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Bipartisan Solutions to Improve the Availability of Long-term Care

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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The Bipartisan Policy Center staff produced this report in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings. BPC would also like to thank experts Henry Claypool, Allison Rizer, Anne Tumlinson, and Elizabeth Burke for their contributions to this report.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

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Glossary of Terms

ADLs – Activities of Daily Living

CAPABLE – Community Aging in Place—Advancing Better Living for Elders

CDCTC – Child and Dependent Care Tax Credit

CHIP – Children's Health Insurance Program

CMS – Centers for Medicare & Medicaid Services

CPI-U – Consumer Price Index Urban Value

EVV – Electronic Visit Verification

FIDE-SNP – Fully Integrated Dual Eligible Special Needs Plan

FLEC – Financial Literacy and Education Commission

FMAP – Federal Medical Assistance Percentage

FPL – Federal Poverty Level

FY – Fiscal Year

HCBS – Home and Community-Based Services

HHS – Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

IADLs – Instrumental Activities of Daily Living

LTC – Long-Term Care

LTCI – Long-Term Care Insurance

LTSS – Long-Term Services and Supports

MA – Medicare Advantage

NAIC – National Association of Insurance Commissioners

SSI – Supplemental Security Income

T-MSIS – Transformed Medicaid Statistical Information System

Executive Summary

For decades, policymakers have sought to improve access to long-term services and supports (LTSS) and to strengthen these services' financing. Today, about half of 65-year-olds will need LTSS at some point in their life.[1] This need will grow as baby boomers age and require more care.

LTSS refer to a broad range of paid and unpaid medical and nonmedical services for individuals with functional limitations due to age, chronic illness, or disability.[2] LTSS include assistance with activities of daily living (ADLs), such as eating, bathing, or dressing, and instrumental activities of daily living (IADLs), such as medication management or meal preparation.[3] Those who need LTSS may include children, adults, or seniors with physical, cognitive, developmental, mental, or other chronic health conditions.[4] In 2018, 14 million adults in the United States reported a need for long-term services and supports.[5]

The challenges associated with providing care to those who require LTSS include both the cost of care and the shortage of caregivers relative to need. The cost for facility and in-home care services has on average increased faster than the rate of inflation since 2004.[6] Long-term care providers saw significant cost increases from 2019 to 2020 as demand rose and caregiver shortages in facilities and in the community worsened. The median for the national annual cost of LTSS in 2020 ranged from $19,240 for adult day health care to $105,850 for a private room in a nursing home.[7]

The U.S. Bureau of Labor Statistics projected a 34% increase, or 1.16 million new home health and personal care aide jobs, over the 10-year period beginning in 2019 – a faster growth rate than the average for all other occupations.[8] According to the most recent data from the bureau, these caregivers earn a median of $13.02 per hour. Experts predict the low pay will result in significant workforce shortages and worsen access to care for individuals needing LTSS.[9] For comparison, social and human service assistants– a similar occupation with similar education requirements – earn a median pay of $17.29 per hour.[10] In addition to low wages, other factors contributing to direct care workforce shortages include challenges in workforce recruitment and retention, high turnover rates, lack of access to benefits, and lack of economic security.[11] The COVID-19 pandemic exacerbated these trends after nursing homes experienced high infection and mortality rates, and the demand for home and community-based care increased.

No single solution will address the needs of those who require LTSS. Improving access to these services will require a combination of public- and private-sector options, and an investment of federal resources. Since 2014, BPC has worked to develop bipartisan solutions to expanding access to LTSS. Our work began with a

group of four leaders: Former Senate Majority Leaders Tom Daschle and Bill Frist; former Secretary of Health and Human Services and Gov. Tommy Thompson; and Alice Rivlin, former vice chair of the Federal Reserve, director of the Office of Management and Budget, and director of the Congressional Budget Office.

BPC's work has focused on solutions designed to improve the availability of home and community-based services, to improve a struggling private long-term care insurance market, and to provide assistance to caregivers. This report outlines policy recommendations, including new proposals to expand the availability of home and community-based services for low- and middle-income individuals. It also includes previous recommendations that BPC has developed to improve private-sector options for those with more financial resources.

RECOMMENDATIONS

I. Expand Access to Home and Community-Based Services

A. Congress should make home and community-based services (HCBS) available for individuals with long-term care (LTC) needs who are ineligible for Medicaid. Services would be available through fully integrated care models, including improved fully integrated dual eligible special needs plans (FIDE-SNPs), Programs of All-Inclusive Care for the Elderly (PACE), or other models approved by the secretary of HHS, and would include sliding-scale subsidies.

B. Congress should develop a transitional program to support the expansion and development of integrated delivery models where they are unavailable, and should build caregiver capacity until the new HCBS program is fully implemented.

II. Address Disparities in the Delivery of HCBS

A. Congress should direct the secretary of HHS to collect data and issue an annual report on disparities in access to HCBS and make recommendations to Congress to address inequities.

III. Create a Caregiver Tax Credit

A. Congress should establish a refundable tax credit for caregivers to help with out-of-pocket costs for paid LTSS-related care.

IV. Improve the Viability of Private Long-Term Care Insurance

A. Congress should standardize and simplify private long-term care insurance to achieve an appropriate balance between coverage and affordability, through "retirement long-term care insurance (LTCI)."

B. **Incentivize employers to offer retirement LTCI and to auto-enroll certain employees (age 45 and older with minimum retirement savings), with an opt-out like many employer-sponsored retirement savings accounts.**

C. **Congress should permit early penalty-free withdrawal from retirement savings accounts to pay retirement LTCI premiums.**

D. **Congress should ask NAIC to modify model laws and regulations to accommodate products that convert from life insurance to long-term care.**

V. Establish a Public Education Campaign for Long-Term Care

A. **The Financial Literacy and Education Commission and partnering federal agencies should coordinate to strengthen educational resources on LTC and incorporate LTC planning into retirement education topics.**

Background

In 2018, an estimated 14 million adults in the United States reported a need for long-term services and supports (LTSS).[12] LTSS refer to a broad range of paid and unpaid medical and nonmedical services that assist individuals with functional limitations due to age, chronic illness, or disability.[13] LTSS include assistance with activities of daily living (ADLs), such as eating, bathing, or dressing, and instrumental activities of daily living (IADLs), such as medication management, or meal preparation.[14] Those who need LTSS may include children, adults, or seniors with physical, cognitive, developmental, mental, or other chronic health conditions.[15]

LTSS include both institutional care – those services provided in skilled nursing facilities, mental health facilities, or other congregate care settings – as well as services provided at home or in other community-based settings, typically referred to as home and community-based services (HCBS).[16] In recent years, there has been a significant shift toward delivering more LTSS in home and community-based settings rather than in institutional settings.[a, 17]

The Cost of Long-Term Services and Supports

Total LTSS spending in the United States was about $426.1 billion in 2019, according to an analysis of National Health Expenditure Account data from the Office of the Actuary at the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS).[18] This represents about 13% of all national spending on personal health care that year.[19]

The cost for facility and in-home care services has, on average, increased faster than the rate of inflation since 2004.[20] Most categories of LTSS saw a significant increase from 2019 to 2020 due to increased demand and labor shortages at home care and facilities; increases that were amplified by COVID-19. The median for the national annual cost of LTSS in 2020 ranged from $19,240 for adult day health care to $105,850 for a private room in a nursing home (Figure 1).[21] According to a recent industry study, most of the facility and home care service providers surveyed planned to increase prices in the six months following the survey, with 43% expecting clients to have to pay at least 5% more than their current contributions.[22]

a For additional background on Medicaid HCBS, see BPC's *Streamlining and Simplifying Medicaid HCBS Part I* (2021).

Figure 1: Annual Median Costs: National (2020)

In-Home Care		Community and Assisted Living		Nursing Home Facility	
Homemaker Services:	$53,768	Adult Day Health Care:	$19,240	Semi-Private Room:	$93,075
Home Health Aide:	$54,912	Assisted Living Facility:	$51,600	Private Room:	$105,850

Source: Genworth (2020).

Who Pays for Long-Term Services and Supports?

A mix of public and private payers cover LTSS. The primary payer is the Medicaid program: states are required to provide LTSS in institutions, such as nursing homes, and may choose to offer care in home or community-based settings through waivers or state plan amendments. To qualify for Medicaid-covered LTSS, individuals must meet the Medicaid eligibility requirements set by their state, including both income and asset limits and deficits in activities of daily living, such as bathing, dressing, or meal preparation.

A common misconception is that Medicare covers the cost of LTSS. Medicare coverage is far from comprehensive; it is limited to up to 100 days of post-acute care in a skilled nursing facility after a three-day qualifying inpatient hospital stay,[b] and select home health services for homebound beneficiaries requiring intermittent skilled nursing care, physical therapy, speech language pathology services, or continued occupational therapy. The Medicare services are generally short term and focused on medical or skilled care. Although limited private long-term care insurance might cover additional LTSS expenses, the policies are unaffordable for most Americans.[23]

The majority of paid LTSS are financed jointly by the federal government and states through the Medicaid program, which covered 43% of total LTSS spending in calendar year (CY) 2019.[c,24] Medicaid-covered LTSS, however, are available only to those with incomes below a certain level who meet all other eligibility criteria. Some home-based services are financed through Medicare. However, these Medicare services are limited and typically short-term.[25] As discussed above, Medicare only covers certain limited benefits, and many who do not qualify for Medicaid must pay out of pocket for LTSS.[26] Many also rely on unpaid caregivers to

b In response to the COVID-19 public health emergency, CMS announced several waivers of Medicare requirements, including waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility stay. These waivers remain in effect through the end of the emergency declaration. See Centers for Medicare & Medicaid Services, "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," updated May 24, 2021. Available at: https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf.

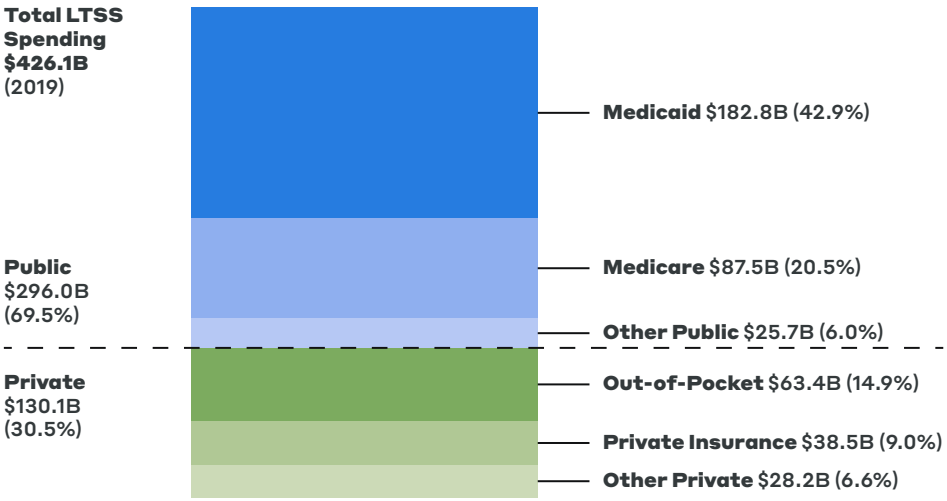
c Note: data cited throughout this report comes from various sources, including the National Health Expenditure Account Data, the CMS LTSS National Expenditure Report, MACPAC, and MACStats. Each of these data sets has different limitations; figures may not match up perfectly.

deliver LTSS.[27] While difficult to fully capture, about 21.3% of American adults (53 million) were unpaid caregivers in 2020.[28] Almost 80% of unpaid caregivers report having out-of-pocket expenses and spend, on average, about a quarter of their income on caregiving activities.[29]

Total LTSS spending in the United States reached $426.1 billion in 2019, according to National Health Expenditure Account data (Figure 2).[30] The large majority of LTSS spending is financed by public payers (70%). Medicaid is the predominant payer, accounting for about 43%, or $182.8 billion, of total LTSS expenditures, while Medicare accounted for only 21%, or $87.5 billion.[31] Total Medicare LTSS spending included post-acute skilled nursing facility care ($41.6 billion) and home health care ($45.9 billion).[32] Policymakers have noted that Medicare was never intended to cover long-term care.

The majority of private LTSS spending is out-of-pocket and accounted for almost 15% of total LTSS expenditures ($63.4 billion). Private insurance, including health and long-term care insurance, accounted for only 9% ($38.5 billion).[33]

Figure 2: Long-Term Services and Supports Spending in Billions, by Payer, 2019



Note: This analysis of NHEA data also includes Medicare post-acute care spending in an expanded definition of LTSS spending.
Source: Congressional Research Service (CRS), August 2021.

Long-Term Care Utilization

The need for LTSS in the United States is already significant, and a rise in the older adult population will further increase demand. About half of Americans turning 65 today will need some type of long-term care during their lifetime.[34] As the population ages, older adults will make up a larger portion of the U.S. population through 2050.[35] The Congressional Budget Office projects that LTSS spending for those ages 65 and older will more than double from 1.3% of gross domestic product in 2010 to 3% in 2050.[36]

Brief History and Recent Action in Long-Term Care

Since Congress established Medicaid in 1965, policymakers have continued to expand the range of LTSS benefits, settings, and authorities available to states to better meet the needs of beneficiaries who require assistance completing personal care tasks. Initially, services provided in skilled nursing facilities for those ages 21 or older were mandatory, and home health services and rehabilitation services were optional. Through the late 1960s and 1970s, Congress allowed states to cover services in additional institutional settings and mandated coverage of home health services for those entitled to skilled nursing facility services. Congress began expanding the federal authorities available to states for covering HCBS in the early 1980s by establishing the first HCBS waiver authority, known as the 1915(c) waiver.

In addition, the Deficit Reduction Act of 2005 sought to: incentivize the purchase of private LTCI by improving consumer protections; limit the ability of individuals to inappropriately transfer assets to qualify for Medicaid; and create new opportunities for individuals and families in need of LTSS – including the first state plan option for HCBS, the Money Follows the Person Demonstration, and a Medicaid buy-in for children with disabilities.[37] The Affordable Care Act, enacted in 2010, created another state plan option for personal care assistance services.[38]

Legislation that offers financial relief for unpaid family caregivers has gained some bipartisan support in Congress. Sens. Joni Ernst (R-IA), Michael Bennet (D-CO), Shelley Moore Capito (R-WV), and Elizabeth Warren (D-MA) have introduced the Credit for Caring Act of 2021 (S.1670). This legislation would give working family caregivers of those requiring long-term care up to a $5,000 nonrefundable tax credit for out-of-pocket caregiving expenses. Rep. Linda Sánchez (D-CA-38) has introduced the companion bill (H.R.3321) in the House.

Throughout the COVID-19 pandemic, high mortality rates associated with congregate care settings, such as nursing homes, have accelerated efforts to expand access to HCBS. The American Rescue Plan Act of 2021 included an incentive for states to enhance, expand, or strengthen Medicaid HCBS.[39] From April 1, 2021, to March 31, 2022, states will be eligible to receive a 10% increase in their federal medical assistance percentage (FMAP) for certain HCBS-related activities, detailed in recent guidance from the Centers for Medicare & Medicaid Services. Examples of qualifying activities address:

- New or additional HCBS;
- HCBS provider payment rate and benefit enhancements;
- Supplies and equipment;
- Caregiver support;
- Support to improve functional capabilities of persons with disabilities;
- Transition support;

- Mental health and substance use disorder services;
- Outreach; and
- Access to COVID-19 vaccines.[40]

States must use the additional funds to increase HCBS spending above current levels.[41] The Congressional Budget Office estimates this will cost the federal government $12.7 billion.[42] Additionally, President Biden's proposed American Jobs Plan calls for a $400 billion investment in HCBS to expand access to services, extend the Money Follows the Person program, and increase wages for caregivers.[43]

Members of Congress have introduced numerous bills to expand the availability of Medicaid home and community-based services, but these measures have little bipartisan support. In June 2021, Sen. Bob Casey (D-PA) and Rep. Debbie Dingell (D-MI-12) introduced the Better Care Better Jobs Act, which builds on the HCBS funding included in the American Rescue Plan Act. The legislation expands HCBS by making permanent the 10% increase in the federal Medicaid match to states for delivering HCBS and provides a temporary 80% federal match for administrative activities related to improving HCBS.[44] States would have to meet several requirements to receive the increased federal match; for example, states must strengthen and expand the HCBS workforce.[45] States would also have to meet certain accountability and quality requirements, including adopting quality measures for HCBS. In addition, they would need to demonstrate, after seven years, increased availability of HCBS, reduced disparities in utilization and availability of HCBS; provide evidence that a majority of direct care workers receive competitive wages and benefits; and show that at least 50% of long-term care spending is on HCBS.[46] The legislation would provide $100 million to states for HCBS infrastructure improvement planning grants.[47] Although the Congressional Budget Office has not provided a public estimate of the proposal, proponents seek to keep the cost under $400 billion.

Sen. Casey has introduced the PACE Plus Act (S.1162) to improve access to PACE,[48] a program that provides comprehensive health care services to frail adults ages 55 and up who are able to live safely in the community.[49] The legislation would make it easier for states to adopt PACE, provide grants to organizations to start PACE centers, expand the number of individuals eligible for the program, and reduce administrative burdens on PACE organizations, among other changes.[50] The legislation would appropriate $30 million for PACE expansion grants and $2 million for state expansion grants.[51]

Because LTSS need exists outside of the Medicaid program, some Democratic members of Congress have introduced legislation to create a federal catastrophic long-term care program.[52,53] Congress and the administration have also explored opportunities to strengthen the declining private long-term care insurance market. The Senate Finance Committee Subcommittee on Health Care held a hearing in November 2019 on Alzheimer's awareness that included testimony on how best to improve the private long-term care insurance market,[54] and

the Federal Interagency Task Force on Long-Term Care Insurance, led by the Department of Treasury, released a report in August 2020 on the current market, with recommendations for improvements.[55] The task force's recommendations were divided into four categories: innovation and product development; regulatory efficiency and alignment; financial literacy and education; and tax incentives.[56]

Some states, such as Minnesota, are exploring innovative private long-term care insurance products, including conversion policies, which are discussed in detail below.

Medicaid Coverage of LTSS

Medicaid covers LTSS in institutional settings as well as services delivered at home and in the community. Federal law requires state Medicaid programs to cover institutional LTSS, while most HCBS are optional.[57]

Institutional settings are generally residential facilities that assume total care of admitted individuals. Institutional LTSS include services delivered in nursing facilities, intermediate care facilities for individuals with intellectual disability (ICF/ID), and mental health facilities for individuals under 21 or ages 65 and older.[58] In FY 2019, fee-for-service spending on institutional LTSS accounted for about $56.5 billion (9.5%) of the total $597.4 billion spent on Medicaid benefits.[59] Medicaid is the primary payer for nursing facilities, covering more than 60% of nursing facility residents.[60]

In recent decades, there has been a shift away from institutional delivery of care to HCBS. In FY 2018, while 44% of Medicaid LTSS dollars went to institutional care, more than half (56%) went to HCBS.[61] The availability of HCBS varies significantly by state. In FY 2018, HCBS made up about 30% of Mississippi's LTSS spending, while Oregon spent 80% of LTSS dollars on HCBS.[62]

Several factors have driven the shift from facility-based services to HCBS. One of the more significant was a 1999 Supreme Court decision, *Olmstead v. L.C.*, in which the justices held that requiring individuals with intellectual and developmental disabilities to live in institutions as a condition of receipt of services under Medicaid violated the Americans with Disabilities Act.[63] The court held that where appropriate, and at the request of an individual, the state must make services available in the community. Recognizing the cost to states, the court permitted states to maintain waiting lists for services, provided that waiting lists moved at a "reasonable pace."

Authorities to Provide HCBS – Waivers and State Plan Amendments

Under federal law, states submit a state plan, which is an agreement between the states and the federal government, describing how states will administer mandatory and optional services. States may make changes to the agreement, such as adding new covered services, through the state plan amendment process. Services authorized through the state plan are entitlements that cannot be capped. If a state wants to cover optional services in a more limited way, they may apply to CMS for a waiver. Waivers relieve states of certain federal Medicaid requirements with the approval of the HHS secretary.

States may choose to provide HCBS through waivers, state plan amendments, or a combination of the two. Most individuals receive HCBS through 1915(c) waivers, which give states predictability in spending by allowing them to offer limited services to specific populations, to set enrollment caps, and to expand income and asset limits.[64] Because these 1915(c) waivers provide an alternative to institutional care by covering a wide range of HCBS, individuals enrolled in 1915(c) waivers must require an institutional level of care. As of March 2020, 47 states operated 254 separate 1915(c) waivers.[65] States also offer HCBS through Section 1115 demonstration waivers.

In addition to waivers, which typically cover a range of benefits defined by the state and outlined in Section 1915(c), states may cover certain HCBS through their state plans. Examples of HCBS state plan benefits include home health services, rehabilitation services, personal care services, or other mandatory or optional services. States can add or modify HCBS benefits in their state plans through one or more of several state plan amendment authorities. The 1915(i) state plan amendment permits states to choose from an array of HCBS to provide care to those populations needing less than an institutional level of care.[66] Another state plan amendment option includes 1915(k), also known as the "Community First Choice" benefit, which allows states to cover home and community-based attendant services and supports through their state plans.[67] Section 1915(k) services must be available to all eligible individuals statewide and cannot target specific populations.[68] For additional details on Medicaid HCBS authorities, see Appendix II and BPC's *Streamlining and Simplifying Medicaid HCBS Part I* (2021).

In FY 2016, the last year for which complete state and federal data are available,[d] Medicaid programs spent approximately $94 billion on HCBS, compared with about $72 billion on institutional services. The Medicare figure represented a 10% increase in HCBS spending over FY 2015.[69]

d CMS released an updated report on Medicaid LTSS expenditures in January 2021, but the report lacks data on managed long-term services and supports (MLTSS) spending in five states. In almost all of those states, MLTSS programs account for a large share of overall LTSS expenditures. As a result, we use data from the next most recent report, which includes MLTSS expenditure data in almost all applicable states except California and South Carolina.

To make costs more predictable, most states limit the number of people receiving HCBS, and this has resulted in delays for services. In most states, individuals who wish to receive waiver services may place their names on waiting lists, and the timing of eligibility screenings varies by state.[70] According to a 2018 survey, more than 800,000 individuals were on waiting lists for HCBS across 41 states.[71] The majority of individuals on waiting lists in 2018 were those with intellectual or developmental disabilities (nearly 590,000 across 37 states), compared with seniors and adults with physical disabilities (about 199,000 in 20 states).[72] States may have different waiting lists for each 1915(c) waiver, and beneficiaries may place their names on multiple waiting lists.[73]

HCBS and COVID-19

In early 2020, Congress and the Trump administration took several actions designed to ease provider restrictions and increase access to care during the COVID-19 pandemic. As hospitals faced surges in patient admissions and nursing facilities struggled with the spread of the coronavirus, CMS outlined significant flexibility to rules to increase access to HCBS. The flexibilities included allowing states to increase the number of individuals served under 1915(c) waivers by temporarily increasing individual eligibility cost limits or modifying targeting criteria. CMS also allowed states to use less restrictive income and resource methodology, expand opportunities for self-directed care, and widen the scope of services offered under 1915(c) waivers.[74]

In 2020, the administration extended the timeframe for states to comply with the Home and Community-Based Settings Regulation, so states could focus their efforts on addressing the pandemic.[75] This 2014 regulation requires that home and community-based settings meet certain qualifications that ensure choice and autonomy to beneficiaries. It also requires person-centered planning for the development of service plans for individuals receiving care through HCBS waivers. The deadline for compliance was extended from March 2022 to March 2023 after states requested extra time to assess settings and determine actions necessary to be compliant with the rule.[76]

Disparities in the Provision of HCBS

Currently, there is no data that comprehensively captures disparities in the delivery of HCBS. Although all states cover HCBS to some extent, the services covered, access to services, and HCBS spending vary significantly by state. As described above, HCBS expenditures as a portion of total LTSS spending differs widely across the country, making it easier to receive HCBS in some states than others.

What is less understood are inequities in access to services within a single state. The targeting allowed by HCBS authorities can result in two individuals with similar LTSS need unable to access the same care because they receive services through different waiver programs. For example, when a state is permitted to waive the Medicaid requirement that services be available statewide, individuals with similar needs who live in different parts of the state may not have equal access

to services. Similarly, waivers are available to different categories of Medicaid-eligible individuals because Medicaid's requirement that services be comparable across populations is itself sometimes waived. This means that a 75-year-old with dementia may not have the same access to care that a 45-year-old with intellectual disabilities receives, even though they have the same level of LTSS need.

With available data lacking, it is difficult to quantify racial and ethnic disparities in the delivery of home and community-based services. Likewise, the lack of comprehensive information about access to services across different age groups or medical conditions makes it challenging to determine the impact of waivers across these populations. Some existing program requirements could be leveraged to help close the gaps that exist in HCBS data. For example, the 21st Century Cures Act included a mandate for states to implement an electronic visit verification (EVV) system for all Medicaid-provided personal care and home health care services, including those provided through the various Medicaid HCBS state plan amendments and waivers.[77] To be compliant, the system must record the time, date, and location of the service, what services were provided, and who provided them.[78] This initiative was primarily motivated by a desire to reduce fraud in the delivery of Medicaid HCBS and ensure that proper services were being provided, but the data collected by EVV systems could improve the care beneficiaries receive. Some providers are already using data collected by EVV systems in innovative ways. For example, some providers use EVV systems to flag missed appointments so a backup plan can be implemented quickly, while others use the system to update health status alerts in real time.[79]

If additional metrics, such as functional assessment data, were reported in or linked to EVV systems, states could use this information to compare the services the beneficiary is receiving with their level of need. It could also allow states to compare the services received by individuals with similar conditions who are covered under different waivers to determine whether disparities in the delivery of HCBS exist within their state.

Because EVV systems are linked to the Transformed Medicaid Statistical Information System (T-MSIS), which contains racial, ethnic, disability, and other demographic and claims data, similar comparisons could be made across these groups. This would also allow T-MSIS to measure beneficiary need. Currently, these metrics are only measured by surveys such as the HCBS Consumer Assessment of Healthcare Providers and Systems Survey, which is not used by all states. Alternatively, improving interoperability between the various systems used for care planning – such as functional assessments, care management systems, and EVV – could achieve a similar goal.

Caregiver Tax Credits

Under current tax law, family caregivers can pursue several avenues to obtain preferential tax treatment for the out-of-pocket expenses associated with paid care. Due to administrative complexities discussed in more detail below, no such policies now provide tax incentives for family caregivers furnishing unpaid care.

Some family caregivers can claim their parent(s) or other older family members as dependent adult relatives ("qualifying relatives"), which, before 2018, allowed for the caregiver to claim a $4,050 personal exemption on income taxes for each qualifying relative. The Tax Cuts and Jobs Act of 2017 suspended, through 2025, personal exemptions for qualifying relatives.[80] Family caregivers, however, can still claim certain tax credits and deductions for expenses related to the care of a qualifying relative.

For an older family member to qualify as a family caregiver's qualifying relative, the caregiver must pay for more than 50% of the older family member's total expenses for the year, including living and food costs – not merely 50% of the care expenses.[81] In addition, the annual gross income of a qualifying relative must be less than $4,300 in 2020.[82] Finally, a qualifying relative must meet certain family relationship criteria with the family caregiver or must cohabitate in the same domicile as the family caregiver.[83]

In certain circumstances, a family caregiver can claim the Non-Reimbursed Medical Expense Deduction for the paid care that the family caregiver covers out-of-pocket on behalf of the qualifying relative. A family caregiver who claims a qualifying relative as a dependent can deduct out-of-pocket expenses contributed toward financing paid care, to the extent that the out-of-pocket expenses exceed 7.5% of the family caregiver's income.[84] A family caregiver's out-of-pocket expenses for long-term care services (or premiums for a long-term care insurance policy) paid on behalf of the qualifying relative can only be claimed if the qualifying relative has functional or cognitive impairments that meet the standards[e] required under HIPAA regulations for a qualifying long-term care insurance contract.[85]

In some cases, an older family member may live with the family caregiver, be financially dependent upon the family caregiver for more than 50% of life expenses, have a family relationship that would otherwise meet the qualifying relative criteria, and have significant functional or cognitive impairment, but may nonetheless fail to meet the criteria for qualifying relative status because he or she has income exceeding the $4,300 cap. In these instances, the family caregiver can often claim the Child and Dependent Care Tax Credit (CDCTC).

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e Standards under HIPAA regulations require that the individual receiving care must have two or more limitations performing activities of daily living (ADLs) without substantial assistance from another individual for at least 90 days due to a loss of functional capacity, or must need substantial supervision to protect the individual from threats to health and safety because of severe cognitive impairment.

Under the CDCTC, the family caregiver may claim the tax credit for their out-of-pocket expenses incurred up to $3,000 for covering paid care for the older family member (or up to $6,000 in care expenses for two or more qualifying individuals).[86] A qualifying individual under the CDCTC includes qualifying relatives and those who could have been dependents except that the care recipient had an income exceeding the $4,300 cap, filed a joint return, or the taxpayer could have been claimed as a dependent on another taxpayer's return.[87] The CDCTC establishes an income-based sliding scale to determine the amount of out-of-pocket expenses that the family caregiver must incur to receive the maximum tax credit. The amount of the credit may be between 20% to 35% of the family caregiver's qualified care expenses, depending on their income. For a comparison of BPC's proposal to current law, see Figure 3.

Figure 3: Current Law and BPC-Analyzed Tax Benefit Options for Family Caregivers

Comparison of Tax Benefit Options for Family Caregivers				
	BPC	**Current Law Deductions**		**Current Law Credits**
	Proposed Caregiver Tax Credit Examined	**Personal Exemption for Dependents *(Suspended from 2018 through 2025)***	**Non-Reimbursed Medical Expenses**	**Child and Dependent Care Tax Credit**
Type of Tax Benefit	Credit	Exemption	Deduction	Credit
Refundable	Yes	N/A	N/A	No
Maximum Deduction/ Credit	$3,000	$4,050 in 2017 (For Each Dependent) $0 in 2018 through 2025	Applicable Expenses in Excess of 7.5% of Caregiver's Income	Varies by Taxpayer Income and Dependent Care Expenses Income Under $15,000: $2,100 max credit (35% of $6,000 in dependent care expenses) Income Over $43,000: $1,200 max credit (20% of $6,000 in dependent care expenses)
Amount of Caregiver Spending Required to Obtain Max Credit	$10,000	N/A	N/A	Up to $3,000 (For One Dependent) Up to $6,000 (Max for Multiple Dependents)
Minimum Amount of Expenses in Order to Claim Benefit	N/A	Must Pay for More than 50% of Dependent's Expenses (All Expenses, Not Just LTSS)	Non-Reimbursed Medical Expenses Must Exceed 7.5% of Income Must Pay for More than 50% of Dependent's Expenses (All Expenses, Not Just LTSS)	Must pay for More than 50% of Dependent's Expenses (All Expenses, Not Just LTSS)
Income Phase-Out Range	$80,000 to $133,000 (Individuals) $120,000 to $200,000 (Couples)	Exemption Reduced for Income Above $261,500 in 2017 (Filing Single) Phased Out for Income Over $384,000 in 2017 (Filing Single)	N/A	N/A

Comparison of Tax Benefit Options for Family Caregivers				
	BPC	**Current Law Deductions**		**Current Law Credits**
	Proposed Caregiver Tax Credit Examined	**Personal Exemption for Dependents *(Suspended from 2018 through 2025)***	**Non-Reimbursed Medical Expenses**	**Child and Dependent Care Tax Credit**
Impairment Standard for Care Recipient	HIPAA Standard	N/A	HIPAA Standard	Person who is not physically or mentally able to care for themself. Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.
Qualifying Expenses that Can Be Claimed Under the Credit	Expenditures for goods, services, and supports that: (1) Assist a qualified care recipient with accomplishing ADLs and IADLs; and (2) Are provided solely for the use of the qualified care recipient	N/A	Qualified long-term care services are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are: (1) Required by a chronically ill individual, and (2) Provided pursuant to a plan of care prescribed by a licensed health care practitioner.	Expenses are for the care of a qualifying person only if their main purpose is the person's well-being and protection. Taxpayer can count care provided outside of the home by a dependent care center only if the center complies with all state and local regulations that apply to these centers.
Income Limits on Care Recipient	None	Care Recipient Income Must be Less Than $4,050 in 2017	Care Recipient Income Must be Less Than $4,300 in 2020	None
Work-Related Expense Requirement	None	None	None	To be claimed under tax credit, the care expenses (paid for by the taxpayer) for the care recipient must be "work-related" expenses, in that the care provided via the expenses allow for the taxpayer (and spouse) to continue to work or look for work.
Taxpayer-Care Recipient Cohabitation Required?	No	No	No	Yes

Improving the Availability and Affordability of Private Long-Term Care Insurance

As discussed above, many Americans are unaware that Medicare does not cover comprehensive LTSS. Medicare only covers up to 100 days of long-term care in a skilled nursing facility, hospice care, and limited home health care. Individuals who need additional LTSS or home and community-based services must either spend-down their savings to qualify for the Medicaid program, pay for expenses out of pocket, or purchase private long-term care insurance.

In August 2020, the Federal Interagency Task Force on Long-Term Care Insurance (made up of the U.S. Departments of Treasury, Health and Human Services, and Labor) released a report with recommendations to improve the regulation of the private LTCI market.[88] According to the report, the private LTCI market is in steep decline.[89] The number of individual LTCI policies sold dropped from a peak of 754,000 in 2002 to 57,000 in 2018, less than 10% of what was previously sold or purchased.[90]

Numerous factors have contributed to the poor performance in the private long-term care industry, including the high cost of insurance premiums, out-of-date federal regulatory requirements, lack of information provided by consumers regarding their risk of LTSS need, and difficulties with how care is financed. Those with conditions that might require later care may be more likely to seek coverage than those who are at lower risk for LTSS needs. This "adverse selection" has resulted in insurers receiving applications from individuals who tend to be higher cost, creating a more costly risk pool. In response, insurers seek to mitigate that risk and to lower premium costs through strict underwriting practices, which leads to a denial of coverage for those with disabilities or chronic conditions.[91] Because consumers are unprepared for these costs, they end up relying on Medicaid and unpaid care. These and other challenges have resulted in rising, unpredictable, and unaffordable premiums, carriers dropping out of the private LTCI market, and private LTCI plans offering limited or insufficient coverage.[92]

Various strategies have been used to incentivize the purchase of LTCI plans to prevent individuals from having to exhaust their financial resources to qualify for Medicaid, including preferential federal tax treatment for policyholders and implementation of the Medicaid Partnership Program. Private LTCI policyholders whose plans meet the HIPAA definition of "qualified long-term care insurance contract" receive preferable federal tax treatment.[93] For example, benefits paid by long-term care insurance policies do not count as taxable income for

the individual.[94] Additionally, policyholders can deduct a portion of the cost of their premiums that increases with age.[95] In 2021, limits range from $450 for policyholders ages 40 or below to $5,640 for those over 70.[96] However, the preferable tax treatment of LTCI does not benefit most middle-income Americans. Many states have provided additional tax relief to policyholders in the form of tax deductions or tax credits.[97] Despite these efforts, private LTCI still remains unaffordable for most individuals and is underutilized.

The Medicaid Partnership Program sought to encourage middle-income Americans to purchase long-term care insurance. The program began as a Robert Wood Johnson Foundation-funded demonstration but was later permanently established by Congress in the Deficit Reduction Act of 2005. States offer a guarantee that if private long-term care insurance does not cover policyholders' long-term care needs, they qualify for Medicaid-covered LTSS under special eligibility rules that prevent them from spending down their assets to reach Medicaid eligibility.[98] According to a recent study on the impact of these incentives in the context of LTCI underwriting, tax incentives and Medicaid Partnership programs each had minimal effect on enrollment.[99]

Innovations in Private LTCI Products

As a result of the declining private LTCI market, carriers and retirement planners have sought innovative alternatives to encourage individuals to plan for future long-term care expenses. In recent years, insurance carriers have begun offering hybrid policies that combine life insurance or annuity products with different riders to cover the cost of long-term care. The most common hybrid products are life insurance policies with chronic illness or long-term care riders.[100] These policies accelerate the individual's death benefit and can be used to pay for LTSS if certain functional requirements, such as the inability to perform two or more ADLs, are met.[101] If the individual does not use the entire policy value to cover LTSS, the rest is payable as a death benefit, making these products attractive to consumers. The policies have become increasingly popular: In 2018, hybrid policies made up 87% of new lives insured in the individual private LTCI market.[102] Although the policies are generally more attractive to consumers than traditional LTCI policies, the combination market is still complex to navigate. Products differ in their benefit structure, type of life insurance offered, pricing, and other features.[103]

BPC's Retirement Long-Term Care Insurance

In a 2016 report, *Initial Recommendations to Improve the Financing of Long-Term Care*, BPC recommended a series of policies to incentivize the purchase of LTCI, including a new simplified and standardized "retirement LTCI" that would strike a balance between coverage and affordability for middle- and upper-income individuals. Retirement LTCI policies would be standardized, with three basic plan designs; each would have limited options for customization. All retirement LTCI plans would share the following features:

- Access to benefits after meeting either a dollar-amount cash deductible or a time-based elimination period and 20% coinsurance.
- Inflation protection with benefits updated annually for growth in the employment cost index.
- A nonforfeiture benefit in which individuals whose policies lapse due to nonpayment of premiums can claim limited benefits under certain conditions for the premiums they did pay.
- An innovative nonlevel premium design with premiums growing annually at a modest rate linked to the Consumer Price Index Urban Value (CPI-U) until the policyholder reaches age 75, at which point premiums will stay level. Carriers will be required to update premiums every three years based on changes to assumptions on interest rates, investment rates, and lapse rates; and every six years based on changes to assumptions on mortality, morbidity, claim severity, and claim duration, with changes continuing until the policyholder reaches 85. This design would be more sustainable for carriers and would offer consumers the opportunity to benefit from lower-than-expected claims experience.
- Plans would be tax-qualified and deemed Partnership-qualified in states that have adopted long-term care Partnership programs. In these states, LTCI meeting certain standards qualifies policyholders to exempt additional assets from resource tests should they eventually rely on Medicaid-covered LTSS.)

State-Based Innovations

States have also become innovators in LTCI. Minnesota is modeling alternatives to traditional policies, including what is being called "LifeStage" insurance. LifeStage insurance, or Conversion LTCI, would begin as term-life insurance, then transition to long-term care insurance after the policyholder enters retirement.[104] Unlike hybrid life insurance policies with chronic illness or long-term care riders, conversion policies would become true long-term care insurance after they transition. Conversion LTCI is built off a term-life chassis, which should keep premiums low and more predictable than traditional LTCI. Based on the modeling prepared for Minnesota, monthly premiums for policies purchased at age 40 would range from $49 to $98 for males, and $45 to $91 for females. If purchased at age 50, they would range from $79 to $156 for males, and $80 to $158 for females.[105] The state would have to address certain state-level regulatory barriers before insurance carriers could sell "LifeStage" insurance. Key features of LifeStage LTCI can be found in Figure 4.

Figure 4: LifeStage Long-Term Care Insurance[106]

	Key Features of LifeStage LTCI
Benefit Design	Individuals select their benefit level ($100,000, $200,000, or $300,000) and the transition age for when the life insurance policy would convert to long-term care insurance.
	The long-term care insurance benefit would provide a daily cash benefit that would cover approximately two years of LTCI coverage. The maximum daily benefit levels would range from $135/day for the smallest benefit package, up to $275/day for the largest benefit package.
Premium setting	Monthly premiums would vary based on the benefit level and transition age, as well as the individual's age when the policy is purchased.
	Underwriting would occur at the time of purchase but not when the policy converts to LTCI.
	This product would be built off term-life insurance, so monthly premiums would remain level.
	Instead of traditional inflation protection, which can make LTC policies unaffordable, the conversion product would include periodic opportunities for consumers to increase the benefit level of the plan.

Recommendations

I. Expand Access to Home and Community-Based Services

A. Congress should make HCBS available for individuals with LTC needs who are ineligible for Medicaid. Services would be available through fully integrated care models, including improved FIDE-SNPs, PACE, or other models approved by the secretary of HHS, and would include sliding-scale subsidies. Key features include:

Services: HCBS would be available through fully integrated health plans and providers. BPC issued a 2020 report recommending that Congress require states to integrate Medicare and Medicaid services for dual eligible individuals. If adopted, all Medicare beneficiaries would have access to integrated plans, including Medicare Advantage, PACE, or other integrated medical home models.[f] Eligible Medicare beneficiaries could choose one of three service packages:

f This policy is designed to be consistent with BPC's earlier recommendation to require states to offer fully integrated Medicare and Medicaid services to dual eligible individuals within eight to 10 years. In states that choose not to integrate services, qualifying Medicare beneficiaries would be able to enroll in a fully integrated Medicare Advantage special needs plan, established through a federal fallback. These policy proposals for integrating Medicare and Medicaid are outlined in *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries* (2020).

- A set of services with a fixed dollar amount to be used by beneficiaries to address their individual needs (similar to the CAPABLE program);[g]
- Up to 10 hours per week of personal care assistance services; or
- Services covered under Section 1915(c) of the Medicaid program.[h] (Note: for the purposes of estimating the cost of the HCBS, BPC is assuming the most expensive of these three options, which is set at the 90th percentile of per capita state spending for 1915(c) waiver services.)

Eligibility and Federal Subsidies: Eligibility would be limited to Medicare beneficiaries who meet functional eligibility requirements and who are not Medicaid-eligible.

- These "qualifying beneficiaries," with incomes at or below 221% of FPL (300% of SSI)[i] would be eligible for low-income subsidies and would incur no cost for HCBS.
- A partial subsidy would be available to those whose incomes fall between 221% and 400% of FPL.
- Medicare beneficiaries who are ineligible for subsidization could access HCBS through their MA or other integrated plan by paying the full cost of the services they choose. This may prove to be a valuable option for them, as the plans are likely to secure discounted rates for HCBS, and to provide those services in a manner that is organized and thus more convenient than is the case today.

In 2021, 300% of SSI is $2,382 per month for an individual.[107] BPC chose this income level to help create equity between institutional care and HCBS, because states may provide nursing home care to individuals with incomes up to 300% of SSI.[108] Participating plans and providers would receive a full subsidy for the cost of providing HCBS to qualifying Medicare beneficiaries whose incomes fall below 221% of FPL and a partial subsidy for qualifying Medicare beneficiaries whose incomes fall between 221% and 400% of FPL.

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g The Community Aging in Place—Advancing Better Living for Elders (CAPABLE) program was developed at the Johns Hopkins School of Nursing. The time-limited program aims to help participants decrease fall risks, improve functional status and independence, and age safely at home. Key components of the program include home-based, one-on-one care from a registered nurse (who provides four visits to each participant), an occupational therapist (who provides six visits to each participant), and a handyperson (who provides up to $1,200 in services including home modification). See Johns Hopkins School of Nursing. "Community Aging in Place – Advancing Better Living for Elders (CAPABLE)." Available at: https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html.

h 1915(c) HCBS include "case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness." § 1915(c)(4)(B) of the Social Security Act.

i Under current law, states may offer nursing home services to individuals with incomes up to 300% of SSI. This policy would fully and partially subsidize the benefit for eligible individuals who enroll in an integrated plan and have incomes below 300% of SSI or between 221% to 400% of FPL, respectively.

Estimated number of newly eligible individuals: BPC contracted with ATI Advisory to estimate the federal cost of the three HCBS service packages and the total number of beneficiaries likely served. Based on the ATI analysis, the total number of individuals newly eligible for services is 2.2 million (1.1 million under 221% FPL, 587,000 between 221% and 400% FPL). At the 90th percentile 1915(c), BPC assumes 50% of the subsidized population and 5% of the partially subsidized population (since their cost would still be about $1,400 per month) would enroll. Approximately 587,000 individuals receiving varying amounts of subsidies are estimated to enroll.

Costs for unsubsidized individuals: ATI estimates that eligible Medicare beneficiaries would experience savings from accessing HCBS through integrated plans compared with purchasing similar services independently in the private market. ATI estimates that individuals would save between 12% and 23%, based on current Medicaid fee schedules and the assumption that the savings would be reflected in reduced buy-in amounts. This range is based on the difference between Medicaid and private-sector personal care reimbursement, with an overall difference of 23% between the two payers, and an average that results in a 12% decrease on private payer reimbursement.

To determine potential savings for unsubsidized individuals, ATI analyzed personal care services reimbursement from 14 states with geographic, demographic, and programmatic diversity: California, Colorado, Connecticut, Florida, Idaho, Maine, Mississippi, Montana, Nevada, North Carolina, Oklahoma, South Carolina, Washington, and Wisconsin. Calculated hourly rates for Medicaid in the sample ranged from $14 to $30.48, with an average across the states of $18.45. A 2020 survey of private home health aides found the hourly rate ranged from $17 in Louisiana to $33 in Minnesota, with a national average of $24 per hour.[109] The national average cost for private homemaker services in 2020 was $23.50.[110]

Cost of Federal Subsidies: For the purpose of determining the cost of this proposal, BPC assumes the most comprehensive and expensive package of services, which includes 1915(c) HCBS services, at a value reflecting 90th percentile state spending. The estimated cost of this approach would be $127.5 billion over 10 years (not adjusted for inflation). For a summary of costs, see Figure 5. This policy also assumes conservative estimated savings associated with reduced hospitalization, readmissions, emergency department visits, and other post-acute care based on the experiences of states participating in CMS' Financial Alignment Initiative.

Payments to MA and Other Eligible Integrated Plans: CMS would provide an add-on to the Medicare benchmark payment to plans to cover the cost of providing HCBS. MA and other eligible integrated health plans would act as care managers and marketplaces. They would also negotiate rates with agencies for personal care assistance hours and would manage and integrate health care and LTSS services.

Enrollment: Qualifying beneficiaries who are eligible for full subsidies could enroll at any time, but other qualifying beneficiaries would enroll during Medicare's open enrollment period.

Adverse Selection Associated with Voluntary Enrollment: BPC was concerned about the impact of adverse selection on federal costs for those who receive full or partial subsidies, and the buy-in cost for unsubsidized enrollees. Because program services would be available at enrollment, a more comprehensive package of services would attract individuals with the highest levels of complexity, thereby increasing the average monthly cost over time if the services were not limited. While it is impossible to completely mitigate the effect of adverse selection, BPC sought to address this problem in two ways:

1. *Assuming the Highest Potential Cost for Subsidized Individuals* – Costs are based on the 90th percentile of state per capita spending for 1915(c) waiver services. By definition these services are available only to individuals at risk for institutionalization and as a result have very high needs. BPC therefore assumes that all enrollees will be the highest-cost individuals. Although there is a normal distribution even within the "institutionally eligible" population, there is likely some degree of adverse selection. However, BPC believes any government costs have been accounted for by assuming high costs.

2. *Basing Buy-In on Actual Cost of Services for Unsubsidized Individuals* – BPC contracted with ATI Advisory to explore the cost of allowing individuals to buy-in to integrated Medicare Advantage plans that coordinate health and LTSS. Again, recognizing the potential for adverse selection, BPC asked ATI to assume that an enrollee's payments to plans would cover the cost of either a fixed number of personal care assistant services, or a package of services similar to those offered through Medicaid home and community-based services waivers, or Section 1915(c) of the Social Security Act. BPC asked ATI not to think of this as a plan or provider going at risk for the cost of services, but instead to think of the plan or provider as a facilitator of services. Plans and providers would charge individuals an amount that represents the average per capita cost of providing services to enrollees each year, less any potential savings associated with care management or integration of services. In summary, the buy-in services should not be considered an insurance product; rather than purchase care directly, individuals could choose to purchase a bundle of services and care management from a plan or provider at what BPC believes would be a lower cost, given purchasing the purchasing power of the plan or provider.

Other options for consideration could include late enrollment penalties, similar to approaches used in Medicare Parts B and D, to address costs associated with adverse selection.

Treatment of Dual-Eligible Individuals: Financing of HCBS for dual-eligible individuals, who receive long-term care through Medicaid, would continue as is under current law. States would be required to maintain their level of spending on HCBS services as of date of enactment and that amount should be adjusted for inflation over time.

Figure 5: ATI Analysis: Select Coverage Scenarios and Resulting Outcomes

The following table summarizes ATI's estimates for each of the three service packages: a base package that provides a monetary payment of $450 per person per month (PPPM) that beneficiaries could use to purchase any range of HCBS; up to 10 hours of personal care assistance services per week; and 1915(c) HCBS at a value of either median or 90th percentile of state spending.

Estimates for each service package include the total number of beneficiaries who would be served, total beneficiaries who would receive a partial or full premium subsidy, and the net annual cost (not adjusted for inflation) to the federal government.

For each package, ATI calculated estimates using both a standard and expanded** definition of the population that would be eligible to enroll in the package. ATI also calculated estimates under two sets of income standards that could be used to define eligibility for the low-income premium subsidy: 1) a full premium subsidy for individuals with incomes up to 100% FPL with no partial subsidy for individuals with incomes above 100% FPL; and 2) a full premium subsidy for individuals up to 221% FPL with a partial subsidy for those with incomes between 221% FPL and 400% FPL. Estimates of total beneficiaries served include those who would not be eligible for a premium subsidy due to income yet still choose to enroll.*

Cost Approach	Full Subsidy	Partial Subsidy	Standard Eligibility Population	Expanded Eligibility Population
Base Package $450 PPPM	≤100% FPL	No partial subsidy	Total Served: 632,633 Total Subsidized: 226,453 Net Annual Cost: $1,144,420,997	Total Served: 671,706 Total Subsidized: 239,346 Net Annual Cost: $1,209,578,093
	<221% FPL	221-400% FPL	Total Served: 803,687 Total Subsidized: 633,929 Net Annual Cost: $2,911,402,009	Total Served: 851,987 Total Subsidized: 675,052 Net Annual Cost: $3,094,244,091
Personal Care Services Only $914 PPPM	≤100% FPL	No partial subsidy	Total Served: 470,161 Total Subsidized: 226,453 Net Annual Cost: $2,406,217,113	Total Served: 498,762 Total Subsidized: 239,346 Net Annual Cost: $2,543,214,005
	<221% FPL	221-400% FPL	Total Served: 728,123 Total Subsidized: 606,867 Net Annual Cost: $6,002,982,663	Total Served: 772,059 Total Subsidized: 645,677 Net Annual Cost: $6,377,297,949
Median State HCBS Spend $1,391 PPPM	≤100% FPL	No partial subsidy	Total Served: 388,925 Total Subsidized: 226,453 Net Annual Cost: $2,489,497,468	Total Served: 412,290 Total Subsidized: 239,346 Net Annual Cost: $2,631,235,890
	<221% FPL	221-400% FPL	Total Served: 652,558 Total Subsidized: 579,805 Net Annual Cost: $5,922,200,824	Total Served: 692,131 Total Subsidized: 616,302 Net Annual Cost: $6,284,809,261
90th Percentile State HCBS Spend $2,803 PPPM	≤100% FPL	No partial subsidy	Total Served: 307,689 Total Subsidized: 226,453 Net Annual Cost: $5,111,777,012	Total Served: 325,818 Total Subsidized: 239,346 Net Annual Cost: $5,402,813,744
	<221% FPL	**221-400% FPL**	**Total Served: 601,245** **Total Subsidized: 552,743** **Net Annual Cost: $12,022,089,512**	**Total Served: 637,480** **Total Subsidized: 586,927** **Net Annual Cost: $12,754,836,128**

***Note:** "Standard" eligibility assumes individuals:
- Need help with 3+ ADLs, *or*
- Have a diagnosis of Alzheimer's disease/dementia/other cognitive impairment, and need help with 2 ADLs, *or*
- Have a diagnosis of Alzheimer's disease/dementia/ other cognitive impairment, and need help with 0-1 ADLs and 3+ IADLs.

****Note:** "Expanded" eligibility assumes individuals need help with 2+ ADLs and 3+ IADLs.

Discussion: Program Administration

One open question is how HCBS offered through Medicare Advantage and other integrated health plans should be administered. While this HCBS expansion could be administered by the federal government through the Medicare program, through states under the Medicaid program, or through an alternative financing model, each option creates both opportunities and challenges. If done through Medicaid as a "buy-in" for higher income individuals, the program would benefit from state experience in contracting for HCBS. However, those residing in states that choose not to operate the program would not receive services. Since BPC assumes that states will continue to finance HCBS for dual eligible individuals, adding this benefit under the Medicare program would set a precedent for excluding certain Medicare beneficiaries from a Medicare benefit. Alternative financing models and their feasibility could also be explored. BPC plans to continue developing this proposal and will provide recommendations on program administration through future work.

See Appendix I for an executive summary of the ATI report. The full ATI report with cost estimates for three other model approaches can be found here.

B. Congress should develop a transitional program to support the expansion and development of integrated delivery models where they are unavailable, and should build caregiver capacity until the new HCBS program is fully implemented.

During discussions with stakeholders, it became clear that while a significant increase in funding for HCBS is needed, many states do not have the capacity to implement a broad expansion in the short term. This is especially true for those states that do not have experience contracting with D-SNPs and PACE providers. At the same time, there are not enough caregivers to address the upcoming demand. It will take time and planning to develop delivery models and capacity to contract with plans, providers, and caregivers to expand the availability of services. For those states that can increase the availability of HCBS in the short term, funding should be made available to expand the availability of HCBS. Elements of the transitional program to expand Medicaid HCBS and build capacity include:

1. **Mandatory Transitional HCBS Grants:** Congress should make up to $12 billion in grant funding available to states over the next four years. These grants should be designed to address states' individual needs by meeting states where they are as they seek to build capacity to provide HCBS and to expand its availability.

2. **Use of Funding for Building Capacity and Incentive Payments:** Funding should be made available to states to build expertise in contracting with integrated delivery systems, such as FIDE-SNPs and PACE, and to help build caregiver capacity. Funds could be used to increase wages and recruit direct care workers. To support HCBS capacity building more broadly, Congress

should make incentive payments available to states that demonstrate meaningful improvements in HCBS capacity. The HHS secretary should establish milestones that states must meet to show meaningful improvements in HCBS capacity to earn these incentive payments. Examples of milestones may include a certain percentage decrease in caregiver turnover rates or an increase in the number of available providers.

3. **Use of Funds for HCBS Expansion:** Funding allocated to states under this expansion would first be used to provide services to Medicaid-eligible individuals on state waiting lists as of January 1, 2021. Remaining funds could go to services covered under 1915(i) for newly eligible individuals with incomes up to 300% of SSI who meet the state's functional status criteria for HCBS. Services that can be funded are those permitted in the Section 1915(i) Medicaid state plan option and housing-related services from CMS's January 2021 State Health Official letter.[111] Funds may not be used for nursing facility services or for care in institutional settings that do not meet Money Follows the Person program requirements. States must make available consumer-directed options that are consistent with the 1915(k) state plan option.

4. **Matching Rates and State Funding Requirements:** Funds would be allocated to states based on the prevalence of low-income individuals in need of a high level of LTSS, as determined by the HHS secretary. Funding used for capacity building would be considered an administrative cost and would be set at an enhanced rate of 90%. Funds used to provide services to Medicaid-eligible individuals would be set at the CHIP matching rate. Maintenance of effort would require states to spend the same amount each year as they spent in FY 2020 on all LTSS (nursing facility services and HCBS), indexed to CPI-U. To advance this goal, the policy could also include a modest grant program to conduct outreach and education in the aging and disability networks to encourage them to involve people from communities of color in all aspects of this work.

5. **CMS Should Review Temporary COVID-19 Policies:** As described earlier, some COVID-19 policies were designed to increase the availability of HCBS. CMS should identify and review those policies that could be made permanent under existing authority, where appropriate. In considering these policies, CMS should assure patient safety, consumer-directed care, and choice of setting. More generally, CMS should ensure that policies do not undermine the home and community-based services settings rule.[112]

II. Address Disparities in the Delivery of HCBS

A. Congress should direct the secretary of HHS to collect data and issue an annual report on disparities in access to HCBS and make recommendations to Congress to address inequities.

Currently, data on disparities in the delivery of HCBS are lacking. Disparities in access to HCBS between racial and ethnic groups, disability category, and age, as

well as between populations both within and across states, exist but are not well understood. Leveraging the data collected by existing systems, such as EVV, and combining them with demographic, disability, and waiver data reported in T-MSIS can help close the gap.

As required under current law, EVV systems must collect and report data on the type of service provided, the individual who is receiving the service, date of service, location where the service is delivered, provider, and time the service began and ended.[113] The system's purpose is to prevent fraud by ensuring beneficiaries are receiving proper care. However, there is significant potential to use the data collected by the system for other purposes. Some providers use their EVV systems to improve quality by sending out alerts of missed appointments so a backup plan can be implemented quickly.[114]

Improving interoperability between the various systems used to build and verify an individual's care plan should be explored. Ideally, the entire process – from functional assessment to verification that the approved services were delivered – would go through a single stream. However, because of the way the system has developed over time, many of these systems are not interoperable. Adding functional assessment data to the EVV system, or linking EVV systems to care management systems that contain functional assessment data, would provide a more holistic view of the individual's care plan.

States and plans can use this information to determine whether the services being provided to beneficiaries are adequate to meet their needs. States and plans could also use the information to track how beneficiaries' needs and service utilization change over time, and this knowledge could be used to update care plans more frequently. Additionally, because EVV systems are linked to the individual's electronic health records and T-MSIS, functional assessment data could appear in those data sets as well. Currently they are not included. Because T-MSIS includes demographic data, states could use the expanded metrics to study disparities in the delivery of HCBS between racial, ethnic, and diagnostic groups.

Although expanding the use of EVV data holds clear benefits, various consumer advocacy groups have raised privacy concerns. The most common concern is that some states could use GPS-based EVV systems to track beneficiaries as they move through the community. As more data is shared across platforms, it will be important to ensure HIPAA compliance.

III. Create a Caregiver Tax Credit

For individuals with significant functional or cognitive impairment, family members often play a key role in providing unpaid care, while also helping to pay for care services and supports that are provided by care professionals and other practitioners. Assistance from family caregivers is particularly critical for individuals who are ineligible for Medicaid (which may cover items and services not covered under the Medicare program), including some individuals who may have limited benefits through private LTCI coverage.

The number of family caregivers in the United States grew from 43.5 million (18.2% of total caregivers) in 2015 to 53 million (21.3%) in 2020.[115] The number of unpaid caregivers increased for recipients of all ages, but increased most significantly for adults ages 50 or older. Over that same period, from 2015 to 2020, the number of unpaid family caregivers for adults ages 50 or older rose from 34.2 million (14.3%) to 41.8 million (16.8%).[116] The population of adults receiving care from unpaid caregivers may also have increasingly complex medical or support needs, given reportedly greater health and functional needs as well as more comorbidities that require care in 2020 compared with 2015.[117]

Caregiving responsibilities enact a financial cost for many family caregivers. For example, one in five family caregivers reports high financial strain, and 23% take on more debt. In addition, they incur roughly more than $7,400 in non-reimbursed out-of-pocket costs each year on paid care and related expenses.[118] Researchers estimate that the economic value of unpaid caregiving was $470 billion in 2017.[119]

The unpaid care and financial assistance that family caregivers provide can help to keep frail and functionally or cognitively limited individuals in their homes. This assistance can delay the need for expensive LTSS, such as nursing facility costs.

A. Congress should establish a refundable tax credit for caregivers to help with out-of-pocket costs for paid LTSS-related care.

The proposed policy would provide a refundable tax credit equal to 30% of a caregiver's qualified out-of-pocket LTSS-related expenses, up to a maximum $3,000 credit for each older family member (i.e., requiring $10,000 worth of expenses to claim the full $3,000 refundable credit). BPC chose to make the tax credit refundable to help subsidize the expenses of those who have no tax liability. The credit would begin phasing out for couples with annual household income above $120,000 (or $80,000 for single filers), and fully phase out at $200,000 for couples (or $133,000 for single filers). For the family caregiver to qualify for the credit, the older family member would need to meet certain family (or co-dweller) relationship criteria with the family caregiver, and the older family member would have to meet the HIPAA standard for functional or cognitive impairment. For out-of-pocket costs to count toward the tax credit, expenditures must assist the care recipient in accomplishing ADLs or IADLs and must be provided solely for the use of the qualified recipient.

BPC's 2017 report, *Financing Long-Term Services and Supports*, explored this refundable caregiver tax credit and contracted with Urban Institute to evaluate the cost to the federal government.[120] At that time, the Urban Institute estimated that the 10-year federal budgetary cost of the tax credit, in the form of reduced federal revenues and increased tax expenditures, would be $130 billion over the 2018-2027 window.[121] The analysis assumed that approximately 10.9 million taxpayers would claim the proposed caregiver tax credit each year between 2018 and 2027.[122]

IV. Improve the Viability of Private Long-Term Care Insurance

A. Congress should standardize and simplify private long-term care insurance to achieve an appropriate balance between coverage and affordability, through "retirement long-term care insurance."

To address the needs of higher income Americans who may have long-term care needs, Congress should address statutory and regulatory barriers to permit the sale of lower-cost, limited benefit plans, which we call "retirement LTCI" plans. Congress should ask NAIC to develop model laws and regulations for these simplified, standardized policies. Retirement LTCI policies should be standardized with three basic plan designs. Each plan design would have limited options for customization. All retirement LTCI policies would have the following features:

- Plans would have a nonlevel premium design with premiums growing annually at a rate linked to CPI-U until the policyholder reaches age 75, at which point premiums will stay level and carriers will be required to update premiums every three years based on changes to assumptions on interest rates, investment rates, and lapse rates, and every six years based on changes to assumptions on mortality, morbidity, claim severity, and claim duration with changes continuing until the policyholder reaches age 85.
- Plans would be tax-qualified and deemed Partnership-qualified in states that have adopted long-term care Partnership programs. In these states, LTCI meeting certain standards qualifies policyholders to exempt additional assets from resource tests should they eventually rely on Medicaid-covered LTSS.

Consumers would have a choice among basic retirement LTCI features, such as daily coverage amounts, length of benefit period, and the size of the cash deductible. This would simplify consumer decision-making. This lower-cost product would cover two to four years of LTSS needs. The policies would reduce but not eliminate the following: 1) the use of personal and retirement savings for out-of-pocket spending for paid services; and 2) the reliance on friends and family members to provide unpaid care.

B. Incentivize employers to offer retirement LTCI and to auto-enroll certain employees (age 45 and older with minimum retirement savings), with an opt-out like many employer-sponsored retirement savings accounts.

To improve the availability of LTCI, employers and health insurance exchanges should be required to offer to enrollees the option to purchase a LTCI policy when seeking health insurance coverage. Employers would not be required to contribute to premiums. To further improve the take-up of retirement LTCI and to increase the number of enrolled individuals, automatic enrollment into retirement LTCI with the option to opt-out could be used. Plan sponsors should be offered a safe harbor and expanded "catch-up" contributions if the sponsor automatically enrolls certain plan participants into a retirement LTCI policy with the option to opt out.

If premiums are affordable and automatic enrollment is targeted appropriately, individuals would be less likely to opt out, which could improve the risk pool and make the approach more viable for carriers. Participants should receive notice of default enrollment, and opting out should be simple to do.

If available in the state, conversion LTCI, outlined below, could be offered by employers as an alternative to retirement LTCI.

C. Congress should permit early penalty-free withdrawal from retirement savings accounts to pay retirement LTCI premiums.

Employees ages 45 and older who either have defined-contribution retirement plans, such as 401(k) and 403(b) plans, or who have individual retirement accounts should be allowed to take early distributions from the plan solely for the purchase of retirement LTCI for themselves or a spouse. Distributions for the purchase of retirement LTCI from tax-deferred plans should be subject to income tax but exempt from the 10% early withdrawal penalty. This proposal would help middle-income individuals pay for LTCI premiums, which they might not be able to afford with employment income alone. Given that LTSS needs are a major threat to retirement security, individuals should be able to use retirement savings to meet potential LTSS needs. Early withdrawal to purchase LTCI is important, because LTCI premiums are higher if issued at older ages and older applicants are more likely to be denied coverage due to underwriting. The recommendation to exempt the early withdrawal penalty for distributions to pay for LTCI premiums has been supported by the Interagency Task Force and the National Association of Insurance Commissioners.[123, 124]

D. Congress should ask NAIC to modify model laws and regulations to accommodate products that convert from life insurance to long-term care.

Advancing the interstate sale of these policies could help make conversion LTCI more viable. Because this is a new product without an existing regulatory framework, Congress should ask NAIC to modify applicable, existing model acts and regulations to allow for the sale of conversion LTCI. States that choose to move forward with conversion LTCI products would be able to adopt the new model language, removing barriers that exist for carriers who wish to sell these products.

Some states, such as Minnesota, are considering legislation that would expand the authority of the state insurance commissioner to incorporate a new product into their regulations. This change would give the commissioner the flexibility to offer a conversion product under the state's current regulatory framework. States that wish to pursue conversion LTCI products before NAIC finalizes model acts and regulations could consider passing similar legislation.

This product has the potential to help consumers make better, more-informed decisions. They can compare benefits and coverage with traditional LTCI policies and minimize the number of decisions they need to make. The product also would

be tied to an insurance product that most consumers already understand and are comfortable with. The product is bound to term-life insurance, allowing premiums to remain lower and more stable. This makes the product more affordable for middle-income Americans — those with annual incomes between $50,000 and $125,000 who would not qualify for Medicaid unless they had extraordinary LTSS expenses. This product is based on the LifeStage product developed in Minnesota.

V. Establish a Public Education Campaign for Long-Term Care

Approximately 70% of adults who reach age 65 will develop severe LTSS needs at some point in their lives–meaning they will need help with two or more activities of daily living for at least 90 days, or will have severe cognitive impairment– and almost half of those individuals will receive some paid LTSS care over their lifetime.[125] Although not all of these individuals will have LTC expenses that exceed their resources, few Americans plan for how they will cover LTSS. Generally, Americans lack information and may have misconceptions about the need, costs, and coverage of LTSS. Many believe that health insurance, such as Medicare, covers these services. This results in individuals having inadequate resources to pay for LTSS, with many spending their assets down to qualify for Medicaid covered LTSS. Public education on long-term care planning would help to clarify these misconceptions.

Congress sought to promote public education through a national long-term care awareness campaign, but it had only limited success. HHS ran the "Own Your Future" campaign from 2005 to 2010. It was an optional federal/state campaign to explain the need for LTCI. Governors of participating states mailed letters to households with residents between ages 45 to 65 and encouraged people to order a free Long-Term Care Planning Kit to help plan for their long-term care needs. The campaigns included press events, public service announcements, and follow-up letters.

Throughout the campaign, 24 states and the District of Columbia participated; 20 million households received letters, and 1.5 million took the next step of ordering the planning kit.[126] Those who received the planning kit were more likely to do some type of long-term care planning, which included activities such as talking to an agent about long-term care, looking into reverse mortgages, reviewing existing coverage, and in some cases buying LTC insurance.[127] However, as the private long-term care industry continues to struggle and individuals continue to spend down into Medicaid to cover LTSS, a new educational approach should be explored.

A. The Financial Literacy and Education Commission and partnering federal agencies should coordinate to strengthen educational resources on LTC and incorporate LTC planning into retirement education topics.

The Financial Literacy and Education Commission (FLEC) was established under the Fair and Accurate Credit Transactions Act of 2003 to develop a national financial education website and national strategy on financial education.[128] The Department of Treasury's *Federal Interagency Task Force on Long-Term Care Insurance* report recognizes the importance of public education on LTC and recommends that Treasury, HHS, the Department of Labor, and other agencies working through the FLEC assess federal education resources on LTC needs and planning, and modify, update, and supplement these resources as needed. The report also recommends that the FLEC integrate LTC planning into retirement education topics.

The educational resources should address common public misperceptions about long-term care. For example, this would include providing clear warnings that Medicare does not cover such services and emphasizing that the Medicaid program has strict income and asset limits that an individual must meet to qualify for LTSS coverage through Medicaid. The federal government should encourage coordination between the agencies that compose the FLEC and provide funding to strengthen educational resources on LTC planning and incorporate them into retirement education.

Conclusion

No single politically viable solution exists to address the nation's LTSS needs. Bipartisan policy solutions that improve upon the LTSS delivery system could help to address the growing demand for these critical services in the United States. BPC's recommendations have the potential to expand access to LTSS for individuals with long-term care needs across a range of income levels, through public and private health insurance programs. We encourage long-term care planning by improving public education, while also providing some financial relief for unpaid family caregivers who remain critical providers in the LTSS delivery system. We hope these recommendations advance discussions among policymakers to support bipartisan policy solutions that improve access to LTSS for children, adults, and seniors with functional or cognitive impairment.

Appendix I

ATI Advisory Report Implementing an Integrated Long-Term Services and Supports Buy-In Program: A Cost Estimate

This study was prepared for the Bipartisan Policy Center as part of its effort to expand and promote improved, integrated care for individuals with long-term services and support needs. It was prepared by ATI Advisory and made possible by funding from The SCAN Foundation and the Robert Wood Johnson Foundation.

EXECUTIVE SUMMARY

The need for long-term services and supports (LTSS) in the United States will continue to grow as the population ages. Formal LTSS is largely provided through the Medicaid program, limiting these services to individuals who are low income and already in need of an institutional level of care. This results in a considerable portion of individuals with LTSS needs lacking access to necessary services, and it forces many to "spend down" their income and assets to qualify for Medicaid. In addition, Medicaid recipients who also qualify for Medicare receive acute care benefits and LTSS benefits administered by two disjointed programs. As the magnitude of individuals with unmet need rises, so does the long-term cost to both Medicaid and Medicare through increased and fragmented utilization of acute care and institutional settings.

This study was undertaken to estimate the federal costs associated with subsidizing an LTSS "buy-in" to the Medicare program or alternatively, as a buy-in to Medicaid benefits. The program would integrate LTSS and acute care services for Medicare beneficiaries living in the community with LTSS needs, and who are not receiving full Medicaid benefits.

Initial cost estimates included in this study are limited to Medicare beneficiaries ages 65 and older. LTSS need was determined based on the level of assistance needed with activities of daily living, level of assistance needed with

instrumental activities of daily living, and presence of cognitive impairment. Different combinations of LTSS coverage, program eligibility, subsidy levels, and longer-term savings expectations were modeled, resulting in annual federal costs for providing subsidized coverage between $1.1 billion and $12.8 billion.

I. Model Inputs

The key model inputs used to estimate federal costs included per person "value," acute care savings, subsidy eligibility and amount(s), and program enrollment. Each of these model inputs is described in greater detail below.

A. Per Person "Value"

Four approaches were developed to approximate the possible per person per month (PPPM) value based on the monetary value of LTSS and the assumed services that would be provided to enrolled individuals.

1. **Base Benefit Package - *$450 PPPM***
   The monetary value of this approach is based on industry trends within private market and other programs similar to this buy-in option, such as the CAPABLE program[j] and previously proposed legislation for a Community-Based Independence Special Needs Plan (CBI-SNP).[k] It allows a limited benefit and assumes that the total combination of services used would be equivalent to $450 PPPM. This package does not specify services.

2. **Personal Care Services Only - *$914 PPPM***
   This approach is based on reimbursement amounts within Medicaid and the private market for personal care services. It assumes that 10 hours of services per week would be provided to an enrolled individual, based on the national median of unpaid caregiver hours. The average reimbursement amounts of personal care services from Medicaid fee schedules across a variety of states were blended with the national averages for private-sector home care to calculate the hourly rate, $21.10, of the services provided.

3. **Median State Home and Community-Based Services (HCBS) Spending on Older Adults - *$1,391 PPPM***
   This approach assumes the buy-in benefit levels would approximate state Medicaid HCBS expenditures for older adults. It uses the median/50th percentile 1915(c) per person spending for aged and physically disabled individuals to account for the substantial variation that exists across states in terms of Medicaid HCBS benefit design and expenditures. The

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j Johns Hopkins School of Nursing, "Community Aging in Place – Advancing Better Living for Elders (CAPABLE)." Available at: https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html.

k Community-Based Independence for Seniors Act of 2019, H.R. 3461, 116th Cong. (2019). Available at: https://www.congress.gov/bill/116th-congress/house-bill/3461/text?r=6&s=1.

PPPM amount also incorporates a 14 percent adjustment based on the likely increase above Medicaid fee schedules that would occur if similar benefit levels were provided through Medicare. This approach does not account for any unmet need that might exceed state benefit limits or other HCBS and HCBS-like services that individuals might receive through other sources, such as state plan services.

4. **90th Percentile State HCBS Spending on Older Adults - *$2,803 PPPM*** This approach replicates all aspects of the median HCBS approach described above but uses the 90th percentile of 1915(c) spending for aged and physically disabled individuals. The associated monetary value represents the likely upper-bound cost of providing HCBS in the Medicare program.

B. Acute Care Savings

This model input represents the assumed medical care savings created as a result of integration of LTSS and acute care needs and services. Three savings values (minimum, average, and maximum) were identified based on findings from the Financial Alignment Initiative and CAPABLE. A higher PPPM value is expected to be associated with greater acute care savings and was modeled as such in this study.

C. Subsidy Eligibility and Amount(s)

Three subsidy components are included as inputs in this model: whether full *and* partial subsidies are provided (versus full only); the income-level threshold(s), as a percentage of the federal poverty level, for the full and partial subsidy participants; and the amount of the partial subsidy as a percentage of the cost. The subsidy eligibility and amounts act as independent variables in this study, and further research and policy specifications will need to define them.

D. Enrollment

The enrollment input represents the anticipated demand among fully subsidized, partially subsidized, and unsubsidized individuals. Medicare Advantage enrollment rates, 40 percent nationwide across all Medicare beneficiaries as of December 2020, informed likely enrollment demand since the program would be tied to a Medicare Advantage plan. In addition, as enrollment demand will likely vary based on out-of-pocket costs, enrollment rates vary in each model scenario. For example, for scenarios with higher PPPM values, lower enrollment demand is expected among unsubsidized and partially subsidized individuals.

II. Outcomes

Twelve cost scenarios were run based on unique combinations of the model inputs described above. These scenarios resulted in annual net federal costs for providing subsidized coverage of between $1.1 billion to $12.8 billion (bolded in Figure 1). In addition, based on the "Base Package" scenario outputs, the federal

government could subsidize a limited LTSS benefit for up to 675,052 Medicare beneficiaries (excluding unsubsidized beneficiaries) at an annual cost of $1.1 billion to $3.1 billion (bolded in Figure 1). It is important to note that this study's savings estimates are likely conservative, and costs to the federal government could be lower. For example, a single prevented hospital stay would save the Medicare program an average of $12,800, which is more than the annual per person cost of two of the four scenarios provided in Figure 1.[1]

Figure 1: Abbreviated Version of Coverage Scenarios and Resulting Outcomes

Cost Approach	Full Subsidy	Partial Subsidy	Standard Eligibility Population	Expanded Eligibility Population
Base Package $450 PPPM	≤100% FPL	No partial subsidy	Total Served: 632,633 Total Subsidized: 226,453 **Net Annual Cost: $1,144,420,997**	Total Served: 671,706 Total Subsidized: 239,346 Net Annual Cost: $1,209,578,093
	<221% FPL	221-400% FPL	Total Served: 803,687 Total Subsidized: 633,929 Net Annual Cost: $2,911,402,009	Total Served: 851,987 **Total Subsidized: 675,052** **Net Annual Cost: $3,094,244,091**
Personal Care Services Only $914 PPPM	≤100% FPL	No partial subsidy	Total Served: 470,161 Total Subsidized: 226,453 Net Annual Cost: $2,406,217,113	Total Served: 498,762 Total Subsidized: 239,346 Net Annual Cost: $2,543,214,005
	<221% FPL	221-400% FPL	Total Served: 728,123 Total Subsidized: 606,867 Net Annual Cost: $6,002,982,663	Total Served: 772,059 Total Subsidized: 645,677 Net Annual Cost: $6,377,297,949
Median State HCBS Spend $1,391 PPPM	≤100% FPL	No partial subsidy	Total Served: 388,925 Total Subsidized: 226,453 Net Annual Cost: $2,489,497,468	Total Served: 412,290 Total Subsidized: 239,346 Net Annual Cost: $2,631,235,890
	<221% FPL	221-400% FPL	Total Served: 652,558 Total Subsidized: 579,805 Net Annual Cost: $5,922,200,824	Total Served: 692,131 Total Subsidized: 616,302 Net Annual Cost: $6,284,809,261
90th Percentile State HCBS Spend $2,803 PPPM	≤100% FPL	No partial subsidy	Total Served: 307,689 Total Subsidized: 226,453 Net Annual Cost: $5,111,777,012	Total Served: 325,818 Total Subsidized: 239,346 Net Annual Cost: $5,402,813,744
	<221% FPL	221-400% FPL	Total Served: 601,245 Total Subsidized: 552,743 Net Annual Cost: $12,022,089,512	Total Served: 637,480 Total Subsidized: 586,927 **Net Annual Cost: $12,754,836,128**

III. Considerations and Conclusion

This study provides an initial cost estimate of subsidizing some level of LTSS for Medicare beneficiaries with LTSS needs and without current Medicaid coverage. The study also highlights the value of additional analysis and policy conversation on addressing increasing and unmet LTSS need among an aging population.

1 $12,800 was the average Medicare fee-for-service payment of a hospital stay in 2019. Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. (March 2021).

Further, the program concept modeled in this study could reduce longer-term Medicare and Medicaid spending that results from a current lack of integration and spend-down into long-term residence in an institutional setting.

The following considerations related to program design were considered beyond the scope of this study:

- Emerging policy efforts and policy design, including proposals to expand Medicaid HCBS
- Cost inflation and wage increases year-over-year
- Growing Medicare population and projecting costs in relation to growth in LTSS need
- Medicare solvency and related political considerations
- Integration experiences of individuals ebbing in and out of program eligibility, or of those already qualified for Medicaid LTSS
- State versus federal administration
- Adverse selection and approaches to mitigate its effects
- Policy considerations
    - Program eligibility, including age and frailty requirements
    - Program design and administration, such as whether the program becomes a new type of Medicare Advantage special needs plan (SNP)
    - Intersection with other programs; for example, whether state Medicaid programs should contribute funding
    - Program payment and savings, including who shares in the resulting savings

Addressing these considerations and defining the policy specifications remain an important next step of this research and are essential to long-term success of efforts to provide LTSS to Medicare beneficiaries.

For the complete report, please visit the BPC website.

Appendix II

HCBS Waivers and State Plan Amendments

HCBS Authorities	Eligibility	Limits and Flexibilities	Population Targeting (Comparability)	Geographic Targeting (Statewideness)	Self-Direction
Section 1915(c)	Individuals who meet the state's institutional level of care (meaning individuals could be admitted to a nursing facility, hospital, ICF/IID); the need for services must be based on an assessed need and identified in a state-approved service plan.	States may cap enrollment. In the aggregate, program services must not cost more than what would have been incurred to care for participants in an institution, referred to as "cost neutrality."	States may target based on age or diagnosis, including children, adults with physical disabilities, individuals with intellectual or developmental disabilities, individuals with traumatic brain injuries, individuals with MH/SUD, and older adults, among others.	States may limit a program geographically.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(i)	Individuals who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community.	No cost neutrality requirement. States may not cap enrollment or maintain waiting lists. States may limit participation through needs-based eligibility criteria.	Option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group. The lower threshold of needs-based criteria must be "less stringent" than institutional and HCBS waiver program level of care.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(k) Community First Choice Optional State Plan Benefit	Individuals who meet the state's institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the state plan) can qualify for services under section 1915(k).	States cannot limit the number of eligible individuals served.	States cannot target the benefit to a particular population.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(j) Optional Self-Directed Personal Assistance Services (PAS)	Individuals must be eligible for state plan personal care services or a section 1915(c) waiver program to qualify for services under section 1915(j).	States may limit the number of people who will self-direct their PAS.	States can target people already getting section 1915(c) waiver services.	PAS may be offered in certain areas of the state or statewide.	PAS is self-directed.

Research and Demonstration Programs

Research and Demonstration Programs	Eligibility	Limits and Flexibilities	Population Targeting (Comparability)	Geographic Targeting (Statewideness)	Self-Direction
Section 1115 Demonstration Authority	States may waive certain statutory provisions such as "comparability" to define target populations for demonstration services/activities, which should be available based on individual assessments of need as defined by the state.	Demonstrations must be budget neutral, meaning that the federal costs associated with the proposed demonstrations cannot exceed the federal Medicaid costs absent the demonstration.	States can target section 1115 demonstration services to particular populations meeting defined characteristics.	States can waive "statewideness" to target demonstration services at particular geographic areas.	States can choose to offer self-directed HCBS under this authority.
Money Follows the Person Demonstration	Participants must be Medicaid beneficiaries residing in an institution for 90 days or more, not counting short-term rehabilitation days. In addition, participants must move to a qualified residence in the community.	States project annual transition benchmarks to determine enrollment based on an annual grant-funded budget.	States can target demonstration services to particular populations meeting a state's institutional level of care and MFP eligibility criteria.	States can target MFP demonstration services at particular geographic areas.	States can choose to offer self-directed HCBS under this project.

Source: CMS, *Long-Term Services and Supports Rebalancing Toolkit*, November 2020

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