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AGING WITH DIGNITY

PROVIDING LONG-TERM SUPPORTS AND SERVICES AT HOME FOR OUR NATION'S ELDERS

Richard Frank, Sherry Glied, Jonathan Gruber,
Vani Agarwal, and Wendell Primus

AUTHOR NOTES AND ACKNOWLEDGEMENTS

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DISCLOSURES

The U.S. population is aging rapidly. In only three states and the District of Columbia in 2020 were more than one in five people over age 65; by 2050, that is projected to be true in 43 states (Gruber and McGarry 2023). This rapid aging of the U.S. population raises a host of important public policy issues for our nation, from how to finance our age-related income transfers to how to pay for rising acute medical care costs. But perhaps most central is how to deal with the demands for supports and services that come with functional impairments associated with aging. One in five community-dwelling individuals over age 65 in the U.S. is unable to carry out one or more of their "Activities of Daily Living," including bathing, dressing, eating, and toileting. For those over age 85, the segment of the population that is growing fastest, that ratio rises to nearly 40%.[1] This pattern of growing needs as individuals age is going to result in a large rise in the need for long-term supports and services (LTSS) in the coming decades.

The U.S. is ill-prepared to meet this growing demand along several dimensions. First, most individuals are underinsured against the financial risks arising from LTSS costs. Among individuals who reach age 65, 70% will, prior to dying, have a significant need for long-term services and supports, and roughly half will pay for those services (Johnson 2019). The average spending on LTSS across all payers for remaining life among people reaching the age of 65 was estimated to be $120,900 in 2020 dollars (Johnson and Dey 2022). In 2023, the median household wealth holdings of those 65 and older were $373,100, but most of this was housing wealth; median non-housing, household financial wealth for householders 65 and older was roughly $114,000, declining from about $140,000 from ages 65 to 69 to about $97,000 for ages 75 and older (U.S. Census Bureau 2025). And the private long-term care insurance (LTCI) market has largely collapsed in the U.S. Despite decades of policy nudges encouraging its purchase, only 3% of Americans over 50 today hold LTCI (LIMRA 2025). What remains is expensive and rejects a substantial share of applicants through underwriting—few people can protect themselves from these costs using private financial instruments (Mnuchin and Faulkender 2020).

Second, our existing public social insurance programs are not prepared to meet the needs of those who cannot self-insure against LTSS costs. Historically, older adults who developed impairments have been cared for by family members or, if destitute, relied on public almshouses. Our public health insurance system for long-term services and supports is rooted in this history, and it is no longer a good fit for our modern society. Increases in female labor force participation, changing housing patterns, and smaller families make informal family care at home less efficient and available (Spillman et al. 2021). We are no longer willing to accept the abysmal quality of care offered by almshouses.

The Medicaid program has become, over time, the public alternative to informal care. Medicaid offers universal coverage of nursing home costs for those whose income is low and who have spent all their assets. This provides some protection, but most people prefer to remain at home if they can (Henning-Smith et al. 2021). Moreover, the quality of care in nursing homes is often inadequate (OIG 2003). Because people have a strong preference for home-based services, and because these may, in some situations, be less costly than nursing home care, Medicaid has gradually and intermittently increased its coverage of home care (Chidambaram and Burns 2024).[2] This coverage is limited to very low-income people who meet Medicaid's asset and income eligibility standards. Even in this group, unlike most of Medicaid, most home and community-based services are not entitlements, so those services are not universally available even to fully-qualified Medicaid beneficiaries. In addition to the lack of financing for LTSS, particularly for those with incomes above Medicaid levels, and especially in light of changing immigration policies, we face a massive shortage of workers who can provide LTSS (Heiks and Sabine 2022; Butcher et al 2022).

The results of these shortfalls compromise the well-being of millions of older adults. As a result, they live in situations that are not best suited for them: directed toward institutions when they would prefer to be at home, or trying to navigate life from home with inadequate services because these services are unaffordable (Smith and Kuretich 2023). Millions of informal caregivers are burdened by the need to provide

forms of care for which they are not formally qualified, and, for many, caregiving keeps them away from formal labor market opportunities that could raise their standard of living (Fahle and McGarry 2018). State budgets are overburdened with spending on Medicaid LTSS. Increased spending on Medicaid can lead state governments to cut essential services and limit the LTSS that they can provide (Craig and Howard 2014; Joffe 2015).

In this paper, we outline an approach to reimagining a more dignified path for all older Americans, to allow them to stay at home with the resources they need if they develop functional impairments. Specifically, we propose a new home care benefit under the Medicare program for beneficiaries who experience significant functional impairments and require LTSS. That program would replace the existing income and asset cutoffs of the existing system with an income- and wealth-related cost-sharing system that provides universal eligibility while ensuring that individuals contribute what they can afford.

This paper proceeds in five parts. In Part I, we provide a description of the existing system for providing LTSS in the U.S., focusing on key shortcomings of the existing system. In Part II, we provide a set of principles that guide our policy suggestions in this area. In Part III, we detail the specific policy formulation that we suggest to meet these principles. Part IV then provides the results of our efforts to score the cost of our policies and to discuss revenue-raising alternatives to pay for these costs. Part V concludes.

I. Background: The existing LTSS system in the U.S.

To understand the necessary reforms to our LTSS system, it's useful to begin by describing the existing system of financing and support of LTSS, which comprises many payers and providers. In this section, we provide an overview of U.S. LTSS.

LTSS FINANCING

The cost of formal long-term care is high relative to the resources of most elderly people (Gruber and McGarry 2023). At the same time, there is little use of private insurance to cover these costs. Only 3% of adults over the age of 50 pay for long-term care insurance, and only 8% of the lifetime costs of home health care for those 65 and older is financed by such insurance (LIMRA 2025; Johnson and Dey 2022). This is in part due to the fact that long-term care insurance is heavily underwritten. For example, one study estimates that roughly 20 to 25% of applicants are rejected (Cornell et al. 2016). The American Association of Long-Term Care Insurance reports that 20% of people in their 50s, 30% of those aged 60 to 64, and 47% of people aged 70 to 74 are rejected (American Association for Long-Term Care Insurance n.d.). There are many explanations of why the long-term care insurance market has failed to thrive, but there is no doubt that this has been the case, despite many policy reform efforts (Brown and Finkelstein 2011). Indeed, the market has continuously weakened over two decades.

Almost all older adult Americans are Medicare beneficiaries, but the Medicare program is intended to provide financial protection against the costs of acute care only. While it pays for post-acute care services, including home health care and skilled nursing home care, leading many people to believe that they have coverage for LTSS, this is not the case. Medicare coverage, limited to services deemed "medically necessary," excludes assistance with activities of daily living (ADLs) or custodial care (CMS 2020). Even within covered post-acute care, Medicare coverage of medically necessary nursing home care is limited to 100 days, and the program includes substantial copayments for stays beyond 20 days (CMS n.d.).[3]

The other major public insurer, Medicaid, provides coverage for a range of long-term services and supports, but this coverage is limited to very low-income

people who are elderly or disabled; most are on the Supplemental Security Income (SSI) program. In order to qualify for Medicaid LTSS, one must meet income, asset, and ADL impairment requirements; eligibility criteria—including income limits, asset limits, and care needs—vary by state. For single individuals, income limits in many states are currently just over $2,982 per month, while asset limits are typically $2,000 (though several important assets, most notably an owner-occupied home, are excluded from the asset limit tests) (American Council on Aging 2025). Older adults and disabled people with slightly higher incomes may also qualify if they incur sufficiently high medical expenses that cause them to "spend down" their incomes below a "medically needy" level. Eligibility rules and whether or not medically needy programs are available also vary significantly across states. In effect, some middle-income older Americans could qualify for Medicaid by exhausting most financial assets. Those with higher pension incomes may not be able to qualify at all.

Medicaid will cover the costs of nursing home care indefinitely, as nursing home care is a Medicaid entitlement that applies to all states. But states differ in whether and how they cover other services, especially home care. Because home care is not an entitlement, states adopt a variety of policies that can limit the scope of services and the populations served by home and community services, including maintaining waiting lists for the receipt of home care. State Medicaid programs set out the terms of coverage and eligibility for home care through a system of federal "waivers" and state plan amendments. The federal government shares in the cost of those services as it does for all other Medicaid benefits. Home care waivers are intended to promote the use of LTSS services that can reduce institutionalization and allow people to remain in the community. Such services include adult day care, respite care, homemaker services, and transportation assistance. Medicaid home and community-based services (HCBS) have expanded substantially, with all states offering some form of home care through an optional waiver program (Mohamed et al. 2026). Medicaid HCBS accounts for an estimated 63.2% of Medicaid's spending on LTSS (Wysocki et al. 2024). Nonetheless, beneficiaries who might receive home care in some states are not able to receive Medicaid-financed care in their homes and communities in other states.

In summary, Medicaid is the primary payer for LTSS in the U.S., covering about 46% of those costs. Out-of-pocket costs account for 14% of LTSS spending, private sources and insurance account for 16% of spending, and other public sources (e.g., Medicare, Veterans' Administration, Department of Defense, Substance Abuse and Mental Health Services Administration) make up roughly 24% of spending (Colello and Sorenson 2025).

LONG-TERM CARE RECEIPT

Many elderly people need long-term care services. Data from the Health and Retirement Survey (HRS) shows that about 14% of community-dwelling people, 65 and over, are receiving some sort of assistance with functional limitations, whether formal or informal. Among the oldest-old (85 and older), one-third receive some assistance; this is mainly driven by higher numbers of ADL limitations in this population.[4] Nonetheless, data suggest that many people are not receiving assistance, even among those with multiple functional limitations. Some of this apparent gap may be due to underreporting of (informal) care and to differences in the severity of what constitutes a limitation.

Most older people (over 80%) who receive care report receiving only informal home care; only about one in 20 receive exclusively formal home care. This is true even among those with three or more ADLs; in this group, more than half receive only informal care.[5] The share receiving formal care—either in a nursing home or at home—rises with the number of ADLs.

FORMAL LONG-TERM CARE SUPPLY

Nursing homes, assisted living, and formal sector home care workers constitute the majority of the formal long-term care sector. In 2022, there were nearly 15,000 nursing homes, with almost 1.6 million beds in the U.S. (National Center for Health Statistics n.d.). Nursing home occupancy rates have fallen over time, and in 2022, under 80% of available beds were occupied (CliftonLarsonAllen LLP 2023). Nursing home

occupancy rates and capacity vary geographically, with the number of beds per 100 elderly residents ranging from 0.9 to 6.2 (Gruber and McGarry 2023).

Medicaid covers about 62% of residents living in nursing homes. A report from the Kaiser Family Foundation found that the share of nursing home residents covered by Medicaid ranged from a high of 80% in the District of Columbia to a low of 48% in Iowa (KFF 2017). Many nursing homes also provide post-acute care services paid for by the Medicare program (MedPac 2024).

There are significant concerns about the quality of care provided in nursing homes. About 43% of individuals in long-term care settings will fall each year, about 8.5% will develop a pressure ulcer, and anywhere between 19 and 26% of individuals will report a urinary tract infection (Berry and Kiel 2024; Sugathapala et al. 2023; Chen et al. 2023). Some evidence suggests that these problems are even more acute in for-profit, private-equity-owned nursing homes (Gupta et al. 2021).

Formal home care services may be provided through home care agencies or independent caregivers. In 2017, the 11,500 agencies reporting cared for almost 5 million people. The great majority of home care agencies are for-profit, and most are quite small, with more than 40% providing care to fewer than 100 people per year (Sengupta et al. 2022). Formal home care providers may offer a wide range of services, from nursing care, personal care, housekeeping services, and therapeutic care.

WHO ARE THE CAREGIVERS?

In 2020, there were an estimated 2.9 million formal direct care workers employed in nursing homes and in patients' homes, providing care to people with long-term care needs (Khaylou et al. 2023). These workers have a wide range of skills and earnings: home health aides typically have minimal training and earn about $12 per hour; nursing aides earn an average of $19 per hour; licensed practical nurses earn an average of $30 per hour and require a year of nursing education; and registered nurses, who average about $45 per hour, and have either a two- or four-year nursing degree (BLS n.d.-a; BLS n.d.-b; BLS 2025a; BLS 2025b). Formal direct care workers typically have a high school diploma, receive some training from agencies that employ them, and, in some states, must be certified (BLS 2025c). Many formal home care workers are immigrants (about one-third), and a little under two-thirds are non-white. Almost all formal care workers are women (all but 13%) (Paraprofessional Healthcare Institute 2019).

About 53 million people report that they provide at least some informal (unpaid) care to a person needing long-term services and supports (Callahan 2025). About 79% of informal care workers are over age 50, and many are well-educated (Gruber and McGarry 2023). An estimated 61% of caregivers to adults are women (National Alliance for Caregiving and AARP 2020). About one-third of informal caregivers are spouses, about one-fourth are daughters, and about one-eighth are sons (Gruber and McGarry 2023).

II. Principles and their rationale

Our reform proposal is guided by a set of principles, which we describe and justify in this section.

PRINCIPLE 1: PRIVATE LTCI IS IRREPARABLY BROKEN

The private LTCI market has failed repeated market tests for broad-based coverage of Americans over the past 25 years. As noted earlier, only about 3% of adults over the age of 50 have LTCI. Prior interventions aimed at strengthening this market have largely proved ineffective (Sun and Webb 2013; Bergquist et al. 2018). For these reasons, we do not consider the private LTSS market as an important mechanism for addressing the risks of needing LTSS across the population. Direct public intervention will be needed. That said, there may be a complementary role for private insurance as discussed below.

PRINCIPLE 2: HOME CARE SHOULD BE AN ENTITLEMENT

Older adults prefer to be cared for at home. A recent American Association of Retired Persons (AARP) survey shows that about 77% of older adults want to remain in their homes even as their functional capacities diminish (Binette and Farago 2021). Currently, Medicaid is the only public program providing long-term home care—but it is not an entitlement. While all income- and asset-eligible people are entitled to nursing home care through Medicaid, many states have significant waiting lists for HCBS, even for those who are income and asset-eligible (Musumeci and Leiser 2024). A new home care benefit should be designed as a targeted entitlement program. While eligibility and contributions will be based on ability to pay, every American should know that if they are sufficiently in need of help, there will be a mechanism to make that care affordable.

PRINCIPLE 3: FISCAL RESPONSIBILITY IMPLIES SUBSIDIZING ONLY FORMAL CARE

Millions of our nation's older adults are already cared for at home informally, by spouses, other family members, or friends. While it seems attractive to provide direct payments to such informal caregivers, doing so would be very costly for taxpayers and is unlikely to generate a significant increase in the availability of care.

Paying informal caregivers is likely to yield relatively little new care to older adults with functional impairments because most of the funds end up being directed to people already providing care (Lieber and Lockwood 2019). In addition to not generating much new care, paying informal caregivers poses severe risks to program integrity. Reporting on receipt of informal care is susceptible to fraud; for example, one common problem is caregivers falsifying paperwork and claiming to work more hours than were actually provided, thereby increasing expenses and leaving the older adults with significant periods of neglect (GAO 2018). The new entitlement program should limit payments to formal caregivers only.

It also promotes greater labor force activity among informal caregivers who are typically middle-aged women. To the extent that these women can earn more in other occupations than they would as caregivers, substituting formal care for informal care may yield higher average incomes and tax contributions. Substituting formal for informal care may also attenuate the physical and emotional stresses of full-time caregiving for a family member (Shen 2024). Finally, demographic trends in the U.S. mean that delivery of LTSS through formal caregiving will be more necessary as dependence ratios, meaning the number of dependent individuals (children or older adults) per working-age adult, increase.

PRINCIPLE 4: PARTICIPANTS SHOULD CONTRIBUTE BASED ON THEIR UNDERLYING ABILITY TO PAY

The primary purpose of a new social insurance program for long-term care should be to make good-quality care more available to people who need it. Current eligibility for publicly funded LTSS is based on sharp cutoffs of income and asset holdings. The sharp income cutoff means that no assistance is available to those who have a pension or other income, even if that income is not sufficient to meet their LTSS needs. This can leave people in a situation where they cannot access the care they need. The sharp asset cutoff means that access to LTSS may not be available at all to people with low incomes but high levels of illiquid assets. Asset tests generally protect housing wealth, which penalizes renters relative to homeowners and distorts savings decisions.

A new program should incorporate contributions based on underlying ability to pay, with ability to pay assessed using a measure that incorporates both income and assets. The program would count all assets, including housing assets, by integrating a functioning reverse mortgage system. Because eligibility would not depend on sharp income or asset cliffs, all Americans who cannot afford the full cost of LTSS care could benefit. Because contributions would be linked to the ability to pay, incorporating both assets and income, the program would be targeted at ensuring access rather than protecting bequests.

Participants should be required to make ability-to-pay–based contributions to program costs that are related to the quantity of home care services they use. Coinsurance of this type is a desirable feature of the program because the demand for home care services is likely to be quite responsive to price. While limiting participation and benefits based on a functional impairment standard will help to promote appropriate use, impairment standards are imperfect, and there is substantial potential for overuse of program benefits. A coinsurance arrangement will also help ensure that care is directed toward those most in need and least able to afford care.

PRINCIPLE 5: HOME CARE SHOULD BE FINANCIALLY INTEGRATED WITH MEDICAL CARE

Home care should be considered part of the continuum of medical care. That means that home care programs should match up to the corresponding medical care programs. Currently, older adults and people on Social Security Disability Insurance (SSDI) have the bulk of their health care paid for by Medicare, yet their home care is paid for by state Medicaid programs. The new program should add a home care benefit to Medicare, available to all those who qualify for Medicare, unifying the continuum of care and potentially leading to improved quality and cost management (Integrated Home Care Services 2022).

For those under age 65 who require home care and receive Supplemental Security Income (SSI), but not Medicare, state Medicaid programs currently pay medical care costs. To link home care to the continuum of care for this population, home care benefits should continue to fall within the Medicaid program for this population.

PRINCIPLE 6: NURSING HOME CARE SHOULD REMAIN PART OF MEDICAID, BUT WITH IMPROVED STANDARDS

Nursing home care is currently an entitlement in Medicaid. Availability and rules governing nursing home care vary less across states than do home and community-based care. Nursing homes also provide a range of both health care and LTSS. Thus, the urgency and benefits of unifying that segment of the benefit with the rest of Medicare are smaller.

Nevertheless, the federal government should play a larger role in ensuring that our nation's nursing homes meet minimum standards for quality of care. Such standards are in place in theory today, but are not very effective in practice. Quality improvement could be achieved in an affordable way by following some of the recommendations of the recent National Academy of Sciences report on nursing homes (National Academies of Sciences, Engineering and Medicine 2022).

III. Details of reform

We propose to create a universal home care benefit. The program would largely (but not fully) replace the state-by-state Medicaid HCBS programs with a universal Medicare benefit. As with the current program, individuals would qualify based on functional status criteria measured using indicators of functional impairments, such as ADL limitations (though these would be standardized nationally). But unlike Medicaid, the benefit would be universal for those who meet this standard. Beneficiaries would pay income-related coinsurance for home care, which would be organized through one or more managed care contractors operating under a budget.

ELIGIBILITY

The initial functional impairment criteria to qualify for the program would be those already established in HIPAA. The individual must be re-certified annually as continuing to experience significant functional impairments. The HIPAA triggers are as follows:

> "Activities of daily living (ADL) trigger – The individual is unable to perform (without "substantial assistance" from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity. Activities of daily living are: bathing, continence[6], dressing, eating, toileting, transferring (Veterans Benefits Administration n.d.; McCann Insurance Services n.d.).
>
> Cognitive Impairment – The individual requires "substantial supervision" to protect such individual from threats to health and safety due to "severe" cognitive impairment."

The federal government would contract with specially trained nurses, fully independent of the managed care companies providing benefits (see below), who would undertake examinations of individuals seeking coverage to determine whether they meet the functional impairment standard. The program would specify detailed processes and guidance for the interpretation of the trigger requirements. Medicare would exercise oversight of the application of trigger definitions in the field. Evaluation would be coordinated with the Medicaid program so that if individuals were found to be likely to be treated more effectively in nursing homes, that recommendation could be passed on.

BENEFIT DESIGN

The proposed benefit would include the following services.

- Home health includes nursing services, home health aide assistance, and some assistive equipment and technologies. These would be distinct from the services and durable medical equipment that are part of the Medicare acute and post-acute coverage.
- Personal care services involve the provision of assistance to individuals experiencing functional impairments in conducting activities of daily living, such as eating and bathing. Personal care services can also focus on instrumental activities of daily living (IADLs) that promote independence. IADLs include activities such as housework, laundry, and meal preparation.
- Homemaker services include housework such as meal preparation, typically provided by a trained homemaker aide.
- Adult day services include regularly scheduled day programs that are aimed at meeting both health and social service needs.
- Care coordination consists of services to aid in accessing needed benefits and services across settings and sectors.
- Transportation includes transportation for non-medical functions and services such as adult day services.

There are ongoing rapid advances in technology for caring for our neediest citizens, particularly with the prospect of generative AI to provide support and companionship for the elderly. Any rules around eligible services should accommodate and not impede ongoing technological innovation.

ADMINISTRATION

The program would be administered as a carve-out to the main Medicare program.[7] The carveout would have multiple functions. The first would be to contract with third party administrators (TPAs) for needs assessment. Those contracts are usually administrative services only contracts and would be modeled on similar practices used by private LTCI programs (Blue Solutions Administrator n.d.). Those contracts outline the services the TPA provides, which include a second function that entails handling claims processing and administering benefits and services necessary to meet the needs of this population. The TPA would assess the underlying home care needs of potential participants through needs assessments of the type called for in the eligibility section. The assessment may include a phone interview or an in-person visit to perform physical and/or cognitive tests. A family member is typically encouraged to participate in this assessment to ensure accurate information is provided. That assessment would be conducted by a specially trained nurse or social worker employed under contract with the TPA. Specifically, if eligibility is confirmed, a care manager from the TPA would approve a plan of care that outlines the specific benefits and hours of care and support a claimant is appropriate to receive. The TPA, using reported income and asset data from the Internal Revenue Service (IRS) and the Social Security Administration (SSA), would then determine the beneficiary's copayment rate. In addition, the TPA may schedule periodic health assessments to ensure the claimant continues to meet the eligibility criteria. The TPA is also charged with ensuring compliance with regulations and maintaining the security and privacy of member information. This third party administrator contract design would allow for individual management of a heterogeneous population that would meet program eligibility standards, while maintaining cost control. The vendor would operate under a population-based budget determined by the number of individuals qualified for the program.

REIMBURSEMENT

The budget would be constructed from the assessment of hours needed among those who currently use home care services. The assessment of hours of care needed would vary by categories of underlying health, such as ADL limitations. The TPA vendor would be paid an administrative fee for managing care under the budget, but would not gain further rewards for realizing savings below the planned budget. That is, the vendor would not own the budget; they would simply administer the assessment of needs and authorize payments to providers. Based on a review of home care use in the U.S., our initial projections are shown in Table 1.

Table 1: Projected Allocated Hours of Care Per Week Based on Health Needs

	No Cognitive Impairments	Cognitive Impairments
0-1 ADLs	0	20
2 ADLs	10	25
3 ADLs	15	25
4 ADLs	15	60
5 ADLs	40	60
6 ADLs	40	60

Note: Activities of Daily Living (ADL)

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These are suggested values; legislation should be based on a comprehensive review of available data and consultation with stakeholders. The capitation rate would then be based on the expected costs of delivering the appropriate mix of care for that number of hours. Our estimates below are based on reviews of the costs of care in existing home care systems.

The TPA vendors would then aid in arranging for services consistent with the assessment of needed hours. Beneficiaries would be offered some flexibility in allowable hours based on the care setting they prefer. For example, beneficiaries might be provided with more hours if they receive care in an adult day program than if they were provided with individual care and support at home, reflecting the lower per-hour or per-person cost of adult day health care.

There is substantial start-up risk for TPA vendors committing to providing these services. As a result, the government should set up a start-up fund for companies participating in this program.

MONITORING

Ensuring quality services is critically important for such vulnerable populations. To address this, there will need to be a robust monitoring system in place. Two types of monitoring will be incorporated in the program: quality measurement and input measurement.

One risk is that the TPA would shirk responsibility for ensuring the quality of services provided. One approach to addressing quality of services is to link the size of the administrative payment to indicators of service quality. Quality measurement for LTSS is notoriously difficult, given that many of the benefits of support are psychosocial and are not obviously reflected in measured medical outcomes. There should be a thorough review of existing quality measurement tools being used in the LTSS space and the development of best practices in this area. This issue is discussed further in the next section, on new Medicaid standards.

Monitors should also directly measure the quantity of home care delivered. Minimums should be established to ensure that care is being delivered in accordance with the assessments of functional impairment.

Both quality and quantity targets should be used as a way to identify outlying bad performers, while allowing TPAs to match need and services. The data used to measure these outcomes are, by nature, noisy, making it hard to differentiate quality that is high versus average.

INTEGRATION WITH THE EXISTING MEDICARE HOME HEALTH BENEFIT

The proposed LTSS home care benefit under Medicare would sit alongside the existing post-acute home health care benefit in Medicare. In some cases, people treated under the post-acute benefit would have financial responsibility for their care shifted to the home care benefit if their circumstances qualified them for the home care benefit.

FINANCING

The financing for this program would come from four sources: individual contributions, reduced federal spending on HCBS, recaptured revenues from state savings on HCBS, and dedicated financing. We present the share of overall expenditures coming from each of these four financing sources below (Table 2).

Individual contributions

The program would incorporate resource-based cost-sharing that considers flows of income and stocks of assets. It is not straightforward to create a single measure of resources that incorporates both income (a flow) and assets (a stock). Fortunately, the U.S. tax code has created a solution for us through the existing rules created by the IRS for minimum distributions from retirement accounts. These rules create a methodology for amortizing assets over the remaining life in a way that turns them into an available flow of resources. In particular, the IRS formula is the sum of annual income and assets transformed into a flow over remaining life.

We then define resources using the IRS formula, which is a function of income, assets, life expectancy, and an

"asset cutoff" below which assets are not counted.[8] Critically, both pension wealth and housing wealth are counted in the asset categories; we discuss the issues this raises for housing consumption below. For couples, we use the life expectancy of the younger spouse.

$$IRS\ Resource\ Formula_t = Income + \frac{Assets}{Life\ Expect.}$$

$$1 < t < Life\ Expect.$$

By adding that amortized flow from assets to income flows, we can measure the resources available for individuals to pay for LTSS. Note that this approach allows all individuals with LTSS needs, even those with high assets, to qualify for the LTSS program.

The program would then include a coinsurance payment from individuals based on their available resources. Such payment has two key features. The first is the amount of "protected income and assets": that is, the amount of income and assets individuals would be able to retain before paying any coinsurance. The second is the coinsurance rate that individuals face beyond these protected levels. We discuss the options for each of these below.

Resource-based coinsurance meets key principles of both equity and efficiency. It is equitable since every American, in principle, has access to this system, and the amount they are required to contribute is based on a fair measure of their available resources. Importantly, unlike existing asset tests, we do not insist that individuals spend down at once and liquidate all their available assets, instead allowing them to draw assets down slowly as needed. It is efficient because it ensures that individuals will weigh a trade-off between their LTSS needs and the share of costs that they bear when deciding whether to participate in the program. This improves budget feasibility for the government.

HCBS savings to the federal government

Inflation-adjusted estimates of 2022 Medicaid spending on HCBS amount to $138 billion.[9] A large share of those who would qualify for this new program are already receiving services under existing state programs, and that spending would be replaced. On average, as we discuss below, the federal government pays for more than two-thirds of these costs. This would offset spending on this new program.

Recaptured revenues from states

A key beneficiary of this proposal is state governments. Spending on LTSS accounts for 37% of state and federal Medicaid spending, and this would provide an enormous source of fiscal relief (Chidambaram and Burns 2023). The program would mandate that some of this fiscal relief be channeled back into improving the elements of LTSS still under state control, notably nursing homes. But some should be recaptured by the federal government to offset the costs of the program.

Dedicated financing

To keep this program from exploding the federal deficit, the government should consider new dedicated sources of federal revenues as well. One option is to dedicate revenues from an expanded estate tax to this program, although there will be many claimants for such a revenue stream. An alternative is a dedicated new source of federal revenues: an age-based income tax surcharge. In particular, all individual filers above age 55, or families filing jointly with at least one spouse above age 55, would face a surcharge on their income taxes. Like the additional Medicare tax for high earners implemented after the passage of the Affordable Care Act, this surcharge will provide dedicated financing to a new part of Medicare. This also has the feature of focusing the financing of this program on the very set of individuals who benefit most from it. Other options, such as sin taxes, should be evaluated as well. Additional revenue collected from these dedicated financing sources could be placed in a separate trust fund with annual actuarial reporting to ensure future revenues match future outlays.

HOUSING OR ASSET LIQUIDATION ISSUES

The requirement that cost-sharing be paid based on a combination of income and amortized assets implies that an efficient means of liquidating housing assets is needed. Estimates suggest that 79% of older adults

owned their own home in 2022 (Joint Center for Housing Studies of Harvard University 2023). Census estimates suggest that older adult households hold the majority of their wealth in the form of housing (U.S. Census Bureau n.d.). For these reasons, it would be important to put in place a mechanism for liquidating assets so that lower-income households with significant assets could meet their cost-sharing obligations under the program. Including housing among assets counted in the program would maintain equity between renters and owners and between those whose homes had appreciated substantially and those whose homes had not.

One mechanism for allowing people to liquidate their housing assets for the purpose of paying for LTSS is the reverse mortgage. To date, there has been low take-up of reverse mortgages in the U.S. Instead, older adult homeowners generally sell their homes when unexpected health events occur (Davidoff 2009). The weakness of the reverse mortgage market may reflect product complexity, the high costs for people with modest incomes, the allocation of risk bearing between government, lender, and borrower, and strong bequest preferences, among other factors (Davidoff et al. 2017; Baily et al. 2019). One set of approaches that addresses some of the barriers to liquidation through reverse mortgages is so-called deferred payment agreements, which are common in the United Kingdom (UK). The per-capita use of such mechanisms for "equity release" in the UK is roughly fivefold that of the U.S. use of reverse mortgages (NRMLA n.d.; Equity Release Council 2023).

Deferred payment agreements are contracts between a homeowner and the government that allow a consumer to delay payment for specified services (here, LTSS) with the payout attached to the value of housing equity held by the household. These agreements would cover the flow of cost-sharing payments that individuals owe under this new program. The asset value against which these expenditures would count is based on the net cash value of a home. That is, it would be a percentage of the assessed value of a home minus any outstanding debt on the property; in the UK, they use 90% as a hedge against the decline in the value of a home (Age UK 2026). However, one might decrease the percentage to a lower figure, like 85%, to further protect taxpayer liability (Davidoff 2019).[10] The risks to lenders would be somewhat reduced since the payouts would tend to be in relatively smaller increments over time than the common lump sum payout from reverse mortgages. Interest on the payment balance would be based on the long-run average risk-free rate. In addition, a small administrative fee would be charged. The homeowner would continue to be responsible for the carrying costs of the home (insurance, utilities, and maintenance). The homeowner or their heirs would be required to pay back the government by sale of the property or a cash payout prior to or following the death of the homeowner. These arrangements are likely to result in lower costs to the homeowner and reduced risks to the government or lender, promoting take-up of this equity release mechanism. In addition, this arrangement would reduce the likelihood of medical bankruptcy in older adults.

THE ROLE OF PRIVATE INSURANCE

The existence of this new entitlement would make private LTCI, as it is defined today, largely irrelevant. But there would still be a potential role for "wraparound" private insurance, as is the case with today's Medicare coverage of acute illness.

In particular, millions of Americans have supplemental "Medigap" insurance that covers the sizeable out-of-pocket costs associated with Medicare. Likewise, there may be demand for wraparound insurance to protect against the copayments imposed by this new entitlement, so that individuals can still use the program while preserving income and assets. This would improve the risk bearing by insurers and would appeal to the types of people that currently buy LTCI (typically well-to-do, healthy older adults). Indeed, the transformation of LTCI from a highly selected full insurance program to wraparound protection may increase overall coverage and expenditures on such insurance.

But such wraparound coverage comes with a cost—or what economists call a "negative fiscal externality"—to the new entitlement. As noted earlier, cost-sharing serves two functions—as a means of sharing costs and as a means of deterring excess care. If these

cost-sharing burdens are insured away, then it will increase the amount of home care demanded. Indeed, this has been well-documented in the Medigap program (Cabral 2019). This potential would be limited by the fixed budget for the benefit that is based on a clinical assessment of functional impairment.

As a result, if such wraparound insurance is allowed, the allowable benefit design would need to take account of the service demand behavior, and it must be priced to incorporate this "negative externality" (Cabral 2019). The exact tax rate will depend on the responsiveness of home care demand to the structure of the supplemental coverage and should be redetermined periodically based on evidence on home care responsiveness.

Improving Medicaid LTSS

Under our proposal, two elements of LTSS would remain with the states. The first is home care for those who are not Medicare eligible. The second is nursing home care. While we do not fundamentally change the structure or financing of these programs, there is an important role for this new program to ensure that (a) they are universal entitlements and (b) they are high quality.

A HOME CARE BENEFIT

For those who qualify and are covered only by Medicaid, a level playing field between home care and nursing home care requires an entitlement to home care benefits. As a result, states should be required to cover HCBS for all qualifying individuals, without waiting lists. The federal government should issue baseline standards for such an entitlement. These standards could naturally follow those used for the new universal Medicare home care benefit.

HIGHER QUALITY STANDARDS FOR MEDICAID LTSS

The existing system of enforcing minimum quality for Medicaid LTSS, both home care and nursing homes, is problematic. The National Academies of Medicine (NAM) report on nursing home quality highlights the long checklists of potential deficiencies in nursing homes that are demanded by a fragmented oversight system that gives little attention to the quality of life of residents (National Academies of Sciences, Engineering, and Medicine 2022). Under our proposal, states will be relieved of much of their LTSS spending; they would be required to use some of this fiscal relief to improve the standards of Medicaid-financed LTSS through several steps.

Better quality measurement

Both home care and nursing home care feature the same type of quality measurement problems described above. Our approach to quality measurement in nursing homes would follow NAM suggestions to refocus attention toward the quality of life of residents of nursing homes receiving LTSS (in contrast to post-acute care) and reduce the lengthy checklists of potential deficiencies (National Academies of Sciences, Engineering, and Medicine 2022). In the HCBS context, there exist few metrics for measuring quality and appropriateness of care. Those would have to be developed anew. Elements from existing measure sets for long-stay residents of nursing homes would be an appropriate starting point (AHRQ 2018). This may require modification of some more subjective elements of the survey and certification process that is set out in the Centers for Medicare and Medicaid Services (CMS) certification handbook (CMS 2023).

Better enforcement mechanisms

The existing mechanisms for enforcing quality in Medicaid LTSS are inconsistent, underfunded, and rely on incomplete information (National Academies of Sciences, Engineering, and Medicine 2022). CMS must redouble efforts to provide support to states in their survey processes through establishing consistent approaches to data collection and reporting, improved training of surveyors, and a greater focus on metrics focused on resident well-being.

In particular, states should be empowered to remove the qualifications of any providers who are systematically providing bad quality care. Recent research

shows that nursing home closures increase patient mortality in the near term but improve patient outcomes over time by allocating patients to better homes (Olenski 2023). The state should develop a plan for transitioning clients of any such removed LTSS provider to new providers. For nursing homes in particular, robust plans for moving patients to appropriate nearby facilities are key.

INVESTING IN THE KEY RESOURCE: PEOPLE

Long-term care is a labor-intensive business. A primary determinant of the patient experience is the quantity and quality of labor delivered by LTSS workers. Yet the sector is understaffed with underpaid workers. If elders are to live with dignity in the U.S., there must be major investments in the labor supplied to this sector.

Minimum staffing requirements for nursing homes

A key determinant of quality in nursing homes is appropriate staffing. CMS recently issued minimum staffing requirements (CMS 2024). While the particular standards chosen have been subject to well-grounded criticism, they can provide a starting point for further consideration of this issue (Cohen et al. 2024).

More funding for LTSS staff

The rates paid to nursing homes and home care agencies make it hard to hire enough staff to meet minimum standards (Bowblis and Brunt 2025). At the same time, given that this sector is almost exclusively private and typically for-profit, there are valid concerns that higher reimbursement will redound not to more labor inputs but rather to more profit. A recent study shows that such concerns can be effectively addressed by tying increases in nursing home reimbursement to increased worker spending (Gandhi et al. 2024). Such mechanisms should be used to ensure that higher funding is improving the quality of care.

Career ladders

It is unlikely that entry-level positions in the LTSS sector will pay sufficient wages to provide a fruitful long-term career trajectory. New programs should be developed that will allow those entering at the lowest levels to move up to higher-paid positions by financing both educational investments and time off from work, with the program costs paid in some arrangement by workers, employers, and the government. A recent pilot in Massachusetts suggests that such a program can provide a leg up for workers moving up the nursing home career ladder (Social Finance n.d.).

IV. Options and Costs

To evaluate the costs of our proposal, we have used a wide variety of resources, as well as developed our own microsimulation model of home care costs. In this section, we describe the costs of various options suggested by our policy plan.

HOME CARE NET COSTS

Cost of new benefit

The basis for costing our new home care entitlement program is a microsimulation model that is described in Appendix A. At a high level, this model uses data from the nationally representative Health and Retirement Survey (HRS) to measure the population eligible for home care based on underlying ADLs. These data include information on assets and income that can then be used to compute coinsurance payments and government costs. The results from this microsimulation model should be interpreted as a static estimate of the annual costs of implementing the proposed benefit.

There are a number of policy parameters that must be chosen to understand the government costs of this new entitlement. We fix some of them—such as the hours of home care and the underlying cost per hour. But we vary others to allow an understanding of how alternative policies will impact both households and the government.

There is also a key behavioral parameter that is central to our modeling: the extent to which individuals will take up this new entitlement. We are aware of no credible U.S.-based evidence on this parameter. We therefore make an assumption as to how enrollment will vary with copayment, assuming that higher copayments will be associated with lower rates of enrollment, and the existing locus of care (those already receiving care will be most likely to enroll). We describe this key assumption in more detail in Appendix A; however, we assume that on average, 46% of individuals eligible for the benefit will participate in the program and will use 88% of their allocated hours.

We begin with a base case: a resource definition that includes housing assets; a resource-based coinsurance schedule; an exemption of counted income up to 150% of the federal poverty line (FPL); and an exemption of assets up to $30,000. We apply the following coinsurance schedule: Individuals in the bottom quartile of total resources face 25% cost-sharing, individuals in the second quartile of total resources face 50% cost-sharing, individuals in the third quartile face 75% cost-sharing, and individuals in the top quartile face 90% cost-sharing. While our modeled policy includes discrete jumps in cost-sharing, any implemented policy should apply a continuous copayment function.

As an example, consider a two-person household with $100,000 in household income and $500,000 in wealth where one individual requires long-term care. To start, we will retain or "protect" income up to 150% of the FPL (about $30,000 for a two-person household), and $30,000 in assets. These retained resources cannot be used to pay the coinsurance and remain with the household. The remaining $70,000 in income and $470,000 in wealth, which will be amortized as described above, will then form the basis for the individual coinsurance payment towards their HCBS services. As determined by their income and asset levels, this household faces a 90% coinsurance rate, meaning they must pay for 90% of their HCBS costs. The actual dollar amount depends on the quantity of care that they require. Additional examples are described in Appendix A.

Table 2 shows the impacts of this policy design. In the first row, we show that 8.2 million individuals would be eligible to receive benefits under this new entitlement. Our modeling suggests that roughly half of those made eligible would enroll in the program, as demonstrated in row two. In the third row, we show overall expenditures on beneficiaries of the program of $111.1 billion per year. Of this, $19.9 billion will come from beneficiary copayments, leaving $91.2 billion to be covered via public dollars. This means, as shown in row six, under this policy design, the share of total home care costs borne by participants under this program is 17.9%.

Table 2: Microsimulation Results with Base Case Policy Specifications

1	Eligibles (Thousands)	8,198
2	Beneficiaries (Thousands)	3,726
3	Total Expenditures (Billions)	111.1
4	Beneficiary Contributions (Billions)	19.9
5	Total Gov. Cost (Billions)	91.2
6	Share of Total Costs Beneficiaries	17.9%
7	Federal Savings	30.4
8	State Clawback	19.8
9	Gov. Costs Covered By Direct Financing (Billions)	41.1

Source: Long-term Care Microsimulation Model.

Note: Base Case includes 150% of the federal poverty level income exemption, $30,000 asset exemption, inclusion of housing assets, and a resource-based copayment schedule of 25%, 50%, 75%, and 90% per resource quartile, respectively. All dollar amounts are annual values in 2024 dollars.

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Impact on net state and federal spending

Row five in Table 2 shows the overall government costs of this proposal in a vacuum. But as noted above, this new program will replace a large share of existing spending on HCBS by both the federal and state government, and this should be reflected in net spending.

This program relieves states of a significant financial burden by absorbing the full costs of any state-funded HCBS for those who are newly entitled to this program. We estimate these costs by leveraging data on HCBS expenditures for dual-eligibles whose HCBS services would transition fully to Medicare under the proposed policy. We describe how we compute the state and federal expenditures on long-term HCBS in the Appendix, but we estimate that total HCBS spending in 2024 was about $90.90 billion. The dual-eligible population, whose care would now entirely transition to Medicare, accounts for 59.5% of this spending. Thus, states and the federal government spend $54.08 billion on the population eligible for the proposed policy—in other words, the Medicaid program would save $54.08 billion under the proposed program.

However, this leaves out individuals who are receiving HCBS or need HCBS but are not covered by the proposed program. This is most often individuals eligible for HCBS because they receive SSI but are not receiving Social Security retirement or disability income. States would be required to continue covering these individuals under the Medicaid program, but would also be expected to expand coverage to all those unable to access HCBS despite meeting the financial and medical eligibility criteria. These individuals are often on waiting lists, although waiting lists are not necessarily a complete representation of unmet HCBS needs. As further described in the appendix, we estimate that states currently spend $36.82 billion on these 2.62 million individuals who would be ineligible for the proposed program. We also estimate that states, to improve coverage, would need to spend an additional $3.94 billion to “wrap around” our new program, amounting to $40.76 billion in total spending for 2.74 million individuals. With this wrap-around, all Medicaid-eligible disabled individuals would be able to access HCBS services.

Considering savings from the transition of dual-eligibles from Medicaid to Medicare, and then subtracting the costs of improved coverage and access to Med-

icaid HCBS for non-duals, total savings for Medicaid under this program amount to $50.14 billion. We then divide this amount into federal dollars and state dollars based on the Federal Medical Assistance Percentage unique to each state. We find that about $30.4 billion comes from the federal government, and therefore, would provide pure savings, while about $19.8 billion comes from state governments, which would need to be clawed back. Row nine of Table 2 shows government costs accounting for both savings, meaning $41.1 billion would need to be covered via dedicated financing.

Effects of alternative policy specifications

The first row of Table 3 repeats the results of the base case as presented in Table 2. However, there is substantial variation in costs and take-up of the program depending on the copayment rates, levels of income and asset protection, and types of countable assets. Importantly, the federal savings and state claw-back do not differ by program design.

For comparison purposes, we show in the second row of Table 3 our simulation of what happens with this group under existing Medicaid financial eligibility criteria, which typically make individuals eligible if their income is below 208% of the FPL and their assets are below $2,000.[11] Government costs here cannot be compared to existing Medicaid spending since (a) we do not cover those receiving HCBS who would not be eligible for our program (e.g., disabled youth) and (b) the existing program is not an entitlement. But the costs of this program can be compared to those in the first row; we find that costs are much lower under this alternative than our base case, amounting to only $48 billion per year.

The higher cost of our alternative relative to even an entitlement under current Medicaid rules reflects the cost of creating truly universal access to home care—even with coinsurance. Our proposed program covers 2.44 times as many individuals as does Medicaid. The difference reflects the fact that there are more than 6 million individuals who meet the disability conditions for home care, but who do not qualify because of current income and asset limitations.

The proposed program does ask many participants—including some who would qualify for free Medicaid

Table 3: Microsimulation Model Results with Different Policy Specifications

	Policy Design	Eligibles (Thousands)	Beneficiaries (Thousands)	Total Expenditures (Billions)	Beneficiary Contributions (Billions)	Total Gov. Cost (Billions)	Share of Total Costs Beneficiaries Incur	Gov. Cost Covered with Direct Financing (Billions)
1	Base Case	8,198	3,726	$111.1	$19.9	$91.2	17.9%	$41.1
2	Medicaid Equivalent	1,811	1,528	$47.9	$0.0	$47.9	0.0%	
3	208% of FPL Income & $2,000 Asset Retention	8,198	3,845	$114.6	$18.5	$96.2	16.1%	$46.0
4	Base Case with 208% of FPL Income Retention	8,198	3,956	$118.4	$17.0	$101.5	14.3%	$51.3
5	Base Case with 100% Asset Retention	8,198	4,327	$133.5	$16.2	$117.3	12.1%	$67.2
6	100% Asset & 88% of FPL Income Retention (Same Cost as Base)	8,198	3,766	$115.1	$23.8	$91.3	20.7%	$41.2
7	Base Case Excluding Housing	8,198	3,924	$118.8	$17.5	$101.3	14.7%	$51.2
8	30k Asset and 110% of FPL Retention (Excluding Housing)	8,198	3,669	$110.4	$21.3	$89.1	19.3%	$39.0
9	Base Case with More Generous Copayment Schedule	8,198	5,171	$146.8	$27.2	$119.5	18.6%	$69.4

Source: Long-term Care Microsimulation Model.

Note: Federal Poverty Line (FPL). The more generous copayment schedule imposes a 10%, 25%, 35%, and 50% copayment per respective resource quartile. All dollar amounts are annual values in 2024 dollars.

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home care today—to contribute to the program. An alternative to ensure that no one pays more than they do today would be to move the income exemption to the average of today's level (208%), but to also lower the asset exemption to today's level ($2,000). This would bring 100,000 more individuals into our program compared to the base case, as shown in the third row of Table 3. In the fourth row of the table, we combine the Medicaid income exemption (208% of FPL), with a higher asset exemption ($30,000). This brings 200,000 more individuals into the program and would increase government costs by $10 billion.

We also show the effects of exempting all assets, and of excluding housing as a countable asset. If excluding all assets but still using a 150% of the FPL income exemption, 600,000 more individuals participate in the program, and costs increase by $26 billion. To achieve government costs equal to the base case, but still excluding all assets, the income exemption would need to decrease to only 88% of the FPL. Modeling the base case, but excluding housing from the calculation of total assets, brings 200,000 more individuals into the program and costs $10 billion more. The income exemption would need to be lowered to 110% of the FPL to achieve similar government costs to the base case if housing were not to be counted.

Finally, we show the effects of providing a more generous copayment schedule where individuals in the bottom quartile of total resources face 10% cost-sharing, individuals in the second quartile of total resources face 25% cost-sharing, individuals in the third quartile face 35% cost-sharing, and individuals in the top quartile face 50% cost-sharing. This would bring 1.4 million more individuals into the program and cost about $28 billion more. These shifts in both participation and costs are a function of increased program take-up under a more generous copayment scheme.

Broader potential labor market effects

A key advantage of a universal home care program is that it will free up informal caregivers, primarily women, to provide more market labor. This additional market labor will yield annual tax revenues to the federal government between $0.8 and $1.55 billion.[12] This program will create a large expansion of the home care sector—along with many new jobs for home care workers, as well as higher wages for those now working in the sector. Assuming wages of $20 per hour, these additional wages could result in higher federal tax revenues up to $3.4 billion per year.[13]

The Congressional Budget Office typically assumes full employment, and in following their modeling standards, we do not offset the costs of the program with the increased tax base from both informal caregivers and home care workers. Thus, these results are presented separately to simply detail some of the larger labor impacts.

Potential national health expenditure effects

In addition to the previously described labor market effects, increased access to high-quality home care can limit adverse health outcomes and mitigate the need for costly interventions in the future—particularly by lowering rates of nursing home placement and hospitalization. Evidence from the U.S. context is inconclusive, exacerbated by inconsistent access to HCBS and poor data reporting (Duan-Porter et al. 2019). Some evidence finds that expanded access to HCBS and increased provision of higher-intensity forms of care, such as personal assistive services, can decrease hospitalizations and the use of nursing facilities (De Jonge et al. 2014; Guo et al. 2015; Van Cleve et al. 2023). Other evidence focusing on poorly targeted expansions of HCBS or less-intensive HCBS services like adult day care, case management, and caregiver support do not find similar effects (Duan-Porter et al. 2020; Wooldridge and Schore 2023).

Alternatively, evidence from Japan and South Korea, which both have universal HCBS programs similar to the proposed policy, indicates more promising effects, finding that HCBS access is associated with decreasing nursing facility placement, hospitalizations, and subsequently, health care expenditures (Choi et al. 2023; Choi et al. 2017; Tomita et al. 2010; Wang et al. 2021; Yoshiyuki et al. 2023). Because evidence specific to the U.S. context is inconclusive, we do not offset the costs of the program with potential future savings. However, such savings could be an important benefit from implementing a universal HCBS program.

V. Conclusions

The rapid aging of the U.S. population is expanding the population that is at risk for needing long-term services and supports for their functional impairments. The need for LTSS is heightened by the growing dependency ratio that is reducing the ability of families to provide informal care for their older family members. The costs of home care are out of reach for most middle-income households. Because home and community-based services in Medicaid are not entitlements, many needy people who qualify for Medicaid find themselves on waiting lists for home care. We propose a home care benefit that is grounded in principles of universal coverage, fairness, and affordability. The home care benefits would be part of Medicare, which means that all Medicare beneficiaries with qualifying impairments would be eligible for home care subsidies. We show that a benefit design and care management system can be established that is financially progressive and incurs reasonable costs that can be adjusted according to budgetary circumstances. The reasonable cost of this alternative suggests that universal home care is well within the reach of the U.S. budget and should be a key focus of future policy.

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Endnotes

1 Author's calculations from the Health and Retirement Study (HRS).

2 By home care, we refer to home-based services that support people with functional impairments as distinct from more clinically oriented home health care. These are referred to as home and community-based services (HCBS) in the Medicaid context.

3 Because Medicare provides limited coverage of what we think of as long-term care (e.g., assistance with ADLs or IADLs) in the statistics below, we exclude these short-term stays in nursing homes.

4 Authors' calculations from the HRS.

5 Authors' tabulations from HRS.

6 The trigger for continence typically requires the use of a colostomy bag, a catheter, or soiling of underwear on a daily basis. In general, individuals must require substantial assistance with their ADLs to receive benefits from their LTCI policy.

7 Medicare already administers carve-out benefits such as hospice care, meaning that a Medicare Advantage (MA) enrollee who elects hospice care remains in their MA plan, but their hospice services are paid for under fee-for-service Medicare.

8 Additional details provided in Appendix A.

9 Additional details provided in Appendix B.

10 Other approaches to reducing the risk to the lender in connection with reverse mortgages have involved requiring the purchase of an annuity (Davidoff, 2019).

11 Author's analysis of state HCBS Medicaid waivers. Described in Appendix A.

12 This calculation is detailed in Appendix C.

13 This calculation is detailed in Appendix D.

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