

# **ELDER LAW AND THE TAX PRACTITIONER HOW TO NAVIGATE THE MURKY WATERS**

**Professor David L. Rice\***  
**California State Polytechnic University, Pomona**

**E-mail: [drice@lawrice.com](mailto:drice@lawrice.com)**

\*David Lee Rice is an assistant Professor At California State Polytechnic University and is in charge of their tax program. Professor Rice received his Juris Doctorate from Loyola University in Los Angeles and his LL.M. in Taxation from the University of San Diego. Professor Rice is a Certified Specialist in Taxation with the State Bar of California and a Certified Elder Law Specialist through the National Academy of Elder Law Attorneys. Mr. Rice is the incoming Chair of the Income and Family Law Tax Committee of the American Bar Association and has been Chair of numerous State Bar Committees.

## INTRODUCTION

In view of the income limitations of many elderly taxpayers, it is extremely important to minimize the tax burden imposed upon them through proper tax planning. If properly planned, the majority of elderly clients' everyday living expenses will likely be deductible for tax purposes as medical expenses.

This paper, therefore, focuses upon various tax planning issues germane to advising elderly clients. Of principal focus are the tax consequences arising from long term care and medical expenses, as well as from expenditures for Personal Service Contracts.

## TAX ISSUES FOR PERSONAL SERVICE CONTRACTS

One of the more common devices used today in Medicaid planning is the Personal Service Contract (herein "PSC"). As a result of the 2005 enactment of the Deficit Reduction Act ("DRA"), facetiously known as the "Nursing Home Bankruptcy Act," PSCs will become even more popular as a tool to assist the elderly clients in their daily care, as well as a planning technique to qualify elderly clients for Medicaid. However, if your client intends to spend-down his or her assets through compensating relatives for caretaking services, then the contract must be set forth in writing. Indeed the Centers for Medicare and Medicaid Services manual provides:

*[W]hile relatives and family members legitimately can be paid for care they provide to the individual, [the agency] presumes that services provided for free at the time were intended to be provided without compensation...However, an individual can rebut this presumption with tangible evidence...[such as] a payback arrangement [that] had been agreed to in writing at the time services were provided.<sup>1</sup>*

All fifty states and the District of Columbia have some form of assisted living regulations.<sup>2</sup> In fact, many state statutes are written in vague terms allowing

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<sup>1</sup> CMS State Medicaid Manual § 3258.1 (2004); see also Richard L. Kaplan, *Federal Tax Policy and Family Provided Care for Older Adults*, 25 VA. TAX REV. 509 (2005).

<sup>2</sup> Jennifer Rae Fleming, *The Blurred Line Between Nursing Homes & Assisted Living Facilities: How Limited Medicaid Funding of Assisted Living Facilities Can Save Tax Dollars While Improving the Quality of Life of the Elderly*, 15 U. Miami Bus. L. Rev. 245, 253 (2007).

assisted living facilities and elderly clients to negotiate a contract defining the standard of care.<sup>3</sup> However, while assisted living facilities, continuing care retirement communities, and adult day care centers exist, most long term care is provided by family members and close friends.<sup>4</sup> One study suggests that family caregiving to the elderly grew from 7 million households in 1987 to more than 21 million in 1997, and with a projection of more than 39 million households by 2007.<sup>5</sup> Actually, the true figure is closer to 50 million today.<sup>6</sup>

Some families believe that inter-generational caregiving contracts are abhorrent and contrary to cultural morals. Indeed, many states have enacted filial responsibility statutes requiring adult children to provide support to their indigent parents. However, if properly planned, elderly clients may realize tax benefits from the formation of PSCs.

In Medicaid planning, it is extremely important that the practitioner has the technical expertise to recognize the tax consequences of whatever planning techniques the practitioner recommends to the client. This certainly is important with respect to PSCs. The tax issues are almost always a factor in a decision. They do not necessarily control the decision, but the client must be fully advised of the tax ramifications.<sup>7</sup>

This paper assumes that the practitioner has a basic understanding of the use of PSCs in the elder law arena and focuses primarily on the tax issues arising from the use of these contracts.

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<sup>3</sup> *Id.*

<sup>4</sup> Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 Va. Tax Rev. 509, 510 (2005).

<sup>5</sup> Donna L. Wagner, Nat'l Alliance for Caregiving, *Comparative Analysis of Caregiver Data for Caregivers to the Elderly: 1987 and 1997*, at 1 (1997), available at <http://www.caregiving.org/data/analysis.pdf>.

<sup>6</sup> National Family Caregivers Association (Summer 2000) (Presentation).

<sup>7</sup> Because you must advise your client of the tax ramifications, it is very important to identify the client. Once you have identified the client, it is equally important to advise others involved in the matter that you do not represent them. It is best to do this in writing. Then there is no confusion concerning to whom you owe your ethical and fiduciary duties as an attorney.

## INCOME TAX ISSUES

In utilizing PSCs it is important to determine the following:

- Is a caretaker a household employee or an independent contractor?
- Can I hire a non U.S. citizen?
- What taxes if any need to be withheld?
- What happens if the caretaker wants only cash and doesn't want any withholding?
- Is the caretaker subject to the minimum wage law?
- Does the elderly client get a tax deduction for payments to the caretaker?
- What are the tax consequences of payments to the caretakers?
- Do taxpayers get a tax credit for payments made to their elderly parent's caretaker?

### IS A CARETAKER AN EMPLOYEE OR AN INDEPENDENT CONTRACTOR?

Generally, if your client or their agent hires someone to perform household work, including caretaker services, that person is deemed to be an employee.<sup>8</sup> The relationship of employer and employee exists when the person for whom the services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which the result is accomplished. In essence, an employee is subject to the will and control of the employer not only as to what shall be done, but as to how it should be done.

It is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if he has the right to do so. The right to discharge is also an important factor indicating that the person possessing the right is the employer. Other factors include how the person is paid, the furnishing of tools and of a place to work, and whether there is real risk that the worker will realize a profit or suffer a loss.<sup>9</sup> If the worker is an employee, it does

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<sup>8</sup> See IRS Pub. 926 (2010); Rev. Rul. 80-365, 1980-2 C.B. 300.

<sup>9</sup> For a number of years the IRS took the position that there were 20 factors to apply to classify a worker, albeit some of the tests were more important than others. See Rev. Rul. 87-41, 1987-1 C.B. 296. As of October 30, 1996, the IRS has acknowledged that the 20 common law factors listed in revenue ruling 87-41 are not the only ones that may be important. The IRS Training Manual provides that the most important test is control, and the agents are to look at three areas:

not matter whether the work is full time or part time, whether the elderly client hired the worker through an agency or a list provided by an agency, or whether the worker is paid hourly, daily, weekly or by the job.<sup>10</sup>

Indeed, the IRS asserts in Pub. 926, that cleaning people, health aides, private nurses, caretakers, and similar domestic workers are employees. Based on the factors set forth above, the IRS is probably correct as to the classification as employees of all the above workers, with the exception of perhaps private nurses and those hired from agencies where the agency is paid for the worker's services.

With respect to private nurses, if the worker is state-licensed and only checks on the patient sporadically or even once a day just to render medical assistance, then that individual may be deemed an independent contractor. On the other hand, if that private nurse is rendering care on an on-going basis, daily, and for many hours a day, then that individual is more likely to be deemed an employee.

If the workers, including private nurses, are hired through an agency, and the agency is paid directly for the services, then the agency will be deemed an employer. However, if all the agency receives is a commission, then your client may very well be deemed the employer. However, if the agency establishes the scope of the work, when the caretaker will be paid and the caretaker rate, then the agency will likely be deemed the employer; however, this should be discussed with the agency ahead of time to assure that your client is not the one responsible for taxes.

In addition, effective January 1988, every employer is required to report information on all newly hired workers within a specified period (generally two weeks), or incur a penalty.<sup>11</sup> Each state has its own designated agency that is responsible for collecting such information.

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(1) behavioral control; (2) financial control; and (3) relationship of the parties. *See* Employment Tax Handbook 104.6 § 5.8.1 (Apr. 21, 1999). However, the Supreme Court has noted that the common law test contains no shorthand formula or magic phrase that can be applied to determine whether a caretaker is an employee or independent contractor, and therefore all of the incidents of the relationship must be assessed and weighed with no one factor being decisive. *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 324 (1992).

<sup>10</sup> IRS Pub. 926 (2010).

<sup>11</sup> *See* Personal Responsibility and Work Opportunity Act of 1996, Pub.L.No. 104-193, 110 Stat. 2105. This section was enacted under the auspices of enforcing child support orders.

## **CAN YOUR CLIENT ENGAGE THE SERVICES OF A NON- U.S. CITIZEN?**

It is unlawful for your client to hire or continue to employ an alien who cannot legally work in the United States. You should advise your client to have a newly hired worker complete and submit the U.S. Citizenship and Immigration Services (USCIS) Form I-9. This should be done on the first day of work. The client is responsible for reviewing original documents that demonstrate an employee's identity and eligibility to work in the United States. Social Security cards may bear special annotations that restrict their use.

If there is a restriction, such as for temporary employment, the client should confirm that the card is still valid by verifying the expiration date. An employer must retain the I-9, either for three years after the date of hire or for one year after the employment is terminated, whichever is later. There are a number of forms that can establish identity, and if in doubt, the client or attorney should review the latest instructions on form I-9. However, in general, a social security card is required along with another form of identification such as a passport, voter's registration card, military card, Alien Registration Receipt Card or Permanent Resident Card, birth certificate or another identification card issued by federal, state or local government agencies or entities.

If the worker doesn't have a social security number, he or she should file form W-7 to request an Individual Taxpayer Identification Number. This number will be used on all tax reports and returns.

## **WITHHOLDING REQUIREMENTS**

If your client hires a caretaker in 2010 and pays wages of \$1500 or more to that individual, the client may need to withhold and pay social security and Medicare taxes, as well as pay federal unemployment tax (FUTA) and certain state employment taxes. For 2010, the social security taxes amount to 15.3% of the wages. The client is responsible for paying one-half (1/2) of such taxes while the employee pays the other half, provided the client withholds the caretaker's portion. If the client does not withhold the caretaker's portion, the client is responsible for paying the full amount of the tax. However, the taxes the client pays to cover the caretaker's portion must be included in the caretaker's wages for income tax purposes.

The caretaker's share of social security and Medicare taxes are not counted as social security, Medicare or FUTA wages. Generally, a federal unemployment tax of 6.2% through 2010, and 6.0% beginning in 2011 for wages up to \$7000 may be imposed on the elderly client. However, after certain credits are applied, the

rate may be reduced to as low as 0.8% of the first \$7000 of wages for each employee. Finally, each state will differ as to its taxes and the practitioner should be knowledgeable with respect to his or her state withholding requirements.

For Medicare, social security and FUTA tax purposes, the client should not count wages paid to a spouse, a child under 12, or a parent. If the caretaker is under the age of 18, and his principal occupation is providing household services, there is no requirement for such caretaker to pay Medicare or social security tax. However, the client is still responsible for paying his or her share (7.65% of the wage base) of those taxes. Note that if the caretaker is under 18 and is a student, then providing household services is not considered to be his or her principal occupation.

A client is not required to withhold federal income tax from wages he or she pays to a caretaker. However, if the caretaker requests that the client withhold tax, and the client agrees, the caretaker should complete a Form W-4 Employee's Withholding Allowance Certificate. If the client doesn't agree, then there is no obligation on the client's part to do so, however the client should notify the caretaker in writing of such non-agreement.

The client is not required to include the following items in the caretaker's income:

- Meals provided to the caretaker at the home for the client's convenience.
- Lodging provided to the caretaker at the client's home for the client's convenience and as a condition of employment.
- Up to \$230 for transit passes the client gives an employee for transportation on a bus or train.
- Up to \$230 a month for parking, provided the caretaker substantiates the expense.

Although food and lodging do not constitute taxable wages, the value of the same can be deemed to be part of wages for purposes of complying with the minimum wage laws.

The client is required to file a W-2 for any caretaker whose social security and Medicare wages were \$1500 or more for the 2010 calendar year. In addition, if both the client and caretaker agreed to withhold income tax, then a W-2 would be required even if \$1500 in wages were not paid. The client can either pay the payroll taxes quarterly or all at once on April 15 of the year subsequent to the time the wages were paid. The client is required to report the wages on Schedule H

with his or her return and if no return is due, then Schedule H can be filed separately.

### **WHAT HAPPENS IF THE CLIENT PAYS THE CARETAKER CASH AND DOESN'T REPORT IT?**

If your client pays cash under the table, he or she could still be personally liable for the payroll taxes, often referred to as the “Nanny Tax.” This could be problematic if a person holding a power of attorney is the individual paying the caretaker his or her salary, as he or she could be deemed personally liable for such taxes under Internal Revenue Code (“IRC”) Section 6672.

In addition, if an executor or the trustee of an estate is aware of the situation and later closes the estate, the estate could be held liable for the taxes. Although there may be no duty to amend a tax return that has already been filed (and this rule may be changing), there certainly is a duty to file tax returns that have not been filed. If the executor or trustee is aware of such returns, then he or she should consider filing amended tax returns. Certainly, if a practitioner is advised of the problem, then, under IRS Circular 230, Section 10.23, the practitioner has a duty to advise the client of the need to file the returns and the potential penalties for not doing so.

Finally, if the caretaker is terminated, he or she may report the matter to the state’s local employment office and the client could be held liable for the unpaid payroll taxes, first at the state level and then at the federal level, as the IRS and most states now have an agreement to share information.

### **IS A CARETAKER ENTITLED TO MINIMUM PAY?**

Caretakers in general must be paid the minimum wage, which is the greater of the amount set forth by the Fair Labor Standards Act (FLSA) or the state in which the caretaker works. Live-in employees must be paid for every hour of work, but they are not automatically entitled to the overtime rate of one and one-half times the normal hourly rate.<sup>12</sup> However, if those services are provided at an assisted living facility, the overtime rules may very well be applicable.<sup>13</sup>

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<sup>12</sup> See Fair Labor Standards Act of 1938, 29 U.S.C. § 213(a)(15).

<sup>13</sup> See *id.*



In 1974, Congress amended the FLSA to include many domestic service employees not previously subject to its minimum wage and maximum hour requirements. Congress simultaneously created an exemption that excluded from coverage under the FLSA certain employees employed in domestic service employment, including companionship workers. The Department of Labor promulgated a set of regulations defining the terms “domestic service employment” and “companionship workers.” Under one of the regulations, “services of a household nature performed by an employee in or about a private home . . . of the person by whom he or she is employed . . . such as nurses [and] caretakers employed on other than a casual basis” are exempt from FLSA coverage.<sup>14</sup> Furthermore, exempt “companionship workers” include those “who are employed by an employer or agency other than the family or household using their services....”<sup>15</sup> The Supreme Court has held that both regulations are valid and binding.<sup>16</sup>

### **WHAT ARE THE TAX CONSEQUENCES TO THE ELDERLY CLIENT WITH RESPECT TO THE PAYMENT FOR A CARETAKER CONTRACT?**

Assuming that the elderly client files his or her own tax return, and doesn't qualify as another's dependent, the client may be entitled to deduct some of the payment as a medical expense under IRC Section 213. However, the elderly client must show that the expenditure qualifies as a medical expense. In the case of payments for caretakers, this should not present a problem as payments for “qualified long-term cares services” are within the definition of medical expenses, as are various capital improvements to the family home to accommodate the elderly client.

Deductible long term expenses are, generally, the same for both chronically ill and non-chronically ill individuals. However, unlike other deductible types of medical expenses, the long term care deduction only encompasses ‘services.’ In this context, ‘services’ will likely include the use or transfer of medical supplies. But, “maintenance or personal care services” should include ancillary medical supplies furnished as a necessary part of the services.<sup>17</sup>

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<sup>14</sup> 29 C.F.R. § 552.3 (1975).

<sup>15</sup> 29 C.F.R. § 552.109(a) (1975).

<sup>16</sup> *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 162 (2007).

<sup>17</sup> See for a thorough and helpful analysis: Vorris J. Blankenship, *Tax Issues Complicate the Costs of Chronic Illness and Long-Term Care Insurance*, 106 J. TAX'N No. 4 (2007).

Long term care services are defined as those services which are “necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services.”<sup>18</sup> However, as “maintenance or personal care services” are not deductible by non-chronically ill taxpayers, to fully deduct long term expenses the services must be provided to a chronically ill individual.<sup>19</sup>

The term “chronically ill” means any individual who has been certified by a licensed health care practitioner as:

*(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity...or*  
*(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.*<sup>20</sup>

It should be fairly easy for most elderly clients to come within the ambit of the statute and thus be deemed to be “chronically ill.” First, the elderly client must be unable to perform at least 2 activities of daily living, which would include dressing, bathing, cooking, eating, normal bathroom functions, or even just getting up from a chair.<sup>21</sup> Secondly, this deficit must be documented annually by a licensed health care practitioner such as a doctor, nurse, or social worker. Assuming these requirements are met, the expenditures for such services should be deductible medical expenses under IRC Section 213.

Although there is, as yet, no exhaustive or definitive listing of deductible services, they would include meal preparation, household cleaning, and other similar services that a chronically ill person is unable to perform. Thus, a medical deduction for a proportionate cost of meals and lodging provided to live-in caretakers will be allowed.

Generally, if an elderly client resides in a retirement home, he or she will not be able to deduct the cost of his or her care, except where, and to the extent that, an independent contractor is utilized to provide medical care on an *ad hoc*

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<sup>18</sup> I.R.C. §§ 213(d)(1)(c) & 7702B(c)(1)-(3).

<sup>19</sup> *Id.* at § 7702B(c)(3).

<sup>20</sup> *Id.* at § 7702B(c)(2)(A).

<sup>21</sup> *Id.* at § 7702B(c)(2)(B).

basis. Thus, for example, only those expenses that are unequivocally medically related are deductible in a retirement home; food, transportation, and general lodging and ancillary expenses will not be deductible expenses.

By way of contrast, if a resident is in an assisted living or skilled nursing facility, the elderly client ought to be able to deduct the majority of care costs, such as payments for an attendant to help bathe, dress, provide medicine, the cost of preparing food, etc., as long as they fall within the scope of providing care to a chronically ill patient. This is axiomatic because clients who unfortunately can no longer care for themselves but need the expert medical and general care only obtainable in an assisted living, or skilled nursing, facility necessarily require constant medical services. Further, the provision of medical and related supplies is, as will normally be the case with residents of specialized care facilities, inextricably intertwined with the medical services themselves.<sup>22</sup>

However, not all costs are deductible, including the rental value of the room, the costs of food assuming that the patient doesn't have to spend extra money for a special diet, or those costs that any taxpayer would incur as a typical personal expenditure. The problem is that there is virtually no guidance on how to compute the value of these personal expenditures. For example, if a taxpayer is placed in an assisted living facility and they pay the facility \$3,000 per month, then how is the costs to be broken down between personal expenditures versus the providing of long term care costs? If a room in the area would rent for \$500, should that be deducted from the \$3,000 monthly charge in determining the amount attributable to long term care expenses? How is the taxpayer to break down the costs of food versus preparation? What about the costs of utilities, especially if the facility has to spend additional amounts due to providing medical care? Or, if recreation is provided, is that a medical cost or a personal cost and what is the deciding factor? Section 213 was enacted solely to allow those deductions that were medically related and was not intended to allow a deduction for personal expenditures.<sup>23</sup>

In the larger and more costly facilities, a percentage breakdown is generally provided to the taxpayers. In smaller facilities, no breakdown of expenses is provided. Hence, it is left up to the taxpayer to determine the proper allocation,

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<sup>22</sup> See, e.g., *Hospital Corporation of America*, 107 T.C. 116 (1996) *aff'd*, 348 F.3d 136 (6<sup>th</sup> Cir. 2003); *Osteopathic Medical Oncology & Hematology, P.C.*, 113 T.C. 376 (1999). Providers' costs are deductible, and, while there are no cases directly on point, the elderly taxpayer, as advocated herein by analogy, ought, him or herself, to be able to deduct these costs.

<sup>23</sup> In speaking with an attorney from the Office of Chief Counsel, the IRS, for purposes of convenience and administration, will continue to allow taxpayers to deduct all costs associated with hospital stays and skilled nursing home costs, even though theoretically, some of the costs, such as food and board, are personal expenditures.

which is truly unfair on a number of points, the most important of which is that the taxpayer in these cases is the least likely of taxpayers who are able to afford representation.<sup>24</sup>

It is also important to note that there is an exception in the IRC which disallows payments made to family members or other “relatives” for caregiver services as a medical deduction.<sup>25</sup> A relative is defined as any spouse, lineal descendant, brother or sister (includes half-brother or half-sister), and various entities, including corporations, trusts or partnerships in which any of the above individuals own more than a 50% interest. In essence, if the elderly client pays his or her child or brother to take care of him or her, then that client is not entitled to a medical deduction. The only exception is where the family caregiver is a “licensed professional with respect to such service,”<sup>26</sup> in which case a payment deduction will be allowed.

Even assuming that the payment is deductible under the above tests, there are two additional limitations. First, the deduction is commonly referred to by tax practitioners as a “below the line deduction” which means it is deductible from AGI,<sup>27</sup> or is classified as an itemized deduction. Consequently, this deduction is only available to taxpayers who itemize their deductions as opposed to taking the standard deduction, which in 2010 is \$5,700 for singles, \$8,400 for a head of household and \$11,400 for married couples. An additional \$1,100 is allowed for a taxpayer who is at least 65 by December 31, 2010, unless the taxpayer is unmarried and is not a surviving spouse, in which case an additional \$1,400 is allowed.<sup>28</sup> However, as a practical matter, fully one-half of all taxpayers over 65 don’t even have a tax liability, making this deduction, at least to them, superfluous.<sup>29</sup>

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<sup>24</sup> The regulations adopted with respect to IRC section 231 haven't been amended since 1960. No regulations have been adopted dealing with the long term care deductions. In speaking with an attorney from the Office of Chief Counsel, the IRS is aware of the need for guidance in this area, but has yet to include it in their business plans. Although nothing has been written at this point, there was a mention that the IRS may consider providing safe harbors in the regulations, if and when they are proposed. Because the determination of whether a cost is a personal expenditure or a medical cost is fact intensive, safe harbors may be a fair proposal for taxpayers.

<sup>25</sup> *Id.* at § 213(d)(11)(A).

<sup>26</sup> *Id.*

<sup>27</sup> I.R.C. § 62(a).

<sup>28</sup> Rev. Proc. 2009-50; 2009-2 C.B. 617 (2009).

<sup>29</sup> Kaplan, *supra* note 1, at 544.

Assuming that the client does indeed have a tax liability and itemizes as opposed to taking the standard deduction, there is still another limitation on the medical deduction. Medical expenses are only allowed to the extent that they exceed 7.5% of AGI. Accordingly, if Mary has AGI of \$40,000, then Mary can only deduct those medical expenses that exceed \$3,000. Moreover, the taxpayer can only deduct those medical expenses that are not covered by insurance, including Medicare.

Taxpayers may take medical expense deductions for all payments for care in assisted living or dementia facilities. Further, nearly all the deductible fees that are paid to assisted living or dementia facilities are also likely to qualify for long term care services.

From the tax perspective of an elderly client, payments made to a caretaker will most likely result in no tax benefit. Payments to family members are not deductible, unless made to a family member who is a “licensed professional” with respect to the services performed. Even if the payments were deductible, the elderly client would have to be a taxpayer with an income tax liability and who itemizes his or her deductions and then would still be subject to the 7.5% deduction from AGI as well as not be entitled to reimbursement by insurance, including Medicare. As a result, unless the payments are substantial in nature, and not made to a family member (unless he or she is a licensed professional), then, in all likelihood, the payments will not be deductible for tax purposes.

### **TAX CONSEQUENCES TO CARETAKERS**

Individuals are taxed on the compensation they receive for services whether that compensation is received in the form of cash, cash equivalents, property or options to acquire property.<sup>30</sup> As a result the recipient of the income will be subject to the following tax consequences:

- ❑ Federal and State income taxes.
- ❑ Social security tax of 12.4% on the first \$106,800 of earnings.
- ❑ Medicaid tax of 2.9% on all earnings.
- ❑ Local taxes such as in New York City.
- ❑ Query whether the city is allowed to charge a business tax since in essence the caretaker is conducting a business in the location in which the services are performed.

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<sup>30</sup> I.R.C. § 61.

On the other hand, if the payments made were deemed gifts, then there would be no tax consequences.<sup>31</sup> However, if Medicaid planning is the goal, then gifting is probably no longer a reasonable alternative in light of the new DRA law, effective February 8, 2006. Under the new law, the penalty period starts not from the date of the gift (as under the old law) but at the time the person is in a nursing home and first qualifies for Medicaid. Consequently, the old gifting techniques, such as staggered gifting or half-a-loaf approach will no longer be a viable method of qualifying for Medicaid.<sup>32</sup>

A number of practitioners have suggested utilizing an annuity agreement along with a caretaker agreement as a Medicaid planning technique. In essence the elderly client would enter into a caretaker agreement with a family member. The elderly client would then purchase an annuity contract and secure payment for the caretaker agreement with the annuity contract. The caretaker would be paid from the annuity contract as long as he or she took care of the elderly client. The gist of the argument is that the transference of the annuity contract as security for the caretaker contract is for valid and sufficient consideration, and hence there should be no period of ineligibility.

A further argument could be made that, in the event the elderly client dies prior to the full payment of the annuity, the annuity could still be paid to the caretaker if the caretaker contract was properly crafted to provide that full payment of the annuity is necessary to induce the caretaker to give up his or her other means of employment to take care of the elderly client. Furthermore, the new law should have no effect on the annuity, as the annuity isn't available since it is security for the performance of contractual services to be provided, and hence doesn't have to comply with the new Medicaid rules under the DRA.

Practitioners should carefully examine the new law prior to implementing this strategy for a number of reasons. First, most state agencies will, in all likelihood, challenge this type of planning, contending that in almost all commercial transactions, securing a caretaker contract with an annuity is unheard of and thus isn't for fair and adequate consideration. Second, giving the caretaker the balance of the annuity if the elderly client dies within a couple months after

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<sup>31</sup> *Id.* at § 102(a).

<sup>32</sup> There will be considerable debate whether gifting through the use of annuities and "half-a-loaf" gifting approach will work under the new law. Some commentators believe that "half-a-loaf" gifting is still possible, by having the elder care client make the gift just before he or she enters the nursing home and then have the donees give back enough money to cover the proposed penalty period. Other commentators believe that a gift can be made with enough money held back to purchase an annuity that would cover the period of ineligibility. Because the annuity is an exempt asset, the elderly person would still qualify for Medicaid.

purchasing it isn't fair and adequate consideration either, and hence the state is entitled to reimbursement. Finally, what happens if the caretaker dies first? Is another family member named as a successor to the contract? Does the caretaker's family get the annuity anyway even if the caretaker hasn't fulfilled his or her obligations?

### **CAN TAXPAYERS CLAIM AN EXEMPTION FOR PAYMENTS MADE TO THEIR ELDERLY PARENT'S CARETAKER?**

A taxpayer is allowed one exemption for each qualifying relative he or she claims as a dependant if three tests are met: First, the taxpayer cannot be claimed as a dependent by another person, even if he or she has a qualifying relative. If the taxpayer is filing a joint return and his or her spouse can be claimed as a dependent by someone else, the taxpayer and the spouse cannot claim any dependents on the joint return. Second, a taxpayer generally cannot claim a married person as a dependent if he or she files a joint return. Lastly, a taxpayer cannot claim a qualifying relative as a dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico.<sup>33</sup> In 2009 and 2010, the amount a taxpayer could deduct for each exemption is \$3,650, up from \$3,500 in 2008.<sup>34</sup>

Even if these tests are satisfied, a dependent must satisfy several requirements to be a qualifying relative. First, a child cannot be a qualifying relative if the child is the taxpayer's qualifying child or the qualifying child of any other taxpayer. Second, the qualifying relative must either live with the taxpayer all year as a member of the household or be related to the taxpayer as a child (including stepchild and foster child) or a descendant of any of them, brother or sister (including half brothers, half sister, stepbrothers and stepsisters), a parent or grandparent (but not a foster parent), stepfather or stepmother, niece or nephew, uncle or aunt, or son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law. Third, the qualifying relative's gross income for the year must be less than \$3650. Lastly, the taxpayer generally must provide more than half of the qualifying relative's total support during the calendar year.<sup>35</sup>

**Multiple Support Agreement.** Sometimes, however, no one provides more than half of the support of a qualifying relative. Instead, two or more

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<sup>33</sup> IRS Pub. 17 (2009).

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

persons, each of whom would be able to take the exemption but for the support test, together provide more than half of the qualifying relative's support. In this instance, all taxpayers who provide more than 10% of the qualifying relative's support can agree that only one of them can claim an exemption for that qualifying relative. Each of the others must sign a statement agreeing not to claim the exemption for that year. The person who claims the exemption must keep the signed statements for his or her record. A multiple support declaration identifying each of the others who agreed not to claim the exemption must be attached to the return of the taxpayer claiming the exemption.

### **DO TAXPAYERS GET A TAX CREDIT FOR PAYMENTS MADE TO THEIR ELDERLY PARENT'S CARETAKER?**

A tax credit, the Dependent Care Credit ("DCC"),<sup>36</sup> is available to taxpayers who must pay for a caretaker of a spouse or dependent elder so that that taxpayer can work. Essentially, the credit is calculated as a percentage of the amount of work related dependent care expenses the taxpayer paid to a caretaker so that that taxpayer can be gainfully employed. For example, a taxpayer, who lives with her mother who is physically incapable of caring for herself and who hires a nurse whose sole duty consists of providing the care of the mother in the home while the taxpayer is at work, may receive a credit, with certain limitations, for the amounts spent for the nursing services.

For the taxpayer to qualify for the DCC, the elder must either be a dependent or spouse of the taxpayer who is mentally or physically incapable of caring for himself or herself and have the same place of abode as the taxpayer for more than half of the taxable year.<sup>37</sup> In addition to having a qualifying dependent, the taxpayer must meet several conditions in order to receive the DCC. For example, the taxpayer and his or her spouse must have earned income from wages, salaries, tips or other taxable employee compensation, or net earnings from self-employment.<sup>38</sup> The taxpayer's spouse is exempt from the earned income requirement if he or she is either a full-time student or physically or mentally incapable of self-care.<sup>39</sup> The taxpayer must maintain a home for the qualifying dependent or elder.<sup>40</sup> The payment for care cannot be paid to someone the

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<sup>36</sup> I.R.C. § 21.

<sup>37</sup> *Id.* at §§ 21(b)(1)(B) & (C).

<sup>38</sup> *Id.* at § 21(d)(1).

<sup>39</sup> *Id.* at § 21(d)(2).

<sup>40</sup> *Id.* at § 21(e)(1).



taxpayer can claim as his dependent on his return or to his child who is under age 19.<sup>41</sup> If married, the couple must file a joint tax return. Additionally, to claim the DCC, the taxpayer must file Form 2441.

The DCC is allowed only with respect to “employment related expenses.” Employment related expenses must be incurred to enable the taxpayer to be gainfully employed.<sup>42</sup> Employment related expenses include expenses for household services and expenses for the care of the dependent elder. If expenses for the dependent elder are for services outside the taxpayer’s household, the taxpayer is given credit only where the dependent elder regularly spends at least eight hours a day in the taxpayer’s household. Employment related expenses incurred for services provided outside the taxpayer’s household by a dependent care center will be taken into account as a potential credit only if such center complies with all applicable laws and the regulations of a state or unit of local government and the dependent care center provides full-time or part-time care for more than six individuals (other than residents of the facility) on a regular basis during the taxpayer’s taxable year and receives a fee, payment, or grant for providing services for such individuals.

There is a limitation on the amount of employment related expenses that can be taken into account. The amount of employment related expenses incurred during any taxable year shall not exceed three thousand dollars (\$3,000) if there is one qualifying elder or six thousand dollars (\$6,000) if there are two or more qualifying elders with respect to the taxpayer for such taxable year.<sup>43</sup>

Expenses for household services include expenses that are paid for the performance in and about the taxpayer’s home of ordinary and usual services necessary to the maintenance of the household.<sup>44</sup> In order to receive a credit for the household services, the services must be attributable to the qualifying elder. For example, amounts paid for the services of a domestic maid or cook are considered to be expenses paid for household services if part of those services is provided to the qualifying individual.

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<sup>41</sup> *Id.* at § 21(e)(6).

<sup>42</sup> I.R.C. § 21(b)(2).

<sup>43</sup> *Id.* at § 21(c).

<sup>44</sup> Treas. Reg. § 1.44A-1(c)(2).

Expenses for the care of a qualifying elder must be incurred “to assure the individual’s well-being and protection.”<sup>45</sup> Generally, amounts paid to provide food, clothing or education are not expenses paid for the care of a qualifying individual. Additionally, expenses incurred for transportation of a qualifying elder between the taxpayer’s home and a place outside the taxpayer’s home where services for the care of the qualifying individual are provided are not incurred for the care of a qualifying individual.<sup>46</sup> In providing care, the taxpayer need not use the least expensive alternative available to the taxpayer.

A reasonable allocation must be made if an expense can be allocated to both an employment related expense and other personal purposes. No allocation is required for *de minimis* allocation where the other purpose was insignificant or minimal. Additionally, no allocation is required where an employment related expense includes expenses for other benefits which are incident to and inseparably a part of the care. As such, the full amount of the expense is considered to be incurred for care.<sup>47</sup> For example, the full amount paid to a dependant care center is considered as care for the dependent elder even though the dependent care center also furnishes food.

### **LONG-TERM CARE EXPENSES: WHAT CONSTITUTES LONG-TERM CARE EXPENSES AND ARE THEY DEDUCTIBLE?**

An important issue affecting many elderly Americans in planning for the costs of long-term care is the tax treatment of long-term care expenses; namely, what constitutes a long-term care expense and whether such expense is deductible. While the IRC currently allows for a medical expense deduction under Section 213,<sup>48</sup> there is significant confusion regarding whether the costs of long-term care delivered in a facility setting qualify for this deduction. This confusion is primarily attributable to the fact that the Treasury Regulations pertaining to IRC Section 213’s medical expense deduction narrow and limit the scope of “medical care” as defined by the Code. As a result, the law is unclear on whether elderly taxpayers, many of whom are unable to afford the cost of their care, can deduct the full cost of a long-term care facility under the medical expense deduction.

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<sup>45</sup> *Id.* at § 1.44A-1(c)(3).

<sup>46</sup> *Id.*

<sup>47</sup> *Id.* at § 1.44A-1(c)(6).

<sup>48</sup> *See* I.R.C. § 213.

IRC Section 213 provides taxpayers with a deduction for “medical care of the taxpayer, his spouse, or a dependent . . . .”<sup>49</sup> Subsection (d) defines “medical care” as amounts paid for “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body . . . for [medically related] transportation . . . [or] for qualified long-term care services . . . .”<sup>50</sup> IRC Section 213’s medical expense deduction only applies to the extent that such expenses exceed 7.5 percent of the individual’s adjusted gross income.<sup>51</sup>

As previously set forth, the term “qualified long-term care services” is defined as “necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services . . . .”<sup>52</sup> For these long-term care services to qualify for the medical expense deduction under IRC Section 213, the care provided must be prescribed by a licensed health care practitioner, and the individual receiving the services must be “chronically ill.”<sup>53</sup> Again, an individual is “chronically ill” when he or she has been certified by a licensed health care practitioner as being “unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity . . . [or] requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.”<sup>54</sup> It should be easy for many elderly individuals to come within the ambit of the statute and thus be deemed “chronically ill,” since the activities of daily living referred to in IRC Section 7702B include “eating, toileting, transferring, bathing, dressing, and continence.”<sup>55</sup> Finally, IRC Section 7702B defines “maintenance or personal care services” as “any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual . . . .”<sup>56</sup> Thus, elderly individuals who receive long-term care services should be able to deduct the costs of such services as a medical care expense pursuant to IRC Sections 213 and 7702B.

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<sup>49</sup> I.R.C. § 213(a).

<sup>50</sup> *Id.* at § 213(d).

<sup>51</sup> *Id.* at § 213(a). Thus, for example, an individual with \$100,000 of adjusted gross income may only deduct medical expenses that exceed a \$7,500 threshold.

<sup>52</sup> *Id.* at § 7702B(c)(1).

<sup>53</sup> *Id.*

<sup>54</sup> *Id.* at § 7702B(c)(2)(A).

<sup>55</sup> I.R.C. § 7702B(c)(2)(B).

<sup>56</sup> *Id.* at § 7702B(c)(3).

As previously set forth, “medical care,” defined in IRC Sections 213 and 7702B, includes qualified long-term care services, which in turn includes “maintenance or personal care services.”<sup>57</sup> Treasury Regulation Section 1.213-1(e)(1), however, severely narrows the statutory definition of “medical care” by omitting from its definition “qualified long-term care” (and thereby eliminating “maintenance or personal care services”).<sup>58</sup> In so doing, the regulation materially alters IRC Sections 213 and 7702B, and eliminates an important and otherwise allowable medical expense deduction.

Regulation Section 1.213-1(e)(1) provides that the cost of meals and lodging paid to an institution is deductible as a medical expense if (1) the institution is regularly engaged in providing medical care or services, (2) one of the principal reasons for the individual’s presence in the institution is the availability of medical care, and (3) the institution furnishes meals and lodging as a necessary incident to the medical care.<sup>59</sup>

Specifically, Treasury Regulation Section 1.213-1(e)(1)(v)(a) states the following:

Where an individual is in an institution because his condition is such that the availability of *medical care (as defined in subdivisions (i) and (ii) of this subparagraph)* in such institution is a principal reason for his presence there, and meals and lodging are furnished as a necessary incident to such care, the entire cost of medical care and meals and lodging at the institution, which are furnished while the individual requires continual medical care, shall constitute an expense for medical care.<sup>60</sup>

Subparagraph (b) however, asserts that where an individual is in an institution, and the person’s condition is such that the availability of medical care in the institution is not a “principal reason for his presence there, only that part of the cost of care in the institution as is attributable to *medical care (as defined in*

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<sup>57</sup> *Id.* at §§ 213(d) & 7702B(c)(1).

<sup>58</sup> *See* Treas. Reg. § 1.213-1(e)(1)(i) & (ii).

<sup>59</sup> *Id.* at § 1.213-1(e)(1)(v); *see also* Blankenship, *Tax Issues Complicate the Costs of Chronic Illness and Long-Term Care Insurance*, 106 J.Tax’n. 216, 221 (2007).

<sup>60</sup> Treas. Reg. § 1.213-1(e)(1)(v)(a) (emphasis added).

*subdivisions (i) and (ii) of this subparagraph*) shall be considered as a cost of medical care.”<sup>61</sup> Thus, for example, “meals and lodging at the institution in such a case are not considered a cost of medical care.”<sup>62</sup> As discussed below, we believe this interpretation is incorrect, as it is inconsistent with the Code.

Subparagraphs (i) and (ii) of subsection (e)(1) define medical care as including “diagnosis, cure, mitigation, treatment, or prevention of disease.”<sup>63</sup> The regulation’s definition of “medical care” *does not* include any mention of qualified long-term care services, maintenance, or personal care services.

The language in the regulation is clearly inconsistent with the plain language of IRC Sections 213 and 7702B. As previously discussed, IRC Section 213 includes “qualified long-term care services”<sup>64</sup> within the definition of “medical care,” which in turn includes “maintenance or personal care services.”<sup>65</sup> “[M]aintenance or personal care services” include “any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual . . . .”<sup>66</sup> By excluding these services from the regulatory definition of medical care, Regulation Section 1.213-1(e)(1) improperly narrows the Code’s definition of “medical care,” thereby precluding the possibility of a chronically ill individual deducting the cost of a retirement home or assisted living facility.

For example, where chronically ill individuals enter either an assisted living facility or a retirement home, pursuant to a plan of care prescribed by a licensed health care practitioner, for the “primary purpose” of receiving assistance with the disabilities that render them chronically ill (i.e., maintenance or personal care services), at a very minimum, the portion of the amount paid to the assisted living attributable to the longer term care costs should be deductible. This is because the Code includes such services within the definition of medical care, and thus the individual’s primary purpose of entering the facility is the availability of medical care. Where the regulations omit “qualified long-term care services” and “maintenance or personal care services” from the definition of medical care, the taxpayer potentially loses the benefit of these valuable deductions.

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<sup>61</sup> *Id.* at § 1.213-1(e)(1)(v)(b) (emphasis added).

<sup>62</sup> *Id.*

<sup>63</sup> *Id.* at § 1.213-1(e)(1)(i) & (ii).

<sup>64</sup> I.R.C. § 213(d).

<sup>65</sup> *Id.* at § 7702B(c)(1).

<sup>66</sup> *Id.* at § 7702B(c)(3).

Similarly, for individuals entering independent living units of continuing care retirement communities, the taxpayer may lose the benefit of the deductions as well. If an individual enters an independent living unit for the “primary purpose” of receiving assistance with the disabilities that render him chronically ill, under the language of the Code, the taxpayer should be allowed the deductions for the long term care costs. Many individuals enter independent living units because individuals with disabilities and terminally ill patients often know best the type of care suited for individuals with similar conditions. However, while an individual may enter an independent living unit with the primary purpose of receiving long-term care medical service, under the narrow definition provided in the Regulations, taxpayers may lose the benefit of deductions for medical care.

Skilled nursing facilities provide constant medical treatment to their residents. Individuals do not typically enter a skilled nursing facility unless their health has deteriorated to a point where they require 24-hour medical attention. The staff of a skilled nursing home includes physicians, registered nurses, and other health care professionals who are qualified to provide medical care and treatment to the elderly resident. A skilled nursing facility is much like a hospital.<sup>67</sup> Therefore, the entire cost of a skilled nursing home should be deductible as a medical expense under IRC Section 213 (subject to the 7.5 percent limitation). As discussed in Regulation Section 1.213-1(e)(1)(v), where the availability of medical care in a facility is the principal reason for an individual’s presence there, the entire cost, including meals and lodging, will be deductible.<sup>68</sup> As is the case with a hospital, nearly every individual who resides in a skilled nursing home is there for the purpose of obtaining “medical care,” as defined by the Code and the Regulations.<sup>69</sup>

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<sup>67</sup> See United States Dept. of Health and Human Services, *Glossary of Disability, Aging, and Long-Term Care Terms*, available at <http://aspe.hhs.gov/daltcp/diction.shtml#assisted> (defining a nursing facility as “licensed by the state to offer the residents . . . skilled nursing care on a 24-hour basis,” and defining skilled nursing care as “[d]aily nursing and rehabilitative care that can be performed only by or under the supervision, skilled medical personnel”).

<sup>68</sup> Treas. Reg. 1.213-1(e)(1)(v)(a).

<sup>69</sup> Recent Tax Court decisions support the notion that all costs expended at a skilled nursing facility are deductible under Section 213. Specifically, *Hospital Corporation of America*, 107 T.C. 116 (1996), *aff’d* 348 F.3d 136 (6th Cir. 2003), held that medical supplies furnished by a hospital are so “inseparably connected” to the performance of medical services that those services necessarily included income attributable to the supplies. By analogy, the auxiliary services provided by a skilled nursing facility (e.g., meals and lodging), are so “inseparably connected” with the provision of medical care, that the entirety of such costs should be deductible. See also *Osteopathic Medical Oncology & Hematology, P.C.*, 113 T.C. 376 (1999); Blankenship, *supra* note 56, at 221.

While IRC Section 213's medical expense deduction arguably includes the entire cost of skilled nursing homes, many taxpayers do not currently avail themselves of this significant benefit. This is simply because the applicability of the medical expense deduction to skilled nursing homes is not clearly laid out in the applicable regulations. The Department of Treasury and the IRS should amend Regulation Section 1.213-1(e)(1) to expressly include all services and costs of a skilled nursing home in IRC Section 213's medical care expense deduction.<sup>70</sup>

An assisted living facility (often referred to as a board and care facility) does not typically provide its residents with "medical care" as defined by Treasury Regulation Section 1.213-1(e)(1) (i.e., "diagnosis, cure, mitigation, treatment, or prevention of disease").<sup>71</sup> These services are commonly outsourced to independent contractors. However, these facilities *do* provide residents with "qualified long-term care services" and "maintenance or personal care services."<sup>72</sup> That is, assisted living facilities provide residents with care, "the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is . . . chronically ill. . . ."<sup>73</sup> Since the latter type of care is considered "medical care" under IRC Sections 213 and 7702B, all medical, including long-term care, costs and expenses incurred at an assisted living facility, where the chronically ill taxpayer's principal reason for entering the facility is the availability of such care, should be deductible. This result is entirely consistent with the plain language of the Code.<sup>74</sup> However, since Treasury Regulation Section 1.213-1(e)(1)(i) & (ii) does not include "qualified long-term care services" in its definition of "medical care," taxpayers, and tax preparers alike, are reluctant to deduct the entire cost of assisted living facilities.

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<sup>70</sup> This is entirely consistent with the IRS' current position regarding nursing homes, where the resident's principal reason for being in the home is to obtain medical care. Specifically, IRS Pub. 502 at 12 (2007) states the following: "You can include in medical expenses the cost of medical care in a nursing home, home for the aged, or similar institution . . . . This includes the cost of meals and lodging if a principal reason for being there is to get medical care." The Regulations should reflect the fact that personal care services and long-term care services are included in the statutory definition of medical care.

<sup>71</sup> There may be a viable argument however, that where the facility provides supervision of, or assistance with, taking medication, the facility is providing medical care as "treatment, or prevention of disease."

<sup>72</sup> See Dept. of Health and Human Services, *supra* note 23 (defining assisted living facility as a "home with services" where "[p]ersonal care services are available on a 24-hour-a-day basis"); see also I.R.C. §§ 213(d) & 7702B(c)(1).

<sup>73</sup> I.R.C. § 7702B(c)(3).

<sup>74</sup> See *id.* at §§ 213(d) & 7702B(c)(1).

The Department of Treasury and IRS should revise Treasury Regulation Section 1.213-1(e)(1) by including long-term care services and personal care services in its definition of medical care, to properly reflect Sections 213 and 7702B of the Code. In doing so, taxpayers could deduct the long term care costs of assisted living facilities with confidence. As discussed above, these regulatory changes would not broaden the definition of medical care, nor would it expand taxpayers' allowable deductions. Rather, the proposed changes would accurately reflect the plain language of the Code, and would permit taxpayers to take the deductions to which they are already entitled, without fear of IRS adjustments.

A retirement home includes an apartment or residential facility which primarily caters to retired individuals.<sup>75</sup> A retirement home will often provide meals and cleaning services for the resident, however the residents of a retirement home are most often self-sufficient and are not confined to the facility.<sup>76</sup> In addition to the provision of meals and cleaning services, retirement homes provide various individual and group activities for their residents, which may include exercise classes, mental conditioning classes, bingo, music performances, lectures, arts and crafts, religious prayer, movies, and regular transportation for shopping or other excursions, to name but a few.

Similar to assisted living facilities, medical services (as defined in Treasury Regulation Section 1.213-1) are rarely provided by a retirement home; rather any such medical services required by the residents are provided by independent contractors or by the residents' own physician. As a result of the outsourced medical treatment, retirement homes are a desirable option for many chronically ill individuals, since these homes are less akin to the hospital environment. Clearly, a retirement home resident will be able to deduct the medical services provided by the independent contractor under IRC Section 213.<sup>77</sup>

However, retirement homes provide assistance with an individual's disabilities, based on the needs of the resident.<sup>78</sup> For example, where a chronically ill individual is unable to bathe him or herself, and has trouble with transferring, the retirement home staff will provide assistance with these activities of daily living. Where this is the case, the costs attributable to medical and long term care

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<sup>75</sup> See Dept. of Health and Human Services, *supra* note 23.

<sup>76</sup> *Id.*

<sup>77</sup> I.R.C. § 213; Treas. Reg. §§ 1.213-1(e)(1)(i), (ii) & (v).

<sup>78</sup> See Dept. of Health and Human Services, *supra* note 23 (describing a retirement home (*i.e.*, a continuing care retirement community) as providing "residential services (meals, housekeeping, laundry), social and recreational services, health care services, personal care, and nursing care").



costs of the facility should be deductible for these individuals, since the care provided is “medical care” under IRC Sections 213 and 7702B; so long as the individual’s principal reason for entering the facility is the availability of such care.<sup>79</sup>

Further, “qualified long-term care services” includes not only “maintenance or personal care services,” but also “necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services . . . .”<sup>80</sup> Where the chronically ill individual is in a retirement home, pursuant to a plan prescribed by a licensed health care practitioner, the costs apportioned to the organized activities provided by the retirement home, which serve the taxpayer’s therapeutic, rehabilitative, or other “qualified long-term care” needs, should be deductible by the taxpayer. Where the principal reason for the chronically ill taxpayer’s presence in the retirement home is to obtain the therapeutic, treating, or rehabilitative services offered by the home, in the form of organized activities, the entire cost attributable to providing such services of the facility should be deductible.<sup>81</sup>

Again, to accurately reflect Congress’ intent, as evidenced by the plain language of IRC Sections 213 and 7702B, Treasury and the IRS should alter Treasury Regulation Section 1.213-1(e)(1) to include “qualified long-term care services” and “maintenance or personal care services” as a deductible medical expense. Accordingly, a chronically ill individual who enters a retirement home for the principal reason of obtaining such services should also be entitled to deduct at least the apportioned cost of those services, including the costs of meal preparation and some of the recreational activities that are prescribed by a physician. **Loans made to continuing care retirement homes.** Retirement care facilities offer various financial arrangements to persons needing long term care. Retirement care facilities not only offer lodging on periodic payment plans, but they also allow payment of entrance and monthly fees to obtain a living unit in cluster homes or condominiums. Depending on the characteristics of the fee, the fee could be equivalent to a loan or a sale. While several factors are considered in determining whether an entrance fee is a loan or a sale, including whether (1) legal title passes, (2) equity was acquired in the property, (3) the contract creates a present obligation on the retirement care facility to execute and deliver a deed and a present obligation on the purchaser to make payments, (4) the right of possession is vested in the purchaser, and (5) which party bears the risk of loss, the most

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<sup>79</sup> Treas. Reg. § 1.213-1(e)(1)(v).

<sup>80</sup> I.R.C. § 7702B(c)(1).

<sup>81</sup> See Treas. Reg. 1.213-1(e)(1)(v).

significant factor is the characterization of the parties to the transaction in their written agreement.<sup>82</sup>

If the entrance fee is considered a loan (i.e., part or all of the entrance fee is refundable), and the loan is a below market loan,<sup>83</sup> generally, the lender (the elderly client) is treated as having transferred on the date the loan was made and the borrower (the retirement care facility) is treated as having received on such date cash in an amount equal to the excess of the amount loaned over the present value of all payments which are required to be made under the terms of the loan.<sup>84</sup> However, for term loans, the deemed transfer is treated as being made on the first day on which Section 7872 applies to the term loan.<sup>85</sup> Furthermore, with a term loan, the lender makes the total transfer in the first year of the loan.<sup>86</sup> Section 7872 requires that the lender (the elderly client) recognize imputed interest income and the borrower (the retirement care facility) recognize imputed interest expense on loans bearing an interest rate less than the market rate.<sup>87</sup>

If the refundable portion of the entrance fee is a demand loan, the applicable rate is the Federal short term rate in effect under Section 1274(d) for the period for which the amount of forgone interest is being determined, compounded semiannually.<sup>88</sup> However, if the refundable portion of the entrance fee is a term loan, the applicable rate is the Federal short term rate in effect under Section 1274(d) as of the day on which the loan was made, compounded semiannually.<sup>89</sup>

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<sup>82</sup> *Highland Farms, Inc. v. Comm’r*, 106 T.C. 237, 253, 255 (1996).

<sup>83</sup> A below market loan is a demand loan in which interest is payable on the loan at a rate less than the applicable Federal rate, or a term loan in which the amount loaned exceeds the present value of all payments due under the loan. I.R.C. § 7872(e)(1).

<sup>84</sup> I.R.C. § 7872(b)(1).

<sup>85</sup> Prop. Treas. Reg. § 1.7872-7(a). It should be noted, however, that proposed regulations do not become effective until after a notice and comment period. The proposed regulations in question were published back in the mid-80s and there has been no further guidance from the Service to taxpayers in this area. Proposed regulations, at best, may offer guidance for a specific section of the Code.

<sup>86</sup> *Id.*

<sup>87</sup> Robert Atkins Walker and Chad E. Turner, *Gold at the End of the Rainbow: Medical Expenses and Below-Market Rate Loans in Continuing Care Retirement Communities*, 18 Va. Tax. Rev. 1, 26 (1998).

<sup>88</sup> I.R.C. § 7872(f)(2)(B).

<sup>89</sup> I.R.C. § 7872(f)(2)(A).

Term loans are valued at discounted present value whereas demand loans are valued at face value.<sup>90</sup> Therefore, it may be in the elderly client's best interest to treat the entrance fee as a term loan.<sup>91</sup>

Furthermore, these rules only apply to loans to a qualified continuing care facility. A qualified continuing care facility is one or more facilities, not including nursing homes, which (1) are designed to provide services under continuing care contracts, (2) include an independent living unit, plus an assisted living or nursing facility, or both, and (3) substantially all of the independent living unit residents are covered by continuing care contracts.<sup>92</sup> In addition, these rules do not apply if the loan was made pursuant to a continuing care contract<sup>93</sup> by a lender or the lender's spouse (the elderly client or the client's spouse) who attains the age of 62 before the close of the calendar year.

Now the question arises as to whether the entrance fees and monthly fees are deductible as medical expenses. If the entrance fee is a loan, it cannot serve as the basis for a medical deduction.<sup>94</sup> The elderly client may only deduct as a medical expense that portion of the fee actually allocable to the retirement home's obligation to provide medical care.<sup>95</sup> With respect to entrance fees, there are three possible amounts that can be deducted: (1) the entire entrance fee regardless of the guaranteed refund, (2) the entrance fee less the face amount of the guaranteed refund, or (3) the entrance fee less the discounted present value of the guaranteed refund. The first amount is unadvisable since the IRS would likely take the position that the entrance fee is a loan. The second amount would likely yield the lowest medical expense deduction depending on how the continuing care facility

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<sup>90</sup> Walker and Turner, *supra*, note 82.

<sup>91</sup> See Walker and Turner, *supra*, note 82 at 28-35 (discussing the benefits of term loan discounting).

<sup>92</sup> I.R.C. § 7872(h)(3).

<sup>93</sup> A continuing care contract is a written contract between an individual and a qualified continuing care facility under which: (1) the individual or his or her spouse may use a qualified continuing care facility for their life or lives, (2) the individual or his or her spouse will be provided with housing, as appropriate for the health of such individual or the spouse in an independent living unit and in an assisted living facility or nursing facility, as is available in the continuing care facility, and (3) the individual or his or her spouse will be provided assisted living or nursing care as the health of such individual or the spouse required, and as is available in the continuing care facility. I.R.C. § 7872(h)(2).

<sup>94</sup> *Finzer v. U.S.*, 496 F.Supp.2d 954, 958 (citing *Comm'r v. Tufts*, 461 U.S. 300, 307 (1983)). Under tax law, issuance or receipt of a loan is not a taxable event. *Tufts*, 461 U.S. at 307.

<sup>95</sup> *Finzer*, 496 F.Supp.2d at 959 (citing Rev. Rul. 75-302, 1975-2 C.B. 86).

calculates the percentage. The third amount, however, may be the safest.<sup>96</sup> Again, residents of continuing care facilities may deduct only the portion of their entrance fees attributable to medical costs.

Residents of continuing care retirement communities are entitled to use a percentage method to determine what portion of their monthly service fees constitute deductible medical expenses (i.e., the facility's health care related costs over total costs). However, the Tax Court uses a modified approach whereby the allocation percentage is based on the number of community residents and the weighted average monthly service fees.<sup>97</sup> Furthermore, the Tax Court has held that no deductions are allowed for the elderly client's use of facility pools, spas, or exercise facilities unless such amenities are in fact used for medical purposes.<sup>98</sup> Deductions for expenditures for medical care are confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness.<sup>99</sup> An expenditure which is merely beneficial to the general health of an individual is not an expenditure for medical care.<sup>100</sup>

## **TAXATION OF QUALIFIED LONG-TERM CARE INSURANCE AND LIFE INSURANCE CONTRACTS**

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<sup>96</sup> See Walker and Turner, *supra*, note 82 at 45. According to Walker and Turner, "The medical expenses allocable to the entrance fee are figured only on the fee net of the discounted present value of the guaranteed refundable portion....By treating the refundable portion as a term loan, the discounted present value of the refund may be less than half of the face value for most residents. This choice will yield a larger deduction than the second choice if the [continuing care facility] inappropriately allocated some of the medical costs to the refund because the refund amount is smaller when discounted." *Id.*

<sup>97</sup> Michael D. Koppel, *Deductibility of Retirement Community Fees*, 12-04 T.T.A. 735 (December 2004).

<sup>98</sup> *Baker v. Comm'r*, 122 T.C. 143, 144, 170 (2004).

<sup>99</sup> *Baker*, 122 T.C. at 181-82 (citing to *Haines v. Comm'r*, 71 T.C. 644, 647 (1979)).

<sup>100</sup> Treas. Reg. § 1.213-1(e)(3)(ii).

Qualified long-term care (“QLC”) insurance policies provide an elderly individual with reasonable means of affording long-term care.<sup>101</sup> A QLC contract may exist on its own, or as part of a life or annuity contract. The IRC provides for favorable tax benefits arising from QLC insurance contracts. Specifically, the premiums paid for a QLC insurance policy are generally deductible, and the benefits received under such a policy may be nontaxable.

The deductibility of QLC premium payments follows the same guidelines as deductible medical expenses under IRC Section 213, and are subject to the same limitations (both of which are discussed above). QLC premium payments however, are subject to an additional limitation: they are not deductible to the extent they exceed an annual limitation, which is defined by IRC Section 213(d)(10). The limitations vary based on age and are indexed for inflation. For 2010, the limitations on the QLC premium deduction for an individual are: 40 years of age or younger is \$330, more than 40 years of age but not more than 50 is \$620, more than 50 years of age but not more than 60 is \$1,230, more than 60 years of age but not more than 70 is \$3,290, and more than 70 years of age is \$4,110.<sup>102</sup>

Benefits received under a QLC insurance contract also receive favorable tax treatment, as they may be excludible from gross income under IRC Section 7702B – governing the rules applicable to reimbursement of medical expenses. This exclusion from income applies regardless of whether the insurance contract exists as a stand-alone policy, or as a rider to a life insurance or an annuity policy.

Similarly, while post-death life insurance payments are generally excludible from gross income, benefits received during one’s life, pursuant to a life insurance policy, may also be nontaxable if the insured is chronically or terminally ill.<sup>103</sup> The IRC defines a “terminally ill” individual as one who “has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less. . . .”<sup>104</sup> A terminally ill individual is entitled to a one-hundred percent exclusion of life insurance proceeds received during life. Additionally, premium payments are fully deductible by the terminally ill individual.

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<sup>101</sup> As a result of consumer fraud, there are stringent requirements governing QLC insurance contracts. *See* Blankenship, *supra* note 17. These requirements are not the relevant to the present discussion.

<sup>102</sup> Rev. Proc. 2009-50; 2009-2 C.B. 617.

<sup>103</sup> *See* I.R.C. § 101(g); Blankenship, *supra* note 17.

<sup>104</sup> I.R.C. § 101(g)(4).

The chronically ill individual's exclusion of life insurance proceeds is limited by the amount of benefits attributable to reimbursement of his or her long-term care costs. The life insurance benefits paid to chronically ill patients are subject to a further limitation, which also limits the excludability of QLC insurance benefits.

**Limitations on Exclusion of Benefits.** As noted above, benefits from QLC insurance policies and life insurance benefits (paid to chronically ill patients) *may* be excludible from gross income. The IRC provides for limitations on the excludability of "periodic payments" from QLC or life insurance contracts; an important factor in determining how to fund one's long-term care.

First, the IRC distinguishes between benefits arising from two different types of contracts: QLC insurance contracts and life insurance contracts. Additionally, the limitation on the nontaxable benefits varies based upon the "status" of the individual (*i.e.*, whether the individual is chronically ill or terminally ill). With these distinct categories in mind, the limitation applies to payments from (1) QLC insurance contracts insuring chronically ill individuals, including terminally ill patients; and (2) life insurance contracts insuring chronically ill individuals, excluding terminally ill patients.

Specifically, IRC Section 7702B(d)(1) sets forth the limitation as follows:

- (1) *In general. If the aggregate of—*
  - (A) *the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and*
  - (B) *the periodic payments received for such period which are treated under section 101(g) as paid by reason of the death of such insured, exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72.*

In other words, periodic payments of applicable insurance benefits are not excludible from gross income to the extent they exceed a "per diem" amount. The section defines the per diem amount as the greater of (1) a defined dollar amount (\$290 per day in 2010), and (2) the long-term care costs, less the total reimbursements for long-term care costs. Thus, the "per diem" amount for an individual with \$100,000 in long-term care costs over a one-year period and

\$40,000 in reimbursements will equal \$65,850.<sup>105</sup> Under Section 7702B(d)(1), the exclusion of qualified benefits received by the individual will be limited to this “per diem” amount.

However, Section 7702B fails to define what constitutes a long-term care “period” for purposes of determining the limitation of nontaxable benefits. Rather, two differing methods are commonly employed, each resulting in different results. These methods are the “equal payment rate” method and the “contract period” method.

Under the equal payment rate method, the long-term care period is the “period during which the insurance company uses the same payment rate to compute your benefits.”<sup>106</sup> As exemplified in the instructions to IRS form 8853, where an insurance carrier computes payments at the rate of \$175 per day from March 1 to May 31, and a rate of \$195 per day from July 1 to December 31, the taxpayer has two long-term care “periods”. Similarly, where the insured receives benefits at a single rate for an entire year, that individual has one long-term care “period”.

Under the “contract method” however, the insured’s long-term care period is equal to the period used by the insurance carrier to calculate the benefits. For example, where the insurance carrier calculates the benefits to be \$20 per day for one year, the insured has 365 long-term care “periods” under this “contract” method. As the examples below indicate, choosing one method over the other can have significantly different tax consequences.

**Example 1 – Equal Payment Rate Method –** Assume a chronically ill individual is insured under a life insurance policy (or a QLC contract) which pays the insured accelerated death benefits during the 2010 taxable year.<sup>107</sup> Those benefits are paid on a monthly basis totaling \$9,000 per month and are scheduled to extend from January 1 to December 31, 2010. During the 2010 taxable year, the insured’s actual long-term care expenses totaled \$70,000, and the insured received reimbursements from other insurance policies totaling \$10,000.

Applying the formula set forth in Section 7702B, the per diem amount equals \$95,850 – which is the greater of (1) the “dollar amount” (i.e., \$290 x 365

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<sup>105</sup> The dollar amount of \$290 per day for one year is \$105,850, which is greater than the long-term care costs of \$100,000. Thus, \$105,850 - \$40,000 = \$65,850.

<sup>106</sup> IRS Form 8853 Instructions (2009).

<sup>107</sup> As previously noted, if the insured is terminally ill, benefits received under a *life insurance policy* are completely excluded from gross income.

days in the period) and (2) the actual long-term care costs (\$70,000), less the amount reimbursed (\$10,000). As noted above, the insured received \$9,000 per month in periodic payments totaling \$108,000. Since those benefits are includible to the extent they exceed the per diem amount, a total of \$12,150 is taxable (\$108,000 in total benefits received - \$95,850 per diem amount).

**Example 2 – Contract Method –** Assume the same facts as Example 1, except that the insured’s actual long-term care costs of \$70,000 breaks down as follows: \$10,000 in January and December, \$12,000 in February, and \$4,222 in each other month. Additionally, the \$10,000 in reimbursed expenses was paid in 12 equal installments of \$833 per month. The insured still receives \$9,000 per month for the entire 2010 taxable year. Under the contract method, since the benefits are calculated by the insurance carrier on a monthly basis for a term of one year, there are 12 periods, and each must be calculated individually.

For January and December respectively, the per diem amount equals \$9,167 (the long-term care costs -- which is greater than the “dollar amount” of \$290 x 31 days -- less the reimbursed expenses for that month). Since the benefits received in January and December do not exceed the per diem amount (i.e., the 7702B limitation), all benefits received during these months are fully excludible from gross income.

For February, which has only 28 days in 2010, the per diem amount equals \$11,167 (the “greater” of the actual expenses and the “dollar amount”, less the amount reimbursed). The benefits received were \$9,000 for February. Similar to January and December, the amount of received benefits does not exceed the limitation amount, leaving no taxable income for this month.

For each month with 30 days, (e.g., April, June, September and November), the per diem equals \$7,867 (\$8,700 - \$833). The difference between the benefits received and the limitation for these months is \$1,113 per month, which is taxable. For these four months, the combined taxable amount is \$4,452.

Finally, for each month with 31 days (March, May, July, August and October), the per diem is \$8,157. The benefits received exceed this amount by \$843, leaving a total of \$4,215 for these five months.

When added together, the amount of the benefits not excludible from gross income (i.e., the taxable amount) equals \$8,767.

In both examples, the insured received exactly \$108,000 in benefits, expended \$70,000 in actual expenses and was reimbursed a total of \$10,000 during the 2010 taxable year. The limitation on the nontaxable benefits differs



however, depending on whether the taxpayer chooses the “equal payment rate” or the “contract period” method. Specifically, under the former method, the taxable income was \$12,150, while under the latter method, the taxable amount was only \$8,767. Using different figures, more disparate amounts may result.<sup>108</sup> Clearly, the limitations found in IRC Section 7702B must be analyzed under both methods before one can properly advise their client.

### CONCLUSION

As the years have gone by, the choices that elders have in terms of living quarters and care have been greatly expanded. Unfortunately, incomes of the Elderly have not kept pace with the ability to make some of these decisions. Proper tax planning early on may allow an elderly person more choices in the future as to his or her care and quality of living quarters.

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<sup>108</sup> See Blankenship, *supra* note 17.