

For Love and Affection: Elder Care and the Law's Denial of Intra-Family Contracts

Nina A. Kohn*

As the U.S. population ages, demand for care providers for older adults is rapidly growing. Although the law's treatment of care contracts between older adults and their family caregivers has substantial implications for the country's ability to meet this demand, there has been no prior empirical examination of the law's current treatment of such agreements. This Article fills that gap by assessing how courts and other legal actors treat intra-family agreements to pay family members for elder care. A look into a long-ignored area of case law—Medicaid eligibility determinations—reveals that courts, administrative law judges, and state regulators typically attach little or no monetary value to elder care provided by family members. Rather, payments for caregiving are routinely treated as fraudulent transfers. The result is that, in the name of combatting Medicaid fraud, states penalize older adults who pay for their own care.

Treating family-provided elder care as lacking monetary value stands in sharp contrast to the high cost of elder care purchased on the open market and is at odds with states' increased willingness to directly pay family care providers. This Article shows that this incongruence can be partially explained by public distaste for Medicaid planning and distrust of agents acting on behalf of older adults. Entrenched stereotypes about care work and related expectations about familial care also contribute to the law's refusal to recognize these agreements and the economic value of care provided under them.

This Article offers lessons for social policy, legal theory, and legal practice. On a policy level, it shows that states are engaged in counterproductive behavior that will discourage the very type of family care they purport to encourage. On a theoretical level, it indicates that attitudes toward care work and courts' willingness to enforce contracts between family members have not changed to the extent commonly described by family law scholars. Finally, at a practical level, it suggests that attorneys should adapt the advice they give clients to better account for distrust of agents.

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* Associate Dean for Online Education, David M. Levy Professor of Law, Syracuse University College of Law. A.B. Princeton University, J.D. Harvard Law School. This Article benefited from the generosity of many colleagues who shared suggestions and critiques in various forums in which earlier drafts were workshopped. The author extends particular thanks to Robert Ashford, Margaret Friedlander Brinig, Keith Bybee, Jessica Weaver Dixon, David Driesen, Lauryn Gouldin, Alicia Kelly, Sandra Mayson, Mary Helen McNeal, and Jeffrey Milder for their comments, and Paul Bern for his assistance with statistical analysis.

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INTRODUCTION

Scholars commonly describe the United States as being in the midst of a shift toward greater recognition of the economic value of care work¹ and toward increased willingness to give effect to contracts within families.² Scholars writing about this shift have focused on care for children,³ and con-

¹ As scholars have explained, childcare provided within families was historically seen as lacking in economic value, with attitudes evolving especially over the last half century. See, e.g., James E. Pratt, *An Input-Output Approach to Valuing Non-Market Household Time*, 9 INT'L J. ECON. DEV. 239, 243 (2007) (discussing how historically, household production, including childcare, was not counted in economic studies because it was seen as outside of the market, and discussing the more recent trend—led by feminist economists—to include such labor in economic analysis). Changes are visible in the nation's divorce courts, where modern approaches to division of property have allowed courts to publicly (and at times generously) value parent's childcare work. See Laura Rosenbury, *Two Ways to End Marriage: Death or Divorce*, 2005 UTAH L. REV. 1227, 1241 (2012) (describing the rise of the partnership theory of marriage and describing the theory as recognizing the value of care work).

² See *infra* notes 197–202 and accompanying text.

³ Cf. Meredith Johnson Harbach, *Childcare Market Failure*, 2015 UTAH L. REV. 659 (2012) (describing the legal literature's treatment of child care issues as extensive, noting that, "[l]egal scholars have engaged in a sophisticated debate about the comparative value of market work versus care work for women. They have analyzed and recommended enhanced protections for childcare providers. They have considered the implications of economic theory for a variety of family law questions. And they have debated the state's responsibility for childcare on philosophical, moral, and equitable grounds."); see also *id.* at 660.

tracts between sexual and romantic partners.⁴ By contrast, little attention has been given to care provided to older family members, or intra-family agreements to provide care to older relatives.⁵

This Article seeks to fill this gap in the literature and to determine whether there has been a similar shift in the valuation of elder care or the law's treatment of agreements between family members to provide such care. It does this by examining a concrete situation in which states must assess whether care provided to older adults has economic value and, if so, how much. Specifically, the study takes advantage of long-ignored data from Medicaid eligibility regulations and determinations in which states assess whether a Medicaid applicant's transfer of money to a caregiver relative is a "payment" (because the applicant received care which had economic value in return) or a "gift" (because the applicant did not receive care with such value in return). This data provides insight into society's current valuation of elder care, including the extent to which the law is shifting toward greater recognition of the economic value of care work and of private contracting between family members.

This Article challenges the accepted narrative about the law's embrace of contracting within families. It shows that elder care provided by family members is frequently construed as non-economic activity and that intra-family contracts for elder care are viewed as suspect and non-binding. Indeed, it finds that states are, quietly and without fanfare, adopting rules that treat contracts between family members for elder care as fundamentally different from those between unrelated parties, and elder care provided by family members as non-economic activity. This trend appears to be the opposite of what has been described in the context of care for children.⁶

The Article proceeds in four parts. Part I provides an overview of personal care contracts and their role in meeting the needs of the aging population. Part II describes the legal treatment of personal care contracts, including the regulatory response to such contracts and how administrative law judges and courts evaluate them. Part III explores explanations for the law's unsympathetic reaction to personal care contracts. This Part demonstrates how this response is shaped not only by a distrust of agents and an aversion to Medicaid planning, but also by entrenched historical expecta-

⁴ See, e.g., MARTHA M. ERTMAN, *LOVE'S PROMISES: HOW FORMAL AND INFORMAL CONTRACTS SHAPE ALL KINDS OF FAMILIES* (2015) (broadly discussing intra-family contracts but not considering ones related to elder care).

⁵ For a rare glimpse of the value courts accord to elder care, analyzing court decisions in the late nineteenth and early twentieth centuries that determined whether to enforce a promise by an older adult to give land to a caregiver in return for care or company, see HENDRIK HARTOG, *SOMEDAY ALL THIS WILL BE YOURS* (2012); see *infra* note 93 and accompanying text. Unfortunately, the types of cases he examined largely disappeared after the first half of the twentieth century and thus Hartog's work does not show whether similar patterns exist today. See Nina A. Kohn, *The Nasty Business of Aging*, 40 *LAW & SOC. INQUIRY* 506, 508–09 (2015) (discussing possibilities for investigating whether such attitudes persist).

⁶ See *supra* notes 1 and 3 and accompanying text.

tions about familial roles, including the assumption that women care for family members out of “love and affection,” and therefore should not expect payment for their labor. Part IV then explores implications for social policy, legal theory, and the practice of law, including how the Article’s findings challenge accepted narratives in legal scholarship and common legal practices.

The Article concludes by considering the consequences of the law’s refusal to recognize intra-family contracts for elder care. It argues that this refusal fails to recognize the true nature and value of the work done by care providers. More importantly, by penalizing older adults who pay family members to provide care, states undermine older adults’ right to contract, and thus their ability to engage in self-protective economic behavior at a time of intense vulnerability.

I. OVERVIEW OF PERSONAL CARE CONTRACTS

As individuals grow older, many find it increasingly difficult to meet their own physical, psychological, and social needs. Those with significant financial resources can purchase a range of services on the open market to meet those needs. Assisted living facilities and continuing care retirement communities can meet the needs of those with substantial physical and cognitive limitations by providing a combination of housing and support services.⁷ Home care agencies can provide professional caregivers who, if resources permit, can allow even older individuals with severe limitations to reside safely at home. However, such arrangements are generally only viable for those with some degree of wealth,⁸ or those who qualify for Medicaid and manage to secure a spot in their state’s “waiver” program for covering home and community-based, long-term care services.⁹ The average monthly cost of assisted living in the United States is over \$3,700 per month,¹⁰ and

⁷ For an overview of the range of services offered by assisted living facilities, see Stephanie Edelstein, *Assisted Living: Recent Developments and Issues for Older Consumers*, 9 *STAN. L. & POL’Y REV.* 373, 374 (1998) (discussing the variation in the extent and quality of services provided by assisted living facilities).

⁸ See GENWORTH SUMMARY OF 2017 SURVEY FINDINGS (2017), https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/cost-of-care/131168_081417.pdf, archived at <https://perma.cc/JDW7-TU4X> (describing the cost of such arrangements). Long-term care insurance can cover such expenses; however, this insurance product is generally only affordable to those who are at least upper middle-class. See Lawrence A. Frolik, *Private Long-Term Care Insurance: Not the Solution to the High Cost of Long-Term Care for the Elderly*, 23 *ELDER L.J.* 371, 372–74 (2016) (discussing the cost of long-term care insurance).

⁹ The demand for such coverage continues to out-pace the number of spots in state programs, a pattern that is notably at odds with the U.S. Supreme Court’s decision in *Olmstead v. Zimring*, 527 U.S. 581 (1999). See Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid’s History*, 26 *GA. ST. U. L. REV.* 937, 966–67 (2010) (discussing waiver programs and the shortfall in community-based long-term care services).

¹⁰ See GENWORTH SUMMARY OF 2017 SURVEY FINDINGS, *supra* note 8.

high-quality assisted living facilities routinely charge significantly more.¹¹ The median hourly cost of professional in-home care is estimated to be \$20 per hour.¹²

Those who cannot afford supportive housing or professional in-home care face a challenge as to how to meet their needs. They can try to manage without assistance. Alternatively, if they are or become impoverished, they can apply to cover the cost of care in a nursing home through their state's publicly funded Medicaid program.¹³ Neither option is likely to be attractive, as few individuals wish to have their needs go unmet or to live in a nursing home.¹⁴ A third option is to turn to family members or close friends.

Family members are often ideal candidates to fill the gap between what older adults need and what they can afford. Ties of loyalty and a sense of duty may lead family members to perform personal care services without pay, for lower pay, or under conditions that professional care providers would reject. Indeed, family members perform, without pay, the bulk of home care provided to older adults; an estimated 80% of those receiving home health care rely exclusively on unpaid caregivers.¹⁵

While most elder care provided by families is unpaid, some is not. Older adults may offer payment to encourage or reward care, or family members may demand it. In some cases, payment may reflect the fact that providing care is not a financially viable option for the care provider without a guarantee of payment.¹⁶

For some older adults, paying for personal care may have an additional benefit: it preserves assets while still allowing the older adult to qualify for public assistance to pay for certain forms of long-term care. Specifically, in recent years, some older adults have begun paying family members in exchange for care in order to preserve resources as part of "Medicaid planning."¹⁷ Medicaid, the primary payer for nursing home care in the United

¹¹ See Edelman, *supra* note 7, at 374–75 (1998) (discussing the variation in quality, services, and price within the assisted living industry).

¹² See GENWORTH SUMMARY OF 2017 SURVEY FINDINGS, *supra* note 8.

¹³ Medicaid is a federal-state partnership program. As such, although the program's general parameters are established at the federal level, Medicaid eligibility criteria and benefits can vary significantly from state to state. Unlike most developed countries, the United States does not have universal long-term care coverage and, instead, Medicaid is a means-tested program.

¹⁴ See HEALTH UNIT, NAT'L SURVEY ON NURSING HOMES (2001), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/kaiser-newshour-national-survey-on-nursing-homes-high-lights-and-chartpack.pdf>, archived at <https://perma.cc/DMSE-VFDY> (finding, in a nationally representative telephone survey of adults age 18 years or older, that only 10% of Americans would readily accept moving to a nursing home if they could not take care of themselves, whereas 47% reported that such a move would either be something they would not like (but would probably come to accept), and 43% described such a move as totally unacceptable).

¹⁵ See THE CAREGIVING PROJECT FOR OLDER AM., CAREGIVING IN AM. 7 (2006). By contrast, only 8% rely exclusively on paid caregivers. See *id.*

¹⁶ See NAT'L ACADS. OF SCIS., ENG'G, & MED., FAMILIES CARING FOR AN AGING AMERICA 128–30 (2016) (discussing the economic hardships faced by family caregivers).

¹⁷ As discussed in Part II.A, this trend was prompted by a change in federal law. See *also infra* notes 25–28 and accompanying text.

States,¹⁸ is a means-tested program for which only those with limited resources qualify.¹⁹ Medicaid planning typically involves reducing an individual's financial resources in order to qualify for Medicaid, while preserving those resources for persons of the would-be Medicaid recipient's choosing.²⁰ Such preservation can do more than simply protect an existing estate plan and inheritance expectations. Where the applicant has a spouse or another individual who is dependent on the applicant's income or resources, it may be necessary to protect that other person's quality of life or financial security.²¹ In addition, the recipient of the protected assets may be able to use those assets for the benefit of the Medicaid applicant, such as by using the assets to pay for goods or services that would not otherwise be available to the applicant.²² Potential Medicaid applicants have to be very careful, however, in how they dispose of assets because, as explained further in Part II.A, the federal Medicaid program makes ineligible for a period of time applicants who have transferred resources for less than fair market value in the five years preceding a Medicaid application.²³

Entering into a personal care contract can be a way to avoid such restrictions on resource transfers. Instead of giving money to an adult child or other loved one—which, if done five years prior to filing the application, would result in a period of ineligibility for Medicaid's long-term care coverage²⁴—an older adult enters into a contract with the person they wish to benefit. Under the terms of the contract, the older adult agrees to pay that

¹⁸ See KAISER FAMILY FOUNDATION, *Distribution of Certified Nursing Facility Residents by Primary Payer Source*, <https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/>, archived at <https://perma.cc/Q9Q9-LWY4> (showing that Medicaid is the primary payer for the majority of residents in certified nursing homes in each state); see also Erica L. Reaves & Mary Beth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer* (Kaiser Family Foundation 2015), <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>, archived at <https://perma.cc/87EF-R755> (discussing the role of Medicaid as a primary payer of long-term care costs across residential settings).

¹⁹ For an overview of Medicaid eligibility rules, see NINA A. KOHN, *ELDER LAW: PRACTICE, POLICY, & PROBLEMS* 277–79 (2014).

²⁰ See *id.* (providing an overview of Medicaid planning); Timothy L. Takacs & David L. McGuffey, *Medicaid Planning: Can It Be Justified? Legal and Ethical Implications of Medicaid Planning*, 29 WM. MITCHELL L. REV. 111, 131 (2002) (discussing the purpose of Medicaid planning and common techniques).

²¹ See NAT'L ACAD. OF ELDER L. ATTORNEYS, *Myths and Realities About Medicaid Planning*, https://www.naela.org/Naelapolicy/Topics/Long-Term_Care/Myths_Realities_About_Medicaid_Planning.aspx, archived at <https://perma.cc/B2R8-RRDE> (discussing how Medicaid planning can be a way for a potential applicant to protect a spouse or other family members in need); Joseph S. Karp & Sara I. Gershbein, *Poor on Paper: An Overview of the Ethics & Morality of Medicaid Planning*, 79 FLA. BAR J. 3 (Oct. 2005) (noting that “Medicaid planning takes on a special sense of urgency when the goal is to preserve assets for a community spouse”).

²² See Karp & Gershbein, *supra* note 21 (noting that, as a practical matter, “[w]hen one engages in Medicaid planning, the cost of nursing care is subsidized, leaving money that can be spent over time to supplement care [for the resident]”).

²³ See *infra* Part II.A.

²⁴ See *id.*; see also KOHN, *supra* note 19, at 303 (discussing Medicaid eligibility for long-term care).

person for rendering personal care services. So long as the would-be Medicaid beneficiary receives value equivalent to what is paid for the services, the transfer should not be considered a transfer for less than fair market value.

Personal care contracts came into prominence as a Medicaid planning device after the passage of the Deficit Reduction Act of 2005,²⁵ which—as part of a federal effort to curb Medicaid planning—severely curtailed the utility of many then-existing Medicaid planning strategies.²⁶ While personal care contracts had always been an option for older adults seeking care, they were disfavored by elder law attorneys and their clients as a Medicaid planning strategy because they, unlike gifts, require the recipient to pay income tax.²⁷ The strategic use of personal care contracts was appealing to both attorneys and older adults not only because it was one of the surviving Medicaid planning techniques, but also because it can help meet care needs.²⁸ Additionally, it had the collateral benefit of allowing resources to be passed to an heir without probate or gift tax (since the resources are transferred during the care recipient's lifetime)²⁹ although not without income tax.³⁰

In short, personal care contracts can be an attractive option for older adults, especially those who are lower-middle class or middle class and need significant personal assistance but neither desire nor require nursing home services. By paying family members to provide care, older adults may be able to continue to reside in a community-based setting in a way that is both safer and more affordable than would otherwise be possible. In addition, such arrangements may help preserve resources for family members that would otherwise be spent on institutional care.

²⁵ See Deficit Reduction Act of 2005, Public L. 109–71 (Feb. 8, 2006); FRANCES M. PANTALEO, DRAFTING PERSONAL SERVICES CONTRACTS AND REIMBURSEMENT AGREEMENTS 179, <http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=45149>, archived at <https://perma.cc/HH9R-JMLT> (explaining that since the Act's enactment, personal service contracts "have been increasingly utilized by elder law practitioners as an alternative Medicaid planning tool.").

²⁶ The Deficit Reduction Act of 2005 created a five-year look-back period for all transfers for less than fair market value, see 42 U.S.C. 1396p(c)(1)(B)(i), and changed the date of onset of the penalty period for such transfers to make it less advantageous for applicants, see 42 U.S.C. 1396p(c)(1)(D). This rendered many then-existing Medicaid planning techniques ineffective. See KOHN, *supra* note 19, at 303 (discussing the change).

²⁷ See PANTALEO, *supra* note 25, at 180.

²⁸ *Id.* at 180, 200 (describing compensation of caregivers as one of the benefits of using personal care contracts as a Medicaid planning strategy). Anecdotal, in teaching law students about Medicaid planning strategies, the author has observed students (even those troubled by Medicaid planning in general) to be very receptive to the use of personal care contracts as a Medicaid planning technique.

²⁹ Personal care contracts also allow resources to be passed to an heir without estate tax (although this is rarely a concern for those engaging in Medicaid planning given the high exemption levels—over \$11 million in 2018). See INTERNAL REVENUE SERV., *Estate Tax*, <https://www.irs.gov/businesses/small-businesses-self-employed/estate-tax>, archived at <https://perma.cc/5236-JJ3V>.

³⁰ See generally Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 VA. TAX REV. 509 (2005) (discussing the income tax implications of such arrangements).

II. THE LAW'S RESPONSE TO MEDICAID APPLICANTS' INTRA-FAMILY PERSONAL CARE CONTRACTS

The legal response to personal care occurs at two levels. First, there is a regulatory response. Both the federal government and the states have adopted regulations that create baseline rules for how states are to assess both the effect of elder care contracts and the value of care provided under them. As discussed in this Part, these regulations, as well as the guidance promulgated by the agencies implementing them, establish factors for agency employees to consider when determining whether a payment made pursuant to a personal care contract should be treated as a transfer of resources for less than fair market value, thus creating a period of ineligibility for Medicaid coverage.³¹

The adjudicatory response constitutes the second level. When a state agency assessing Medicaid eligibility denies coverage to an applicant on the basis that monies transferred pursuant to a personal care contract were actually gifts, administrative law judges—and ultimately courts—may be asked to reconsider that decision. To do so, they must determine the legal effect of the agreement between the parties and the value of the services performed under it.³²

This Part describes both the regulatory and adjudicatory responses, revealing the circumstances under which the law treats personal care contracts as enforceable agreements and the value the law ascribes to the care of older adults.

A. *The Regulatory Response*

Both federal and state regulations govern the impact of personal care contracts on Medicaid eligibility. This section outlines those regulations, and explains that, although federal regulations fully permit states to allow would-be beneficiaries to enter into personal care contracts without risking ineligibility, those same regulations provide a framework for states to substantially restrict the use of such contracts. State regulators are increasingly taking advantage of this latitude by adopting stringent eligibility criteria that make it difficult for individuals to qualify for Medicaid when they have paid family caregivers.

1. *Federal Regulatory Framework*

As briefly discussed in Part I,³³ individuals are ineligible for Medicaid coverage for long-term care under federal law if, within five years of apply-

³¹ See *infra* Part II.A.

³² See *infra* Part II.B.

³³ See *supra* notes 23–24 and accompanying text.

ing for Medicaid, they have transferred resources for less than fair market value for the purpose of establishing Medicaid eligibility.³⁴ All transfers for less than fair market value are “presumed to have been made for the purpose of establishing SSI or Medicaid eligibility unless the individual (or eligible spouse) furnishes convincing evidence that the resource was transferred exclusively for some other reason.”³⁵ A wide variety of actions and inactions are considered transfers for less than fair market value, including a transfer of income or resources made without consideration and a transfer of income or resources in exchange for something worth less than the income or resources transferred.³⁶

When an individual applies for Medicaid, the state can scrutinize the applicant’s finances to determine whether the individual has gifted money. Transfers to family are naturally more likely to be treated as suspect as individuals typically wish to preserve resources for their family. Accordingly, when an applicant has transferred money to a family member and asserts that rather than a mere gift, the money was payment for services, the state must determine what—if any—value those services had. If the state agrees that the transfer was, in fact, a payment for services of equal or greater value, the transfer will not affect the applicant’s ability to receive Medicaid benefits.

If, however, the state determines that the transfer was not a payment for services, or that the payment was above the fair market value for those services, the consequences are significant. The applicant will be rendered ineligible for Medicaid coverage for long-term care for a “penalty period,” calculated by dividing the dollar value of the transfer by the average monthly cost of nursing home care in the applicant’s geographic region.³⁷ The resulting number is the number of months that the individual will be ineligible for Medicaid.³⁸ Thus, in a region where the average cost of a month of nursing home care is \$8,500, an \$85,000 transfer will result in a

³⁴ See 20 C.F.R. § 416.1246(a) (2017) (“An individual (or eligible spouse) who gives away or sells a non-excluded resource for less than fair market value for the purpose of establishing SSI or Medicaid eligibility will be charged with the difference between the fair market value of the resource and the amount of compensation received. The difference is referred to as uncompensated value and is counted toward the resource limit (see § 416.1205) for a period of 24 months from the date of transfer.”).

³⁵ 20 C.F.R. § 416.1246(e) (2017).

³⁶ 20 C.F.R. §§ 416.1246(c–d) (2017).

³⁷ See 42 U.S.C. § 1396p(c)(1)(e) (2017).

³⁸ The underlying logic is that coverage should be denied for the length of time that the transferred assets could have covered the applicant’s nursing care had they been retained by the applicant. Since the private pay rate for nursing homes typically exceeds the Medicaid regional rate, the length of the penalty period is generally longer than the length of time for which the assets would actually have covered nursing home care. See Vincent Mor et al., *Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care*, 82 MILBANK QUARTERLY 227, 231 (2004) (“Although Medicaid payment rates vary dramatically from state to state, they generally are substantially lower than the private-pay rate . . . and often fall below costs.”).

ten-month penalty period.³⁹ This period runs from the first day of the month after the transfer, or on the first day of the month an institutionalized individual is receiving nursing facility services for which Medicaid would otherwise pay, whichever is later.⁴⁰ Thus, the penalty is designed such that if an individual, found impoverished and in need of nursing home services, is deemed to have made a transfer of resources for less than fair market value, such an individual becomes ineligible for coverage for those very services.

The federal regulatory prohibition on transfers for less than fair market value does not itself pose a significant obstacle to personal care contracts. Federal law permits caregiving services, like other types of services for which one might pay, to be treated as having monetary value when calculating whether a Medicaid applicant has transferred resources for less than fair market value.⁴¹ This is true regardless of who provides those services.⁴² The one limitation on paying for personal care services under federal law is that services must have been provided “pursuant to a binding (legally enforceable) agreement in effect at the time of transfer” in order not to be considered a prohibited transfer.⁴³ Thus, federal law does not single out transfers made under personal care contracts for special treatment, but rather subjects such transfers to the same rules applicable to other transfers made by a Medicaid applicant.

2. *State Regulatory Response*

States have broad latitude both to interpret federal Medicaid regulations and to adopt their own regulations so long as those regulations are not inconsistent with federal law.⁴⁴ As detailed in this section, many states have adopted regulations or promulgated administrative guidance that specifically address when monies paid under a personal care contract will be treated as transfers for fair market value. Such regulations and administrative guidance typically make it difficult for older adults paying for caregiving services provided by family members to avoid a penalty.

A common approach for states is to create a presumption that care provided by family members is provided without expectation of payment—and thus that any monies purportedly transferred to pay for that care are gifts.⁴⁵

³⁹ See 42 U.S.C. § 1396p(c)(1)(e) (2017).

⁴⁰ See 42 U.S.C. § 1396p(c)(1)(d)(ii) (2017).

⁴¹ See 20 C.F.R. § 416.1246(c) (2017).

⁴² See *id.*

⁴³ See *id.*

⁴⁴ Courts have been quite generous with states in finding that state-specific Medicaid regulations that run contrary to the spirit of federal law, but are not inconsistent with the letter of the law, are not preempted. See, e.g., *Poindexter v. Illinois*, 890 N.E.2d 410, 424 (Ill. 2008) (finding that a state regulation that allowed states to seek reimbursement from spouses whose resources were exempt from consideration in Medicaid eligibility determinations under federal law was not preempted by federal law).

⁴⁵ See 10 COLO. CODE REG. 2505-10 § 8.100.7.G.4 (creating a presumption that transfers to family members lack consideration); IDAHO ADMIN. CODE r. 16.03.05.831.02 (creat-

Some states describe this approach as a presumption that the services were provided for “love and affection;” since “love and affection” is not adequate consideration, states conclude that there is no obligation to pay, and any purported “payments” are actually gifts.⁴⁶ Thus, care provided by relatives in these states is treated as having no monetary value, even when the same care provided by non-relatives would be treated as having value.⁴⁷

Another approach for states is to restrict who may enter into a personal services contract without penalty. Specifically, some states provide that if the caregiver is simultaneously the surrogate decision-maker who contracted for caregiving services on behalf of the applicant, transfers under a personal care contract will be treated as transfers for less than fair market value as a matter of law.⁴⁸

States may also restrict what types of services may be covered by a personal care contract without penalty. Some states, for example, refuse to recognize personal care contracts if the care recipient is institutionalized.⁴⁹ Thus, compensation for any services provided to an institutionalized person

ing a presumption that a contract for services from a relative was made to qualify for Medicaid); MICH. DEP'T OF HEALTH & HUMAN SERVS., BRIDGES ELIGIBILITY MANUAL § 405, <https://dhhs.michigan.gov/OLMWEB/EX/BP/Public/BEM/405.pdf>, archived at <https://perma.cc/E8QT-LRW6> (creating a presumption that relatives who provide services do so for “love and affection,” not compensation); W. VA. DEP'T OF HUMAN RES., INCOME MAINTENANCE MANUAL, Ch. 17.10(B)(8a), https://dhhr.wv.gov/bcf/Services/familyassistance/PolicyManual/Documents/Chapter%2017/ch17_10.pdf, archived at <https://perma.cc/63YP-CKGX> (“Personal care services provided to an individual by a relative or friend are presumed to have been provided for free, at the time rendered, when a Personal Care Contract (PCC) did not exist.”).

⁴⁶ See MICH. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 45; 10 COLO. CODE REG. 2505-10 § 8.100. Notably, although New Hampshire does not explicitly create a presumption that transfers to family members are gratuitous, it nevertheless advises state employees assessing Medicaid eligibility that transfers made for “love and consideration” are to be treated as transfers for less than fair market value. See New Hampshire Medical Assistance Manual § 415.11, https://www.dhhs.nh.gov/mam_htm/html/415_11_evaluation_of_transfers_mam_.htm, archived at <https://perma.cc/SCK6-G39J>.

⁴⁷ This result is actually a deviation from the result that would be expected under common law. Although the common law treats love and affection as invalid consideration, a promise may be enforced despite a failure of consideration where it has reasonably induced action. See RESTATEMENT (SECOND) OF CONTRACTS §§ 90, 273 (AM. LAW. INST. 1981).

⁴⁸ See, e.g., 10 COLO. CODE REG. 2505-10 § 8.100.7.g.4 (treating as gifts payments pursuant to a personal services contract when surrogate who signs the agreement is also “beneficiary” of agreement); IDAHO ADMIN. CODE 16.03.05.831.02(b) (2017) (“The contract must be signed by participant or a legally authorized representative through a power of attorney, legal guardianship or conservatorship. A representative who signs the contract must not be the provider of the personal care services under the contract.”); MICH. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 45 (treating as gifts payments pursuant to a personal services contract when the surrogate who signs the agreement is also the care provider).

⁴⁹ See, e.g., ALA. ADMIN. CODE 560-X-25-.09(k); ME. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE FOR FAMILY INDEPENDENCE, Ch. 336 (2012), <https://www.maine.gov/sos/cec/rules/10/144/144c336.doc>, archived at <https://perma.cc/A98T-U3KQ>; MO. DEP'T OF SOCIAL SERVICES, ELIGIBILITY REQUIREMENTS § 1040.020.25 (2012), https://dss.mo.gov/fsd/iman/dec1973/1040-020-00_1040-020-30.html, archived at <https://perma.cc/B3LF-CA72>; WASH. STATE HEALTH CARE AUTH., WAC 182-513-1363 (2017), <https://www.hca.wa.gov/health-care-services-supports/program-administration/asset-transfers>, archived at <https://perma.cc/KR3J-DXZX>; W. VA. DEP'T OF HUMAN RESOURCES, *supra* note 45, at Ch. 17 (allowing for payment during a period of institutionalization only if the institutionalization is temporary).

is treated as a “gift.” A related approach is to treat payments for services that another individual or entity (e.g., a nursing home) had a duty to provide as mere gifts.⁵⁰ For example, in New York, payments made for services already covered by Medicaid are treated as gifts.⁵¹ Thus, a care provider may not receive payment for providing services that a nursing home has an obligation to provide, even if the nursing home is not actually providing those services or is providing a lower quality of service.⁵²

Some states limit services that can be provided without penalty under a personal care contract to services that a physician has said are necessary to avoid institutionalization.⁵³ In such states, individuals who are not sufficiently physically or cognitively frail to qualify for institutional care—but who need and pay for care to meet their needs for health and safety in a community-based setting—risk being denied Medicaid for nursing home care should they subsequently require it. Such requirements may have the effect of leaving older adults with no practical way to pay for their own care.⁵⁴

⁵⁰ See, e.g., 10 COLO. CODE REG. 2505-10 § 8.100.7.g.4 (services cannot duplicate “services that another party is being paid to provide or which another party is responsible to provide”); Letter from Judith Arnold, N.Y. Office of Health Ins. Programs, to Local District Comm’rs, Medicaid Dirs. (Sept. 24, 2007), http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/07ma019.pdf, archived at <https://perma.cc/WE2W-B9MZ>; 907 KY. ADMIN. REGS. 20:030 (2007), <http://www.lrc.ky.gov/kar/907/020/030.pdf>, archived at <https://perma.cc/W8MU-723W>; MONT. DEP’T PUB. HEALTH & HUMAN SERVS., MED. ASSISTANCE POLICY MANUAL § 404-1 (2017), <https://dphhs.mt.gov/Portals/85/hcsd/documents/mamannual/CMA404-1March012017.pdf>, archived at <https://perma.cc/9PNG-JJWM> (“Services provided through a personal care contract cannot duplicate services that are being provided or are available as part of another existing contract, or encompassed by the package of services provided by a nursing home, assisted living facility, or adult foster home in which the individual is residing[.] For example, nursing homes provide dietary services, and, when necessary, assistance in eating; a separate contract paying a third party to also provide assistance in eating is not a valid personal care contract expense. Contracts and payments for duplicative services are considered uncompensated asset transfers.”).

⁵¹ See Letter from Judith Arnold, *supra* note 50.

⁵² See *id.* This is a problematic result because research suggests that most nursing homes are not equipped to provide the level of services they are contractually bound to provide. See HEALTH CARE FIN. ADMIN., APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES E.S.-6 (2000), <http://web.archive.org/web/20001018155907/http://www.hcfa.gov/medicaid/reports/rp700exs.pdf>, archived at <https://perma.cc/LU5A-CSCA> (finding that more than 92% of nursing homes had insufficient staff to meet the basic quality of care standards required of nursing homes that receive Medicare or Medicaid funding).

⁵³ See, e.g., ALA. ADMIN. CODE 560-X-25-.09(k); ME. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 49; MICH. DEP’T OF HEALTH & HUM. SERVS., *supra* note 45; MO. DEP’T OF SOC. SERVS., *supra* note 49, at 1040.020.30; WASH. STATE HEALTH CARE AUTH., *supra* note 49; W. VA. DEP’T OF HUMAN RES., *supra* note 45, at ch. 17.10(B)(8).

⁵⁴ Alabama creates an ultimate Catch-22 situation for such applicants because the state extends the requirement of a doctor’s letter to situations where the care provider is not a family member. See ALA. ADMIN. CODE 560-X-25-.09(k) (requiring that services provided under a personal care contract were “[a]t the time of the receipt of the services . . . recommended in writing and signed by the applicant’s physician, as necessary to prevent the admission of the applicant to a nursing facility.”). The legal effect is that there is no party with whom an Alabama older adult can contract for care that would avoid institutionalization without risking losing eligibility.

Texas imposes a particularly onerous limitation on what services may be paid for without penalty. Administrative guidance promulgated by Texas Health and Human Services states that: “Compensation is not allowed for services that would normally be provided by a family member (such as house painting or repairs, mowing lawns, grocery shopping, cleaning, laundry, preparing meals, transportation to medical care).”⁵⁵ In an example, the guidance explains that payment to a grandson for home maintenance (including painting the house and yardwork every other week for two years) would be treated as a gift, resulting in a period of ineligibility for Medicaid.⁵⁶

States also regulate the terms of personal care contracts. A particularly common approach is to refuse to recognize contracts that provide for prospective payments, limiting recognition to those contracts that provide for payment at the time of service or shortly thereafter.⁵⁷ The intent, sometimes stated explicitly, is to limit prepayments and lump sum payments.⁵⁸

Finally, many states have created strict requirements for the type of proof needed to show that adequate consideration was paid. The proof requirements vary widely. Some requirements are fairly mundane, paralleling requirements for enforceable contracts in other contexts or requiring the agreement to stipulate key provisions (e.g., the frequency and duration of services).⁵⁹ Other requirements are more burdensome, such as those that re-

⁵⁵ TEX. HEALTH & HUMAN SERVS., MEDICAID FOR THE ELDERLY AND PEOPLE WITH DISABILITIES HANDBOOK, Ch. I-4140, <https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-people-disabilities-handbook/chapter-i-transfer-assets/i-4000-determining-uncompensated-value>, archived at <https://perma.cc/NH7S-K7YF>.

⁵⁶ See *id.*

⁵⁷ See, e.g., ALA. ADMIN. CODE 560-X-25-.09(k); ARIZ. HEALTH CARE COST CONTAINMENT SYS., MEDICAL ASSISTANCE ELIGIBILITY POLICY MANUAL § 904.4, <https://www.azahcccs.gov/Resources/GuidesManualsPolicies/EligibilityPolicy/EligibilityPolicyManual/index.html#page/MA/MA900/MA0904.html>, archived at <https://perma.cc/8YX9-FAJV> (explaining that, with certain exceptions, the agreement must provide for payment at least monthly); IDAHO ADMIN. CODE r. 16.03.05.831 (2017); MONT. DEP’T PUB. HEALTH & HUMAN SERVS., *supra* note 50; UTAH DEP’T OF HEALTH, MEDICAID POLICY MANUAL § 575(B)(6), <http://health.utah.gov/chip/Medicaidpolicy/DOHMedicaid.htm>, archived at <https://perma.cc/TL2P-PP22> (prohibiting prepayment for more than a month); WASH. STATE HEALTH CARE AUTH., *supra* note 49; LA. DEP’T OF HEALTH, LA. MEDICAID ELIGIBILITY MANUAL § I-1673 (2018), <http://ldh.la.gov/assets/medicaid/MedicaidEligibilityPolicy/I-1670.pdf>, archived at <https://perma.cc/XK6U-UNER>.

⁵⁸ See, e.g., ALA. ADMIN. CODE 560-X-25-.09(k)(iii) (explicitly prohibiting lump sum payments).

⁵⁹ See, e.g., Letter from Judith Arnold, *supra* note 50 (“A personal service contract that does not provide for the return of any prepaid monies if the caregiver becomes unable to fulfill his/her duties under the contract, or if the [applicant] dies before his/her calculated life expectancy, must be treated as a transfer of assets for less than fair market value. If there are no such legally enforceable provisions, there is no guarantee that FMV will be received for the prepaid monies. If a personal service contract stipulates that services will be delivered on an ‘as needed’ basis, a determination cannot be made that FMV will be received in the form of services provided through the contract. A transfer of assets penalty must be calculated for an otherwise eligible individual.”); see also ILL. DEP’T OF HEALTH AND FAMILY SERVS., HFS 3191, *Long Term Services & Information for Couples*, <https://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Brochures/Pages/HFS3191.aspx>, archived at <https://perma.cc/>

quire caregivers to keep hourly logs of activity.⁶⁰ Other requirements go far beyond what would be expected in a contract for care with third party providers. For example, some states require the agreement to be notarized,⁶¹ which is not required for service contracts to be enforceable in other contexts.⁶² Another substantial burden that some states impose is the requirement of a signed doctor's letter to prove that services are necessary to avoid institutionalization.⁶³

Among those states that specifically regulate the use of personal care contracts, it is common to combine multiple approaches. For example, to rebut the presumption that relatives who provide assistance are doing so out of "love and affection," Michigan requires that: (1) the services were provided after a written, signed, and notarized agreement was in place; (2) the services were only paid for after they were provided (thus prospective payments are prohibited); (3) the care recipient does not live in a nursing home or other specified institution and is ineligible for certain forms of in-home

2REX-J2YV; 907 KY. ADMIN. REGS. 20:030, *supra* note 50; ME. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 49; MINN. HEALTH CARE PROGRAMS ELIGIBILITY MANUAL, 42 U.S.C. § 1396p(c), http://hcopub.dhs.state.mn.us/epm/#t=2_4_1_3.htm&rhsearch=personal%20care&rhhlterm=personal%20care&rhsyns=%20, archived at <https://perma.cc/E9ZN-DGZP>; MISS. DIV. OF MEDICAID, ELIGIBILITY POLICY AND PROCEDURES MANUAL § 306 (2014), <https://medicaid.ms.gov/wp-content/uploads/2015/02/Chapter-306.pdf>, archived at <https://perma.cc/ME7X-T4WS>; PENN. DEP'T OF HUMAN SERVS., LONG TERM CARE HANDBOOK § 440 (2015), http://services.dpw.state.pa.us/oimpolicymanuals/ltc/440_Resources/440_8_Disposition_assets_fair_consideration.htm, archived at <https://perma.cc/6WUJ-4JKH>.

⁶⁰ See Letter from Judith Arnold, *supra* note 50 ("In order to assess the value of these furnished services, the district must be provided with credible documentation (e.g., a log with the dates and hours of services already provided). Any amount subtracted (i.e., the credit for caregiver services actually provided) must be commensurate with a reasonable wage scale, based on fair market value for the actual job performed and the qualifications of the caregiver. If credible documentation is not provided, no credit is deducted when calculating the uncompensated transfer amount. For assistance in evaluating job duties and pay rates, districts may refer to the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook. . . . If a district determines that a reasonable pay rate for a particular job/service is less than the amount spelled out in the contract, the district should use the lesser amount in calculating the amount of compensation received for the transfer.").

⁶¹ Wisconsin, Minnesota, and Idaho require notarization for personal service contracts entered into with relatives. See IDAHO ADMIN. CODE r. 16.03.05.831 (2017); MINN. HEALTH CARE PROGRAMS ELIGIBILITY MANUAL, *supra* note 59; WIS. DEP'T OF HEALTH SERVS., MEDICAID ELIGIBILITY HANDBOOK, § 17.8.1 (2018), <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>, archived at <https://perma.cc/5ZUP-VYGS>. Kentucky also requires notarization, but does not limit the requirement to agreements with family care providers. See 907 KY. ADMIN. REGS. 20:030, *supra* note 50.

⁶² See Howard O. Hunter, MODERN LAW OF CONTRACTS § 7:1 (2018) (noting that certain formalities, such as having a notary public or attesting officer witness signatures, may be part of the ceremony of contracting but are not necessary for the creation of an enforceable contract). Indeed, in many contexts, even signature of a contract is not strictly required for contracts to be enforced. See 17 C.J.S. *Contracts* § 83 (2018) ("[S]ignatures of one or both parties are not always essential to the binding force of an agreement, provided there is other evidence of acceptance, for example by performance.").

⁶³ See, e.g., ALA. ADMIN. CODE 560-X-25-.09.10(k) (requiring services pursuant to a personal service agreement be, at the time provided, "recommended in writing and signed by the applicant's physician, as necessary to prevent the admission of the applicant to a nursing facility.").

help; (4) the services were recommended in a signed writing by the care recipient's physician as necessary to prevent the transfer of the recipient to a residential care or nursing facility; and (5) the care provider is not the surrogate decision-maker who signed the contract on behalf of the care recipient.⁶⁴

Applicants are unlikely to satisfy such burdensome procedural and proof requirements unless they have had sophisticated legal assistance in drafting the contract.⁶⁵ This is because the professionals most likely to know of such requirements, other than the public employees who administer them, are attorneys who specialize in helping clients structure their affairs to maximize eligibility for Medicaid.⁶⁶ The result is ironic in two regards. First, such requirements are likely to have the least effect on those who entered into a personal care contract because an attorney advised them to do so for Medicaid planning purposes (i.e., the very people for whom the regulations presumably were designed).⁶⁷ It is this group that is most likely to have had the legal advice necessary to comply with such regulations. Second, the requirements may, in effect, be most problematic for low-income individuals, the population for whom Medicaid was originally designed, given that sophisticated legal advice is more likely to be unaffordable for low-income individuals. Thus, these regulations may have the effect of rewarding those who enter into personal care contracts for Medicaid planning purposes, while penalizing those who do so simply as a means of obtaining care.

B. Case Adjudications

Court opinions and administrative agency decisions assessing the value of care provided under personal care contracts provide additional insight into the legal treatment of such agreements and the valuation of elder care more broadly. These cases come to administrative law judges (ALJs) and state courts in the form of appeals. When the state agency responsible for determining Medicaid eligibility denies a Medicaid application, or imposes a period of ineligibility for Medicaid, on the basis that payment to a family caregiver was a transfer for less than fair market value, the applicant has a

⁶⁴ MICH. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 45, at 8.

⁶⁵ *Accord* RICK L. LAW & KERRY PECK, *ALZHEIMER'S AND THE LAW: COUNSELING CLIENTS WITH DEMENTIA AND THEIR FAMILIES* (2013) (explaining how to draft personal care contracts that are likely to satisfy the requirements of the Medicaid program and how to amass the necessary accompanying documentation).

⁶⁶ *Cf.* Richard Kaplan, *Elder Law as Proactive Planning and Informed Empowerment During Extended Life* 40 *STETSON L. REV.* 15, 64–69 (2010) (discussing the role of specialized elder law practitioners and the extensive knowledge lawyers need to learn in order to be in a position to provide clients with advice regarding Medicaid counseling, and noting that “even a cursory examination of Medicaid can quickly become rather technical.”).

⁶⁷ *Cf.* Letter from Judith Arnold, *supra* note 50 (noting that the uptick in the use of personal care contracts following the enactment of the Deficit Reduction Act prompted the state to issue new guidance restricting recognition of such contracts).

right to appeal that decision by requesting an administrative hearing.⁶⁸ If the applicant exercises the right to appeal, an ALJ must decide whether the care the applicant was provided has monetary value and, if so, how much.⁶⁹ If applicants are dissatisfied with the ALJ determination, they generally have a right to appeal to a court.⁷⁰ This section discusses the approaches ALJs and courts have taken in deciding these appeals.

1. *Administrative Hearing Determinations*

To understand how ALJs assess the value of care provided under a personal care contract, the author initially sought to identify and systematically code all hearing decisions that considered the issue. Two factors substantially complicated this ostensibly simple aim. First, ALJ decisions are highly fact-specific and, due in part to privacy concerns, generally made available only in a form that omits key demographic information. For example, such decisions are almost entirely devoid of information about applicants' race or ethnicity. Second, there is no comprehensive reporting system for these adjudications, and most states do not even make the decisions publicly available.⁷¹ Those that do, moreover, often make available only a small, potentially unrepresentative, subset of opinions.

To systematically understand how ALJs value care provided under personal care contracts, the author examined states that make their fair hearing decisions publicly available. The author identified four states (Michigan, New Jersey, New York, and Ohio) that appear to make all⁷² fair hearing decisions decided after a particular point in time⁷³ available online.⁷⁴ From

⁶⁸ See 42 C.F.R. § 431.220(a) (2016) (granting Medicaid applicants the right to a fair hearing to challenge a determination of ineligibility or denial of benefits).

⁶⁹ See 20 C.F.R. § 416.1246(a) (2017) (setting forth federal limitation on transfers for less than fair market value made within five years of an applicant's Medicaid application).

⁷⁰ See 42 U.S.C. § 1396(a)(3) (requiring a state plan for medical assistance to "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness."); see also *Shakhnes v. Berlin*, 689 F.3d 244, 263 (2d Cir. 2012) (holding that an individual's right under 42 U.S.C. § 1396(a)(3) is enforceable under 42 U.S.C. § 1983).

⁷¹ While Medicaid is a federal-state partnership, Medicaid determinations are made at the state level. Just as benefits and eligibility criteria vary by state, so do processes for making determinations publicly available.

⁷² It was effectively impossible for the author to know whether state databases are actually complete as there is no way for the author to know which cases, if any, might be missing.

⁷³ States vary in what years they began making hearing decisions publicly available on their online databases, and how many years of decisions they retain in these databases. The differences in the period of time covered by different state databases contributed to the author's decision not to attempt to combine states' cases for the purpose of statistical analysis.

⁷⁴ Michigan decisions are made available by the state's Department of Licensing and Regulatory Affairs. See <https://www.michigan.gov/lara/0,4601,7-154-10576---,00.html>, archived at <https://perma.cc/P553-MS8E>. New Jersey decisions are made available on a database provided by Rutgers University. See <http://njlaw.rutgers.edu/collections/oal/>, archived at <https://perma.cc/CA55-7QD9>. New York decisions are made available by the state's Office of Temporary and Disability Assistance. See <http://otda.ny.gov/hearings/search/>, archived at <https://perma.cc/DQN4-XL5N>. Ohio decisions are made available by the state's Bureau of State Hear-

these states, the author identified 124⁷⁵ administrative hearing decisions that considered whether a payment to a family member under a personal care contract was a transfer for less than fair market value.⁷⁶ Of these decisions, roughly 80% found the entire amount under consideration—which was purportedly paid for personal services—was a transfer for less than fair market value.⁷⁷

a. Observed Patterns in Administrative Hearing Determinations

The outcomes of the administrative hearing decisions reviewed by the author could not be fully explained by the regulatory requirements, as the decisions showed ALJs not only engaging in fact finding but also interpreting the regulations—frequently in ways unfavorable to applicants. For example, ALJs in a number of cases construed regulations unfavorably to applicants by requiring contract terms not required by the underlying regulations. One Michigan decision held, without the Michigan regulations or federal guidance requiring it, that a personal care contract lacked monetary value because it stated services were to be provided “as needed.”⁷⁸ In another case, a New Jersey ALJ found that a non-transferable personal care contract lacked all monetary value because the state made a “convincing

ings. See <http://www.odjfs.state.oh.us/HearingsAppeals/>, archived at <https://perma.cc/MEC9-FEA6>.

⁷⁵ Of these, seven were from Michigan; twenty-two, New Jersey; sixty-six, New York; and twenty-nine, Ohio. The majority were fair hearing decisions. However, some cases had both a fair hearing decision and a decision from an appeal of that decision. In a handful of cases (primarily older Ohio cases), the author could only identify the appeals decisions. Where there was both an initial determination and an appeals decision, the two were treated as a single case; information from both decisions was coded but the outcome was coded based on the outcome on appeal. Where it appeared likely the caregiver was a family member, but it could not be determined conclusively, the case was not counted or otherwise included in the study.

⁷⁶ As part of this research, the author identified a handful of decisions in which the services in dispute were provided by a non-family member. The author also identified several cases where it was unclear whether the person paid was a family member, and several in which it appeared the person was not technically a family member but was treated as such by the family (e.g., a fiancée who provided care or a very close family friend). The cited number reflects only those cases in which there was an ascertainable explicit family relationship. These include one case in which the ALJ stated the caregiver was not a relative because the caregiver was the sister of the applicant’s son-in-law, not the applicant’s daughter-in-law as the agency had originally believed. See, e.g., N.Y. State Dep’t of Health, Fair Hearing No. 6766975N (June 30, 2014), available at http://otda.ny.gov/fair%20hearing%20images/2014-9/Redacted_6766975N.pdf, archived at <https://perma.cc/464L-DQEY> (reversing agency determination imposing a penalty period based, at least in part, on the agency’s mistaken belief that caregiver was a family member).

⁷⁷ See *infra* Appendix A, Table 4.

⁷⁸ See, e.g., Mich. Office of Admin. Hearings & Rules, 2008-22170/JWO at 11–12 (Sept. 22, 2009) (acknowledging that case was decided based on state rules in place prior to state adopting rules specific to personal care contracts and that this requirement was not included in then-existing regulations).

argument” that the underlying regulation⁷⁹—which did not mention transferability—should be interpreted as requiring it.⁸⁰

Similarly, in many of the New York cases, ALJs broadly interpreted the federal requirement that a transfer be made exclusively for purposes other than qualifying for Medicaid⁸¹ as requiring applicants show that neither they nor their family contemplated the applicant would ever need nursing home care.⁸² A common approach was to conclude that, given the applicant’s advanced age, the applicant’s family must have contemplated a future need for nursing home care—regardless of the testimony proffered.⁸³ In other cases, ALJs found that applicants failed to rebut the presumption that a transfer was made exclusively for a purpose other than qualifying for Medicaid if a need for nursing home care was objectively foreseeable,⁸⁴ although the underlying standard is a subjective one.⁸⁵

Another way in which ALJs decided cases in a way that was less favorable to applicants than was required by the underlying law was by finding that care provided to applicants was worth substantially less than it would cost to buy that care on the open market. For example, a 2013 New Jersey fair hearing decision considered whether a woman had made a transfer for less than fair market value by paying her daughter-in-law and grand-

⁷⁹ See N.J. ADMIN. CODE § 10:71-4.10(b)(6)(i)(2018) (stating that in “determining whether or not an asset was transferred for fair-market value, only tangible compensation, with intrinsic value shall be considered. For example, a transfer for ‘love and affection’ shall not be considered a transfer for fair market value”).

⁸⁰ See N.J. Office of Admin. L., Docket No. HMA1036-08 (2008) (deciding to accept the state’s argument that the state regulatory requirement that the applicant receive something of “intrinsic value” in return for a transfer should be interpreted as requiring a penalty to be imposed where the applicant transferred money in return for a care contract that could not be sold to another because such contracts lack intrinsic value).

⁸¹ See 20 C.F.R. § 416.1246(e) (2017). For a discussion of this presumption, see *supra* note 35 and accompanying text.

⁸² See, e.g., N.Y. State Dep’t of Health, Fair Hearing No. 7618429M at 11 (Sept. 25, 2017) (finding that applicant failed to show transfers were made for a purpose other than qualifying for Medicaid because “[t]he record did not establish that the [applicant] and her family did not consider that Appellant might have to reside in a nursing home and/or might need Medicaid”; N.Y. State Dep’t of Health, Fair Hearing No. 6057311Y (Mar. 19, 2012)).

⁸³ See, e.g., N.Y. State Dep’t of Health, Fair Hearing No. 6057311Y at 7 (Mar. 19, 2012) (finding that applicant’s daughter’s “admission that her mother could have been residing in a nursing home as far back as 2003” had the daughter not provided care, coupled with the applicant’s “advanced age,” shows applicant failed to rebut presumption that transfers were made exclusively for a purpose other than establishing Medicaid eligibility”).

⁸⁴ See, e.g., N.Y. State Dep’t of Health, Fair Hearing No. 6347500M at 11 (Apr. 10, 2013) (treating evidence of a daughter’s extensive care for her mother as evidence that nursing home placement was objectively foreseeable, without finding it was foreseeable by the applicant or her daughter, and treating this foreseeability as outcome determinative); N.Y. State Dep’t of Health, Fair Hearing No. 6494316L at 10 (Sept. 18, 2013) (finding applicant’s serious medical conditions made it foreseeable he would “have to go in to [sic] a Nursing Home at some point” and that, given the applicant’s condition, his son-in-law and daughter’s testimony that they had not considered this possibility was not credible).

⁸⁵ See *supra* note 35 and accompanying text.

son for care.⁸⁶ The woman had paid her daughter-in-law (a dental hygienist) and grandson (an emergency medical technician) \$25 per hour to assist her with such tasks as shopping, showering, laundry, meal planning and preparation, medication administration, washing and combing her hair, cleaning her dentures, laundry, and paying bills.⁸⁷ This was done upon the advice of her lawyer, who had told her that \$25 per hour was a reasonable rate for such services.⁸⁸ The woman and her family subsequently acknowledged that private home health aides in her region are generally paid \$20 per hour, which was undisputed.⁸⁹ Nevertheless, the state Medicaid office did not investigate the cost of hiring a caregiver on the private market to perform the same tasks before denying the Medicaid application, instead valuing the services received at \$10.80 per hour based on the Department of Labor rate for non-licensed providers.⁹⁰ The ALJ held that the state's calculation was proper (i.e., that the services were worth only \$10.80 per hour) and therefore held that there had been an improper transfer in the amount of \$39,760.⁹¹

b. Statistical Analysis

The fact that there is a strong pattern of affirming agency action that runs contrary to general trends in ALJ decision-making, and that the underlying regulatory framework cannot alone explain ALJ determinations,⁹² raises the question: what other factors are at play? Past empirical and theoretical research on caregiving suggests that caregiver gender plays a critical role in whether care is seen as having monetary value.⁹³ The author therefore hypothesized that caregiver gender would affect ALJ determinations as to whether care provided pursuant to a personal services contract had monetary value. Specifically, the author hypothesized that ALJs would be more likely to find that personal care services lacked monetary value, or had minimal monetary value, when those care services were performed by a woman, and even more so when they were performed by a woman for another woman.

⁸⁶ See *E.H. v. Div. Med. Asst. & Health Servs.*, N.J. Office of Admin. L., Docket No. HMA09604-13 (2014).

⁸⁷ See *id.*

⁸⁸ See *id.*

⁸⁹ See *id.*

⁹⁰ See *id.*

⁹¹ See *id.*

⁹² See Office of the Inspector Gen., Soc. Sec. Admin. Cong. Response Report: The Social Security Administration's Review of Administrative Law Judges' Decisions 1, 2012, <https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-07-12-21234.pdf>, archived at <https://perma.cc/EBY4-FPY8> (finding that 62% of ALJ decisions were in favor of beneficiary).

⁹³ See, e.g., HARTOG, *supra* note 5, *passim* (finding that care by women was less likely to be treated as economic activity than care by men in early 19th and early 20th century cases in which courts were asked to enforce promises by older adults to give land to caregivers in return for care or company).

(1) *Methodology*

In order to empirically examine the author's hypotheses, the author coded administrative hearing decisions for (1) whether the services were determined to have no value or some value; (2) care recipient gender; (3) care provider gender; (4) familial relationship; (5) agency relationship (i.e., whether the caregiver was also the applicant's attorney-in-fact); (6) gendered language;⁹⁴ and (7) language about familial and role expectations.⁹⁵ Such coding was possible because, while ALJ opinions lacked other legally irrelevant demographic information, almost every decision included information about the gender of the applicant and his or her caregivers. An applicant's gender was most commonly indicated by possessive pronouns indicating the relationship between the caregiver and the applicant (e.g., "her son" or "her daughter-in-law").⁹⁶

Of the states considered, only New York had a sufficient number of hearing decisions for statistical analysis. The author therefore compared New York cases in which the ALJ found that the personal care services lacked any monetary value to those where the ALJ found such services had monetary value (either in the amount the applicant alleged or some lesser amount). The author performed a log-linear analysis on the New York data to examine whether determinations that care services lacked monetary value varied based on caregiver gender and recipient gender.⁹⁷

(2) *Findings*

The analysis of New York hearing decisions found a statistically significant relationship between care provider gender and a determination of whether the services had monetary value: when controlling for care recipient gender, caregiver gender was a statistically significant predictor of whether

⁹⁴ "Gendered language" was considered to be language that implied or stated expectations about the party's behavior (either actual or desirable) based on the party's gender. An example would be the language used in *Estate of Barnett*, 2006 WL 1668138, at *2 (2006), discussed *infra* note 113 and accompanying text.

⁹⁵ "Language about familial and role expectations" was considered to be language that clearly implied or stated expectations about the party's behavior (either actual or desirable) based on the party's familial relationship to the applicant or the party's role within the applicant's family. *See, e.g.*, Ohio Dep't of Job & Family Servs., Bureau of State Hearings, Dkt. No. 27 2005-AA-0293 ("The 'service' being provided by the granddaughter is nothing outside that which an ordinary family member would be expected to do for an elderly relative. This 'service' is something usually performed for love and affection and, therefore, does not have a fair market value.").

⁹⁶ Such descriptors typically are embedded in the ALJ's statement of the facts. *See, e.g.*, R.M. v. Ocean County Bd. of Soc. Servs., Docket No. HMA2677-01 (2002) ("the petitioner and her daughter executed a Service Contract for an Elderly Parent").

⁹⁷ *See infra* Appendix A, Tables 1 & 2. In cases involving more than one gender of caregiver, the caregiver was coded as female. This was consistent with the hypothesis that a woman performing the work would affect the judgment as to the monetary value of that work. One New York case was not included in the analysis because the gender of the care provider could not be determined.

ALJs deemed that the care provided had any economic value.⁹⁸ Specifically, care was less likely to be found to have monetary value when it was provided exclusively by male caregivers. This finding is consistent with the hypothesis that caregiver gender would affect the value determination. However, it is contrary to the author's prediction that female gender would be associated with a finding of no value.

(3) *Discussion of Findings*

Multiple plausible explanations exist for the findings described in the prior subsection. One possibility is that male relatives are more likely to claim payment under circumstances in which they are not entitled to it relative to female caregivers and this result simply reflects accurate determinations by ALJs. Another possibility is that care by women—contrary to the author's hypothesis—is perceived by ALJs as more valuable than care provided by men.

There are also several possible explanations for the results that are consistent with the hypothesis that traditional gender norms and stereotypes influence the valuation of care work. For example, if social service workers making initial eligibility determinations have the predicted bias against female caregivers (i.e., are less likely to see them as performing a service with value), this could result in a greater proportion of meritorious appeals from agency determinations that involve female caregivers. Similarly, if men are less likely to be perceived as true caregivers, then claims involving male caregivers may be more likely to be viewed as suspect. However, given the small sample size and the number of potentially confounding, unaccounted for factors, it would be imprudent to draw a conclusion from the statistical analysis alone.

Therefore, in addition to engaging in statistical analysis, the author analyzed the hearing decisions qualitatively to more fully interrogate the relationship between caregiver gender and the perceived value of care and determine whether gender stereotypes or familial role expectations influence ALJ determinations.⁹⁹ Three key patterns emerged.

First, a subset of the opinions contained normative language about familial role expectations.¹⁰⁰ For example, one Ohio decision considered whether a granddaughter had provided compensable care when she agreed to monitor the institutionalized applicant's health, to attend and oversee doctor

⁹⁸ The author's analysis resulted in a p-value of 0.0412. See *infra* Appendix A, Table 3. A p-value of 0.05 or less is generally agreed to be strong evidence against the null hypothesis (i.e., strong evidence of a statistically significant relationship). See Ronald L. Wasserstein & Nicole A. Lazar, *The ASA's Statement on P-Values: Context, Process, and Purpose*, 70 *AMERICAN STATISTICIAN* 179 (2016) (discussing the scientific consensus that a p-value of 0.05 represents a statistically significant result, and the proper use of the p-value).

⁹⁹ To identify themes, decisions were read, coded as detailed earlier in this section, and grouped into meaningful units related to the study's underlying questions.

¹⁰⁰ These cases came disproportionately, but not exclusively, from Ohio.

appointments, and to oversee the maintenance and sale of the applicant's home.¹⁰¹ The ALJ described these services as "nothing outside that which an ordinary family member would be expected to do for an elderly relative," and thus lacking market value.¹⁰² Another Ohio opinion reasoned that an applicant's payments to her sons for care could not be considered transfers for fair market value because, among other reasons, "many of the services are considered personal services which an adult child should provide out of legal or moral obligation" and cited as examples "speaking to the Appellant, their mother, on the phone about wanting cinnamon rolls or simply to check on her."¹⁰³ Similarly, another Ohio decision held that transfers to an applicant's daughter under a personal care contract were improper because the daughter had a pre-existing legal obligation to care for her mother under Ohio's filial responsibility statute,¹⁰⁴ a statute that creates a limited obligation to provide financial support to indigent parents, rather than creating the legal obligation described in the decision.¹⁰⁵

Second, language about familial role was frequently intertwined with a discussion of the caregiver's role as the applicant's agent. ALJs frequently noted that the caregiver was simultaneously the applicant's attorney-in-fact under a power of attorney.¹⁰⁶ In some cases, the agency relationship was explicitly a factor in finding the transfer improper. For example, several Ohio cases reasoned that transfers were improper because the agent had a legal obligation as attorney-in-fact to provide some of the contracted services,¹⁰⁷ although this point was inconsistent with the state's law governing powers of attorney.¹⁰⁸

¹⁰¹ Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Docket No. 2005-AA-0293 (March 16, 2005).

¹⁰² *Id.*

¹⁰³ Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Appeal No. 1456886 (Mar. 26, 2009); *see also* Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Appeal No. 1456881 (July 20, 2009) (suggesting transfers were not proper because applicant's children had a pre-existing duty to provide support under state's filial responsibility law).

¹⁰⁴ Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Docket No. AA-2271 (Jan. 25, 2008).

¹⁰⁵ *See* OHIO REV. CODE § 2919.21(A)(3) (2017) (creating a limited obligation to financially support one's "aged or infirm parent or adoptive parent, who from lack of ability and means is unable to provide adequately for the parent's own support," and not creating an obligation to provide other forms of support).

¹⁰⁶ The modern trend is to refer to a durable power of attorney simply as a power of attorney (POA). Indeed, the Uniform Power of Attorney Act takes the position that all powers of attorney are durable unless they state otherwise and thus only uses the term "power of attorney." *See* UNIF. POWER OF ATTORNEY ACT (UNIF. LAW COMM'N 2006). This Article, therefore, adopts this streamlined terminology.

¹⁰⁷ *See* Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Docket No. AA-2271 (Jan. 25, 2008); Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Docket No. AA-2345 (Feb. 8, 2008) (finding a transfer purportedly for care to lack economic value because attorney-in-fact relationship already created duty to provide contracted-for-services); Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Appeal No. 1456881 (July 20, 2009) (same).

¹⁰⁸ *See* OHIO REV. CODE § 1337.34 (2017) (setting forth duties of an agent under a power of attorney in Ohio, which do not include duty to provide such services).

More commonly, ALJs did not explicitly attach any legal significance to an individual's dual roles as caregiver and attorney-in-fact. But the salience of the agency relationship was evident in the terminology used to describe the caregiver. For example, one New York decision referred to the caregiver interchangeably as the "niece and POA," "POA," "niece (POA)," and "provider."¹⁰⁹

Third, the administrative law decisions generally did not include language that explicitly indicated that ALJs were influenced by the gender of the caregiver or care recipient, but, in the process of making findings of fact, they frequently described caregivers engaging in tasks that are consistent with traditional gender norms.¹¹⁰ In addition, in a number of cases involving exclusively or primarily female caregivers, a key rationale offered by the ALJ for finding the care to be noneconomic in nature was the fact that the care had previously been provided for free, and that this was either evidence that the work was done without expectation of compensation,¹¹¹ or triggered regulatory provisions prohibiting the care from being treated as having value.¹¹² However, it is not possible to determine whether this reflects differential treatment of female caregivers. It could also reflect the fact that women are disproportionately likely to provide unpaid elder care, or it could simply be the artifact of a small sample, or of confounding factors, such as differential treatment by state agency employees making initial eligibility determinations.

In short, the author's analysis of ALJ decisions demonstrates that ALJs are cognizant of the gender of the parties involved, and that familial role expectations are salient to administrative law judges as they consider these cases.

2. Court Decisions

Relatively few court decisions considered whether personal care contracts have economic value.¹¹³ Of those decisions, a few have held that trans-

¹⁰⁹ See N.Y. State Dep't of Health, Fair Hearing No. 5611905J, 9–10 (Feb. 15, 2011). The term "POA" was used most often.

¹¹⁰ This may reflect that families appear to frequently divide tasks consistent with traditional gender roles. See, e.g., N.Y. State Dep't of Health, Fair Hearing No. 5691276Y (Dec. 16, 2010) (describing applicant's son as providing extensive home maintenance and remodeling services; applicant's daughter-in-law as providing laundry, dusting, cleaning, and toileting care; and applicant's granddaughter as providing assistance with intimate care).

¹¹¹ See, e.g., Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Docket No. 2005-AA-5161 (Mar. 30, 2010) (finding the fact that daughter had been providing her mother with the same services subsequently contracted for showed real purpose of transfer was to qualify for Medicaid, and thus the state had correctly imposed penalty period).

¹¹² See, e.g., N.Y. State Dep't of Health, Fair Hearing No. 7174738R, 9 (Nov. 11, 2015) (relying on N.Y. administrative guidance).

¹¹³ The author identified thirteen decisions from seven different states decided since the adoption of the Deficit Reduction Act of 2005. See *Scott v. Zucker*, 129 A.D.3d 1527, 1528 (N.Y. App. Div. 2015) (upholding imposition of a penalty period where father contracted with son and daughter-in-law to provide services, but provided no documentation and little explana-

tion of services rendered); *Swartz v. N.Y. State Dep't of Health*, 946 N.Y.S. 2d 698, 699–700 (N.Y. App. Div. 2012) (holding a transfer for less than fair market value occurred when a daughter was paid for caring for her parents during nighttime hours because daughter did not contemporaneously document the services provided each night, and that such a transfer also occurred to the extent the wage father paid daughter—which was equivalent to what he would have paid a local healthcare agency—was greater than mean hour wage for a home care worker in the state according to the Bureau of Labor statistics); *Forman v. Dir. of Office of Medicaid*, 944 N.E.2d 1081, 1086–87 (Mass. Ct. App. 2011) (finding entire payment was a transfer for less than fair market value because contract had no ascertainable fair market value since its value was uncertain, where a mother transferred a lump sum of \$20,000 to her daughter in return for a personal services contract under which daughter was to provide a myriad of services for as long as they were appropriate; in doing so, the court emphasized that daughter had provided services to mother prior to contract for free, although recognizing daughter had not done so to the same extent prior to the contract); *Joyner v. N.C. Dep't of Health & Human Servs.*, 715 S.E.2d 498, 506–08 (N.C. Ct. App. 2011) (finding that a personal care contract in which a mother paid her son a lump sum for anticipated future services was a transfer for less than fair market value because anticipatory lump sum payments can likely never be said to represent fair market value payment for services; remanding the case for consideration as to whether a care provider son had successfully rebutted the presumption that a payment for services rendered in the past had been performed “in obedience to a moral obligation and without expectation of compensation”); *Austin v. Ind. Family & Soc. Servs. Admin.*, 947 N.E.2d 979, 985–86 (Ind. Ct. App. 2011) (finding that full value of an aunt’s transfer of \$35,000 to her nephew and his wife pursuant to a “life services agreement” was a transfer for less than fair market value; in so doing, expressing concern that agreement did not provide for a return of funds should aunt not live to her full life expectancy, finding that most of the services to be provided were duplicative of those provided by the aunt’s nursing home, and that nephew and niece’s visits to aunt had no market value because they appeared to fall “within the realm of ‘love and affection’”); *Gauthier v. Dir. of Office of Medicaid*, 956 N.E.2d 1236, 1240–42, 1246 (Mass. App. Ct. 2011) (finding that where a mother paid her son and daughter-in-law, a registered nurse, \$182,000 for room and board and services, the entire value of the payment should not have been considered a transfer for less than fair market value because care providers had designed and built a handicapped-accessible area in their house for mother’s use in which she resided for approximately twenty-two months; therefore, remanding case to Office of Medicaid Board of Hearings); *E.S. v. Div. of Medicaid Assistance & Health Servs.*, 990 A.2d 701, 704, 710 (N.J. Super. Ct. 2010) (finding that a life care contract entered into for \$56,550 between a daughter and her mother after mother had moved to a nursing home had no monetary value despite that it was calculated based on the mother’s life expectancy, a set number of hours per week, and an hourly rate based on market knowledge; the court reasoned that this was because the agreement had “no value on the open market” because the care recipient was prohibited in transferring her rights under the contract to another party”); *Dambach v. Dep't of Soc. Servs.*, 313 S.W.3d 188, 192 (Miss. Ct. App. 2010) (finding that payments made pursuant to a verbal agreement between mother and daughter that mother would use whatever money she had to pay her daughter to provide room, board, and personal care were made in return for “fair and valuable consideration”); *In re Kerner v. Monroe Cty. Dep't of Human Servs.*, 75 A.D.3d 1085, 1086–87 (N.Y. App. Div. 2010) (finding that state had erred in finding services provided by a son and his wife to son’s mother lacked fair market value, and remanded for a determination of the services’ value); *Barbato v. N.Y. State Dep't of Health*, 65 A.D.3d 821, 823 (N.Y. App. Div. 2009) (considering a group of cases involving applicants who had contracted for care on an “as needed basis” and finding imposition of a penalty period lawful because “petitioners cannot demonstrate that transfer of assets for prospective services was for fair market value, because there is no basis upon which to conclude that transfer of a specific amount of assets for services that may or may not be rendered is for fair value”); *Brewton v. State Dep't of Health & Hosps.*, 956 So. 2d 15, 19–20 (La. Ct. App. 2007) (finding that a couple did not make a transfer for less than fair market value when they transferred approximately \$159,000 to a nephew, niece, and the niece’s husband pursuant to a personal services contract, reasoning that, although the couple was in a nursing home for much of the time during which services were performed, many services were not duplicative of those provided by institutions); *Estate of Barnett v. Dep't of Health & Human Servs.*, No. Civ.A.AP-

fers pursuant to a personal care contract had economic value when the state argued they did not.¹¹⁴ In the Mississippi case of *Dambach v. Dept. of Social Services*, a mother and daughter entered into a verbal agreement that the mother would pay her daughter to provide room, board, and personal care because she preferred to live with her daughter rather than move to a nursing home.¹¹⁵ The daughter initially charged the mother \$75 per day—later reduced this to \$50 per day—which she reported on her federal income tax return as income in exchange for care.¹¹⁶ The Mississippi Court of Appeals determined that these payments were intended, and in fact were, made in return for “fair and valuable consideration.”¹¹⁷

Most courts, however, have taken the approach generally observed in ALJ decisions, determining that care provided lacked economic value.¹¹⁸ In some cases, courts have made clear that this determination is because the type of services provided were those that the care provider should be expected to perform without compensation as a result of the care provider’s position within the family. In the 2006 case *Barnett v. Department of Health & Human Services*, a Maine court considered a case in which an adult daughter was paid for “paying bills . . . filing paperwork; shopping for supplies, medications, clothing, and holiday presents; and taking [her mother] to her appointments with her doctor, dentist, and lawyer” and, “assisting . . . with meals, brushing her teeth, giving her manicures, trimming her hair, cleaning her hands and face, and bringing her sister for a visit.”¹¹⁹ The court refused to find these services had any monetary value—declaring them simply “the services that any daughter would provide for her ailing mother without charge.”¹²⁰ Likewise, the Indiana Court of Appeals, considering the fair market value of a “life care contract” (a form of personal services contract in which there is an explicit agreement to provide care for the life of an individual) entered into by a childless nonagenarian, her nephew, and his wife, refused to find that contracted-for visits by the nephew and wife had

05-060, 2006 WL 1668138, at *2 (Me. Super. Ct. 2006) (finding impermissible services charged for and provided by a nursing home resident’s daughter pursuant to a personal services contract that were the same services provided by the nursing home, particularly assistance with meals, personal hygiene, and visitation, because the services “do not fall within the definition of support for basic necessities for which fair market value can be assessed”); *Carpenter v. State Dep’t of Health & Hosps.*, 944 So.2d 604, 607, 614 (La. Ct. App. 2006) (finding that a mother had entered into a written personal services contract with her daughter fifteen years prior to nursing home placement and that the nearly \$30,000 transferred pursuant to that agreement was not a transfer for less than fair market value).

¹¹⁴ See *Dambach*, 313 S.W.3d at 192; see also *Brewton*, 956 So. 2d at 19–20; *Carpenter*, 944 So. 2d at 607, 614.

¹¹⁵ See *Dambach*, 313 S.W.3d at 189–90.

¹¹⁶ *Id.* at 192.

¹¹⁷ *Id.*

¹¹⁸ See, e.g., *Scott*, 129 A.D.3d at 1528; *Swartz*, 946 N.Y.S. 2d at 699–700; *Forman*, 944 N.E.2d at 1086–87; *Joyner*, 715 S.E.2d at 506–08; *Austin*, 947 N.E.2d at 985–86; *E.S.*, 990 A.2d at 710; *Barbato*, 65 A.D.3d at 823; *Estate of Barnett*, 2006 WL 1668138, at *2.

¹¹⁹ *Estate of Barnett*, 2006 WL 1668138, at *2.

¹²⁰ *Id.*

any market value because, according to the court, “such visitations appear to fall within the realm of ‘love and affection.’”¹²¹

Another common approach taken by courts is to treat personal care contracts as lacking monetary value where the payment is a lump sum payment in exchange for future services.¹²² Such future services are treated as too uncertain to have an ascertainable fair market value,¹²³ which is ironic given that there is a clear parallel to such anticipatory contracts in the elder care marketplace: the continuing care retirement community (CCRC).¹²⁴ CCRCs commonly require entrants to pay a large lump sum fee in return for future services, despite the fact that the duration of those services is uncertain; should the individual die shortly after paying the fee, the CCRC typically retains the fee.¹²⁵ In many cases, the lump sum payments being offered to family members function as a “poor man’s version” of the CCRC contract: older adults who could not afford the large fees typically associated with CCRCs get a similar right to lifetime services by paying a lower price to their relatives.

Some courts treat personal care contracts as lacking monetary value because they contain terms that, according to the courts, render the agreements essentially worthless. For example, in *E.S. v. Division of Medicaid Assistance & Health Services*, a New Jersey court ruled that a personal care contract between a mother and a daughter had “no value on the open market,” because the care recipient was prohibited from transferring her rights under the contract to another party.¹²⁶ Similarly, in *Austin v. Indiana Family & Social Services Administration*, the Indiana Court of Appeals held a “life services agreement” suspect because it did not provide for a return of funds

¹²¹ *Austin*, 947 N.E.2d at 986.

¹²² See *Forman*, 944 N.E.2d at 1087; *Joyner*, 715 S.E.2d at 506–08; *Austin*, 947 N.E.2d at 985–86; *E.S.*, 990 A.2d at 710; *Barbato*, 65 A.D.3d at 823.

¹²³ See *Forman*, 944 N.E.2d at 1087 (“[T]he contract does not quantify the number of hours per week to be worked by the daughter in caring for the mother, nor does it provide a likely duration for which the \$20,000 lump-sum payment was contemplated. Because we evaluate the fair market value ‘based on the prevailing price at the time of transfer,’ the contract’s ‘ascertainable fair-market value’ is therefore highly uncertain.”); *Joyner*, 715 S.E.2d at 507–08 (stating that “as a practical matter, it is very difficult for us to see how a lump sum advance payment for future services could ever actually represent the fair market value of those services . . .” and “simply put, there are too many contingencies that must be addressed and accounted for in order to determine whether such a lump sum amount actually reflected the market value of what was received.”); *Barbato*, 65 A.D.3d at 823 (“[P]etitioners cannot demonstrate that the transfer of assets for prospective services was for fair market value, because there is no basis upon which to conclude that the transfer of a specific amount of assets for services that may or may not be rendered is for fair value.”).

¹²⁴ A CCRC is a living arrangement in which lifelong housing, household assistance, and nursing care is provided, typically in exchange for an entrance fee and monthly fees. The particular setting or unit within which one resides in a CCRC typically changes as one’s individual needs change. See generally U.S. GOV’T ACCOUNTABILITY OFF., GAO-10-611, CONTINUING CARE RETIREMENT COMMUNITIES CAN PROVIDE BENEFITS, BUT NOT WITHOUT SOME RISK 3–7 (2010) (describing common fee structures for CCRCs).

¹²⁵ See *id.*

¹²⁶ *E.S.*, 990 A.2d at 710.

should the aunt not live to her full life expectancy.¹²⁷ Notably, contracts with these same terms would generally be fully permissible and enforceable if entered into with a non-relative care provider.¹²⁸ Indeed, were contracts with professional service providers such as assisted living facilities and CCRCs held to such standards, it seems probable that they would routinely be held unenforceable.¹²⁹

In short, court decisions considering the market value of personal service contracts typically find that these contracts lack monetary value. In so doing, the decisions frequently identify as key factors the familial relationship between care provider and care recipient, the intimate nature of the care, and the lack of certainty as to the length and scope of the care to be provided. Yet in many cases, these factors appear to be what motivate older adults to seek family care in the first place.¹³⁰ As an applicant's daughter opined at a fair hearing conducted as part of an appeal for a denial of benefits based on payments made for personal care provided by the applicant's granddaughter: "It is very sad that it's okay to pay a lot of money to an Agency for aides who are unreliable and for the most part uncaring, but it's not okay for a family member who you know loves and cares about you."¹³¹

III. EXPLANATIONS FOR THE HOSTILE RESPONSE TO PERSONAL CARE CONTRACTS

As described in the preceding Part, older adults who have entered into personal care contracts with relatives have been heavily penalized for doing so by being denied Medicaid coverage to pay for essential long-term care services. This Part seeks to explain this harsh regulatory and adjudicatory reaction and how it has occurred despite calls by policymakers and advocates for greater support for family caregivers.¹³²

¹²⁷ *Austin*, 947 N.E.2d at 986–87.

¹²⁸ For example, CCRCs are not required to refund fees in such situations, and, in some states, are not required to refund fees at all. *See generally* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 124.

¹²⁹ *See id.* (discussing current fee structures for CCRCs).

¹³⁰ *See* Ruping Fan, *Which Care? Whose Responsibility? And Why Family? A Confucian Account of Long-term Care for the Elderly*, 32 J. MED. & PHIL. 495, 498–500 (2007) (reporting that in all three cities studied, Houston, Beijing, and Hong Kong, older adults preferred family care over care by non-family members, and arguing that intimate nature of the care is one reason for this preference); *see also* CAROL LEVINE & TERESA LEE, "I CAN TAKE CARE OF MYSELF!": PATIENTS' REFUSALS OF HOME HEALTH CARE SERVICES (2017) at 7, <http://uhfnyc.org/publications/881209>, archived at <https://perma.cc/E9TN-YF9J> (explaining older adults' reluctance to have strangers provide intimate care).

¹³¹ N.Y. State Dep't of Health, Fair Hearing No. 6955729H at 8–9 (Feb. 11, 2015), http://otda.ny.gov/fair%20hearing%20images/2015-7/Redacted_6955729H.pdf, archived at <https://perma.cc/6BM9-83HW>.

¹³² For a discussion of efforts to increase support for family care at both the state and federal level, and an example of one such call, see NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 16, at ch. 5.

A. *Opposition to Medicaid Planning*

At first blush, it is appealing to simply attribute the backlash against personal care contracts to the strong sentiment against Medicaid planning. Governmental and public distaste for Medicaid planning is palpable. It has been criticized as unethical and as a form of elder abuse;¹³³ Congress even went so far as to attempt to criminalize the practice.¹³⁴ Medicaid planning has also been sharply criticized in the popular press; major national newspapers have published editorials condemning the practice.¹³⁵ Those who engage in Medicaid planning are depicted as greedy and their lawyers as unethical.¹³⁶

Distaste for Medicaid planning can partially explain the reaction against personal care contracts. The state regulations that single out personal care contracts were certainly a response to the rise in the use of personal care contracts as a Medicaid planning strategy. Such a rise occurred after Congress passed the Deficit Reduction Act of 2005, which, as previously noted, severely curtailed the utility of many then-existing Medicaid planning strategies.¹³⁷ In addition, a subset of triers of fact that have considered the value of care provided under such contracts have described their work as protecting the integrity of Medicaid against those who might abuse it.¹³⁸

Nevertheless, disdain for Medicaid planning is an incomplete explanation for hostility to personal care contracts. State regulations defining when a

¹³³ See Milan Markovic, *Lawyers and the Secret Welfare State*, 84 *FORDHAM L. REV.* 1845, 1855 (2016) (arguing that many forms of Medicaid planning should be considered unethical, stating “[e]ven strategies that do not run afoul of current ethics rules may be unethical. Americans do not have a right to Medicaid benefits, and it is unclear why attorneys should be able to assist clients to engage in transactions that have no purpose other than Medicaid qualification.”); see also Timothy L. Takacs & David L. McGuffey, *Medicaid Planning: Can it be Justified? Legal and Ethical Implications of Medicaid Planning*, 29 *WM. MITCHELL L. REV.* 111 (2002) (providing a lengthy discussion of debate over ethics of Medicaid planning).

¹³⁴ In 1996, Congress passed a statute criminalizing certain forms of Medicaid planning. The Act, nicknamed the “Granny Goes to Jail Act,” was soon repealed; instead, Congress attempted to bar attorneys from counseling clients about Medicaid planning. In response, Attorney General Janet Reno announced she would not enforce the new Act because it violated the First Amendment. The U.S. District Court for the Northern District of New York subsequently enjoined enforcement of the Act. See *N.Y. State Bar Assoc. v. Reno*, 999 F. Supp. 710 (N.D.N.Y. 1998).

¹³⁵ See Editorial, *Medicaid for Millionaires*, *WALL ST. J.*, Feb. 24, 2005 (describing Medicaid planning practices as “inheritance protection for the children of well-off seniors”); see also Editorial, *Pretending to be Poor*, *N.Y. TIMES*, Apr. 14, 1996 (describing Medicaid planning as “the blatant and often unethical misuse of the program by well-to-do patients in nursing homes”).

¹³⁶ See, e.g., Ron Lieber, *The Ethics of Adjusting Your Assets to Qualify for Medicaid*, *N.Y. TIMES*, July 21, 2017, at B1 (“At any given moment, there is a large group of citizens who want nothing more than to make absolutely certain that they are impoverished enough to qualify for Medicaid sooner rather than later. Someday, you might be one of them.”).

¹³⁷ See *supra* notes 25-26 and accompanying text.

¹³⁸ See, e.g., Mich. Office of Admin. Hearings & Rules, 2008-22170/JWO (Sept. 22, 2009) (incorporating a lengthy description of the Medicaid program that describes the program as one “intended to provide needed services to the poor in our society” and transfer rules as designed to assure that beneficiaries “are in fact poor”).

payment to a family member is considered to be in return for fair market value services are generally not tailored to situations in which the payment would be motivated by Medicaid planning. In fact, in many cases, the regulations are so complex that only those engaged in sophisticated Medicaid planning will likely comply. For example, a Michigan resident who paid family members for care would face ineligibility unless the applicant had a complex, formal contract with the family members.¹³⁹ Yet it is only with the guidance of a sophisticated elder law specialist that such complex terms are likely to be satisfied.

Similarly, a review of ALJ decisions considering the effect of payments to family caregivers on Medicaid eligibility reveals that, in many cases, ALJs are finding that services provided lacked monetary value without finding that the payment was motivated in whole or in part by a desire to qualify for Medicaid.¹⁴⁰

Finally, hostility toward personal care contracts cannot be wholly attributed to disdain for Medicaid planning, as that sentiment is itself likely the result of other factors. Indeed, the two additional explanations provided in this Part—distrust of agents and historical biases—may contribute to hostility toward Medicaid planning.

B. Distrust of Agents

In addition to reflecting antipathy to Medicaid planning, the hostile reaction to family care payments may reflect unease with the multiple roles played by caregivers. In many of the administrative decisions and court cases reviewed,¹⁴¹ the caregiver was simultaneously a paid caregiver, a family member, and the applicant's legal agent under a power of attorney (often referred to as an "attorney-in-fact").¹⁴² The contract with the care provider was hardly an arms-length transaction, but rather the result of the caregiver acting in one capacity (typically, as an attorney-in-fact under a durable power of attorney) contracting with him or herself in another capacity (care provider) and doing so because of yet another role (family member).

¹³⁹ See *supra* note 64 and accompanying text.

¹⁴⁰ See, e.g., *J.W. v. Div. of Med. Assistance & Health Servs. & Hunterdon Cty. Bd. of Soc. Servs.*, Hearing No. HMA4558-14 (Aug. 12, 2014) (finding that services could not be valued because of insufficient documentation of the provision of those services and thus finding against applicant despite not finding that payment was made in order to qualify for Medicaid).

¹⁴¹ See *supra* note 113 for a list of court cases reviewed.

¹⁴² Whether this pattern is representative of caregivers in all personal care arrangements considered by state agencies administering Medicaid is unknown. If unease with caregivers performing in multiple roles is a factor, it may be that applications which involve such caregivers are disproportionately denied at the agency level, leading to greater concentration of such cases in the fair hearing process.

Such self-dealing by caregivers is not necessarily improper. The power of attorney¹⁴³ creates an unusual type of fiduciary relationship.¹⁴⁴ Like all fiduciaries, an agent under a power of attorney has a duty of loyalty.¹⁴⁵ However, in this context, that duty can be consistent with self-dealing. As the author has discussed elsewhere, loyalty in surrogate decision-making relationships, including power of attorney relationships, is generally seen as not barring agents from acting in ways that benefit themselves.¹⁴⁶ Indeed, the Uniform Power of Attorney Act (UPA) permits agents to have conflicts of interest and to use the authority granted by the principal to act in ways that benefit the agent.¹⁴⁷ A comment to the relevant UPA provisions describes this approach as modeled after “state statutes which provide that loyalty to the principal can be compatible with an incidental benefit to the agent.”¹⁴⁸ The underlying logic is that the agent is to use substituted judgment (i.e., to act in accordance with the principal’s wishes or directions) and the principal may wish or direct the agent to so act. Allowing the agent to act in a manner that benefits the agent also reflects the fact that most agents acting under a power of attorney are family members,¹⁴⁹ and family members typically have inherent conflicts of interest as a result of, among other things, inheritance expectations and jointly-held property.¹⁵⁰

Nevertheless, such self-dealing draws the attention of both policymakers and triers of fact. Some state regulations treat personal care contracts differently if they are executed by an agent. For example, Michigan and Idaho deem personal care contracts lacking in monetary value as a matter of law if the caregiver is also the agent who executed the agreement.¹⁵¹

Out of thirteen court cases considering the value of care provided under a personal care contract,¹⁵² seven mentioned that the caregiver served as the applicant’s agent under a power of attorney.¹⁵³ While the majority of these

¹⁴³ Notably, the term power of attorney is also used in some states to refer to a document that creates a surrogate decision-maker for health care. In this Article, as is common practice, the term is used exclusively to refer to a power of attorney for finances. This is consistent with the approach in the Uniform Power of Attorney Act. *See generally* UNIF. POWER OF ATTORNEY ACT, *supra* note 106.

¹⁴⁴ *See* Nina A. Kohn, *Fiduciary Principles in Surrogate Decision-Making*, in OXFORD HANDBOOK OF FIDUCIARY LAW (Sitkoff et al., eds., forthcoming 2018).

¹⁴⁵ *See id.*

¹⁴⁶ *See id.* (discussing the unusual approach to the duty of loyalty observed in surrogate decision-making relationships).

¹⁴⁷ *See* UNIF. POWER OF ATTORNEY ACT, *supra* note 106, at § 114(d).

¹⁴⁸ *Id.* § 114 cmt. at para. 6.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *See* IDAHO ADMIN. CODE r. 16.03.05 § 831.2.b (2017) (“A representative who signs the contract must not be the provider of the personal care services under the contract[.]”); Mich. Dep’t of Health & Human Servs., *supra* note 45 (“If the agreement is signed by a representative, that representative cannot be the provider or beneficiary of the contract/agreement.”).

¹⁵² *See supra* note 113 for a list of cases.

¹⁵³ *See Forman*, 944 N.E.2d at 1083; *Austin*, 947 N.E.2d at 980; *E.S.*, 990 A.2d at 704; *Dambach*, 313 S.W.3d at 190; *Brewton*, 956 So. 2d at 16; *Estate of Barnett*, 2006 WL 1668138, at *2; *Carpenter*, 944 So. 2d at 609; *E.S.*, 990 A.2d at 701.

noted the dual role without indicating that it was relevant to the underlying eligibility determination,¹⁵⁴ two treated it as relevant to the court's determination.¹⁵⁵ For example, the Indiana Court of Appeals explained:

There can be no doubt here that this particular transaction was not an “arm’s-length” one, with the Macks signing the Agreement both on their own behalf and on behalf of Austin as her attorneys-in-fact. Indeed, this appears to be “a classic example of self-dealing by a fiduciary.” . . . In such a situation, we believe [the Indiana Family and Social Services Administration] and the courts are justified in turning a skeptical eye toward “personal care” contracts and carefully examining whether they truly represent a fair market value exchange for cash or assets of a nursing home resident.¹⁵⁶

A New Jersey court took an even harsher approach, suggesting not only that the agency relationship made the transaction suspect¹⁵⁷ but also that the court saw the caregiver as the true party of interest in the case:

E.K., who holds a durable power of attorney for petitioner, entered into the [Life Care Contract (LCC)], on behalf of petitioner, on September 26, 2007. She named herself as the designated “caregiver” who was to receive a payment of \$56,550 for services to be rendered to her mother, the “resident,” as specified in the LCC. Although throughout this opinion we refer to petitioner as the party in interest, in reality, it is E.K. who is pursuing the appeal.¹⁵⁸

Many fair hearing decisions likewise noted the dual role. Specifically, in approximately half of the administrative decisions the author reviewed, the ALJ noted that an agent acting on behalf of the older adult—and not the older adult applying for Medicaid—had entered into the personal services agreement,¹⁵⁹ and, in a subset of those, commented negatively on the agent's behavior.¹⁶⁰ Several decisions, moreover, incorrectly concluded that money

¹⁵⁴ *Forman*, 944 N.E.2d at 1083; *Dambach*, 313 S.W.3d at 190; *Brewton*, 956 So. 2d at 16; *Estate of Barnett*, 2006 WL 1668138, at *2; *Carpenter*, 944 So. 2d at 609.

¹⁵⁵ *Austin*, 947 N.E.2d at 985; *E.S.*, 990 A.2d at 704.

¹⁵⁶ *Austin*, 947 N.E.2d at 985.

¹⁵⁷ In addition, the court treated the fact that the caregiver had not sought her sibling's approval of the contract as relevant to the determination that the transfer was for less than fair market value. *See E.S.*, 990 A.2d at 709. This is an odd argument in that the sibling would have had no legal right to approve or disapprove the contract, but suggests that the court may have been concerned that the caregiver was engaged in self-dealing to avoid sharing an inheritance with a sibling.

¹⁵⁸ *E.S.*, 990 A.2d at 704.

¹⁵⁹ *See infra* Appendix A, Table 5.

¹⁶⁰ *See, e.g.*, *Estate of S.B. v. Div. of Med. Assistance & Health Servs. & Union Cty. Bd. of Soc. Servs.*, Docket No. HMA9372-00 (2011) (“I find that this was not an arm’s length transaction but a breach of the fiduciary duty which D.B. [the attorney-in-fact for the appli-

paid pursuant to a personal services agreement was a transfer for less than fair market value because the caregiver's status as attorney-in-fact created a preexisting duty to provide services.¹⁶¹

Thus, applicants may face a Catch-22 situation. Consistent with the law governing powers of attorney for finances,¹⁶² the applicant and the applicant's agent are treated as a single entity for the purpose of determining whether the applicant made a transfer. Thus, the applicant is held fully responsible for the agent's decision to transfer funds. However, in determining the value of services received in return for the transfer, the applicant and agent are treated as separate entities. The fact that it is the agent who has signed on behalf of the applicant affects the trier of fact's evaluation of the economic value of the underlying services.

It is hardly surprising that triers of fact treat such agreements executed by potentially conflicted agents as suspect. Indeed, triers of fact trained to recognize the signs of financial exploitation might rightfully note that such transactions raise many red flags associated with such exploitation. At the same time, treating care agreements entered into by agents who provide care as improper does not directly punish the suspected exploiter; rather, it denies medically necessary services to the victim by preventing the victim from obtaining Medicaid coverage for a length of time.¹⁶³

C. Devaluation of Care Work

The author's review of the regulatory response, hearing decisions, and court cases considering the effect of personal care contracts on Medicaid eligibility strongly suggests that the negative adjudicatory and regulatory re-

cant,] owed to [the applicant] as her attorney-in-fact. It was her obligation as [the applicant's] attorney-in-fact to use the power of attorney to protect and preserve [the applicant's] assets and use them for [the applicant's] benefit, not to usurp them for the benefit of D.B. and her children while leaving [the applicant] S.B. a ward of the State.”)

¹⁶¹ See, e.g., Ohio Dep't of Job & Family Servs. Bureau of State Hearings, Docket No. 2005-AA-4205 (July 20, 2009) (“[T]he daughter-in-law had a fiduciary duty to provide some of these contract services as your power-of-attorney under Chapter 1337 of the Ohio Revised Code.”). The latter is an incorrect statement of the law. A person has no duty, including no duty under the cited Code, to accept appointment as an agent under a power of attorney. Moreover, the agent's duty to act—to the extent it exists—does not include a duty to directly provide personal care. See Kohn, *supra* note 144.

¹⁶² Each state has adopted a statute enabling durable powers of attorney by which one person can appoint another to make decisions on his or her behalf. See Nina A. Kohn, *Elder Empowerment as a Strategy for Curbing the Hidden Abuses of Durable Powers of Attorney*, 59 RUTGERS U. L. REV. 1, 6–7 (2006) (describing states' statutory embrace of durable powers of attorney).

¹⁶³ Any punishment of the caregiver would be indirect. A caregiver who felt guilty about monies paid, and who had the resources to refund the older adult, might give money back to the applicant, allowing the applicant to pay for needed care. Even if the caregiver did so (and was thus “punished”) the older adult would still face a penalty for the transfer in the first place and thus be ineligible for Medicaid. Moreover, the monies returned would, in all likelihood, be insufficient to pay for the needed care as the private pay rate for long-term care substantially exceeds the Medicaid pay rate. See *supra* note 38.

sponse also reflects a continuation of historical biases against, and stereotypes about, care work.

Historically, the law and society more broadly generally treated intra-family care as lacking in economic value.¹⁶⁴ Care work has been associated with the feminine and private sphere,¹⁶⁵ a sphere seen as operating largely outside of the economic system,¹⁶⁶ despite the fact that the family is a vital economic unit.¹⁶⁷ Hendrik Hartog's analysis of court decisions in the late 19th and early 20th centuries considering the enforceability of promises between older adults and caregivers demonstrates that whether courts saw the underlying caregiving behavior as economic in nature varied significantly based on the care provider's gender, with care provided by women as less likely to be seen as economic.¹⁶⁸ But because such cases were rarely brought after the early 20th century, Hartog was unable to assess whether gender bias continued to influence the enforcement of such promises.¹⁶⁹

Today's regulatory approaches to personal care contracts suggest that historical attitudes remain relatively unchanged. For example, in presuming that family caregivers provide services exclusively because of "love and affection,"¹⁷⁰ states adopt the same reasoning courts employed in the 19th century when refusing to enforce agreements to pay for care.¹⁷¹ Indeed, states' reliance on this reasoning when assessing the impact of intra-family contracts on Medicaid eligibility moves well beyond the common law doctrine of "love and affection."¹⁷² Traditionally, that doctrine was used to allow one party to avoid performance of a promise on the grounds that the promise was merely supported by "love and affection," which was inadequate considera-

¹⁶⁴ See *supra* note 1. Notably, the historical shift and the critique of the traditional approach can be seen in the debate over how to measure national productivity. See generally MARILYN WARING, *IF WOMEN COUNTED: A NEW FEMINIST ECONOMICS* (1988) (critiquing measures of national productivity for not including care work commonly provided by women); Caroline Saunter & Paul Dalziel, *Twenty-Five Years of Counting for Nothing: Waring's Critique of National Accounts*, 23 *FEMINIST ECON.* 200 (2017) (showing there has been growing recognition of the value of care work since Waring's account was published, including by the United Nations in its System of National Accounts, but that GDP still fails to fully account for it).

¹⁶⁵ See Linda K. Kerber, *Separate Spheres, Female Worlds, Woman's Place: The Rhetoric of Women's History*, 75 *J. AM. HIST.* 9, 13, 29 (1988) (describing how scholars have conceptualized the feminine sphere, and treated it as a space for private, non-market activity).

¹⁶⁶ See *id.*

¹⁶⁷ For a classic article making this point, see Heather L. Ross & Isabel V. Sawhill, *The Family as Economic Unit*, 1 *WILSON Q.* 84 (1977).

¹⁶⁸ See HARTOG, *supra* note 5.

¹⁶⁹ See *id.* (discussing this limitation of the study).

¹⁷⁰ See *supra* note 45 and accompanying text.

¹⁷¹ See HARTOG, *supra* note 5, at 240, 243, 251 (discussing how parties argued about whether care was provided in expectation of payment or merely out of "love and affection" and explaining that "[r]evaluations of sharing and caring and love could become destructive to the case the lawyer [for the caregiver] wanted to make").

¹⁷² See RESTATEMENT (SECOND) OF CONTRACTS § 71 (AM. LAW INST. 1981) (restating the common law as to the requirement of exchange for a contract to be valid, and describing how the common law has treated "love and affection" as inadequate consideration); 17 *C.J.S. Contracts* § 123 (2018) (describing the contours of the doctrine).

tion.¹⁷³ In the context of Medicaid today, by contrast, states dramatically extend the doctrine to penalize parties for making such promises, and do so even in circumstances in which both parties wish to be bound by the agreement and performance has already occurred. The result is to treat payments made by parties presumed to feel “love and affection” as if they were fraudulent.¹⁷⁴ By doing so, these regulatory approaches truly embrace the antiquated vision of the family as a non-economic sphere free of market forces.

The Medicaid eligibility cases discussed in Part II.B likewise suggest that the attitudes Hartog observed retain a powerful influence on public policy and that historical attitudes about care work as a non-economic form of labor persist. For example, ALJs¹⁷⁵ and at least one court¹⁷⁶ have held that a personal services contract has no value if the right to a provider’s caregiving services is limited to the particular care recipient and the care recipient cannot sell rights under the contract to another care recipient. Thus, the intimate, highly personal nature of the care relationship is what makes it non-monetary. Likewise, the explicit language tying expectations about family care for older adults to outcomes in some decisions,¹⁷⁷ as well as the prominence of language referencing familial roles and status,¹⁷⁸ suggest that determinations may be shaped by historical biases about care work and care providers.

Persistence of this type of bias in ALJ and court decisions suggests these attitudes remain a powerful force in the United States. It is perhaps understandable that regulators are skeptical of personal care contracts due to vigilance about curbing Medicaid planning, and that regulators might draw upon available stereotypes about care work when trying to limit the use of such contracts. The persistence of such attitudes even when individual ALJs and judges are confronted with actual people, and people who have in many cases indisputably been devoted care providers, suggests the attitudes are deeply entrenched.

Indeed, these cases may suggest that the bias against care work has actually expanded, disadvantaging both men and women who perform this work. The administrative hearing and court cases analyzed in Part II.B support the conclusion that administrative law decisions lean in favor of treating all personal care services as non-monetary labor, and that this trend occurs with both female and male caregivers. Thus, to the extent that there have been advances in terms of gender equality in the context of personal care contracts, it may not have been to the benefit of women, but rather to the disadvantage of men whose care work is similarly devalued.

Whether the gender of an applicant’s caregiver changes the likelihood that any given applicant will be denied Medicaid coverage remains unan-

¹⁷³ See *supra* note 45.

¹⁷⁴ See *supra* note 45 and accompanying text.

¹⁷⁵ See *supra* note 75 and accompanying text.

¹⁷⁶ See *E.S.* 990 A.2d at 703.

¹⁷⁷ See *supra* notes 95–103 and 110–112 and accompanying text.

¹⁷⁸ See *id.*

swered. The New York data suggests that caregiver gender may affect outcomes in a predictable way, but the sample size of cases involving exclusively male care providers is too small to draw any robust conclusions.¹⁷⁹ More importantly, the data cannot meaningfully account for potential differences in the initial treatment of male and female caregivers by state agencies as it only captures cases in which the agency made a determination unfavorable to the applicant. For example, it is possible that one reason so few male providers are implicated in the fair hearing decisions studied is that state agencies treat care provided by men and women differently. If state agencies were to give more favorable treatment to care provided by men, then there would be fewer applicants with exclusively male caregivers having a negative determination from which to appeal. In addition, if such differential treatment occurred, applicants with exclusively male caregivers who did have negative determinations from which to appeal would also, relative to those with female caregivers, be expected to have weaker claims. Thus, while the data suggests that both the gender of the care provider and care recipient affect the likelihood that care will be treated as having economic value, the impact in a given case remains fairly unpredictable.

IV. PRACTICAL AND THEORETICAL IMPLICATIONS OF STUDY

By showing when and how the law treats personal care provided by family members to Medicaid applicants as having monetary value, this Article fills an important gap in caregiving literature. The findings, however, also have theoretical and practical implications that extend well beyond the context of personal care contracts, and even beyond the elder care context. This Part explores key implications for public policy, legal theory, and the practice of law.

A. *Public Policy Implications*

As detailed in Part II.A.2, many states have adopted regulations which undermine older adults' ability to pay for the care they need. Moreover, as detailed in Part II.B, both administrative agencies tasked with adjudicating appeals of Medicaid coverage denials, and state courts that hear appeals from those agency adjudications, typically interpret state regulations in a manner unfavorable to applicants who have paid a family member for personal care.

This approach is problematic in at least three regards. First, it may constrict the pool of available elder care providers at a time when there are already insufficient caregivers to meet needs. Due to changing demographics, the ratio of older adults needing daily assistance to younger

¹⁷⁹ See *infra* Appendix A, Tables 1 & 2.

adults is increasing.¹⁸⁰ The result is a growing gap between the need for affordable care and the availability of affordable care.¹⁸¹ Paying family members to provide elder care may expand the pool of available workers,¹⁸² thereby increasing the likelihood that older adults will be able to obtain the care they need in community-based settings.¹⁸³ In recognizing the benefits of paying family members to provide elder care, many states now provide payment for family members who provide care to disabled Medicaid beneficiaries.¹⁸⁴ In contrast, by penalizing applicants who have paid family members for care, states may—at least when the public becomes aware of the penalty—discourage much-needed family care.

Second, penalizing applicants who have paid family members to provide care undermines caregivers' economic well-being and power. Serving as an informal, unpaid care worker comes at significant cost. Not only do individuals assuming this role face a lost opportunity in terms of acquiring paid work or obtaining career advancement,¹⁸⁵ but they also lose both the occupational safety protections afforded to paid care workers,¹⁸⁶ and other

¹⁸⁰ UNITED NATIONS, DEP'T OF ECON. & SOC. AFFAIRS, WORLD POPULATION PROSPECTS: KEY FINDINGS & ADVANCE TABLES (2017), https://esa.un.org/unpd/wpp/Publications/Files/WPP2017_KeyFindings.pdf, archived at <https://perma.cc/B8R2-CCWW> (showing that this shift is occurring worldwide).

¹⁸¹ See NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 16, at 160 (describing the existing gap between supply and demand for elder care and its implications); Richard W. Johnson et al., *Meeting the Long Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions*, URBAN INSTITUTE 27 (2007), <http://www.urban.org/research/publication/meeting-long-term-care-needs-baby-boomers>, archived at <https://perma.cc/V5MC-HU55> (estimating that “the number of older paid home care users per working-age adult will increase by about 80% between 2000 and 2040, while the number of older nursing home residents per working-age adult will increase by about 75%”).

¹⁸² Cf. 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, 688–91 (2011) (discussing how consumer-directed care, which can allow for the hiring of family members, can increase the pool of labor available for long-term care services).

¹⁸³ While some have cautioned that payment may reduce the pool of caregivers by decreasing intrinsic motivation, payment can promote intrinsic motivation where it is seen as acknowledging the value of contributions. See Nancy Folbre & Julie A. Nelson, *For Love or Money—Or Both?*, 14 J. ECON. PERSP. 123, 133 (2000) (explaining this phenomenon).

¹⁸⁴ These payments are made as part of states' consumer-directed care programs that seek to empower individuals with disabilities and increase access to community-based living. See CTRS. FOR MEDICAID & MEDICARE SERVS., SELF-DIRECTED CARE, <https://www.medicaid.gov/medicaid/ltss/self-directed/index.html>, archived at <https://perma.cc/V9YA-XV66> (discussing the history of Medicaid payments for self-directed care and providing links to information about states' self-directed care programs). Notably, to the extent that payment for family care is debated in the public arena, the debate is over whether the state should directly pay family care providers. See, e.g., Kraiem, *supra* note 182 (discussing and participating in this debate).

¹⁸⁵ See NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 16, at 128–130 (assessing the impact of caregiving on paid work); Nicole B. Porter, *Synergistic Solutions: An Integrated Approach to Solving the Caregiver Conundrum for “Real” Workers*, 39 STETSON L. REV. 777, 781 (2010) (discussing how caregivers are disadvantaged in the workforce).

¹⁸⁶ Occupational safety protections are already much weaker in the home care context than in most industries. See Peggie R. Smith, *Aging and Caring in the Home: Regulating Paid Domesticity in the Twenty-First Century*, 92 IOWA L. REV. 1835, 1860–65 (2007) (exploring the relative lack of protection for home care workers and its historical underpinnings).

benefits—such as retirement benefits—that accompany paid work.¹⁸⁷ Because women are the primary providers of family-based elder care,¹⁸⁸ such costs accrue largely to them.¹⁸⁹ Thus, paying family care providers may help reduce gender-based income inequality, including in retirement.¹⁹⁰ However, treating contracts to pay family members for such care as “fraudulent,” and penalizing applicants who enter into such contracts, may have the impact of increasing such inequality.

Third, this approach of disfavoring applicants who have paid family members for personal care may well be counterproductive to states’ budgetary goals as intra-family personal care has the potential to reduce overall state expenditures. To the extent that payment to family caregivers allows the elderly to remain in the community rather than to use public funds by moving into a nursing home, it also benefits taxpayers. The average cost to the Medicaid program of nursing home care is, on average, approximately \$206 per day,¹⁹¹ although rates vary significantly from state to state.¹⁹² Thus, each day nursing home admission is delayed represents a savings for taxpayers. It is no wonder, then, that federal and state lawmakers have enacted a range of policies designed to encourage family members to care for elderly

¹⁸⁷ For example, since both eligibility for Social Security benefits, and the amount of such benefits, are calculated based on paid work, unpaid care work can potentially undermine both eligibility for such benefits and the amount of benefits ultimately received. See MADONNA HARRINGTON MEYER & PAMELA HERD, MARKET FRIENDLY OR FAMILY FRIENDLY?: THE STATE AND GENDER INEQUALITY IN OLD AGE 32 (2007) (discussing the impact of unpaid care work on Social Security benefits).

¹⁸⁸ See AARP PUBLIC POLICY INSTITUTE & NATIONAL ALLIANCE FOR CAREGIVING, CAREGIVING IN THE U.S. 6 (2015), <https://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf>, archived at <https://perma.cc/23CU-4FGR> (finding that 60% of family caregivers for adults are female). Notably, women also disproportionately provide paid elder care. See PHI, U.S. HOME CARE WORKERS: KEY FACTS (2017), https://phinational.org/wp-content/uploads/2017/09/phi_homecare_factsheet_2017_0.pdf, archived at <https://perma.cc/7SSF-LCRH> (citing the U.S. Census Bureau’s 2016 American Community Survey for the proposition that 88% of individuals employed as home care workers are female).

¹⁸⁹ See Kraiem, *supra* note 182 (discussing the gender implications of paid versus unpaid care).

¹⁹⁰ See Jennifer L. Morris, *Explaining the Elderly Feminization of Poverty: An Analysis of Retirement Benefits, Health Care Benefits, and Elder Care-Giving*, 21 NOTRE DAME J.L. ETHICS & PUB. POL’Y 571, 598–99 (2007) (arguing that the predominance of women as primary informal caregivers reflects gender-based social norms and criticizing U.S. retirement system for failing to consider effect these norms have on women).

¹⁹¹ See Liz Liberman, *Medicaid Reimbursement Rates Draw Attention*, NIC CARES BLOG (Mar. 21, 2018), <https://www.nic.org/blog/medicaid-reimbursement-rates-draw-attention/>, archived at <https://perma.cc/3VXP-NWRZ>.

¹⁹² See Mor et al., *supra* note 38, at 231. The private pay rate is substantially higher and is often necessary to obtain a private room. In 2013, the average cost of a private nursing home room was just over \$94,000 per year and the cost of a semi-private room was nearly \$83,000 per year. See JOHN HANCOCK, COST OF CARE SURVEY (2013), <http://www.sfppfinancial.com/files/16915/2013%20Cost%20of%20Care.pdf>, archived at <https://perma.cc/3ZDR-WQBA>.

relatives.¹⁹³ Yet, penalizing applicants who have paid family caregivers is likely to discourage that care.

In short, in the name of combatting Medicaid fraud and curbing Medicaid planning,¹⁹⁴ states are adopting regulatory approaches, and courts and administrative agencies are adjudicating Medicaid eligibility cases, in a way that undermines both the states' economic interests and the states' interest in the well-being of their citizens. From a public policy perspective, it is advantageous for older adults to pay family members for care, and thus likely counterproductive to penalize such payments.¹⁹⁵ Ironically, as discussed in Part. II.A.2, rather than curtailing Medicaid planning, such policies may have the unintended effect of further rewarding those who engage in sophisticated planning techniques relative to those who do not.¹⁹⁶

B. Implications for Legal Theory

Family law literature has described the United States as in the midst of two fundamental shifts related to care work. First, the family law literature reports that there has been a fundamental shift toward greater recognition of the economic value of care work.¹⁹⁷ This is most evident in the move toward equitable distribution of property in divorce.¹⁹⁸ Second, the family law literature reports that the law has moved toward increased willingness to enforce contracts related to care between intimates.¹⁹⁹ States are increasingly willing to enforce contracts between sexual and romantic partners, including cohabi-

¹⁹³ See NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 16, at 191–93 (listing state and federal policies with this aim).

¹⁹⁴ Medicaid fraud involves intentionally providing erroneous information to qualify for benefits; Medicaid planning, by contrast, involves structuring finances in order to maximize eligibility for benefits in accordance with the applicable law.

¹⁹⁵ Accord Sheena J. Knox, Note, *Eldercare for the Baby-Boom Generation: Are Caregiver Agreements Valid?*, 45 SUFFOLK U. L. REV. 1271, 1294–95 (2012) (describing personal care contracts and recommending that Massachusetts regulations be designed in a way that encourages their use).

¹⁹⁶ See *supra* notes 65–67 and accompanying text.

¹⁹⁷ See *supra* note 1.

¹⁹⁸ See JOANNA L. GROSSMAN & LAWRENCE M. FRIEDMAN, *INSIDE THE CASTLE: LAW AND THE FAMILY IN 20TH CENTURY AMERICA* 197 (2011) (describing “concern for non-economic contributions to marriage,” including care work as “a driving force in developing modern laws on equitable distribution” in the event of divorce).

¹⁹⁹ See, e.g., Erez Aloni, *The Puzzle of Family Law Pluralism*, 39 HARV. J.L. & GENDER 317, 317 (2016) (discussing and critiquing this shift); JILL HASDY, *FAMILY LAW REIMAGINED* 162–63 (2014); Eric Rasmusen & Jeffrey Evans Stake, *Lifting the Veil of Ignorance: Personalizing the Marriage Contract*, 73 IND. L.J. 453, 481–83 (1998) (situating the trend toward increased enforcement of family contracts in the general move from status to contract); Jana B. Singer, *The Privatization of Family Law*, 1992 WIS. L. REV. 1443, 1550–51 (1992) (describing courts' increased willingness to enforce contracts between unmarried cohabitants). This phenomenon is not limited to the United States. See, e.g., Mary Keyes & Kylie Burns, *Contract and the Family: Whither Intention*, 26 MELB. U. L. REV. 577, 591–92 (2002) (discussing developments in Australian law allowing for enforcement of contracts made on traditional family law matters).

tation agreements, prenuptial agreements, postnuptial agreements, parenting agreements, and even surrogacy agreements.²⁰⁰

To be sure, scholars have recognized that these shifts are incomplete. The economic value of care work is far from fully recognized in legal systems,²⁰¹ and while states are overall more willing to enforce contracts among intimates, they are less willing to enforce contracts between intimates related to care work than they are to enforce contracts related to financial affairs.²⁰²

However, this Article's study of administrative hearing decisions and court cases regarding Medicaid eligibility determinations suggests both shifts may be more limited than previously described in the family law literature. Specifically, it suggests how, in the context of care for older adults, there may not have been a parallel shift in attitudes toward care work or a parallel shift toward increased willingness to enforce contracts between family members. Rather, in this context, care work continues to be seen as largely non-economic activity and the law continues to treat intra-family contracts for that care as unenforceable.

Of course, drawing broad conclusions about the valuation of elder care based on the limited set of cases arising in the context of Medicaid eligibility determinations would be imprudent. However, the regulatory and adjudicatory treatment of personal services contracts discussed in this Article is far from the only evidence of the persistence of the notion that elder care should be provided by family members without remuneration. The past two decades have seen a wave of state statutes that, in the name of preventing elder neglect, expand the circumstances under which a family member can be held liable for failing to provide personal care services to older adults.²⁰³ A vari-

²⁰⁰ See Aloni, *supra* note 199, at 332, 349–50 (discussing enforceability of prenuptial and cohabitation agreements). Notably, the Uniform Law Commission has been at the forefront of this shift, and continues to be so with its July 2017 adoption of the revised Uniform Parentage Act, which allows for enforceable gestational surrogacy agreements.

²⁰¹ For example, care work is not considered work for the purposes of Social Security benefits. See Smith, *supra* note 186, at 1853.

²⁰² See Aloni, *supra* note 199, at 359 (showing how default rules about enforceability of intra-family contracts create this effect); HASDY, *supra* note 199, at 76 (“Starting in the 1970s and 1980s . . . more and more courts began enforcing agreements governing the distribution of property and cash between spouses, whether the agreements were signed before or after marriage”); Katharine Silbaugh, *Turning Labor into Love: Housework and the Law*, 91 Nw. U. L. REV. 1, 28–29 (1996) (describing the current state of the law in 1996, where contracts related to financial affairs between romantic partners were more likely to be enforced than those related to service provision between romantic partners).

²⁰³ See A. KIMBERLEY DAYTON ET AL., ADVISING THE ELDERLY CLIENT § 4A:27 (2017) (“Many states have enacted laws that criminalize neglect by caretakers or others who have a legal duty to care for a dependent adult, and there is a subtle trend towards imposing on children a duty to care for aging, vulnerable parents in some circumstances.”); see also Lindsey E. Wylie & Eve M. Brank, *Assuming Elder Care Responsibility: Am I a Caregiver?*, 6 J. EMPIRICAL LEGAL STUD. 899, 901–02 (2009) (criticizing statutory approaches to neglect that hold family members criminally liable for neglect when those family members may not realize they have a legal duty and may not consider themselves to be caregivers).

ety of commentators have suggested that even broader liability is in order.²⁰⁴ For example, one commentator argued that adult children should be treated as having a “special relationship” with their aging parents that gives rise to a duty to provide care, and that failure to do so should be actionable as a tort.²⁰⁵

Likewise, this Article’s study is not the only evidence of state willingness to restrict older adults’ ability to contract with family members. For example, Maine’s Improvident Transfer Act, originally adopted in 1988, is increasingly promoted by advocates for older adults as a model for states looking to address problems of undue influence and other forms of financial exploitation of older adults.²⁰⁶ The Act has the effect, however, of limiting older adults’ ability to create enforceable contracts. It does so by creating a presumption that certain contracts made by older adults with family members are voidable.²⁰⁷ The Act’s definition of “dependent older adult” is broad enough to encompass a sizeable portion of older adults and is not limited to those with diminished capacity.²⁰⁸ Moreover, a cause of action to undo the transaction may be brought not only by the older adult, but also by the individual’s legal representative or the personal representative of the individual’s

²⁰⁴ See, e.g., Lara Queen Plaisance, Comment, *Will You Still . . . When I’m Sixty-Four: Adult Children’s Legal Obligations to Aging Parents*, 21 J. AM. ACAD. MATRIM. LAW. 245, 259 (2008); Stephanie M. Rzeszut, Note, *The Need for a Stronger Definition: Recognizing Abandonment as a Form of Elder Abuse Across the United States*, 55 FAM. CT. REV. 444, 452 (2017) (urging criminal liability for adult children who abandon their elderly parents); Lauren S. Winchell, Note, *TennCare: Expanded Estate Recovery—Recover at All Cost*, 45 U. MEM. L. REV. 711, 744–45 (2015) (suggesting that forcing families to provide care to older relatives would be beneficial to society).

²⁰⁵ See Plaisance, *supra* note 204.

²⁰⁶ See, e.g., Editorial, *Protect Older Adults from Real Estate Scams*, BOSTON GLOBE, June 16, 2016, <https://www.bostonglobe.com/opinion/editorials/2016/06/16/editorial-protect-older-property-owners-from-real-estate-scams/uHkRZV3aoJR5nIZrscSDUL/story.html>, archived at <https://perma.cc/CE3K-MQ8B> (arguing in favor of Massachusetts adopting Maine’s approach); Sally M. Wagley, *Maine’s Improvident Transfers Act: A Unique Approach to Protecting Exploited Elders*, 36 BIFOCAL 1 (2014) (promoting the law as a model for the nation in the publication of the American Bar Association’s Commission on Law and Aging); David Godfrey et al., *Legal Remedies to Financial Exploitation of the Elderly: Let’s Get Grandpa’s House Back!*, Webinar for the National Elder Rights Training Project, NAT’L CONSUMER LAW CTR., https://www.nclc.org/images/pdf/conferences_and_webinars/webinar_trainings/presentations/2014-2015/LegalRemediesFinancialExploitationofProperty.pdf, archived at <https://perma.cc/C46T-HGC5> (promoting the Act as a model for the nation).

²⁰⁷ Specifically, the law presumes a “transfer of real estate or major transfer of personal property or money for less than full consideration or execution of a guaranty” is voidable if made between a dependent older adult and an individual with whom the adult has a confidential or fiduciary relationship (a category the law defines as including all those with whom the individual has a “family” relationship). ME. STAT. tit. 33, § 1022 (2003).

²⁰⁸ The Act defines “dependent older adult” as “wholly or partially dependent upon one or more other persons for care or support, either emotional or physical, because the elderly person: A. Suffers from a significant limitation in mobility, vision, hearing, emotional or mental functioning or the ability to read or write; or B. Is suffering or recovering from a major illness or is facing or recovering from major surgery.” ME. STAT. tit. 33, § 1021(1) (2017). The definition is a fine example of an exception potentially swallowing the rule. After all, emotional interdependency is a common human condition and the level of impairment described is common as well.

estate.²⁰⁹ The older adult need not support the action, nor is the older adult's capacity or consent to the transaction a defense.²¹⁰ Thus, the law allows a transaction to be undone, against the wishes of a fully cognitively competent older adult. It thus has the effect of restricting older adults' ability to enter into enforceable contracts.

A recognition of these counter-trends in the context of old age care shows the limitations of the two key "progress" narratives in family law literature of: (1) increased enforcement of contracts between family members; and (2) increased recognition of the economic value of care work (and the corresponding commodification of such work).²¹¹ Perhaps more fundamentally, this recognition points toward a central weakness in the field of family law itself. Family law, as a field of study, claims to broadly understand the law of family relations, but remains narrowly focused on relations between romantic partners, and between minors and their families.²¹² Older adults are generally included in family law courses and scholarship only when in a role that directly affects minors (e.g., the case of grandparent visitation rights) or, to a lesser degree, in romantic partnerships in which they could have been involved as young adults.²¹³ Were the field of family law not as constrained in its vision of family—and instead embraced older adults' family relationships as an important subject within the field—perhaps the dominant progress narrative might have developed in a more nuanced way.

C. Implications for Legal Practice

The distrust of agents reflected in this Article's analysis of state regulations, ALJ decisions, and court cases has implications for legal practice, particularly for lawyers working in the intertwined fields of trusts and estates and elder law. This distrust suggests that the ability of an attorney-in-fact or other agent to effectively act on behalf of a principal may depend not only on the authority granted to the agent in the underlying document, but also on third party perceptions of the agent and the nature of the agent-principal relationship.²¹⁴

²⁰⁹ ME. STAT. tit. 33, § 1023(1) (2003).

²¹⁰ See *id.* (not requiring the older adult's objection or involvement and not providing for any such defense).

²¹¹ For a discussion of this literature, see *supra* notes 1–4 and accompanying text.

²¹² See HASDY, *supra* note 199, at 162–63 (2014) ("Family law's persistent orientation around marriage and parenthood is such a standard feature of the field that the lack of attention devoted to other family relationships generally goes without explicit notice[.]").

²¹³ See, e.g., JOHN E.B. MYERS & HARRY D. KRAUSE, FAMILY LAW IN A NUTSHELL (6th ed. 2017) (in a handbook designed to provide law students with grounding in family law, essentially limiting coverage of family law issues in later life to a section on whether pension and retirement benefits are marital/community property, and a brief discussion of grandparent visitation).

²¹⁴ See *supra* notes 106–108, 151–160 and accompanying text (discussing skepticism toward personal care contracts entered into by attorneys in fact).

That perceptions of an agent and the nature of agency relationships may affect judgments about the agent's actions is consistent with what social psychologists have known for generations. The psychology literature has long recognized that perceived personal qualities and characteristics of a decision-maker, like an agent, affect the manner in which third parties evaluate the propriety, fairness, and legitimacy of decisions made by that decision-maker. For example, the "halo effect," a cognitive bias whereby a decision or action is judged more favorably if the decision-maker is attractive or otherwise has positive characteristics (e.g., intelligence, generosity), has been the focus of extensive exploration.²¹⁵ Similarly, extensive literature on the "fundamental attribution error," another well-studied cognitive bias, shows that third parties look to a decision-maker's internal characteristics to evaluate the quality of decisions reached by the decision-maker.²¹⁶

Nevertheless, neither legal theory nor legal practice adequately account for the fact that the agency relationship itself may color third party evaluations of the legitimacy of decisions made by agents. The legal theory of agency focuses instead on determining the effect of an agent's acts by determining whether those acts fall within the scope of the agent's authority.²¹⁷ Factors that are legally irrelevant to the propriety of the agent's actions, but might influence the ability of an agent to effectively use her authority, are generally not considered relevant to the legal theory of agency as they do not alter the scope of such authority.²¹⁸ Similarly, practicing attorneys often caution clients about the potential for attorneys-in-fact to abuse authority,²¹⁹ but generally do not warn them that an attorney-in-fact's decisions on behalf of the client may be treated differently than those made directly by the client.

The patterns observed in the regulations and cases discussed in this Article suggest, by contrast, that counseling about how the agency relationship might affect perceptions of an agent's actions would be advisable, especially where a family member is being considered for appointment. In deciding whether to appoint an attorney-in-fact or other agent, and especially when considering whom to appoint, individuals should consider how a potential appointee's exercise of authority will be received by third parties. For example, even if the agent is competent and trustworthy, the agent's efficacy may

²¹⁵ See generally Sheldon J. Lachman & Alan R. Bass, *A Direct Study of Halo Effect*, 119 J. PSYCH. 535 (1985) (discussing the history of research on the halo effect theory); DANIEL KAHNEMAN, *THINKING, FAST AND SLOW* 81–83 (2011) (providing a broad overview of the theory and its implications for human decision-making).

²¹⁶ While the theory has benefited from the work of multiple generations of scholars, the term was coined by psychologist Lee Ross in a 1977 article. See Lee Ross, *The Intuitive Psychologist and His Shortcomings*, in *ADVANCES IN EXPERIMENTAL SOCIAL PSYCHOLOGY* 173 (L. Berkowitz ed., 1977).

²¹⁷ See generally RESTATEMENT (THIRD) OF AGENCY § 2.02 (AM. LAW INST. 2006).

²¹⁸ See, e.g., *id.*; 3 AM. JUR. 2D AGENCY § 30 (explaining that extrinsic evidence should generally not be considered in determining the agent's authority).

²¹⁹ For a sample description of the commonly recommended approach, see John C. Craft, *Preventing Power of Attorney Abuse—A Lawyer's Role*, 75 ALA. LAW. 117 (2014) (outlining how attorneys should counsel clients with regard to potential power of attorney abuse).

be compromised if the agent is someone who is generally perceived as dishonest by others.

Thus, to provide sound counsel as to whom should be appointed as an attorney-in-fact or other type of agent, attorneys may need to have some knowledge about the appointee—e.g., his or her reputation, past acts, and interpersonal style. This is especially important if the client anticipates she may want to either pay the agent for certain services or make gifts to the agent. As the cases studied in this Article show, the state may be inclined to treat such payments or gifts as improper,²²⁰ with negative consequences for both the client and the agent.²²¹

Likewise, it may be prudent for attorneys to advise clients that the client—not the client's attorney-in-fact—should make sensitive decisions for as long as the client has capacity to ensure their decisions are viewed with less skepticism than the decisions would be if made by an agent. Such advice could be particularly valuable to clients who have executed a power of attorney well in advance of significant cognitive decline, as such clients might be inclined to have an agent act for them out of convenience, as opposed to need.²²² Similarly, prudent attorneys might counsel clients to consider not appointing a particular individual as agent if the client wants the agent to engage in acts which would be seen as self-dealing (e.g., paying the agent to provide needed personal care, gifting resources to the agent or to the agent's nuclear family). In such situations, clients might also be counseled about alternative arrangements, such as the establishment of a trust, which could meet their needs while being viewed with less skepticism.²²³

In short, attorneys advising clients on advanced planning and helping clients to appoint surrogate decision-makers should consider expanding their counseling to include information about the impact that third party perceptions of potential appointees might have on the appointee's ability to meet the client's needs.

²²⁰ See *supra* notes 141–163 and accompanying text.

²²¹ As discussed in Part II.A.1, the effect on the client is Medicaid ineligibility. The effect on the agent may include being compelled to choose between having a loved one's needs go unmet or paying the private pay rate to have those needs met. As noted earlier, the private pay rate typically exceeds the Medicaid rate by a significant amount for long-term care services. See *supra* note 38.

²²² This is a common situation. Older adults routinely execute powers of attorney well in advance of significant cognitive decline in part because it is common for trusts and estates attorneys to have clients who execute both a will and a power of attorney for finances in the same representation. Indeed, as even a brief internet search of estate planning advertisements will reveal, estate planning attorneys frequently offer powers of attorney as part of a "will package" for clients.

²²³ The increased formality of the trust relationship and greater specificity included in the trust instrument might reduce such skepticism. Further research, however, would be helpful to identify whether trusts and other alternative arrangements would have this effect.

CONCLUSION

An analysis of both the conditions under which state regulations require payments for elder care to be deemed gifts, and the circumstances under which ALJs and courts affirm denials of Medicaid coverage on the grounds that alleged care payments were impermissible gifts, helps paint a picture of how elder care is valued—or not—in modern America. The analysis shows that, despite the fact that elder care is a booming industry, triers of fact continue to treat care provided by family members as lacking economic value and agreements to pay for that care as less than fully binding contracts. This approach appears to reflect more than an aversion to Medicaid planning or a distrust of agents, although both seem to contribute to the hostile treatment of personal care contracts. Rather, the language used in fair hearing and court decisions considering the value of such care suggests that familial role expectations—which grew out of the historically gendered nature of care work and continue to be disproportionately directed at women—continue to affect the legal system’s valuation of such care.

The legal treatment of intra-family contracts for elder care is not disturbing simply because it reflects a lack of appreciation for the nature of the work done by care providers. It also impedes the economic progress of women, who constitute the vast majority of family care providers. In addition, it is concerning because it undermines older adults’ fundamental right to contract for care they need. Such contracts may be the most affordable way for lower-middle and middle-class older adults to maintain their quality of life and to avoid institutionalization. By treating care provided under these contracts as lacking economic value, states significantly handicap older adults’ ability to engage in essential self-protective economic behavior at a time of intense vulnerability.

APPENDIX A: FAIR HEARING DECISION ANALYSIS—KEY TABLES

TABLE 1: NEW YORK FAIR HEARING DECISIONS FINDING THAT
PERSONAL CARE HAD NO ECONOMIC VALUE
(BY NUMBER OF CASES)

	Caregiver(s) Female or Multiple Gender	Caregiver(s) Exclusively Male
Care Recipient Female	29	12
Care Recipient Male	15	2

TABLE 2: NEW YORK FAIR HEARING DECISIONS FINDING PERSONAL CARE
HAD SOME ECONOMIC VALUE (BY NUMBER OF CASES)

	Caregiver(s) Female or Multiple Gender	Caregiver(s) Exclusively Male
Care Recipient Female	8	0
Care Recipient Male	1	1

TABLE 3: LOG-LINEAR ANALYSIS OF NEW YORK FAIR HEARING DECISIONS

Key: *A=Care Recipient Gender*
B=Care Provider Gender
C=Value or No Value Condition

	G squared	Degrees of freedom	P value
ABC	7.12	4	0.1297
AB	0.46	1	0.4976
AC	0.28	1	0.5967
BC	1.18	1	0.2774
AB(C)	5.66	2	0.059
AC(B)	5.48	2	0.0646
BC(A)	6.38	2	0.0412

TABLE 4: NUMBER OF FAIR HEARING DECISIONS* FINDING TRANSFERS
PURPORTEDLY FOR CARE HAD ECONOMIC VALUE (BY STATE)

State	Some value	No value
Michigan	0	7
New Jersey	7	15
New York	10	56
Ohio**	6	22

* A handful of decisions considered multiple, consolidated cases.

* One Ohio case considering the value of a personal care contract was remanded without an indication of whether value should be found. Hence, it is not included in this chart.

TABLE 5: NUMBER OF FAIR HEARING DECISIONS* ASSESSING VALUE OF
INTRA-FAMILY CARE CONTRACT STATING THAT CAREGIVER
WAS ALSO APPLICANT'S AGENT (BY STATE)

State	Total cases identified	Number of cases in which the ALJ identified a caregiver as the applicant's agent	Percent of cases where the dual role was identified
Michigan	7	2	29%
New Jersey	22	13	59%
New York	66	42	64%
Ohio	29	7	24%
All above states	124	64	52%

* A handful of decisions considered multiple, consolidated cases.