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Direct Spending on Care Work

Thinking Beyond the Tax Code for Caregiving Infrastructure

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I. Executive Summary

Addressing the caregiving crisis facing tens of millions of working- and middle-class families—and the entire United States—will require robust and well-designed policy solutions. This report highlights the economic and well-being impacts of the current lack of affordable, high-quality care choices, with a focus on paid family leave, childcare, and long-term care infrastructure. The caregiving crisis in the US affects nearly all of us, with the immediate burdens often falling on women, especially women of color, who provide a disproportionate share of paid and unpaid care—exacerbating existing racial and gender inequalities in economic security and workforce participation.

Public investment in caregiving infrastructure through direct federal spending is the only path to ensuring that families have access to the support they need to thrive. Relying solely on tax-based care policies, as many bipartisan and conservative proposals tend to do, is inevitably insufficient and inefficient, doing little to ensure the quality care and paid leave that America's working- and middle-class families deserve while wasting funds on higher-income households and highly profitable corporations. This report offers a framework for evaluating care investment proposals through the dimensions of funding, access and reach, and quality. It then applies that framework to compare the strengths and weaknesses of various federal direct spending programs and tax expenditures and explores their impact on families, care infrastructure, and the workforce that is needed to provide quality early education and long-term care.

Key takeaways are as follows:

- The high costs of childcare and long-term care and the lack of paid family and medical leave create significant challenges for American families, especially working-class families but also middle-class families.
- Current tax expenditures for care are often regressive and inefficient as they primarily benefit higher-income families, fail to address systemic issues like supply and quality, and often involve eligibility requirements that exclude those with the most need for care.
- Direct spending programs, while generally underfunded, offer greater potential for ensuring quality care, building out the care workforce, and providing equitable access to quality services.
- Policymakers have the opportunity to prioritize caregiving needs through a combination of tax changes and increased direct spending.

Though 2025's expected tax reform bill was an opportunity for constructive reform, indications are now that it will more likely be harmful. This report nevertheless offers recommendations for both the near and long term.

A comprehensive approach combining reformed tax policies—especially those that raise reasonable revenues to pay for care investments—with increased and well-designed direct spending is essential to strengthen caregiving infrastructure, enable greater workforce participation, improve child development outcomes, support economic well-being for families, and boost national economic competitiveness. While some tax-based care policies do benefit some families, they broadly lack the effectiveness, efficiency, and reach of direct spending policies due to their often limited flexibility in aligning with families' preferences, weaknesses in ensuring both care quality *and* choice in care provider, and inability to even reach—never mind meaningfully support—families with significant care needs. If our goal is to ensure an efficient, effective, and equitable care infrastructure for working- and middle-class families of all races, genders, and communities—especially rural communities—policymakers should raise more revenues to boost and shift our national care investments away from tax-based spending and toward direct spending that provides families meaningful choices to meet their diverse care needs.

II. Introduction: Caregiving Needs and Policy Crossroads

American families face impossible challenges in meeting their caregiving needs. The lack of affordable, high-quality caregiving options creates a ripple effect that impacts not only individual families but also their communities and the overall economy. When forced to make difficult choices between work and caregiving, families may reduce work hours and lose income, in turn decreasing tax revenue (Maestas, Messel, and Truskinovsky 2024). Additionally, the strain of caregiving can harm both physical and mental health (Schulz and Sherwood 2008). A credible 2022 analysis estimated that guaranteed paid leave and universal childcare alone would grow economic activity by 4 percent of GDP—then nearly $1 trillion—from 2023 to 2032 (Moody's 2022).

Many policy advocates expected the 2025 federal tax reform debate to serve as one opportunity to prioritize caregiving needs. By directing greater public funds toward caregiving programs and services, policymakers could have made a significant investment in the well-being of families. This outcome seems highly unlikely now given the makeup of Congress and the Trump administration's priorities, but as policymakers fight over tax cuts for the wealthy and corporations, it's worth remembering how that money could be responsibly spent.

Yet, there has been growing bipartisan recognition of the importance of public investment in caregiving. The Biden administration proposed significant investments in key areas such as childcare (Murakami 2024), paid leave (Mayer 2024), and home and community-based services (CMS 2024a). Similarly, as the Democratic nominee for the presidency, Kamala Harris proposed expanding Medicare to cover home health care (Luhby and Davis 2024), establishing national paid leave (Huckelbridge 2024), and

capping families' out-of-pocket childcare costs (Luhby 2024a). These proposals aimed to provide families with a comprehensive support system that enables them to balance work and caregiving responsibilities. By expanding access to affordable, high-quality caregiving options, policymakers can strengthen families, boost the economy, and promote the overall well-being of society.

Leaders and organizations right of center have also voiced support for greater federal investments in caregiving. For example, the 2024 Republican Party platform included the following plank:

> **Protect Care at Home for the Elderly**
>
> Republicans will shift resources back to at-home Senior Care, overturn disincentives that lead to Care Worker shortages, and support unpaid Family Caregivers through Tax Credits and reduced red tape. (The American Presidency Project 2024)

At a rally late in his 2024 presidential campaign, Donald Trump said

> I am announcing a new policy today that I will support a tax credit for family caregivers who take care of a parent or a loved one. It's about time that they were recognized, right? They add so much to our country, and they are never spoken of ever, ever, ever, but they are going to be spoken of now. (Luhby 2024b)

Unfortunately, no details have been shared subsequently, and the early months of the Trump administration and the 119th Congress have seen more proposed cuts than investments in care. Even if such a tax credit moved forward, there is a risk that it would disproportionately benefit higher-income households. For example, Rep. Blake Moore (R-UT) has proposed legislation similar to previous bills in Congress to expand the Child Tax Credit substantially (Moore 2025).[1] However, the reform would do so by discriminating against people with the lowest incomes—a common shortcoming of tax subsidies—and excluding many citizens and other lawfully residing children and adults with their own caregiving needs, as well as by undermining abortion care. In addition to reducing support for immigrant families, undermining reproductive health care, shrinking investments in care for people with disabilities and seniors, and penalizing parents who are not married, the current Republican congressional majority could also make things worse by showering the wealthiest Americans with tax cuts that create political pressure to offset with reduced caregiving investments.

This report focuses on the need for greater investments in meeting families' care needs through **direct spending programs**. Relying on tax subsidies alone will mean that we

[1] See Box 2 for more on the Child Tax Credit.

continue to fail tens of millions of hardworking families.[2] While tax subsidies can help offset some caregiving costs, they will necessarily fall short of the scale and nature of the care challenges we face because they are insufficiently effective at supporting the families with the greatest care needs and ensuring availability of the high-quality care options that Americans deserve. Tax and budget proposals should be evaluated on how well they help American families meet their care needs now and in the future, including by ensuring adequate revenues to pay for necessary spending programs. A successful approach must rely on increasing direct spending and the revenues to fund that spending, ensuring that it's seamless and affordable for each family to meet its caregiving needs. Though that outcome is highly unlikely in 2025, it's important to understand what a government that took its responsibility seriously would do—and should do—in the years to come.

III. The State of Caregiving Underscores the Need for Public Investments

With significant challenges across the spectrum of early childhood, family and medical leave, and long-term care for older adults and people with disabilities, the nation's caregiving infrastructure remains fragmented and underfunded, leaving millions of families struggling to access affordable, quality care. More than 700,000 older adults and people with disabilities remain on waiting lists for years for life-saving, essential long-term care (KFF 2024a). As of 2023, 38 million Americans provided unpaid care to adult family members (Reinhard et al. 2023), resulting in substantial economic losses not only for individuals but for the nation as a whole (Houser 2023).[3] Unpaid caregivers work fewer hours and earn less than their non-caregiving counterparts, reducing economic activity, labor supply, and tax revenue (Maestas, Messel, and Truskinovksy 2024). Meanwhile, as of 2019, 3.4 million children lacked access to formal childcare, costing the US up to $217 billion in economic output annually (Smith, Williams, and Mercado 2023). Workers and their families in 37 states without paid family and medical leave programs lose an estimated $34 billion in wages annually due to unpaid or partially paid leave (Andrews, Mehta, and Milli 2024). And in 2024, family caregivers' unpaid care was valued at approximately $1 trillion—had they been paid a plausible and still insufficient hourly wage of $15.74—without even factoring in out-of-pocket costs and lost wages (Robbins and Mason 2024).

[2] While regulatory requirements applying to workers outside the federal workforce are another essential tool to ensure care quality, they must be accompanied by separate and sufficient public funding one way or another to maintain or expand access to child and long-term care. For example, the CHIPS and Science Act includes a requirement that companies applying for semiconductor investment funds from the Commerce Department include a plan for meeting workers' childcare needs, tying funding to the regulatory requirement (White House 2023).

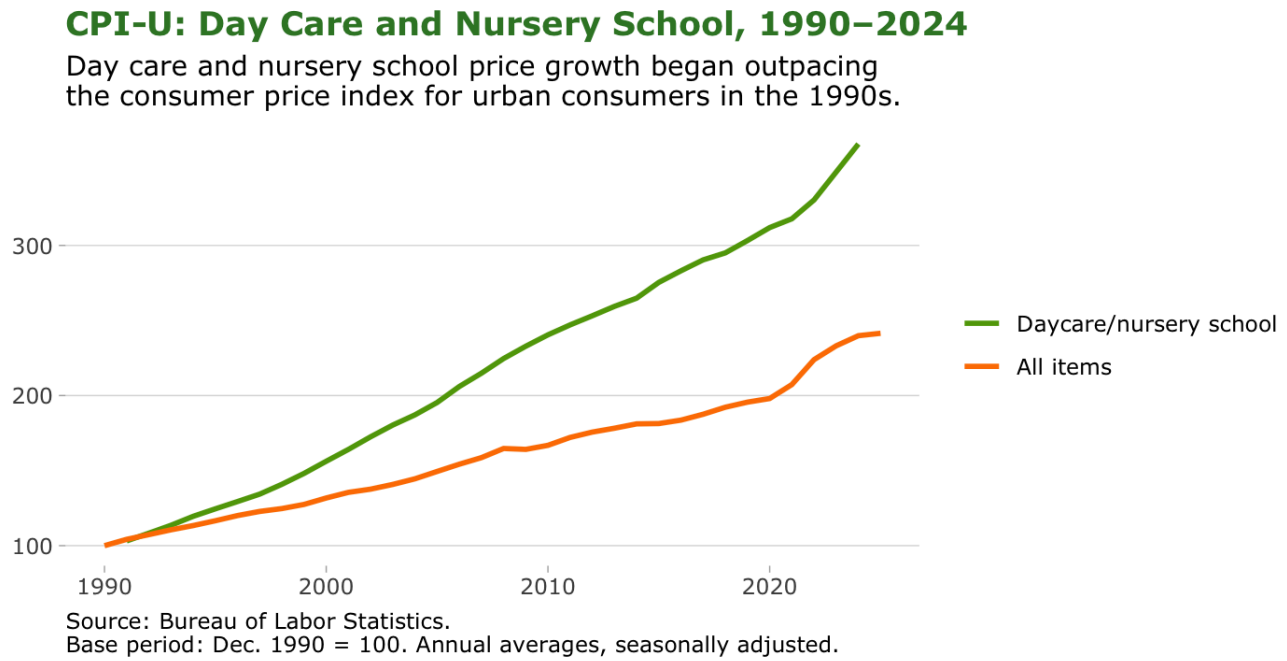
[3] Farmer and Ramchand (2024) use a more expansive definition of caregiver, including non–family members and adults who live outside the caregiver's home but still receive care. Using this approach, they estimate that 105.6 million people are caregivers of adults.

The imperative for public investment in caregiving stems from an aging population (Mather and Scommegna 2024), a worsening shortfall in a high-quality care workforce, the essential role care plays in childhood development, and the current state of the caregiving system in the US. The existing system is plagued by a lack of affordable, accessible, and quality care options, leaving many families struggling to meet their caregiving needs. This, in turn, undermines families' economic security and opportunity, as well as the well-being of both caregivers and care recipients. It undermines productivity (Fakeye et al. 2023) and unequivocally imposes substantial costs on the US economy, including reduced labor force participation, particularly among women and especially women of color (Mason and Robbins 2023). The care workforce is disproportionately composed of women of color—particularly Black, Latina, Native, and multiracial women—who often face lower wages and fewer benefits than their white counterparts (Mason and Robbins 2023; Mefferd and Dow 2023). This disparity in working conditions not only perpetuates existing racial inequalities but also places a heavier burden on women of color who are more likely to be both care workers and primary caregivers for their families. All of this lowers economic output overall and undermines our international competitiveness. Broad and sustained public investment—including to support care by family members and other loved ones—is the only plausible path forward for addressing the various challenges and failures facing both the supply and demand sides of the caregiving market (Kahn 2024).

Childcare

The demand for early care and education is high, but affordability and alignment with work hours are major barriers. The average annual cost of childcare—across a range of care settings—for one child in 2022 was $10,853, a significant financial burden for many families (NWLC 2024a). In many metropolitan areas, childcare costs more than rent for a two-bedroom apartment (Davis 2024), and in many states costs more than college tuition (Child Care Aware 2023). Childcare prices have also grown greater and faster than overall goods and services since the 1990s (see Figure 1). On average, a family needs over $180,000 per year of income for infant care to be affordable (Javaid and Boteach 2025). The financial strain of childcare expenses is exacerbated by the fact that the main federal program for providing childcare assistance, the Child Care and Development Block Grant (CCDBG), is severely underfunded. As a result, only 16 percent of federally eligible children receive care (NWLC 2024a), while nine states maintained waiting lists or froze intake in 2023 (Schulman 2024). Additionally, employer-provided childcare is available to only about 11 percent of civilian workers as of 2021, with lower-wage workers having even less access (Crandall-Hollick and Boyle 2023).

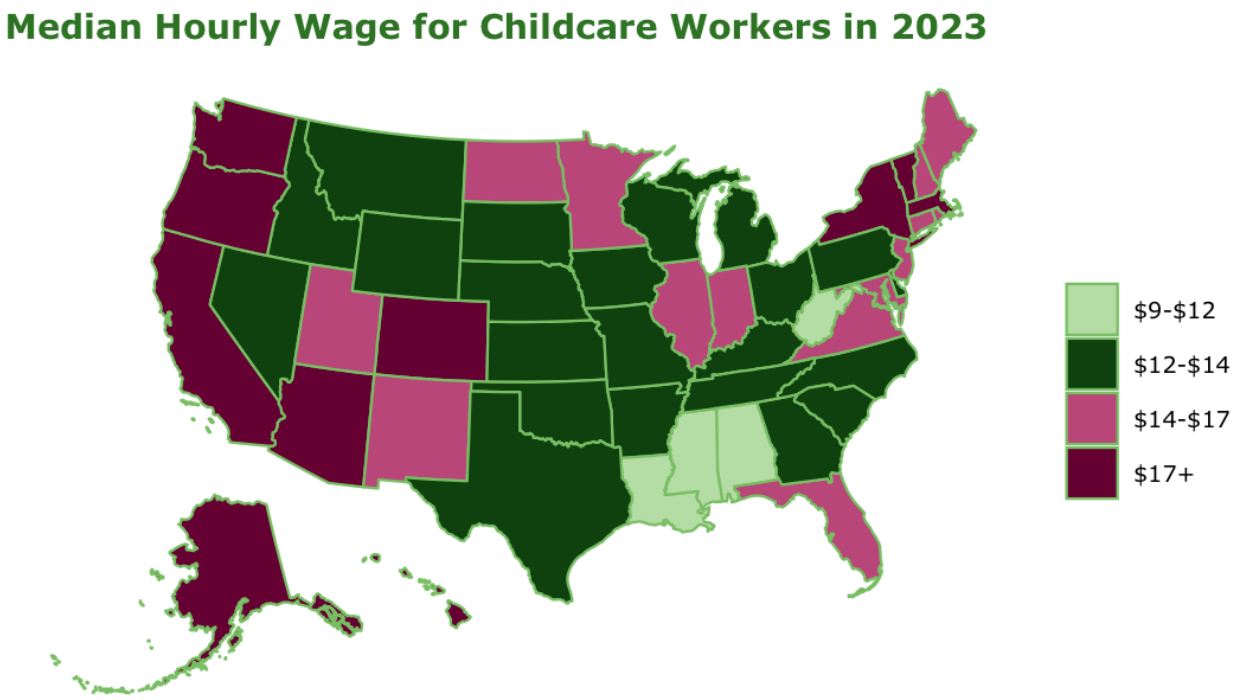
Figure 1



Our lack of investment has led to poor job quality and a shortage of qualified childcare workers. Despite performing essential work, childcare workers frequently earn poverty wages—in 2023, the median hourly wage for a childcare worker was only $14.60 (BLS 2024) (see Figure 2), or less than two-thirds of the median wage for all workers (BLS 2023a). The childcare workforce also lacks access to many employer-provided benefits (Coffey and Khattar 2022), contributing to high economic stress and making it challenging for childcare workers to provide for their own families. Low pay and lack of benefits not only discourage workers from entering the childcare field but also lead to high turnover rates, contributing to the shortage of qualified workers (NAEYC 2024). The undervaluation and undercompensation of caregiving jobs have disproportionately harmed women, especially women of color, due to occupational segregation (Mason and Robbins 2023). This devaluation of care work contributes to racial and gender wealth gaps.

If our goal is to ensure an efficient, effective, and equitable care infrastructure for working- and middle-class families of all races, genders, and communities—especially rural communities—policymakers should raise more revenues to boost and shift our national care investments away from tax-based spending and toward direct spending that provides families meaningful choices to meet their diverse care needs.

Figure 2



Source: Bureau of Labor Statistics.

Beyond underfunding and a general shortage of supply, the current childcare infrastructure is often exclusionary and inflexible, failing to meet the diverse needs of families. For example, while employer-provided childcare is a lifeline to some, other families may prefer childcare located closer to their homes rather than near their workplaces (Crandall-Hollick and Boyle 2023). Additionally, nontraditional work hours, common among low-paid workers, often fall outside typical childcare center hours, posing a significant challenge for working families (Adams et al. 2024). Data indicate limited availability of care—especially center-based care—during nonstandard hours (OPRE 2023) and in childcare "deserts" (Malik et al. 2018), both disproportionately in rural communities (Parker and Rendleman 2025; Henly and Adams 2018). This state of affairs means that many families are forced to make difficult choices, such as reducing work hours or leaving the workforce altogether due to the lack of affordable childcare (Boteach et al. 2019). Among households with children under 12 years of age, 20.8 percent reported that at least one child was unable to attend childcare as a result of childcare being closed, unavailable, unaffordable, or because they were concerned about their child's safety in care from January to October 2024.[4]

Childcare providers often operate with razor-thin profit margins, frequently less than 1 percent (Grunewald and Davies 2011), despite the childcare market being valued at an

[4] This figure was calculated using a 10-month average of the Census Pulse survey (US Census Bureau n.d.) (encompassing the time frame from January 9 to October 29, 2024). We subset the data to include only families with children under 12 and used person-level survey weights.

estimated $62 billion in 2024 (Grand View Research 2023). This contrasts sharply with private equity firms, who own a large and growing share of the largest for-profit childcare providers and generate profit margins as high as 20 percent. These private equity firms achieve such high profits by implementing cost-cutting measures, increasing student-to-teacher ratios, and catering exclusively to families who can afford full-price care (Haspel 2023). This stark reality underscores that only through public investment can we adequately address the childcare needs of both our families and our economy.

Long-Term Care

At the same time, demand for long-term care is rising, with our infrastructure unable to meet the demand of years past. The population of adults aged 65 and older is projected to reach 88.8 million by 2060 (ACL 2024a)—bringing with it an estimated need for 860,000 new direct care jobs by 2032 (PHI 2024). Just as the population ages, the availability of family caregivers is projected to fall (National Academies 2016). Already, two in five adults with limitations undertaking activities of daily living, like getting dressed or bathed, receive no help with those activities (Forden and Ghilarducci 2023). More than 710,000 people are on waiting lists for Medicaid Home and Community-Based Services (HCBS) in states that maintain such lists (Burns et al. 2024).[5] Long-term care is impossibly out of reach for families lacking Medicaid long-term care coverage. To qualify for Medicaid's long-term care benefit, potential recipients must spend down their assets to meet strict state income and asset limits (NCOA 2024). Medicare lacks these harsh constraints but provides limited support (Lankford 2023),[6] and private insurance is prohibitively expensive and limited in scope (Johnson 2016). Long-term care—including in-home care and care at an assisted living or nursing home facility (but excluding adult day care)—costs more than a typical worker's earnings (BLS 2025; CareScout n.d.).[7] A room in a nursing home costs about $100,000 per year while aging and disability care at home costs between $60,000 and over $288,000 per year (Chidambaram and Burns 2024).

Despite high costs for care recipients and their families, we face a growing shortage of long-term care workers and providers (Jones and Dolsten 2024; Abelson 2023). Long-term or direct-care workers' low wages, limited benefits, and lack of career advancement opportunities hinder recruitment and retention. Home health and

[5] Relative to institutional care, HCBS—the essential supports that people with disabilities and older adults rely on to live and age with dignity in their own homes and communities—have become increasingly important (Chidambaram and Burns 2023). Research has shown that 87 percent of adults over age 50 would prefer to age in place with caregiver assistance (Hart Research Associates 2023), and more than 86 percent of long-term services and support users received HCBS in 2021 (Mathematica 2024).
[6] Under some circumstances, Medicare will cover the cost of medical services in a long-term care setting, but it won't cover the cost of staying in long-term care or of the custodial care received there.
[7] Monthly median care costs are compared to BLS weekly median earnings, assuming there are 4.35 weeks in a month.

personal care aides and nursing assistants are paid just $16.12 hourly, significantly below a family-sustaining wage (BLS 2023a).[8] Persistent closures of nursing homes have created "nursing home deserts" in 40 additional US counties since February 2020, with 85 percent of these deserts occurring in rural communities, severely limiting access to skilled nursing care for seniors in these areas (AHCA 2024).

Though long-term care is an enormous market (valued at $520 billion in 2024) (Healy 2024), small profit margins (2.8 percent among skilled nursing facilities [Taylor, Wocken, and Wilson 2022] and likely comparable [Healy 2024] for home and community-based services), unaffordability for families and low-quality jobs suggest that only public investment can ensure affordable supply. The failure to act at a large scale and with appropriate safeguards has left the sector open to abuse. Private equity firms have been increasingly acquiring long-term care providers, with over 8 percent of eldercare facilities owned by private equity in 2014 compared to essentially none in 2004 (Gupta et al. 2023).[9] Private equity investment in nursing homes often prioritizes profit over patient care (Atkins 2021), leading to cost-cutting measures like reduced staffing and limited resources (Gupta et al. 2023). These practices can result in inadequate care, higher mortality rates, and other adverse outcomes for vulnerable residents (Rafiei 2022). As with childcare, the market failures in the long-term care market make clear that public investment is essential to adequately meet our nation's long-term care needs.

Family and Medical Leave

Paid family and medical leave remains a glaring gap in the US social contract. The absence of a national paid leave policy forces many workers to choose between their jobs and caring for themselves or loved ones. The United States is one of just seven countries—and the only high-income country—that fails to guarantee at least paid maternity leave (WORLD 2023). It is also one of a handful of high-wealth OECD countries not to guarantee any paid paternity leave (Adema et al. 2023) and one of two without paid sick leave (OECD 2020). As of January 2025, 13 states and Washington, DC, have enacted paid family and medical leave programs (Williamson 2025), leaving more than 100 million workers behind (Andrews, Mehta, and Milli 2024).[10] While these state

[8] MIT's Living Wage Calculator shows that $16.12 is below the statewide living wage in every state for a single adult with no children (MIT n.d.).

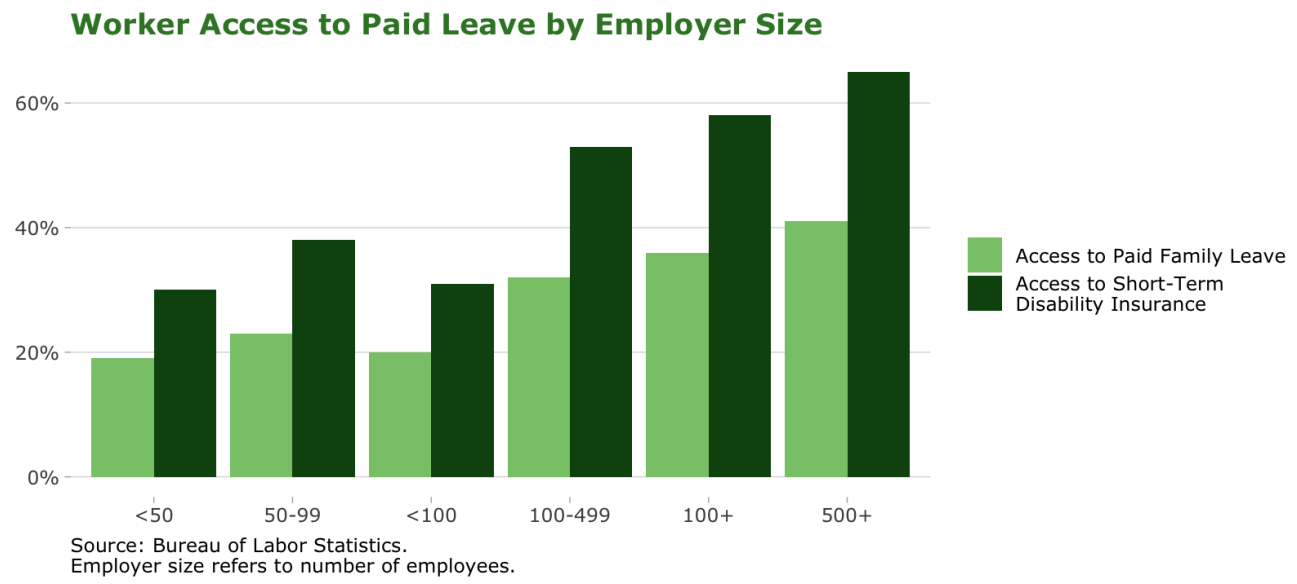
[9] It is difficult to precisely estimate the share of eldercare facilities owned by private equity due to their opaque ownership reporting (GAO 2023a), although a Biden administration rule improved transparency (CMS 2023).

[10] This report focuses on federal policy. Many states have care-focused tax subsidies for the care workforce, employers, and child and dependent care. As of November 2024, 30 states, including Washington, DC, offer state Child and Dependent Care tax credits (BPC 2024). Two states—Colorado and Louisiana—offer refundable tax credits for credentialed childcare workers employed at a qualified setting (NWLC 2024a). These credits are limited to workers in center-based care and some family childcare homes; informal providers are excluded. Additionally, the qualified setting is defined as one that is part of the quality rating system, and workers have to be employed there for six months, which further limits

programs generally provide at least 12 weeks of benefits (A Better Balance n.d.), the vast majority of workers in the US still lack access to comprehensive paid leave (Shabo 2025a): Just 27 percent of civilian workers (DOL 2024a) had paid family leave through an employer's plan in 2023, and only 4 in 10 had access to an employer's short-term disability insurance policy in 2020 (BLS 2020). Disparities by employer size are substantial, with 41 percent of employees at large private employers (500+ employees) and just 20 percent of employees of small employers (1–99 employees) having access to paid family leave—and 65 percent of employees at large employers compared to just 31 percent at small employers having access to short-term disability insurance (BLS 2023b) (see Figure 3).

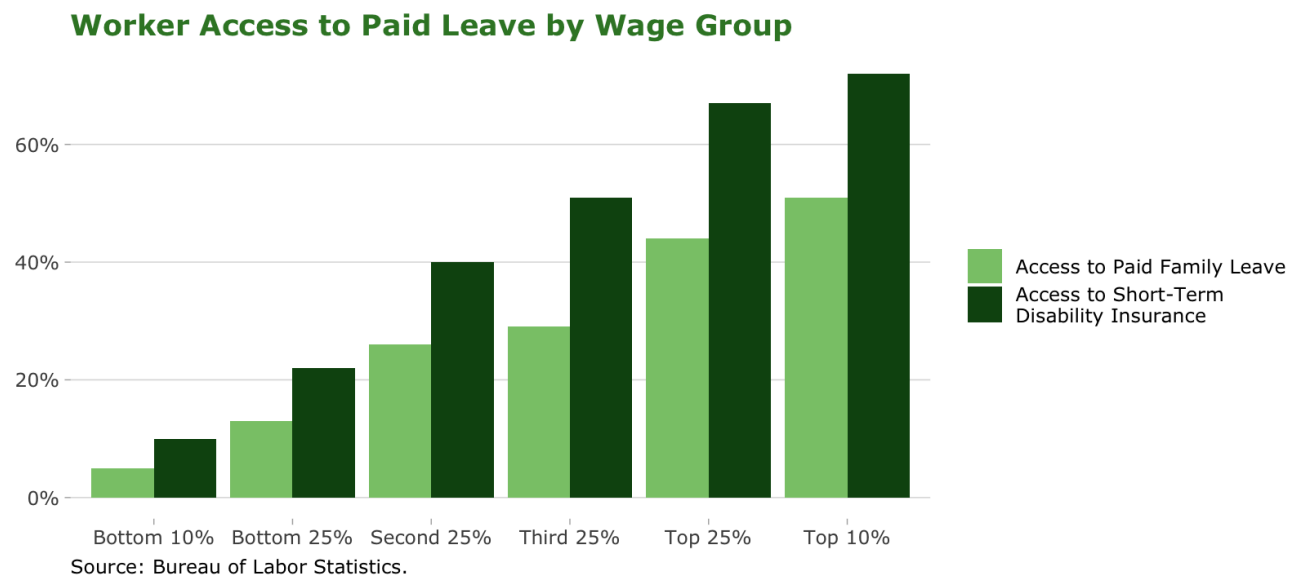
A national paid leave policy could also level the playing field for smaller businesses and low-paid workers alike (Williamson 2024). Workers in the top wage decile are eight times more likely to have access to paid family leave than are the lowest-wage workers (BLS 2023c) (see Figure 4). A federal paid family and medical leave program would not only support workers and their families but also benefit employers through increased retention and productivity (McSwigan, Colavito, and Moller 2024). Analyses of state paid leave programs found that access to paid family leave decreased the likelihood of women leaving their jobs after their spouses are hospitalized by 7 percent (Coile, Rossin-Slater, and Su 2022). Paid leave also increased work hours and wage incomes of mothers with young children (Rossin-Slater, Ruhm, and Waldfogel 2013).

Figure 3



worker eligibility. Several states have experimented with tax credits for employers to invest in their workers' childcare needs; however, these credits have been underutilized (NWLC 2018), mistargeted (FitzPatrick and Campbell 2002), and often repealed. Louisiana utilizes a unique package of tax credits, known as the School Readiness Tax Credits, integrated with its childcare quality rating and career development systems, to provide financial incentives to childcare providers, staff, families, and businesses, aiming to improve the quality of childcare (Campbell et al. 2015).

Figure 4



For the nearly one-quarter of US adults in a "sandwich" generation (Horowitz 2022)—those dealing with both childcare and the long-term care needs of aging loved ones—the lack of paid leave creates a perfect storm of challenges. Without comprehensive paid leave, many workers are forced to juggle caregiving responsibilities for children or older loved ones with their professional obligations, often at great personal and financial cost. The absence of comprehensive paid leave and affordable care options creates barriers to workforce participation, particularly for women (DePillis, Smialek, and Casselman 2022), who often bear the brunt of caregiving responsibilities for both children and aging parents (Weber-Raley 2019). It also strains an already under-resourced care system and under-resourced families, disproportionately affecting low-income families and those with nonstandard work schedules and thus further widening socioeconomic disparities (Do, Cohen, and Brown 2014). Many of these unpaid family caregivers—primarily women of color—are also navigating barriers to employment or advancement at work, adding to the instability they experience (Mefferd and Dow 2023). The lack of support worsens health outcomes for both caregivers and care recipients (two fluid and overlapping groups) (Schulz and Sherwood 2008) and results in significant economic costs due to lost productivity (Maestas, Messel, and Truskinovksy 2024). Childcare and long-term care costs can consume a substantial portion of household income, and public assistance accessing these care options is commonly out of reach.

IV. Two Investment Levers: Direct Spending vs. Tax-Based Policies

Direct spending refers to government funds allocated directly to programs and services, whereas **tax-based policies** are delivered through the tax code and primarily forgo government revenues via deductions, exclusions, and credits that reduce federal income tax liability.[11] Though care investments in the context of tax reform in 2025 and beyond can include both direct spending and tax-based policies, tax policies alone are simply insufficient—and frequently inefficient—for meeting families' varied caregiving needs.

Federal Direct Spending

Federal direct spending primarily comprises a few programs that meet a range of families' needs:[12]

- **Medicaid's Institutional Long-Term Care** program and **Home and Community-Based Services (HCBS)** provide funding for long-term care services and support for older adults and individuals with disabilities.
- The **Child Care and Development Fund (CCDF)** is composed of the Child Care and Development Block Grant (CCDBG) and Child Care Entitlement to States (CCES), which together provide funding to states for childcare assistance for low-income families.
- **Head Start and Early Head Start** promote school readiness and healthy development for children from low-income families.
- **Preschool Development Grants** support states in expanding preschool programs for low- and moderate-income families.
- **Individuals with Disabilities Education Act (IDEA) grants** for infants, toddlers, and preschool provide education and intervention services for young children with disabilities.
- The **Social Services Block Grant program** allows states to spend funds in part on childcare and adult day care.

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[11] One specific type of policy, a tax credit paid out without regard to federal income tax liability (i.e., a refundable tax credit), can technically consist of both direct spending and tax expenditures. For the purposes of this paper, policies that include tax expenditures are considered tax-based care policies due to their delivery mechanism.

[12] Notably, during the COVID-19 pandemic, the federal government significantly increased direct spending on care. Childcare received a boost in funding through grants and subsidies to childcare providers, enabling them to stay afloat and continue providing essential services to families. Additionally, home- and community-based services were bolstered through increased Medicaid funding to states, allowing for expanded access to essential care services for older adults and people with disabilities.

- The **Military Child Development Program**, which represents the largest employer-sponsored childcare program in the United States, serves approximately 200,000 children of servicemembers and Department of Defense civilians.

Just four major programs make up an overwhelming share of direct federal spending on care: Child Care and Development Fund (CCDF), Head Start (including Early Head Start), Medicaid funding for institution-based long-term care, and the largest component, Medicaid funding for Home and Community-Based Services (HCBS), which dwarfs the other programs in size.

Smaller federal programs contributing to our nation's caregiving infrastructure include the Veterans Affairs Department's Program of Comprehensive Assistance for Family Caregivers (PCAFC), which offers compensation as well as health insurance, training, counseling, and other services to family caregivers of veterans (VA n.d.a), and the Department of Education's Child Care Access Means Parents in School (CCAMPIS), which provides competitive grants to higher education institutions to encourage campus-based child services targeting student parents with low incomes (Edgerton 2024). In addition, a few federal programs support job preparation and training for care workers.[13] Notably, the federal government lacks a paid family and medical leave program, which has in part spurred 13 states and Washington, DC, to guarantee many workers paid leave (Shabo 2025b).

Recent federal direct spending proposals aim to comprehensively expand access to affordable, high-quality care services for all individuals, encompassing various stages of life and diverse care needs. These include:

Childcare

- substantial funding increases for the Child Care and Development Fund, including Child Care and Development Block Grant (CCDBG), to expand eligibility and access to high-quality childcare for families (FFYF 2024a)
- universal prekindergarten programs to ensure all children have access to early learning opportunities that prepare them for success in school (ECD 2022)
- expansion of Head Start and Early Head Start programs to provide comprehensive early childhood education and family support services to low-income families (FFYF 2021)

Paid Family and Medical Leave[14]

- expanded paid family and medical leave programs to enable individuals to take time off work to care for new children, family members with serious health

[13] See Box 1 for more on workforce development programs.
[14] Paid family and medical leave direct spending programs often include a revenue-raising component—typically a payroll tax—as is the case for every state paid leave program in the United States. However, the wage replacement itself is not delivered through the tax code—and other revenue sources can be used to pay for the program.

conditions, or their own health needs without losing income or employment (Mayer 2024)

Long-Term Care

- Medicaid expansion and reform to cover a broader range of long-term care services and support individuals with disabilities and chronic illnesses (TCF 2024)
- Medicare expansion to cover additional and extended caregiving services, including home care, adult day care, and respite care, to support family caregivers and enable seniors and individuals with disabilities to live independently and age with dignity in their homes and communities (Neuman, Burns, and Rudowitz 2024)
- support for family caregivers through respite care, training, and financial assistance (ACL 2022a)

Care Workforce

- leveraging federal funding to raise wages, improve benefits, and expand professional development opportunities for childcare providers, home health aides, and other care workers, sometimes accompanied by stronger federal labor protections for care workers, including the right to organize and bargain collectively (CMS 2024a)
- expanded federal funding for training and education programs for care workers to ensure a skilled and qualified workforce, sometimes accompanied by immigration reform to provide a pathway to citizenship for undocumented care workers and ensure a stable workforce and higher quality care (PHI 2021)

These comprehensive proposals aim to create a care infrastructure that supports individuals and families at all stages of life, promotes economic security, and ensures that everyone has access to the care they need to live healthy, productive lives.

Federal Tax-Based Care Subsidies

Federal tax-based care subsidies are made up of four programs and are limited in reach and effectiveness. These provisions aim to reduce the financial burden on some families and incentivize employer-provided benefits.

- The **Child and Dependent Care Tax Credit (CDCTC)** is a nonrefundable credit that allows eligible families to claim a percentage of their work-related child or dependent care expenses up to the lower of a specific dollar limit or their federal income tax liability—but it cannot result in a tax refund. The amount of the credit is based on a percentage of expenses, with the percentage decreasing as income rises. Because the CDCTC is nonrefundable, many low- and moderate-income families with little or no net federal income tax liability do not benefit from it (Guarino 2024).

- The **Dependent Care Assistance Program (DCAP)** allows employees to set aside pretax income in an employer-sponsored flexible spending account (FSA) to pay for care expenses. DCAP is more likely to benefit higher-income taxpayers because it requires employer participation and the ability to forgo current income (FFYF 2024b). Additionally, because each dollar of DCAP exclusion results in a dollar-for-dollar reduction in the maximum expenses a taxpayer can apply toward the CDCTC, the two provisions can interact in ways that limit benefits (Smith and Osborn 2023).
- The **Employer-Provided Child Care Tax Credit** (Sec. 45F of the Internal Revenue Code) is a nonrefundable credit for employers who provide childcare benefits to their employees, such as onsite care or contracting with childcare facilities. This credit is meant to encourage businesses to offer childcare support, but it has seen low uptake (Stevens 2024).
- The **Employer Tax Credit for Paid Family and Medical Leave** (Sec. 45S of the Internal Revenue Code) is a tax credit for for-profit employers who provide paid family and medical leave to their employees (IRS 2024a).

Current proposals to reform tax-based policies for care and caregiving aim to address the limitations of existing provisions and promote greater equity, with a focus on aiding low- and moderate-income families. These include:

- making the CDCTC fully refundable so that low-income families with little or no tax liability can benefit, or increasing the maximum credit amount and the percentage of expenses that can be claimed, as well as indexing the credit to inflation (Guarino 2024)
- expanding the DCAP by increasing the amount of pretax income that can be set aside, (thus offering more help to those with higher incomes) (FFYF 2024b)
- reforming the 45F credit by increasing the maximum credit amount, expanding the definition of qualifying expenses, and creating a targeted system that favors small businesses and those in rural areas, while limiting windfall subsidies to larger businesses (Child Care Availability 2025)
- enhancing the 45S credit by making the credit permanent as well as expanding eligibility and outreach (Wielk 2024)
- introducing a tax credit for working family caregivers to offset the expenses of caregiving (Credit for Caring 2024)

While expanding the Earned Income Tax Credit (EITC) and Child Tax Credit (CTC) also could provide more support to families with care costs, these credits are not a substitute for direct investment in childcare programs.[15]

Proposed reforms generally acknowledge that the existing tax-based policies for care fail to adequately support low- and moderate-income families and exacerbate existing

[15] See Box 2.

inequities. While the tax code can be a tool for advancing equity, reforms need to be designed and implemented to complement direct spending programs and address the specific needs of low- and moderate-income families and the workforce—including the current and future care workforce—to ensure high-quality care. And no amount of reform to tax-based care policies can change the reality that direct spending programs offer the best foundation for providing any family the right support at the right time.

V. Why Direct Spending Is Better than Tax Subsidies at Meeting Families' Needs

How should policymakers evaluate direct spending versus tax-based policies? The following interconnected evaluation framework can help policymakers understand where policies, especially tax-based policies, fall short of the goal of efficiently, effectively, and equitably meeting our nation's care needs.

A Framework for Evaluating Care Policy Design

The framework consists of three overarching aspects of a policy or program: funding, access and reach, and quality. These aspects are further broken down into specific characteristics, and the framework provides criteria for evaluating the effectiveness of each.

Funding

Federal funding for caregiving can be allocated through direct spending or tax-based investments, each with their own set of funding structures that impact the stability and accessibility of care supports.

- **Funding Certainty.** The structure of federal funding significantly impacts the stability and accessibility of care supports. Investments in care can be mandatory (automatically funded) or discretionary (subject to annual appropriations negotiations in Congress and with the president), which determines the certainty year after year for those families who directly or indirectly rely on a particular funding source. Direct spending on care consists primarily of mandatory spending but includes significant discretionary spending, especially for childcare. Tax-based investments for care are currently mandatory, providing some funding stability. However, the level of certainty for individual families benefiting from tax-based subsidies depends on the policies' structure. Subsidies not tied to income or to tax liability provide consistent benefits, while those linked narrowly to federal income tax liability can fluctuate, limiting access for families during periods when their income may be low—often precisely due to caregiving responsibilities.

- **Funding Cap.** The decision to cap or leave open-ended the level of maximum spending of a care policy affects access to needed supports. Discretionary funding is always capped, while mandatory funding is sometimes capped and sometimes open-ended to allow for whatever spending materializes under program rules. Open-ended funding makes waiting lists or denials for otherwise eligible individuals, families, and other entities far less likely. Tax-based care funding currently is open-ended (uncapped) and available to all eligible applicants. Direct spending care investments, unfortunately, are sometimes explicitly capped, though they tend to be far more significant in size, scope, and reach due to their funding levels.

- **Funding Allocation.** The method by which funding is allocated can impact quality of care. Block grants to states (fixed sums based on formulas and statutory specifications), matched federal funding for states, and competitive grants to community-based organizations or localities are the primary allocation methods for direct spending on care. Block grants often offer states and tribes more flexibility, but are capped and thus incentivize states to reduce eligibility or access. In contrast, matched funding tends to be open-ended. Tax-based care funding is currently allocated based on eligibility, which occasionally includes some minimal quality standard or certification requirement. For either direct spending or tax-based investments, competitive grants can also offer more accountability vis-à-vis grant recipients, and allow the administering agency to directly incentivize higher quality services and supports. (Though no tax-based care program is currently capped, a capped tax-based care funding program targeting organizations providing care[16] could be distributed through a competitive process.)

Access and Reach

The accessibility of direct spending and tax-based care programs vary and can be evaluated by examining the program's level of responsiveness to families' needs, cash-on-hand requirements, and extent of provider choice.

- **Responsiveness to Families' Needs.** The status, eligibility, and needs of families often change, whether due to a physical move to a new region, changes in employment status or hours worked, other income volatility, a death in the family, or other circumstances. To differing degrees, direct spending and tax-based care programs facilitate integration with broader local or state care infrastructure—public and private, including for-profit and nonprofit providers—to help families fulfill their care needs across their changing

[16] Note that tax-based care policies distributing funds to community-based organizations would need to be available to nonprofits, while current employer tax-based subsidies for care are not.

circumstances. In some instances, direct spending care programs are the single largest payer for certain types of care and thus significantly influence market conditions, such as by making unsubsidized care options more affordable and making available a wide range of subsidized options. Direct spending can more easily and directly address barriers to access faced by different racial, gender, and geographic groups, such as language barriers and lack of transportation. Unfortunately, families can also face stigma depending on how eligibility is determined—initially and on an ongoing basis—for many direct spending programs. In addition, their choices may be limited by restrictions on how a program provides qualifying care—for example, by effectively putting preferred providers out of reach. Though tax-based care subsidies for families limit stigmatization, they frequently exclude or limit assistance for people with lower incomes, as well as nonprofit and public care providers.

- **Cash-on-Hand Requirement.** Both direct spending and tax-based funding for care providers operate through reimbursements for expenses, requiring providers to have upfront cash on hand. For direct spending, the reimbursements occur throughout the year, typically monthly. While this can be challenging for smaller community organizations, it is less so for states, insurance companies, and managed care organizations. Fortunately, direct spending does not require families to pay fully upfront for care. In contrast, tax-based care funding typically requires families and providers to incur costs that are later reimbursed just once a year, necessitating more upfront cash on hand. This poses a challenge for families and small businesses. Tax-based care subsidies using pretax dollars are less beneficial to families with low federal marginal income tax rates, as they need more support than the modest discount on care expenses that pretax spending provides. Pretax benefits are sometimes even detrimental due to use-it-or-lose-it rules (Shrove 2022) and complex interactions with the Child and Dependent Care Tax Credit (Smith and Osborn 2023). The cash-on-hand requirement is less of an issue for large for-profit entities.

- **Provider Choice.** Public and nonprofit employers and care providers are frequently excluded from tax-based care investments because these entities lack a net federal income tax liability. This exclusion undermines the ability of these entities, who often lack access to the same capital as for-profit entities, to compete with for-profit providers, potentially leading for-profit entities to undercut nonprofit providers in pricing (Haspel 2022). Placing nonprofit entities at a disadvantage can lead to a reduction in the quality of care and a decrease in access for those who rely on public and nonprofit services or otherwise cannot rely on for-profit providers (Aspan 2021). Because public and nonprofit entities often serve marginalized and underserved populations, excluding these entities from tax-based care investment may inadvertently reinforce existing disparities and limit the reach of essential services (Brickley 2024). At the same time, when

taken as a whole, both direct spending and tax-based care investments can promote some choice among providers, though tax-based investments as a category exclude publicly provided care.

Quality

The quality of a direct spending or tax-based program can be assessed on quality standard-setting incentives and processes and workforce investment potential.

- **Quality Standard-Setting and Incentive Potential.** Direct spending can require thorough and well-designed incentives and accountability mechanisms to be built into care services, thus advancing care quality—though this ability depends not only on the program funding and requirements but also on annual congressional appropriations for agency staffing. Tax-based care funding, on the other hand, has limited ability to improve care quality. Typically, this funding is provided for care that meets minimal and binary requirements—such as the provider having a Tax Identification Number (IRS 2024b)—with zero or nearly zero effect on provider quality. To be sure, to enforce quality, tax subsidies for care *could* be limited to providers that meet quality standards, but such a subsidy would almost assuredly fail to simultaneously improve quality *and* expand access to meaningful choices, including through support for widely preferred friend, family, and neighbor care. Direct spending programs and proposals, such as paid family and medical leave and Medicaid HCBS, offer more flexibility in helping families pay for different types of care.

- **Workforce Investment Potential.** Funding care directly allows for flexible and targeted investments in the care workforce, particularly at local and regional levels, depending on program rules. These investments can center on job quality and preparation, which in turn affects care quality. Tax-based care funding, however, is limited in its ability to support such investments. This is partly because tax-based administration and mechanisms cannot effectively discern variations in and hold entities accountable for workforce preparation, training, job quality, and other investment in a high-quality care workforce.

Evaluating the Design of Federal Caregiving Investments

Examining existing federal care investments helps illustrate how to apply this framework to assess the effectiveness of different programs. This section highlights key programs as representing defined approaches to meeting families' caregiving needs, starting with direct spending investment and followed by tax-based investments.

Direct Spending Care Investment Models

The following direct spending models are organized by how each model relates to and interacts with state governments, as well as a public provision model.

1. **Skipping States:** Federal programs that bypass states and fund caregiving directly at the local level, such as Head Start and Early Head Start
2. **Capping States:** Federal programs that provide capped funding to states, whether annually appropriated or automatically funded, such as the Child Care and Development Fund, which includes the Child Care Entitlement to States (CCES) and Child Care and Development Block Grant (CCDBG)
3. **Mandating States:** Federal programs that require states to use funding from a broader federal-state cost-sharing program on caregiving, primarily Medicaid Long-Term Care Institution Funding
4. **Allowing States:** Federal programs that permit states to use funding from a broader federal-state cost-sharing program on caregiving, primarily Medicaid Home and Community-Based Services (HCBS)
5. **Forgoing States (Public Provision):** Federal programs that directly provide care through funding and operation of care services, such as the Military Child Development Program and VA Nursing Homes

1. Skipping States: Head Start, Including Early Head Start

Federal Head Start and Early Head Start funding does not involve states and instead flows directly to sub-state entities, including private (for-profit and nonprofit) ones.

- **Funding:** As a discretionary program, Head Start's funding is subject to annual congressional appropriations, which can create uncertainty for grantees and families served. However, its long-standing bipartisan support has generally ensured consistent funding over time. (Though, the extreme right Project 2025, which has been a blueprint for the current Trump administration [Cruz et al. 2025], proposes eliminating the entire program [Holmes 2024].) The program operates with a funding cap, as determined by annual appropriations, which can limit its reach and contribute to long waiting lists (Prado 2017; NHSA 2023).[17] Funding is allocated through competitive grants directly to local public and private nonprofit and for-profit organizations, tribal governments, and school systems, allowing the Office of Head Start at the Department of Health and Human Services to ensure targeted accountability, technical assistance, and quality incentives. (Funding can be provided directly to community-based organizations because the program's early developers were appropriately

[17] To be sure, Head Start programs are required to maintain waiting lists (Lynch 2014).

concerned about the racial equity implications of relying on states to administer the program [Truschel 2022].)

- **Access and Reach:** Enrolled families do not need to pay for Head Start—there is no cost sharing in the program. However, the funding cap and inefficient and inequitable implementation variation across communities mean that in practice, Head Start programs reach less than half of children living in poverty, although all are eligible (Guevara 2022).

- **Quality:** The program's comprehensive performance standards and monitoring systems provide significant leverage to ensure quality across grantees. Additionally, Head Start's funding structure allows for investments in the care workforce, including requirements for staff compensation, qualifications, and professional development, which help ensure education and care quality for children and families.

2. Capping States: Child Care and Development Fund (CCDF)

The federal Child Care and Development Fund (CCDF), which includes Child Care Entitlement to States (CCES) and Child Care and Development Block Grant (CCDBG), comprises both guaranteed and annually appropriated flexible, capped funding for states.

- **Funding:** CCDF consists of two main components: the Child Care Entitlement to States (CCES), which provides mandatory funding, and the Child Care and Development Block Grant (CCDBG), which provides discretionary funding. The CCES is permanently authorized and provides a capped entitlement to states, while CCDBG funding is subject to annual appropriations. For FY2024, CCDBG is funded at $8.75 billion, while CCES provides $3.55 billion annually, bringing total CCDF funding to $12.3 billion (FFYF n.d.).[18] Funds are allocated to states, territories, and tribes through a formula (Lynch and Boyle 2023). States may also transfer up to 30 percent of their Temporary Assistance for Needy Families (TANF) funds to CCDF (Guevara 2024).

- **Access and Reach:** CCDF allows states to subsidize childcare for eligible families, typically those with incomes below 85 percent of the state median income, though states often set lower thresholds. States are required to cap childcare co-payments at 7 percent of family income or below, lowering the cost burden for families (FFYF 2024c). However, due to limited funding, only about 15 percent of income-eligible children are served by CCDF, leading to long waiting lists.

[18] These funding figures do not include state TANF transfers to CCDF, which totaled nearly $1 billion in FY2022, the latest year with data available (Lynch 2024).

Families are able to choose providers that fit their needs, although not all providers accept subsidies, limiting family choice (Lieberman 2023).

- **Quality:** The fund requires states to invest in improving the overall quality and supply of childcare, including supporting the childcare workforce through training and professional development opportunities. States have flexibility in implementing CCDF programs but must follow federal guidelines on eligibility, health and safety standards, and quality improvement initiatives.

3. Mandating States: Medicaid Long-Term Care Institution Funding

Medicaid funds long-term care at institutions through uncapped, federal funds. States are required to use these funds for caregiving.

- **Funding:** Federal Medicaid funding for long-term care at institutions comes with mandatory coverage requirements and provider standards, is open-ended (uncapped), and is automatically guaranteed to states. Medicaid is the primary payer for long-term care services in the United States (more than 60 percent of all spending [Chidambaram and Burns 2024][19]), with a significant portion (32 percent in 2021) of its funding directed toward institutional care (Colello and Sorenson 2023). Medicaid funding for long-term care institutions, including nursing homes and other residential care facilities, is composed of state funds and federal funds that match state spending at specified rates that vary by state per capita income (KFF 2025).

- **Access and Reach:** Medicaid eligibility rules are set within federal parameters on a state-by-state basis, based on income levels and household size (Medicaid.gov n.d.a). All children with family income below 133 percent of the poverty line are covered, and most enrollees have minimal or no cost-sharing requirement (Medicaid.gov n.d.b). About one in five Americans are covered by Medicaid, with wide variation across communities (Kliff and González Gómez 2025). Covering long-term care at institutions is mandatory for states participating in the base Medicaid program, which all states have opted to do.[20] However, staffing shortages and low reimbursement rates limit access and quality (Chidambaram, Burns, and Rudowitz 2023). In contrast, Medicaid HCBS (see "4. Allowing States") are considered optional services, leading to waiting lists and limits on eligibility based on location and other factors (Burns, Mohamed, and Watts 2023a).

[19] The Congressional Research Service estimates this figure at 44.3 percent due to different definitions of long-term care services.
[20] Some states have failed to opt into the Affordable Care Act's federally subsidized Medicaid eligibility expansion for otherwise excluded individuals with incomes up to 138 percent of the federal poverty line, but covering long-term care at institutions does not require opting into that expansion (Harker and Sharer 2024).

- **Quality:** Recent policy changes, including new reporting requirements and staffing standards, aim to increase transparency in how Medicaid payments to institutions are spent on direct care worker compensation and to improve the quality of care in these settings (CMS 2024b). Despite these efforts, chronic understaffing (Munday 2023) and high worker turnover rates (Scales 2021)—both stemming in part from low Medicaid reimbursement rates and low pay and job quality sector-wide (Martinez Hickey, Sawo, and Wolfe 2022; Pace et al. 2024)—continue to pose challenges for ensuring access to high-quality services in institutional settings.

4. Allowing States: Medicaid Home and Community-Based Services (HCBS)

Federal Medicaid Home and Community-Based Services (HCBS) allows individuals to receive services in their homes or communities rather than in institutional settings. Several state options and waivers permitted states to fund HCBS through Medicaid.

- **Funding:** HCBS funding for states is optional and flexible, but generally capped and federally regulated. HCBS is funded through a combination of federal and state Medicaid dollars, with states having significant flexibility in program design and implementation. The federal funding structure helps pay for both mandatory and optional services, with many HCBS programs operating under waivers that allow states to modify their Medicaid programs and target specific populations and services. HCBS spending under these waivers must be cost neutral, meaning states must demonstrate that they are not spending more than they would have without the waivers, though the total amount of spending is otherwise uncapped. Alternatively or additionally, states may choose among multiple state options to fund specific HCBS needs without facing cost neutrality requirements.

- **Access and Reach:** States typically allocate HCBS funding through a mix of provider reimbursements and self-directed options for beneficiaries where beneficiaries can identify family, friends, or other providers to be paid for their care and support needs (CMS n.d.). The HCBS program faces ongoing challenges, particularly workforce shortages, with nearly all 50 states reporting difficulties in recruiting and retaining direct care workers (Chidambaram, Mudumala, Burns, and Rudowitz 2024), and many eligible beneficiaries face long waiting lists (Burns, Mohamed, and Watts 2023).

- **Quality:** HCBS programs offer states leverage to ensure quality care through comprehensive quality assurance systems (Medicaid.gov n.d.c) and allow for investments in the care workforce through training and career advancement opportunities (MACPAC 2022).

5. Forgoing States (Public Provision): Military Child Development Program

Funding for the Military Child Development Program is allocated directly to military installations rather than through states, allowing for centralized quality control and accountability.

- **Funding:** The military's Child Development Program (CDP) operates as a discretionary program, with funding subject to annual congressional appropriations. The CDP is also partly funded through military families' childcare cost-sharing payments and other military-generated revenues (e.g., earnings stemming from military exchanges, which operate like retail stores [Torreon and Kamarck 2024]), with over $1 billion in congressionally appropriated funds spent in fiscal year 2021 (GAO 2023b).

- **Access and Reach:** The lack of open-ended mandatory funding has led to waiting lists, creating uncertainty for military families relying on these services (Pettypiece 2024)—despite the program's strong support within the Department of Defense and Congress. The program is the nation's largest employer-sponsored childcare program and supports approximately 200,000 children (Kamarck 2024). The program offers seamless integration for military families across different installations and duty stations, addressing the unique needs of frequent relocations and nontraditional working hours. Families pay subsidized weekly fees based on their income, with DOD covering the remaining costs, avoiding the need for families to have significant cash on hand (DOD 2024).

- **Quality:** The CDP ensures quality through mandatory national accreditation for its child development centers and through investments in its workforce through training and development opportunities (GAO 2023b).

Box 1. Federal Care Worker Workforce Development Investments

A high-functioning care system requires a well-compensated workforce that is prepared to meet the growing demands for services. Federal investments (virtually all through direct spending) in job preparation, retention, and advancement for child and direct care workers are spread out across several programs.

Medicaid Home and Community-Based Services (HCBS)

Medicaid HCBS funding encourages a variety of investments in direct care workers.

- States have flexibility in directing Medicaid HCBS funding to support the workforce through wage increases, training initiatives, and career advancement programs (Burns, Mohamed, and Watts 2023b).
- Enhanced federal matching funds for state HCBS spending during the COVID-19 pandemic helped states implement policies to stabilize the workforce, particularly by increasing worker wages (Lyons and Watts 2024).

Medicaid Long-Term Care Institutional-Setting Funding

The federal government recently finalized a rule that would increase nursing facility staffing requirements, necessitating the hiring of more staff (Chidambaram, Burns, Neuman, and Rudowitz 2024). These facilities currently serve 1.2 million people (KFF 2024b).

- The rule provides financial incentives for training and education.
- The rule requires transparency from states around compensation paid to direct care workers (Chidambaram, Burns, Neuman, and Rudowitz 2024).

Child Care and Development Fund (CCDF)

The CCDF, comprising the automatically funded Child Care Entitlement to States and the annually appropriated Child Care and Development Block Grant, supports quality improvement, including through workforce investments.

- States must use a portion of their funds to invest in quality improvements and may use set-aside funds to support training workforce initiatives (OCC 2015).
- States must develop a system of professional development for childcare workers and providers (OCC 2017).

Workforce Innovation and Opportunity Act (WIOA)

WIOA provides federal funding for workforce development programs that can support training for both direct care and childcare workers (DOL 2024b). Many WIOA programs also help participants access childcare while they receive job training (Durham et al. 2019).

- WIOA Title I programs fund job training and services for adults, dislocated workers, and youth.
- Local workforce boards can use WIOA funds to support sector partnerships and training programs in direct care and early childhood education fields.

Department of Health and Human Services (HHS) Administration for Community Living (ACL)[21]

- The relatively new Direct Care Workforce Capacity Building Center at HHS's ACL supports "recruitment, retention, and professional development of workers who provide home and community-based services" (ACL 2022b).
- ACL is also home to the Direct Care Workforce (DCW) Strategies Center, which provides tools and information sharing designed to help address the poor job quality and limited opportunities for advancement in direct care work (ACL 2024b).

Other Federal Programs

- The Senior Community Service Employment Program (SCSEP) program provides job training and part-time employment opportunities in community service settings (DOL n.d.), including long-term and childcare facilities (NCOA 2023), for unemployed low-income adults aged 55 and older.
- The Department of Veterans Affairs VA Caregiver Support program includes a Program of General Caregiver Support Services (PGCSS), which offers opportunities for caregivers of veterans to access skills training, peer support, coaching, and referrals to additional resources (VA n.d.b).
- The Department of Labor (DOL) and HHS collaborate on initiatives to improve data collection and support for both the direct care and childcare workforces (DOL and HHS 2024).
- Federal registered apprenticeship programs can be used to support training for direct care (ApprenticeshipUSA n.d.a) as well as early learning and childcare occupations (ApprenticeshipUSA n.d.b).
- HHS's Health Professions Opportunity Grants (HPOG) can utilize apprenticeship programs and support retention and advancement in the long-term care workforce (HPOG 2014).

Tax-Based Care Investment Models

Two existing federal tax-based care-focused programs each represent a distinct tax-based model defined by who each subsidizes:

[21] The Trump administration is abolishing the ACL (Gleckman 2025).

1. **Subsidizing For-Profit Employers:** Federal tax subsidies for for-profit employers to spend on employee childcare or paid leave
2. **Subsidizing Middle- and Higher-Income Families:** Federal programs that provide tax benefits to families with middle or high incomes who incur qualified care expenses

1. Subsidizing For-Profit Employers: Employer-Provided Child Care Tax Credit (45F) and Paid Leave Tax Credit (45S)

The Employer-Provided Child Care Tax Credit (45F) offers a tax subsidy to for-profit employers to provide childcare.

- **Funding:** As an open-ended mandatory tax provision, 45F provides funding certainty to eligible businesses based on their childcare expenditures.

- **Access and Reach:** While the 45F credit could integrate with broader care infrastructure by including referral services and allowing up to 70 percent of enrolled children at a subsidized facility to come from outside employee families, its impact is limited due in part to underutilization. In 2021, employers only claimed $15.5 million in associated childcare costs (Xu 2024). The credit's structure favors larger, more financially stable companies over smaller businesses, as it requires significant cash on hand by reimbursing up to 25 percent of qualified childcare expenditures and 10 percent of resource and referral expenditures, capped at $150,000 annually. This incentivizes investment in corporate childcare chains rather than smaller independent providers, limiting parental choice and diversity within the childcare ecosystem. Additionally, connecting childcare to an employer can create disruption for children if their parents change jobs. Despite this credit, employer-provided childcare is only available to about 11 percent of civilian workers as of 2021, with lower-paid workers having even less access (Crandall-Hollick and Boyle 2023). There is no evidence that this credit has demonstrably increased supply.

- **Quality:** The 45F credit has limited potential for improving overall care quality, despite employer investments in care worker training and scholarships qualifying for the subsidy. The credit carries minimal quality requirements beyond state and local licensing standards (Crandall-Hollick and Boyle 2023).

The Paid Leave Tax Credit (45S), the first federal paid leave policy in US history, subsidizes for-profit employers for providing paid leave.

- **Funding:** The 45S credit is a mandatory tax provision in place for leave taken through 2025. Its use by employers is voluntary (IRS 2024a). Lawmakers have

proposed making the credit permanent after the expiration of the Tax Cuts and Jobs Act (Wielk 2024).

- **Access and Reach:** The credit has been marked by limited uptake—and then primarily by the wealthiest corporations, who likely did not need it, which suggests that it has been inadequate for smaller and less profitable businesses (Shabo 2023). The credit rate varies from 12.5 percent to 25 percent of wages paid, depending on the percentage of normal wages provided as paid leave, with a minimum requirement of 50 percent of normal wages to be eligible (Cilluffo 2023). The credit is limited to certain lower-compensated employees, with a maximum compensation threshold of $96,000 for 2026 based on 2025 earnings (IRS 2024c). Its effectiveness in changing employer behavior is questionable, as some employers may receive a "windfall" for benefits they provided anyway. Indeed, nearly $9 in $10 (88 percent) of paid leave tax credits went to firms with over $1 billion in revenue between July 2020 and June 2021 (OTA 2023).[22]

- **Quality:** The credit lacks meaningful reporting or accountability mechanisms to ensure efficient and effective implementation and employers claiming the credit.

2. Subsidizing Moderate-to-High-Income Families: Child and Dependent Care Tax Credit (CDCTC)

The Child and Dependent Care Tax Credit (CDCTC) serves as a tax-subsidy model aimed at supporting moderate-to-high-income families with caregiving expenses.

- **Funding:** The CDCTC is an open-ended, mandatory tax provision providing all eligible applicant families a partial reimbursement once a year through annual tax filings.

- **Access and Reach:** As a nonrefundable credit, the CDCTC provides tax relief to eligible families who incur expenses for the care of children under 13 or other dependents who require supervision. The credit covers a percentage of up to $3,000 in care expenses for one dependent or $6,000 for two or more dependents, with the percentage ranging from 20 to 35 percent, based on the taxpayer's income. The CDCTC's impact is limited by its nonrefundable nature, which means that many millions of families who would otherwise be eligible but lack sufficient federal income tax liability cannot benefit fully from the credit (Crandall-Hollick and Boyle 2021). Taken together with a lack of a full phaseout of the credit for high-income households, this structure favors middle-to-high-income families who have enough tax liability to utilize the credit fully (Wielk 2025). Additionally, the CDCTC requires upfront cash payments from families, as

[22] Calculated by dividing the total number of dollars of claims during that time period by the dollars of claims only by companies with over $1 billion in revenue.

it reduces their tax liability only when they file their returns annually and claim the credit against incurred expenses. Just like the CTC and EITC, CDCTC rules regarding noncustodial parents (Buonincontri 2021) and who qualifies as a child create confusion and exclusion (TAS 2024).

- **Quality:** The CDCTC has limited potential for directly improving care quality, including by strengthening the care workforce, as it does not impose specific quality standards on care providers beyond basic compliance with state and local laws for dependent (including child) care centers (Crandall-Hollick and Boyle 2021).

Box 2. Federal EITC and CTC: Effective but Insufficient to Meet Our Care Needs

Though they fail to significantly help families with very low incomes, the federal Earned Income Tax Credit (EITC) and the Child Tax Credit (CTC), especially its refundable portion (Additional Child Tax Credit), improve health, economic security, and educational outcomes for low- and moderate-income working families, particularly those raising children. The tax credits provide after-tax cash income that can be used for meeting a wide range of personal and family needs in a country where cash is essential. However, these tax credits fall well short of addressing the full scope of families' *caregiving* needs in the United States:

- **Limited Impact on Care Quality:** Relying solely on tax credits like the EITC and CTC will not improve the quality of care. The credits do little to nothing to raise caregivers' hourly *wages* or weekly earnings (as opposed to annual household income through a lump sum tax credit once a year), attract and retain workers to build a care workforce pipeline, improve working conditions, or expand access to high-quality care options in underserved areas and during nontraditional work hours.
- **Exclusion of Certain Groups:** The structure of the EITC and CTC leaves out some families with caregiving needs. For example, the EITC's earned income requirement excludes those not in the formal labor market, including many students, people with disabilities, and some caregivers.
- **Complexity and Administrative Barriers:** Navigating the eligibility requirements and claiming processes for the EITC and CTC can be complex, particularly for low-income families. This can lead to reliance on paid tax preparers, which can reduce the net benefit received from the credits. EITC error rates are estimated at around 25 percent, the vast majority of which is due to the complexity of IRS rules around qualifying children (Greenstein, Wancheck, and Marr 2019). This leads to costly and time-consuming audits, and contributes to EITC claimants being audited at more than four times

the rate of all individual income tax filers (TPC 2024a). Barriers to filing taxes mean that many low-income families do not file at all and therefore don't receive tax credits they are eligible for (Anderson et al. 2022). Half of the very lowest-income eligible families don't receive the EITC, mostly because they do not file federal income taxes, even though they pay other taxes (Nichols and Rothstein 2015).[23] In addition, different eligibility requirements for the CTC and EITC contribute to confusion, as the same child might qualify a taxpayer for one but not the other (BPC 2022).

- **Insufficient Benefits Compared to Need:** While the EITC and CTC provide valuable support, the cost of care for families needing care typically dwarfs the value of even the maximum credits.

The EITC and CTC offer essential support for low- and moderate-income families with caregiving responsibilities by boosting their incomes in a country rife with low-paying work and a weak social protection system, and they are essential to expand. But they are ultimately **insufficient** tools for tackling the complexities of caregiving needs in the US. A two-pronged approach involving direct spending programs that establish a seamless care system and a more equitable tax system that raises more revenues to finance that spending is crucial to address the multifaceted challenges faced by caregiving families and the care workforce.

The Case for More Direct Spending on Caregiving Infrastructure

While tax subsidies for families can provide financial relief, they are often insufficient to address the systemic issues underlying the child and long-term care crisis (NWLC 2024b), such as low wages for early educators and other caregivers, care supply mismatched with where people live and work, and lack of access for families with nontraditional work hours (Boteach et al. 2019). Paid leave delivered through tax credits paid out once a year would poorly match the timing of families' financial needs—often excluding those with the greatest needs—while pretax child and dependent care accounts for families do little to help those with the greatest need for financial support. Tax subsidies for employers would risk doing as much or more to boost employer profits as they would to boost actual leave available to American workers, as the subsidies are largely captured by employers who already do or would provide leave without the incentive. Tax subsidies for care providers may be able to incentivize supply, but they cannot help build a seamless system of high-quality care options—and

[23] Data suggest that those eligible for credits under $100, especially in the phase-in range, had take-up rates below 40 percent, likely due to low filing rates among individuals with minimal earnings.

the quality care jobs such a system requires—that would help families meet their needs with ease. From a fiscal perspective, tax-based care subsidies often provide less bang for the buck than a direct spending approach with the same accounting cost. And tax-based subsidies have never been scaled up to even remotely meet families needs, probably in part because they are so inefficient.

More specifically, there are several overlapping reasons why focusing more on tax subsidies would be insufficient, inefficient, ineffective, and inequitable as a national caregiving strategy.

Mistargeting

Tax-based care policies often spend money on higher-income families without meaningfully increasing care supply or care quality, while failing to support many working- and middle-class workers and their families.

- **Greater waste:** Tax-based care spending tends to be less efficient and less fiscally responsible than direct spending on care. Because tax subsidies are often blunt, allow for limited administrative discretion, and are often provided for services that would have existed regardless, they are less able to increase and improve care than are direct spending programs.

- **More regressivity:** Tax-based care investments are consistently tilted to higher-income households for families' care needs. Tax benefits like the Dependent Care Assistance Program (DCAP) primarily benefit higher-income families who have more disposable income to incur care expenses pretax (NWLC 2024c). Similarly, the current structure of the nonrefundable CDCTC means a large proportion of the benefit goes to higher-income households, despite the significant non-federal-income-tax taxes paid by low-, moderate-, and middle-income households (Boteach et al. 2019). This is largely a design choice that can be addressed, but even a well-designed care tax subsidy may struggle to reach families with the greatest need, as families who are less likely to interact with the federal income tax filing system are disproportionately low income (Gee et al. 2024; TPC 2024b; Orszag and Hall 2003).

- **Limited reach:** In addition to being regressive—and partly *because* they are regressive—existing care tax subsidies have limited reach. Some low- and moderate-income families are not required to file federal income taxes annually and thus do not. In addition, tax subsidies for families require significant cost sharing and are thus too small to meaningfully help millions of families. Employer-provided childcare benefits and tax credits for businesses providing childcare are not widely utilized (NWLC 2024c) and have not been effective at expanding access to care (Crandall-Hollick and Boyle 2023).

- **Cash-on-hand requirement:** Current tax-based subsidies require families (and businesses) to be able to afford care up front. Many working- and middle-class families (and small businesses) cannot afford to prepay their expenses or set aside in advance sufficient funds for an employer-sponsored pretax spending account, which they frequently lack access to in the first place. Though the IRS has shown itself capable of paying tax subsidies in advance of filing time, doing so is rare historically and nonexistent currently, has always risked families unexpectedly owing money at filing time (Boteach et al. 2019), and likely would lag behind the speed of what direct spending could accomplish. Advance payments could and should have robust safe harbor protections, otherwise risking significant repayments by well-meaning taxpayers whose circumstances change during the tax year. Regardless, current care tax credits do not allow for advance payments.

Administrative Constraints

Tax-based care funding often fails to meet diverse needs, ensure adequate supply, support preferred care options, or be easily administered, and other agencies may be better equipped to oversee care systems.

- **Limited flexibility:** Even beyond mismatched timing and limited reach, tax-based care funding is unable to meet diverse family and community needs. A more tax-focused approach would not likely ensure adequate supply during nontraditional hours or in rural areas. It likely would not support nonprofit or public care options that families may prefer. Though a tax-based approach could include competitive grants and reach the state or community-level to support tailored approaches, such as the New Markets Tax Credit (NMTC) does for promoting private investment in distressed communities, in practice, no care-focused tax subsidy does so (TPC 2024c).

- **Challenging administration:** Though it can be relatively seamless and stigma-free to transfer resources via the IRS to families, as in the case of the Child Tax Credit, tax subsidies can also involve sophisticated administration and coordination exceeding the IRS's expertise and—now declining (Duehren and Schmidt 2025)—infrastructure, the risk of devastating audits of well-intentioned families struggling to make ends meet, and overly complex eligibility requirements set by Congress (Boteach et al. 2019). Although interagency coordination and collaboration is often desirable, HHS on its own has nearly all the expertise required to effectively implement and oversee childcare and long-term care systems, with workforce expertise contributions from the DOL and potentially the Education Department. The Social Security Administration also has the expertise and much of the data needed to effectively implement and oversee a comprehensive paid family and medical leave program.

Ineffective Quality Improvement

Tax-based care investments are limited by weak incentives, few accountability tools, and an inability to sufficiently direct workforce investments; in contrast, direct spending can effectively improve quality and choice simultaneously.

- **Limited quality standard-setting and incentives:** Tax-based care investments typically have weak or blunt incentives and accountability tools. Direct spending programs, however, allow for the oversight and regulation that is crucial for maintaining and improving care quality. By setting performance standards for providers (Kahn 2024), monitoring their performance, and providing training and support, these programs can help ensure that care meets the needs of individuals and families. Tax subsidies often lack the same level of oversight, standards enforcement, information sharing, and learning loops in part because of how they are administered. To be sure, tax-based approaches could be better designed to promote quality (Hamm and Martin 2015), but even the strongest proposals struggle with providing parents meaningful choices such as friend, family, and neighbor care and are subject to the other pitfalls described here. As a result, tax-based care policies focused on quality depend meaningfully on complementary direct spending.

- **Limited workforce investment:** Tax-based care funding can expand care access but falls short in its ability to directly boost care job preparation, quality, retention, and advancement. Though policies could be designed to boost take-home pay and benefits for care workers, tax-based spending does not do so now and is relatively ill-equipped to do so when compared to direct spending (NWLC 2024b). Indeed, one prominent set of bipartisan Senate bills intended to strengthen our care infrastructure relies on tax provisions to advance affordability, but direct spending provisions to ensure workforce investments (Kaine 2024).

Policymakers Have Recognized the Benefits of Direct Spending

An analysis of federal care expenditures makes clear that federal spending on care programs—though well below the levels we need, as documented throughout this report—is overwhelmingly composed of direct spending programs. Direct spending programs represent an estimated 98 percent of all care spending, in part due to the Medicaid spending on long-term supports and services (see Direct Spending on Care Work workbook), which represents an estimated 88 percent of overall care spending. Yet, even if we exclude Medicaid long-term care spending, childcare direct spending

represents at least 76 percent of total *dependent* care spending.[24] This finding runs counter to the idea that policymakers generally prefer spending federal dollars through tax-based policies rather than direct spending, at least when it comes to care investments at a meaningful scale. In reality, policymakers have, over many decades, strongly—and correctly—preferred direct spending over tax-based spending to address families' caregiving needs.

2025's Tax Reform Presents Significant Risks

This year's tax reform presented a rare opportunity to restructure the tax code and federal spending to support caregiving. Doing so would require a comprehensive approach that leverages both tax changes to raise revenue *and new direct spending*. Instead, policymakers seem on track to do the opposite. The 2017 Trump tax cuts that are set to expire this year would cost more than $4 trillion over 10 years to extend (OTA 2025), and additional tax proposals under consideration could cost trillions more (TaxNotes 2025). Many lawmakers are on the record having called for these tax cuts for the ultra-wealthy and big corporations to be paid for in part by cutting investments in American families. Thus, the 2025 Republican agenda may significantly shrink childcare assistance by eliminating Head Start, slash Medicaid and its long-term funding directly or indirectly through cost shifts to states, and undermine prospects for comprehensive paid family and medical leave with feeble policies and the gutting of revenues. These proposals could harm families' ability to get the care they need in multiple ways.

Starving Our Nation of Tax Revenues

Continuing to cut taxes, especially for the wealthy, causes far-reaching harms to our care infrastructure. These tax policies not only decrease government revenues but also pose a significant risk to existing care investments. Tax breaks for the rich can lead politicians to offset the reduced funds available to the government by further cutting childcare assistance (including Head Start) and Medicaid, which accounts for more than half of the $400 billion-plus spent annually on long-term care in the United States (Chidambaram and Burns 2024). These cuts would further the pattern of the wealthy benefiting from tax breaks while the rest of us bear the brunt of the resulting austerity measures. The erosion of existing investments can have long-term consequences for living standards and social mobility, further entrenching class, gender, and racial inequities and hindering upward mobility.

Cutting Crucial Spending

Republicans are exploring trillions in potential cuts to offset tax cuts and other priorities.

[24] Data do not readily permit estimation of dependent care tax expenditures for children versus other dependents.

Cutting childcare assistance: Project 2025, a conservative policy blueprint, proposes completely eliminating Head Start, which has served nearly 40 million children over 60 decades (NHSA n.d.). This would severely restrict access to childcare, especially in rural areas (Peeks 2024).

Cutting long-term care assistance: The most substantial risk for long-term care is deep cuts to Medicaid, which would severely impact long-term care funding:

- House Republicans are proposing potentially $880 billion in Medicaid cuts over 10 years (Sperling 2025). These cuts could include imposing per capita caps on federal Medicaid spending, reducing the federal share of costs for Affordable Care Act expansion, and imposing work-reporting requirements (Rudowitz et al. 2025; Park 2025).[25]
- Such drastic cuts would likely force states to reduce the number of people covered (Rudowitz et al. 2025), limit benefits, and cut payment rates for providers like nursing homes. The nursing home sector is expected to face significant impacts, as over 60 percent of nursing home residents rely on Medicaid (Siddiqi 2025). Rural areas and providers are likely to be disproportionately affected by potential Medicaid cuts (McAuliff 2025).

Cutting other relevant programs: Other programs that may be cut currently free up family resources or complement larger care programs. For example, eliminating the Social Services Block Grant and TANF Contingency Fund—both options under consideration (TaxNotes 2025)—could increase pressure on Medicaid and childcare assistance programs.

Falling Dramatically Short on Paid Leave

Though there are no publicly known plans to undermine state paid family and medical leave programs or military employees' paid leave in the 2025 reconciliation bill, previous Republican proposals have focused on more limited approaches to paid leave, such as using unemployment insurance systems or tax credits and providing only parental leave (McSwigan and Moller 2024). Regardless, the absence of a comprehensive federal paid leave program means that any cuts related to other care programs will further undermine workers' ability to juggle care responsibilities.

[25] While these deep cuts to Medicaid would harm all of us, they would have a devastating impact on older adults and people with disabilities, particularly those from low-income communities and communities of color, who rely heavily on these services. These Medicaid cuts would also place an even greater burden on family caregivers, who are disproportionately women.

Relying on Tax Policies Alone

Though direct spending is broadly allowed as part of the 2025 tax bill, Republicans developing the bill may not include any net increases in direct spending directed at care. As this report argues, tax policies will necessarily fall short of delivering the care infrastructure Americans need—a care infrastructure that should ensure adequate funding, universal access and reach, and high care quality. While some care-focused tax proposals may provide some families relief, they will likely disproportionately benefit higher-income families, who are less likely to be headed by single mothers or people of color, thus widening existing harmful disparities.

Although these proposals are being discussed, they are not yet finalized. President Trump indicated earlier this year that he would not cut Medicaid (Brownstein 2025), though he left open the possibility of reductions ostensibly limited to "abuse or waste" (Leonard 2025). Yet House Republicans subsequently moved forward with a budget resolution potentially requiring an astonishing $880 billion in 10-year cuts to Medicaid (Blake 2025), which Trump subsequently endorsed (Budget Committee 2025).

If politicians were serious about meeting our nation's care needs, they would make investments in childcare, long-term care, and paid leave through multipronged legislation that isn't limited to tax changes. An integrated approach of combining *reformed* tax-based policies with increased and well-designed direct spending is essential to strengthen the caregiving infrastructure and, in turn, enable greater workforce participation, improve child development outcomes, support economic wellbeing for families, and boost our national economic competitiveness.

VI. Policy Considerations

When developing and implementing comprehensive caregiving policies that are sufficient, efficient, effective, and equitable, policymakers must address several key considerations and potential concerns.

Sufficient and Efficient Funding

- **Sustainable Revenue Sources:** Identify sufficient, stable, long-term funding sources to support or offset the upfront fiscal cost of expanded caregiving programs. This may include a combination of new and more progressive taxation, closing tax loopholes, and savings from undesirable current spending outside of programs that meet working- and middle-class families' needs.
- **Cost-Sharing Mechanisms:** Explore options for cost sharing between federal and state governments, as well as employers and high-income households, to distribute the financial burden fairly.

- **Invest in Supply and Demand:** Our care infrastructure suffers from both insufficient supply and financial demand, though the need for greater care is readily apparent. Thus, policymakers should explore investments in both sides of the coin.

Effective, Quality Care

- **Balancing and Integrating Sectors:** Leverage the strengths and acknowledge the weaknesses of public, private for-profit, and nonprofit care providers to create a balanced care system that creates high-quality options for all families of all incomes in all communities. Consider whether incentives for employer-provided care benefits complement and integrate with the rest of our care infrastructure, especially when workers change employers.
- **Evidence-Based Quality Measures:** Establish quality measures that are grounded in empirical evidence and reflect best practices in care provision while ensuring meaningful provider choices adapting to families' actual lives.
- **Quality Reporting and Accountability:** Standardize reporting requirements across all provider types to facilitate comparisons and ensure transparency, and implement clear accountability mechanisms to track performance, identify areas for improvement, and incentivize high-quality care.
- **Advancing a High-Quality Care Workforce:** Explore strategies to professionalize the care workforce, including improved training, competitive wages and benefits, and career advancement opportunities, recognizing the essential role care workers play in delivering high-quality care.

Equitable Access and Utilization by Working- and Middle-Class Families

- **Limiting Discriminatory Policies:** Ensure that policies do not discriminate against or exclude people when they are struggling to find stable work or unemployment and most need care support.
- **Seamless Integration of Existing Programs:** Because families' eligibility for care programs can shift due to changes in income, employment, and location, which may create instability and challenges in accessing consistent care, ensure that there are no gaps in the care infrastructure. Consider how care programs adapt to these changing needs and access barriers of families, while avoiding stigma against families who have fallen on hard times (often due to caregiving needs).
- **Targeted Outreach:** Develop strategies to increase awareness and uptake of caregiving support programs among working- and middle-class families who may be less likely to access public supports.

- **Flexibility for Local Needs:** Allow for some degree of state and local flexibility in program implementation to address regional, and especially local, variations in caregiving needs and costs, as well as labor market differences.

VII. Policy Recommendations

In light of these considerations, policymakers can develop a more robust, equitable, and effective caregiving infrastructure that meets the diverse needs of American families while managing fiscal responsibilities by adopting the following recommendations:

1. Increase Direct Spending on Care Infrastructure

- Make Home and Community-Based Services (HCBS) required under Medicaid to ensure equitable access to long-term care services across all states.
- Increase federal Medicaid support for HCBS to expand access to long-term care services for older adults and people with disabilities and bolster the direct care workforce.
- Implement a nationwide paid family and medical leave program that ensures all workers receive adequate income replacement to mitigate financial strain during a period of leave to address their own medical needs or to care for loved ones. This program should offer progressive wage replacement so that lower-paid working people receive a higher percentage of their typical earnings.
- Expand mandatory childcare funding, potentially through CCDF, to guarantee long-term access to high-quality childcare for low-to-middle-income families and good jobs for early childhood educators.
- Develop and implement a robust public option for care, which through direct public management can prioritize equitable provision.

2. Reform Tax-Based Care Policies

- Short of the long-term goal of reallocating the 45F and 45S tax credits to more efficient and inclusive direct spending programs that support care providers, workers, and families, refocus the 45F and 45S tax credits to prevent them from primarily benefiting large and highly profitable companies, such as by making them more accessible to workers at smaller employers.
- Short of reallocating the Dependent Care Assistance Program (DCAP) (sometimes referred to as employer-sponsored Dependent Care Flexible Spending Accounts) to direct spending programs supporting care workers and families, limit DCAP's utilization by higher-income households and reallocate a portion of the revenue savings toward expanding the Child and Dependent Care Tax Credit (CDCTC).

- Short of reallocating the CDCTC to direct spending child and dependent care assistance programs that better supporting low- and middle-income families, make the CDCTC fully refundable so that it does not discriminate against people who only pay federal payroll taxes, local sales and property taxes, and state sales, property, and income taxes because they owe no net federal income taxes in a particular year.

3. Align Tax and Direct Spending Policies

Short of reallocating spending through tax programs on more effective and efficient direct spending programs,

- *expand* eligibility criteria for tax-based care policies to better align with direct spending care policies;
- align benefit and phaseout levels of remaining tax-based care policies with direct spending care policies to create a more seamless system of support for families across the income spectrum; and
- integrate remaining care tax credit outreach with direct spending programs to improve program participation rates among eligible families.

4. Expand Choice by Investing in Supply and Demand

- Prioritize additional grant funding for the development of nontraditional hour care options in underserved areas, including through subsidies, quality support, and technical assistance for friend, family, and neighbor care.
- Fund and require states to offer a range of care options, including center-based and home-based care, in areas with insufficient supply.
- Directly finance the creation of childcare and long-term care options in underserved areas.
- Target policies to reduce care disparities for underserved communities and ensure inclusivity of diverse family arrangements—including sandwich generation (three or more generation) families—and cultural needs.

5. Invest in the Caregiving Workforce

- Require states and localities receiving significant federal care or workforce development funding to develop career pathways (Guevara 2023) and professional development opportunities in the caregiving sector to improve job quality and retention (ACL 2024c).

- Tie increased funding to states through existing childcare and long-term care funding to competitive compensation for childcare workers, direct care workers, and other caregiving professionals.

6. Leverage Tax Reform to Fund Care Investments

- In 2025, allow tax cuts for high-income households to expire as scheduled to fund much-needed care infrastructure.
- Close tax loopholes exploited by the wealthy and corporations, such as carried interest deductions, offshore tax havens, and excessive executive compensation deductions, to ensure that wealthy individuals and corporations pay their fair share to fund essential care infrastructure and other national priorities.
- Expand and strengthen taxes on wealth and high incomes by raising estate and gift taxes, capital gains and dividend taxes, corporate taxes, and taxes on those with the highest incomes so that those with the greatest financial capacity contribute more significantly to funding essential care infrastructure and other national needs.

VIII. Conclusion: A Vision for a Comprehensive Caregiving Infrastructure

The current state of the caregiving system in the US demands a significant increase in public investment. This investment should focus on expanding access to affordable and high-quality care, improving the wages and benefits of care workers, and creating a more flexible and inclusive caregiving infrastructure that meets the needs and preferences of all families. Failing to prioritize public investment in caregiving will perpetuate existing inequalities and harm families, the economy, and society as a whole. How we deliver that investment will matter too—in the real lives of real people. Direct federal spending, outside of tax subsidies, is an essential tool in making sure our future public care investments work equitably and effectively.

Caregiving investment through direct spending offers numerous benefits. Not only can it ensure that our care systems reach *everyone* who needs care, but it permits a comprehensive strategy that may be likelier to garner strong public support, as it addresses the diverse needs of families across different socioeconomic backgrounds and geographies. Moreover, direct spending supporting caregiving helps manage risks by creating a more resilient and adaptable caregiving infrastructure that can respond to changing societal needs and unforeseen challenges.

The economic and social benefits of direct spending on caregiving are substantial and better documented than tax-based spending on caregiving. For example, research confirms that spending on childcare assistance significantly raises employment for the

population targeted—low-income women with young children (Burgess, Chien, and Enchautegui 2016). Increased investment can boost labor market participation and productivity by enabling more individuals, particularly women, to enter or remain in the workforce. This, in turn, helps close the gender wage gap. For children, improved access to high-quality care and early education can lead to better developmental and educational outcomes, with long-term positive benefits for society.

Direct spending on caregiving also has a greater potential to significantly improve the health and well-being of both care recipients and caregivers, both paid and unpaid. Providing more seamless and timely support and resources reduces the physical and emotional toll often associated with caregiving responsibilities. Furthermore, investing in the caregiving workforce through improved job quality, wages, and benefits can lead to better outcomes for paid caregivers, reducing turnover and enhancing the quality of care provided.

Prioritizing public investment in caregiving through direct federal spending is not just a matter of economic fairness; it is an economic imperative. By creating a more robust, equitable, and effective caregiving infrastructure, we can address longstanding inequalities, support families, and foster a more productive and inclusive society. The benefits of such investment—financed by higher tax revenues—will ripple through our communities, strengthening our economy and improving the quality of life for millions of Americans. As we move forward, it is crucial that policymakers and stakeholders work together to implement comprehensive caregiving policies that reflect the diverse needs of our nation's people and lay the foundation for a more caring and prosperous future.

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