

## Tax, Class, Women, and Elder Care

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### ABSTRACT

Elder care is a large and growing sector in the comprehensive health care system in the United States. It is an issue of particular importance to women because women live longer than men, have higher incidences of degenerative ailments, and are more likely to be institutionalized. Women also face greater financial challenges in funding their health care maintenance. Whereas wealthy individuals enjoy a multitude of elder care choices and can even self-insure to avoid the steep expense and risk of long-term care insurance, most women do not possess the resources to exercise such a wide degree of choice. Middle-income women increasingly feel the squeeze of concurrent rises in medical and housing costs and must often engage in contingency Medicaid planning. Low-income women, particularly those who are single, living in rural areas, or members of an ethnic minority, have few viable health care options and are the most likely to be herded into institutional care facilities. Nursing homes carry high costs and often do not offer high-level or personalized care. Current tax policy, however, is structured to favor institutional care. Conspicuously lacking are adequate subsidies to facilitate home-based options and meaningful support for caregiving labors, both key factors that contribute to the dearth of care options for our poorest citizens. The tax system is in dire need of modification to address this exploding elder care crisis, requiring explicit acknowledgment of the need to generate revenues dedicated to fulfilling our public commitment to the basic welfare of this rapidly growing cohort of the American population.

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## INTRODUCTION

I was concluding my cross-country road trip east from Oregon, having finally exited the broad asphalt ribbon that is Interstate 70, which had been my companion for the last 500-odd miles, in favor of the country roads that would take me to my hometown of Coshocton, Ohio. This is where I grew up and where my 102-year-old mother still resides. I took a year-long sabbatical from the University of Oregon School of Law and had given my mom a birthday “gift”: twelve months of the best personal care money cannot buy! Driving into town conjured memories of my youth, viewing a crazy-quilt landscape of rolling hills, groves of deciduous trees, farm fields of corn and soybeans, livestock pastures, and abandoned coal mines and open pits. This is east-central Ohio in its essence—a unique blend of bedrock Midwestern farm culture and values tempered by the hardscrabble struggles of life in Appalachian coal country. Coshocton is a town of about 11,000 inhabitants, the seat of the county bearing the same name. This community is typical of many in this rural setting, featuring a gradually declining population, diminishing commercial base, and conspicuous decaying infrastructure.

My mom is part of what has been labeled the “Greatest Generation,” having been born in 1917, the year America sent troops to Europe for the first time during the Great War, two years before the Volstead Act was adopted that ushered in Prohibition, and three years before ratification of the 19th Amendment, which granted women the right to vote. Her “coming of age” years were largely shaped and defined by the conditions of the Great Depression, which engendered her lifelong attitude to “do what it takes” to get through what life dishes out. This ethic was tested many times over the years. She married my dad, a soldier who served in the Philippines, survived the infamous Bataan Death March and 40 months of captivity in Japanese prisoner-of-war camps—only to be killed in Korea just a few years later, his body never recovered. Mom raised my brother and me by playing the organ in our church and giving piano lessons in our home, augmented by survivor’s income generated by her status as a war widow.

Today she subsists on the approximate \$2,000 monthly income generated by her combined social security and veteran’s benefits. As her already long years have advanced, her daily life has become more challenging. On the one hand, age has taken a toll in diminishing her physical abilities, while on the other hand, increased costs of health maintenance and everyday living expenses have challenged her pocketbook. Yet unlike many people her age, she is mentally sharp and

still somewhat physically mobile. She made the decision to forego the opportunity to live in the warmth of Florida for her remaining years in favor of the chillier seasonal climates of Ohio, a decision made with a mind toward the familiarity of home, the relative fiscal affordability of small-town America, and the proximity of well-known neighbors and friends.

My mother has fared better than most people who reach her age with considerably better apparent financial situations. She has enjoyed the comfort and stability of her home environment and the care of family and friends who have been willing and able to assist her. These personal resources cannot be considered commonplace and have contributed greatly to her station of not having experienced any acute or debilitating medical event—until very recently, that is. Mom experienced a nighttime fall on a trip to the bathroom. She suffered a broken femur. Unable to move, she remained on the floor until the next day, when a regularly visiting friend called on her and discovered the scene. This is when some of the themes explored in this Article were dramatically played out within my own family.

The short version of events unfolded in this order. First, the local community hospital was not equipped nor staffed to treat such an orthopedic injury that might involve a surgical option. Second, a larger regional facility some forty-five minutes away rejected her outright because of her advanced age. The only facilities that offered a full menu of treatment options were located over seventy-five miles away in the nearest major urban center of Columbus. Without structural strengthening of her fractured bone, my mother would never walk again. With insertion of a stabilizing pin, she would have a chance. Because I was able to fly back home and help navigate the treatment options, we were able to exercise the choice to have the surgery performed. But my mom is in the minority for individuals living in similar sets of life circumstances. For many, there are no viable options.

The elder care crisis is so serious because it is not simply the issue of an immediate lack of financial means for obvious populations of low-income, physically isolated individuals. It is a lurking danger for a large swath of the American population, due to a social environment featuring increasing life expectancies, escalating health and housing costs, inadequate contingency planning and resources, and an acute shortage of caregivers.<sup>1</sup> Add to this a misguided public policy regime that favors

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1. See U.S. Dep't of Health & Human Servs., *Who Will Provide Your Care?*, LONGTERMCARE.GOV (Sept. 21, 2018) [hereinafter *Who Will Provide Your Care?*], <https://longtermcare.acl.gov/the-basics/who-will-provide-your-care.html> [https://perma.cc/JST9-HAAJ]; see also HEALTH ADVOCATE, CAREGIVING: THE IMPACT ON THE WORKPLACE 2 (2010), <http://www.healthadvocate.com/downloads/webinars/caregiving.pdf> [https://perma.cc/3GHQ-ZJ8W]

expensive, impersonal institutional care over personally preferred and effective home-based care.<sup>2</sup> As currently written, provisions in the Internal Revenue Code (the Code) dedicated to long-term care are neither fiscally nor therapeutically optimal.<sup>3</sup> Wealthy taxpayers who itemize can take advantage of the limited below-the-line deductions for medical care to cover the cost of insurance, long-term care services (including meals and lodging), and even remodels to homes. Taxpayers of more modest means, on the other hand, receive meager tax benefits. The Code tacitly devalues the unpaid caregiving services of family members who exhibit the very desirable values of personal responsibility that public policy measures are supposed to incentivize. These disincentives extend to the ungenerous taxation treatment of low-wage care workers, the net result of which is an erosion of official policy support for a growing elder population in dire need of a more dedicated commitment from the public sector.

Part I of this Article discusses the adverse impact of the elder crisis on women. Part II shows how this crisis adversely impacts women in various economic groups, particularly those in rural areas, single women, and women in poverty. Part III discusses the failure of our tax system to help these low-income elderly women, illustrating a bias towards institutional care, tax provisions that favor the rich, and inadequate support for those who care and who lack income and wealth. Part IV suggests several tax measures to address the most acute shortcomings attached to this growing long-term care crisis. Part V offers some conclusory remarks.

### I. LONG-TERM CARE IS A WOMEN'S ISSUE

Long-term care is a crisis for all,<sup>4</sup> but particularly for women. Women make up a major percentage of those likely to require long-term care. They live longer than men and are more likely to have debilitating

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(finding that approximately 65.7 million people in the United States, or one in four adults, identified themselves as family caregivers in 2009 and about 87% of caregivers provide care for those over 50, 15% provide care to someone 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).

2. See Nancy E. Shurtz, *Long-Term Care and the Tax Code: A Feminist Perspective on Elder Care*, 20 GEO. J. GENDER & L. 107, 112 (2018) (Suggesting “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.”).

3. 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 (TCJA) of 2017, Pub. L. 115-97, 131 Stat. 2054, reference is made to that Act.

4. See *Who Will Provide Your Care?*, *supra* note 1.

health problems and be institutionalized. Women are also less likely to be able to afford the high costs of long-term care, given their history of lower wages and breaks from the workplace for caregiving activities. These women tend to rely on younger women for their care, and these younger women, in turn, often make sacrifices in their careers and future financial security in order to act in service to the elderly.<sup>5</sup> This syndrome combines economically undervalued labor with detrimental long-term effects on future financial stability and helps perpetuate the feminization of poverty.

#### A. Women Are the Principal Recipients of Long-Term Care

Seventy-two percent of women age sixty-five and older will require some kind of long-term care.<sup>6</sup> According to the *New England Journal of Medicine*, the odds are one-in-two that an older woman will need long-term care, compared to one-in-three for a man.<sup>7</sup> Women have an increased need for long-term care partly because of their increased life expectancy.<sup>8</sup> Women age sixty-five today can expect to live about twenty-one more years, compared with eighteen years for men.<sup>9</sup> Women are also more likely

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5. 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, 606 (2007).

6. Leslie Scism, *Long-Term-Care Insurance: Is It Worth It?*, WALL ST. J. (May 1, 2015), <http://www.wsj.com/articles/long-term-care-insurance-is-it-worth-it-1430488733> [https://perma.cc/NRR8-4QCG]; see also U.S. Dep't of Health & Human Servs., *Who Needs Care?*, LONGTERMCARE.GOV, <http://longtermcare.acl.gov/the-basics/who-needs-care.html> [https://perma.cc/X4EZ-XW7J] (“[M]ost Americans turning age 65 will need long-term care services at some point in their lives.”); L. HARRIS-KOJETIN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., LONG-TERM CARE SERVICES IN THE UNITED STATES: 2013 OVERVIEW, at 33 (2013), [http://www.cdc.gov/nchs/data/nsltcp/long\\_term\\_care\\_services\\_2013.pdf](http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf) [https://perma.cc/SWQ6-2RB8] (finding that nearly two-thirds of home care users and institutionalized care recipients are women. As of 2012, women composed 72% of the people in residential care homes and composed almost 68% of the individuals living in nursing homes).

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

8. 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/> [https://perma.cc/2G4H-F9J7]; *Long Term Care Insurance Fact Sheet*, NAT'L ASS'N OF INS. COMM'RS (May 2018), [http://www.naic.org/documents/consumer\\_alert\\_ltc.htm](http://www.naic.org/documents/consumer_alert_ltc.htm) [https://perma.cc/8769-74DT]; see also *Women and Long-Term Care: Fact Sheet*, AARP (Apr. 2007), [https://assets.aarp.org/rgcenter/il/fs77r\\_ltc.pdf](https://assets.aarp.org/rgcenter/il/fs77r_ltc.pdf) [https://perma.cc/CS7G-BVKJ].

9. U.S. Dep't of Health & Human Servs., *How Much Care Will You Need?*, LONGTERMCARE.GOV, <http://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html> [https://perma.cc/3Q77-E8YC]; see also SOC. SEC. ADMIN., SOCIAL SECURITY IS IMPORTANT TO WOMEN 1 (2019), <https://www.ssa.gov/news/press/factsheets/women-alt.pdf> [https://perma.cc/UE93-28C8] (“[W]omen reaching age 65 in 2018 are expected to live, on average, an additional 21.4 years compared with 18.9 years for men.”).

to have illnesses that will require formal long-term care.<sup>10</sup> For instance, older women experience multiple chronic conditions (such as arthritis, osteoporosis, and hypertension) at higher rates than older men.<sup>11</sup> They also tend to be frailer than men, and according to the National Center for Health Statistics, older women are more likely than older men to have health problems that require “special equipment such as a cane, a wheelchair, a special bed, or a special telephone.”<sup>12</sup> Also, women comprise the majority population for all categories of dementia.<sup>13</sup> According to the Alzheimer’s Association, almost two-thirds of the millions of baby boomers that develop Alzheimer’s will be women.<sup>14</sup> A large percentage of these women will spend a significant portion of their remaining lives in institutional care settings.<sup>15</sup>

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10. *Medicare’s Role for Older Women*, KAISER FAM. FOUND. (May 16, 2013), <http://kff.org/womens-health-policy/fact-sheet/medicares-role-for-older-women> [https://perma.cc/HF67-PD3U] (“Women live longer than men, on average, and a greater share of older women than older men face health and functional problems.”).

11. *Id.*

12. KRISTEN ROBINSON, CTR. FOR DISEASE CONTROL, TRENDS IN HEALTH STATUS AND HEALTH CARE USE AMONG OLDER WOMEN 5 (2007), [http://www.cdc.gov/nchs/data/ahcd/aging\\_trends/07olderwomen.pdf](http://www.cdc.gov/nchs/data/ahcd/aging_trends/07olderwomen.pdf) [https://perma.cc/8SSL-FPHH] (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”).

13. 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> [https://perma.cc/NDA3-72M6]; Amy Little, *Women and Dementia: The Overlooked Majority*, ALZHEIMER’S SOC’Y (Sept. 15, 2017), <https://www.alzheimers.org.uk/blog/women-and-dementia-overlooked-majority> [https://perma.cc/JH6G-MW78] (“Women are more at risk of dementia than men with women making up to 65% of people who currently have [it.]”); see also SHERENA CORFIELD, REPORT: WOMEN & DEMENTIA: A GLOBAL CHALLENGE (2017), <https://www.gadaalliance.org/report-women-dementia-a-global-challenge/> [https://perma.cc/9557-549E]; Alice Park, *A New Hope for the Treatment and Prevention of Alzheimer’s*, TIME (Nov. 12, 2015), <https://time.com/4109872/new-hope-for-the-treatment-and-prevention-of-alzheimers/> [https://perma.cc/2VR8-GYXE] (stating that “by 2050, an estimated 160 million people worldwide will be diagnosed with Alzheimer’s”).

14. ALZHEIMER’S ASS’N, GENERATION ALZHEIMER’S: THE DEFINING DISEASE OF THE BABY BOOMERS 1 (2011), [http://act.alz.org/site/DocServer/ALZ\\_BoomersReport.pdf?docID=521](http://act.alz.org/site/DocServer/ALZ_BoomersReport.pdf?docID=521) [https://perma.cc/H9YU-3A8F] (estimating that 10 million baby boomers will develop this disease).

15. DR. JASSIN M. JOURIA, MEMORY LOSS, HEALTH CARE ISSUES AND END OF LIFE CARE: AGING AND LONG-TERM CARE PART II 6–7 (2012), <https://nursee4less.com/Tests/Materials/N078DMaterials.pdf> [https://perma.cc/LH7K-A4ML] (“Elderly patients with AD and other dementias require more and longer . . . skilled nursing facility stays” than patients without Alzheimer’s Disease. “[A]pproximately two-thirds of elderly with dementia die in nursing homes, compared with only 20% of cancer patients and 28% of people dying from all other causes.”).

*B. Women Are More Likely to Be Institutionalized*

Women make up over 70% of those residing in nursing homes.<sup>16</sup> For patients in nursing homes over eighty-four years of age, 74% are women.<sup>17</sup> Furthermore, a woman's stay in a nursing home is typically much longer than that of a man. Women require an average of 3.7 years of extended long-term care support.<sup>18</sup> While roughly half of all men in nursing homes are discharged within three months, some 64% of women remain longer.<sup>19</sup>

Both women and men generally prefer home-based or community care.<sup>20</sup> By avoiding institutionalization, elder patients better retain powers of autonomy, engagement, and control, all of which contribute to an improved quality of life. This preference for home-based elder care is increasing,<sup>21</sup> and the percentage of the elderly population residing in nursing homes is declining.<sup>22</sup> This decline has occurred as the number of elderly citizens requiring long-term care is reaching new highs.<sup>23</sup> Yet it is sadly ironic that, while women generally prefer a low-intrusive style of medical care,<sup>24</sup> they often end up in facilities that employ expensive and ineffective measures and procedures.<sup>25</sup> It also seems perverse that those least likely to afford such care receive such care.<sup>26</sup> Furthermore, there is strong evidence to suggest that, based on established medical criteria to determine appropriate assignment of patients to nursing homes, many of

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16. See ARI HOUSER, AARP PUB. POL'Y INST., NURSING HOMES 2 (2007), [https://assets.aarp.org/rgcenter/il/fs10r\\_homes.pdf](https://assets.aarp.org/rgcenter/il/fs10r_homes.pdf) [<https://perma.cc/QF84-LM3D>].

17. *Senior Living Resident Profile*, NAT'L CTR. FOR ASSISTED LIVING, <https://seniorpath.com/senior-living-resident-profile/> [<https://perma.cc/F98G-9N6E>].

18. U.S. Dep't of Health & Human Servs., *How Much Care Will You Need?*, LONGTERMCARE.GOV (Oct. 10, 2017), <http://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html> [<https://perma.cc/3Q77-E8YC>].

19. Scism, *supra* note 6 (stating that only 36% of women stay in a nursing home for less than three months).

20. See generally Candace Howes, *Who Will Care for the Women?*, 30 J. WOMEN, POL. & POL'Y 248 (2009).

21. ADVISOR'S GUIDE, *supra* note 7.

22. *Id.*

23. See *id.* at 8; see also Scism, *supra* note 6 (The growing numbers 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," 31% were for nursing homes, and 19% for assisted-living facilities.).

24. ATUL GAWANDE, BEING MORTAL: MEDICINE AND WHAT MATTERS IN THE END 100 (2014) (arguing that elderly women have simple needs at the end of life).

25. 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/> [<https://perma.cc/99FQ-U3AG>].

26. It is also perverse that the American taxpayer will have to pay for these expenses when better and cheaper home care could be subsidized. See Michael F. Cannon, *Medicaid's Unseen Costs*, 548 CATO INST. POL'Y ANALYSIS 1 (2005) ("Medicaid is now larger than Medicare (the federal health program for the elderly and disabled) and is the single largest item in state budgets, even larger than elementary and secondary education.").

these women should not be there.<sup>27</sup> Many of these women do not meet the threshold levels of degraded function to qualify as “chronically ill” because they do not need assistance with *two* activities of daily living.<sup>28</sup> Nevertheless, these women are classified as such simply because they are already institutionalized.

### C. Women Are Less Able to Afford Long-Term Care

Long-term care services can be expensive, and 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.<sup>29</sup> As a consequence of these conditions, an older woman’s income on average is three-fifths of an older man’s income and less than half the income of that of an older couple.<sup>30</sup> Women collect less in Social Security benefits,<sup>31</sup> yet more than half of elderly women depend on Social Security for over half of their income.<sup>32</sup> Older women thus tend to have much less income and wealth than their male counterparts.<sup>33</sup>

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27. *Long-Term Care in Rural America: A Family and Health Policy Challenge: Joint Hearing Before the Special Committee on Aging and the Pepper Commission*, 101st Cong. Sess. 1, 33 (Aug. 22, 1989) [hereinafter *Joint Hearing*] (statement of James Maupin, Ark. State Board of Health) (“Multitudes of people are forced into nursing homes before they really need to go to nursing homes.”).

28. I.R.C. §§ 7702B(c)(2)(A)(i), (iii)–(B) (2018) (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: (i) “being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a 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.”) The daily activities of living include eating, toileting, dressing, bathing, mobility, and these are distinct from “independent activities of daily living,” such as (1) shopping for oneself, (2) preparing one’s own food, (3) maintaining one’s house, (4) doing one’s own laundry, (5) managing ones’ medications, (6) making phone calls, (7) traveling on one’s own, and (8) handling one’s own finances. GAWANDE, *supra* note 24, at 15.

29. Rebecca Korzec, *A Feminist View of American Elder Law*, 28 U. TOL. L. REV. 547, 560 (1997) (stating that “a woman with a forty-year career who takes seven years out of the workplace may get half of the pension benefits she might have enjoyed with continuous employment”) (quoting Carol Moseley-Braun, *Women’s Retirement Security*, 4 ELDER L.J. 493, 494–95 (1996)).

30. TORI FINKLE ET AL., INST. FOR WOMEN’S POL’Y RES., BRIEFING PAPER: THE ECONOMIC SECURITY OF OLDER WOMEN AND MEN IN THE UNITED STATES 1, 2 (Nov. 2007).

31. See Morris, *supra* note 5, at 606 (this is because of lower wages and care responsibilities.).

32. Selena Caldera, *Social Security: Who’s Counting on it?*, AARP PUB. POL’Y INST. 1, 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](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) [<https://perma.cc/JWM3-YXDM>]; Haley Sweetland Edwards, *Inside the Next Social Security Crisis*, TIME (July 23, 2015), <https://time.com/3969233/inside-the-next-social-security-crisis/> [<https://perma.cc/3SCZ-NPJZ>] (this contrasts to “fewer than a fourth of married couples” who depend on Social Security as their only source of income).

33. See Caldera, *supra* note 32; Edwards, *supra* note 32.

Women are not working at the type of jobs that contribute to their own financial security, even though 74% of women participate in the U.S. workforce and over half of all households have a female breadwinner.<sup>34</sup> Women often earn less than a man for the same work.<sup>35</sup> They are also more likely than men to experience financial hardships due to their caregiving responsibilities for children, partners, and older parents.<sup>36</sup> Over ten million American women drop out of the workforce to care for children full-time,<sup>37</sup> and the number of women caring for adults tripled between 2001 and 2016.<sup>38</sup> According to one Social Security Administration study, women averaged some twelve years out of the workforce for these caring responsibilities.<sup>39</sup> Finally, women often directly bear the costs of these care responsibilities,<sup>40</sup> including large expenditures such as college tuition for their children.<sup>41</sup>

The economic disadvantages women face, coupled with their caregiving responsibilities, translate into lost wages, lower savings and pensions,<sup>42</sup> and fewer resources available for long-term care needs.<sup>43</sup>

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34. Edwards, *supra* note 32, 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.”).

35. See NAT’L EQUAL PAY TASK FORCE, FIFTY YEARS AFTER THE EQUAL PAY ACT: ASSESSING THE PAST, TAKING STOCK OF THE FUTURE 2, 4 (2013) (caring for children in particular has an adverse impact on women’s earnings and ability to save).

36. See Sarah H. Matthews, *Gender Roles and Filial Responsibility*, in GENDER ROLES THROUGH THE LIFESPAN: A MULTIDISCIPLINARY PERSPECTIVE 245, 250 (Michael R. Stevenson ed., 1994).

37. 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> [https://perma.cc/QY62-Q9CA]. According to Pew Research, approximately 10% of women with a master’s degree or higher are dropping out of the workforce to care for their children. *Id.*

38. 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/> [https://perma.cc/3MCB-BXWL].

39. *Women and Caregiving: Facts and Figures*, FAM. CAREGIVING ALLIANCE: NAT. CTR. ON CAREGIVING (Dec. 31, 2003) [hereinafter *Women and Caregiving*], <https://www.caregiver.org/women-and-caregiving-facts-and-figures> [https://perma.cc/6ZL8-QPMH].

40. ALEXANDRA CAWTHORNE, CTR. FOR AM. PROGRESS, THE STRAIGHT FACTS ON WOMEN IN POVERTY 1, 2 (Oct. 2008), [https://www.in.gov/icw/files/women\\_poverty.pdf](https://www.in.gov/icw/files/women_poverty.pdf) [https://perma.cc/E8H5-5Q6V] (“Women are more likely to bear the costs of raising children.”); 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).

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

42. See Morris, *supra* note 5, at 582–83 (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.)

43. Korzec, *supra* note 29, at 560.

Failure to plan for the costs of long-term care is a major cause of impoverishment among elderly women.<sup>44</sup> Across the board, poverty rates for widows far outpace poverty rates for widowers,<sup>45</sup> and poverty is exacerbated for women who are single,<sup>46</sup> of color,<sup>47</sup> or live in rural settings.<sup>48</sup>

#### D. Women Provide the Vast Majority of Caregiver Services

Caregiving can be informal, which is unpaid care by family members and friends,<sup>49</sup> or it can be formal and paid.<sup>50</sup> In either case, women are

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44. Lisa Alecxih & David Kennell, *The Economic Impact of Long-Term Care on Individuals*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Oct. 1994), <https://aspe.hhs.gov/basic-report/economic-impact-long-term-care-individuals> [<https://perma.cc/6Q8P-GFH2>]; Tate Blahnik, *The Elderly Become a New Export*, [https://web.stanford.edu/class/e297c/poverty\\_prejudice/citypoverty/theelderly\\_become.htm](https://web.stanford.edu/class/e297c/poverty_prejudice/citypoverty/theelderly_become.htm) [<https://perma.cc/9A3K-J6VJ>] (“[T]he 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*, AARP (Mar. 24, 2016), <https://www.aarp.org/politics-society/advocacy/info-2016/effect-of-poverty-on-older-adults.html> [<https://perma.cc/RQ9K-HQWG>] (“Women in particular are subject to fall into poverty because of widowhood, withdrawing from the workforce to care for children or other family members and declining health.”).

45. Youngae Lee & Jinkook Lee, *The Poverty of Widows: How Do They Become the Poor?* (unpublished paper), <http://paa2006.princeton.edu/papers/61592> [<https://perma.cc/42HZ-BJ43>] (“Three of every four older poor individuals are women, with women being twice as likely to be living in poverty as men . . . . It is the loss of a spouse and his economic resources that is associated with declines in the economic well-being of widows.”); Alicia H. Munnell, Geoffrey T. Sanzenbacher & Alice Zulkarnain, *What Factors Explain the Decline in Widows’ Poverty?* (Ctr. For Ret. Research at Bos. Coll., Working Paper No. 2018-4) (women’s poverty has declined over past decade because of three factors: (1) more education, (2) greater participation in the labor force, and (3) shifting patterns of marriage and divorce.).

46. See discussion *infra* Section II(C)(2)(a).

47. See discussion *infra* Section II(C)(2)(b).

48. See discussion *infra* Section II(C)(2)(c). See generally M. L. Reig, *The Unspoken Poor: Single Elderly Women Surviving in Rural America*, 9 ELDER L. J. 257 (2001).

49. See WAN HE ET AL., AN AGING WORLD: 2015, at 79 (Mar. 2016), <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p95-16-1.pdf> [<https://perma.cc/757A-DRDH>].

50. See HARRIS-KOJETIN ET AL., *supra* note 6, at 14 (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 (HHAs), social workers, and lowly-paid personal aids or helpers in the home.); see also GALINA KHATUTSKY ET AL., UNDERSTANDING DIRECT CARE WORKERS: A SNAPSHOT OF TWO OF AMERICA’S MOST IMPORTANT JOBS 19–24 (Mar. 2011), [http://www.ahcanca.org/quality\\_improvement/Documents/UnderstandingDirectCareWorkers.pdf](http://www.ahcanca.org/quality_improvement/Documents/UnderstandingDirectCareWorkers.pdf) [<https://perma.cc/A6VB-VYCW>]; ROBYN I. STONE, LONG-TERM CARE FOR THE ELDERLY WITH DISABILITIES: CURRENT POLICY, EMERGING TRENDS, AND IMPLICATIONS FOR THE TWENTY-FIRST CENTURY 10–12 (Aug. 2000), [http://www.milbank.org/uploads/documents/0008stone/LongTermCare\\_Mech5.pdf](http://www.milbank.org/uploads/documents/0008stone/LongTermCare_Mech5.pdf) [<https://perma.cc/WM3V-W6DB>]. The paid care-provider can work independently or for a care facility or care agency. “[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 who deliver the largest share of the primarily low-tech personal care and the assistance with

more likely to be the care provider.<sup>51</sup> Women represent the majority of family caregivers<sup>52</sup> and over 90% of direct care workers.<sup>53</sup> Both types of caregivers make significant financial, personal, and health sacrifices to accommodate their caregiving responsibilities.<sup>54</sup>

The impacts of caregiving on the unpaid informal caregivers can be dramatic and significant.<sup>55</sup> The informal care provider typically juggles the demands of professional or work life and childcare with the responsibilities of elder care. A majority of family caregivers are employed full-time in market labor, while an additional 11% are employed part-time.<sup>56</sup> These conditions often require caregivers to lose or forego financial resources on account of their caregiving commitments.<sup>57</sup> The

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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.* “[A]pproximately 697,000 . . . home health aides 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.*

51. 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 Carers’ Psychological Needs*, 9 *ADVANCES IN PSYCHIATRIC TREATMENT* 45, 45 (2003); see, e.g., GAWANDE, *supra* note 24, 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 someday he himself would share his master’s fate.”).

52. *Women and Caregiving: Fact and Figures*, FAM. CAREGIVING ALLIANCE: NAT’L CTR. ON CAREGIVING (May 2003), <https://www.caregiver.org/women-and-caregiving-facts-and-figures> [<https://perma.cc/2UAP-WBNV>].

53. ROBYN I. STONE & JOSHUA M. WIENER, WHO WILL CARE FOR US: ADDRESSING THE LONG-TERM CARE WORKFORCE CRISIS 11–12 (2001), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/310304-Who-Will-Care-For-Us-Addressing-the-Long-Term-Care-Workforce-Crisis.PDF> [<https://perma.cc/6LWW-44D5>]; see also U.S. DEP’T OF HEALTH & HUMAN SERVS., THE DIRECT CARE WORKFORCE: AN INTEGRAL PART OF LONG-TERM SERVICES AND SUPPORTS 1 (Apr. 2013) [hereinafter DIRECT CARE WORKFORCE], <https://aspe.hhs.gov/sites/default/files/pdf/177271/dcwIB.pdf> [<https://perma.cc/6Q9J-UMCF>].

54. *Caregiving*, FAMILY CAREGIVER ALLIANCE: NAT’L CTR. ON CAREGIVING [hereinafter *Caregiving*], <https://www.caregiver.org/caregiving> [<https://perma.cc/8UH2-BR5U>].

55. Studies show that over “60% of female caregivers make career sacrifices to accommodate care-giving responsibilities.” ADVISOR’S GUIDE, *supra* note 7, 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 caregiving responsibilities.” *Id.* at 13. Further, “[t]hirty-one percent quit work due to providing care for a loved one.” *Id.*; see 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, 76 (2003) (quoting U.S. DEP’T OF LABOR, *FUTUREWORK: TRENDS & CHALLENGES FOR WORK IN THE 21ST CENTURY* 28, 32 (1999)) (“Six percent of caretakers report that they had to leave the labor force entirely, and more than fifty percent report making changes at work, such as leaving early, going in late, changing to a part-time work schedule, or taking time off during the day.”).

56. See ADVISOR’S GUIDE, *supra* note 7, at 13.

57. *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>

caregiver may need to leave work early, 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.<sup>58</sup> Most of these workers do not receive paid family leave from their employer or their state and cannot afford to take unpaid leave.<sup>59</sup> The individual impacts of lost and foregone financial resources on caregivers is dramatic across the board, but it is especially harmful for women. For women, the caregiver's lost wages, lost social security benefits, and the impact on pensions results in an overall financial impact of \$324,044.<sup>60</sup> For men, the total financial impact is \$283,716.<sup>61</sup> 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.”<sup>62</sup> On the employer side of the ledger, U.S. businesses are expected to lose in excess of \$33 billion per year from “absenteeism, decline in productivity, interruptions . . . decreased morale and motivation, unwillingness [of the employee] to travel, and inability to relocate.”<sup>63</sup>

In addition to the financial losses, informal caregiving can also have a negative emotional, mental, and physical impact on the caregiver.<sup>64</sup> Nearly 80% of primary family caregivers who report that caregiving is stressful are women.<sup>65</sup> Part of this added stress is due to the “second shift” work—when the caregiver’s market-labor job is layered with domestic duties.<sup>66</sup> The burdens of these care responsibilities “can hinder the

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[<https://perma.cc/2Y6Y-SH6U>] (finding that: (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).

58. See ADVISOR’S GUIDE, *supra* note 7, at 12–13; see also Harms, *supra* note 55, at 75–76.

59. The FMLA is unpaid and is not available to most workers (and definitely not available to the low-paid elder care workers in the home)—so taking off time to care for a family member often results in lost wages. See ADVISOR’S GUIDE, *supra* note 7, at 12; Nancy Folbre, *Reforming Care*, 36 POL. & SOC’Y 373, 379 (2008). New Code section 45S gives employers a credit for certain workers who take paid family leave. 26 U.S.C. § 45S (2017).

60. ADVISOR’S GUIDE, *supra* note 7, at 13.

61. *Id.* at 14.

62. *Id.* at 13. The estimated impact of lost wages amounts to \$142,693, estimated lost social security benefits equals \$131,351, and impact on pensions is about \$50,000. *Id.*

63. *Id.* at 14; see also Harms, *supra* note 55, at 86 (“This issue is important to employers as the impact of caregiver issues costs an estimated \$29 to \$31 billion annually.”).

64. See *Caregiver Health*, FAMILY CAREGIVER ALLIANCE: NAT’L CTR. ON CAREGIVING [hereinafter *Caregiver Health*], <https://www.caregiver.org/caregiver-health> [<https://perma.cc/9FJS-CCCW>].

65. KATHERINE MACK, CTR. ON AN AGING SOC’Y AT GEORGETOWN UNIV., HOW DO FAMILY CAREGIVERS FARE?: A CLOSER LOOK AT THEIR EXPERIENCES 1–2 (June 2005) (“[R]oughly three-quarters of primary caregivers who report feeling ‘very strained’ physically, emotionally, or financially as a result of providing care are female.”).

66. See generally ARLIE HOCHSCHILD & ANNE MACHUNG, *THE SECOND SHIFT* (1990).

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."<sup>67</sup> Many of these caregivers also suffer from depression<sup>68</sup> at a rate much higher than those not engaged in caregiving activities,<sup>69</sup> and there are even heightened risks of premature death.<sup>70</sup> 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."<sup>71</sup> As a consequence of these increased emotional, mental, and physical health risks, many informal caregivers ultimately have to make the decision to place their impaired relative in an institutional facility.<sup>72</sup>

Paid caregivers,<sup>73</sup> like their unpaid counterparts, tend to be "sandwiched"—balancing work with care responsibilities at home.<sup>74</sup> 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.<sup>75</sup> Over 90% of these workers are women, and they provide hands-on care for more than 13 million elderly and disabled Americans.<sup>76</sup> These care providers are on average forty years of age or

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67. ADVISOR'S GUIDE, *supra* note 7, at 12; *see also Caregiver Health, supra* note 64.

68. *Caregiver Health, supra* note 64.

69. *See* Elizabeth Shell, *Value of Voluntary Long Term Care for Family Reaches Staggering Amounts*, PBS (Apr. 8, 2014), <http://www.pbs.org/newshour/rundown/what-working-a-part-time-job-for-five-years-for-free-looks-like/> [<https://perma.cc/XVJ8-SJWX>] ("20 percent of employed women caregivers over [fifty-years-old] report symptoms of depression, compared to 8 percent of their non-caregiving peers.").

70. ADVISOR'S GUIDE, *supra* note 7, at 12 (citing Elissa S. Epel et al., *Accelerated Telomere Shortening in Response to Life Stress*, 101 PROCEEDINGS OF THE NAT'L ACAD. OF SCI. No. 49, 17312, 17315 (Dec. 4, 2004)).

71. ADVISOR'S GUIDE, *supra* note 7, at 12 (citing N. Christakis & P. Allison, *Mortality After the Hospitalization of a Spouse*, 354 NEW ENG. J. MED. 7 (2006)).

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

73. 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. *See* HARRIS-KOJETIN ET AL., *supra* note 6, at 14.

74. *Id.* at 11. NEW YORK CITY CONSUMER AFFAIRS, LIFTING UP PAID CARE WORK 20 (2018) <https://www1.nyc.gov/assets/dca/downloads/pdf/workers/Lifting-up-Paid-Care-Work.pdf> [<https://perma.cc/X9LH-ZZ4S>] ("Due to low wages, care workers face severe financial challenges, including an inability to provide for their own and their families' needs . . . . Fifty-nine percent (59%) of care workers who participated in the [Consumer Affairs] survey reported struggling to cover expenses[.]"); *see also* Folbre, *supra* note 59 ("About half are able to support their families only by recourse to public assistance."); KHATUTSKY ET AL., *supra* note 50, at 11.

75. HARRIS-KOJETIN ET AL., *supra* note 6, at 14.

76. KHATUTSKY ET AL., *supra* note 50, at 1, 4. 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 7, at 28.

older.<sup>77</sup> About 30% of paid caregivers are women of color<sup>78</sup> and 25% are immigrants.<sup>79</sup>

These direct care providers can be independent contractors or work as employees for a business or care agency.<sup>80</sup> Direct care workers, even those working for an agency, are generally poorly paid, with such jobs “offering few benefits and few incentives to increase skills, experience or tenure.”<sup>81</sup> On average, direct care workers made around \$10 per hour in 2018, or a little over \$20,000 per year.<sup>82</sup> The lack of employer benefits further exacerbates the paid worker’s financial situation. Only slightly over half of these workers “work for organizations that offer benefits such as paid sick leave and holidays, health insurance, and retirement/pension plans.”<sup>83</sup> Ironically, most direct care workers who were offered health insurance by their employer did not enroll in the coverage offered—usually reporting that health insurance was still too expensive.<sup>84</sup> The low pay places many in this population beneath the official poverty line.<sup>85</sup>

77. KHATUTSKY ET AL., *supra* note 50, at 4.

78. See Peggie R. Smith, *Who Will Care for the Elderly?: The Future of Home Care*, 61 BUFF. L. REV. 323, 329 n.29 (2013) [hereinafter Smith, *Who Will Care for the Elderly*].

79. See Gerald F. Seib, *How Immigration Could Affect Grandma’s Care*, WALL ST. J., Jan. 22, 2018, at A4 (citing 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).

80. STONE, *supra* note 50, at 10–12.

81. Folbre, *supra* note 59, at 378. Skilled nursing jobs carry a higher salary than other paid caregiving work. See *CNA Careers & Salary Outlook by State*, NURSE J., <http://nursejournal.org/certified-nursing-assistant/cna-careers-salary-outlook/> [https://perma.cc/V8NV-HDDF].

82. *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) [https://perma.cc/5TEB-9PQR]; see also 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/> [https://perma.cc/7GRZ-SCKQ]; KHATUTSKY ET AL., *supra* note 50, at 25; *Direct Care Worker Salaries*, GLASSDOOR (July 19, 2019), [https://www.glassdoor.com/Salaries/direct-care-worker-salary-SRCH\\_KO0,18.htm](https://www.glassdoor.com/Salaries/direct-care-worker-salary-SRCH_KO0,18.htm) [https://perma.cc/H588-ANVG].

83. KHATUTSKY ET AL., *supra* note 50, at 29.

84. *Id.* at 31; see ABBY MARQUAND, PARAPROFESSIONAL HEALTH CARE INST., *TOO SICK TO CARE: DIRECT-CARE WORKERS, MEDICAID EXPANSION, AND THE COVERAGE GAP 1* (2015) (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.”); 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> [https://perma.cc/SPY2-G28M].

85. Gravity Care, *Why Home Caregivers Are Paid So Low & What Can We Do to Fix It*, MEDIUM (May 27, 2017), <https://medium.com/@gravitycaredocs/why-home-caregivers-are-paid-so-low-what-we-can-do-to-fix-it-236b1291efb2> [https://perma.cc/2AC7-V7DJ] (finding that “[m]ost caregivers are living at or below the federal poverty line” and have an “average turnover rate” of 60%); see U.S. DEP’T OF HEALTH & HUMAN SERVS., *U.S. FEDERAL POVERTY GUIDELINES* (2019) [hereinafter

Nearly 25% of direct care workers reportedly received welfare benefits for their families and about 42% have received food stamps.<sup>86</sup>

Women in need of elder care tend to rely on younger women for their care. These younger women often sacrifice their careers, their future financial security, and even their personal health to act in service to these elderly women.<sup>87</sup> Thus, this cycle combines undervalued care labor with resulting long-term adverse financial consequences for the care provider and helps perpetuate the feminization of poverty.

## II. LONG-TERM CARE IS A CLASS ISSUE

The difficulty of paying for long-term care expenses can vary significantly across class categories. Women of wealth have a great number of elder care choices and can even self-insure and avoid the high costs and risks of long-term care insurance. Middle-class women face daunting housing and health expenses and are often forced to engage in Medicaid planning by either spending down their savings or giving away their wealth to qualify for Medicaid benefits. Those in lower socioeconomic groups have the fewest choices, and in the absence of unpaid family caregivers, often end up in nursing homes that can cost the taxpayer tens of thousands of dollars each year.<sup>88</sup> Single women, women of color, and rural women are three of the most vulnerable groups, each with their unique set of problems.

### *A. Wealthy Women Have the Greatest Choices*

Elderly women with financial resources have wide choices in handling their long-term care. First, a wealthy woman can afford any number of elite community-based centers, many of which have nursing home care facilities located on the premises. If skilled care is needed, then wealthy women can find a high-quality nursing home facility. In the alternative, a wealthy woman can afford to stay in her home with round-the-clock quality care. If she is bored with her home environment, she can afford a wide variety of entertaining adult day cares. In addition, the wealthy woman can avoid the costs and risks of long-term care insurance

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*Poverty Guidelines*], [http://adnsd.nv.gov/uploadedFiles/agingnv.gov/content/Programs/Grant/fed\\_poverty.pdf](http://adnsd.nv.gov/uploadedFiles/agingnv.gov/content/Programs/Grant/fed_poverty.pdf) [<https://perma.cc/6BGD-R5R4>] (for 2019, poverty is \$12,490 for a single person, \$16,910 for a household of two, and \$25,750 for a household of four).

86. KHATUTSKY ET AL., *supra* note 50, at 6.

87. Morris, *supra* note 5, at 606.

88. *See generally* U.S. DEP'T OF HEALTH & HUMAN SERVS., SPOUSES OF MEDICAID LONG-TERM CARE RECIPIENTS (2005), <https://aspe.hhs.gov/system/files/pdf/74086/spouses.pdf> [<https://perma.cc/FL2U-HSQK>].

and self-insure.<sup>89</sup> Unfortunately, however, even wealthy women in rural areas may have limited choices.

### 1. Wealthy Women Can Afford Continuing Care Retirement Communities

A wealthy woman may choose to purchase a unit in the increasingly popular continuing care retirement community (CCRC).<sup>90</sup> CCRCs, also known as senior independent living communities, offer a variety of dining, recreational, fitness, and living options.<sup>91</sup> Many offer swimming, golf, tennis, movie theaters,<sup>92</sup> and specialized features, such as professionally designed interiors and highly trained chefs.<sup>93</sup> CCRCs make it easier for seniors to surround themselves with their peers<sup>94</sup> and allow married couples to remain close together even when one of the spouses requires more intensive care services.<sup>95</sup>

To enter into a CCRC, seniors need to be able to live independently<sup>96</sup>—generally speaking, this means the senior is over the age of fifty-five and in good health.<sup>97</sup> When the seniors' care needs increase, these facilities often offer additional services to adapt to personal need, referred to generally as “assisted living.”<sup>98</sup> This type of care can help with

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89. See LAWRENCE A. FROLIK, *ELDER LAW AND LATER-LIFE LEGAL PLANNING* 76 (2017).

90. And receive numerous tax benefits (such as deductions for real estate taxes, medical expenses, etc.) all discussed *infra* Section III(B).

91. Dawn Wotapka, *A New Senior Moment*, WALL ST. J. (Mar. 28, 2013), <https://www.wsj.com/articles/SB10001424127887324557804578374574086213166> [<https://perma.cc/ZG8N-MMLK>].

92. See ADVISOR'S GUIDE, *supra* note 7, at 30–31.

93. *Id.* Others are affiliated with major universities and are known as “university-based retirement communities” or UBRCs. See Sarah Stevenson, *University Based Retirement Communities, A PLACE FOR MOM: SENIOR LIVING BLOG* (Sept. 3, 2014), <https://www.aplaceformom.com/blog/9-3-14-seniors-head-back-to-school/> [<https://perma.cc/KF7E-4SX7>] (for example, Dartmouth College in Hanover, New Hampshire; Notre Dame in Notre Dame, Indiana; University of Florida in Gainesville, Florida; and Stanford University in Palo Alto, California).

94. Often the elderly do not want to be alone. See Dawn S. Markowitz, *Luxury Assisted Living for the Wealthy and Tax-Wise*, 58 TR. & EST. 48, 49 (2004) (“[M]ost retirement communities that offer independent living units, high-end CCRCs 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.”).

95. *Id.*

96. *Id.*

97. *Id.* at 48.

98. Medical Definition: “A living arrangement in which personal care services (e.g., meals, housekeeping, transportation assistance with ADLs) are available as needed to people living on their own in a residential facility.” SEGEN'S MEDICAL DICTIONARY (2011), <https://medical-dictionary.thefreedictionary.com/Assisted+living+facility> [<https://perma.cc/W9DU-AJML>]; see also *How Many Assisted Living Facilities Exist?*, MCKNIGHT'S LONG-TERM CARE NEWS (Jan. 1, 2008) [hereinafter MCKNIGHT'S NEWS], <https://www.mcknights.com/industry-faq/how-many-assisted-living-facilities-exist/article/104028/> [<https://perma.cc/SYRY-SW93>] (the typical resident is “an 83-year-old woman” and average female to male ratio is 74% to 26%).

medications, meals, hygiene, housekeeping, and some therapeutic regimes.<sup>99</sup> An assisted living facility (ALF), often part of a continuing care residential campus, is usually operated independently.<sup>100</sup>

A growing number of CCRCs have developed skilled nursing facilities<sup>101</sup> and sophisticated health centers within their campuses.<sup>102</sup> These provide help with acute conditions as well as chronic illness and can provide twenty-four-hour care.<sup>103</sup> What is particularly interesting is that the costs of these skilled on-campus facilities are substantially lower than similar services performed outside the retirement community. One study indicated that as much as 50% of the costs were reduced.<sup>104</sup> This model of saving costs through economies of scale could provide a model for a more sustainable elder care system in the future.

The most important advantage to the CCRCs is that they offer women the opportunity to age in place while lessening the burden of care responsibility on the family.<sup>105</sup> Women are very concerned about the emotional and financial strains the requirements of long-term care can

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99. ADVISOR'S GUIDE, *supra* note 7, at 31; *see also* U.S. Ctrs. for Medicare & Medicaid Servs., *What Are My Other Long-Term Care Choices?*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/part-a/other-long-term-care-choices.html> [<https://perma.cc/7DP9-FKAM>].

100. About one-quarter of the more than 2.2 million seniors reside in the 20,000 to 30,000 CCRCs in the United States. *See* Nathalie D. Martin, *Funding Long-Term Care: Some Risk-Spreaders Create More Risks Than They Cure*, 16 J. CONTEMP. HEALTH L. & POL'Y 355, 361 (2000). More than one million seniors live in the more than 28,000 ALFs in the United States. *See* MCKNIGHT'S NEWS, *supra* note 98.

101. *See generally* MCKNIGHT'S NEWS, *supra* note 98. There is an increasing demand for such facilities. *Id.*

102. Most CCRCs are not substitutes for nursing homes. *See Assisted Living vs Skilled Nursing*, SENIORLIVING.ORG, <https://www.seniorliving.org/compare/assisted-living-vs-skilled-nursing/> [<https://perma.cc/9L8J-LM8P>] (listing the differences between the two); *see also* GAWANDE, *supra* note 24, at 102.

103. Tia Mitchell, *Villages Retirement Community Asks Legislature for Nursing Home*, TAMPA BAY TIMES (Apr. 10, 2013), <http://www.tampabay.com/news/health/the-villages-the-retirement-town-thought-to-have-everything-asks-the/2114163> [<https://perma.cc/B6ZT-4B9N>] (where a popular 95,000-person retirement center asked the legislature of Florida to grant a license for a nursing home facility on their premises). However, some CCRCs are for temporary stays only. *See* ADVISOR'S GUIDE, *supra* note 7, at 30–31.

104. Markowitz, *supra* note 94, at 50. 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. *See How to Spend Down Income and/or Assets to Become Medicaid Eligible*, MEDICAIDPLANNINGASSISTANCE.ORG (Jan. 21, 2019), <https://www.medicaidplanningassistance.org/medicaid-spend-down/> [<https://perma.cc/W2EC-CTPC>]. Medicare may pay for medical expenses after the mandatory three-day hospital stay. *See* ADVISOR'S GUIDE, *supra* note 7, at 45. 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. *See id.* at 67.

105. *See* ADVISOR'S GUIDE, *supra* note 7, at 30.

have on their families.<sup>106</sup> A study of wealthy baby boomers conducted by global financial firm UBS found that 42% of the elderly feared “being a burden” on their families.<sup>107</sup> CCRCs, particularly those with on-site nursing homes, provide the requisite flexibility to alleviate many of these fears.<sup>108</sup>

CCRCs also provide seniors with an opportunity to invest in real estate and perhaps pass some valued assets onto their families.<sup>109</sup> These facilities often offer seniors 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.”<sup>110</sup> 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.”<sup>111</sup> 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.<sup>112</sup> For example, units at The Cypress of Hilton Head in South Carolina have appreciated at a rate of 8% per year.<sup>113</sup>

The major downside of a CCRC is its high costs. Initial fees vary depending upon whether the arrangement is a purchase or a rental, the location and size of the unit, the various amenities, whether accommodations are shared, and the current health status of the

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106. BMO WEALTH INST., FINANCIAL CONCERNS OF WOMEN 3–4 (2015), <https://www.bmo.com/privatebank/pdf/Q1-2015-Wealth-Institute-Report-Financial-Concerns-of-Women.pdf> [<https://perma.cc/6QBT-NXDJ>].

107. Anya Kamenetz, *Have a Plan Now to Avoid Being a Burden on Children Later*, CHI. TRIB. (Jan. 21, 2016), <http://www.chicagotribune.com/business/success/savingsgame/tca-have-a-plan-now-to-avoid-being-a-burden-on-children-later-20160121-story.html> [<https://perma.cc/4C4D-D6DC>].

108. See Bernard A. Krooks & Kameron L. Kirkevold, *Why Elder Law?*, PROB. & PROP., May–June 2014, at 38, 38–39.

109. Options available in the CCRC include renting or buying. See Paul Kelley, *Understanding Assisted Living: Rental vs. Ownership (Pros and Cons)*, THE ANN ARBOR CO.: SENIOR LIVING BLOG (Mar. 14, 2016, 2:00 PM) <https://blog.arborcompany.com/understanding-assisted-living-rental-vs-ownership> [<https://perma.cc/62YA-U9CG>] (“There are benefits to paying your rent check every month, one of which is the flexibility to move out when your health requires. . . . [Ownership can also offer] you a feeling of long-term commitment.”); *Is Assisted Living the Right Choice?* Consumer Reports (Jan. 2001) (on file with author) (many require extensive income and assets to qualify).

110. See Markowitz, *supra* note 94, at 49.

111. *Id.* (“While specifics vary many luxury buy-in CCRCs 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.”).

112. *Id.*

113. *Id.* “[M]ost [of these units] have appreciated between 3 to 4 percent annually . . . but The Cypress of Hilton Head [Island in South Carolina] has seen an 8 percent annual appreciation in value.” *Id.* at 50.

residents.<sup>114</sup> Entrance fees can range from \$20,000 on the low end to half a million dollars or more on the high end.<sup>115</sup> Yearly costs routinely average between \$25,000 and \$60,000 a year after the initial fee.<sup>116</sup> A certain amount of liquid assets are highly advisable when a sudden change in care necessitates a physical transfer outside the facility to institutional care.<sup>117</sup> None of these expenses, however, will be a problem for the wealthy woman.

## 2. Wealthy Women Can Afford Expensive Nursing Home Care

Nursing homes, or skilled nursing facilities, are designed for those who need round-the-clock medical care as well as significant help with their activities of daily living.<sup>118</sup> Generally, a licensed physician supervises the care of each resident, assisted by a nurse and other qualified medical personnel.<sup>119</sup> Nursing homes provide the sophisticated medical care that any resident might require.<sup>120</sup>

Perhaps the single biggest drawback of nursing home care is its cost. Estimates vary by region and locality. The most reputable surveys set the annual cost per patient between \$70,000 and \$100,000.<sup>121</sup> According to Genworth Financial, in 2018 the annual median cost was \$100,375 for a private room and around \$77,380 for a shared room—an increase of 3% over 2017 costs.<sup>122</sup> In some states or localities the care can be double this

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114. ADVISOR'S GUIDE, *supra* note 7, at 59–60.

115. *Id.* at 59.

116. Martin, *supra* note 100, at 366.

117. Wotapka, *supra* note 91 (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 7, at 58–60.

118. ADVISOR'S GUIDE, *supra* note 7, at 31; *What is a Skilled Nursing Facility?*, MCKNIGHT'S LONG-TERM CARE NEWS (Jan. 1, 2008), <https://www.mcknights.com/news/what-is-a-skilled-nursing-facility/> [<https://perma.cc/5YEG-2KHE>] (defining “Nursing Facility” as those that provide custodial care, rehabilitative care (such as physical, occupational or speech therapy) or specialized care (such as for Alzheimer's patients)).

119. ADVISOR'S GUIDE, *supra* note 7, at 31.

120. *See also Skilled Nursing Facility (SNF) Care*, MEDICARE.GOV, <https://www.medicare.gov/coverage/skilled-nursing-facility-care.html> [<https://perma.cc/7LSM-Z83U>]. Most residents (with the average age of 84) require help with at least three activities of daily living. KEVAN H. NAMAZI & PAUL K. CHAFETZ, ASSISTED LIVING: CURRENT ISSUES IN FACILITY MANAGEMENT AND RESIDENT CARE 16 (2001).

121. *See* ADVISOR'S GUIDE, *supra* note 7, 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 (2012), <https://www.hsd.org/?view&did=707282> [<https://perma.cc/A2SD-U65F>] (“In 2011, the annual median cost of nursing home care was about \$70,000 for a semi-private room and just under \$78,000 for a private room.”).

122. *Median Cost of Care Trends and Insights*, GENWORTH (Dec. 17, 2018), <https://www.genworth.com/aging-and-you/finances/cost-of-care/cost-of-care-trends-and-insights.html> [<https://perma.cc/N8L7-XGEV>]; *see* GENWORTH, GENWORTH 2018 COST OF CARE SURVEY SUMMARY OF

amount.<sup>123</sup> Still, none of these expenses should create a problem for the wealthy woman.

The other major drawback to nursing homes is the low levels of satisfaction among residents.<sup>124</sup> The most common complaints of nursing home residents have been coined the “Three Plagues”: boredom,<sup>125</sup> loneliness, and helplessness.<sup>126</sup> Operational shortcomings are also common sources of displeasure, including chronic understaffing<sup>127</sup> and

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2018 FINDINGS 2 (2018), <https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf> [<https://perma.cc/2H2E-HB9J>] (stating that a semi-private room went up 4.11% from 2017, but a private room went up only 3%); see also Matthew Craft, *Families Face Tough Decisions as Cost of Elder Care Soars*, ASSOCIATED PRESS (July 25, 2015), <https://www.usatoday.com/story/money/personalfinance/2015/07/24/families-face-tough-decisions-cost-elder-care-soars/30587503/> [<https://perma.cc/Y2TJ-Y7JX>].

123. GENWORTH, GENWORTH COST OF CARE SURVEY 2018: RANKED STATE DATA TABLES 6 (2018), <https://pro.genworth.com/riiproweb/productinfo/pdf/298701.pdf> [<https://perma.cc/M7LQ-8TWQ>] (showing that the median annual cost of a semi-private room in 2018 ranged from a low of \$57,579 in Texas to a high of \$351,495 in Alaska).

124. See INST. OF MED., DYING IN AMERICA: IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE (2014) [hereinafter DYING IN AMERICA]; Nicholas G. Castle et al., *Use of Resident Satisfaction Surveys in New Jersey Nursing Homes and Assisted Living Facilities*, 23 J. APPLIED GERONTOLOGY 156 (2004); Genevieve N. Thompson et al., *Understanding Bereaved Family Members' Dissatisfaction with End-of-Life Care in Nursing Homes*, 38 J. GERONTOLOGICAL NURSING 49 (2012) (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 NAT'L INST. OF NURSING RESEARCH, CHANGING PRACTICE, CHANGING LIVES: 10 LANDMARK NURSING RESEARCH STUDIES 20, <https://www.ninr.nih.gov/sites/files/docs/10-landmark-nursing-research-studies.pdf> [<https://perma.cc/AWK4-KJYF>]; *Study: Nursing Homes Increasingly Pushing Patients into Rehab at End-of-Life*, U. ROCHESTER MED. CTR. (Oct. 3, 2018), <https://www.urmc.rochester.edu/news/story/5434/study-nursing-homes-increasingly-pushing-patients-into-rehab-at-end-of-life.aspx> [<https://perma.cc/7Q8G-AKLY>].

125. GAWANDE, *supra* note 24, at 116. Gawande tells the story of Bill Thomas, who accepted a job as director of Chase Memorial Nursing Home in New York with eighty 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.* at 125. Citing Josiah Royce, a Harvard philosopher who wrote *The Philosophy of Loyalty*, Gawande says that “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 125–26; see also Anthony Cirillo, *Activities for Nursing Homes and Assisted Living*, VERYWELLHEALTH (Mar. 27, 2019), <https://www.verywellhealth.com/activities-for-nursing-homes-and-assisted-living-197773> [<https://perma.cc/H73K-HE27>].

126. GAWANDE, *supra* note 24, at 116.

127. 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. 42 U.S.C. § 1395 i-3 (2018). 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 finances; (7) the right to privacy, dignity, and respect; (8) the right to personal possessions; (9) the right to be free from

inadequate resources to meet individual needs,<sup>128</sup> which result in non-responsiveness to the patient call button—particularly for toileting needs.<sup>129</sup> Food quality and delivery also receive a high incidence of negative complaints.<sup>130</sup> However, some private nursing homes cater to the wealthy and even refuse to take Medicaid patients. Wealthy seniors will likely be able to afford this care for a considerable period of time, but in many cases may wish to reside at home.

### 3. Wealthy Women Can Afford to Stay in Their Homes

Home care is long-term care provided to recipients in their homes by a family member, friend, or a paid caregiver, such as a health professional or trained helper.<sup>131</sup> This type of care can range from simple companion duties to specialized skilled care. The principal benefit of home care is one of physical and mental comfort. Most people prefer the familial environments of everyday life and often take a proactive role in selecting the types of services they receive in the home setting.<sup>132</sup> They also prefer to be taken care of by their loved ones who can stay in their house to provide care. Care from family members is “likely to result in higher level[s] of quality” of care than when done by a stranger<sup>133</sup> because a family member has a “stronger personal ethical commitment and personal attachment” to a parent or other care recipient.<sup>134</sup>

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abuse and restraints; (10) the right to voice grievances 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).

128. 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).

129. 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 USA Hospitals*, BMC HEALTH SERVS. RES., Feb. 26, 2010, at 1, 1–2, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2841165/pdf/1472-6963-10-52.pdf> [<https://perma.cc/HD9L-7893>].

130. See Sandra F. Simmons et al., *Resident Complaints about the Nursing Home Food Service: Relationship to Cognitive Status*, 64 J. GERONTOLOGY: PSYCHOL. SCI. 324, 324 (2009).

131. Thomas Day, *About Long Term Care at Home*, NAT'L CARE PLAN. COUNCIL, [https://www.longtermcarelink.net/eldercare/long\\_term\\_care\\_at\\_home.htm](https://www.longtermcarelink.net/eldercare/long_term_care_at_home.htm) [<https://perma.cc/NNF2-AYZJ>] (explaining that care in home is provided by both paid and non-paid providers).

132. See ADVISOR'S GUIDE, *supra* note 7, at 8; see also Harms, *supra* note 55, at 85 (explaining that staying in one's house can provide a “feeling of personal control” and added sense of autonomy); *Putting Home Care in Perspective*, NAT'L CARE PLAN. COUNCIL (June 25, 2009), <https://www.longtermcarelink.net/article-2009-6-25.htm> [<https://perma.cc/EY9R-Q6XF>] (discussing statistics on home care for those with cognitive impairment, although not severe cognitive impairment). Those patients who suffer severe cognitive impairment meet, by definition, “qualified long-term care” requirements under section 7702B of the Tax Code. 26 U.S.C. § 7702B (2018). Remaining in home for care is a particularly crucial factor because more than “half of home care recipients are cognitively impaired” and many of them require around-the-clock supervision. *Id.*

133. See Harms, *supra* note 55, at 84.

134. *Id.* at 85.

Sometimes home care can be the least expensive long-term care option when provided by nonpaid caregivers. However, paid skilled care can also exceed that of a nursing home. According to Genworth Financial, “round-the-clock home care can top \$170,000.”<sup>135</sup> Again, this expense will not be a problem for the wealthy woman.

Home care is not always an option for families. 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.<sup>136</sup> 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.<sup>137</sup> Unfortunately, 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.<sup>138</sup>

#### 4. Wealthy Women Can Afford Adult Day Care

An adult day care (ADC) center can forestall the wealthy woman’s boredom of staying at home by providing social, therapeutic, and medical services outside the home in a community setting.<sup>139</sup> Seniors may attend ADC for a full day or for just a few hours at a time.<sup>140</sup> Two-way transportation, as well as meals and snacks, may also be provided.<sup>141</sup> Some adult day cares focus primarily on medical care, while others may focus purely on social interaction.<sup>142</sup> Social activities may include exercise

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135. *Median Cost of Care Trends and Insights*, *supra* note 122; *see also* Martin, *supra* note 100, at 366 (range of \$20,000 to \$70,000); Scism, *supra* note 6.

136. *See* ADVISOR’S GUIDE, *supra* note 7, at 28.

137. *See* Alana Semuels, *Who Will Care for America’s Seniors?*, ATLANTIC (Apr. 27, 2015), <http://www.theatlantic.com/business/archive/2015/04/who-will-care-for-americas-seniors/391415/> [<https://perma.cc/7NCE-KDWQ>].

138. *See* Emily Study, *Caregiver Turnover Spikes 9%, Fuels Home Care Challenges*, HOME HEALTH CARE NEWS (Apr. 19, 2015), <https://homehealthcarenews.com/2015/04/caregiver-turnover-spikes-9-fuels-home-care-challenges/> [<https://perma.cc/6BJQ-QY9W>].

139. ADVISOR’S GUIDE, *supra* note 7, at 29.

140. *About Adult Day Services*, NAT’L ADULT DAY SERVS. ASS’N, <http://www.nadsa.org/learn-more/about-adult-day-services/> [<https://perma.cc/V6U9-8MXX>]. However, some service providers do provide overnight care for up to two weeks. *See Overnight Respite*, MISSION HEALTH, <https://missionhealth.org/services-treatments/adult-care/overnight-respite/> [<https://perma.cc/H58P-N8D9>].

141. *See* ADVISOR’S GUIDE, *supra* note 7, at 29

142. *What Is Adult Day Care?*, NAT’L CAREGIVERS LIBR., <http://www.caregiverslibrary.org/caregivers-resources/grp-caring-for-yourself/hsggrp-support-systems/what-is-adult-day-care-article.aspx> [<https://perma.cc/H9EG-ZCKS>]; *About Adult Day Services*, NAT’L ADULT DAY SERVS. ASS’N, <https://www.nadsa.org/learn-more/about-adult-day-services/> [<https://perma.cc/KP64-U35T>].

activities, musical entertainment, and field trips.<sup>143</sup> Therapeutic and medical services might include things such as nursing care and rehabilitation therapy.<sup>144</sup> In addition, these settings may feature specialized services directed at patients with cognitive impairment, neurological, or other special issues.<sup>145</sup> For seniors and their families, ADC can provide additional assurance against elder abuse because it reduces seniors' isolation at home.

The cost of ADC can be reasonable, at least in comparison to nursing home or other residential care, and, of course, it should not be a financial strain for the wealthy family.<sup>146</sup> Nationwide, this type of service averages about \$17,000 a year.<sup>147</sup> Depending on the geographical location, costs can range from around \$6,500 to \$35,000 per year.<sup>148</sup> 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.<sup>149</sup>

##### 5. Wealthy Women Can Self-Insure and Avoid the High Cost and Risks of Long-Term Care Insurance

The wealthy can self-insure and thus avoid the expense and risk of long-term care insurance. Long-term care insurance was supposed to offer a solution to the long-term care crisis in America, but this has not materialized. The federal and state partnerships to encourage the purchase of long-term care insurance have largely failed.<sup>150</sup> The CLASS Act mandating the employer purchase of long-term care insurance was

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143. *Id.*; see also *Activities in Adult Day Care*, ADULT DAY CARE <https://www.adultdaycare.org/resources/activities-in-adult-day-care/> [<https://perma.cc/U4MA-5XAR>] (mentioning singing and field trips).

144. See ADVISOR'S GUIDE, *supra* note 7, at 29.

145. *Id.*; see *Specialized Alzheimer's Care & Service Centers*, ALZHEIMER'S COMM. CARE, <http://www.alzcare.org/specialized-adult-day-service-centers> [<https://perma.cc/4XM5-D7X8>].

146. Martin, *supra* note 100, at 365.

147. *Median Cost of Care Trends and Insights*, *supra* note 122.

148. *Id.* (low in Alabama and the high in Vermont).

149. See Howard Gleckman, *Healthcare and the Long-Term Fiscal Outlook*, 65 TAX L. REV. 835, 854 (2012) (explaining that those types of costs are normally included in nursing home costs, but not considered in these estimates of adult care expenditures).

150. The Partnership for Long-Term Care (PLTC) program allowed states to require residents of states to purchase LTC insurance and in return, the states would waive some or all of the Medicaid asset depletion requirements, but this program has been largely unsuccessful because people perceive insurance as undesirable, premiums are still expensive (especially for women), and asset protection is not a driving force for residents. See 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).

repealed.<sup>151</sup> In fact, the insurance industry is undergoing a crisis,<sup>152</sup> with rates rising dramatically and only a dozen or so insurers even selling coverage.<sup>153</sup> Long-term care insurance is complicated, with elimination periods and inflation adjustments, and it is risky, with a lot of litigation surrounding companies' refusal to pay and some even going bankrupt.<sup>154</sup>

Long-term care insurance is expensive—especially so for women.<sup>155</sup> Insurance premiums for a single woman are higher than the cost for a married woman of a joint long-term care insurance purchase with her husband.<sup>156</sup> Spousal discounts exist because insurance companies “expect couples will care for each other if one becomes ill.”<sup>157</sup> Wealthy women can afford these premiums, but they are often much better off financially if they self-insure. They can adopt a “wait and see” approach, hedging their bets that they may never need long-term care. Then, if they do need care, they receive a tax benefit from bunching all the long-term care expenses into one year.<sup>158</sup>

## 6. The Wealthy Usually Purchase Elder Care, Often Paying Low Wages

Families in higher socioeconomic groups tend to not personally provide physical care to their loved ones but instead “purchase elder care

151. Howard Gleckman, *Requiem for the CLASS Act*, 30 HEALTH AFFAIRS 2231, 2231 (Dec. 2011) (providing that the goal of the Community Living Assistance services and Supports (CLASS) Act “was to make it possible for people to purchase government-sponsored insurance during their working years so that if they became unable to care for themselves, they could tap a daily cash benefit to purchase services at home or in a care facility”).

152. 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> [https://perma.cc/M2UL-GQMG].

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

154. *Id.*

155. *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/> [https://perma.cc/8WFN-H7C2] (explaining that 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 C. Andrew Lafond et al., *The Tax Implications of Long-Term Care Insurance*, 95 PRAC. TAX STRATEGIES 159, 161 (2015) (providing that a policy that would pay a daily \$200 benefit for three years with a 3% compound inflation option is now between \$3,549 and \$4,746); *Long-Term Care Insurance Tax-Deductibility Rules*, AM. ASS'N FOR LONG-TERM CARE INS., <http://www.aaltci.org/long-term-care-insurance/learning-center/tax-for-business.php/> [https://perma.cc/LT7H-H6LB].

156. See Elizabeth O'Brien, *Women Face a New Long-Term Care Dilemma*, MARKETWATCH (Mar. 7, 2013), <http://www.marketwatch.com/story/women-face-a-new-long-term-care-dilemma-2013-03-07> [https://perma.cc/9HLV-28KT].

157. Lafond et al., *supra* note 155.

158. This will give them a larger tax deduction. See discussion *infra* Section III(C). This is definitely a perverse policy as it runs counter to the very rationale of purchasing long-term care insurance in the first place.

services, provide financial gifts, buy alternative lodging, and remodel homes to accommodate an elder.<sup>159</sup> These families often pay low wages to the direct caregivers they hire. As discussed earlier, these workers are generally poorly paid, have few job benefits, and little incentive to increase skills or experience.<sup>160</sup>

In 2007, in *Long Island Care at Home, Ltd. v. Coke*,<sup>161</sup> the Supreme Court unanimously ruled that elder care workers in the home were not covered under the Fair Labor Standards Act (FLSA), the statute that requires minimum wage and overtime compensation.<sup>162</sup> The Court held that the FLSA did not cover a home worker hired by a home care agency who often slept in her client's home providing night care.<sup>163</sup> They held this type of worker was akin to a casual babysitter who provides "companionship services for individuals who (because of age or infirmity) are unable to care for themselves."<sup>164</sup> The Court held that, in the absence of clear Congressional authority to the contrary, the intent of the FLSA was not to cover these types of workers.<sup>165</sup> Subsequent to this case, the Department of Labor adopted new regulations interpreting FLSA 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.<sup>166</sup> However, care providers that work independently and who are not specialized are not covered under the FLSA. Thus, the wealthy can still hire care workers at very low wages.

### 7. Challenges Remain for Wealthy Women in Rural Areas

Ten million Americans over the age of sixty-five, or one out of four, live in rural areas.<sup>167</sup> This elder population comprises over 15% of the total rural population and these proportions are steadily increasing.<sup>168</sup> This

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159. Ann Bookman & Delia Kimbrel, *Families and Elder Care in the Twenty-First Century*, 21 FUTURE OF CHILDREN 117, 126 (2011).

160. See earlier discussion *supra* notes 73–86 and accompanying text; see also Folbre, *supra* note 59.

161. See *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 167–72 (2007).

162. *Id.* at 168.

163. *Id.* at 164.

164. 29 U.S.C. § 213(a)(15) (2018); *Long Island Care at Home, Ltd.*, 551 U.S. at 168–69.

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

166. See *id.* at 169–171; 29 C.F.R. §§ 552.6, 552.109(a) (covering certified nursing assistants, home health aides, personal care aides, or live-in caretakers in the household).

167. Clare Ansberry, *For Elderly in Rural Areas, Volunteers Step In*, WALL ST. J. (Dec. 10, 2018), <https://www.wsj.com/articles/for-elderly-in-rural-areas-volunteers-step-in-1544451792> [https://perma.cc/2TPS-3KQX].

168. NAT'L RURAL HEALTH ASS'N, LONG TERM CARE IN RURAL AMERICA 1 (May 2001) [hereinafter LONG TERM CARE IN RURAL AMERICA], [https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents-\(ME\)/Archive-\(ME\)-\(1\)/paper21.html.aspx?lang=en-US](https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents-(ME)/Archive-(ME)-(1)/paper21.html.aspx?lang=en-US) [https://perma.cc/H9PU-Q4TH]; see also U.S. CENSUS BUREAU, 2013–2017 ACS 5-YEAR ESTIMATES,

entire cohort of elder, rural citizens, including the financially affluent, faces limitations to their access to long-term care services. First, the range of medical options, including specialty doctors, certain categories of medical services, and proximity to full-service hospitals, are restricted. Second, non-medical support services are often not available. Third, infrastructure features, such as public transportation, are frequently of meager dimensions or absent altogether. Fourth, family members have often moved to other geographic areas, rendering them unable to offer assistance and care.<sup>169</sup>

According to the Healthcare Resources and Services Administration, 60% of localities facing shortages in trained health professionals are located in rural or semi-rural areas.<sup>170</sup> Primary care physicians service rural areas at only 80% of the concentration available in urban areas.<sup>171</sup> Shortages of specialists cover the gamut of medical practice, ranging from cardiology and oncology to orthopedics and surgery of various types.<sup>172</sup> The dearth of available health services goes beyond physicians and includes dentists<sup>173</sup> and trained health professionals, such as physical therapists, social workers, and nurse's aides.<sup>174</sup> In rural areas, nurses are "expected to be proficient in all areas of nursing" and specialization is

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<https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2017/5-year.html> [<https://perma.cc/BWQ5-T2SZ>].

169. See AMERICAN IMMIGRATION COUNCIL, FOREIGN-TRAINED DOCTORS ARE CRITICAL TO SERVING MANY U.S. COMMUNITIES (Jan. 2018), <https://www.americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities> [<https://perma.cc/LBX7-BVUM>].

170. NAT'L RURAL HEALTH ASS'N, COMMUNITY HEALTH WORKERS: RECOMMENDATIONS FOR BRIDGING THE HEALTHCARE GAPS IN RURAL AMERICA 1, 4 (2017), [https://www.ruralhealthweb.org/NRHA/media/Emerge\\_NRHA/Advocacy/Policy%20documents/Community-Health-Workers\\_Feb-2017\\_NRHA-Policy-Paper.pdf](https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf) [<https://perma.cc/Q4LB-VQ5U>] ("As of August 2014, non-metropolitan areas accounted for 60% of Primary Medical Health Professional Shortage Areas according to the Health Resources and Services Administration (HRSA) Data Warehouse.").

171. Olga Khazan, *Why Are There So Few Doctors in Rural America?*, ATLANTIC (Aug. 28, 2014), <https://www.theatlantic.com/health/archive/2014/08/why-wont-doctors-move-to-rural-america/379291/> [<https://perma.cc/YTX3-HHAG>] ("Rural areas have about 68 primary care doctors per 100,000 people, compared with 84 in urban areas . . . Put another way, about a fifth of Americans live in rural areas, but barely a tenth of physicians practice there.").

172. *Rural Physician Shortage Demands Innovative Solutions*, HOSPITALS & HEALTH NETWORKS (Jan. 21, 2016), <https://www.hhnmag.com/articles/6881-rural-physician-shortage-demands-innovative-solutions> [<https://perma.cc/53M8-UFNU>].

173. Anne Kim, *Cavity Country: Rural America Has Too Few Dentists—and Too Few Patients Who Can Pay*, WASH. POST (June 7, 2018), [https://www.washingtonpost.com/news/posteverything/wp/2018/06/07/feature/rural-america-has-too-few-dentists-but-also-too-few-jobs-to-create-paying-patients/?utm\\_term=.1e9a06883899](https://www.washingtonpost.com/news/posteverything/wp/2018/06/07/feature/rural-america-has-too-few-dentists-but-also-too-few-jobs-to-create-paying-patients/?utm_term=.1e9a06883899) [<https://perma.cc/N2NS-3R9L>] ("About 43 percent of rural Americans lack access to dental care, according to the National Rural Health Association."); see also Miriam Jordan, *Rural Areas Brace for a Shortage of Doctors Due to Visa Policy*, N.Y. TIMES (Mar. 18, 2017), <https://www.nytimes.com/2017/03/18/us/doctor-shortage-visa-policy.html> [<https://perma.cc/35SQ-FQDG>].

174. LONG TERM CARE IN RURAL AMERICA, *supra* note 168.

relatively rare.<sup>175</sup> An important adjunct consequence of this phenomenon is increased dependency in rural communities on foreign-trained doctors, the majority of whom are practicing in the United States on work visas since many cannot obtain permanent immigrant resident status.<sup>176</sup>

Another related problem is decreasing access to high technology services in rural medical facilities.<sup>177</sup> Worse yet, rural hospitals are closing at an alarming rate. According to researchers at the University of North Carolina at Chapel Hill, more than 120 hospitals in rural areas have closed since 2005,<sup>178</sup> leaving residents in affected areas without even basic healthcare services.<sup>179</sup> In about 2,000 rural communities, the pharmacist is the only credentialed healthcare professional.<sup>180</sup>

Non-medical support services for seniors are also in short supply in rural America.<sup>181</sup> It is commonplace to find no network of coordinated elder services at all.<sup>182</sup> These absent services include rudimentary aid such as transportation, personal hygiene, meal preparation, or light housekeeping.<sup>183</sup> Assistance with such basics often spells the difference for infirm elders between being able to live at home or face forced institutionalization.<sup>184</sup> Even among more affluent senior populations, rural enclaves feature a scarcity of full-featured retirement facilities or adult day care operations. On the other hand, rural areas have relatively more nursing homes than urban zones.<sup>185</sup> The reason for this is that in rural settings, the lack of a full range of elder care and service options renders nursing homes as the default care selection in many cases.

One of the leading impediments to delivery of essential care services to rural elders is widespread lack of transportation. According to Transportation for America, 40% of rural residents live in counties with no public transportation.<sup>186</sup> This problem adversely affects execution of

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175. *Challenges in Healthcare for Rural America*, U. OF TEX. (June 23, 2017), <https://degree.utpb.edu/articles/nursing/challenges-healthcare-rural-america.aspx> [<https://perma.cc/8TNF-MG83>].

176. LONG TERM CARE IN RURAL AMERICA, *supra* note 168. For example, in Great Falls, Montana, 60% of doctors specializing in hospital care, serving “230,000 people in 15 counties” are foreign-born doctors on work visas.

177. *See Joint Hearing*, *supra* note 27, at 24.

178. Ansberry, *supra* note 167.

179. *Id.*

180. *Id.*

181. *Id.* (citing Carrie Henning-Smith, *Caring for Caregivers: Available Support for Unpaid Caregivers in Rural Areas*, RURAL HEALTH RES. GATEWAY, <https://www.ruralhealthresearch.org/projects/100002412> [<https://perma.cc/4ANE-A3KF>]).

182. *See Joint Hearing*, *supra* note 27, at 35.

183. *Id.*

184. *Id.* at 35–36.

185. *Rural Long-Term Care Facilities*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/long-term-care> [<https://perma.cc/QKD7-MB5B>].

186. *Id.*

everyday non-medical functions as well as retards access to even routine medical maintenance resources.<sup>187</sup> Elders often have to travel long distances to consult their doctors or stock their grocery shelves, logging hours of commuting time for such basics.<sup>188</sup> Furthermore, many rural communities feature roads with no sidewalks and narrow shoulders, cracked or cratered pavements, unlit pathways, and other hazards to safety and health.<sup>189</sup>

In general, the smaller size of contemporary families coupled with modern demographic shifts leaves fewer family members available to care for elders.<sup>190</sup> Children of rural-dwelling parents often do not live in close proximity,<sup>191</sup> exacerbated by the out-migration of younger people from rural to urban zones (the so-called “brain drain”) largely for reasons of economic opportunity.<sup>192</sup> According to the National Alliance for Caregiving and the AARP Public Policy Institute, the number of family caregivers in rural areas nearly halved just from 2009 to 2015.<sup>193</sup> A shrinking corps of unpaid family caregivers has placed increased strain on available paid direct care workers, as well as on the resources of care institutions, such as nursing homes.<sup>194</sup>

*B. Middle-Class Women Struggle with Health and Housing Costs and Often Engage in Medicaid Planning*

Middle-class women have fewer elder-care choices than wealthy women. They not only have lower asset bases to work with, but are more vulnerable to the dual threats of escalating healthcare and housing costs. As a result, many middle-class women feel compelled to engage in Medicaid planning.

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187. See *Joint Hearing*, *supra* note 27, at 24 (statement of Joyce T. Berry, Commissioner of Administration on Aging).

188. See *Transportation to Support Rural Healthcare*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/transportation> [<https://perma.cc/87KE-QLFZ>].

189. *Lack of Sidewalks in Rural Towns Create Safety and Public-Health Concerns*, THE RURAL BLOG (Aug. 8, 2016), <http://irjci.blogspot.com/2016/08/lack-of-sidewalks-in-rural-towns-create.html> [<https://perma.cc/BP29-N5TZ>].

190. See generally Scism, *supra* note 6.

191. 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/> [<https://perma.cc/3NLG-LNBL>].

192. Patrick J. Carr & Maria J. Kefalas, *The Rural Brain Drain*, CHRON. HIGHER EDUC. (Sept. 21, 2009), <https://www.chronicle.com/article/The-Rural-Brain-Drain/48425> [<https://perma.cc/U4ZH-WRF6>].

193. Ansberry, *supra* note 167.

194. LYNN FEINBERG ET AL., AARP PUB. POL’Y INST., VALUING THE INVALUABLE: 2011 UPDATE: THE GROWING CONTRIBUTIONS AND COSTS OF FAMILY CAREGIVING 1 (2011), <https://assets.aarp.org/rgcenter/ppi/lrc/i51-caregiving.pdf> [<https://perma.cc/UFF9-Q7KL>].

### 1. Middle-Class Women Have Fewer Choices than Wealthy Women

Many middle-class women may feel tempted to purchase long-term care insurance, but as discussed earlier in this Article, such a choice can be risky and exorbitantly expensive.<sup>195</sup> An alternative is entering a non-profit CCRC, such as some church-affiliated centers that cater to lower net-worth residents.<sup>196</sup> Some of these organizations even offer subsidies to residents who exhaust their resources.<sup>197</sup> Monthly fees at these facilities may run as low as \$500 but may range upwards of several thousand dollars.<sup>198</sup> Home care is often a viable option for middle-class women, employing a combination of family care and inexpensive non-skilled assistance.<sup>199</sup> ADC provides an outboard or adjunct style of care that can represent another option to augment home life.<sup>200</sup> However, ADC involves an out-of-pocket expense for middle-class situations that may not fit budgets universally.<sup>201</sup> This variety of care can provide invaluable relief to unpaid caregivers who also perform market labor during daytime hours.<sup>202</sup> The last care alternative is also the most severe—institutionalization. This option is usually exercised in cases in which the middle-class woman has a medical need for skilled nursing home care. To execute this, she will have to spend down her assets in order to eventually qualify for Medicaid assistance because this brand of care is the most expensive variety.

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195. See earlier discussion *supra* Section II(A)(5).

196. *Christian Retirement Communities Have Stated Missions*, BEST GUIDE: RETIREMENT COMM.COM, <https://www.bestguide-retirementcommunities.com/christianretirementcommunities.html> [<https://perma.cc/K9XW-QCSL>] (listing facilities and their prices in most of the 50 states); see generally WHITE HOUSE FAITH-BASED AND COMM. INITIATIVES, GUIDANCE TO FAITH-BASED AND COMMUNITY ORGANIZATIONS ON PARTNERING WITH THE FEDERAL GOVERNMENT (2001), [https://www.nationalservice.gov/sites/default/files/documents/faith\\_guidance.pdf](https://www.nationalservice.gov/sites/default/files/documents/faith_guidance.pdf) [<https://perma.cc/E9SR-KSMG>].

197. *Id.* at 59.

198. *Id.*

199. See discussion *infra* notes 228–32.

200. 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/> [<https://perma.cc/47NC-42XY>].

201. Ruben Castaneda, *What Care Options Are Available for Aging People on a Budget?*, U.S. NEWS & WORLD REP. (Oct. 31, 2017), <https://health.usnews.com/health-news/best-nursing-homes/articles/2017-10-31/what-care-options-are-available-for-aging-people-on-a-budget> [<https://perma.cc/8QLY-T8GM>].

202. EMBLEM HEALTH & NAT'L ALLIANCE FOR CAREGIVING, CARE FOR THE FAMILY CAREGIVER: A PLACE TO START 1 (2010) [hereinafter A PLACE TO START], [http://www.caregiving.org/data/Emblem\\_CfC10\\_Final2.pdf](http://www.caregiving.org/data/Emblem_CfC10_Final2.pdf) [<https://perma.cc/2PPS-G5WD>]. Some facilities do provide hours during the evenings or on weekends.

## 2. Middle-Class Women Often Cannot Afford Health and Housing Expenses

Medicare is a federal entitlement program that pays for certain medical care services for persons over the age of sixty-five.<sup>203</sup> It covers some preventative care, acute care, and offers partial prescription drug coverage (under Part D) but does not cover routine (i.e., “non-medical”) maintenance for eyes, ears, and teeth.<sup>204</sup> Many people believe—incorrectly—that Medicare or private health insurance (obtained under the Affordable Care Act) will pay for long-term care.<sup>205</sup> While Medicare and private health insurance cover “short-term needs,”<sup>206</sup> a large percentage of the costs associated with long-term care are paid out of personal savings,<sup>207</sup> including unpaid family care.

In addition to health expenses, the elderly middle-class suffer from increasing housing expenses, oftentimes exceeding half of their disposable incomes. The federal government’s General Accounting Office has reported that affordable housing is “the single greatest problem facing elderly households.”<sup>208</sup> The chief challenge in play here involves rising rents that are difficult to absorb on fixed incomes. Slow growth of new housing, especially in areas of robust economic growth, contribute to the upward price pressure on rents. Political resistance to higher density housing units in many areas also contributes to price increases by arbitrarily creating greater demand for fewer available housing units.<sup>209</sup> Another complaint is substandard housing, but little has been done on the federal, state, or local fronts to address these issues of housing affordability and quality.

Similar pressures afflict middle-class, elderly homeowners, who face rising real estate taxes, plus higher costs for utilities, maintenance, and

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203. It is tied to those eligible for social security benefits. See Morris, *supra* note 5, at 586.

204. *Medicare and Dental, Eye, and Hearing Care*, THE MEDICARE CONSUMER BLOG (Sept. 3, 2018), <http://www.citizensfed.org/?p=1866> [<https://perma.cc/8S9P-GQC3>]; see also *Does Medicare Part B Pay for Prescription Drugs?*, SENIOR CORPS, <http://www.seniorcorps.org/medicare/does-medicare-part-b-pay-for-prescription-drugs/> [<https://perma.cc/V36D-RWL3>].

205. See William Galston, *Live Long and Pay for it: America’s Real Long-Term Cost Crisis*, 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> [<https://perma.cc/3XBS-LARK>].

206. Medicare imposes a 100-day maximum on its payment coverage per qualifying episode or three-day stay in a hospital. See FROLIK, *supra* note 89, at 76.

207. U.S. Dep’t of Health & Human Servs., *Costs & How to Pay*, LONGTERMCARE.GOV, <http://longtermcare.gov/costs-how-to-pay/> [<https://perma.cc/8K2U-K472>] (savings can include annuities, retirement funds, reverse mortgages on homes, etc.).

208. Patricia E. Salkin, *A Quiet Crisis in America: Meeting the Affordable Housing Needs of the Invisible Low-Income Healthy Seniors*, 16 GEO. J. POVERTY L. & POL’Y 285, 288 (2009).

209. Issi Romem, *California’s Housing Prices Need to Come Down*, CITYLAB (Mar. 28, 2018), <https://www.citylab.com/life/2018/03/californias-housing-prices-need-to-come-down/556637/> [<https://perma.cc/BW25-GJUS>].

repairs that far outpace inflationary trends in other segments of economic activity.<sup>210</sup> Accompanying challenging medical conditions often require physical modifications to the home, such as wheelchair ramps, grab bars, stair lifts, and the like. Unlike wealthy seniors who can generally absorb such modification costs, the expense attached to such alterations can seriously challenge the pocketbooks of middle-class seniors, particularly women.<sup>211</sup> Homeowners often employ strategies such as reverse mortgages to finance these functional housing upgrades.

### 3. Middle-Class Women Often Engage in Medicaid Planning

In order to afford the increasing costs of health maintenance, long-term care, and housing, many middle-class women are forced to become poor by spending down their savings or giving away their wealth to qualify for Medicaid.<sup>212</sup> Medicaid planning is challenging and can be expensive. For example, if middle-class elders want to transfer their assets to children or grandchildren, they must plan around the “clawback” or “look back period”—or the period in which Medicaid may examine an applicant’s financial records to identify transactions designed to reduce their wealth in order to qualify for public assistance. Most states employ a five-year look-back rule, except for California, which has a two-and-a-half year clawback period.<sup>213</sup> Assets given away more than five (or two-and-a-half in California) years prior to their Medicaid application will not be “clawed back” by the state as justification to deny assistance. Furthermore, a family member who has stayed in the home of a Medicaid-qualifying elder for two years prior to institutionalization is entitled to the house under the governing rules.<sup>214</sup> Ultimately, Medicaid leaves women with fewer options

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210. Salkin, *supra* note 208, at 287–88.

211. *Id.* at 288.

212. Joanna K. Weinberg, *The Past, Present, and Future of Long-Term Care—a Women’s Issue?*, 25 J. HEALTH POL. POL’Y & L. 565, 568–69 (2000); Thomas G. Donlan, *Middle-Class Medicaid*, BARRON’S (July 1, 2017), <https://www.barrons.com/articles/middle-class-medicaid-1498887732> [<https://perma.cc/E9NR-SQ37>]; Anna Gorman & Barbara Feder Ostrov, *Nursing Home Bills Are Swamping Medicaid*, MONEY (July 29, 2016), <http://time.com/money/4427532/long-term-care-medicaid-costs/> [<https://perma.cc/HP2J-ACNQ>] (“[M]iddle-class Americans . . . often must spend down or transfer their assets to qualify for Medicaid coverage.”).

213. *What Is the Medicaid Look-Back Period? What Penalties, Exemptions & Workarounds Exist?* PAYING FOR SENIOR CARE (June 2019), <https://www.payingforseniorcare.com/medicaid/look-back-period.html> [<https://perma.cc/5LBD-C5RE>].

214. U.S. DEP’T OF HEALTH & HUMAN SERVS., *Medicaid Treatment of the Home: Determining Eligibility and Repayment for Long-Term Care*, ASPE (Apr. 1, 2005), <https://aspe.hhs.gov/basic-report/medicaid-treatment-home-determining-eligibility-and-repayment-long-term-care> [<https://perma.cc/5LBD-C5RE>] (“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 recipient’s admission to a nursing home or other medical institution.”); *see also* discussion *infra* Section III(E)(2).

for their long-term care.<sup>215</sup> Medicaid planning involves a risky trade-off for middle-class women. On one hand, some of their estate distribution desires may be satisfied, but there is inherent risk that they will reach a state of physical infirmity that does not outlast the lurking “clawback period.” This may scuttle their plans and plunge them into liquidating their assets anyway, while still forcing them into institutional facilities, with their high built-in costs and less-than-optimal levels of care.

*C. Poor Women Often Rely on Unpaid or Low-Paid Care or Become Institutionalized*

Elderly women, particularly single women, women of color, and those in rural areas, experience high rates of poverty. Women comprise 75% of impoverished seniors and are more than twice as likely as men to be poor.<sup>216</sup> Almost 50% of single women rely on their Social Security “for 90% or more of their income.”<sup>217</sup> These poor and single women have the highest risk of needing long-term care.<sup>218</sup> Unlike women in upper- or middle-class economic situations, these poor women lack the liquid resources to exercise options to purchase a unit in a CCRC, attend adult day care, or pay for trained caregivers in the home. These women, like their middle-class counterparts, struggle with rising health and housing costs, but unlike middle-class women, are eligible for Medicaid. They are highly dependent on unpaid care of family and friends and, in the absence of such care, will often find themselves in nursing homes contrary to their desires.

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215. See ANDREW MELNYK & HARSH SHARMA, WHO WILL PAY FOR OUR LONG-TERM CARE, AM. COUNCIL OF LIFE INSURERS 1 (2014), [https://www.acli.com/-/media/ACLI/Public/Files/PDFs-PUBLIC-SITE/Public-Consumer-Info/LTC-insurance/LTC\\_Report.ashx?la=en](https://www.acli.com/-/media/ACLI/Public/Files/PDFs-PUBLIC-SITE/Public-Consumer-Info/LTC-insurance/LTC_Report.ashx?la=en) [https://perma.cc/EBL4-S8PB].

216. See Morris, *supra* note 5, at 571. This is in part due to their longevity and proclivity for certain ailments. *Id.*; see also *supra* Part I(A).

217. See Stan Hinden, *Women and Social Security Benefits*, AARP (Feb. 2017) <https://www.aarp.org/work/social-security/info-2014/women-and-social-security-benefits.html> [https://perma.cc/N8SH-WXNG] (“Social Security reports that almost 50 percent of elderly unmarried females who receive Social Security benefits rely on them for 90 percent or more of their income.”); MARGARET B. NEAL & DONNA L. WAGNER, WORKING CAREGIVERS: ISSUES, CHALLENGES, AND OPPORTUNITIES FOR THE AGING NETWORK 8 (2002), <http://www.caregiverslibrary.org/Portals/0/Working%20Caregivers%20-%20Issues%20for%20the%20Aging%20Network%20Fin-Neal-Wagner.pdf> [https://perma.cc/M9TM-PBUM]; *Long-Term Care—Important Information for Women*, AM. ASS’N FOR LONG-TERM CARE INS. [hereinafter *Important Information for Women*], <http://www.aaltci.org/long-term-care-insurance/learning-center/for-women.php> [https://perma.cc/Q8WF-VWDU].

218. Morris, *supra* note 5, at 589 n.113 (citing Peggie R. Smith, *Elder Care, Gender, and Work: The Work-Family Issue of the 21<sup>st</sup> Century*, 25 BERKELEY J. EMP. & LAB. L. 377 (2004)).

### 1. The Poor Provide the Care Themselves

The working poor and their families are the most likely population to provide direct elder care themselves, for they are the least able to hire professional care providers.<sup>219</sup> Low-income families, in those rare instances in which they do employ formal aid services, retain professional providers only for brief periods, whereas middle- and upper-class households generally hire professional assistance for longer time frames.<sup>220</sup> Around 80% of long-term care in America<sup>221</sup> is provided by unpaid caregivers, with most caregivers acting as solo operators.<sup>222</sup> Most of these caregivers are women. Four-in-ten women over eighteen years old provide some degree of elder care.<sup>223</sup> While men are becoming more engaged in caregiving,<sup>224</sup> women invest an average of “50 percent more time giving care than men do.”<sup>225</sup> 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.”<sup>226</sup> The typical profile for an unpaid caregiver is a middle-aged woman working the equivalent of a half-time job taking care of her mother.<sup>227</sup>

The types of elder care provided by family members or friends vary widely by type and level of sophistication—they range from skilled specialized services to simple companion duty.<sup>228</sup> These caregivers often require supplemental assistance from trained personnel.<sup>229</sup> However,

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219. This can result in significant financial, physical, and other sacrifice to the care-provider. See *Caregiver Health*, *supra* note 64 and accompanying text.

220. *Id.*

221. BARBARA COLEMAN & SHEEL M. PANDYA, AARP PUB. POL’Y INST., FACT SHEET: FAMILY CAREGIVING AND LONG-TERM CARE 1 (2002), [http://assets.aarp.org/rgcenter/il/fs91\\_ltc.pdf](http://assets.aarp.org/rgcenter/il/fs91_ltc.pdf) [<https://perma.cc/5NZG-F4RY>]; 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 caregivers 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.”).

222. ADVISOR’S GUIDE, *supra* note 7, at 4.

223. See generally Shell, *supra* note 69.

224. See ADVISOR’S GUIDE, *supra* note 7, 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).

225. *Important Information for Women*, *supra* note 217.

226. Edwards, *supra* note 32, at 50.

227. *Important Information for Women*, *supra* note 217.

228. Care can be personal (help with daily activities of living, such as with bathing, dressing, and incontinence), practical (such as help with housework, meals, finances, and transportation to the doctor, etc.), or simply companionship care (talking, reading, watching TV, etc.). The definition of care is very important for FMLA, FLSA, and LTC insurance purposes, but for my Article and my proposals, I define care very broadly to encompass all types of care. See *infra* Sections IV(C) & (D).

229. See Smith, *Who Will Care for the Elderly*, *supra* note 78; see also FROLIK, *supra* note 89, at 167 (finding that only 7% of the elderly who have a family caregiver live in an institution).

fewer than one-in-ten long-term care recipients rely solely on paid care services.<sup>230</sup> Half of unpaid caregivers perform duties that were once only performed by trained nurses.<sup>231</sup> By contrast, many states restrict (by statute) the execution of certain skilled care actions to certified professionals.<sup>232</sup> The effects of such rules and restrictions, including their associated financial costs, result in higher incidences of institutionalization for elders, often in opposition to their wishes.

Even the least expensive alternatives to home care pose substantial challenges to unpaid caregivers. For instance, ADC can provide vital relief for overworked unpaid caregivers, but affordability is an elusive factor.<sup>233</sup> ADC is generally not a subsidized brand of care, chiefly because it is not medically-oriented in design.<sup>234</sup> Neither Medicare nor long-term care insurance covers this family of services,<sup>235</sup> although Medicaid may, under certain restrictive conditions and only in certain states, cover ADC. Some states, most notably California, had expansive ADC programs at one time,<sup>236</sup> but due to the most damaging fiscal wounds inflicted by the Great Recession, these programs were significantly scaled back or completely shut down.<sup>237</sup> California's Medicaid program (Medi-Cal) eliminated funding for some 300 ADC centers in 2012.<sup>238</sup>

## 2. Special Issues Arise for Poor Single Women, Women of Color, and Rural Women

Single women—particularly those who have never married or do not have children—are more likely to be institutionalized. Women of color,

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230. Lynn Feinberg, *Populations in Need of LTSS and Service Delivery Issues: Testimony Before the Commission on Long-Term Care*, AARP PUB. POL'Y INST. 1, 2 (2013), [http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Feinberg-Testimony\\_Commission-on-Long-Term-Care.pdf](http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Feinberg-Testimony_Commission-on-Long-Term-Care.pdf) [<https://perma.cc/Q2Y4-BMFN>] (“[A]most half (46%) of family caregivers reported performing medical/nursing tasks for loved ones with multiple chronic conditions . . . Almost half of the family caregivers were administering five to nine prescription medications a day.”).

231. Adina Wingate, *More Americans Serving As Home Caregivers*, ARIZ. DAILY STAR (Jan. 25, 2015), [https://tucson.com/news/local/more-americans-serving-as-home-caregivers/article\\_7096b74d-956b-510f-a086-8b18878d1dd0.html](https://tucson.com/news/local/more-americans-serving-as-home-caregivers/article_7096b74d-956b-510f-a086-8b18878d1dd0.html) [<https://perma.cc/VR3T-LPKP>] (according to the National Survey of Caregiving, the daily tasks performed by family caregivers are becoming “increasingly complex, costly and difficult to manage”).

232. 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](https://www.ahcancal.org/ncal/advocacy/regs/Documents/2011_reg_review.pdf) [<https://perma.cc/8QXX-Q2DZ>].

233. See *supra* text accompanying notes 147–49.

234. See Thomas Day, *Paying the Cost of Care*, NAT'L CARE PLAN. COUNCIL, [https://www.longtermcarelink.net/eldercare/paying\\_the\\_cost\\_of\\_care.htm](https://www.longtermcarelink.net/eldercare/paying_the_cost_of_care.htm) [<https://perma.cc/YCK8-7GNW>].

235. *Medicare Coverage of Adult Daycare*, CARING.COM, [https://www.caring.com/medicare\\_information/medicare-coverage-of-adult-daycare](https://www.caring.com/medicare_information/medicare-coverage-of-adult-daycare) [<https://perma.cc/3HAK-YQZG>].

236. See Gleckman, *Battle*, *supra* note 200.

237. *Id.*

238. *Id.*

by contrast, tend to eschew nursing homes in favor of less formal and more “personal” care settings. For rural women, recent demographic trends have seen family members, and the support systems they represent, move away to more affluent urban settings.

#### a. Single Women

Many women face financial hardship as a residue of being single, whether by divorce, widowhood, or by lifelong choice.<sup>239</sup> One-third of baby-boom women are single.<sup>240</sup> According to the Pew Research Center, just 50% of the adult American population are married and 20% have never married—the highest such figure tallied to date.<sup>241</sup> This large cohort of single women, characterized by their lower aggregate levels of wealth and income, is “overwhelmingly more vulnerable than men” to financial calamity in later life.<sup>242</sup>

Women generally fare better economically when attached to a partner.<sup>243</sup> When married, for instance, women can benefit from income pooling, joint tax returns, higher potential Social Security benefits, and prospects for garnering inherited assets from their spouses.<sup>244</sup> Even unmarried but partnered women can still enjoy shared income, the benefits of economies of scale, and the possibility of inheritance from their

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239. Purvi Sevak et al., *Perspectives: The Economic Consequences of a Husband’s Death*, 65 SOC. SECURITY BULL. 3 (2003) (indicating that “[two] data sources show the enormous differential in poverty rates between married and unmarried women”).

240. I-Fen Lin & Susan L. Brown, *Unmarried Boomers Confront Old Age: A National Portrait*, 52 THE GERONTOLOGIST 153, 153 (2012); Edwards, *supra* note 32, at 50 (“There’s something cringe-worthy in these modern times about suggesting that a woman of any age needs a husband.”); 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/> [<https://perma.cc/8VF9-SVVK>] (“In 2009, nearly 20 percent of unmarried baby boomers were poor, compared with only 4 percent of married baby boomers.”).

241. See D’Vera Cohn et al., *Barely Half of U.S. Adults are Married—A Record Low*, PEW RES. CTR. (Dec. 14, 2011), <https://www.pewsocialtrends.org/2011/12/14/barely-half-of-u-s-adults-are-married-a-record-low/> [<https://perma.cc/XF5W-HWYM>] (“The median age at first marriage has never been higher for brides (26.5 years) and grooms (28.7).”); 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/> [<https://perma.cc/ZXT9-CSQ4>] (“Men are more likely than women to have never been married (23% vs. 17% in 2012).”).

242. CTR. FOR COMTY. CHANGE & OLDER WOMEN’S ECON. SEC. TASK FORCE, EXPANDING SOCIAL SECURITY BENEFITS FOR FINANCIALLY VULNERABLE POPULATIONS 3–6 (Oct. 2013); Richard L. Kaplan, *Top Ten Myths of Social Security*, 3 ELDER L.J. 191 (1995); Edwards, *supra* note 32, at 48.

243. Edwards, *supra* note 32, 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/> [<https://perma.cc/PW3B-5ZLD>].

244. David A. Weaver, *Widows and Social Security*, 70 SOC. SECURITY BULL. 3 (2010). Joint returns allow for the splitting of income benefits. I.R.C. § 1 (2018).

partners.<sup>245</sup> Divorced women who have been married at least ten years can access a former spouse's Social Security benefits.<sup>246</sup>

It is noteworthy that nearly 80% of widows who end up in poverty were not poor while their husbands were still alive.<sup>247</sup> The U.S. Census Bureau reports an estimated 800,000 Americans lose a spouse each year.<sup>248</sup> A vast majority of these individuals—a whopping 80%—are women.<sup>249</sup> More telling is the prospect that a married woman over sixty-five years-of-age will “live nearly 15 years past the death of her spouse.”<sup>250</sup> As these women age, they are less likely to retain family caregivers, increasing the chances that they will need more formal long-term care.<sup>251</sup> As a result, they also tend to bleed-down their financial resources more readily, speeding up the onset of reliance on public assistance programs via Medicaid and, ultimately, a nursing institution.<sup>252</sup>

Taking care of an infirm husband or significant other can be taxing on a woman, both physically and financially.<sup>253</sup> As mentioned earlier, caring for a spouse can result in adverse health consequences, including depression and even premature death.<sup>254</sup> Since married women often provide care for their husbands, this can delay or even prevent her from receiving formal long-term care herself. When the husband is in need of long-term care, family resources are often spent on his care, leaving the wife with less funds for her own care.<sup>255</sup> Even women who bring more

245. See Alicia Brokars Kelly, *Navigating Gender in Modern Intimate Partnership Law*, 14 J.L. & FAM. STUD. 1 (2012).

246. *If You Are Divorced*, SOC. SEC. ADMIN., <https://www.ssa.gov/planners/retire/divspouse.html> [<https://perma.cc/4JPB-A938>].

247. 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. Nor is there data on gay and lesbian marriages. As such, the author focuses her discussion on the subjects of the study.

248. Dan Rasmussen, *Widows Can Now Take Control of RMDs When Their Spouse Passes Away* (Sept. 20, 2016), <https://www.irahelp.com/slottreport/widows-can-now-take-control-rmds-when-spouse-passes-away> [<https://perma.cc/BTJ3-SC37>] (nearly 700,000 of these people were women who lost their husbands)

249. *Id.*

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

251. *Id.* at 453.

252. *Id.* at 465.

253. Elizabeth O'Brien, *Women Face a New Long-Term Care Dilemma*, MARKETWATCH (Mar. 7, 2013), <http://www.marketwatch.com/story/women-face-a-new-long-term-care-dilemma-2013-03-07> [<https://perma.cc/J33S-XQYQ>].

254. See discussion *supra* notes 68–71; see also *Women and Caregiving*, *supra* note 39 (“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.”).

255. Rick L. Law & Diana M. Law, *A Woman's Nightmare: Long-Term Care—Two Elder Law Attorneys' Perspectives*, CATALYST, June 2008, <https://www.isba.org/committees/women/newsletter/2008/06/awomansnightmarelongtermcaretwoelde> [<https://perma.cc/R9ME-7HVM>] (“Her husband's

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.<sup>256</sup> Often, the end result of a wife assuming control of care for her husband is detrimental to her own long-term care needs.

*b. Women of Color*

It is beyond the scope of this Article to discuss in detail the differences with respect to elder care for women informed by the principle populations of color—Asian, Hispanic, and African American. These groups differ in their poverty rates, general states of health, and the availability of care to them. One shared similarity among all three ethnic categories is that of cultural influences that results in a general preference for “informal care to nursing homes” and environments “encouraging family care and discouraging institutionalization.”<sup>257</sup>

African American and Hispanic women are more likely to be poor than their white counterparts.<sup>258</sup> According to 2013 Census data, the poverty rate for African American women sixty-five years-of-age and over was approximately one-in-three; the poverty rate is even higher—at 50%—for Hispanic senior women.<sup>259</sup> For white senior women, the poverty rate is approximately one-in-six.<sup>260</sup> Senior Asian women are trending towards higher rates of poverty over time, in part because their populations tend to dwell in expensive urban enclaves with high concentrations of their ethnic groups. For instance, in New York, approximately 24.8% of senior Asian women live below the poverty line.<sup>261</sup> When white women or

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care [in the nursing home] will be offset by Medicaid if—and only if—she and her husband meet strict income and asset limitations.”).

256. 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.

257. Andy Sharma, *Assessing the Risk of Institutional Entry: A Semi-nonparametric Framework Using a Population-based Sample of Older Women*, 26 WOMEN'S HEALTH ISSUES 564, 570 (2016).

258. See Beverly I. Moran, *A Black Critique of the Internal Revenue Code*, 1996 WIS. L. REV. 751 (1996).

259. See CARMEN DENAVAS-WALT & BERNADETTE D. PROCTOR, U.S. CENSUS BUREAU, INCOME AND POVERTY IN THE UNITED STATES: 2014, at 12–15 (Sept. 2015), <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf> [<https://perma.cc/773F-NL8U>].

260. *Id.*

261. PROFILE OF ASIAN AMERICAN SENIORS IN THE UNITED STATES, ASIAN AMERICAN FED'N CENSUS INFO. CTR. (2009), <http://aafny.org/cic/briefs/useniors2009.pdf> [<https://perma.cc/CZS8-JZJW>].

women of color have immigrated to the United States, they are even more likely to live in poverty than their native counterparts.<sup>262</sup>

Household makeup varies among the various ethnic groups as well. African American senior women are the most likely to be single, whereas Asian elder women are over twice as likely to live in multigenerational households than other populations.<sup>263</sup> Asian women are also the most likely to receive in-home care from a family member.<sup>264</sup> African American women are also more likely to suffer serious health issues and carry no health insurance.<sup>265</sup> Consequently, their life expectancies average about four years less than white women.<sup>266</sup> In all group cases, the lack of familial or other unpaid care dramatically increases the likelihood of institutionalization.

### *c. Rural Women*

In addition to the multitude of problems that even wealthy women encounter in rural settings—inadequate medical facilities, support services, and infrastructure features<sup>267</sup>—poor rural women face additional challenges. First, impoverished senior women may suffer severe housing issues, both in terms of escalating rents and sub-standard physical conditions. Second, the difficulty of securing unpaid care at home becomes more acute with family members increasingly moving to geographically remote locales—illustrating the well-publicized “brain drain” phenomenon plaguing many rural enclaves across the nation. Third, access to quality medical care may be limited as doctors may be reluctant

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262. *Immigration in the United States: A Profile of America's Foreign-Born Population*, CTR. FOR IMMIGRATION STUDIES tbl.10, <https://cis.org/Immigrants-United-States-Profile-Americas-ForeignBorn-Population> [<https://perma.cc/N6W3-F6DJ>].

263. *Id.*; 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. (Mar. 8, 2016), <https://www.epi.org/publication/women-over-65-are-more-likely-to-in-poverty-than-men/> [<https://perma.cc/FB7X-LGKF>] (stating that “older, minority, and unmarried women are at greatest risk” of poverty).

264. NAT'L ASIAN PACIFIC CTR. ON AGING, <https://www.napca.org> [<https://perma.cc/2EC3-35FC>].

265. Sophia Kerby, *State of Women of Color in the United States*, CTR. FOR AM. PROGRESS (July 17, 2012), <https://www.americanprogress.org/issues/race/reports/2012/07/17/11923/the-state-of-women-of-color-in-the-united-states/> [<https://perma.cc/2VAS-UZ2S>] (women of color more likely to have bad health and be uninsured); see also Vernellia R. Randall, *Inequality in Health Care is Killing African Americans*, 36 HUM. RTS. 20, 20 (2009) (stating that “Black Americans are sicker than white Americans”).

266. Philip C. Aka, Aref A. Hervani & Elizabeth Arnott-Hill, *Protection Against the Economic Fears of Old Age: Six Micro and Macro Steps for Bridging the Gap in Retirement Security Between Blacks and Whites*, 40 VT. L. REV. 1, 11 n.53 (citing Steven Reinberg, *U.S. Blacks Still Lag Whites in Life Expectancy*, WEBMD (July 18, 2013), <http://www.webmd.com/heart-disease/news/20130718/us-blacks-still-lag-whites-in-lifeexpectancystudy>).

267. See discussion *supra* Section II(A)(7).

to take on Medicaid or Medicare patients that generate inadequate reimbursements, forcing these elder women to make difficult choices to ensure a steady supply of needed care.

A large percentage of rural residents rent their homes.<sup>268</sup> Nearly 30% of rural households, representing more than 7.3 million people, live in housing with at least one significant issue involving affordability, structural quality, or household crowding.<sup>269</sup> Rural renters are more than twice as likely to live in sub-standard dwellings as homeowners.<sup>270</sup> Like their urban counterparts, rural women living on fixed incomes are vulnerable to rising rental costs. Nearly half of rural renters spend more than 30% of their monthly incomes on rent.<sup>271</sup> This high percentage spent on housing siphons off resources that could be dedicated to other basic needs, such as nutrition, clothing, transportation, or medical care.

If one has family or friends available, in-home elder care can be relatively inexpensive, if calculated strictly on an out-of-pocket cash basis.<sup>272</sup> This brand of care is a staple to impoverished rural women. As referenced earlier, in the years following the Great Recession, the availability of family care providers has dropped precipitously in rural enclaves, increasing the financial and emotional strain on the remaining resident senior women.

Because of the marginal existence so many rural elderly women experience, obtaining good quality health services is a constant challenge. Many physicians in rural areas simply do not take on Medicaid patients.<sup>273</sup> There is already a dearth of primary care and specialty doctors in the country, so this phenomenon makes a scarce supply situation more acute. This is further exacerbated by generally lower reimbursement rates for Medicare in rural areas, creating dilemmas for healthcare providers concerning the types of medical services doctors are willing to offer.<sup>274</sup> Additionally, these affected senior women simply do not have the practical option to travel to better-staffed and better-equipped facilities in the city to attend to needed personal attention. They also have difficulty affording basic non-medical, practical care items and services, such as housekeeping, meal preparation, help with personal hygiene, and the

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268. RAPOZA ASSOCIATES, THE LOW-INCOME HOUSING TAX CREDIT: OVERCOMING BARRIERS TO AFFORDABLE HOUSING IN RURAL AMERICA (2015) [hereinafter RAPOZA], [https://www.novoco.com/sites/default/files/atoms/files/rapoza\\_rural-lihtc-report\\_081313.pdf](https://www.novoco.com/sites/default/files/atoms/files/rapoza_rural-lihtc-report_081313.pdf) [https://perma.cc/Q2LM-TE23].

269. *Id.*

270. *Id.*

271. *Id.*

272. See discussion of the financial, physical, and emotional impact on this caregiving, *supra* Section I(D).

273. *Long-Term Care in Rural America*, *supra* note 27, at 24.

274. *Id.* at 30.

like.<sup>275</sup> When such routine aspects of daily maintenance begin falling by the wayside, the chronic lack of adequate resources is usually a precursor to inevitable and unnecessary institutionalization.

### III. TAX SYSTEM FAILURES

The tax system fails in its policies with respect to elder care.<sup>276</sup> It favors institutionalization—the most expensive, least preferred, and unsustainable type of elder care—when abundant evidence exists that home care provides the best combination of patient comfort, care quality, and cost effectiveness. Furthermore, the tax system favors the wealthy by excluding their long-term care Medicare benefits and by allowing an itemized medical deduction for large and varied expenditures, including remodels to homes. For those wealthy enough to purchase a retirement unit, real estate taxes and mortgage interest can also be deducted. On the other hand, inadequate subsidies exist for the low-income care recipient, the unpaid supportive caregiver, and the low-paid care provider.

#### *A. The Tax System Favors Institutionalization*

The tax system provides several generous tax subsidies for nursing home care. It 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. In addition, it allows for a partial exclusion of nursing home care if it is paid through long-term care insurance. The value of these exclusions can be substantial, particularly for the wealthy taxpayer receiving these benefits.

##### 1. Exclusion of Medicare and Medicaid Benefits Received for Long-Term Care

If an individual receives benefits through government entitlement programs, the welfare exception in the tax area would preclude the taxability of these benefits.<sup>277</sup> These benefits include the value of the room,

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275. *Id.* at 36.

276. Often focusing on the value of personal responsibility. See Nancy E. Shurtz, *Sweden, Singapore, and the States: A Comparative Analysis of the Impact of Taxation on the Welfare of Working Mothers*, 55 ST. LOUIS U. L.J. 1087 (2011); see also *infra* Section IV(A) and Congressional focus on personal responsibility concepts in proposed legislation: (1) the taxpayer should save for retirement; (2) tax subsidies should be non-refundable; (3) subsidies should be for out-of-pocket expenses; (4) subsidies should go to businesses for hiring and retaining older workers; (5) taxpayers should be educated on retirement savings; and (6) taxpayers should purchase long-term care insurance.

277. See Theodore P. Seto & 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 rulings known collectively as the ‘general welfare doctrine,’ excludes most safety net payments from income—an issue of vital importance to people with disabilities.”).

meals, and care (including other services received by the patient). Thus, all nursing home costs reimbursed through Medicare and Medicaid are excluded from the recipient's gross income. This is an extremely valuable benefit, particularly for the wealthy taxpayer entitled to Medicare. For example, if the annual value of a private nursing home room is approximately \$100,000, and if that value were included in the senior's taxable income, under the 2018 federal income tax system the marginal tax rate would be approximately 24%.<sup>278</sup> If the taxpayer were wealthy, the marginal rate could be as high as 37%.<sup>279</sup> Essentially, if the value of the rich taxpayer's nursing home room is \$100,000, each year the government provides her with \$37,000 worth of tax subsidies.

## 2. Exclusion of Long-Term Care Insurance Benefits Received

Long-term care insurance is mostly the province of the wealthy. They enjoy the station that allows them to purchase and retain this expensive brand of care. If such an individual receives cost reimbursements under a long-term care insurance policy for the cost of nursing home care, the recipient can totally or partially exclude the amount of the care.<sup>280</sup> Long-term care policies that reimburse a set daily amount without regard to actual expenses incurred are not taxable up to a per diem amount (\$360 in 2018).<sup>281</sup> Since the average private room costs \$267 and a semi-private room costs \$235, this per diem exclusion amount is very generous.<sup>282</sup> On

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278. *Id.* at 1108; see I.R.C. § 1 (2018) (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.).

279. Assume taxpayer is already in the 37% bracket with taxable income over \$510,301. Assume she receives Medicare benefits for a year, then receives a \$37,000 tax benefit. Of course, she is only entitled to Medicare for 100 days after a three-day hospital stay, but such Medicare benefits can often last more than a year.

280. Amounts received for nursing home care are generally excludable from income as amounts received for personal injury or sickness. 26 U.S.C. § 7702B(a)(2) (2018); INTERNAL REVENUE SERV., PUB. NO. 525, TAXABLE AND NONTAXABLE INCOME 27–28 (2018), <https://www.irs.gov/pub/irs-pdf/p525.pdf> [<https://perma.cc/4MJY-TNUG>] ("Don't include in your income governmental benefit payments from a public welfare fund based upon need . . . . Medicare benefits received under Title XVIII of the Social Security Act aren't includible in . . . gross income . . ."). 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. See 26 U.S.C. § 213(d) (2018) for definitions.

281. MASS. MUTUAL LIFE INS. CO., 2018 TAX IMPLICATIONS OF LONG-TERM CARE INSURANCE (LTCI) FOR INDIVIDUALS AND BUSINESSES 1 (2018), <https://www.massmutual.com/efiles/ltc/pdfs/ltc1419.pdf> [<https://perma.cc/SY3E-LB96>]. 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. See J.K. LASSER, YOUR INCOME TAX 2017 TAX GUIDE 393 (2017).

282. See GENWORTH, *supra* note 122.

the other hand, long-term care policies that pay or reimburse actual expenses are not taxable at all.<sup>283</sup> Again, on an annual basis, a wealthy person with a \$360 per day (\$131,400 per year) exclusion will receive a tax benefit of \$48,618.<sup>284</sup>

### *B. The Tax System Favors the Wealthy Who Can Afford CCRCs*

The taxation subsidies for CCRCs are complicated but generally favor the wealthy. Like long-term care insurance, the wealthy are the ones who can afford this type of care.<sup>285</sup> First, if the senior owns the condo or residence, then all the tax benefits of home ownership apply. Second, if the facility is a nonprofit organization, then any charitable transfer to that facility could be a charitable deduction. Lastly, a portion of the upfront charge and maintenance fee as well as costs of meals and lodging may be a qualified medical expense and an itemized deduction. Again, the problem is that all of these subsidies favor the wealthy taxpayer.<sup>286</sup> Wealthier taxpayers are more likely to itemize their deductions rather than take the standard deduction; so deductions for real estate taxes, mortgage interest, charitable contributions, and medical expenses will favor this group.<sup>287</sup> Most elderly women have no tax liability and thus will receive little or no benefit from these deductions.<sup>288</sup>

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283. See Lafond et al., *supra* note 155, 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.” Any payments that represent dividends or refunds are taxed.)

284. Calculation: \$131,400 x 37% bracket.

285. See earlier discussion *supra* Section III(A)(2).

286. Most elders are not even taxpayers. See *Why Most Elderly Pay No Federal Tax*, CTR. FOR RETIREMENT RES. AT B.C. (Apr. 14, 2016), <http://squaredawayblog.bc.edu/squared-away/why-most-elderly-pay-no-federal-tax/> [<https://perma.cc/C5X9-MVFE>]. Elders, of course, pay no payroll taxes. See Robertson Williams, *Why Nearly Half of Americans Pay No Federal Income Tax*, TAX POL’Y 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> [<https://perma.cc/XV2A-QUJ7>].

287. Under the TCJA the basic 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 for 2018. I.R.C. § 63(c)(7)(A) (2018). These amounts will be adjusted for inflation for future years. I.R.C. § 63(c)(7)(B). In addition, those over sixty-five will also receive an additional standard deduction. Both the basic and additional standard deductions would be compared to the taxpayer’s itemized deduction to see what the greater deduction would be. See Richard Rubin, *Tax Law Spurred a Rush to Charitable-Giving Funds*, WALL ST. J. (Feb. 2, 2018), <https://www.wsj.com/articles/charity-funds-take-off-as-tax-law-reshapes-giving-1517502089> [<https://perma.cc/2YCS-7E3C>] (the Tax Policy Center estimates that “about 11% of house-holds are projected to itemize deductions, down from 26% under the prior” tax law).

288. I.R.C. §§ 63(b)(1), (3) (2018); *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> [<https://perma.cc/4WWC-79UE>]. In fact, most taxpayers do not pay federal income taxes. Brad Plumer, *Who Doesn’t Pay Taxes in Eight Charts*,

### 1. The Tax Benefits of Property Ownership

Seniors who own their residence or condo units will be able to take an itemized deduction for a portion or all of their mortgage interest on any acquisition indebtedness on their home (or second home) and a portion or all of their real estate property taxes.<sup>289</sup> The Tax Cuts and Jobs Act of 2017 (TCJA)<sup>290</sup> allows a mortgage interest deduction (for a main and secondary home) of up to \$750,000 of acquisition indebtedness.<sup>291</sup> In addition, a taxpayer may claim a deduction of up to an aggregate amount of \$10,000 for state and local property taxes as well as state and local income taxes.<sup>292</sup> If taxpayers live in high tax states, their real property tax deduction may be limited.

Other tax benefits from property ownership arise upon the sale of a principal residence and upon death of the owner of property. If the senior must sell his or her CCRC to move into a nursing home, the senior will continue to be able to exclude up to \$250,000 of the gain (\$500,000 if married filing jointly) from the sale as long as they have resided there for two out of five years.<sup>293</sup> Upon the death of the senior, no realization occurs so no income tax gain arises on the transfer of property to the heirs. Furthermore, the heirs will receive a stepped-up basis in any property they receive from the decedent.<sup>294</sup> Under the TCJA, a taxpayer can die with \$10 million (adjusted for inflation) of property and pay no estate tax.<sup>295</sup> Thus, the fair market value of the home will most likely not be subject to any federal estate tax.

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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](https://www.washingtonpost.com/news/wonk/wp/2012/09/18/who-doesnt-pay-taxes-in-charts/?noredirect=on&utm_term=.8f5142785cb0) [https://perma.cc/5K49-TJXN]; see also Williams, *supra* note 286. Under the Tax Code, deductions can be above-the-line or deduction in reaching adjusted gross income, I.R.C. §§ 62 (a)(1)–(21) (2018) (which lists those deductions specifically), or deductions can be below-the-line. I.R.C. § 63(d)(1) (2018). The medical deduction of section 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 basic standard deduction (plus “old age” additional amount) or will use form Schedule A and itemize their deductions.

289. Taxpayers are allowed a mortgage interest deduction on two residences. I.R.C. § 163(h)(3)(F)(i)(III) (2018).

290. The TCJA has limited both of these itemized deductions for years 2018 through 2025. I.R.C. §§ 164(b)(6), 163(h)(3)(F) (2018).

291. I.R.C. § 163(h)(3)(F)(i)(III) (2018).

292. I.R.C. § 164(b)(6) (2018). State sales taxes can be taken in lieu of state income taxes. Under the TCJA, no deduction is allowed for foreign real property taxes paid. I.R.C. § 164(b)(6)(A) (2018). This \$10,000 limit is the same for married couples as it is for the individual.

293. I.R.C. § 221 (2018). Any excess capital gain may be taxed at zero percent if the elder is in a 0–15% ordinary income tax bracket.

294. I.R.C. § 1014 (2018).

295. See I.R.C. § 2001 (2018).

## 2. The Charitable Deduction

A wealthy taxpayer may also be entitled to an itemized charitable deduction if she decides to reside in a religiously affiliated CCRC. Any transfer made to the qualified religious organization must be exclusively for the benefit of the charity with no strings attached.<sup>296</sup> Thus, any amounts transferred must not be required for admission or be in consideration for any services rendered.<sup>297</sup> Under the TCJA, if the contribution is made in cash, this itemized deduction can be as much as 60% of the taxpayer's contribution base or adjusted gross income.<sup>298</sup> Otherwise, if the gift is of property, the limit is 50% of the taxpayer's contribution base. In either case, this deduction can be substantial. A charitable deduction is better than a medical expense because it does not have a floor.<sup>299</sup> But again, only the wealthy taxpayer that itemizes and does not take the standard deduction will benefit from this tax provision.

## 3. Deduction for Medical Care in Continuing Care or Assisted Living Facilities

In general, fees paid for independent living at a Continuing Care (CCRC) are not deductible. However, upfront charges and entrance fees, as well as separate charges for meals and lodging in an Assisted Living Facilities (ALF), may be deductible if they (or part of them) are allocable to medical care for the chronically ill.<sup>300</sup> Such a deduction may be allowed upon a showing that the facility historically allocates a specified percentage of the fee or charge to future medical care.<sup>301</sup> The IRS uses a "percentage method," rather than an "actuarial method," for allocating the

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296. See Lori A. Tobias, *Brinley v. Commissioner: A Modified Charitable Deduction Standard for Missionary Support Payments*, 40 SMU L. REV. 1267, 1269 (1987) (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) the transfer must be absolutely for the benefit of the recipient. Any quid pro quo for the transfer will disqualify it).

297. I.R.C. § 170 (2018). The IRS will be weary of such schemes if they fly in the face of the statute.

298. I.R.C. § 170(b)(1)(G)(i) (2018).

299. I.R.C. § 170 (2018) had no floor limitation. (Compare this with I.R.C. § 213 with a 7.5% floor).

300. 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](http://www.flicra.com/uploadedFiles/File/Senior_Living_Tax_Deductions_Guide.pdf) [<https://perma.cc/7GSQ-EU6G>]. ALF is eligible 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. See *Vorris J. Blankenship, Tax Issues Complicate the Costs of Chronic Illness*, 106 J. TAX'N 216, 220 n.32-34 (2007).

301. GORDON, *supra* note 300, at 5.

community medical expenses among the residents, and this method has been approved by the Tax Court.<sup>302</sup> Under the percentage method, the annual medical expenses of the community are divided by the total operating expenses. This method is complicated because a determination must be made as to how certain expenses should be treated and how the allocated medical care percentage once determined should be split among the residents.<sup>303</sup>

Under certain circumstances, the senior may also deduct the cost of meals and lodging paid to an ALF.<sup>304</sup> The costs of meals and lodging comprise a large part of the cost of an ALF, as well as a person's general personal budget, so having a deduction for this amount could provide a significant tax benefit.<sup>305</sup> Again, this tax benefit goes to the wealthy taxpayer who itemizes and does not take the standard deduction.

### *C. The Tax System Favors the Wealthy with the Itemized Medical Expense Deduction*

Medical expenses, other than those paid to a CCRC or an ALF, may also be claimed as an itemized deduction. These would include personal care for the chronically ill, the purchase of long-term care insurance, and even expensive modifications to one's home. In addition, payments of qualified medical expenses made by relatives for the care of their loved ones may also be covered under this medical expense deduction provision. Again, this deduction is an itemized deduction and will be allowed to those wealthy taxpayers who do not take the standard deduction.<sup>306</sup>

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302. See *Baker v. Comm'r*, 122 T.C. 143, 163 (2004). In *Baker*, 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. *Id.* at 143. The Tax Court rejected this methodology, stating 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. *Id.* at 167–68.

303. *Id.* at 167, 173–77, 181. The Tax Court has held that the community's interest expenses on any debt and depreciation allowances must be included in both the numerator and denominator when dividing medical costs by operation cost to determine the medical care allocation percentage. It held 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. *Id.* at 181.

304. See Blankenship, *supra* note 300, at 220 nn.32–34. These costs will be deductible if (1) the qualified 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.

305. *How Much Does Assisted Living Cost?*, WHERE YOU LIVE MATTERS, <https://www.wheretheyoulivematters.org/how-much-does-assisted-living-cost/> [<https://perma.cc/24FL-N729>].

306. 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 they 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*

In order to qualify for this itemized deduction, the medical care deduction must be over a floor amount. Under the TCJA, the overall AGI percentage limit will be 7.5% until January 1, 2020, regardless of whether the taxpayer paying for the care is under the age of sixty-five.<sup>307</sup> For example, if a taxpayer pays nursing home expenses of \$50,000 and has an AGI of \$100,000, then \$50,000 less \$7,500 (or \$42,500) will be deductible as an itemized deduction. This 7.5% limit will be increased after January 1, 2020<sup>308</sup> to 10% for taxpayers under the age of sixty-five but remains at 7.5% for those over age sixty-five.

### 1. Deduction for Medical and Personal Care of the Chronically Ill

The medical deduction broadly covers “medical care”<sup>309</sup> but also, more specifically, care services for the chronically ill.<sup>310</sup> These include “rehabilitative services” as well as “maintenance or personal care services.”<sup>311</sup> Rehabilitative services are the skilled-type services or help with daily activities of living. By contrast, “maintenance or personal care services” can cover a broad range of applications,<sup>312</sup> including help with meal preparation,<sup>313</sup> housework,<sup>314</sup> transportation,<sup>315</sup> or some lodging—if essential to the chronically ill patient’s care.<sup>316</sup> Any wages paid to the

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*Tax Policy and Family-Provided Care for Older Adults*, 25 VA. TAX REV. 509, 544 nn.229–30 (2005). See also discussion *supra* notes 287–88.

307. I.R.C. § 213(f)(2) (2018). On January 1, 2020, a recalculation under the alternative minimum tax of 2.5% will need to be made. See I.R.C. § 56(b)(1)(B) (2018).

308. I.R.C. § 213(f)(2) (2018).

309. Medical expenses are those for the diagnosis, cure, relief, or treatment of disease or bodily malfunction (including medical insurance and some transportation.) I.R.C. §§ 213 (d)(1)(A)–(C). For example, nursing care is a qualified medical expense even if it is not performed for the chronically ill. 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 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. LASSER, *supra* note 281, at 278.

310. I.R.C. § 7702(B) (2018).

311. I.R.C. § 213(d) (2018); 28 U.S.C. § 7702B(c)(1) (2018).

312. *Baker v. Comm’r*, 122 T.C. 143 (2004) (holding that a percentage of the monthly fees paid to a CCRC can be deducted as a qualifying medical expense); *Osteopathic Med. Oncology & Hematology, P.C. v. Comm’r*, 113 T.C. 376 (1999) (indirectly indicating that chemotherapy treatment and related medicines are covered Medicare and medical expenses).

313. See *Blankenship*, *supra* note 300, at n.14.

314. *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, 104TH CONG., GENERAL EXPLANATION OF TAX LEGISLATION ENACTED IN THE 104TH CONGRESS 338 (Joint Comm. Print 1996).

315. I.R.C. § 7702B(c)(3) (2018); *Blankenship*, *supra* note 300, at 218.

316. *Blankenship*, *supra* note 300, 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.”).

caregiver, including the cost of the caregiver's meals or lodging,<sup>317</sup> are included in the medical expenses. Also included would be any state and federal income taxes paid, Social Security or Medicare taxes paid, and federal and state unemployment taxes attached to the caregiver's wages.<sup>318</sup> If the caregiver stays in the home of the care-receiver, then the costs of his or her meals are also deductible, as well as the cost of lodging for that paid caregiver. Lodging, however, would be deductible only to the extent the expense exceeded the normal expenses of the household.<sup>319</sup> Thus, for example, if a one-bedroom apartment is needed, rather than a studio apartment, or there are extra utility expenses in the home, then these extra amounts could constitute a qualified medical expense.<sup>320</sup>

The medical expense deduction covers all paid caregivers, even if they are not certified professionals, as long as they are paid for services to the chronically ill.<sup>321</sup> However, deductions are expressly prohibited for services rendered to the chronically ill by unlicensed relatives.<sup>322</sup> An exception to this relative-care rule was found in the unusual case of *Ungar v. Commissioner*.<sup>323</sup> Here, the taxpayer rented an apartment outfitted with medical equipment and hired a relative, who was not a professional, to provide caregiving services to his ninety-year-old mother.<sup>324</sup> The Tax Court held that the taxpayer was entitled to deduct the cost of the apartment, the medical equipment, and the wages of the relative assistant.<sup>325</sup> The court reasoned that this result supported the policy that these expenses avoided the larger, more direct expense of hiring nurses or

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317. 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." *Id.* at 218.

318. See Stephanie Breedlove, *Understanding the Tax Rules for Caregivers*, NEXT AVENUE (Mar. 31, 2014), <http://www.nextavenue.org/understanding-tax-rules-caregivers/> [<https://perma.cc/6T58-USGY>].

319. *Estate of Marantz v. Comm'r*, 39 T.C.M. 516 (1979); 19 Rev. Rul. 76-106, 1976-1 C.B. 71.

320. I.R.C. § 162 (2018); I.R.C. § 119 (2018). This excess expense could also be deductible as an employer business expense when the caregiver is a paid worker. It is interesting to note that under the Tax Cuts and Jobs Act of 2017, the employer will receive no deduction for meals provided on the business premises as a convenience to the employer, but no such limitation applies to lodging. See I.R.C. § 274(o) (2018) (specifically denying a deduction for meals (but not lodging) in the § 119 context).

321. *Estate of Marantz*, 39 T.C.M. at 516; 19 Rev. Rul. 75-317, 1975-2 C.B. 57.

322. I.R.C. § 213(d)(11)(A) (2018); see also I.R.C. §§ 152 (d)(2)(A)–(G) (2018) (stating that "[r]elatives" in this context generally include children (or the children's spouse), grandchildren, brothers (or brothers-in-law), sisters (or sisters-in-law), nieces or nephews, and step-siblings. Also included are parents and step-parents).

323. *Ungar v. Comm'r*, 22 T.C.M. 766 (1963).

324. *Id.*

325. *Id.* (including social security taxes and unemployment and other fees mentioned above.) In this arrangement, either the employer or the independent contractor would be obligated to pay these expenses. *Id.*

placing the patient in an expensive hospital or nursing home.<sup>326</sup> Thus, allowing this medical deduction served the fiscal interests of both the federal and state treasuries.<sup>327</sup> This rule, however, could only apply to a taxpayer wealthy enough to afford such relative-care.<sup>328</sup> 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.<sup>329</sup>

## 2. Deduction for Long-Term Care Insurance

Qualified medical expenses would also include the premiums on any qualified long-term care insurance. The maximum amount allowed as a deduction is based on the taxpayer's age at the end of the year.<sup>330</sup> For 2018, \$420 is allowed for a taxpayer forty years old or under at year-end, \$780 for a taxpayer forty-one through fifty, \$1,560 for a taxpayer fifty-one through sixty, \$4,160 for a taxpayer sixty-one through seventy, and \$5,200 for a taxpayer over seventy years old.<sup>331</sup> While these premiums alone might not exceed the floor amount for the medical deduction, these insurance costs can be combined with other medical expenses of the taxpayer during the year. Because most long-term care policies have an elimination period in which the taxpayer is required to bear some initial care costs, the insurance premiums plus other medical expenses could provide a significant tax benefit for the wealthy taxpayer who itemizes their deductions.

## 3. Deduction for Consumer-Directed Care<sup>332</sup>

Families in higher socioeconomic groups tend to remodel homes to accommodate an elder.<sup>333</sup> These expenses can qualify as a medical care

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326. *Id.*

327. *Id.*

328. In such a case, the relatively affluent senior might already be claiming real estate taxes or other itemized deductions and might also exceed the 7.5% threshold limit under the medical care provision. 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(h)(3)(F) (2018) 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 \$750,000. I.R.C. § 164(b)(6) (2018) now limits the itemized tax deduction for personal state taxes paid to \$10,000.

329. *See supra* Section II(C)(1).

330. *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> [<https://perma.cc/YFE4-L6KW>].

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

332. ADVISOR'S GUIDE, *supra* note 7, at 28.

333. Ann Bookman & Delia Kimbrel, *Families and Elder Care in the Twenty-First Century*, 21 FUTURE OF CHILDREN 117, 126 (2011).

deduction for the elders themselves or for those charged with their care. Consumer-directed care includes medically-driven installations,<sup>334</sup> such as home or bathroom remodels, that are not covered by insurance but make the home more user-friendly.<sup>335</sup> Typically, installation of rails, ramps, bath seats, and elevators could qualify.<sup>336</sup> Technological devices, such as medical alarm bracelets, remote electronic monitors, mobility machinery, adjustable beds, blood pressure gages, and other testing devices, would also be counted.<sup>337</sup>

Tax limitations apply to home remodels, as these would normally be nondeductible personal expenses.<sup>338</sup> The *Gerard* rule holds that if the remodel is medically-driven and if the remodel does not increase the value of the house, then the entire cost is considered a medical expense.<sup>339</sup> In most cases, installation of special features, such as installing railing and support bars, adding ramps, modifying doorways and stairways, and altering fixtures, outlets, or cabinets, 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 fully claimed as medical expenses. The full costs of operating and maintaining the equipment installed for medical reasons could also be claimed. If, on the other hand, the improvement does increase the value of the house, then the medical

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334. 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 . . . may, 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.”).

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

336. 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).

337. I.R.S. Pub. 502, *Medical and Dental Expenses*, IRS.GOV (2018), <https://www.irs.gov/publications/p502> [<https://perma.cc/49X2-3KQ5>]; see also *Why Long-Term Care Is A Women's Issue*, OPRAH.COM (Oct. 14, 2010), <http://www.oprah.com/spirit/from-our-sponsor-why-long-term-care-is-a-womens-issue#ixzz2N19x8TCl> [<https://perma.cc/L4SS-7RS3>].

338. I.R.C. § 262 (2018).

339. *Gerard v. Comm’r*, 37 T.C. 826, 829–30 (1962) (holding that the difference between the medical expense and increase in value to the home may be deducted); see also *Evanoff v. Comm’r*, 44 T.C.M. 1394 (1982) (no deduction for year-round swimming facility); *Robbins v. Comm’r*, 44 T.C.M. 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).

expense will be reduced by the amount of value added to the house.<sup>340</sup> In *Gerard*, the taxpayers installed an air system for medical purposes, a piece of equipment that cost \$1,300, but added \$800 in value to the house. Therefore, only \$500 was granted as the deductible expense.

#### 4. Deduction for Long-Term Care Expenses Paid by Relatives

Families in higher socioeconomic groups tend to provide financial gifts to accommodate an elder.<sup>341</sup> Thus, when the elderly parent has not saved enough to pay for long-term care, their children might pay for these “medical care” expenses.<sup>342</sup> A taxpayer who pays for these qualifying expenses—including the wages of workers who perform the skilled or personal care of a chronically ill dependent—may be able to receive an itemized medical expense deduction. In addition to the hurdles discussed in the previous section relating to medical deductions generally, the elderly relative must be a qualifying “dependent.”<sup>343</sup> Anyone fitting the definition of “qualifying relative” would count,<sup>344</sup> as long as taxpayer pays over half the support of that relative needing medical care.<sup>345</sup> Furthermore, no gross income test is applied for purposes of validating the deduction.<sup>346</sup>

When the family member makes the medical payment directly “to any person who provides medical care (as defined in Section 213(d)),”<sup>347</sup> then no gift tax will be imposed on the donor for federal gift tax purposes. Failing this test, donors avoid gift tax upon transfers to their loved ones equal to the per donee annual exclusion, which currently stands at \$15,000.<sup>348</sup> For the elderly recipient of the gift, these transfers are excludable from the recipient’s gross income.<sup>349</sup> Clearly these transfers fall within the *Duberstein* rule, as they most likely would be motivated by disinterested generosity out of love, respect, and affection.<sup>350</sup>

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340. *Id.*

341. Ann Bookman & Delia Kimbrel, *Families and Elder Care in the Twenty-First Century*, 21 FUTURE OF CHILDREN 117, 126 (2011).

342. See *supra* Section III(C)(4).

343. I.R.C. § 213(f)(2) (2018). Fortunately, the new law will not result in any recalculation under the alternative minimum tax.

344. See I.R.S. Pub. 502, *supra* note 337, at 3–4.

345. See I.R.S. Pub. 502, *supra* note 337.

346. 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 377.

347. I.R.C. § 2503(e)(2)(B) (2018).

348. I.R.C. § 2503(b) (2018).

349. I.R.C. § 102 (2018).

350. *Comm’r v. Duberstein*, 363 U.S. 278, 286 (1960).

#### *D. Tax System Provides Inadequate Benefits for the Family Caregiver*

In general, meager tax benefits are provided for the family caregiver. The Code offers a form of splitting of income through the head of household status. It also provides a minimal dependent tax credit and a dependent care credit for the paid caregiver that works.

##### 1. Head of Household Status May Provide Splitting Opportunities

Head of household status provides a form of splitting income between the care provider and the dependent.<sup>351</sup> This status, however, can only apply to the single taxpayer, as married couples are ineligible for this status.<sup>352</sup> Qualifying for head of household status can lead to lower federal tax rates than single taxpayers or married couples filing separately.<sup>353</sup> In addition, heads of households receive a larger federal standard deduction than either of the other categories.<sup>354</sup> To qualify as head of household, the taxpayer must pay for more than half of the “maintenance costs of the home” for a “qualifying person.”<sup>355</sup> Home maintenance expenses include rent, repairs, utilities, property insurance, mortgage interest and property taxes, as well as household expenditures on yard upkeep, housework, and

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351. The head of household status is eliminated under the alternative minimum tax (AMT) as there are just two status categories: individual and joint. Under that provision, head of household taxpayers are considered single taxpayers, thus ignoring their role as care providers. Before the TCJA, all dependent exemptions were eliminated in the AMT calculation. 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. I.R.C. § 55(d) (2018). 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. 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/> [https://perma.cc/TM39-MRLE]. 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) (2018). 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) (2018).

352. 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 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) (2018).

353. See I.R.C. § 1(j)(2)(B) (2018).

354. 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) (2018).

355. I.R.C. § 2(b)(1)(B) (2018).

food “consumed on the premises.”<sup>356</sup> However, it does not include cost of medical expenses, long-term care insurance, transportation, or clothing. The value of the rent provided to the resident relative or parent cannot be included in the maintenance of the household test,<sup>357</sup> and the value of any practical, personal, or custodial care performed by the taxpayer is not counted.<sup>358</sup>

A qualifying person must be a “qualifying relative” under the dependency rules. This means that a relationship test, a support test, and gross income test must be met.<sup>359</sup> However, the dependency rules require taxpayers to provide over half the support of the qualifying relative, whereas the head of household rules require that taxpayers cover over half the home maintenance costs.<sup>360</sup> The head of household rules also vary depending upon whether the qualifying dependent is a relative or a parent.

When the qualifying dependent 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.<sup>361</sup> When the qualifying dependent relative is a parent, the parent need not live with the taxpayer, but the taxpayer must pay for more than half of the parent’s household costs.<sup>362</sup> When the taxpayer stays in their parent’s home, the value of the lodging the taxpayer receives must be deducted from this calculation.<sup>363</sup> Thus, the fair rental value of the lodging furnished by the parent to the taxpayer must be offset against the amount the taxpayer actually spends for the parent’s household expenses.<sup>364</sup> If, on the other hand, the parent lives 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.

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356. *Id.*

357. It also cannot be counted in the support test.

358. These would include such things as house cleaning or yard mowing as well as the time spent on caring for the elderly. See LASSER, *supra* note 281, at 24–25; see also the suggestions for reform *infra* Part IV(D).

359. I.R.C. §§ 151–152 (2018). Head of household status also available if taxpayer maintains home for a qualifying child. I.R.C. § 2(b)(1)(A)(i) (2018). Contrast with medical expense rules where dependency has on gross income test or half of the support test.

360. Thus, even if taxpayers can claim the dependent tax credit, they may not be able to qualify as head of household. 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 306, and discussion *infra* notes 378–85 and accompanying text.

361. Kaplan, *supra* note 306, at 544.

362. See LASSER *supra* note 281, at 24–25.

363. *Id.*

364. 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 head of household status. 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 281, at 25.

## 2. The Dependent Tax Credit Provides Very Meager Benefits

The TCJA eliminated the dependency exemption and adopted a new provision: the dependent tax credit.<sup>365</sup> In general, credits are better than exemptions for poorer taxpayers.<sup>366</sup> However, under the new provision the taxpayer will receive only a meager \$500 credit. This compares to a dependency exemption of \$4,150 (in 2018) and a per child credit of \$2,000.<sup>367</sup> Furthermore, this new credit is allowed only if certain dependency requirements are met. The dependent must be a citizen or national and can no longer be an alien resident of the United States or a resident of a country contiguous to the U.S, i.e., that of Canada or Mexico.<sup>368</sup> In addition, the dependent must also meet the relationship test, which includes a gross income and over half the support requirement.<sup>369</sup>

For our purposes,<sup>370</sup> any senior or other relative, such as the taxpayer's parents, step-parents, grandparents, great-grandparents, or other ancestors, can qualify under the relationship test.<sup>371</sup> Blood-related uncles and aunts will only qualify if they live in the household of the taxpayer.<sup>372</sup> Even in-laws, such as fathers-in-law and mothers-in law, removed by the death or divorce of a spouse, can qualify.<sup>373</sup>

A person qualifying as a relative or member of the taxpayer's household must have gross income less than the exemption amount. Although TCJA holds this amount is now zero,<sup>374</sup> the IRS has recently held that the gross income for purposes of the dependent tax credit will be the same as the dependency exemption amount in 2018 (\$4,150).<sup>375</sup> Thus, if

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365. I.R.C. § 24(h)(4)(A) (2018).

366. See Kaplan, *supra* note 306, at 551–59 (stating that deductions favor the wealthy).

367. I.R.C. § 24(h) (2018).

368. I.R.C. § 24(h)(4)(B) (2018). 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.” Thus, the new rule narrows the definition of “qualifying relative” and “qualifying child” to exclude those persons from Mexico who are not citizens or nationals.

369. I.R.C. § 152 (2018).

370. This can include children with no social security numbers, as well as grandchildren, great grandchildren, brothers, sisters, step-brothers, or their descendants—all of whom are not elderly. I.R.C. § 151(c) (2018).

371. It could also include brothers and sisters. I.R.C. § 152(d)(2)(C) (2018).

372. This is because members of the household including all unrelated or distantly related dependents living with the taxpayer will qualify, but only if this relationship is not “contrary to local law.” I.R.C. § 152(f)(3) (2018); see I.R.C. § 152(d)(2)(H) (2018). INTERNAL REVENUE SERVICE, DEP'T OF THE TREASURY, PUB. NO. 4491, VOLUNTEER INCOME TAX ASSISTANCE (VITA)/ TAX COUNSELING FOR THE ELDERLY (TCE), at 7-1 (2018).

373. I.R.C. § 152(d)(2)(G) (2018).

374. I.R.C. § 151(d)(5)(A) (2018). The term “exemption amount” means “zero.” *Id.*

375. Normally there would be a technical corrections bill that would correct this. Laura Saunders, *Your Kids Could Cut Your Tax Bill Like Never Before*, WALL ST. J. (Aug. 31, 2018), <https://www.wsj.com/articles/your-kids-could-lower-your-tax-bill-like-never-before-1535707850> [<https://perma.cc/AQP6-TT9R>]. (“The IRS said the indigent relative is allowed to have income equal

the dependent has interest, dividends, private pension, capital gains, and other gross taxable 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. However, if the dependent’s income consists of nontaxable gifts, veteran’s benefits, social security, tax-exempt municipal bond interest, or other excludable amounts, and these amounts are less than \$4,150 (in 2018), a dependent credit will be allowed.<sup>376</sup> Thus, a somewhat affluent elder receiving Social Security and Veteran’s Affairs (VA) benefits can qualify as a dependent under the new credit rule, whereas a taxpayer with an equal amount of money from a private pension cannot qualify.<sup>377</sup>

The support test requires a determination of what is “support” and then a determination that the taxpayer provided “over half” of that support. Support includes all the out-of-pocket cost of medical care,<sup>378</sup> transportation,<sup>379</sup> lodging, clothes, as well as the cost of meals, meals on wheels, or costs of preparing a meal.<sup>380</sup> Like the head-of-household requirement, if the taxpayer pays the rent, utilities, repairs, insurance, mortgage, or real estate taxes, this could apply towards the one-half of the support requirement.<sup>381</sup> However, the Regulations say “it will be necessary to measure the amount . . . [of the housing provided] . . . in terms of its fair market value.”<sup>382</sup> Thus, the out-of-pocket amount is not determinative but rather the rental value of the lodging is the key.<sup>383</sup> Like all the other tax tests, this support test only values the actual expenses made for the elder care, not the value of the practical, custodial, or other care services performed by the unpaid caregivers.<sup>384</sup> The Seventh Circuit specifically

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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 I.R.C. § 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) (2018).

376. See LASSER, *supra* note 281, at 312–15.

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

378. All medical expenses including care provided by a paid caregiver count in this calculation.

379. Treas. Reg. § 1.152-1(a)(2)(i) (as amended in 2012) (“[F]ood, shelter, clothing, medical, and dental care, education, and the like.”).

380. I.R.C. § 152(d)(1)(C) (2018) (if support is the test than providing food should count).

381. INTERNAL REVENUE SERVICE, DEP’T OF THE TREASURY, PUB. NO. 501, DEPENDENTS, STANDARD DEDUCTION, AND FILING INFORMATION (2018).

382. Treas. Reg. § 1.152-1(a)(2)(i) (as amended in 2012).

383. See Kaplan, *supra* note 306, 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 people’s family residences.”).

384. 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.,

held in *Markarian v. Commissioner* that taxpayers may not count the value of their unpaid services in caring for their dependent relative because no out-of-pocket expense are involved in such care.<sup>385</sup>

After support is calculated, the “over one-half” test must be met.<sup>386</sup> Here, the senior’s income, including tax-exempt interest, social security, and veteran’s benefits would be accounted for on the senior’s side of the ledger. For example, if the father provides \$1,500 of his support from Social Security (\$1,000) and interest (\$500), but son only provides \$1,450 of his dad’s support, the son does not receive the tax benefit.<sup>387</sup> The senior’s entire Social Security is counted for this test.<sup>388</sup> Because Social Security provides at least half of the income of 62% of aged beneficiaries who receive it, this support test might also be difficult to pass.<sup>389</sup>

Neither member of a married couple who files a joint return can be claimed as a dependent.<sup>390</sup> And no dependent tax credit is allowed to a married couple when one spouse is taking care of the other spouse.<sup>391</sup> 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, married couples will never be able to claim head of household status.<sup>392</sup>

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qualifies. However, under both tests, the value of the services performed by unpaid relatives in providing elder care is not considered.

385. *Markarian v. Comm’r*, 352 F.2d 870, 872 (7th Cir. 1965).

386. I.R.C. § 152(d)(3) (2018). Adult children can take turns caring for their parents or other relatives and can sign a “multiple support agreement.” Before the TCJA, if together the children met the “over one-half of the support” test of the otherwise qualifying dependent, and one child was giving more than 10% 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. This allowed the children to share the benefit of the dependency exemption by alternating the exemption each year. 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 (no one person can contribute over one-half of such support. Rather, 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, and the taxpayer must have contributed over 10% 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.). See Kaplan, *supra* note 306, 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.”).

387. See Treas. Reg. § 1.152-1(a)(2)(ii) (as amended in 2012).

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

389. OFFICE OF RESEARCH, EVALUATION & STATISTICS, SOC. SEC. ADMIN., PUB. NO. 13-11785, FAST FACTS & FIGURES ABOUT SOCIAL SECURITY (2017).

390. I.R.C. §§ 152(b)(2), (c)(1)(E) (2018). In this case, it may be more advantageous from a tax standpoint for the elderly parents to file separately.

391. However, the married couple will get the benefit of income splitting.

392. See *supra* note 352 and accompanying text. Only the refundable portion of the per child credit is adjusted for inflation under TCJA of 2017. I.R.C. § 24(h)(5)(B) (2018).

### 3. The Dependent Care Tax Credit Helps Those that Work and Care

The dependent care credit and the dependent care assistance exclusion deliver limited benefits<sup>393</sup> to the unpaid taxpayer caregiver who must also perform market work.<sup>394</sup> A taxpayer cannot claim the benefits of both provisions for the same dollar of expense.<sup>395</sup> The expense must be for the care of dependent parents or other qualifying relatives.<sup>396</sup> Even if a parent or relative does not qualify as “dependent” for the dependent tax credit (because their income exceeds the exemption amount), he or she can still be declared dependent for purposes of this provision, just like they would for the payment of medical expenses.<sup>397</sup> The size of the credit is variable, depending upon the level of care expenses and the number of dependents.<sup>398</sup> In addition, it is phased down as taxpayer income increases.<sup>399</sup>

The maximum amount of care expenses that are calculated in the credit is \$3,000 for one dependent and \$6,000 for two or more dependents.<sup>400</sup> This is far less than even the low range for this kind of care as yearly expenses for ADCs can easily surpass \$17,000 a year.<sup>401</sup> Since many care providers are “sandwiched,” it may be possible that they send their children to daycare at the same time as they send their parent to adult care. Thus, they would use the \$6,000 amount. However, under the dependent care assistance plan a slightly higher amount is available for one dependent. Under this plan, a taxpayer can exclude from gross income up to \$5,000 of earned income.<sup>402</sup> This exclusion is not phased down for higher income taxpayers. Thus, with only one dependent, the tax benefit of the exclusion is much better for the wealthier taxpayer than the credit.

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393. I.R.C. §§ 21, 129 (2018); *see also* INTERNAL REVENUE SERVICE, DEP'T OF THE TREASURY, PUB. NO. 503, CHILD AND DEPENDENT CARE EXPENSES (2018). Sections 21 and 129 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 (dependent care assistance) and limitations (earn income limitation). Both provide that the exclusion or credit is limited to the earned income of the lesser-earning spouse. I.R.C. § 21(d)(1) (2018), I.R.C. § 129(b)(1)(B) (2018).

394. I.R.C. § 21(b)(2) (2018) (employment related expenses are expenses incurred for the care of a qualifying individual to allow the taxpayer to be gainfully employed).

395. I.R.C. § 129(e)(7) (2018).

396. I.R.C. § 21(b)(1) (2018).

397. I.R.C. § 21 (b)(1)(B) (2018).

398. I.R.C. § 21(c)(2) (2018) (the amount could be \$6,000 in the case of two dependents).

399. I.R.C. § 21(a)(2) (2018) (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%).

400. I.R.C. § 21(c) (2018).

401. *See supra* notes 139–49 and accompanying text.

402. *See* I.R.C. § 129(a)(1) (2018).

*E. The Tax System Provides Inadequate Benefits to the Low-Paid Caregiver*

In general, the tax benefits for paid caregivers are quite limited. 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. Family relatives who provide care and receive certain payments under a Medicaid waiver program may also be able to exclude these payments from their income.<sup>403</sup> Finally, an earned income credit may be available for the low-paid care provider.

1. The Exclusion for Meals and Lodging

A great fringe benefit accorded to paid caregivers is the exclusion for meals and lodging provided on the business premises for the convenience of the employer.<sup>404</sup> Since the largest portion of a person's personal budget goes for rent and food, an exclusion for these amounts can provide a substantial financial benefit. For example, if the senior employer provides meals and lodging worth \$3,000 a month, that would be \$36,000 a year. This exclusion could incentivize live-in care, taking paid caregivers away from their families. However, most paid caregivers do not live in the house of the receiver of care. Under FLSA regulations, live-in care providers hired by a third-party agency or who qualify as a health aide must be paid minimum wage and overtime. Thus, this type of home care may only be affordable to the very wealthy.<sup>405</sup> Typically, the senior will be paying just for the care provider's meals. 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.<sup>406</sup> This rule might be similar to the gross income requirement discussed earlier under the dependent tax credit provision—a mistake by the legislature that needs to be technically corrected by Congress or by the IRS. However, if this is not a mistake, this non-deductibility for meals plus the FLSA wage requirements would

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403. INTERNAL REVENUE SERVICE, DEP'T OF THE TREASURY, PUB. NO. 907, TAX HIGHLIGHTS FOR PERSONS WITH DISABILITIES (2018), <https://www.irs.gov/pub/irs-pdf/p907.pdf> [<https://perma.cc/A8TQ-AT36>]. In addition, the caregiver may also get car expenses for caregiving, calculated at 14 cents per mile. Press Release, Internal Revenue Service, 2016 Standard Mileage Rates for Business, Medical and Moving Announced (Dec. 17, 2015), <https://www.irs.gov/uac/Newsroom/2016-Standard-Mileage-Rates-for-Business-Medical-and-Moving-Announced> [<https://perma.cc/R465-9RC9>].

404. 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, 28 T.C.M. (CCH) 1194 (1969).

405. *See* discussion *supra* Section II(A)(3).

406. *See* I.R.C. § 274(o)(2) (2018) (stating meals provided for convenience of employer under Section 119(a) are no longer allowed as a deduction).

disincentivize living with the elderly, thus encouraging institutionalization for those requiring such care.

## 2. The Exclusion to Caregivers for Amounts Paid Under Medicaid

In general, family care providers can be paid for their labors by loved ones, but compensation for these services results in taxable income under federal and state law.<sup>407</sup> The care provider is also obligated to pay self-employment taxes or social security tax on these earnings.<sup>408</sup> Under Medicaid rules, parents can enter into personal care contracts with their children or a friend (or others) and still comply with eligibility requirements.<sup>409</sup> The relative or friend can receive Medicaid payments that are excludable from the recipient's income.<sup>410</sup> These rules also permit children to retain their parent's house if they live with their parents and have provided care for at least two years.<sup>411</sup> If the care-receiver promises an inheritance to a family caregiver, on the other hand, the will provisions will most likely take precedent over any implied care contracts.<sup>412</sup>

## 3. The Earned Income Credit

Both the paid worker in the home and the unpaid caregiver who works in the marketplace may be able to receive benefits from the earned income credit.<sup>413</sup> This is a refundable credit to those who work, are poorly paid, and bear a disproportionate tax burden for paying social security taxes at a flat rate with no exemption. The chief problem of this credit is

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407. I.R.C. § 61(a)(1) (2018) (“Gross income means all income from whatever source derived, including . . . [c]ompensation for services.”).

408. *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> [<https://perma.cc/V9G7-E5EP>].

409. See David L. Rice, *Elder Law and the Tax Practitioner: How to Navigate the Murky Waters*, TAX DEV. J., Spring 2011, at 1; Sheena J. Knox, Note, *Eldercare for the Baby-Boom Generation: Are Caregiver Agreements Valid?*, 45 SUFFOLK U. L. REV. 1271 (2012).

410. These would fall under the welfare exception. See Seto & Buhai, *supra* note 277.

411. OFFICE OF ASSISTANT SEC'Y FOR POLICY AND EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAID TREATMENT OF THE HOME: DETERMINING ELIGIBILITY AND REPAYMENT FOR LONG-TERM CARE (2005), <https://aspe.hhs.gov/basic-report/medicaid-treatment-home-determining-eligibility-and-repayment-long-term-care> [<https://perma.cc/5866-8Q85>] (“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 recipient[']s 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 (2018).

412. See Marshall B. Kapp, *For Love, Legacy, or Pay: Legal and Pecuniary Aspects of Family Caregiving*, 14 CARE MGMT. J. 205, 210 (2013).

413. Qualification for and the amount of the credit available depends on earned income, marital status, and dependents claimed. See I.R.C. § 32 (2018).

that it is totally inadequate,<sup>414</sup> particularly for caregivers who do not have children.<sup>415</sup> Expansion of this credit would make sense, as this is an instance in which the interests of caregivers intersect with those receiving needed care.<sup>416</sup>

#### IV. PROPOSALS FOR REFORM

In the legislative arena, tax proposals and policy directives generally favor the values of personal responsibility over those attached to caring. If one samples the legislative proposals in this area, savings, paid work, and education receive subsidies. On the care front, out-of-pocket expenditures for support measures are subsidized; meanwhile, unpaid care labor provided by family members and friends goes unacknowledged and is ineligible for benefits. In addition, proposed credits are not refundable, rendering them worthless to low-income people who do not have any tax liability.

A reformulation of care priorities starts with bold tax policy initiatives.<sup>417</sup> Refundable credits must be available to both the poor care-receiver and the unpaid caregiver. Furthermore, unpaid caregiving must be valued in the medical deduction, dependent tax credit, and other provisions of the Code. The earned income credit should treat qualifying relatives just like a qualifying child. Finally, revenues must be generated to pay for these reforms.

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414. See Sara Sternberg Greene, *The Broken Safety Net: A Study of Earned Income Tax Credit Recipients and a Proposal for Repair*, 88 N.Y.U. L. REV. 515 (2013) (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 Zelenak, *Redesigning the Earned Income Credit as a Family-Size Adjustment to the Minimum Wage*, 57 TAX L. REV. 301 (2004).

415. 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> [<https://perma.cc/PKH5-PWBS>].

416. *Id.* See suggestions for modification of this provision, *supra* Section IV(E); 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).

417. In my analysis, some of the tax policy criteria originally discussed by Joseph T. Sneed in his article *The Criteria of Federal Income Tax Policy* are referenced. 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.* (emphasis added). 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. A Sampling of Proposed Statutes*

A sampling of bills introduced into Congress illustrates how the values of personal responsibility and the market are emphasized over the values of caring and relationships. The first type of legislative proposal is one that encourages retirement savings, both for the worker and to the employer. For example, the Retirement Savings and Security Act of 2005<sup>418</sup> proposed a nonrefundable saver's tax credit for low and middle-income workers to contribute to employment retirement plans and specifically to protect women from exhausting their retirement funds. It also suggested an annuity that would ensure that the money lasts over the woman's lifetime. Similarly, the Women's Retirement Security Act of 2005 increased the retirement savings ceiling for women, while also allowing them to take time off from work and still contribute to their plans.<sup>419</sup> This bill even provided subsidies to small businesses to provide savings plans for these part-time women workers and tried to increase the financial literacy of women by allowing taxpayers to exclude from their income any qualified retirement planning services.<sup>420</sup> More recently in 2017, Rep. Richard Neal (D-Mass.) of the House Ways & Means Committee, introduced a bill that would have required most business with more than ten workers to offer retirement plans that automatically enroll their employees. Also, in 2019, a bipartisan bill sponsored by Sen. Rob Portman (R-Ohio) and Ben Cardin (D-Md.) would give employees incentives to increase the standard default contribution rate to 6% (from 3%) with the eventual goal of raising employees' savings rates to 10% per year. The bill also encourages creation of 401(k)-style plans designed to generate savings amounts sufficient for participants to transfer their balances into lifetime annuities.

These proposals are flawed because they do not address underlying contributions to the problem. Women save less because they are paid less than men in the marketplace. Additionally, women allot more non-market time to caregiving and family responsibility and spend a higher proportion of their discretionary incomes. Women simply have a lower ability to save significant sums or devote higher contribution rates to their retirement plans relative to men.

A second type of legislative proposal focuses on employment and work issues. For example, in The Older Worker Opportunity Act of 2005, employers were subsidized so they could hire and retain older workers.<sup>421</sup>

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418. Proposed by Senator Gordon Smith and Gaylord Conrad in 2005, S. 1359, 109th Cong. (2005).

419. See Morris, *supra* note 5, at 601.

420. *Id.*

421. Proposed by Senator Herb Kohl in 2005. S. 1826, 109th Cong. (2005).

More recently, in 2017, the Geriatrics Workforce and Caregiver Enhancement Act attempted to address elder care workforce shortages.<sup>422</sup> However, it attempted to address this challenge, not by providing fiscal support (through refundable credits) for caregiving activity, but through supports for geriatrics education and training. Subsidies to employers only tangentially impact women, and then only marginally. Refundable credits to both caregivers and care-receivers are the most direct and efficient means of creating that critical link that can close the “care gap” that afflicts our elder population, particularly those who exist on the economic margins. Work-readiness programs do nothing to address the real dual issues of undervaluation of care labor coupled with the lack of affordability for the most vulnerable in need of caregiving services.

A last type of legislative proposal involves subsidizing out-of-pocket expenditures made for elder care. Some of these proposals are tied to work,<sup>423</sup> but most are not. A good example of this type of proposal was one introduced by Senator Barbara Mikulski (D-Md.) called the Family Caregiver Relief Act in 2003.<sup>424</sup> Supported by co-sponsors, such as (then) Senators Hillary Clinton (D-NY) and Edward Kennedy (D-Mass.), this bill provided a nonrefundable credit for actual out-of-pocket expenses (up to \$5,000) for adult day care, custodial, and respite care. Similarly, the Senior Elder Care Relief and Empowerment Act of 2005 proposed a credit (again nonrefundable) for “qualified elder care expenses.”<sup>425</sup> More recently, the Americans Giving Care to Elders (AGE) Act of 2018 contained a nonrefundable credit of up to \$6,000 for these fundamental categories of adult day care, custodial, respite, and medical care.<sup>426</sup> Such proposals suffer the basic deficiency of assuming that recipient parties possess adequate resources to initially *afford* caregiving services, let alone meet income thresholds high enough to makes use of these credits. Again, the basic question of access to quality care is ignored in such legislation. Moreover, the central component of nonrefundable credits in these proposals ensures full benefit only for taxpayers with incomes high enough to incur tax liability.<sup>427</sup> Poorer citizens are not only left out of this loop but also reduced to increased reliance upon unpaid family or volunteer care.

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422. H.R. 3713, 115th Cong. (2017).

423. See H.R. 323 introduced in 116th Cong. on January 8, 2019, which appears identical to H.R. 329 introduced the previous session, on January 5, 2017 in the 115th Cong.

424. S. 1214, 108th Cong. (2003) (discussed by Richard L. Kaplan, *supra* note 306).

425. S. 835, 109th Cong. (2005).

426. S. 3028, 115th Cong. (2018).

427. See Morris, *supra* note 5, at 605 (describing President Clinton’s nonrefundable caregiver tax credit proposal of 1999).

*B. A Refundable Credit for the Poor Care-Receiver*

Policymakers should adopt refundable credits as major assist tools to aid lower-income care-receivers who live on their own. Such provisions make sound sense, for as we have seen, many low-income elderly women cannot afford the added expenses for increased health maintenance and long-term care needs on top of their already marginal abilities to live independently. Refundable credits enhance women's sense of autonomy, exercise of individual choice, and flexibility in directing critical funds to the types of care that best fit their needs. It could—if applied in tandem with like-minded credits for unpaid caregivers—act as viable alternatives to institutionalization. It could also act as a practical and functional “equalizer” for many rural populations that endure significantly lower access to effective and affordable elder care options relative to their urban counterparts. Many have argued over the years for a universal basic income or negative income tax as a means of building in a measure of broad-based income security for our most vulnerable citizens, but one with some qualifying measures based on need and age appear to be the most efficient, fair, politically palatable, and least expensive.<sup>428</sup>

Such a credit would support home care. By encouraging home care, the government comports with the wishes of the vast majority of seniors who desire to age in place.<sup>429</sup> Such a proposal would also relieve some of the growing financial strain generated by increasing costs of the social safety net and thus save taxpayer dollars.<sup>430</sup> It would comport with the recommendations made by the National Academies of Science to eliminate “perverse financial incentives” that encourage expensive hospital and nursing home procedures.<sup>431</sup> It could help save the U.S. taxpayer millions of dollars paid on expensive nursing home care.

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428. Samuel Hammond, *Universal Basic Income Tax is Just Like a Negative Income Tax with a Leaky Bucket*, NISKANEN CTR. (June 6, 2016), <https://niskanenctr.org/blog/universal-basic-income-is-just-a-negative-income-tax-with-a-leaky-bucket/> [<https://perma.cc/YE8T-NVMK>].

429. Joseph L. Matthews, *Does Medicaid Cover Long-Term In-Home Care?*, CARING.COM, <https://www.caring.com/questions/medicaid-in-home-care> [<https://perma.cc/3NC9-VD8B>] (discussing how waivers from the normal rules can be received by states to provide home care); see also Laura Snyder & 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/> [<https://perma.cc/Q548-YV8Y>] (“A program as large as Medicaid will always be a focus of budget scrutiny at the state and federal levels.”).

430. In 2013, state and federal governments spent approximately \$130 billion on long-term care services. See U.S. SENATE COMMISSION ON LONG-TERM CARE, Y 3.2:L 85/R 29, REPORT TO CONGRESS (2013), <http://www.medicareadvocacy.org/wp-content/uploads/2014/01/Commission-on-Long-Term-Care-Final-Report-9-18-13-00042470.pdf> [<https://perma.cc/2UXW-EM2V>]; Carol Raphael et al., *Financing End-of-Life Care in the USA*, 94 J. ROYAL SOC. MED. 458, 458 (2001) (finding a growing number of people are choosing to die in their homes).

431. See DYING IN AMERICA, *supra* note 124.

Many European countries give direct subsidies in the form of cash allowances to care-receivers or to family care providers.<sup>432</sup> A refundable credit regime could accomplish a number of similarly desirable policy objectives here in the U.S.<sup>433</sup> It may also be more politically palatable since it may be perceived as directed at a specific beneficial activity rather than doled out as a direct “handout.”<sup>434</sup> Such a benefit set would also materially advantage both care-receivers and their caregivers. The amount of the subsidy could vary, but standard levels (using the European examples) fall in the \$3,000 to \$5,000 range annually.<sup>435</sup> To confirm eligibility for these subsidies, means-tests could easily be applied to both income and asset bases.

### C. A New Refundable Credit for the Unpaid Caregiver

As alluded to earlier, an important adjunct to refundable credits for care-receivers is enactment of a refundable credit for *unpaid* caregivers. Unpaid care is a principal component of the larger, long-term care matrix—especially when applied to populations at the margins of economic viability—because most people prefer to dwell in their houses to be cared for family and friends.<sup>436</sup> Family caregivers routinely suffer

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432. 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). Asian countries handle this 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* (Apr. 29, 2014) (unpublished M.A. thesis, Virginia Polytechnic Institute and State University), [https://vtechworks.lib.vt.edu/bitstream/handle/10919/48419/Kanti\\_M\\_T\\_2014.pdf?sequence=1](https://vtechworks.lib.vt.edu/bitstream/handle/10919/48419/Kanti_M_T_2014.pdf?sequence=1) [<https://perma.cc/3XSA-LUM9>].

433. Stanley S. Surrey, *Tax Incentives as a Device for Implementing Governmental Policy: A Comparison with Direct Government Expenditures*, 83 HARV. L. REV. 705 (1970) (arguing that tax incentives are generally inferior to direct subsidies as a means of achieving economic, social, or equitable goals.).

434. 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](http://www.nytimes.com/2015/12/19/us/congress-spending-bill.html?_r=0) [<https://perma.cc/LV75-S3C2>].

435. EUROPEAN SOC. NETWORK, *SERVICES FOR OLDER PEOPLE IN EUROPE* 13 (2008), [https://ec.europa.eu/health/sites/health/files/mental\\_health/docs/services\\_older.pdf](https://ec.europa.eu/health/sites/health/files/mental_health/docs/services_older.pdf) [<https://perma.cc/WLA3-JP26>].

436. A PLACE TO START, *supra* note 202, 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 Senate Bill 1031 was introduced which provided a tax credit of \$3,000 to the “eligible caregiver” of an “applicable individual.” S. 1031, 108th Cong. (2003). 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). In 2003, Senators Hillary Clinton and Edward Kennedy introduced the “Family Caregiver Relief Act of 2003.” S. 1214, 108th Cong. (2003). The Bill based the tax benefit on actual out-of-pocket expenses. This provision was phased out for higher income taxpayers.

from a diminished ability to save as well as significant losses in income and earnings.<sup>437</sup> Given the chronic shortage of care providers, support for this type of care should be a priority.<sup>438</sup> A definition of unpaid care providers would need to be arrived at, and a combination of out-of-pocket expenses plus a calculation of time spent in care activities would be part of this equation. This provision should apply to care supplied to chronically ill persons as well as other disabled relatives, even if their conditions do not fit the formal contours of chronic illness.<sup>439</sup> Similarly, this broadening of its dimensions should include “qualifying relatives” as well as loved ones living in the taxpayer’s household, similar to those now defined in Section 152, but without a support or gross income test. One possible measure creates a \$3,000-to-\$5,000 income-tied, refundable credit similar to the existing per child credit and the previously described refundable credit proposed for care-receivers. In cases in which there are more than one caregiver, processes such as those contained in “multiple support agreement” could be applied.<sup>440</sup> This credit could be designed to phase-out for wealthy taxpayers, since a chief thrust of its implementation is meant to provide a measure of relief for caregivers who reduce their own marginal economic well-being to engage in vital support work for their loved ones.

An alternative option could adopt expansion of the dependent tax credit. This acted to replace the dependency exemption in the TCJA but has proven woefully inadequate in this mission. The meager \$500 credit should be increased to dimensions that more closely match the new \$2,000 per child credit. Certain features of this credit, such as the dependency definition for a qualifying relative, should be altered to eliminate the gross income test or reformulated along the contours of the basic standard deduction plus the additional standard deduction. This provision should also feature refundability. Such a measure would allow married couples,

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437. See discussion *supra* Section I(D); see also Jason A. Frank, *The Necessity of Medicaid Planning*, 30 U. BALT. L.F. 29, 32 (1999).

438. See Maja Lopez-Hartmann et al., *The Effect of Caregiver Support Interventions for Informal Caregivers of Community-Dwelling Frail Elderly: A Systematic Review*, 12 INT’L J. INTEGRATED CARE 2 (2012). The estimated cost of allowing this is \$428 million by 2009. See JOINT COMM. ON TAXATION, *Estimated Budget effects of the Conference Agreement for H.R. 2488: Fiscal years 2000–2009* (Aug. 5, 1999), <http://www.jct.gov/x-61-99r.pdf> [<https://perma.cc/8GU5-THSD>].

439. Joshua M. Weiner, *Pitfalls of Tax Incentives for Long-Term Care*, URB. INST. (2000) <https://www.urban.org/sites/default/files/publication/64021/900205-Pitfalls-of-Tax-Incentives-For-Long-Term-Care.pdf> [<https://perma.cc/RGJ2-NBTC>]. 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 et al., *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> [<https://perma.cc/A8PZ-RT5Z>].

440. I.R.C. § 152(d)(3) (2018); see multiple agreement discussion in Kaplan, *supra* note 306.

particularly two-earner couples who do not benefit either from income-splitting or head of household status, to receive a meaningful subsidy for providing support to their parents or other elder dependent relatives. It logically follows that fairness decrees that two-earner couples who “maintain a household” or provide over half the support for a parent or other “qualifying relative” deserve a substantial tax credit. Again, the incurring of expenses or out-of-pocket cost for care is distinct from the provisions of care for no pay, though both exert an economic price. The Tax Code should properly recognize both categories of activity attached to care endeavors and provide support accordingly. In many cases, such combined taxation benefits can forestall unnecessary institutionalization and the additional taxpayer burdens that accompany such misfortunes.

#### *D. Value Caregiving for the Unpaid Caregiver*

No policy reform regime in the elder care realm will prove fully effective without explicit acknowledgement 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, the earned income credit, and the dependent definition in the head of household status provision ignore the value of care contributed by the unpaid care worker, but rather focus on the out-of-pocket expenses for care. This situation *demand*s change. Once the determination has been made that this category of labor has tangible economic worth, the key formal tasks are those of calculating reasonable figures of time and labor value for making workable the pertinent tax provisions. The care valuation, for example, could be tied directly to periods of leave from the caregivers’ primary employment, subject to a designated formula. Most employers already maintain sophisticated systems for tracking employees’ work logs and schedules. Calculation of worktime lost would generally involve only routine recordkeeping. Moreover, doctors could certify that the care provided was medically or therapeutically necessary. If a taxpayer takes leave under the FMLA, a similar set of calculations could be employed based on the average time of worktime lost for the purpose of caregiving, again subject to medical confirmation of necessity. If the taxpayer is not employed, the time calculation could be determined by a medical evaluation of the estimated time investment required to aid the chronically ill elder, subject to a forty-hour limit.

A mechanism for determining a remunerative value on heretofore unvalued labor may be approached in several ways. Viewed from a minimum valuation perspective, the base calculation would equal the state or local minimum wage or federal prevailing wage rate. Using the federal minimum wage as an example, if a taxpayer takes twelve weeks of unpaid

family leave to devote care to a chronically ill parent, a forty-hour weekly investment at \$7.25 per hour yields a total care value of \$3,480. On the upper end of the valuation calculation, the value of the care labor may equal the caregivers' current market wage, subject to a ceiling.

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

The earned income credit (EIC) is intended to encourage low-income taxpayers to work. Expansion of this credit to apply to caregiving could prove beneficial to both those who work a low-paying market job in addition to providing unpaid care, and to low-wage workers employed in the caregiving trade.<sup>441</sup> Under this current EIC regime, the largest benefits are realized by single taxpayers with multiple dependent children. This credit should be broadened to more favorable dimensions when a taxpayer cares for a "qualifying relative." The current requirement that the taxpayer must be twenty-five years of age to qualify for the credit should be eliminated. Support designed to encourage desirable behavior should commence at the earliest opportunity an individual can adopt such behaviors, not determined by arbitrary dictates of a calendar.

As the provisions of the credit currently stand, taxpayers who are single and have two "qualifying children" garner the largest refundable earned income credit amount. If the credit were expanded to include dependents such as those designed as "qualifying relatives" under Section 152, then care for elderly dependents would be granted similar status as dependent children.

The EIC could play a role in redressing a conspicuous inequity in taxation policy. At present, the EIC discriminates against those under twenty-five years of age as well as low-income individuals who are childless. Expansion of credit size and eligibility could yield the double dividend of providing tools of stabilization for some of our most economically vulnerable populations, and it would serve to provide incentive for more paid caregivers to maintain their station in a field known for its high turnover and chronic shortages of available participants. Such EIC revisions could act to jointly aid the interest of caregivers and care-receivers alike.

*F. Increase Tax Revenues on the Wealthy to Finance Elder Care Reform*

Achievement of the important reforms outlined above will require creation of fresh tax revenue sources, either through new funding regimes

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441. The EIC is available based on earned income, marital status, and the number of dependents. I.R.C. § 32 (2018). See also *Earned Income Tax Credit (EITC)*, IRS.GOV (Mar. 11, 2016), <https://www.irs.gov/Credits-&-Deductions/Individuals/Earned-Income-Tax-Credit> [<https://perma.cc/RGL3-YNUT>].

or increases in existing ones. All of these proposals require a public sector response by simple virtue of the perpetual failure of the existing market system to acknowledge or account for the vast economic values represented in execution of elder and long-term care activities. As a first step to raising adequate funds, an increase of the existing 3.8% Medicare tax on net investment income is necessary. This tax is levied on wealthy taxpayers and is relatively easy to administer. It makes sense on both simplicity and equity grounds. A second important measure to be considered is expansion of the social security income tax base. At the minimum, the current taxable ceiling from wage labor income should be raised from its current level of \$132,900. The rationale for this is simple. Wealthy taxpayers derive a higher proportion of their incomes from unearned sources than other taxpayers. Those unearned sources are not subject to social security and Medicare taxes, meaning that this group of high-income earners provide less than their fair share to the entire family of critically important social safety net programs. Lastly, wealthy recipients of Medicare could pay a levy based on a portion of the fair market value of their long-term care benefits received. The most likely outcome will be a “tapestry” system of *ad hoc*, uncoordinated measures working in loose combination, much as the aggregate U.S. tax system as a whole has operated for generations.

#### V. CONCLUSION

Long-term care, and how to pay for it, is one of the central issues facing women today. It is a particularly pressing concern given the basic facts that women generally outlive men, experience higher rates of debilitating conditions, and are less wealthy—all factors that increase women’s risk of late-life poverty and/or institutionalization. This Article argues that tax laws should be augmented to elevate the value of care labor while offering greater autonomy for those receiving this vital care. The principles of personal responsibility, including the touted virtues of thrift and industriousness, are given short shrift in a political, legislative, and market matrix that chronically undervalues care labor and process. The tools of tax policy offer powerful potential to open remedial paths for the greater public good. A mix of policy measures can begin to reverse the damage visited upon elderly women, particularly those in rural areas or who already dwell in poverty, doubly inflicted by markets and governments that have denied the true value of this essential care. Efforts aimed at increasing individual autonomy and exercise of choice concurrently reduce outcomes that result in forced institutionalization. A refundable credit for both care-receiver and provider, expansion and liberalization of the dependent tax credit and earned income credit, as well

as explicitly recognizing the value of unpaid care, represent practical initial steps. In addition, tax revenues need to be raised in commensurate measure to support this higher valuation on care activities. Attention to elevating the station of caregiving activities to reflect higher market and policy values is an investment in elevating our collective social and moral values.