

RESEARCH REPORT

# Tax Credits for Caregivers' Out-of-Pocket Expenses and Respite Care Benefits: Design Considerations and Cost and Distributional Analyses

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# Introduction

As the population ages, families will face challenges caring for disabled family members and friends, and the state and federal governments will face budget pressures as they offer last-resort care through income-tested programs like Medicaid. Currently, family caregivers deliver a disproportionate share of assistance to older people with disabilities. For example, Wolff, Spillman, Freedman, and Kasper (2016) report that 14.7 million family and unpaid caregivers gave assistance to 7.7 million community-dwelling older adults in 2011. In comparison, about 4.8 million older Americans, about 45 percent of whom were ages 65 or older, received long-term supports and services (LTSS) from Medicaid in 2012 (Eiken, Sredl, Saucier, and Burwell 2015b).

In a recent report, the Bipartisan Policy Center's Long-Term Care Initiative (2016) identified two incremental and potentially cost-effective solutions which policymakers should explore for reducing caregiver burdens in coming decades, when baby boomer aging will increase overall demands for family and formal caregiving. These include expanding tax credits to help caregivers with out-of-pocket expenses and respite care for certain Medicare beneficiaries.<sup>1</sup>

This report presents cost and distributional projections for several versions of these two policies based on a dynamic microsimulation model, the Urban Institute's Dynamic Simulation of Income Model (DYNASIM). We firmly ground our projection estimates in empirical estimates based on historic data from the National Study of Caregiving (NSOC), a supplement to the National Health and Aging Trends Study (NHATS), which we also present. Due to modest sample sizes, differing sampling frameworks, and measurement challenges, we calibrate the NSOC estimates to other sources from the literature.

# Policy Objectives

Caregiver policies can strive to meet several important social and fiscal objectives. They may be aimed at:

1. keeping workers who also need to provide care in the labor force, so that they can continue to support their families, can leverage their firm-specific and position-specific experience, and can contribute to collective well-being through their income and payroll tax contributions;
2. keeping care recipients in their homes, where most would prefer to be (Barrett 2014), in order to avoid or at least slow down institutionalization, which imposes significant financial burdens on families and governments;
3. increasing the quality of care for people with disabilities and increasing self-direction of care by beneficiaries and their families; and
4. Protecting caregivers financially during their periods of caregiving, or at least limiting their financial losses, especially if they are economically vulnerable.

Tax credits for out-of-pocket care expenses fall mainly into the latter space of limiting caregivers' financial harm, but there may be important interactions between these objectives and domains.

Respite care benefits, in contrast, are more focused on keeping individuals with disabilities in their homes, keeping their caregivers healthy, and preventing their caregivers from declining physically or emotionally. Previous literature suggests that family help with basic personal care can slow the rate of institutionalization among community-dwelling older adults with disabilities (LoSasso and Johnson 2002). This could reduce government expenditures for those with disabilities, for example through Medicaid. Other literature has suggested that strain can negatively affect caregivers' own health and finances (Wolff, Spillman, Freedman, and Kasper 2016). Caregiver stress can lead to increased institutionalization of care recipients (Spillman and Long 2009, Spillman 2014).

Keeping these differing objectives in mind can be helpful when considering design and parameters of interventions aimed at supporting caregivers.

# First Policy Option Modeled: Tax Credits for Caregivers' Out-of-Pocket Expenses

## Relationship to Current Law Tax Policies

Under the current law personal income tax system, many caregivers have limited ability to deduct/receive credit for any out-of-pocket expenses related to the care they provide. Through the Child and Dependent Care Tax Credit (CDCTC), working people or those seeking work can receive offsets for child or dependent care costs, subject to limits.<sup>2</sup> The Joint Committee on Taxation (2017, table 1) estimates that in 2016 tax expenditures for the CDCTC amounted to approximately \$4.2 billion.<sup>3</sup> The Tax Policy Center (2017) estimates that about 12.7 percent of families with children benefited from the credit, and the average reduction in income tax was about \$551 that same year.

The CDCTC is nonrefundable. This limits its reach for those with lower personal income tax liability—and renders it irrelevant for those with no liability. The CDCTC is also limited to expenses one incurs on behalf of one's dependents who are claimed on one's tax form. Criteria for dependency include coresidence; financial dependence;<sup>4</sup> and, for care for a person age 13 or older when the care is provided, physical and mental inability to care for him or herself.<sup>5</sup> Thus, much family and unpaid caregiving does not fall under the scope of the CDCTC. For example, if one provides financial support out-of-pocket to a non-coresident parent or sibling who is not financially dependent for at least 50 percent of their costs of living in the tax year, one cannot currently deduct any out-of-pocket care expenses.

Under the current law personal income tax, care recipients can reduce their own income tax liability through the medical expense deduction if their qualifying expenses exceeded 10 percent of their adjusted gross income or 7.5 percent of their adjusted gross income if one spouse in the tax filing unit is age 65 or older. Expenses for LTSS, including long-term care insurance premiums, can be deducted only to the extent that, alone or in combination with other medical expenses, they exceed 10 or 7.5 percent of adjusted gross income.<sup>6</sup> This deduction is available only to those who itemize their deductions—and the decision to itemize is itself generally closely related to how one's potential deductions, including for health care expenses, relate to the standard deduction. The most common deductions include those for state and local income taxes.<sup>7</sup> About 30 percent of filers itemize their deductions under current law, with the proportion itemizing increasing rapidly with income (Lu 2017). Only about 1 to 12 percent of itemizers claim the medical expense deduction, again depending on income (Lowry 2014).<sup>8</sup> The Joint



Committee on Taxation (2017, table 1) estimates that in 2016 tax expenditures for the medical expense and long-term care deduction amounted to approximately \$10 billion.

This option to deduct care expenses through the medical expense deduction applies mainly to married caregivers who are filing jointly with their care recipient spouse who is disabled at a high level and who have incurred expenses like qualified long-term care services.<sup>9</sup> Long-term care insurance premiums are potentially deductible regardless of a tax filer's disability status if her plan qualifies according to Internal Revenue Service (IRS) rules.

Those with expenses that qualify for the CDCTC or the medical expense deduction can apply their out-of-pocket expenses to either of the two benefits, but cannot apply them to both.

## Features

Table 1 presents the features of the three versions of the caregiver tax credit that we model. Unlike the CDCTC, the new credit would be refundable.<sup>10</sup> Receipt would be restricted to those caring for people whose disabilities meet the standards enumerated in the Health Insurance Portability and Accountability Act (HIPAA) regulations for a qualifying long-term care insurance contract—two or more limitations performing activities of daily living (ADLs)<sup>11</sup> or need for substantial supervision to protect the individual from threats to health and safety because of severe cognitive impairment. Cohabitation is not required, and there are no income limits for the care recipient. There would be no restrictions on care recipients' ages, but this refundable credit is available only to people ages 25 and older. This restriction would be consistent with other aspects of federal tax law, which uses various age thresholds to promote compliance with certain goals, such as targeting adults who are financially independent. For example, age 25 is also the minimum eligibility age to qualify for the earned income tax credit for those without a qualifying child. Similarly, starting at age 25, the IRS no longer considers students automatically eligible to be a qualifying child for tax purposes; coresidence and financial dependency must be expressly established.

Table 1 describes the relationships that caregivers/tax payers must have with care recipients for their expenses to be allowed under the credit; these relationships include siblings, parents, stepparents, parents-in-law, aunts and uncles, and coresidents who are members of the taxpayer's household. An important issue is whether spouses are intended to be included in this group and how the credit would treat of out-of-pocket expenses for a spouse's care. As indicated above, spouses who file their taxes jointly can under current law deduct certain LTSS expenses if they itemize and their expenses exceed a

certain share of their income (10 percent, or 7.5 percent if at least one spouse is age 65 or older). This proposed refundable credit would be more valuable than the medical expense deduction, as it applies at the first dollar of expenses. Under Medicaid rules for personal care, spouses are generally considered “legally responsible” for one another and in some state programs are thus ineligible to be compensated for providing personal care for their spouse (see, for example, section 4480 of the state Medicaid manual).<sup>12</sup> States currently have discretion to compensate a range of family caregivers, including spouses, and some states do.<sup>13</sup> We currently assume that spouses are not eligible to deduct caregiving expenses for their spouses.

The proposed credit would potentially be available to most people with qualifying relationships who provide care, automatically excluding only those with adjusted gross income above \$200,000 if married or \$133,333 if single.<sup>14</sup> Partial credits are available for those with incomes between \$120,000 and \$200,000 if married and \$80,000 to \$133,333 if unmarried. (We describe the distribution of caregivers’ relative incomes below.)

## Alternatives

The three versions of the proposal we model vary solely based on maximum size of the credit. The baseline version of the credit would allow individuals to receive up to \$3,000 if they spent \$10,000 or more out-of-pocket on “goods, services, or supports” that assisted a qualified care recipient with accomplishing ADLs or IADLs and were provided solely for the use of the care recipient.<sup>15</sup> The less generous version would allow a credit of up to \$1,500 for those with expenses of \$5,000 or higher, and the more generous version would allow a credit of up to \$5,000 for those with expenses of \$16,666 or higher.

# Second Policy Option Modeled: Respite Care Benefit for Medicare Beneficiaries

## Features

Table 2 presents the features of the proposed respite care benefit that we model. The respite care benefit would be available only to those who receive chronic care management (CCM) services from Medicare (for details, see American College of Physicians 2015; Centers for Medicare and Medicaid Services 2017a; and Department of Health and Human Services, Center for Medicare and Medicaid Services 2016).<sup>16</sup> Because the CCM program is a relatively new component of Medicare, taking effect in just January of 2015, it is difficult to know how widely physicians and patients will be using it a few years from now, the earliest point at which the respite care program would presumably commence. Early indications suggest that physicians have been slow to participate in CCM (Robeznieks 2015; Sullivan 2015). The most recent published statistics, from the *Federal Register* in late 2016, indicate that although participation is growing, to date only about 513,000 unique Medicare beneficiaries have received CCM services under code 99490.<sup>17</sup> Beneficiaries received services an average of four times, with payments totaling \$93 million. Given that there are roughly 57 million Medicare beneficiaries today, about two-thirds of whom are estimated to have at least 2 chronic conditions (Lochner and Cox 2013), this would suggest an initial CCM take-up rate of between 1 and 2 percent of eligible Medicare beneficiaries.

Changes effective January 1 of 2017 have attempted to address a range of provider concerns that may have contributed to the relatively low take-up. These program changes could have important implications for participation in coming years and thus for our cost estimates and analogous estimates for costs to Medicare and benefits to providers.<sup>18</sup>

## Alternatives

As table 2 indicates, we model the respite care benefit with and without spouse eligibility. We also consider three separate benefit levels, with different limits in the number of days for which respite care is available. These range from 4 days per year for the least generous alternative to 14 days per year for the most generous alternative. By way of context, the Veterans Administration (VA) has a respite care program for family caregivers of qualified veterans that covers a maximum of 30 days of respite

services over the course of one year.<sup>19</sup> Medicare provides up to five days of respite care at a time, but only to those who are terminally ill—expected to live less than six months—and receiving hospice services (Centers for Medicare and Medicaid Services 2017b).

## Design Considerations Common to Both Proposals

Both of these caregiver support proposals could pose a wide range of implementation challenges designers should consider. Here we outline a few of them.

### Measurement of Care Recipients' Disability

One great challenge for the program could be certification of disability levels for care recipients. Functional limitations can be difficult to measure, somewhat subjective, and can change relatively rapidly over a period of time (Wolf and Gill 2009). Cohen, Gordon, and Miller (2011), for example, report that in practice private long-term care insurance companies implement benefit triggers in a wide variety of ways. The Medicaid and CHIP Payment and Access Commission catalogues (2016; 2017) the types of tools that states have used to assess functional status for Medicaid.

### Administrative Expenses

Under either of the new programs, administrative expenses associated with verifying disability status of the care recipient could be significant. The greater the administrative resources, the greater the capability to adhere closely to the program criteria. If administrative expenses are more limited, then disability levels among those deemed eligible could vary more. The tradeoffs to ensuring closer adherence to program disability standards likely vary based on the size of the benefit. For example, if a respite benefit lasted for a maximum of four days per year, program administrators might determine that the additional compliance costs for certifying and recertifying disability between benefit periods could outweigh the cost savings one might achieve, whereas for a benefit that lasted for up to 14 days per year, their cost-benefit calculation could be different. Analogously, the more generous tax credit would likely also generate greater pressure to monitor whether the expenses claimed are proper than would the less generous credit.

The Social Security Administration provides screening and payment services for two disability programs: Social Security Disability Insurance and Supplemental Security Income. Administrative expenses for these programs are estimated to be about 2 and 7 percent of total expenditures, respectively.<sup>20</sup> Not surprisingly, expenses are higher for the means-tested Supplemental Security Income program than for Disability Insurance, which does not have a means test.

## ADL “Creep”/ “Inflation”

Previous research has suggested that individuals—including both potential beneficiaries and the providers of their medical care—may overstate disability levels if they have a financial incentive or other incentives with no financial disincentive.<sup>21</sup> This is sometimes referred to as disability “creep” or “inflation.” Cost estimates are likely to be biased downward if they fail to integrate this phenomenon, and previous modeling projects in the literature have been careful to account for this possibility. Murtaugh, Spillman, and Warshawsky (2001) provided estimates of a life care annuity in which they made three alternative assumptions about how ADL creep might vary by timing and level. In their analyses, one set of assumptions assumes qualification at *lower* disability levels, a second assumes *earlier reporting*, and a third focuses on certification of disability upon entrance to a nursing home.

## Other Forms of Behavioral Response

In addition to ADL creep/inflation, potential beneficiaries of the new programs may make additional changes to their behavior because of the new policies. These might include increasing their formal caregiving expenditures (for example, by switching from informal care to formal care) and shifting from expenditure types that are not allowable under the credit to types that are allowable, among other behaviors.

## Progressivity

With any program, tensions arise between treating everyone equally and directing more resources to those with the greatest economic or physical/emotional needs. A perennial question for program design is whether ability to pay—for out-of-pocket care expenses or respite care—should be a factor.

Under the tax credit as now designed, ability to pay out-of-pocket to help meet the care recipient's need is currently a factor only insofar as those married couples with more than \$200,000 in income are ineligible, and those with \$120,000 to \$200,000 receive a reduced credit. (For single people, the corresponding income thresholds are \$80,000 to 133,333 for partial credit.)

Under the respite care benefit as now designed, not having copayments would reduce financial barriers to participation for those with lower incomes who qualify. Should the program include copayments, income-relating these copayments could similarly be important for progressivity.

An additional distributional aspect that shapes progressivity is the presence and persistence in differentials in disability status by education and lifetime earnings/income. Because people with lower incomes and less education are more likely to become disabled (National Research Council 2004; Schoeni, Freedman, and Martin 2009; Schoeni, Martin, Andreski, and Freedman 2005), they often receive higher shares of benefits from disability-related programs. Higher-income individuals' greater longevity (Waldron 2013), and thus greater exposure time to the program, can partially offset this inherent progressivity, depending on program design.

## Design and Modeling Considerations Specific to Caregiver Tax Credits

Some implementation issues that are specific to the caregiver tax credit are listed below.

### Defining Qualifying Expenses

As table 1 indicates, the current proposal would count as qualifying expenses any expenditures for “goods, services, or supports” that “assist a qualified care recipient with accomplishing ADLs and IADLs” and “are provided solely for the use of the care recipient.” Our preliminary choices about allowable expenses correspond as closely as possible to this wording and are informed by the language and intentions conveyed in existing tax law, for example regarding expenses that can be deducted as medical expenses.

Appendix table 1 describes IRS regulations for the medical expense deduction for a selection of the types of expenses that would likely be applicable and analogous to the caregiver tax credit. One can draw a few broad conclusions from a review of the IRS guidance. Generally speaking, day-to-day

expenses—including, for example, rent/mortgage, food, clothing, home maintenance, legal fees—are not allowable expenses, nor is one allowed to profit from any deducted expenses. For example, deductions for home modifications that facilitate accomplishing ADLs are specifically allowable, but only to the extent that they are necessary because of a person’s disability. (Improvements to increase property value or improve a home’s aesthetics are not allowable on their own.) Any payments for hands-on help with performing ADLs, for example from home care aides, are clearly allowable, as are assistive devices. For residential care facilities, fees related to the provision of medical and ADL care are allowable, but those related to other facility services are not. Transportation specifically for helping a person with a disability get to medical appointment is allowable, so travel to the care recipient’s home to provide ADL assistance might be an appropriate extension for a family caregiver, and travel expenses, including for example hotel stays, could be included if modest (“not extravagant” and capped at a given amount per night). Meals can be counted if delivered in-hospital as part of treatment, but generally routine meals at home cannot be counted. Prescription drugs or insulin are allowable, but over-the-counter medications are not.

One issue worth special consideration is the treatment of out-of-pocket medical expenses themselves, like insurance premiums (e.g., Part B or Part D premiums) and point-of-service cost shares (copayments and deductibles), and specifically whether a caregiver can deduct medical expenses made on behalf of a care recipient. These expenses may fall into an ambiguous area. Although they benefit the care recipient alone, and the monitoring and promoting of the care recipient’s health can help him or her to maintain function, they do not necessarily directly involve “assistance with accomplishing ADLs.” Some such expenses are now deductible by the care recipients who file personal income taxes only to the extent to which they would exceed 10 percent of their adjusted gross income or 7.5 percent of their adjusted gross income if one spouse is age 65 or older. Consequently, if such expenses were fully allowable under the new credit, care recipients and their family caregivers could face an arbitrage opportunity given the first-dollar applicability under the credit: that is, the expenses would generally not be creditable if the care recipient paid them, but they would be creditable if the caregiver paid them.

The decision whether to include these expenses is potentially quite important, as 20 percent of caregivers in the AARP retrospective survey (Rainville, Skufca, and Mehegan 2016) report paying for a care recipient’s health insurance premiums, as do 9.3 percent of the NSOC respondents. Likewise, 20.6 percent of the NSOC respondents report paying for a care recipient’s medications. The current estimates assume that most of these expenses are included, but we can revisit this assumption.

## Nonfilers

Many people who are likely to qualify for the caregiver tax credit are not required to file personal income tax returns under current law (henceforth “nonfilers”). In 2016, for example, single people aged 65 or older did not need to file income tax returns if their gross taxable income was less than \$11,900.<sup>22</sup> Recent estimates by the Tax Policy Center (2015) suggest that 27.5 million potential tax units were nonfilers under current law in 2016. In earlier work, Orszag and Hall (2003) reported that nonfilers are disproportionately single and childless; other work notes geographic differences in filing status.<sup>23</sup>

## Take-Up

As we model the caregiver tax credit proposal, we must consider take-up rates for the credit. An extensive literature documents incomplete take-up in benefit program take-up, and emphasizes the importance of transaction costs and perceived “stigma” (Currie 2006 provides one review<sup>24</sup>). Take-up assumptions are especially important for non-filers who provide unpaid care and have out-of-pocket expenses. These take-up rates are likely to be a function of the extent to which the government and nonprofit organizations, including aged advocacy organizations, caregiver support organizations, and tax preparation services, conduct outreach campaigns, especially to nonfilers, given research suggesting that nudges can increase filing.<sup>25</sup>

Even those eligible individuals who are required to file personal income tax returns under current law may not take-up their benefits if they are unaware of the credit and are not financially sophisticated or do not use high-quality commercial software when filing their tax returns. They could, for example, miss the relevant line on the tax form or choose to file a simpler form (1040-EZ or 1040A, rather than 1040, for example, if those taking the credit need to file form 1040). We assume a plausible range of take-up behaviors, described below in our methods.

## Compliance

Given the potential richness and refundability of the caregiver tax credit, compliance could be an issue. Without third-party reporting of the caregiver expenses, tax filers may tend to overstate out-of-pocket costs or misunderstand whether what they paid for could be legally counted toward the credit. Outright fraud (for example, people claiming a benefit without incurring any out-of-pocket expenses) could become an issue. Fraud could potentially be stemmed through monitoring, for example, requiring credit



claimants to provide the Social Security number of the care recipient and then checking death records of these reported care recipients, through third-party reporting of expenses above a certain threshold, through increased taxpayer audits, or even through design of the portion of the form where expenses are reported.

## **Up-Front Nature of the Out-of-Pocket Expenditures**

The difference between the time in which one incurs out-of-pocket caregiver expenses—potentially every day or week in the year—and the disbursement of the tax credit—typically between February and May of the next calendar for those filing taxes in January through April—could be important for some caregivers. The lower one’s income, the less feasible it may be to cover an expense in January of one year if one cannot be reimbursed, and then only partially, until April of the next year.

This disconnect between the time expenses are incurred and when they are credited may be relevant for potential beneficiary choices about paying for care and thus for our modeling. Those family and unpaid caregivers with less disposable income may not be able to front the expenses. We do not currently need to assume different participation levels in the tax credit or differential spending conditional on participation, beyond that observed in the historic data, for such caregivers.

If policymakers made it possible to claim an advance credit, this timing disconnect could be less important, but at the expense of additional administrative complexity. The US Government Accountability Office (2007) discusses many of the challenges with participation and compliance that have been associated with the Advance Earned Income Tax Credit.

# **Design and Modeling Considerations Specific to Respite Care**

## **Integration with CCM**

The respite care proposal is designed to integrate with Medicare’s chronic care management program. As this program is relatively new, historical data against which we could calibrate participation are extremely limited. More importantly, participation in the first few years of the program may not be representative of ultimate participation rates when the program is more fully phased in, and physicians

and patients have greater awareness of its benefits and challenges, which are still evolving due to rule changes that just went into effect on January 1 of 2017 year (see descriptions in Burton, Berenson, and Zuckerman 2017 and Pershing Yoakley and Associates 2017). Consequently, we impute a wide range for take-up in CCM among potential beneficiaries who meet the other program criteria.

## Take-Up

Take-up of the respite care benefit conditional on CCM enrollment is also likely to be important to its cost and distributional effects. The process is likely to differ in important ways from the participation in the tax credit due to potentially different sets of impediments to full participation in the program. For example, personal preferences for privacy and for providing the care oneself vary. Other factors include distance between caregivers and care recipients, the number of caregivers in the care network, and the availability of formal providers with whom caregivers and care recipients would be comfortable, itself a function of the proximity and density of formal providers. Although now quite dated, a study by Montgomery (1988) that examined a respite care program in King County, Washington from 1983 through 1987 that used an experimental design suggests that even when a program is fully subsidized, only about two-thirds of eligible families may take-up benefits.

## Feedbacks

Another issue is whether respite care could slow the progression of some care recipients from community residence into institutions. We ignore the potential for such feedbacks in these analyses given a lack of strong evidence about the direction and magnitude of the effects for the Medicare population in the literature (Mason et al. 2007; Vandepitte et al. 2016). Recent studies focusing on older Medicare beneficiaries (Spillman 2016) and Medicaid beneficiaries (Guo et al. 2015) found that paid home care more broadly was significantly associated with reduced nursing facility use, but the reduction fell far short of offsetting the home care cost. We also ignore any macrodynamic effects of caregivers potentially staying in the labor force longer.

## Payment Rates

As the specifications indicate, payment rates for respite care would be assigned by the Secretary of the Department of Health and Human Services, and these could vary by provider (skilled nursing facility,

inpatient hospital, advance practice nurse, or home health agency). For purposes of these estimates, we assume a rate of \$20 per hour of respite care in 2016, consistent with national median reported by Genworth (2016) for home health and homemaker assistance, and subsequently wage index this value. This is consistent with the notion that the program would generally focus on providing services to individuals in the community, and specifically in their own homes, with the intention of helping people to stay in their homes as long as possible. Estimates would differ should the program focus change.

## Cost Sharing

The proposal could also integrate cost sharing by beneficiaries served under the program, and this revenue stream could materially affect the net costs to the government depending on the size of the copayment. Under most likely scenarios, low-income subsidies would apply, so the cost offset from copayments would depend on the income distribution of the care recipients under the proposal. Policymakers could use several models for designing the program cost sharing. Here we describe three alternatives.

1. **Like home health under Medicare Part A:** Under Medicare Part A, there is no copayment for home health services. If the cost sharing were to be treated like Medicare Part A, then no copayment would apply. This is our default assumption in these analyses.
2. **Like CCM services:** If Medicare were to implement this copayment similarly to that of other CCM services, some beneficiaries would need to make payments while others would not. Specifically, those enrolled in Medicare Supplement Insurance (Medigap) plans would not need to bear the copayments. This might have implications for program take-up, given that copayments may deter some beneficiaries from participating. It may also have second-order effects on the level of Medigap premiums, which could affect supplemental insurance choice among Medicare beneficiaries.
3. **Like VA Respite:** Under the VA program, copayments for respite care are related to beneficiary resources and depend on whether one's disability is service-connected, with a maximum copayment of \$15 per day of respite care. Colello and Panangala (2017) provide an overview. Copayments commence only on the 22nd day on which services are received.<sup>26</sup> VA respite services include paid home health aide assistance at home, attendance at an adult day health center, or a brief stay in a VA nursing home or medical center. The VA respite care benefit is limited to 30 days in a calendar year and may include a combination of these services.

# Historical Data Sources

## National Health and Aging Trends Study and National Study of Caregiving

Our historical estimates rely primarily on data from the 2011 base year of the NHATS and the companion NSOC. The NHATS conducts an annual longitudinal survey of a nationally representative sample of Medicare beneficiaries age 65 or older designed to enable studies of both trends and trajectories of health and functioning. The sample includes persons in all settings. Facility interviews are conducted for persons living in nursing homes, and in-person interviews are conducted with remaining sample members living in all community settings, including both traditional housing and supportive settings, such as assisted living. Facility interviews also are conducted for the latter group. NHATS replenished the sample in 2015 to restore cross-sectional representation.

The NSOC, conducted first with the 2011 survey, interviews roughly 2,000 caregivers identified by NHATS respondents who receive assistance from an unpaid caregiver for self-care (bathing, eating, dressing, toileting), mobility (transferring or getting around indoors), or household activities (laundry, meals, shopping, paying bills/banking, and taking medications). The NSOC solicits detailed information from each caregiver interviewed on assistance provided; the caregiver's family and living situation; and work, income, and other economic information, including spending for disability-related items or services and financial assistance for the NHATS respondent. The NSOC is unique in that it interviews up to five caregivers per respondent, so that estimates represent the full range of caregivers assisting older persons, rather than a single "primary" caregiver. The NSOC was repeated in 2015 when the NHATS sample was replenished.

When surveying caregivers about their out-of-pocket expenses, the NSOC distinguishes between medications; health insurance (Medicare or other insurance premiums, copayments or coinsurance); mobility devices; assistive devices, other than mobility equipment, that make it easier or safer for the recipient to do activities or do them independently, including devices to help seeing, hearing, holding things, or picking things up; features to make the recipient's home safer such as a railing or a ramp, grab bars in the bathroom, a seat for the shower or tub, or an emergency call system; and in-home help.

For estimates related to the proposed respite benefit under the Medicare CCM benefit, we rely on the sample of 7,609 NHATS respondents, who live in settings other than nursing homes for the in-person interview. Estimates related to the caregiver tax credit rely on data from the NSOC linked with relevant characteristics of the care recipient from the main NHATS survey. For both the respite benefit

and the caregiver tax credit, we have constructed a measure simulating whether the older individual meets the HIPAA benefit criteria for tax-qualified, long-term care contracts. Specifically, the HIPAA “triggers” require assistance with two or more self-care activities or transferring (HIPAA does not include mobility assistance) or substantial assistance or supervision because of cognitive impairment. Our measure includes assistance with eating, bathing, dressing, toileting, and transferring for at least 90 days or having probable dementia. For dementia, we use a measure constructed from reported diagnosis, responses to a dementia screening interview administered to proxy respondents, and cognitive testing of the NHATS respondent. Details of construction and validation are in a technical paper available at NHATS.org (Kasper, Freedman, and Spillman 2013).

For all estimates, we use analysis weights provided with the NHATS and NSOC that adjust for differential probability of selection and nonresponse at both the NHATS respondent and NSOC respondent levels. Information on content and weighting is available at [www.NHATS.org](http://www.NHATS.org) (Kasper and Freedman 2016; Kasper, Freedman, and Spillman 2016).

Appendix table 2 provides some descriptive statistics on the caregivers in the sample. We compare a small selection of results to those from Rainville, Skufca, and Mehegan (2016), labeled “AARP” for convenience.

## Other Literature on Caregivers

We supplement the microdata from NHATS/NSOC with summary data from Rainville, Skufca, and Mehegan (2016), which we have adjusted to account for expenses that would not be allowable under the caregiver tax credit.<sup>27</sup> This survey considers:

1. direct care expenses (for example home health aides);
2. medical, dental, vision expenses for the care recipient, including major equipment;
3. household expenses and housing (mortgage, property, utilities, phone, computer, lawn care [likely excluded], and repairs and modifications, which are potentially countable if they are specifically related to disability needs);
4. personal care items (including items such as clothing, shampoo, and pet care--which would almost surely not be countable--and incontinence supplies, which could more arguably be countable because they are directly ADL related); and
5. educational, legal, and travel expenses related to the care provision, including relocation and retrofitting vehicles.

Appendix table 3 juxtaposes the Rainville, Skufca, and Mehegan (2016) survey with NHATS/NSOC detail and information about the IRS guidance on medical expenses. This table presents the adjustments we made to a subset of the Rainville, Skufca, and Mehegan (2016) estimates to try to capture these distinctions in what might be allowable. (These are also described in note 4 in table 4A.)

We also use some statistics from Caring.com (2015) because they can give us some insight into the variance of caregivers' out-of-pocket expenditures, which we cannot ascertain adequately with our current resources.

## Medicare Current Beneficiary Survey

To supplement our estimates from the NHATS/NSOC and Rainville, Skufca, and Mehegan (2016), we use the 2011, 2012, and 2013 Cost and Use files from the Medicare Current Beneficiary Survey (MCBS) to better understand the characteristics of Medicare beneficiaries under age 65.

The MCBS is a continuous, in-person survey of a representative national sample of the Medicare population. It is sponsored by the Office of Enterprise Data and Analytics of the Centers for Medicare and Medicaid Services in partnership with the Center for Medicare and Medicaid Innovation. Linked to Medicare claims data, the survey was designed to aid the Centers for Medicare and Medicaid Services in administering, monitoring, and evaluating the Medicare programs. It has been carried out for more than 20 years, encompassing more than 1 million interviews.

Importantly for this project, the MCBS includes an extensive set of questions aimed at understanding the chronic conditions and functional limitations of Medicare beneficiaries. Because many of those with the severest disabilities (for example, severe cognitive impairment) may be unable or unwilling to answer these sorts of questions, the survey collects information from proxies (in the community) and providers (in facilities).

Because we pool three years of the MCBS survey, we adjust the survey's annual calendar year weights.

# Historical Estimates of Distributions of Caregiver Incomes and Expenses Used for Modeling Tax Credits

Table 3A displays the income distribution in 2011 for caregivers from the NSOC by the caregiver's own marital status and the HIPAA disability status of the care recipient.

Relevant to the first policy, the caregiver tax credit, we see that only about 10 percent of the married caregivers of care recipients ages 65 and older who are receiving Medicare and whose disabilities meet the HIPAA threshold would fall into the credit phase-out range. Most therefore would be eligible to receive the full credit for their out-of-pocket, care-related expenses. Among unmarried people caring for people with HIPAA-qualifying disabilities, more than 95 percent would be eligible for the full benefit if their expenses were that high.

Table 3B repeats this information on the income distribution, but focuses instead on the caregiver's relationship to the care recipient, using four relationships: spouse, unmarried relative, married relative, and nonrelative. We assume that three categories other than spouse (unmarried other relative, married other relative, and unrelated) are most applicable when estimating the prospective beneficiary pool for the credit. Once more, it appears that relatively few caregivers have income that exceeds or would fall within the benefit's phase-out range.

Tables 4A and 4B describe the prevalence of out-of-pocket care expenditures (4A) and financial helps and gifts (4B) reported by NSOC respondents, and examine cases in which the care recipient meets the HIPAA disability standards separately from those in which the care recipient does not. Among those meeting the HIPAA standard, we separately examine those who meet the criteria by ADL limitations alone, because of severe cognitive impairment alone, or due to the combination of these impairments. The survey only asked the ranges of possible out-of-pocket expenses, so we cannot compute means or percentiles; we can only report the share of respondents who fall into the possible ranges. For comparison, we display a small selection of results from Rainville, Skufca, and Mehegan (2016), labeled "AARP" for convenience, in table 4A.

Not surprisingly, those caring for people with disabilities who meet the HIPAA threshold are more likely to report out-of-pocket spending than those caring for people at lower disability levels: 45 percent compared to 33 percent (see columns labeled "percent of group"). They are also more likely to be in the highest expenditure group (those reporting more than \$2,000 in out-of-pocket expenses): 6.1 percent compared to 1.6 percent. Given the IRS wording and the language about the policy specification

in table 1, we interpret virtually all the expenses measured in NHATS/NSOC as likely to qualify under the credit, though there is a case for considering items 1 and 2 specially, as we describe further below.

The percent with positive out-of-pocket expenses is markedly lower in the NSOC sample than in the survey by AARP (Rainville, Skufca, Mehegan 2016). Because the AARP survey counts more types of expenses and has a different sample (i.e., it includes expenses of spouse caregivers, as discussed above), results are not directly comparable. To try to enhance comparability, we adjust the mean AARP expense partially accounting for expenses that are likely not excludable under the tax credit, as described above and documented further in appendix table 3.<sup>2728</sup>

The estimates from Rainville, Skufca, Mehegan (2016) differ from the estimates from the NSOC, both in level and composition of expenses. Level differences persist even after we consider the extra expenses the AARP study includes that the NSOC does not include and that the credit would be unlikely to cover (e.g., household expenses like utilities). One potential reason for this is that the study by Rainville, Skufca, Mehegan (2016) includes spouse caregivers, who comprise about 14 percent of the total, and whose expenses tend to be higher than those of non-spouse caregivers (see figure 6A, for example).

## Historical Estimates of Chronic Conditions, Care, and Their Joint Distribution Used for Modeling Respite Care Benefits

Table 5 indicates that almost 70 percent of the community-dwelling Medicare population age 65 and older is potentially eligible for CCM. The table's measure of chronic conditions is based on the number of *diagnosed* chronic conditions reported by NHATS respondents. The conditions included in this estimate are heart attack, heart disease, hypertension, arthritis, osteoporosis, diabetes, lung disease, stroke, dementia, and cancer.<sup>29</sup> Additional persons may qualify for CCM based on conditions not included in our count. Our estimate is quite similar to the 68.4 percent prevalence of chronic conditions among Medicare beneficiaries estimated by Lochner and Cox (2013) in earlier work that used claims data and information about 15 chronic conditions.

Table 6A then tries to isolate the share of the Medicare population ages 65 and older with caregivers that could be eligible for the respite care benefit by cross-walking the reported chronic conditions with HIPAA-level disability and prevalence of in-home potential caregivers. The lower right-



hand quadrant of the table presents our best estimates of those ages 65 and older most likely to take up the respite care benefit in 2011. Per these estimates, about 2.57 million people would qualify that year if spouses were included and 1.51 million if spouses were not included. We could also imagine that most individuals in the column for fewer than two chronic conditions but who meet the HIPAA criteria are likely very to qualify for CCM. Our existing measure fails to capture all possible chronic conditions. Reporting error is potentially considerable; at the same time, verification of chronic conditions is also subject to error. These errors are a greater issue for estimation if they differ in their directions and magnitudes.

Table 6B presents similar information, but for the Medicare population younger than 65. A similar pattern emerges: about 9 percent of the Medicare beneficiaries under age 65—roughly 780,000 people in 2011 to 2013—are likely to qualify for respite care benefits because of their chronic conditions and disability status before accounting for family and caregiver relationships.

To help us understand the extent to which beneficiary cost shares might offset the costs of the CCM-based respite care benefit, table 7 describes the income distribution of those likely to qualify for the respite care benefit: those meeting both the CCM criteria and the HIPAA criteria. The table shows that those most likely to qualify for the respite benefit tend to have relatively low incomes and relatively high Medicaid qualification rates. Overall, roughly half have incomes below 135 percent of poverty and about 31 percent receive Medicaid. When we restrict to the sample with *any* current potential in-home caregivers, we see that the shares are similar. When we look only at those with nonspouse potential in-house care, closer to three-fifths are below 135 percent of poverty, and 38 percent receive benefits from Medicaid.

# Simulation Data Sources and Methods

## Tools

To project costs and distributional effects of these two proposed programs, we use the Urban Institute’s DYNASIM anchored to the historical sources just described. DYNASIM is a model of the US population based on the Survey of Income and Program Participation. More information about DYNASIM is available in Favreault, Smith, Johnson (2015).<sup>30</sup> Information about our caregiver equations is available in Favreault, Butrica, and Mudrazija (2017). Favreault, Gleckman, and Johnson (2015) documents the projections of needs for and use of long-term services and supports. As these projections were completed in mid-2017, they do **not** include the effects of the Tax Cuts and Job Act of 2017, which was signed into Law on December 22, 2017.

## Unit of Analysis

For the caregiver tax credit, the unit of analysis is the caregiver with out-of-pocket expenses. For the respite care benefit, the unit of analysis is the care recipient whose chronic conditions and disabilities meet the program standards.

## Assumptions:

Table 8 presents a summary of the alternative assumptions we use in determining the bounds for the program costs. The rows in the table reflect the many modeling issues that we have just described and that the literature has identified as important when considering costs and distributional effects of proposals like these. They include the following: administrative costs, take-up for the CCM program, ADL/disability creep, intensity of program use, and program take-up, including how this varies by relevant characteristic (income tax filing status; expected financial benefit as a share of income; and care recipient characteristics, like severity of disability). Our analyses address the possibility of ADL creep by presenting a range of estimates. In the low-cost assumptions, we assume that disability would be measured consistently with our best guess of prevalence. In the intermediate assumptions, we assume a small amount of ADL “inflation,” and under the high-cost assumptions, we assume more disability inflation.

An additional issue is the intensity of the care required during the respite care period. Those caregivers with lower incomes tend to provide more hours of support than those with higher incomes (Evercare 2007). Thus, we might potentially wish to assume differential intensity in respite participation and receipt based on income of caregivers.

An important possibility is that assumptions should vary depending on the parameters in the simulation (less generous, intermediate, or more generous benefit), not just whether we are estimating lower-bound, intermediate, or higher-bound costs. The literature suggests that transaction costs and benefit generosity often influence program take-up. Under both programs, the transaction costs for beneficiaries with relatively high out-of-pocket expenses or high utilization would increase/decline as a share of the expected benefit under the low/high generosity. Thus, in the row on take-up assumptions we report three values, corresponding to preliminary assumptions we use in the three alternative parameterizations: less generous, intermediate, and most generous.

Our use of the low-cost, intermediate-, and high-cost assumptions is highly stylized and aimed at describing plausible bounds for the analyses. In practice, one might imagine that in some cases the high-cost assumptions should be paired with low-cost or intermediate assumptions. For example, one can imagine that the higher the administrative costs, the lower the take-up and ADL inflation, all else equal.

## **Timing**

We assume that the multiple versions of the two proposals would go into effect next year (2018).

## **Distributional Results**

We currently present simple, high-level distributional results for each of the options for the two policies, focusing on the percentage of benefits directed to various income quintiles.

## Simulation Results: Costs and Benefit Receipt for Both Programs (Caregiver Tax Credits and Respite Care)

Table 9A presents the low-cost, intermediate, and high-cost projections for the caregiver tax credit for out-of-pocket expenses. Even in the short run, we can only measure—and thus project—potential impacts imprecisely, given differing limitations in the data sources currently available to us that document out-of-pocket expenses. The costs for the caregiver credit could thus vary markedly depending on take-up and behavioral response to the tax credit, including factors like ADL creep/inflation. We project that the intermediate-sized credit—of up to \$3,000—would cost between \$10.0 and \$13.6 billion in the program’s first year (assumed to be 2018) and from \$133 to \$167 billion over the first ten years. Figure 1 shows graphically how costs for the intermediate credit level (with the maximum of up to \$3,000) vary based on assumptions.

Table 9B displays the projected prevalence of receipt of the caregiver tax credit. In the first few years of the tax credit, about 8.2 million people would be expected to file for and receive a credit under the intermediate value with intermediate assumptions. (We conduct this analysis at the individual level rather than at the tax-unit level to make it easier to make comparisons with the respite care benefit, which operates at an individual level.)

Figure 2 provides an illustrative flow chart of how this prevalence of receipt evolves with the various eligibility criteria, focused on what would happen if the proposal were to take affect this year. The figure considers people at the individual level—focusing on the caregivers. The number of people affected at the tax-unit level, which can include the caregivers’ spouses who may or may not also be assisting with the care, will differ. The step which excludes the most caregivers is the requirement that the care recipient meets the criteria for severe disability; as we showed in the bottom row of table 4B, only about 46.6 percent of caregivers for care recipients ages 65 and older are providing care to someone whose disabilities are estimated to be this severe (estimates are lower for care recipients who are younger). With each of the subsequent steps (income screening, evaluating expenses, checking relationships to caregivers, and filing taxes), more of the population drops from the sample.

The costs of the respite care credit are also quite uncertain given the potential range of take-up and the intensity of use, conditional on take-up.<sup>31</sup> Table 10A presents our range of estimates, this time for six different versions of the benefit: three maximum permissible service days, with and without allowing spouses to claim the credit. Gross costs for the intermediate benefit level—up to 168 hours, or 7 days, of respite care in a calendar year—including coverage for spouse caregivers are projected to be about \$0.6 billion in the first year. Costs start out relatively low due in large part to the fact that current

participation in CCM is limited to just a few percent of Medicare beneficiaries. Assuming CCM participation increases steadily in coming years, costs are projected to increase to \$8.1 billion in 2027 under the intermediate assumptions.

Figure 3 shows graphically how costs for the intermediate respite benefit (with a maximum of 168 hours, or 7 days of respite) vary based on our analytic assumptions. Because of the projections' sensitivity to the assumption about CCM take-up, the alternative scenarios diverge more significantly over time in percentage terms than do the projections for the caregiver tax credit. Importantly, under the high cost assumptions, where CCM take-up approaches 90 percent at the end of the project horizon, 2027 costs would more than double relative to the intermediate assumptions, to almost \$19 billion.

Table 10B presents the corresponding prevalence of the respite care benefit under the alternative assumptions and benefit levels. We project that in 2018, as the program is ramping up, roughly 200,000 Medicare beneficiaries would receive respite services under the intermediate assumptions. We anticipate that this would grow rapidly, to cover about 1.7 million beneficiaries at the end of our projection horizon (2027), due both to population aging and, more importantly, the assumed more widespread utilization of the CCM program. Consistent with the cost differentials, the number of beneficiaries could more than double under the higher cost assumptions in later years of the simulation, reaching 3.6 million beneficiaries, due in large part to the more aggressive assumptions about the adoption of CCM. Excluding the spouse caregivers from receipt would reduce prevalence by between 30 to 40 percent in most years, consistent with the NHATS estimates in table 6A that show that about 40 percent of those eligible have only spousal caregivers.

Figure 4 again provides a flow chart of how the various eligibility criteria influence these beneficiary-prevalence estimates, assuming implementation this year. Policymakers should be aware that the flows are currently most significantly affected by the CCM participation requirement and then by the restrictions requiring that care recipients' disabilities meet the HIPAA threshold for severity.

Appendix table 4 describes how net costs could change if the program integrated a modest copayment of \$15 per service day, indexed by the average of wages and prices from 2017, for those with income above certain thresholds (generally coinciding with Medicaid eligibility). Consistent with the information we present in table 7, we project that many respite beneficiaries would be eligible for cost-sharing relief.

## Simulation Results: Distributional Differences in Both Programs (Caregiver Tax Credits and Respite Care)

Tables 11 and 12 describe the distributional properties of the caregiver tax credit and respite care benefit, respectively, pooled over person year observations from 2018 through 2027. The metric that we use in this table is the share of benefits directed to various income quintiles, where income includes earnings, Social Security benefits, pension benefits, and the annuitized value of financial wealth for both oneself and one's spouse, where applicable. We define income both on a per capita basis and then using poverty-adjusted income, to show sensitivity of results to the selected equivalence scale. When a group receives more than the quintile's share of the population (20 percent, by definition) then a group can be seen as benefitting disproportionately from the intervention.

The caregiver tax credit for out-of-pocket expenses is capped so that it excludes the top of the income distribution and phases out for those close to the top of the distribution (table 11). Otherwise, it directs benefits to all quintiles in relatively even proportions. As the benefit becomes more generous (the maximum credit of \$5,000), we see a bit of shifting toward higher income quintiles, reflecting greater ability to pay (and lower provision of informal care) among those higher in the income distribution.

Because the burden of disability falls so highly, in relative terms, on lower-income people, the respite care benefit directs markedly more gross benefits to lower quintiles of the income distribution than does the care credit (table 12). As the benefit becomes more generous, changes tend to be very modest. When beneficiaries with only spouse caregivers are excluded from receiving the respite care benefit (in the right-hand side columns), its distribution is tilted more toward the lower income quintiles, reflecting the relatively higher income of married people with disabilities relative to their unmarried counterparts.

### Caveats

All results in this report reflect our best guess as of this writing. One important limitation is that the estimates of out-of-pocket expenditures by caregivers to which we have access are primarily limited to means by categories (as in Rainville, Skufca, Mehegan 2016) or narrow categorical ranges (as in NHATS/NSOC).<sup>32</sup> Given that caregiver tax credits with different limits could be particularly sensitive to the spending of outliers, cautious interpretation is warranted. Also, our modeling of the population of caregiver recipients under age 51, in the case of the tax credit, and CCM enrollees under age 65 (in the

case of the respite care benefit) is highly stylized.<sup>33</sup> Finally, as our discussion has indicated, take-up is highly uncertain for both the tax credit and the respite benefit, and itself a function of many different processes.

## Conclusions

We have combined historical and projection analyses to help understand the potential cost and distributional effects of two interventions aimed at supporting family caregivers: a caregiver tax credit for out-of-pocket expenses and a respite care benefit. Our historical analyses from the NSOC/NHATS reveal that few caregivers would be affected by the income phase-out integrated into the tax credit. They also show that many—if not most—potential respite care beneficiaries have relatively limited means to share in the cost of their care.

Our projections show that the costs and distributional effects of proposals to support caregivers will depend on the specific parameters integrated in the proposals and in implementation choices that program developers and administrators make. Take-up is likely to be an important determinant of costs and benefit reach. At present, our projections suggest potential for a wide range of participation levels and thus costs depending on how individuals respond to the programs' incentives. It will be important to monitor trends in program and CCM take-up, and adjust expectations and cost estimates as more data from more recent experience become available.

Distributionally, we see that the respite care benefit tends to be quite progressive given the high prevalence of disability among those with lower incomes. The income tax credit is more proportional, though the income phase-out leads to limited benefits to those in the top quintile of the income distribution.

# Notes

1. Many other analysts have proposed related benefits. See, for example, chapter seven of the National Academies of Sciences, Engineering, and Medicine (2016). Davis, Willink, and Schoen's proposal for Medicare Help at Home (2016) is another example.
2. Currently, the credit ranges from 20 to 35 percent applies only to the first \$3,000 of allowable expenses for one child or \$6,000 for two children. For details, see <https://www.irs.gov/taxtopics/tc602.html>.
3. This estimate includes exclusions for employer-provided child care.
4. This typically requires that the dependent live with the taxpayer for at least half the year and provides at least half of their support during the tax year.
5. Specifically, as a result of a physical or mental defect, the person needs to be incapable of caring for his or her hygiene or nutritional needs or needs the full-time attention of another person for the individual's own safety or the safety of others. See <https://www.irs.gov/taxtopics/tc602>.
6. IRS publication 502 enumerates the other types of medical expenditures that are deductible under current law. These include qualified long-term care services; home modifications to accommodate the conditions/activities for persons with disabilities (e.g., ramps, widening entrances, railings or grab bars, porch lifts); assistive devices (hearing aids, glasses, wheelchairs); and non-extravagant travel expenses and transportation to receive medical treatment from licensed providers. Meals and lodging in a nursing home can be deducted if a principal reason a person is staying there is for medical treatment but not if staying there for personal reasons. For details, see <https://www.irs.gov/pub/irs-pdf/p502.pdf>.
7. The IRS describes the prevalence of different deductions for itemizers. For details, see <https://www.irs.gov/pub/irs-soi/14inalcr.pdf>.
8. These estimates are from a Congressional Research Service report. Lowry reports also that those in the \$50,000 to \$100,000 category having the highest shares with such deductions. For those taking medical expense deductions, average deductions range from \$7,200 (for those in the \$20,000 to \$50,000 range) to over \$100,000 (for those in the range over \$1 million).
9. Caregivers who are managing a care recipient's finances could use this mechanism to deduct care-related expenses the care recipients paid for themselves as well.
10. Batchelder, Goldberg, and Orszag (2006) describe some of the reasons why uniform refundable credits can be a particularly effective tool for subsidizing behaviors government wishes to encourage, like caregiving.
11. The limitations in the statute are eating, toileting, transferring, bathing, dressing, and continence.
12. Sections of the manual, including chapter 4 which includes these regulations, can be downloaded at <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.
13. Newcomer, Kang, and Doty (2011) explore how one such policy, in place in California, might affect Medicaid service use and expenditures.
14. By way of context, the Census Bureau (Semega, Fontenot, and Kollar 2017, table A-1) reports that about 7.0 percent of households had income above \$200,000 in 2016. Tables from the Internal Revenue Service's Statistics of Income division (Publication 1304, Table 1.2) suggest that 90 percent of single tax filers and 92 percent of tax filers had adjusted gross income of less than \$75,000 in 2015, while 62 percent of married filers had adjusted gross income of less than \$100,000 and 10 percent had income of less than \$200,000. Tax filers of course differ from non-filers.



15. We assume that the limit applies to the filing unit, not the individuals in the filing unit. So if two spouses (or any other two people) in a filing unit are each paying out-of-pocket for a parent or relative who meets the criteria, we assume that they can claim one credit up to the limit, but not two credits.
16. Individuals who are solely eligible for Medicaid would not be available for the respite care benefit.
17. See especially page 80244 of “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements.” *Federal Register* 81(220): 80170-80562. Published November 15, 2016. <https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf>
18. Prior research has shown that the financial implications for physician participation in CCM are potentially quite large and depend in important ways on who in the practice delivers most of the program services (Basu, Phillips, Bitton, Song, and Landon 2015).
19. Costs for this program were estimated at almost \$35.4 million in fiscal year 2015 for 326,284 visits, yielding a per-visit cost of about \$108 (Colello and Panangala 2017). Criteria for participation in the program are similar to the HIPAA disability definition, with some adjustments. Specifically, the veteran needs to “have dependencies in three or more ADLs or significant cognitive impairment or require care as adjunct to home hospice services or two ADL dependencies and any two of the following: three IADLs dependencies; recent nursing facility discharge; age 75 or older; three hospitalizations in a year; clinical depression diagnosis.
20. See <https://www.ssa.gov/OACT/STATS/admin.html> and [https://www.ssa.gov/OACT/ssir/SSI16/IV\\_E\\_AdminCosts.html](https://www.ssa.gov/OACT/ssir/SSI16/IV_E_AdminCosts.html).
21. For example, a physician who is motivated to see that a patient receives the best possible care so that any medical complications will be avoided may interpret benefit criteria through that lens.
22. For many, this threshold would exclude their entire Social Security benefit. Social Security benefits are the primary income source for many older adults. Beneficiaries only need to pay tax on their Social Security benefits if their total income, including taxable Social Security benefits, is more than \$25,000 for a single person or \$32,000 for a couple. When beneficiaries are single and their incomes fall between \$25,000 and \$34,000 or when they are married and file taxes jointly with their spouses and the incomes fall between \$32,000 and \$44,000, at most, they will pay tax on 50 percent of their Social Security income. If their incomes exceed these higher thresholds (\$34,000 for singles and \$44,000 for those married filing jointly), 85 percent of their Social Security benefits may be taxable. See the IRS website for information about filing thresholds for other filing statuses: [https://www.irs.gov/publications/p501/ar02.html#en\\_US\\_2016\\_publink1000220687](https://www.irs.gov/publications/p501/ar02.html#en_US_2016_publink1000220687)
23. Guyton, Manoli, Schafer, and Sebastiani (2015) display the percentage of nonfilers for each year from 2005 to 2013, by county. They find that nonfilers are disproportionately represented in the Southeastern U.S.
24. For example, Caswell and Waidmann (2017) recently analyzed take up of eligible people in Medicare Savings Programs, which help lower-income people with Medicare premiums and cost shares. Other literature estimates claiming of benefits from programs like Supplemental Security Income (SSI) or Medicaid or credits like the earned income tax credit and the Making Work Pay and other stimulus-type refundable credits.
25. Guyton, Manoli, Schafer, and Sebastiani (2015) for example, found that one-time reminders increased tax filing, including for those due refunds, but that these effects did not necessarily persist over time. Bhargava and Manoli (2015) similarly explore issues of earned income tax credit claiming, and find evidence that reminders can be helpful for increasing take-up.
26. This has some similarity to Medicare co-payments for skilled nursing facilities, which can commence on day 21 depending on the timing and circumstances of admission.
27. Earlier studies in this area include: Evercare in collaboration with National Alliance for Caregiving (2007) and Caring.Com (2014, 2015).

28. The statistic labeled “adjusted mean” excludes all reported expenses for independent living retirement community fees, relocation, services such as household care (cleaning, lawn, maintenance), other housing payments (including rent and utilities), and home repair as well as 50 percent of the reported expenditures on assisted living home facility fees, travel expenses, legal fees, and caregiver support, and 90 percent of clothing in the retrospective survey (non-redundant amount) component of Rainville, Skufca, Mehegan (2016).
29. We limited the cancer screening variable to reports of cancers other than skin cancer.
30. An important aspect of our projections of personal income tax liability is that the model uses a match to the IRS Statistics of Income file to project income tax liability because the model does not currently generate projections of every income and deduction source on the tax form.
31. For example, there is potentially a difference of 300 percent in costs between individuals who would require 8 hours of daily care and those who would require 24 hours of each care. Adding in multiple care settings increases this uncertainty even further.
32. One exception is the Caring.Com survey (2015), which includes much larger categories of spending levels than the Rainville, Skufca, and Mehegan (2016) study or NSOC levels that we report. This study reports that 9 percent of caregivers reported expenses of \$50,000 or more.
33. In 2012, 18 percent of Medicare beneficiaries were younger than age 65. Using data from the 1994 through 1996 MCBS Cost and Use file, analyses by Foote and Hogan (2001) suggest that as many as a quarter of these beneficiaries may meet HIPAA criteria, as 3 percent are reported to have dementia and another 21 percent report two or more ADL limitations. Our own preliminary analyses of more recent MCBS data, reported in Table 6B, suggest that about 9 percent may meet both the chronic conditions criteria for CCM and the HIPAA-level disability criteria.

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TABLE 1

## BPC Specifications for Caregiver Tax Credit Proposal

|  |  |
|--|--|
| Maximum credit   | \$3,000 (with alternative analysis of \$1,500 and \$5,000).<br>This threshold is price indexed.  |
| Refundable tax credit  | Yes  |
| Structure  | 30 percent of caregiver's LTSS-related expenses between \$0 and \$10,000<br>(Between \$0 and \$5,000 for \$1,500 credit; between \$0 and \$16,666 for \$5,000 credit); assume only one credit per filing unit.   |
| First dollar applicability   | Yes  |
| Amount of caregiver spending required to obtain maximum credit                                 | \$10,000<br>(\$3,000 maximum credit = 30 percent of \$10,000)<br>(\$5,000 for \$1,500 credit / \$16,666 for \$5,000 credit)  |
| Minimum amount of expenses in order to begin claiming the benefit                              | None   |
| Income (based on AGI)<br>Phase-out range   | Couples: \$120,000 to \$200,000; single people: threshold is two-thirds of the couple threshold (\$80,000 to \$133,333); assumed to be price indexed<br>The credit phase out is assumed to be linear.  |
| Care recipient's relationship with the taxpayer  | Care recipient can be:<br>(A) brother/sister, stepbrother/sister;<br>(B) father/mother or ancestor of either, including father/mother-in-law of a widow(er) who is no longer in a tax unit with the child;<br>(C) stepfather/mother;<br>(D) brother/sister of father or mother of taxpayer; or<br>(E) individual with same principal place of abode as the taxpayer and member of taxpayer's household (default excludes spouses). |
| Impairment of care recipient standard qualifying expenses that can be claimed under the credit | Two or more ADL limitations for 90+ days during year<br>Or<br>Requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment<br>"Expenditures for goods, services, and supports" that:<br>(1) assist a qualified care recipient with accomplishing ADLs and IADLs; and<br>(2) are provided solely for the use of the qualified care recipient.                              |
| Income limits on care recipient  | None   |
| Taxpayer-care recipient cohabitation required?   | No (except in E above)   |
| Caregiver age restriction?   | Individuals cannot claim the credit before age 25.   |

Source: BPC staff.

Notes: AGI =adjusted gross income.



TABLE 2

**BPC Specification for Medicare Respite Benefit Proposal**

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

Source: BPC staff.

TABLE 3A

## NSOC Estimates of Caregiver Incomes by Caregiver Marital Status and HIPAA-Level Disability Status of Care Recipient, 2011

|       | All Caregivers |           |            | Not HIPAA-Qualified |           |           | HIPAA-Qualified |           |           |
|-------|----------------|-----------|------------|---------------------|-----------|-----------|-----------------|-----------|-----------|
|       | All            | Unmarried | Married    | All                 | Unmarried | Married   | All             | Unmarried | Married   |
| N     | 17,949,107     | 5,876,285 | 11,805,330 | 9,995,632           | 3,126,037 | 6,766,526 | 7,953,476       | 2,750,248 | 5,038,804 |
| n     | 1,996          | 726       | 1,242      | 1,026               | 362       | 651       | 970             | 364       | 591       |
| P_5   | 400            | 0         | 10,000     | 47                  | 0         | 11,000    | 400             | 0         | 10,000    |
| P_10  | 7,000          | 5         | 18,000     | 8,000               | 0         | 18,000    | 6,000           | 50        | 16,989    |
| P_15  | 10,800         | 1,000     | 20,000     | 12,000              | 700       | 22,000    | 10,000          | 1,800     | 20,000    |
| P_20  | 15,000         | 5,000     | 24,000     | 15,600              | 5,000     | 25,000    | 13,000          | 5,200     | 22,000    |
| P_25  | 18,044         | 8,000     | 28,600     | 20,000              | 8,000     | 30,000    | 18,000          | 7,000     | 25,000    |
| P_30  | 22,000         | 10,000    | 32,000     | 24,000              | 10,000    | 35,000    | 20,000          | 10,000    | 30,000    |
| P_35  | 25,000         | 11,000    | 36,000     | 27,000              | 12,000    | 40,000    | 24,000          | 10,068    | 35,000    |
| P_40  | 30,000         | 13,000    | 40,000     | 30,000              | 14,000    | 42,000    | 27,000          | 12,000    | 40,000    |
| P_45  | 34,000         | 15,000    | 45,000     | 35,000              | 15,000    | 49,000    | 30,000          | 14,000    | 40,000    |
| P_50  | 38,600         | 18,000    | 50,000     | 40,000              | 18,000    | 55,000    | 35,000          | 18,000    | 48,000    |
| P_55  | 41,000         | 22,000    | 60,000     | 45,000              | 22,000    | 60,000    | 40,000          | 22,000    | 52,000    |
| P_60  | 50,000         | 25,000    | 65,000     | 50,000              | 25,000    | 70,000    | 45,000          | 25,000    | 60,000    |
| P_65  | 55,000         | 28,000    | 75,000     | 60,000              | 27,000    | 75,000    | 50,000          | 28,000    | 70,000    |
| P_70  | 64,320         | 30,000    | 80,000     | 68,000              | 30,000    | 80,000    | 60,000          | 31,000    | 75,000    |
| P_75  | 75,000         | 36,000    | 82,000     | 75,000              | 35,000    | 90,000    | 70,000          | 40,000    | 80,000    |
| P_80  | 80,000         | 40,000    | 97,000     | 82,000              | 41,000    | 100,000   | 76,000          | 40,000    | 86,000    |
| P_85  | 90,000         | 50,000    | 105,000    | 100,000             | 50,000    | 110,000   | 80,000          | 50,000    | 100,000   |
| P_90  | 108,000        | 60,000    | 125,000    | 120,000             | 63,000    | 140,000   | 100,000         | 60,000    | 120,000   |
| P_95  | 150,000        | 75,000    | 175,000    | 160,000             | 75,000    | 180,000   | 130,000         | 70,000    | 160,000   |
| P_100 | 500,000        | 200,000   | 500,000    | 500,000             | 200,000   | 500,000   | 500,000         | 200,000   | 500,000   |

Source: Authors' calculations from NHATS/NSOC, 2011.

TABLE 3B

**NSOC Estimates of Caregiver Incomes by Caregiver Relationship to Care Recipient and HIPAA-Level Disability Status of Care Recipient, 2011**

|       | Recipient Not HIPAA-qualified |           |           |           | Recipient HIPAA-qualified |           |           |           |
|-------|-------------------------------|-----------|-----------|-----------|---------------------------|-----------|-----------|-----------|
|       | Other relative                |           |           |           | Other relative            |           |           |           |
|       | Spouse                        | Unmarried | Married   | Unrelated | Spouse                    | Unmarried | Married   | Unrelated |
| N     | 2,437,453                     | 2,659,382 | 3,852,589 | 1,046,208 | 1,365,022                 | 2,490,475 | 3,558,581 | 539,398   |
| n     | 252                           | 325       | 369       | 80        | 170                       | 353       | 407       | 40        |
| P_5   | 8,088                         | 0         | 15,000    | 7,000     | 1,248                     | 0         | 12,000    | 14        |
| P_10  | 14,500                        | 0         | 24,000    | 10,000    | 10,000                    | 50        | 18,000    | 7,000     |
| P_15  | 18,000                        | 14        | 30,000    | 14,768    | 11,040                    | 1,000     | 22,000    | 10,000    |
| P_20  | 19,392                        | 1,200     | 35,000    | 18,000    | 18,000                    | 4,000     | 29,000    | 11,000    |
| P_25  | 22,000                        | 6,000     | 40,000    | 18,000    | 20,000                    | 6,000     | 35,000    | 14,000    |
| P_30  | 25,000                        | 8,000     | 45,000    | 20,000    | 21,000                    | 8,500     | 40,000    | 18,000    |
| P_35  | 28,000                        | 10,000    | 50,000    | 24,000    | 23,000                    | 10,000    | 45,000    | 20,000    |
| P_40  | 30,000                        | 12,000    | 55,000    | 29,000    | 25,000                    | 12,000    | 50,000    | 20,000    |
| P_45  | 34,410                        | 14,400    | 60,000    | 32,000    | 27,000                    | 14,000    | 54,000    | 23,000    |
| P_50  | 38,000                        | 16,000    | 70,000    | 35,000    | 28,000                    | 18,000    | 60,000    | 24,000    |
| P_55  | 41,000                        | 20,000    | 75,000    | 40,000    | 31,000                    | 20,400    | 70,000    | 28,000    |
| P_60  | 45,000                        | 25,000    | 75,000    | 42,000    | 33,800                    | 25,000    | 75,000    | 28,000    |
| P_65  | 50,000                        | 26,000    | 80,000    | 63,000    | 37,200                    | 30,000    | 80,000    | 30,000    |
| P_70  | 60,000                        | 30,000    | 85,000    | 67,500    | 38,000                    | 35,000    | 80,000    | 31,000    |
| P_75  | 65,000                        | 35,000    | 100,000   | 75,000    | 41,000                    | 40,000    | 90,000    | 32,000    |
| P_80  | 75,000                        | 40,000    | 100,000   | 100,000   | 46,000                    | 45,000    | 100,000   | 40,000    |
| P_85  | 94,000                        | 48,000    | 120,000   | 120,000   | 55,000                    | 54,000    | 120,000   | 52,000    |
| P_90  | 100,000                       | 60,000    | 150,000   | 160,000   | 75,000                    | 60,000    | 130,000   | 52,000    |
| P_95  | 140,000                       | 75,000    | 180,000   | 240,000   | 90,000                    | 80,000    | 175,000   | 80,000    |
| P_100 | 430,000                       | 200,000   | 500,000   | 250,000   | 430,000                   | 200,000   | 500,000   | 88,000    |

Source: Authors' calculations from NHATS/NSOC.

TABLE 4A

**NSOC Estimates of the Joint Distribution of Out-of-Pocket Caregiving Expenses and Care Recipients' HIPAA-Level Disability Status among Non-Spouse Caregivers in 2011**

| Caregiver paid for              | All       |      | AARP<br>%<br>of<br>spending | Recipient Not<br>HIPAA-Qualified |      | Recipient HIPAA-Qualified |      |           |     |               |      |                   |     |
|---------------------------------|-----------|------|-----------------------------|----------------------------------|------|---------------------------|------|-----------|-----|---------------|------|-------------------|-----|
|                                 | Frequency | %    |                             | Frequency                        | %    | All                       |      | ADLs only |     | Dementia only |      | Dementia and ADLs |     |
|                                 | Frequency | %    |                             | Frequency                        | %    | Frequency                 | %    | Frequency | %   | Frequency     | %    | Frequency         | %   |
| Medications                     | 2,916,372 | 20.6 |                             | 1,151,481                        | 8.1  | 1,764,891                 | 12.5 | 427,301   | 3.0 | 742,465       | 5.2  | 595,126           | 4.2 |
| Health insurance <sup>1</sup>   | 1,312,990 | 9.3  | 8.9                         | 459,080                          | 3.2  | 853,910                   | 6.0  | 223,204   | 1.6 | 388,525       | 2.7  | 242,180           | 1.7 |
| Mobility devices                | 1,079,938 | 7.6  | 1.1                         | 468,771                          | 3.3  | 611,167                   | 4.3  | 193,558   | 1.4 | 201,668       | 1.4  | 215,941           | 1.5 |
| Assistive devices <sup>2</sup>  | 1,666,298 | 11.8 | 1.4                         | 767,078                          | 5.4  | 899,220                   | 6.4  | 167,080   | 1.2 | 357,684       | 2.5  | 374,457           | 2.6 |
| Safety equipment <sup>3</sup>   | 2,776,683 | 19.6 | 12.0                        | 1,274,367                        | 9.0  | 1,502,316                 | 10.6 | 417,853   | 3.0 | 577,684       | 4.1  | 506,779           | 3.6 |
| <b>In-home help</b>             | 703,255   | 5.0  | 1.8                         | 199,070                          | 1.4  | 504,185                   | 3.6  | 81,815    | 0.6 | 189,907       | 1.3  | 232,463           | 1.6 |
| Any                             | 5,181,850 | 36.6 |                             | 2,362,791                        | 16.7 | 2,819,059                 | 19.9 | 784,446   | 5.5 | 1,053,926     | 7.5  | 980,687           | 6.9 |
| None                            | 8,632,302 | 61.0 |                             | 5,039,803                        | 35.6 | 3,592,499                 | 25.4 | 831,603   | 5.9 | 1,615,750     | 11.4 | 1,145,146         | 8.1 |
| Some items                      |           |      |                             |                                  |      |                           |      |           |     |               |      |                   |     |
| DK/RF                           | 381,065   | 2.7  |                             | 195,269                          | 1.4  | 185,796                   | 1.3  | 40,424    | 0.3 | 41,490        | 0.3  | 103,882           | 0.7 |
|                                 |           |      | <b>Mean</b>                 |                                  |      |                           |      |           |     |               |      |                   |     |
| <b>Expenditure in last year</b> |           |      | \$6,954                     |                                  |      |                           |      |           |     |               |      |                   |     |
| Missing                         | 601,488   | 4.3  |                             | 263,072                          | 1.9  | 338,416                   | 2.4  | 70,391    | 0.5 | 112,965       | 0.8  | 155,061           | 1.1 |
| none                            | 8,632,302 | 61.0 |                             | 5,039,803                        | 35.6 | 3,592,499                 | 25.4 | 831,603   | 5.9 | 1,615,750     | 11.4 | 1,145,146         | 8.1 |
| <\$500                          | 2,908,717 | 20.6 |                             | 1,510,037                        | 10.7 | 1,398,680                 | 9.9  | 422,376   | 3.0 | 540,984       | 3.8  | 435,319           | 3.1 |
| \$500-<\$1000                   | 902,309   | 6.4  |                             | 317,534                          | 2.2  | 584,775                   | 4.1  | 154,101   | 1.1 | 222,462       | 1.6  | 208,213           | 1.5 |
| \$1000-<\$2000                  | 574,174   | 4.1  |                             | 303,736                          | 2.1  | 270,438                   | 1.9  | 69,133    | 0.5 | 113,404       | 0.8  | 87,901            | 0.6 |
| > \$2000                        | 527,643   | 3.7  |                             | 123,997                          | 0.9  | 403,645                   | 2.9  | 101,645   | 0.7 | 108,985       | 0.8  | 193,015           | 1.4 |

Source: Authors' calculations from NHATS/NSOC and Rainville, Skufca, Mehegan (2016).

Notes: 1.) Medicare or other insurance premiums, copays or coinsurance; 2.) Assistive devices other than mobility equipment to make it easier or safer for the recipient to do activities or do them independently, including devices to help seeing, hearing, holding things or picking things up; 3.) Features to make the recipient's home safer such as a railing or a ramp, grab bars in the bathroom, a seat for the shower or tub, or an emergency call system; 4.) Adjusted mean excludes all reported expenses for independent living retirement community fees, relocation, services such as household care (cleaning, lawn, maintenance), other housing payments (including rent and utilities), and home repair as well as 50 percent of the reported expenditures on assisted living home facility fees, travel expenses, legal fees, and caregiver support, and 90 percent of clothing in the retrospective survey (non-redundant amount) component of Rainville, Skufca, Mehegan (2016). See also appendix table 3 for clarification.

TABLE 4B

**NSOC Estimates of the Joint Distribution of Caregivers' Financial Help and Gifts and Care Recipients' HIPAA-Level Disability Status among Non-Spouse Caregivers in 2011**

| Caregiver paid for                          | All        |       | Recipient Not HIPAA-Qualified |      | Recipient HIPAA-Qualified |      |           |      |               |      |                   |      |
|---|------------|-------|-------------------------------|------|---------------------------|------|-----------|------|---------------|------|-------------------|------|
|   | Frequency  | %     | Frequency                     | %    | All                       |      | ADLs only |      | Dementia only |      | Dementia and ADLs |      |
|   | Frequency  | %     | Frequency                     | %    | Frequency                 | %    | Frequency | %    | Frequency     | %    | Frequency         | %    |
| <b>Financial help or gifts to recipient</b> |            |       |                               |      |                           |      |           |      |               |      |                   |      |
| Missing                                     | 702,566    | 5.0   | 322,718                       | 2.3  | 379,848                   | 2.7  | 80,016    | 0.6  | 97,713        | 0.7  | 135,538           | 1.0  |
| None  | 9,339,905  | 66.0  | 5,089,496                     | 36.0 | 4,250,408                 | 30.0 | 1,083,281 | 7.7  | 1,756,227     | 12.4 | 1,410,901         | 10.0 |
| < \$100                                     | 778,501    | 5.5   | 351,134                       | 2.5  | 427,367                   | 3.0  | 126,058   | 0.9  | 144,563       | 1.0  | 204,010           | 1.4  |
| \$100-<500                                  | 1,807,608  | 12.8  | 1,036,847                     | 7.3  | 770,760                   | 5.4  | 219,379   | 1.6  | 323,793       | 2.3  | 227,589           | 1.6  |
| \$500-<\$1000                               | 656,829    | 4.6   | 302,054                       | 2.1  | 354,775                   | 2.5  | 47,541    | 0.3  | 230,248       | 1.6  | 96,302            | 0.7  |
| \$1000 or more                              | 861,224    | 6.1   | 455,929                       | 3.2  | 405,295                   | 2.9  | 92,974    | 0.7  | 162,006       | 1.1  | 150,315           | 1.1  |
| Nonspouse denominator                       | 14,146,632 | 100.0 | 7,558,179                     | 53.4 | 6,588,453                 | 46.6 | 1,649,249 | 11.7 | 2,714,550     | 19.2 | 2,224,655         | 15.7 |

Source: Authors' calculations from NHATS/NSOC.

TABLE 5

**Distribution of Chronic Conditions among Medicare Beneficiaries Ages 65 and Older in the Community to Estimate Potential CCM Eligibility, 2011**

| <b>Number of<br/>Chronic<br/>Conditions</b> | <b>n</b> | <b>N</b>   | <b>Percent</b> |
|---|----------|------------|----------------|
| <b>Community residents</b>                  | 7,609    | 35,305,631 | 100.0          |
| <2  | 2,051    | 10,726,025 | 30.4           |
| 2+  | 5,558    | 24,579,606 | 69.6           |

**Source:** Authors' calculations from NHATS.

**Notes:** Number of chronic conditions is based on diagnosed chronic conditions reported by NHATS respondents. Included conditions are heart attack, heart disease, hypertension, arthritis, osteoporosis, diabetes, lung disease, stroke, dementia, and cancer. We limited cancer to cancers other than skin cancer. Additional persons may qualify for CCM based on conditions not included in our count. Our estimate is very similar to the 68.4 percent prevalence estimated by Lochner and Cox (2013).

TABLE 6A

## Respite Care Benefit Eligibility and In-Household Potential Care Resources among Medicare Beneficiaries Ages 65 and Older, 2011

|   | Fewer than Two Conditions   |         |                     |         |                 |         | Two or More Conditions |         |                 |         |
|---|---|---------|---------------------|---------|-----------------|---------|------------------------|---------|-----------------|---------|
|   | All   |         | Not HIPAA-qualified |         | HIPAA-qualified |         | Not HIPAA-qualified    |         | HIPAA-qualified |         |
|   | N   | Percent | N                   | Percent | N               | Percent | N                      | Percent | N               | Percent |
| <b>Total</b>                                  | 35,305,631  | 100     | 9,956,440           | 28.2    | 769,585         | 2.2     | 20,736,388             | 58.7    | 3,843,218       | 10.9    |
| <b>Potential in-household care</b>            | <b>Distribution by potential in-household unpaid care resources</b> |         |                     |         |                 |         |                        |         |                 |         |
| None  | 10,654,493  | 30.2    | 2,544,211           | 25.6    | 285,270         | 37.1    | 6,556,401              | 31.6    | 1,268,611       | 33.0    |
| Spouse only                                   | 16,412,351  | 46.5    | 5,536,608           | 55.6    | 257,489         | 33.5    | 9,554,735              | 46.1    | 1,063,518       | 27.7    |
| Spouse and others                             | 3,290,625   | 9.3     | 942,595             | 9.5     | 68,440          | 8.9     | 1,893,177              | 9.1     | 386,413         | 10.1    |
| Child   | 3,488,196   | 9.9     | 601,886             | 6.0     | 93,857          | 12.2    | 1,877,748              | 9.1     | 914,706         | 23.8    |
| Other relative                                | 1,101,357   | 3.1     | 240,982             | 2.4     | 53,943          | 7.0     | 664,701                | 3.2     | 141,731         | 3.7     |
| Other nonrelative                             | 358,609   | 1.0     | 90,158              | 0.9     | 10,585          | 1.4     | 189,626                | 0.9     | 68,239          | 1.8     |
| <b>Total with potential in-household care</b> |   |         |                     |         |                 |         |                        |         |                 |         |
| All   | 24,651,138  |         | 7,412,229           |         | 484,314         |         | 14,179,987             |         | 2,574,607       |         |
| At least one non-spousal                      | 8,238,787   |         | 1,875,621           |         | 226,825         |         | 4,625,252              |         | 1,511,089       |         |

**Source:** Authors' calculations from NHATS/NSOC. Number of chronic conditions is based on diagnosed chronic conditions reported by NHATS respondents. Included conditions are heart attack, heart disease, hypertension, arthritis, osteoporosis, diabetes, lung disease, stroke, dementia, and cancer. We limited cancer to cancers other than skin cancer. Additional persons may qualify for CCM based on conditions not included in our count.

TABLE 6B

**Respite Care Benefit Eligibility and In-Household Potential Care Resources among Medicare Beneficiaries Younger Than Age 65 Who Live in the Community, Pooled 2011–2013**

|           | Fewer Than Two Conditions |         |                     |         |                 |         | Two or More Conditions |         |                 |         |
|-----------|---------------------------|---------|---------------------|---------|-----------------|---------|------------------------|---------|-----------------|---------|
|           | All                       |         | Not HIPAA-qualified |         | HIPAA-qualified |         | Not HIPAA-qualified    |         | HIPAA-qualified |         |
|           | N                         | Percent | N                   | Percent | N               | Percent | N                      | Percent | N               | Percent |
| All       | 8,586,762                 | 100%    | 3,441,682           | 40.1%   | 343,128         | 4.0%    | 4,019,264              | 46.8%   | 782,687         | 9.1%    |
| Married   | 2,995,407                 | 100%    | 907,225             | 30.3%   | 138,301         | 4.6%    | 1,534,899              | 51.2%   | 414,982         | 13.9%   |
| Unmarried | 5,591,354                 | 100%    | 2,534,456           | 45.3%   | 204,827         | 3.7%    | 2,484,365              | 44.4%   | 367,706         | 6.6%    |

**Source:** Authors' calculations from MCBS pooled for 2011, 2012, and 2013. Number of chronic conditions is based on diagnosed chronic conditions reported by MCBS respondents (or proxy respondents for those unable to respond). Included conditions are heart attack, heart disease, hypertension, arthritis, osteoporosis, diabetes, lung disease, stroke, dementia, and cancer. We limited cancer to cancers other than skin cancer. Additional persons may qualify for CCM based on conditions not included in our count. Question wording and coding differs modestly for a few of the chronic conditions across years of the survey. Weights adjusted to account for pooling multiple survey years.



TABLE 7

**Poverty and Medicaid Status among Medicare Beneficiaries Ages 65 and Older Most Likely to Be Eligible to Receive CCM Respite Care Benefit by In-Household Potential Care Resources, 2011**

| Potential in-household care   |                   | n     | Percent with Income Below |                 |                 |                 |                 | n     | Percent Medicaid-enrolled |
|---|-------------------|-------|---------------------------|-----------------|-----------------|-----------------|-----------------|-------|---------------------------|
|   |                   |       | 100% of poverty           | 135% of poverty | 150% of poverty | 200% of poverty | 300% of poverty |       |                           |
| 1   | None              | 347   | 36.3                      | 54.8            | 59.8            | 69.3            | 86.9            | 320   | 35.6                      |
| 2   | Spouse only       | 264   | 16.1                      | 31.0            | 38.1            | 54.9            | 75.6            | 258   | 12.9                      |
| 3   | Spouse and others | 102   | 25.5                      | 38.6            | 47.1            | 63.9            | 81.3            | 95    | 24.9                      |
| 4   | Child             | 318   | 44.8                      | 67.1            | 72.1            | 82.3            | 92.8            | 308   | 41.2                      |
| 5   | Other relative    | 60    | 48.3                      | 70.9            | 74.0            | 85.0            | 88.1            | 57    | 39.4                      |
| 6   | Other nonrelative | 17    | 36.8                      | 65.3            | 76.2            | 88.4            | 100.0           | 15    | 53.3                      |
| All with chronic conditions meeting HIPAA criteria and with current potential in-household care (2–6)           |                   | 761   | 32.4                      | 51.0            | 57.2            | 70.7            | 85.1            | 733   | 29.2                      |
| All with chronic conditions meeting HIPAA criteria and with current potential nonspouse in-household care (3–6) |                   | 497   | 41.0                      | 61.7            | 67.4            | 79.1            | 90.1            | 475   | 38.1                      |
| All with chronic conditions meeting HIPAA criteria  |                   | 1,108 | 33.6                      | 52.2            | 58.0            | 70.3            | 85.6            | 1,053 | 31.2                      |

**Source:** Authors' calculations from NHATS/NSOC. Sample: 1,108 NHATS respondents who meet both chronic condition and HIPAA criteria for CCM and proposed respite benefit. The "None" category includes 11 cases in which the only other person living in the household was paid.

**Note:** Medicaid enrollment is missing for 55 responses.

TABLE 8

Alternative Assumptions Used in Low-, Intermediate-, and High-Cost Estimates for the Two Proposals

| Assumption  | Caregiver Tax Credit   |                                 |   | Respite Care Benefit within CCM                                     |  |  |
|---|--|---------------------------------|---|---|--|--|
|   | Low  | Intermediate                    | High  | Low   | Intermediate   | High   |
| Administrative expense (as % of expenses)                                 | 1%   | 2%                              | 4%  | 1%  | 2%   | 4%   |
| CCM take-up among those HIPAA-qualified with required chronic conditions  | N/A  | N/A                             | N/A   | Increase to 10% over the next ten years, higher if higher need      | Increase to 50% over the next ten years, higher if higher need | Increase to 90% over the next ten years, higher if higher need |
| "Creep/inflation" in ADLs, chronic counts                                 | None   | Low                             | High  | None  | Low  | High   |
| Intensity of use  | N/A  | N/A                             | N/A   | Many, especially less needy, get less than half of maximum duration | Scaled relative to need  | All get maximum duration                                       |
| Out-of-pocket spending estimates: Percent of caregivers with any expenses | 60% (based on NSOC value of 45% for HIPAA-qualified, nonmissing) | 72.5% (average of high and low) | 85% (based on modest increase of AARP at HIPAA) | N/A   | N/A  | N/A  |
| Out-of-pocket spending estimates: Level among those with any spending     | 90% of AARP-adjusted value                                       | 95% of AARP-adjusted value      | Based on AARP-adjusted                          | N/A   | N/A  | N/A  |

TABLE 8 (CONTINUED)

Alternative Assumptions Used in Low-, Intermediate-, and High-Cost Estimates for the Two Proposals

| Assumption   | Caregiver Tax Credit   |  |  | Respite Care Benefit within CCM  |  |  |
|--|--|--|--|--|--|--|
|  | Low  | Intermediate   | High   | Low  | Intermediate   | High   |
| Take-up, personal income tax filers under baseline         | Ultimate average 65/70/85%, higher for those with higher expected benefit/income; 5-10% lower in years 1 & 2 | Ultimate average 80/85/90%, higher for those with higher expected benefit/income; 5-10% lower in years 1 & 2 | Ultimate average 95/99/99%, higher for those with higher expected benefit/income | Ultimate average 50/60/67%, varies by beneficiary need, with cognitive status a strong predictor, rather than filing status and expected benefit | Ultimate average 75/80/85%, varies by beneficiary need, with cognitive status a strong predictor, rather than filing status and expected benefit | Ultimate average 90/95/99%, varies by beneficiary need, with cognitive status a strong predictor, rather than filing status and expected benefit |
| Take-up, nonfilers of personal income taxes under baseline | Ultimate average 55/65/75%, higher for those with higher expected benefit/income; 5-10% lower in years 1 & 2 | Ultimate average 75/80/85%, higher for those with higher expected benefit/income; 5-10% lower in years 1 & 2 | Ultimate average 90/95/99%, higher for those with higher expected benefit/income |  |  |  |
| Prevalence of receipt at younger ages                      | Low  | Medium   | High   | Low  | Medium (use MCBS, Foote & Hogan 2001)  | High   |

**Notes:** The three take-up rate values correspond to the least generous, intermediate, and most generous parameterizations, respectively. CCM participation phases in linearly over the 10-year horizon. Benefit take-up is assumed to be lowest in year one, next lowest in year two, and reaches the ultimate rate in year three.

N/A=not applicable to the policy simulation.

TABLE 9A

**Cost Projections for Three Separate Versions of the Caregiver Tax Credit for Out-of-Pocket Expenses, 2018–2027, under High-, Intermediate-, and Low-Cost Assumptions**

|                 | Option 1: Maximum Credit of \$1,500 |              |      | Option 2: Maximum Credit of \$3,000 |              |       | Option 3: Maximum Credit of \$5,000 |              |       |
|-----------------|-------------------------------------|--------------|------|-------------------------------------|--------------|-------|-------------------------------------|--------------|-------|
|                 | Low                                 | Intermediate | High | Low                                 | Intermediate | High  | Low                                 | Intermediate | High  |
|                 | <b>Billions (nominal \$)</b>        |              |      |                                     |              |       |                                     |              |       |
| 2018            | 4.6                                 | 5.9          | 6.5  | 10.0                                | 12.0         | 13.6  | 18.0                                | 19.7         | 22.0  |
| 2019            | 5.2                                 | 6.6          | 7.0  | 11.2                                | 13.4         | 14.5  | 19.8                                | 21.6         | 23.0  |
| 2020            | 5.5                                 | 6.8          | 7.1  | 12.5                                | 14.6         | 15.3  | 21.3                                | 23.3         | 24.4  |
| 2021            | 5.3                                 | 6.8          | 7.1  | 12.3                                | 14.5         | 15.1  | 21.1                                | 23.1         | 24.1  |
| 2022            | 5.5                                 | 6.8          | 7.3  | 12.5                                | 14.8         | 15.7  | 22.2                                | 24.2         | 25.3  |
| 2023            | 6.0                                 | 7.6          | 8.2  | 13.8                                | 16.0         | 17.0  | 24.1                                | 26.6         | 27.4  |
| 2024            | 6.3                                 | 8.0          | 8.3  | 14.3                                | 16.5         | 17.7  | 25.0                                | 27.2         | 28.4  |
| 2025            | 6.4                                 | 8.1          | 8.6  | 15.0                                | 17.4         | 18.4  | 26.0                                | 28.6         | 29.5  |
| 2026            | 6.9                                 | 8.6          | 9.0  | 15.6                                | 18.5         | 19.5  | 27.9                                | 30.2         | 31.5  |
| 2027            | 6.8                                 | 8.6          | 9.1  | 15.9                                | 18.6         | 19.8  | 28.7                                | 31.2         | 32.4  |
| 2018–2027 total | 58.3                                | 73.8         | 78.2 | 133.1                               | 156.3        | 166.8 | 234.2                               | 255.7        | 268.0 |

**Source:** Authors' calculations from DYNASIM run 919 calibrated to various data from NSOC and Rainville, Skufca, Mehegan (2016).

**Notes:** Intermediate estimate integrates our best guess assumptions on take-up, administrative costs, ADL creep/inflation, beneficiaries younger than 51, and out-of-pocket expenditures. Low-cost estimate assumes low take-up, low administrative costs, no ADL creep/inflation, lower prevalence of beneficiaries younger than 51, and lower-bound out-of-pocket expenditures. High-cost estimate assumes near-universal take-up among eligibles, high administrative costs, some ADL creep/inflation, higher prevalence of beneficiaries younger than 51, and higher-bound out-of-pocket expenditures. (See table 8.)

TABLE 9B

Projections of Number of Recipients for Three Separate Versions of the Caregiver Tax Credit for Out-of-Pocket Expenses, 2018–2027, under High-, Intermediate-, and Low-Cost Assumptions

|      | Option 1: Maximum Credit of \$1,500 |              |      | Option 2: Maximum Credit of \$3,000 |              |      | Option 3: Maximum Credit of \$5,000 |              |      |
|------|-------------------------------------|--------------|------|-------------------------------------|--------------|------|-------------------------------------|--------------|------|
|      | Low                                 | Intermediate | High | Low                                 | Intermediate | High | Low                                 | Intermediate | High |
|      | People (millions)                   |              |      |                                     |              |      |                                     |              |      |
| 2018 | 4.4                                 | 5.6          | 7.2  | 6.5                                 | 7.6          | 9.6  | 9.2                                 | 10.0         | 11.9 |
| 2019 | 4.8                                 | 6.2          | 7.6  | 7.1                                 | 8.4          | 10.0 | 9.9                                 | 10.7         | 12.2 |
| 2020 | 4.9                                 | 6.0          | 7.3  | 7.2                                 | 8.3          | 9.9  | 9.9                                 | 10.8         | 12.2 |
| 2021 | 4.7                                 | 6.0          | 7.3  | 7.0                                 | 8.1          | 9.7  | 9.7                                 | 10.5         | 11.9 |
| 2022 | 4.7                                 | 6.0          | 7.3  | 7.1                                 | 8.3          | 9.9  | 9.9                                 | 10.6         | 12.0 |
| 2023 | 4.8                                 | 6.1          | 7.5  | 7.1                                 | 8.2          | 9.9  | 9.8                                 | 10.7         | 12.1 |
| 2024 | 4.9                                 | 6.2          | 7.6  | 7.3                                 | 8.4          | 10.2 | 10.0                                | 10.8         | 12.4 |
| 2025 | 4.8                                 | 6.1          | 7.5  | 7.2                                 | 8.4          | 10.0 | 10.0                                | 10.8         | 12.2 |
| 2026 | 4.9                                 | 6.2          | 7.5  | 7.2                                 | 8.4          | 10.1 | 10.0                                | 10.8         | 12.3 |
| 2027 | 4.7                                 | 5.9          | 7.3  | 7.0                                 | 8.2          | 9.9  | 9.9                                 | 10.7         | 12.1 |

**Source:** Authors' calculations from DYNASIM run 919 calibrated to various data from NSOC and Rainville, Skufca, Mehegan (2016).

**Notes:** Intermediate estimate integrates our best guess assumptions on take-up, administrative costs, ADL creep/inflation, beneficiaries younger than 51, and out-of-pocket expenditures. Low-cost estimate assumes low take-up, low administrative costs, no ADL creep/inflation, lower prevalence of beneficiaries younger than 51, and lower-bound out-of-pocket expenditures. High-cost estimate assumes near-universal take-up among eligibles, high administrative costs, some ADL creep/inflation, higher prevalence of beneficiaries younger than 51, and higher-bound out-of-pocket expenditures. (See table 8.)

TABLE 10A

**Gross Cost Projections for Three Versions of the CCM-Based Respite Care Benefit, 2018–2027, under High-, Intermediate-, and Low-Cost Assumptions**

|                 | Including Spouse Caregivers               |      |      |                     |      |      |                     |      |       | Excluding Spouse Caregivers |      |      |                     |      |       |                     |       |       |
|-----------------|---|------|------|---------------------|------|------|---------------------|------|-------|-----------------------------|------|------|---------------------|------|-------|---------------------|-------|-------|
|                 | Option 1: 96 hours                        |      |      | Option 2: 168 hours |      |      | Option 3: 336 hours |      |       | Option 1: 96 hours          |      |      | Option 2: 168 hours |      |       | Option 3: 336 hours |       |       |
|                 | Low                                       | Int. | High | Low                 | Int. | High | Low                 | Int. | High  | Low                         | Int. | High | Low                 | Int. | High  | Low                 | Int.  | High  |
|                 | <b>Gross costs (billions, nominal \$)</b> |      |      |                     |      |      |                     |      |       |                             |      |      |                     |      |       |                     |       |       |
| 2018            | 0.1                                       | 0.3  | 0.8  | 0.2                 | 0.6  | 1.4  | 0.4                 | 1.2  | 3.0   | 0.2                         | 1.5  | 3.7  | 0.4                 | 2.8  | 6.7   | 0.9                 | 5.7   | 13.6  |
| 2019            | 0.1                                       | 0.8  | 1.7  | 0.3                 | 1.5  | 3.0  | 0.6                 | 3.0  | 6.0   | 0.2                         | 1.7  | 4.5  | 0.4                 | 3.2  | 7.9   | 0.9                 | 6.6   | 16.1  |
| 2020            | 0.1                                       | 0.9  | 2.2  | 0.2                 | 1.7  | 3.9  | 0.5                 | 3.6  | 8.1   | 0.2                         | 2.1  | 5.6  | 0.5                 | 4.0  | 10.0  | 1.1                 | 8.4   | 20.3  |
| 2021            | 0.2                                       | 1.3  | 3.0  | 0.4                 | 2.4  | 5.4  | 0.9                 | 5.0  | 11.1  | 0.3                         | 2.7  | 6.8  | 0.6                 | 5.0  | 12.3  | 1.5                 | 10.6  | 25.0  |
| 2022            | 0.2                                       | 1.8  | 4.1  | 0.4                 | 3.3  | 7.5  | 0.9                 | 6.8  | 15.2  | 0.4                         | 3.1  | 7.3  | 0.8                 | 5.7  | 13.1  | 1.7                 | 11.6  | 26.6  |
| 2023            | 0.2                                       | 2.1  | 5.3  | 0.5                 | 3.9  | 9.6  | 1.2                 | 8.0  | 19.5  | 0.2                         | 3.2  | 7.8  | 0.5                 | 6.0  | 14.0  | 1.1                 | 12.5  | 28.5  |
| 2024            | 0.2                                       | 2.6  | 6.5  | 0.5                 | 4.9  | 11.4 | 1.2                 | 10.0 | 23.3  | 0.3                         | 3.2  | 8.2  | 0.7                 | 5.9  | 14.7  | 1.5                 | 12.3  | 29.9  |
| 2025            | 0.3                                       | 2.9  | 7.8  | 0.6                 | 5.4  | 13.9 | 1.4                 | 11.4 | 28.3  | 0.3                         | 3.4  | 8.4  | 0.7                 | 6.4  | 15.4  | 1.6                 | 13.4  | 31.3  |
| 2026            | 0.4                                       | 3.8  | 9.9  | 0.8                 | 7.1  | 17.8 | 1.9                 | 14.9 | 36.1  | 0.4                         | 4.0  | 9.5  | 0.8                 | 7.3  | 17.0  | 1.8                 | 14.9  | 34.6  |
| 2027            | 0.6                                       | 4.3  | 10.4 | 1.2                 | 8.1  | 18.6 | 2.5                 | 16.6 | 37.7  | 0.5                         | 4.2  | 10.7 | 1.0                 | 7.8  | 19.0  | 2.1                 | 16.4  | 38.8  |
| 2018-2027 total | 2.4                                       | 20.8 | 51.7 | 5.2                 | 38.9 | 92.6 | 11.5                | 80.5 | 188.3 | 3.1                         | 29.0 | 72.5 | 6.4                 | 54.2 | 130.1 | 14.2                | 112.4 | 264.8 |

**Source:** Authors' calculations from DYNASIM run 919.

**Notes:** Int. = intermediate. Intermediate estimate integrates our best guess assumptions on take-up, administrative costs, ADL creep/inflation, beneficiaries younger than 51, and intensity of use. Low-cost estimate assumes low take-up, low administrative costs, no ADL creep/inflation, lower prevalence of beneficiaries younger than 51, and lower-bound intensity of use. High-cost estimate assumes near-universal take-up among eligibles, high administrative costs, some ADL creep/inflation, higher prevalence of beneficiaries younger than 51, and higher-bound intensity of use. (See table 8.)

TABLE 10B

Projections of Number of Beneficiaries for Three Versions of CCM-Based Respite Care Benefit, 2018–2027, under High-, Intermediate-, and Low-Cost Assumptions

|      | Including Spouse Caregivers |      |      |                     |      |      |                     |      |      | Excluding Spouse Caregivers |      |      |                     |      |      |                     |      |      |
|------|-----------------------------|------|------|---------------------|------|------|---------------------|------|------|-----------------------------|------|------|---------------------|------|------|---------------------|------|------|
|      | Option 1: 96 hours          |      |      | Option 2: 168 hours |      |      | Option 3: 336 hours |      |      | Option 1: 96 hours          |      |      | Option 2: 168 hours |      |      | Option 3: 336 hours |      |      |
|      | Low                         | Int. | High | Low                 | Int. | High | Low                 | Int. | High | Low                         | Int. | High | Low                 | Int. | High | Low                 | Int. | High |
|      | Beneficiaries (millions)    |      |      |                     |      |      |                     |      |      |                             |      |      |                     |      |      |                     |      |      |
| 2018 | 0.0                         | 0.2  | 0.4  | 0.1                 | 0.2  | 0.4  | 0.1                 | 0.2  | 0.4  | 0.0                         | 0.1  | 0.3  | 0.0                 | 0.1  | 0.3  | 0.0                 | 0.1  | 0.3  |
| 2019 | 0.1                         | 0.4  | 0.8  | 0.1                 | 0.4  | 0.8  | 0.1                 | 0.4  | 0.8  | 0.1                         | 0.3  | 0.6  | 0.1                 | 0.3  | 0.6  | 0.1                 | 0.3  | 0.6  |
| 2020 | 0.0                         | 0.4  | 1.0  | 0.1                 | 0.4  | 1.0  | 0.1                 | 0.5  | 1.0  | 0.0                         | 0.3  | 0.7  | 0.0                 | 0.3  | 0.7  | 0.1                 | 0.3  | 0.7  |
| 2021 | 0.1                         | 0.6  | 1.3  | 0.1                 | 0.6  | 1.3  | 0.1                 | 0.6  | 1.4  | 0.1                         | 0.4  | 0.9  | 0.1                 | 0.4  | 0.9  | 0.1                 | 0.4  | 0.9  |
| 2022 | 0.1                         | 0.8  | 1.7  | 0.1                 | 0.8  | 1.8  | 0.1                 | 0.8  | 1.8  | 0.0                         | 0.5  | 1.2  | 0.1                 | 0.5  | 1.2  | 0.1                 | 0.6  | 1.3  |
| 2023 | 0.1                         | 0.9  | 2.2  | 0.1                 | 0.9  | 2.2  | 0.1                 | 1.0  | 2.3  | 0.1                         | 0.6  | 1.5  | 0.1                 | 0.7  | 1.5  | 0.1                 | 0.7  | 1.6  |
| 2024 | 0.1                         | 1.0  | 2.5  | 0.1                 | 1.1  | 2.6  | 0.1                 | 1.1  | 2.6  | 0.1                         | 0.7  | 1.8  | 0.1                 | 0.7  | 1.8  | 0.1                 | 0.8  | 1.8  |
| 2025 | 0.1                         | 1.1  | 2.9  | 0.1                 | 1.2  | 3.0  | 0.2                 | 1.2  | 3.0  | 0.1                         | 0.8  | 2.1  | 0.1                 | 0.9  | 2.1  | 0.1                 | 0.9  | 2.2  |
| 2026 | 0.1                         | 1.4  | 3.6  | 0.2                 | 1.5  | 3.7  | 0.2                 | 1.6  | 3.7  | 0.1                         | 1.0  | 2.5  | 0.1                 | 1.1  | 2.5  | 0.2                 | 1.1  | 2.6  |
| 2027 | 0.2                         | 1.6  | 3.6  | 0.2                 | 1.7  | 3.7  | 0.3                 | 1.7  | 3.8  | 0.1                         | 1.1  | 2.6  | 0.2                 | 1.2  | 2.6  | 0.2                 | 1.2  | 2.7  |

Source: Authors' calculations from DYNASIM run 919.

Notes: Int. = intermediate. Intermediate estimate integrates our best guess assumptions on take-up, administrative costs, ADL creep/inflation, beneficiaries younger than 51, and intensity of use. Low-cost estimate assumes low take-up, low administrative costs, no ADL creep/inflation, lower prevalence of beneficiaries younger than 51, and lower-bound intensity of use. High-cost estimate assumes near-universal take-up among eligibles, high administrative costs, some ADL creep/inflation, higher prevalence of beneficiaries younger than 51, and higher-bound intensity of use. (See table 8.)

TABLE 11

**Distributional Projections for Caregiver Tax Credit, Pooled Person Years 2018–2027: Aggregate Share of Benefits to Each Per Capita and Poverty-Adjusted Income Quintile**

|  | Option 1: Maximum Credit of \$1,500 |              |      | Option 2: Maximum Credit of \$3,000 |              |      | Option 3: Maximum Credit of \$5,000 |              |      |
|--|-------------------------------------|--------------|------|-------------------------------------|--------------|------|-------------------------------------|--------------|------|
|  | Low                                 | Intermediate | High | Low                                 | Intermediate | High | Low                                 | Intermediate | High |
| <b>Percent of aggregate benefit to this per capita income quintile</b> |                                     |              |      |                                     |              |      |                                     |              |      |
| Lowest   | 21.6                                | 21.5         | 21.9 | 19.7                                | 19.7         | 20.3 | 17.6                                | 17.7         | 18.6 |
| Second   | 23.3                                | 23.3         | 22.7 | 23.7                                | 23.5         | 23.1 | 23.5                                | 23.4         | 23.1 |
| Middle   | 23.2                                | 23.1         | 22.8 | 23.7                                | 23.7         | 23.3 | 24.1                                | 24.1         | 23.7 |
| Fourth   | 21.6                                | 21.7         | 21.8 | 22.3                                | 22.3         | 22.3 | 23.6                                | 23.5         | 23.2 |
| Highest  | 10.2                                | 10.4         | 11.0 | 10.7                                | 10.7         | 11.0 | 11.2                                | 11.2         | 11.4 |
| <b>Percent of aggregate benefit to this income/poverty quintile</b>    |                                     |              |      |                                     |              |      |                                     |              |      |
| Lowest   | 17.6                                | 17.5         | 18.2 | 16.2                                | 16.1         | 16.9 | 14.8                                | 14.9         | 15.9 |
| Second   | 20.6                                | 20.7         | 20.6 | 20.5                                | 20.6         | 20.6 | 20.1                                | 20.0         | 20.3 |
| Middle   | 24.6                                | 24.5         | 24.0 | 25.0                                | 25.0         | 24.3 | 25.2                                | 25.1         | 24.5 |
| Fourth   | 24.0                                | 24.0         | 23.8 | 24.8                                | 24.7         | 24.2 | 25.7                                | 25.8         | 25.0 |
| Highest  | 13.1                                | 13.1         | 13.6 | 13.7                                | 13.5         | 13.9 | 14.3                                | 14.3         | 14.3 |

Source: Authors' calculations from DYNASIM run 919.



TABLE 12

**Distributional Projections for CCM-Based Respite Care Benefit, Pooled Person Years 2018–2027: Aggregate Share of Benefits to Each Per Capita Income and Poverty-Adjusted Income Quintile**

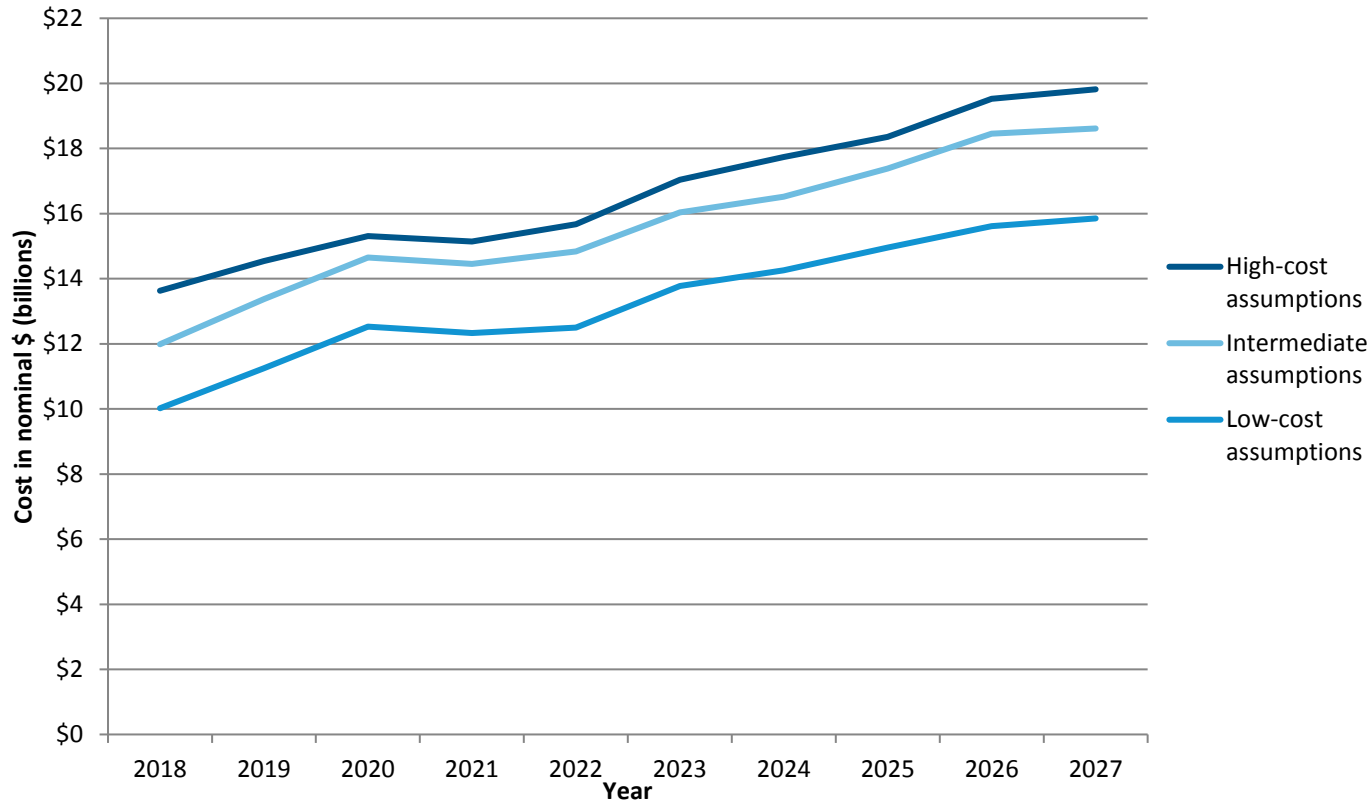
|   | Including Spouse Caregivers |      |      |                     |      |      |                     |      |      | Excluding Spouse Caregivers |      |      |                     |      |      |                     |      |      |
|---|-----------------------------|------|------|---------------------|------|------|---------------------|------|------|-----------------------------|------|------|---------------------|------|------|---------------------|------|------|
|   | Option 1: 96 hours          |      |      | Option 2: 168 hours |      |      | Option 3: 336 hours |      |      | Option 1: 96 hours          |      |      | Option 2: 168 hours |      |      | Option 3: 336 hours |      |      |
|   | Low                         | Int. | High | Low                 | Int. | High | Low                 | Int. | High | Low                         | Int. | High | Low                 | Int. | High | Low                 | Int. | High |
| <b>Percent of benefits to this per capita income quintile</b> |                             |      |      |                     |      |      |                     |      |      |                             |      |      |                     |      |      |                     |      |      |
| Lowest  | 34.4                        | 32.6 | 30.8 | 34.1                | 32.5 | 30.7 | 34.1                | 32.4 | 30.7 | 35.6                        | 34.1 | 32.2 | 35.1                | 33.9 | 32.1 | 34.9                | 33.8 | 32.1 |
| Second  | 33.2                        | 29.7 | 29.9 | 33.0                | 29.7 | 30.0 | 33.1                | 29.6 | 30.0 | 33.7                        | 30.7 | 30.8 | 33.6                | 30.7 | 30.8 | 34.5                | 30.5 | 30.8 |
| Middle  | 18.2                        | 20.3 | 20.4 | 19.0                | 20.3 | 20.4 | 18.6                | 20.3 | 20.3 | 16.3                        | 19.7 | 19.4 | 17.7                | 19.7 | 19.5 | 17.1                | 19.8 | 19.4 |
| Fourth  | 14.6                        | 14.8 | 15.6 | 13.8                | 14.9 | 15.6 | 14.0                | 14.9 | 15.6 | 14.9                        | 13.1 | 14.0 | 14.0                | 13.4 | 14.1 | 14.2                | 13.3 | 14.0 |
| Highest   | 8.3                         | 9.9  | 10.4 | 8.9                 | 9.8  | 10.4 | 8.9                 | 9.9  | 10.4 | 6.2                         | 7.6  | 8.0  | 6.5                 | 7.7  | 8.0  | 6.1                 | 7.6  | 8.0  |
| <b>Percent of benefits to this income/poverty quintile</b>    |                             |      |      |                     |      |      |                     |      |      |                             |      |      |                     |      |      |                     |      |      |
| Lowest  | 31.7                        | 30.5 | 29.1 | 31.3                | 30.5 | 29.0 | 30.9                | 30.2 | 29.1 | 37.8                        | 36.5 | 35.0 | 37.2                | 36.4 | 34.9 | 36.6                | 36.2 | 34.9 |
| Second  | 27.2                        | 24.7 | 24.6 | 27.0                | 24.6 | 24.6 | 27.5                | 24.6 | 24.6 | 24.7                        | 23.1 | 23.6 | 24.5                | 23.0 | 23.6 | 25.7                | 23.0 | 23.6 |
| Middle  | 18.2                        | 20.3 | 20.4 | 19.0                | 20.3 | 20.4 | 18.6                | 20.3 | 20.3 | 16.3                        | 19.7 | 19.4 | 17.7                | 19.7 | 19.5 | 17.1                | 19.8 | 19.4 |
| Fourth  | 14.6                        | 14.8 | 15.6 | 13.8                | 14.9 | 15.6 | 14.0                | 14.9 | 15.6 | 14.9                        | 13.1 | 14.0 | 14.0                | 13.4 | 14.1 | 14.2                | 13.3 | 14.0 |
| Highest   | 8.3                         | 9.9  | 10.4 | 8.9                 | 9.8  | 10.4 | 8.9                 | 9.9  | 10.4 | 6.2                         | 7.6  | 8.0  | 6.5                 | 7.7  | 8.0  | 6.1                 | 7.6  | 8.0  |

Source: Authors' calculations from DYNASIM run 919.

Note: Int. = intermediate.

FIGURE 1

Cost Projections for the Version of the Caregiver Tax Credit for Out-of-Pocket Expenses with a Maximum Value of \$3,000, 2018–2027, under High-, Intermediate-, and Low-Cost Assumptions

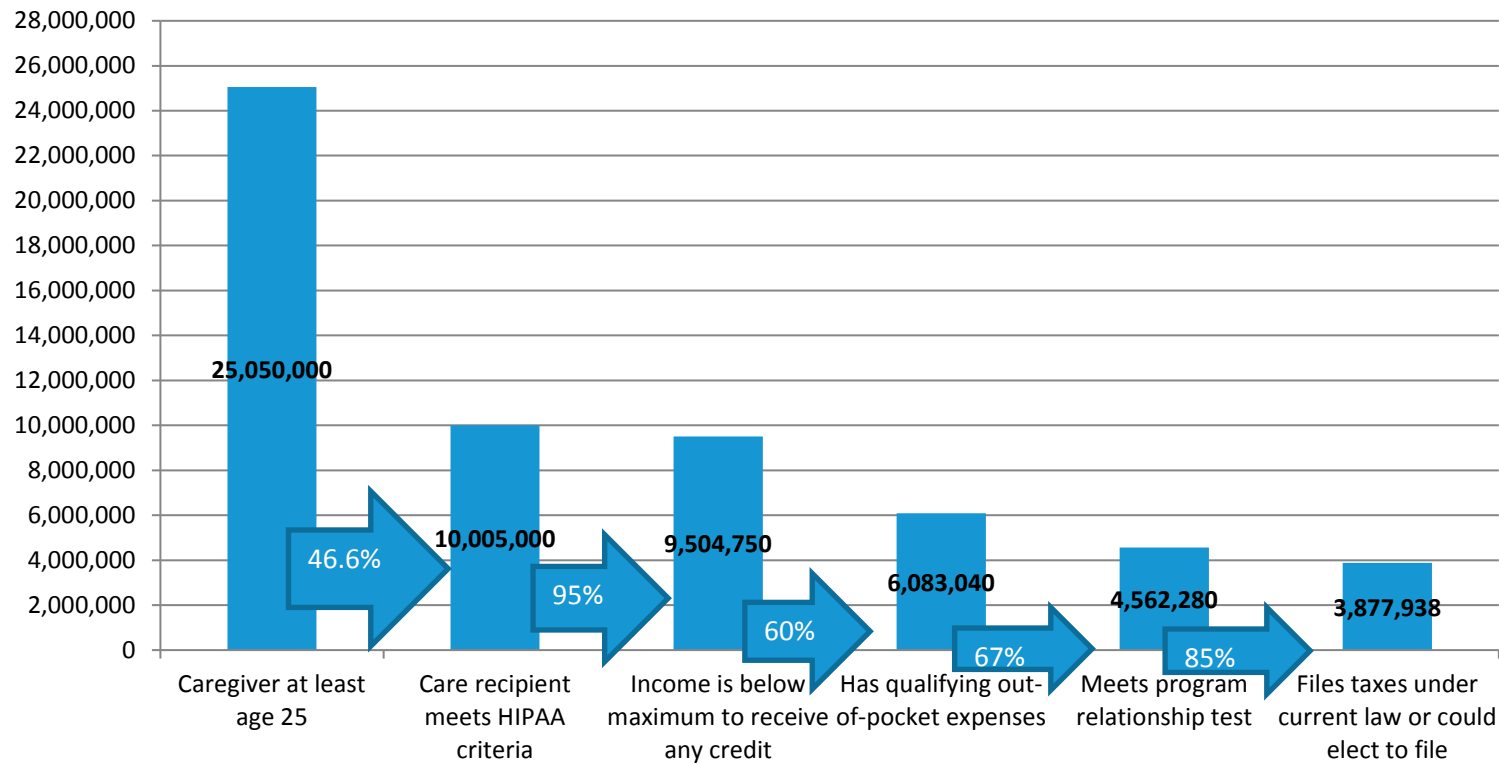


Source: Authors' calculations from DYNASIM run 919.

Note: See table 8 for description of differences in assumptions across options.

FIGURE 2

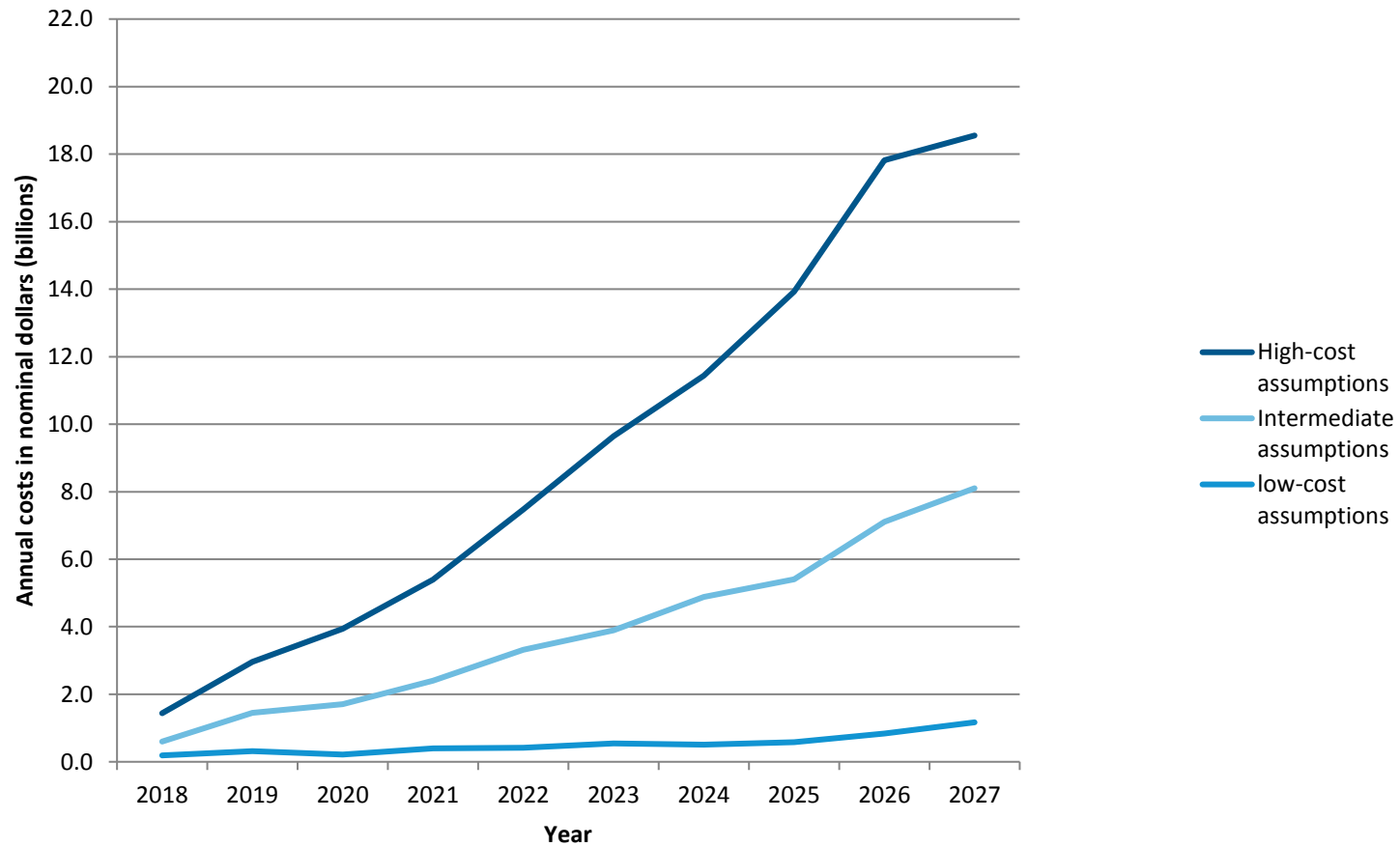
Stylized Representation of the Qualification Process for a Caregiver for the Caregiver Tax Credit, 2016



**Sources:** Authors' estimates from various sources, including NHATS/NSOC, AARP, etc. and assumptions from table 8. Some percentages will reflect weighted average of effects for groups with different rates and so may not correspond directly to any given estimate in a table. Estimates conditional on the prior sample restrictions will differ from estimates for the entire population. Also, this analysis occurs at the caregiver level, rather than at the level of all people, some of whom will file taxes with a caregiver while not paying taxes themselves.

FIGURE 3

Cost Projections for the Version of the Caregiver Tax Credit for Out-of-Pocket Expenses with a Maximum Value of \$3,000, 2018–2027, under High-, Intermediate-, and Low-Cost Assumptions

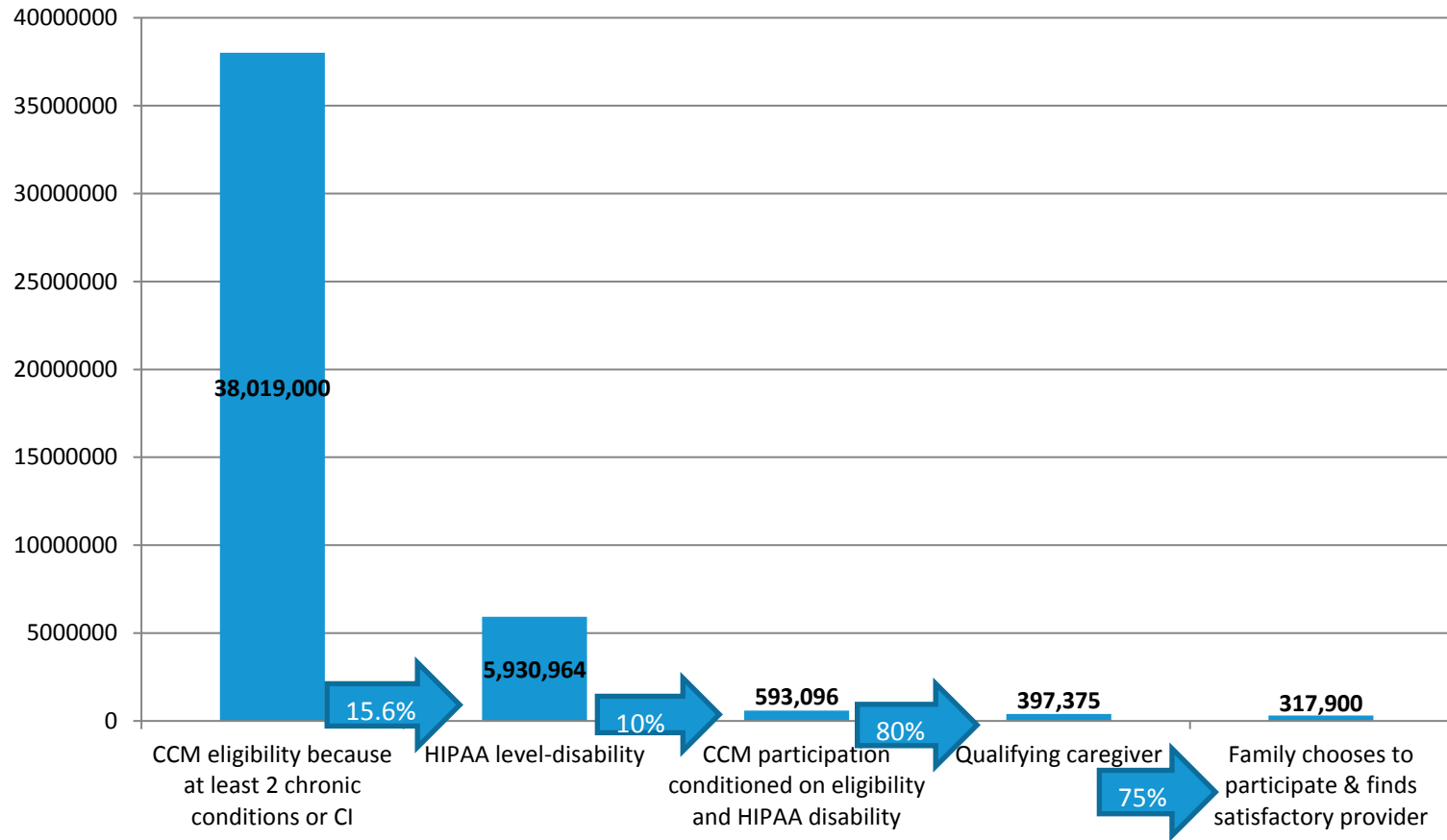


Source: Authors' calculations from DYNASIM run 919.

Note: See table 8 for description of assumption differences across options.

FIGURE 4

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



**Sources:** Authors' estimates from various sources, including NHATS/NSOC, AARP, etc. and assumptions from table 8. We use much higher than expected CCM participation in 2016 for ease of illustration. Some percentages will reflect weighted average of effects for groups with different rates and so may not correspond directly to any given estimate in a table.

## APPENDIX TABLE 1

### IRS Information on Selected Expenses Allowed under the Current Law Medical Expense Deduction as Examples of Analogous Expenses Potentially Allowable under the Proposed Caregiver Tax Credit

#### Assistive devices, including crutches, eyeglasses, hearing aids, wheel chairs

##### Car

- Cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.
- Difference between the cost of a regular car and a car specially designed to hold a wheelchair.

##### Capital expenses

- Special equipment installed in a home or improvements, if their main purpose is medical care.
  - The cost of permanent improvements that increase the value of your property may be partly included as a medical expense.
    - This is reduced by the increase in the value of your property. If the improvement does not increase the value of your property, the entire cost is included.
  - Certain improvements made to accommodate a home to disabled condition don't usually increase the value of the home and the cost can be included in full as medical expenses. (Aesthetic improvements are not allowable.) These include, but aren't limited to, the following:
    - Constructing entrance or exit ramps for your home.
    - Widening doorways at entrances or exits to your home.
    - Widening or otherwise modifying hallways and interior doorways.
    - Installing railings, support bars, or other modifications to bathrooms.
    - Lowering or modifying kitchen cabinets and equipment.
    - Moving or modifying electrical outlets and fixtures.
    - Installing porch lifts and other forms of lifts (but elevators generally add value to the house).
    - Modifying fire alarms, smoke detectors, and other warning systems.
    - Modifying stairways.
    - Adding handrails or grab bars anywhere (whether in bathrooms or not).
    - Modifying hardware on doors.
    - Modifying areas in front of entrance and exit doorways.
    - Grading the ground to provide access to the residence.

#### Guide dog or other service animal

#### Insurance premiums for health care

#### Insurance premiums for long-term care if qualified plan

#### Legal fees

- Legal fees you paid that are necessary to authorize treatment for mental illness. However, you can't include in medical expenses fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that aren't necessary for care.

#### Lifetime care—advance payments

- The part of the payment you include is the amount properly allocable to medical care. The agreement must require that you pay a specific fee as a condition for the home's promise to provide lifetime care that includes medical care.

#### **Lodging or meals**

- The cost of meals and lodging at a hospital or similar institution if a principal reason for being there is to receive medical care.

#### **Maintenance and personal care services**

#### **Long-term care**

- Subject to person meeting disability criteria and provided pursuant to a plan of care prescribed by a licensed health care practitioner.

#### **Nursing home**

#### **Nursing services**

#### **Prescribed medicines and drugs**

- A prescribed drug is one that requires a prescription by a doctor for its use by an individual. You can also include amounts you pay for insulin. Except for insulin, you can't include in medical expenses amounts you pay for a drug that isn't prescribed.

#### **Transportation**

- Applies to transportation to and from medical appointments.
  - Excludes commuting expenses, personal travel.
- You can include out-of-pocket expenses, such as the cost of gas and oil, when you use a car for medical reasons. You can also include parking fees and tolls. You can add these amounts to your medical expenses whether you use actual expenses or the standard mileage rate (19 cents a mile).
  - Excludes depreciation, insurance, general repair, or maintenance expenses.

#### **Trips**

- Some expenses for out-of-town trips can be deducted if the trips are primarily to receive medical treatment.
- Limited to up to \$50 for each night for each person.

**Source:** Descriptions and wording are drawn directly from IRS publication 502, *Medical and Dental Expenses (Including the Health Coverage Tax Credit)*, available at: <https://www.irs.gov/pub/irs-pdf/p502.pdf>

APPENDIX TABLE 2

Description of the Sample of Caregivers, 2011

|                                       | AARP    |    |            | NSOC       |         |           |                               |         |                           |           |         |
|---------------------------------------|---------|----|------------|------------|---------|-----------|-------------------------------|---------|---------------------------|-----------|---------|
|                                       | All     |    | n          | All        |         |           | Recipient not HIPAA-Qualified |         | Recipient HIPAA-Qualified |           |         |
|                                       | Percent |    |            | Frequency  | Percent | n         | Frequency                     | Percent | n                         | Frequency | Percent |
| <b>All</b>                            |         |    | 17,949,107 | 100.0      |         | 9,995,631 | 100.0                         |         | 7,953,476                 | 100.0     |         |
| <b>Relationship to recipient</b>      |         |    |            |            |         |           |                               |         |                           |           |         |
| Spouse/partner                        |         |    | 422        | 3,802,475  | 21.2    | 252       | 2,437,453                     | 24.4    | 170                       | 1,365,022 | 17.2    |
| Daughter                              |         |    | 701        | 5,262,512  | 29.3    | 328       | 2,649,425                     | 26.5    | 373                       | 2,613,086 | 32.9    |
| Son                                   |         |    | 308        | 3,287,224  | 18.3    | 153       | 1,750,756                     | 17.5    | 155                       | 1,536,468 | 19.3    |
| Son or daughter-in-law                |         |    | 115        | 1,017,676  | 5.7     | 52        | 493,198                       | 4.9     | 63                        | 524,478   | 6.6     |
| Brother or sister                     |         |    | 68         | 460,251    | 2.6     | 33        | 281,340                       | 2.8     | 35                        | 178,912   | 2.2     |
| Grandchild                            |         |    | 138        | 1,390,552  | 7.7     | 71        | 684,528                       | 6.8     | 67                        | 706,024   | 8.9     |
| Niece/nephew                          |         |    | 67         | 539,173    | 3.0     | 26        | 268,609                       | 2.7     | 41                        | 270,564   | 3.4     |
| Other relatives                       |         |    | 57         | 603,638    | 3.4     | 31        | 384,114                       | 3.8     | 26                        | 219,524   | 2.8     |
| Unrelated                             |         |    | 120        | 1,585,606  | 8.8     | 80        | 1,046,208                     | 10.5    | 40                        | 539,398   | 6.8     |
| <b>Age</b>                            |         |    |            |            |         |           |                               |         |                           |           |         |
| <45                                   | 18-34   | 19 | 256        | 2,947,805  | 16.8    | 131       | 1,524,053                     | 15.5    | 125                       | 1,423,753 | 18.5    |
| 45-54                                 | 35-50   | 24 | 443        | 4,190,782  | 23.9    | 226       | 2,350,815                     | 23.9    | 217                       | 1,839,966 | 23.9    |
| 55-64                                 | 51-70   | 46 | 595        | 4,760,300  | 27.1    | 295       | 2,522,445                     | 25.6    | 300                       | 2,237,855 | 29.0    |
| 65-74                                 |         |    | 371        | 3,291,711  | 18.7    | 207       | 2,113,409                     | 21.5    | 164                       | 1,178,302 | 15.3    |
| 75+                                   | 71-91   | 9  | 291        | 2,372,883  | 13.5    | 148       | 1,339,200                     | 13.6    | 143                       | 1,033,683 | 13.4    |
| <b>Race/ethnicity</b>                 |         |    |            |            |         |           |                               |         |                           |           |         |
| White, non-Hispanic                   |         | 69 | 1220       | 12,665,311 | 70.6    | 670       | 7,414,920                     | 74.2    | 550                       | 5,250,390 | 66.0    |
| Black, non-Hispanic                   |         | 8  | 607        | 2,322,028  | 12.9    | 283       | 1,219,515                     | 12.2    | 324                       | 1,102,513 | 13.9    |
| Other, non-Hispanic                   |         | 8  | 49         | 907,542    | 5.1     | 29        | 526,121                       | 5.3     | 20                        | 381,421   | 4.8     |
| Hispanic                              |         | 15 | 120        | 2,054,227  | 11.4    | 44        | 835,076                       | 8.4     | 76                        | 1,219,152 | 15.3    |
| <b>Female</b>                         |         | 60 | 1327       | 11,095,924 | 61.8    | 658       | 6,034,700                     | 60.4    | 669                       | 5,061,224 | 63.6    |
| Lives with recipient (all caregivers) |         |    | 992        | 8,031,203  | 44.7    | 498       | 4,568,603                     | 45.7    | 494                       | 3,462,600 | 43.5    |



APPENDIX TABLE 2 (CONTINUED)

Description of the Sample of Caregivers, 2011

|   | AARP           |      | NSOC             |         |                               |           |         |                           |           |         |
|---|----------------|------|------------------|---------|-------------------------------|-----------|---------|---------------------------|-----------|---------|
|   | All<br>Percent | n    | All<br>Frequency | Percent | Recipient not HIPAA-Qualified |           |         | Recipient HIPAA-Qualified |           |         |
|   |                |      |                  |         | n                             | Frequency | Percent | n                         | Frequency | Percent |
| Lives with recipient (nonspouse caregivers) |                | 570  | 4,228,728        | 29.9    | 246                           | 2,131,150 | 28.2    | 324                       | 2,097,578 | 31.8    |
| Employed (all caregivers)                   |                | 820  | 7,837,764        | 44.2    | 414                           | 4,263,774 | 43.3    | 406                       | 3,573,990 | 45.3    |
| Employed (nonspouse caregivers)             |                | 753  | 7,140,080        | 50.9    | 367                           | 3,779,536 | 50.5    | 386                       | 3,360,544 | 51.3    |
| <b>Financial difficulty level</b>           |                |      |                  |         |                               |           |         |                           |           |         |
| None/little                                 |                | 1625 | 14,702,365       | 81.9    | 886                           | 8,738,237 | 87.4    | 739                       | 5,964,128 | 75.0    |
| Some  |                | 228  | 2,054,036        | 11.4    | 86                            | 805,938   | 8.1     | 142                       | 1,248,098 | 15.7    |
| Substantial                                 |                | 143  | 1,192,707        | 6.6     | 54                            | 451,457   | 4.5     | 89                        | 741,250   | 9.3     |

Source: Authors' calculations from NHATS/NSOC and Rainville, Skufca, Mehegan (2016).

APPENDIX TABLE 3

Comparison of Survey Questions with IRS Guidance on Medical Expenses and Hypothesized Allowability of Expenses under a Caregiver Tax Credit

| Item  | AARP Survey | NHATS/<br>NSOC | Listed in Related IRS<br>Regulations or Guidance and<br>Likely Inclusion Given Policy<br>Description? | Adjustment to AARP Estimate<br>to Derive Share Excludable on<br>Tax Filing? |
|---|-------------|----------------|---|---|
| <b>Retrospective survey items</b>                             |             |                |   |   |
| Home modification related to mobility/safety                  | Yes         | Yes            | Yes   | 1   |
| Remote health or safety monitoring                            | Yes         |                | Unclear, likely   | 1   |
| Nursing home or long-term care facility fees                  | Yes         |                | Only care portion   | 1   |
| Assisted living or other residential setting fees             | Yes         |                | Only care portion   | 0.5   |
| Independent living/retirement community fees                  | Yes         |                | Only care portion   | 0   |
| Travel (airfare, trains, hotels, parking, gas, etc.)          | Yes         | No             | Limited   | 0.5   |
| Legal fees related to caregiving situation                    | Yes         | No             | Limited   | 0.5   |
| Relocation costs for caregiver or care recipient              | Yes         | No             | Limited   | 0   |
| Major medical equipment like a scooter or wheel chair         | Yes         | Yes            | Yes   | 1   |
| Home health, adult day services                               | Yes         | Yes            | Yes   | 1   |
| Medical, dental, or vision premiums                           | Yes         | Yes            | Unclear   | 0.5   |
| LTCi premiums   | Yes         |                | Yes if qualified  | 1   |
| Caregiver support (geriatrician)                              | Yes         |                | Yes if qualified  | 0.5   |
| Services such as household care (cleaning, lawn, maintenance) | Yes         | No             | No  | 0   |
| Clothing  | Yes         | No             | Likely very limited   | 0.1   |
| Other housing payments: rent, utilities                       | Yes         | No             | No  | 0   |
| Home repair   | Yes         | No             | No  | 0   |
| Retrofit van or vehicle                                       | Yes         |                | Yes   | 1   |
| <b>Diary items</b>  |             |                |   |   |
| Medical   | Yes         |                | Some  | 1   |
| Household expenses  | Yes         |                | Limited   | 0.5   |
| Personal care items   | Yes         |                | Limited   | 0.5   |
| Educational/legal/travel                                      | Yes         |                | Limited   | 0.5   |
| Caregiver/personal/respite                                    | Yes         |                | Yes   | 1   |

Sources: IRS publication 502, *Medical and Dental Expenses (Including the Health Coverage Tax Credit)*, available at: <https://www.irs.gov/pub/irs-pdf/p502.pdf>; Rainville, Skufca, Mehegan (2016), especially table A2.

APPENDIX TABLE 4

Gross and Net Cost Projections for Three Versions of CCM-Based Respite Care Benefit, 2018–2027, under High-, Intermediate- and Low-Cost Assumptions When Integrating a Modest Copayment

|   | Including Spouse Caregivers |      |      |                     |      |      |                     |      |       | Excluding Spouse Caregivers |      |      |                     |      |       |                     |       |       |
|---|-----------------------------|------|------|---------------------|------|------|---------------------|------|-------|-----------------------------|------|------|---------------------|------|-------|---------------------|-------|-------|
|   | Option 1: 96 hours          |      |      | Option 2: 168 hours |      |      | Option 3: 336 hours |      |       | Option 1: 96 hours          |      |      | Option 2: 168 hours |      |       | Option 3: 336 hours |       |       |
|   | Low                         | Int. | High | Low                 | Int. | High | Low                 | Int. | High  | Low                         | Int. | High | Low                 | Int. | High  | Low                 | Int.  | High  |
| <b>Gross costs (billions, nominal \$)</b>                           |                             |      |      |                     |      |      |                     |      |       |                             |      |      |                     |      |       |                     |       |       |
| 2018  | 0.1                         | 0.3  | 0.8  | 0.2                 | 0.6  | 1.4  | 0.4                 | 1.2  | 3.0   | 0.2                         | 1.5  | 3.7  | 0.4                 | 2.8  | 6.7   | 0.9                 | 5.7   | 13.6  |
| 2019  | 0.1                         | 0.8  | 1.7  | 0.3                 | 1.5  | 3.0  | 0.6                 | 3.0  | 6.0   | 0.2                         | 1.7  | 4.5  | 0.4                 | 3.2  | 7.9   | 0.9                 | 6.6   | 16.1  |
| 2020  | 0.1                         | 0.9  | 2.2  | 0.2                 | 1.7  | 3.9  | 0.5                 | 3.6  | 8.1   | 0.2                         | 2.1  | 5.6  | 0.5                 | 4.0  | 10.0  | 1.1                 | 8.4   | 20.3  |
| 2021  | 0.2                         | 1.3  | 3.0  | 0.4                 | 2.4  | 5.4  | 0.9                 | 5.0  | 11.1  | 0.3                         | 2.7  | 6.8  | 0.6                 | 5.0  | 12.3  | 1.5                 | 10.6  | 25.0  |
| 2022  | 0.2                         | 1.8  | 4.1  | 0.4                 | 3.3  | 7.5  | 0.9                 | 6.8  | 15.2  | 0.4                         | 3.1  | 7.3  | 0.8                 | 5.7  | 13.1  | 1.7                 | 11.6  | 26.6  |
| 2023  | 0.2                         | 2.1  | 5.3  | 0.5                 | 3.9  | 9.6  | 1.2                 | 8.0  | 19.5  | 0.2                         | 3.2  | 7.8  | 0.5                 | 6.0  | 14.0  | 1.1                 | 12.5  | 28.5  |
| 2024  | 0.2                         | 2.6  | 6.5  | 0.5                 | 4.9  | 11.4 | 1.2                 | 10.0 | 23.3  | 0.3                         | 3.2  | 8.2  | 0.7                 | 5.9  | 14.7  | 1.5                 | 12.3  | 29.9  |
| 2025  | 0.3                         | 2.9  | 7.8  | 0.6                 | 5.4  | 13.9 | 1.4                 | 11.4 | 28.3  | 0.3                         | 3.4  | 8.4  | 0.7                 | 6.4  | 15.4  | 1.6                 | 13.4  | 31.3  |
| 2026  | 0.4                         | 3.8  | 9.9  | 0.8                 | 7.1  | 17.8 | 1.9                 | 14.9 | 36.1  | 0.4                         | 4.0  | 9.5  | 0.8                 | 7.3  | 17.0  | 1.8                 | 14.9  | 34.6  |
| 2027  | 0.6                         | 4.3  | 10.4 | 1.2                 | 8.1  | 18.6 | 2.5                 | 16.6 | 37.7  | 0.5                         | 4.2  | 10.7 | 1.0                 | 7.8  | 19.0  | 2.1                 | 16.4  | 38.8  |
| <b>2018–2027 total</b>  | 2.4                         | 20.8 | 51.7 | 5.2                 | 38.9 | 92.6 | 11.5                | 80.5 | 188.3 | 3.1                         | 29.0 | 72.5 | 6.4                 | 54.2 | 130.1 | 14.2                | 112.4 | 264.8 |
| <b>Net costs after including co-payments (billions, nominal \$)</b> |                             |      |      |                     |      |      |                     |      |       |                             |      |      |                     |      |       |                     |       |       |
| 2018  | 0.1                         | 0.3  | 0.7  | 0.2                 | 0.6  | 1.4  | 0.4                 | 1.2  | 2.9   | 0.2                         | 1.5  | 3.7  | 0.4                 | 2.7  | 6.6   | 0.9                 | 5.7   | 13.6  |
| 2019  | 0.1                         | 0.7  | 1.6  | 0.3                 | 1.4  | 2.8  | 0.6                 | 2.9  | 5.9   | 0.2                         | 1.7  | 4.4  | 0.4                 | 3.2  | 7.8   | 0.9                 | 6.6   | 16.1  |
| 2020  | 0.1                         | 0.9  | 2.1  | 0.2                 | 1.6  | 3.8  | 0.5                 | 3.5  | 7.9   | 0.2                         | 2.0  | 5.5  | 0.5                 | 3.9  | 9.9   | 1.1                 | 8.3   | 20.2  |
| 2021  | 0.2                         | 1.2  | 2.9  | 0.4                 | 2.3  | 5.2  | 0.9                 | 4.8  | 10.8  | 0.2                         | 2.6  | 6.7  | 0.6                 | 5.0  | 12.2  | 1.4                 | 10.5  | 25.0  |
| 2022  | 0.2                         | 1.7  | 4.0  | 0.4                 | 3.2  | 7.3  | 0.8                 | 6.6  | 14.8  | 0.4                         | 3.0  | 7.2  | 0.7                 | 5.6  | 13.0  | 1.6                 | 11.6  | 26.5  |
| 2023  | 0.2                         | 2.0  | 5.2  | 0.5                 | 3.8  | 9.4  | 1.1                 | 7.8  | 19.1  | 0.2                         | 3.1  | 7.7  | 0.5                 | 5.9  | 13.9  | 1.1                 | 12.4  | 28.5  |
| 2024  | 0.2                         | 2.5  | 6.3  | 0.5                 | 4.7  | 11.2 | 1.1                 | 9.7  | 22.8  | 0.3                         | 3.1  | 8.0  | 0.7                 | 5.9  | 14.5  | 1.5                 | 12.3  | 29.8  |
| 2025  | 0.3                         | 2.8  | 7.6  | 0.5                 | 5.3  | 13.6 | 1.4                 | 11.1 | 27.7  | 0.3                         | 3.3  | 8.3  | 0.6                 | 6.3  | 15.3  | 1.6                 | 13.3  | 31.2  |
| 2026  | 0.3                         | 3.7  | 9.6  | 0.8                 | 6.9  | 17.4 | 1.8                 | 14.6 | 35.4  | 0.4                         | 3.9  | 9.3  | 0.8                 | 7.2  | 16.8  | 1.8                 | 14.8  | 34.5  |
| 2027  | 0.5                         | 4.2  | 10.1 | 1.1                 | 7.9  | 18.1 | 2.4                 | 16.3 | 36.9  | 0.4                         | 4.1  | 10.5 | 0.9                 | 7.7  | 18.9  | 2.0                 | 16.2  | 38.7  |
| <b>2018–2027 total</b>  | 2.2                         | 20.0 | 50.2 | 4.8                 | 37.7 | 90.2 | 11.0                | 78.6 | 184.2 | 2.8                         | 28.4 | 71.4 | 6.1                 | 53.4 | 129.0 | 13.9                | 111.6 | 264.0 |

Source: Authors' calculations from DYNASIM run 919.

Notes: Int. = intermediate. Intermediate estimate integrates our best guess assumptions on take-up, administrative costs, ADL creep/inflation, beneficiaries younger than 51, and intensity of use. Low-cost estimate assumes low take-up, low administrative costs, no ADL creep/inflation, lower prevalence of beneficiaries younger than 51, and lower-bound

intensity of use. High-cost estimate assumes near-universal take-up among eligibles, high administrative costs, some ADL creep/inflation, higher prevalence of beneficiaries younger than 51, and higher-bound intensity of use. (See table 8.)

# About the Authors



**Melissa Favreault** is a senior fellow in the Income and Benefits Policy Center at the Urban Institute, where her work focuses on the economic well-being and health status of older Americans and individuals with disabilities. She studies social insurance and social assistance programs and has written extensively about Medicaid, Medicare, Social Security, and Supplemental Security Income. She evaluates how well these programs serve Americans today and how various policy changes and ongoing economic and demographic trends could alter outcomes for future generations. Much of her research relies on dynamic microsimulation, distributional models that she develops to highlight how educational and economic advantages shape financial outcomes, disability trajectories, health care needs, and longevity. She has a special interest in the economic risks that people face over their lives. Favreault has published her research in *Demography*, *Health Affairs*, *Health Services Research*, and the *Journal of Gerontology: Social Sciences* and coedited *Social Security and the Family: Addressing Unmet Needs in an Underfunded System*. She served on the Social Security Advisory Board's 2011 Technical Panel on Assumptions and Methods and now serves on the board of the International Microsimulation Association. Favreault earned her BA in political science and Russian from Amherst College, and her MA and PhD in sociology from Cornell University.



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