NOTES

INCENTIVIZING THE CARE OF ADULT FAMILY MEMBERS THROUGH A TWO-PART TAX CREDIT

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In the United States, nearly thirty-four million individuals provide informal care for their adult family members each year. Adult care recipients experience positive emotional and health-related outcomes when cared for by relatives, but this responsibility also places significant stress on caregivers. The government should subsidize and encourage family adult care, not only because of these social impacts, but also because this care can reduce healthcare costs. Family caregivers help their relatives avoid expensive institutional care and are also cost-efficient providers of care due to their relationships with the care recipients. The tax code is an effective and politically palatable vehicle through which the government can provide this subsidy, despite some structural limitations. However, existing and recently proposed tax incentives do not adequately target the benefits associated with family caregiving. Therefore, this Note proposes a new two-part advanced refundable tax credit that will help the government reduce costs and enhance social benefits.

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INTRODUCTION

Samuel[1] is eighty-five years old and has suffered from major health events since age fifty-five, including a below-the-knee leg amputation, several heart attacks, and a stroke. He cannot perform many daily tasks and requires skilled nursing care, so a part-time professional aide covered by Medicare assists him. When she is not there, his wife, also over eighty years old, and daughter, who lives thirty minutes away and is raising three children, care for him. Although Samuel cannot physically care for himself, he is mentally alert. He wants to continue living in his own home, and he gets frustrated when others

[1] The stories of Samuel and Amy have been fictionalized, but they are based on the experiences of family and friends of the author. Their names have been changed to protect their privacy.

imply that he is incapable of forming his own opinions. After all, he has taken care of himself his whole life: He started working when he was eighteen, fought in a war, and raised and provided for a family of five. Even though his body cannot perform many functions that it formerly could, he does not want to lose control over his life.

Amy is in a much different situation than Samuel. She is ninety-six years old and lives alone, without any serious restrictions on her physical or mental activities. Though she can generally get along on her own, her son visits several times a week to help her with important tasks, such as grocery shopping and traveling to doctors' appointments. Amy is not eligible for any state or federal healthcare programs due to her high functional and mental capacity. Her son is a sixty-seven-year-old retiree who has two adult children and is starting to experience his own health concerns, but he feels blessed that his mother has remained in his life for so long.

While many individuals hope to remain independent forever, at a certain point in life, most will require aid to maintain healthy lives. For some, such as Samuel, this consists of serious medical attention beginning at an early age, while others, such as Amy, simply require help shopping for groceries near the ends of their lives. In the United States in 2015, 33.83 million individuals informally provided this assistance to adult relatives.[2] Informal family care is prevalent because individuals prefer to receive aid from those with whom they share relationships.[3] It also adheres to social norms[4] and allows care recipients to maintain autonomy and flexible care schedules.[5] Caregiving,

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[2] *See* AARP PUB. POLICY INST. & NAT'L ALL. FOR CAREGIVING, CAREGIVING IN THE U.S. 2015, at 6, 20 (2015) [hereinafter CAREGIVING IN THE U.S. 2015] (reporting that 39.8 million informal caregivers provided care to an adult and eighty-five percent of those caring for an adult provided care to a relative). Informal caregivers provide about $470 billion worth of care per year. Dhruv Khullar, *Who Will Care for the Caregivers?*, N.Y. TIMES (Jan. 19, 2017), https://www.nytimes.com/2017/01/19/upshot/who-will-care-for-the-caregivers.html.

[3] *See* Bridget Haeg, *The Future of Caring for Elders in Their Homes: An Alternative to Nursing Homes*, 9 NAELA J. 237, 240 (2013) ("The intimate nature of some personal assistance tasks, combined with care from a familiar face, makes it a comfortable alternative to hiring strangers."). Due to this familial relationship, studies have suggested that individuals may pay close attention to their relatives' health, leading to positive care outcomes. *See* Karen Syma Czapanskiy, *Disabled Kids and Their Moms: Caregivers and Horizontal Equity*, 19 GEO. J. POVERTY L. & POL'Y 43, 55 (2012).

[4] *See* Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 VA. TAX REV. 509, 511 (2005) (noting that the phenomenon of informal, long-term care by friends and family "reflects a wide range of cultural norms in this country").

[5] *See* Daniela Kraiem, *Consumer Direction in Medicaid Long Term Care: Autonomy, Commodification of Family Labor, and Community Resilience*, 19 AM. U. J. GENDER SOC. POL'Y & L. 671, 694 (2011) (noting that home care allows for care during convenient, non-traditional hours). Homecare is also in line with patients' preferences. Laura T. Tetrault & William J. Brisk, *Help Clients Assess Alternatives to Nursing Home Care*, 42 ELDER &

however, produces substantial financial,[6] emotional,[7] and physical stress.[8] As baby boomers age, the need for this care and the pressure on relatives to provide it will only continue to rise.[9] In recognition of the plight of family caregivers, academics, politicians, and other stakeholders have actively debated the suitability of a caregiving subsidy.[10] In fact, both major party candidates in the 2016 presidential election proposed a subsidy for family caregivers.[11] In 2018, Congress passed the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act,[12] which calls for the development of a national strategy to support family caregivers and creates an advisory body of stakeholders from both the private and public sectors.[13]

DISABILITY PLAN. 42, 43 (2015) ("Most clients emphatically prefer to remain in their homes as long as possible and receive care at home when necessary.").

[6] *See* CAREGIVING IN THE U.S. 2015, *supra* note 2, at 10 ("About one in five caregivers reports experiencing financial strain . . . ."); METLIFE MATURE MARKET INST., THE METLIFE STUDY OF CAREGIVING COSTS TO WORKING CAREGIVERS: DOUBLE JEOPARDY FOR BABY BOOMERS CARING FOR THEIR PARENTS 15 (2011), https://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf (estimating the financial losses sustained by the average informal caregiver who leaves the workforce to care for a parent to be about $300,000).

[7] *See* METLIFE MATURE MARKET INST., *supra* note 6, at 16 (finding that adult caregivers reported that they lost time with friends and family and experienced lower levels of health, including thirty-one percent reporting stress, anxiety, or depression); Khullar, *supra* note 2 ("[T]hose who experienced mental or emotional stress while caring for a disabled spouse were 63 percent more likely to die within four years than noncaregivers . . . .").

[8] *See* CAREGIVING IN THE U.S. 2015, *supra* note 2, at 10 ("One in five caregivers reports a high level of physical strain resulting from caregiving . . . ."); Khullar, *supra* note 2 ("[L]ong-term caregivers have disrupted immune systems even three years after their caregiving roles have ended.").

[9] *See* DONALD REDFOOT ET AL., AARP PUB. POLICY INST., THE AGING OF THE BABY BOOM AND THE GROWING CARE GAP: A LOOK AT FUTURE DECLINES IN THE AVAILABILITY OF FAMILY CAREGIVERS (2013), https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf.

[10] *See* Haeg, *supra* note 3, at 247–54 (discussing the policy debate concerning family care subsidies); Patricia San Antonio et al., *Lessons from the Arkansas Cash and Counseling Program: How the Experiences of Diverse Older Consumers and Their Caregivers Address Family Policy Concerns*, 22 J. AGING & SOC. POL'Y 1, 2–3 (2010) (same).

[11] Howard Gleckman, *Donald Trump's Plan to Support Family Caregivers*, FORBES (Sept. 14, 2016, 11:40 AM), https://www.forbes.com/sites/howardgleckman/2016/09/14/donald-trumps-plan-to-support-family-caregivers.

[12] RAISE Family Caregivers Act, Pub. L. No. 115-119, 132 Stat. 23 (2018) (to be codified at 42 U.S.C. § 3030s note).

[13] Robin Seaton Jefferson, *Congress Passes, Trump Signs RAISE Family Caregivers Act 'Elevating Caregiving to a Priority*,' FORBES (Jan. 24, 2018, 2:30 AM), https://www.forbes.com/sites/robinseatonjefferson/2018/01/24/congress-passes-trump-signs-raise-family-caregivers-act-elevating-caregiving-to-a-priority.

This Note contributes to this debate. Part I establishes the necessity of targeting a subsidy solely at family adult care, rather than at all informal care. Part II argues that this care should be subsidized in order to reduce healthcare costs and generate social benefits. Though previous literature has explored these benefits, this Note is the first to consider the manner in which relatives' internal motivation to care for their loved ones can be utilized to generate cost-efficient care. Part III then determines that the tax code is an effective way to provide this subsidy. Part IV evaluates the existing tax code's success at generating cost-savings and acknowledging the unique characteristics of adult care recipients. After ascertaining that the tax code does not already effectively accomplish these goals, Part V explores the ideal structure for a new subsidy. Section V.A considers recently proposed tax incentives and finds them inadequate. Ultimately, Section V.B proposes a novel two-part advanced refundable tax credit and considers counterarguments.

I
Family Adult Care Should Be Discussed Separately from Other Informal Care

While informal care is provided to relatives and friends of all ages, this Note focuses on care delivered to relatives at least eighteen years old. This emphasis is not novel; previous proposals have also excluded care for relatives under eighteen years old, though without providing explanations.[14] Before exploring the proper form for a subsidy, this Part defends this narrower focus.

First, this Note excludes childcare because there are significant differences between adult care recipients and children. Many policies treat adult care recipients paternalistically, assuming that they cannot manage their own care.[15] In reality, adult care is often provided to individuals accustomed to exercising autonomy.[16] For these care recipients, like Samuel, retaining some independence is critical to continuing to live with dignity. Allowing care recipients to participate

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[14] *See* CARE Act of 2007, S. 2121 § 3, 110th Cong. (2007) (defining individuals needing long-term care to be (among other qualifications) over eighteen years old).

[15] *See* Haeg, *supra* note 3, at 250.

[16] *See id.* at 239 (discussing social movements advocating for policies that "help the elderly and disabled *maintain* their independence" (emphasis added)); Nancy E. Shurtz, *Long-Term Care and the Tax Code: A Feminist Perspective on Elder Care*, 20 Geo. J. Gender & L. 107, 152–53 (2018); Holly Shaver Bryant, Note, *Funding Kinship Care: A Policy-Based Argument for Keeping the Elderly in the Family*, 8 Wm. & Mary J. Women & L. 459, 487 (2002) (stating that many healthcare practices "strip [care recipients] prematurely of their autonomy," suggesting that the care recipients have exercised autonomy up to this point).

in planning their own care can also lead to more positive health outcomes.[17] Consequently, adult care policies should enable adults to retain as much control over their lives as possible, even if they require care at an early age.[18] This concern is not relevant when crafting childcare policies, as children often are not equipped to manage their own care.[19] Furthermore, adult care requires new, creative solutions due to the rapid expansion of the elderly population[20] and the shortage of professional home health aides.[21] Finally, though childcare is not always planned, adult care is even less predictable. While age is associated with increased care, it is hard to forecast exactly when a relative will require care. For these reasons, this Note focuses solely on adult care.

This Note also excludes friends who provide informal care to adults with whom they do not live. This is practically necessary to limit the size of the covered population, as it would be difficult to define

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[17] *See* A.E. Benjamin et al., *Comparing Consumer-Directed and Agency Models for Providing Supportive Services at Home*, 35 HEALTH SERVS. RES. 351, 360 (2000) (asserting that greater consumer choice in home care can lead to greater compatibility between caregivers and care recipients and, as a result, better care outcomes).

[18] *See* Bryant, *supra* note 16, at 473 (citing Marshall B. Kapp, *Enhancing Autonomy and Choice in Selecting and Directing Long-Term Care Services*, 4 ELDER L.J. 55, 64, 90 (1996)) (discussing why reform goals in adult care policies should protect the autonomy of the aging and ill). While there are adult care recipients who cannot contribute to decisions, we should not assume this is the case for all. *See* Shurtz, *supra* note 16, at 153 (arguing that "[b]y avoiding institutionalization, elderly patients better retain powers of engagement and exercise of choice," suggesting that there are care recipients who can successfully exercise these powers). In fact, the success of consumer-directed programs illustrates that many care recipients can meaningfully contribute to decisions about their care. *See* Benjamin et al., *supra* note 17, at 356 (describing positive results of a consumer-directed care program); Lori Simon-Rusinowitz et al., *Paying Family Caregivers: An Effective Policy Option in the Arkansas Cash and Counseling Demonstration and Evaluation*, 37 MARRIAGE & FAM. REV. 83 (2005) [hereinafter Simon-Rusinowitz, *Paying Family Caregivers*] (same); Hermer, *infra* note 80, at 71–72 (describing the consumer-directed model). Our healthcare programs should aide all care recipients in retaining as much autonomy as possible. *See* Richard L. Kaplan, *Elder Law as Proactive Planning and Informed Empowerment During Extended Life*, 40 STETSON L. REV. 15, 70 (2010) ("The key is empowerment of the older citizen so that person can exercise maximum control over his or her assets and autonomy.").

[19] This Note defines childcare as care provided to individuals under eighteen years old. While eighteen years old is a somewhat arbitrary line, this line has to be drawn somewhere, and societal norms support the age of eighteen as an indicator of adulthood in a number of other contexts.

[20] *See* DAVID C. NIXON, UNIV. OF HAW. MANOA SOC. SCIS. PUB. POLICY CTR., TAX INCENTIVES FOR FAMILY CAREGIVERS: A COST-BENEFIT ANALYSIS 2 (2008) ("With the aging U.S. population fueled by the 'baby boomer' generation, there will be an increasing demand for elder care as well as the need for a well-trained elder care workforce.").

[21] *See* Haeg, *supra* note 3, at 240; Leilani Pino, *Improvements in the Modern Home Healthcare Industry: Responses to Nursing Shortages & New Technological Advancements*, 19 ANNALS HEALTH L. ADVANCE DIRECTIVE 176, 177 (2010) ("Demands for home care services . . . are being harmed by the shortage of nurses.").

"friends" and predict their uptake. Moreover, many advantages of family caregiving are due to close relationships between caregivers and care recipients, which promote high quality care. If non-cohabitating, unrelated individuals were included in the incentive, unconnected individuals may try to take advantage of the subsidy even though they do not actually share close relationships with care recipients. Thus, this Note is justified in limiting its scope.

II
Family Adult Care Should Be Subsidized in Order to Encourage Cost-Savings and Social Benefits

Much of the literature supporting family caregiving subsidies focuses on the social benefits associated with this care and the fact that homecare can reduce healthcare costs as compared to institutional care. Section II.A argues that, while homecare is indeed less expensive than institutional care, family-provided care can be even more cost-efficient than professional home health agency (HHA) care. Section II.B describes the social benefits created by this care. Taken together, these factors justify a family adult care subsidy.

A. Family Members Can Provide Cost-Efficient Adult Care

Family caregiving is a cost-efficient method for delivering adult care. First, this care reduces both current and future Medicare and Medicaid costs. In terms of current costs, home health care is less expensive than institutional care.[22] In fact, the Centers for Medicare and Medicaid Services (CMS) have aimed to decrease costs by shifting care from expensive institutions to home and community-based settings.[23] Transferring care to family providers specifically can also reduce costs. Even if a relative only provides a portion of an indi-

[22] *See* Jing Guo et al., *The Causal Effects of Home Care Use on Institutional Long-Term Care Utilization and Expenditures*, 24 Health Econ. 4, 14 (2015) (finding that home health care offsets nursing home costs, although the cost offset is not one-to-one); Haeg, *supra* note 3, at 241 (noting that the AARP has estimated that the cost to Medicaid of one individual in a nursing facility is equal to that of three adults receiving home or community care); Steven Landers et al., *The Future of Home Health Care: A Strategic Framework for Optimizing Value*, 28 Home Health Care Mgmt. & Prac. 262, 270 (2016) ("Home health care is also a relatively low-cost setting of care. As the health care system grapples with high costs and expenditures, home health's efficiency could support the goal of high-quality, low-cost care."); Pino, *supra* note 21, at 180 (stating that home health care is cheaper than institutional care partially because "visits to the physician's office are significantly decreased").

[23] *See* Jane Perkins & Randolph T. Boyle, *Addressing Long Waits for Home and Community-Based Care Through Medicaid and the ADA*, 45 St. Louis U. L.J. 117, 119 (2001) ("Medicaid agencies are looking for ways to control costs. Most states have reduced

vidual's care,[24] the amount of formal care required could be reduced. This could enable the recipient to remain in her home and receive care from a home health aide supplemented by family care, rather than enter an expensive institution. Furthermore, there is a severe shortage of home health aides.[25] This scarcity means that some individuals may receive government-funded institutional care when they could receive home care. Subsidizing family care would increase the supply of workers and could shift care away from institutions.[26] Relatives may only be able to provide the less-skilled aspects of care, so care recipients may also require some professional care. However, this would still enable home health aides to assist more individuals. With respect to future costs, evidence further suggests that home health care reduces the future need for expensive hospitalization and nursing home care.[27] Therefore, promoting home health care can reduce future health care costs as well.

Second, family adult care can generate even more cost savings than HHAs. HHAs provide professional nursing care, therapy, and personal care services to care recipients in their homes.[28] Some evidence suggests that consumer-directed homecare,[29] where care recipients directly choose their providers, may be less expensive than HHAs, though this is not completely due to family caregivers.[30] Family care does avoid the large administrative overhead costs and profits associated with HHAs.[31]

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costly institutional care by shifting some public funding to home and community settings.").

[24] Care recipients often receive a combination of professional and family care. *See* CAREGIVING IN THE U.S. 2015, *supra* note 2, at 49 (reporting that thirty-two percent of informal caregivers whose care recipient was not in the hospital responded that the care recipient also received paid care).

[25] *See supra* note 21 and accompanying text.

[26] *See* Haeg, *supra* note 3, at 240 ("[F]amily caregiving will help assuage an impending workforce supply issue."); Kraiem, *supra* note 5, at 692 ("Consumer direction increases the labor supply by tapping into the labor of friends and family members who are unlikely to work for a home health agency . . . .").

[27] *See* Czapanskiy, *supra* note 3, at 55 (describing the results of home care programs that had reduced hospital and nursing home admissions); Larry Polivka, *Closing the Gap Between Knowledge and Practice in the U.S. Long-Term Care System*, 10 MARQ. ELDER'S ADVISOR 75, 82 (2008) (describing a study that found that home and community-based services (HCBS) programs were "cost-effective alternatives to nursing home care").

[28] *See* Benjamin et al., *supra* note 17, at 352 ("Home care agencies staffed by nurses, social workers, and paraprofessional aides are reimbursed to provide care to people in their own homes.").

[29] *See infra* note 83 and accompanying text (describing the consumer-directed model).

[30] *See* Benjamin et al., *supra* note 17, at 351–52 (suggesting consumer-directed models are less costly); Polivka, *supra* note 27, at 99 (same).

[31] PAMELA DOTY ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., CONSUMER-DIRECTED MODELS OF PERSONAL CARE: LESSONS FROM MEDICAID 8 (1996).

Family members may also be willing to accept a lower payment for care than an unrelated professional. Many relatives who provide free care are motivated by feelings derived from their familial connections to recipients, such as altruism,[32] a "warm glow effect,"[33] and a sense of duty.[34] Other relatives who do not provide care may feel these same motivations but face resource constraints. For example, a daughter who works several jobs to support her family may not have time to care for her father, regardless of her sense of duty. If provided a subsidy, she may be able to care for her father and still earn a sufficient income. Moreover, there may be individuals who feel some internal motivation, but require slightly more inducement to provide care.[35] A financial incentive could deliver this extra stimulus. In both of these situations, the financial incentive could be lower than the amount necessary to motivate a home health aide to provide the same care because the payment would be combined with the individual's intrinsic motivation to care for her relative.[36] Professional aides likely

[32] According to a 2017 study, sixty-three percent of caregivers reported providing care because they wanted to care for their loved one, suggesting an altruistic motivation. *See* TRANSAMERICA INST., THE MANY FACES OF CAREGIVERS: A CLOSE-UP LOOK AT CAREGIVING AND ITS IMPACTS 36 (2017).

[33] The "warm glow" effect posits that individuals perform good deeds, such as providing care to loved ones, because it makes them feel good inside. *See* Wojciech Kopczuk, *Economics of Estate Taxation: Review of Theory and Evidence*, 63 TAX L. REV. 139, 144 (2009). In 2017, sixty-eight percent of caregivers reported pride in "doing the right thing," implying a warm glow effect. *See* NW. MUT., 2017 C.A.R.E. STUDY: CAREGIVING AND LONGEVITY 16 (2017).

[34] *See* CAREGIVING IN THE U.S. 2015, *supra* note 2, at 9 (reporting that about half of caregivers feel that they do not have a choice in providing care); Bryant, *supra* note 16, at 468–72 (describing society's "implied moral duty" for relatives to care for each other); Marshall B. Kapp, *Home and Community-Based Long-Term Services and Supports: Health Reform's Most Enduring Legacy?*, 8 ST. LOUIS U. J. HEALTH L. & POL'Y 9, 29 (2014) ("Most Americans say they would feel morally obligated to provide assistance to a parent in a time of need.").

[35] *See* Lori Simon-Rusinowitz et al., *Payments to Families Who Provide Care: An Option that Should Be Available*, 22 GENERATIONS 69, 71 (1998) [hereinafter Simon-Rusinowitz, *Payments to Families Who Provide Care*] ("Paying family caregivers will attract some relatives who are outside the workforce, not currently assisting their needy family, and draw them into regular paid employment.").

[36] Previous studies have found that the presence of intrinsic motivation encourages individuals to make economic sacrifices in a variety of different contexts. *See, e.g.*, Gregory A. Guagnano, *Altruism and Market-Like Behavior: An Analysis of Willingness to Pay for Recycled Paper Products*, 22 POPULATION & ENV'T 425, 434–35 (2001) (finding that individuals were willing to pay more for paper towels made from recycled materials); Therese Hedlund, *The Impact of Values, Environmental Concern, and Willingness to Accept Economic Sacrifices to Protect the Environment on Tourists' Intentions to Buy Ecologically Sustainable Tourism Alternatives*, 11 TOURISM & HOSPITALITY RES. 278, 284 (2011) (finding that those valuing universalism were willing to accept economic sacrifices to protect the environment); Nicole Koschate-Fischer et al., *Willingness to Pay for Cause-Related Marketing: The Impact of Donation Amount and Moderating Effects*, 49 J.

do not have this same internal motivation because they do not have an emotional connection with the care recipient. Thus, the same amount of care could be funded at a lower cost if family members replaced professional aides, making family care an efficient adult care option. This cost-efficient care would be especially beneficial in low-income communities, because large amounts of Medicaid funds are spent on long-term services and supports for members of these communities.[37] Replacing long-term professional care with family-provided health care would ensure that these funds are spent in a cost-efficient manner, allowing the government to either reduce Medicaid spending or to allocate the money towards other programs within Medicaid.

In determining whether family care is cost-efficient, it is important to consider opportunity costs.[38] For example, if the daughter described above quit her job in order to provide care to her father, her opportunity cost would include her lost wages. If those wages were much higher than the amount that would be paid to a home health aide for the same care, she may actually require a higher payment than a professional, regardless of her internal motivation. Hence, she would no longer be the cost-efficient caregiver. If the subsidy offered was lower than the home health aide salary and she still quit her high-paying job to claim it, she would forgo a significant amount of income. This substitution would not increase overall social welfare. Therefore, a subsidy aiming for cost-efficiency must be carefully structured to

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MARKETING RES. 910, 923 (2012) ("[A] donation to a cause leads to significantly higher [willingness to pay for a product] in almost all cases."); Peter T.L. Popkowski Leszczyc et al., *Bidding Behaviors in Charity Auctions*, 26 MARKETING LETTERS 17, 26 (2015) ("[C]haritable bidders on average bid 94% higher in charity auctions for the same product than in non-charity auctions."). The law may even already recognize the impact of familial relationships on pricing decisions. For example, we appear to be willing to pay foster parents more to care for foster children than we are willing to pay parents to care for their biological children. *See* Hannah Roman, *Foster Parenting as Work*, 27 YALE J.L. & FEMINISM 179, 216 (2016) ("Foster care stipends are significantly greater than [Temporary Assistance for Needy Families (TANF)] benefits, and the same amount is provided for each additional child, rather than the marginal increase per child generally available under TANF.").

[37] In 2016, approximately $167 billion were spent on Medicaid long-term services and supports, comprising thirty percent of total Medicaid expenditures. STEVE EIKEN ET AL., MEDICAID INNOVATION ACCELERATOR PROGRAM, MEDICAID EXPENDITURES FOR LONG-TERM SERVICES AND SUPPORTS IN FY 2016, at 2, 5 (2018). Medicare coverage of long-term services and supports is much more limited. *See* KIRSTEN J. COLELLO, CONG. RESEARCH SERV., WHO PAYS FOR LONG-TERM SERVICES AND SUPPORTS? 2 (2018) ("Unlike Medicaid, Medicare is not intended to be a primary funding source for [long-term services and supports].").

[38] Opportunity cost is "the cost associated with opportunities that are foregone by not putting the [actor's] resources to their best alternative use." ROBERT S. PINDYCK & DANIEL L. RUBINFELD, MICROECONOMICS 222 (7th ed. 2009). Essentially, opportunity cost measures the value of the alternative that an actor forgoes when selecting a certain path.

account for opportunity costs and should target low-income caregivers.

An important counterargument to this cost-efficiency theory is that caregivers are motivated solely by price-inelastic considerations which financial payments cannot replicate in those who do not already provide care.[39] If true, this would create an inframarginality problem; instead of increasing this price-inelastic behavior in new caregivers, only individuals who would provide unpaid care anyway would claim the subsidy.[40] This would generate high costs without truly changing behavior and, given limited resources, the opportunity costs of the subsidy may exceed the benefits.[41] The behavioral economics theory termed the "crowding out effect"[42] would even posit that a subsidy could decrease caregiving because the caregiver would no longer feel altruistic if her acts were subsidized; her warm glow would be a little less warm if she were compensated for her good deed.[43]

However, a financial incentive would impact the caregiving calculus by creating an additional, monetary reason to provide care, tilting the balance further in the direction of caregiving. This is especially true for low-income families in which a relative may wish to provide care but may lack the resources to do so. In fact, evidence shows that financial motivations do play a role in the caregiving calculus.[44] Furthermore, there is value in rewarding those who already

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[39] *See* Karin C. Ottens, Note, *Using Tax Incentives to Solve the Long-Term Care Crisis: Ineffective and Inefficient*, 22 VA. TAX REV. 747, 768 (2003) (asserting that because caregivers are motivated by altruism, duty, love, and other emotional considerations, one cannot "assume that family caregivers can be bribed into taking care of disabled family members with a . . . tax exemption").

[40] *See* NIXON, *supra* note 20, at 8 (asserting that the subsidy could simply serve as a "windfall payment to those who would have engaged in the behavior, anyway"); Haeg, *supra* note 3, at 251 (noting that a "meager salary combined with an extensive planning process will temper the urges of many to line up for compensation").

[41] *See* Ottens, *supra* note 39, at 767–69 (arguing against a tax incentive for informal caregivers partially because it would not increase caregiving at all and the cost would not be worth the expense).

[42] This theory asserts that providing extrinsic incentives for good deeds "crowds out," or decreases, intrinsic motivation to do the right thing, and therefore leads to lower overall levels of the behavior. *See* Bruno S. Frey & Reto Jegen, *Motivation Crowding Theory*, 15 J. ECON. SURVS. 589, 590 (2001). Behavioral economists and psychologists have suggested a number of potential causes for this phenomenon. *See id.* at 592 (describing explanations based on actors' changes in preferences and changes in perceptions).

[43] *See* Uri Gneezy & Aldo Rustichini, *Pay Enough or Don't Pay at All*, 115 Q.J. ECON. 791, 803 (2000) (describing this effect); Uri Gneezy et al., *When and Why Incentives (Don't) Work to Modify Behavior*, 25 J. ECON. PERSP. 191, 192–93 (2011) ("[D]ecreasing the signal about a person's prosocial preferences and increasing the signal about a person's greediness may result in lower image motivation.").

[44] For example, some caregivers are motivated by cost-savings and report that they provide care because they cannot afford paid care. *See* CAREGIVING IN THE U.S. 2015,

provide care.[45] Due to the significant stress on these caregivers, a subsidy may be necessary to ensure that current levels of care are sustainable, especially given the growth and increased longevity of the elderly population.[46] Finally, there is no evidence that a subsidy would crowd out care from current caregivers. In fact, caregivers have reported that they would appreciate a financial subsidy for their activities.[47] Besides, those who wish to provide care out of the goodness of their hearts or who find the subsidy to be too small could also simply reject it.[48]

Family care can reduce government expenses by eliminating current and future institutional care. Relatives are also cost-efficient care providers due to their internal motivation to help their family members. In order to encourage this behavior and reduce costs, the government should target a subsidy at care that promotes these cost-savings.

B. Family Adult Care Creates Social Benefits

While cost-savings are a valuable goal, it is also important to consider the social benefits created by family care.[49] As discussed *supra* Part I, policies should allow care recipients to maintain autonomy and contribute to decisions about their care.[50] If individuals wish to be cared for by a relative, they should not have to choose between requiring their relatives to provide care for free or receiving government-funded care from a stranger. Indeed, uncompensated family care may not be a legitimate option for low-income families in

supra note 2, at 62 (reporting that higher-hour caregivers who lost their jobs were more likely to attribute it to an inability to afford paid care).

[45] Simon-Rusinowitz, *Payments to Families Who Provide Care*, *supra* note 35, at 70 ("[P]aying them for their personal assistance work will make it easier for them to make a commitment to that work, decrease the financial penalty associated with it, and legitimize their work at a modest public cost.").

[46] *See, e.g.*, Polivka, *supra* note 27, at 78 (discussing how and why the "capacity of the 'unpaid' informal care system to provide the current level of assistance is likely to shrink"); Khullar, *supra* note 2 ("While the demand for caregivers is growing because of longer life expectancies and more complex medical care, the supply is shrinking, a result of declining marriage rates, smaller family sizes and greater geographic separation.").

[47] *See* CAREGIVING IN THE U.S. 2015, *supra* note 2, at 71; *cf.* AP-NORC CTR. FOR PUB. AFFAIRS RESEARCH, *Percentage of U.S. Adults Who Supported Select Programs for Caregivers as of 2018*, STATISTA, https://www.statista.com/statistics/730342/support-for-caregiver-programs-in-united-states (last visited Aug. 8, 2019) (showing that around eighty percent of U.S. adults supported select financial incentive programs for caregivers).

[48] *See* Haeg, *supra* note 3, at 251 (noting that if only a small salary were offered, many caregivers would likely forgo seeking payment altogether).

[49] *See* Polivka, *supra* note 27, at 109 ("The development of these programs should not be governed by cost-effectiveness criteria only. There is value in preserving autonomy that should be included in any assessment of . . . costs and outcomes." (footnote omitted)).

[50] *See supra* notes 15–18 and accompanying text.

which each family member's income is necessary for survival. If family care is not subsidized, government-funded care from an unrelated caregiver may be the only care available to these low-income care recipients, regardless of their preferences.[51] This both limits their decisional autonomy and could lead to more negative health outcomes due to the lack of compatibility between caregiver and recipient.[52] The situation is even more dire for low-income individuals who do not qualify for government-funded healthcare. These individuals do not have access to private healthcare and must rely on informal family care.[53] Additionally, their family members may be less able to spare the resources to care for them. This forces low-income care recipients to either receive care from an overburdened relative[54] or receive low-quality care.[55] A family caregiver subsidy could allow these relatives to provide the care that their family members need without sacrificing income. Accordingly, an incentive for family adult care should be designed to encourage caregiving in low-income communities.

Finally, we must consider the autonomy of individuals who may be forced to receive institutional care due to the shortage of home health aides. Encouraging family adult care could allow those individuals to receive the home-based care they desire, providing them with a choice in their care and enabling them to remain in their preferred environment where they can retain some control.[56]

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[51] While some government-funded programs allow family members to provide care, not all programs cover this care. *See infra* note 88 and accompanying text. In programs that do not allow related caregivers, if a family member cannot provide care for free due to financial constraints and cannot receive government funding for providing care, the care recipient will have to accept care from a government-funded nonrelative.

[52] *See* Benjamin et al., *supra* note 17 and accompanying text.

[53] *See* Ezra Golberstein et al., *Effect of Medicare Home Health Care Payment on Informal Care*, 46 INQUIRY 58, 68–69 (2009) (finding that reduced Medicare coverage of home health care led to increased family-provided care in low-income families but not in higher-income families); Shurtz, *supra* note 16, at 125 ("The working poor and working-class families are more likely to provide direct care themselves, as they cannot afford to hire professional care-providers."); CAREGIVING IN THE U.S. 2015, *supra* note 2, at 50 ("Lower income caregivers are among the least likely to report that their loved one receives paid help.").

[54] *See* Julie Carter, *Person-Centered Planning? Not Without Family Caregivers!*, 37 BIFOCAL 13, 13 (2015) (describing Christina who "works full time, provides child care for her grandchildren, and also spends several hours a day providing care and companionship for her mother").

[55] *See id.* at 14 ("These stresses on the caregivers' time and health, exacerbated by care plans that over-rely on family, can eventually force them to give up the role. This in turn leads to a decline in the available care for loved ones and possible institutionalization.").

[56] *See* Kaplan, *supra* note 18, at 40 ("[A] survey by AARP found that seventy-one percent of Americans age forty-five and over want to live in their current home until the end of their lives.").

C. The Imputed Income Problem

While the previous sections have emphasized the reasons to subsidize family adult care, one argument against a subsidy is that caregivers already receive an implicit subsidy because imputed income is not taxed.[57] Imputed income exists when a taxpayer provides free services to herself or her family rather than engaging in an exchange with someone else.[58] Since there is no exchange, the taxpayer does not receive any income for her services. Under our tax code, she does not have to include any value in her gross income, and therefore is not taxed on the benefit created by her services.[59] For example, if a daughter provides unpaid care to her father, she will not need to include the value of her caregiving services in her gross income, and she will not pay any additional tax. Conversely, if a professional aide provides paid care to the father, she will receive income and will be taxed on that income. If the untaxed daughter can also claim an explicit, untaxed subsidy, such as a tax credit, she will receive a double subsidy—the tax credit itself and the absence of tax on her imputed income. One solution is to provide a subsidy and tax caregivers' imputed income.[60]

Taxing imputed income is troublesome, however, due to both administrative and privacy concerns,[61] so this Note does not advocate for this measure. Though the imputed income problem is a complication, it does not eliminate the earlier-described benefits associated with a family adult care subsidy. Instead, it is simply necessary to consider this problem when designing the subsidy. Further, if a subsidy is targeted at low-income individuals and generates the cost-savings and social benefits discussed above, these positives may outweigh the issue of a double subsidy. Consequently, the government should create a family adult care subsidy properly targeted to promote the potential cost-savings and social benefits explored in this Part.

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[57] RICHARD SCHMALBECK ET AL., FEDERAL INCOME TAXATION 118 (4th ed. 2015).

[58] *See id.*

[59] *Id.*

[60] *See, e.g.*, Laura C. Bornstein, *Homemakers and Social Security: Giving Credits Where Credits Are Due*, 24 WIS. J.L. GENDER & SOC'Y 255, 264–65 (2009) (describing arguments in favor of taxing imputed income from domestic labor).

[61] *See id.* at 265–66 (arguing that taxing imputed income from domestic labor would be politically unfeasible, difficult to enforce, and that tax relief would unevenly benefit different income brackets); Michal A. Johnson, Note, *A Gap in the Analysis: Income Tax and Gender-Based Wage Differentials*, 85 GEO. L.J. 2287, 2298–99 (1997) (pointing to valuation problems and liquidity concerns as frequently cited administrative concerns associated with taxing imputed income); Nancy E. Shurtz, *Gender Equity and Tax Policy: The Theory of "Taxing Men,"* 6 S. CAL. REV. L. & WOMEN'S STUD. 485, 514–15 (1997) (discussing the difficulties with taxing imputed services, including concerns with valuation, liquidity, and placing additional burdens on single women).

III
The Tax Code Is an Effective Vehicle for this Subsidy

Part II established that a family adult care subsidy is appropriate. This Part will now identify a suitable vehicle for this subsidy. There are various approaches through which the government can subsidize desirable behavior, but one popular option is to provide a tax subsidy, such as a credit or deduction.[62] After considering the benefits and drawbacks of this method, this Part determines that a properly crafted tax incentive can effectively subsidize family adult care.

A. Advantages and Disadvantages of the Tax Code

There are several benefits associated with incentivizing this behavior with a tax subsidy. First, the tax code operates at the federal level. While some family adult care providers are currently eligible for public funding, these programs vary greatly by state.[63] If a subsidy were located within the federal tax code instead, the benefit would be nationally standardized. This would reduce complications and ensure that every caregiver could receive a subsidy. Another advantage is that tax subsidies are administered through an established system, whereas other subsidies may require the government to create an entirely new program.[64] Since caregivers have experience paying taxes and are familiar with the tax system, the subsidy would be streamlined into their existing practices. Tax subsidies are also generally viewed more favorably than programs requiring explicit government expenditures and are perceived to involve less governmental interference than these alternatives.[65] Therefore, a tax subsidy may be more positively

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[62] Ottens, *supra* note 39, at 757 (stating that from 1996 to 2003, Congress introduced more than ten bills providing tax subsidies for long-term care). Similar bills have continued to be introduced in recent years, as discussed *infra* Section V.A.

[63] *See infra* notes 84–90 and accompanying text (discussing the variations in these programs in more detail).

[64] *See, e.g.*, Lisa Philipps, *Disability, Poverty, and the Income Tax: The Case for Refundable Credits*, 16 J.L. & Soc. Pol'y 77, 92 (2001) (discussing the benefits of using the tax system to achieve public policy objectives).

[65] *See, e.g.*, Nixon, *supra* note 20, at 7 ("Rather than redistributing funds, the government merely avoids collecting taxes and thus tax credits are seen as a 'costless form of subsidy.'" (quoting Robert E. Pitts & James L. Wittenbach, *Tax Credits as a Means of Influencing Consumer Behavior*, 8 J. Consumer Res. 335, 335 (1981))); Philipps, *supra* note 64, at 92 ("Politically, tax-based programs are often more viable than direct spending initiatives because they are widely, if wrongly, perceived to involve less government interference in the economy. . . . [D]ecisions to forego revenue are . . . seen as somehow less costly and less activist than direct expenditures.").

received than a scheme involving direct payments. Finally, caregivers have expressed that they would appreciate a tax subsidy.[66]

However, critics raise several concerns about a tax subsidy. One of the largest weaknesses is the timing of tax benefits, which are generally only available once a year after the year has ended.[67] Hence, a tax benefit may provide little help to low-income caregivers, who incur expenditures and work throughout the year but would not receive the subsidy until months later.[68] This also makes tax subsidies less responsive to urgent, unexpected needs.[69] The impact of these shortcomings can be reduced, however, if the tax subsidy is structured as an advanced credit.[70] Another concern is that the incentive may not reach the entire caregiving population. In order to receive the benefit, a caregiver must know of the subsidy and be sophisticated enough to file for it.[71] If the credit is nonrefundable, the caregiver will also need sufficient tax liability to offset the credit.[72] Again, this could have the perverse effect of preventing low-income caregivers from benefiting from the subsidy.[73] Unfortunately, the current system of subsidies available to family caregivers is already indecipherable for low-

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[66] *See* CAREGIVING IN THE U.S. 2015, *supra* note 2, at 71 (reporting that thirty-six percent of working caregivers would prefer to be compensated with an income tax credit); AP-NORC CTR. FOR PUB. AFFAIRS RESEARCH, *supra* note 47 (showing that a tax break for providing care was one of the most preferred caregiver support programs).

[67] Philipps, *supra* note 64, at 95.

[68] *See, e.g.*, MELISSA M. FAVREAULT & BRENDA C. SPILLMAN, URBAN INST., TAX CREDITS FOR CAREGIVERS' OUT-OF-POCKET EXPENSES AND RESPITE CARE BENEFITS 13 (2018); NIXON, *supra* note 20, at 8.

[69] Philipps, *supra* note 64, at 95.

[70] Under an advanced credit system such as the Canada Child Tax Benefit, an individual's benefits for the year are determined in advance and the credit amount is paid in periodic installments throughout the year. *See, e.g.*, *id.* At the close of the taxable year, any difference in the amount advanced and the amount actually earned can be accounted for by requiring the taxpayer to pay back any excess received or granting her the remaining amount to which she was entitled. An example of an advanced tax credit in the United States is the Advanced Premium Tax Credit of the Affordable Care Act, which can be used to lower taxpayers' monthly health insurance payments. *See Advance Premium Tax Credit (APTC)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/advanced-premium-tax-credit (last visited May 20, 2019).

[71] FAVREAULT & SPILLMAN, *supra* note 68, at 12; *see also* NIXON, *supra* note 20, at 8–9 ("Factors leading to gender disparities in claims for [the Canadian Caregiver Tax Credit] include: differential knowledge of the tax credit and access to professional tax advisors . . . .").

[72] *See* SCHMALBECK ET AL., *supra* note 57, at 742 (arguing that those parents with little to no pre-credit income are in greatest need of a child subsidy, but do not see the benefits because the credit is not fully refundable).

[73] *See* NIXON, *supra* note 20, at 9 ("[T]hose most in need of care [are] least likely to apply for reimbursement, because more affluent caregivers, who may be in less need of support, have greater capacity to claim the tax benefits.").

income, and perhaps even high-income, caregivers.[74] The vast array of options suggests that a single, standardized federal subsidy would improve upon the incomprehensible status quo. Additionally, utilizing a refundable tax credit can ensure that more low-income caregivers are covered.[75] Finally, tax incentives may not give care recipients control over their care.[76] Generally, whether or not an individual receives a tax incentive is based on her own filing of her tax return on which she will claim any credits to which she believes she is entitled.[77] This means that the caregiver would enter the information and receive the subsidy without input from the care recipient. Any tax subsidy in this context should be structured to ensure that the care recipient retains a voice in her care. While these concerns are valid, they can be addressed through careful design and implementation. The tax code can effectively deliver this subsidy on a national level, creating a baseline benefit for caregivers in every state.

B. Superiority over Direct Medicare or Medicaid Payments to Caregivers

While various alternative strategies to support family adult care have been proposed,[78] one of the most instinctive counterarguments to using the tax system is that caregivers should be paid directly through Medicare and Medicaid.[79] In fact, there are some programs in which federal and state Medicaid funding is directly paid to family

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[74] *See infra* Section III.B (discussing the limitations of currently available subsidies due in part to the large number of programs offered and the variations between them).

[75] *See* Kaplan, *supra* note 4, at 561 ("Making such tax credits refundable for caregivers with low or nonexistent tax liability would enhance their value still further.").

[76] *See* Haeg, *supra* note 3, at 250 (discussing how elderly care recipients often are not afforded the autonomy they deserve); *infra* Section V.A (describing proposed tax credits that do not account for care recipients' autonomy).

[77] *See, e.g.*, *How Do I Claim the EITC?*, IRS, https://www.irs.gov/credits-deductions/individuals/earned-income-tax-credit/claiming-earned-income-tax-credit-eitc (last visited May 20, 2019) (explaining how to claim the EITC on one's tax return); *Publication 503 (2018), Child and Dependent Care Expenses*, IRS, https://www.irs.gov/publications/p503 (last visited Apr. 1, 2019) (explaining how to claim the Child and Dependent Care Credit on one's tax return).

[78] *See, e.g.*, Briana Bunn, Comment, *A New Class of Employees: Family Members Aiding the Disabled*, 8 U. PA. J. LAB. & EMP. L. 505, 505 (2006) (arguing that caregivers should be considered employees); Thomas P. Gallanis & Josephine Gittler, *Family Caregiving and the Law of Succession: A Proposal*, 45 U. MICH. J.L. REFORM 761, 780–85 (2012) (proposing a revision to the Uniform Probate Code to allow caregivers to receive a share of the decedent's estate).

[79] *See, e.g.*, Kaplan, *supra* note 4, at 559–60 ("Perhaps the most appropriate course of action would be for the Medicare program to actually pay family caregivers for the elder care services that they provide at regular market rates."); Philipps, *supra* note 64, at 91 ("The most obvious alternative would be a direct payment through the social assistance system or some other transfer program.").

adult care providers in an attempt to replace institutional care with home and community-based services (HCBS). Federally funded programs are operated mainly by states through HCBS waivers or other similar incentive programs, and most states offer an HCBS waiver program for elderly people.[80] States also fund their own programs that offer expanded coverage.[81] Finally, there is a national program targeted directly at veterans.[82] Many of these programs follow a consumer-directed model, in which the care recipient is provided with funds and selects and pays her caregivers.[83]

Although these programs exist, a tax incentive is still justified. Unlike the current system, a federal tax incentive would promote simplicity and uniformity.[84] Presently, there is an overwhelming range of options and information is not easy to access or comprehend.[85] If a care recipient moves to a different state, she may no longer be eligible for funding as the eligibility requirements differ among states.[86] Even within a single state, there may be multiple programs, and programs

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[80] *See* Laura D. Hermer, *Rationalizing Home and Community-Based Services Under Medicaid*, 8 ST. LOUIS U. J. HEALTH L. & POL'Y 61, 72 (2014). A full analysis and history of HCBS waivers and programs and their use is beyond the scope of this Note, but see *id.* at 72–88 for an in-depth discussion.

[81] For example, New York's Expanded In-Home Services for the Elderly Program serves those over sixty years old who require aid with daily activities but are not eligible for Medicaid. *See Expanded In-Home Services for the Elderly (EISEP)*, N.Y. ST. DEP'T HEALTH (Mar. 2010), https://www.health.ny.gov/health_care/medicaid/program/longterm/expand.htm.

[82] *Veteran Directed Care Program (Formerly VD-HCBS)*, ACL, https://acl.gov/programs/veteran-directed-home-and-community-based-services/veteran-directed-home-community-based (last modified on Apr. 24, 2019).

[83] *See* Hermer, *supra* note 80, at 71–72 (describing the consumer-directed model); *see also, e.g.*, ARIZ. HEALTH CARE COST CONTAINMENT SYS., SELF-DIRECTED ATTENDANT CARE MEMBER INFORMATION 2, https://www.azahcccs.gov/Members/Downloads/ALTCS/SDAC_Manual_Part3_MemberInformation.pdf (last visited May 20, 2019) (utilizing this model); *Personal Preference Program (PPP)*, N.J. DEP'T HUM. SERVS., https://www.state.nj.us/humanservices/dds/services/ppp (last visited May 20, 2019) (same).

[84] *See* Hermer, *supra* note 80, at 71 ("[T]he optional and piecemeal character of these programs limits their full potential.").

[85] *Id.* at 78; *see also, e.g.*, *State Plan Personal Care*, OKLA. DEP'T HUM. SERVS., http://www.okdhs.org/services/aging/Pages/stateplanpersonalcare.aspx (last updated Oct. 26, 2016) (requiring individuals to contact their county office to determine eligibility and simply stating that income and physical condition are factors); *Home Care Allowance (HCA)*, GRAND CTY. COLO., https://co.grand.co.us/267/Home-Care-Allowance-HCA (last visited May 20, 2019) (stating that "[i]ncome guidelines vary depending on age and severity of disability" and advising individuals to call Social Services).

[86] *See Frequently Asked Questions—Community Services for Elderly and Adults with Disabilities*, ST. ME. AGING & DISABILITY SERVS. (2019), https://www.maine.gov/dhhs/oads/home-support/elderly-physically-disabled/faq.html (stating that just because an individual was eligible for funding in her previous home state does not mean that she will be eligible in Maine).

may vary by county.[87] This complexity skews the benefits of these programs towards sophisticated caregivers with resources. Additionally, these programs exclude many family caregivers. Some programs do not allow relatives to serve as caregivers, and many exclude legally responsible family members, such as spouses and guardians.[88] HCBS waiver programs also do not include all Medicaid recipients, as these programs are targeted at specific portions of the Medicaid population.[89] Even individuals covered by an HCBS program may not receive funding, due to long waitlists.[90] Benefits are even less uniform for caregivers of Medicare recipients or individuals who do not qualify for Medicare or Medicaid. While states do offer some programs for individuals not covered by Medicaid, eligibility requirements and

[87] *See, e.g.*, Hermer, *supra* note 80, at 78–79 (describing the eight different HCBS waivers available in California); *Area Agencies on Aging*, MONT. DEP'T PUB. HEALTH & HUM. SERVS., https://dphhs.mt.gov/SLTC/aging/areaagenciesonaging (last visited May 20, 2019) (listing ten different regional agencies on aging connecting elderly Montanans to programs); *State Plan Personal Care*, *supra* note 85 (requiring individuals to contact their county office to determine eligibility).

[88] Haeg, *supra* note 3, at 242 ("Family members deemed 'legally liable relatives,' which includes legally assigned caretaker relatives (which each individual state defines) and spouses, cannot receive Medicaid reimbursement unless states decide otherwise."); *see also, e.g.*, ARIZ. HEALTH CARE COST CONTAINMENT SYS., ANNUAL HCBS REPORT CY 2017, at 6–7 (2018), https://www.azahcccs.gov/Shared/Downloads/HCBS/AnnualHCBS_Report_CYE2017.pdf (allowing spouses to serve as paid caregivers); ARIZ. HEALTH CARE COST CONTAINMENT SYS., *supra* note 83, at 2 (covering care provided by family members, friends, and neighbors, but excluding care provided by spouses, parents of children eighteen and younger, and legal guardians); *Connecticut Home Care Program for Elders (CHCPE)*, CT.GOV, https://portal.ct.gov/DSS/Health-And-Home-Care/Connecticut-Home-Care-Program-for-Elders/Connecticut-Home-Care-Program-for-Elders-CHCPE (last visited June 23, 2019) (excluding family members as eligible paid caregivers except under very limited circumstances).

[89] *See* Hermer, *supra* note 80, at 73 (describing the "fragmentation that has resulted in HCBS" because waivers are targeted only at specific populations); *see also, e.g.*, John A. Miller & Aaron O. Roepke, *Medicaid Planning in Idaho*, 52 IDAHO L. REV. 507, 513 (2016) ("[L]imits are placed on the [Idaho HCBS waiver] program that are different than those for other Medicaid services."); *Medicaid Aged and Disabled Waiver*, NEB. DEP'T HEALTH & HUM. SERVS., dhhs.ne.gov/Pages/Medicaid-Aged-and-Disabled-Waiver.aspx (last visited June 23, 2019) (covering individuals of all ages who are eligible for Medicaid, have needs at a nursing facility level, would prefer to live at home, and can be served safely at home).

[90] Perkins & Boyle, *supra* note 23, at 119; *see also* Hermer, *supra* note 80, at 80 ("In 2012, nearly 524,000 individuals were on waiting lists for HCBS in thirty-nine states. Such individuals remained on these lists for an average of two years."); *Montana Big Sky Home and Community Based Services Program*, MONT. DEP'T PUB. HEALTH & HUM. SERVS., https://dphhs.mt.gov/SLTC/csb#147868309-montana-big-sky-waiver-program (last visited May 20, 2019) (admitting that there are waitlists for the Montana Big Sky Waiver program). Though the federal government has attempted to entice states to include programs in their state plans, which would eliminate waitlists, states have continued to use waivers under which they can limit the number of spots available. Hermer, *supra* note 80, at 73–75, 79–80.

availability vary.[91] A federal tax incentive would implement one nationally standardized subsidy available to all caregivers who meet the requirements.

Though some may concede that the current system of state level programs is overly complex, they may believe that the solution is not a tax incentive, but rather action by the federal government to nationally and uniformly cover direct payments to family adult caregivers under Medicare and Medicaid. In fact, this was proposed in The Family Caregiver Security Act of 2005.[92] Coverage could also be expanded to cover more caregivers, services, and hours. A tax incentive is still superior to these direct payments, however, because care recipients may feel uncomfortable paying their family members for care,[93] whereas a tax incentive is slightly more covert. More importantly, given the current political climate, federal healthcare expansion is improbable.[94] A subsidy framed as a tax incentive, especially one that encourages cost-savings, may appeal to a broader political base.[95] While direct payments may seem to be the most natural option, a tax incentive can achieve the same goals in a more politically appealing manner and with a relatively simple structure.[96] Hence, the government can effectively utilize the tax code to provide a family adult care subsidy.

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[91] *See, e.g.*, *Expanded In-Home Services for the Elderly (EISEP)*, *supra* note 81 (covering all individuals over sixty "who need help with everyday activities to take care of themselves"); *Senior Care Act (SCA)*, KAN. DEP'T AGING & DISABILITY SERVS., https://www.kdads.ks.gov/commissions/commission-on-aging/in-home-services/senior-care-act-(sca) (last visited May 20, 2019) (covering residents sixty years or older who pass a functional limitations test and contribute to the cost of services based on their ability to pay).

[92] H.R. 175, 109th Cong. (2005) (proposing to allow Medicare payments to family caregivers equal to the amount that would be paid to a professional aide for the same services).

[93] *See* Kaplan, *supra* note 4, at 527 ("For some families, moreover, the very notion that inter-generational caregiving is a compensable service is abhorrent and contrary to popular norms.").

[94] Congress has been deadlocked with respect to healthcare reform since the Affordable Care Act was passed in 2010. *See, e.g.*, Tami Luhby, *Health Care Battle Cheat Sheet: Democrats v. GOP*, CNN: BUS. (Jan. 12, 2017, 8:32 AM), https://money.cnn.com/2017/01/12/news/economy/obamacare-republicans-health-care/index.html (comparing Republican healthcare proposals to the Affordable Care Act); *see also* Kaplan, *supra* note 4, at 560 (acknowledging a similar political limitation in 2005 because Medicare had recently been expanded); Landers et al., *supra* note 22, at 268–69 (discussing the lack of consensus as of 2016 around modifying Medicare's home health benefit).

[95] *See* Bryant, *supra* note 16, at 481 (stating that tax relief is more appealing to fiscal conservatives).

[96] Shurtz, *supra* note 16, at 185 (explaining that a refundable credit could accomplish the same objectives as direct payments while being more "politically palatable").

IV
The Tax Code Does Not Already Provide an Adequate Subsidy

Part III determined that a family adult care tax subsidy is warranted. This Part will now examine whether the tax code already provides an effective incentive. In doing so, it will reiterate that the goal of this subsidy is not only to alleviate the stresses of caregiving, but also to encourage the benefits identified in Part II and account for the unique characteristics of the adult care recipient population described in Part I.

The Dependent Tax Credit[97] is the only existing federal tax incentive that assists individuals who provide care to adult relatives on their own.[98] Added in the 2017 Tax Cuts and Jobs Act (TCJA),[99] § 24(h) of the Internal Revenue Code (I.R.C.) authorizes a $500 refundable credit for each dependent that is not a qualifying child.[100] The credit is reduced as adjusted gross income increases beyond a threshold amount and no credit is available above a certain level of income.[101] In order to qualify for this credit, caregivers must provide care to a "dependent" as defined in § 152. To fulfill this definition, the care recipient must first be either a citizen or a national and must also be a "qualifying" relation of the caregiver.[102] Qualifying relations include many family members and all individuals who live with the taxpayer besides her spouse.[103] This means that wives who help to care for their husbands, like Samuel's wife, are automatically excluded from the credit. If the care recipient passes the qualifying relation test, there are two further limitations: the income test and the support test.

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97 I.R.C. § 24(h) (Supp. V 2018).

98 Caregivers can deduct medical expenses for qualified recipients, I.R.C. § 213, and receive a credit for caregiving expenses incurred while working or searching for a job, § 21. However, both of these apply to the purchase of caregiving services in the market, and thus do not offer relief to those providing care themselves.

99 *See* Shurtz, *supra* note 16, at 164. This was added in order to compensate for the removal of the dependent personal exemption. *See id.*

100 I.R.C. § 24(h) (Supp. V 2018). A qualifying child must be a descendant of the taxpayer, the taxpayer's sibling or stepsibling, or a descendent of a sibling or stepsibling. I.R.C. § 152(c) (2012). The child must live with the taxpayer for at least half of the year and be either under the age of nineteen or a student under the age of twenty-four. *Id.* The child must not have provided over one-half of her own support during the year and cannot have filed a joint return for the year. *Id.*

101 I.R.C. § 24(b) (2012).

102 I.R.C. § 152(a)–(b) (2012).

103 *Id.* The listed individuals are a child or child's descendant; a sibling or stepsibling; a parent or parent's ancestor; a stepparent; a niece or nephew; an aunt or uncle; a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; and an individual, besides a spouse, who at any time during the taxable year has the same principal place of abode as the taxpayer and is a member of the taxpayer's household. *Id.*

Under these tests, the care recipient must (1) have gross income below the personal exemption amount for the year[104] and (2) receive over half of her support for the year from the caregiver or fit within a multiple support agreement exception.[105]

The income and support tests can be difficult to satisfy. The income test considers all of the care recipient's taxable income, including income from private pensions, capital gains, dividends, and interest.[106] Under the support test, caregivers must identify the total amount of "support" provided to a care recipient during the year and determine if any one individual contributed at least half of that support.[107] Support includes "food, shelter, clothing, medical and dental care, education, and the like."[108] However, support does not include unpaid healthcare provided by the taxpayer, so the caregiver cannot account for this care when identifying whether she provides sufficient support.[109] Furthermore, in determining the support received, the caregiver must include the care recipient's own sources of income, which count as support he provided for himself.[110] If the care recipient's income is greater than half of his total support, he does not qualify as a dependent for any other taxpayer.[111] Due to these limitations, many family adult caregivers cannot claim the Dependent Tax Credit.[112] These restrictive tests also fail to promote the goals identified in Part II, specifically with respect to cost-savings and imputed

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104 *Id.* § 152(d)(1). This threshold is based on the personal exemption amount as defined in § 151. Although the TCJA reduced this amount to zero for 2018–2025, this is not taken into account when determining eligibility under other provisions. I.R.C. § 151(d)(5) (Supp. V 2018). Thus, the amount that would have been the exemption amount is used to determine the income threshold for this Credit. *See* Shurtz, *supra* note 16, at 165–66. In 2018, this was $4150. *Id.* at 166.

105 I.R.C. § 152(d)(1), (3) (2012). The multiple support agreement provision applies when (A) no one person contributed over half of the support, (B) over half of the support was received from two or more people who could claim the recipient as a dependent if there was no support test, (C) the taxpayer contributed over ten percent of the support, and (D) all others who contributed over ten percent certify they will not claim the recipient as a dependent. *Id.*

106 Shurtz, *supra* note 16, at 166. It does not include veteran's benefits, tax-exempt municipal bond interest, gifts, or some Social Security payments. *Id.*

107 I.R.C. § 152(d)(1)(C) (2012) (requiring that "the taxpayer provide[s] over one-half of the individual's support for the calendar year in which such taxable year begins").

108 Treas. Reg. § 1.152-1(a)(2)(i). Out-of-pocket costs are generally used to determine the value of support, although there are specific rules for certain expenses. *See* Kaplan, *supra* note 4, at 539.

109 Shurtz, *supra* note 16, at 165.

110 *Id.*

111 *See id.* (giving an example in which a father provides over half of his own support from Social Security and therefore does not qualify as his son's dependent).

112 *See* DAVID KENDALL & JACQUELINE GARRY LAMPERT, THIRD WAY, FAMILY CAREGIVERS DESERVE A TAX CREDIT (2017), https://www.thirdway.org/report/family-caregivers-deserve-a-tax-credit (discussing how far more parents than adult caregivers may

income. They do not target caregivers who can create cost-savings. Moreover, although the income test does direct the credit towards low-income care recipients, the threshold is very low, and the test does not account for the caregiver's income.[113]

The credit's structure and amount are also not ideal. Though it is refundable, the structure does not address the timing issues associated with the tax code. Additionally, the credit does not maintain the care recipient's autonomy, as the caregiver entirely controls whether she receives the credit. Finally, the amount of the credit is very low when considering the amount of time spent on this care.[114] This seemingly arbitrary token amount is unlikely to incentivize cost-savings. Hence, the current federal tax code does not provide a broadly accessible incentive that addresses the positive benefits created by family adult care or the unique characteristics of the adult population, justifying the creation of a new tax incentive.

V
Proposing a Two-Part Advanced Refundable Tax Credit

Since the tax code does not already provide a suitable family adult care incentive, the remaining task of this Note is to identify a superior subsidy. Section V.A first analyzes recently proposed tax incentives. After finding them lacking, Section V.B proposes a two-part advanced refundable tax credit and considers counterarguments.

A. The Inadequacy of Recently Proposed Tax Incentives

Politicians have suggested a variety of tax incentives to address the family adult care crisis. This Section examines recently proposed subsidies and their effectiveness at promoting the benefits identified in Part II and accounting for the distinctive characteristics of adult care recipients described in Part I. It is important to note that none of these proposals directly addresses the potential cost savings that can be achieved by replacing government-funded home health aides with family caregivers.[115]

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claim the Dependent Tax Credit despite similarities of costs between caregiving and parenting).

113 The income threshold is based entirely on the care recipient's taxable income and includes no consideration of the caregiver's taxable income. *See supra* note 106 and accompanying text.

114 *See* Shurtz, *supra* note 16, at 166 ("The new credit amount is very stingy . . . .").

115 For a discussion of the importance of considering such cost savings, see *supra* Section II.A.

1. *Expanded Earned Income Tax Credit*

The EITC Modernization Act of 2018 proposes to expand the Earned Income Tax Credit (EITC).[116] The EITC is a refundable credit, the value of which depends on the number of "qualifying children" claimed by a taxpayer and which phases out as income increases.[117] This bill would replace "qualifying child" with "qualifying dependent," defined as a qualifying child or an aged or disabled dependent.[118] An aged or disabled dependent includes dependents who are at least sixty-five years old or determined to be disabled under the Social Security Act.[119] If a caregiver is entitled to a total credit of at least $240, she can elect to receive monthly payments rather than a lump sum at the end of the year.[120]

Since it can be advanced, this proposal does address timing concerns. The credit is also refundable and is built into an existing credit which has proven to be effective and administrable.[121] A drawback of this proposal is that it is still limited to care recipients that qualify as dependents. However, the proposal is targeted at a subgroup within the limited dependent population that can create large cost savings because it is restricted to aged or disabled dependents. These care recipients are either over sixty-five years old or qualify as disabled under the Social Security Act, which indicates that they require extensive publicly-funded healthcare.[122] This bill therefore rewards relatives who reduce federal spending by caring for high-risk individuals. Thus, this credit is more targeted at cost savings than the Dependent Tax Credit. An additional shortcoming of this proposal is that it does not enhance care recipients' autonomy, potentially because the EITC is not solely focused on incentivizing care, but instead aims to encourage and reward work.[123] Furthermore, the existing EITC targets families with children,[124] so there is no need to account for the "care recipients'" autonomy in the structure of the credit.

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116 EITC Modernization Act of 2018, H.R. 6873, 115th Cong. (2018).

117 I.R.C. § 32 (2012).

118 H.R. 6873 § 3(a)(2).

119 *Id.* § 3(a)(2)(E).

120 *Id.* § 3(d).

121 *See generally* CHUCK MARR ET AL., CTR. ON BUDGET & POLICY PRIORITIES, EITC AND CHILD TAX CREDIT PROMOTE WORK, REDUCE POVERTY, AND SUPPORT CHILDREN'S DEVELOPMENT, RESEARCH FINDS (2015) (discussing studies finding positive effects of the EITC).

122 H.R. 6873 § 3(a)(2).

123 CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS: THE EARNED INCOME TAX CREDIT 2 (2018).

124 *See, e.g.*, *supra* note 117 and accompanying text (explaining that the EITC increases with the number of "qualifying children"); *see also* CHUCK MARR ET AL., CTR. ON BUDGET & POLICY PRIORITIES, STRENGTHENING THE EITC FOR CHILDLESS WORKERS WOULD

2. *Expanded Dependent Definition*

The Elder Care Tax Credit Act of 2014 proposes to expand the definition of "dependent," with the goal of including parents and grandparents who do not live with the caregiver but are still physically or mentally incapable of caring for themselves.[125] In order to do so, the bill eliminates the income and support tests when determining whether the taxpayer's parents or any of their ancestors qualify as dependents.[126] This proposal was made before the TCJA; however, a similar expansion of "dependent" could be proposed for the Dependent Tax Credit. While this expanded definition would affect some care recipients, most relatives would still have to fulfill the income and support tests. The bill also does not describe how caregivers can prove that care recipients are physically or mentally unable to care for themselves, so the size of the covered population is not entirely clear. This expansion is not targeted at family care that reduces costs and does not preserve care recipients' autonomy. In fact, by bluntly stating that care recipients must be "incapable" of caring for themselves, the bill perpetuates the view that care recipients cannot contribute to their care. While any subsidy should cover more individuals than those who qualify as dependents, this proposal is not the best path to achieving this goal.

3. *Specified-Amount Tax Credit*

Another potential type of subsidy is a specified-amount credit, such as the Senate's Caregiver Assistance and Relief (CARE) Act of 2007[127] and the House's Caregiver Financial Relief Act of 2008.[128] Both of these proposals offer a $3000 credit per applicable individual to eligible caregivers, which decreases as adjusted gross income increases.[129] In the Senate proposal, a caregiver can claim the credit for her spouse, any dependents that qualify as applicable individuals,

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PROMOTE WORK AND REDUCE POVERTY: IMPROVEMENT TARGETED AT LONE GROUP TAXED INTO POVERTY 1 (2016) (discussing the fact that the EITC successfully encourages work and offsets taxes in low-income working families, but is so small for childless adults that it does not accomplish these goals).

125 H.R. 4145, 113th Cong. (2014). This was also proposed in 2012, 2009, and 2008. Elder Care Tax Credit Act of 2012, H.R. 3820, 112th Cong. (2012); Elder Care Tax Credit Act of 2009, H.R. 517, 111th Cong. (2009); Elder Care Tax Credit Act of 2008, H.R. 7036, 110th Cong. (2008). This is very similar to the Tax Relief for Working Caregivers Act of 2007, H.R. 1911, 110th Cong. (2007), and a portion of the Caregiver Financial Relief Act of 2008, H.R. 6390 § 3, 110th Cong. (2008).

126 H.R. 4145 § 3(a)(1).

127 CARE Act of 2007, S. 2121, 110th Cong. (2007).

128 H.R. 6390. *See* Kaplan, *supra* note 4, at 553–55 (providing analysis of similar proposals from 2003 and 2004).

129 S. 2121 § 3; H.R. 6390 § 2.

and herself under limited circumstances.[130] The House proposal authorizes the credit for a slightly broader population, including the taxpayer, her spouse or dependents, and individuals who qualify under more generous income and support tests.[131] The House proposal limits the number of care recipients to two per taxpayer.[132] In order to qualify as an applicable individual, a care recipient must be certified by a physician as having long-term care needs for at least 180 consecutive days.[133] The proposals define long-term care needs slightly differently, but both focus on care recipients' inability to perform activities of daily living[134] due to loss of functional capacity, the presence of chronic conditions,[135] and the necessity of substantial assistance to protect care recipients from threats to health and safety.[136]

These proposals are interesting for two reasons. First, the covered care recipients represent both an expansion and retraction compared to the Dependent Tax Credit. Both proposals allow a taxpayer to claim the credit for a spouse or herself under certain conditions, neither of which are included in the standard dependent definition. The House bill also slightly softens the income and support tests.[137] On the other hand, the proposals create long-term care requirements to restrict the expanded pool of qualifying recipients.[138] Compara-

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130 S. 2121 § 3.

131 *Compare* H.R. 6390 § 2 (providing an unreduced credit for unmarried caregivers with incomes up to $100,000), *with* S. 2121 § 3 (providing an unreduced credit for unmarried caregivers with incomes up to $75,000). For example, the proposal replaces the support test with a residency test for a subset of individuals. *Id.*

132 H.R. 6390 § 2.

133 *Id.*; S. 2121 § 3.

134 S. 2121 § 3. Activities of daily living are defined with reference to § 7702B(c)(2)(B), and include eating, toileting, transferring, bathing, dress, and continence. I.R.C. § 7702B(c)(2)(B) (2012).

135 A chronic condition is defined in the Act as lasting for at least six months and requiring ongoing medical care. S. 2121 § 3.

136 S. 2121 § 3 (requiring the care recipient to either (1) be unable to perform at least three activities of daily living without substantial assistance due to a loss of functional capacity; (2) (a) require substantial supervision to protect her from threats to her health and safety due to cognitive impairment and (b) be unable to perform at least one activity of daily living or unable to engage in age-appropriate activities; or (3) have five or more chronic conditions and be unable to perform at least one activity of daily living without substantial assistance due to loss of functional capacity); H.R. 6390 § 2 (requiring the same limitations as the first two Senate categories with an additional category covering care recipients who require substantial supervision to be protected from threats to health or safety due to a severe psychological disability, mental retardation, or related developmental disability and would otherwise require institutional care).

137 *See supra* note 131 and accompanying text (comparing the House and Senate bills' requirements and discussing how the House's bill had slightly relaxed qualification tests).

138 *See supra* notes 133–36 and accompanying text (discussing the long-term care requirements in the proposals).

tively, the Dependent Tax Credit is available to all dependents regardless of the level of care required.[139]

These proposals cover a more appropriate population than the Dependent Tax Credit with respect to the goals of reducing costs and respecting care recipients' autonomy. The proposals include spouses, which would extend the credit to about five million additional caregivers.[140] One could argue that spouses should not receive a subsidy because their behavior is unlikely to change—if one cares about her spouse enough, she will already provide free care. In reality, a subsidy could make spouses' many hours of care more sustainable or enable them to provide care themselves instead of hiring others. This respects care recipients' independence by allowing them to be cared for by those from whom they have personally chosen to receive support throughout their lives. These proposals also more directly target care that reduces healthcare costs. Care recipients with long-term care needs and chronic conditions are likely those who would require expensive healthcare, potentially covered by government funding.[141] Hence, this credit targets an improved population, but the coverage is still not ideal because the income and support tests are not entirely eliminated.

These proposals are also notable because the amount does not vary by caregiver. This uniformity eliminates the need for individualized determinations and record keeping. However, the simplicity comes at a price: Without authentication, taxpayers could more easily commit fraud. The amount of the credit is also less personalized, risking overcompensating caregivers who provide minimal care and undercompensating those who spend a large amount of time and money. Due to this lack of individualization, the credit may not incentivize the correct amount of care for every care recipient. It also may lead to excessive costs if caregivers who provide minimal care are allotted an amount much higher than they deserve.

4. Expense-Based Tax Credit

Members of Congress also frequently endorse expense-based credits. The Credit for Caring Act, proposed in the Senate and House

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[139] Though one could argue that this requirement is implicitly built into the income and support tests. That is, these tests function as a way of determining whether the care recipient is "limited" enough to warrant a credit, but these measures are very indirect.

[140] CAREGIVING IN THE U.S. 2015, *supra* note 2, at 14, 15 & fig.1, 20 fig.11 (stating that spouses and partners accounted for twelve percent of 43.5 million informal caregivers in 2015, or 5.22 million spousal or partner caregivers).

[141] *See* Landers et al., *supra* note 22, at 263 ("Estimates suggest that chronic illness accounts for three quarters of total national health care expenditures.").

in 2016[142] and 2017,[143] offers a credit for thirty percent of qualified expenses paid by an eligible caregiver to the extent that those expenses are greater than $2000. The credit is capped at $3000 and phases out as gross income increases.[144] To be eligible for this credit, a caregiver must incur qualified expenses in the care of a qualified care recipient and earn income greater than $7500.[145] The care recipient must (1) be either the spouse of the caregiver or fulfill the qualifying relation test from the dependent definition, and (2) be certified by a physician as having long-term care needs for at least 180 consecutive days.[146] The proposals define long-term care similarly to those in the previous Section.[147] Notably, the care recipient does not need to fulfill the income or support tests. Qualified expenses include goods, services, or supports that assist a care recipient with activities of daily living and instrumental activities of daily living and are used only by the care recipient.[148] An eligible caregiver can also include some other expenses related to care, such as lost wages for unpaid time off and expenditures for caregiver counseling or training.[149]

The Americans Giving Care to Elders (AGE) Act, which has been proposed multiple times in both the House and Senate,[150] offers a similar credit. The 2018 Senate proposal calls for a credit equal to twenty percent of qualified expenses, capped at $6000, and phasing out as income increases.[151] Care recipients must be at least sixty-five

142 Credit for Caring Act of 2016, S. 2759, 114th Cong. (2016); Credit for Caring Act of 2016, H.R. 4708, 114th Cong. (2016).

143 Credit for Caring Act of 2017, S. 1151, 115th Cong. (2017); Credit for Caring Act of 2017, H.R. 2505, 115th Cong. (2017).

144 S. 1151 § 2; H.R. 2505 § 2.

145 S. 1151 § 2; H.R. 2505 § 2.

146 S. 1151 § 2; H.R. 2505 § 2.

147 *Compare* S. 1151 § 2, *and* H.R. 2505 § 2 (defining individuals needing long-term care to be (among other qualifications) over six years old and unable to perform two activities defined in I.R.C. § 7702B(c)(2)(B)), *with* CARE Act of 2007, S. 2121 § 3, 110th Cong. (2007) (defining individuals needing long-term care to be (among other qualifications) over eighteen years old and unable to perform three activities defined in I.R.C. § 7702B(c)(2)(B)).

148 S. 1151 § 2; H.R. 2505 § 2. Activities of daily living are defined through I.R.C. § 7702B(c)(2)(B). Instrumental activities of daily living are defined by the Social Security Act as including, but not limited to, "meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community." 42 U.S.C. § 1396n(k)(6)(F) (2012).

149 S. 1151 § 2; H.R. 2505 § 2.

150 *See, e.g.*, Kaplan, *supra* note 4, at 555–57 (analyzing a similar bill from 2003, the Family Caregiver Relief Act of 2003); Americans Giving Care to Elders (AGE) Act of 2016, H.R. 5196, 114th Cong. (2016) (proposing the same credit in the House in 2016).

151 Americans Giving Care to Elders (AGE) Act of 2018, S. 3028 § 2, 115th Cong. (2018).

years old, require assistance with activities of daily living, and be either the taxpayer or her spouse's parent, parent-in-law, or step-parent; an ancestor of any of those individuals; or an individual who lives with the taxpayer.[152] This proposal covers more individuals than the Credit for Caring Act, as it does not require physician certification or long-term care needs.[153] This is offset by a restricted set of covered expenses; the credit is limited to six categories listed in the bill, excluding items such as lost wages.[154] While some of these expenses do not benefit caregivers providing care on their own, there are three categories of expenses that benefit this population: assistive technologies and devices, environmental modifications, and counseling or training for a caregiver.[155]

These proposals again look beyond the dependent definition in determining eligibility. The definitions in the Credit for Caring Act resemble those in the previously discussed specified-amount credits,[156] but the AGE Act's coverage is much broader. While it excludes most extended family members and those under sixty-five years old, it does not include a stringent test for medical limitations.[157] Since it does not test the medical conditions of care recipients, this bill is not targeted at generating the greatest cost savings. This also may make the credit more susceptible to fraud, although the fact that taxpayers can provide receipts to verify their expenses could make an expense-based credit less vulnerable to fraud than a specified-amount credit. This opportunity for authentication further ensures that the amount of the credit is determined on an individualized basis. Nevertheless, this increased accuracy must be balanced with the added complications to filing and administration.

Overall, though there are some benefits, expense-based credits are not well suited to subsidizing family adult care. These caregivers largely create positive benefits through time spent caring for relatives. If hours are not considered in the calculation of the credit amount, caregivers investing different amounts of time, but the same amount of money, would receive the same subsidy. These proposals also do not appropriately target this population because some covered expenses are not incurred by relatives providing care on their own,

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152 *Id.*

153 *See supra* notes 142–47 (discussing these requirements in the Credit for Caring Act).

154 S. 3028 § 2.

155 *Id.*

156 *See supra* note 147 and accompanying text (noting that the Credit for Caring Act defines long-term care similarly to the specified-amount credits).

157 *See supra* text accompanying notes 152–53 (describing the eligibility criteria for the credit and the fact that physician certification and long-term care needs are not required).

but rather are relevant to the purchase of caregiving services on the market.[158] Finally, the previously proposed expense-based credits do not address autonomy or timing concerns.

5. *Expense-Based Tax Deduction*

Though there have been no official bills proposing expense-based tax deductions, President Donald Trump endorsed this form of subsidy during the 2016 election.[159] President Trump proposed to allow family caregivers with incomes below a certain threshold to deduct up to $5000 for the costs of homecare, adult day care, or other similar programs.[160] Unfortunately for many family caregivers, these expenses are not incurred by those providing care to relatives on their own.

Even if this deduction were available for a wider array of expenses, a deduction is not an appropriate structure for this subsidy. Deductions are only beneficial to taxpayers who itemize their deductions, rather than claiming the standard deduction.[161] Due to the TCJA's increase in the standard deduction, a minority of taxpayers are expected to itemize.[162] Additionally, deductions benefit high-income taxpayers more than low-income taxpayers. This is because credits represent a fixed dollar reduction in the amount of taxes paid, while deductions reduce taxpayers' taxable income; therefore, a deduction's value depends on the taxpayer's tax bracket.[163] As an

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158 For example, the AGE Act covers expenses for paid care, such as day care and custodial care, which family members do not incur when providing care on their own. S. 3028 § 2.

159 Gleckman, *supra* note 11.

160 *Id.*

161 *See* Margaret Quartararo, *The Devaluation of Women's Labor and the Internal Revenue Code*, 16 SEATTLE J. SOC. JUST. 527, 540 (2017) (noting that taxpayers will typically only choose to itemize their deductions if it is more financially beneficial than claiming the standard deduction).

162 Erica York, *Nearly 90 Percent of Taxpayers Are Projected to Take the TCJA's Expanded Standard Deduction*, TAX FOUND. (Sept. 26, 2018), https://taxfoundation.org/90-percent-taxpayers-projected-tcja-expanded-standard-deduction.

163 *See* Kaplan, *supra* note 4, at 552 (describing that a deduction's value varies with the "taxable position" of the taxpayer who claims it). This variance results from the differing times when the subsidies are imposed. Tax credits are subtracted after taxes have been calculated, whereas deductions are subtracted from taxable income, which is then multiplied by the tax rate. For instance, imagine an individual with $100,000 of taxable income, entitled to a $5000 tax subsidy, and subject to a ten percent income tax. If there were no subsidy, the individual's taxes would be $100,000 x .10 = $10,000. If the subsidy were a tax credit, the individual's taxes would be $100,000 x .10 = $10,000 – $5000 = $5000. The credit would reduce taxes by the entire $5000. If the subsidy were a tax deduction, the individual's taxes would be $100,000 – $5000 = $95,000 x .10 = $9500. The deduction would only reduce taxes by $500 (which equals the amount of the deduction multiplied by the tax rate, or $5000 x .10).

example, consider a caregiver who can deduct $5000 of expenses related to her mother's care. If the caregiver were wealthy, she would be subject to a thirty-seven percent income tax rate and the deduction would be worth $1850.[164] Comparatively, if she were in a lower bracket, such as the twelve percent bracket, she would only save $600.[165] On the other hand, if caregivers were entitled to a $5000 tax credit, the credit would be worth $5000 to all. Since any subsidy for family adult care should prioritize low-income caregivers, a deduction is not the proper instrument because it favors those in higher tax brackets.

While most of these proposals are superior to the status quo, they all contain serious flaws. Most do not address timing concerns or care recipients' autonomy, and some do not support caregivers who provide care on their own. Furthermore, these proposals limit eligible care recipients in ways that appear arbitrary in light of the goal of encouraging cost-efficiency and do not exploit the potential cost-savings that could be achieved by replacing government-funded professional caregivers with family members. While eligibility limitations are necessary given cost constraints, the lines defining qualified care recipients should be more carefully drawn.

B. Proposal of a Two-Part Advanced Refundable Tax Credit

As previously proposed tax incentives do not accurately address the factors identified in Parts I and II, this Part proposes a new tax credit. This credit should consist of two parts targeted at different populations: (1) those who provide care that would be covered by Medicare or Medicaid if provided by an official caregiver and (2) those who do not. While both populations can reduce costs, relatives who provide care that would otherwise qualify for public funding can create concrete savings by delivering more cost-efficient care than that currently used.[166] Caregivers in the second group reduce costs more indirectly by preventing expensive future care.[167] In order to generate cost savings, these groups should receive slightly different subsidies. This Part will first explain each portion of the credit and then address counterarguments.

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164 $5000 x .37 = $1850.

165 $5000 x .12 = $600.

166 *See supra* note 22 and accompanying text; *see also* Guo et al., *supra* note 22, at 14–15 (explaining that in order to create cost savings, programs promoting homecare should target care recipients who are likely to require expensive institutional care and for whom homecare can adequately replace that institutional care).

167 *See supra* note 27 and accompanying text.

1. *Caregivers Providing Care that Would Qualify for Medicare or Medicaid*

The first portion of this credit would target family adult caregivers who deliver care that would otherwise be covered by Medicare or Medicaid. In the examples from the introduction, this would cover care delivered by Samuel's wife or daughter if either began to provide the custodial care currently performed by the Medicare-funded professional aide. This Section will describe both the proposed eligibility requirements for the credit and the mechanisms that would determine the amount of the credit for each caregiver.

a. Eligible Care Recipients and Services

As an initial matter, the credit must define qualifying care recipients and services. An advantage of tying the population to Medicare and Medicaid coverage is that Congress would not have to create, and taxpayers would not have to grapple with, many complicated new definitions for these terms. In order to incentivize efficient care, the credit would aim for broad coverage of familial relationships and would cover the caregiver's spouse and all individuals who satisfy the qualifying relation test.[168]

Since the credit would be based on Medicare and Medicaid coverage, eligibility requirements should match these programs' requirements. Medicare is a fully federal program, and the eligibility requirements are relatively uniform;[169] care recipients would have to (1) receive services that qualify for original Medicare and (2) be (A) at least sixty-five years old or (B) at least eighteen years old and satisfy Medicare's disability requirements.[170] Of course, there are some medical services covered by Medicare that family members cannot

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[168] *See supra* note 103 (listing the individuals satisfying this test). This would still exclude some caregivers, such as those who care for friends with whom they do not live, but a line needs to be drawn to limit the covered population. *See supra* Part I (discussing the difficulty of including within these proposals friends who provide informal care to adults with whom they do not live).

[169] *What is the Difference Between Medicare and Medicaid?*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html (last updated Oct. 2, 2015) ("Medicare is a federal program. It is basically the same everywhere in the United States and is run by the Centers for Medicare & Medicaid Services, an agency of the federal government.").

[170] Medicare covers those under sixty-five who (1) were entitled to Social Security disability benefits for at least twenty-four months, (2) receive a disability pension from the Railroad Retirement Board and meet certain conditions, (3) have Lou Gehrig's disease, and (4) have permanent kidney failure requiring regular dialysis and meet certain requirements. *Do You Qualify for Medicare?*, AM. ASS'N OF RETIRED PERSONS, https://www.aarp.org/health/medicare-insurance/info-04-2011/medicare-eligibility.html (last updated Mar. 1, 2016).

successfully provide. The credit would not cover those claiming to deliver this care because they would either be fraudulently claiming the credit or providing inadequate care.[171] This would be guaranteed by the reporting mechanism described below. Nevertheless, there are some covered services that family members could provide. Original Medicare covers hospice care and limited home health services if received under a plan of care regularly reviewed by a doctor.[172] It does not cover custodial or personal care if that is the only care required,[173] a limitation which would exclude many family adult care providers. However, the family member would not need to provide all of her relative's care, so she could provide and claim the credit for routine personal care services while a Medicare-covered home health aide delivered the more serious medical care.

Medicaid eligibility varies by state because it is a joint federal and state program.[174] The federal government requires coverage of certain services and groups, such as low-income individuals, and states can expand this coverage.[175] The credit would first require care recipients to be at least eighteen years old. In order to most accurately replace current Medicaid costs, the credit's medical eligibility requirements should mirror each state's requirements; if the state Medicaid program would cover the same care provided by a nonrelative, the credit would be available to the relative. However, this Note aims to provide a simple, uniform national benefit and, as explained *supra* Section III.B, states currently offer a complicated mix of home health care coverage. Tying the credit to these programs' eligibility requirements

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171 Furthermore, providing an extremely high level of care in the care recipient's home can result in costs comparable to institutional care, eliminating the fiscal savings. *See* Shurtz, *supra* note 16, at 154 (discussing the fact that as a patient's condition deteriorates, and she requires more intensive at-home care, the costs can become comparable to that of a nursing home).

172 *Home Health Services*, MEDICARE, https://www.medicare.gov/coverage/home-health-services (last visited Apr. 11, 2019); *Hospice Care*, MEDICARE, https://www.medicare.gov/coverage/hospice-care (last visited Apr. 11, 2019). For home health services, a doctor must also certify that the care recipient requires one or more of: (1) intermittent (and not more than part-time) skilled nursing care; (2) physical therapy, speech pathology, or occupational therapy services that will improve in a reasonable period of time or is required to maintain a condition; or (3) being homebound. *Home Health Services*, *supra*. If these tests are satisfied, Medicare covers part-time or intermittent skilled nursing or home health aide care, physical therapy, occupational therapy, speech-language pathology services, and medical social services. *Id.*; *see also* Landers et al., *supra* note 22, at 270 (discussing Medicare home health care benefits); Shurtz, *supra* note 16, at 156–57 (same).

173 *Home Health Services*, *supra* note 172.

174 *Financial Management*, MEDICAID, https://www.medicaid.gov/medicaid/finance/index.html (last visited June 25, 2019).

175 *Eligibility*, MEDICAID, https://www.medicaid.gov/medicaid/eligibility/index.html (last visited June 25, 2019); *Mandatory & Optional Medicaid Benefits*, MEDICAID, https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html (last visited June 25, 2019).

would not promote simplicity. Instead, the credit should clearly state one eligibility requirement for medical limitations: Care recipients would be covered if they could safely receive care at home and would otherwise require more expensive Medicaid-covered institutional care, as certified by a physician.[176] This would create a single standard aligned with the goal of reducing institutional care costs. Though more individuals would be covered than under existing Medicaid programs, costs would not increase. Individuals would only qualify for the credit if they would otherwise require institutional care covered by Medicaid. Since institutional care is generally more expensive than homecare,[177] the credit's broad coverage should reduce Medicaid costs. This expansion would also include more low-income care recipients without access to other care. The care recipient's income eligibility, however, should be determined based on state level Medicaid requirements due to variations in cost of living.

For both Medicare and Medicaid beneficiaries, the credit would require physician certification of the care recipient's needs and healthcare plan. Physicians would be required to re-certify these needs in person every six months by completing a form that the caregiver would submit when claiming the credit. On this form, capable care recipients would certify that they would like to receive a certain amount of care from specific relatives, preserving the care recipient's voice in her care. This could encompass all or only a portion of the required care, but the caregiver would need to provide a minimum number of hours of care to qualify for the credit. The caregiver would also be required to certify that Medicare or Medicaid did not cover this care, so that she does not receive multiple subsidies. This could be further monitored by requiring the caregiver to include documentation of any of the care recipient's care covered by these programs.

Practically implementing this portion of the credit may require amendment to the Center for Medicare & Medicaid's (CMS) payment practices. CMS pays HHAs through a prospective payment system mandated by Congress that includes consolidated billing.[178] Through

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176 At a certain point of high-intensity care, home health care becomes more expensive than institutional care. *See* Shurtz, *supra* note 16, at 154 (discussing that the cost of home care can approximate that of a nursing home as a patient's condition degrades). It would not be cost-efficient to cover these services. This is probably also care that a relative could not provide effectively, and thus would not be covered by the credit anyway.

177 *See supra* note 22 and accompanying text.

178 *Home Health PPS*, CTRS. MEDICAID & MEDICARE SERVS., https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html (last modified Mar. 8, 2019); *Medicare Home Health Benefit*, CTRS. MEDICAID & MEDICARE SERVS. (Feb. 2018), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-health-benefit-fact-sheet-ICN908143.pdf. Note that

this system, CMS pays HHAs a bundled payment that includes both personal care services and skilled care.[179] Therefore, CMS could not separate the payment for personal care services provided by a relative from the rest of the payment to the HHA who provided the skilled medical care; costs may be duplicated by granting the relative a tax credit and still paying the agency the full cost. In order to address this issue, when creating the credit, Congress could amend the system to allow for unbundled payments that could be more easily integrated with the credit. If the government were hesitant to implement unbundled payments, CMS could use the Center for Medicare & Medicaid Innovation (CMMI) to test the efficacy of potential unbundled payment options and identify the most successful systems.[180] Finally, caregivers for Medicaid recipients who do not require skilled care could still receive the credit because they could provide all of the individual's care. Medicaid would not pay any fee to the HHA, eliminating the complication of unbundling payments.

b. Amount of Credit

Next, the credit would provide mechanisms for determining the amount of the subsidy. The caregiver's credit would be based on the number of hours of care provided. Ideally, each caregiver would be paid the amount necessary such that, when combined with her internal motivation, she would be willing to provide care. This would be based on her natural amount of internal motivation as well as the opportunity costs of providing care. Regrettably, it is not feasible to calculate this precise amount for each caregiver. Thus, the credit would be an approximation that attempts to capture these concepts. The basic hourly wage for each caregiver would be equal to some percentage, such as ninety percent, of her average post-tax hourly income over the past three years with a minimum wage equal to the federal minimum hourly wage.[181] The average post-tax hourly income over a three-year period is an attempt to capture the caregiver's opportunity cost; it

Medicaid payment systems vary by state, but most pay through a bundled payment schedule. E-mail from Dr. Marjorie Kanof, MD, MPH, Principal, Health Policy Alts., Inc. to author (Feb. 25, 2019) (on file with author).

[179] *See Home Health PPS*, *supra* note 178 ("[A] HHA must bill for all home health services which includes nursing and therapy services, routine and non-routine medical supplies, home health aide and medical social services . . . .").

[180] CMMI was created to test innovative payment and service delivery models to improve quality of care, reduce costs, and promote patient-centered practices. *About the CMS Innovation Center*, CTRS. MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/About (last updated May 14, 2019).

[181] $7.25 as of April 11, 2019. *Minimum Wage*, U.S. DEP'T LAB., https://www.dol.gov/general/topic/wages/minimumwage (last visited Apr. 11, 2019).

approximates the amount of income that the caregiver would forfeit to provide each hour of care. This is discounted to account for the caregiver's intrinsic motivation, which makes her willing to accept a lower payment than her full opportunity cost.[182] The minimum hourly wage accounts for the fact that some caregivers may not have any income in the previous three years, but the credit still aims to incentivize these relatives to provide care. The measure of each individual's opportunity cost would be based on post-tax, rather than pre-tax, income in order to account for the imputed income problem. By netting taxes out of individuals' earnings, the credit implicitly eliminates the double subsidy.

The credit would also include an income-based phaseout. Recall that Part II asserts that the credit should primarily target low-income families. Even without a phaseout, this credit would chiefly benefit low-income care recipients because Medicaid, which covers most low-income taxpayers, includes a wider array of services than Medicare. Consequently, caregivers of low-income care recipients, who have less access to healthcare, could claim the credit for more services. This, however, does not address the *caregiver's* income. If the basic hourly wage calculation above resulted in a value higher than the hourly rate paid to a home health aide for the same care, the relative would not be a cost-efficient provider. This would occur if the relative had a high opportunity cost due to a high-paying job. If the credit perfectly promoted cost-efficiency, it would only be available to those for whom the basic hourly wage calculation resulted in an amount less than or equal to the average hourly rate paid to a home health aide for the same care.[183] Caregivers with calculations that resulted in higher values would not be entitled to collect the credit at all. This would ensure that a high-earning caregiver did not decrease overall social welfare by forfeiting that high income to claim the relatively low-value credit.[184]

Nevertheless, since this credit aims to promote both cost savings and social benefits, this Note does not advocate for this hard cap. Caregiver wages are low, so many low-income family caregivers would

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[182] Further empirical research should determine the appropriate altruistic discount rate, but this determination is beyond the scope of this Note.

[183] The average hourly rate for a home health aide in 2017 was around eleven dollars per hour. *Home Health Aides and Personal Care Aides*, U.S. BUREAU LAB. STATS., https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm (last modified Mar. 7, 2019) [hereinafter *Home Health Aides*].

[184] A relative could still forfeit some income to claim the credit because of the intrinsic motivation discount, but this would be a relatively small amount.

be excluded from the credit under this cap.[185] Instead, there should be a more gradual income-based phaseout of the credit based on both the care recipient and caregiver's income. The care recipient's income should be included in the phaseout to ensure that the credit is not provided to, for example, a daughter who provides care to her wealthy father, whose assets she has not yet inherited but will in the future. The structure of this phaseout should be determined through a cost-benefit analysis examining the number of caregivers likely to claim the credit and their income levels. Although this phaseout would not promote perfect cost-efficiency, it would ensure access to low-income communities that truly require the credit.

As opposed to specified-amount or expense-based credits, this credit would be based on hourly wages. This directly compensates caregivers for the amount of time that they provide care, as opposed to awarding an arbitrary amount or an amount based on expenses.[186] A concern with an hourly rate is that a caregiver could inflate her hours without detection, creating excessive costs.[187] Three features of this credit would protect against this fraud. First, the care recipient and physician would indicate the number of hours of care the relative provided, so the caregiver would not entirely control reporting. Second, the care recipient could only receive the amount of care that would be covered by Medicare or Medicaid. This would both limit the total number of hours that the family member could claim and signify the amount of care that the care recipient genuinely required. If the relative claimed to provide more care than she did, the care recipient would not receive adequate care. This would make the fraud more easily detectable by a physician and may make the caregiver less likely to commit fraud because it would harm her relative's health.[188] Finally, to further combat fraud and preserve the care recipient's

185 *See Home Health Aides*, *supra* note 183 (reporting that the average hourly wage for a home health aide is only around eleven dollars an hour).

186 *See supra* Sections V.A.3 and 4 (discussing the problems with specified-amount and expense-based credits).

187 *See* Hermer, *supra* note 80, at 82 (discussing the government's fear that it will be difficult to detect "ghost employees" who fraudulently claim to provide care for any family caregiver credit).

188 For example, Medicaid may only cover a limited amount of homecare for a care recipient, such as the equivalent to thirty hours of care per week. Presumably, this is actually the amount of care that the individual requires. If the caregiver only provides twenty hours of care, but claims to provide all of her relative's care, the care recipient will not receive the requisite care and Medicaid will not cover any additional care. Since the individual actually requires more care than she receives, her health may deteriorate, and her physician may recognize that she is not receiving adequate care. Furthermore, the caregiver will observe that fraudulently claiming extra hours harms her family member. The effect on her relative may make the caregiver more hesitant to commit fraud as compared to when the government is the only victim.

autonomy, capable care recipients would be required to file affidavits at the close of the caregiver's taxable year stating that their relatives provided a certain number of hours of adequate care.[189] This affidavit would be simple to understand and complete, so that many care recipients could do so on their own.

To address timing concerns, the credit would be advanceable; the caregiver could choose to receive monthly payments or a lump-sum payment at the close of the taxable year. Since the care recipient would indicate to her physician how much care she plans to receive from her relative, the amount to which the caregiver would be entitled for the year should be clear. That amount would then be divided into twelve advanced payments and any inconsistencies would be accounted for at the end of the year. The credit would also be refundable.

2. *Caregivers Providing Care that Would Not Qualify for Medicare or Medicaid*

The first portion of this credit would exclude a large number of family adult caregivers: those who deliver care that would not receive public funding if provided by a professional. This includes those who provide care that is not eligible for Medicare or Medicaid funding, like Amy's son, and those who deliver additional services to individuals who qualify for limited coverage, like the supplementary care provided by Samuel's wife and daughter. These caregivers reduce future healthcare costs, but it is difficult to measure the precise cost reduction. This Section proposes a second portion of the credit targeted at these caregivers.

a. Eligible Care Recipients and Services

Eligible care recipients would still include spouses and those listed in the dependent definition without the income or support tests. Care recipients would also have to be at least eighteen years old and require assistance with at least three activities of daily living as defined in § 7702B(c)(2)(B) or instrumental activities of daily living as defined in § 1915(k)(6)(F) of the Social Security Act.[190] This repre-

[189] The affidavit would ensure that the caregiver was not solely responsible for reporting her caregiving activities. Involving another individual in the process provides a check on the caregiver's claims and requires a second person to agree to any fraudulent claims. *See* Telephone Interview with Dr. Marjorie Kanof, MD, MPH, Principal, Health Policy Alts., Inc. (Feb. 5, 2018) (stating that one measure to combat fraud is to require patients to sign a form certifying that their aide came and provided care).

[190] *See supra* note 134 (listing activities of daily living); *supra* note 148 (listing instrumental activities of daily living).

sents an appropriate balance between covering too broad or too narrow of a population and targets the caregiving area with the highest potential.[191] Care recipients who are so limited that they cannot complete these simple tasks will likely require future expensive care. If the credit was restricted to individuals with severe medical limitations, such as the long-term needs requirements in previous proposals, this portion of the credit would not cover many more caregivers than the first portion. On the other hand, if there were no functionality limit, the costs could be excessive. In order to avoid fraud, the credit would require the same physician certifications as the first portion. Again, relatives could not claim the credit if the care was covered by another form of government funding.

b. Amount of Credit

This portion of the credit would be structured similarly to the first: Caregivers would be entitled to a credit equal to a percentage of their average post-tax hourly income over the past three years with a minimum hourly wage and an income-based phaseout. The logic motivating this formula remains the same as the first portion of the credit.[192] However, there should be a greater discount percentage to account for the fact that these caregivers provide uncertain, and therefore more risky, benefits by preventing future unknown costs, rather than saving currently quantifiable public funds.[193] Again, there is a legitimate concern that this structure could lead to excessive costs and allow caregivers to fraudulently claim extra hours. The required physician certifications and care recipient affidavit should help to combat fraud. Costs would also be controlled through the income-based phaseout on both the care recipient and caregiver's income. Finally, these concerns would be addressed by including a lower and upper bound on the number of hours that each caregiver could claim and by not allowing caregivers to claim the credit for hours worked with a professional caregiver.

An in-depth cost-benefit analysis could determine a suitable hourly limit and phaseout structure. As an example, the limit could be

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191 *Caregiving Areas with the Highest Potential Due to an Increasing 50+ U.S. Population in 2016 and 2020 (in Billion U.S. Dollars)*, STATISTA, https://www.statista.com/statistics/688293/caregiving-areas-with-highest-potential-in-over-50-us-population (last visited Apr. 11, 2019).

192 *See supra* notes 180–81 and accompanying text.

193 For example, if the first portion of the credit discounted the opportunity cost by ten percent, the second portion could be discounted by twenty percent. Again, an in-depth empirical analysis of costs and risks could determine the appropriate additional discount.

set at twenty hours of care per week per care recipient.[194] At an hourly rate of $8.80,[195] the credit limit per caregiver would be about $9152 per year.[196] This is much higher than past proposals and could generate excessive costs, perhaps warranting a lower limit. However, these costs are overstated for several reasons. First, this calculation does not exclude caregivers who would receive the first portion of the credit or would not qualify for the credit due to the limitations on eligible care recipients. The calculation also presumes that all caregivers would claim the maximum hours of care and does not account for offsetting decreases in costs. Lastly, the calculation includes those who the income-based phaseout would exclude.

This portion of the credit would also be advanced and refundable. Again, since the credit would require physician certification of the care recipient's needs and plan, it should be feasible to predict the credit amount and account for inconsistencies at the close of the taxable year.

3. Counterarguments Against this Proposed Credit

There are several counterarguments against this proposal. One social concern is that the credit would encourage women to leave the workforce. Most caregivers are female[197] and some believe that subsidizing family care would encourage more women to stay home to provide care.[198] This argument ignores the many women who already adjust their labor force participation to provide uncompensated care to adults.[199] A subsidy would reward this unpaid work and provide

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194 This limit was selected because sixty-nine percent of informal caregivers of recipients over eighteen years old provided twenty hours of care or less in 2015. CAREGIVING IN THE U.S. 2015, *supra* note 2, at 34.

195 The eleven dollar average hourly rate of professional home health care workers multiplied by an eighty percent discount.

196 A limit of twenty hours of care per week would allow caregivers a maximum of 1040 hours of care per year. One thousand and forty hours at a rate of $8.80 each would result in a credit equal to $9152.

197 METLIFE MATURE MARKET INST., *supra* note 6, at 180; CAREGIVING IN THE U.S. 2015, *supra* note 2, at 6.

198 *See* Anne L. Alstott, *Tax Policy and Feminism: Competing Goals and Institutional Choices*, 96 COLUM. L. REV. 2001, 2046–47 (1996) (explaining the argument that because women are often primary caregivers, the income transfer accompanying a subsidy for caregiving would encourage them to continue to be primary caregivers).

199 *See, e.g.*, Shurtz, *supra* note 16, at 122–29 (condemning the effects of long-term care provision on women's careers and financial security); *Percentage of Experienced U.S. Caregivers that Had Select Career or Job Impacts Due to Caregiving Responsibilities as of 2017*, STATISTA, https://www.statista.com/statistics/779058/caregivers-that-have-had-job-impacts-due-to-caregiving (last visited Apr. 11, 2019) (showing that more than half of caregivers report that caregiving has impacted their careers); CAREGIVING IN THE U.S. 2015, *supra* note 2, at 10–11 (reporting that sixty percent of informal caregivers state that

these women with income, instead of forcing them to rely on others.[200] Additionally, flexible caregiving schedules and partial provision of care can allow caregivers to continue working.[201] Finally, the subsidy may not be large enough to completely replace many women's wages.[202]

Another counterargument is that private agreements between relatives can create these benefits without government involvement. Unfortunately, many find it inappropriate for family members to make these agreements,[203] while a tax subsidy may be viewed more favorably since the caregiver is not directly receiving her relative's money. Formal caregiving agreements are also subject to federal and state taxes, as well as Medicare taxes and Social Security.[204] Lastly, care recipients simply may not have the resources to pay their caregivers.

Additionally, some argue that it could be dangerous for untrained relatives to provide these services. Since relatives are the ones who often uncover caregiver abuse, mistreatment and substandard care may go undetected.[205] Recall, however, that relatives providing care beyond their abilities would not be covered by the credit and that physicians should notice if care recipients do not receive adequate care. Relatives could also be required to receive licensing or certification, though onerous requirements may deter care.[206] Furthermore, technological advancements make it possible to provide care without advanced training.[207] Much of this care, especially under the second part of the credit, would constitute services that are not medical, such

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they make an accommodation to their work when there is a conflict between work and caregiving).

[200] *See, e.g.*, Bryant, *supra* note 16, at 481 (discussing the benefits of providing women with income for caregiving responsibilities); Simon-Rusinowitz, *Paying Family Caregivers*, *supra* note 18, at 99 (same).

[201] *See* San Antonio et al., *supra* note 10, at 15 (reporting on interviews in which caregivers describe both providing at-home care and maintaining employment with flexible work schedules).

[202] *See* Alstott, *supra* note 198, at 2047 (noting that family allowances would only provide a small income supplement).

[203] *See* Kaplan, *supra* note 4, at 527 ("[Families] may see such services as obligatory in a moral or even religious sense, or perhaps as a privilege, an opportunity to pay back the love, nurturing, and care that they received . . . .").

[204] *Id.* at 528.

[205] *See* DOTY ET AL., *supra* note 31, at 20–21 (discussing the mistreatment and neglect of those receiving care).

[206] *See* Hermer, *supra* note 80, at 86 (reporting on Medicaid requirements that require family members who provide care to undergo training in order to receive reimbursement).

[207] *See* Pino, *supra* note 21, at 177 (noting that demand for in-home care is increasing due to technological advances that make it more convenient).

as help with daily activities and healthcare planning.[208] In fact, studies on consumer-directed state programs have found that relatives provide higher quality care than nonrelatives.[209] Finally, family relationships are powerful; though some caregivers may be willing to abuse their relatives, it seems more likely that a stranger with no relationship to the care recipient would commit abuse.[210]

A final objection is that it is improper to pay family members to care for one another because these relationships should not be commodified.[211] Since this proposal is structured as a tax credit rather than a direct payment from the care recipient, it may seem less like a market exchange. The credit would also be voluntary; relatives could choose not to claim it if they found it unseemly. Further, many individuals pay others to care for their family and it does not seem more inappropriate to accept a payment to provide care themselves.[212] In doing so, they more suitably respond to their familial duty instead of passing their relative off to a stranger.[213]

CONCLUSION

Family adult caregivers can provide cost-efficient care while also creating social benefits. The government should create a tax subsidy for these caregivers that promotes cost savings and targets low-income communities. Existing and recently proposed tax incentives, however, do not adequately promote the benefits of family care or account for care recipients' autonomy. The two-part advanced refundable tax credit proposed in this Note directly achieves these goals while lim-

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208 *See* Haeg, *supra* note 3, at 251–54 (noting that training and licensing do not necessarily correlate with quality of care because personal care involves non-technical work); *Percentage of U.S. Caregivers who Indicated They Provided Select Duties During Their Caregiving Experience as of 2017*, STATISTA, https://www.statista.com/statistics/784408/caregiving-responsibilities-among-us-caregivers (last visited Apr. 11, 2019) (listing the types of duties provided by caregivers).

209 *See, e.g.*, Benjamin et al., *supra* note 17, at 356 ("[R]ecipients with family providers report more positive outcomes than do those with non-family workers on five outcomes related to safety and service satisfaction . . . ."); Simon-Rusinowitz, *Paying Family Caregivers*, *supra* note 18, at 101 (finding that clients with family caregivers reported positive health and satisfaction despite differences in training).

210 *See* Haeg, *supra* note 3, at 248 (reporting on abuse and fraud associated with agency-directed and nursing home care). *But see* Shurtz, *supra* note 16, at 153 ("[T]here are reported cases of elder abuse by family members.").

211 Kraiem, *supra* note 5, at 693 (describing "the general discomfort with conceiving family as a labor supply or care work as something that family members could or should commodify").

212 *See* Haeg, *supra* note 3, at 254 (noting that payment for care services "merely recognizes that services rendered can burden a family").

213 *See id.* ("[A] person discharges this duty [to care for one's family] by entrusting his loved ones to strangers.").

iting costs and opportunities for fraud. A tax credit of this nature could increase family adult care and ensure that current levels of care remain sustainable. This solution is incredibly important given the high costs of institutional care and rising median age of the United States population.