

Not Just for Kids—Child and Dependent Care Credit Benefits for Elder Care

Gabrielle Pepin and Yulya Truskinovsky*

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Abstract

A growing number of adults in the United States care for a relative with a long-term illness or disability. Family caregivers provide critical support while incurring substantial private costs, including out of pocket expenses. The Child and Dependent Care Credit (CDCC) allows households to receive tax credits for certain expenses associated with the care of a dependent, defined as a child under 13 or a spouse or other dependent who is incapable of self-care. However, very few childless households claim tax benefits that may be used for elder care. In this paper, we examine the value of the CDCC for qualifying households caring for adults. We first describe CDCC eligibility requirements and benefits across the income distribution and by the relationship of the dependent. We show that potential benefits during 2021 are substantially higher for a coresident dependent parent than for a spouse. We then use data from the Health and Retirement Study to document the size of the population most likely affected by tax credits for elder care, finding that, as of 2016, more than 10 percent of individuals aged 50 to 65 had a coresident spouse or parent in need of assistance with activities of daily living. Using median cost-of-care data, we estimate how state and federal CDCC benefits affect post-tax costs of typical qualifying caregiving services, such as home health aides. We show that the different tax treatment of households with coresident parents and spouses in need of help substantially affects post-tax costs of care. This paper demonstrates the potential benefits of the CDCC for families caring for older adults, highlights important heterogeneity in the value of the credit across family types, and lays the groundwork for future investigations into how to design comprehensive tax credits for older adults and their caregivers.

Keywords: Elder care, Child and Dependent Care Credit, American Rescue Plan Act of 2021

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*Pepin: W.E. Upjohn Institute for Employment Research. Truskinovsky: Wayne State University. We thank Gerrit Anderson and Kane Schrader for excellent research assistance.

I. Introduction

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

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

In this paper, we examine the value of the CDCC for qualifying households caring for adults (primarily spouses and parents of working taxpayers). We first describe CDCC eligibility requirements and maximum benefits across the income distribution as of 2020. We show that households with caregiving responsibilities and between \$8,000 to \$125,000 in adjusted gross income (AGI) could receive up to \$600 in nonrefundable tax benefits during 2020. We then use data from the Health and Retirement Study (HRS) to document the size of the population most likely to be eligible for tax credits for family caregiving. We show that, as of 2016, more than 10 percent of individuals aged 50 to 65 had a coresident spouse or parent in need of assistance with activities of daily living or with dementia. Caregiving responsibilities are negatively associated with household income, though

¹See, for example Coe and Courtney Harold Van Houtven 2009; Skira 2015; Maestas, Truskinovsky, and Messel 2021; Fahle and McGarry 2017; Courtney Harold Van Houtven, Coe, and Skira 2013; Schmitz and Westphal 2017

42 and 62 percent of respondents with coresident parents and spouses, respectively, work.

Next, we illustrate how the American Rescue Plan Act of 2021 temporarily increased CDCC generosity differentially across households with different types of qualifying individuals incapable of self care. In particular, we document that households caring for a coresident non-spouse dependent and \$8,000 to \$125,000 in AGI could receive up to \$4,000 in benefits during 2021, while households with nonworking disabled spouses were only eligible for up to \$1,500 per year in benefits.

Finally, we use median cost-of-care data to document changes in costs of typical caregiving services between 2020 and 2021 and to estimate effects of CDCC benefits on out-of-pocket care costs across states. We first show that median annual care costs increased by 5-15 percent in most states between 2020 and 2021. We then find that while 2020-level CDCC benefits generate small decreases in post-tax costs of care, the 2021 expanded CDCC led to substantial decreases in post-tax care costs, especially for households with non-spouse elderly dependents. In particular, expanded benefits for households with coresident parents decrease the annual out-of-pocket cost of hiring a home health aide for 10 hours per week from between \$12,500 and \$17,500 to less than \$12,500 in most states. The different tax treatment of households with spouse and non-spouse qualifying individuals, however, generates considerable differences in post-tax costs across household types.

II. Institutional Details

A. Long-Term Care and Out-of-Pocket Costs

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

National expenditures for LTSS totaled over \$475 billion in 2020, representing over 14 percent of all health spending (Colello 2022). This number does not take into account the value of unpaid care provided by family, friends and other uncompensated caregivers. A substantial portion of these costs (an estimated 13 percent of LTSS costs, or approximately \$64 billion) is paid for out of pocket because public and private insurance for LTSS 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 18 percent of LTSS spending. Medicaid, the largest public payer of LTSS, accounts for 42 percent of all LTSS spending and has both financial and functional eligibility requirements. Most Medicaid LTSS recipients first pay directly for services, spending down assets until they qualify for benefits (Johnson 2019). Estimated lifetime average out-of-pocket costs for LTSS are \$72,000, or \$140,000 for the 37 percent of LTSS users with positive costs. However, there is a wide distribution of costs, and one in twelve LTSS recipients will spend over \$250,000 out of pocket (Favreault and Dey 2016).

Family caregivers, who provide the majority of LTSS, can take on a significant portion of these out-of-pocket costs, though there is limited evidence on how long-term care expenditures are shared within families (National Academies of Sciences and Medicine 2016). A recent survey found that over three-quarters of family and other unpaid caregivers report out-of-pocket spending related to their caregiving role, and annual (conditional) spending is over \$7,000 (AARP and National Alliance for Caregiving 2021). Out-of-pocket spending on caregiving is concentrated among female, nonwhite, and working-age caregivers, as well as those with more intensive caregiving roles and those caring for dementia patients (AARP and National Alliance for Caregiving 2021). Their expenditures include payments to care facilities and in-home care providers, many of which are qualifying expenditures under the CCDC. In the following sections, we provide institutional details about the CDCC before using survey data to describe the population that could benefit from tax credits for caregiving expenditures.

B. Child and Dependent Care Credit

Congress implemented the federal CDCC in 1976 and expanded it in 1981 and 2001. The latter expansion took effect in 2003, and between 2003 and 2020, households were able to claim up to \$3,000 worth of dependent care expenses per year for each of up to two qualifying individuals. Qualifying individuals include those physically or mentally incapable of self-care who lived with

the taxpayer for more than half of the tax year, such as a disabled spouse or parent. Qualifying expenses include out-of-pocket spending on care both inside and outside of the home, such as fees paid to adult daycare facilities and to attendants assisting dependents with activities of daily living (ADLs). This precludes expenses covered by Medicare, Medicaid, or another health insurer.

Between 2003 and 2020, households with qualifying individuals and expenditures could receive a tax credit worth up to 35 percent of qualifying expenses, or \$1,050 per qualifying individual. Beginning at \$15,000 in AGI, the benefit rate decreased by 1 percentage point for each additional \$2,000 until it remained at 20 percent for those with \$43,000 or more in AGI, who could receive up to \$600 in benefits per qualifying individual. The CDCC, however, was nonrefundable, so taxpayers without positive tax liability after other deductions did not benefit.

Moreover, CDCC claimants had to work to qualify for benefits. In households where each spouse was capable of self-care, this included both spouses among married taxpayers filing jointly. Additionally, if either spouse's earnings were less than dependent care expenditures, then the CDCC was calculated as a percent of the lesser of the two taxpayers' earnings. For households with a spouse incapable of self-care, the CDCC benefit calculation was a bit more complicated. While the IRS allowed these households to receive benefits, even if the disabled spouse did not work, for the purpose of calculating benefits, they imputed the disabled spouse's monthly earnings as the maximum of their actual earnings and \$250.² By construction, the disabled spouse's imputed annual earnings totaled at least \$3,000 per year, the maximum qualifying expenditure amount. Thus, households with spouses incapable of self-care could receive the maximum CDCC benefit. To claim the credit, taxpayers had to list their earnings, dependent care expenditures, and dependent care providers' tax identification or Social Security numbers on federal Form 2441. Benefits decreased taxes due at tax filing time.³

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, only about half of

²For households with two or more qualifying individuals, the IRS imputed the disabled spouse's monthly earnings as the maximum of their actual earnings and \$500.

³Since 1986, some workers have had access to dependent care flexible spending account (FSA) through their employers. 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 annual elder care expenses had set \$2,000 in pretax earnings aside for an FSA, they could claim the remaining \$1,000 in eligible dependent care expenditures for the CDCC.

states offer refundable tax credits, and some limit qualifying expenditures to spending on care for young children, precluding households with adult care responsibilities.

Despite substantial heterogeneity in state tax policies, households with access to state CDCCs benefit from additional tax relief. In Section IV, 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.

III. Who Benefits from Tax Programs for Elder Care?

Relatively few childless households claim the CDCC, suggesting that taxpayers rarely make use of the credit for adult care expenses. In particular, Crandall-Hollick and Boyle (2020) show that, during 2017, fewer than 160,000 households without children younger than 13 years old claimed the CDCC. Consistent with low levels of participation, only two percent of federal CDCC benefits were allocated toward these childless taxpayers in that year. As the CDCC may provide economically meaningful benefits to households with disabled spouses and other elderly dependents, in this section we document the size of the population most likely affected by tax programs for adult care. To do so, we use data from the 2016 wave of the HRS.

The HRS is a nationally-representative, biennial panel survey of about 20,000 individuals aged 50 and older and their spouses. In addition to a broad range of socio-demographic characteristics, we observe whether a respondent has a qualifying coresident spouse or parent who needs help with ADLs, such as eating, bathing, and getting dressed, or has memory or cognitive limitations due to Alzheimer’s disease or related dementia (ADRD). We also observe each respondent’s current employment status and annual earnings and household income as of 2015. Finally, the HRS collects information about health insurance and health care spending, including a detailed breakdown of out of pocket (OOP) spending on a range of health-related expenses.

To identify the population most likely affected by tax benefits for adult care, we limit the sample to about 10,500 respondents aged 50 to 65. Table 1 displays summary statistics by the presence of a coresident spouse or parent who would be a qualifying person from the perspective of the CDCC. We identify an HRS respondent with a qualifying coresident parent if the HRS respondent coresides with a parent and reports the parent needs help with basic personal needs like dressing, eating or bathing or cannot be left alone for an hour or more. We identify an HRS respondent with a qualifying coresident spouse if the HRS respondent has a coresident spouse who reports difficulty with at least one ADL 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).⁴

Table 1 shows that 0.9 percent of HRS respondents, representative of just over 450,000 individuals aged 50-65, live with a qualifying parent (column 1) and 9.3 percent, representative of just over 5 million individuals, live with a qualifying spouse (column 2). Column 3 presents results for the remaining respondents aged 50-65 without a coresident qualifying adult. Respondents in each column are similar in age, but other demographic characteristics vary substantially across caregiving needs. Respondents with qualifying coresident parents are considerably more likely to be female (78%) and Hispanic (30%) and less likely to be married than those in the other two groups. Only 45 percent of respondents with a qualifying spouse have college degrees, while 63 percent of respondents with qualifying coresident parents or without qualifying coresident family members are college-educated. Turning to labor market outcomes, some 62 percent of respondents with qualifying coresident spouses and 42 percent of respondents with qualifying coresident parents combine work and caregiving. This compares to a 68 percent employment rate among similar individuals without caregiving responsibilities. Average household incomes total \$60,000 for respondents with qualifying coresident parents, \$67,000 for respondents with qualifying coresident spouses, and \$107,000 for the remaining respondents.

Next, to study household caregiving expenditures and CDCC eligibility, we focus on the HRS respondents in Table 1 with qualifying coresident spouses. (The HRS does not contain information on caregiving expenditures or public health insurance coverage for coresident parents.) Because taxpayers must work to claim the CDCC, Table 2 describes respondents' qualifying expenditures on health and long term care for spouses by whether the respondent works.⁵ Beyond spending on health insurance premiums and prescription drug costs, the HRS survey asks about three categories of health-related spending that may qualify for CDCC: spending on home health care, including "professional nurses, visiting nurse's aides, physical or occupational therapists, chemotherapists, respiratory oxygen therapists, and hospice caregivers"; 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 other medical expenses not covered by insurance, including "medications, special food, equipment such as a special bed or chair, visits by health professionals, or

⁴We rely on HRS respondents' reports of parent health, but self reports for spousal health, as HRS surveys both spouses in a household. In cases when the spouse cannot respond to the survey, we use proxy respondent reports.

⁵We further restrict the sample to respondents whose qualifying spouses who do not work, in order to most accurately identify the subset of HRS respondents who might qualify for the CCDC.

other costs.”

The sample of just under 600 HRS respondents aged 50-65 with qualifying coresident spouses represent over 2.8 million adults, and nearly half of this sample works for pay (Table 2, column 1). While rates of spousal physical care needs (as measured by number of reported ADL difficulties) are very similar across household types, HRS respondents who do not work (Table 2, column 2) are more likely to have a spouse with ADRD (8.9% vs. 12.9%). HRS respondents who do not work are also more likely to have a spouse receiving Medicaid (21.6% vs. 41.0%) but less likely to have and use long term care insurance (7.9 % vs. 3.3% having, 3.2% vs. 0.6% using), suggesting substantial differences in how these households pay for care. Notably, approximately one out of five qualifying spouses in both categories report having forgone care because of costs, though qualifying spouses of working HRS respondents do so to a slightly lesser extent.

The qualifying spouses of both working and non-working HRS respondents report substantial OOP expenditures, but Table 2 shows that these costs are higher among spouses of working respondents.⁶ Three-quarters of qualifying spouses of HRS respondents have OOP health care costs, spending over \$5,000 over two years on average compared with 56 percent of qualifying spouses of non-working HRS respondents whose two-year average spending sums to \$2,750. With the exception of home health care, qualified spouses of working HRS respondents are also more likely have OOP expenditures for health-related spending that would qualify for the CDCC, as defined in the previous section. Notably, the qualifying spouses of working HRS respondents are three times more likely to spend out of pocket on other health services, which include adult care centers and transportation for the elderly or disabled, and their conditional spending in this category is more than twice as high as that of the qualifying spouses of non-working HRS respondents. Conditional on having any CDCC-qualifying health-related spending, households with a working HRS respondent spend an average of \$1,800 over two years, compared with just under \$1,300 for households with a non-working HRS respondent.

Tables 1 and 2 imply that a substantial proportion of adults between the ages of 50 and 65 care for a coresident family member and that caregiving responsibilities are negatively associated with household income. Although CDCC benefits may provide additional income to many households with caregiving responsibilities, others may be ineligible for the tax credit because the primary taxpayer—or their spouse if caring for a parent—does not work. Nonetheless, Tables 1 and 2 suggest that many family caregivers combine work and caregiving.

⁶We rely on the RAND detailed imputation files for detailed medical expenditures.

IV. CDCC Benefits under the 2021 Temporary Expansion

In light of an increased need for caregiving during the COVID-19 pandemic, the American Rescue Plan Act of 2021 (ARP) temporarily expanded the CDCC and made it fully refundable. 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. However, ARP did not increase the earnings imputation for spouses incapable of self-care. As illustrated in Figure 1, this generates a difference in maximum benefits for households with a nonworking coresident parent, compared to those with a nonworking disabled spouse.

Specifically, the blue line in Figure 1 documents maximum federal CDCC benefits by federal AGI for households with a nonworking coresident parent or other non-spouse dependent and no other qualifying individuals as of 2021.⁷ The figure shows that maximum benefits increase considerably relative to 2020 benefit levels (green line), which peak at just \$840 for those with around \$30,000 in AGI.⁸ In contrast, in 2021, benefits for households with coresident parents increase with income at low income levels, where benefits are a function of earnings. As expected, benefits peak at \$4,000 for taxpayers with \$8,000 to \$125,000 in AGI. Benefits then begin phase out so that those with \$183,000 or more in AGI receive \$1,600 in CDCC benefits. The red line in Figure 1 documents maximum benefits for otherwise similar households in which the qualifying individual is a nonworking disabled spouse. Maximum benefit levels are much lower for these households, though still more generous than they were under the 2020 CDCC. As with households with coresident parents, benefits increase with income at low income levels. Benefits peak, however, at only \$1,500 beginning at \$3,000 in AGI. When benefits begin to phase out at \$125,000, they decrease to just \$600 among the highest-income households. In the next section, we consider how the different benefit amounts generated by the CDCC expansions impacted OOP caregiving costs during 2021.

⁷Among 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.

⁸The figure displays maximum 2020 CDCC benefit after accounting for the nonrefundability of the 2020 credit.

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

In this section, we first document changes in costs of typical caregiving services between 2020 and 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 Genworth, which contacted nearly 60,000 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 during 2020 and nearly 70,000 providers during 2021. Interviews were conducted during July-August 2020 and June-November 2021.⁹ Hence, we can compare costs of care during the early months of the pandemic to those after vaccines were widely available within the United States. Given increased inflation rates and shortages of home health care staff experienced during 2021, we expect increases in caregiving costs across the two survey waves.¹⁰

In Panel A of Figure 2, we use the Genworth data to document median annual pre-tax costs of hiring a home health aide for 10 hours per week during 2021 across states.¹¹ Median annual costs vary substantially across states, from \$9,750 in Wyoming to \$18,850 in Minnesota. In most states, median annual costs range between \$12,500 and \$17,500. Based on results from Table 1, this constitutes about 20 percent of household income among individuals aged 50-65 with a coresident spouse in need of help and about 25 percent of household income among similar individuals with a coresident parent in need of help.

Panel B of Figure 2 illustrates the percentage change in care costs between the 2020 and 2021 Genworth surveys. Median costs increase in every state but Wyoming; in most states, costs increase by 5-15 percent. This greatly outpaces both the 1.23 percent inflation rate during 2020 and the 4.70 percent rate during 2021.

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.¹² Panel A of Figure 3 displays estimated median costs after accounting for 2020-level state and federal CDCC benefits. Post-tax costs of care range from about \$9,150 to \$17,650 across states, slightly lower than the pre-tax costs

⁹See <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>.

¹⁰See <https://www.npr.org/2021/09/28/1031651663/shortage-home-health-aides-elderly>.

¹¹Estimated median annual pre-tax costs during 2020 can be found in Appendix Figure A1.

¹²We 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. We include results using median costs of care as of 2020 in Appendix Figures A2-A3.

shown in Figure 2.

We then estimate median annual post-tax costs of care under the 2021 expanded CDCC. Given differences in benefit generosity across households with spouse and non-spouse qualifying individuals documented in Section II, the remaining panels of Figure 3 separately document post-tax costs of care for households with nonworking coresident spouses in need of care and for those with non-spouse elderly dependents, such as coresident parents. The panels yield three key takeaways. First, the 2021 CDCC expansion substantially decreased median estimated post-tax costs of care: post-tax costs during 2021 range from \$8,250 to \$16,750 for households with coresident spouses and from \$5,740 to \$14,250 for households with coresident parents. Second, although the CDCC expansion decreased estimated costs of care for all household types, it lowered costs by a much larger margin for households with non-spouse elderly dependents. Among these households, annual estimated median costs of care fall below \$12,500 in all but five states. Finally, on average, estimated median costs are lower in states with their own CDCCs (diagonal lines). Specifically, in Panel C, median costs of care average about \$9,500 in states with CDCCs and \$10,300 in states without them. This compares to pre-tax 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 home-maker 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, especially for households with non-spouse dependents.

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

As a subsidy for caregiving expenditures, CDCC benefits encourage household members to increase eligible health-related spending. Because the qualifying individual must reside in the household for the primary taxpayer (and their spouse, if applicable) to receive benefits, the CDCC also promotes in-home (rather than institutional) care, as well as co-residence with adult children. By lowering the costs of paid LTSS relative to unpaid care, CDCC benefits should further increase the use of paid care inside the home and reduce the use of institutional care, including nursing home stays.

Additionally, since all non-disabled primary taxpayers and spouses must work to receive benefits, the CDCC encourages labor force participation among potential caregivers. While intensive margin labor supply incentives vary across the income distribution, the 2021 CDCC 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. Hence, a similar benefit

expansion theoretically would decrease work hours among such individuals.

Labor supply elasticities increase over the life course (French 2005; French and Jones 2012) and as average age of family caregivers in our HRS sample is 58, employment effects of the CDCC may be quite large. Specifically, under labor supply elasticities with respect to caregiving benefits found in existing literature (Geyer and Korhage 2015), our results imply that permanently increasing federal benefits from their 2020 levels to their 2021 levels for non-spouse dependents would increase labor force participation by about 10 percentage points among individuals aged 50-65 with caregiving responsibilities and \$43,000 to \$125,000 in AGI, all else equal. Of course, benefit increases of this magnitude could generate increases in costs of LTSS that would dampen such labor supply effects.

Given that many family caregivers in our sample already work, one may be concerned that income effects of an expanded CDCC (along with substitution effects for those with around \$20,000-\$25,000 and \$125,000 or more in AGI) would lead to decreases in work hours. Evidence from the Earned Income Tax Credit (EITC), however, which, similarly to the expanded CDCC for non-spouse dependents, had a maximum value of nearly \$4,000 for families with one child as of 2021, suggests any decreases in work hours would be relatively small. In particular, Chetty, Friedman, and Saez (2013) estimate intensive margin labor supply elasticities with respect to EITC benefits of 0.14 in the credit's phase-out range, where income and substitution effects discourage work. This is in spite of the EITC having very high phase-out rates (0.16 for households with one child as of 2021) relative to the expanded CDCC (0.04 for households with non-spouse dependents) and beginning to phase out at much lower AGI levels (around \$20,000 for households with children). While the EITC is targeted at low- and moderate-income families with children, who differ on many dimensions from family caregivers for adults, small intensive margin labor supply responses to the EITC's much stronger incentives imply adult caregivers would exhibit small work hours responses to a permanently expanded CDCC.

VII. Conclusion and Policy Implications

A growing share of Americans provide uncompensated care for aging and disabled family members. In this paper, we consider the Child and Dependent Care Credit (CDCC) from the perspective of taxpayers who care for non-child dependents. Although tax credits are a popular policy proposal among family caregivers, only a very small share of households who claim the CDCC do not have children under 13. We describe the value of the tax credit for these households and use the Health and Retirement Study (HRS) to describe the population who would be eligible to claim benefits.

We find that despite very low take-up, a non-negligible number of households could benefit from the CDCC.

Then, we document how the CDCC expansion under the American Rescue Plan Act of 2021 increased the tax credit's value for households with caregiving responsibilities. Expanded federal CDCC benefits during 2021 covered a much larger proportion of typical care costs than CDCC benefits as of 2020. However, households with non-spouse qualifying individuals were eligible for considerably larger benefits than otherwise similar households with qualifying spouses. This, in turn, generates substantial differences in estimated post-tax median costs of formal LTSS, such as home health aides.

The coronavirus, which spread rapidly through long-term care facilities and caused many to experience long-term illness, increased the prevalence of coresident family members in need of care and created financial difficulties for many (Truskinovsky and Wiemers 2022). In light of this, an unprecedented number of households with caregiving responsibilities may stand to benefit from the CDCC now and in the future. Furthermore, as staffing issues and increased costs of protective equipment lead to long-term care facility closures, flexibility in terms of qualifying dependent care expenses for the CDCC, coupled with other policies such as paid family leave, may prove especially beneficial.¹³ Thus, expanding the CDCC in a way that is equitable across household types could prove especially beneficial to families with caregiving responsibilities at this time, as it would increase their incomes while encouraging work.

¹³American Health Care Association and National Center for Assisted Living, ■Long Term Care Closures Mount as COVID-19 Exacerbates Financial Shortfalls,■ <https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Long-Term-Care-Closures-Mount-As-COVID-19-Exacerbates-Financial-Shortfalls.aspx>.

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Table and Figures

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

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

Notes: Characteristics of respondents aged 50-65 in wave 2016 of the HRS, by whether they care for a coresident spouse or parent or have a coresident spouse or parent who needs assistance with activities of daily living. Household income is from the previous calendar year.

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

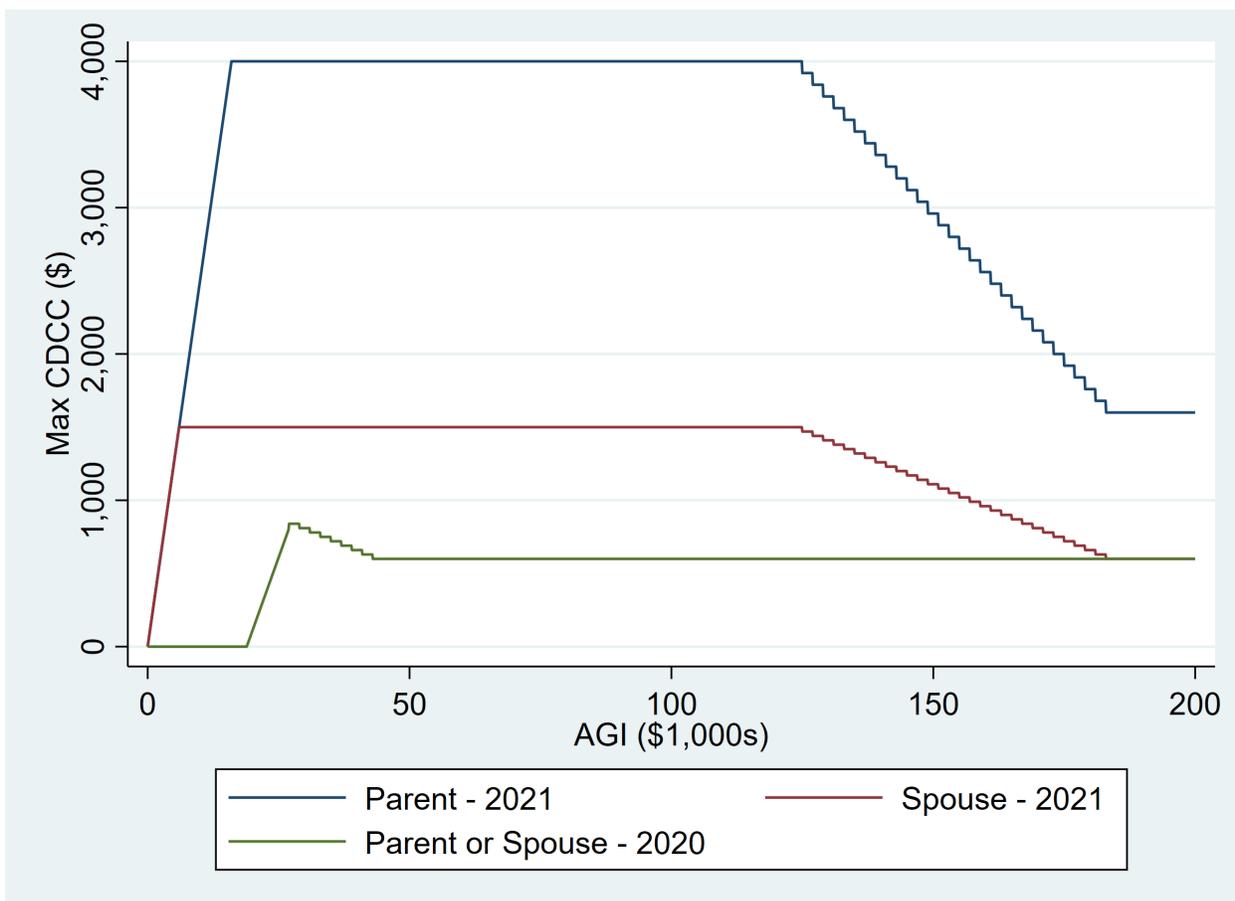
Table 2: Qualifying Spouse Health and Long-term Care spending

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

Notes: Sample consists of HRS respondents in the 2016 wave who have a coresident spouse who does not work and who has at least one ADL difficulty and/or ADRD. Column one includes respondents who work for pay, while column two includes respondents who do not work for pay. Home health care includes care in the home from “Medically-trained persons including professional nurses, visiting nurse’s aides, physical or occupational therapists, chemotherapists, respiratory oxygen therapists, and hospice caregivers.” Other health services include: “any special facility or service which we haven’t talked about, such as: an adult care center, a social worker, an outpatient rehabilitation program, physical therapy, or transportation for the elderly or disabled” Other medical expenses include: “other out-of pocket expenses, that is, expenses not covered by insurance, such as medications, special food, equipment such as a special bed or chair, visits by health professionals, or other costs?” Total OOP LTC expenditure includes any OOP spending in home health, special facilities or services or other health services. Total OOP spending include costs associated with: hospitalization, nursing home, surgery, dr appointments, dentists, prescription drugs, in home care and other medical care.

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

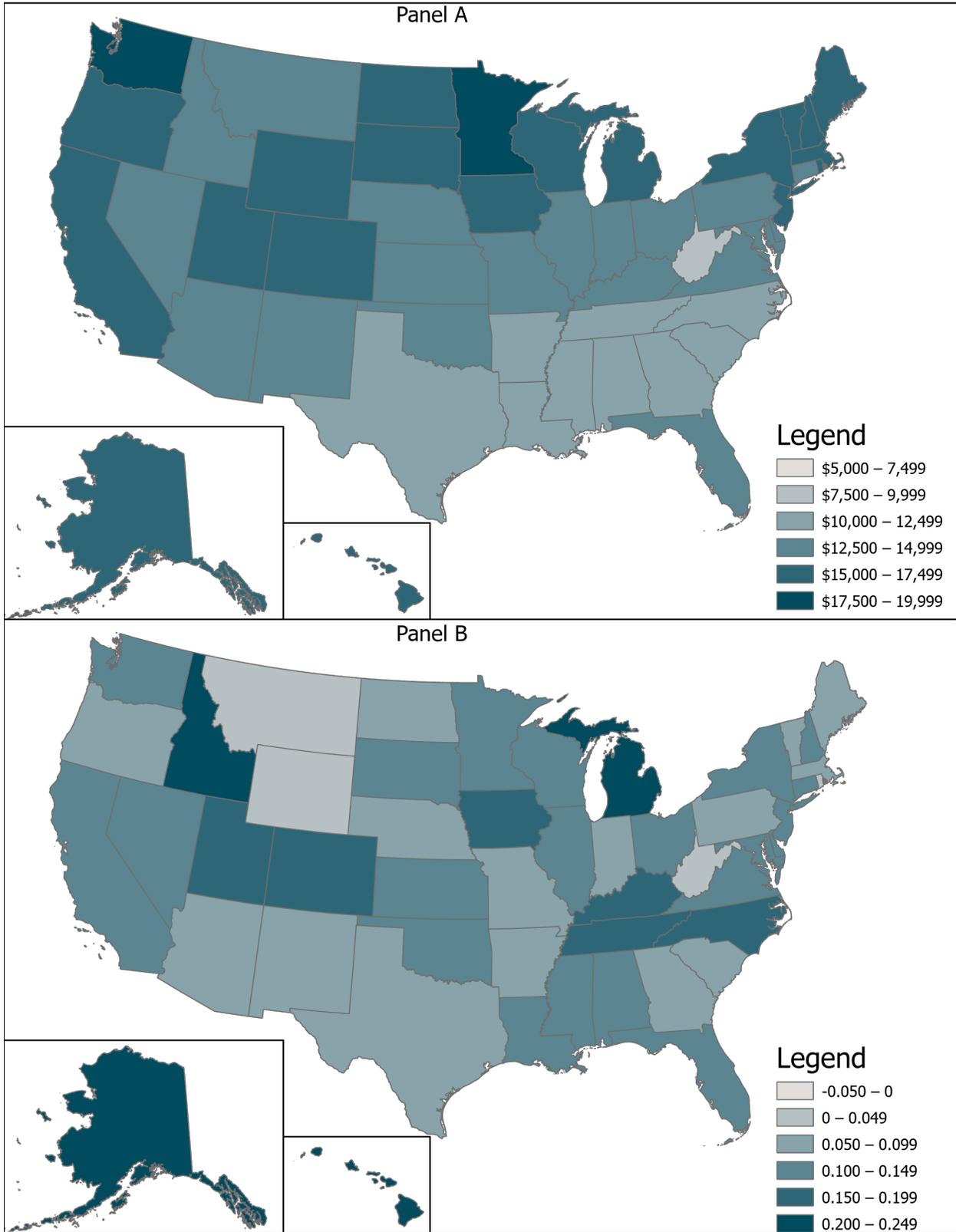
Figure 1: Maximum Federal CDCC Benefits by AGI



Notes: Maximum federal CDCC benefits for households with one qualifying dependent, by federal AGI and whether the qualifying dependent is a nonworking spouse as of 2021.

Source: Authors' calculations using federal tax forms.

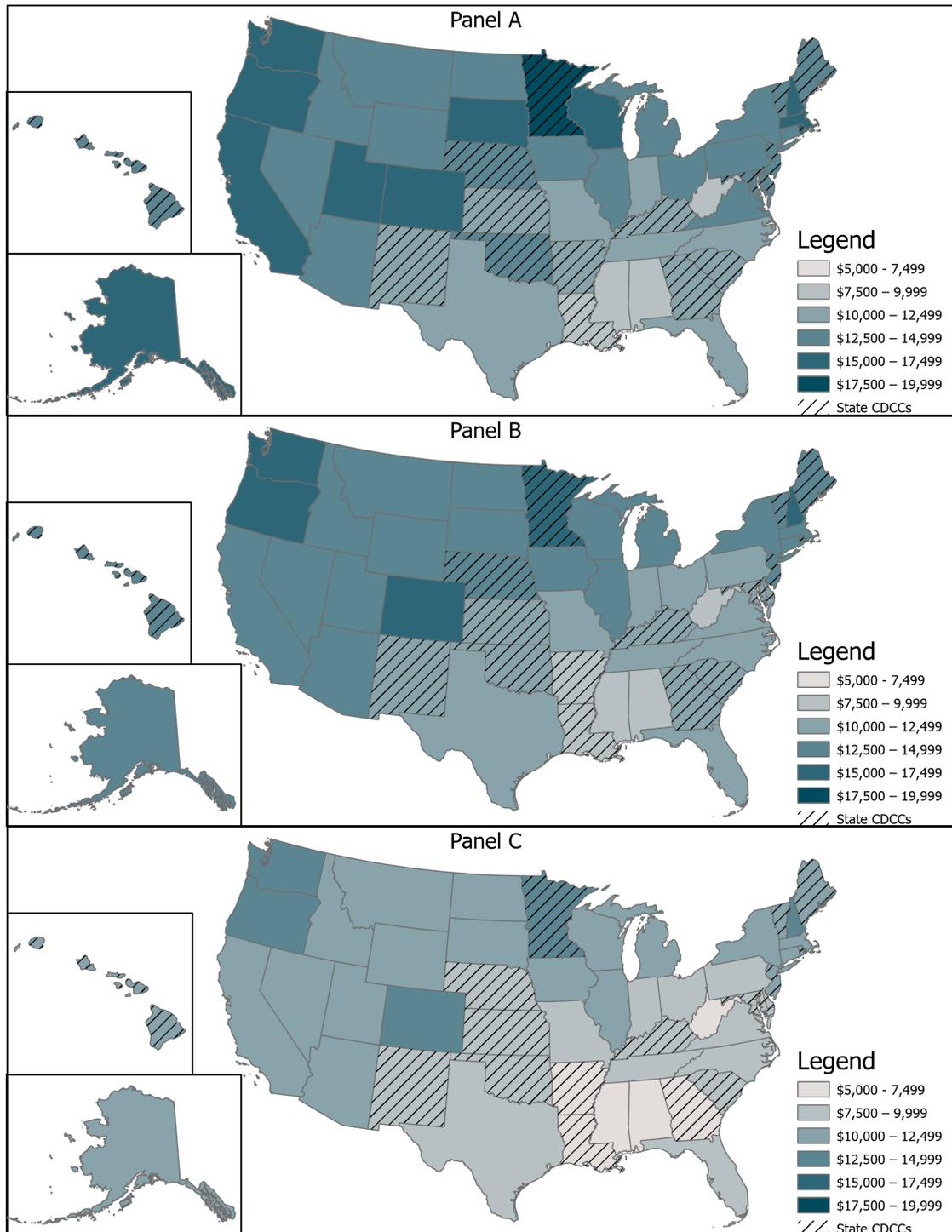
Figure 2: Pre-Tax Home Health Aide Costs by State



Notes: Panel A: Median annual pre-tax costs of hiring a home health aide for 10 hours per week across states as of 2021. Source: Genworth median cost-of-care data.

Panel B: Percentage change in median annual pre-tax costs of hiring a home health aide for 10 hours per week across states between July-August 2020 and June-November 2021. Source: Authors' calculations using Genworth median cost-of-care data.

Figure 3: Post-Tax Home Health Aide Costs by State

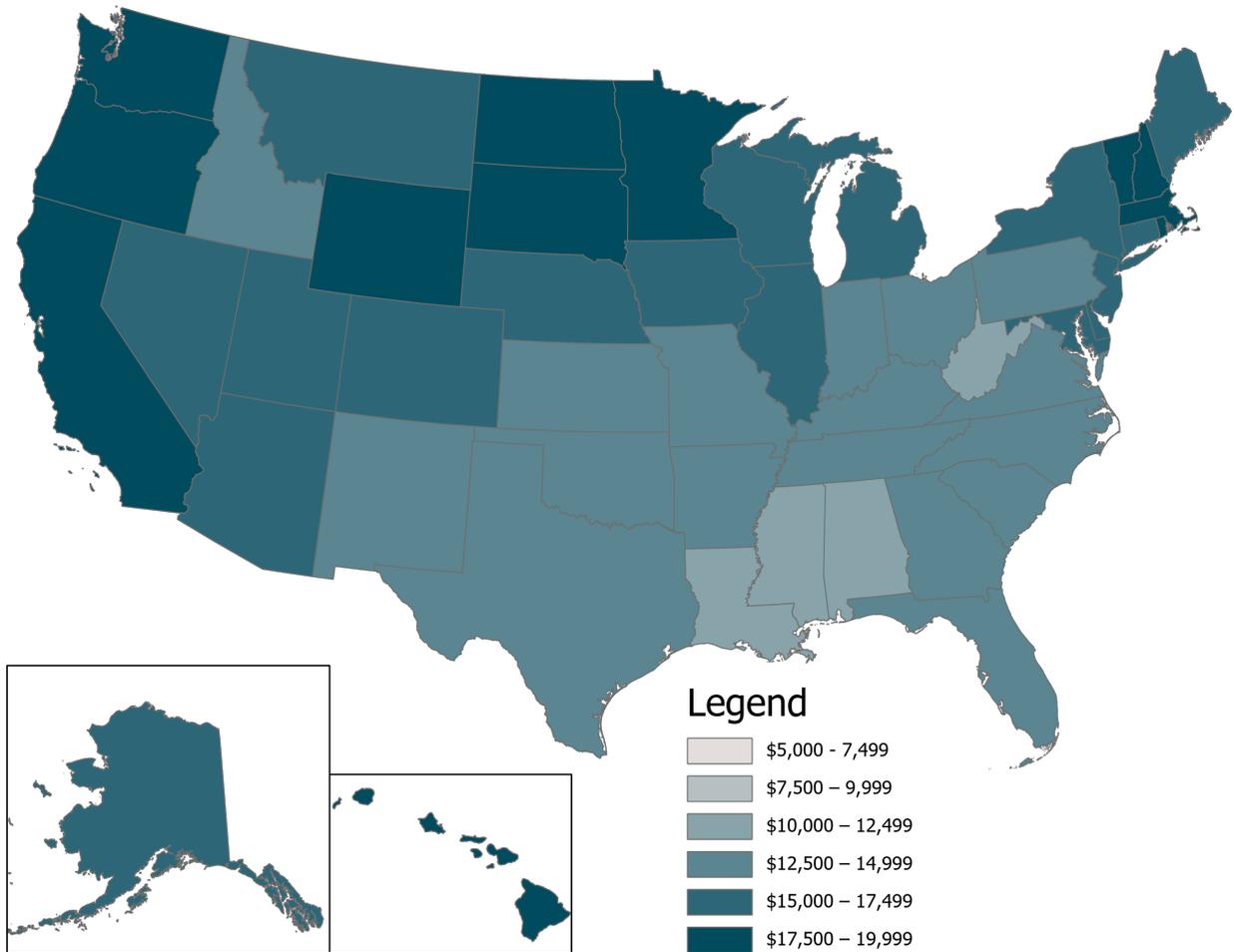


Notes: Median annual post-tax costs of hiring a home health aide for 10 hours per week as of 2021, after accounting for state and federal CDCC benefits for households with \$50,000 in income, across states. Panel A: Median annual post-tax costs of care, after accounting for 2020-level CDCC benefits. Panel B: Median annual post-tax costs of care for a nonworking, disabled coresident spouse, after accounting for 2021-level CDCC benefits. Panel C: Median annual post-tax costs of care for a non-spouse coresident elderly dependent, after accounting for 2021-level CDCC benefits.

Source: Authors' calculations using Genworth median cost-of-care data and state and federal tax forms.

Appendix

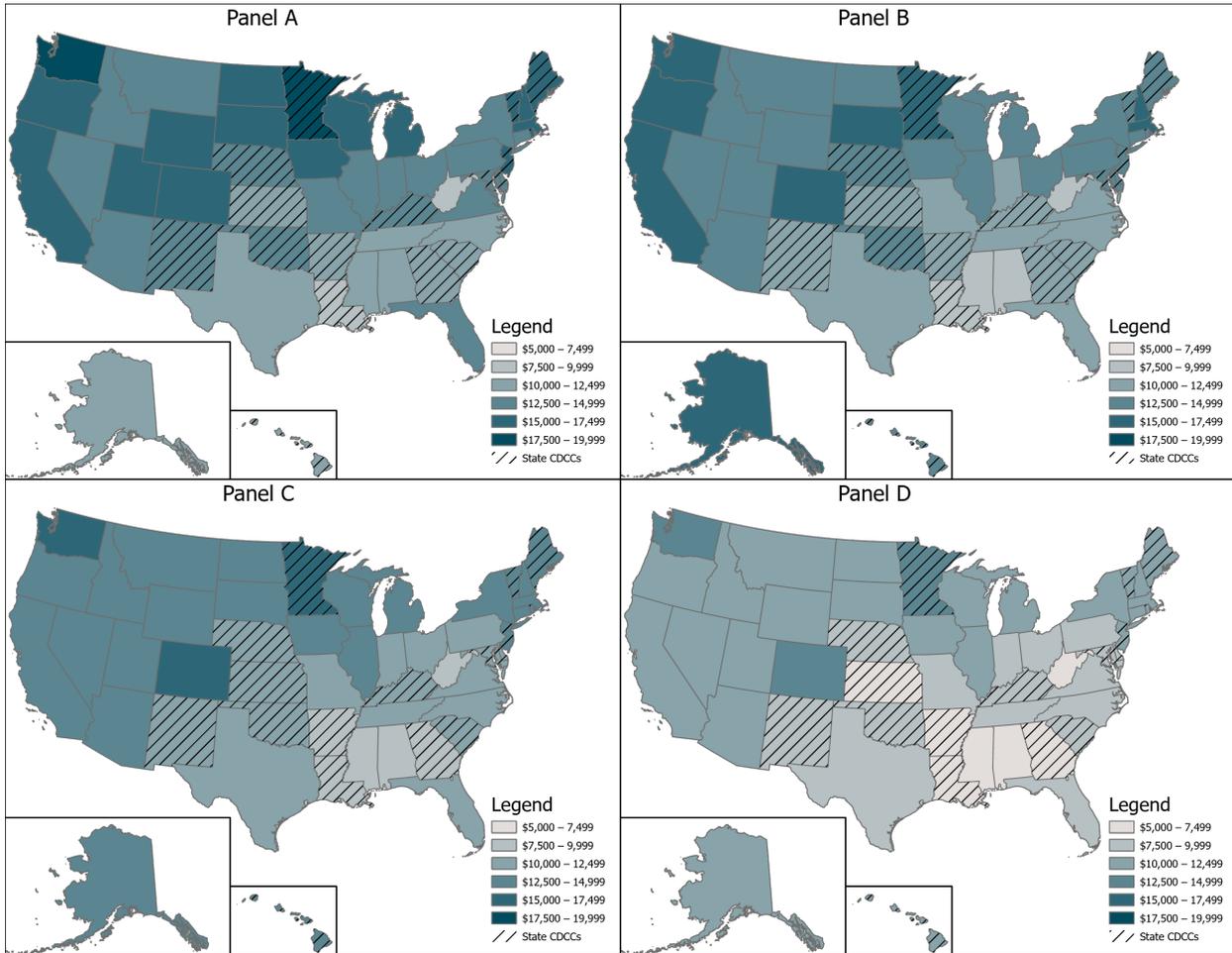
Figure A1: Pre-Tax Home Health Aide Costs by State as of 2020



Notes: Median annual pre-tax costs of hiring a home health aide for 10 hours per week across states as of 2020.

Source: Genworth median cost-of-care data.

Figure A2: Pre- and Post-Tax Homemaker Services Costs by State



Notes: Median annual costs of 10 hours per week of homemaker services as of 2021 for households with \$50,000 in income across states.

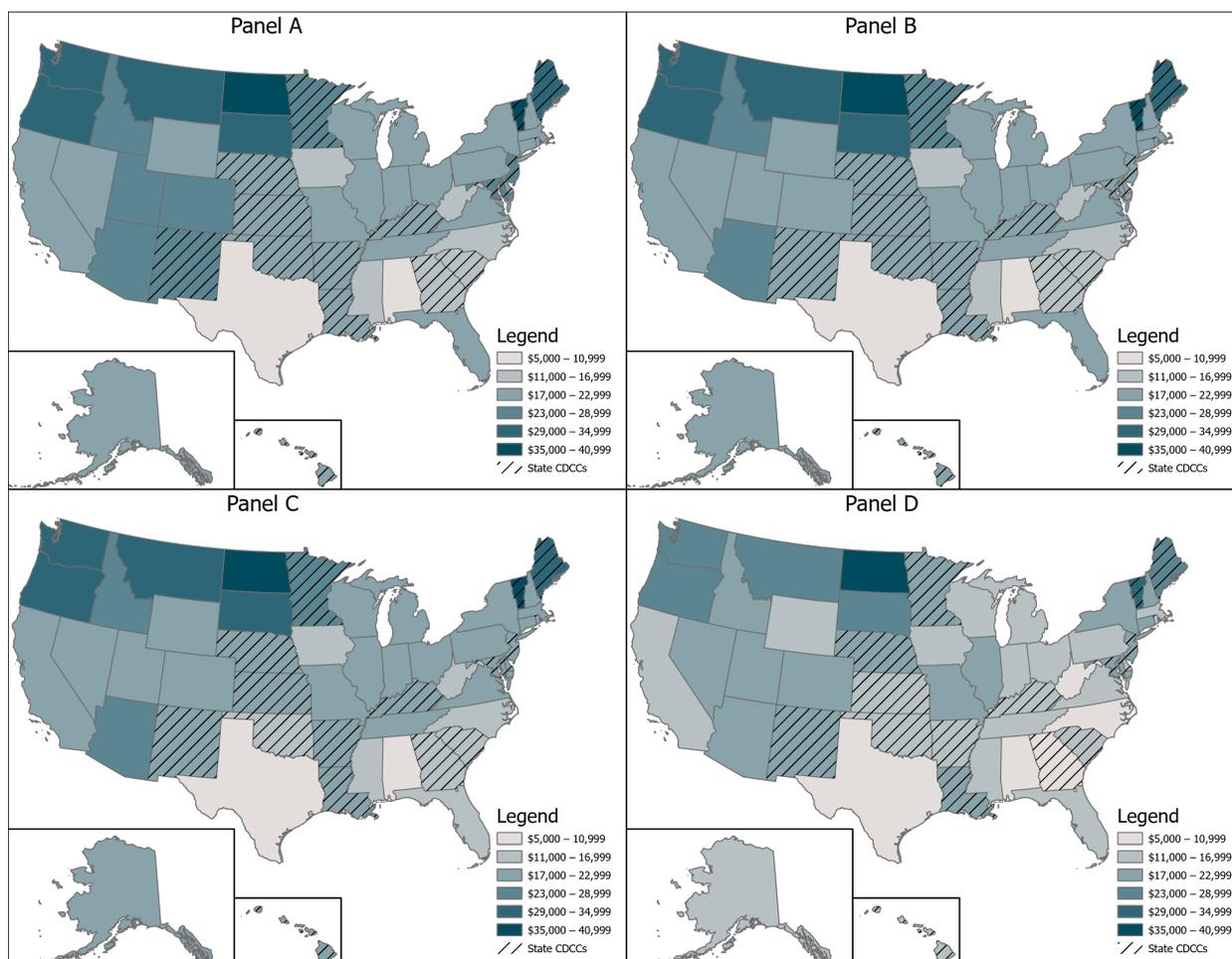
Panel A: Median annual pre-tax costs of care. Source: Genworth median cost-of-care data.

Panel B: Median annual post-tax costs of care, after accounting for 2020-level state and federal CDCC benefits. Source: Authors' calculations using Genworth median cost-of-care data and state and federal tax forms.

Panel C: Median annual post-tax costs of care for a nonworking, disabled coresident spouse, after accounting for 2021-level state and federal CDCC benefits. Source: Authors' calculations using Genworth median cost-of-care data and state and federal tax forms.

Panel D: Median annual post-tax costs of care for a non-spouse coresident elderly dependent, after accounting for 2021-level CDCC benefits. Source: Authors' calculations using Genworth median cost-of-care data and state and federal tax forms.

Figure A3: Pre- and Post-Tax Adult Day Health Care Costs by State



Notes: Median annual costs of 10 hours per week of adult day health care as of 2021 for households with \$50,000 in income across states.

Panel A: Median annual pre-tax costs of care. Source: Genworth median cost-of-care data.

Panel B: Median annual post-tax costs of care, after accounting for 2020-level state and federal CDCC benefits. Source: Authors' calculations using Genworth median cost-of-care data and state and federal tax forms.

Panel C: Median annual post-tax costs of care for a nonworking, disabled coresident spouse, after accounting for 2021-level state and federal CDCC benefits. Source: Authors' calculations using Genworth median cost-of-care data and state and federal tax forms.

Panel D: Median annual post-tax costs of care for a non-spouse coresident elderly dependent, after accounting for 2021-level CDCC benefits. Source: Authors' calculations using Genworth median cost-of-care data and state and federal tax forms.