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Could more seniors use the tax code to help pay for medical care?

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Introduction

Despite nearly universal coverage by Medicare for those over age 65, out-of-pocket medical costs represent a significant budget item in retirement. Medicare enrollees are not subject to out-of-pocket spending caps and some services (e.g., dental, hearing aids, long-term care) are not covered by Medicare. While several programs seek to reduce out-of-pocket spending among certain Medicare beneficiaries, not all low-income Medicare beneficiaries qualify for support for these expenses, and not all who are eligible are enrolled (Caswell & Waidmann, 2017). As a result, half of Medicare beneficiaries spend at least 16% of their income on premiums, cost-sharing, and non-Medicare-covered services, and the share of income is higher among Black and Hispanic beneficiaries (17% and 23%, respectively) (Noel-Miller, 2023).

The tax code subsidizes certain out-of-pocket medical expenses for those who qualify. Households can deduct eligible medical expenses from income on their tax returns as itemized medical deductions (IMDs). Eligible expenses include those paid that year for medical and dental care for the taxpayer, their spouse, and their dependents that exceed 7.5% of adjusted gross income. These can include payments to doctors and hospitals, premiums for insurance policies, and many services and items health insurance typically does not cover, including the costs of home improvements made due to a disabling condition and transportation and lodging for medical purposes. In aggregate, IMDs totaled $75.9 billion in 2021, with over two thirds of the total deducted by tax units headed by someone 65 or older (IRS, 2022). IMDs are estimated to reduce federal tax revenues by almost $10 billion, approximately a third of the forgone revenue as a result of mortgage interest deductions (U.S. Treasury, 2023).

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Are all eligible households aware of this subsidy? And do all households that qualify take advantage of it? Claiming the IMD requires incurring medical spending above the income threshold, filing a tax return, keeping track of qualifying medical expenses and other potential itemized deductions (such as charitable donations), and determining whether it's advantageous to itemize deductions rather than claim the standard deduction. Similar to the numerous steps required to apply for social insurance benefits or the complexity of enrolling in a retirement plan, it is possible that the steps required to receive the tax savings from the IMD result in people not claiming tax benefits they're eligible to receive.

This study examines what share of eligible deductions (and their associated tax savings) is claimed, and what share of households have eligible spending that is not claimed. It also explores potential reasons some taxpayers are leaving tax savings on the table, and the impact of any frictions associated with claiming benefits have on how tax savings from the IMD are distributed among the population.

Key takeaways:

- Half of all eligible medical deductions and 62% of associated tax savings are claimed, resulting in about $65 billion in forgone medical deductions and $5.4 billion in forgone tax savings among households with someone age 50 or over each year.
- Approximately 18% of households fail to take full advantage of the IMD and forgo $4,714 in annual deductions on average.
- The share of eligible medical deductions claimed is lower for those with lower levels of education, lower income and wealth, and those with worse health, but there are no significant differences in claiming rates by race/ethnicity.
- Households claim a higher share of eligible deductions as they are eligible additional times, suggesting that households learn about the deduction over time.
- Among those who are eligible, those who claim the medical deduction are healthier, spend less on medical care, and have higher income and wealth relative to those who do not, suggesting that frictions associated with claiming benefits make it harder for high-need populations to access these tax subsidies for medical spending.

Data and methods

To determine whether people claim IMDs they're eligible for requires data that allows one to observe both detailed information on out-of-pocket medical spending, income and other financial data that may go on someone's tax return, and data on tax filing behavior. These data are available between 1995 and 2012 from the Health and Retirement Study (HRS), a biennial, nationally representative panel study that surveys approximately 20,000 respondents age 50 and over and their spouses.

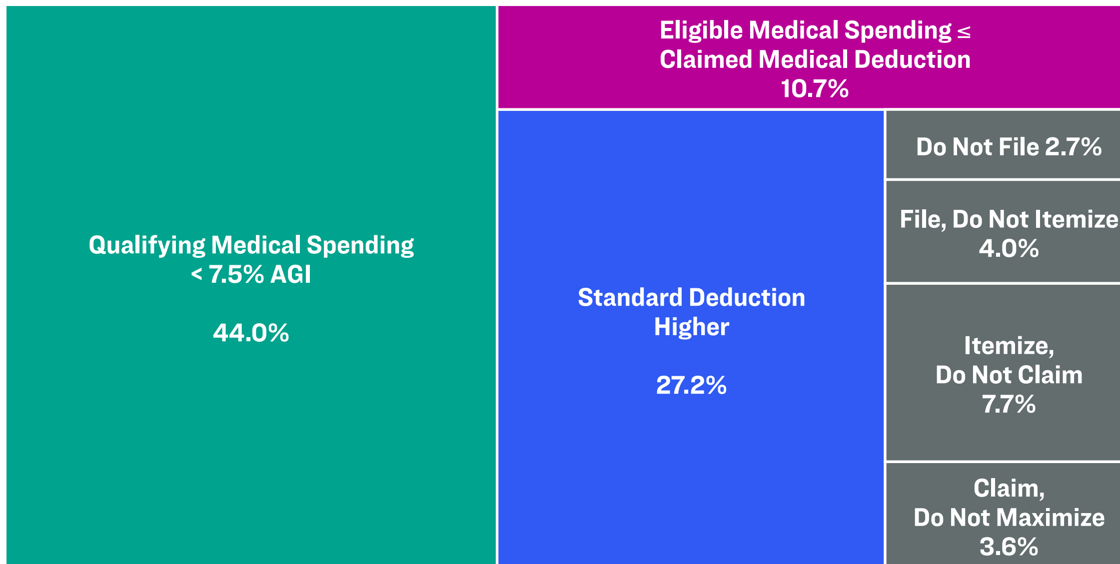
The HRS provides measures of out-of-pocket medical spending for hospital, nursing homes, outpatient surgery, doctor visits, dental bills, prescription drugs, home health services and other medical costs as well as measures of amounts paid for health and long-term care insurance premiums. Financial variables include various components of income that can be used to build a proxy for adjusted gross income (AGI), and data on whether households filed a federal income tax return, itemized their deductions, itemized medical deductions, and how much was claimed.

These data allow me to determine both claimed and forgone IMDs for each household, matched with other demographic and socioeconomic characteristics to examine how eligibility and claiming of the medical deduction varies across different groups. I combine these data with a tax calculator, TAXSIM, that calculates state and federal tax liabilities with and without the medical deduction in order to construct measures of claimed and forgone tax savings for each household. The calculations take into account that even if households spend more than 7.5% of their AGI on medical care, some of those households wouldn't benefit from itemizing their deductions and would be better off claiming the standard deduction. All analysis is reported in 2023 dollars.

Results and implications

Figure 1 shows the distribution of households by the presence of forgone medical deductions. As shown in the figure, 44% of households don't spend enough on medical care to exceed the 7.5% of AGI threshold. Approximately one quarter (27%) do spend more but wouldn't benefit from itemizing their deductions because their standard deduction is higher than their itemized deduction would be, even if they fully took advantage of the medical deduction. While 10.7% of households claim the medical deduction, another 18% are either not claiming the deduction when they could benefit or are claiming it but not maximizing its full potential.

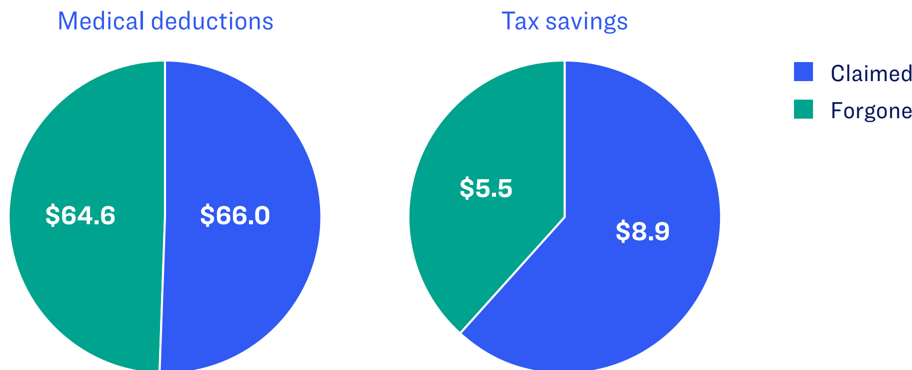
FIGURE 1. DISTRIBUTIONS OF HOUSEHOLDS BY PRESENCE OF FORGONE MEDICAL DEDUCTIONS



Notes: Author's calculations using Health and Retirement Study, Waves 3–11, 1995–2012. Share with forgone medical deductions includes households that don't file or itemize with eligible medical spending above standard deduction, and households that itemize and don't claim the medical deduction or don't maximize the amount claimed. All values are reported at the household level and weighted using household weights. See *Research Dialogue* for more details.

Aggregating over all households represented in the HRS using household weights, I find that $66.0 billion dollars of medical deductions are claimed each year (Figure 2). However, almost the same amount, $64.6 billion dollars in annual deductions, is estimated to be forgone annually. Figure 2 also shows claimed and forgone tax savings aggregated over these households. While older households receive $8.9 billion in tax savings annually from the IMD, by not claiming all potential medical deductions, older Americans are leaving approximately $5.5 billion in tax savings on the table each year.

FIGURE 2. CLAIMED AND FORGONE MEDICAL DEDUCTIONS AND ASSOCIATED TAX SAVINGS



Notes: Author's calculations using Health and Retirement Study, Waves 3–11, 1995–2012. All dollar values represent annual figures reported in 2023 dollars. Tax savings include federal and state tax values. See *Research Dialogue* for more details.

What characteristics are associated with forgoing medical deductions and the corresponding tax savings? I find that households with lower levels of education, income and wealth and households with poorer measures of health are more likely to forgo claiming IMDs for which they are eligible. However, I do not find evidence that the share of eligible deductions claimed varies by race and ethnicity.

I next turn to potential explanations of why households may neglect to claim the tax savings for which they are eligible, a finding that mirrors research in the context of various other forms of social insurance, e.g., unemployment benefits or nutritional assistance. The three main classes of explanations include 1) lack of awareness; 2) the hassle costs of claiming benefits (e.g., tracking medical spending, determining eligibility, and having to verify your spending in the case of an audit); and 3) stigma associated with claiming public benefits. While stigma is unlikely to be a large factor in this context given tax returns are not visible by others, it is possible that lack of knowledge about the medical deduction or the numerous and complex steps involved in claiming the deduction result in fewer households taking advantage of it.

Since the HRS samples the same respondents every two years, we can observe some households eligible for the IMD multiple times. We see that each subsequent time a household is eligible for the IMD, they are more and more likely to take advantage of it. This finding is consistent with the idea that households learn about the deduction as they are eligible longer, and suggests that lack of awareness can explain, in part, why all eligible deductions are claimed.

If the hassle costs of claiming the IMD are a factor in explaining why not all households claim the medical deduction, we might expect that in situations where the subsidy is more generous, a larger share of eligible deductions are claimed. Indeed, if we compare households in different states that vary in their tax rates but are otherwise similar, we find that the households that live in high-tax states—and thus stand to gain more from deducting their medical expenses—are more likely to claim the IMD, all else equal. This suggests that hassle costs play a role in explaining why some households do not take advantage of the IMD as the savings need to be large enough to justify these non-monetary costs.

Some theorize that making public resources harder to obtain will result in those who are the neediest receiving benefits, but this study's findings point in the other direction. Restricting attention to only those eligible for the medical deduction, the data show that those who claim the IMD are healthier on several dimensions and have higher income and wealth. Specifically, those who are eligible and claim the IMD are younger, more highly educated, more likely to be married and more likely to be working than those who are eligible and don't claim the deduction. Eligible claimers have fewer limitations in activities of daily living (ADLs), are 22% less likely to report being in fair or poor health status, and spend $3,010 less each year on medical care as compared to eligible nonclaimers. Finally, eligible claimers have 117% higher AGI, 82% higher income, 48% higher financial wealth and 37% higher wealth overall than those who are eligible and don't claim the medical deduction.

These results indicate that the frictions that cause people to not claim the IMD give rise to a healthier and financially stronger profile of beneficiaries of the tax deduction than we would expect if all eligible deductions were claimed. In other words, the hassle in claiming the IMD diverts benefits away from populations that appear to be poised to benefit from the subsidy more.

These findings have important implications for policy. A complete assessment of the itemized medical deduction requires understanding the potential insurance value the subsidy provides, how it impacts other economic incentives, and the distributional implications of the tax subsidy.

Meanwhile, this study can inform how well subsidizing out-of-pocket medical spending through the tax code targets those who incur large medical expenses. It may also highlight considerations for other government benefits delivered through the tax code.

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Gopi Shah Goda is a senior fellow at the Stanford Institute for Economic Policy Research at Stanford University. She also serves as a senior economist at the White House Council of Economic Advisers and on California Governor Gavin Newsom's Council of Economic Advisors.

Gopi's research informs how policy can best serve aging societies, including how individuals make healthcare, saving and retirement decisions as they age and the sustainability of public programs serving older populations. Her current scholarship examines the implications of subsidizing medical spending through the tax code and how long-term care is financed in the U.S. and other countries.

She earned her BS in mathematics and actuarial science from the University of Nebraska - Lincoln, obtained a PhD in economics from Stanford University, and completed a postdoctoral fellowship as a Robert Wood Johnson Scholar in Health Policy Research at Harvard University.

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