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ATI Advisory

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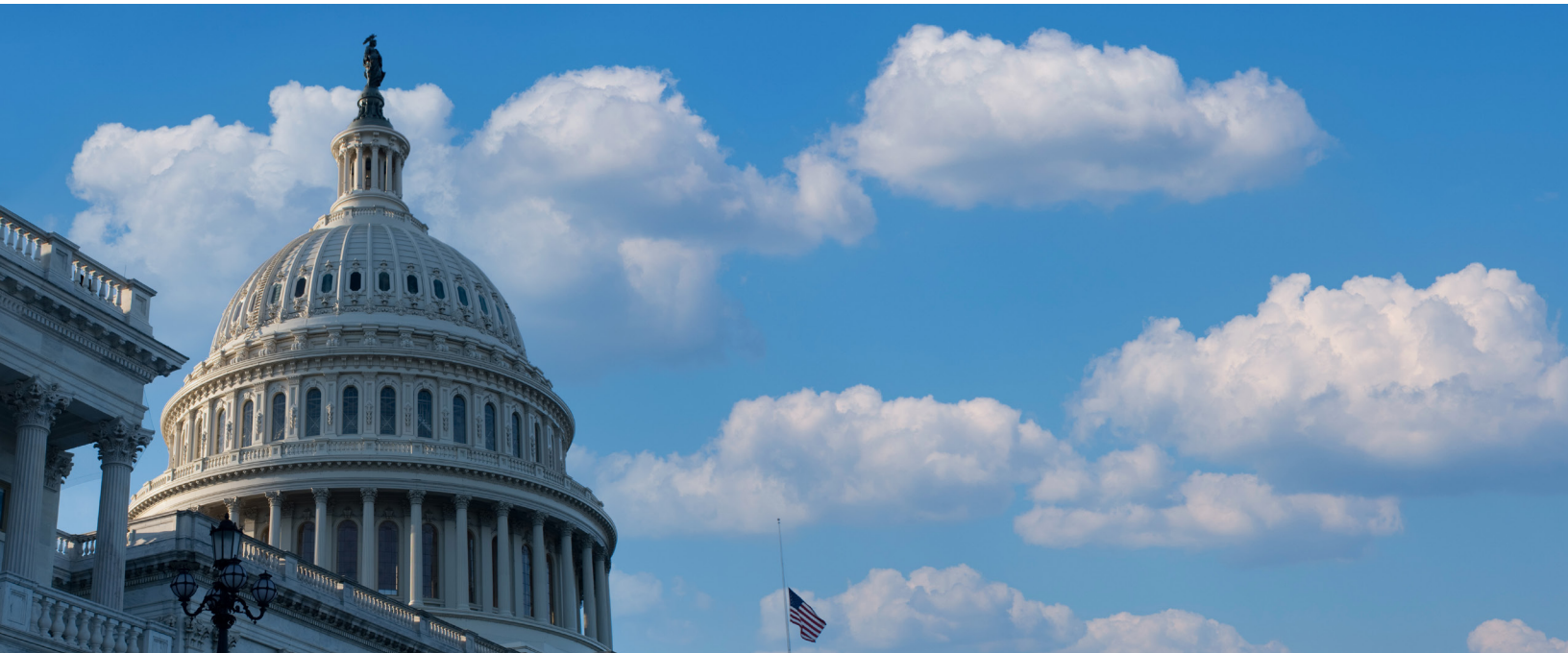
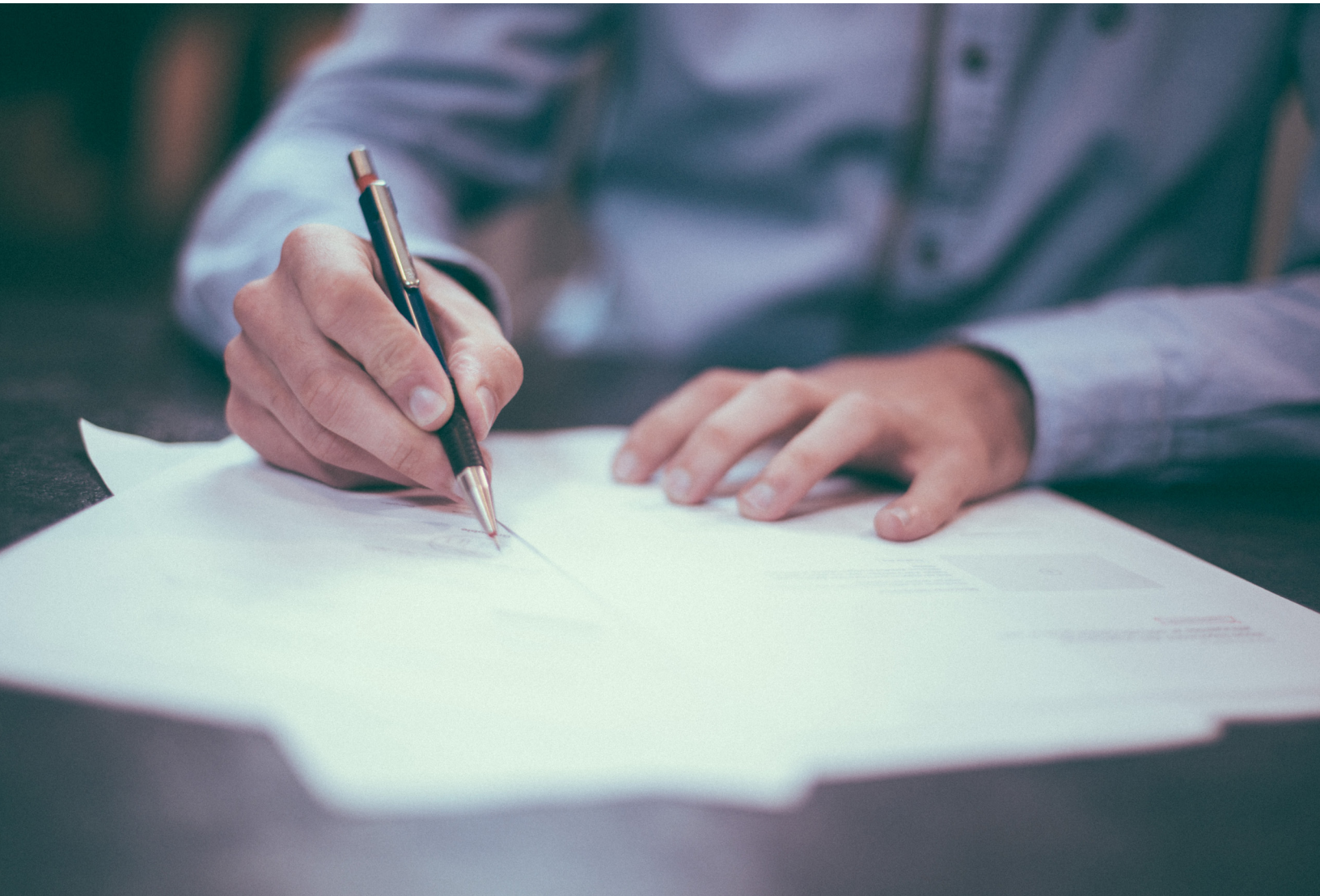
Compendium of Federal Long-Term Services and Supports (LTSS) Financing Policy Options



About this Work

Supported by The SCAN Foundation, LeadingAge LTSS Center @ UMass Boston and ATI Advisory (ATI) compiled federal policy solutions and proposals for long-term services and supports (LTSS) financing reform in this publication. The primary objective of this work was to create a concise, practical compendium of LTSS financing reform solutions for federal policymakers.

The team conducted a comprehensive environmental scan to identify recently proposed solutions and policy ideas. This scan, combined with the team's expertise and input from LTSS financing subject matter experts, resulted in a thorough compilation of potential proposals. The resulting compendium categorizes the proposals into three key areas: 1) Legislative Proposals for Public LTSS Financing Coverage Reform, 2) Legislative Proposals for the Private Long-Term Care Insurance Market, and 3) Commission Reports.



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Foreword

HISTORICAL CONTEXT OF LTSS FINANCING INITIATIVES

Since 1988, policymakers have recognized the lack of coverage for long-term services and supports (LTSS)[1] as a major gap in the insurance and retirement system for older adults and individuals with disabilities. More than 35 years later, the LTSS system remains significantly underfunded and the gap identified then remains today. Most individuals needing help with daily living activities like bathing, eating, and dressing pay for care using private savings, if available, and rely heavily on unpaid family caregivers. When families deplete private resources, they turn to Medicaid, a social safety net program that guarantees payment for nursing facility care, but does not consistently cover services in a home or community-based setting.

Over the past three decades, experts have seen a growing need for LTSS as the lifespan has lengthened and the "baby boom" generation has approached old age. In that time, policymakers have generated many ideas and proposals to close LTSS financial gaps, which are compiled in this compendium. The concepts are categorized according to whether they focus primarily on expanding private market solutions or creating or expanding public coverage options:

- **Creating or expanding public coverage options**. Policymakers and experts have proposed creating new or expanding existing programs that would provide coverage to a broad swath of the population and protect against financial risk associated with needing and paying for LTSS. Proposals have included new stand-alone public insurance programs, expansions of the existing Medicare public health insurance program (which does not currently cover LTSS), strengthening or expanding Medicaid LTSS, and strategies that embrace more than one of these components.
- **Expanding private market solutions.** Policymakers and experts have proposed strategies for expanding private market solutions mainly by changes to federal tax law that effectively reduce the cost of private long-term care (LTC) insurance. Public awareness campaigns and a collaboration between the public and private sector focus on encouraging and enabling individuals to plan ahead for their LTSS needs have also been pursued.

Experts and advocates have historically framed the debate as a choice between these two options, either a primarily public or private solution. Opposition to public coverage options has stemmed from concerns about budgetary impacts and the need for new taxes. One enacted policy attempted to merge the two systems: a voluntary public insurance program created by the Community Living and Assistance Services and Supports (CLASS) Act legislation, which had a $50 a day, lifetime, cash benefit and was included in 2010's Patient Protection and Affordable Care Act (ACA). This policy design skirted the requirement for new taxes by giving taxpayers a choice to enroll and pay a premium. It also allowed room for a private market solution to enhance the limited daily benefit.

In the process of implementing the CLASS Act, however, federal officials determined that the voluntary nature of the program made it actuarially unsound, and Congress subsequently repealed it in 2013. Coming out of this, the U.S.

1 This compendium and policies referenced within it use the phrases long-term care (LTC) and LTSS interchangeably.

Senate convened a LTC commission in 2013 which spurred experts and researchers to regroup and consider other approaches to reform.

The SCAN Foundation, LeadingAge, and AARP jointly funded research by the Urban Institute and Milliman, Inc., conducted between 2014 and 2016, to analyze the impact of a broad array of policy options to finance LTSS using the most recent demographic information on need, combined with data on public and private coverage costs. In February 2016, the Bipartisan Policy Center, LeadingAge, and the Long-Term Care Financing Collaborative (the Collaborative) released policy recommendations, building largely from this research and modeling work. These efforts represented new and significant consensus around multi-pronged solutions with a substantive role for the private market, public catastrophic coverage, and a refocused role for Medicaid.

The COVID-19 pandemic further spurred interest in LTSS financing reform, as the public observed the vulnerability of institutional residents and the LTSS workforce. Congress temporarily funded increases in federal Medicaid spending on home and community-based services (HCBS) and infrastructure but did not make these increases permanent.

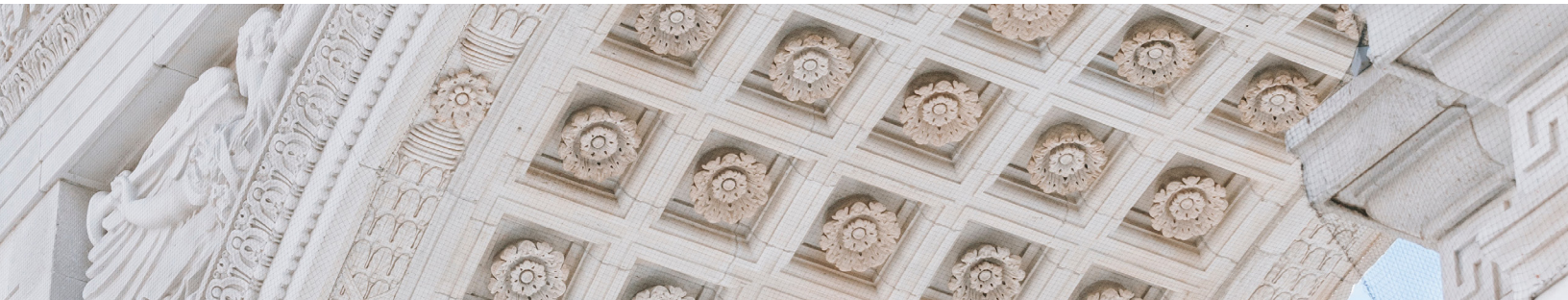
Policy and political leaders continue to grapple with various options, including recent proposals such as former Vice President Kamala Harris' 2024 proposal to add a home care benefit to Medicare and Representative Tom Suozzi's (D-NY-3) Well-Being Insurance for Seniors to be At Home (WISH) Act, legislation first introduced in 2012 that would create a public catastrophic insurance program for LTSS.

The baby boom generation will soon begin entering their 80s. Developing LTSS financing and affordability solutions has become extremely urgent given the large and growing impact that status quo stagnancy has on access, care quality, costs, and the broader workforce and economy. This compendium serves as a resource for policymakers and their staff who have the hard job of taking 30 years of work and turning it, finally, into meaningful reform.

METHODS

This compendium captures major LTSS financing reform proposals put forward in the past three decades. To create this, the authors first conducted desktop research to identify relevant legislation, commission reports, and research proposals dating back to 1990. Desktop research included a review of congressional websites and archives, including commentary pieces on proposals, as well as a targeted search for notable authors, academic literature, and institutions that have focused on LTSS financing as part of their research and advocacy portfolio.

The development of this inventory was then vetted among other experts and further refined to the most relevant pieces of legislation. Additional proposals not initially captured but referenced within the legislation and reports themselves were also added to the list. The authors reviewed this inventory with LTSS financing subject matter experts—including Stuart Butler from the Brookings Institute and Judy Feder from Georgetown University—resulting in a more comprehensive inventory of proposals.



HOW TO USE THIS DOCUMENT

This compendium is organized into three sections:

1. Legislative Proposals for Public LTSS Finance Coverage Reform
2. Legislative Proposals for the Private Long Term Care Insurance Market and
3. Commission Reports and Research Papers.

Within Sections 1 and 3, proposals are organized into the following areas based on the overarching category of proposed reform:

- → Expanding Medicare Coverage
- → Creating a New Program
- → Reforming Medicaid Structures
- → Introducing Private Market Incentives
- → Transforming Healthcare Structures (any combination of the four areas above)

Each proposal in Sections 1 and 3 provides an overview, program details, population participation requirements (e.g., vesting if any), covered services, benefit amounts and durations. Where available, proposed cost and revenue source, and financing and implementation details are also provided. Because the proposals for Section 2 are, by definition, more narrowly focused on changes to the tax treatment of LTC insurance, there are fewer program design categories for analysis. It is also important to note the following:

Status of Legislation. The status of legislation is not indicated within the tables. This is because, with the exception of the CLASS Act, which was briefly enacted into law and then later repealed, none of the proposals included in the compendium have been enacted into law. The compendium focuses on finance reform proposals that have been developed and put forward by legislators, which while representing promising concepts that have gained some traction, have not yet become law.

Personal Financial Responsibility. For each proposal, we identify copayments, premiums, or deductible payments that might be the financial responsibility of the participant receiving benefits. This excludes any revenue contribution that may derive from the overall funding source for the proposal. As well, in many cases, the proposals do not include information on costs or revenue sources for funding it. When such information is available, it is recorded but it is treated as separate and distinct from the payments related to the financial responsibility of the individual receiving benefits.

Dollar Amounts. All dollar amounts for expected costs, budgets, benefit amounts, and other details reflect the dollar amounts included in and at the time of the proposal, as noted in the entry. Costs are not indexed to reflect the present value of those dollars.

PROPOSALS BY CATEGORY

By clicking on the links in the summary table below, users can navigate to different sections within this compendium and to the specific proposal cited. This table categorizes proposals based on the five categories identified in the "How to Use this Document" subsection above.

Proposals	Medicare Expansion	Medicaid Reform	New Program	Private Market Solutions
Section 1: Legislative Proposals for Public LTSS Finance Coverage Reform				
Long-Term Care Assistance Act of 1988	X			
Lifecare Long-Term Care Protection Act, 1990			X	
MediPlan Long-Term Care Act, 1991	X			
Universal Health Care Act, 1991			X	
Secure Choice Act, 1991			X	X
Comprehensive Care Act of 1992	X			
Long Term Care Family Security Act of 1992			X	
Health Security Act, 1993. Subtitle B. Long Term Care	X		X	X
Health Security Act, 1994			X	X
Community Living Assistance Services and Supports Act (CLASS), 2010			X	
Well-Being Insurance for Seniors at Home Act, 2021			X	
Medicare for All Act, 2023	X			
Better Care Better Jobs Act, 2023		X		
HCBS Access Act, 2023		X		
Amend Title XIX of the Social Security Act, 2024		X		
Section 2: Legislative Proposals for the Private Long-Term Care Insurance Market				
Tax-Related Legislative Proposals to Expand Private Market Solutions				X
Non-Tax Related Proposals to Expand Private Market Solutions				X
Section 3: Commission Reports and Research Papers				
The Pepper Commission, 1991: A Call for Action: Blueprint for Health Care Reform			X	

Proposals	Medicare Expansion	Medicaid Reform	New Program	Private Market Solutions
Georgetown University Long-Term Care Financing Project, 2007: Trade-Off Proposal for Funding Long-Term Care			X	
U.S. Senate Commission on Long-Term Care, 2013: Report to the Congress			X	X
Long-Term Care Financing Collaborative (LTCFC), 2015: Principles for Improving Financing and Delivery of Long Term Services and Supports		X	X	X
Urban Institute, 2015: Microsimulation Analysis of Financing Options for Long-Term Services and Supports			X	
LeadingAge, 2017: A New Vision for Long-Term Services and Supports			X	
The American Long-Term Care Insurance Program, 2017: The American Long Term Care Insurance Program: A Solution to Reduce Cost and Provide Stability				X
The National Academy for Social Insurance, 2019: Designing a State-Based Social Insurance Program for Long-Term Services and Supports			X	
Milken Institute, 2021: New Approaches to Long-Term Care Access for Middle-Income Households	X			X
Bipartisan Policy Center, 2022: An Updated Policy Roadmap: Caring for Those with Complex Needs	X	X		X
The Brookings Institution, 2024: Home Care Benefit for Medicare	X			
Mark Warshawsky, National Affairs, 2024: Financing Long-Term Care		X		X

Section 1: Legislative Proposals for Public LTSS Finance Coverage Reform

INTRODUCTION

Proponents of new or expanded public coverage approaches argue that they would protect individuals from having to impoverish themselves by spending down their savings paying for LTSS before becoming eligible for Medicaid. However, critics emphasize the need for people to take personal responsibility in planning for LTSS expenses and argue that public coverage programs are too costly and undermine the private insurance market.

While these proposals focus on advancing public coverage and financing of LTSS, they vary in terms of program type, target populations, scope of service, and administrative roles of federal and state governments. These factors can greatly influence a program's impact on individuals experiencing LTSS need. Several implications to consider include:

- **New vs. Existing Program.** Establishing a new program, rather than building on existing structures via Medicare or Medicaid, offers policymakers the flexibility to define a more inclusive population, varied financing, and tailored benefit structures. Because of this ability to define a broader target population, proposals for new programs often introduce several cost management tactics, such as income-based cost sharing, elimination periods, more limited coverage levels (e.g., catastrophic risk). These types of cost containment levers, while creating coverage limitations, can have important advantages: allow benefits to be allocated to individuals experiencing significant LTSS needs; result in a larger impact on reducing Medicaid expenditures for states; and create incentives and opportunities for private market products to fill in gaps by supporting, for example, front-end coverage and programs for family caregivers. Conversely, introducing new programs into the already-crowded LTSS coverage environment adds complexity and may create additional care navigation challenges for individuals and their families.
- **Program Administration.** Some proposals leverage federal authority and funding and delegate responsibilities to states, while others propose streamlining program administration at the federal level. Delegating program administration to states enables states to customize programs (e.g., via benefit design, eligibility parameters, cost-containment strategies, and other programmatic features) to best meet the needs of their residents and may create efficiencies by building on existing state-based LTSS infrastructures, including Medicaid and others. However, this approach also has several trade-offs. For example, varied program configurations across states means that access to benefits cannot be guaranteed and may not be applied uniformly, resulting in and reinforcing disparities that may exist across states. Further, the issue of benefit portability for individuals who move out of state must be addressed. On the other hand, programs that are centrally managed at the federal level offer consistent eligibility parameters, establish program enrollment and benefits as entitlements, and reduce financial volatility for state budgets. Federal programs may lack the nuance to be effective across different state markets and policymakers need to design programs with some flexible parameters to address specific local considerations.

→ **Workforce Capacity.** Workforce capacity is a critical and increasingly urgent issue for LTSS sustainability. There is growing consensus that inadequate compensation paid to LTSS workers, among other issues, has resulted in workforce shortages, quality of care issues, and other access problems for individuals experiencing LTSS need. Although few of these proposals directly address workforce capacity, their program designs and structures will inherently affect the LTSS workforce, in different ways and by different magnitudes. Program design variables, ranging from payment methodologies to provider requirements, influence the pool of workers available and their willingness to contract with and maintain continued participation in the program. For example, a program that pays a cash benefit to beneficiaries will affect the workforce differently than one that reimburses contracted providers directly. Specifically, a program with no or few provider eligibility requirements such as a cash benefit (e.g., does not require licensure, certification, or agency oversight) may add new individuals to the workforce pool, but introduces risk to quality of care standards. Regardless of the downstream impact of program design, there is little debate regarding the need for additional financing to support the development of a more robust LTSS workforce—and each of these proposals are designed to establish new or increase existing revenue sources to help accomplish this.

EXPANDING MEDICARE COVERAGE

▼ *Medicare for All Act, 2023* (H.R.3421)

OVERVIEW	
Type of Reform	Expanding Medicare Coverage
Program Description	Establish a national, single-payer health insurance program to provide comprehensive protection against the costs of health care and health-related services, including a home and community-based LTSS benefit.
Sponsor/Cosponsors	→ Introduced by Rep. Pramila Jayapal (D-WA) on May 17, 2023. → 113 Democratic co-sponsors. → Companion bill S. 1655 Medicare for All Act was introduced by Senator Bernie Sanders (B-VT) on May 17, 2023.
Impact and Action	→ House Committee Referrals: Energy and Commerce, Ways and Means, Education and the Workforce, Rules, Oversight and Accountability, Armed Services, Judiciary.
PROGRAM DETAILS	
Participation Criteria	Automatic enrollment for all U.S. residents upon birth. Phased enrollment approach each year after implementation for individuals currently ages 35 through 64 years.
Conditions for Receiving Benefits	Enrolled individuals who meet one of the following criteria: → Have a functional limitation in performing one or more activity of daily living (ADL). → Require a similar need of assistance in performing instrumental activities of daily living (IADLs).
Scope of Services	→ Long-term nursing services, regardless of service setting. → LTSS, including home and community-based services (HCBS) and other non-institutional settings.
Amount of Services	Not specified.
Participant Financial Responsibility	→ Co-payments, deductibles, and cost-sharing for LTSS benefits prohibited. → Balance-billing by providers prohibited.

Elimination Period	Not applicable.
Provider Requirements	→ Any provider that is licensed or certified to provide the service can participate. → Participating providers enter into participation agreements with the program, which outlines responsibilities regarding billing, reporting, duty of ethics and more. → The program may establish provider minimum standards (e.g., wait times, minimum staffing ratios, etc.).
Provider Payment Levels	Payment schedules to be developed by the Department of Health and Human Services (HHS).
Inflation Adjustments	Provider payments will take inflation into account, among other factors.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	No cost estimate available.
Program Administration	→ Conducted in collaboration with HHS and regional Medicare for All offices (established by the program). → Standards and quality measures implemented and evaluated by the Center for Clinical Standards and Quality of the Centers for Medicare and Medicaid Services (CMS) or such other agencies determined appropriate by the Secretary, in coordination with the Agency for Healthcare Research and Quality and other offices of the HHS. → State Medicaid programs maintain responsibility for nursing facility and other facility care coverage. → Prohibits private insurance that duplicates coverage provided.

▼ *Comprehensive Care Act of 1992* (H.R. 6063)

OVERVIEW	
Type of Reform	Expanding Medicare Coverage
Program Description	Expands Medicare by providing: → Medicare Part A coverage of facility care without requiring a prior hospital stay for chronically dependent individuals. → Medicare Part B coverage of home care services to severely dependent individuals.
Sponsor/Cosponsors	→ Introduced by Rep. Eliot Engel (D-NY) on September 30, 1992. → No co-sponsors.
Impact and Action	→ Introduced by Rep. Eliot Engel (D-NY) on September 30, 1992 (House Committee on Energy and Commerce and Ways and Means). → House Committee Referrals: Subcommittees on Health, Subcommittee on Health and the Environment.
PROGRAM DETAILS	
Participation Criteria	Existing Medicare participation criteria.

Conditions for Receiving Benefits	→ Coverage of facility care is available to chronically dependent individuals who cannot perform two or more of five ADLs or suffer from cognitive impairment. ▪ Coverage of home care services is available to severely dependent individuals who cannot perform three or more of five ADLS or pose harm to themselves/others.
Scope of Services	Nursing facility, home care, homemaker, personal care, adult day, therapies, respite, hospice care, care management, patient, and caregiver training, among others.
Amount of Services	Not specified.
Participant Financial Responsibility	Medicare deductibles apply.
Elimination Period	Not specified.
Provider Requirements	Defines home care agencies; no other provider types specified or defined.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	No cost estimate available.
Program Administration	The Department of Health and Human Services would administer new Medicare provisions.

▼ *MediPlan Long-Term Care Act, 1991* (H.R. 651)

OVERVIEW	
Type of Reform	Expanding Medicare Coverage
Program Description	→ Creates a "MediPlan" universal social insurance program within Medicare to provide coverage of LTSS for all U.S. citizens. → Removes Medicare's existing post-hospitalization requirement and extends nursing home coverage beyond the existing 100-day limit.
Sponsor/Cosponsors	→ Introduced by Rep. Pete Stark (D-CA). → Three Democratic co-sponsors.
Impact and Action	→ Introduced in the House. → House Committee Referrals: Energy and Commerce, Ways and Means, Subcommittee on Health, Subcommittee on Health and the Environment. → Subcommittee Hearings Held March 1991.
PROGRAM DETAILS	
Participation Criteria	All U.S. citizens.

Conditions for Receiving Benefits	Chronically ill individuals who meet the below criteria, which varies by service: → Nursing Facility Care ▪ Ages 65+ years and unable to perform three or more ADLs (or having a similar level of disability due to cognitive impairment). → HCBS ▪ Unable to perform two or more ADLs (or having a similar level of disability due to cognitive impairment).
Scope of Services	Nursing facility services and HCBS
Amount of Services	→ HCBS: Up to three years. → Nursing Facility Care: Up to six months, with an extension for individuals who have not been an inpatient for at least six consecutive months, have a different diagnosis, or where there has been a substantial worsening of their condition since the last discharge.
Participant Financial Responsibility	20% copay for nursing facility costs, after two-month deductible; 20% copay for home care. Deductibles and copayments are waived for persons with incomes below 200% of FPL. Balance billing is prohibited.
Elimination Period	Not applicable
Provider Requirements	Contract with fiscal intermediaries based on rules established by the Department of Health and Human Services.
Provider Payment Levels	→ Payment amounts based on a prospective payment methodology. → Coordination of benefits with Medicare so that the LTC MediPlan Trust Fund is the secondary payer.
Inflation Adjustments	Provider payments inflated based on an index of increased costs specific to LTSS.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	→ Income tax. Annual premium paid of 2% of the excess (if any) of the modified gross income of the taxpayer over $16,000 ($32,000 in the case of a joint return). → Also funded by Medicaid savings.
Total Program Costs	Brookings/ICF LTC Financing Model[2] estimated $47 billion in additional public spending, with a reduction in out-of-pocket spending of $12.6 billion (in 1992 dollars).
Program Administration	The Department of Health and Human Services will be responsible for program administration and monitoring. No additional details specified.

Long-Term Care Assistance Act of 1988[3] *(S. 2305)*

OVERVIEW	
Type of Reform	Expanding Medicare Coverage
Program Description	→ Establishes LTC benefits under Medicare Part B to cover chronic home care services, respite, and nursing care for eligible individuals. → Provides chronic home and community-based care to severely disabled individuals under the existing Medicare program, with deductibles and cost-sharing for those who are not low-income.

2 ICF is a global advisory firm, found in 1969 and originally named the "Inner City Fund"
3 Bill text not available

Sponsor/Cosponsors	→ Introduced by Sen. George Mitchell (D-ME) on April 17, 1988. → Ten co-sponsors, including Republicans, Democrats, and an Independent.
Impact and Action	Referred to Senate Subcommittee on Health (Finance), Hearings held. Companion Bill H.R. 4763.
PROGRAM DETAILS	
Participation Criteria	All Medicare beneficiaries.
Conditions for Receiving Benefits	An individual who has dementia and cannot perform at least two ADLs. In addition, to receive respite care, the individual must also be receiving unpaid care from someone with whom they reside.
Scope of Services	Chronic home care services, including homemaker and chore aide services, respite care and nursing facility care.
Amount of Services	→ Respite care is limited to the lesser of $1,000 or 50% of respite care costs per year. → Other benefit limits are not specified.
Participant Financial Responsibility	→ HCBS: $500 deductible and 20% co-pay. → Nursing Facility Services: 30% copay.
Elimination Period	Nursing facility services become available two years after an individual meets the functional/cognitive criteria for receiving benefits.
Provider Requirements	Not specified.
Provider Payment Levels	Payments for HCBS are capped at 65% of the average cost of Medicare skilled nursing facility services.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	→ Adds a $2 increase in the Medicare Part B premium. → Adds a supplemental premium on each $150 of federal income tax due from a Part B beneficiary. → Eliminates the limit on wages or self-employment income subject to the Medicare hospital insurance tax. → Imposes a 5% surtax on transfers by gift or inheritance of assets more than $200,000.
Total Program Costs	Estimated $12.7 billion public spending increase with a reduction in out of pocket spending of $15 billion (in 1992 dollars).[4]
Program Administration	The Department of Health and Human Services would administer new Medicare provisions.

4 Estimate from Brookings/ICF Long Term Care Financing Model as cited in https://aspe.hhs.gov/reports/analysis-long-term-care-reform-proposals-0

REFORMING MEDICAID STRUCTURES

Amend Title XIX of the Social Security Act, 2024 (H.R. 8106)

OVERVIEW	
Type of Reform	Reforming Medicaid Structures
Program Description	→ Seeks to amend title XIX of the Social Security Act to enhance transparency and broaden coverage options for HCBS under Medicaid waivers. → Requires states to publicly report more detailed information on various aspects of HCBS, such as wait times, eligibility screening processes, and the actual delivery of services compared to what was authorized. Information must be made publicly available on the CMS website starting January 1, 2028. → Allows states to extend HCBS to additional individuals who may not meet the traditional eligibility criteria if expansions do not negatively impact the wait times or service levels for current recipients.
Sponsor/Cosponsors	→ Introduced by Rep. Cathy McMorris-Rogers (R-WA) on April 23, 2024. → Rep. Frank Pallone (D-NJ) co-sponsored.
Impact and Action	House Committee Referrals: Energy and Commerce, Subcommittee on Health.
PROGRAM DETAILS	
Participation Criteria	Medicaid enrolled individuals (criteria varies by state).
Conditions for Receiving Benefits	→ Allows states to request a waiver to extend HCBS to additional individuals who may not meet traditional eligibility criteria if there are no adverse impacts (e.g., wait times, services levels) for current individuals. → Mandates the Department of Health and Human Services to issue guidance to states on how to provide up to 60 days of interim HCBS coverage for individuals who have been determined eligible but are awaiting the finalization of their written care plans.
Scope of Services	Standard Medicaid HCBS services available in each state.
Amount of Services	Not specified.
Participant Financial Responsibility	Not specified.
Elimination Period	Not specified.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	No cost estimate available.

Program Administration	HHS oversees state administration and operation of new Medicaid requirements. Specific reporting and oversight requirements include: → Requirements for states to publicly report detailed information on various aspects of HCBS, such as wait times, eligibility screening processes, and the actual delivery of services compared to what was authorized on the CMS website by January 1, 2028. → If a state imposes a new HCBS waiver with waitlists, it must provide a report that outlines: • How it maintains the waitlist. • Whether the state screens and/or periodically re-screens individuals to determine whether such individuals are eligible to receive such services under a new waiver. • The average amount of time that individuals approved to receive such services were on the waitlist. • A description of the types of services furnished, including the average amount of time from when such services are initially approved for an individual to when such individual begins receiving such services, and the average percentage of hours of HCBS authorized under written plans of care that are actually provided.

Better Care Better Jobs Act, 2023 *(S.100/H.R. 547)*

OVERVIEW	
Type of Reform	Reforming Medicaid Structures
Program Description	Creates new programs and funding for state Medicaid programs to improve HCBS and the direct care workforce by: → Requiring states to submit an HCBS infrastructure improvement plan to increase access to HCBS and strengthen the direct care workforce. → Increasing federal matching rate for HCBS in states that develop plans and meet specified benchmarks for improvements. → Requiring states to expand financial eligibility criteria for HCBS up to federal limits. → Requiring states to implement Medicaid buy-in programs for workers with disabilities. → Making permanent: • The Money Follows the Person Rebalancing Demonstration Program (grant program to help states increase use of HCBS and decrease the use of institutional care). • Certain provisions regarding Medicaid eligibility that protect against spousal impoverishment for recipients of HCBS.
Sponsor/Cosponsors	→ Introduced by Sen. Bob Casey (D-PA) on January 23, 2023. → 41 co-sponsors.
Impact and Action	→ Senate Committee Referrals: Finance.
PROGRAM DETAILS	
Participation Criteria	Medicaid enrolled individuals (criteria varies by state).
Conditions for Receiving Benefits	Criteria for receiving HCBS varies by state.

Scope of Services	Requires states to cover: → Personal care services for all eligible populations receiving HCBS in the state. → Community-based behavioral health services that are coordinated with employment, housing, and transportation supports. → Family caregiver supports, including providing respite care, and may include providing such services as caregiver assessments, peer supports, or paid family caregiving.
Amount of Services	Not specified.
Participant Financial Responsibility	Not specified; varies by state.
Elimination Period	Not applicable.
Provider Requirements	Not specified.
Provider Payment Levels	→ Requires states to evaluate sufficiency of and regularly update HCBS payment rates. → Enacts processes to ensure that rate increases are passed through to direct care workers to increase wages.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	No cost estimate available.
Program Administration	→ HHS oversees state administration and operation of new Medicaid provisions. → States newly required to: • Adopt HCBS quality measures. • Designate an Ombudsmen office to help individuals navigate HCBS programs. • Meet maintenance of effort requirements for amount, duration, and scope of and eligibility for HCBS in order to receive planning grants. • Involve individuals who are recipients of HCBS, unpaid caregivers, providers, health plans, direct care workers, and aging, disability, and workforce advocates in HCBS improvement planning. → Federal Medicaid matching rates increase: • By 10% (not to exceed 95%) for HCBS, including administrative costs of expanding HCBS. • To 80% for quality management activities (see above).

▼ *HCBS Access Act, 2023* (S. 762/H.R. 1493)

OVERVIEW	
Type of Reform	Reforming Medicaid Structures
Program Description	Expands access to HCBS and ends the Medicaid funding institutional bias by: → Requiring state Medicaid programs to provide HCBS at the same level as they must cover nursing facility services. → Eliminating the need for HCBS waivers when HCBS becomes a mandatory benefit. → Creating additional programs and requirements to support providers who furnish HCBS.

Sponsor/Cosponsors	→ Introduced by Rep. Debbie Dingell (D-MI; HR 1493) and Sen. Bob Casey (D-PA; S. 762) on March 9, 2023. → No co-sponsors.
Impact and Action	→ Senate Committee Referrals: Finance. → House Committee Referrals: Energy and Commerce, Subcommittee on Health.
PROGRAM DETAILS	
Participation Criteria	Medicaid enrolled individuals (criteria varies by state).
Conditions for Receiving Benefits	→ Eliminates waiting lists and enrollment caps for states HCBS programs. → Individuals meeting the below requirements are eligible for HCBS: • Are determined to have a functional impairment that affects daily living and that is expected to last at least 90 days. • During the five-year period after the bill is enacted, are already receiving HCBS through Medicaid under a demonstration waiver or other state option. • Income does not exceed the greater of 150% of the federal poverty level or 300% of the Supplemental Security Income (or a higher state-designated limit). • Are under the age of 21 and are otherwise eligible.
Scope of Services	Establishes minimum, mandatory HCBS benefits, including but not limited to: → Supported employment and integrated day services. → Personal assistance, including personal care attendants, direct support professionals, home health aides, private duty nursing, homemakers and chore assistance, and companionship services. → Non-emergency, nonmedical transportation services to facilitate community integration. → Respite and other caregiver/family supports. → Case management, including fiscal intermediary and support brokerage services. → Direct support services during acute hospitalizations. → Necessary medical and nursing services to remain in the community (e.g., hospice). → Home and community-based intensive behavioral health, crisis intervention, and peer supports. → Housing support, including transitional housing or transitional support services for individuals experiencing homelessness, and wrap-around services. → Necessary home modifications and assistive technology. → Transition services to support an individual transitioning from an institutional setting to the community. → Any other service recommended by the [Secretary-appointed advisory panel].
Amount of Services	Not specified.
Participant Financial Responsibility	Not specified.
Elimination Period	Not applicable.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.

FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	No cost estimate available.
Program Administration	→ HHS oversees state administration and operation of new Medicaid provisions and must provide: • 100% federal match funding to states for HCBS for 10 years. • 80% federal match funding for quality and reporting activities to implement core set and supplemental set of HCBS quality measures. • Implementation grant funding for states to expand their capacity to meet the needs of people who prefer HCBS, following a detailed implementation plan. → Oversight and reporting mechanisms include: • Development and implementation of federally mandated HCBS quality measures for states and Medicaid managed care organizations. • Aggregation of quality metrics and other data across the full array of HCBS reported by recipients' demographic characteristics to identify disparities in access and utilization. → States must involve the following individuals in program design: recipients of home HCBS, family caregivers of such recipients, providers, health plans, direct care workers, chosen representatives of direct care workers, and aging, disability, and workforce advocates.

CREATING A NEW PROGRAM

Well-Being Insurance for Seniors at Home Act, 2021[5] *(H.R. 4289)*

OVERVIEW	
Type of Reform	Creating a New Program
Program Description	Create a universal, catastrophic LTC insurance program meant to: → Improve access to LTSS by bringing additional money into LTSS system. → Reduce family out-of-pocket spending. → Stabilize and improve the private market by reducing the tail-end risk. → Reduce Medicaid spending.
Sponsor/Cosponsors	→ Introduced by Rep. Tom Suozzi (D-NY) on July 30, 2021. → No co-sponsors.
Impact and Action	→ House Committee Referrals: Subcommittee on Social Security, Ways and Means. → Being prepared for re-introduction in 2025.

5 Bauer, E. (2024a, November 11). *Is the wish act a real fix for long-term care costs?*. Forbes. https://www.forbes.com/sites/ebauer/2021/08/13/is-the-wish-act-a-real-fix-for-long-term-care-costs/?sh=28a1ff301de9+and+https%3A%2F%2Fdrjoannelynn.org%2F2022%2F04%2F18%2Fwish-act-hr-4289-summary%2F

PROGRAM DETAILS	
Participation Criteria	Individuals who have reached full retirement age (as defined in section 216(l)(1)) of the Social Security Act) or have disabilities and worked to contribute the following amounts to the new Long Term Care Insurance Trust Fund: → (Full Benefits) At least 40 credits (10 years of work). → (Partial Prorated Benefits) At least five credits, but less than 40.
Conditions for Receiving Benefits	Demonstrate need for LTSS by having met one of the following criteria: → Inability to perform two or more of six basic ADLs without the help of another person. → Require supervision due to a Severe Cognitive Impairment.
Scope of Services	Flexible cash benefit to cover services of choice. There are no limitations or definitions of covered services.
Amount of Services	Monthly cash benefit of $3,600 (estimated to cover for six hours of direct care at home per day in 2021 dollars).
Participant Financial Responsibility	Not specified.
Elimination Period	→ People with incomes in the lowest 40th percentile can receive cash payments one year after their eligibility for benefits has been established. → People with incomes up to the 70th percentile can receive cash payments three years after their eligibility for benefits has been established. → Anyone above the 70th percentile of income can receive cash payments four years after their eligibility for benefits has been established.
Provider Requirements	No limitations or definitions of eligible providers. Individuals can hire independent care workers, agency-based providers, and/or pay family members, along with any other uses of the cash payment.
Provider Payment Levels	Not applicable.
Inflation Adjustments	Monthly cash payments would be adjusted annually for wages and inflation.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	New tax as follows: → Federal payroll deduction of 0.6% of payroll (uncapped) for each employee (0.3% from employee and 0.3% from employer). → Self-employed individuals will pay the 0.6% tax in its entirety.
Total Program Costs	No cost estimate available.
Program Administration	→ Administered through the Social Security Administration. → Education and awareness campaign conducted by HHS.

Community Living Assistance Services and Supports Act (CLASS)[6], 2010 (S.697)

OVERVIEW	
Type of Reform	Creating a New Program
Program Description	Creates a federally administered voluntary insurance program offering a cash benefit that eligible individuals can use to purchase various LTSS to enable them to continue to live in the community.
Sponsor/Cosponsors	→ Introduced by Sen. Edward Kennedy (D-MA) on March 25, 2009. → Six Democratic co-sponsors including Sen. Tom Harkin (D-IA), Chris Dodd (D-CT), Sherrod Brown (D-OH), Bob Casey (D-PA), Sheldon Whitehouse (D-RI) and Kirsten Gillibrand (D-NY).
Impact and Action	→ Signed into law By President Obama on March 23, 2010. → After extensive actuarial, administrative and market research analysis, the CLASS program was deemed unsustainable due to adverse selection, lack of market appeal, and the absence of risk management provisions within the program design. → The Act was repealed on January 1, 2013, as part of the American Taxpayer Relief Act.
PROGRAM DETAILS	
Participation Criteria	→ Actively employed individuals ages 18+ who receive wages that are taxable under the Old Age Survivors and Disability Insurance program or Railroad Retirement Tier 1 Benefits, including those who are self-employed. → Individuals who satisfy the following requirements: • Five-year vesting period of having paid monthly premiums to the program for at least five years and worked during at least three of those five years. • Minimum earnings requirement of one quarter of Social Security coverage (for 2011 the amount was $1,120). → Program participation is voluntary; there is no medical underwriting or pre-existing condition exclusion.
Conditions for Receiving Benefits	Demonstrate need for LTSS by meeting one of the following criteria: → The inability to perform two or more of six basic ADLs without the help of another person. → Requiring supervision due to a Severe Cognitive Impairment. → Residing in a care facility are therefore presumed eligible.
Scope of Services	Flexible cash benefit to cover services of choice. There are no limitations or definitions of covered services.
Amount of Services	Minimum daily cash benefit of $50. Beneficiaries can defer daily benefits into a Life Independent Account (accessible via debit card), but funds cannot be "rolled over" into future years.

6 Offices of CLASS, ASPE, and the General Counsel. U.S. Department of Health and Human Services. A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS Program. October 2011.

Participant Financial Responsibility	→ Monthly premiums, which: • Vary by age at enrollment, poverty status, or student status.[7] • Can be increased for certain individuals if the program costs are not sufficient. → Congressional Budget Office (CBO) estimated average monthly premiums at $123 for $75 per day benefits. CMS estimated $240 monthly premiums for $50 per day benefits.
Elimination Period	None specified once benefits begin.
Provider Requirements	No limitations or definitions of eligible providers. Individuals can hire independent care workers, agency-based providers, and/or pay family members, along with any other uses of the cash payment.
Provider Payment Levels	Not applicable.
Inflation Adjustments	Indexed for inflation; no additional details specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Premiums paid by participating individuals into the Class Independence Fund.
Total Program Costs	→ Premiums are intended to be set to cover the cost of the program on an actuarial basis. Estimates of $120 million for start-up administrative costs. → Estimates of the federal budget impacts varied due to different assumptions about adverse selection and voluntary participation rates. → Estimates focused on the impact CLASS would have on reducing the federal deficit, with expected cost savings from the five to 10-year vesting period during the program's startup and the program's ability to adjust premiums as needed. → The Centers for Medicare & Medicaid Services estimated net federal savings of $38 billion over 10 years, while CBO estimated a $70 billion savings.
Program Administration	U.S. Administration on Aging responsible for implementation and oversight.

▾ *Long Term Care Family Security Act of 1992* (H.R. 6076)

OVERVIEW	
Type of Reform	Creating a New Program
Program Description	Creates a new state-administered program to provide community and nursing facility care to individuals with moderate to severe disability with the following goals: → Enhance access to HCBS for individuals with moderate to severe disabilities. → Provide some facility-based reimbursement for care. → Limit federal financial participation in Medicaid for services covered under this new program and modify Medicare skilled nursing facility (SNF) coverage to avoid duplication. → Establish national standards for private LTC insurance policies (*details not discussed here*).
Sponsor/Cosponsors	→ Introduced by Rep. Henry Waxman (D-CA) on October 1, 2002 → Co-sponsor Rep. Richard Andrew Gephardt (D-MO).

7 Individuals with incomes below the federal poverty level and employed full-time students ages 18-21 years pay a monthly premium of $5. CBO estimated average monthly premiums at $123 for $75 per day benefits, while CMS estimated $240 monthly premiums for $50 per day benefits.

Impact and Action	→ House Committee Referrals: Subcommittee on Health and the Environment, Subcommittee on Commerce, Consumer Protection and Competitiveness, Energy and Commerce, Ways and Means.
PROGRAM DETAILS	
Participation Criteria	U.S. citizens and resident aliens.
Conditions for Receiving Benefits	Meeting one of the following criteria: → A severe disability, defined as needing help with three or more ADLs. → A severe cognitive impairment. → A severe to profound mental retardation. States have the discretion to determine benefit eligibility from among the eligible population based on an assessment and care plan.
Scope of Services	States have flexibility to define the scope of HCBS, but must provide at least the following: → Personal assistance services. → An option for consumer-directed care.
Amount of Services	Not specified; presumed to be established by each state. Benefits may be offered on a "funds available" basis and are not guaranteed entitlements.
Participant Financial Responsibility	Cost-sharing for nursing facility care (co-insurance amount), with two levels of subsidies for low-income individuals (100% and 200% of FPL), and with resource limits like Medicaid rules (but with an increase in the personal needs allowance and monthly maintenance amount for the at-home spouse).
Elimination Period	Not specified.
Provider Requirements	Likely based on the specifics of each state's plan.
Provider Payment Levels	None specified.
Inflation Adjustments	Payment rates intended to be increased every five years, based on the program's determination of average annual percentage rates of increase for the cost of community and facility care.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	None specified.
Total Program Costs	→ Program designed to be phased in over seven years, with 2003 targeted as first fully funded year. → Federal expenditures estimated at $56.7 billion for FY 1996 through FY 2000. → Additional federal "cost" related to the tax and Medicaid reform provisions estimated at roughly $3 billion over timeframe.[8]

8 Office of the Assistant Secretary for Planning and Evaluation, Cost estimates for the long-term care provisions under the health security act (1994). Washington, DC; U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

Program Administration	→ HHS establishes the program structure and allocates funding to states (based on a formula with a federal share of program costs ranging from 78% to 95%). → States fund the non-federal share of costs and administer the program in line with federal parameters.

Universal Health Care Act, 1991 *(H.R. 1300)*

OVERVIEW	
Type of Reform	Creating a New Program
Program Description	Creates a national, single-payer health insurance program, under which every U.S. citizen would be eligible for enrollment, that provides protection against the costs of health care and health-related services, including benefits for facility and home-based LTSS.
Sponsor/Cosponsors	→ Introduced by Rep David Obey (D-WI) on November 25, 1991. → Two Democratic co-sponsors.
Impact and Action	→ House Committee Referrals: Subcommittee on Health and the Environment, Subcommittee on Commerce, Consumer Protection and Competitiveness, Ways and Means, and Energy and Commerce.
PROGRAM DETAILS	
Participation Criteria	All U.S. citizens.
Conditions for Receiving Benefits	→ Nursing Facility: Available when medically necessary. → HCBS: Requires support with two or more ADLs.
Scope of Services	Not specified but mentions both nursing care and HCBS.
Amount of Services	Not specified.
Participant Financial Responsibility	Not specified.
Elimination Period	Not applicable.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	Brookings/ICF LTC Financing Model estimated $72.5 billion in additional public spending, with a reduction in out-of-pocket spending of $28.8 billion (in 1992 dollars).
Program Administration	→ Department of Health and Human Services establishes and oversees program and allocates funding to states (based on a formula taking into account the percent of the population ages 75+ and payments made to states under the Social Security Act). → States administer the program in line with and subject to federal approval. → Prohibits private insurance that duplicates coverage provided.

Lifecare Long-Term Care Protection Act, 1990[9] *(S. 2163)*

OVERVIEW	
Type of Reform	Creating a New Program
Program Description	Creates the Lifecare Long-term Care Protection Program that would: → Create state-based assessment and care management agencies to determine eligible individuals and maintain provider registries. → Provide up to three years of home and community-based care. → Provide up to six months of facility care (with the option for more). → Create optional insurance program for longer facility care stays.
Sponsor/Cosponsors	→ Introduced by Sen. Edward Kennedy (D-MA) on February 22, 1990. → Two Democratic co-sponsors.
Impact and Action	→ Senate Committee Referral: Senate Committee on Labor and Human Resources.
PROGRAM DETAILS	
Participation Criteria	Adults ages 65+, persons under age 19, or those receiving certain Social Security benefits.
Conditions for Receiving Benefits	Differ by age: → Individuals ages 65+ meeting one of the following criteria: • Completely dependent in one ADL. • Unable to perform two or more ADLs without help or supervision. • Cognitively impaired posing risk to self/others. → Individuals ages 19 and under meeting one of the following criteria: • Unable to perform two or more age-appropriate ADLs. • Reliant on a medical device. • Has a medical prognosis of less than one year to live.
Scope of Services	Adult day health, respite, heavy chore service, homemaker, home health aide, home mobility aids, home nursing, therapies, transportation, nutrition, and others.
Amount of Services	→ Care manager determines care plan based on individual assessment and resource availability in jurisdiction. → Respite care limited to 30 days or 720 hours per calendar year. → HCBS limited to duration for three years. → Facility care limited to six months with an extension for individuals who have not been an inpatient setting for at least six consecutive months, have a different diagnosis, or where there has been a substantial worsening of their condition since the last discharge.
Participant Financial Responsibility	→ Copayments are the lesser of 5% of the insurance benefits the individual receives under Title II of the Social Security Act (if any) or 10% of the costs of their services. → Balance billing prohibited.
Elimination Period	Not specified.
Provider Requirements	Care Management Agencies determine eligible providers and provider requirements.

9 S.2163 - A bill to amend the Public Health Service Act to establish a lifecare long-term care program, and for other purposes. (n.d.). https://www.congress.gov/bill/101st-congress/senate-bill/2163?q=%7B%22search%22%3A%22long-term+care%22%7D&s=5&r=58

Provider Payment Levels	→ Limits HCBS payment levels to 65% of the average Medicare payment amount for nursing facility care for the first three years of care, and then to the cost of nursing facility care (less room and board) thereafter. → Payments adjusted based on need severity.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	Estimated $15 million for FY 1991, $20 million for FY 1992, and $25 million for FY 1993.[10]
Program Administration	→ HHS contracts with states/non-profits to operate Care Management Authorities that administer Lifecare. → Care Management Authority responsibilities include making eligibility determinations, overseeing plans of care, and maintaining a registry of qualified providers.

TRANSFORMING HEALTHCARE STRUCTURES

Health Security Act, 1994[11] (S. 2537)

OVERVIEW	
Type of Reform	Transforming Healthcare Structures (New Program and Private Market Incentives)
Program Description	→ Creates a state-based HCBS program for hospitalized individuals who need LTSS as an alternative to nursing facility placement. → Clarifies favorable tax treatment of private LTC insurance and LTC expenses by treating policies as accident or health insurance contracts and assuring that payments are not taxable because they are treated as reimbursement for expenses actually incurred for medical care.
Sponsor/Cosponsors	→ Introduced by Sen. Mitchell (D-ME) on August 3, 1994. → No cosponsors.
Impact and Action	→ One title within major senate leadership legislation to reform the health care system. → Built on the Health Security Act of 1993 (S. 1757).
PROGRAM DETAILS	
Participation Criteria	Each state that has a plan for HCBS for individuals with disabilities submitted to and approved by the Secretary under section 2102(b) is entitled to payment in accordance with section 2108 under the program.

10 Office of the Assistant Secretary for Planning and Evaluation, Cost estimates for the long-term care provisions under the health security act (1994). Washington, DC; U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

11 Brown, L. D., & Marmor, T. R. (1994a). The Clinton Reform Plan's administrative structure: The reach and the grasp. *Journal of Health Politics, Policy and Law*, *19*(1), 193–199. https://doi.org/10.1215/03616878-19-1-193

Conditions for Receiving Benefits	Demonstrated need for LTSS by meeting one of the following criteria: → Needing help with three or more ADLs expected to last >90 days. → Having severe cognitive or mental impairment. → Having a symptom of one or more serious behavioral problems. → Having severe or profound mental retardation. → Being under age six and having a severe or chronic medical problem.
Scope of Services	Home care, homemaker, personal care, home modification, adult day care, respite care, care management, rehabilitation, transportation, person-centered care.
Amount of Services	Amounts and maximums at the discretion of each state in accordance with their approved state plans.
Participant Financial Responsibility	→ Copayments on a sliding-scale based on income: • No copayment for incomes <150% of FPL. • Up to 40% copayment for incomes of 400% FPL or more. → Annual deductibles on a sliding-scale based on income: • $100 for incomes <175% of FPL. • Up to $600 for incomes at 150% FPL or more.
Elimination Period	None specified.
Provider Requirements	Criteria determined by state; state plans cannot limit provider participation to only licensed/certified providers.
Provider Payment Levels	Payment methodologies to be determined by the state.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	→ ASPE estimates $4.5 billion in 1996 to $18.7 billion in 2000 for the HCBS new program component only. → CBO estimates $5 billion to $20 billion over the same time period.
Program Administration	→ Secretary of HHS will designate the agency responsible for program administration and funding. → States will develop HCBS state plans and administer programs in accordance with federal requirements (including providing assessment services, benefit determinations, provider payments, and more). → Federal funding allotments to states for HCBS State Programs are based on estimates of the population with disabilities, costs of care, and percent of low-income individuals in the state.

Health Security Act, 1993. Subtitle B. Long Term Care[12] *(S.1757)*

OVERVIEW	
Type of Reform	Transforming Healthcare Structures (Medicare Expansion, New Program, and Private Market Incentives)
Program Description	→ Expands Medicare by (1) extending Medicare Part A coverage to extended care services to chronically dependent individuals; and (2) providing coverage of home care services under Medicare Part B. → Requires states to establish and support state plans to provide home and community-based care to individuals with disabilities without regard to age or income.[13] → Clarifies favorable tax treatment of private LTC insurance premiums and benefits. → Provides a tax credit to working individuals with disabilities, for up to 50% of their care costs, up to a maximum of $15,000 per year. → Provides federal grants for consumer education and counseling on LTC insurance.
Sponsor/Cosponsors	→ Introduced by Sen. Mitchell (D-ME) on November 23, 1993. → 23 co-sponsors, including 15 Democrats and eight Republicans.
Impact and Action	→ Major health care reform legislation including new benefits within Medicare to cover LTC (Title II; Subtitle B). → Called for tax advantaged treatment for premiums and benefits from LTC insurance (Title VI; Subtitle G). → Laid the groundwork for other Medicare expansion bills, e.g., The Health Security Act of 1994 (S. 2357).
PROGRAM DETAILS ***(Medicare Expansion Only)***	
Participation Criteria	Individuals meeting one of the following criteria: → Older adults with Medicare. → Chronically ill individuals as defined in the Conditions for Receiving Benefits (below).
Conditions for Receiving Benefits	Specific criteria determined by each state, but generally individuals meeting one of the following criteria: → Requiring help with three or more ADLs expected to last at least 180 days. → Having severe cognitive impairment or mental impairment. → Having profound or severe mental retardation. → Being a child under six years old with a severe disability or chronic medical condition that would otherwise require facility-based care.
Scope of Services	Including, but not limited to, care management, homemaker and chore help, home modification, respite, assistive technology, adult day care, and home health services. Room and board are excluded.

12 U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, Summary of long-term care provisions under the health security act (1994). Washington, DC.

13 Legislative language clarifies that nothing in the creation of the New Benefits is an entitlement or a requirement that the State expend all the funds it allocates each year

Amount of Services	Amount and limits of services determined by each state.
Participant Financial Responsibility	Co-insurance amounts based on income: → Incomes below 150% FPL: 0% → Incomes of 150% to 200% FPL: Up to 10% → Incomes of 200% to 250% FPL: Up to 25% → Incomes more than 250% FPL: 25%
Elimination Period	Not specified.
Provider Requirements	Determined by each state.
Provider Payment Levels	Determined by each state.
Inflation Adjustments	→ Program budget increases annually, keeping with the increase for the national health care budget and the growth in the number of persons with severe disabilities. → Provider payment methodology, including inflation adjustments, determined by each state.
FINANCING & IMPLEMENTATION ***(Medicare Expansion Only)***	
Revenue Source(s)	Not specified.
Total Program Costs	For FY 1996, the initial budget estimate was $4.5 billion, increasing annually up to $38.3 billion in 2003.
Program Administration	→ Department of Health and Human Services establishes the program structure and allocates funding to states (based on a formula with a federal share of program costs ranging from 78% to 95%). → States fund the non-federal share of costs and administer the program including specifying covered services, creating protocols for determining need, certifying provider eligibility, overseeing program quality, and more.

▼ *Secure Choice Act, 1991*[14] *(H.R. 1668)*

OVERVIEW	
Type of Reform	Creating a New Program (New Program and Private Market Incentives)
Program Description	Creates a new program that provides LTC services for older adults. Creates a state-based, public-private partnership LTSS program for older adults with three components: → Expanding HCBS to older adults below the poverty level (through state-based programs serving elders with incomes up to 240% of FPL). → Establishes the Secure Choice Insurance Option Program, that lets states (and federal match) subsidize LTC insurance benefit costs for persons ages 55+ years with incomes between 240% and 400% of FPL. → Clarifying tax treatment of LTC benefits & employer-paid insurance as employee benefit *(details not discussed)*.
Sponsor/Cosponsors	→ Introduced by Sen. Packwood (R-OR) on August 2, 1991. → Six high ranking Republican co-sponsors.

14 Office of the Assistant Secretary for Planning and Evaluation, Burwell, B. O., Harahan, M., Kennell, D., & Alecxih, L., An analysis of long-term care reform proposals (1993). Washington, D.C; U.S. Dept. of Health and Human Services.

Impact and Action	→ Legislation developed by the principal Republicans Leadership on the Senate Finance Committee. → Senate Committee Referrals: Committee on Finance.
PROGRAM DETAILS	
Participation Criteria	Adults 55+ with incomes up to 400% of FPL.
Conditions for Receiving Benefits	Demonstrates LTSS need by meeting one of the following criteria: → Being unable to perform two of the following five ADLs: Bathing/dressing; mobility; toileting; transferring; eating; or having a diagnosis of Alzheimer's/similar dementia. → Needing supervision with three or more of these five ADLs; or poses harm to self/others.
Scope of Services	Nursing facility, home care, homemaker, personal care, adult day, therapies, respite, care management, etc.
Amount of Services	Not specified.
Participant Financial Responsibility	States are prohibited from imposing cost-sharing that exceeds a "nominal" amount.
Elimination Period	Not specified.
Provider Requirements	Must meet criteria and conditions as outlined by the state plan (e.g., no balance billing).
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	No cost estimate available.
Program Administration	→ HHS establishes the program structure and allocates quarterly payments to states (based on a formula with a federal share of program costs ranging from 50% to 90%, based on the category of the expense to which the funds will be used). Funds obligated may not exceed the higher of $125,000 or 0.25% of the sums expended by the federal, state, and local governments during the previous quarter. → States administer the program in line with federal parameters and funds the non-federal share of costs. → If the state participates in the Secure Choice Insurance Option, a new program created by this legislation, the state would pay a benefit subsidy to the insurer (along with the federal share) for insured individuals ages 55+ with low-incomes who have purchased insurance and need benefits.

Section 2: Legislative Proposals for the Private Long-Term Care Insurance Market

INTRODUCTION

This section describes legislative proposals designed to expand private market solutions for financing LTSS, principally by encouraging and enabling individuals to take personal responsibility for planning ahead for their LTSS needs. While current LTC insurance solutions serve well those who have them, only a small portion (5%) of adults ages 40+ currently own a policy. Current market penetration falls well below market potential, estimated in a 2010 study at roughly 50% of adults ages 18+, taking into account affordability and insurability.[15] A primary approach has been to "lower the cost" of private LTC insurance to consumers by providing tax credits and/or deductions for premiums paid for coverage, allowing tax- and penalty-free withdrawals from retirement savings to finance premiums, and other strategies. Additionally, incentives focused on the employer group market to enable and encourage more employers to offer LTC insurance as a part of their voluntary benefits package are also viewed as important vehicles to expanding participation in the private sector.

Proponents of advancing private LTC insurance products argue that the appropriate role of government is to support market-based solutions by encouraging personal responsibility and planning by making private options more affordable and accessible (e.g., through the tax code and by distributing products through employers). Opponents have argued that tax incentives skew towards subsidizing private insurance for higher income individuals, who could likely afford insurance even in the absence of such incentives. Moreover, they also raise concerns that a voluntary and private insurance market alone may not provide sufficient coverage to protect middle-income Americans because many people could be excluded from coverage due to medical conditions and affordability issues.

Historical Context of Tax Treatment

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provided limited tax advantages to LTC insurance premiums, benefits, and out-of-pocket expenses. For example, premium costs could only be deducted for individuals who itemized deductions and had medical expenses exceeding 7.5% of Adjusted Gross Income (AGI). Because the benefits were considered very modest and very few people took advantage of or knew about them, over the last two decades, several legislative proposals have sought to expand the tax treatment of premium payments to lower the cost of insurance to consumers and spur demand for the product.

In addition to increasing demand for the product, tax-advantaged LTC insurance premiums signaled insurers to enter the market and provide products that would meet increased demand. Such incentives were also viewed as a way to encourage more employers to offer LTC insurance as a voluntary employee benefit.

15 Private Financing of Long Term Care: Market Penetration and Market Potential, Academy Health Annual Research Meeting, Boston, June 2010 (materials not publicly available)

The tax proposals put forward included changes to the HIPAA requirements as well as new ways to lower the effective cost of the insurance. These included:

- → Removing the requirement that only those who itemize deductions and have medical expenses of 7.5% of AGI may take a tax deduction for LTC insurance;
- → Allowing the use of pre-tax dollars, up to various specified amounts, for the purchase of LTC insurance, including traditional and combination product types;
- → Allowing tax-free exchanges of funds within a retirement account to be used to purchase LTC insurance;
- → Allowing products to be offered under employer cafeteria plans and Flexible Spending Accounts (FSA);
- → Allowing premium costs to be included as qualified medical expenses within a Health Spending Account, even for consumers who do not have a High Deductible Health Plan;
- → Creating new types of LTC savings accounts where contributions can grow tax-free; and
- → Allowing tax-free and/or penalty-free withdrawal from retirement plans (e.g., IRAs, 401(k), 403(b), 457 plans) and similar retirement accounts when used for LTC insurance premiums (and care expenses).

A separate set of proposals developed in federal legislation focused on increasing consumer awareness of the value of planning ahead for LTSS needs and considering LTC insurance. These included two major programs (described below): (1) The Partnership for Long-Term Care and (2) The Own Your Future Long-Term Care Awareness Campaign.

Current State of Tax Treatment

For Individuals. People with a tax-qualified (TQ) LTC insurance policy can deduct the premiums they pay from their taxes, with limits shown in the table below. The cost of premiums can be combined with other itemized medical expenses including uncovered LTC expenses. Individuals can deduct a portion of their premiums based on age, if they itemize deductions and the total itemized medical expense exceeds 7.5% of AGI, up to the amounts shown in the table below.

Like health insurance or life insurance, benefits one receives from LTC insurance are not taxable as income . The vast majority of LTC insurance policies sold today are TQ. These policies meet standardized requirements for consumer protection. The cover page of the policy contains a prominent statement regarding the policy's TQ status, as shown in the figure below.

Maximum Deductions for Qualified LTC Insurance Premium

Attained Age Before Close of Year	2024	2025
40 years old or less	$ 470	$480
More than 40 years old but no more than 50 years old	$ 880	$900
More than 50 years old but no more than 60 years old	$1,760	$1,800
More than 60 years old but no more than 70 years old	$4,710	$4,810
More than 70 years old	$5,880	$6,020

TQ Status Policy Statement

IMPORTANT NOTICE: This Policy is intended to be a tax qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996–Public Law 104-191).

For Corporations. Partners in a Partnership, members of an LLC, or shareholders of greater than 2% of a Subchapter S Corporation are taxed as self-employed individuals. If the entity pays the LTC insurance premium, and the partner, member, shareholder includes the premium in its AGI, then the partner, member, shareholder may deduct the age-based eligible amount on its tax return. It is not necessary to meet the 7.5% AGI threshold. When a C Corporation purchases LTC insurance on behalf of any of its employees, spouses or dependents, the corporation is eligible to take a 100% tax deduction as a business expense on the total of the premiums paid. The LTC insurance premium tax deduction is not subject to the age-based limitations in the table above. The employer may even be selective on the class of employees it wishes to elect to cover with LTC insurance benefits. Additionally, several states also offer various tax deductions or tax credits for LTC insurance.

TAX-RELATED LEGISLATIVE PROPOSALS TO EXPAND PRIVATE MARKET SOLUTIONS

Bill	Type	Key Components
118TH CONGRESS (2023-2025)		
Improving Access to Long-Term Care Insurance Act (H.R. 8820) *Rep. Burlison (R-MO)* *House Ways & Means*	Tax Deductions	Allow taxpayers to take a deduction for LTC insurance premium amounts without satisfying the requirement that medical expenses exceed 7.5% of AGI. The age-based premium limits currently in effect would not change.
Amends Internal Revenue Code of 1986 (H.R. 5774) *Rep. Adrian Smith (R-NE)* *House Ways & Means*	Use of HSA Funds	Allow use of HSA funds for LTC expenses. By amending the Internal Revenue Code (IRC) of 1986 to Clarify Treatment of Distributions from Health Savings Accounts (HSAs) for LTC Services.
117TH CONGRESS (2021-2023)		
LTC Affordability Act (H.R. 7107) *Rep. Ann Wagner (R-MO)* *House Ways & Means*	Use of Retirement Funds	Reintroduces S. 4820 from 116th Congress. Amend the IRC to expand the use of retirement plan funds for purchasing LTC insurance and for other purposes. Exclude from taxable income amounts withdrawn from eligible retirement amounts if used for LTC insurance premiums, including riders to a life insurance policy, up to $2,500, subject to cost-of-living adjustments annually. Allow a government retirement plan to provide up to $3,000 for the purchase of health and/or LTC insurance without those funds being considered taxable income.
LTC Affordability Act (S. 2415) *Sen. Patrick Toomey (R-PA)* *Senate Finance*	Use of Retirement Funds	Ability to use Retirement Account Funds to Pay for LTC insurance premiums without added 10% tax on early distributions. Permits consumers to use funds from a retirement plan (up to $2,500 per year) to make premium payments for "certain specified" LTC insurance contracts. The Treasury would maintain a website providing consumer education regarding LTC insurance contracts.

Bill	Type	Key Components
Health Savings Freedom Act of 2022 (H.R. 6474) *Rep. Beth Van Duyen (R-TX)* *House Ways and Means*	Use of HSA Funds	Revise HSA provisions to (1) increase the limit on contributions to such accounts for individuals and families, (2) eliminate the requirement to maintain high deductible coverage as a condition of eligibility for participation in such accounts, and (3) expand the definition of qualified medical expenses for purposes of HSAs to include medicine, drugs and certain LTC expenses.
HELPS Retirees Improvement Act of 2022 (H.R. 7203) *Rep. Steve Chabot (R-OH)* *House Ways and Means*	Use of Retirement Funds	Increases from $3,000 to $6,000 the amount of the exclusion from gross income of distributions from a tax-exempt retirement plan for health and LTC insurance for public safety officers. It also eliminates the requirement that insurance premiums must be paid directly to the provider of the accident or health plan or LTC insurance contract as a condition of eligibility for the tax exclusion.
116TH CONGRESS (2019-2021)		
LTC Affordability Act (S. 4820) *Sen. Patrick Toomey (R-PA)* *Senate Finance*	Use of Retirement Funds	Amend the IRC to exclude up to $2,500/year from gross income distributions from eligible retirement plans if used to purchase LTC insurance or chronic illness benefit under a life insurance policy. Includes IRAs, 401K, 403b, 457 plans. The $2,500/year is indexed for inflation.
112TH CONGRESS (2011-2013)		
LTC Retirement and Security Act (H.R. 6005) *Rep. Joe Courtney (D-CT)* *House Ways and Means*	Tax Deductions; Use of FSA Funds and Cafeteria Plans	Create tax deduction for LTC insurance premiums, starting at 25% in 2013 and increasing to 65% in 2015, and 100% thereafter. Allow deductions to be made for long-term care insurance under both cafeteria plans and flexible savings accounts (FSAs).
111TH CONGRESS (2009-2011)		
Simple Cafeteria Plan Act (S. 988) *Sen. Olympia Snowe (R-ME)* *Senate Finance*	Use of FSA Funds and Cafeteria Plans	Reintroduce S. 723 from 109th Congress. Amend the IRC of 1986 to allow small businesses to include LTC insurance in cafeteria plans.
110TH CONGRESS (2007-2009)		
Tax Relief for LTC Act (H.R. 6237) *Rep. Joe Courtney (D-CT)* *House Ways and Means*	Tax Credits	Amend the IRC to provide tax credit for LTC premiums and for family caregivers living with a family member or dependent with LTC needs. Phases in maximum credit of $3,000 from 2009 to 2013. Reduces credit amount for taxpayers with adjusted gross income over $75,000 ($150,000 for joint filing).

Bill	Type	Key Components
LTC Family Accessibility Act (S. 3365) *Sen David Vitter (R-LA)* *Senate Finance*	Tax Credits	Amend the IRC to provide a nonrefundable tax credit for LTC insurance premiums. The income-based tax credit would be 50% of the first $4,000 of premiums paid for LTC insurance for the taxpayer or for their family member or dependents coverage.
LTC and Retirement Security Act of 2008 (H.R. 5559) *Rep. Adam Putnam (R-FL)* *House Ways and Means*	Use of FSA Funds and Cafeteria Plans	Allow LTC insurance to be offered under employer sponsored cafeteria plans and Flexible Savings Accounts (FSAs). Allows above the line tax deduction for LTC insurance premiums and a tax credit for family caregivers. Enhances consumer protections for insurance under the National Association of Insurance Commissioners (NAIC) Model Regulation and Act.
Alzheimer's Family Assistance Act of 2007 (S. 897) *Sen. Barbara A. Mikulski (D-MD)* *Senate Finance*	Tax Deductions	Establish above the line tax deduction for purchase of LTC insurance and tax credit for family caregivers. Level of tax deduction varies by the number of years of continuous coverage: 60% of premium cost for less than one year of coverage, up to 100% for four years or more. The percentages start at 70% for persons ages 55+ and rises to 100% after two years of continuous coverage up to $3,000/year.
Qualified LTC Fairness Act of 2007 (H.R. 2582) *Rep. Ginny Brown-Waite (R-FL)* *House Ways and Means*	Tax Deductions	Establish above-the-line tax deduction for LTC insurance and service expenses; does not require individuals to itemize deductions or have medical expenses that exceed 7.5% (now 10%) of AGI.
LTC Trust Account Act (S. 504) *Sen. Gordon Smith (R-OR)* *Senate Finance*	New Tax-Advantaged Savings Account	Create a new type of savings account (a LTC Trust Account). Individuals can contribute up to $5,000/year and receive a refundable 10% tax credit on the contribution. Interest earned on the account is not taxed. Funds can be withdrawn for the purchase of LTC insurance or to pay for LTC expenses.
LTC Trust Account Act (S. 1809, H.R. 3088) *Sen. John Thune (R-ND)* *Senate Finance,* *Rep. Terry Lee (R-NE)* *House Ways and Means*	Use of Retirement Funds	Allow individuals to use funds from 401(k), 403(b) and 457 plans to pay for LTC insurance without penalty for early withdrawal and without paying taxes on the amounts withdrawn.
LTC Affordability and Security Act (H.R. 3363, S. 2337) *Rep. Earl Pomeroy (D-ND)* *House Ways and Means*	Use of FSA Funds and Cafeteria Plans	Allow premiums for LTC insurance to be paid on a pre-tax basis through section 125 cafeteria plans and FSAs.
109TH CONGRESS (2005-2007)		
Simple Cafeteria Plan Act (S. 723) *Rep. Olympia Snowe (R-ME)*	Use of Cafeteria Plans	Amend the IRC of 1986 to allow small businesses to include LTC insurance in cafeteria plans.

Bill	Type	Key Components
Healthcare Enhancement for Local Public Safety Retirees Act (H.R. 2177) *Rep. Chris Chocola (R-IN)* *House Ways and Means*	Use of Retirement Funds	Amend the 1987 IRC to permit tax-free distributions up to $5,000 from government retirement plans for premiums for LTC insurance for public safety officers. Includes premiums for public safety officers and/or spouse.
Amends the IRC of 1986 (H.R. 1150) *Rep. Ginny Brown-Waite (R-FL)* *House Ways and Means*	Tax Credits	Allow individual taxpayers a tax credit for certain long-term health care insurance premiums and expenses paid for the taxpayer, the taxpayer's spouse, or dependents. Limits the amount of such credit to $1,000 per year ($2,000 for joint returns).
LTC and Retirement Security Act of 2005 (H.R. 2682) *Rep. Nancy Johnson (R-CT)* *House Ways and Means*	Tax Deductions and Credits; Tax-Free Exchanges; Use of FSA Funds and Cafeteria Plans	Amend the IRC to: (1) allow a tax deduction from gross income for LTC insurance premiums; (2) include LTC insurance in employee benefit cafeteria plans and flexible spending arrangements; (3) allow a tax credit for certain LTC costs; (4) set forth certain consumer protections for LTC insurance contracts; and (5) allow tax free exchanges of LTC insurance contracts.
LTC Support and Incentive Act. (H.R. 2935) *Rep. Susan Davis (D-CT)* *House Ways and Means*	Tax Deductions	Amend the IRC to: (1) allow a tax deduction from gross income for 50% of the LTC premiums paid under a qualified LTC insurance contract for individuals under age 65 (increases the deduction percentage to 75% for premiums paid for individuals age 65+); (2) permit qualified LTC insurance contracts to be offered in a cafeteria plan and FSAs under certain conditions; (3) allow a nonrefundable tax credit of $4,000, subject to a phase-out for incomes exceeding $150,000 (joint returns) or $75,000 (individuals), for each individual age 65+ who has been certified as having LTC needs for at least 180 consecutive days in a taxable year and for whom the taxpayer is acting as a caregiver; and (4) mandate certain consumer protections for insurance contracts.
LTC Tax Reduction Act (H.R. 4220) *Rep. John McHugh (R-NY)* *House Ways and Means*	Use of Retirement Funds	Amends the IRC to exclude from gross income distributions from an individual retirement account and other tax-exempt retirement plans used to pay LTC insurance premiums.

Bill	Type	Key Components
Comprehensive LTC Support Act or 2006 (H.R. 6211) *Rep. Stephanie Herseth Sandlin (D-SD)* *House Ways and Means; Education and Workforce*	Use of Retirement Funds	Amend the IRC to allow a deduction from gross income (available for taxpayers who do not itemize deductions) for the cost of LTC premiums for the taxpayer and certain family members. Phases in the deduction (50% in 2007, 75% in 2008 and 100% in 2009 and thereafter). Allows LTC insurance as a benefit under tax-qualified cafeteria plans and FSAs. Allows a tax credit for caregivers of individuals with long-term health care needs. Phases in a $3,000 credit amount for 2011 or thereafter, beginning with $1,000 in 2007, $1,500 in 2008, $2,000 in 2009, and $2,500 in 2010. Reduces the amount of the credit for taxpayers with AGI over $75,000 ($150,000 for joint returns), adjusted for inflation after 2007.
LTC Act of 2005 (H.R. 976, S. 1706) *Sen. George Allen (R-VA)* *Senate Finance*	Use of Retirement Funds	Amend the IRC to exclude from gross income distributions from an individual retirement account and other tax-exempt retirement plans used to pay LTC insurance premiums.
Long-Term Care Improvement Act of 2006 (H.R. 6405) *Rep. Heather Wilson (R-NM)* *House Ways and Means*	Tax Deductions; Use of FSA Funds and Cafeteria Plans	Amend the IRC to: (1) allow individuals a tax deduction for LTC insurance premiums; (2) allow LTC insurance to be offered in cafeteria plans and FSAs; and (3) make certain consumer protection provisions applicable to LTC insurance contracts.
Improving Long-Term Care Choices Act of 2005 (S. 1602) *Sen. Chuck Grassley (R-IA)* *Senate Finance*	Tax Deductions; Use of FSA Funds and Cafeteria Plans	Companion bill to H.R. 6405 (above). Amend the IRC of 1986 to allow individuals a deduction for qualified LTC insurance premiums, the use of such insurance under cafeteria plans and flexible spending arrangements.

Bill	Type	Key Components
LTC and Retirement Security Act, 2003 (HR 2096) *Rep. Nancy Johnson (R-CT)*	Tax Deductions; Use of FSA Funds and Cafeteria Plans	Companion bill to S. 1335 (below) from 108th Congress. Phase in deductions for LTC insurance premiums over 5 years, starting at 25% and going up to 100% by 2008 and beyond. Premiums would be tax-deductible without requiring itemized deductions and not subject to the 7.5% medical expenses of AGI. Deductions are limited by age-related caps determined by Individual Retirement Accounts that are adjusted annually for inflation protection. Allow LTC insurance under cafeteria and FSA plans. Includes a phased-in family caregiver tax credit.
108TH CONGRESS (2003-2005)		
LTC and Retirement Security Act (S. 1335) *Sen. Chuck Grassley (R-IA)* *Senate Finance*	Tax Deductions; Use of FSA Funds and Cafeteria Plans	Companion bill to H.R. 2096 (above), but schedule of phase-in is 60% to 100% for ages 54 and below, and 70% to 100% for ages 55+. 10-year cost estimate $37.6 billion, of which $23.1 billion for premium deductions, $1.6 billion for cafeteria/FSA and $12.9 billion for caregiver tax credit.
Ronald Reagan Alzheimer's Breakthrough Act of 2004 (S. 2533, H.R. 4595) *Sen. Edward Markey (D-MA)* *Energy and Commerce; Education and Workforce; Ways and Means*	Tax Deductions; Use of FSA Funds and Cafeteria Plans	Same as S. 1335 (above), but no cost estimate and does not include cafeteria plan/FSA.

NON-TAX RELATED PROPOSALS TO EXPAND PRIVATE MARKET SOLUTIONS

Proposals below are authorized by Section 6201(d) of the Deficit Reduction Act (DRA) of 2005.

Program	Type	Summary
Own Your Future Long Term Care Awareness Campaign	Consumer Awareness and Education	The Own Your Future (OYF) Awareness Campaign was a joint federal-state effort to raise awareness about and planning for LTC. HHS (including the Administration on Aging (AOA), Office of the Assistant Secretary for Planning and Evaluation (ASPE), and CMS) partnered with selected states to conduct campaigns, which include a letter signed by the state's governor, to all households with members who are 45-65 years of age. The letter offers information about the importance of planning for LTC, including a free Planning Guide that can be ordered by mail or downloaded from the National Clearinghouse for LTC. 24 states conducted campaigns. Some states (e.g., Minnesota) had accompanying campaigns on product innovation and stakeholder engagement. Federal funding for OYF is no longer available but some states continue to maintain their websites and other outreach (e.g., Minnesota state fair promotes information on LTC awareness).
Long Term Care Clearinghouse	Consumer Awareness and Education	A comprehensive and interactive website was created as a companion to OYF. The National Clearinghouse for LTC website was developed as part of Section 6021 (d) of the DRA, which allocated funds to HHS to help individuals take an active role in planning for LTC needs. The website is a collaboration between the (then) AOA, CMS, and ASPE. The site is operational, but has not been updated due to lack of funding.

Long-Term Care Partnership Program	Private-Public Partnership	The program allows Medicaid to disregard assets in an amount equal to the insurance benefit payments made under a Partnership-qualified (PQ) LTC insurance policy if and when someone with a PQ plan exhausted their private coverage and applied for Medicaid. The DRA enabled the expansion and simplification of an early demonstration program in public-private sector collaboration for insuring LTC. Previously authorized to operate in only four states (CA, CT, NY, and IN), the passage of the DRA allowed any state to establish a Partnership Plan by filing a State Plan Amendment (SPA). The simpler rules for the new Partnership plans enabled LTC insurance policies to be designated as "Partnership-qualified" so long as they were purchased with specific types of age-based benefit increase options (inflation-protection) that met the Act's requirements. All but nine states (and DC) have established Partnership Programs. All states except CA recognize reciprocity, meaning that "spend down" protection will be honored in another state with a Partnership program if someone moves there after buying a Partnership qualified policy in another state. Eligibility for Medicaid is not automatic and the services covered under Medicaid may differ from what was included in the PQ private coverage. Medicaid income and other eligibility requirements still apply. State partnership programs remain operational, but several states lack dedicated staff due to funding challenges. Insurers sell both PQ and non-PQ policies.

Section 3: Commission Reports and Research Papers

INTRODUCTION

This section provides a high-level summary of the recommendations from commission reports and research papers that have attempted to address various aspects of LTSS finance reform over the last 30 years. These proposals largely derive from nonpartisan and not-for-profit think-tanks, research centers, and academic institutions. Some focus exclusively on approaches for public finance programs, while others identify initiatives that would enhance the private LTC insurance market or some combination of both.

The proposals vary in the degree of detail provided. Some provide detailed technical specifications and financial impacts, while others focus more on the underlying philosophical rationale for specific policy design choices. Thus, the recommendations summarized below include both conceptual proposals meant to stimulate thinking about LTSS financing reform as well as more fully-formed programs with specific policy design parameters modeled. For these reasons, the level of detail in each of the program descriptions varies.

EXPANDING MEDICARE COVERAGE

The Brookings Institution, 2024: Home Care Benefit for Medicare	
OVERVIEW	
Type of Reform	Expanding Medicare Coverage
Description	Develop and finance a universal home care benefit program for Medicare beneficiaries, which would have a measurable impact on access for individuals with functional and/or cognitive impairments who do not financially qualify for Medicaid. Recommend program design options that could be "dialed up or down" depending on the balance between program generosity and fiscal feasibility.
Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization:** The Brookings Institution is a non-profit organization whose mission is to conduct in-depth, nonpartisan research to improve policy and governance at local, national, and global levels. → **Key Authors:** Sherry Glied, Richard G. Frank, Jonathan Gruber, Vani Agarwal, and Wendell Primus.
Impact and Action	While the concept of a universal home care benefit has been explored in other proposals, this commentary provides the first set of broad concepts for making it potentially universal and financially feasible.
PROGRAM DETAILS	
Participation Criteria	Medicare beneficiaries.
Conditions for Receiving Benefits	Individuals who are determined (via independent clinical review) to be unable to perform at least two ADLs.

Scope of Services	HCBS provided by formal caregivers associated with home care agencies. No additional details provided.
Amount of Services	Not specified.
Participant Financial Responsibility	Cost-sharing varies based on an individual's income and asset levels: → No cost sharing is required for individuals with incomes of up to 150% of the poverty line and assets of up to $30,000 (in 2024). → Increasing levels of cost-sharing based on financial means for individuals above this limit.
Elimination Period	Not specified.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Federal savings from shifting home care benefits from Medicaid to Medicare would be used to defray program costs. No additional details on revenue sources provided.
Total Program Costs	Estimated to be $40 billion annually.
Program Administration	Not specified.
Private Sector Role	Not specified.

CREATING A NEW PROGRAM

▼ *The National Academy for Social Insurance, 2019:* Designing a State-Based Social Insurance Program for Long-Term Services and Supports

OVERVIEW	
Type of Reform	Creating a New Program
Description	→ Focuses on an analysis of social insurance solutions and intended as a roadmap for state policymakers. → Identifies the key design issues for consideration in the design of a social insurance program for LTSS. → Speaks to the preliminary design and concepts of the Washington State LTSS social insurance program, Washington Cares (WA Cares).
Sponsoring Organization Key Author(s)	→ **Sponsoring Organization:** The National Academy of Social Insurance is a nonprofit, nonpartisan organization comprised of experts on social insurance. This report was produced by an expert study panel convened specifically to explore issues in the development of LTSS social insurance. → **Key Authors:** The report was the work of two study panels comprised of 29 policy experts meeting over the course of a year. Key authors include: Benjamin W. Veghte, Marc Cohen, Eileen J. Tell, and Alexandra Bradley. Key workgroup members include: Robert Espinoza, Henry Claypool, Judith Feder, Mary Sowers, and more.
Impact and Action	Provides an important road map for states wanting to explore options for a state-based social insurance program.

PROGRAM DETAILS	
Participation Criteria	Not specified; discussed within the context of alternative program designs.
Conditions for Receiving Benefits	Discussed within the context of alternative program designs. Impact of alternative criteria discussed in report. Report speaks to criteria consistent with HIPAA: → Need support with two or more ADLs. → Have a severe cognitive impairment expected to last at least 90 days.
Scope of Services	Actuarial modeling within the report explores programs with different combinations of covered services including: → A home care only program. → A comprehensive program that includes HCBS, assisted living, and nursing facility care.
Amount of Services	→ Discusses the issues and impact of paying a benefit that is reimbursement for services versus a cash benefit and combinations and options along that continuum. → Compares front-end coverage (after a brief 30-to-90-day elimination period), back-end catastrophic coverage (after a two to three year elimination period) and comprehensive benefit that are paid during the entire period of need.
Participant Financial Responsibility	Individuals are responsible for costs during the waiting period, which varies for individuals depending on Lifetime Benefit Limits set. Some designs may specify co-payments as a cost management feature.
Elimination Period	Discusses a variety of approaches, depending upon the nature of the lifetime amount of services.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Discusses revenue sources (and combinations), including: tax on social security; Medicare Part A; Part B; Medicare Net Investment Income Tax; state income surtax; sales surtax; provider fees; estate tax; property surtax; general revenues; premiums and other.
Total Program Costs	Actuarial modeling was provided by Edward Armentrout and Gordon Trapnell in the "Actuarial Report on Long-Term Care Financing Proposals," an unpublished report produced for NASI, October 2018. They modeled the tax rates required to run a sample program under alternative designs (front-end; back-end; comprehensive; home care only) and using different revenue sources. For example, considering a payroll tax only, the payroll tax rate for a $100/day benefit for the following plan types would be as follows: → One-year front-end: 0.59% → Home health only $36,500 lifetime max: 0.85% → Home health only $73,000 lifetime max: 1.37% → Home health unlimited lifetime max: 3.19% → Catastrophic with income-related waiting period: 0.58%
Program Administration	→ States design, implement, and monitor the program. → Federal role not addressed.
Private Sector Role	Discusses opportunities for private sector integration and supplemental coverage under various public approaches.

LeadingAge, 2017: A New Vision for Long-Term Services and Supports[16]	
OVERVIEW	
Type of Reform	Creating a New Program
Description	Goals to develop a fairer and more rational financing system to ensure access to quality LTSS. Recommends a flexible and universal LTSS insurance program grounded in the principles of shared risk and consumer flexibility. Re-directs health and LTC dollars already in the system and creates new funding that relies on a universal public catastrophic insurance program that insures against the risk of long periods of high need.
Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization**: LeadingAge is an association of not-for-profit and mission-driven organizations dedicated to delivering high-quality LTSS. Members include providers, state partners, consumer group, research partners, and foundations. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy, and research. → **Key Authors:** Lead by Pathways Task Force, overseen by Olivia Mastry, with expertise from a panel of policy, academic, research, advocacy, and practice professionals and experts. Actuarial analysis and modeling provided by Milliman, Urban Institute, and ATI.
Impact and Action	Represents provider association, in collaboration with policy and advocacy experts, proposing finance reform and offering options and solutions.
PROGRAM DETAILS	
Participation Criteria	Universal and mandatory enrollment.
Conditions for Receiving Benefits	Not specified.
Scope of Services	Not specified.
Amount of Services	Not specified; recommends benefits be paid based on a "managed cash" benefit structure, provides individuals with flexibility to use a mix of LTSS that best meet their needs (similar to Medicaid's Cash and Counseling program).
Participant Financial Responsibility	Eligible individuals are responsible for LTSS expenses (or care) during an initial two-year elimination period.
Elimination Period	Benefits begin after the individual has met the functional or cognitive criteria for benefit eligibility for at least two years.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not specified.
Total Program Costs	None estimated.
Program Administration	Not specified.

16 Builds on prior work from 2016, including: LeadingAge Pathways Report and Perspectives on the Challenges of Financing Long-Term Services and Supports.

Private Sector Role	→ Recommends that private LTC insurance be used to finance care during the two-year elimination period. → Views presence of a public insurance program as a catalyst for innovation in a reinvigorated private LTC insurance market.

Urban Institute, 2015: Microsimulation Analysis of Financing Options for Long-Term Services and Supports[17]

OVERVIEW	
Type of Reform	Creating a New Program
Description	To assess alternative LTSS financing options and better understand how policy changes could expand the role of insurance. Compares outcomes under various program designs: → A front-end public insurance benefit covering up to two-years of care. → A catastrophic-only (back-end) program with a two-year waiting period. → A comprehensive insurance program.
Sponsoring Organization & Key Author(s)	→ **Sponsoring Organization:** Nonprofit policy research organization. The Urban Institute conducts research and offers evidence-based policy solutions. → **Key Author(s):** Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson.
Impact and Action	This was an important technical development that allowed several ideas (including ones explored in the Convergence collaborative and other proposals) to be assessed more rigorously and comprehensively than was possible before. The study has helped advance efforts to design workable and combinable LTSS proposals, including on Capitol Hill.
PROGRAM DETAILS	
Participation Criteria	→ Report modeled both universal/mandatory and voluntary approaches. → Adults younger than age 70 eligible to enroll in the new program (no individuals eligible for benefits until age 65).
Conditions for Receiving Benefits	Individuals ages 65+ who: → Meet one of the following support needs: • Need support with two or more ADLs. • Have a severe cognitive impairment expected to last at least 90 days. → Meet one of the following employment requirements: • Mandatory Approach: 40 quarters of employment covered by Social Security. • Voluntary Approach: Premiums paid into the program for five years.
Scope of Services	LTSS in both the community and facilities, transportation, home modifications, family caregivers, etc.
Amount of Services	→ Daily cash benefit of $100 (in 2015 dollars). → Benefit limits based on the definitions of front-end and catastrophic protection periods.
Participant Financial Responsibility	Costs above $100/day would fall on the individual.

17 This report is one component of a larger initiative assessing alternative financing options for long-term services and supports in collaboration with Milliman, Inc.

Elimination Period	→ 90-day elimination period for the front-end and comprehensive program. → Two-year waiting period for the back-end program.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	3% inflationary adjustment per year.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Varies by program type, as following: → Mandatory Program: Payroll tax on employees, subject to a wage cap. → Voluntary Program: Individual premiums. Subsidies available to low-income individuals financed by general revenues (incomes under 200% of poverty).
Total Program Costs	Varies by program type; costs to individual are as follows: → Mandatory Program: Individual costs estimated at 0.6% of earnings for the front-end program; 0.75% for the back-end program; and 1.35% for the comprehensive program. → Voluntary Program: Premiums depend on age and assumptions about participation rates. At age 45, for example, 2016 annual premiums range from $1,200 for the front-end program, $1,900 for the back-end program, and $2,400 for the comprehensive program. These would be roughly 3 times higher at age 65.
Program Administration	Not specified.
Private Sector Role	Not addressed.

▼ *Georgetown University Long-Term Care Financing Project, 2007:* A Trade-Off Proposal for Funding Long-Term Care

OVERVIEW	
Type of Reform	Creating a New Program
Description	→ Following a cafeteria benefit model, public social insurance program that "trades" a small portion (5%) of individuals' Social Security benefits to use for LTC coverage. It would create in the public sector a social insurance program for covering basic LTC by enabling people to exchange a small part of their income protection for LTC protection. Exchanging some income protection for some LTC protection will strengthen one's total economic security, defined to encompass both income security and health care security (including LTC). As well, giving up a small amount of Social Security benefit for some basic LTC benefit is akin to paying the premium (a small but certain loss) for an insurance policy in order to avoid a large potential loss. → Complementary private insurance to supplement public program. The notion is that new private products would emerge to fill the gap in mandatory public coverage at the same time that the demand for private insurance would increase, thus making products cheaper for consumers as the risk pool grows.

Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization:** The purpose of the Georgetown University Long-Term Care Financing Project was to elevate discussion of policy initiatives to improve LTC financing and access to needed LTC. → **Key Authors:** Included the editors of the papers (Judith Feder and Sheila Burke) as well as the individual authors of various papers: Judith Feder, Harriet L. Komisar, Robert B. Friedland, John Cutler, Lisa M. Shulman, Mark Litow, Mark J. Warshawsky, James Knickman, Marty Lynch, Carroll Estes, Mauro Hernandez, Christine E. Bishop, Anne Tumlinson, Jeanne Lambrew, Yung-Ping Chen, Leonard E. Burman, and Richard W. Johnson.
Impact and Action	Not addressed.
PROGRAM DETAILS	
Participation Criteria	Universal-Mandatory for all individuals eligible for Social Security benefits.
Conditions for Receiving Benefits	Not addressed; raised as topic for further consideration.
Scope of Services	All covered supportive service (NOTE: only the care component covered, no room and board costs).
Amount of Services	Amount and limit not addressed and raised as topic for further consideration.
Participant Financial Responsibility	Not addressed and raised as topic for further consideration.
Elimination Period	Not addressed and raised as topic for further consideration.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Cost of living increases linked to Social Security increases.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Funded by 5% of Social Security cash benefits, with an exemption for low-income individuals.
Total Program Costs	None estimated.
Program Administration	Not addressed.
Private Sector Role	Assumes supplemental insurance coverage will be provided to the base coverage funded by the new Social Security LTC Coverage and that such coverage may include combination products, that is, LTC coverage combined with life insurance or an annuity plan.

The Pepper Commission, 1991: A Call for Action: Blueprint for Health Care Reform

OVERVIEW	
Type of Reform	Creating a New Program
Description	Proposes mandatory social insurance program for HCBS and the first three months of nursing facility care would be covered for all Americans, regardless of income. Individuals would be required to contribute to the costs of care with subsidies for low-income individuals. For individuals with longer nursing facility stays, up to a higher level of assets would be excluded from consideration for Medicaid eligibility to diminish the risk of impoverishment, and there would be protection of income for spouses and an income allowance for the purposes of establishing Medicaid eligibility.
Sponsoring Organization	Congress created the U.S. Bipartisan Commission on Comprehensive Health Care to recommend legislative reform to ensure health and LTC coverage for all Americans. It was later renamed the Pepper Commission in honor of its first chair and creator, Representative Claude Pepper of Florida.
Impact and Action	The Pepper Commission laid out to Congress and the LTSS policy community the case for a social insurance model to address LTSS needs. Thus, many progressive proposals and bills trace their origins to the Pepper Commission.
PROGRAM DETAILS	
Participation Criteria	Universal and mandatory for individuals who are age 65+ as well as all severely disabled persons regardless of age, underlying disease or disabling condition, would be eligible for public benefits.
Conditions for Receiving Benefits	Individuals who need one of the following: → Hands-on or supervisory assistance with three out of five ADLs. → Constant supervision because of cognitive impairment that impedes ability to function or because of behaviors that are dangerous, disruptive, or difficult to manage.
Scope of Services	→ HCBS: home health care; physical occupational, speech and other therapies; personal care services; homemaker chore services; grocery shopping and transportation; medication management; adult day health care; respite care; and cost-effective training for family caregivers. → Nursing Care: skilled and custodial care in a nursing facility.
Amount of Services	→ Based on individual care plan developed by care manager and tailored to the needs of the individual, taking into accounts the availability of informal supports. → Benefit Limits: • HCBS: None cited. • Nursing Facility Program: 90 days.
Participant Financial Responsibility	→ HCBS: A 20% copayment, with the federal government subsidizing the coinsurance for persons with incomes below 200% of FPL. → Nursing Care: • Individuals contribute a 20% copayment, with the federal government subsidizing the coinsurance for persons with incomes below 200% of FPL. • Individuals also contribute their income towards the cost of care, minus a housing and personal needs allowance. Non-housing assets are protected below $30,000 for a single person and $60,000 for a couple.
Elimination Period	Not applicable.

Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not applicable.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	None specified.
Total Program Costs	$42.8 billion ($24 billion for HCBS and $18.8 billion for Nursing Care).
Program Administration	→ Federal Role: Provides financing; contracts with states to administer the program; sets standards and guidelines for administration including assessment criteria for benefit eligibility, determining care manager budgets and participation requirements and provider payment rates. Set standards for tax-qualified private LTC insurance plans. → State Role: Build on current infrastructure to manage and deliver services; design and implement the system; certify providers, establish and benefit eligibility review and appeals process. State and federal government share responsibility for financing the Nursing Facility Program, and for standards and oversight of the private LTC insurance market.
Private Sector Role	Incentive to provide coverage to supplement the new program through clarification of favorable tax treatment (treated similarly to health insurance premiums and benefits).

INTRODUCING PRIVATE MARKET INCENTIVES

The American Long-Term Care Insurance Program, 2017: The American Long Term Care Insurance Program: A Solution to Reduce Cost and Provide Stability

OVERVIEW	
Type of Reform	Introducing Private Market Incentives
Description	Goals are to make private coverage more affordable for middle-income buyers, relieve pressure on Medicaid budgets, and draw new consumers into the LTC market by: → Creating a federally regulated electronic exchange for the distribution of private LTC insurance as an alternative, lower-cost distribution channel. → Providing incentives for insurers to participate by reducing education and distribution costs, reducing regulatory burdens, and spreading risk.
Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization**: Not Applicable. → **Key Author:** Paul D. Forte, former CEO of the company responsible for administering the Federal Employees LTC Insurance Program (FLTCIP); views represent the author's alone.
Impact and Action	Offers a framework for a more efficient and lower-cost distribution channel for private LTC insurance, as a standalone or as a supplement to expanded public financing.
PROGRAM DETAILS	
Participation Criteria	Voluntary participation and open to all consumers and insurers agreeing to the exchange's conditions for participation.

Conditions for Receiving Benefits	All participating policies would use HIPAA criteria for benefit eligibility. Individuals who meet one of the following criteria: → Need support with two or more ADLs. → Have a severe cognitive impairment expected to last at least 90 days.
Scope of Services	To be determined by participating insurers, but policies must be tax-qualified.
Amount of Services	To be determined by participating insurers, but policies must be tax-qualified.
Participant Financial Responsibility	To be determined by participating insurers, but policies must be tax-qualified.
Elimination Period	To be determined by participating insurers, but policies must be tax-qualified.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	To be determined by participating insurers, but policies must be tax-qualified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Funding would be required to support federal agency management and program oversight, but benefit costs would be covered by the premiums paid by participating consumers.
Total Program Costs	Not specified.
Program Administration	Federal role includes congressional approval, assignment of a sponsoring federal agency, and likely approval from both the Treasury and IRS.
Private Sector Role	Creates a federally regulated exchange on which individuals can purchase and insurers can offer private LTC insurance, along with education, information, coverage comparison tools, and consumer protection standards.

TRANSFORMING HEALTHCARE STRUCTURES

▼ *Mark Warshawsky, National Affairs, 2024:* Financing Long-Term Care

OVERVIEW	
Type of Reform	Transforming Healthcare Structures (Medicaid Reform and Private Market Incentives)
Description	Directs public program resources to those who cannot afford care and otherwise encourages self-reliance among those who could afford care through private funds or insurance. Report focuses on: → Refocusing Medicaid as a social safety net for poorer individuals by closing financial eligibility loopholes and tightening administration of the program through the following reforms: • All retirement assets should be countable when considering Medicaid eligibility. • Asset transfer mechanisms, such as Medicaid annuities and pooled trusts, should be prohibited. • Estate recovery should be enforced, with the federal government providing reduced federal matching rates until states reach goals. → Expands and increases awareness of the LTC Partnership Program, allowing single premium and combination products to be Partnership-Qualified.

Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization:** Not applicable. → **Key Author:** Mark Warshawsky is a Senior Fellow at the American Enterprise Institute (AEI) and, among other positions, previously served as the Deputy Commissioner for Retirement and Disability Policy at the Social Security Administration, as the Vice Chairman of the Federal Commission on Long-Term Care, and Assistant Secretary for Economic Policy at the U.S. Treasury Department.
Impact and Action	The philosophical underpinning of this report is based on the theory that Medicaid may crowd out the private insurance market and suppress demand for planning and purchasing LTC insurance.
PROGRAM DETAILS	
Participation Criteria	Not applicable.
Conditions for Receiving Benefits	Not applicable.
Scope of Services	Not applicable.
Amount of Services	Not applicable.
Participant Financial Responsibility	Not applicable.
Elimination Period	Not applicable.
Provider Requirements	Not applicable.
Provider Payment Levels	Not applicable.
Inflation Adjustments	Not applicable.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Not applicable
Total Program Costs	Not applicable.
Program Administration	Not applicable.
Private Sector Role	Not applicable.

▼ *Bipartisan Policy Center, 2022:* An Updated Policy Roadmap: Caring for Those with Complex Needs[18]

OVERVIEW	
Type of Reform	Transforming Healthcare Structures (Medicare Expansion, Medicaid Reform, and Private Market Incentives)

18 Builds on a series of reports issued from 2013 to 2018, including A Policy Roadmap for Individuals with Complex Care Needs (2018)

Description	Federal Catastrophic Long-Term Care Insurance. Presents a mix of publicly funded programs and private insurance approaches to financing LTSS as a package of solutions designed to be financially and politically viable. Components include programmatic changes to expand the role of the private market, improvements to public programs such as Medicaid and Medicare, and consideration of a new social insurance program for protection against catastrophic LTSS costs. → To enhance multiple financing approaches representing a collaboration of public and private sectors thereby injecting new dollars into the system to improve service delivery and quality of care in the context of controlled spending. → Components include programmatic changes to expand the role of the private market, improvements to public programs such as Medicaid and Medicare, and consideration of a new social insurance program for protection against catastrophic LTSS costs. → Other objectives include maximizing opportunities for: (1) person- and family-centered care; (2) coordinated care across program silos; and (3) support for family caregivers.
Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization:** The Bipartisan Policy Center is a non-profit that seeks to combine politically balanced policymaking with strong advocacy and outreach. It was founded in 2007 by former Senate Majority Leaders Baker, Daschle, Dole, and Mitchell. → **Key Authors:** Authors bring significant expertise and experience in the public sector (including positions with Congress and state Medicaid agencies) and include: Lisa Harootunian, Katherine Hayes, G. William Hoagland, Brian O'Gara, Kamryn Perry.
Impact and Action	→ The report represents a culmination of recommendations from a dozen prior reports, providing policy guidance for Congress and federal agencies. → This report is a part of the Bipartisan Policy Center's Health Project, which develops bipartisan policy recommendations to improve health care quality, lower costs, and enhance coverage and delivery. This project is under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D.
PROGRAM DETAILS	
Participation Criteria	Individuals who have worked 40 quarters. Eligibility would be phased in over 10 years.
Conditions for Receiving Benefits	Individuals who have demonstrated need for LTSS by meeting one of the following criteria: → Being unable to perform two or more ADLs. → Requiring supervision due to severe cognitive impairment.
Scope of Services	Includes both HCBS and facility care.
Amount of Services	Up to $110/day cash benefit (2014 dollars).
Participant Financial Responsibility	Not applicable.

Elimination Period	Waiting period varies depending on individual lifetime incomes (based on distribution of income in quintiles): → One year for those in the lowest two quintiles. → Two years for those in the third quintile. → Three years for those in the fourth quintile. → Four years for those in the fifth quintile.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Annual benefits increase pegged to hourly cost increase for home health aides.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Premium surcharge on Medicare tax.
Total Program Costs	No cost estimates provided.
Program Administration	Federal government collects revenue and administers the program with reforms to Medicare and Medicaid: → Medicare · Change Medicare's risk adjustment model to account for functional impairment. · Provide incentives through quality measures for profusion of non-Medicare covered support services. · Allow Medicare Advantage plans to provide health-related social supports and services. → Medicaid · Create incentives for states to expand HCBS by streamlining and consolidating state plan amendments and waivers. · Allow states to offer LTSS-only buy in for persons with disabilities whose employment would result in the loss of Medicaid coverage. · Dual Eligible Plans: ▪ *PACE:* Newly authorize various demonstrations and expansions of the Program for All-inclusive Care for the Elderly (PACE) by making the program available at all ages and consolidating regulatory authority, etc. ▪ *Special Needs Plans (SNPs):* Better program alignment for demonstrations and Medicare advantage plans serving dual eligibles through SNPs.
Private Sector Role	Incentives could help the private market provide front-end support and/or insurance coverage by: → Creating limited benefit Retirement LTC insurance with three basic design options for simpler, lower-cost, limited-duration coverage. Include term life to LTC insurance conversions for adults in the workplace. → Allowing individuals age 45+ to use retirement savings (401(k), 403(b), IRA) to purchase Retirement LTC insurance without early withdrawal penalties, subject to income tax but exempt from the 10% penalty. → Providing safe harbor and expanded catch-up contributions for employers enrolling employees in Retirement LTC insurance. → Permitting Retirement LTC insurance policies to be sold on health insurance marketplaces and strengthening public education on LTC planning, including in financial literacy and retirement materials.

Milken Institute, 2021: New Approaches to Long-Term Care Access for Middle-Income Households

OVERVIEW	
Type of Reform	Transforming Healthcare Structures (Medicare Expansion and Private Market Incentives)
Description	→ Goal to develop complementary public-private LTSS financing solutions focused on front-end protection provided by the state. → Identifies three promising areas for increased financing and delivery opportunities: • Medicare expansion solutions. • Technology solutions. • Public and private LTC insurance solutions.
Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization:** The Milken Institute is a nonprofit, nonpartisan think tank. Milken conducts research and analysis and convenes top experts, innovators, and influencers to offer expertise and insight to construct programs and policy initiatives. → **Key Authors:** This report summarizes key findings of a Financial Innovations Lab® organized by the Milken Institute Center for the Future of Aging and Innovative Finance teams in Fall 2020. The Lab convened an expert group of stakeholders from government, health care, LTC delivery, senior housing, insurance, technology, finance, and academia to develop solutions to improve access to care for middle-income households. Key authors include: Jason Davis and Caroline Servat, along with Milken Institute colleagues Caitlin MacLean, Nora Super, Théo Feldman, and Cara Levy.
Impact and Action	Not addressed.
PROGRAM DETAILS	
Participation Criteria	Medicare beneficiaries. Limited to vested adults (vesting criteria not specified).
Conditions for Receiving Benefits	Consistent with benefit eligibility triggers used in the private insurance market and consistent with Treasury regulations for tax exemption, individuals must meet the following criteria: → Loss of two or more ADLs. → Severe cognitive impairment.
Scope of Services	Not specified.
Amount of Services	Amount and limits determined by states, presumably equivalent to a one or two-year benefit.
Participant Financial Responsibility	Not specified.
Elimination Period	Not specified.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Determined by state. Possibilities include increases to payroll tax, Medicare tax, and income tax surcharges.

Total Program Costs	None estimated.
Program Administration	→ Federal recommendations include: • Designing Medicare Advantage demonstration projects with an emphasis on technology and data to better address middle-income LTSS costs to reduce risks of individuals becoming more medically complex. • Scaling up integrated care programs for dual eligibles, such as PACE and D-SNPs. → States formulate and administer the insurance program.
Private Sector Role	→ Recommends private LTC insurance to provide supplemental coverage to a public program like enhanced daily amount and/or longer coverage duration. → Simplifies private insurance products to make them easier for consumers to understand and facilitate decision making. → Allows private LTC insurance to have a 365-day elimination period so it coordinates with front-end state public insurance program. → Allows multi-tier products (e.g., $50,000; $100,000, plus) to provide lower benefit levels for those with more limited affordability. → Explores the impact on premiums and participation rates for federal support for the market through a reinsurance program for private LTC insurance.

Long-Term Care Financing Collaborative (LTCFC), 2015: Principles for Improving Financing and Delivery of Long Term Services and Supports

OVERVIEW

Type of Reform	Transforming Healthcare Structures (Medicaid Reform, New Program, and Private Market Incentives)
Description	→ Recommends a combination of public and private sector reforms: • Universal catastrophic insurance program of financial support for those with extended LTC needs. • Various initiatives to revitalize the private LTC insurance market to better address non-catastrophic care needs. • Stronger support for family caregivers. • Modernization of the Medicaid safety net for LTSS.
Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization:** In 2012, a group of policy experts representing a wide range of interests and ideological views created The Long-Term Care Financing (Collaborative) to work towards consensus around ways to improve the LTC financing system. The group was convened by the Convergence Center for Policy Resolution which works to facilitate efforts to build trust, identify solutions, and form alliances for action. → **Key Author(s):** Members of the Collaborative included policy experts, consumer advocates, service providers, insurance industry representatives, bipartisan representation from senior executive branch officials, former congressional aides, and former top state health officials. Key authors include: Jonathan Westin, Stuart Butler, Howard Gleckman, Sheila Burke, Marc Cohen, and Don Redfoot.
Impact and Action	Broad range of stakeholder involvement generated thoughtful proposals for both public finance reform and actions to enhance the private market.

PROGRAM DETAILS	
Participation Criteria	Universal and mandatory enrollment.
Conditions for Receiving Benefits	Not specified; report discusses the importance of including coverage for young people with disabilities.[19]
Scope of Services	All LTSS, whether provided through a facility or in the community.
Amount of Services	Not specified.
Participant Financial Responsibility	Not specified.
Elimination Period	A front-end waiting period (e.g., one to two years before public insurance program eligibility), consistent with principles of a "back-end" catastrophic program.
Provider Requirements	Not specified.
Provider Payment Levels	Not specified.
Inflation Adjustments	Not specified.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	Suggests options such as payroll tax, value-added tax, premiums, or some combination.
Total Program Costs	None estimated.
Program Administration	Federal role dependent on revenue source agreed upon.
Private Sector Role	Incentives outlined in the report could help the private market provide front-end support before public coverage begins. Private sector reform recommendations include: → Encourage industry, employers, and policymakers to adopt cost-effective policies that promote consumer purchases, including products combining LTC and life insurances, Medicare supplements, and annuities. ▪ Recommended ways to reduce policy costs by changing policy designs and regulatory approaches (e.g., allow benefits and premiums to increase over time, streamline the policy approval process, and examine multi-state reinsurance approaches). → To encourage greater insurance up-take, employers automatically enroll employees in LTC insurance programs. Employees would have to affirmatively "opt out" of a program rather than affirmatively "opt in." → Examine which tax incentives would have the greatest impact on consumer interest in LTC insurance purchase, including use of retirement savings without early withdrawal penalties, and more. → Allow LTC insurance policies to be sold through an electronic marketplace. Strengthen public education of risks and costs of LTSS and the need to plan ahead. Consider including information about care needs in Social Security statements.

19 NOTE: A more fleshed out version of the initial set of recommendations along with premium and benefit estimates was published in 2018 and additional recommendations put forward in an updated report also published in 2022. This became the basis for the WISH Act (H.R. 4289).

▼ *U.S. Senate Commission on Long-Term Care, 2013:* Report to the Congress

OVERVIEW	
Type of Reform	Transforming Healthcare Structures (New Program and Private Market Incentives)
Description	→ Section 643 of the American Taxpayer Relief Act of 2012 directed the Commission to develop a plan for the establishment, implementation, and financing of LTSS for individuals, including older adults, those with cognitive or functional limitations, and others who require assistance to perform ADLs. → The Commission did not agree on a financing approach, and, therefore, made no recommendation. However, it offered two different approaches to illustrate ways that Congress could achieve a restructuring of LTSS financing: • Option A: Strengthen LTSS financing through private options ▪ Create tax advantages for LTC products through retirement and health accounts. ▪ New Product Designs: Support new forms of products, including combination life/LTC and annuity/LTC; Allow product innovations such as flexibility in pricing and product design not currently allowed. ▪ Allow individuals to "opt out" of Medicaid when claiming Social Security, receiving a portion of the expected Medicaid benefits as a subsidy to purchase LTC insurance, in exchange for forfeiting future Medicaid LTC services. ▪ Create a financing mechanism for the catastrophic LTC costs. Create safety net for catastrophic costs through private or public reinsurance. ▪ Ease regulatory requirements on private LTC insurance to enable innovation and affordable products. ▪ Raise awareness of the risks and costs of LTC and the need to plan ahead for how to meet those needs. Make consumers aware of financial incentives and private finance options, including encouraging use of reverse mortgages and Partnership for LTC Policies. • Option B: Strengthen LTSS financing through Social Insurance through two approaches ▪ Create a comprehensive Medicare benefit for LTSS in Medicare Part A that would be triggered when an individual is certified to meet certain qualifying criteria. ▪ Create a basic LTSS benefit within Medicare or a New Public Program which would create a more limited benefit, either within Medicare or as a new public program, to insure only catastrophic risk and making clear the "hole" that people able to prepare in advance should plan to fill through private resources.
Sponsoring Organization and Key Author(s)	→ **Sponsoring Organization:** The Commission on Long-Term Care was established under Section 643 of American Taxpayer Relief Act of 2012 (P.L. 112–240), signed into law January 2, 2013. → **Key Author(s):** The Commission was established with 15 members. Three members each were appointed by the President of the United States, the majority leader of the Senate, the minority leader of the Senate, the Speaker of the House of Representatives, and the minority leader of the House of Representatives.
Impact and Action	The bipartisan commission created a compendium for Senate lawmakers and others of reform ideas that were being discussed among advocates and policy experts to address the LTSS finance considerations and related workforce, service delivery, and quality issues.

PROGRAM DETAILS	
Participation Criteria	→ Medicare-eligible, with possible accommodations for individuals who meet eligibility criteria but are not otherwise part of the Medicare program. → Contemplates inclusion of younger people who are impaired and those with current needs, but specifics not provided.
Conditions for Receiving Benefits	→ Assistance with at least two ADLs expected to last at least 90 days. → Ongoing and continued cognitive or mental health issues, such that independence is impossible or contraindicated.
Scope of Services	LTSS including: skilled nursing facility care, home health care, personal care attendant services, care management and coordination, adult day care, respite care, outpatient therapies and other reasonable and necessary services.
Amount of Services	→ Not specified, contemplates that dollar amounts may vary with level of impairment. → Program would cover only catastrophic risk, making clear the coverage gap that people need to address privately during the income-based waiting period.
Participant Financial Responsibility	Responsible for costs during the income-based waiting period.
Elimination Period	Income-based waiting period with accommodations for younger people who become impaired and individuals with significant disability age 75+ at the time the program is established.
Provider Requirements	Not specified.
Provider Payment Levels	Set federal payment rates to providers, adjusted for geographic variation in input costs; "site-neutral" payments, that is, payment of providers based on the service provided to the consumer rather than site of care, and alignment of payments to reward providers for outcomes, quality of care and quality of life.
Inflation Adjustments	Not addressed.
FINANCING & IMPLEMENTATION	
Revenue Source(s)	→ If established as a Medicare Benefit: Finance through an increase to the current Medicare payroll tax and the creation of a Part A premium. → If established as a new Social Insurance Program: Finance through a combination of Medicaid savings and a surcharge on income tax.
Total Program Costs	Not addressed
Program Administration	Not addressed.
Private Sector Role	Recommendations include: (1) standardize LTCI policies similar to the Medigap market; (2) create an electronic exchange and broad consumer education and awareness; (3) strengthen consumer protections in private market; (4) enable and encourage product innovation and regulatory reform.

Appendix

GLOSSARY

Term	Definition
Activities of Daily Living	Activities of daily living (ADLs) are basic personal care actions that people perform on a daily basis. There are six basic ADLs: (a) bathing; (b) dressing; (c) toileting; (d) transferring (moving to and from a bed or a chair); (e) eating; and (f) caring for continence. The inability to perform a certain number of ADLs (such as two of six) is what many LTSS and LTC programs evaluate in order to determine when individuals are eligible for benefits. Loss in individuals' ability to do these basic ADLs is an objective and reliable indicator of the need for LTSS.[20]
Adjusted Gross Income	Adjusted gross income, also known as (AGI), is defined as total income minus deductions, or "adjustments" to income that one is eligible to take. Gross income includes wages, dividends, capital gains, business and retirement income as well as all other forms income.
Adverse Selection	Adverse selection is a situation where one party in a transaction has significantly more information about the product or service than the other party, allowing them to exploit that knowledge to their advantage, often at the expense of the less informed party. The term is typically applied to insurance markets where high-risk individuals are more likely to purchase coverage while low-risk individuals may choose not to, leading to higher premiums for everyone.
Alzheimer's disease	Alzheimer's disease is a progressive, degenerative form of dementia that causes severe intellectual deterioration. Individuals with Alzheimer's Disease often have problems with short-term memory and with orientation to person, place or time. They are often able to independently perform personal care but may require supervision to keep themselves safe and to ensure that they do not wander and get lost.
Bathing	An activity of daily living (ADL), bathing is defined as washing by sponge bath, or in either a tub or shower. This activity also includes the task of getting into or out of the tub or shower.
Cafeteria plan	A "cafeteria plan" is an employee benefit plan where employees can choose from a variety of pre-tax benefits, similar to selecting options at a cafeteria, allowing them to customize their benefits package by picking the ones that best suit their needs, like health insurance, dental, vision, and flexible spending accounts (FSAs), all deducted from their paycheck before taxes are calculated; it is also often called a "Section 125 plan" due to the IRS code that governs it or a "flexible benefits plan."
Care management	Care management consists of services that help an individual and their family identify care needs and arrange for services. These services may be provided by a Care Advisor/Manager, usually a nurse or social worker specially trained in the LTSS field, who helps to monitor and coordinate services to address care needs as they change over time. Care Advisors/ Managers consult with the individual and their family and develop a plan of care consistent with their needs and preferences.
Cash and Counseling	Cash and Counseling is a financial and care assistance program usually associated with Medicaid, that gives the beneficiary cash assistance and the flexibility to "self-direct" how to spend it on the providers and services they prefer.

20 https://www.msdmanuals.com/professional/multimedia/table/modified-katz-activities-of-daily-living-adl-scale

Cognitive Impairment	Cognitive impairment is a deficiency in a person's short or long-term memory, their orientation to person, place and time, their deductive or abstract reasoning, or in their judgment as it relates to safety awareness. (A well-known example of a severe cognitive impairment is Alzheimer's disease.)
Continence	An activity of daily living (ADL), continence consists of the ability to maintain control of bowel and bladder function, or when unable to maintain control of these functions, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
Daily/Monthly Benefit Limit	The daily/monthly benefit limit is typically the maximum dollar amount that a LTC insurance policy or program will pay to reimburse the costs of covered services. The limit is expressed as either an amount per day or an amount per month.
Dressing	An activity of daily living (ADL), dressing involves putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs. Dressing includes the ability to get to and from the closet or dresser and obtain clothing.
Dual eligible	A dual eligible individual is someone who is eligible for both Medicare and Medicaid benefits. People can become dual eligible due to age, disability, or low income. They can enroll in Medicare first and then qualify for Medicaid, or vice versa.
Eating	An activity of daily living (ADL), eating consists of feeding by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously. Eating does not mean preparing the food to be consumed.
Elimination Period (waiting period)	The elimination period and the deductible period are insurance and program terms used interchangeably to describe the length of time an insured person must pay for covered services or be disabled before a LTC insurance policy or program will begin to make payments. The longer the elimination period, the more an individual has to personally bear the costs of care and the lower the insurance premium.
Family caregiver	A family caregiver is a person who provides unpaid care to a family member, friend, or neighbor who needs help with daily tasks. This care can be due to illness, disability, aging, mental health problems, or addiction. Family caregivers can be spouses, parents, children, siblings, or other relatives. They can also be members of a family of choice such as neighbors, friends, or the like.
Full retirement age	Full retirement age, also known as normal retirement age, is the age at which individuals can receive full Social Security benefits. It ranges from those who are born in 1957 or earlier who are already eligible for full benefits, to age 67 for those born in 1960 or later.
Functional criteria	Functional criteria refer to the degree and nature of loss in the ability to perform ADLs. The precise definition of the functional criteria is what defines the circumstances under which a LTC insurance policy or program pays for LTSS.
Health Savings Account	Health Savings Account (HSA) is a type of savings account that lets individuals set aside money on a pre-tax basis to use as needed, to pay for qualified medical expenses. By using untaxed dollars in an HSA to pay for deductibles, copayments, coinsurance, and other expenses not covered by insurance (e.g., vision, dental or medications), individuals may be able to lower out-of-pocket health care costs. Only someone who has a qualified health insurance policy that is eligible as a High Deductible Health Plan can establish an HSA. An HSA may earn interest or other earnings, which are not taxable. Banks, credit unions, and other financial institutions offer HSAs.

Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act (HIPAA) of 1996 clarified the tax treatment of LTC insurance premiums and benefits, and created standards that policies must meet to be deemed as a tax-qualified (TQ) LTC policy. The IRS treats LTC insurance premiums and LTC costs as medical expenses that are deductible under certain circumstances (e.g., age-based limits).
Home- and community-based care/services (HCBS)	Home and community-based services (HCBS) refers to a broad range of services provided in the home or community when someone needs help with ADLs or has a cognitive impairment or other physical or mental disability. HCBS includes skilled nursing and personal care, adult day care, respite care, home-delivered meals, in-home or community-based therapies, transportation, hospice care, nutrition care, medication management, and more.
Inflation Adjustment	Inflation adjustment is a policy provision that allows benefit payments to increase over time, either automatically or periodically. These increases help coverage keep pace with inflation-driven increases in the costs of care. Inflation protection provisions are structured in many different ways. The insured generally chooses from several options for how they want this provision to work within their policy, or they can choose not to have their benefits increase over time.
Internal Revenue Code	The Internal Revenue Code (IRC) of 1986 is the domestic portion of federal statutory tax law in the US. It covers federal income tax, payroll tax, and estate, gift and excise taxes.
Lifetime Benefit Limit	The Lifetime Benefit Limit is the maximum dollar benefit an individual may receive under an insurance policy, plan, or program. Once the lifetime limit is reached, no additional benefits or payments will be made.
Long-term care (LTC)	LTC is a term used interchangeably with LTSS.
Long-term services and supports (LTSS)	LTSS encompass the broad range of paid and unpaid medical and personal care services that assist with ADLs and instrumental ADLS (IADLs; e.g., preparing meals, managing medication, and housekeeping). LTSS are provided to people who need care because of aging, chronic illness, or disability. LTSS include nursing facility care, adult day care, home health aide and personal care services, transportation, and more. LTSS may be provided over a period of several weeks, months, or years.
Mandatory	Mandatory refers to the requirement that anyone and everyone who meets the eligibility requirements for a specified program is required to enroll/participate in it. The only exception might be if conditions or time periods for the ability to “opt out” are specified in the program rules.
Medicaid	Medicaid is jointly financed and administered by federal and state governments authorized under Title XIX of the Social Security Act Amendments of 1965. It pays for health care services for those with very limited assets and low incomes, or those who have very high medical bills in relation to their income and/or assets.
Medicare	Medicare is the federal program organized under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965. It provides hospital and medical expense benefits for persons age 65+, or those meeting specific disability standards. Benefits for nursing facility and home health services under Medicare are very limited.

Medicare Advantage	Medicare Advantage consists of Medicare-approved plans from private companies that offer alternatives to traditional Medicare for health care coverage. These "bundled" plans include Part A, Part B, and usually Part D. Plans may offer some extra benefits that traditional Medicare does not (e.g., limited dental, vision, hearing, etc.)
National Association of Insurance Commissioners	The National Association of Insurance Commissioners (NAIC) is a trade association of state insurance commissioners that issues model insurance acts and regulations that states can adopt.
PACE	The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing facility or other care facility.
Partnership-qualified long-term care insurance plan	A partnership qualified LTC insurance plan is a type of private LTC coverage that allows individuals to keep some additional assets beyond the usual Medicaid impoverishment limits, if they apply for Medicaid after using up the benefits of private LTC coverage. The amount of "spend down protection" received (i.e., the additional amount of assets individuals can keep) is equal to the amount of benefits paid to under a private Partnership policy.
Person-centered care	Person-centered care (PCC) is a way of delivering health care that focuses on the needs of each individual and takes account and places at the center of care their goals, values, and preferences. It is based on the idea that people should be treated as individuals, not just as a bundle of conditions to be treated.
Respite care	Respite care is temporary care in a nursing facility, assisted living facility, adult day care center, or at home. Respite Care is intended to provide time off for informal caregivers who ordinarily care for individuals on a regular basis. Respite care is usually short-term – typically 14 to 21 days of care per year.
Social insurance	Social insurance is a universally funded financial safety net administered by the government. Programs include Social Security, unemployment insurance, and Medicare, among others. Social insurance differs from public assistance based on funding sources. Social insurance is funded by contributions of each citizen who benefits from the services (typically through a tax on payroll or premium) rather than exclusively on general tax revenues.
State Plan Amendment (SPA)	State Plan Amendment (SPA) is the formal procedure and documentation that a state is required to use when it is planning to make a change in its Medicaid program coverage or administrative or eligibility procedures.
Tax-qualified long-term care insurance plan	A tax-qualified LTC insurance plan is a policy that conforms to certain standards in federal law and offers certain federal tax advantages to people buying the policy.
Toileting	An activity of daily living (ADL), toileting involves getting to and from, and on and off the toilet, and performing associated personal hygiene.
Transferring	An activity of daily living (ADL), transferring involves moving into and out of a bed, chair or wheelchair.
Universal	Universal refers to the type of coverage where anyone and everyone who meets the eligibility requirements for a specified program is required to enroll/participate in it. The only exception might be if conditions or time periods for the ability to "opt out" are specified in the program requirements.

ADDITIONAL READING MATERIAL

Section 1: Legislative Proposals for Public LTSS Finance Coverage Reform

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Section 3: Commission Reports and Research Papers

→ Cohen, M., Feder, J., & Favreault, M. (2018, January). A New Public-Private Partnership: Catastrophic Public and Front-End Private LTC Insurance. Bipartisan Policy Center.

About the LeadingAge LTSS Center

The LeadingAge LTSS Center @UMass Boston conducts research to help our nation address the challenges and seize the opportunities associated with our nation's growing older adult demographic group. The LTSS Center combines the resources of a major research university with the expertise and experience of applied researchers working with providers of long-term services and supports (LTSS).

This joint venture of LeadingAge – a national organization representing 6,000 non-profit aging services providers – and the University of Massachusetts, Boston translates research into policy and practice to improve quality of care and quality of life for the most vulnerable older Americans. As an independent entity, the LTSS Center conducts applied research for the benefit of government agencies and other policymakers, providers and the general public. It builds on UMass Boston's partnership with Community Catalyst, a national consumer health advocacy organization. For more information, visit ltsscenter.org.

About The SCAN Foundation

The SCAN Foundation envisions a society where all of us can age well with purpose. We pursue this vision by igniting bold and equitable changes in how older adults age in both home and community. We work at the diverse intersections of aging with partnerships that expand across the aging, healthcare, disability, policy, social entrepreneur, racial justice, and social justice sectors. With deep roots across the state of California, our work aims to influence national transformation of the systems and supports that enable all older adults to age well at home with purpose. For more information, visit thescanfoundation.org.

About ATI Advisory

ATI Advisory is a healthcare research and advisory services firm dedicated to system reform that improves health outcomes and makes care better for everyone. ATI guides public and private leaders in solving the most complex problems in healthcare through objective research, deep expertise, and bringing ideas to action. For more information, visit atiadvisory.com.