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ABSTRACT

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

As the U.S. population ages, family caregivers face substantial out-of-pocket costs and financial risks while providing the majority of long-term care. The Child and Dependent Care Credit (CDCC), a tax credit based on income and care spending, subsidizes caregiving expenses but has low participation among adult caregivers. This paper evaluates the CDCC's current structure, documenting its limited impact on reducing caregiving costs and examining reforms to increase its utility for adult caregivers. Simulations of proposed changes—higher benefits, refundability, and relaxed eligibility requirements—demonstrate potential to expand access and enhance support for family caregivers within the existing policy framework.

JEL Classification: H24, J14

Keywords: adult care, Child and Dependent Care Credit, American Rescue Plan Act of 2021, participation, eligibility

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1. Introduction

As the U.S. population ages, the increasing costs of long-term care present substantial risks for older adults and their families. While around 70 percent of the measurable direct costs of long-term care are publicly subsidized through various insurance programs, unpaid family caregivers provide the majority of support to individuals with care needs while incurring substantial private costs (Van Houtven et al. 2020). These include out-of-pocket spending on care-related goods and services and lower labor supply and forgone earnings related to hands-on caregiving.[1] Policymakers have an interest in subsidizing out-of-pocket costs incurred by family caregivers because they pose an uninsured risk to families that can result in financial hardship, and they may keep older adults out of costly institutional care, which can generate cost-savings for states (Wiener et al. 2017; National Academies of Sciences, Engineering, and Medicine 2016).

A comprehensive national long-term-care scheme can support family caregivers through a number of policies, such as paid family leave, pension-based work credits, respite services, and direct reimbursement for out-of-pocket expenditures (National Academies of Sciences, Engineering, and Medicine 2016). In the United States, direct reimbursement through the tax code is popular among family caregivers, many of whom must file taxes, and falls in line with a number of other safety net benefits that are administered through the tax system. In particular, nearly 70 percent of adult caregivers surveyed by AARP affirmed that "an income tax credit ... to help offset the cost of care" would help them manage their caregiving responsibilities (AARP and National Alliance for Caregiving 2020, p.81). Fewer respondents reported that paid leave would be helpful (54%), suggesting that caregivers value cost reimbursement above in-kind benefits for time spent caregiving.

In fact, a caregiving 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. Despite stated preferences, participation in the tax program is low among taxpayers caring for adults: as of 2017, 95 percent of CDCC claims were made exclusively for child dependents (Crandall-Hollick and Boyle 2021). Low participation among adult caregivers may reflect the fact that the CDCC was designed "to help families pay employment-related expenses for care of a child" (Gitterman and Howard 2003, p.19), and some of its eligibility requirements, namely a coresidency and an earnings requirement, are better targeted at parents paying for child care than at adult caregivers. In many cases, adult

[1] See, for example, Skira (2015), Maestas, Messel, and Truskinovsky (2024), Fahle and McGarry (2017), Van Houtven, Coe, and Skira (2013), AARP and National Alliance for Caregiving (2021), and Chari et al. (2015).

caregivers do not live with their care recipients, and they tend to have much shorter future earnings trajectories than parents of young children.

As the CDCC is an existing federal policy mechanism that has the potential to play an important role in the U.S. long-term-care landscape, in this paper, we consider whether and how changes to its structure could better meet adult caregivers' needs. We examine the credit's value for taxpayers caring for disabled spouses and parents, estimate their take-up rates, and consider possible reasons for low participation. We examine how the CDCC's value to these caregivers would change under four hypothetical reforms within the scope of current policy: (1) increasing benefit levels, (2) making the credit refundable, (3) lifting its earnings requirement, and (4) lifting its coresidency requirement. Under each of the reforms, the CDCC would continue to subsidize out-of-pocket care expenditures, though other tax program incentives would change. We lay out the behavioral implications of each of our proposed reforms for the population of adult caregivers specifically, acknowledging that, in many cases, implications for parents of young children differ. We posit that if policymakers find certain modifications desirable for adult caregivers only, the tax program could be split into separate child and adult care credits.

We begin by describing 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 find that, in recent years, some 8 percent of individuals aged 51–65 had a coresident spouse or parent with self-care needs or dementia. Caregiving responsibilities are negatively associated with household income, though the majority of respondents with coresident parents and spouses (54 and 56 percent, 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 current CDCC benefits generate small decreases in post-tax costs of care, we find that a benefit expansion similar to the pandemic-era American Rescue Plan expansion would substantially decrease post-tax care costs. We then simulate eligibility for the CCDC and find that eligibility rates are low: 10–16 percent of spousal caregivers and up to 16 percent of parental caregivers are eligible for the CDCC. Along with these eligibility rates, we estimate a bounded CDCC take-up rate among adult caregivers of 11–57 percent.

Finally, we discuss theoretical effects of CDCC reforms and simulate their effects on eligibility

rates. We find that, all else equal, making the credit refundable would approximately double the number of eligible spousal caregivers. Spousal caregivers aged 51–65 who become eligible for benefits under refundability come from demographic groups with relatively high Medicaid participation rates, and their spouses tend to have more care needs. We also study effects of lifting the CDCC's earnings and coresidency requirements. Lifting the earnings requirement, in particular, would lead to large increases in adult caregivers' eligibility for the CDCC.

Policies like the CDCC can provide targeted financial relief to families grappling with out-of-pocket caregiving expenses. Our analysis highlights significant barriers to participation among adult caregivers, including restrictive eligibility requirements and low benefit levels that do little to offset the substantial costs of caregiving. By simulating the effects of proposed reforms—such as increasing benefit levels, making the credit refundable, and relaxing earnings and coresidency requirements—we illustrate how these changes could meaningfully expand eligibility and enhance the program's value to adult caregivers. While the CDCC alone is not a comprehensive solution, the modifications that we examine could make it a more effective tool for addressing the financial risks faced by caregivers, reducing reliance on Medicaid, and supporting the broader long-term care system.

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 CDCC reforms on taxpayers' behavior. In Section 6, we estimate CDCC eligibility and take-up rates and examine effects of policy reforms on eligibility. In Section 7, we conclude.

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

Around 70 percent of Americans turning 65 will require long-term services and supports (LTSS) at some point in their remaining lifetime (Johnson 2019). LTSS encompasses assistance with basic personal tasks, such as eating, bathing, and dressing, as well as services including housekeeping, meal preparation, transportation, money management, and home modifications (Reckrey et al. 2023). Different types of providers in various settings administer LTSS, depending on level of disability, costs, caregiver availability, 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. Direct costs depend on the type of care arrangement and may include payments to care facilities and in-home formal caregivers such as nurses or home health aides; 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). Indirect costs, which are difficult to measure but are estimated to be at least as high as direct costs, include forgone earnings due to uncompensated hands-on caregiving (Nandi et al. 2024; Chari et al. 2015). Children and spouses of individuals with self-care needs are the main providers of uncompensated care (Skira 2015; Maestas, Messel, and Truskinovsky 2024; Van Houtven, Coe, and Skira 2013).

National direct expenditures on LTSS 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 direct costs (an estimated 13 percent of the costs of LTSS, or approximately $64 billion in 2020) is paid for out of pocket because public and private insurance for these services is limited (Colello 2022). Very few individuals own private long-term-care insurance policies that would cover the costs of LTSS. 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 just 18 percent of spending on LTSS. Medicaid, the largest public payer of LTSS, accounts for 54 percent of this spending and has both financial and functional eligibility requirements (Chidambaram and Burns 2022). Most Medicaid recipients in need of LTSS first pay directly for services, spending down assets until they qualify for benefits (Johnson 2019).

Family caregivers, who provide the majority of hands-on LTSS, also take on a significant portion of out-of-pocket caregiving costs, though there is limited evidence on how families share long-term care expenditures (National Academies of Sciences, Engineering, and Medicine 2016). While no national surveys systematically collect information about the share of out-of-pocket care costs for long-term care incurred by family caregivers (National Academies of Sciences, Engineering, and Medicine 2016), a recent nationally representative telephone survey found that over three-quarters of family and other unpaid caregivers report out-of-pocket spending related to their caregiving role, with annual (conditional) spending totaling over $7,000 (AARP and National Alliance for Caregiving 2021).

The CDCC can help to defray such out-of-pocket caregiving expenditures for certain family caregivers. In every year since 2003 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 spouses and dependents "physically or mentally incapable of self-care" who live with the taxpayer for more than half of the tax year. Additionally, for, say, a parent to qualify as a dependent for tax filing purposes, they must have gross taxable income of less than $5,050 and receive at least half of their financial support from the taxpayer.[2] CDCC 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.

The solid line in Figure 1 displays maximum CDCC benefits for households with one qualifying individual as of 2020, by federal AGI.[3] The figure shows that because the CDCC is nonrefundable, 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. Those with $43,000 or more in AGI can receive up to $600.

CDCC claimants must work to qualify for benefits. For married taxpayers filing jointly, this includes the non-disabled spouse or both spouses if neither is disabled.[4] 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 Act of 2021 temporarily expanded the CDCC and made it fully refundable during tax year 2021 only. As depicted in the dashed line 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.[5]

[2]The gross taxable income limit is for 2024.

[3]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.

[4]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. However, the Internal Revenue Service imputes disabled spouses' monthly earnings as the maximum of their actual earnings and $250 (for households with one qualifying individual) or $500 (for households with two or more qualifying individuals) so that their households may remain eligible for the maximum CDCC benefit.

[5]The American Rescue Plan Act of 2021 did not increase the earnings imputation for spouses incapable of self

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 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 one aspect of a patchwork of tax-based, in-kind, and other limited supports available to some families with caregiving expenses. In addition to the CDCC, this patchwork includes dependent care flexible spending accounts (FSA), state caregiver tax credits, employer-provided or state-mandated family and sick leave, and caregiving supports for targeted groups, such as veterans or those with very low incomes and assets.[6] The CDCC and dependent care FSA are the only federal programs that directly subsidize family caregivers' out-of-pocket care-related expenditures. Additionally, the CDCC has the potential to reach taxpayers who may not benefit from the dependent care FSA: less than half of civilian workers have access to these accounts, and FSAs require forward planning of expenditures that may preclude taxpayers whose caregiving responsibilities begin mid-year.[7]

For comparison, we briefly describe public funding that is available for child care costs. 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 can 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. Overall, public funding for adult care dwarfs public spending on child care in terms of both spending levels and as a share of total public and private spending (Gould and Blair 2020). Notably, conditional on need, the cost of care is still much higher for LTSS than for child care. Families allocate 8.7 percent of annual income to child care costs on average (Herbst 2023), and costs generally decrease as children age. Meanwhile, median annual

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.

[6] Details of these programs can be found in the appendix.

[7] 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.

costs for nursing-home-equivalent LTSS exceed the median annual income of older adults with care needs (Chidambaram and Burns 2022).

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, about 315,000 households with qualifying individuals older than 13 years claimed the CDCC. Consistent with low levels of participation, only 2 percent, or $70 million out of $3.72 billion, of federal CDCC expenditures were allocated toward 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 waves 2010–2018 of the Health and Retirement Study (HRS). The HRS is a nationally representative biennial panel survey of individuals aged 51 and older and their spouses. In addition to a broad range of socio-demographic characteristics, we observe whether a respondent has a coresident or non-coresident spouse or parent who needs help with activities of daily living, such as eating, bathing, and getting dressed, or has memory or cognitive limitations due to dementia. We also observe each respondent's current employment status, annual earnings, and household income as of the previous year. Finally, the HRS collects information about health insurance and health-care spending for survey respondents and spouses, 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—hereafter, the target population—we limit the sample to respondents aged 51 to 65.[8] Columns 1 and 2 of Table 1 display 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 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). 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 care like dressing, eating, and bathing, cannot be left alone for an hour or more, or has been diagnosed with Alzheimer's

[8] One limitation of the HRS is that it does not include a nationally representative sample of adults younger than 51, so our estimates do not capture younger caregivers.

disease or related dementia.[9] Because we cannot observe parents' income in the HRS, we assume that disabled, coresident parents meet the dependent requirements of having gross taxable income of less than $5,050 and receiving at least half of their financial support from the taxpayer. While this may lead to overestimates of the number of qualifying parents, disabled parents relying solely on Social Security and non-taxable retirement benefits likely meet the dependent requirements. Social Security income is not taxable unless benefits and other income exceed $50,000, and, therefore, it generally does not count toward the gross income test. Many taxpayers with coresident parents also are likely to establish the financial support test, which accounts for the fair market value of the parent's lodging and their portion of the household food budget. Even if the parent receives a substantial amount of retirement income, the taxpayer is only required to account for the portion of that income that the parent spends on their own support, not income that is saved.

Table 1 shows that, between 2010 and 2018, 1.3 percent of HRS respondents aged 51 to 65, representative of just under 3.9 million individuals, lived with a qualifying parent (column 1), and 6.7 percent, representative of just over 18 million individuals, lived with a qualifying spouse (column 2). For comparison, column 5 presents results for HRS respondents aged 51 to 65 without a qualifying parent or spouse. Demographic characteristics vary substantially across caregiving needs. Respondents who have a qualifying coresident parent are younger (57.5 years), more likely to be female (63.5%), more likely to have more than a high school education (69.7%), and less likely to have children under 13 in the household (1.6%) than the other two groups. While respondents with qualifying spouses are more demographically similar to non-caregivers, they have substantially lower levels of education (45.8% vs 60.1% have more than a high school diploma). Additionally, respondents in the target population are less likely to be white and more likely to be Black or Hispanic compared with respondents without a spouse or parent with care needs. Turning to labor market outcomes, some 54 percent of respondents with qualifying parents and 56 percent of respondents with qualifying spouses combine work and caregiving. This compares to a 63 percent employment rate among individuals without such caregiving responsibilities. Average household incomes total $57,000 for respondents with qualifying parents, $63,000 for respondents with qualifying spouses, and $97,000 for non-caregivers.

While CDCC eligibility is limited to qualifying individuals who are coresident, nationally, the majority of family caregivers (60%) report providing care to someone outside their household (AARP

[9]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.

and National Alliance for Caregiving 2020; Mommaerts and Truskinovsky 2020). To understand how caregiving is distributed across coresident and non-coresident households, we include in Table 1 households with a parent (column 3) or spouse (column 4) with care needs who does not reside with the respondent. We find that coresidence varies by the identity of the qualifying individual. While 99 percent of HRS respondents who have a spouse with care needs reside with that spouse, less than 5 percent of respondents who have a parent with care needs reside with that parent. Non-coresident parents reside in nursing homes (16%), with another relative (22%), or alone (65%).[10] Notably, 24 percent of respondents with non-coresident disabled parents provide unpaid care, though their care recipients have less intensive care needs as measured by the presence of cognitive impairment. Additionally, respondents with non-coresident parents are younger (57.1), less likely to be female (50.8%), more likely to be married or partnered (73.7%), more likely to have children under 13 in the household (4.5%), and more likely to be working (73.7%) than respondents with coresident parents.

Next, to study household caregiving expenditures and CDCC eligibility in the target population, we focus on the HRS respondents in Table 1 with qualifying coresident spouses (the HRS does not contain information on caregiving expenditures or 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.[11] Beyond out-of-pocket spending on health-insurance premiums, medical care, 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 2,700 HRS respondents aged 51 to 65 with qualifying spouses represents about 13 million adults, including 6.7 million who work for pay (Table 2, column 1). Working spouses

[10] Percentages add up to more than 100 because respondents can have multiple parents with care needs and different living arrangements. Specifically, 3.3 percent of respondents with coresident parents and 5 percent of respondents with non-coresident parents with care needs have parents in different living arrangements. All non-coresident spouses with care needs reside in a nursing home or other residential care facility.

[11] 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 be eligible for and benefit from the CCDC.

are younger (58.3 vs 59.9 years old) and less likely to be female (50.2% vs 56.8%) than nonworking spouses. Household income for households with working respondents is nearly twice that of nonworking respondents ($65,360 vs $37,645). While rates of spousal physical-care needs (as measured by number of reported difficulties with activities of daily living) are similar across household types (53% of spouses of working respondents have more than one ADL limitation, compared with 52% of spouses of nonworking respondents), HRS respondents who do not work (Table 2, column 2) are more likely to have a spouse with dementia (10.1% vs. 14.8%), and their care recipients are more likely to receive both paid and unpaid help with activities of daily living (3.4% vs. 6.5% paid, 61% vs. 66% unpaid). HRS respondents who do not work also are more likely to have a spouse receiving Medicaid (17.2% vs. 31.3%) but are less likely to have and use long-term care insurance (8.4% vs. 6.9% having, 2.7% vs. 0.7% using), suggesting substantial differences in how working and nonworking households pay for long-term care. Veterans Affairs insurance and Social Security Disability Income receipt rates are similar across groups.

Table 2 suggests that access to LTSS-related benefits is limited in this population, regardless of work status. Along with low rates of private long-term care insurance, only a small share of qualifying spouses have access to Veterans Affairs health insurance (which could provide a caregiver subsidy based on eligibility), and only a relatively small share have Medicaid. More qualifying spouses—but still less than 40%—report receiving Social Security Disability Income. Notably, approximately one in five qualifying spouses report not being able to afford necessary medical care.

The qualifying spouses of both working and nonworking HRS respondents report substantial out-of-pocket health expenditures, but Table 2 shows that these costs are higher among spouses of working respondents.[12] Eighty-one percent of qualifying spouses of working HRS respondents have out-of-pocket health-care costs, spending more than $5,800 over two years, on average, compared to 71 percent of qualifying spouses of nonworking HRS respondents, whose two-year average spending sums to $3,400. Qualified spouses of working HRS respondents are 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 (36% vs 25%). Conditional on having any health-related spending that may qualify for the CDCC, households with a working HRS respondent spend an average of $1,580 over two years, compared with $1,820 for households with a nonworking HRS respondent.

Tables 1 and 2 imply that a substantial share of adults between the ages of 51 and 65 care for a coresident family member and that caregiving responsibilities are negatively associated with

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

household income. Although CDCC benefits may provide additional income to many households in the target population, other households with care needs may be ineligible for the tax credit because the qualifying individual does not reside with them or the primary taxpayer—or that person's spouse if caring for a parent—does not work or does not earn enough to owe income taxes. Nonetheless, Tables 1 and 2 suggest that many family caregivers combine work and caregiving and live with family members in need of care. In Section 6, we directly simulate CDCC eligibility across households in the target population and estimate impacts of reforms on eligibility rates.

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 West Virginia 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 25 percent of household income among individuals aged 51–65 with a coresident spouse or 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.[13] 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

[13]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.

substantially decreased median estimated post-tax costs of care: post-tax costs during 2021 range from $5,740 to $14,250, or closer to 15 percent of average household income for the caregivers of coresident family members from Table 1. 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 CDCC Reforms on Taxpayers' Behavior

In this section, we first consider how an increase in CDCC benefit levels similar to the American Rescue Plan temporary expansion would affect taxpayers' behavior. We then discuss expected behavioral responses to combinations of three possible changes to the CDCC's structure: (1) making the credit refundable, (2) lifting its earnings requirement, and (3) lifting its coresidency requirement. 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 (Tsai 2015). Increases in benefits also promote the purchase of additional care hours among households already participating in paid care, as well as higher-quality (or at least more preferred) care services that may be more expensive (Goda, Golberstein, and Grabowski 2011). 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 encourages coresidence with adult children while discouraging institutional care (Mommaerts 2018). Moreover, for qualifying parents with multiple children capable of providing care, benefit increases promote coresidence with children who work and have incomes high enough to benefit from the nonrefundable credit, as opposed to lower-income and nonworking children.

More generally, because all nondisabled primary taxpayers and spouses must work to receive benefits, the CDCC encourages labor force participation among potential caregivers. As French (2005) and French and Jones (2012) find that labor supply elasticities increase from around 0.3–0.4 to 1.0–1.3 over the life course (French 2005; French and Jones 2012) and the average age of family caregivers in our HRS sample is 58, employment effects of expanding the CDCC could be quite

large. Specifically, under an extensive margin labor supply elasticity with respect to caregiving benefits among coresident family caregivers of 0.02 (Geyer and Korhage 2015), results from Table 1 imply that permanently increasing federal CDCC benefits to their 2021 levels would increase labor force participation by about 10 percentage points among caregivers in the target population with $43,000 to $125,000 in AGI, all else being equal. This finding is consistent with evidence from Laun (2017), who relies on income tax changes in Sweden to estimate an extensive margin labor supply elasticity among older workers of 0.22, and Snyder and Evans (2006), who find large increases in labor force participation among older workers in response to decreases in Social Security generosity.

Of course, benefit increases of a large magnitude similar to that of the American Rescue Plan expansion could generate increases in the cost of LTSS that would dampen labor supply effects. Employment effects could be further dampened if a benefit expansion were to increase the prevalence of coresidence and family caregiving (Rennane 2020).

While the CDCC's intensive margin labor supply incentives vary across the income distribution, the 2021 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 caregivers in the target population 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 French and Jones (2012) suggests that any decreases in work hours would be relatively small. The authors find that most employed older workers work full-time hours and argue that both employees and employers face a fixed cost of work, resulting in limited ability or desire to manipulate the number of hours worked, conditional on working.

Turning to proposed changes to the CDCC's structure, refundability would strengthen its incentives for out-of-pocket care spending, work, and coresidence among low-income households who do not benefit from the existing nonrefundable tax credit. It also could lead to an increase in qualifying parents' coresidency with lower-income children, who would be newly eligible for benefits.

While making the CDCC refundable largely would reinforce existing program incentives, lifting its earnings or coresidency requirement would change those incentives dramatically. For example, removing the earnings requirement would eliminate the CDCC's work incentive, which could decrease labor force attachment among older adults and pose a risk to their economic security in retirement (Bartel et al. 2023; Wolff et al. 2016). A possible increase in the share of qualifying parents living with nonworking children could further exacerbate threats to economic well-being at

older ages. Nonetheless, as Table 1 suggests that the majority of households eligible for the CDCC are single earners (who may have a nonworking, disabled spouse), lifting the earnings requirement would only have bite if the credit also were made refundable. That is, most of these households' incomes would be too low to benefit from a nonrefundable CDCC if they did not work.

Removing the CDCC's coresidency requirement would newly subsidize out-of-pocket care spending among children of parents who live outside the household. This would weaken the CDCC's incentive for qualifying individuals to reside in the community by allowing children to claim benefits for parents living in institutional care facilities.[14] In practice, however, if the coresidency requirement were lifted, it is likely that the majority of CDCC benefits would continue to be allocated toward households with coresident spouses and dependents: the CDCC only subsidizes out-of-pocket spending, and institutional care largely is funded by Medicaid. Additionally, it could be difficult for children with non-coresident parents to establish the dependent requirement of providing at least half of their financial support, which includes food, lodging, transportation, recreation, and other expenses often included in Medicaid-funded institutional care.[15]

6. Why Is Participation So Low Among Adult Caregivers?

While the CDCC generates spending, coresidency, and labor-supply incentives, behavioral responses to increases in generosity among households in the target population 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 within the target population may explain low participation rates. In particular, to be eligible for benefits, households in the target population must work, have positive spending on qualifying expenses, and have positive income tax liabilities. We use the National Bureau of Economic Research's TAXSIM program to simulate adult caregivers' eligibility rates both under current rules and under potential tax program changes.

We estimate federal CDCC eligibility among the target population with spouse qualifying individuals in the first column of Table 3.[16] Table 3 reports that 10 percent of spousal caregivers,

[14] Eliminating the coresidency requirement could lead to tax compliance issues. For example, siblings in different tax units could struggle to determine who may claim a non-coresident 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 nonresident qualifying individual. Further, policymakers could limit nonresident qualifying individuals to disabled parents and spouses, as we consider in our analyses.

[15] The requirements to claim a parent as a dependent do not vary based on whether that parent is coresident.

[16] We adjust income measures for inflation and use 2020 federal individual income tax parameters. 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

representative of about 450,000 households per year, are eligible for the CDCC under current tax law. Comparing our estimate of the number of eligible households to the annual number of CDCC claims with qualifying individuals aged 13 years and older (Crandall-Hollick and Boyle 2021) yields an upper bound on the take-up rate among adult caregivers of 88 percent. However, this is almost certainly an overestimate, as our estimate of the eligible population does not include households where the respondent is younger than age 51, who we do not observe in the HRS, households with qualifying parents, for whom we do not observe care expenditures, households caring for disabled adult children, or households caring for other disabled relatives. Additionally, the population of claimants with qualifying individuals aged 13 years and older likely includes households with qualifying disabled children aged 13–17, who we do not observe. In light of these limitations, we also estimate eligibility among parental caregivers, under the assumption that they all have positive spending, in the appendix. We find that, at most, about 1 percent of parental caregivers, or about 190,000 households in a given year, are eligible for the CDCC in its current form. Accounting for these households yields a more realistic CDCC upper-bound take-up rate for adult caregivers of 57 percent.

Turning to characteristics of eligible taxpayers, Table 3 shows that, compared to the characteristics of the target population of spousal caregivers described in Table 1, CDCC-eligible individuals are more likely to be white (87% vs. 64%), more likely to have more than a high school degree (68% vs. 46%), and equally likely to care for spouses who require assistance with multiple activities of daily living (46% vs. 47%) but less likely to care for spouses with dementia (1.3% vs. 11.3%). Eligible households also have relatively high AGI of about $117,000 (2019 dollars).

In the second 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. Under refundability, newly-eligible spousal caregivers are 12 percentage points more likely to be Black or Hispanic and 18 percentage points less likely to have more than a high school degree than currently-eligible households. In the online appendix, we show that these demographic groups have relatively high Medicaid participation rates, which suggests that additional CDCC expenditures under a refundable credit could be offset by decreased Medicaid expenditures if newly-eligible

and their tax liability as simulated by TAXSIM. In doing so, we assume that effects of child care expenditures, 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 qualifying expenses for the CDCC.

households were to reduce their reliance on Medicaid-funded LTSS.

Additionally, Table 3 documents that caregivers who would become eligible for the CDCC if it were made refundable are 5 percentage points more likely to have a child in the household than currently-eligible caregivers. As expected, newly-eligible households tend to have much lower incomes—around $30,000 on average—than currently-eligible households. Caregivers who would become eligible for the CDCC under refundability also have more intensive caregiving responsibilities, as their spouses are 14 percentage points more likely to require assistance with multiple activities of daily living and 5 percentage points more likely to have dementia. Existing work suggests that these households are more likely to rely on nursing homes for LTSS (Wolff et al. 2016).

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.[17] Under these CDCC reforms, an additional 20 percent of spousal caregivers become eligible for benefits, bringing the number of eligible households to approximately 1.3 million per year. 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, though they tend to have lower household incomes and are more likely to have qualifying individuals with dementia.

In the appendix, we conduct similar simulations of CDCC reforms by the caregiver's race and education and by the qualifying individual's level of disability. While sample sizes are small in some analyses, the pattern of differences in characteristics across currently-eligible and newly-eligible caregivers under policy reforms remains similar across demographic groups. Additionally, because very few disabled spouses live outside the caregiver's household, we simulate effects of lifting the CDCC's coresidency requirement among HRS caregivers with disabled parents in the appendix. As with the eligibility analysis, we assume that all households have some care spending and that all parents meet the dependent requirements to estimate an upper bound on the share of parental caregivers eligible under various reforms. Under these assumptions, lifting the coresidency requirement would expand eligibility substantially, to another 41 percent of households with disabled parents.

The simulated eligibility rates that we estimate for parental and spousal caregivers aged 51 to 65 suggest that low eligibility, rather than low take-up, is a primary driver of the limited CCDC expenditures allocated towards childless taxpayers. However, as we note, the HRS does not cap-

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

ture the full target population, including households where the respondent is younger than age 51, households caring for disabled children ages 13 and older, and households caring for other disabled relatives. Given these limitations, we turn to the Survey of Income and Program Participation (SIPP) to calculate a lower bound for the take-up rate. The SIPP is a nationally-representative, longitudinal survey that collects data on demographics, income, household composition, and program participation in a series of continuous panels. We use the 2014, 2018, 2019, and 2020 panels and TAXSIM to estimate the number of households that could be included in the population of claimants (of all ages) with qualifying individuals aged 13 years and older for the years 2014, 2016, 2017, 2018, and 2019. Because the SIPP does not document care expenditures for these groups, we assume that all households have some care spending and that all care recipients meet the dependent requirements to generate weighted estimates of the number of "potentially eligible" households: those that have a coresident qualifying individual, meet the earnings requirement, and have positive tax liability after other deductions. We conduct an exercise similar to the eligibility analysis in Table 3 to get the results displayed in Table 4.[18]

We estimate that there are 2.2 million households in the target population annually. Spouses constitute the majority of qualifying individuals, followed by parents and older children. We estimate that 16 percent of households of all ages with coresident qualifying spouses are potentially eligible for the CDCC. It is unsurprising that this estimate is slightly higher than the 10 percent estimate from Table 3, which was conditional on observed qualifying expenditures. Potential eligibility rates are slightly higher among households with most other types of qualifying individuals in Table 4, ranging from 12–21 percent. The 80,000 households with multiple types of qualifying individuals are an exception; they have the lowest potential eligibility rate of 8 percent. Consistent with the results in Table 3, estimates from the SIPP imply that, among households with qualifying spouses, making the CDCC refundable would nearly double the number of potentially-eligible households, and also lifting the earnings requirement would expand eligibility further, all else equal. Results suggest that making the CDCC refundable would have even larger effects on potential-eligibility rates among households with other types of qualifying individuals.

[18]We assume that effects of the following income sources on tax liabilities are negligible: wage and salary income of children and other dependents with disabilities, nonwage income of non-disabled children, and income of adult household members who are not spouses or disabled and do not file their own tax returns. Additionally, we rely on the following assumptions: investment and property income is taxed as short-term capital gains; income from non-pension Veterans Affairs benefits, workers' compensation, unemployment compensation, and Social Security is taxed as gross Social Security income; and other income that does not come from earnings or means-tested transfers is taxed as gross Social Security income for qualifying children and as taxable pensions and IRA distributions for other household members.

Results from Table 4 imply a lower-bound CDCC take-up rate for adult caregivers of 11 percent. This yields our preferred bounded take-up rate measure of 11–57 percent. To put these estimates into perspective, take-up rates for the EITC and Expanded Child Tax Credit hover around 80 percent (Hamilton et al. 2022; Jones 2014). Although CDCC take-up rates for adult caregivers likely are lower than take-up rates for other family tax benefits, results suggest that very low eligibility rates may play a more important role in explaining low participation.

There are 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 share 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.[19] While low-income taxpayers with CDCC claims are eligible for free tax preparation services through the Internal Revenue Service's Volunteer Income Tax Assistance program, tax returns with CDCC claims were not 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, such as the one available under 2021 expanded CDCC, 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 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.

[19] 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.

7. Policy Implications and Directions for Future Research

A growing share of Americans provide uncompensated care for aging and disabled family members and incur substantial caregiving-related out-of-pocket costs. This paper examines the Child and Dependent Care Credit (CDCC) as a mechanism to offset caregiving expenses for family members caring for older adults. Although tax credits are a popular policy proposal among family caregivers, only a very small share of childless households claim the CDCC. We consider the CDCC from the perspective of taxpayers who care for spouses and adult dependents 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 adult caregivers could benefit from the tax program.

Next, we examine the degree to which the CDCC reduces caregivers' post-tax costs and find that it is low. Expanded federal CDCC benefits during 2021 covered a much larger share of typical care costs, relative to current benefits. We discuss 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 additional CDCC policy reforms and show that while eligibility is low under current rules, making the credit refundable would increase eligibility rates substantially, especially among populations likely to rely on Medicaid-funded long-term services and supports. Notably, we find that eligibility would increase among caregivers who are nonwhite, have lower incomes, and have more intensive caregiving responsibilities, who tend to report the highest out-of-pocket caregiving costs and experience the largest caregiving burden (AARP and National Alliance for Caregiving 2021; Wolff et al. 2016). We find that eliminating the credit's earnings requirement would lead to further increases in eligibility.

Despite very different demographics, we find that eligibility rates for the CDCC among adult caregivers are similar to eligibility rates among parents of young children documented in existing literature (Pepin 2022). Nevertheless, all else equal, the reforms that we propose would lead to much larger increases in eligibility rates among adult caregivers, who have lower labor force participation rates and are less likely to reside with care recipients (Pepin 2022).

While the CDCC is not a comprehensive solution to the challenges that caregivers face, it has the potential to serve as a politically feasible and well-targeted tool in alleviating out-of-pocket

expenses and promoting work among caregivers. Through policy simulations, we highlight how modest expansions or adjustments to eligibility criteria could enhance its effectiveness, offering actionable insights for policymakers seeking to support family caregivers in the absence of broader long-term care reforms. Additional research is needed to understand the size of behavioral responses to proposed changes to the tax credit. Future research also should address the degree to which lack of knowledge and administrative burden impede CDCC take-up and explore strategies to lessen these barriers to participation. Perhaps most importantly, improved data collection around how families share out-of-pocket caregiving costs would allow researchers to examine whether and to what extent tax credits, perhaps in concert with other policies, can reduce the financial strain on family caregivers.

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Tables and Figures

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

	Hh member w/care needs		Non-hh member w/care needs		
	Parent (1)	Spouse (2)	Parent (3)	Spouse (4)	No care needs (5)
Age	57.5	58.8	57.1	61.6	58.9
	(3.8)	(3.9)	(3.7)	(2.9)	(3.9)
Female	0.635	0.525	0.508	0.467	0.525
	(0.482)	(0.499)	(0.500)	(0.506)	(0.499)
White	0.586	0.639	0.746	0.839	0.721
	(0.493)	(0.480)	(0.435)	(0.373)	(0.449)
Black	0.158	0.129	0.081	0.126	0.124
	(0.365)	(0.336)	(0.274)	(0.336)	(0.330)
Hispanic	0.193	0.165	0.109	0.030	0.100
	(0.395)	(0.371)	(0.312)	(0.172)	(0.299)
Partnered/married	0.335	1.000	0.737	1.000	0.668
	(0.472)	(0.000)	(0.440)	(0.000)	(0.471)
More than HS	0.697	0.458	0.666	0.515	0.601
	(0.460)	(0.498)	(0.472)	(0.507)	(0.490)
Child under 13 in HH	0.016	0.032	0.045	0.000	0.035
	(0.126)	(0.177)	(0.207)	(0.000)	(0.184)
Respondent working	0.535	0.560	0.737	0.365	0.628
	(0.499)	(0.497)	(0.440)	(0.489)	(0.483)
Respondent earnings ($)	27,334	24,672	46,234	13,041	36,015
	(49,079)	(42,913)	(73,586)	(30,160)	(69,166)
HH income ($)	56,576	62,604	109,354	50,352	96,947
	(85,842)	(78,497)	(169,142)	(44,651)	(167,349)
Provide unpaid care	0.741	0.513	0.242	0.410	
	(0.487)	(0.500)	(0.428)	(0.499)	
Parent with care needs					
Parent has dementia	0.384		0.285		0.000
	(0.487)		(0.451)		(0.000)
Parent lives in nursing home	0.002		0.158		0.008
	(0.047)		(0.365)		(0.090)
Parent lives with other relatives	0.006		0.222		0.063
	(0.078)		(0.416)		(0.243)
Parent lives alone	0.025		0.654		
	0.156		(0.476)		
Spouse with care needs					
Spouse dementia		0.113		0.484	0.000
		(0.316)		(0.507)	(0.000)
Multiple ADLs		0.469		0.943	0.000
		(0.499)		(0.235)	(0.000)
Paid care		0.037		1.000	
		(0.188)		(0.000)	
N	727	3,681	11,787	34	29,762
Weighted N (across 5 waves)	3,889,213	18,162,456	76,388,576	196,215	177,700,000

SOURCE: Waves 2010–2018 of the HRS using individual sample weights.

NOTE: Characteristics of respondents aged 51–65, by the presence of a disabled parent or nonworking spouse in or outside of the household. Column 1 includes respondents with coresident disabled parents, column 2 includes respondents with coresident disabled, nonworking spouses, column 3 includes respondents with non-coresident disabled parents, column 4 includes respondents with non-coresident disabled, nonworking spouses, and column 5 includes respondents without parents or nonworking spouses in need of care. "More than HS" indicates whether the respondent has more than a high school education. "Child under 13 in HH" denotes the presence of a child younger than 13 years old in the household."Respondent earnings ($)" and "HH income ($)" denote the respondent's earnings and the household's income from the previous year. "Multiple ADLs" indicates that the qualifying individual has difficulty with more than one activity of daily living. Standard deviations are listed in parentheses.

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

	Respondent works	Respondent does not work
Respondent/HH characteristics		
Age	58.3	59.9
	(3.8)	(3.9)
Female	0.502	0.568
	(0.500)	(0.496)
HH income ($)	65,360	37,645
	(58,206)	(53,546)
Spouse characteristics		
Age	58.888	61.194
	(7.530)	(7.518)
Multiple ADLs	0.535	0.519
	(0.499)	(0.500)
Dementia	0.101	0.148
	(0.301)	(0.355)
Medicare	0.487	0.597
	(0.500)	(0.491)
Medicaid	0.172	0.313
	(0.378)	(0.464)
VA health insurance	0.06	0.076
	(0.237)	(0.265)
SSDI	0.396	0.378
	(0.489)	(0.485)
Have LTC insurance	0.084	0.069
	(0.278)	(0.254)
Use LTC insurance	0.027	0.007
	(0.163)	(0.083)
Receive help with ADLs	0.623	0.673
	(0.485)	(0.469)
Unpaid help	0.614	0.664
	(0.487)	(0.473)
Paid help	0.034	0.065
	(0.180)	(0.246)
Need medical care but cannot afford	0.222	0.200
	(0.416)	(0.400)
Spouse out-of-pocket health spending		
Any health care spending	0.812	0.714
	(0.391)	(0.452)
Amount (conditional $)	5,861	3,412
	(13,574)	(7,915)
Any CDCC-eligible spending	0.362	0.254
	(0.481)	(0.435)
Amount (conditional $)	1,582	1,820
	(3,204)	(6,454)
N	1,291	1,437
Weighted N (across 5 waves)	6,674,788	6,424,740

SOURCE: Waves 2010–2018 of the HRS using individual sample weights.

NOTE: Characteristics of respondents aged 51–65 with nonworking spouse qualifying individuals. Column 1 includes respondents who work for pay, and column 2 includes respondents who do not work for pay. "HH income ($)" is annual household income from the previous year. "Multiple ADLs" and "Receive help with ADLs" indicate whether the qualifying individual has difficulty with more than one activity of daily living and receives help with activities of daily living, respectively. "VA health insurance," "SSDI," "Have LTC insurance," and "Use LTC insurance" indicate whether the qualifying individual has or uses Veterans Affairs health insurance, Social Security Disability Income, and long-term care insurance, respectively. "CDCC-eligible spending" includes spending that may constitute CDCC qualifying expenditures. Standard deviations are listed in parentheses.

Table 3: Simulations of CDCC Reforms

		Newly-eligible households	
	Current	Refundable	Refundable & no earnings
Share of spousal caregivers	0.102	0.087	0.197
Age	57.530	57.717	58.683***
	(0.2668)	(0.3339)	(0.2168)
Female	0.459	0.443	0.488
	(0.0370)	(0.0378)	(0.0249)
White	0.871	0.673***	0.674***
	(0.0202)	(0.0345)	(0.0229)
Black	0.076	0.138**	0.113*
	(0.0152)	(0.0226)	(0.0125)
Hispanic	0.036	0.096**	0.117***
	(0.0120)	(0.0210)	(0.0155)
More than HS	0.684	0.502***	0.476***
	(0.0346)	(0.0380)	(0.0250)
Child under 13 in HH	0.012	0.025	0.034*
	(0.0084)	(0.0115)	(0.0100)
Child under 18 in HH	0.032	0.083**	0.091***
	(0.0114)	(0.0215)	(0.0153)
AGI ($)	116,949	31,679***	22,698***
	(6,133)	(1,393)	(1,404)
Multiple ADLs	0.464	0.608***	0.587***
	(0.0372)	(0.0369)	(0.0245)
Dementia	0.013	0.062**	0.101***
	(0.0073)	(0.0173)	(0.0155)
N	286	306	756
Weighted N (across 5 waves)	1,803,505	1,538,123	3,501,722

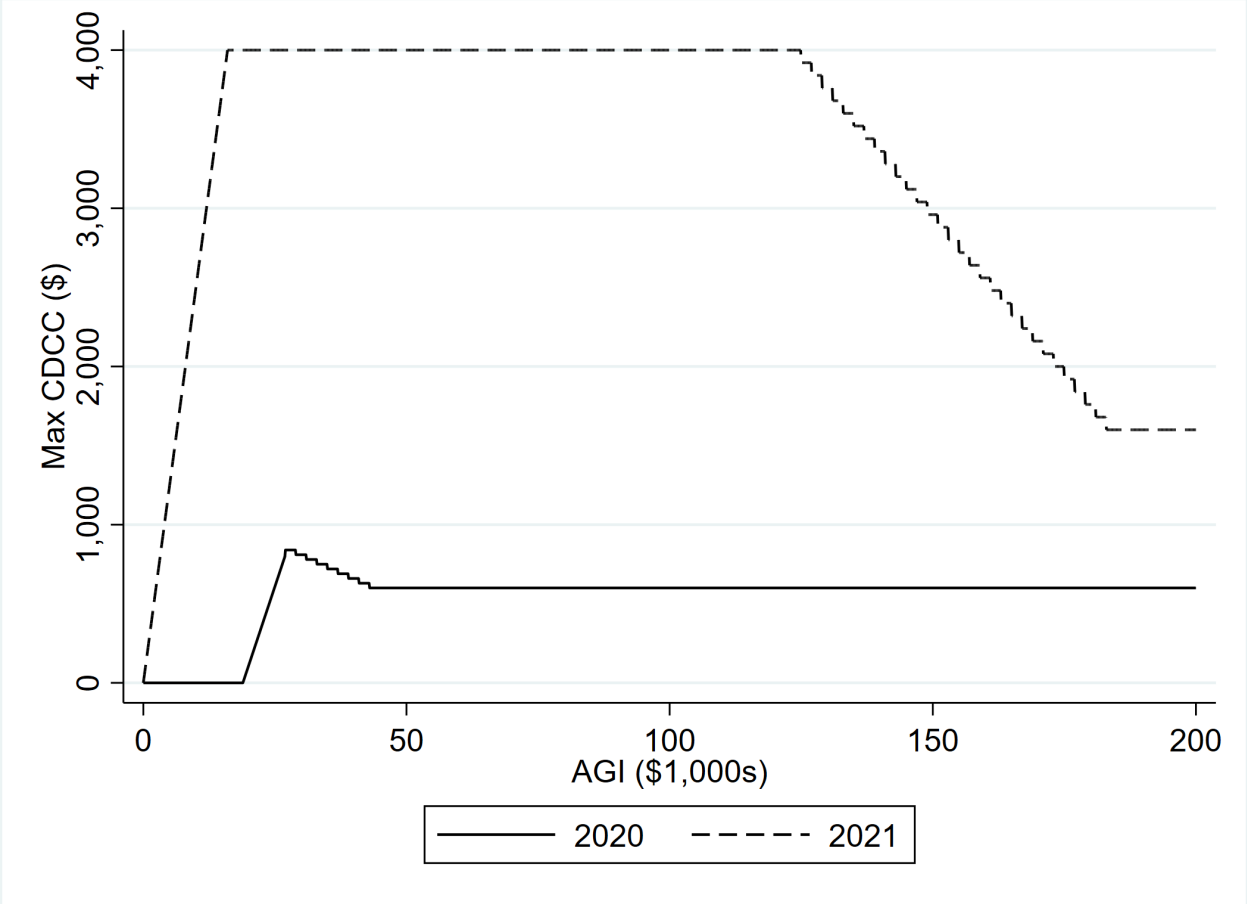
SOURCE: Authors' calculations using Waves 2010–2018 of the HRS, federal tax forms, and TAXSIM.
NOTE: Share and characteristics of spousal caregivers who are or would become eligible for the federal CDCC under policy reforms to current tax law, among those aged 51–65 with nonworking spouse qualifying individuals. "Current" denotes eligibility under existing policy, "Refundable" denotes eligibility if the CDCC were made refundable, and "Refundable & no earnings" denotes eligibility if the CDCC were made refundable and the earnings requirement were lifted. "More than HS" indicates whether the respondent has more than a high school education. "Child under 13 in HH" and "Child under 18 in HH" denote the presence of a child younger than 13 and 18 years old, respectively, in the household. "Multiple ADLs" indicates that the qualifying individual has difficulty with more than one activity of daily living. Standard deviations are listed in parentheses. Asterisks denote statistical significance at the 1% (***), 5% (**), and 10% (*) levels. Statistical significance is relevant to current law.

Table 4: Annual Number of Households Potentially Eligible for the CDCC under Reforms

	Current	Refundable	Refundable & no earnings
Child age 13-17	75,808	229,483	379,527
Child age 18+	108,221	383,402	896,664
Spouse	1,609,431	3,046,690	9,876,146
Parent	276,364	885,946	1,326,585
Other relative	41,928	231,671	429,076
Multiple types of qualifying individuals	78,319	232,159	1,022,154
N	2,023	4,770	14,526

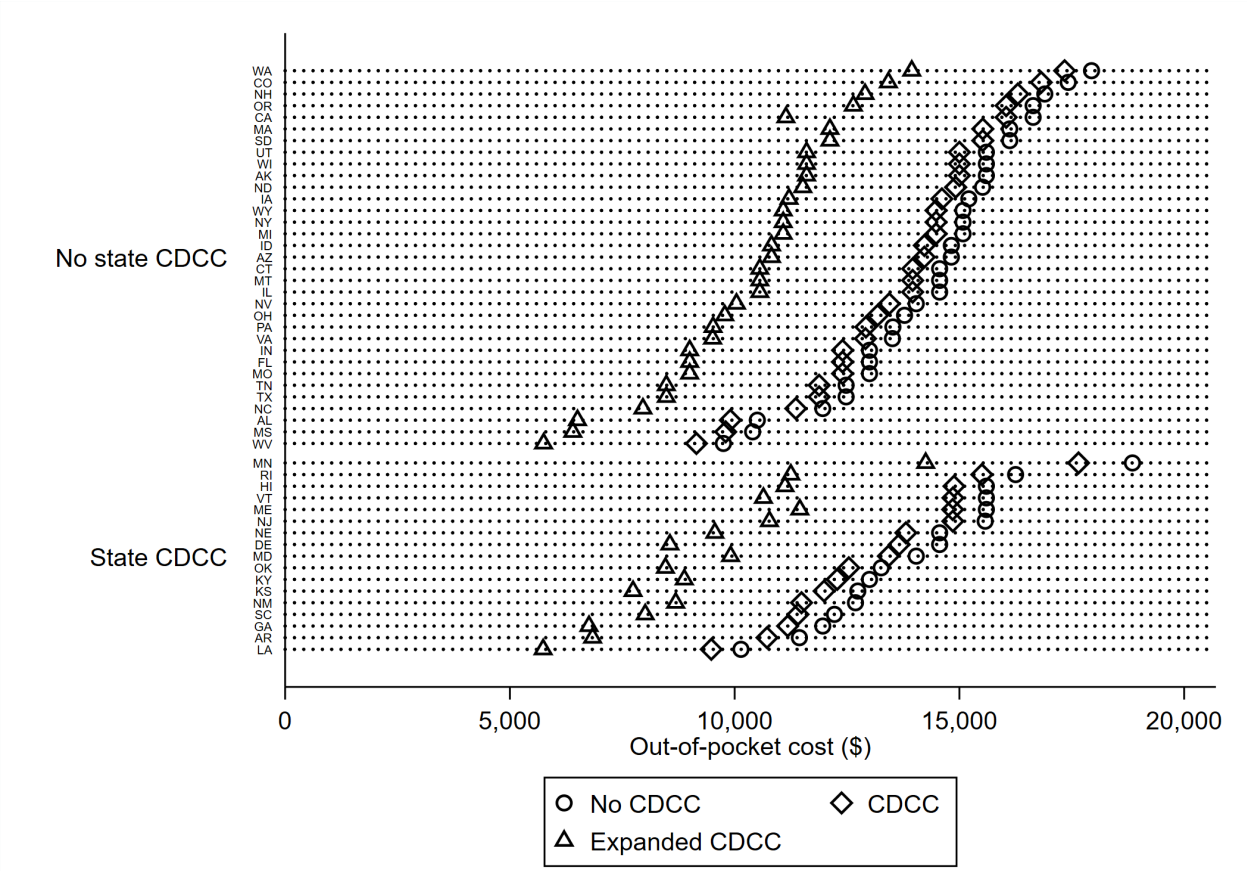
SOURCE: Authors' calculations using the 2014, 2018, 2019, and 2020 SIPP panels with household weights and TAXSIM.
NOTE: Annual number of households that would be eligible for the CDCC if they had positive qualifying expenditures and their care recipients met the dependent requirements under policy reforms to current tax law, by type of qualifying individual. "Current" denotes potential eligibility under existing policy, "Refundable" denotes potential eligibility if the CDCC were made refundable, and "Refundable & no earnings" denotes potential eligibility if the CDCC were made refundable and the earnings requirement were lifted.

Figure 1: Maximum Federal CDCC Benefits by AGI



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

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



SOURCE: Authors' calculations using Genworth median cost-of-care data.
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.

Appendix A Additional Institutional Details

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.[1] 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 and 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 unforeseen 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.[2]

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 $50,000 for single filers or $100,000 for joint filers. Unlike with the CDCC, work is not required for eligibility, and the care recipient does not need to be coresident.

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,

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

[2] 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.

spouse, or parent who has a serious health condition.[3] To be eligible for leave, employees must have worked at their firm for at least 12 months and accumulated at least 1,250 work hours. While the U.S. does not mandate paid family leave, in recent years, thirteen states and several municipalities have implemented their own paid leave mandates. In these areas, workers who meet a given work history requirement receive partial wage replacement up to a maximum weekly benefit. Some, but not all, 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.[4]

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 an 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.[5]

Finally, there are caregiving supports for targeted groups. For instance, in addition to free medical care, the U.S. Department of Veterans Affairs 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, several federal programs support children and adults with disabilities, and benefits can be used to pay for care needs (Rennane 2020). For example, 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. As with the CDCC, some states supplement the federal SSI program with their own state benefits. Similarly, Social Security Disability Insurance (SSDI) is a federal social insurance program for adults under the age of 65 with a work-limiting disability. To qualify, an individual must have a sufficient work history, and benefits are calculated as a share of previous wages.

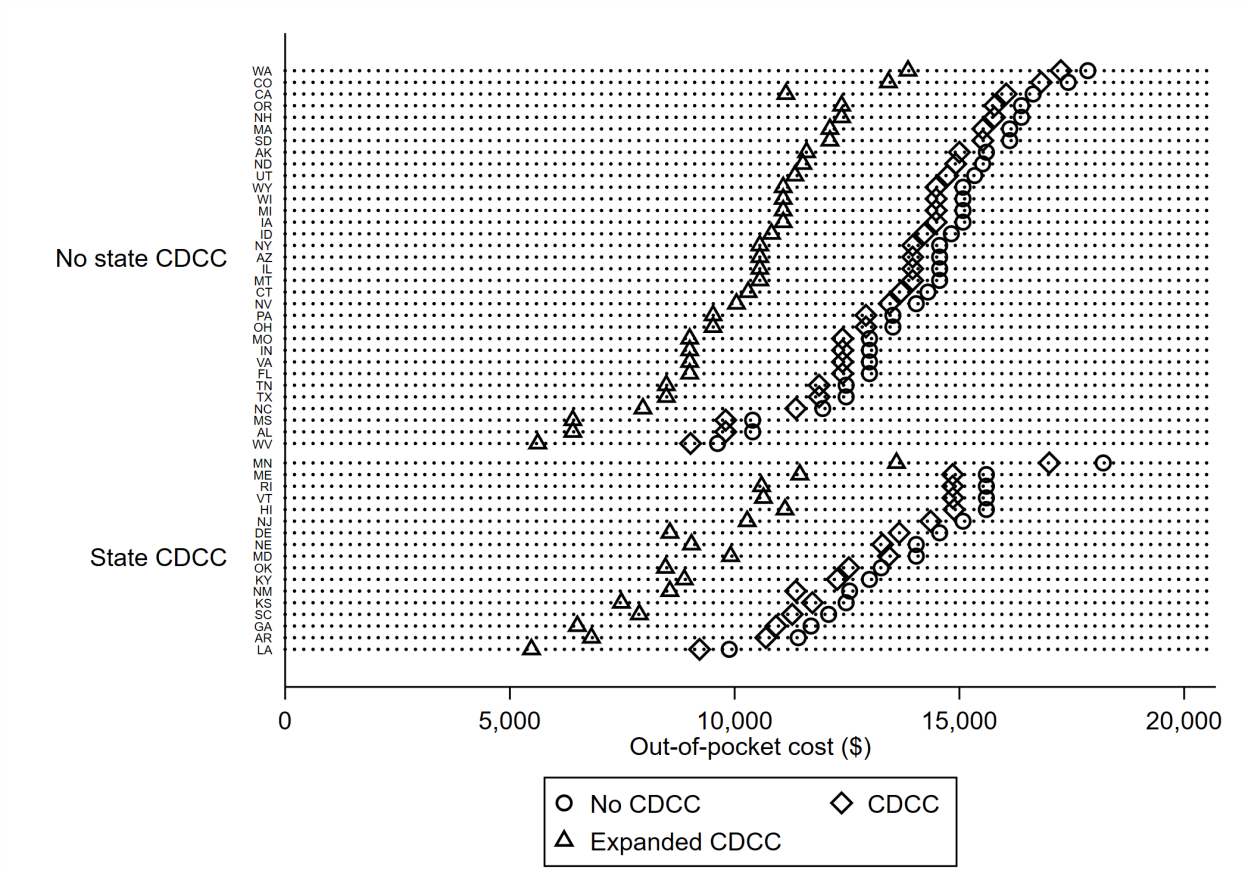
[3]Employers with at least 50 employees within 75 miles of the worksite for at least 20 weeks of the last year must offer 12 weeks of unpaid leave, though some states have lower firm size thresholds or require longer leave lengths. Employers may refuse job protection for their highest-paid 10 percent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

[4]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.

[5]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.

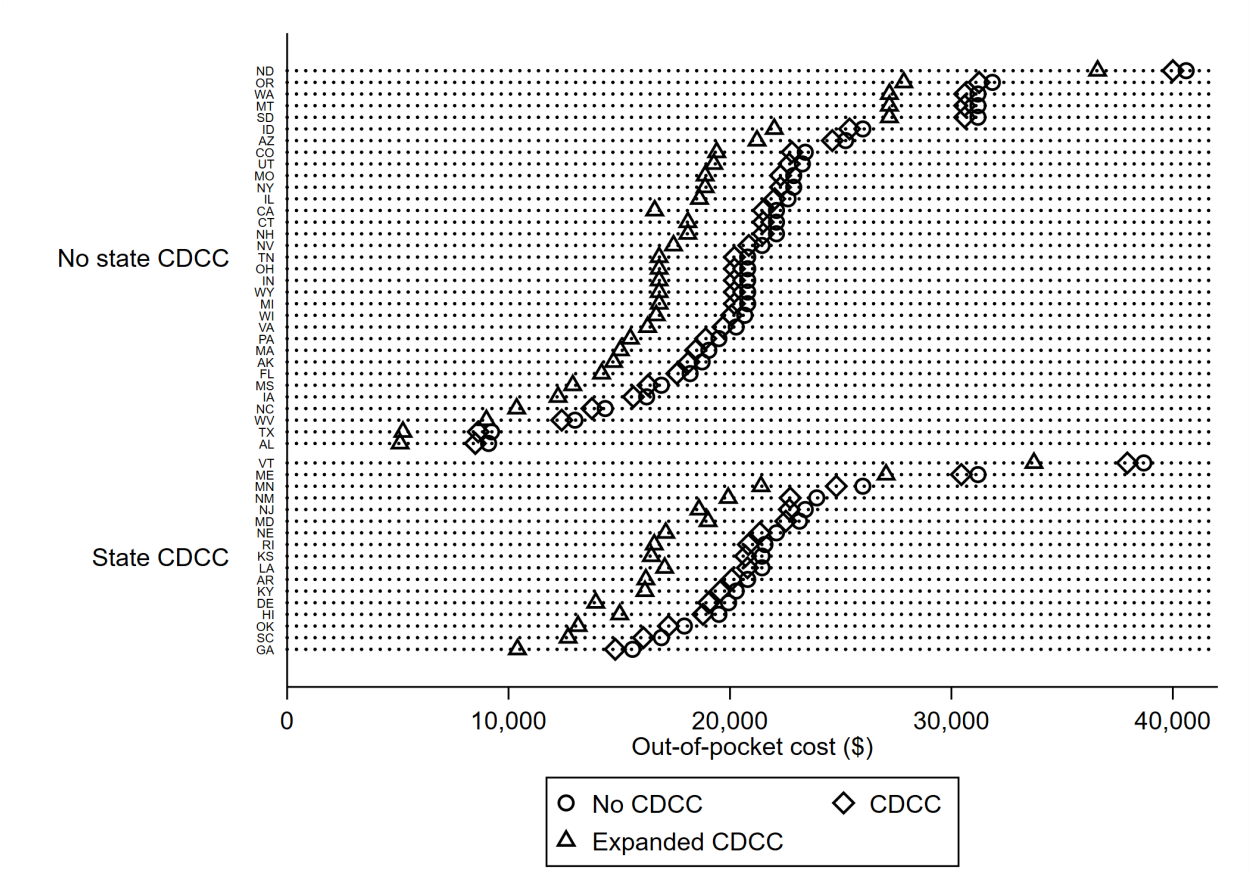
Appendix B Figures and Tables

Figure A.1: Out-of-Pocket Homemaker Services Costs by State



SOURCE: Authors' calculations using Genworth median cost-of-care data.
NOTE: Out-of-pocket costs of 10 hours per week of homemaker services 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.

Figure A.2: Out-of-Pocket Adult Day Health Care Services Costs by State



SOURCE: Authors' calculations using Genworth median cost-of-care data.
NOTE: Out-of-pocket costs of 10 hours per week of adult day health care 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.

Table A.1 Qualifying Spouse Health and Long-Term Care Spending

	Education		Race/Ethnicity			Dementia		ADL Limitations	
	HS +	HS or less	Black	White	Hispanic	Yes	No	<2	2+
Respondent Characteristics									
Age	59.0	59.1	58.5	59.1	59.2	59.3	59.0	59.3	58.8
	(3.9)	(3.9)	(4.1)	(3.9)	(3.9)	(4.0)	(3.9)	(3.9)	(3.9)
Female	0.573	0.507	0.549	0.547	0.508	0.692	0.514	0.536	0.536
	(0.495)	(0.500)	(0.498)	(0.498)	(0.500)	(0.462)	(0.500)	(0.499)	(0.499)
HH Income (%)	67,801	39,312	39,951	60,285	31,576	45,702	52,534	56,671	47,186
	(67,467)	(44,699)	(36,734)	(60,761)	(52,852)	(60,734)	(56,975)	(68,608)	(44,729)
SSDI	0.117	0.185	0.231	0.16	0.056	0.177	0.152	0.15	0.161
	(0.321)	(0.388)	(0.422)	(0.367)	(0.231)	(0.382)	(0.359)	(0.357)	(0.367)
Spouse characteristics									
Age	59.9	60.0	59.5	60.2	60.2	61.9	59.7	60.5	59.5
	(8.0)	(7.3)	(7.6)	(7.7)	(7.4)	(9.1)	(7.4)	(7.8)	(7.5)
Multiple ADLs	0.516	0.534	0.537	0.519	0.53	0.346	0.551	0	1
	(0.500)	(0.499)	(0.499)	(0.500)	(0.499)	(0.476)	(0.497)	(0.000)	(0.000)
Dementia	0.102	0.142	0.202	0.089	0.192	1	0	0.172	0.082
	(0.302)	(0.349)	(0.402)	(0.284)	(0.394)	(0.000)	(0.000)	(0.377)	(0.274)
Medicare	0.532	0.547	0.552	0.565	0.419	0.666	0.522	0.531	0.548
	(0.499)	(0.498)	(0.498)	(0.496)	(0.494)	(0.472)	(0.500)	(0.499)	(0.498)
Medicaid	0.167	0.299	0.376	0.164	0.392	0.285	0.235	0.221	0.26
	(0.373)	(0.458)	(0.485)	(0.371)	(0.489)	(0.452)	(0.424)	(0.415)	(0.439)
VA health insurance	0.092	0.049	0.123	0.072	0.02	0.037	0.072	0.058	0.077
	(0.289)	(0.216)	(0.329)	(0.258)	(0.140)	(0.188)	(0.259)	(0.233)	(0.266)
SSDI	0.369	0.402	0.472	0.412	0.193	0.379	0.389	0.347	0.425
	(0.483)	(0.491)	(0.500)	(0.492)	(0.395)	(0.486)	(0.488)	(0.476)	(0.494)
Have LTC insurance	0.103	0.056	0.088	0.084	0.039	0.07	0.077	0.075	0.077
	(0.305)	(0.229)	(0.283)	(0.277)	(0.194)	(0.255)	(0.267)	(0.264)	(0.267)
Use LTC insurance	0.027	0.01	0.009	0.021	0.007	0.022	0.017	0.012	0.021
	(0.162)	(0.098)	(0.096)	(0.143)	(0.083)	(0.146)	(0.127)	(0.111)	(0.145)
Receive help with ADLs	0.628	0.649	0.468	0.808	0.636	0.655	0.646	0.642	0.659
	(0.484)	(0.477)	(0.499)	(0.394)	(0.481)	(0.475)	(0.479)	(0.480)	(0.474)
Unpaid help	0.601	0.642	0.460	0.797	0.621	0.650	0.643	0.628	0.657
	(0.490)	(0.479)	(0.499)	(0.402)	(0.485)	(0.477)	(0.479)	(0.484)	(0.475)
Paid help	0.067	0.047	0.011	0.083	0.056	0.044	0.050	0.043	0.030
	(0.251)	(0.211)	(0.105)	(0.277)	(0.230)	(0.205)	(0.218)	(0.202)	(0.170)
Need care, cannot afford	0.181	0.233	0.263	0.189	0.246	0.195	0.213	0.19	0.229
	(0.385)	(0.423)	(0.441)	(0.392)	(0.431)	(0.397)	(0.409)	(0.392)	(0.421)
Spouse out-of-pocket spending									
Any health care spending	0.801	0.732	0.662	0.829	0.621	0.745	0.765	0.788	0.739
	(0.399)	(0.443)	(0.474)	(0.377)	(0.485)	(0.437)	(0.424)	(0.409)	(0.439)
Amount (conditional $)	5647	3866	3936	5353	2579	3709	4772	3961	5251
	(10,981)	(11,302)	(9,986)	(12,375)	(6,728)	(9,740)	(11,382)	(8,578)	(13,088)
Any CDCC-eligible spending	0.357	0.269	0.248	0.348	0.178	0.222	0.32	0.242	0.367
	(0.479)	(0.444)	(0.432)	(0.477)	(0.383)	(0.416)	(0.466)	(0.428)	(0.482)
Amount (conditional $)	2161	1207	1486	1817	767	2093	1649	1208	1975
	(6,061)	(2,889)	(4,619)	(5,059)	(1,104)	(2,714)	(4,940)	(3,252)	(5,477)
N	1,026	1,721	708	1,157	716	436	2,312	1,297	1,451
Weighted *N* (across 5 waves)	5,732,736	7,461,439	1,803,669	8,243,653	2,146,246	1,642,912	11,553,751	6,257,838	6,938,825

SOURCE: Waves 2010–2018 of the HRS using individual sample weights.
NOTE: Characteristics of respondents aged 51–65 with nonworking spouse qualifying individuals, by the qualifying individual's disability status and the respondent's education and race. Column 1 includes respondents who work for pay, and column 2 includes respondents who do not work for pay. "HH income ($)" is annual household income from the previous year. "Multiple ADLs" and "Receive help with ADLs" indicate whether the qualifying individual has difficulty with more than one activity of daily living and receives help with activities of daily living, respectively. "VA health insurance," "SSDI," "Have LTC insurance," and "Use LTC insurance" indicate whether the qualifying individual has or uses Veterans Affairs health insurance, Social Security Disability Income, and long-term care insurance, respectively. "CDCC-eligible spending" includes spending that may constitute CDCC qualifying expenditures. Standard deviations are listed in parentheses.

Table A.2: Simulations of CDCC Reforms by Race

	White			Black			Hispanic		
		Newly-eligible households			Newly-eligible households			Newly-eligible households	
	Current	Refundable	Refundable & no earnings	Current	Refundable	Refundable & no earnings	Current	Refundable	Refundable & no earnings
Share of spousal caregivers	0.139	0.091	0.208	0.058	0.090	0.167	0.023	0.051	0.143
Age	57.580	57.863	58.718***	57.365	56.797	57.912	56.913	57.998	59.066
	(0.2941)	(0.4275)	(0.2713)	(0.7133)	(0.7486)	(0.5357)	(1.4716)	(0.8478)	(0.4726)
Female	0.462	0.455	0.513	0.453	0.370	0.384	0.545	0.449	0.512
	(0.0409)	(0.0475)	(0.0311)	(0.1040)	(0.0867)	(0.0553)	(0.1638)	(0.1146)	(0.0703)
More than HS	0.698	0.565**	0.541***	0.537	0.301*	0.307**	0.691	0.209***	0.300***
	(0.0378)	(0.0471)	(0.0309)	(0.1051)	(0.0800)	(0.0511)	(0.1271)	(0.0730)	(0.0626)
Child under 13 in HH	0.010	0.009	0.028	0.042	0.128	0.093	0	0.012	0.019*
	(0.0093)	(0.0090)	(0.0121)	(0.0314)	(0.0655)	(0.0374)		(0.0119)	(0.0102)
Child under 18 in HH	0.031	0.062	0.085**	0.065	0.196	0.151	0	0.075	0.090***
	(0.0127)	(0.0255)	(0.0202)	(0.0387)	(0.0717)	(0.0417)		(0.0505)	(0.0296)
AGI ($)	117,541	32,170***	23,698***	104,408	30,245***	20,636***	117,531	28,401***	20,598***
	(6,910)	(1,810)	(1,868)	(7,876)	(3,141)	(2,448)	(13,127)	(3,011)	(3,524)
Multiple ADLs	0.464	0.595**	0.578**	0.616	0.584	0.622	0.305	0.703**	0.603*
	(0.0411)	(0.0469)	(0.0304)	(0.0970)	(0.0867)	(0.0576)	(0.1454)	(0.0884)	(0.0690)
Dementia	0.013	0.053*	0.091***	0.021	0.082	0.121**	0.006	0.047*	0.128**
	(0.0082)	(0.0191)	(0.0181)	(0.0179)	(0.0546)	(0.0416)	(0.0070)	(0.0225)	(0.0491)
N	202	164	385	54	75	178	20	46	145
Weighted N (across 5 waves)	1,570,776	1,034,482	2,358,432	136,468	212,547	394,792	65,803	147,841	410,244

SOURCE: Authors' calculations using Waves 2010-2018 of the HRS, federal tax forms, and TAXSIM.

NOTE: Share and characteristics of spousal caregivers who are or would become eligible for the federal CDCC under policy reforms to current tax law, among those aged 51–65 with nonworking spouse qualifying individuals, by race. "Current" denotes eligibility under existing policy, "Refundable" denotes eligibility if the CDCC were made refundable, and "Refundable & no earnings" denotes eligibility if the CDCC were made refundable and the earnings requirement were lifted. "More than HS" indicates whether the respondent has more than a high school education. "Child under 13 in HH" and "Child under 18 in HH" denote the presence of a child younger than 13 and 18 years old, respectively, in the household. "Multiple ADLs" indicates that the qualifying individual has difficulty with more than one activity of daily living. Standard deviations are listed in parentheses. Asterisks denote statistical significance at the 1% (***), 5% (**), and 10% (*) levels. Statistical significance is relevant to current law within the given racial group.

Table A.3: Simulations of CDCC Reforms by Education

	More than HS			HS or less		
		Newly-eligible households			Newly-eligible households	
	Current	Refundable	Refundable & no earnings	Current	Refundable	Refundable & no earnings
Share of spousal caregivers	0.152	0.095	0.206	0.059	0.079	0.190
Age	57.892	57.785	58.842**	56.748	57.648	58.538***
	(0.3395)	(0.4999)	(0.3190)	(0.4015)	(0.4444)	(0.2959)
Female	0.450	0.479	0.514	0.476	0.406	0.464
	(0.0449)	(0.0555)	(0.0368)	(0.0658)	(0.0512)	(0.0338)
White	0.890	0.757***	0.766***	0.830	0.588***	0.590***
	(0.0223)	(0.0456)	(0.0293)	(0.0417)	(0.0505)	(0.0333)
Black	0.059	0.083	0.073	0.111	0.194	0.149
	(0.0132)	(0.0260)	(0.0142)	(0.0382)	(0.0366)	(0.0199)
Hispanic	0.037	0.040	0.074	0.036	0.153***	0.156***
	(0.0164)	(0.0138)	(0.0174)	(0.0134)	(0.0384)	(0.0246)
Child under 13 in HH	0.018	0.036	0.029	0	0.014	0.039***
	(0.0122)	(0.0197)	(0.0129)		(0.0116)	(0.0141)
Child under 18 in HH	0.042	0.107*	0.096**	0.010	0.060*	0.087***
	(0.0161)	(0.0340)	(0.0211)	(0.0095)	(0.0261)	(0.0220)
AGI ($)	123,147	32,234***	26,192***	103,558	31,119***	19,529***
	(8,031)	(2,064)	(2,067)	(8,439)	(1,885)	(1,912)
Multiple ADLs	0.480	0.580	0.581*	0.429	0.635**	0.593**
	(0.0453)	(0.0548)	(0.0361)	(0.0660)	(0.0492)	(0.0334)
Dementia	0.017	0.068*	0.108***	0.006	0.056**	0.095***
	(0.0105)	(0.0261)	(0.0238)	(0.0046)	(0.0227)	(0.0201)
N	188	141	322	98	165	434
Weighted N (across 5 waves)	1,232,893	771,728	1,665,354	570,612	766,395	1,836,368

SOURCE: Authors' calculations using Waves 2010-2018 of the HRS, federal tax forms, and TAXSIM.

NOTE: Share and characteristics of spousal caregivers who are or would become eligible for the federal CDCC under policy reforms to current tax law, among those aged 51–65 with nonworking spouse qualifying individuals, by whether the spousal caregiver has more than a high school degree. "More than HS" indicates that the respondent has more than a high school degree, and "HS or less" indicates that the respondent has a high school degree or less. "Current" denotes eligibility under existing policy, "Refundable" denotes eligibility if the CDCC were made refundable, and "Refundable & no earnings" denotes eligibility if the CDCC were made refundable and the earnings requirement were lifted. "Child under 13 in HH" and "Child under 18 in HH" denote the presence of a child younger than 13 and 18 years old, respectively, in the household. "Multiple ADLs" indicates that the qualifying individual has difficulty with more than one activity of daily living. Standard deviations are listed in parentheses. Asterisks denote statistical significance at the 1% (***), 5% (**), and 10% (*) levels. Statistical significance is relevant to current law within the given education group.

Table A.4: Simulations of CDCC Reforms by Level of Disability

	Needs help with 2+ ADLs			Does not need help with 2+ ADLs		
		Newly-eligible households			Newly-eligible households	
	Current	Refundable	Refundable & no earnings	Current	Refundable	Refundable & no earnings
Share of spousal caregivers	0.101	0.113	0.249	0.102	0.064	0.152
Age	57.974	57.736	58.417	57.146	57.687	59.061***
	(0.3865)	(0.4139)	(0.2658)	(0.3634)	(0.5616)	(0.3599)
Female	0.431	0.484	0.502	0.483	0.378	0.467
	(0.0533)	(0.0493)	(0.0328)	(0.0517)	(0.0577)	(0.0383)
White	0.872	0.658***	0.663***	0.870	0.694***	0.688***
	(0.0292)	(0.0457)	(0.0298)	(0.0280)	(0.0522)	(0.0358)
Black	0.100	0.133	0.119	0.054	0.147**	0.103*
	(0.0265)	(0.0269)	(0.0157)	(0.0167)	(0.0398)	(0.0206)
Hispanic	0.024	0.111**	0.120***	0.047	0.073	0.113**
	(0.0125)	(0.0314)	(0.0204)	(0.0196)	(0.0216)	(0.0239)
More than HS	0.708	0.479***	0.470***	0.663	0.537*	0.483***
	(0.0506)	(0.0493)	(0.0328)	(0.0477)	(0.0593)	(0.0385)
Child under 13 in HH	0.008	0.014	0.035**	0.016	0.042	0.033
	(0.0053)	(0.0104)	(0.0120)	(0.0149)	(0.0243)	(0.0158)
Child under 18 in HH	0.030	0.060	0.077**	0.034	0.120*	0.112**
	(0.0126)	(0.0198)	(0.0186)	(0.0183)	(0.0444)	(0.0257)
AGI ($)	101,698	31,498***	19,810***	130,138	31,958***	26,806***
	(5,645)	(1,629)	(1,400)	(10,140)	(2,512)	(2,720)
Dementia	0.023	0.070	0.123***	0.005	0.049**	0.070***
	(0.0153)	(0.0249)	(0.0223)	(0.0030)	(0.0212)	(0.0197)
N	140	189	457	146	117	299
Weighted N (across 5 waves)	836,357	934,563	2,056,163	967,148	603,560	1,445,559

SOURCE: Authors' calculations using Waves 2010-2018 of the HRS, federal tax forms, and TAXSIM.

NOTE: Share and characteristics of spousal caregivers who are or would become eligible for the federal CDCC under policy reforms to current tax law, among those aged 51–65 with nonworking spouse qualifying individuals, by whether the qualifying individual requires assistance with at least two activities of daily living. "Current" denotes eligibility under existing policy, "Refundable" denotes eligibility if the CDCC were made refundable, and "Refundable & no earnings" denotes eligibility if the CDCC were made refundable and the earnings requirement were lifted. "More than HS" indicates whether the respondent has more than a high school education. "Child under 13 in HH" and "Child under 18 in HH" denote the presence of a child younger than 13 and 18 years old, respectively, in the household. "Multiple ADLs" indicates that the qualifying individual has difficulty with more than one activity of daily living. Standard deviations are listed in parentheses. Asterisks denote statistical significance at the 1% (***), 5% (**), and 10% (*) levels. Statistical significance is relevant to current law within the given disability group.

Table A.5: Simulations of CDCC Reforms among Parental Caregivers

		Newly-eligible households				
	Current	Refundable	Refundable & no earnings	No coresidency	Refundable & no coresidency	Refundable, no earnings, & no coresidency
Share of parental caregivers	0.012	0.007	0.031	0.410	0.521	0.988
Age	56.909	57.300	57.526	56.197*	56.178*	56.731
	(0.3818)	(0.5076)	(0.2492)	(0.0699)	(0.0614)	(0.0462)
Female	0.726	0.676	0.644	0.529***	0.539***	0.541***
	(0.0510)	(0.0555)	(0.0295)	(0.0096)	(0.0083)	(0.0059)
White	0.695	0.530**	0.540***	0.831***	0.788**	0.742
	(0.0436)	(0.0602)	(0.0306)	(0.0062)	(0.0060)	(0.0046)
Black	0.125	0.148	0.170	0.061***	0.073**	0.082*
	(0.0236)	(0.0315)	(0.0197)	(0.0030)	(0.0030)	(0.0023)
Hispanic	0.118	0.291***	0.218***	0.048**	0.078	0.111
	(0.0287)	(0.0565)	(0.0255)	(0.0031)	(0.0036)	(0.0031)
More than HS	0.845	0.606***	0.624***	0.752**	0.715***	0.665***
	(0.0357)	(0.0569)	(0.0292)	(0.0082)	(0.0073)	(0.0054)
Child under 13 in HH	0.004	0.011	0.028**	0.039***	0.046***	0.048***
	(0.0034)	(0.0060)	(0.0096)	(0.0039)	(0.0037)	(0.0026)
Child under 18 in HH	0.141	0.103	0.081	0.147	0.161	0.151
	(0.0419)	(0.0342)	(0.0169)	(0.0071)	(0.0063)	(0.0044)
AGI ($)	116,564	21,317***	23,887***	141,084**	117,399	87,612***
	(10,293)	(1,761)	(2,665)	(2,138)	(1,858)	(1,483)
Dementia	0.356	0.414	0.3978	0.257**	0.262*	0.283
	(0.0492)	(0.0609)	(0.0296)	(0.0084)	(0.0073)	(0.0053)
N	194	133	565	4,647	6,438	13,344
Weighted N (across 5 waves)	950,380	504,358	2,393,772	31,704,190	40,263,104	76,314,912

SOURCE: Authors' calculations using Waves 2010–2018 of the HRS, federal tax forms, and TAXSIM.

NOTE: Share and characteristics of parental caregivers who are or would become eligible for the federal CDCC under policy reforms to current tax law, among those aged 51–65 with parent qualifying individuals. We assume that eligible expenditures are positive for all caregivers and that all parents meet the dependent requirements. "Current" denotes eligibility under existing policy, "Refundable" denotes eligibility if the CDCC were made refundable, "Refundable & no earnings" denotes eligibility if the CDCC were made refundable and the earnings requirement were lifted, "No coresidency" denotes eligibility if the coresidency requirement were lifted, "Refundable & no coresidency" denotes eligibility if the CDCC were made refundable and the coresidency requirement were lifted, "Refundable, no earnings, & no coresidency" denotes eligibility if the CDCC were made refundable and the earnings and coresidency requirements were lifted. "More than HS" indicates whether the respondent has more than a high school education. "Child under 13 in HH" and "Child under 18 in HH" denote the presence of a child younger than 13 and 18 years old, respectively, in the household. "Multiple ADLs" indicates that the qualifying individual has difficulty with more than one activity of daily living. Standard deviations are listed in parentheses. Asterisks denote statistical significance at the 1% (***), 5% (**), and 10% (*) levels. Statistical significance is relevant to current law.