Not Just for Kids: Child and Dependent Care Credit Benefits for Adult Care

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Abstract

The Child and Dependent Care Credit (CDCC) subsidizes caregiving expenses for working households with a disabled spouse or adult dependent, but few childless households claim it. We examine the value of the CDCC for households caring for adults. We find that, as of 2016, over 10 percent of 50- to 65-year-olds had a coresident spouse or parent likely to be a qualifying individual. We document how state and federal benefits decrease post-tax costs of caregiving services across states and household types. Making the CDCC refundable would nearly double the number of eligible spousal caregivers aged 50 to 65.

Key words: Adult care, Child and Dependent Care Credit, American Rescue Plan Act of 2021, participation, eligibility

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1. Introduction

A growing number of adults in the United States care for a relative with a long-term illness or disability (AARP and National Alliance for Caregiving 2020), and nearly three-quarters of older adults with long-term care needs receive care at home from an unpaid family member or friend (Van Houtven et al. 2020). Estimates place the value of uncompensated family care at more than $500 billion annually (Chari et al. 2015). Family caregivers provide critical and valuable support to relatives with care needs while incurring substantial private costs, which can vary from negative effects on physical and emotional health to reductions in labor supply and earnings, early retirement, and out-of-pocket expenses.[1] Existing policies to provide respite services and support to family caregivers, such as meal delivery, financial compensation, and paid leave, are largely private-pay or available at the discretion of state legislatures. Thus, they are piecemeal and limited in scope.

In a recent executive order, the Biden Administration notes that high-quality care "costs far more than many families and individuals can afford, causing them to forgo care altogether, seek lower-quality care options, juggle unconventional shifts at work, reduce their own paid work hours, drop out of the labor force, or make other arrangements."[2] In addition to helping families, financial supports for caregivers can yield cost-savings for states: when discussing a new tax credit for family caregivers, policymakers in Oklahoma mentioned that keeping disabled adults out of institutional care facilities, which largely are funded by Medicaid dollars, would help their state's budget.[3]

Consistent with limited financial support available to caregivers, in a 2019 AARP survey, nearly 70 percent of adult caregivers affirmed that "an income tax credit ... to help offset the cost of care" would be helpful (AARP and National Alliance for Caregiving 2020, p.81). This constitutes a larger percentage than those who would find direct caregiver compensation and paid leave helpful (65 percent and 54 percent, respectively). In fact, an income tax credit already exists: the Child and Dependent Care Credit (CDCC) allows households to receive tax benefits for certain expenses associated with the care of a child under 13 or a spouse or adult dependent who is incapable of self care. However, participation in the tax credit among taxpayers caring for adults is quite low: as of 2017, 95 percent of CDCC claims were made exclusively for child dependents (Crandall-Hollick and

[1] See, for example, Coe and Van Houtven (2009), Skira (2015), Maestas, Truskinovsky, and Messel (2021), Fahle and McGarry (2017), Van Houtven, Coe, and Skira (2013), and Schmitz and Westphal (2017).

[2] The White House, "Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers," April 18, 2023, https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/.

[3] Oklahoma Senate, "Senate approves Caring for Caregivers Act," April 25, 2023, https://oksenate.gov/press-releases/senate-approves-caring-caregivers-act.

Boyle 2021).

In this paper, we examine the value of the CDCC for qualifying households caring for adults (primarily spouses and parents of working taxpayers). We first describe CDCC eligibility requirements and maximum benefits across the income distribution. We document that households with caregiving responsibilities and between $43,000 and $125,000 in adjusted gross income (AGI) can receive up to $600 in annual nonrefundable tax benefits. We then use data from the Health and Retirement Study (HRS) to document the size of the population most likely to be eligible for tax credits for family caregiving. We show that, as of 2016, more than 10 percent of individuals aged 50 to 65 had a coresident spouse or parent in need of assistance with activities of daily living or with dementia. Caregiving responsibilities are negatively associated with household income, though 42 and 62 percent of respondents with coresident parents and spouses, respectively, work.

Next, we use median cost-of-care data to document how the CDCC affects post-tax costs of typical caregiving services across states. While CDCC benefits generate small decreases in post-tax costs of care, we find that a benefit expansion similar to the American Rescue Plan (ARP) expansion that occurred during the pandemic would substantially decrease post-tax care costs. In particular, such expanded benefits would decrease the annual out-of-pocket cost of hiring a home health aide for 10 hours per week from between $12,500 and $17,500 to less than $12,500 in most states.

Finally, we discuss expected effects of permanently expanding the CDCC on taxpayers' behavior. We note that increases in credit generosity would promote the use of noninstitutional paid-care services and coresidence with adult children. A back-of-the-envelope calculation using labor supply elasticities from existing literature also suggests that making the ARP expansion permanent would substantially increase labor force participation among potential caregivers. We note, however, that behavioral responses to increases in CDCC generosity may be limited because of low participation in the tax program, so we simulate effects of various reforms on eligibility rates. We find that, all else being equal, making the credit refundable would nearly double the number of eligible spousal caregivers aged 50 to 65. We find that spousal caregivers who become eligible for benefits under refundability are 6 percentage points more likely to be female, 16 percentage points more likely to be Black or Hispanic, and 21 percentage points less likely to have college degrees than currently eligible spousal caregivers. Additionally, newly eligible caregivers' average AGI is nearly $90,000 less than that of currently eligible caregivers.

In the following section, we provide institutional details on long-term care costs, the CDCC, and other supports available to family caregivers. In Section 3, we describe the population most

likely to benefit from tax programs for adult care. In Section 4, we estimate effects of state and federal CDCC benefits on the post-tax costs of typical caregiving services. In Section 5, we discuss expected effects of permanently expanding the CDCC on taxpayers' behavior and simulate effects of policy reforms on eligibility. In Section 6, we conclude.

2. Long-Term Care, Out-of-Pocket Costs, and Supports Available to Family Caregivers

The need for long-term services and supports due to functional or cognitive limitations is one of the most substantial financial risks facing older adults. Long-term services and supports encompass assistance with basic personal tasks, such as eating, bathing, and dressing, as well as housekeeping, transportation, and money management. Around 70 percent of Americans turning 65 will require these services and supports at some point in their remaining lifetime (Johnson 2019). Different types of providers in various settings administer long-term services and supports, depending on level of disability, costs, and preferences. Nearly 80 percent of older adults with care needs reside in the community and receive paid or unpaid care at home, while the remainder receive care in a nursing home or other residential setting. Costs depend on the type of care arrangement and may include payments to care facilities and in-home formal caregivers; expenditures on medical care, housekeeping, meal delivery, and transportation services; and one-time costs for home modifications, specialized vehicles, and other assistive technologies (Favreault and Dey 2016).

National expenditures for long-term services and supports totaled more than $475 billion in 2020, representing over 14 percent of all health spending (Colello 2022). This number does not take into account the value of unpaid care provided by family, friends, and other uncompensated caregivers. A substantial portion of these costs (an estimated 13 percent of the costs of long-term services and supports, or approximately $64 billion) is paid for out of pocket because public and private insurance for long-term services and supports is limited (Colello 2022). Very few individuals own private long-term-care insurance policies that would cover the costs of long-term services and supports. Medicare, which is available primarily to adults aged 65 and older and has significant cost sharing, covers only a limited amount of post–acute care and accounts for 18 percent of spending on long-term services and supports. Medicaid, the largest public payer of long-term services and supports, accounts for 42 percent of this spending and has both financial and functional eligibility requirements. Most Medicaid recipients in need of long-term services and supports first pay directly for services, spending down assets until they qualify for benefits (Johnson 2019). Estimated lifetime

average out-of-pocket costs for long-term services and supports are $72,000, or $140,000 for the 37 percent of users with positive costs. However, there is a wide distribution of costs, and 1 in 12 recipients will spend over $250,000 out of pocket (Favreault and Dey 2016).

Family caregivers, who provide the majority of long-term services and supports, can take on a significant portion of these out-of-pocket costs, though there is limited evidence on how families share long-term care expenditures (National Academies of Sciences, Engineering, and Medicine 2016). A recent survey found that over three-quarters of family and other unpaid caregivers report out-of-pocket spending related to their caregiving role, and annual (conditional) spending is over $7,000 (AARP and National Alliance for Caregiving 2021). Out-of-pocket spending on caregiving is concentrated among female, nonwhite, and working-age caregivers, as well as those with more intensive caregiving roles and those caring for dementia patients (AARP and National Alliance for Caregiving 2021). Spending includes payments to care facilities and in-home care providers, and many of these payments qualify as expenditures eligible for CCDC claims. Nonwhite caregivers in particular are more likely to care for adults with more care needs, to use more support services, and to report financial hardship (Fabius, Wolff, and Kasper 2020).

The CDCC can help to defray out-of-pocket caregiving expenditures for certain family caregivers. Congress implemented the federal CDCC in 1976 "to help families pay employment-related expenses for care of a child" but also extended the provision to expenses for adult dependents and disabled spouses (Gitterman and Howard 2003). Congress subsequently expanded the CDCC in 1981 and 2001. The latter expansion took effect in 2003, and in every year since then except 2021, households have been able to claim up to $3,000 worth of care expenses per year for each of up to two qualifying individuals. Qualifying individuals include those "physically or mentally incapable of self-care" who live with the taxpayer for more than half of the tax year, such as a disabled spouse or parent. Qualifying expenses include out-of-pocket spending on care both inside and outside the home, such as fees paid to adult daycare facilities and to attendants assisting dependents with activities of daily living. This precludes expenses covered by Medicare, Medicaid, or another health insurer.

Households with qualifying individuals and expenditures can receive a tax credit worth up to 35 percent of qualifying expenses, or $1,050 per qualifying individual. Beginning at $15,000 in AGI, the benefit rate decreases by 1 percentage point for each additional $2,000 until it remains at 20 percent for those with $43,000 or more in AGI, who can receive up to $600 in benefits per qualifying individual. The CDCC, however, is nonrefundable, so taxpayers without a positive tax liability after other deductions do not benefit. The solid line in Figure 1 displays maximum CDCC benefits

for households with one qualifying individual as of 2020, by federal AGI.[4] The figure shows that taxpayers' incomes must exceed the tax filing threshold of $19,000 to be eligible for benefits. For taxpayers with incomes above this threshold, benefits increase with income before reaching a peak of $840 at $27,000 in AGI.

CDCC claimants must work to qualify for benefits. In households where each spouse is capable of self care, this includes both spouses of married taxpayers filing jointly. Additionally, if either spouse's earnings are less than care expenditures, then the CDCC is calculated as a percentage of the lesser of the two taxpayers' earnings. For households with a spouse incapable of self care, the CDCC benefit calculation is a bit more complicated. While the Internal Revenue Service (IRS) allows these households to receive benefits even if the disabled spouse does not work, for the purpose of calculating benefits, they impute the disabled spouse's monthly earnings as the maximum of their actual earnings and $250.[5] By construction, the disabled spouse's imputed annual earnings total at least $3,000 per year, the maximum qualifying expenditure amount. Thus, households with spouses incapable of self care can receive the maximum CDCC benefit. To claim the credit, taxpayers must list their earnings, dependent-care expenditures, and dependent-care-providers' tax identification or Social Security numbers on Federal Form 2441. Benefits decrease taxes due at tax filing time.

In light of an increased need for caregiving during the COVID-19 pandemic, the American Rescue Plan (ARP) temporarily expanded the CDCC and made it fully refundable during tax year 2021 only. As depicted in Figure 1, the policy change increased the maximum qualifying expenditure amount from $3,000 to $8,000 per qualifying individual and increased the benefit rate so that claimants with less than $125,000 in AGI could receive a refundable tax credit worth 50 percent of qualifying expenditures. Benefits then decreased as income increased, until they plateaued at 20 percent of qualifying expenditures for taxpayers with $183,000 or more in AGI. The credit phased out among taxpayers with more than $400,000 in AGI.[6]

In addition to the federal CDCC, taxpayers in 24 states and the District of Columbia can receive additional benefits through state supplements to the federal credit. Maximum benefits vary

[4]Among low-income households, we assume that all income comes from earnings. Results are similar for low-income taxpayers with unearned income, though benefits are less generous. Additionally, at low-income levels where benefits are a function of earnings, we display maximum benefits for single households. Results are similar for married households, though benefits are less generous.

[5]For households with two or more qualifying individuals, the IRS imputes the disabled spouse's monthly earnings as the maximum of that spouse's actual earnings and $500.

[6]ARP did not increase the earnings imputation for spouses incapable of self care. Because of this, maximum benefits were lower among households with nonworking qualifying spouses. The analyses of post-tax costs of care and CDCC eligibility under the 2021 CDCC expansion in Sections 4 and 5 focus on the benefit expansion for non-spouse qualifying individuals.

considerably across states, from $197 to $1,055 for households with one qualifying individual as of 2020. Other state tax-credit policy choices also affect generosity. For instance, about half of states offer refundable tax credits, and some limit qualifying expenditures to spending on care for young children, precluding households with adult care responsibilities. In Section 4, we consider how both state and federal policies, along with differences in caregiving costs across states, lead to heterogeneous post-tax costs of caregiving services across households.

The CDCC is not the only support measure available to family caregivers. Since 1986, employees who receive FSAs from their employers have been able to set aside up to $5,000 of earnings before taxes for caregiving expenses.[7] The employer deducts this income from employees' paychecks, but employees are reimbursed for qualified caregiving expenses, which, similar to the CDCC, include care expenditures for coresident spouses dependents incapable of self-care. Unlike the CDCC, however, the decision to set aside funds for an FSA occurs before the employee's caregiving expenditures are realized.

While taxpayers may receive benefits from both FSAs and the CDCC, they may not double count expenses across the two dependent-care subsidy programs. Furthermore, taxpayers must reduce their qualifying CDCC expenses by every pretax dollar claimed under an FSA. For example, if a family with one qualifying individual and $5,000 in eligible-care expenditures had set aside $2,000 in pretax earnings for an FSA, they could claim the remaining $3,000 in eligible-care expenditures for the CDCC.

FSAs generally provide larger tax benefits per dollar than the federal CDCC, given the CDCC's nonrefundability and high marginal tax rates among high-income taxpayers. Nevertheless, households that spend over $5,000 per year in caregiving expenses can benefit from both programs, and households that face unexpected increases in caregiving expenses due to unexpected medical events may benefit more from the CDCC. In addition, less than half of civilian workers are offered dependent care FSA benefits.[8]

In 2023, Oklahoma established additional supports for its residents by becoming the first state to pass a caregiver tax credit with the Caring for Caregivers Act. Starting in 2024, caregivers may claim a credit for up to 50 percent of eligible caregiving costs, with an annual cap of $2,000 for most participants and $3,000 for those caring for a veteran or someone with a dementia-related diagnosis. The credit is means-tested: to be eligible caregivers must have federal adjusted gross income below

[7] The expense limit was increased to $10,500 during 2021.

[8] Bureau of Labor Statistics, Employee Benefits in the United States, March 2023, https://www.bls.gov/ebs/publications/employee-benefits-in-the-united-states-march-2023.htm.

$50,000 for a single filer or $100,000 for joint filers. Unlike with the CDCC, the care recipient does not need to be coresident or listed as a dependent.

In addition to tax-related benefits, many workers have access to family and sick leave, an in-kind caregiving benefit. Under the Family and Medical Leave Act of 1993, firms with at least 50 employees must offer eligible employees 12 weeks of job-protected unpaid leave for care for a child, spouse, or parent who has a serious health condition.[9] To be eligible for leave, employees must have worked at their firm for at least 12 months and have accumulated at least 1,250 work hours. While the U.S. does not mandate paid family leave, in recent years, several states have implemented their own paid leave mandates. In these states, workers who meet a given work history requirement receive partial wage replacement up to a maximum weekly benefit. Some, but not all, state mandated paid leave programs also offer job protection. As of March 2023, 27 percent of civilian workers had access to paid family leave and 90 percent had access to unpaid family leave.[10]

Paid sick leave is another in-kind benefit that provides workers with paid time off to address intermittent caregiving needs. Workers typically accrue one hour of paid sick leave for every 30-40 hours worked, up to a annual maximum number of days per year. Like paid family leave, there is no federal right to sick leave access, but many more states have passed paid sick leave laws, and many more employers offer paid sick leave even without a mandate. As a result, 80 percent of workers have access to paid sick leave.[11]

Finally, there are caregiving supports for targeted groups. For instance, in addition to free medical care, the U.S. Department of Veterans Administration provides nursing home services to veterans based on eligibility criteria, such as level of disability, and available resources. Eligible caregivers of veterans also have access to income support, training, and mental health services, among other supports. While not directly tied to caregiving, Supplemental Security Income (SSI) is a means-tested program that provides cash payments and Medicaid eligibility to disabled children and adults and individuals aged 65 and older. As of 2023, the monthly Federal Benefit Rate was $914 per individual and $1,371 per couple. Monthly benefits are reduced by any non-SSI income the individual receives. Similarly to the CDCC, some states supplement the federal SSI program

[9]Employers with at least 50 employees within 75 miles of the worksite for at least 20 weeks of the last year must offer 12 weeks of unpaid leave, though some states have lower firm size thresholds or require longer leave lengths. Employers may refuse job protection for their highest-paid 10 percent of employees if leave would generate economic harm.

[10]Bureau of Labor Statistics, Employee Benefits in the United States, March 2023, https://www.bls.gov/ebs/publications/employee-benefits-in-the-united-states-march-2023.htm.

[11]Bureau of Labor Statistics, Employee Benefits in the United States, March 2023, https://www.bls.gov/ebs/publications/employee-benefits-in-the-united-states-march-2023.htm.

with their own state benefits.

The various supports available for adult caregiving expenses pale in comparison with those available for child care expenses. While CDCC, dependent care FSA, and family leave benefits are the same for families with adults and children in need of care, low-income families with children often receive free or subsidized child care services via Child Care and Development Fund subsidies or Head Start and Early Head Start. Universal schooling is available to children beginning at age five, and several states offer universal pre-kindergarten beginning at age three or four. While not directly tied to care expenses, the Child Tax Credit and Credit for Other Dependents illustrate inequities in caregiving supports by family type: households may receive up to $2,000 in benefits per child but only up to $1,000 in benefits per non-child dependent via these tax programs. Similarly, Earned Income Tax Credit (EITC) benefits are largest for taxpayers with qualifying children, and taxpayers who are older than 65 and do not have qualifying children may not claim the credit. In spite of the additional supports available to families with children, the Biden Administration recently requested $16 billion from Congress to stabilize the child care sector and make care more affordable for families.[12] Thus, there likely is much scope for caregiving supports to impact families' access to care and financial resources.

3. Who Benefits from Tax Programs for Adult Care?

Relatively few childless households claim the CDCC, which suggests that taxpayers rarely make use of the credit for adult care expenses. In particular, Crandall-Hollick and Boyle (2021) show that, during 2017, fewer than 160,000 households without children younger than 13 years old claimed the CDCC. Consistent with low levels of participation, only 2 percent of federal CDCC benefits were allocated toward these childless taxpayers in that year. As the CDCC may provide economically meaningful benefits to households with disabled spouses and other adult dependents, in this section, we document the size of the population most likely affected by tax programs for adult care. To do so, we use data from the 2016 wave of the Health and Retirement Study, the HRS.

The HRS is a nationally representative biennial panel survey of about 20,000 individuals aged 51 and older and their spouses. In addition to a broad range of sociodemographic characteristics, we observe whether a respondent has a qualifying coresident spouse or parent who needs help with

[12]Office of Management and Budget Briefing Room, "State Breakdown: The Biden-Harris Administration's Funding Request Would Help Prevent Families Across the Country from Losing Child Care," November 2, 2023, https://www.whitehouse.gov/omb/briefing-room/2023/11/02/state-breakdown-the-biden-harris-administrations-funding-request-would-help-prevent-families-across-the-country-from-losing-child-care/.

activities of daily living, such as eating, bathing, and getting dressed, or has memory or cognitive limitations due to Alzheimer's disease or related dementia. We also observe each respondent's current employment status and annual earnings and household income as of 2015. Finally, the HRS collects information about health insurance and health-care spending, including a detailed breakdown of out-of-pocket spending on a range of health-related expenses.

To identify the population most likely affected by tax benefits for adult care, we limit the sample to about 10,500 respondents aged 50 to 65. Table 1 displays summary statistics by the presence of a coresident spouse or parent who would be a qualifying person from the perspective of the CDCC. We identify an HRS respondent as having a qualifying parent if that respondent resides with a parent and reports that the parent needs help with basic personal needs like dressing, eating, or bathing or cannot be left alone for an hour or more. We identify an HRS respondent as having a qualifying spouse if they have a coresident spouse who reports difficulty with at least one activity of daily living because of a health or memory problem or is categorized as having dementia by having a score of 0–6 out of 27 points on the Langa-Weir Classification of Cognitive Function (Crimmins et al. 2011).[13]

Table 1 shows that 0.9 percent of HRS respondents aged 50 to 65, representative of just over 450,000 individuals, live with a qualifying parent (column 1), and 9.3 percent, representative of just over five million individuals, live with a qualifying spouse (column 2). Column 3 presents results for the remaining HRS respondents aged 50 to 65 without a qualifying parent or spouse. Respondents in each column are similar in age, but other demographic characteristics vary substantially across caregiving needs. Specifically, respondents who have a coresident spouse or parent with care needs are more likely to be Black or Hispanic. Respondents with qualifying parents, in particular, are considerably more likely to be female (78%) and Hispanic (30%) and less likely to be married (35%) than those in the other two groups. Additionally, only 45 percent of respondents with qualifying spouses have college degrees, while 63 percent of the remaining respondents are college educated. Turning to labor market outcomes, some 62 percent of respondents with qualifying spouses and 42 percent of respondents with qualifying parents combine work and caregiving. This compares to a 69 percent employment rate among similar individuals without such caregiving responsibilities. Average household incomes total $60,000 for respondents with qualifying parents, $67,000 for respondents with qualifying spouses, and $107,000 for the remaining respondents.

[13]We rely on HRS respondents' reports of parental health but self reports for spousal health, as the HRS surveys both spouses in a household. For cases in which the spouse cannot respond to the survey, we use proxy respondent reports.

Next, to study household caregiving expenditures and CDCC eligibility, we focus on the HRS respondents in Table 1 with qualifying spouses. (The HRS does not contain information on caregiving expenditures or public health-insurance coverage for coresident parents.) Because taxpayers must work in order to claim the CDCC, Table 2 describes respondents' qualifying expenditures on health and long-term care for spouses by whether the respondent works.[14] Beyond spending on health-insurance premiums and prescription drug costs, the HRS survey asks about three categories of health-related spending that may qualify for the CDCC: 1) spending on home health care, including "professional nurses, visiting nurse's aides, physical or occupational therapists, chemotherapists, respiratory oxygen therapists, and hospice caregivers"; 2) other health services, including "an adult care center, a social worker, an outpatient rehabilitation program, physical therapy, or transportation for the elderly or disabled"; and 3) other medical expenses not covered by insurance, including "medications, special food, equipment such as a special bed or chair, visits by health professionals, or other costs."

The sample of just under 600 HRS respondents aged 50 to 65 with qualifying spouses represents about 2.9 million adults, including 1.6 million who work for pay (Table 2, column 1). While rates of spousal physical-care needs (as measured by number of reported difficulties with activities of daily living) are very similar across household types, HRS respondents who do not work (Table 2, column 2) are more likely to have a spouse with Alzheimer's disease or related dementia (8.7% vs. 12.9%). HRS respondents who do not work also are more likely to have a spouse receiving Medicaid (21.6% vs. 41.0%) but are less likely to have and use long-term care insurance (7.9% vs. 3.3% having, 3.2% vs. 0.6% using), suggesting substantial differences in how working and nonworking households pay for long-term care. Notably, approximately one in five qualifying spouses in both categories report having forgone care because of costs, though qualifying spouses of working HRS respondents do so to a slightly lesser extent.

The qualifying spouses of both working and nonworking HRS respondents report substantial out-of-pocket expenditures, but Table 2 shows that these costs are higher among spouses of working respondents.[15] Seventy-seven percent of qualifying spouses of HRS respondents have out-of-pocket health-care costs, spending more than $5,000 over two years, on average, compared to 56 percent of qualifying spouses of nonworking HRS respondents, whose two-year average spending sums to $2,750. With the exception of home health care, qualified spouses of working HRS respondents are

[14] We further restrict the sample to respondents whose qualifying spouses do not work, so as to most accurately identify the subset of HRS respondents who could qualify for and benefit from the CCDC.

[15] We rely on the RAND detailed imputation files for detailed medical expenditures.

also more likely to have out-of-pocket expenditures for health-related spending that would qualify for the CDCC, as defined in the previous section. It is particularly striking that the qualifying spouses of working HRS respondents are nearly three times more likely to spend out of pocket on other health services, which include adult care centers and transportation for the elderly or disabled. Their conditional spending in this category also is more than twice as high as that of the qualifying spouses of nonworking HRS respondents. Conditional on having any health-related spending that may qualify for the CDCC, households with a working HRS respondent spend an average of $1,800 over two years, compared with just under $1,300 for households with a nonworking HRS respondent.

Tables 1 and 2 imply that a substantial proportion of adults between the ages of 50 and 65 care for a coresident family member, and that caregiving responsibilities are negatively associated with household income. Although CDCC benefits may provide additional income to many households with caregiving responsibilities, others may be ineligible for the tax credit because the primary taxpayer—or that person's spouse if caring for a parent—does not work. Nonetheless, Tables 1 and 2 suggest that many family caregivers combine work and caregiving. We consider the impact of removing the earnings requirement on eligibility rates in Section 6.

4. Effects of State and Federal CDCCs on Post-Tax Caregiving Costs

In this section, we first document median costs of typical caregiving services across states as of 2021. We then consider how state and federal CDCC benefits affect post-tax costs of such services. In doing so, we rely on state-level median cost-of-care data from the insurance company Genworth, which contacted nearly 70,000 randomly selected providers from its nationwide database of home-health-care providers, adult day health-care facilities, licensed assisted-living facilities, and certified and licensed nursing homes (Genworth Financial, Inc. 2023). Interviews were conducted during June–November 2021.

The circles in Figure 2 document median annual pretax costs of hiring a home health aide for 10 hours a week across states based on the Genworth data. Median annual costs vary substantially across states, from $9,750 in Wyoming to $18,850 in Minnesota. In most states, median annual costs range between $12,500 and $17,500. Based on results from Table 1, this constitutes about 20 percent of household income among individuals aged 50 to 65 with a coresident spouse in need of help, and about 25 percent of household income among similar individuals with a coresident parent in need of help.

Next, we use the Genworth data to estimate median annual *post-tax* costs of hiring a home

health aide after accounting for the CDCC. In doing so, we subtract estimated CDCC benefits for households with $50,000 in income from the median cost of care as of 2021, though the pattern of results is similar for households with different income levels.[16] The diamonds in Figure 2 display estimated median costs after accounting for state and federal CDCC benefits as of 2020. Post-tax costs of care range from about $9,150 to $17,650 across states, slightly lower than pretax costs.

Finally, the triangles in Figure 2 represent estimated median annual post-tax costs of care under the 2021 expanded CDCC. Results yield two key takeaways. First, the 2021 CDCC expansion substantially decreased median estimated post-tax costs of care: post-tax costs during 2021 range from $5,740 to $14,250. Second, on average, estimated median costs are lower in states with their own CDCCs. Specifically, median costs of care average about $9,500 in states with CDCCs and $10,300 in states without them. This compares to pretax averages of $14,000 and $14,400 in states with and without CDCCs, respectively.

In appendix figures, we conduct similar analyses of the annual median post-tax costs of homemaker services and adult day health care. As with home health aides, estimated post-tax costs of these services are substantially lower under the 2021 expanded CDCC.

5. Expected Effects of Expanding the CDCC on Taxpayers' Behavior

In this section, we consider how increases in CDCC generosity, similar to those under the ARP temporary expansion, would affect taxpayers' behavior. In particular, we discuss incentives related to care expenditures, coresidency, and labor supply.

First, as a subsidy for caregiving expenditures, increases in CDCC generosity encourage household members to substitute away from unpaid care in favor of paid care services. Increases in benefits also would promote additional care hours among households already participating in paid care, as well as higher-quality care services that may be more expensive. Additionally, because the qualifying individual must reside in the household for the primary taxpayer (and the taxpayer's spouse, if applicable) to receive benefits, the CDCC promotes coresidence with adult children while discouraging institutional care. Hence, increases in CDCC generosity should increase the use of paid and higher-quality noninstitutional long-term services and supports, such as services provided by home health aides and adult day-care facilities, by lowering their relative cost.

Moreover, because all nondisabled primary taxpayers and spouses must work to receive bene-

[16] We assume that households have at least $8,000 in earnings. The pattern of results for households with lower earnings levels is similar, though their post-tax costs of care are higher.

fits, the CDCC encourages labor force participation among potential caregivers. As labor supply elasticities increase over the life course (French 2005; French and Jones 2012) and the average age of family caregivers in our HRS sample is 58, the employment effects of expanding the CDCC could be quite large. Specifically, under labor-supply elasticities with respect to caregiving benefits found in existing literature (Geyer and Korhage 2015), results from Table 1 imply that permanently increasing federal CDCC benefits to their 2021 levels for nonspouse qualifying individuals would increase labor force participation by about 10 percentage points among individuals aged 50 to 65 with caregiving responsibilities and $43,000 to $125,000 in AGI, all else being equal. Of course, benefit increases of this magnitude could generate increases in the cost of long-term services and supports that would dampen such labor supply effects. Employment effects could be further dampened if a benefit expansion were to generate large increases in coresidence and demand for family caregiving services.

While the CDCC's intensive margin labor-supply incentives vary across the income distribution, the ARP expansion, which increased benefits without affecting marginal tax rates for those with $43,000 to $125,000 in AGI, generated positive income and no substitution effects for many taxpayers. Given that many family caregivers in our HRS sample already work, one may be concerned that the income effects of a similar benefit expansion (along with substitution effects for those with around $20,000-$25,000 and $125,000 or more in AGI) would lead to decreases in work hours. Evidence from the EITC, however, which, similarly to the expanded CDCC for nonspouse dependents, had a maximum value of nearly $4,000 for families with one child as of 2021, suggests that any decreases in work hours would be relatively small. In particular, Chetty, Friedman, and Saez (2013) estimate intensive margin labor-supply elasticities with respect to EITC benefits of 0.14 in the credit's phaseout range, where income and substitution effects discourage work. This is in spite of the facts that the EITC has very high phaseout rates (0.16 for households with one child as of 2021) relative to the 2021 CDCC (0.04 for households with nonspouse qualifying individuals) and begins to phase out at much lower AGI levels (around $20,000 for households with children). While the EITC is targeted at low- and moderate-income families with children, who likely exhibit lower labor supply elasticities, evidence from French (2005) suggests that differences in the extensive margin, rather than the intensive margin, drive differences in labor supply elasticities by age.

While the CDCC generates spending, coresidency, and labor-supply incentives, behavioral responses to increases in generosity among households without children may be limited because of their low participation rates. There are several possible reasons why relatively few households claim

the CDCC for adult care expenses. First, low CDCC eligibility rates among individuals with caregiving responsibilities may explain low participation rates. To examine this possibility, we use the National Bureau of Economic Research's TAXSIM program to simulate adult caregivers' eligibility rates under potential tax program changes, including making the credit refundable and eliminating its earnings requirement. In the CDCC's current form, these program changes would affect all beneficiaries, including families with children, who comprise the vast majority of claimants. We acknowledge that some of the tax program changes we propose may be better targeted at adult caregivers, who tend to have considerably lower future potential earnings. We posit that, if policymakers find certain modifications desirable for adult caregivers only, they could split the tax program into separate child and adult care credits.[17]

We simulate households' annual tax liabilities and credits to estimate federal CDCC eligibility among the sample of HRS respondents with qualifying spouses in the first column of Table 3.[18] The table shows that 11 percent of spousal caregivers, representative of about 420,000 households, are eligible for the CDCC under current tax law. Compared to the characteristics of all spousal caregivers described in Table 1, eligible individuals are less likely to be female (38% vs. 51%), more likely to be white (88% vs. 63%), and more likely to have a college degree (58% vs. 45%). Eligible households also have relatively high AGI of about $118,000 on average as of 2015.

In the next column of Table 3, we consider how eligibility rates and characteristics of the eligible population would change if the CDCC were made refundable, all else being equal. Results indicate that making the CDCC refundable would nearly double the number of eligible households to about 750,000. Under refundability, newly eligible spousal caregivers are 6 percentage points more likely to be female, 16 percentage points more likely to be Black or Hispanic, and 21 percentage points less likely to have a college degree than currently eligible caregivers. As expected, newly eligible households also tend to have much lower incomes—less than $30,000 on average—than currently

[17]While eliminating the coresidency requirement likely would increase eligibility rates, it also could lead to tax compliance issues. For example, siblings in different tax units could struggle to determine who may claim a nonresident parent. These types of issues have plagued tax credits targeted at families with children (Maag, Peters, and Edelstein 2016), so to avoid taxpayer confusion, policymakers would need to clarify who should claim a nonresibdent qualifying individual. Further, policymakers could limit nonresident qualifying individuals to disabled parents and spouses, as we consider in our analyses.

[18]TAXSIM explicitly simulates CDCC benefits among households with children only. Therefore, we first use federal tax rules to simulate the CDCC benefits for which each household would be eligible if the credit were refundable. We then estimate the household's nonrefundable CDCC benefits by taking the minimum of their simulated refundable benefits and their tax liability as simulated by TAXSIM. In doing so, we assume that effects of child dependents, dividend income, interest received, capital gains, and a few other sources of nonwage income on tax liabilities are negligible. We also assume that households who report out-of-pocket spending on home health care, other health services, or other medical expenses have at least some care expenditures that are eligible expenses for the CDCC.

eligible households.

In the final column of Table 3, we consider how concurrently eliminating the CDCC's earnings requirement and making the credit refundable would affect eligibility and characteristics, all else being equal.[19] Under these CDCC reforms, an additional 18 percent of spousal caregivers become eligible for benefits, bringing the number of eligible households to approximately 1.1 million. With the exception of having lower household incomes, individuals who become eligible under a refundable CDCC without an earnings requirement appear to be fairly similar to individuals who become eligible under refundability alone. Taken together, results from Table 3 suggest that eligibility rules explain some, but not all, of the lack of CDCC participation among adult caregivers.

There remain several reasons why households may not take up the CDCC, even if they are eligible for benefits. First, households may not be aware that they are eligible for the credit. Evidence from the EITC indicates that lack of tax program awareness prevents take-up among eligibles (Bhargava and Manoli 2015), and it is plausible that some individuals with adult care responsibilities may not realize that they are eligible for a Child and *Dependent* Care Credit. Second, additional evidence from the EITC suggests that administrative burden impedes tax credit take-up (Bhargava and Manoli 2015; Kopczuk and Pop-Eleches 2007). The CDCC's claiming requirements of filing taxes and completing Federal Form 2441 may therefore limit the number of claimants. Administrative burden may play a particularly important role in explaining low CDCC take-up rates among childless adults because, as indicated by Figure 2, in its current form, the credit is worth only a small proportion of the costs of typical caregiving services. Such administrative burdens may be compounded by financial burdens associated with claiming the CDCC. For instance, TurboTax, the filing software used by 42 million taxpayers during 2022, requires taxpayers with CDCC returns to use the paid version of their software.[20] While low-income taxpayers with CDCC claims are eligible for free tax preparation services through the IRS's Volunteer Income Tax Assistance program, the IRS does not expect that tax returns with CDCC claims will be covered in its 2024 Direct File pilot. The fact that it costs taxpayers time and money to receive benefits likely deters them from claiming the CDCC. A more generous credit or increased access to free filing services could increase take-up.

Finally, even if households are aware of their eligibility for the CDCC and willing to comply with administrative and financial costs required to claim it, some may not participate if they are reluctant

[19] We also simulated effects of eliminating the earnings requirement under nonrefundability. Less than 1 percent of spousal caregivers gain eligibility under this reform.

[20] Ford, Brody and Ben Steverman, "Free IRS TurboTax Competitor Is Closer After Biden Funding," *Bloomberg*, March 14, 2023, https://www.bloomberg.com/news/articles/2023-03-14/turbotax-competitor-from-irs-may-happen-after-biden-funding.

to report payments made to caregivers "under the table" on their federal tax forms. Increasing CDCC generosity would discourage this tax evasion behavior by increasing the benefits of claiming relative to those of avoiding taxes paid to care providers.

6. Conclusion and Policy Implications

A growing share of Americans provide uncompensated care for aging and disabled family members. In this paper, we consider the CDCC from the perspective of taxpayers who care for spouses and adult dependents. Although tax credits are a popular policy proposal among family caregivers, only a very small share of households who claim the CDCC do not have children under 13. We describe the value of the tax credit for these households and use the HRS to describe the population most likely affected by tax programs for adult care. We find that despite low participation rates, a non-negligible number of households could benefit from the CDCC.

We then document the tax credit's value for households with caregiving responsibilities. Expanded federal CDCC benefits during 2021 covered a much larger proportion of typical care costs than current CDCC benefits. We discuss the expected effects of permanently expanding the CDCC on taxpayers' behavior. Increases in credit generosity should increase the use of noninstitutional paid care services, coresidence with adult children, and labor force participation. Nonetheless, low eligibility rates, lack of knowledge, and administrative burden likely impede CDCC participation and may limit behavioral responses to increased generosity among family caregivers. We simulate effects of CDCC policy reforms and find that making the credit refundable would increase eligibility rates substantially among female, nonwhite, and low-income spousal caregivers.

For many years, high out-of-pocket costs borne by family caregivers have impeded their financial stability, labor force participation, and overall well-being. As the Social Security Administration projects that the number of individuals aged 65 and older will increase from less than 60,000 in 2022 to more than 80,000 in 2050 (Social Security Administration 2023), policymakers should consider how more generous subsidization of caregiving services may impact many families' access to care and financial resources. Although additional supports for family caregivers could require increases in state and federal expenditures, our results suggest that due to increases in caregivers' labor supply and less reliance on institutional care funded by Medicaid, increases in benefits that are tied to work could generate cost-savings while improving individuals' well-being.

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Tables and Figures

Table 1: Characteristics of Individuals Aged 50–65 by Caregiving Status

	Coresident parent needs help	Coresident spouse needs help	No coresident parent or spouse who needs help
Age	57.5	58.3	57.8
Female	0.777	0.513	0.518
White	0.512	0.631	0.699
Black	0.121	0.122	0.114
Hispanic	0.297	0.164	0.112
Married	0.348	1.000	0.671
College	0.623	0.445	0.627
Respondent working	0.423	0.620	0.690
Spouse working	0.294	0.304	0.468
Respondent earnings ($)	24,088	26,209	43,196
Spouse earnings ($)	57,850	12,002	45,260
Household income ($)	60,035	67,231	107,320
N	100	976	9,434
Representative of	454,652	5,004,154	57,996,559

SOURCE: Wave 2016 of the HRS using individual sample weights.
NOTE: Characteristics of respondents aged 50–65 in Wave 2016 of the HRS, by the presence of a qualifying spouse or parent in the household. Earnings and income are from the previous calendar year.

Table 2: Qualifying Spouse Health and Long-Term Care Spending

	Respondent works	Respondent does not work
Spouse age	58.4	61.0
Number of ADLs	2.04	2.00
Has ADRD	0.087	0.129
Has Medicaid	0.216	0.410
Has Medicare	0.509	0.563
Has LTC insurance	0.079	0.033
Receives LTC insurance benefits	0.032	0.006
Forgoes care because of costs	0.188	0.213
Any out-of-pocket spending on home health care	0.033	0.050
Any out-of-pocket spending on other health services	0.151	0.056
Any out-of-pocket spending on other medical expenses	0.281	0.258
Out-of-pocket spending on home health (conditional) ($)	757.6	151.4
Out-of-pocket spending on other health services (conditional)($)	1301.5	558.6
Out-of-pocket spending on other medical expenses (conditional) ($)	1423.0	1246.6
Total out-of-pocket LTC expenditure (conditional) ($)	1798.0	1278.7
Any out-of-pocket health spending	0.765	0.564
Out-of-pocket health spending (conditional) ($)	5178.9	2751.0
Household income ($)	67,576	37,834
N	290	308
Representative of	1,640,032	1,223,307

SOURCE: Wave 2016 of the HRS using individual sample weights.

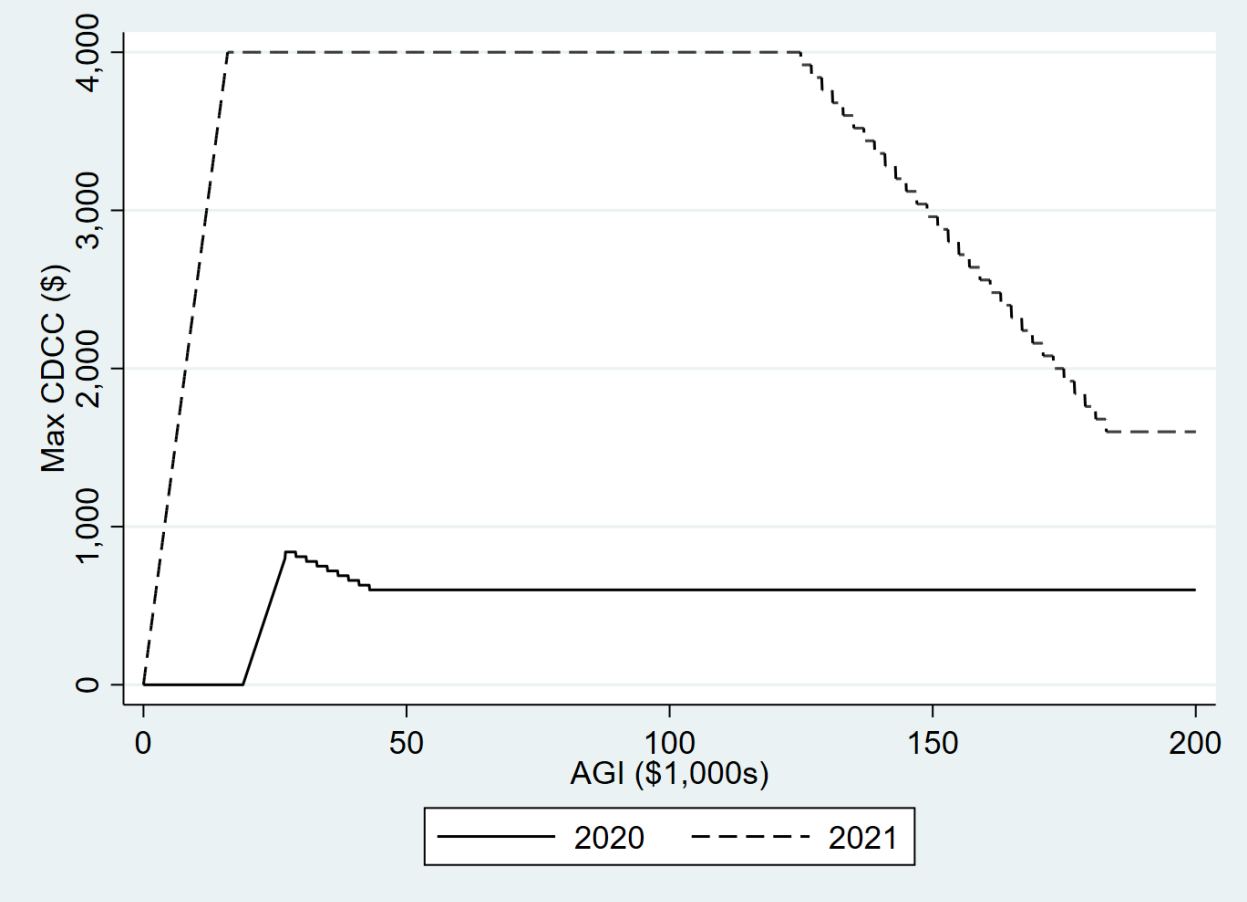
NOTE: Characteristics of respondents aged 50–65 in Wave 2016 of the HRS with spouse qualifying individuals who do not work. Column 1 includes respondents who work for pay, and Column 2 includes respondents who do not work for pay. "Number of ADLs" denotes the number of activities of daily living with which the qualifying individual has difficulty. "Has ADRD" denotes whether the qualifying individual has Alzheimer's disease or related dementia. "Home health care" includes care in the home from "medically trained persons including professional nurses, visiting nurse's aides, physical or occupational therapists, chemotherapists, respiratory oxygen therapists, and hospice caregivers." "Other health services" includes "any special facility or service which we haven't talked about, such as: an adult care center, a social worker, an outpatient rehabilitation program, physical therapy, or transportation for the elderly or disabled." "Other medical expenses" include "other out-of pocket expenses, that is, expenses not covered by insurance, such as medications, special food, equipment such as a special bed or chair, visits by health professionals, or other costs." "Total out-of-pocket LTC expenditure" includes any out-of-pocket spending on home health, special facilities or services, or other health services. Total out-of-pocket spending includes costs associated with hospitalization, nursing home, surgery, doctor and dentist appointments, prescription drugs, in-home care, and other medical care. Household income is from the previous calendar year.

Table 3: Simulations of CDCC Reforms

	Current law	Newly eligible households if refundable	Newly eligible households if refundable & eliminate earnings requirement
Share of spousal caregivers	0.113	0.088	0.184
Age	57.752	58.042	58.691
Female	0.381	0.442	0.407
White	0.878	0.593	0.579
Black	0.093	0.182	0.134
Hispanic	0.028	0.102	0.129
College	0.581	0.373	0.433
AGI ($)	117,881	28,975	20,654
N	65	81	169
Representative of	417,333	327,816	681,911

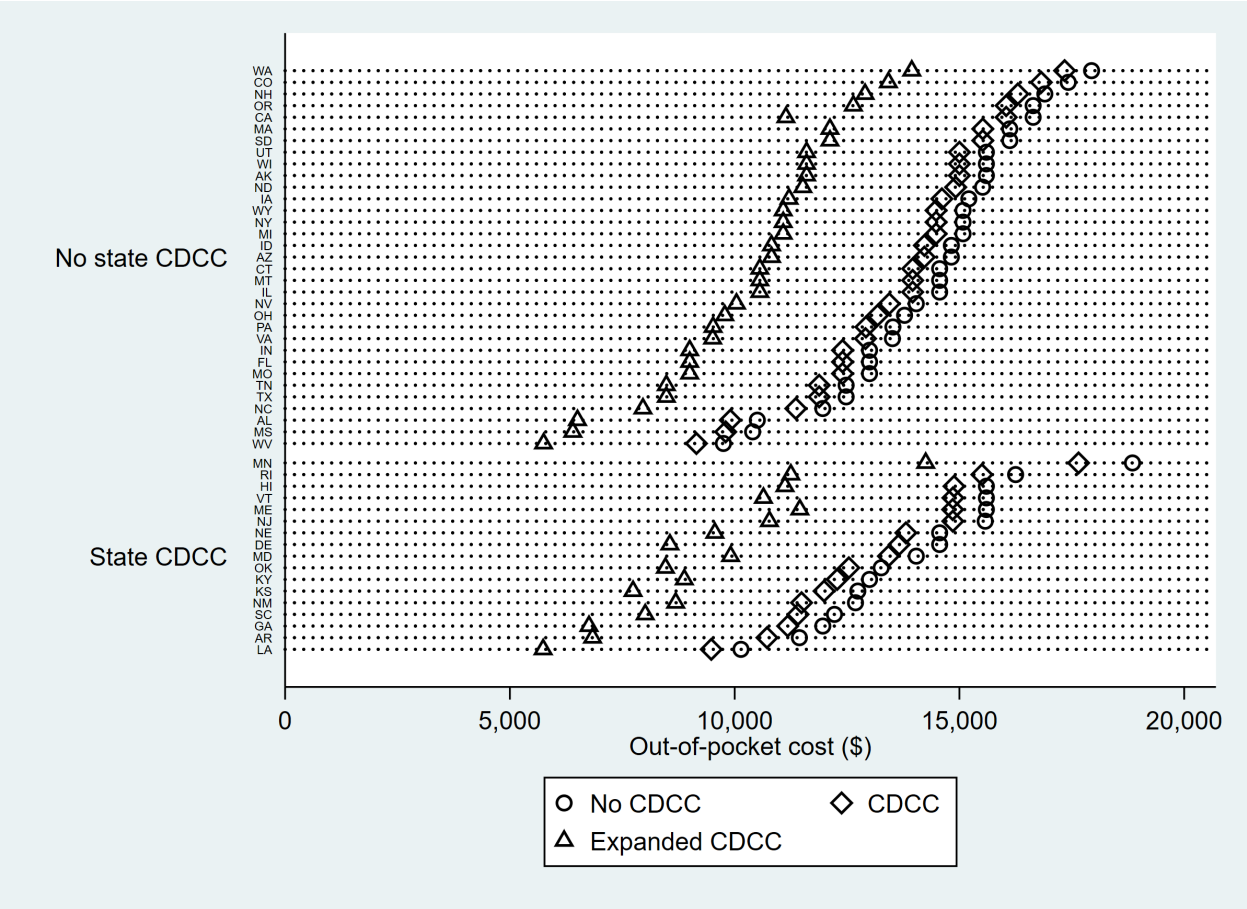
SOURCE: Authors' calculations using Wave 2016 of the HRS, federal tax forms, and TAXSIM.
NOTE: Share and characteristics of households who are or would become eligible for the CDCC under policy reforms to current tax law, among those aged 50–65 with nonworking spouse qualifying individuals.

Figure 1: Maximum Federal CDCC Benefits by AGI



NOTE: Maximum federal CDCC benefits for households with one qualifying individual, by federal AGI as of 2020 and 2021.
SOURCE: Authors' calculations using federal tax forms.

Figure 2: Out-of-Pocket Home Health Aide Costs by State



NOTE: Out-of-pocket costs of hiring a home health aide for 10 hours per week for households with one qualifying individual as of 2021, by state. Circles: Median annual pretax costs. Diamonds: Median annual post-tax costs, after accounting for state and federal CDCC benefits for households with $50,000 in income. Triangles: Median annual post-tax costs, after accounting for 2021 state and federal CDCC benefits for households with $50,000 in income.
SOURCE: Authors' calculations using Genworth median cost-of-care data.