities.³⁶³ About seventy-one percent of all long-term care insurance claims begin with home care.³⁶⁴ However, long-term care insurance requires a ninety-day elimination period, meaning that the policyholder must pay a home health-care aid twice a week for forty-five weeks before policy coverage begins.³⁶⁵ Despite this financial burden, care-receivers continue to file claims for home care; clearly, aging in place is an important priority for the care-receiver.

In addition to the physical and mental comfort in-home care provides, home care is “likely to result in higher level[s] of quality” of care when done by a family member.³⁶⁶ A family member’s “stronger personal ethical commitment and personal attachment” to a parent or other relative will likely produce better health results than with stranger care.³⁶⁷ Despite this benefit, home care is not always the best or easiest option. For example, there are reported cases of elder abuse by family members.³⁶⁸ Additionally, because home care may not provide the degree of social interaction and stimulation of more “communal” care settings, there is a premium on selecting the “right” caregiver to alleviate some of the loneliness associated with home care.³⁶⁹

358. See Harms, *supra* note 110, at 85 n.119.

359. National Care Planning Council, *supra* note 37. Those patients who suffer severe cognitive impairment meet, by definition, “qualified long-term care” requirements under §7702 of the tax code.

360. ADVISOR’S GUIDE, *supra* note 73, at 4.

361. *Id.*

362. *Id.* at 8.

363. Scism, *supra* note 72.

364. Lafond, *supra* note 210, at 160.

365. *Id.*

366. See Harms, *supra* note 110, at 84 n.117.

367. *Id.* at 85.

368. See DEP’T OF HEALTH & HUM. SERVS., *Statistics/Data*, <https://ncea.acl.gov/whatwedo/research/statistics.html>.

369. Consumer Reports, *Spectrum of Available Care: Other Options to Consider* (Jan. 2001), www.CONSUMERREPORTS.COM.

Home care is not always an option for the family. In modern life, family members often live far away from relatives and hiring care close to the senior may be challenging given a chronic shortage of paid caregivers. In addition, it can be difficult to retain competent home care providers.³⁷⁰ Low-paid private caregivers can be unreliable, and are noted for a high turnover rate, which might induce hiring through the added expense of an agency.³⁷¹ However, caregiver turnover at the agency level is also becoming a major challenge as care workers earn low wages, lack benefits, and often endure difficult work environments.³⁷²

Matters of affordability and cost effectiveness are omnipresent concerns in any discussion of care services. Care provided by family members or friends can be relatively inexpensive, if one only counts direct out-of-pocket expenses.³⁷³ While this type of care is nominally free, as mentioned previously, family members, low-cost hires, and even employers often bear some hidden costs of this type of elder care.³⁷⁴ For this reason, family members often retain some degree of paid help—usually at a low wage, though where the care required involves skilled personnel, such as registered nurses, family members pay higher rates.³⁷⁵ Home care is, the most flexible and cost-effective option because the cost of home care varies with the level of care required. However, if a given patient's base condition is at a more degraded level, requiring skilled care and twenty-four-hour supervision, the cost of home care can suddenly approximate that of a nursing home.³⁷⁶ According to Genworth Financial, “round-the-clock home care can top \$170,000.”³⁷⁷

Some argue that promoting home care is a vital endeavor in reinforcing the social fabric. Mona Harrington, in her book *Care and Equality: Inventing a New Family Politics*,³⁷⁸ equates the actions of directed care as a manifestation of a core national value.³⁷⁹ Active engagement in care activities strengthens an awareness of the “common life” that serves as the grounding for the exercise of all our

370. ADVISOR'S GUIDE, *supra* note 73, at 28.

371. See Alana Semuels, *Who Will Care for America's Seniors*, THE ATLANTIC, Apr. 27, 2015, <http://www.theatlantic.com/business/archive/2015/04/who-will-care-for-americas-seniors/391415/>.

372. Emily Study, *Caregiver Turnover Spikes 9%, Fuels Home Care Challenges*, HOME HEALTH CARE NEWS (April 19, 2015), <https://homehealthcarenews.com/2015/04/caregiver-turnover-spikes-9-fuels-home-care-challenges/>.

373. See *supra* Part I(C).

374. *Id.*

375. Consumer Reports, *Spectrum of Available Care: Other Options to Consider* (Jan. 2001), [www.CONSUMERREPORTS.COM](http://www.consumerreports.com) (the family should expect to pay around \$20 an hour if they hire a Medicare-certified agency or a licensed home health agency).

376. Consumer Reports, *Spectrum of Available Care: Other Options to Consider* (Jan. 2001), [www.CONSUMERREPORTS.COM](http://www.consumerreports.com).

377. GENWORTH, *supra* note 205; Scism, *supra* note 72; Martin, *supra* note 35, at 366 (range of \$20,000 to \$70,000).

378. Mona Harrington, *CARE & EQUALITY: INVENTING A NEW FAMILY POLITICS* (Jane Garrett ed., 2000).

379. See Harms, *supra* note 110, at 83 (citing Harrington, *supra* note 378, at 48–49).

rights and liberties.³⁸⁰ Thus, Harrington thinks that care “should become a primary principle of our common life, along with the assurance of liberty, equality and justice.”³⁸¹ She argues that care “is essential to human health and balanced development,” and “is crucial to developing human moral potential to instilling and reinforcing in an individual a sense of positive connection to others.”³⁸² In a similar vein, K. Nicole Harris echoes this emphasis on the connection between an acknowledgement of a universal requirement for care at some state in life and our larger social identity that is defined by mutual interdependence.³⁸³

Anyone who has provided care for another living being—whether it is a child caring for a pet, a parent caring for a child, or a caregiver providing care for a family member—can attest to the lessons learned from being responsible for the needs of another. These profound opportunities to connect with another person in a meaningful way, and to develop a responsible attitude in providing essential care benefits society as these positive traits spill over into other aspect of life.³⁸⁴

Beyond national social benefits, home care can benefit the nation in fiscally practical ways. Medicaid and Medicare can support only a fraction of the total population in need of long-term care, and are expensive programs to manage.³⁸⁵ By supporting home care, the government can be relieved of some of the growing financial strain generated by costs of the social safety net.³⁸⁶ A voluminous report published in 2014 titled *Dying in America* called for a “major reorientation and restructuring of Medicare, Medicaid and other health care delivery programs.”³⁸⁷ The report also argued for eliminating “perverse financial incentives” that encourage expensive hospital and nursing home procedures.³⁸⁸ By encouraging

380. HARRINGTON, *supra* note 378, at 49.

381. *Id.* at 48.

382. *Id.* at 49. And it is this sense of connection that makes possible the whole range of mutual responsibilities that allow the people of a society to respect and work toward common goals.

383. Harms, *supra* note 110, at 83. She says that “every person will at some time either require and/or provide care, the reality of our dependence on others is clear.” She says that, “providing care for one another is a basic element of a properly functioning society.”

384. *Id.*

385. See Stone, *supra* note 94, at 13–17.

386. In 2013, state and federal governments spent approximately \$130 billion on long-term care services. See *Report to Congress*, U.S. SENATE COMMISSION ON LONG-TERM CARE (Sept. 18, 2013), <http://www.medicareadvocacy.org/wp-content/uploads/2014/01/Commission-on-Long-Term-Care-Final-Report-9-18-13-00042470.pdf>; Carol Raphael et al., *Financing End-of-Life Care in the USA*, 94 J. ROYAL SOC. MED. 458, 458 (2001), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1282187/pdf/0940458.pdf> (growing number of people are choosing to die in their homes).

387. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, NATIONAL ACADEMIES OF SCIENCE, ENGINEERING, MEDICINE (Sept. 17, 2014), <http://www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx> [hereinafter *Dying in America*].

388. See *id.*

home care, the government comports with the wishes of the vast majority of seniors who desire to age in place and, in addition, saves taxpayer dollars.³⁸⁹

This argument extends to end-of-life care: encouraging increased home hospice service would lower public expenditures and satisfy prevailing patient preferences.³⁹⁰ It would also accelerate a movement away from the institutionalization of death.³⁹¹ Hospice care is being used more frequently but is not employed to its potential level of effectiveness. Because of both its beneficial physical and psychologically effects for dying patients and their families,³⁹² and the additional evidence of cost-effectiveness vis-à-vis institutional alternatives, supporting this brand of end-of life care appears to promote sound policy objectives.³⁹³

1. *Government and Other Financing*

Home care services are generally not financed through the Medicare program.³⁹⁴ Medicare will cover long-term care in the home on a short-term basis

389. Joseph L. Matthews, *Does Medicaid Cover Long-Term In-Home Care?*, CARING.COM, <https://www.caring.com/questions/medicaid-in-home-care> (last visited Oct. 18, 2018) (discussing how waivers from the normal rules can be gotten by states to provide home care.); see also Laura Snyder and Robin Rudowitz, *Medicaid Financing: How Does It Work and What Are the Implications*, HENRY J. KAISER FAM. FOUND. (May 20, 2015), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/> (“A program as large as Medicaid will always be a focus of budgetary scrutiny at the state and federal levels.”).

390. Gawande, *supra* note 11, at 153 (In the United States, 25 percent of all Medicare spending is for the 5 percent of patients who are in their final years of life, and most of that money goes for care in their last couple of months that is of little apparent benefit).

391. *Id.* at 193 (in 1945, “deaths in the house went from a clear majority to just 17 percent in the late eighties, since the nineties, the numbers have reversed direction”).

392. *Id.* at 177–78 (quoting Zen: People can “actually live longer” if they stop “trying to live longer. Additionally, the families are less likely to experience depression and the patients were more at peace).

393. Gawande, *supra* note 11, at 193, 176 (by 2010, 45 percent of American died in hospice. More than half of those who passed away in their homes received in-home hospice care, “and the remainder received it in an institution, usually an inpatient hospice facility for the dying or a nursing home.” Additionally, studies have shown that cost can fall by almost a quarter through hospice care.).

394. Medicare was established by Title XVIII of the Social Security Act, designated as “Health Insurance for the Aged, and Disabled.” It is a federal program providing primarily skilled medical care and medical insurance for people aged sixty-five and older. Medicare covers ninety-five percent of our nation’s aged population. There are four parts of Medicare: (1) Medicare Part A, Hospital Insurance (HI), (2) Medicare Part B, Medical Insurance (MI), (3) Medicare Part C, Medical Advantage (MA), and (4) Medicare Part D, prescription drug coverage. HI is generally provided automatically, and free of premiums, to persons age sixty-five or over who are eligible for Social Security or Railroad Retirement Benefits. Medicare’s HI program primarily covers inpatient hospital care. It also covers Skilled Nursing Facilities (SNF) if the stay there follows within thirty days (generally) of a hospitalization of three or more days and is certified as medically necessary. Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of both HI and SMI. These liabilities may be paid by the Medicare beneficiary, by a third party, such as an employer-sponsored retiree health plan, private Medicare Supplemental Insurance (Medigap), or by Medicaid, if the person is eligible. While Medigap policies typically cover Medicare’s deductibles and coinsurance amounts, they do not provide benefits for long-term care. Like Medicare, Medigap policies primarily cover hospital and doctor bills. See *Long-Term Care Choices*, *supra* note 264.

under “certain limited conditions.”³⁹⁵ First, such care must be medically necessary and prescribed by a doctor.³⁹⁶ Second, such care is only allowed after a three-day hospital stay, and then only up to the first 100 days of skilled nursing care.³⁹⁷ Third, the care must only be needed part-time.³⁹⁸ Furthermore, the senior must be “confined” or unable to leave the home without the assistance of another person.³⁹⁹ Lastly, Medicare requires a partial co-pay.⁴⁰⁰

While home care, as a general proposition, is not financed through Medicaid,⁴⁰¹ some states created waivers to allow certain skilled-type nursing and specialty care in the home.⁴⁰² Despite these state-level waivers, Medicaid limits home care to a maximum ceiling dollar amount, partly because these types of home care services tend to be more expensive than similar services performed in a pooled-resource environment like a nursing home.⁴⁰³ For 2013, Medicaid payments for home health services exceeded \$5.9 billion.⁴⁰⁴ While this is not a trivial sum, it

395. *Long-Term Care Choices*, *supra* note 264; FROLIK, *supra* note 80, at 75 (“Home health services include physical, occupational and speech therapy; durable medical equipment; medical supplies; and “part time and intermittent” nursing care” but does not cover 24-hour-a-day care at home; meals delivered to the individual’s home; homemaker services like shopping, cleaning and laundry if that is the only care needed by the individual; and personal care given by home health aides like bathing, dressing, and using the bathroom if this is the only care needed.”).

396. 42 U.S.C. § 1395f (the individual must contact a Medicare-approved home health agency, which creates a written plan of care established by a doctor and reviewed every two months by a doctor).

397. STAFF OF H. COMM. ON WAYS & MEASURES, 104th Cong. *Overview of Entitlement Programs* 906 (1996). It covers Skilled Nursing Facilities (SNF) if the stay there follows within 30 days (generally) of a hospitalization of 3 or more days and is certified as medically necessary. HI covers the first 100 visits following a 3-day hospital stay or a skilled nursing facility stay; MI covers any visits thereafter. For skilled nursing facility (SNF) stay covered under HI, Medicare fully covers the first 20 days of SNF care in a benefit period. However, for days 21-100, a co-payment of \$152 per day (in 2014) is required from the beneficiary. The insured is responsible for 100 percent of all expenses after the first 100 days. Klees, Barbara S. and Christian J. Wolfe, *Brief Summaries of Medicare & Medicaid*, DEP’T OF HEALTH & HUM. SERVS. 7 (2013) (the number of SNF days provided under Medicare is limited to 100 days per benefit period). Covered inpatient care services include: a room, meals, nursing services, intensive care, inpatient prescription drugs, laboratory tests, and long-term care (LTC) hospitalization when medically necessary.; *see also* MASS. BAR ASS’N, 2017 *Elder Law Education Program* 26 (2017).

398. *See* FROLIK, *supra* note 80, at 76 (care must be “less than eight hours per day and no more than 28-35 hours per week”).

399. 42 U.S.C. § 1395f(a)(2)(C) (home health care services are available to individuals who are not able to leave their houses except to seek medical assistance with help from others or by using a device such as a walker or wheelchair).

400. *See* FROLIK, *supra* note 80, at 76 (“There are co-pays or deductibles for home health care except for a co-pay of 20 percent n durable medical equipment”).

401. 42 U.S.C. Ch 36.

402. 45 U.S.C. §§ 1396n(d)(1); *Long-Term Care Choices*, *supra* note 264 (“If you’re already eligible for Medicaid (or would be eligible for Medicaid coverage in a nursing home), you may be able to get help with the costs of some home- and community-based services, like homemaker services, personal care, and respite care. . . States have home- and community-based waiver programs to help people keep their independence while getting the care they need outside of an inpatient facility.”).

403. Ben Mandelbaum, *Understanding Medicaid Reimbursements*, MCKNIGHT’S LONG-TERM CARE NEWS (Sept. 30, 2015), <https://www.mcknights.com/guest-columns/understanding-medicaid-reimbursement/article/441886/>.

404. *Medicaid Home Health Expenditures*, HENRY J. KAISER FAM. FOUND. (2014), <https://www.kff.org/health-reform/state-indicator/home-health-expenditures/?currentTimeframe=0&sortModel=%>

represents a minor portion of aggregate home care costs. Most home care costs are paid for by private savings, low-paid care workers, free family/friend care, and long-term insurance, with the tax system providing some limited benefits.

2. *Tax Subsidies*

As discussed earlier, the tax system provides a valuable exclusion for benefits provided by Medicaid, Medicare, and a portion of payments under long-term care insurance, all of which can include the value of meals and lodging. In contrast, the tax system provides meager benefits for home care. For the care receiver, a medical deduction is available for qualified medical expenses (including home renovations), but the same hurdles apply here as in the nursing home context. For the unpaid caregiver the only tax benefit arises if they pay for the elder's medical care, pay for their support, or maintain a household for their parent or other dependent relative. For a limited time only, a new provision in the TCJA allows employers a credit for a portion of salary paid to employees who take family leave, but this benefit goes directly to the employer. Except for the exclusion of meals and lodging, in the rare case in which the paid worker lives in the home of the care-receiver, the subsidies for the paid worker are minimal. Lastly, the Earned Income Credit (EIC) provides inadequate monetary benefit to the low-income caregiver.⁴⁰⁵

a. Itemized Medical Deduction for the Care Receiver. As is the case in nursing home care, the care receiver may obtain a medical expense deduction for the unreimbursed costs of "medical care" services provided in their home if they are chronically ill. They may also receive a deduction for "consumer directed care," such as structural modifications to their home living space.

i. Deductions for Medical Care/Personal Care of the Chronically Ill. As we mentioned earlier, qualified medical expenses include certain long-term care services for the chronically ill, defined as "necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services," as well as "maintenance or personal care services."⁴⁰⁶ "Rehabilitative services" are the skilled-type services or help with daily activities of living. Thus, any related expenses, including wages paid, are deductible. By contrast, "maintenance or personal care services" can cover a broad range of applications, some outside the immediate scope of the routine activities of daily life.⁴⁰⁷ These include any required

7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (these figures were calculated as the sum of the three categories of home health coverage offered under Medicaid: a) mandatory home health services state plan benefits; b) optional home health services state plan benefits; and c) optimal section 1915(c) HCBS waivers).

405. I.R.C. § 32 (2016). The EIC can provide tax benefits to both the unpaid care-provider who works and the lowly paid care-provider.

406. I.R.C. §§ 213(d) & 7702B(c)(1) (2006).

407. *Baker v. Comm'r*, 122 T.C. 143 (2014); *Osteopathic Med. Oncology & Hematology*, P.C. 113 T.C. 376 (1999).

assistance with factors that are impeded by the disability of the chronically ill patient.⁴⁰⁸ This can include help with housework,⁴⁰⁹ transportation,⁴¹⁰ meal preparation, and some lodging—if essential to the patient’s care.⁴¹¹ Wages paid to the caregiver, as well as any Social Security or Medicare tax, federal or state unemployment tax, in addition to the aforementioned qualifying expenses, are also deductible.⁴¹²

The medical deduction for home care is not exactly parallel to that applied to nursing home care—where 100% of the meals and lodging can be excluded. There are similarities and differences. For instance, the cost of meal preparation for a chronically ill senior is clearly identified as a deductible service.⁴¹³ If the care worker stays at the home of the care-receiver, then the costs of her meals are also deductible. In all likelihood, the ingredients for the meals of all involved parties are deductible, since they are considered “incidental to the preparation process and distinguishable from the mere sale of the ingredients.”⁴¹⁴ However, delivered meals, such as “meals on wheels” could arguably be classified as a “food product” rather than a care adjunct and, therefore, stand disqualified for deductibility.

Next, the costs of lodging are generally personal—that is, not directly related to a state of infirmity—therefore they are not deductible medical expenses.⁴¹⁵ However, if the home aide is providing qualified long-term care, then the cost of lodging for that paid caregiver would be deductible as a medical expense to the extent the expense exceeded the normal expenses of the household.⁴¹⁶ Thus, for example, if a two-bedroom apartment is needed, rather than a one bedroom, or there are extra utility expenses in the home, then these could constitute a qualified medical expense. This excess expense could also be deductible as an employer business expense when the caregiver is a paid worker.⁴¹⁷ It is interesting to note that under the Tax Cuts and Jobs Act of 2017, the employer will receive no

Donahoe v. Dept. of Rev., 2016 Ore. Tax 121 (2016); Hosp. Corp. of Am., 107 T.C. 116 (1996), *aff’d* 348 F. 3d 136, (6th Cir. 2003) cert. denied; Osteopathic Med. Oncology & Hematology, P.C. 113 T.C. 376 (1999).

408. See Vorriss J. Blankenship, *Tax Issues Complicate the Costs of Chronic Illness*, 106 J. TAX’N 216, 217 (2007) (citing I.R.C. § 7702B(c)(3)).

409. *Id.* at 217-18 (Simple housework or simple repairs may be included but not nonmedical supplies such as cleansers, detergents, etc. However, it seems problematic to hire a cleaning service where the product is not allowable. See Staff of the Joint Committee on Taxation, *General Explanation of Tax Legislation Enacted in the 104th Congress*, JCS -12-96 at 338 (1996)).

410. *Id.* at 218; I.R.C. § 7702B(c)(3).

411. *Id.* at 218 (meal preparation is one of the daily activities and “[a] taxpayer also may argue that food ingredients provided and used by the preparer should be deductible as an integral part of the preparation services”).

412. See Stephanie Breedlove, *Understanding the Tax Rules for Caregivers*, NEXT AVENUE (Mar. 31, 2014), <http://www.nextavenue.org/understanding-tax-rules-caregivers/>.

413. See Blankenship, *supra* note 408, at 208 n.14.

414. *Id.* at 218.

415. I.R.C. § 262 (1988).

416. Estate of Marantz v. Comm’r, T.C. Memo. 1979-463; Rev. Rul. 76-106, 1976-1 C.B. 71.

417. I.R.C. § 162; I.R.C. § 119.

deduction for meals provided on the business premises as a convenience to the employer, but no such limitation applies to lodging.⁴¹⁸

It does not matter whether workers performing these care services (whether staying in the home or not) are certified professionals, as long as they are paid for services to the chronically ill.⁴¹⁹ However, deductions are expressly prohibited for services rendered to the chronically ill by unlicensed relatives.⁴²⁰ “Relatives” in this context, are defined to include parents (or parents-in-law), children (or the children’s spouse), grandchildren, brothers (or brothers-in-law), sisters (or sisters-in-law), and nieces or nephews, step-fathers, step-mothers, and step-siblings.⁴²¹ I would hazard a guess that there would be no meal or ingredient deductions for this class of unpaid caregiver either.

An exception to this rule is in the books, however. In the case of *Ungar v. Commissioner*,⁴²² a caregiver was a relative and her wages were deducted as qualified medical care. In this case, the taxpayer had placed his ninety-year-old mother in an apartment outfitted with medical equipment and hired the aforementioned relative a nonprofessional assistant to provide caregiving services.⁴²³ The Tax Court held that the taxpayer was entitled to deduct both the cost of the apartment and the (relative) assistant’s wages.⁴²⁴ The court reasoned that this result supported the policy that these expenses avoided the larger, more direct expense of hiring nurses, or interring the patient in a hospital or nursing home.⁴²⁵ Furthermore, it served the fiscal interests of the federal and state treasuries.⁴²⁶ Based on this decision, one could fashion an argument that paying relatives to perform elder care under a service contract could result in a sizeable deduction to the care-receiver. However, the care-provider would have to include all amounts paid in their ordinary income, and also pay Social Security and other self-employment taxes.⁴²⁷ The end conclusion here is that the frequency with which these circumstances are likely to be repeated is low, with minimal net tax benefits for the effort.

Hiring a nurse or other health professional may also be a qualified medical expense, even if not tied to expenses for the chronically ill.⁴²⁸ A nurse does not need to be registered or licensed so long as he/she provides nursing care. Nursing care includes bathing, dressing, and giving medications. The cost of the nurse’s

418. See I.R.C. §274(o) specifically denying a deduction for meals (but not lodging) in the §119 context.

419. Estate of Marantz v. Comm’r, T.C.M. 1979-463; Rev. Rul. 75-317, 1975-2 C.B. 57.

420. I.R.C. § 213(d)(11)(A) (2017)

421. I.R.C. § 152 (d)(2)(A) - (G) (2017)

422. *Ungar v. Comm’r*, T.C. Memo. 1963-159.

423. *Id.*

424. *Id.*

425. *Id.*

426. *Id.*

427. In this arrangement, either the employer or the independent contractor would be obligated to pay these expenses.

428. Lasser, *supra* note 341, at 390.

meals is included in the medical expenses as well as any Social Security or Medicare taxes, and federal and state unemployment taxes attached to the nurse's wages. If the nurse provides non-medical personal or custodial services, then no deduction is allowed, unless the patient is designated as chronically ill and these services are deemed essential care.⁴²⁹ However, care for practical services would most likely not be covered in any case.

Essentially these rules encourage the hiring of paid caregivers if the care receiver is in a high enough income tax-bracket to afford it. In such case, the relatively affluent senior might already be claiming real estate taxes as a deduction and might also exceed the 7.5% threshold limit under the medical care provision.⁴³⁰ Thus, depending on the food and caring expenses, the care receiver/taxpayer could realize a significant tax benefit from this medical deduction. On the other end of the spectrum, poor families unable to afford this kind of care, perform these care tasks by themselves, generating no recognized economic value and no commensurate taxation benefit.⁴³¹

ii. Deductions for Consumer-Directed Care⁴³². Consumer-directed care includes medically-driven decisions,⁴³³ such as home renovations, that are not covered by insurance.⁴³⁴ Taxpayers may choose to renovate their homes to make them more user-friendly, both for themselves and for those charged with their care. These include features such as ramps, rails, bath seats, bathroom conversions, elevators, wheelchairs, etc.⁴³⁵ Others might install technology to maximize

429. *Id.*

430. Real estate taxes on the principal residence would be itemized deductions, as could mortgage interest, although both of these provisions may be limited under the Tax Cuts and Jobs Act of 2017. I.R.C. § 163 allows a deduction for acquisition indebtedness on a qualified residence (including both the principal residence and one other residence), but only up to an amount of \$675,000. I.R.C. § 164 now limits the itemized tax deduction for personal state taxes paid to \$10,000.

431. See *supra* notes 124 and 125 and accompanying text.

432. ADVISOR'S GUIDE, *supra* note 73, at 28.

433. Treas. Reg. § 1.213-1(e)(1)(iii) ("[A] capital expenditure made by the taxpayer may qualify as a medical expense, if it has as its primary purpose the medical care . . . of the taxpayer, his spouse, or his dependent . . . [A] capital expenditure for permanent improvement or betterment of property which would not ordinarily be for the purpose of medical care . . . many, nevertheless, qualify as a medical expense to the extent that the expenditure exceeds the increase in the value of the related property, if the particular expenditure is related directly to medical care.").

434. The physician may not actually have prescribed these modifications, but the facts and circumstances of the illness illustrate the necessity of the expenditure.

435. Rev. Rul. 87-106, 1987-2 C.B. 67 (including constructing entrance or exit ramps to the residence; widening doorways at entrances or exits to the residence; widening or otherwise modifying hallways and interior doorways; installing railing, support bars, or other modifications to bathrooms; lowering of or making other modifications to kitchen cabinets and equipment; altering the location of or otherwise modifying electrical outlets and fixtures; installing porch lifts and other forms of lifts [other than elevators]; modifying fire alarms, smoke detectors, and other warning systems; modifying stairs; adding handrails or grab bars whether or not in bathrooms; modifying hardware on doors; modifying areas in front of entrance and exit doorways; and grading of ground to provide access to the residence.

independence for the patient,⁴³⁶ such as medical alarm bracelets, remote electronic monitors, mobility machinery, adjustable beds, blood pressure gages, and other testing devices.⁴³⁷

Many of these expenses would be deductible if not part of a home remodel. The *Gerard* rule stated that if the remodel (which in that case involved an air system for medical purposes) does not increase the value of the house, then the entire cost is considered a medical expense.⁴³⁸ If the improvement does increase the value of the house, then the medical expense will be reduced by the amount of value added to the house.⁴³⁹ In this case, the Gerards installed a piece of equipment that cost \$1,300, but it added \$800 in value to the house. Therefore, only \$500 was granted as the deductible expense. In most cases, installation of special features, such as adding ramps, modifying doorways and stairways, installing railing and support bars, and altering cabinets, outlets, fixtures, and warming systems would not add to the market value of the properties. Therefore, most of the time such expenditures when employed for legitimate medical purposes can be claimed as medical expenses. In addition, the full costs of maintaining and operating the equipment installed for medical reasons could also be claimed.

b. The Unpaid Caregiver. Unpaid caregivers who pay for medical care of a dependent may also receive a medical expense deduction and such payments will not be subject to gift tax when made directly to the medical provider. Unpaid caregivers who pay for companion-type care may be eligible for the Dependent Care Credit or the Dependent Care Assistance exclusion, both of which are discussed in section E, under “Adult Day Care.” In addition, the caregiver may receive a Dependent Tax Credit (a new provision under the TCJA) and the head of household status. These caregivers, like their low-paid care-provider counterparts, might be eligible for the Earned Income Credit.

i. Deductions for Payment for Long-Term Care by Relative. While taxpayers who pay for “medical care” of qualifying relatives (including the wages of workers who performs the skilled or personal care of a chronically ill dependents) may be able to receive a deduction for these expenses, several hurdles exist. First, the deduction only applies above a set floor amount, which was changed by the TCJA. Before the TCJA, only qualified expenses exceeding 7.5% of the taxpayer’s adjusted gross income (AGI) or (10% if the taxpayer was under the age of

436. See *From Our Sponsor [AARP]: Why Long-Term Care Is A Women’s Issue*, OPRAH.COM, <http://www.oprah.com/spirit/from-our-sponsor-why-long-term-care-is-a-womens-issue#ixzz2NI9x8TCl>; see also *Why Long-Term Care Is A Women’s Issue*, AARP EDUCATION & OUTREACH, http://www.aarp.org/relationships/caregiving/info-10-2009/boomer_women.html.

437. See Pub. 502, *Medical and Dental Expenses* (2017) <https://www.irs.gov/publications/p502>.

438. *Gerard v. Comm’r*, 37 T.C. 826 (1962); see also *Evanoff v. Comm’r*, 44 T.C.M. (CCH) 1394 (1982) (no deduction for year-round swimming facility); *Robbins v. Comm’r*, 44 T.C.M. (CCH) 1254 (1982) (no part of the purchase price for a new home with a pool is deductible); *Ferris v. Comm’r*, 582 F.2d 1112 (7th Cir. 1978) (no deduction for in-ground swimming pool).

439. *Id.*

65) would be allowed as a medical deduction. The TCJA changes this limit to 7.5% for all taxpayers until January 1, 2019.⁴⁴⁰ Thus, this new provision will help the children who pay for the senior's qualified nursing home expenses.

Second, only certain medical care amounts for qualifying relative dependents will receive the deduction. As we discussed earlier in this Article, these could include long-term care for the chronically ill, changes in home that meet the Gerard test, and other "medical care" type expenses.⁴⁴¹ If taxpayers cannot provide care in their home for a parent or other relative and pay for the nursing home care or assisted living care that comports with standards of qualified medical care, they could be entitled to the medical expense deduction.⁴⁴² The costs of meals and lodging may be considered medical expenses if the elder patient is deemed chronically ill.⁴⁴³ The value of the actual care provided by the unpaid caregivers themselves, regardless of whether that care qualifies as recognized "medical care," does not qualify. Similarly, any medical care reimbursed by insurance will not count.

As for the qualifying "dependent" under the medical expense deduction, that definition is much broader than the definition under the Dependent Tax Credit (discussed in the next section). Anyone fitting the definition of "qualifying relative" would count.⁴⁴⁴ No gross income test is applied for qualifying relative dependents for purposes of validating the deduction.⁴⁴⁵ Only the relationship and support test must be met.⁴⁴⁶

For federal gift tax purposes, no gift tax will be imposed on the donors if the medical payment is made directly "to any person who provides medical care (as defined in Section 213(d))."⁴⁴⁷ Otherwise, donors are limited to the per donee annual exclusion, which currently stands at \$15,000.⁴⁴⁸ For the elderly, these gift transfers are excludable from the recipient's gross income⁴⁴⁹ because they fall within the *Duberstein* rule. Clearly these transfers would most likely be motivated by disinterested generosity out of love, respect, and affection.⁴⁵⁰ The planning tip here is to make sure the relative pays the medical institution directly.

440. I.R.C. § 213(f)(2). Fortunately, the new law will also not result in any recalculation under the alternative minimum tax.

441. See *supra* note 432 and accompanying text.

442. See earlier discussion, *supra* note 406 and accompanying text.

443. See earlier discussion, *supra* note 413 and accompanying text.

444. See IRS Pub. 502, *supra* note 437, at 3-4.

445. This is important, as under the TCJA, no Dependent Tax Credit will be available to many taxpayers supporting their senior relatives if that senior has gross income less than \$4,150. See discussion, *infra* note 471.

446. See IRS Pub. 502, *supra* note 437.

447. I.R.C. § 2503(e).

448. I.R.C. § 2503(b).

449. I.R.C. § 102. Transfers directly to a medical institution would also be exempt from the gift tax. I.R.C. § 2503(e).

450. *Comm'r v. Duberstein*, 363 U.S. 278, 286 (1960).

ii. Dependent Tax Credit. Family members may be able to include a senior relative under the Dependent Tax Credit. The dependency exemption was eliminated by the TCJA and replaced by a Dependent Tax Credit.⁴⁵¹ Under new Section 24(h), taxpayers will receive a \$500 credit if the taxpayer provides over half of the support to certain dependents. First, the dependent must be a citizen or national.⁴⁵² Secondly, a relationship or member of the household test must be met, which may include a gross income test.⁴⁵³ Thirdly, a support test is applied. Lastly, a married taxpayer who files joint returns cannot be claimed as a dependent.⁴⁵⁴ This credit provides meager benefits to those caring for others, reduces significantly the benefits of earlier law, and is not even adjusted for inflation.⁴⁵⁵

TCJA tightened up the nationality rules for dependence under the new credit. The dependent can no longer be an alien resident of the United States or a resident of a country contiguous to the U.S.⁴⁵⁶ This designates residents of Canada or Mexico. Only U.S. citizens or U.S. nationals qualify.

For the relationship test, any dependent not considered a “qualifying child” under the per-child credit provision, can qualify.⁴⁵⁷ For our purposes, that could include brothers and sisters that are defined as “qualifying children” under the dependency rules. Also, those constituting “qualifying relatives” constitute dependents. The taxpayer’s parents, grandparents, great-grandparents, or other ancestors, step-parents, sons-in-law, brothers-in law and sisters-in law can qualify here.⁴⁵⁸ Established members of the household including all unrelated or distantly related dependents living with the taxpayer can qualify,⁴⁵⁹ but only if this relationship is not “contrary to local law.” Since immigration law is federal and not local, prohibitions as to this must come under the first rule described above. Blood-related aunts and uncles will only qualify if they live in the household of the taxpayer. Even in-laws, such as fathers-in-law and mothers-in law, removed by the death or divorce of a spouse can qualify.⁴⁶⁰

The support test requires a determination of what is “support” and then a determination of whether the taxpayer provided “over half” of that support. The test here is slightly different from that employed to establish head-of-household status. Here, the cost of meals, lodging, clothes, medical care, and transportation

451. I.R.C. § 24(h)(4)(A).

452. I.R.C. § 24(h)(4)(B).

453. I.R.C. § 152.

454. I.R.C. § 152(b)(2).

455. Only the refundable portion of the per child credit is adjusted for inflation. I.R.C. § 24(h)(5)(B).

456. *Id.* This new provision modifies § 152(3)(A) by eliminating the exception language “resident of the United States” and resident of a “country contiguous to the United States.”

457. This can include children with no social security numbers, as well as grandchildren, great grandchildren, brothers, sisters, step-brothers, or their descendants. I.R.C. § 151(c).

458. I.R.C. § 152(d)(2)(C).

459. I.R.C. § 152(d)(2)(H); I.R.C. § 151(f)(3) (stating individual not treated as a member of the taxpayer’s household if the relationship is “contrary to local law”). *Dependency Exemptions*, IRS, https://apps.irs.gov/app/vita/content/globalmedia/4491_dependency_exemptions.pdf

460. I.R.C. § 152(d)(2)(G).

would be taken into account.⁴⁶¹ Like the head-of-household requirement, if the taxpayer pays the mortgage, real estate taxes, rent, utilities, repairs, or insurance, this could apply towards the one-half of the support requirement.⁴⁶² However, the Regulations say “it will be necessary to measure the amount. . . [of the housing provided].. in terms of its fair market value.”⁴⁶³ Thus, the out-of-pocket amount is not determinative but rather the rental value of the lodging.⁴⁶⁴ On the other hand, the out-of-pocket costs of food, or meals on wheels, or costs of preparing meals will also qualify.⁴⁶⁵ Furthermore, all medical expenses including care provided by a paid caregiver count in this calculation. Thus, the maintenance and personal services or personal/custodial care qualify if the elder is chronically ill. In addition, practical care, including housekeeping tasks, lawn mowing, etc., qualifies. However, under both tests, the value of the services performed by unpaid relatives in providing elder care is not considered. This support test, like all the other tax tests, only values the actual expenses made, not the value of the caring services performed. In *Markarian v. Commissioner*, the Seventh Circuit held that taxpayers may not count the value of their unpaid services in caring for their dependent relative because no out-of-pocket expense was involved.⁴⁶⁶

Once support is determined the “over one-half ” test must be met. The senior’s income, including all exempt amounts, would be counted. Thus, social security, veteran’s benefits, and tax-exempt interest would count on the senior’s side of the ledger. An example in the regulations illustrates this calculation: father provides \$1,200 of his support from Social Security (\$800) and interest (\$400), but son only provides \$1,000 of his dad’s support.⁴⁶⁷ Thus, son does not receive the tax benefit. The senior’s entire Social Security is counted for this test.⁴⁶⁸ Since Social Security provides at least half of the income of sixty-two percent of aged beneficiaries who receive it, this support test might also be difficult to pass.⁴⁶⁹

Another difficult dependency test to meet is the “gross income” test. A person qualifying as a relative or member of the taxpayer’s household must have gross income less than the exemption amount, which is now zero under the TCJA.⁴⁷⁰

461. Treas. Reg. § 1.152-1(a)(2)(i). (“food, shelter, clothing, medical, and dental care, education, and the like”).

462. *IRS Publication 501, Exemptions, Standard Deduction and Filing Information*, <https://www.irs.gov/publications/p501>.

463. Treas. Reg. § 1.152-1(a)(2)(i).

464. See Kaplan, *supra* note 350, at 539 (This rule is “difficult to implement, because there usually is little information about the rental value for lodging that is comparable to living in most peoples’ family residences.”).

465. I.R.C. § 152(d)(1)(C) (if support is the test than providing food should count).

466. 352 F. 2d 870, 872 (7th. Cir. 1965).

467. Treas. Reg. § 1.152-1(a)(2)(ii).

468. *Id.* Alisobhani v. Comm’r, 68 T.C.M. (CCH) 1493 (1994) (holding that SSI payments are treated as the recipient’s self-support).

469. OFFICE OF RESEARCH, EVALUATION & STATISTICS, SOC. SEC. ADMIN., *Fast Facts & Figures About Social Security* (2017), https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2017/fast_facts17.pdf.

470. I.R.C. § 151(d)(5)(A) (the term “exemption amount” means “zero”).

Before the TCJA, the dependency exemption was \$4,150 (2018) and the IRS has recently applied that exemption amount for the gross income test under the dependent tax credit provision.⁴⁷¹ Thus, if the dependent has a private pension, capital gains, dividends, interest, and other gross income equal or greater than that amount, no Dependent Tax Credit can be claimed—even if the taxpayer provided over half of the person’s support. In contrast to the support test, gross income would not include veteran’s benefits, tax-exempt municipal bond interest, gifts, or in certain circumstances, social security.⁴⁷² Thus, a somewhat affluent elder receiving VA (Veteran’s Affairs) benefits and Social Security can qualify as a dependent under the new credit rule, whereas a taxpayer with an equal amount of money from private pensions cannot qualify.⁴⁷³ In some circumstances the elder could place all his/her funds into tax-exempt bonds, and assuming she/he is not subject to the alternative minimum tax, could qualify as a dependent.⁴⁷⁴ This disparity in treatment between otherwise deserving dependents presents both horizontal and vertical equity issues. Thus, some commentators have recommended that this gross income limitation be modified or eliminated.⁴⁷⁵

Other commentators have pointed out that a credit is better than an exemption as it relates to dependency, as the latter favors the wealthy.⁴⁷⁶ However, when you combine the support and the gross income test with the meager dollar amount of the credit, one can conclude that our tax system does not support the caring of others. The new credit amount is very stingy and equals only twenty-five percent of the new per child credit. Thus, if we truly want to support the elderly and keep them off Medicaid, then this support should be dramatically increased.

Adult children can take turns caring for their parents or other relatives and can sign a “multiple support agreement.”⁴⁷⁷ Before the TCJA, if together the children met the “over fifty percent of the support” test of the otherwise qualifying

471. Laura Saunders, *Your Kids Could Cut Your Tax Bill Like Never Before*, WALL ST. J. at B4 (Aug. 31, 2018), <https://www.wsj.com/articles/your-kids-could-lower-your-tax-bill-like-never-before-1535707850>. (“The IRS said the indigent relative is allowed to have income equal to what the personal exemption would have been after inflation. For 2018, the limit is \$4,150.”). Interestingly (and similarly) for estates and trusts under § 642(b)(2)(C)(iii)(I) the exemption amount is \$4,150 and is adjusted for inflation. I.R.C. §642(b)(2)(C)(iii)(II).

472. See Lasser, *supra* note 341, at 312-315. Gross income consists of gross income from business less costs of good sole but partnership income could be the share of gross, not net income.

473. In other areas of the tax code (and law) nontaxable income is counted in the formula.

474. The TCJA temporarily increases both the exemption amount and the exemption amount phase-out thresholds for the individual AMT. The AMT exemption amount is increased to \$109,400 for married taxpayers filing jointly and \$70,300 for all other taxpayers, including heads of households. The phase-out thresholds are increased to \$1,000,000 for married taxpayers filing jointly and \$500,000 for all other taxpayers. I.R.C. § 55(d)(4)(A)(i). A tax rate of 26% is applied on the first \$175,000 (adjusted for inflation in 2018 to \$191,100) and then at a rate of 28% for amounts over that amount. I.R.C. § 55(b)(1)(A)(i), (c)(3)(B)(i).

475. See Deborah Sken, *Simplification for Individual Taxpayers: Problems and Proposals*, 45 TAX L. REV. 121, 134-44 (1989) (proposing changes to the provisions dealing with dependency exemptions).

476. See Kaplan, *supra* note 350 at 551-559 (discussing several legislative proposals for family provided care).

477. I.R.C. § 152(d)(3).

dependent, and one child was giving more than ten percent of this support, then the other children could agree that the child providing the greater amount of support could take the exemption in any given tax year.⁴⁷⁸ This allowed the children to share the benefit of the dependency exemption by alternating the exemption each year.⁴⁷⁹ After the TCJA, the \$500 dependent credit can still alternate among the children based on these rules. Such an agreement could help in the situation where mom lives with one child and the other children provide most of mom's support.⁴⁸⁰

If the senior files a joint income-tax return for the same year, the senior cannot qualify as a dependent under the Dependent Tax Credit unless the return was filed only to claim a refund.⁴⁸¹ In this case, it may be more advantageous from a tax standpoint for the elderly parents to file separately. No Dependent Tax Credit is allowed to a married couple, even if one spouse is taking care of the other spouse who is truly dependent. However, the married couple will get the benefit of income splitting. On the other hand, if a married couple jointly provides care for a parent, in-law or other relative, they might get the new Dependent Tax Credit if all the dependency tests are met. However, they will never be able to claim head of household status. In the last section of my Article I recommend a new credit that would allow two-earner couples a credit for maintaining a household for a parent.

IV. HEAD OF HOUSEHOLD STATUS

Qualifying for head of household status can lead to several tax advantages. First, heads of households pay lower federal tax rates than single taxpayers or married couples filing separately.⁴⁸² Second, heads of households receive a larger federal standard deduction than either of the other categories.⁴⁸³ Lastly, heads of households are often treated like joint return taxpayers under state law. This allows them to split their income with those in a vertical dependency relationship, such as a senior parent in need of care.

To qualify as head of household, the taxpayer must not be married at the end of the year.⁴⁸⁴ Thus, this status is not available to married couples, even when they

478. *Id.* (No one person can contribute over one-half of such support but over one half the support must be received from two or more persons who meet one of the qualifying relationships that are required for dependency status, the taxpayer contributed over 10 percent of such support and each person who contributed over 10 percent, other than the taxpayer, must file a written declaration that such person will not claim the tax benefit.)

479. *Id.*

480. Kaplan, *supra* note 350 at 539 (“Such agreements can be useful if, for example, Mom lives with her daughter while each of her two sons provide approximately one-third of Mom’s support.”).

481. I.R.C. § 152(c)(1)(E).

482. *See* I.R.C. § 1(j)(2)(B).

483. Under the TCJA, I.R.C. § 63(c)(7) provides for a basic standard deduction of \$18,000 for a head of household (\$4,400 for 2017) versus a \$12,000 standard deduction for a single individual (\$3,000 for 2017). Both of these amounts are adjusted for inflation. I.R.C. § 63(c)(7).

484. A taxpayer is unmarried if they are single at the end of the year, a widow or widower and the taxpayer’s spouse has died, is legally separated or divorced under a final court decree as of the end of the

may be supporting and maintaining a home for multiple parents or other relatives. In addition, to be head of household, the taxpayer must have paid for more than half of the “maintenance costs of the home” for a “qualifying person.”⁴⁸⁵ A qualifying person must be a “qualifying relative” under the dependent exemption rules.⁴⁸⁶ However, the dependency rules, which require taxpayers to provide over half the support of the qualifying relative, are different than the head of household rules, which require that taxpayers cover over half the home maintenance costs.⁴⁸⁷ Thus, even if taxpayers can claim the Dependent Tax Credit, they may not be able to qualify as head of household.

The head of household rules vary depending upon whether the qualifying dependent is a parent or another category of relative. When the qualifying dependent relative is a parent, the taxpayer must pay for more than half of the parent’s household costs.⁴⁸⁸ If this parent does not live with the taxpayer, all rent, property taxes, mortgage interest, utilities, repairs, and property insurance would be counted in the “maintenance costs of the home” calculation.⁴⁸⁹ This includes household expenditures on housework, cleaning, yard upkeep, and food “consumed on the premises.”⁴⁹⁰ However, it does not include practical care related to the running of the household, such as a personal or custodial care, nor does it include cost of clothing, medical expenses, life insurance, and transportation. Lastly, the value of the work the taxpayer performs around the parent’s dwelling would not be appraised nor counted.⁴⁹¹

Unfortunately, when the taxpayer provides care in the parent’s home, the value of the rent the taxpayer receives from living in their parent’s home “tax free,” must be deducted from this calculation.⁴⁹² Thus, the fair rental value of the lodging furnished to the taxpayer must be offset against the amount the taxpayer actually spends for the parent’s household expenses. For example, suppose the taxpayer provides for over half the rent for a parent and stays there to care for the parent during this time. The value of the housekeeping, lawn mowing, repairs, or other practical care that the taxpayer performs, is not figured into the calculation but the imputed value of the rent of the taxpayer is subtracted from the calculation. Thus, it would make sense for the taxpayer to own the house that the parent lives in, perhaps charging the parent rent for part of this, in order to qualify for

year, and married to an individual who was a nonresident alien during part of the year and the taxpayer did not elect to file jointly. I.R.C. § 2(b).

485. I.R.C. § 2(b)(1)(B).

486. Head of household status also available if taxpayer maintains home for a qualifying child. I.R.C. § 2(b)(1)(A)(i).

487. The value of the home is calculated for dependency purposes, but the out-of-pocket expenses are what are used for head of household purposes. See Kaplan, *supra* note 350, and discussion in note 463 and accompanying text.

488. See Lasser *supra* note 341, at 24–25.

489. *Id.*

490. *Id.*

491. See Lasser, *supra* note 341, at 24–25.

492. *Id.*

head of household status.⁴⁹³ If the parent does happen to live in the taxpayer's home, the taxpayer cannot include the value of the lodging provided to the parent as part of the half-maintenance requirement. Nor is any value of the practical care provided by the taxpayer counted.

When the qualifying dependent relative is a relative other than a parent, the relative must live with the taxpayer in order for the taxpayer to claim head of household status.⁴⁹⁴ As with a dependent parent, the value of the rent provided to the resident relative cannot be included in the maintenance of the household test⁴⁹⁵ and the value of any practical care performed by the taxpayer, such as housekeeping and lawn mowing, is not counted.

The benefit of the head of household status is eliminated when that higher-income taxpayer is subject to the alternative minimum tax (AMT). Under that provision, head of household taxpayers are considered single taxpayers, thus ignoring their role as care providers.⁴⁹⁶ Before the TCJA, all dependent exemptions were eliminated in the AMT calculation.⁴⁹⁷ Thus, the fact that the taxpayer supported multiple dependents did not reduce his or her AMT, as it did under the regular tax calculation. Under the TCJA, this status discrimination remains—head of households will continue to be treated as single taxpayers—but now the dependency exemption is eliminated and is replaced by a credit. The Dependent Tax Credit can now offset AMT liability, just like all similar credits could do before the TCJA.⁴⁹⁸ Thus, after the TCJA, the discrimination against higher-income taxpayer with dependents has lessened. In addition, the TCJA expands the threshold and phase-out limits, thus reducing the number of middle-income taxpayers likely to be subject to this tax.⁴⁹⁹

Interestingly, under some state laws, heads of households are treated comparably to married couples for purposes of taxation.⁵⁰⁰ This reveals an important divergence between perspectives of certain states concerning relationships of

493. In the alternative, it would make sense for the taxpayer to take out a lease on their parent's house or apartment in their name. See Lasser *supra* note 341, at 25.

494. *Id.*

495. It also cannot be calculated in the support test.

496. I.R.C. § 55(d).

497. This is because the AMT starts with taxable income before the exemptions are calculated.

498. Under the old AMT rules, credits (like the child tax credit, the adoption credit, the dependent care credit, etc.) could reduce AMT liability. Thus, the new Dependent Credit of \$500 will reduce AMT liability. See Paul Neiffer, *Good News: Certain Credits Offset AMT*, AGRIBUSINESS BLOG (Jan. 13, 2013), <http://blogs.claconnect.com/agribusiness/good-news-certain-credits-offset-amt/>.

499. For 2018 the exemption amount is \$70,300 for a single taxpayer and \$109,400 for a married taxpayer filing jointly. The exemption amount begins to phase out once AMTI reaches \$500,000 for single taxpayers and \$1,000,000 for married taxpayer filing jointly. I.R.C. § 55(d)(4)(A)(i) & (ii). The Tax Policy Center expects those affected by the AMT to go from five million down to about 200,000 returns. See Laura Saunders, *Alternative Minimum Tax*, WALL ST. J., Feb. 14, 2018, at R3.

500. See *Oregon Income Tax Return Form 40* and *Oregon Income Tax Table*, <http://www.tax-rates.org/oregon/income-tax> (Only two filing statuses, single and couple—and head of household file as couple.)

dependency and that of the federal government.⁵⁰¹ Recognizing the importance of the caregiving endeavors of the taxpayer, these states, acting within the limited scope of their authority over state taxes, allow income-splitting for heads of households, a privilege not allowed under federal law. Under federal doctrine, heads of households are treated as single taxpayers with limited added tax benefits.⁵⁰²

C. EMPLOYER CREDIT FOR EMPLOYEE ON FAMILY LEAVE

A new provision enacted by the TCJA, Section 45S, allows eligible employers to claim a business credit for a portion of qualified wages paid to qualifying employees during any period in which that employee takes family and medical leave⁵⁰³ to care for a loved one. While it is beyond the scope of this Article to discuss all the employer provisions dealing with long-term care, this is a potentially transformative provision.

This credit allows a maximum of 12 weeks per year of family and medical leave.⁵⁰⁴ An eligible employer is one who has in place a written policy that allows all full-time employees not less than two weeks of annual paid family and medical leave and who allows all less-than full time qualifying employees a commensurate amount of leave on a pro rata basis. To be an eligible employer, the employer must provide certain protections under FMLA regardless of whether they would apply to the employer, specifically those relating to nondiscrimination and discharge of employee asserting their rights under the law.⁵⁰⁵ To be an eligible employee, the employee must have been, per the FLSA, employed by the employer for one year or more and had compensation not in excess of sixty percent of the compensation threshold for highly compensated employees in the preceding year.⁵⁰⁶ For 2017, this amount is \$120,000.⁵⁰⁷ Thus, employers will not receive credits for leaves granted to employees earning more than \$72,000, although they can still grant these employees paid leave.

The amount of the credit can vary from 12.5% to twenty-five percent of the amount of wages paid to the qualifying employee.⁵⁰⁸ In order for wages to qualify

501. See FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCE* (2004) in which she champions greater state recognition of the primacy of dependency relationships.

502. See generally I.R.C. §§ 291, 529, 401 (various sections referencing AMT, education, Roth, and other benefits).

503. “Family and medical leave” is defined as leave described under sections 102(a)(1)(a)-(e) or 102(a)(3) of the Family and Medical Leave Act of 1993.

504. I.R.C. § 45S(b)(3).

505. Thus, the employer must prove leave in compliance with a policy which ensures that the employer will not interfere with, restrain, or deny the exercise of or the attempt to exercise, any right provided under the policy and will not discharge or in any other manner discriminate against any individual for opposing any practice prohibited by the policy. See *Joint Explanatory Statement of the Committee of Conference* 294, <http://docs.house.gov/billsthisweek/20171218/Joint%20Explanatory%20Statement.pdf>.

506. I.R.C. § 45S(d)(2).

507. I.R.C. § 414(g)(1)(B).

508. I.R.C. § 45S(a)(2).

they must be fifty percent of the wages normally paid to that employee.⁵⁰⁹ The credit increases from the basic 12.5% amount by .25% (but not above twenty-five percent) for each percentage point by which that rate of payment exceeds fifty percent of those wages. For example, suppose an employee earns \$70,000 on an annual basis and receives only half of normal salary during their qualified leave period, or a salary of \$17,000. The employer would receive a credit of \$2,125 or 12.5% under the new provision. While this new provision is very innovative and might encourage employers to establish family leave policies, the provision expires in January 2020.⁵¹⁰

D. THE PAID CAREGIVER

In general, the tax benefits for paid caregivers are quite restrictive. Paid caregivers may receive an exclusion from their income for the value of any meals and lodging provided to them on the home premises of the care-receiver. Low-paid care-providers may also receive an Earned Income Credit. Family relatives, who provide care and receive certain payments under a Medicaid waiver program designed to secure care for low-income recipients in their homes, may also be able to exclude these payments from their income.⁵¹¹

1. *The Exclusion for Meals and Lodging*

Perhaps the best fringe benefit accorded paid caregivers is the exclusion for meals and lodging provided on the business premises for the convenience of the employer.⁵¹² Since the cost of lodging and meals takes up the largest portion of a person's personal budget, to have this paid for by the employer is a substantial financial benefit. For example, if the senior employer provides meals and lodging worth \$2,000 a month, that would be \$24,000 a year. It is worth noting that this can incentivize live-in care, taking paid caregivers away from their families. However, most paid caregivers do not live in the house of the care-receiver. Typically, the senior will be paying just for meals of the care-provider. However, under the TCJA, the employer is no longer able to deduct any meals provided on the business premises as a convenience of the employer.⁵¹³ Under new FLSA regulations seniors must now pay these live-in care-provider minimum wage and overtime so this type of home care may only be affordable to the very wealthy.⁵¹⁴

509. I.R.C. § 45S (c)(1)(B).

510. I.R.C. § 45S(i).

511. I.R.S. Pub. 907: Tax Highlights for Persons with Disabilities, U.S. DEP'T OF TREASURY (Dec. 18, 2015), <https://www.irs.gov/pub/irs-pdf/p907.pdf>. In addition, the caregiver may also get car expenses for caregiving, 14 cents per mile. I.R.S. News Release IR-84-2015-137 (Dec. 17, 2015), <https://www.irs.gov/uac/Newsroom/2016-Standard-Mileage-Rates-for-Business-Medical-and-Moving-Announced>.

512. For lodging there is also a condition of employment test, which is very similar to the convenience of the employer test. I.R.C. § 119(a) (2012); see also *Hatt v. Comm'r, T.C.M. (CCH)* 1969-229 (1969).

513. See I.R.C. § 274(o)(2) (stating meals provided for convenience of employer under Section 119 (a) are no longer allowed as a deduction).

514. See *supra*, note 62 and accompanying text.

Thus, we again see the adverse impact of federal policy on seniors trying to stay in their home.

2. *The Earned Income Credit*

Both the unpaid caregivers who work in the marketplace and paid workers in the home may be able to garner benefits from the Earned Income Credit.⁵¹⁵ The chief demerit of this credit is that it is woefully inadequate,⁵¹⁶ particularly for caregivers who do not have children.⁵¹⁷ This highlights an instance in which the interests of caregivers intersect with those receiving needed care. A considerable strengthening of this provision could work greatly to the benefit of all associate parties.⁵¹⁸

c. Continuing care. Continuing care retirement communities (CCRCs), also known as senior independent living communities, offer a variety of living, dining, fitness, and recreational facilities⁵¹⁹ and, most importantly, allow seniors to age in place with different levels of care as they age. As a prerequisite for entry into such a facility, seniors need to be able to live independently,⁵²⁰ meaning that, generally, CCRCs are restricted to those over the age of fifty-five and in good health.⁵²¹ When the seniors' care needs increase, these facilities often offer somewhat elevated services to adapt to personal need, referred to generally as "assisted living." This type of care provides a level of personal service—help with medications, meals, housekeeping, hygiene, and some therapeutic regimes.⁵²² An assisted living facility (ALF), often part of a continuing care residential campus, operates as an independent operation. Residents in these facilities are overwhelmingly older (the majority over 80 years of age),

515. Qualification for and the amount of the credit available depends on earned income, marital status, and dependents claimed. See I.R.C. § 32 (2016).

516. See Sara Sternberg Greene, *The Broken Safety Net: A Study of Earned Income Tax Credit Recipients and A Proposal for Repair*, 88 N.Y. UNIV. L. REV. 515 (2013), <http://www.nyulawreview.org/sites/default/files/pdf/NYULawReview-88-2-Greene.pdf> (arguing that credit should be refunded throughout the year); Anne L. Alstott, *The Earned Income Tax Credit and the Limitations of Tax-Based Welfare Reform*, 108 HARV. L. REV. 533 (1995); Lawrence Zelanak, *Redesigning the Earned Income Credit as a Family-Size Adjustment to the Minimum Wage*, 57 TAX L. REV. 301 (2004).

517. See Chuck Marr et al., *Strengthening the EITC for Childless Workers Would Promote Work and Reduce Poverty*, CTR. ON BUDGET & POL'Y PRIORITIES (Apr. 11, 2016), <http://www.cbpp.org/research/federal-tax/strengthening-the-eitc-for-childless-workers-would-promote-work-and-reduce>.

518. *Id.*; see also William Julius Wilson, WHEN WORK DISAPPEARS 223 (1996) (advocating for the expansion of the credit to raise all full-time working-poor families out of poverty).

519. ADVISOR'S GUIDE, *supra* note 73, at 30–31.

520. *Id.*

521. Dawn S. Markowitz, *Luxury Assisted Living for the Wealthy and Tax-Wise*, 58 TRUSTS & ESTATE 48, 49 (Nov. 2004) (most retirement communities that offer independent living units, high-end CCRC's require medical certification that purchasers and their spouses are in good enough health to live independently. Once a resident, however, seniors can stay until the end, even if they become ill").

522. ADVISOR'S GUIDE, *supra* note 73, at 31.; see also *What Are My Other Long-Term Care Choices?*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicare.gov/what-medicare-covers/part-a/other-long-term-care-choices.html>.

single, and female.⁵²³ About one-quarter of the more than 2.2 million seniors reside in the 20,000 to 30,000 CCRCs in the United States.⁵²⁴ More than one million seniors live in the more than 28,000 ALFs in the United States.⁵²⁵

The most important advantage to the CCRCs is that they offer seniors a choice to satisfy their desire to age in place—providing autonomy, familiarity, and stability.⁵²⁶ CCRCs allow seniors to avoid a common fear: burdening their families. A recent study of wealthy baby boomers conducted by global financial firm UBS found that forty-two percent feared “being a burden” on their families.⁵²⁷ These types of living facilities, particularly those with on-site nursing homes, provide the requisite flexibility to quell many of these fears. CCRCs allow residents to become comfortable with their facilities and plan their lives on a longer-term basis, possibly for life.⁵²⁸

CCRCs also make it easier for seniors to surround themselves with their peers. These residences allow married couples to remain close together even when one of the spouses requires more intensive care services.⁵²⁹ Often the elderly do not want to be alone⁵³⁰ and these facilities feature an impressive array of options for the active retiree.⁵³¹ Many offer golf, tennis, swimming and movie theaters, as well as social events “that would exhaust even a teenager.”⁵³² Many CCRCs market specialized selling points, such as professionally designed interiors and highly trained chefs.⁵³³ Others are affiliated with major universities, creating an atmosphere of an alumni club.⁵³⁴

CCRCs provide seniors with an opportunity to invest in real estate and perhaps pass some valued assets onto their families. These facilities often offer seniors

523. Long-Term Care Education *What is Assisted Living?*, University of North Carolina—Chapel Hill (2017) (78% of the surveyed facility residents were women and only 3% of the residents were married.). See also *How Many Assisted Living Facilities Exist?*, McKnight’s Long-Term Care News (Jan. 1, 2008), <https://www.mcknights.com/industry-faq/how-many-assisted-living-facilities-exist/article/104028/> (the typical resident is “an 83-year old woman” and average male female ratio is 74% to 26%).

524. Martin, *supra* note 35, at 361.

525. See McKnight’s News, *supra* note 523.

526. See ADVISOR’S GUIDE, *supra*, note 73, at 30.

527. Anya Kamenetz, “Have a plan now to avoid being a burden on children later,” Chicago Tribune (Jan. 21, 2016, 3:39 p.m.), <http://www.chicagotribune.com/business/success/savingsgame/tca-have-a-plan-now-to-avoid-being-a-burden-on-children-later-20160121-story.html>.

528. See Bernard A. Krooks & Kameron L. Kirkevold, *Why Elder Law?* 28 PROB. & PROP. 3, 38–39 (May/June 2014).

529. *Id.*

530. See Markowitz, *supra* note 521, at 48.

531. Dawn Wotapka, “A New Senior Moment,” WALL ST. J. (March 28, 2013, 2:24 p.m.) <https://www.wsj.com/articles/SB10001424127887324557804578374574086213166> (last visited Sept. 20, 2018).

532. *Id.*

533. *Id.*

534. Valerie Finholm, *Over-55 Communities Near College Campuses on the Increase*, Retirement-Living.com <https://www.retirement-living.com/proaging-network/over-55-communities-near-college-campuses-are-on-the-increase/> (for example, Penn State in State College, Pennsylvania, University of Florida in Gainesville, Florida, and Stanford University in Palo Alto, California).

the ability to purchase units that may appreciate in value. Unit designs run the gamut from simple “one-bedroom apartments in high-rise buildings to multi-bedroom low-rise villas to sprawling homes with garages and private yards.”⁵³⁵ Purchase prices can range from “the low hundred thousands and often soar into the millions, with maintenance fees that can exceed \$6,000 a month.”⁵³⁶ The ability to purchase these kinds of homes is appealing to wealthy seniors who like the degree of control that comes with owning an equity stake in a property, at the same time enjoying the prospects of appreciation in value.⁵³⁷ However, this option will not be available to the typically poor elder woman.

The major downside of CCRCs is that, generally speaking, initial costs are high and significant savings may be necessary to afford this level of care. CCRCs usually allow the resident to “buy or rent a living unit for use while they can still live independently.”⁵³⁸ A certain amount of liquid assets are highly advisable in case there is a sudden change in care requirements that could necessitate a physical transfer to another kind of care.⁵³⁹ Initial fees will vary depending upon whether the arrangement is a rental or a purchase, the size and location of the unit, the amenities covered, whether accommodations are shared, the current health status of the residents, and the type of contract signed.⁵⁴⁰ Entrance fees can range from \$20,000 on the low end to half a million dollars or more on the high end.⁵⁴¹ However, some CCRCs are nonprofit entities, such as church-affiliated centers,⁵⁴² and cater to lower net-worth residents, some even offer subsidies to residents who exhaust their resources.⁵⁴³ Monthly fees at these facilities may run as low as \$500 but may range upwards of several thousand dollars.⁵⁴⁴ Yearly costs routinely average \$25,000 to \$60,000 a year after the initial fee.⁵⁴⁵

One hazard of a CCRC occurs when a resident experiences a steep decline in health and has to move out of the complex.⁵⁴⁶ Although these communities offer

535. See Markowitz, *supra* note 521, at 49.

536. *Id.* (“While specifics vary, many luxury buy-in CRCs are set up so that 90 percent of the purchase price is applied to owning the home, the other 10 percent (usually nonrefundable) is applied to membership in shared facilities. The monthly fee is based on the size and type of residence purchased.”).

537. *Id.*; see also Markowitz, *supra* note 521, at 50 (“[M]ost of these units have appreciated between 3 and 4 percent annually. . .but The Cypress of Hilton Head Island [in South Carolina] has seen an 8 percent annual appreciation in value.”).

538. Consumer Reports, *Spectrum of Available Care: Other Options to Consider* (Jan. 2001) www.CONSUMERREPORTS.COM, (many require extensive income and assets to qualify).

539. Wotapka, *supra* note 531 (CCRCs require a large initial fee in addition to monthly fees and any additional fees when transferring from one facility to another within the campus. Sometimes the monthly fee is included in the total cost, other times the monthly fee is separate but does not increase over the life of the inhabitant); see also ADVISOR’S GUIDE, *supra* note 73, at 58.

540. ADVISOR’S GUIDE, *supra* note 73, at 59–60.

541. *Id.* at 59.

542. *Id.*

543. *Id.* at 59.

544. *Id.*

545. Martin, *supra* note 35, at 366.

546. See ADVISOR’S GUIDE, *supra* note 73, at 60.

a range of long-term care,⁵⁴⁷ they are not substitutes for nursing homes.⁵⁴⁸ Most CCRCs do not admit or retain residents who require ventilators, catheters, or need help with continence problems.⁵⁴⁹ More than one-third of all CCRC residents eventually go to nursing homes when their medical needs exceed the capabilities of the CCRC.⁵⁵⁰ An additional two percent of residents transfer to nursing homes because they have consumed their assets and can no longer afford the care.⁵⁵¹ A 2003 survey of 1,500 ALFs showed that only eleven percent allowed frail people to remain in residence.⁵⁵²

In response, a growing number of CCRSs have developed nursing facilities and sophisticated health centers on their campuses, although some are only for temporary stays.⁵⁵³ Here seniors can receive help with daily care elements such as personal hygiene and dressing; if they need 24-hour care they can move into the health center. Due to increased demand, CCRCs are adding skilled nursing centers⁵⁵⁴ that provide help with acute conditions as well as chronic illness.⁵⁵⁵ Where such skilled on-campus facilities exist, treatment costs are substantially lower than for similar services performed outside the retirement community—savings may amount to as much as 50 percent.⁵⁵⁶

CCRCs are generally not subsidized by Medicaid or Medicare. Some qualified long-term care services provided at these facilities could be subsidized through Medicaid, assuming the seniors in question spend down all their assets and are able to fall beneath qualifying income caps. Medicare may pay for medical expenses after the mandatory three-day hospital stay. Similarly, some variety of long-term care insurance may cover these types of facilities when the medical needs of the insured senior qualify for long-term care.

The taxation subsidies for CCRCs are complicated. First, if the senior owns the house then all the tax benefits of home ownership apply. Second, if the facility is a nonprofit organization, then any charitable transfer could be a charitable deduction. Lastly, a portion of the upfront charge and maintenance fee could be a qualified medical expense if considered for the chronically ill. The problem is that all

547. *What Are My Other Long-Term Care Choices?*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicare.gov/what-medicare-covers/part-a/other-long-term-care-choices.html>; see also ADVISOR'S GUIDE, *supra* note 73, at 30.

548. Congress of California Seniors, *Is Assisted Living the Right Choice?*, SENIORS.ORG, <http://www.seniors.org/wherewestand.asp?id=1033> (last visited Sept. 20, 2018).

549. *Id.* (There are some CCRC's that also have nursing homes).

550. *Id.* (36% to be exact).

551. *Id.*

552. GAWANDE, *supra* note 11, at 102.

553. ADVISOR'S GUIDE, *supra* note 73, at 30–31.

554. *Id.*

555. Tia Mitchell, *Villages Retirement Community Asks Legislature for Nursing Home*, Tampa Bay Times, (April 10, 2013), <http://www.tampabay.com/news/health/the-villages-the-retirement-town-thought-to-have-everything-asks-the/2114163> (last visited Sept. 20, 2018) (where a popular 95,000 retirement center asked the legislatures of Florida to grant a license for a nursing home facility on their premises).

556. Markowitz, *supra* note 521, at 50.

of these subsidies favor the wealthier taxpayer and most elders are not even taxpayers.⁵⁵⁷

i. Tax benefits of ownership. If seniors own houses or condo units at the CCRC and itemize their deductions, they will be able to deduct a portion of all of their real estate property taxes and all or a portion of their mortgage interest on any acquisition indebtedness on their home (or homes).⁵⁵⁸ The TCJA has limited both of these itemized deductions for years 2018 through 2025.⁵⁵⁹ A taxpayer may now claim a deduction of only up to an aggregate amount of \$10,000 for the following taxes: (1) state and local property taxes, and (2) state and local income (or sales taxes in lieu of income taxes).⁵⁶⁰ Thus, if taxpayers live in high tax states, their real property tax deduction may be limited.⁵⁶¹ Furthermore, the TCJA allows a mortgage interest deduction (for a main and secondary home) to no more than \$750,000 of acquisition indebtedness.⁵⁶² Of course, the tax and mortgage interest deductions are itemized deductions and in most cases the senior will be taking the standard deductions. If the seniors must sell their CCRC to move into a nursing home, they will continue to be able to exclude up to \$250,000 of the gain (\$500,000 if married filing jointly) as long as they have resided there two out of five years.⁵⁶³

ii. Charitable deduction. If taxpayers go into or reside in a religiously affiliated CCRC, they may be entitled to an itemized charitable deduction,⁵⁶⁴ but only if they pay a separate fee to the qualified charitable organization that is not required for admission or services rendered to them. A no-strings attached gift, exclusively for the benefit of the charity, should be deductible.⁵⁶⁵ Under the

557. *Why Most Elderly Pay No Federal Tax*, Center for Retirement Research at Boston College, (Arpil 14, 2016), <http://squaredawayblog.bc.edu/squared-away/why-most-elderly-pay-no-federal-tax/>. Elders, of course, pay no payroll taxes. See Robertson Williams, *Why Nearly Half of Americans Pay No Federal Income Tax*, TAX POLICY CTR. (June 7, 2010), <https://www.taxpolicycenter.org/sites/default/files/alfresco/publication-pdfs/412106-Why-Nearly-Half-of-Americans-Pay-No-Federal-Income-Tax.PDF>.

558. Under the TCJA the standard deduction has been expanded to \$12,000 for single taxpayer, \$18,000 for head of households, and \$24,000 for married couples filing jointly. I.R.C. § 63(c)(7)(A). These amounts will be adjusted for inflation. I.R.C. § 63(c)(7)(B). In addition, those over 65 will also receive an additional basic deduction. Both of these amounts would be compared to the new standard deduction to see what would be the greater deduction. The Tax Policy Center estimates that “about 11% of house-holds are projected to itemize deductions, down from 26% under the prior” tax law. See Richard Rubin, *Tax Law Spurred a Rush to Charitable-Giving Funds*, WALL ST. J. (Feb. 2, 2018), at A2.

559. I.R.C. §§ 164(b)(6), 163(h)(3)(F).

560. I.R.C. § 164(b)(6). This \$10,000 deduction is the same for married couples as it is for individuals.

561. Under the TCJA, no deduction is allowed for foreign real property taxes paid. I.R.C. § 164(b)(6)(A).

562. I.R.C. § 163(h)(3)(F)(i)III).

563. I.R.C. § 221. Any excess capital gain may be taxed at zero percent if the elder is in a zero tax bracket.

564. I.R.C. § 170.

565. See Lori A. Tobias, *Brinley v. Commissioner: A Modified Charitable Deduction Standard for Missionary Support Payments*, 40 SMU L. REV. 1267, 1269 (1987), <http://scholar.smu.edu/cgi/>

TCJA, this itemized deduction has been increased to sixty percent of the taxpayer's contribution base or adjusted gross income if the contribution is made in cash.⁵⁶⁶ A charitable deduction is better than a medical expense deduction, which is limited to 7.5% of adjusted gross income. Of course, the IRS will be weary of such schemes if they fly in the face of the statute.⁵⁶⁷ But again, only the wealthy who itemize and do not take the standard deduction will benefit from this tax provision.

iii. Itemized Medical Deduction. In general, fees paid for independent living at a CCRC are not deductible. However, upfront charges and entrance fees to an ALF are deductible if they (or part of them) are allocable to medical care for the chronically ill.⁵⁶⁸ The deduction may be allowed upon a showing that the facility historically allocates a specified percentage of the fee to future medical care.⁵⁶⁹ The IRS and the Tax Court have approved the use of the "percentage method" for allocating the community medical expenses among the residents.⁵⁷⁰ In general, the annual medical expenses of the community are divided by the total operating expenses. In *Baker*, a Tax Court case from 2004, the IRS argued that the service fee should be figured using an "actuarial method," which would have reduced the taxpayers' two-year deduction by several thousand dollars.⁵⁷¹ The Tax Court rejected this methodology, saying it requires projections of longevity and lifetime utilization of health-care services and was so complicated that the IRS could not fully explain the method to the court.⁵⁷² The court held the percentage method was appropriate.⁵⁷³ However, in applying this method, the Court had to resolve disputes over how certain expenses should be treated and how the allocated medical care percentage once determined should be split among the residents.⁵⁷⁴ For example, the Court held that the community's interest expenses and depreciation allowances must be included in both the numerator and denominator when

viewcontent.cgi?article=2652&context=smulr (discussing the three prerequisites to the deductibility of direct charitable transfers: (1) the transfer must be gratuitous or a gift, (2) the transfer must benefit a qualified recipient, and (3) must be absolutely for the benefit of the recipient. Any quid pro quo for the transfer will disqualify it).

566. I.R.C. § 170(b)(1)(G)(i). Otherwise, a deduction of property is limited to 50% of the taxpayer's contribution base.

567. See Alejandro Lazo, *California Advances Tax Workaround*, WALL ST. J., Jan. 30, 2018, at A3s <https://www.wsj.com/articles/california-senate-passes-tax-workaround-bill-1517358225> (stating that California is attempting to circumvent the tax laws limitation on state tax by establishing state-run charity).

568. Paul Gordon, *Medical Expense Tax Deductions: A Guide for Senior Living Providers and Residents* 5 (2012), http://www.flicra.com/uploadedFiles/File/Senior_Living_Tax_Deductions_Guide.pdf.

569. *Id.*

570. See *Baker v. Comm'r*, 122 T. C. 143 (2004).

571. *Id.* at 162.

572. *Id.* at 167–68.

573. *Id.*

574. *Id.* at 167.

dividing medical costs by operation cost to determine the medical care allocation percentage.⁵⁷⁵

The senior may deduct the cost of meals and lodging paid to an ALF if: (1) the institution regularly engages in providing medical care or services (including qualified long-term care), (2) one of the principal reasons for the individual's presence in the institution is the availability of medical care (including supervisory care for an individual who is unsafe when left alone due to severe cognitive impairment), and (3) the institution furnishes meals and lodging as a necessary incident to the medical care.⁵⁷⁶ One of the themes running through this paper is the different treatment of meals and lodging in the tax system under the various care options. The costs of meals and lodging comprise a large part of a person's personal budget, so having an exclusion⁵⁷⁷ or, in this case, a deduction for this amount, could provide a significant tax benefit, assuming the taxpayer itemizes and does not take the standard deduction.

d. Residential Care. Residential care homes, also known as adult family homes, personal care homes, adult foster homes, or board-and-care homes, provide long-term care for adults in a home-like family setting.⁵⁷⁸ These homes work well for those who do not want to live in a larger community residence but do not have help in their home or do not want to be alone at home.⁵⁷⁹ Often third parties who have space in their homes obtain a license and provide care and assistance with activities of daily living to 20 or fewer residents.⁵⁸⁰ In many states, the licensing board can certify the facility based on the following criteria: safety, types of services provided, and the number and type of residents they can care for.⁵⁸¹ Whether the home provides skilled nursing care will vary among states.⁵⁸² Residential homes can specialize in particular types of care, like those with memory problems, those with neurological afflictions, those with dietary issues like diabetes, and those with foreign language, religious, or cultural needs.⁵⁸³

575. *Id.* at 173–77, 181 (holding that the Bakers could not simply multiply the percentage of the facility fee allocated to medical care by the amount they paid but rather had to obtain a weighted average of the service fee).

576. See Blankenship, *supra* note 408, at 220 n.32-34.

577. See earlier discussion, *supra* note 415 and accompanying text. We should point out that an exclusion is much better than an itemized deduction.

578. ADVISOR'S GUIDE, *supra* note 73, at 30.

579. *Id.*

580. Residential Facilities, Assisted Living and Nursing Homes, National Institute on Aging, <https://www.nia.nih.gov/health/residential-facilities-assisted-living-and-nursing-homes> ("Board and care homes, also called residential care facilities or group homes, are small private facilities usually with 20 or fewer residents."). See Milbank Memorial Fund & the Council of Large Public Housing Authority, Public Housing and Supportive Services for the Frail Elderly: A Guide for Housing Authorities and Collaborators (2006), <http://www.milbank.org/uploads/documents/0609publichousing/0609publichousing.html>.

581. Admin. on Aging, *Glossary*, *supra* note 34 (definition of Board and Care Homes).

582. See Ctrs. for Medicare & Medicaid Servs., What Are My Other Long-Term Care Choices? 25, <https://www.medicare.gov/Pubs/pdf/02174-Nursing-Home-Other-Long-Term-Services.pdf>.

583. See ADVISOR'S GUIDE, *supra* note 73, at 30.

Theoretically, residential homes have many of the same drawbacks of home care. There may be little social stimulation and the quality of the care is highly dependent on the level of experience and knowledge of the person(s) providing the care. Recent reports of elder abuse at these types of homes in California resulted in two bills having been introduced in that state legislature concerning public information on these homes and investigative processes on complaints, respectively.⁵⁸⁴ However, research indicates that “in units with fewer than twenty people there tends to be less anxiety and depression, more socializing and friendship, an increased sense of safety, and more interaction with staff—even in cases when residents have developed dementia.”⁵⁸⁵

Residential care homes can be financed similarly to CCRCs and are likely to be less expensive.⁵⁸⁶ First, residential care homes, like CCRCs, are not covered by Medicare because they are considered non-medical facilities.⁵⁸⁷ Medicaid does not pay for room-and-board in these living arrangements but may pay for the portion of services that fall under the canopy of long-term care services⁵⁸⁸ and may pay for skilled care if the resident qualifies. Additionally, long-term care insurance could cover this care if the policy specifically includes this category of residence. The tax benefits are also on par with those applying to ALFs, principally a medical deduction for the portion of the expense relating to the long-term care. Second, residential care homes are likely to be less expensive than CCRCs and nursing homes, but are still more expensive than home care.⁵⁸⁹ The cost will depend on a number of factors such as the type of accommodation (private room, etc.), the range of services needed (specialized services for dementia are more expensive, etc.), and the geographic area.⁵⁹⁰ The average cost is from \$2,500 to \$5,000, but can be as low as \$900 for the senior on Supplemental Security Income.⁵⁹¹

e. Adult Day Care. At the opposite end of the spectrum from nursing homes is adult day care (ADC), which provides social, therapeutic, and medical services in a supportive group environment or outside the home in a community setting.⁵⁹²

584. Katie Nelson, *Bills to Tighten Scrutiny of Elderly Care Homes Killed by California Legislature*, MERCURY NEWS (Aug. 15, 2014, 6:26 p.m.), http://www.mercurynews.com/breaking-news/ci_26349099/bills-tighten-scrutiny-elderly-care-homes-killed-by.

585. GAWANDE, *supra* note 11, at 129.

586. *Continuing Care Retirement Communities (CCRCs)* <https://www.seniorliving.org/lifestyles/ccrc/>, (“By far, a CCRC is the most expensive senior living option.”).

587. *Residential Care Options*, FAMILY CAREGIVER ALLIANCE, <https://www.caregiver.org/residential-care-options>.

588. THE SCAN FOUNDATION, *Data Brief: Residential Care Facilities and Medicaid* (2012).

589. Jacquelyn Sanders, *Continuing Care Retirement Communities: A Background and Summary of Current Issues* 5, 12 (Feb. 24, 1997), <https://aspe.hhs.gov/sites/default/files/pdf/72901/ccrcrpt.pdf>.

590. See Senior Sanctuary, *How Much do Residential Facility Care for the Elderly (RFCE) Cost?*, <http://www.seniorsanctuary.com/assistedliving/rfce-cost.html>.

591. *Id.*

592. ADVISOR’S GUIDE, *supra* note 73, at 29.

ADCs allow unpaid caregivers the flexibility to continue with their market labor while still caring for their family member.

Unlike residential programs, and as the name implies, no overnight services are provided.⁵⁹³ Seniors may attend the program for several hours at a time, other times for the full day.⁵⁹⁴ Social activities may include music, exercise activities, and field trips.⁵⁹⁵ Therapeutic and medical services might include things such as nursing care and rehabilitation therapy.⁵⁹⁶ In addition, these settings may feature specialized services directed at patients with Alzheimer's or dementia, neurological ailments, or other special issues.⁵⁹⁷ Meals, snacks, and two-way transportation may also be provided.⁵⁹⁸

The variety of care ADCs provide affords needed relief to the unpaid caregivers who perform market labor during the day.⁵⁹⁹ As mentioned earlier, many caregivers have a full-time job and dropping off their loved one at a day care center provides much needed support and relief.⁶⁰⁰ However, these care-providers are often responsible for "double shift" work if such care is not available in the evenings or on weekends.⁶⁰¹ The cost of ADC can be reasonable, at least in comparison to nursing home or other residential care, but it can still be a financial strain on many families.⁶⁰² Nationwide, this brand of service averages about \$17,000 a year.⁶⁰³ Costs range from around \$6,500 per year (in Alabama) to \$35,000 per year (in Vermont).⁶⁰⁴ Real cost savings are hard to calculate because ADC expenses are added onto the "normal" home costs of rent, mortgage, utilities, food and so on.⁶⁰⁵ In many cases, low-paid care in the home may be less expensive.

593. However, some service providers do provide overnight care for up to two weeks. *Overnight Respite*. CARE PARTNERS, <https://missionhealth.org/services-treatments/adult-care/overnight-respite/>.

594. *About Adult Day Services*, NAT'L ADULT DAY SERVS. ASS'N, <http://www.nadsa.org/learn-more/about-adult-day-services/>.

595. *Id.*; see also, *Activities in Adult Day Care*, <https://www.adultdaycare.org/resources/activities-in-adult-day-care/> (mentions singing and field trips).

596. See ADVISOR'S GUIDE, *supra* note 73, at 29.

597. *Id.*; *Specialized Alzheimer's Care & Service Centers*, ALZHEIMER'S COMM. CARE, <http://www.alzcare.org/specialized-adult-day-service-centers>.

598. See ADVISOR'S GUIDE, *supra* note 73, at 29; Admin. on Aging, *Adult Day Care*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Oct. 15, 2015), http://www.eldercare.gov/Eldercare.NET/Public/Resources/Factsheets/Adult_Day_Care.aspx.

599. Emblem Health & Nat'l Alliance for Caregiving, *Care for the Family Caregiver: A Place to Start 17* (2010), http://www.caregiving.org/data/Emblem_CfC10_Final2.pdf [hereinafter *A Place to Start*].

600. *Id.* at 13.

601. Some facilities do provide hours during the evenings or on weekends. See *Adult Day Care*, SENIORADVISOR.COM, <https://www.senioradvisor.com/ind/adult-day-care>.

602. Martin, *supra* note 35, at 365.

603. GENWORTH, *supra* note 205.

604. *Id.*

605. See Gleckman *Healthcare*, *supra* note 318, at 854 (those types of costs are normally included in nursing home costs but not considered in these estimates of adult care expenditures).

For seniors, the ADC option is often attractive because of the opportunities for personal and social stimulation.⁶⁰⁶ For seniors and their families, it can add an extra layer of assurance against elder abuse since these seniors are not isolated and vulnerable at home. ADCs provide an adjunct type of care by encouraging and augmenting home life, which is a high priority for women.⁶⁰⁷ Unfortunately, this care is not available for many chronically ill elders because most facilities are not equipped for those with serious health problems.⁶⁰⁸ Thus, ADC is not a substitute for skilled nursing home care.

Because ADC is not a medically-based type of care, there is little subsidized funding available for it.⁶⁰⁹ Medicare will not cover this type of care, nor will long-term care insurance.⁶¹⁰ Unless a state issues a waiver to pay for such care, Medicaid will not cover this expense, and even when seniors qualify, parameters are tight.⁶¹¹ Some states, such as California, have extensive ADC programs,⁶¹² but due to the ravages of the Great Recession and continuing pressures on state treasuries, these home care benefits have been reduced or gutted.⁶¹³ For example, the funding for California's Medicaid program (Medi-Cal) was slashed for approximately 300 ADC programs starting in 2012.⁶¹⁴

Two tax subsidies are available—the Dependent Care Credit and the Dependent Care Assistance exclusion—but a taxpayer cannot claim the benefits of both provisions for the same dollar of expense.⁶¹⁵ The Dependent Care Credit delivers only limited benefits.⁶¹⁶ First, unpaid taxpayer caregivers must incur the

606. Some adult day care focuses primarily on social interaction, while others may focus on medical care and Alzheimer's care. *What is Adult Day Care?*, <http://www.caregiverslibrary.org/caregivers-resources/grp-caring-for-yourself/hgrp-support-systems/what-is-adult-day-care-article.aspx>.

607. See Howard Gleckman, *The Battle Over California's Adult Day Programs*, FORBES (Jan. 4, 2012), [hereinafter *Gleckman Battle*], <http://www.forbes.com/sites/howardgleckman/2012/01/04/the-battle-over-californias-adult-day-programs/>.

608. See Eugene Rich et al., *Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions 5* (2012), <https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf> (discussing how elders with high needs require more care than is typically available at adult day care centers).

609. See *Paying the Cost of Care*, NAT'L CARE PLAN. COUN., https://www.longtermcarelink.net/eldercare/paying_the_cost_of_care.htm. As I mention earlier in the tax section, *supra* notes 451-480, when the elderly person is a dependent, then a Dependent Tax Credit may be available. However, this credit is inadequate.

610. *Medicare Coverage of Adult Daycare*, CARING.COM, https://www.caring.com/medicare_information/medicare-coverage-of-adult-daycare.

611. *Long-Term Care Choices*, *supra* note 264 (“If you’re already eligible for Medicaid (or would be eligible for Medicaid coverage in a nursing home), you may be able to get help with the costs of some home- and community-based services, like homemaker services, personal care, and respite care. . . States have home- and community-based waiver programs to help people keep their independence while getting the care they need outside of an inpatient facility.”).

612. See *Gleckman Battle*, *supra* note 607.

613. *Id.*

614. *Id.*

615. I.R.C. § 129(e)(7).

616. I.R.C. § 21. Also see IRS Pub. 503, IRS.GOV, <https://www.irs.gov/publications/p503/ar02.html> (last updated Jan. 2, 2018).

requisite care expenses that enable them to perform market work.⁶¹⁷ Second, expenses must be for the care of dependent parents or other qualifying relatives.⁶¹⁸ Luckily, even if a parent or relative does not qualify as “dependent” for the Dependent Tax Credit (because their income exceeds the exemption amount), they can still be declared dependents for purposes of this provision, just like they would for the payment of medical expenses.⁶¹⁹ Third, the maximum amount of care expenses that are calculated in the credit is \$3,000,⁶²⁰ far less than even the low range for this kind of care. As mentioned previously, yearly expenses for ADCs can easily surpass \$17,000 a year. Lastly, this credit is phased-down as taxpayer income increases.⁶²¹ The size of the credit is variable, depending upon the level of care expenses and the number of dependents.⁶²² It is conceivable that many care-providers are “sandwiched”—that is, they send their children to day-care at the same time as they send their parent to adult care. It is easy to see how such a low maximum credit amount is of limited benefit to many low and middle-income taxpayers who carry substantial care responsibilities.

A slightly higher amount—\$5,000—is available under Section 129, which allows a taxpayer to exclude from gross income up to \$5,000 of dependent care assistance provided by an employer under a qualifying dependent care assistance plan.⁶²³ Sections 129 and 21 share a common goal of providing a tax benefit for taxpayers who incur expenses for the care of dependents seniors so that the taxpayer can work. They also share some common definitions (depend care assistance) and limitations (earned income limitation).⁶²⁴ But Section 129 offers an exclusion from gross income, while Section 21 provides a tax credit and this credit is phased down for wealthier taxpayers. Thus, in terms of tax benefit, Section 129 provides a better tax benefit for the high-income taxpayer.

f. Summary. To conclude, the type of care best suited to an individual varies with the totality of the situation. What level of daily care is required? Are there family members available to assist? What does the overall financial picture look like? See [Table I](#), below, for a summary of the different types of care and their distinguishing features. Viewed from a perspective that seeks the best comprehensive outcomes for care-recipients, home care most consistently attains these

617. I.R.C. § 21(b)(2). (employment related expenses are expenses incurred for the care of a qualifying individual to allow the taxpayer to be gainfully employed).

618. I.R.C. § 21(b)(1).

619. I.R.C. § 21 (b)(1)(B). *See* discussion *supra*, in II(B)(2)(b)(I) or notes 444-446.

620. I.R.C. § 121(c).

621. I.R.C. § 21(a)(2). (The applicable percentage depends on the taxpayer’s adjusted gross income (AGI). For taxpayers with AGI of \$15,000 or less, the applicable percentage is 35%. The applicable percentage drops by one percentage point for every increase of \$2,000 (or fraction thereof) over \$15,000 in AGI, but never falls below 20%).

622. I.R.C. § 21(c)(2) (the amount could be \$6,000 in the case of two dependents).

623. I.R.C. § 129(a)(1).

624. Both provide that the exclusion or credit is limited to the earned income of the lesser-earning spouse. I.R.C. § 129(b)(1)(B); I.R.C. § 21(d)(1).

TABLE I: COMPARISON CARE CHART

	Care Provided	Tax Subsidies	Financed through Long-term Care Insurance	Financed through Government Assistance	Costs
Home Care	Skilled, personal, practical, companion, supportive	Medical, Dependent Tax Credit, Head of Household, Dependent Care Credit, or Dependent Care Assistance	Sometimes	Rarely	Low to High
Adult Day Care	Mostly personal and companion	Dependent Care Credit or Dependent Care Assistance	Generally not	Generally not	Low to Medium
Continuing Care Retirement Communities	Mostly personal, sometimes skilled	Medical, Charitable, Home Ownership	Sometimes	Generally not	Usually High
Residential Care Homes	Skilled, personal		Yes, usually	Can be	Low to Medium
Nursing Homes	Skilled, personal	Exclusion for benefits and medical	Yes	Yes	High

objectives. Home care provides the most flexible care platform, is fiscally responsible and cost effective, and comports with prevailing attitudes of patients who wish to reside in familiar surroundings with people they know and trust. The best medical evidence clearly shows that maximum positive health outcomes are achieved when personalized care regimes are carried out in comfortable surroundings mingled with interactive engagement, all of which uphold core feminist principles.

Ironically, the thrust of prevailing public policy toward elder care runs counter to the attainment of optimal health, happiness, and fiscal outcomes. It is immediately clear that the tax system—a main driver in policy implementation—provides woefully inadequate subsidized support for the care of the elderly. First, the medical deduction is only an itemized deduction and has a significant floor. Second, the dependency exemption has been abolished and in its place a Dependent Tax Credit that provides little or no tax benefit. Third, the head of household status discriminates against married couples and is taken away with the alternative minimum tax. Fourth, the unpaid caregiver receives inadequate benefits from the Earned Income Credit. In every instance, the value of the actual care given is discounted—and sometimes results in reverse discrimination. These backwards policies require bold, yet practical policy reforms.

V. PROPOSALS FOR REFORM

The long-term care system is subsidized largely through unpaid and low-paid caregiving. Yet, the care given is not adequately valued or supported in the tax code. Elderly women want to age in place, yet the tax subsidies that exist favor institutional care. The tax rules even punish the unpaid caregiver while favoring wealthy care-recipients who can afford paid care. However, reform of the tax code is not enough here. The FLSA, the FMLA, Medicaid, and Medicare must also be modified. In addition, the CLASS Act (or some facsimile thereof) should be resurrected and expanded. Revenues for these endeavors must be generated. Both tax and non-tax policy reforms are examined below.⁶²⁵

625. I reference in my analysis some of the tax policy criteria originally discussed by Joseph T. Sneed, *The Criteria of Federal Income Tax Policy*, 17 STAN. L. REV. 567, 568 (1965). According to Sneed there are seven pervasive principles of tax policy. These criteria are: (1) to supply adequate revenue, (2) to achieve a *practical* and workable income tax system, (3) to impose *equal* taxes upon those who enjoy incomes [(horizontal equity)], (4) to assist in achieving economic *stability*, (5) to *reduce economic inequality* [(vertical equity)], (6) to avoid impairment of the operation of the *market-oriented economy* and (7) to accomplish a high degree of harmony between the income tax and the sought-for *political order*. *Id.* In addition to his macro-criteria there are a series of micro-criteria, which, according to Sneed, are less pervasive and more particularized ends. *Id.* at 569. Although no definite list of them is made, they are still important in the tax policy discussion. As problems with the long-term care system and possible solutions are raised, issues of tax policy will be prevalent.

A. TAX SUGGESTIONS

1. *Refundable Credit for the Poor Care Receiver*

At a federal or state level, policymakers should enact a refundable credit for poor care-receivers. While the United States is not in the habit of following the policy leads of our neighbor nations in the western world, it can be informative to observe the initiatives other countries are undertaking to address these very same issues of caring for a burgeoning elder population with massive health and late-life needs.⁶²⁶ For example, some European countries give cash allowances directly to the care-receiver or to a family care-provider.⁶²⁷ A refundable credit regime could accomplish many of the same policy objectives here in the U.S. and be more politically palatable than a direct “handout.”⁶²⁸ This would benefit both the care-receiver and the care-provider. The amount of this subsidy could vary, but a standard amount in Europe is \$3,000 to \$5,000 a year. A means-test that would include both income and assets might be needed to establish eligibility.

2. *Value Caregiving for the Unpaid Caregiver*

Policies must take account of the varied contributions made by unpaid care-providers. As we have seen, eligibility rules for applying the Dependent Tax Credit, the medical care deduction, and the Earned Income Credit ignore the monetary value contributed by the unpaid care worker. These labors are valued as if they were never performed. This situation *must* change. The key task here is to fashion a valuation method for this unaccounted labor that translates into effective policymaking. Readily available avenues exist to determine the amount of this labor, and once the amount of labor is calculated, it can be valued and then counted as providing support or work under various tax provisions.

For example, if the taxpayer takes leave under the FMLA, the care valuation could be directly tied to the length of the care leave, calculated by a designated formula. Employers could supply the average amount of time their employee is sacrificing by performing care duties, and the need for the care could be certified by the care-receiver’s doctor or other professional. If the taxpayer takes leave from work (but not under the FMLA), the employer could assess the amount of work lost and therefore the amount of time spent on elder care. Again, a doctor could certify that the care was required.

626. Asian countries handle this with as part of their culture, which mandates that adult children take care of parents. See May K. Kanti, *The Experience of Asian Americans Caring for Elderly Parents*, VIRGINIA POLYTECHNIC INST. AND STATE UNIV. 2 (Apr. 29, 2014), https://vtechworks.lib.vt.edu/bitstream/handle/10919/48419/Kanti_M_T_2014.pdf?sequence=1 (Masters of Science in Human Development Thesis).

627. See Barbara Da Roit & Blanche Le Bihan, *Similar and Yet so Different: Cash-for-Care in Six European Countries’ Long-Term Care Policies*, 88 MILBANK Q. 286, 286 (2010), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000929/pdf/milq0088-0286.pdf>.

628. However, until recently Congress has not been willing to increase public spending in any form. See David M. Herszenhorn, *Congress Passes \$1.8 Trillion Spending Measure*, N.Y. TIMES (Dec. 18, 2015), http://www.nytimes.com/2015/12/19/us/congress-spending-bill.html?_r=0.

If the taxpayer is not employed, a doctor could certify that the elder who is chronically ill needs a certain amount of help each day for completing daily activities. Once the hours of care are determined then a mechanism for valuing the hours could be made. At a minimum, the value of the performed care labor would equal the state or local minimum wage rate or the federal prevailing wage. At a maximum, the value of the care labor may equal the caregiver's market wage, subject to a ceiling limit. For example, if a person takes twelve weeks of unpaid leave to care for a chronically ill parent, then forty hours a week at the federal minimum wage rate of \$7.25 per hour would result in a care value of \$3,480. Thus, when calculating the support test under the Dependent Tax Credit, the medical care provided under the medical expenses deduction,⁶²⁹ or work performed under the Earned Income Credit, this amount would be counted and given credit in these provisions.

A new credit specifically for the *unpaid* caregiver could also be enacted. Unpaid care is the backbone of long-term care, because most people want to stay at home and be cared for by loved ones,⁶³⁰ who are generally willing parties in these endeavors. Given the ever growing need for care-providers, this type of care should be supported.⁶³¹ One viable measure is to create a \$3,000 to \$5,000 income-related, refundable tax credit (similar to the existing per child tax credit) available for families helping to care for the chronically ill person as well as for regular medical care under the broader health services definition.⁶³² This

629. A recommendation could be made to change the medical deduction to a credit as the deduction favors higher income taxpayers. See William J. Turnier, *Personal Deductions and Tax Reform: The High Road and the Low Road*, 31 VILL. L. REV. 1703, 1718–1720 (1986), <https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=2578&context=vlr>.

630. A Place to Start, *supra* note 599, at 14. The Bush Administration proposed an additional exemption for members who cared for someone in their household who has “long-term care needs.” This proposal was adopted by the U.S. House of Representatives on July 25, 2002 but never became law. H. R. 4946, 107th Cong. § 3(a)(2002). The exemption has the problem of having more value to the higher income taxpayer. Thus, a year later S. 1031 (108th Cong.) was introduced which provided a tax credit of \$3,000 to the “eligible caregiver” of an “applicable individual.” This tax benefit was not tied to providing out-of-pocket support but merely by providing a principal abode for the over half the year. Similar provisions made in the following two years: H.R. 2096, 108th Cong. (2003) and H.R. 5110, 108th Cong. (2004). Then in 2003 Senators Hilary Clinton and Edward Kennedy introduced the “Family Caregiver Relief Act of 2003.” S. 1214, 108th Cong. (2003) that based the tax benefit on actual out-of-pocket expenses. This provision was phased-out for higher income taxpayers.

631. See Maja Lopez-Hartman et al., *The Effect of Caregiver Support Interventions for Informal Caregivers of Community-Dwelling Frail Elderly: A Systematic Review*, 12 INT’L J. OF INTEGRATED CARE 2 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3601532/>. The estimated cost of allowing this is \$428 million by 2009. JOINT COMM. ON TAXATION, *Estimated Budget effects of the Conference Agreement for H.R. 2488: Fiscal years 2000-2009*, JCX-61-99R (1999), <http://www.jct.gov/x-61-99r.pdf>.

632. Joshua M. Weiner, *Pitfalls of Tax Incentives for Long-Term Care*, TAX NOTES, 1299, n. 37 (2000). It should be noted that while this author makes this statement, the main point of most of his articles is that the use of the tax code to solve long-term care problems raises issues of fairness and effectiveness. See also Joshua M. Weiner, *Financing Long-Term Services and Supports: Continuity and Change*, RTI Press, 2017, <https://www.rti.org/rti-press-publication/financing-long-term-services-and-supports-continuity-and-change>.

provision should support caring for disabled relatives even if they are not chronically ill. When more than one caregiver provides the care, a mechanism like the existing “multiple support agreement” would apply. As mentioned earlier, family caregivers suffer financial loss in the form of diminished income and earnings.⁶³³ This credit could be phased-out for wealthy taxpayers but would provide others a partial relief from the financial and emotional strain placed on the caregivers who reduce their own savings and sacrifice their own work-related pensions to support their loved ones. This provision should be broadly interpreted to include qualifying relatives as well as loved ones living in the taxpayer’s household, similar to those now in Section 152. Unlike Section 152, there should be no support or gross income text.

In the alternative, the Dependent Tax Credit could be expanded. This credit replaced the dependency exemption in TCJA and is totally inadequate. The dependency definition for a qualifying relative in this credit should be changed to eliminate the gross income test or the gross income amount should be equated with the basic standard deduction plus additional standard deduction. In addition, the current \$500 credit should be increased to be more comparable to the new \$2,000 per child credit.

We should also implement policies to allow married couples, particularly two-earner couples who do not benefit from the splitting of their income, to receive a tax subsidy similar to the head of household status available to single taxpayers. It would make sense that if the two-earner couple “maintain a household” for their parent or other “qualifying relative,” they should get a partial tax credit. As discussed earlier, incurring expenses for the household is different from providing the care. The tax code should recognize and reward this type of activity because eventually these various combined tax benefits for the care-provider could prevent institutionalization and the accompanying taxpayer expenses that inevitably accompany it.

Lastly, the TCJA restriction on the deductibility of meals should be eliminated. The tax benefits for paid caregivers are quite restrictive: the most valuable tax benefit for the paid caregiver is the exclusion for meals and lodging provided on the business premises for the convenience of the employer.⁶³⁴ The costs of lodging and meals constitute the biggest out-of-pocket expenditures in most persons’ budgets. To have these items paid for by the employer is a substantial boon to the paid caregiver and should be encouraged. The vast majority of paid caregivers do not live with their patients, but when they do, the FLSA now requires minimum wage and overtime protection.⁶³⁵ Most paid care providers receive free meals

633. See *supra* note 143 and accompanying text. Also see Jason A. Frank, *The Necessity of Medicaid Planning*, 30 UNIV. BALT. L. F. 29, 32 (1999).

634. See *supra* discussion in Part II(B)(2)(d)(I), note 512 and accompanying text. For lodging there is also a condition of employment test, which is very similar to the convenience of the employer test. I.R.C. § 119 (2012).; see also *Hatt v. Comm’r*, T.C. Memo 1969-229, 29–33 (1969).

635. A Place to Start, *supra* note 599, at 13. Because these jobs are often 24 hours seven days a week, the pay can be significant and thus these types of jobs should be promoted.

while preparing the meals for the senior, even if they are not living with the senior. Unfortunately, TCJA disallows any deduction to the employer for these meal expenses. This not only financially hurts the elder employer but also discourages one of the few benefits that can aid the low-paid caregiver.

3. *Expand the Earned Income Credit for the Low-Paid Caregiver*

The Earned Income Credit (EIC) provides a tax benefit to both the unpaid caregiver (who also works in the market) and the low-paid caregiver.⁶³⁶ This credit is inadequate, particularly if the caregiver does not have children. This credit should be expanded to allow for a favorable credit when the taxpayer has a “qualifying relative.” The credit should also be substantially increased and expanded to allow those under the age of twenty-five years of age to obtain the credit.

As it currently stands, taxpayers who are single and have two “qualifying children” stand to obtain the largest refundable earned income credit amount. If the earned income credit were expanded to include those who qualify as dependents (“qualifying relatives” under Section 152) then care for the elderly dependent would be given similar treatment to those of children. If old age is in fact considered one’s “second childhood” then such a policy would promote horizontal equity in cases in which elders require a similar level of care as dependent children.

By substantially increasing the credit and eliminating its discrimination against the young and childless populations, who are some of the most economically vulnerable in modern America, the EIC would not only help correct a glaring inequity in tax policy but could incentivize more caregivers to remain in a field notorious for high turnover. There is already an acute shortage of caregivers in the U.S. and this serious problem requires redress. Changing the EIC would be a good first step. Furthermore, this tax recommendation is one where the interests of the caregivers’ mesh with the interests of the care-receivers; strengthening this provision makes sense from all perspectives.

Additionally, the new Employer Credit for employees taking family leave should be expanded. Under TCJA, this provision only applies for two years. It should be extended to 2025 along with the other individual income tax changes or made permanent. One could also argue that this provision should be expanded as to time, amount, and workers covered, but this would be a “second best” approach. The best approach is discussed below and that involves an expansion of the existing federal FMLA program.

4. Increase the Net Investment Income Tax to Finance Elder Care

To achieve the goals outlined here requires either instituting a new separate payroll tax or increasing an existing tax. Both of these proposals require a public or government solution, rather than a private solution, to the long-term care

636. The EIC is available based on earned income, marital status, and the number of dependents. I.R.C. § 32 (2016). *See also Earned Income Tax Credit (EITC)*, IRS.GOV (Mar. 11, 2016), <https://www.irs.gov/credits-deductions/individuals/earned-income-tax-credit>.

problem. To raise adequate funds, the best solution is to increase the existing 3.8% Medicare tax on net investment income.⁶³⁷ Such a new tax could easily be justified on both simplicity and equity grounds. Wealthy citizens who derive their incomes from unearned sources rather than wage labor avoid contributing their fair share to social security and other social safety programs. In addition, wealthy recipients of Medicare could be taxed on a portion of the fair market value of the long-term care benefits they receive. In all likelihood, and like most of the U.S. taxation system, some patchwork system of mostly uncoordinated tax measures will combine to address a crisis of care approaching a proportion of “critical mass.”

B. NON-TAX SUGGESTIONS

1. *Modify the Fair Labor Standards Act Regulations*

Some aspects of elder care should not be subject to minimum wage and overtime rules under the FLSA.⁶³⁸ It is difficult here to balance both the interests of the care-receiver and care-provider.⁶³⁹ In its 2015 regulation, the Labor Department was justified in holding that those hired through an agency and other certifiable assistants (like “certified nursing assistants,” “home health aids,”⁶⁴⁰ and “personal care aids”⁶⁴¹) should be covered employees under the FLSA. All of these workers can be trained and certified.⁶⁴² However, the regulation’s holding that includes the live-in care-providers is misplaced. These workers already receive tremendous tax benefits from the exclusion of both the value of meals and lodging provided on the business premises. Night care in many instances might not involve any skilled activity, but could trigger huge overtime expenses under FLSA. These expenses could run so high that they could result in seniors losing their ability to afford their in-home care. If these workers are not hired by an agency and are not providing the certified-type of care under the Labor Department regulations, they should not be covered employees under the FLSA.

637. Under the ACA, a new 3.8% net investment income tax is imposed on high-income taxpayers as well as a 0.9% increase in the Medicare tax on high earners. *Questions and Answers for the Additional Medicare Tax*, IRS.GOV (Jan. 8, 2016), <https://www.irs.gov/businesses/small-businesses-self-employed/questions-and-answers-for-the-additional-medicare-tax>.

638. See discussion *supra* notes 62-67 and accompanying text.

639. See double bind discussion, *supra* notes 9 and 192, and accompanying text.

640. Home Health Aide (HHA), COMMUNITY HOME HEALTH CARE, <http://commhealthcare.com/home-care-services/home-health-aides-hha/> (defining a HHA as being both trained and certified).

641. Personal Care Assistant Certification and Certificate Program Info, https://study.com/articles/Personal_Care_Assistant_Certification_and_Certificate_Program_Info.html.

642. See Home Health Aide, *supra* note 640 (defining the functions of the HHA as follows: (1) Personal assistance, including personal hygiene, bathing, dressing, feeding, toileting, shopping, laundry, exercise, escort to appointments, run errands as needed, and accompany to medical appointments, (2) home chores, including washing dishes, cleaning the house, emptying the trash, grocery shopping, taking care of pets, watering the plants, and preparing food, and (3) companionship, including converse with the patient read to the patient, help the patient with hobbies, monitor diet and exercise, remind to take medication, help with communication to others, play games, organizing incoming and outgoing mail, and assist in exercises).

Similarly, much of the work of personal care, practical care and companionship care that can be done by non-certified workers should not be covered.

2. *Change the Family Medical Leave Act*

The FMLA should be amended to (1) expand paid family leave to up to twelve weeks per year, and (2) loosen restrictions on qualifying relations. As it currently stands, the FMLA—a federal statute that assists working caregivers taking leave to take care of family members⁶⁴³—requires that, upon returning to work, employees must be restored to their original positions or to equivalent positions with equivalent “benefits, pay and other terms and conditions of employment.”⁶⁴⁴ Some states have similar statutes with additional provisions and protections.⁶⁴⁵

First, family leave should be paid up to twelve weeks per year.⁶⁴⁶ Additional unpaid leave could also be granted, since cases in elder care often run much longer than twelve weeks.⁶⁴⁷ Right now, family leave is limited to twelve weeks. This is problematic in cases involving a chronically ill patient, in which the required care period may be much longer. In Sweden and other social democracies, *paid* leave can extend up to one year.⁶⁴⁸

Second, family leave should loosen restrictions on qualifying relations. Family leave should be allowed for anyone who wants to take care of an elder person they care about. Medical certifications documenting the need for care can be supplied. Right now, the FMLA is limited to a narrow range of relatives—a caregiver is not granted federal leave to care for a brother, sister, or grandparent (except under very strict exceptions). Additionally, the FMLA only applies to employers with fifty or more employees,⁶⁴⁹ leaving many workers (and potential caregivers) without this benefit to face difficult personal and financial dilemmas. For those who can avail themselves of this benefit, it is unpaid. According to a Department of Labor survey, eighty-eight percent of the respondents who wanted to take the

643. 29 U.S.C. § 2614(a)(1)(B) (2008).

644. 29 U.S.C. § 2614(a)(1) (2008).

645. See generally STATE FAMILY AND MEDICAL LEAVE LAWS, NAT’L CONF. OF STATE LEG., Dec. 31, 2014, <http://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx> (providing an overview of state medical leave acts as of the end of 2014).

646. Three states (California, New Jersey and Rhode Island) are leading the way in this regard. See *State Family and Medical Leave Laws*, NATIONAL COUNCIL OF STATE LEGISLATURES, (July, 19, 2016), <http://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx>.

647. There is already precedent for this under the FMLA which can extend to 26 weeks of unpaid leave. *Fact Sheet: Military Caregiver Leave for a Current Servicemember under the Family and Medical Leave Act*, US DEP’T OF LABOR, <https://www.dol.gov/whd/regs/compliance/whdfs28ma.pdf> (last visited Oct. 18, 2018).

648. *Why Swedish Men take so much Paternity Leave*, ECONOMIST (July 22, 2014), <http://www.economist.com/blogs/economist-explains/2014/07/economist-explains-15>.

649. 29 C.F.R. § 825.104 (2017); *Family & Medical Leave Act*, U.S. DEP’T OF LABOR, <https://www.dol.gov/general/topic/benefits-leave/fmla> (last visited Oct. 18, 2018).

leave indicated they could not afford it because of its unpaid status.⁶⁵⁰ This is unacceptable. The FMLA should be structured like that of many European countries—it should provide leave with pay.

3. *Modify the CLASS Act and Mandate Employer Coverage of Long-Term Care Insurance*

If market forces are not working—that is, not providing enough players to drive competition for buyers of desired good—then the “second best” measures are required. This was the idea behind the Community Living Assistance Services and Supports Act, an adjunct portion of the Affordable Care Act.⁶⁵¹ It was established as a voluntary employer-provided, government sponsored, long-term care insurance program whereby coverage would be available to all those who work and were over the age of eighteen and who meet certain quarterly earnings amounts.⁶⁵² Essentially, there was no health qualification requirement.⁶⁵³ Benefits could be claimed after 60 months of contributions, including a stretch of 24 consecutive months in that calculation.⁶⁵⁴ Premiums were going to be set high enough that participation would be low. Actuarial studies concluded that premiums would be high because only enrollees who anticipated needing the long-term coverage would purchase it.⁶⁵⁵ Other “healthier” workers, who would increase the premium pool in theory, would not voluntarily contribute to a coverage they (rightly or wrongly) believed they never would need.⁶⁵⁶

The Obama Administration abandoned implementing the Class Act in 2012, and Congress repealed it shortly thereafter due to the apparent fiscal unworkability of the scheme.⁶⁵⁷ One of the problems inherent in a program with voluntary

650. See Harms, *supra* note 110, at 73 n.3 (citing David Cantor et al., *Balancing the Needs of Families and Employers: The Family and Medical Leave Surveys 2000 Update*, U.S. DEP'T LABOR 2-16, <http://www.dol.gov/asp/fmla/chapter2.pdf>).

651. Kirsten J. Colello & Janemarie Mulvey, *Community Living Assistance Services and Supports (CLASS): Overview and Summary of Provisions*, CONG. RES. SERVS. 4 (Feb. 13, 2013), <http://www.ncsl.org/documents/statefed/health/CLASSOverview21313.pdf>; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 8001-02, 124 Stat. 119 at 828-47 (2010) (codified at 42 U.S.C. § 3011 et. seq.).

652. They would have to earn the equivalent of one Social Security earnings quarter a year and have paid enrollment premiums for sixty months, including at least twenty-four consecutive months. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 8002(a), 124 Stat. 119 at 829 (2010) (codified at 42 U.S.C. § 30011-1(6)(A)). See also Gleckman, *supra* note 318, at 855-56.

653. ADVISOR'S GUIDE, *supra* note 73, at 10 (CLASS “was primarily designed as a program to provide future assistance to the working disabled. It was not an insurance program.”).

654. *Id.* at 9.

655. Kathy Greenlee, *A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS*, U.S. DEP'T OF HEALTH & HUM. SERVS. 22, Appendix Q, Table 2 (Oct. 2011), <http://aspe.hhs.gov/daltcp/Reports/2011/class/index.pdf> (the premiums would reach as high as \$391 and would likely reach 5% of wages).

656. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, §§ 8002(a), 124 Stat. at 834-36 (2010) (codified at 42 U.S.C. § 30011-3) (The coverage would be automatic but only if the employer chooses to offer the program.) See also Gleckman, *supra* note 318, at 856.

657. Howard Gleckman, *Requiem for the CLASS Act*, HEALTH AFFAIRS (Dec. 2011), <http://content.healthaffairs.org/content/30/12/2231.full.pdf+html>.

involvement is that the most vulnerable participants—those most likely to need the benefits—are also least able to afford it. These are—by and large—women, who earn considerably less than men but also live considerably longer with a higher commensurate expectation of requiring long-term care.

The CLASS Act was a government attempt to expand market accessibility to a population with a growing need that went largely unrecognized. One of the roles of government is to step in as a proxy actor when glaring inequities (and harm) are created by failures or breaches in the “open” market system. In this case, government did not step in far enough. In order for the Class Act concept to work enrollments must be expanded dramatically. Realistically, this translates to participation mandates. Employer mandates make the most sense, since premiums can easily be collected via the same apparatus used in most states for taxes, workers compensation insurance, etc.⁶⁵⁸

Mandates are widely viewed as politically unpopular—representing government “intrusion” into matters of individual choice.⁶⁵⁹ However, few citizens complain about state mandates in every jurisdiction requiring insurance for all licensed drivers. Old age and *some* level of infirmity is a certainty for most of us. Somebody must take care of the attendant needs that accompany aging, and for a growing contingent of an ever-aging populace. This means supplying long-term care. Some sort of universal participation serves the public good—and spreads the cost across a population that never knows when it is going to need it.

658. Gail A. Jensen & Michael A. Morrisey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance*, HEALTH BENEFITS COALITION (Jan. 1999), http://lobby.la.psu.edu/001_Managed_Care_Reform/Organizational_Statements/HBC/HBC_Mandated_Benefit_Laws_and_Employer_Sponsored_Health_Insurance.htm.

659. *Id.* For both sides of the argument see Gail A. Jensen & Michael A. Morrisey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 MILBANK Q. 425, 440–41, 661 (1999). One view of mandates is that they “correct inefficient or inequitable market practices.” This view holds that health insurance mandates correct problems in the health care market, and an attempt to provide access to coverage or specific treatment practices valued by subscribers but withheld by employers or insurers. Thus, mandating this coverage benefits the worker. *Id.* at 440. “By requiring coverage of the service, its net price is reduced, and so more people utilize the service.” The argument is that workers value this type of insurance, and it is less expensive when purchased through an employer than when purchased individually. “There are three reasons for this. First, federal and state tax codes do not treat health insurance as taxable income. Second, employed individuals are generally healthier than those who are not, and are therefore likely to file fewer claims and have lower costs. Finally, administrative costs on a per-individual basis are lower when coverage is purchased through an employer.” *Id.* at 671. Opponents argue that this “benefit” comes with higher premiums and further state that “[m]andates have increased the uninsured population, priced some small firms out of the group market altogether, and forced workers to go uninsured or buy coverage on their own.” Another problem might be that the worker pays for health insurance mandates “in the form of reduced wages or fewer benefits.” Others argue that these mandates stem from an attempt by self-interested parties to further their private interests. This “view holds that the passage of insurance mandates is driven by providers of clinical services who want to increase the demand for their services or thwart the ability of their rivals to achieve a competitive advantage.” It is argued that passage of mandates may also be driven by patient advocacy groups who want to lower the out-of-pocket costs for certain services., http://www.milbank.org/uploads/documents/featured-articles/html/Milbank_Quarterly_Vol-77_No-4_1999.htm.

Such a mandate could go a long way in revitalizing the current depressed long-term care insurance market. Only “a dozen or so insurers still sell the coverage, down from more than 100.”⁶⁶⁰ Although twenty percent of the population has long-term care insurance, only a small percentage of long-term care is provided through this mechanism.⁶⁶¹ Prices are increasing and claims are being denied.⁶⁶² By mandating such insurance through work this could also buttress the state run PLTC program.⁶⁶³

4. *Change Medicaid and Medicare and Institute a Single-Payer Long-Term Care Health Program*

A more radical solution would be to change Medicare and Medicaid to allow for more payment of in-home health care. Rather than incentivizing expensive hospital and nursing home care, Medicare and Medicaid reimbursements should focus on home health services which, as shown earlier, exhibits a greater range of care options and better cost efficiency than other models of care. In addition, both of these programs should provide better coverage of long-term care for the frail elderly person who is not chronically ill.

A further suggestion is to institute a single-payer, multiple insurer multiple provider model in which the government pays the premiums and consumers then choose their insurers and providers. Again, the history of the ACA illustrates how difficult a one-payer government system would be to enact here in the United States.⁶⁶⁴ However, an argument exists that social insurance is a better mechanism to meet the growing needs of elder care than private long-term care insurance. The government can pool risks, encourage reciprocity, and increase solidarity.⁶⁶⁵ Since we all age, “[e]veryone in our society deserves adequate long-term care that provides support and respite for family caregivers, funding for home health care aides to assist family caregivers, and high-quality community-based nursing homes for those who require them.”⁶⁶⁶ This model might harness the power of competition to make aging in place financially more viable. I do not think that such a model would be dead on arrival in Congress as both parties are now actively competing for the senior vote.

660. See Scism, *supra* note 208, at A10.

661. *Id.* at A10 (“[t]he industry is in financial turmoil, causing misery for many of the 7.3 million people who own a long-term-care policy, equal to about a fifth of the U.S. population at least 65 years old”). See also *supra* note 336 and accompanying text.

662. *Id.* at A1.

663. See *supra* note 303 and accompanying text.

664. Not one Republican voted for the ACA. See STEVEN BRILL, *AMERICA’S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM* 185 (2015) (“...there were no Republicans who were going to vote for anything they [the Democrats] came up with”).

665. See Folbre, *Reforming Care*, *supra* note 140, at 381–82.

666. *Id.*

VI. CONCLUSION

Long-term care is one of the central issues facing women today. Women live longer than men, suffer more chronic and debilitating ailments, and possess fewer financial resources, due both to their lower earning power in the marketplace, and their lower ability to save, which owes significantly to their participation in unpaid care for others. This Article argues government involvement in this crisis is vital. Care labor is largely unrecognized as viable economic activity, and those who engage in this necessary work are among the most poorly compensated sectors of the labor force. When cultural paradigms and the market economic system combine to artificially discount the value of care labor and the people performing it, then it falls to the tools of public policy to undertake remedial measures for the greater public good. Elderly women disproportionately suffer the damaging consequences of this double scourge of market indifference and de facto governmental denial of value this population has woven into the national tapestry.

Taxation policy, though sure to raise debate about fundamental traditional concerns of equity and economic impacts, must also weigh its potential influence in promoting social stability, political egalitarianism, and justice for the underserved. Several viable options can work towards these ends. Explicitly recognizing unpaid care in the tax code and significantly expanding and liberalizing the Dependent Tax Credit, the Earned Income Credit, and the Employer Credit for family leave offer sound first steps. Tax expenditures may not prove the most effective avenue for addressing the crisis of providing and funding long-term care. Some resurrection of the CLASS Act idea—this one involving mandated employer participation—along with bold federal expansion of the FMLA and FLSA—are all non-tax strategies that will acknowledge the importance of integrating long-term care strategies into the comprehensive social policy mix. As part of this multi-pronged approach, Congress should expand Medicare and Medicaid funding beyond the current boundaries of payroll taxation and should consider raising more revenue through an expanded net investment tax. Ultra-wealthy citizens who derive their incomes from unearned sources avoid contribution to social security and other social safety programs that are funded solely from wage-labor sources. It is time for them to participate in supporting the late-life care of a generation that has earned that care through their collective contributions to our society.