



Financing Long-Term Services and Supports:

Seeking Bipartisan Solutions
in Politically Challenging Times

July 2017



BIPARTISAN POLICY CENTER

LONG-TERM CARE INITIATIVE

In December 2013, BPC launched a Long-Term Care Initiative under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, former Congressional Budget Office Director Dr. Alice Rivlin, and former Wisconsin Governor and Secretary of the Department of Health and Human Services Tommy Thompson. BPC's Long-Term Care Initiative seeks to raise awareness about the importance of finding a sustainable means of financing and delivering long-term services and supports, and to improve the quality and efficiency of publicly and privately financed long-term care.

ACKNOWLEDGEMENTS

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Executive Summary and Recommendations

For more than a quarter-century, policymakers have sought solutions to improve the financing and delivery of long-term services and supports (LTSS). Recent analyses suggest that roughly 52 percent of individuals turning age 65 will require LTSS at some point in their life.¹ In 2016, driven by recommendations from private sector policy experts,^a a general consensus formed around a multi-track approach that included:

1. Private Long-Term Care Insurance Improvements

- Standardize and simplify private long-term care insurance (LTCI) to achieve an appropriate balance between coverage and affordability, which we called “retirement long-term care insurance”;
- 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; and
- Permit penalty-free withdrawal from retirement savings accounts to pay retirement LTCI insurance premiums, recognizing that LTSS is a significant drain on retirement savings.

2. Medicaid

Simplify state plan options and waivers under Medicaid to provide additional flexibility to states to offer home and community-based LTSS, as well as an “LTSS-only buy-in” as a supplement to private health insurance for working individuals with disabilities.

3. Catastrophic Coverage

Recognize that for the 15 percent of the population that will have significant LTSS expenses, the private market, and personal savings are not adequate to cover LTSS needs. Further, states will not be able to sustain spending for LTSS under Medicaid as baby boomers begin to need these services and supports. While BPC’s leaders stopped short of endorsing a public catastrophic program financed through an additional Medicare payroll tax on individuals, proposals to limit the federal share of Medicaid reimbursement could further stress state budgets, and limit the availability of Medicaid-covered LTSS.

Since the release the February 2016 report, *[Initial Recommendations to Improve the Financing of Long-Term Care](#)*, which outlines these recommendations in detail, BPC has also issued two reports that have implications for LTSS financing and coordination of care for high-cost, high-need Medicare beneficiaries. These two reports, *[Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid](#)* and *[Improving Care for High-Need, High-Cost Medicare Patients](#)*, recommend providing additional flexibility to better integrate health and social services and supports for the highest-cost Medicare beneficiaries.

Following on these reports and recommendations, BPC analyzed additional options and issues related to the financing of LTSS. After evaluating a variety of options discussed in more detail in this report, BPC offers the following recommendations to improve the availability of affordable LTCI and financing of LTSS.

^a BPC, LeadingAge, and The Long-Term Care Financing Collaborative issued separate recommendations outlining a public-private approach to financing LTSS. Additional information available online at: <http://www.thescanfoundation.org/side-side-review-long-term-care-financing-policy-recommendations> (Accessed June 19, 2017).

New Analysis and Recommendations

1. Private Long-Term Care Insurance Improvements

Permit penalty-free (but not tax-free) withdrawal from retirement savings accounts for employer-offered private LTCI. Permitting individuals to use retirement savings to purchase “retirement LTCI” would help defray LTSS costs, which for many Americans depletes retirement savings.

2. Medicare Respite Benefit

Build on previous recommendations to permit Medicare Advantage (MA) plans, and other Medicare provider organizations operating under a “benchmark,” the flexibility to offer a respite care benefit to high-need, high-cost Medicare beneficiaries. Respite care, along with other services, could be offered under this flexibility, so long as the services are part of a person- and family-centered care plan for a subset of individuals that meet the eligibility criteria, which includes patients with three or more chronic conditions and functional or cognitive impairment.

3. Beneficiary-Financed Medicare Supplemental Benefit

Permit Medigap and MA plans to market a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed exclusively through additional premiums paid by Medicare beneficiaries who choose to enroll. For the purposes of estimating the added cost of the benefit to Medigap or MA premiums, BPC assumed a \$75 maximum daily benefit, with a 180-day elimination period that would need to be satisfied prior to the commencement of the benefit. Consistent with existing Medigap policies, beneficiaries would have a one-time option to purchase this coverage when they enroll in Medicare. BPC’s analysis suggests that such a policy could result in premiums of \$35 to \$40 per member per month (PMPM).

Previous Recommendations

1. Establish lower-cost, limited-benefit retirement LTCI policies.

Statutory and regulatory barriers should be cleared to permit the sale of lower-cost, limited-benefit “retirement LTCI.” Retirement LTCI policies would be standardized, with three basic plan designs, each of which would have limited options for customization. Consumers would have choice among basic retirement LTCI features, such as daily coverage amounts, length of benefit period, and the size of the cash deductible, simplifying decision-making.

2. Allow working-age retirement plan participants aged 45 and older to use retirement savings, without early withdrawal penalties, to purchase retirement LTCI.

Employees aged 45 and older in defined-contribution retirement plans, such as 401(k) and 403(b) plans, and IRA owners aged 45 and older, would be allowed to take distributions from the plan solely for the purchase of retirement LTCI for themselves and/or a spouse. Distributions for the purchase of retirement LTCI from tax-deferred plans would be subject to income tax but exempt from the 10 percent early withdrawal penalty.

3. Make retirement LTCI policies more widely available by providing incentives for employers to offer them through workplace retirement plans on an opt-out basis.

Plan sponsors should be offered a safe harbor and expanded “catch-up” contributions if the sponsor automatically enrolls certain plan participants (who would have the ability to opt out) into a retirement LTCI policy. The proposed safe harbor would limit fiduciary liability for plan sponsors that implement automatic enrollment according to certain standards.

4. Allow retirement LTCI policies to be sold on state and federal health insurance marketplaces.

All health insurance marketplaces would have the option to facilitate sales of retirement LTCI policies. Participating marketplaces could accept distributions from workplace retirement plans and IRAs for the payment of retirement LTCI premiums from savers aged 45 and older.

5. Create incentives for states to expand the availability of Home and Community Based Services (HCBS).

Streamline and simplify existing authorities under current law waivers and State Plan Amendments (SPAs) and extend enhanced federal matching to encourage states to take advantage of the new streamlined authority. States should retain the ability to use the existing waiver process, and existing HCBS SPAs should be grandfathered in. Finally, once operational, the HHS secretary should make recommendations to Congress on whether to repeal existing SPAs.

6. Should a catastrophic program be adopted, states that offer expanded HCBS through the new SPA would have lower maintenance-of-effort requirements.

Conclusion

We believe that collectively, these policies have the potential to advance the broader understanding of the challenges and policy opportunities, and to provide solutions to challenges faced by patients, their families and other caregivers, private insurers, states, and policymakers.

Background and Overview

For more than a quarter-century, policymakers have sought solutions to improve the financing and delivery of long-term services and supports (LTSS). Recent analyses suggest that roughly 52 percent of individuals turning age 65 will require LTSS at some point in their life. In 2016, driven by recommendations from private sector policy experts, a general consensus formed around a multi-track approach that included:

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- Permit penalty-free withdrawal from retirement savings accounts to pay retirement LTCI insurance premiums, recognizing that LTSS is a significant drain on retirement savings.

2. Medicaid

Simplify state plan options and waivers under Medicaid to provide additional flexibility to states to offer home and community-based LTSS, as well as an “LTSS-only buy-in” as a supplement to private health insurance for working individuals with disabilities.

3. Catastrophic Coverage

Recognize that for the 15 percent of the population that will have significant LTSS expenses, the private market, and personal savings are not adequate to cover LTSS needs. Further, states will not be able to sustain spending for LTSS under Medicaid as baby boomers begin to need these services and supports. While BPC’s leaders stopped short of endorsing a public catastrophic program financed through an additional Medicare payroll tax on individuals, proposals to limit the federal share of Medicaid reimbursement could further stress state budgets, and limit the availability of Medicaid-covered LTSS.

Since the release the February 2016 report [*Initial Recommendations to Improve the Financing of Long-Term Care*](#), which outlines these recommendations in detail, BPC has also issued two reports that have implications for LTSS financing and coordination of care for high-cost, high-need Medicare beneficiaries. These two reports, [*Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*](#) and [*Improving Care for High-Need, High-Cost Medicare Patients*](#), recommend providing additional flexibility to better integrate health and social services and supports for the highest-cost Medicare beneficiaries.

In this report, BPC analyzes several policy options to improve the availability of affordable LTCI and financing of LTSS, and makes recommendations for the implementation of several of these policy options.

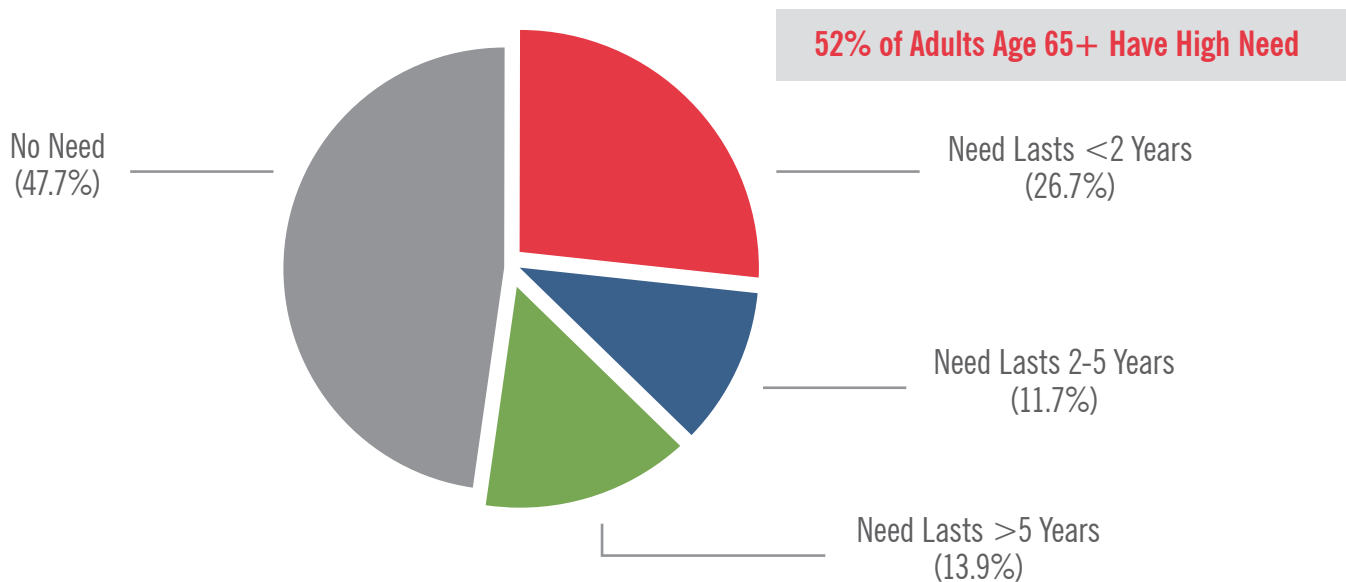
Defining LTSS

LTSS refers to a range of health and social services provided to individuals who need help with daily tasks or activities of daily living (ADLs), such as eating, bathing, or dressing, or with instrumental tasks, such as medication management or meal preparation. People who need LTSS typically have physical, cognitive, developmental, or other chronic health conditions and require assistance with one or more of these tasks.² LTSS can be provided in institutional settings, which include nursing homes and assisted living facilities, or through home and community-based services (HCBS). In recent decades, there has been a shift toward HCBS and away from institutional care, driven in part by preference among most individuals with LTSS needs to remain in their homes.^{3,4}

The Need for LTSS

Over 12 million adults in the United States rely on LTSS, and the need for LTSS is expected to rise dramatically in the coming decades.⁵ Approximately 70 percent of adults age 65 and older will need LTSS at some point in their lives, and more than half will experience a *high level* of care need, defined as assistance with two or more ADLs for at least 90 days or severe cognitive impairment (**Figure 1**).^{6,7} Among older adults who develop a high level of care need, the average duration of LTSS need is 3.9 years, with about 14 percent of individuals needing care for five or more years.⁸ Women age 65 and older are more likely to have high levels of care need on average compared to men, and are expected to need LTSS for an average of 4.4 years, compared to 3.2 years for men.⁹

Figure 1. Length of High Need for Adults Aged 65+



Source: Original data: Favreault, M. M., & Dey, J. 2015. Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief. Available at: <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

Graphical concept: Anne Tumlinson Innovations. 2016. The Case for Financing Older America's Long-Term Care Need. Available at: http://www.thescanfoundation.org/sites/default/files/financing_long-term_care_chartpack_092016_final.pptx.

Of the approximately 10.9 million older adults who reported having LTSS needs in 2011, 1.1 million received care in nursing homes, 1.6 million lived in supportive care settings (e.g., assisted living facilities), and 8.2 million lived in the community.¹⁰ Among those receiving help in non-nursing home settings, nearly two-thirds reported receiving all of their LTSS care from unpaid caregivers; only 5.3 percent reported relying solely on paid help.¹¹ As the diversity of LTSS settings and role of informal caregivers have increased in recent decades, concerns about unmet needs have grown; about 20 percent of community-dwelling older adults with LTSS needs report having unmet care need.^{12,13}

Cost of LTSS

The costs of LTSS can be significant regardless of setting. In 2015, the median annual cost for a home health aide was approximately \$45,800, the median annual cost for community-based adult day-care centers was \$17,900, and the median annual cost to live in a nursing facility was approximately \$91,300.¹⁴ In 2013, total national spending for formal LTSS services amounted to \$339 billion, with public spending accounting for about 72 percent of this amount.¹⁵ Formal LTSS spending for older Americans was approximately \$192 billion in 2011.¹⁶ These costs are expected to rise as the population ages, consuming a larger portion of federal and state Medicaid budgets and placing an even greater burden on older Americans' and their families' personal finances.

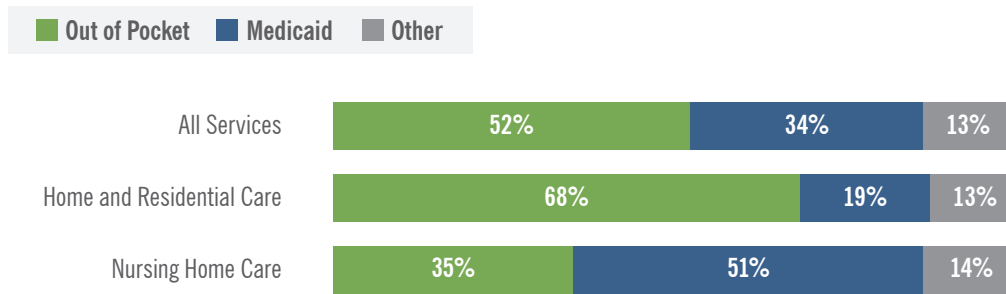
Formal LTSS expenditures do not tell the whole story—most LTSS in the United States is provided by unpaid informal caregivers who are family members or friends of the care recipient.¹⁷ In 2013, informal caregivers provided an estimated \$470 billion worth of unpaid care.¹⁸ The responsibilities of caregiving often take a heavy toll on informal caregivers; caregiving can cause significant physical and emotional stress for caregivers, leading to poorer health outcomes.¹⁹ Additionally, informal caregivers often experience financial strain because of lost income and out-of-pocket expenses to provide care. The 2011 MetLife Study of Caregiving Costs found that family caregivers aged 50 and older sustain an average of \$303,880 in lost income and benefits over the caregiver's lifetime.²⁰

Who Pays for LTSS?

There is significant variation in LTSS spending across individuals; while nearly half of Americans turning 65 today are expected to have no LTSS expenditures, approximately 27 percent will have costs of at least \$100,000, and approximately 15 percent will have costs exceeding \$250,000.²¹ The average expected lifetime LTSS cost for a 65-year-old American today is \$138,000. Average lifetime LTSS costs for women are twice as much those of men—\$182,000 compared to \$91,000.²²

People who receive LTSS rely heavily on out-of-pocket spending to meet their needs. An estimated 52 percent of average lifetime LTSS costs of people turning 65 today will be paid out-of-pocket by individuals and their families (**Figure 2**). According to an Urban Institute projection of national LTSS spending by payer in 2030, about 53 percent of total LTSS spending across all ages will be covered out-of-pocket, assuming no changes in financing options.²³ Private long-term care insurance is virtually inaccessible to most people who need it, and only accounts for an estimated 2.7 percent of average lifetime costs for adults age 65 and older.²⁴

Figure 2. Average Lifetime LTC Spending for Adults Aged 65+ by Source



Source: Original data: Favreault, M. M., & Dey, J. 2015. Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief. Available at: <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

Graphical concept: Anne Tumlinson Innovations. 2016. The Case for Financing Older America's Long-Term Care Need. Available at: http://www.thescanfoundation.org/sites/default/files/financing_long-term_care_chartpack_092016_final.pptx.

For those who lack sufficient personal resources to pay out-of-pocket, Medicaid is the primary payer of LTSS costs. Medicaid is expected to cover about 34 percent of average lifetime LTSS costs of people turning 65 today (**Figure 2**), and is projected to account for over 40 percent of total national LTSS spending by 2030.²⁵ LTSS accounts for about one quarter of total Medicaid spending and 69 percent of Medicaid spending for older adults with full Medicaid benefits.^{26,27}

Challenges in Financing LTSS through Private Insurance Alone

Only about 11 percent of older adults have private LTCI coverage, and the private market is in decline.^{28,29} Currently available LTCI policies are too expensive and complex for most consumers and the traditional policy design has not been sustainable for carriers. Even for those who can afford limited-benefit private insurance-based LTCI products, such policies are not widely available. As a result, many middle-income Americans rely on modest personal savings and the support of unpaid caregivers to meet LTSS needs. In recent years, plans have limited policies to a capped “indemnity policy” (e.g., plans will reimburse covered services up to a lifetime cap) while others may offer a cash benefit that is capped at a daily, weekly, or monthly amount.³⁰ Individuals with catastrophic LTSS costs must spend down their personal resources before qualifying for Medicaid. As the population ages and the need for LTSS grows, the increased burden on Medicaid is expected to place unsustainable strain on both state and federal budgets.³¹

BPC's History in LTSS

In previous reports, BPC identified several key barriers to achieving consensus on long-term care financing, including:

- Different opinions on the respective roles of public programs, the commercial private market, and individuals and their families;
- Concern about the cost of public funding for new programs;

- Lack of awareness about the costs and risks of needing LTSS and the incorrect belief that Medicare or Medicaid will cover LTSS needs;
- Concern that enacting a comprehensive LTSS program will supplant private spending for those who have the resources to pay for care or have services provided by unpaid caregivers; and
- Significant variation in the need for LTSS. For example, while more than half of Americans age 65 and older will need LTSS during their lifetimes, only 15 percent will have LTSS expenses exceeding \$250,000 during their lifetimes.

Given these challenges, BPC concluded that there is currently no single, comprehensive solution to address the growing demand for affordable LTSS that would be financially or politically viable. Therefore, BPC’s initial recommendations focused on a series of programmatic improvements designed to address the needs of specific populations. These initial recommendations called for policymakers to:

- Increase access to the private insurance market through the establishment of lower-cost, limited-benefit “retirement LTCI” plans;
- Encourage states to expand the availability of home and community-based services (HCBS) for older Americans and individuals with disabilities under Medicaid;
- Extend access to Medicaid LTSS benefits to working individuals with disabilities through an LTSS-only “buy-in”; and
- Pursue a catastrophic insurance approach for individuals with significant long-term care needs such as Alzheimer’s disease or a debilitating physical impairment.

Additional Options for Financing LTSS

In this report, BPC’s leaders identified five additional broad policy options to be evaluated. They include:

1. Examining the revenue impact of permitting individuals to use penalty-free (but not tax-free), retirement dollars to purchase private LTCI offered voluntarily through employer benefit plans;
2. The cost and feasibility of adding a respite benefit to the Medicare program, beyond current-law benefit limited to those in hospice;
3. The cost and feasibility of providing a caregiver tax credit for expenses incurred for a caregiver of a person receiving LTSS that is financed by the caregiver;
4. The cost and feasibility of adding a limited LTSS benefit as an optional Medicare supplemental benefit in Medigap policies and Medicare Advantage (MA) plans; and
5. The political feasibility of a public catastrophic LTSS program.

The results of each of these five analyses are outlined below, along with recommendations for the policy options for which BPC found that implementation would be feasible and valuable.

Analyses and Recommendations

Private Long-Term Care Insurance

In its 2016 report, [BPC proposed a series of policies](#) designed to incentivize the purchase of private LTCI. Recommendations included new simplified and standardized “retirement LTCI” insurance policies that sought to strike a balance between coverage and affordability for middle- and upper-income individuals.

These policies were designed to be offered as group policies to employers, and included through auto-enrollment for certain individuals with an opt-out option, similar to retirement savings. BPC also proposed the use of penalty-free withdrawal from retirement accounts to pay premiums, noting that LTSS will be one of the largest retirement expenditures for more than half of older adults. Finally, BPC recommended moving away from level premiums for these policies, and allowing for automatic increases and decreases in premiums (subject to audit) to better reflect claims experience. These lower-cost products are designed to cover two to four years of LTSS need, after a deductible or exclusion period is met, and includes coinsurance. In this proposal, BPC includes estimated participation and federal revenue impact for this policy.

Using Retirement Savings to Purchase Private LTCI

At BPC’s request, the District Economic Group (DEG) conducted an analysis of the tax-related provisions included in the 2016 report. Under this approach, individuals could use the balance in a fixed or defined contribution (DC) plan to fund retirement LTCI premiums, and retain the exclusion from income for payments from long-term care policies for services and supports. Premium payments for retirement LTCI would be taxable as income but exempt from the 10 percent early withdrawal penalty. According to DEG analysis, this policy would increase participation in private LTCI by making available assets that were previously unavailable for distribution without incurring a penalty for early withdrawal. DEG’s estimates that approximately 8.5 million new enrollees would purchase retirement LTCI, and pay \$51 billion in additional associated federal income tax over the 10-year budget window.

The new retirement LTCI product would allow individuals age 45 years and older to pay retirement LTCI premiums from their DC accounts without being subject to the 10 percent early withdrawal penalty applicable to distributions before the age of 59½. However, retirement LTCI policy premiums remain included as part of ordinary income under this proposal.

For participating individuals, the current year cost of the premium essentially becomes the amount of income tax on the premium, and not the amount of the premium itself. This is a significant reduction in the up-front cost of LTCI for those with sufficient account balances.^b Research indicates that price sensitivity of taxpayers to purchasing LTCI is elastic^c—meaning small reductions in the price of LTCI can lead to significant increases in purchased LTCI policies.³² According to the 2015

^b DEG analysis contains two “no bankruptcy” conditions imposed on the auto-enrollment provision. First, individuals must have sufficient assets in their DC accounts to afford a retirement LTCI product. The second rule requires employers who offer auto-enrollment to deny participation in LTCI purchases from within a retirement plan for employees who do not contribute at least the amount of the LTCI premium, to safeguard the employer from promoting a policy that erodes employee savings.

^c Price sensitivity of private market LTCI is -3.3, compared to a price elasticity of -.06 used by the Congressional Budget Office when analyzing health insurance.

analysis of a two-year comprehensive voluntary LTCI benefit by Milliman Inc., for those who enrolled at age 45, annual premiums in 2015 would be approximately \$2,400.^d People who enrolled at a later age would pay higher annual premiums because, on average, they would contribute for fewer years.³³ By making available retirement assets for the payment of LTCI premiums, for a person with a marginal tax rate of 25 percent, the direct cost of the premium paid from a retirement account becomes 25 percent of the premium. Rather than exposure to a \$2,400 premium, the direct cost for an individual purchasing retirement LTCI at this rate would now be \$600 annually. With a reduction of direct costs to this extent, retirement LTCI creates a new incentive to buy LTCI for those who have sufficiently large retirement accounts so that dividend and interest income within the account would be sufficient to pay for the premiums.

The very strong responsiveness to the purchase of LTCI due to price elasticity is compounded by auto-enrollment.³⁴ In total, penalty-free, income-inclusion retirement LTCI would create incentives for 8.5 million new policies to be sold to individuals aged 45 to 69, more than doubling the current market.^e Over the 10-year budget window, this policy is expected to increase tax revenue from individuals age 45 to 69 by approximately \$51 billion.

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According to the analysis, an individual between the ages of 45 to 54 would need an account balance of \$89,000 during the first year, increasing to approximately \$110,300 over the next 10 years to finance retirement LTCI premiums. Account balances of these sizes are typically associated with income levels of more than \$75,000 of Adjusted Gross Income (AGI). Though approximately 25 percent of individuals in this age range would not purchase retirement LTCI with DC funds because their account balances are less than \$20,000, the remaining purchasers of retirement LTCI are considered to be part of an upper-middle income distribution based on this analysis.^f For potential enrollees age 55 to 64 to afford retirement LTCI, the necessary DC account balance would be \$132,684, which is associated with an AGI in the \$75,000 range. Nearly 50 percent of all eligible individuals ages 45 to 69 with DC retirement accounts would not participate due to small account balances.^g

^d The Milliman Inc. analysis premiums use a 2 percent annual increase and for this report we further increased the indexing to the CPI-U as forecasted by the CBO in the January 2017 baseline.

^e This accounts for about 44 percent of individuals whose employers currently offer long-term care insurance (DEG analysis).

^f Pew Research Center details middle-income households ranging from about \$42,000 to \$125,000 in 2014.

^g The “no bankruptcy” conditions applied to the analysis performed for this report effectively eliminate persons with AGI of less than \$50,000.

DEG estimates that making premium distributions non-taxable would further increase LTCI policy sales by approximately 15.3 million individuals, or about 45 percent of all eligible individuals who meet DC account balance criteria. However, because premiums would not be subject to income tax, this would result in a decrease of potential federal income tax of approximately \$92 billion over the 10-year budget window. Rather, by allowing penalty-free distributions for LTCI premiums that are taxable income, plan participants and IRA owners can more effectively use their retirement savings to protect against a major risk to financial security in retirement, while also increasing federal revenues over the 10-year budget window.

BPC Recommendation

Permit penalty-free (but not tax-free) withdrawal from retirement savings accounts for employer-offered private LTCI. Permitting individuals to use retirement savings to purchase “retirement LTCI” would help defray LTSS costs, which for many Americans depletes retirement savings.

Additional Private LTCI Regulatory Issues

Since the release of our [February 2016 report](#), the National Association of Insurance Commissioners (NAIC) issued recommendations to federal policymakers, many of which mirror BPC recommendations. Although not addressed in BPC’s 2016 report, industry experts suggested that limiting options for employer-sponsored coverage to private LTCI plans may not realize the full potential of engaging employees in planning for retirement. Further consideration should be given to “combination” or “hybrid” policies which combine life insurance and LTCI. These policies convert from life insurance to LTCI should an individual need LTSS.

The private long-term care industry has also, in recent months, suggested moving from a “rate stability” regulatory model to an “annual rate sufficiency” model. This approach, similar to the recommendation included in BPC’s February 2016 report, would allow carriers to automatically increase or decrease premiums based on claims experience, rather than setting premiums relative to cost predictions. The private insurance industry experts suggest that an annual rate sufficiency model not be limited to “retirement LTCI.” While BPC is not specifically endorsing the annual rate sufficiency model proposed by the long-term care industry, we encourage policymakers to further explore adjusting LTCI premiums relative to updated actuarial analysis and claims experience. As these options move forward, however, consideration should be given to the amount of administrative complexity, if any, that would be added to an already confusing market.

Medicare Respite Care Benefit

Family caregivers deliver a significant share of assistance to those in need of LTSS. In 2011, 14.7 million family and unpaid caregivers gave assistance to 7.7 million community-dwelling older adults.³⁶ By comparison, Medicaid programs, the largest payer of LTSS, financed services for 4.8 million older Americans.³⁷

Background

According to the Family Caregiver Alliance, caregivers spend an average of 13 days per month on tasks including shopping, preparing food, housekeeping, transporting, and administering medication for family members with LTSS needs.⁴⁰ Family caregivers spend six days per month providing personal care such as feeding, dressing, grooming, bathing, and assisting with toileting.⁴¹ Respite care helps to keep individuals with functional or cognitive impairment in their homes by giving their family caregivers a reprieve from caregiving, which can prevent the caregiver from declining physically or emotionally.

Structure of Respite Care Policy Analyzed by BPC

BPC asked the Urban Institute to estimate the cost of a respite care benefit in Medicare. In traditional Medicare Fee-for-Service (FFS), there are typically very few limits to the volume of services provided. Today, respite care benefits are available only for Medicare FFS beneficiaries who are enrolled in Medicare's hospice benefit, a benefit which is only available for beneficiaries who are expected to die within six months.⁴² In effect, the hospice provider determines whether respite care services are needed for the enrollee's caregiver. The challenge of providing and estimating the cost of a respite benefit is that not all Medicare beneficiaries have serious end-of-life conditions or full-time caregivers who need respite.

There are a number of administrative challenges in developing a respite benefit. For example, what type of Medicare provider would determine the need for services and how would the services be paid? Ultimately, for the purposes of analysis, BPC and the Urban Institute examined a proposed respite care benefit in Medicare FFS and MA that would be triggered when certain Medicare providers determined that respite care was needed. Under the analyzed policy, to receive a referral for the respite care benefit, Medicare beneficiaries would either need to: (1) be enrolled in an MA plan or an accountable care organization (ACO), or (2) be receiving chronic care management (CCM) services from a Medicare FFS clinician. It is important to note that current Medicare rules for the provision of CCM services require that the beneficiary must have two or more chronic conditions in order to be eligible for CCM services.

In further defining eligibility for respite care, it is necessary to target services to those who need a caregiver. Under our criteria, to receive a respite care referral, a beneficiary must have two or more ADL limitations or severe cognitive impairment; and must either: (1) have a primary, unpaid caregiver that resides with the beneficiary; or (2) qualify as an adult in need of emergency placement because of concerns that they are the victim of abuse. Data from the National Health and Aging Trends Survey (NHATS) show that about 40 percent of those eligible for the proposed Medicare respite care benefit have only spousal caregivers, making inclusion of relief for spousal caregivers a key design consideration. For the purposes of data analysis, the results presented in this report include estimates that assume Medicare beneficiaries with spousal caregivers would be eligible for the respite care benefit, as well as alternative estimates that assume this group would be ineligible for the benefit.

Under the analyzed policy, respite services may be provided either by temporary institutional placement of the care recipient, or in the recipient's home. Service provider options for care include a Medicare inpatient hospital or skilled nursing facility; or Medicare certified provider, advance practice nurse, or home health agency.

Table A. BPC Specifications for Medicare Respite Benefit Proposal

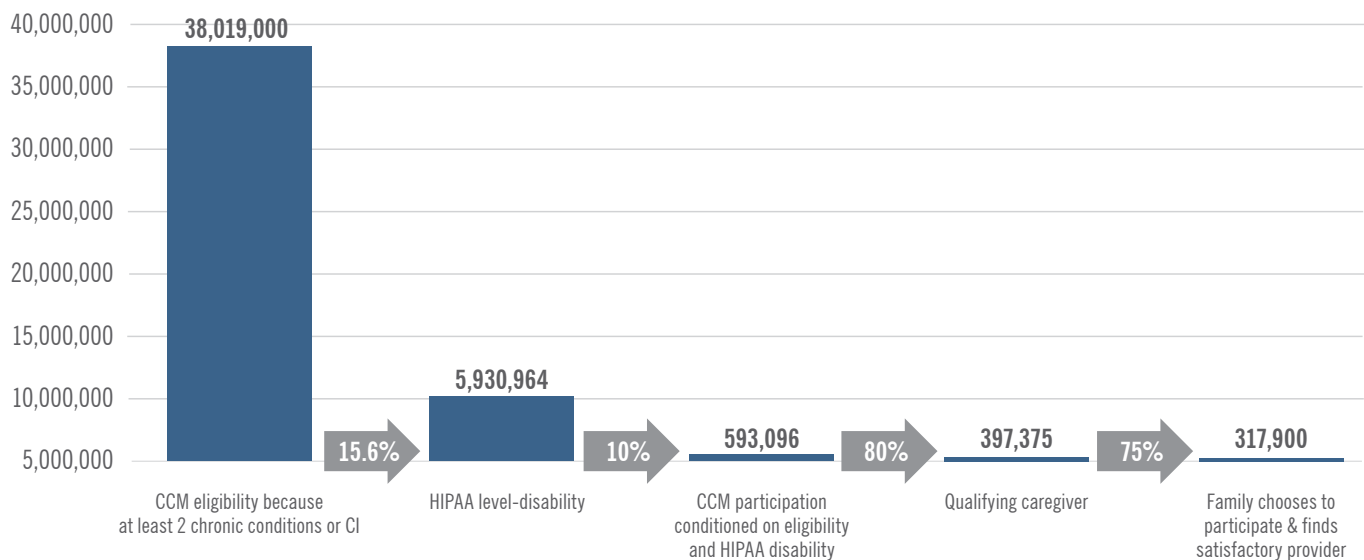
BPC Specifications for Medicare Respite Benefit Proposal	
Eligibility	Available to a Medicare beneficiary who is receiving CCM services, and who: <ul style="list-style-type: none"> • has two or more of limitations with ADLs or severe cognitive impairment; • has a primary, unpaid caregiver that resides with the beneficiary; or • is an adult in need of emergency placement because of concerns that they are the victim of abuse. • Note: Cost for both with and without spouse eligibility.
Gate keeper/benefit administration case management	Available through risk-based plans or provider organizations (Medicare Advantage plans, Accountable Care Organizations, Comprehensive Primary Care Initiative, etc.). For those who remain in Medicare fee-for-service, the benefit is administered by the physician receiving reimbursement for CCM services.
Service provider options for care	<ul style="list-style-type: none"> • Medicare inpatient hospital or skilled nursing facility; or • Medicare certified provider, advance practice nurse, or home health agency
Benefit limits	Option 1: Limited to no more than 96 hours, or 4 days, per year. Option 2: Limited to no more than 168 hours, or 7 days, per year. Option 3: Limited to no more than 336 hours, or 14 days, per year.
Setting for respite care	Respite services may be provided either by temporary institutional placement of the care recipient, or in the recipient's home. We currently assume only community residents are eligible.
Cost-sharing requirements	Part A or Part B cost sharing applies based on setting. Low-income subsidies apply. Note: Cost sharing could vary by provider. Current estimates assume that because respite is being provided in the community (like Part A home health care services), there is no mandated cost sharing.
Reimbursement	The Secretary would determine rates, which could vary by provider. Incorporated into the revised benchmark or "budget" for a risk-based organization. In fee-for-service, reimbursed at a TBD daily per diem for inpatient care and hourly rate for home-based services based on needed level of care. For example, for those needing 24-hour nursing care, payment should be similar to home health rate, and a lower rate for a personal care attendant. For fee-for-service, payment would be paid to the provider. For the purposes of these cost estimates, we assume that care costs \$20/hour in 2016, subsequently indexed to wage inflation.

BPC considered three durational limitations for the respite care benefit: (1) a benefit of no more than 96 hours, or four days per year; (2) a benefit of no more than 168 hours, or seven days per year; or (3) a benefit of no more than 336 hours, or 14 days per year. We currently assume only community-residing Medicare beneficiaries would be eligible. Medicare Part A or Part B cost-sharing applies based on setting, and low-income subsidies apply. The Centers for Medicare and Medicaid Services (CMS) would determine provider payment rates for providers furnishing the respite care. These payment rates could vary by provider type and geographic area. For risk-based organizations, such as MA plans or ACOs, the cost would be incorporated into the revised benchmark or "budget" for a risk-based organization. In Medicare FFS, care would be reimbursed at a daily per diem for inpatient care and an hourly rate for home-based services based on needed level of care. For the purposes of the estimates in this report we assumed an initial \$20 per hour rate of reimbursement.

Analytical Methodology and Results

At BPC's direction, the Urban Institute analyzed information from the NHATS and the National Study of Caregiving (NSOC) to provide estimates of the number of Medicare beneficiaries who might use a respite care benefit, as well as the cost of providing that care. **Figure 3** illustrates the process by which the number of Medicare beneficiaries eligible for and potentially participating in a respite care benefit could be determined. These figures assume that Medicare beneficiaries with spousal caregivers would qualify for the benefit.

Figure 3. Stylized Representation of the Qualification Process for Respite Care Benefit for Which Spouse Caregivers Would Qualify, 2016



Of the 38 million community-based Medicare beneficiaries who would meet the qualifications for CCM, the Urban Institute estimates that 5.9 million meet the Health Insurance Portability and Accountability Act (HIPAA) definition of disability – being unable to perform (without substantial assistance from another individual) at least two ADLs for a period of at least 90 days due to a loss of functional capacity or requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Current low rates of use of CCM services – fewer than 2 percent of Medicare beneficiaries received CCM services in 2015 – suggest that participation in the respite benefit would initially be low, and would remain so unless CCM service participation increases.

The cost analysis examined three take-up rates: low, intermediate, and high. The intermediate estimate is based on best-guess assumptions on take-up, administrative costs, ADL creep/inflation, beneficiary age distribution, and intensity of use. It assumes that use of CCM increases to 50 percent of eligible Medicare beneficiaries over the next 10 years. Under the intermediate estimate assumptions, the 10-year federal budgetary cost for a 96-hour respite benefit would be \$29 billion, if beneficiaries with spousal caregivers were included, and \$21 billion if beneficiaries with spousal caregivers were excluded. For a 168-hour benefit, the comparable federal costs over 10 years would be \$54 billion and \$39 billion, depending on the

inclusion or exclusion of beneficiaries with spousal caregivers. The analysis suggest that the respite care benefit would direct a significant portion of gross benefits to the lower quintiles of the income distribution, due to the fact that individuals with HIPAA-level functional or cognitive impairment are more likely to have lower incomes. In fact, more than 60 percent of the estimated benefits accrued to the lowest two quintiles.

Challenges for the Policy

Finding an appropriate delivery mechanism has been a challenge for the design of this benefit. The lack of infrastructure within Medicare FFS to administer the benefit and the low participation rates in CCM raises issues about delivering the benefit in an administratively efficient and accountable manner. There are tradeoffs between administrative complexity and accountability. Administrative expenses associated with measuring and the verifying disability status of the care recipient, and documenting allowable expenses, could be significant. The greater the administrative resources, the greater the capability to adhere closely to the program criteria, but the higher the cost of the benefit. Given the modest level of benefits provided, the proposed policy attempts to operate within existing systems rather than constructing additional administrative mechanisms.

Generally, there was a concern that the projected value of the respite benefit in traditional Medicare FFS is low relative to the projected federal budgetary cost of the benefit. Therefore, the expected cost of adding a respite benefit to traditional Medicare FFS, along with administrative complexities, preclude adding respite care as a Medicare FFS benefit at this time. However, flexibility should be provided for MA plans and provider organizations such as ACOs to furnish the respite care benefit in a manner that does not add new federal costs to the Medicare program.

BPC Recommendation

Build on [previous recommendations](#) to permit Medicare Advantage (MA) plans and other Medicare provider organizations operating under a “benchmark,” the flexibility to offer a respite care benefit to high-need, high-cost Medicare beneficiaries. Respite care, along with other services, could be offered under this flexibility, so long as the services are part of a person- and family-centered care plan for a subset of individuals that meet the eligibility criteria, which includes patients with three or more chronic conditions and functional or cognitive impairment.

Tax Credits for Family Caregivers

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

Background

Quantifying the value of assistance provided by family caregivers can be difficult—as the value of unpaid care furnished by family members is assessed differently than the costs of paid care that is financed by family members. In 2015, 43.5 million family caregivers personally furnished unpaid care to an adult or child at some point during the year, including 34.2 million caregivers who provided that unpaid care to an adult age 50 or older.⁴³ Researchers estimate that unpaid care translated into \$470 billion of economic value in 2013.⁴⁴ In addition to personally furnishing unpaid care and assistance, family caregivers incur roughly \$7,000 in non-reimbursed out-of-pocket costs each year on paid care and related expenses.⁴⁵

“*In 2015, 43.5 million family caregivers personally furnished unpaid care to an adult or child at some point during the year, including 34.2 million caregivers who provided that unpaid care to an adult age 50 or older.⁴⁶ Researchers estimate that unpaid care translated into \$470 billion of economic value in 2013.⁴⁷ In addition to personally furnishing unpaid care and assistance, family caregivers incur roughly \$7,000 in non-reimbursed out-of-pocket costs each year on paid care and related expenses.⁴⁸*”

Both forms of family caregiver assistance can help keep frail and functionally or cognitively limited individuals in their homes by filling gaps in ADL assistance need. This function can result in a delay in the need for expensive LTSS, including nursing facility costs, which may ultimately be financed through the Medicaid program for many individuals with ADL needs who “spend down” to Medicaid levels.⁴⁹

Current Tax Benefits for Caregivers

Under current tax law, there are several avenues through which family caregivers could potentially obtain preferential tax treatment for the out-of-pocket expenses associated with paid care that the family caregiver finances on behalf of their older family member. No such policies currently exist to provide tax incentives for family caregivers furnishing unpaid care, due to administrative complexities discussed in more detail below.

Some family caregivers are able to claim their parent(s) or other older family members as dependent adult relatives (or “qualifying relatives”), which allows for the family caregiver to claim a \$4,050 personal exemption on income taxes for each qualifying relative, and, in certain circumstances, to also claim the Non-Reimbursed Medical Expense Deduction for the paid care that the family caregiver finances out-of-pocket on behalf of the qualifying relative. For an older family member to qualify as a family caregiver’s qualifying relative, the family caregiver must pay for more than 50 percent of the older family member’s expenses for the year—which include all expenses⁵⁰ (e.g. living and food expenses), not merely 50 percent of the older family member’s care expenses. In addition, a qualifying relative must have annual gross income of less than \$4,050.⁵¹ Finally, a qualifying relative must meet certain family relationship criteria with the family caregiver or cohabit in the same domicile as the family caregiver.⁵²

In addition to the \$4,050 personal exemption applied to the family caregiver’s income taxes, a family caregiver who claims a qualifying relative as a dependent can also deduct out-of-pocket expenses contributed toward financing paid care for the qualifying relative, to the extent that the out-of-pocket expenses exceed 10 percent of the family caregiver’s income.⁵³ 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 standardsⁱ enumerated in the HIPAA regulations for a qualifying long-term care insurance contract.⁵⁴

In some cases, an older family member may live with the family caregiver, be financially dependent upon the family caregiver for more than 50 percent 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 due to the fact that he or she has income in excess of \$4,050 cap. In these instances, the family caregiver can often claim the Child and Dependent Care Tax Credit (CDCTC). Under the CDCTC, the family caregiver may claim the tax credit for out-of-pocket expenses incurred in financing paid care for the older family member, up to a maximum credit of \$3,000 for each older family member (for whom the family caregiver finances paid care).⁵⁵ The CDCTC establishes an income-based sliding scale to determine the amount of out-of-pocket expenses that must be incurred by the family caregiver in order to receive the maximum tax credit.

“ An older family member may live with the family caregiver, be financially dependent upon the family caregiver for more than 50 percent 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 due to the fact that he or she has income in excess of \$4,050 cap. In these instances, the family caregiver can often claim the Child and Dependent Care Tax Credit. ”

More information on current tax incentives for family caregivers may be found in Appendix C.

ⁱ Standards under the HIPAA regulations require that the individual receiving care must have two or more limitations performing activities of daily living (ADLs) or have the need for substantial supervision to protect the individual from threats to health and safety because of severe cognitive impairment.

Structure of Tax Credit Analyzed by BPC

While the tax policies discussed above provide some financial support for certain family caregivers who finance paid care for older family members, tax incentives are not currently available for family caregivers who provide out-of-pocket expense support for older family members who: (1) have incomes that exceed the \$4,050 limitation for qualifying relative status, and (2) do not share a residence with the family caregiver—even though the older family member may have functional or cognitive impairment. With these and other situations in mind, BPC examined policy options for providing a caregiver tax credit that addresses many of the shortcomings of current tax policy.

Although the importance of unpaid care provided by family caregivers can be easily recognized, the structure of the U.S. income tax system presents many administrative and compliance obstacles to implementing a tax credit that is tied to the hours of unpaid care that a family caregiver provides. While paid care results in identifiable financial expenses that can be verified through recordkeeping and subsequently examined in an audit, taxpayer-reported hours spent providing unpaid care (and the value of that time) cannot be as easily recorded and verified. Some policymakers have developed proposals to elevate Social Security payments for family caregivers who provide unpaid care.^j Although this approach would involve similar obstacles for verification of hours spent furnishing unpaid care, the approach is worthy of future study and consideration. However, due to the administrative and compliance issues associated with accounting for unpaid care, BPC’s analysis focused on a tax credit for family caregivers who finance paid care for an older family member, including many family caregivers who currently cannot count out-of-pocket paid care expenses toward existing tax credits and deductions in an effective way.

The proposed tax credit would be tied to a caregiver’s out-of-pocket costs for paid care. Specifically, the proposed policy would provide a refundable tax credit equal to 30 percent 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). The credit would begin phasing out for couples with annual 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 need 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 Instrumental Activities of Daily Living (IADLs)” and “must be provided solely for the use of the qualified recipient.”

Analytical Methodology and Results

BPC worked with the Urban Institute to project the potential impacts of the Caregiver Tax Credit, using the Urban Institute’s Dynamic Simulation of Income Model (DYNASIM). DYNASIM is a model of the U.S. population based on the Survey of Income and Program Participation. To project costs and distributional effects of the proposed Caregiver Tax Credit, the analysis uses

^j S. 1255, the “Social Security Caregiver Credit Act of 2017” (115th Cong.) would artificially credit family caregivers’ reported annual wages (only for purposes of future Social Security payment calculations) to account for hours spent providing unpaid care that could have otherwise generated Social Security-applicable income in employment settings.

DYNASIM, as anchored by historical sources of caregiver out-of-pocket expenses, such as the NHATS, the NSOC, and the Medicare Current Beneficiary Survey (MCBS).

The analysis projects that roughly 10.9 million taxpayers would claim the proposed caregiver tax credit each year between 2018 to 2027.^k The 10-year federal budgetary cost of the tax credit, in the form reduced federal revenues and increased tax expenditures, would be \$130 billion over the 2018-2027 window.

The projections suggest that the distribution of benefits does not vary significantly by income—with the lowest two quintiles (by income and poverty measures) receiving an estimated 37 percent of the aggregate benefit of the policy, and the upper two quintiles accounting for 38 percent of the aggregate benefit.

Challenges for the Policy

The analyzed policy would not provide any relief for family caregivers who provide exclusively unpaid care (and have no out-of-pocket costs attributable to purchased LTSS and related items). A federal investment of the magnitude projected in the DYNASIM analysis that does not address unpaid care in a more significant way would not be an optimal allocation of resources to address the needs of family caregivers.^k Given the high budgetary cost of the policy, and considering the direction of Congress and the administration in advocating for tax reform legislation that reduces tax rates while eliminating tax expenditures (deductions, credits, etc.), the policy does not seem feasible in the current environment.

BPC's Final Assessment of the Policy

BPC does not recommend the adoption of the proposed Caregiver Tax Credit. More research is needed to develop administratively-viable methods of providing financial support to family caregivers in a manner that can account for unpaid care furnished by the caregiver as well as out-of-pocket expenses incurred by the family caregiver in financing paid care.

LTSS Benefit in Medicare Advantage and Medigap Supplemental Insurance Coverage

Most older Americans who are not eligible for Medicaid are enrolled in either a Medicare supplemental insurance policy or a MA plan, but do not have private LTCI. BPC asked Milliman Inc. to analyze the beneficiary premium cost and feasibility of adding a limited LTSS benefit to Medigap supplemental insurance policies and to MA.

Background

Medigap insurance is offered on a guarantee issue basis without medical underwriting at the time in which beneficiaries enroll in the Medicare program. Using Medigap as a model, this approach would have the benefit of reaching a large market of individuals who do not have LTCI coverage.

^k All estimates highlighted in this report use the analysis' "Intermediate Assumptions" for projecting taxpayer participation, budgetary cost, and benefit distribution.

Similarly, MA plans enroll Medicare beneficiaries for coverage of traditional Medicare-covered services, covered under Medicare Part A and Part B, while also providing protection against high out-of-pocket expenses on Medicare cost-sharing, through statutorily-required caps on beneficiary out-of-pocket expenses. When MA plans are able to hold costs for traditional Medicare services below spending benchmarks, many MA plans also provide supplemental benefits for many services that are not covered under Medicare Part A or Part B. These benefits are referred to as “mandatory supplemental benefits” that must generally be provided to all enrollees. Alternatively, MA plans can provide “optional supplemental benefits,” under which the MA plan provides the beneficiary with the option of enrolling in coverage of additional non-Medicare-covered services in exchange for additional premiums that are paid by the beneficiary when the beneficiary elects to enroll in the optional supplemental coverage.

Structure of the Limited LTSS Benefit Policy Analyzed by BPC

The limited LTSS benefit would provide reimbursement for provision of home-based services similar to the level of services covered in the existing LTCI market, including services provided in the home by a licensed medical practitioner or home care aide, as well as other services to help individuals remain in their homes. The base LTSS plan coverage modeled includes the following features: individuals issued coverage at age 65; unisex-rated \$100 daily benefit, paid based on actual service costs incurred up to the daily limit; coverage for home-based services only, similar to the level of home health coverage offered in private LTCI plans; a 90-day elimination period; a one-year benefit period with a pool-of-money design; and automatic annual compound benefit increases indexed to a consumer price index (CPI).

Similar to Medigap, Medicare beneficiaries would have a one-time opportunity to purchase the limited LTSS benefit in either MA or Medigap. If a beneficiary chooses not to purchase coverage, and they seek coverage later, plans may medically underwrite and deny coverage, or permit coverage with a higher premium.

Rather than requiring that all Medigap and MA plans must offer a limited LTSS benefit, BPC chose to analyze a voluntary approach, under which CMS would amend Medigap and MA requirements to permit plans to offer existing benefits along with a new limited LTSS benefit, which beneficiaries could elect to enroll in, and pay corresponding premiums to cover the cost of the benefit. Requiring all Medigap and MA plans to offer a limited LTSS benefit, while limiting adverse selection, would require Medicare beneficiaries to either buy the limited LTSS benefit or forego Medigap and MA plans altogether. Because of political sensitivities, this “take it or leave it” approach was rejected in favor of the voluntary approach.

Analytical Methodology and Results

At BPC’s direction, the Milliman Inc. analysis provides illustrative market-wide premiums reflecting average nationwide costs for 65-year-olds assumed to enroll in a new coverage vehicle. Although private LTCI coverage uses underwriting to address adverse selection concerns and develop premium rates, the proposed structure forgoes underwriting during the Medigap “open enrollment” election period, increasing the challenge of matching premium rates to the underlying risk.

At BPC’s direction, the Milliman Inc. analysis varied several parameters to assess their impact on estimated premiums: hypothetical starting participation levels to illustrate the large, potential impact of adverse selection; discount rates which are used to develop the present value of expected claims and premium revenue at issue age 65, and loss ratios. In addition, Milliman Inc. examined alternative daily benefit levels—\$50; \$75; and \$100 and 90—and 180—day elimination periods. BPC set an initial monthly premium target of \$50, in order to make the product cost competitive. Because Medigap and LTCI markets are highly price-sensitive, a number of options were considered to reduce premiums, including capping the daily benefit and increasing the elimination period. Reducing the daily benefit to \$50 reduced the monthly premium by half. Increasing the elimination period from a 90- to 180-day elimination period reduces premiums by roughly 14 percent.

Under the base plan assumptions, Milliman Inc. estimated starting monthly premiums at age 65 would vary from roughly \$50 to \$200, for the \$100-per-day base benefit depending on assumed variations in starting participation level, discount rate, and provisions for expenses and profit. The premiums are particularly sensitive to the participation level. Milliman Inc. estimated that a participation level of approximately 60 percent resulted in monthly premiums within the range of \$50-\$60.

Table B. Issue Age Starting Premiums Per Member Per Month (PMPM)

85 Percent Loss Ratio by Assumed Participation Rate (base plan assumptions)				
Discount Rate	100% Participation Scenario	5% Participation Scenario	40% Participation Scenario	60% Participation Scenario
3%	\$55	\$197	\$70	\$61
4%	\$51	\$190	\$65	\$57
5%	\$47	\$183	\$61	\$53

Challenges for the Policy

The assumed mix of individuals with both lower and higher levels of anticipated LTSS needs is an important consideration when participation is less than 100 percent. Under a voluntary structure with no underwriting, 100 percent participation by Medicare beneficiaries is highly unlikely, and it is possible, that a plan could reach a “tipping” point where it is unsustainable, as lower-risk individuals choose not to purchase coverage, leaving only higher-risk individuals.

BPC Recommendation

Permit Medigap and MA plans to market a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed exclusively through additional premiums paid by Medicare beneficiaries who choose to enroll. For the purposes of estimating the added cost of the benefit to Medigap or MA premiums, BPC assumed a \$75 maximum daily benefit, with a 180-day elimination period that would need to be satisfied prior to the commencement of the benefit. Consistent with existing Medigap policies, beneficiaries would have a one-time option to purchase this coverage when they enroll in Medicare. BPC’s analysis suggests that such a policy could result in premiums of \$35 to \$40 per member per month (PMPM).

Federal Catastrophic Long-Term Care Insurance

As stated above, 70 percent of all older Americans will need LTSS at some point in their lives. By 2050, the age 65 and older population is expected to double and the 85 and older population, which has the highest rate of LTSS use, will triple.⁵⁶ As it stands, this growing LTSS burden will be met primarily through a combination of out-of-pocket spending, unpaid family care, and Medicaid, with private insurance covering a relatively small portion of costs.

“ 70 percent of all older Americans will need LTSS at some point in their lives. By 2050, the age 65 and older population is expected to double and the 85 and older population, which has the highest rate of LTSS use, will triple.⁵⁷ ”

While many older adults are able to meet their LTSS needs through out-of-pocket spending and unpaid care, these resources are not adequate for most individuals who face extraordinary LTSS expenses, such as the approximately 15 percent of older adults who will have lifetime costs over \$250,000. Most private LTCI policies are not designed to cover such catastrophic LTSS costs; private policies are generally capped to a lifetime maximum and are limited to three to five years of coverage.⁵⁸ Therefore, the vast majority of older adults who face catastrophic costs must deplete their personal resources to qualify for Medicaid.⁵⁹ In many cases, LTSS costs are shifted to younger generations, as family caregivers often incur income losses in order to provide care and may even use their own retirement savings to pay for their loved one's care.

In 2015, Milliman Inc. and the Urban Institute modeled voluntary front-end approaches to LTCI, such as the one described in this report, as well as a catastrophic approach.⁶⁰ In its analysis, Urban specified variations in the price of premiums, participation, and benefits. In its comparison of a mandatory catastrophic (or “back-end”) program to a front-end policy approach, Urban found higher participation, especially among individuals with lower incomes, in the catastrophic policy option. This option was projected to offset more Medicaid costs than a voluntary front-end policy due to the extent to which participation in a catastrophic program included lower-income individuals. Ultimately, the Urban Institute found no singular ideal approach to LTCI, as the policy considerations simulated showed varying costs and benefits in terms of affordability, participation, and savings (both out-of-pocket and Medicaid).

The current state of LTSS financing is burdensome on individuals and their families and unsustainable for state and federal Medicaid budgets. Additionally, current proposals to significantly reduce federal Medicaid funding would further strain state budgets. If these cuts are realized, many states will need to choose between cutting LTSS services, eligibility, and/or provider payment rates.

Advocates have advanced a number of approaches to funding LTSS. In 2016, BPC concluded that scarce federal resources should be targeted to populations that cannot be served either through the private market or through personal savings. The

most promising approach is to target federal resources to cover the catastrophic or back-end of costs of LTSS for those with the highest need. Such a program could include a two-to-three year waiting period, and would need to be mandatory in order to spread risk and remain financially feasible. By covering catastrophic costs, this approach would lower state and federal Medicaid spending. Additionally, the insurance industry has argued that a catastrophic backstop would increase sales of private policies.

BPC's Final Assessment of the Policy

Changing demographics, as well as the increasing burden on working-age individuals necessitate a thoughtful discussion on the financing of LTSS for the 14 percent of individuals. While we are not able to reach agreement on a politically viable means of financing a public catastrophic benefit, we agree that a credible overall LTSS framework would include a public catastrophic LTSS program with a waiting period of two-to-three years. Such a policy, which should not add to the deficit, would help address the unmet needs of those individuals with significant LTSS needs and would incentivize the purchase and greater use of private LTCI.

Conclusion

As previously noted, a number of recommendations from BPC's prior report, as well as the recommendations listed above, have potential for advancing the financing of LTSS in the short-term. Given the political environment, policymakers may legitimately question the viability of a federally funded catastrophic health insurance program. Nonetheless, the omission of it means that millions of Americans will continue to face catastrophic expenses until they spend down into Medicaid eligibility (and the burden it will continue to impose on and be shared by states).

Appendix A

Impact of Retirement LTCI on Federal Tax Revenues with Auto-Enrollment, 2015 nominal dollars

2015 One-year estimate, by age	45-54 year olds	55-64 year olds	65-69 year olds	Total 45-64	Total 45-69
Individuals with sufficiently large defined contribution retirement accounts, currently enrolled in LTCI coverage	1,090,915	622,352	900,165	1,713,266	2,613,432
New enrollees in LTCI coverage resulting from 100 percent firm take-up of auto enrollment	7,819,919	4,649,259	6,551,417	12,469,178	19,020,595
New enrollees in LTCI coverage resulting from estimated firm take-up	3,487,261	2,073,318	2,921,578	5,560,579	8,482,157
Estimated increase in federal income tax	\$1,852	\$1,871	\$1,956	\$3,723	\$5,679
10-year estimate over federal budget window 2018-2028 (in millions of dollars)				\$33,512	\$51,119

Source: DEG calculations on behalf of BPC

Appendix B

Estimates of Defined Contribution Retirement Account Balances and LTCI Take-Up at 2015 levels

	45-54 year olds	55-64 year olds	Total
Number of insured lives with defined contribution accounts	1,492,996	1,332,158	2,825,154
Number of additional insured lives with defined contribution accounts, under auto-enrollment	3,623,118	2,154,090	5,777,208
Average retirement LTCI indexed premiums (weighted by population)	\$2,259	\$3,517	
Minimum defined contribution retirement account balance needed for LTCI annual premiums	\$88,546	\$137,135	
Median account balance	\$87,200	\$103,200	
Total LTCI premiums paid through defined contribution accounts, under auto enrollment (in millions of dollars)	\$10,965	\$11,300	\$22,265

Source: DEG calculations based on SOI 2013, SCF 2013 and EBRI 2017.

Appendix C

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

Comparison of Tax Benefit Options for Family Caregivers				
	BPC	Current Law Deductions (Taxpayer Can Claim Both)		Current Law Credits (Taxpayer Cannot Claim Dependents)
	Proposed Caregiver Tax Credit Examined	Personal Exemption for Dependents	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	Applicable Expenses in Excess of 10% of Caregiver's Income	\$3,000 (For One Dependent) \$6,000 (Max for Multiple Dependents)
Amount of Caregiver Spending Required to Obtain Max Credit	\$10,000	N/A	N/A	Varies by Taxpayer Income Income Under \$15,000: \$8,571 Income Over \$43,000: \$15,000
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 expenses must exceed 10% of income Must Pay for More than 50% of Dependent's Expenses	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)	N/A	N/A	N/A
Impairment Standard for Care Recipient	HIPAA Standard	N/A	HIPAA Standard	Person who is not physically or mentally able to care for himself or herself. 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.

Comparison of Tax Benefit Options for Family Caregivers (continued)

	BPC	Current Law Deductions (Taxpayer Can Claim Both)		Current Law Credits (Taxpayer Cannot Claim Dependents)
	Proposed Caregiver Tax Credit Examined	Personal Exemption for Dependents	Non-Reimbursed Medical Expenses	Child and Dependent Care Tax Credit
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, or rehabilitative services, and maintenance and 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	Care Recipient Income Must be Less Than \$4,050	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

Appendix D

Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid, September 2016

Recommendations to Align Programs for Dual-Eligible Beneficiaries

Medicare Advantage Special-Needs Plans (SNPs)

1. Permanently authorize Medicare Advantage Dual-Eligible SNPs. However, all plans should meet the requirements of Fully Integrated Duals Special-Needs Plans, which fully integrate clinical health services, behavioral health, and LTSS by January 1, 2020.
2. Authorize the Department of Health and Human Services (HHS) secretary to align the Medicare and Medicaid grievance and appeals processes. Where adopting one standard would adversely affect a beneficiary, the HHS secretary should resolve the issue to the benefit of the enrollee. For example, under the aligned process, Medicare claims, like Medicaid claims under current law, should be paid during appeal.
3. The HHS secretary should ensure that the combined Medicare and Medicaid benefits offered through all SNPs are seamless to the beneficiary and to providers. Materials provided to a beneficiary must show the combined benefit, the plan must have a single cost-sharing structure, a single care manager, a single enrollment process and enrollment card, a single claims submission process, and a single contact number for beneficiaries and providers.

Financial Alignment Demonstrations

1. For ongoing demonstrations, CMS should:
 - a. Revise contracts to ensure that, where appropriate, rates reflect unanticipated costs of infrastructure investment or significant differences in cost associated with serving certain special-needs populations, such as those with previously untreated mental illnesses or homeless individuals. Note: CMS has made these adjustments in some states;
 - b. Ensure that adjustments do not result in increased cost to the federal government over the five-year demonstration period;
 - c. Work with states to develop unique state-specific quality and access measures, and to the extent there are savings, permit states to share in a greater percentage of those savings or, where appropriate for high-performing states, permit added flexibility in the scope of covered benefits, while assuring that beneficiaries continue to receive optimal access to care; and
 - d. Align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services.

2. CMS should establish additional demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries based on findings from the evaluations of the first-round demonstrations. New demonstrations will allow additional states to gain experience providing managed LTSS to dual-eligible populations and coordinating these services with Medicare acute care.

Program of All-Inclusive Care for the Elderly (PACE)

1. Through newly authorized demonstration authority, CMS should test:
 - a. An expansion to individuals, regardless of age, who meet all other PACE criteria and who do not require a nursing home level of care;
 - b. An option that permits individuals to enroll in PACE, but opt out of adult day services; and
 - c. An option that includes both Medicare-covered services and a beneficiary “buy-in” of a limited LTSS benefit that is less than the full-range of Medicaid-covered LTSS for individuals who are not eligible for Medicaid and whose income exceeds 300 percent of Social Security income.
2. CMS should permit PACE organizations to enroll beneficiaries during the month, rather than requiring them to wait until the first of the month to enroll. CMS should pro-rate the monthly per-capita payment.

Recommendations to Integrate Care for Dual-Eligible Beneficiaries

Align Oversight of Programs Serving Dual-Eligible Beneficiaries within the Centers for Medicare and Medicaid Services

Consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office. Congress directed HHS to establish an office responsible for integrating care for dual-eligible beneficiaries; however, existing agencies within CMS retain regulatory authority over programs serving dual-eligible beneficiaries. Consolidating this authority will help ensure that decisions affecting these programs are made through the lens of an integrated program that takes into account the impact on beneficiaries, as well as state implementation.

Reimbursement structures would include SNPs, PACE, current and future demonstrations, and a new contract authority described below. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a leadership team whose single focus is addressing the unique needs of low-income populations with complex needs through an entity that has the authority to address those needs.

Develop a Revised Regulatory Structure

1. Policymakers should build on lessons learned from existing programs and demonstrations to develop a contractual model similar to the innovative “three-way” contract between CMS, states, and plans under the financial alignment demonstration. A new model three-way contract should be uniform with respect to basic structure, beneficiary protections, quality requirements, care coordination, and continuity of care requirements. At the same time, it should be flexible enough to permit variation in delivery, provider, and reimbursement models, as well as state-level decisions, such as eligibility for optional populations.

2. In developing a framework for a model contract:
 - a. The HHS secretary should make decisions based on recommendations of an informal working group consisting of stakeholder organizations, including consumer and family representatives, non-provider experts in the delivery of clinical health services, LTSS, including home and community-based care, community and public health services for special-needs populations, employers (for those participating in a Medicaid buy-in program), disability experts, health plans, health care providers, state Medicaid officials and other relevant stakeholder organizations. The HHS secretary should promulgate regulations based on the framework developed; or
 - b. Alternatively, require negotiated rulemaking under the Administrative Procedure Act to develop the framework of a three-way contract. This approach, while more complicated than the regular “notice-and-comment” rulemaking process, would provide for greater transparency and give an equal voice to all members of the appointed rulemaking committee.

Appendix E

Improving Care for High-Need, High-Cost Medicare Patients, April 2017

Final BPC Recommendations on Risk Adjustment and Quality Measurement Incentives

- 1. Improving Medicare’s Risk Adjustment Model to Account for Functional Impairment:** In conjunction with action on the recommendation to waive uniform benefit requirements, the Centers for Medicare and Medicaid Services (CMS) should examine potential modifications to the CMS–Hierarchical Condition Categories (CMS–HCC) risk adjustment model to ensure more accurate predictions of medical expenses for the highest- and lowest-cost Medicare beneficiaries. Under this scenario, CMS could enhance existing survey platforms used to measure frailty and/or develop a functional status assessment tool that would be implemented and used across MA and Medicare FFS to evaluate and document functional impairment of the Medicare beneficiary. If this approach proves feasible—and data gathered by CMS support the use of a frailty adjustment factor or other functional status measure in the risk model—the otherwise applicable risk scores could be adjusted upward for MA plans and ACOs with higher proportions of beneficiaries with functional impairments, and adjusted downward for MA plans and ACOs that treat fewer beneficiaries with functional impairments. To allow MA plans and ACOs to become more familiar with the impact that a frailty or functional impairment adjustment factor would have on risk scores, benchmarks, and bid pricing, CMS should phase in any finalized adjustment factor policy over multiple years.
- 2. Incentivizing the Provision of Non-Medicare-Covered Supports Through Quality Measurement:** In conjunction with action on the recommendation to waive uniform benefit requirements, CMS should develop MA Star Ratings Program measures and ACO Quality Measurement metrics that evaluate the incorporation of non-Medicare-covered health-related social supports and services (that can be reasonably financed within existing MA rebates and ACO shared savings amounts) into the MA and ACO care model. MA plans and ACOs with greater levels of social support and service integration should be rewarded with higher scores on these quality measures, while MA plans and ACOs with less comprehensive integration of these services should receive lower scores. Additional quality measure-focused approaches could include applying one measure of all-cause hospital readmissions for beneficiaries with multiple chronic conditions and functional or cognitive impairments, and a separate measure of all-cause hospital readmissions for all other enrolled or attributed beneficiaries. For MA plans, consistent with past Medicare Payment Advisory Commission recommendations, and to the extent feasible, CMS should improve the Star Ratings Program by examining options for assessing these and other quality measures at the plan benefit package level, rather than the contract level.

Final BPC Recommendations for Medicare Advantage

- 1. Modifying the Uniform Benefit Requirement:** Congress should direct CMS to modify the MA uniform benefit requirement to allow MA plans to target non-Medicare-covered health-related social supports and services to plan enrollees who: (1) are not dually eligible for full Medicaid benefits; (2) have three or more chronic conditions; and (3) either have functional or cognitive impairment. Supports and services covered under this policy must be reasonably related to optimizing health or functional status, and must be part of a “person-centered care plan,” as defined by CMS. CMS should take steps to establish appropriate conditions of participation for MA plans availing themselves of this flexibility and should ensure that the offer of these targeted services cannot be inappropriately used for marketing purposes by MA plans. These non-

Medicare-covered health-related supports and services can be included as mandatory supplemental benefits, financed through existing MA rebates. This recommendation is consistent with the general policy approach of the Senate Finance Committee’s “Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016.”

2. **Waiving the Primarily Health-Related Requirement and Other Supplemental Benefit Rules:** CMS should provide an exception to the current requirement that supplemental benefits be primarily health-related and should also waive existing regulatory limitations on the provision of in-home meal delivery services, case management services, and home modifications as supplemental benefits. This exception should only apply to benefits that are targeted to enrollees who are not dually eligible for full Medicaid benefits and who have three or more chronic conditions and functional or cognitive impairment. Such benefits must be a part of a person-centered care plan, as defined by CMS. This recommendation is consistent with the general policy approach of the CHRONIC Care Act of 2016.
3. **Counting Health-Related Non-Medical Supports and Services Costs Toward the Medical Loss Ratio:** CMS should modify the definition of “incurred claims costs” in medical loss ratio (MLR) regulations to include the costs of health-related supports and services provided on an in-kind basis to enrollees who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. Such supports and services must be a part of a person-centered care plan. For audit and verification purposes, MA plans should be required to keep records of payment of claims or other invoices for such services whose costs are included in the “incurred claims costs” calculation.

Final BPC Recommendations for ACOs and Medical Homes

1. **Clarifying ACO Patient Incentive Waivers and Extending Waivers to the CPC Plus Model:** CMS should clarify that the Patient Incentive Waiver under the Medicare Shared Savings Program (MSSP) Program and the Next Generation ACO Program will allow for the free or no-charge provision of non-Medicare-covered health-related supports and services that optimize health or functional status for ACO-attributed beneficiaries who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. The waiver should be limited to supports that are identified in a person-centered care plan, as defined by CMS. CMS should also provide a Patient Incentive Waiver, similar to the waiver applicable for MSSP ACOs and Next Generation ACOs, for participants in “Track Two” of the Comprehensive Primary Care (CPC) Plus Initiative, provided that the in-kind furnishing of supports and services by CPC Plus practices are part of a person-centered care plan, as defined by CMS.
2. **Establishing Voluntary Enrollment Pathways within MSSP ACOs:** Consistent with past BPC recommendations, CMS should establish voluntary enrollment processes within the MSSP and make related changes to the underlying attribution and payment reconciliation structures to ensure that ACOs have a more predictable pool of attributed beneficiaries and care expenses, as ACO participants transition to greater risk-sharing.

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Notes

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