

The Medicare Long-Term Care Services and Supports Act of 2018
Fact Sheet
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There is no viable long-term care financing system in this country, leaving millions of individuals each year with nothing. Long-term care financing is in a crisis state and is one of the greatest threats to retirement security for seniors and the adult children who care for them. Most Americans who receive formal long term care supports and services (LTSS) and do not qualify for Medicaid have to pay out-of-pocket, an average of \$140,000, until resources are depleted enough for Medicaid coverage. In 2014, formal out-of-pocket expenses accounted for over \$53 billion, nearly 16 percent of national LTSS spending. Across the country, 17 percent of working adults provide unpaid care for family members or friends, providing an estimated \$470 billion annually in labor costs. Lost productivity is estimated to cost the economy an additional \$34 billion annually.

More than 70 percent of individuals over the age of 65 will need LTSS. As the baby boomer wave continues, by the year 2050, the population of Americans over age 65 is expected to double and the population above 85 will triple. This will result in approximately 90 million Americans over age 65 by 2055, with half of these individuals over 75. At this trajectory, LTSS expenses are predicted to double as a share of the economy over the next 30 years. Additionally, beyond the senior population, those under the age of 65 with intellectual and developmental disabilities, behavioral health diagnoses, spinal cord or traumatic brain injuries or other disabling chronic conditions and their families struggle to afford the full range of care that is needed.

The Medicare Long-Term Care Services and Supports Act of 2018:

There is no silver bullet to the nation's long-term care problem. Three major bipartisan consensus reports have all independently agreed, however, on three actions Congress must take to begin to address it:

- 1) Strengthen and simplify Medicaid long-term care,
- 2) Build a more consumer-friendly long-term care private insurance market, and
- 3) Create a federal program to provide care to those with substantial long term care costs.

More than 15 percent of all individuals that need LTSS will have costs in excess of \$250,000. Such costs will not be picked up by the private market, and cannot be sustained by Medicaid. **To address the third prong above, this draft legislation provides a strong federal program to serve as that public back-end benefit to pick up long-term and costly LTSS.**

More specifically:

The legislation would establish a back-end LTSS benefit designed for everyone regardless of income or where someone lives in the Medicare program, mitigating the burden on state Medicaid budgets and family caregivers.

- The new benefit would apply to all those eligible for Part A and those under the age of 65 not otherwise eligible for Medicare Part A that meet certain SSDI criteria and disability thresholds outlined in the bill. The benefit would begin after a two year waiting period that functions as a deductible, between eligibility certification and receipt of benefits, allowing the new public benefit to fit within the private marketplace. There is an option for the waiting period that allows a person with three or more activities of daily living and substantial impairment to access the benefit immediately by instead paying a cash deductible scaled to income.
- The self-directed benefit could be used towards all needed LTSS. LTSS provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). LTSS include, but are not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and assistance provided by a family caregiver.
- The legislation harnesses the needed flexibility of a self-directed cash benefit, with strong accountability controls, providing the equivalent of five hours of care in the home daily. The benefit would be adjusted based on area wages, inflation and the intensity of care needed.
- The legislation would supplement Medicaid benefits for dually-eligible beneficiaries, working with the state to offset the costs of care.

This model would have several advantages over the current system for LTSS. The proposed LTSS benefit in Medicare would:

- Allow for a public-private partnership in financing long-term care by not crowding out private or family options to cover the first two years of LTSS need and to fill in the gaps around the new benefit.
- Continue incentives for people to seek care at home, the setting where most people want to be, and with family support. However, the benefit can also be used towards nursing homes.
- Provide the necessary flexibility of cash benefits, because the services needed are broad, numerous, and vary significantly based on the patient's needs and abilities, but also provide strong and regular accountability and support for beneficiaries to manage the benefit.
- Limit reliance on Medicaid as a fallback option. People only receive LTSS benefits through Medicaid when they have expended most if not all of their liquid financial resources. Middle-income families are currently the worst off because they typically spend down to Medicaid or go broke paying out of pocket.
- Relieve overburdened caregivers. This benefit can be used towards family caregivers and respite care. Caregivers find value in what they do, but may also lose income, other retirement benefits, and career opportunities if they have to cut back on work hours or leave the workforce.