# Developing a Long Term Care Proposal

In discussions among staff at HHS and OPM issues divided into 3 categories:

1. Consensus items
2. Areas in which we need more information
3. Other approaches

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## *Consensus Items*

### Eligible Enrollees

- All Federal employees and annuitants
  - Guaranteed issue or minimal underwriting for all employees in pay and duty status
  - All others must demonstrate insurability at time of purchase

### Financing

- Enrollee pay all (no Government contribution)
- Payroll deduction
- Agencies transmit withholdings directly to carriers (no Long Term Care trust fund)
- Carriers at risk; enrollees have recourse to carriers only (no underwriting of risk by the Government)

### Startup Costs

- Funded by OPM
- OPM will propose funding mechanism for initial education and promotion costs

### Benefits Design (also see Need More Information section)

Eligible enrollees will have choice of several benefit packages

- Core package
  - Typical dollars/day for both home care and nursing home care, *e.g.*, $60/$120
  - HIPAA benefit triggers (including cognitive impairment)
  - Reasonable deductible period, *e.g.*, 90 days
- Vertical enhancements (higher dollar per day benefit levels)
- Horizontal enhancements (*e.g.*, coverage for parents and in-laws)

## *Areas in Which We Need More Information*

### Benefits Design

- Core vs. enhancement issues
  - inflation protection
  - non-forfeiture provisions
  - upgrades and downgrades
- Employee/annuitant prime contract holder with spouses, parents, in-laws add ons to prime contract vs. independent contracts for eligible family members

### Contracting Process and Consumer Choice

- Single carrier vs. segmentation of risk pool
- RFP specifying core benefits package and several levels of enhancements vs. negotiation of vendor-proposed benefits packages
- Rebidding issues: frequency, reserve transfers, operational concerns
- Options to purchase up-grades and downgrades

### State Requirements and Preemption

- Financial solvency requirements
- State mandates
- Consumer protections

## *Other Approaches*

- Open market (Mica proposal)
- Life insurance rider
- Broad general legislation giving OPM authority to contract with one or more State qualified carriers for long term care in insurance that meets HIPAA standards as a minimum

## Options to Assist Taxpayers with Long-Term Care Needs

Reason for Change: Taxpayers with long-term care needs do not have the same ability to pay taxes as taxpayers who do not incur such costs.

Issues

- To whom should assistance be provided?
  -- Either chronically ill individuals or the caregivers who care for them.
  -- Caregivers of chronically ill individual only.

- How should chronic illness be defined?

  -- Two activities of daily living limitations or severe cognitive impairment.
  – Same as above but require three activities of daily living limitations.
  -- Aged dependents.

- What type of care?

  -- Any kind (home, community, and nursing home; both cash expenses and in-kind services).
  -- Only home or community based care (both cash expenses and in-kind services).
  -- Only cash expenses (home, community, and nursing home).

Options

Revenue estimates are still rough and preliminary.

- Option 1: Expand eligibility for the partially refundable $500 child credit to taxpayers with a chronic illness or a chronically ill spouse or dependent. To qualify as chronically ill, the individual must be unable to perform at least two activities of daily living or meet a mental impairment test. Revenue cost: $4.7 billion between FY 1999 and 2003 and $11.4 billion between FY 1999 and 2008. (If maximum credit is increased to $1,000, revenue costs increase to $9 billion over first five years and $21.6 billion over ten years.)

- Option 2: Create a new nonrefundable tax credit of $1,000 for taxpayers who pay for or provide home-based or community long-term care services for themselves or a chronically ill spouse or dependent. To qualify as chronically ill, the individual must be unable to perform at least three activities of daily living or meet a mental impairment test. Revenue cost: $4.7 billion between FY 1999 and 2003 and $11.8 billion between FY 1999 and 2008.

- Option 3: Create a new nonrefundable tax credit equal to 75 percent of first $2,000 of qualified long-term expenses for taxpayer with chronic illness or chronically ill spouse or dependent. Maximum credit would be equal to $1,500. To qualify as chronically ill, the individual must be unable to perform at least three activities of daily living or meet a mental impairment test. Revenue cost: $4.6 billion between FY 1999 and 2003 and $10.5 billion between FY 1999 and 2008.

## Options to Assist Taxpayers with Long-Term Care Needs

### Current Law

There are several provisions in the tax code that provide assistance to taxpayers with a disabled family member or with long-term care expenses. A taxpayer can receive a child and dependent care tax credit for expenses incurred to care for a disabled spouse or dependent so the taxpayer can work. A low-income working taxpayer can qualify for the earned income tax credit if he or she has a disabled child (of any age). A taxpayer who itemizes can deduct expenses for qualified long-term care services if he or she is chronically ill or such expenses were incurred on behalf of a chronically ill spouse or dependent. However, taxpayers can only deduct medical expenses, including expenses for qualified long-term care services, that exceed 7.5 percent of adjusted gross income. These provisions are described in the "Background on Current Law" section at the end of the memorandum.

### Reason for Change

Taxpayers who pay for their own long-term care or care for chronically ill spouses and dependents do not have the same ability to pay taxes as taxpayers who do not incur such costs. Subsidizing long-term care expenses is a more equitable and efficient way of recognizing these costs and responsibilities than expanding subsidies for the purchase of long-term care insurance. Additional tax subsidies for expenditures on long-term care insurance would primarily benefit individuals who have sufficient resources to purchase insurance without a subsidy. In contrast, subsidies for long-term care expenses will ensure that assistance is provided to those who are currently burdened with the costs of a chronic illness.

### Option 1

The existing $500 child credit would be expanded so that a taxpayer could claim the credit not only for each dependent child under age 17, but also for (a) himself or herself if chronically ill; (b) a chronically ill spouse; or (c) each chronically ill dependent age 17 or older. Chronically ill dependents would be individuals who meet all the dependency tests except the gross income test.[1] Thus, an individual who had gross income in excess of $2,750 in 1999 but met all the other dependency tests would be a qualifying individual. A taxpayer would not be eligible for the credit if he or she were a chronically ill dependent of another taxpayer.

An individual is chronically ill if he or she has been certified by a licensed health care practitioner within the previous 12 months as being unable for at least 90 days to perform at least two activities of daily living without substantial assistance from another individual, due to loss of

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[1] To qualify as a dependent, an individual must (1) be a specified relative or member of the taxpayer's household; (2) be a U.S. citizen or resident or resident of Canada or Mexico; (3) not be required to file a joint tax return with his or her spouse; (4) have gross income in excess of $2,750 in 1999 (if not the taxpayer's child); and (5) receive over half his or her support from the taxpayer.

functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence. Alternatively, the individual must require substantial supervision to be protected from threats to his or her own health and safety due to severe cognitive impairment. This definition of chronic illness is used in the provision allowing an itemized deduction for qualified long-term care expenses.

The taxpayer would be required to provide a correct taxpayer identification number for the qualifying chronically ill individual. Failure to provide a correct TIN will be subject to mathematical error procedures. Further, the taxpayer would be required to attach a certificate from a doctor or other specified medical professional to their tax return the first time that they apply for the tax credit.[2] The certificate would state that the individual was chronically ill (as defined above) and must be signed by the doctor or medical professional. Failure to attach the certificate would also be subject to mathematical error procedures. Medical professionals who intentionally falsify certificates would be subject to fines equal to $500 per false certificate. Further, the taxpayer may be required to provide other proof of the existence of the chronic illness in such form and manner, and at such times, as the Secretary may require.

The income thresholds would continue to operate as they do for the child credit under current law. Also, a taxpayer would be eligible for the refundable portion of the credit if the taxpayer has three or more qualifying individuals in any combination from the four categories (dependent children under age 17, chronically ill dependents age 17 or older, chronically ill taxpayers, and chronically ill spouses).

**(Rough, Preliminary) Cost Estimate**

FY 1999 - 2003: $4.7 billion
FY 1999 - 2008: $11.4 billion

If maximum credit is increased to $1,000 for chronically ill individuals:

FY 1999 - 2003: $9.0 billion
FY 1999 - 2008: $21.6 billion

**Pros**

- Taxpayers incur expenses for long-term care for both themselves and for their dependents, and such expenses reduce their ability to pay taxes. The proposed credit would partially offset these expenses.

- Taxpayers would be eligible for the credit, regardless of whether they purchase long-term

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[2] Non-elderly chronically ill individuals could be required to attach the certificate on a more regular basis (every three or five years).

care services outside the home, pay for services within their own home, or rely on relatives for care. The credit helps enable taxpayers to choose the most appropriate care for themselves and their dependents.

- Taxpayers would not have to retain extensive records to demonstrate long-term care expenses. Taxpayers who are burdened by their own illness or the care of chronically ill spouses and dependents need assistance, but should not be further burdened by extensive record-keeping requirements.

**Cons**

- Long-term care is very expensive. Long-term care expenses will typically greatly exceed a $500 tax credit.

- Most low-income taxpayers would not benefit from this provision because the tax credit would only be partially refundable. But making the tax credit fully refundable may reopen Congressional battles regarding the earned income tax credit.

  -- Some moderate-income taxpayers may not benefit from the proposal because they can not claim their incapacitated relatives as dependents, even though the taxpayers provide much of their care. For example, a taxpayer may provide largely in-kind support (e.g., transportation to the doctor, shopping for food, help with bathing) for his or her incapacitated relative, who uses social security or SSI benefits to pay for other living expenses. Because the taxpayer can not demonstrate that he or she supports the relative, the taxpayer cannot legally claim the relative as a dependent. And if the incapacitated relative's income is too low, the relative will not be able to claim the credit on his or her own behalf.

- The IRS would find it difficult to enforce compliance without actually engaging in expensive and possibly intrusive audits of taxpayers. A social security or another government assistance office may be better able than the IRS to verify the existence of a disability before any payment is made to the taxpayer.

  -- Taxpayers would be required to attach a physician's letter certifying that the qualifying individual is incapacitated, but processing the additional paper would be difficult and costly for the IRS. Additional computer programming changes would be necessary in order to determine when a taxpayer was required to file a certificate, but the IRS' programming resources are generally unavailable until the year 2000 problem has been fixed.

  -- Even with the certification process, the IRS would still need to conduct further investigations to determine the veracity of disability claims. With the IRS under attack in recent years, examiners and investigators might be reluctant to audit taxpayers who claim

a disability. While medical professionals may be a more sympathetic target of an audit probe, it will be difficult (and expensive) for the IRS to prove intent.

**Ways to Reduce Costs of Option 1 and/or Increase the Amount of the Credit**

- Require that qualifying individuals, other than the taxpayer or spouse, meet all dependency tests (including the gross income test).

- Tighten the definition of chronically ill by increasing the number of required activities of daily living limitations from two to three (out of six) or by requiring that the two activities of daily living limitations include eating and toileting.

- Increase the number of days that a qualifying individual must be expected to be chronically ill from 90 days to 360 days.

- Deny credit if incapacitated individual receives Medicaid long-term care services (nursing home benefits, home care services, and/or other community care benefits). But this restriction is largely unenforceable unless HCFA or the states are required to report to the IRS on an ongoing basis who is receiving Medicaid long-term care services.

**Option 2**

A taxpayer could be eligible for a nonrefundable tax credit equal to $1,000 if he or she is chronically ill and pays for long-term care services in the home or community or if the taxpayer provides or purchases long-term care services in the home or community for a chronically ill spouse or dependent. Long-term services could occur in either the taxpayer's or dependent's home or community. The credit would be phased-out in the same manner as under option 1. This option is a variant of the first option, but provides a larger credit to a more narrow class of taxpayers -- those with home or community based care. Unlike the first option, this option is also totally nonrefundable.

To qualify, the chronically ill individual must receive long-term care services in the taxpayer's or dependent's home or community for over half the period of time during the year that the individual is receiving long-term care services. Thus, a taxpayer could claim the credit if a chronically ill dependent was receiving care in his or her home for four months and in a nursing home for two months. During the time that the chronically ill individual is receiving care in the home or the community, the taxpayer must provide either the majority of care or pay for over half the costs of the care or, in combination, provide and pay for the majority of care. Definitions of both home and community based long-term care services have not yet been defined, but must be specified in as enforceable a manner as possible.

The definitions of a qualifying chronically ill individual and long-term care services are the same as under option 1 except that the individual must be unable to perform at least three

activities of daily living (not two). The reporting requirements are also the same as under option 1.

**(Rough, Preliminary) Cost Estimate**

FY 1999 - 2003: $4.7 billion
FY 1999 - 2008: $11.8 billion

**Pros**

- Some caregivers may have had to reduce their hours of work or other activities in order to provide personal care within the home or in adult day care. Because they did not purchase long-term care services, these taxpayers would not qualify for a credit that is based on expenses (as in Option 3, described below) but would benefit from this credit.

- By subsidizing nursing home costs for low-income individuals, Medicaid policy may encourage some individuals (particularly those with little or no assets) to turn to institutionalized care for their long-term needs. A tax credit that would be targeted to home or community-based care would help offset the incentive effects under Medicaid to enter an institutionalized setting and may encourage some disabled individuals to be more fully integrated within the community.

**Cons**

- For some chronically ill individuals, care provided by professionals in a nursing home setting may be more beneficial than care provided at home or in the community. Yet, taxpayers may incur significant costs in order to pay for their own or dependent's nursing home care. This option treats these taxpayers inequitably by not recognizing their costs and contributions to the care of their family members.

- Some individuals with long-term care expenses may receive no assistance at all from the government under the proposal. For example, they may not have purchased tax-preferred long-term care insurance. Now disabled, they incur out-of-pocket expenditures, but they do not qualify for Medicaid (because their income or assets are still too high) or to claim an itemized deduction (because their total deductions are too low to benefit from itemizing).

- As under the preceding options, some low-income or middle-income taxpayers would not benefit from this provision because the tax credit would be nonrefundable or they cannot claim the chronically ill individual as a dependent.

- Potential compliance problems are larger than under option 1 because eligibility would depend on where assistance is provided, as well as on the presence of a disability. Generally, the IRS would not be able to determine where assistance was actually provided. Even in the

rare cases where an audit was initiated, it will be difficult for the IRS to determine retrospectively where (or even if) the care occurred. Two or three years after a tax return has been filed (when the rare audit occurs), taxpayers who provide in-kind services for chronically ill individuals in their own homes will not be easily able to verify that they were the primary caregivers.

**Ways to Reduce Costs of Option 2 and/or Increase the Amount of the Credit**

- Eligibility could be limited to caregivers.

  -- Chronically ill individuals who must pay for their own care would receive no benefit at all.

- Eligibility could be limited to caregivers who personally provide care for the individual in the home or community.

  -- Caregivers who pay for the care of an individual in their own home (possibly because they work or because a professional caregiver would provide better services) would receive no benefit at all.

**Option 3**

A taxpayer could be eligible for a nonrefundable tax credit equal to 75 percent of the costs of long-term care services for themselves (if chronically ill) or for chronically ill spouses and dependents. Taxpayers could not claim more than $2,000 of long-term care expenses. Thus, the maximum credit could not exceed $1,500. Taxpayers could not claim creditable expenses as an itemized deduction. The credit would be phased-out in the same manner as under option 1.

The definitions of a qualifying chronically ill individual and long-term care services are the same as under option 1 except that the individual must be unable to perform at least three activities of daily living (not two). The reporting requirements are also the same as under option 1.

**(Rough, Preliminary) Cost Estimate**

FY 1999 - 2003: $4.6 billion
FY 1999 - 2008: $10.5 billion

**Pros**

- The maximum value of the credit would be $1,500. It would thus represent a greater proportion of taxpayers' actual expenditures than the credit under option 1. The proposed credit is also more sharply targeted to individuals who incur large expenses for their own care or the care of a spouse or dependent.

- While some taxpayers may be able to claim an itemized deduction for actual long-term care expenditures for themselves and their dependents, many moderate-income taxpayers may not have sufficient deductions to be able to take advantage of itemizing. However, they would be eligible for a tax credit.

**Cons**

- The option may not provide much, or even any, assistance to taxpayers who care for low-income incapacitated relatives in the home. These caregivers may not, in fact, pay for long-term care services, but provide much of the care themselves. In many cases, they may have given up jobs outside the home in order to provide this care, but the foregone wages cannot be quantified and would not qualify as long-term expenses.

- In-home caregivers may also find it difficult to distinguish the costs of caring for their relatives from the normal costs of maintaining the home for the healthy members of the household.

- Low-income taxpayers would not benefit from this provision because the tax credit would be nonrefundable.

- Potential compliance problems are larger than under option 1 because eligibility would depend on expenditures, as well as on the presence of a disability.

  -- The IRS can best verify eligibility when an independent third party is required to report to the IRS. But it would be very difficult (and probably impossible) to impose independent reporting requirements of long-term care expenditures. While taxpayers would be required to maintain records of actual expenses, the IRS would not have an opportunity to observe these records unless the agency was auditing the taxpayers.

## Background on Current Law

$500 Child Tax Credit: Taxpayers may be eligible for a tax credit for qualifying children of up to $500 per child in 1999. The credit is reduced by $50 for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted gross income exceeds $110,000 ($75,000 if the taxpayer is not married and $55,000 if the taxpayer is married but filing a separate return).

Qualifying children must meet four tests. First, they must be a dependent of the taxpayer.[3] Second, they must be under the age of 17. Third, they must be a son or daughter of the taxpayer, or a descendant of either, or an eligible foster child. Fourth, the child dependent must be a U.S. citizen or national.

The credit is generally nonrefundable. However, taxpayers with three or more children may be eligible for an additional refundable amount that cannot exceed the difference between the employee share of social security taxes and the EITC.

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[3] To qualify as a dependent, an individual must meet five tests:

1) Member of household or relationship test: The individual must be the son or daughter of the taxpayer or a descendant of either, a sibling, a parent or ancestor, a niece or nephew, or an aunt or uncle. Certain relationships by marriage are also included in this definition. Non-relatives may be dependents if they reside in the taxpayer's place of abode throughout the year as a member of the taxpayer's household, and the relationship does not violate local law.

2) Citizenship test: The dependent must be U.S. citizen or resident, or resident of Canada or Mexico.

3) Joint return test: Generally, a taxpayer cannot claim a dependent exemption for an individual who files a joint return.

4) Gross income test: Unless the dependent is the taxpayer's child and under the age of 19 (24 if a full-time student), the dependent's gross income (generally, taxable income) cannot exceed the exemption amount ($2,750 in 1999). Nontaxable social security benefits are not included in gross income.

5) Support test: The taxpayer must generally provide over half the total support of the dependent. Total support includes amounts spent to provide food, lodging, clothing, education, and medical and dental care. The taxpayer may not count assistance provided by the state (e.g., TANF or SSI benefits) as counting toward his or her contribution for the support of the dependent. Medical insurance premiums, including Medicare Part B premiums, are included in total support; medical insurance benefits (including Medicare Part A and B benefits and state Medicaid payments) are not part of support.

Taxpayers must provide a valid taxpayer identification number (e.g., a social security number) for each qualifying child. The IRS may use mathematical error procedures to deny the tax credit if a correct TIN has not been provided.

Child and Dependent Care Tax Credit: A taxpayer who incurs expenses for the care of a qualifying individual in order to work is eligible for a nonrefundable tax credit.[4] In general, a qualifying individual is (1) a dependent of the taxpayer who is under the age of 13[5]; (2) a dependent of the taxpayer who is physically or mentally incapable of taking care of himself or herself; or (3) the spouse of the taxpayer if the spouse is physically or mentally incapable of taking care of himself or herself.

According to IRS regulations, an individual is considered to be physically or mentally incapable of self-care if as a result of a physical or mental defect the individual is incapable of caring for his or her hygienical or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others. The fact that an individual, by reason of a physical or mental defect, is unable to engage in any substantial gainful activity, or is unable to perform the normal household functions of a homemaker or to care for minor children, does not of itself establish that the individual is physically or mentally incapable of self-care. An individual who is physically handicapped or is mentally defective, and for such reason requires constant attention of another person, is considered to be physically or mentally incapable of self-care.

Employment-related expenses are limited to $2,400 for one qualifying individual and $4,800 for two or more qualifying individuals. Taxpayers with adjusted gross income of $10,000 or less are allowed a credit equal to 30 percent of eligible employment-related expenses. For taxpayers with adjusted gross incomes between $10,000 and $28,000, the credit rate is reduced by one percentage point for each $2,000 or fraction thereof above $10,000. The credit is limited to 20 percent of employment-related child and dependent care expenses for taxpayers with adjusted gross incomes above $28,000. (These dollar amounts are not indexed and have not been adjusted for inflation since 1982.)

Taxpayers are required to report the taxpayer identification number (e.g., the social security number) of both their care provider and their qualifying individuals. The IRS may use mathematical error procedures to deny the credit if the taxpayer has not provided a correct TIN for the qualifying individuals.

Earned Income Tax Credit: Low and moderate income working taxpayers may be eligible for a refundable tax credit of up to $3,832 (1999 dollars). The size of the credit depends on the

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[4] If married, both spouses must generally be employed in order to claim the credit.

[5] Qualifying individuals may include children who could have been claimed by the taxpayer, but the taxpayer waived the dependent exemption in order to allow the non-custodial parent to claim the children.

number of qualifying children, as well as the taxpayer's earned income and modified adjusted gross income. Eligibility for the EITC phases-out entirely when income exceeds $30,706. The EITC income thresholds are indexed for inflation.

Qualifying children must meet three tests. First, they must be the son or daughter of the taxpayer or descendant of either or a foster child. Second, they must live with the taxpayer in the United States for over six months (the full year, if a foster child). Third, the qualifying child must be under the age of 19 or, if a full-time student, 24. Qualifying children do not have to meet the age requirement if they are permanently and totally disabled at any time during the year. If, based on the preceding three criteria, more than one taxpayer qualifies to claim the same qualifying child, then only the taxpayer with the highest adjusted gross income is eligible to claim the child.

An individual is permanently and totally disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Participation in nonwork activities may indicate that a person is not totally disabled. However, the fact that a taxpayer can take care of himself or herself at home, engage in hobby activities, engage in institutional therapy or training, or engage in social activities does not mean, in and of itself, that the person is not disabled for purposes of the tax credit. Taxpayers may be required to provide proof of the existence of the disability.

Taxpayers must provide a valid taxpayer identification number (e.g., a social security number) for each qualifying child. The IRS may use mathematical error procedures to deny the tax credit if a correct TIN has not been provided.

Itemized Deduction for Medical Expenses: Taxpayers are eligible to claim an itemized deduction for medical expenses in excess of 7.5 percent of adjusted gross income. Medical expenses may include unreimbursed qualified long-term care expenses, and within certain limits, premiums paid for qualified long-term care insurance. Qualified long-term care services include personal care services. Such services must be required by a chronically ill individual and provided pursuant to a plan of care prescribed by a licensed health care practitioner.

A chronically ill individual is one who has been certified by a licensed health care practitioner within the previous 12 months as being unable for at least 90 days to perform at least two activities of daily living without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence. Alternatively, the individual must require substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

## Long-Term Care Options for Federal Employees

Notes on OPM presentation

**Structure**

- Not a part of FEHBP; distinct offering (e.g., own booklet, etc).
- Premiums payed for through payroll deductions, but agencies, not OPM, send the premiums to the insurers; no trust fund; no Federal government contribution
- Schedule:
  - Education campaign in first year
  - Open enrollment in second year
  - Rolling enrollment for new employees
  - Subsequent open enrollments every 5 years (note: need to work on details)
- Eligibility: Federal active workers, annuitants, and spouses

**Pricing and Plans**

- OPM will issue a RFP for several different benefits packages (described below)
- All plans must be HIPAA qualifying plans, prove financial stability; except for benefits and premiums, subject to state law
- Guarantee issue during open enrollment, for new employees only. Others will be underwritten

**Product**

- Core: HIPAA qualifying plan plus inflation protection
- Enhancements:
  - Vertical: Richer benefits
  - Horizontal: innovative additions, such as:
    - Nonforfeiture
    - Disability model (benefits more like cash payment)
    - Allow to buy for parents, in-laws (underwritten)
    - Case management

THE WHITE HOUSE

WASHINGTON

June 4, 1998

**TO:** Gene

**FROM:** Chris and Jeanne

**RE:** **TREASURY MEMO ON LONG-TERM CARE TAX INCENTIVES**

This is a quick note to let you know that we have both process and substantive problems with the memo that Karl sent to you yesterday on tax incentives for long-term care insurance.

**Process**: Per your request, we have set up an NEC/DPC process to explore options. This process is underway but not completed. We intend, in the usual way, to prepare options and paper that reflect the interagency consensus (or at least recognizes difference of opinion). It would be good to get a sense of your timing, but we were aiming for late June (recognizing that tobacco could accelerate the need for options).

If you personally asked Karl to write up these point, separate from this process, it is understandable that he sent over this memo before the process is over and without review. However, neither Chris nor I knew that this memo was going to be submitted. A draft was given to Chris on Tuesday night at the end of a meeting on non-LTC health, but the timing and intent were not made clear. It is inaccurate to suggest or imply that we agree with the content or have cleared it in any way.

**Substance**: Treasury raises some valid concerns about subsidizing private long-term care policies. It is difficult to target, through tax policy, the people who need long-term care insurance the most. And, there long-term care policies on the market today are often limited and of low-value. Although we could use new tax incentives as leverage to improve the standards of such policies, there is a possibility that JCT could say that the higher prices that result will cause no one to purchase them -- and, worse, some people to drop policies.

That said, we have not concluded that there are no good options in this area. Moreover, there are a number of other types of long-term care related tax policies that could be considered. For example, we are exploring whether we can give families caring for the elderly at home a tax credit for respite care. We also are thinking of how we can encourage savings for long-term care through IRAs.

As soon as we have completed the analytic and policy review, we will prepare a discussion of such options.

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

June 3, 1998

**MEMORANDUM FOR GENE SPERLING**
**ASSISTANT TO THE PRESIDENT FOR ECONOMIC POLICY**
**AND DIRECTOR OF THE NATIONAL ECONOMIC COUNCIL**

**FROM:** **KARL SCHOLZ** KS
**DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)**

**SUBJECT:** **Long-Term Care Tax Preferences**

Attached are talking points on long-term care tax preferences. These have been (at least briefly) reviewed by Jon Gruber, Gary Claxton (HHS) and Chris Jennings. View this as a "down payment" on what you have asked for. In particular, this piece identifies our policy concerns about initiatives in this area. We are working on a second piece that will provide additional background and analytic underpinnings of our concerns. Chris Jennings is hosting a meeting on these issues Friday afternoon. I apologize for taking so long to get you this first installment.

# Long-term Care Tax Preferences

## Summary


- Should long-term care tax preferences be expanded? Neither narrow nor broad expansions of tax preferences for long-term care would be good policy. Narrow expansions would continue down a slippery slope and would not be cost effective in providing needed long term care services nor in reducing Medicaid expenditures. Broad expansions designed to jump-start the long-term care insurance market would not be any more effective, but would be even more costly.


## Concerns

- **Providing additional subsidies for long-term care insurance has dubious policy merit.** Because of the very important Medicaid backstop, long-term care insurance is typically a form of asset protection rather than a vehicle for getting more long-term care services to people. In fact, most policies pay a fixed dollar amount per diem rather than reimbursing actual expenses. If additional Federal resources are to be spent on long-term care, these resources should be targeted to expanding long-term care services to those with the greatest physical and financial need rather than spent subsidizing the insurance market.

- **It may be very costly to jump-start the long-term care insurance market.** Long-term care insurance is not a wise buy for many, if not most, individuals because the cumulative value of the stream of premiums in real terms is typically large compared with the assets that the insurance is designed to protect. As a result, subsidies would have to be very large to jump-start the long-term care insurance market.

- **Expanding tax preferences for long-term care is unlikely to substantially reduce Medicaid expenditures.** Expansion of long-term care insurance may not save enough Medicaid money to warrant large tax expenditures. Individuals who buy long-term care insurance may buy policies covering only a year or two of long-term care services. Seventy percent of projected nursing home use for 80 year-old individuals occurs after the first year of nursing home residence. Many individuals that purchase long-term care insurance would otherwise have assets that could contribute toward long-term care expenses for one, or more, years. As a result, Medicaid savings are likely to be very small, yet tax benefits even under current law could be quite large.

- **Some individuals could fall prey to insurance companies.** A not so insignificant number of individuals, especially those who have less ability to make complicated financial decisions, could fall prey to insurance companies. Many individuals with few assets might purchase long-term care insurance and not be able to maintain premium payments. For example, lapse rates for one major insurance company were as high as 60 percent resulting in the majority of purchasers paying premiums but being without coverage during their high risk years. Other individuals that continue to make the payments would do better by saving instead of paying premiums and using the savings and Medicaid to pay for long-term care. Still other insured individuals may find that they do not qualify for insurance payments because their needs do not

meet the contract criteria or that inflation has substantially eroded the value of the benefit, leaving them with a very large shortfall.

- **Expanding the insurance market could have a variety of unintended consequences.** Just as health insurance contributed to inflation in the health market, long-term care insurance is likely to contribute to inflationary pressures in the long-term care market. For example, providing tax subsidies for policies that pay more than Medicaid for nursing home care could result in pressure to raise Medicaid payment rates.

  In addition, the few policies that reimburse expenses are likely to lead to over consumption of long-term care services, also creating inflationary pressures. The more common per diem type policies will avoid these inflationary pressures but will require insurance companies to take a more active role in determining who actually gets paid. Given the long lag between the time a policy is purchased and the time a qualifying disability is likely to occur increases the chance that individuals do not really know what they are buying. Some of the kinds of bad issues that are turning up in the medical managed care area today are likely to surface later in the long-term care arena.

- **The subsidy for employer-provided long-term care insurance is already generous.** Employer contributions to qualified long-term care insurance are deductible for an employer and are excludable from an employee's income for income and employment tax purposes. Employees (or former employees) also exclude insurance benefits from taxable income when they are received. In essence, employer-provided long-term care insurance combines the favorable tax treatment of health insurance with the tax-free build-up element of pension plans. As a result, employer-provided long-term care insurance receives two more favorable tax treatments than wage and salary income.

- **Expanding tax preferences for long-term care expenses would create inequities.** Currently medical expenses, including long-term care expenses, are deductible to the extent that they exceed 7 ½ of adjusted gross income. It would not be sensible to give long-term care services more tax preferences than basic medical care. Unlike basic medical care, long-term care services are frequently difficult to distinguish from everyday needs (e.g. housekeeping). It would be inequitable to provide a tax deduction for housekeeping services while not allowing a deduction for cancer treatment. Because long-term care services for those with substantial needs tend to be very large, taxpayers in these circumstances are already eligible to deduct almost all their long-term care expenses. Furthermore, expanding tax preferences for long-term care expenses would complicate the tax system and reduce compliance.

- **Current law already allows penalty-fee withdrawals from IRAs for long-term care expenses under many circumstances.** Medical expenses, including long-term care expenses, for individuals with expenses above 7 ½ percent of adjusted gross income and for long-term unemployed individuals are exempt from early withdrawal penalties. In addition, the early withdrawal penalty does not apply to any withdrawal made by individuals 59 ½ years of age or older. Individuals that meet certain disability standards are also exempt from early withdrawal penalties. IRAs already provide a good way to save for long-term care needs. For individuals that do not develop long-term care needs, this form of long-term care saving provides the flexibility to take care of other needs as well.

Draft

June 2, 1998

**TO:** Gene S.

**FROM:** Chris J. and Jeanne L.

**RE:** **POSSIBLE THEME FOR SAVER SUMMIT SPEECH: IRAS FOR LONG-TERM CARE**

**cc.** Karl S., Emil P.

As you know, the President has expressed interest in tax incentives for long-term care. We have set in motion a policy development process to come up with options. However, the Savers Summit may offer an opportunity to talk about the importance of saving, through IRAs, for long-term care. Although this is not a new option, it is something that we do not often highlight and, in fact, the idea has been raised in the Medicare Commission discussions.

The following are some facts about long-term care and IRAs.

- **Neither private insurance nor Medicare cover very much long-term care**
  - Only 10 percent of home health care and 5 percent of nursing home care is paid for by private health insurance.
  - Most long-term care is paid for by Medicaid, which covers people who become impoverished due to high health and long-term care expenses. About two-thirds of nursing home residents are covered by Medicaid.
- **Out-of-pocket long-term care costs can be devastating.**
  - Over $100 billion was spent on nursing home and home health care in 1996. Over $30 billion of this amount was paid for out-of-pocket -- higher than the amount paid out-of-pocket for physicians for all Americans.
  - Long-term care expenditures account for nearly half (44 percent) of all out-of-pocket health expenditures for Medicare beneficiaries.
  - Nursing home costs average more than $40,000 per year.

- **The importance of saving for long-term care will grow as the Baby Boomers age.**
  - Two trends underscore the importance of saving for long-term care:
    - The doubling of the number of elderly by 2030, and the
    - Increased longevity of the elderly. About one in four people age 85 and older reside in a nursing home, and the proportion of people in this age group will double by 2030.
  - One study estimates that out-of-pocket costs for nursing home costs will increase from about $30 billion to $158 billion in 2030 (adjusted for inflation).
- **IRAs offer tax-free savings and possibly a lower tax rate for out-of-pocket long-term care expenditures.**
  - People can prepare for potentially catastrophic long-term care costs by taking these costs into account when planning their IRAs.
  - Not only are most long-term care costs incurred after turning age 60 (when people can withdraw money from their IRAs without penalty):
    - People with disabilities or people with medical expenses that are at least 7.5 percent of income may withdraw funds to pay for long-term care at any age; and
    - For people who do not develop illnesses that require long-term care, they may use their savings for other purposes.

If you would like more information or background, please call us or Karl.

## Table 3

### Socio-Demographic Characteristics of Individual Purchasers, Non-Purchasers, Surveyed Elders, and the General Population Over Age 55, 1994

| Socio-Demographic Characteristics | Purchasers | Non-Purchasers | Surveyed Elders Age 55+ | General Population Age 55 + |
|---|---|---|---|---|
| Average age | 69 | 71 | 67 | 68 |
| 55 to 64 | 19% | 15% | 42% | 40% |
| 65 to 69 | 32 | 26 | 19 | 19 |
| 70 to 74 | 23 | 23 | 17 | 16 |
| 75 and over | 26 | 35 | 22 | 25 |
| Gender | | | | |
| Male | 39% | 53% | 43% | 44% |
| Female | 61 | 47 | 57 | 56 |
| Marital status | | | | |
| Never married | 6% | 6% | 5% | 5% |
| Married | 62 | 60 | 62 | 64 |
| Divorced/separated | 6 | 6 | 7 | 7 |
| Widowed | 27 | 28 | 26 | 24 |
| Income status | | | | |
| Less than $20,000 | 21% | 33% | 36% | 64% |
| $20,000 to $24,999 | 16 | 14 | 14 | 9 |
| $25,000 to $34,999 | 24 | 21 | 19 | 11 |
| $35,000 to $49,999 | 18 | 16 | 14 | 9 |
| $50,000 and over | 20 | 16 | 17 | 8 |
| Total liquid assets | | | | |
| Less than $20,000 | 18% | 27% | 41% | 60% |
| $20,000 to $29,999 | 10 | 10 | 10 | 9 |
| $30,000 to $49,999 | 13 | 11 | 13 | 10 |
| $50,000 to $74,999 | 10 | 9 | 10 | 9 |
| $75,000 to $99,999 | 8 | 9 | 5 | 6 |
| $100,000 and over | 41 | 35 | 22 | 7 |
| Education level | | | | |
| Less than high school | 7% | 9% | 22% | 36% |
| High school graduate | 28 | 25 | 37 | 36 |
| Post high school | 29 | 29 | 18 | 15 |
| College graduate | 36 | 36 | 23 | 13 |
| Someone in household employed | 23% | 23% | 39% | N.A. |
| Average monthly savings | $316 | $272 | $212 | N.A. |

Sources: LifePlans, Inc., survey of 2,601 buyers and 1,245 non-buyers, 1994; U.S. Bureau of the Census, unpublished data, 1992, Washington, D.C.; U.S. Bureau of the Census, *Current Population Reports*, P-25-1095, 1992, Washington, D.C.; U.S. Bureau of the Census, *Current Population Reports*, P-20-468, 1992, Washington, D.C.

*Research Findings*

The average premiums reported by the 1995 leading sellers have decreased about 5 percent when compared to the average premiums for the leading sellers in 1994. The change in premiums for the different age and policy categories ranged from a decrease of about 8 percent to an increase of about 1 percent. (It is important to note that the leading sellers in 1994 were not necessarily the same as the leading sellers of 1995.)

Premiums increased dramatically when a lifetime 5 percent compounded inflation protection feature and/or nonforfeiture benefits were added to the base plan. When both options were added to the base policy, premiums increased an average of 198 percent, 158 percent, and 99 percent for ages 50, 65, and 79 respectively. ◆

**Table 6**

**Average Annual Premiums for Leading Individual and Group Association Long-Term Care Sellers in 1995***

| Age | Base Plan | With Lifetime 5% Compounded Inflation Protection Only | With Nonforfeiture Benefit Only | With Nonforfeiture and Lifetime 5% Compounded Inflation Protection |
|---|---|---|---|---|
| COVERAGE AMOUNT: $80/40 A DAY NURSING HOME/HOME HEALTH CARE | | | | |
| 50 | $310 | $651 | $451 | $929 |
| 65 | 817 | 1,481 | 1,158 | 2,149 |
| 79 | 3,353 | 4,579 | 4,738 | 6,800 |
| COVERAGE AMOUNT: $100/50 A DAY NURSING HOME/HOME HEALTH CARE | | | | |
| 50 | $378 | $798 | $540 | $1,124 |
| 65 | 1,010 | 1,881 | 1,395 | 2,560 |
| 79 | 4,148 | 5,889 | 5,676 | 8,146 |

* Generally, for a 20-day elimination period and four years of coverage.
Source: HIAA LTC Market Survey, 1996.

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File Long Term Care

UNIVERSITY OF MARYLAND

CENTER ON AGING

Hi Chris -

Here is the paper I mentioned that provides insight on our LTC Insurance Partnership program. To date about 50,000 applications have been taken by the four RWJ States - not too bad by our social experiment track record with programs like PACE & SHMO

Mark

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9-17-97 (Draft)

Source: Meiners, Mark R. "Conceptualization of Public-Private Partnerships," forthcoming 1998 in Balancing Responsibilities for Financing Long Term Care: The Integration of Public and Private Roles, ed. Walker, Bradley, and Wetle, (The Johns Hopkins University Press, Baltimore, MD).

# Conceptualization of Public-Private Partnerships

by

**Mark R. Meiners, Ph.D.**
**University of Maryland Center on Aging**

## I. Purpose

Recent public policy debates stimulated by the Clinton administration's health care reform proposals sent two critical messages regarding the financing and organization of health care for the elderly and disabled: long-term care is important but expensive, and neither the public nor the private sector alone is capable of providing adequate funding for that component of the health care delivery system (Meiners, 1996). In order to begin to address major gaps in long-term care, the Clinton team recommended the following: incremental policy that encouraged innovation on the part of the states in the area of home and community care; improvements in means tested public programs; and support for private sector responsibility (Clinton administration, 1993). States will continue to have a major role in administering and reforming our long-term care system.

Subsequent to the failure of the Clinton health care plan concern about the financial prospects of Medicare and Medicaid have served to reinforced the incremental approach to long-term care system improvements. The recent passage of long-term care insurance tax clarification language in the Kassenbaum-Kennedy legislation marked a first step. This legislation is intended to make

long-term care insurance more visible and acceptable as a way to prepare for the risk of catastrophic long-term care costs. An early indication of the effect of tax-favored status of long term care insurance is anticipated within the next few years, as the baby boom generation enters its 50's, the age for pre-retirement planning.

However, it is quite likely that more than just this incremental step is needed to address long term care financing needs of the population (Freudenheim, 1997). Significant progress on long-term care will require a public-private financing partnership that includes consideration of Medicaid by careful design, not by default. The private market could be helped by government support of experimentation with new systems of care and financing. The government assistance could occur through innovation in the Medicaid program because it is the principle payer for long-term care. A new means tested program for long-term care that is designed to complement private market options is one logical way to proceed.

Means testing for long-term care is the approach states are most familiar with, since they have experience with this approach through administration of the Medicaid program. However, means testing is unacceptable to some policy analysts and interest groups, who maintain this approach leads to poorly funded, inadequate programs because the political constituency is not broad enough to advocate effectively against these trends. Strategies to minimize this risk must be developed, such as structuring a linkage of the means tested program with long-term care insurance.

This is the approach being used in the Partnership for Long-Term Care Program, a multi-state initiative to create a model of long term care financing which relies on both public and private responsibilities (Meiners and McKay, 1989). Supported by the Robert Wood Johnson Foundation (RWJF), the program focuses on the potential role that private insurance might play in filling the need for long term care within the nation's health care system (Somers and Merrill, 1989, 1991). This chapter discusses the design features of this "Partnership" program and some of the key learning experiences

throughout program development and early implementation. The Partnership program is a real time case study of one approach to balancing public and private responsibilities for financing long-term care.

## II. Background

*The concept of public-private partnerships*

A public private partnership may take many forms, depending on how broadly the issue is defined. For example, most long-term care is either provided by family and friends directly or purchased by them. The interrelationship between public and private sources of support can be complicated. However, any realistic public intervention must support, not replace, individuals' willingness to accept personal responsibility for long-term care needs.

Private enterprise can be used to forge a strong public-private collaboration to the greatest extent possible. High quality, affordable products that meet long term care needs as perceived by consumers and their families must be developed and marketed. Examples that have recently emerged include the growing number of home and community care options, assisted living communities, health systems that are designed to integrate acute and long-term care, and long-term care insurance. Accordingly, one form of partnership is for the government to support the formulation and promulgation of such options, leaving the payment decision and responsibility up to the individual.

A more aggressive approach is to reform the financing of long term care. One approach is to segment the risk, covering some of the risk through public programs and leaving the rest as the responsibility of individuals. For example, the long-term care risk could be partitioned so that nursing home care is paid publicly and home and community care is paid privately. Another approach would require the individual to assume the initial risk, and the government to bear the long-term catastrophic risk. Currently,

Medicare provides skilled nursing home and home care benefits while Medicaid offers extensive coverage of custodial nursing home care. This configuration bears a striking resemblance to ideas of segmenting risk, although more by default than by design. The Partnership for Long-Term Care attempts to improve the system, within the limitations of current and future public financing.

*The Partnership for Long-Term Care*

To stimulate the long-term care insurance market and to help balance competing pressures between product value and price, four states (California, Connecticut, Indiana, and New York), implemented an innovative long-term care insurance program. The program involves a public-private partnership which provides consumers protection against depletion of their assets in the financing of long term care. Under an asset protection model, individuals who purchase a state certified Partnership insurance policy are allowed to access Medicaid covered benefits without becoming impoverished.

The states expect to benefit if the long-term care insurance market can be expanded to include those at risk of spending down their resources to the level of impoverishment where Medicaid must pay. Program incentives encourage the elderly and their children to buy insurance policies that will protect them from ever having to spend all of their life savings on home care or nursing home services. The policies also serve as an alternative to the growing appeal of Medicaid estate planning (as discussed in Chapter xx).

Partnership long term care insurance policies work in the following way. By buying a Partnership policy, a person qualifies for Medicaid benefits under special Medicaid rules. Once a non-Partnership policy runs out, an individual must spend virtually all of their savings before they qualify for Medicaid. In contrast, when a Partnership policy is exhausted, the policyholder is permitted to retain assets equal to the amount his or her insurance paid out (in NY they can keep all remaining assets). The person is then eligible for coverage under Medicaid without having to deplete previous savings.

Insurers participating in the Partnerships must meet the program certification standards (McCall, Knickman, and Bauer, 1991). These standards ensure that participating long-term care policies are of high quality. Among the standards required in each state are inflation protection, minimum benefit amounts, and agent training. Participating insurers are also required to provide the state with information on purchasers of certified products and on the utilization of benefits.

*The "dollar for dollar" model*

The Partnership model in California, Connecticut, and Indiana provides a dollar of asset protection for each dollar paid out by a state certified long-term care insurance policy (Mahoney and Wetle, 1992).. The program allows for a variety of product designs with benefits ranging from one year of coverage on up. This flexible approach allows persons of different means the option of choosing the amount of protection most in line with their resources and ability to pay.

The impoverishment protection feature of the Partnership programs being implemented by the participating states is designed to be budget neutral. Impoverishment protection encourages individuals to plan for their long-term care needs by purchasing long-term care insurance protection in an amount commensurate with their assets. Thus, an individual with $25,000 in assets might buy $25,000 in insurance protection while another individual with $150,000 in assets might buy $150,000 in insurance protection. Insurance payments for long-term care services would be considered as equivalent to the spending of assets for the purpose of establishing Medicaid eligibility. Once on Medicaid, individuals would be able to keep control of assets up to the amount that insurance paid; income would still have to be applied toward long-term care expenses.

The opportunity to avoid impoverishment by buying long-term care insurance is an incentive intended to help those who are most at risk of depleting their resources when long-term care is needed.

Middle income elderly ($20,000-$40,000 per year) generally have less assets to protect and are least able to afford currently offered private insurance "lifetime" protection (4 years or more) that would minimize the risk of impoverishment. Yet when they need long-term care, the cost of Medicaid (spending down assets and income to the poverty level) can very well be catastrophic.

In order to have enough protection to cover the risk of an average length of stay, middle income elderly in the current market must buy insurance benefits that often substantially exceed their assets. Consequently, the market for this type of insurance is unlikely to extend to this group without the impoverishment protection incentive offered by the Partnership. This incentive makes purchases of 1-3 years of protection both more meaningful and more affordable to those in the middle income group, who are most at risk for spending down their resources and requiring Medicaid.

*The "total assets" model*

The model used by New York bases its asset protection incentive on time rather than the dollar amount of coverage purchased (Holubinka, 1992). Partnership policies are required to pay three years of nursing home care, six years of home care, or some combination (with two days of home care equaling one day of nursing home care), after which all remaining assets are protected.

A high priority of the New York approach is to offer a viable alternative to asset transfers (Nussbaum, 1992). With about 80% of its nursing home residents on Medicaid, compared to a national average of about 60%, New York feels this approach is best suited to keeping people with significant financial means from using Medicaid unnecessarily. Transfer of assets is thought to be quite common in New York and such a growing phenomena that any strategy which encourages individuals to take financial responsibility for their own care could yield savings to the state.

## III. Program Analysis

*Arguments in support of the Partnership*

The Partnership states selected the strategy of linking the purchase of long-term care insurance to Medicaid eligibility after considering several alternatives (Meiners, 1988). The Partnership has a number of strengths. The program is fiscally conservative, helps middle income people avoid impoverishment, serves as an alternative to Medicaid estate planning, promotes better quality insurance products which promote consumer protection efforts, enhances public awareness regarding long term care needs and options, and helps maintain public support for the Medicaid program (Meiners, 1994).

The Partnership provides a fiscally conservative form of premium subsidy, in that only those who buy a policy and use the benefits receive the special protection. Program related expenditures occur well after program initiation, and savings would be accruing to cover future costs. In contrast, traditional premium subsidies (including tax breaks) entail public expenditures at the time of purchase for all purchasers.

Under the Partnership, middle income people may obtain assistance with catastrophic long-term care expenses without becoming impoverished. Under special arrangements with the state, participating insurance companies can assure policy holders they no longer have to be impoverished to qualify for Medicaid. Assets protected under the Partnership can mean the difference between autonomy and dependence if a policy holder exhausts their insurance and still needs assistance.

There has been significant attention from policymakers in recent years devoted toward the practice of Medicaid estate planning. Partnership purchasers have no reason to resort to legal maneuvering to hold onto their savings. The Partnership policies are an alternative to transferring assets to relatives or friends in order to avoid spending savings on long-term care. Participants can control

their funds instead of worrying about how someone else might be handling their money. Policyholders also do not have to be concerned about state and federal government efforts to stop Medicaid estate planning. The states can pursue regulations to minimize Medicaid estate planning with less controversy, knowing people are being given a reasonable alternative.

The Partnerships bring the states into a close working relationship with insurers, providing both the means and the incentive to monitor insurer performance. Partnership policies are subject to a rigorous review beyond that conducted for non-partnership policies and carry a stamp of approval from the states indicating they have meet rigid state certification requirements. Further, regulatory oversight is also strengthened to help consumer protection and confidence. All participating insurers are required to provide the state with extensive data for program monitoring. The data will make possible a variety of special studies, including analysis of underwriting rules, utilization patterns and insured event criteria.

As part of the program, educational campaigns are increasing public awareness about what long term care is, risks of needing long term care and the limited financing options. The public information campaigns are multifaceted, directed at persons for whom long term care insurance may be especially beneficial. This component of the Partnership has been successful in each of the states.

Finally, the Partnership program can help mitigate concerns about means-testing; that programs for the poor are poor programs because they lack broad-based political support. By linking the Partnership incentive to Medicaid, the constituency for the means-tested program can be enhanced rather than eroded.

*Arguments against the Partnership*

In the early stages of program development, arguments against the Partnership were raised primarily by social insurance advocates who viewed the program as an incremental step which would erode

support for more ambitious reform (Meiners, 1993). As the Partnership was implemented, insurers voiced their own dissatisfaction with certain aspects of the program design because it deviated from some of the standard approaches used to market this coverage and required extra attention beyond that for non-partnership products.

As long-term care insurance began to emerge as a viable reform instrument, it was viewed by some as more an obstacle than a help with long-term care reform since it did not provide universal insurance. Any further growth of the private long term care insurance market would both relieve public pressure for reform and build opposition to social insurance reform from private sector advocates whose stake in future long term care insurance policymaking increased. For advocates of social insurance, Medicaid, as a means tested program, was viewed as part of the problem crying for a social insurance solution. The linking of long-term care insurance with Medicaid as a way to address financing problems of long-term care was philosophically unacceptable, if not damaging to the cause.

Concerns about the link to Medicaid also resonated with the Partnership insurers and their agents, as well as the program developers. The applicability of the model is limited because many state Medicaid programs do not offer comprehensive home and community benefits, or a system of care management which supports the continuity of care desired in such a partnership. States which have not developed strong programs for the poor will have trouble justifying asset protection models. Discussion of block grant programs and cutbacks in Federal funding, the future form and substance of Medicaid is uncertain.

This uncertainty surrounding Medicaid reinforces the standard marketing practice of insurance agents selling against Medicaid. A basic message from many insurance agents is to not depend on Medicaid, in fact, avoid it at all reasonable cost. Compatible with this message has been the emphasis on lifetime coverage in order to assure avoidance of Medicaid. Over this early period of market

development, the standard product has increased from 3 years (designed to cover the average of two and half years in a nursing home) to lifetime coverage.

These complexities have made getting insurance agents to understand and buy into the Partnership message more difficult than initially anticipated. Though lifetime coverage only assures avoidance of Medicaid if the product is inflation protected and covers both nursing home and home care, these features are often relegated to secondary consideration in the marketing presentation. The bottom up message of the Partnership -- everyone should have some coverage, trading lifetime coverage for shorter, comprehensive, inflation- protected benefits, and then, if necessary, accessing Medicaid coverage without being impoverished -- is difficult to integrate into mainstream selling practices.

Equally important is the fact that the primary target audience for Partnership policies differs from the market agents have customarily worked with. Selling to the high end of the income and asset spectrum is easier than targeting sales to those most in need of the Partnership products. The problem is compounded by the fact that agent commissions are directly related to the size of the premiums they sell.

A subtle that may work against Partnership sales is that the Medicaid rules under which the Partnership operates do not wave income rules along with the asset rules. As a result, income must be applied to the cost of care once insurance runs out. People expecting to have high income when they exhaust their insurance may not need the extra asset protection because their income will cover the entire bill. This tends to be a greater problem at the high end of the market but can make the decision between Partnership and non-partnership coverage more difficult.

The lack of portability of the asset protection feature has also been cited as a barrier to sales. Since only a few states have Partnership programs and the details of each state's Medicaid program are variable, reciprocity agreements that allow asset

protection away from the home state have not been established at the time of this writing. While this has no effect on the value of the insurance benefit payment itself, it is a concern for those who feel they may move and depend on the asset protection feature as the primary motivation for choosing a Partnership policy.

The participating insurers have also cited state by state differences in Partnership program details as being too costly and time consuming. Nearly all insurers participating in the Partnership maintained their regular product offerings. The Partnership policy development, approval process, and data reporting is an additional set of responsibilities they have committed to carry out. Only in the case of the data reporting system have the participating states agreed to do things in a uniform way. In nearly every other aspect, even when states used the same asset protection model, differences in program details are required.

Another concern raised about the Partnership is that increased Medicaid costs could result because the extra protection offered by the States would be available to those who would have purchased long-term care insurance even without the partnership incentive. The concern is that the program could not be targeted only to people who would not have bought long-term care insurance without the Partnership incentive (Nyman, 1994). Because there is an emerging market for long-term care insurance that has significant growth potential, the merits of this targeting problem have been debated (Meiners and Goss, 1994).

A related concern has to do with "crowding out" segments of the private market that might have emerged if the government supported asset protection incentive were not offered. For example, this could happen if someone who would have bought lifetime inflation protected coverage instead buys a shorter less expensive Partnership policy because of the asset protection.

In summary, there are essentially three perceived drawbacks of the Partnership approach. The first is political in nature, that is, this incremental step takes the wind out of radical, comprehensive

reform of long term care. The second is somewhat process oriented. Getting both the insurers and agents to truly "buy in" to the concept and promote it effectively can be challenging. Finally, there are issues of economic efficiency having to do with targeting the incentive and possible crowding out private responsibility for financing care.

## IV. Experiences in Partnership implementation

Most of the arguments for and against the Partnership share common issues viewed from different perspectives. Central to the strategy is the fact that Medicaid is the primary public payer for long-term care, that states are the key decision makers regarding Medicaid rules and insurance regulation, and that the states need to be at least budget neutral in their efforts to provide a positive incentive to the insurance market. At the time when the Partnership programs were initiated, two countervailing forces clashed. First, state interest in the Partnership grew well beyond the four states funded by the Robert Wood Johnson Foundation. In fact, 12 states passed enabling legislation to create programs modeled on the RWJF program.

Second, the Omnibus Reconciliation Act of 1993 (OBRA '93), enacted shortly after the RWJF Partnership was implemented, contained language with both indirect and direct impact on the expansion of Partnership programs. Indirectly, the Act closed several loopholes in the Medicaid eligibility process, thereby providing further incentives for persons to purchase private insurance for long-term care. The Act also makes specific mention of Partnership programs. The statute contains a "grandfather" clause which recognizes as approved the four initial states, plus a future program in Iowa and a modified program in Massachusetts (protecting only the home from estate recovery). These states were allowed to operate their partnerships as planned since the Health Care Financing Administration had approved their state plan amendments before May 14, 1993.

While states obtaining a state plan amendment after that date are allowed to proceed with Partnership programs, they are also required to recover assets from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the Partnership is in effect only while the insured is alive. After the policyholder dies, states must recover what Medicaid spent from the estate, including protected assets. With participating insurers already concerned about variability in state by state approaches, this has had the effect of stifling the growing interest in replicating the Partnership in other states.

*Partnership policy sales*

Partnership policy sales at the time of this writing indicate steadily growing interest in public-private long-term care insurance policies. However, the numbers also reveal that the public is still wary about the need for such policies. The following are highlights from Partnership policy sales in four states (CA, CT, IN, and NY) as of June 30, 1996.

More than 26,000 applications have been received for the purchase of Partnership policies by mid-year 1996 across the four participating states. From these applications almost 20,000 partnership policies have been purchased (there is a lag between application and purchase). Of these purchases, there are currently more than 15,000 policies in force in the four states.

Three of the four states allow the sale of one and two year Partnership policies, (CA, CT, IN). The proportion of purchasers in these states buying one and two year polices remains high; California: 91%, Connecticut: 49%, and Indiana: 40%. The majority of Partnership policy purchasers are first time buyers. The proportion of first timers ranges from a high of 95% in California, to a low of 79% in Indiana. A significant proportion of Partnership policy purchasers is under age 65, ranging from a high of 56% in Connecticut to a low of 31% in California.

*Variations on the Partnership theme*

Several states decided to proceed with Partnership programs in the aftermath of the OBRA '93 restrictions. Believing that access to Medicaid coverage without impoverishment was a major benefit for citizens, Maryland and Illinois secured state-plan amendments to offer Partnership programs modified to meet the OBRA '93 requirements. Each state modified the programs developed and implemented by their predecessors.

Maryland decided to make all state certified long-term care insurance policies eligible for asset protection rather than have special rules associated with Partnership policies. This approach made the Partnership strategy more visible and eliminated marketing against the Partnership. Though targeting concerns might be exacerbated by this approach, it was also a way to develop widespread knowledge concerning the partnership incentive among the middle income people who need the protection the most.

One major change implicit in this model was that Maryland did not require inflation protection. In the development of the RWJF Partnership program, inflation protection was a major point of contention with the insurers and the agents, who preferred that inflation protection not be required since the significant price increase reduces demand. However, all the RWJF Partnership states require inflation protection because they feel it is important to the budget neutrality of the program. It also helps assure the State's promise of protection of assets. Without inflation protection, the growing cost of deductible and co-pays could impoverish a policy holder before much asset protection could be secured. Maryland planned to deal with the inflation issue through consumer education campaigns, leaving the choice to consumers.

As the Maryland approach has not been implemented, this partnership strategy has not received a market test. Maryland tabled its program because of concerns about the estate recovery language in OBRA '93. The definition of the estate is broader than currently in use in Maryland, which would have the potential of

penalizing insurance purchasers relative to those who had not purchased insurance; quite the opposite of the intent of the program (McKay, 1995).

Illinois, the other state approved after OBRA '93, did not share this concern with Maryland and has implemented their program. Although initially Illinois chose the dollar-for-dollar model, they recently revised the program, developing a hybrid approach that switches to total asset protection for those who buy $200,000 of protection. The required inflation protection is optional. These changes were made to stimulate sluggish insurer interest. At this writing, it is too soon to tell whether the changes will overcome the perceived problems.

Colorado took yet a different approach in the face of the OBRA '93 estate recovery provisions. The State Legislature requires that any insurer certified to sell insurance in Colorado must also actively market a basic and a standard policy that meet specific requirements, using its normal sources and methods of distribution. The basic plan was to be one that would be affordable to purchasers of moderate income, while the standard plan was to reflect the features most commonly sold in the existing market (middle or high income purchasers). No special asset protection provisions were made. The Colorado strategy combines the dissemination of a shopper's guide along with a consumer education campaign and relatively simple comparable product offerings to focus attention on long-term care insurance and help consumers make an educated purchase decision.

Another approach of note has been implemented by the California Public Employees Retirement System (CalPERS) in cooperation with the California Partnership program. The CalPERS long-term care insurance program is a group offering for active public employees, retirees, and their dependents designed to achieve lower premiums through group marketing economies. A range of ten options were offered which included a one and two year Partnership policy. Through this initiative, California took the lead in encouraging employer-group offerings as a way to mainstream this type of

protection at younger ages where it is especially affordable. CalPERS is self funding and relies on its own investment expertise, thereby freeing itself from a number of regulatory and reserving requirements normally exercised by the State Insurance Department.

In a span of only 18 months over 70,000 policies were sold (about 5 percent were Partnership policies). A new open period offering will be launched during 1997 so the self-funded CalPERS program may soon be among the largest group long-term care programs in the country. This initial success has been attributed to three key ingredients (Mahoney, 1996). First, PERS solid reputation for managing health care costs without sacrificing quality of care gave it special credibility with this completely new program. Second, the design of the product was based on elements members had identified as essential and simplicity was emphasized. Third, CalPERS and United Health Care (the private contractor administering the program) made a serious commitment to member education and marketing efforts.

Finally, the Partnership insurance strategy has also captured international attention. Great Britain, faced with long-term care gaps in their public funding systems similar to those in the United States, is in the early stages of debating the details of a National version of the RWJF Partnership program (HM Secretary of State for Health, 1997). It appears the favored scheme is the "pound-for-pound" modified to provide a greater incentive (pound and a half or even two pounds of asset protection) and greater assurance that protection of the home would be accomplished for those at the low end of the resource spectrum.

## V. Movement to a national partnership

The idea of a uniform nation-wide public-private partnership approach that uses extra asset protection as an incentive to buy long-term care insurance is not new. It has been suggested by representatives of both sides of our political system. In 1990 then Senators Packwood and Dole took the lead in proposing such an

approach, along with a revised Medicaid program designed to be more uniform across the states (Packwood and Dole, 1993). More recently, to compliment the Clinton long-term care proposals, Senators Kennedy and Wofford proposed a self-funded public insurance program for nursing home care very much modeled on the RWJF Partnership for Long-Term Care (Kennedy and Wofford, 1994). The voluntary program included a special incentive of asset protection from Medicaid rules of $30,000 to $90,000, depending on the amount of insurance purchased. The proposed program was to be publicly run with more liberal enrollment rules than private insurance. It would have allowed all individuals to enroll during an open period at each of ten year intervals, beginning at age 35, regardless of preexisting conditions.

Because state by state development is costly and dependence on Medicaid as the basis for the stop loss protection does not easily allow for reciprocity agreements between states, the idea of uniform national partnership has prompted discussions among the states and insurers who have been most active in the current RWJF Partnership effort. However, consensus on how to implement a national partnership program that would simplify the implementation and operation for states and insurers has been difficult to achieve. Two approaches emerged from these efforts.

One approach is to determine a core set of insurance features that would comprise a partnership policy approved by all participating states. From this "cafeteria" of features, insurers could choose the details of their partnership product and receive timely approval in those states. The set of features and approval process would be independent of what the participating state did with non-partnership products. The strength of this approach is it achieves uniformity across the states in all basic partnership policy features. The weakness is that insurers offering partnership and non-partnership policies would still have two separate products with separate filing requirements. One suggestion to further simplify this approach is to have the partnership product reflect a limited set of options (e.g. a 2 year and a 4 year policy only) with the features fully standardized.

The second approach is to distinguish a partnership policy by requiring a limited set of features such as inflation protection and uniform data reporting. The remaining features would be the same as those for non-partnership policies in the participating states. The approval process would be expedited and paperwork minimized by allowing companies to use their current policy as the base, with the option of including the partnership requirements if they wanted it to qualify for the special asset protection.

Although both approaches require agreement on partnership features, the second approach requires agreement on a smaller set of features. The second model may also be easier for states to accept, as it fits with the current insurance regulatory environment where states have considerable control over what gets sold.

None of this addresses the issue of Medicaid as the backup. The asset insurance model and a more uniform means tested long-term care program in the states would be mutually complimentary. Yet improvements to the means tested program cannot be sustained unless affordable and appealing private market financing options can serve to keep people from using those benefits unless it is as a legitimate last resort.

By linking the Partnership incentive to Medicaid (or a new means tested long-term care program) the constituency for the means-tested program should be enhanced rather than eroded. As noted earlier, this strategy is intended to help secure middle and upper class support for a viable and good quality means-tested program by making it part of what they may also need to depend on in the face of otherwise catastrophic long-term care expenses. However, insurance agents often find it easiest to market against Medicaid. This basic conflict has yet to be resolved in the Partnership program.

One approach to this problem would be to separate the asset protection from Medicaid. This could be done by creating a new entitlement under Medicare that would require the purchase of a certified private long-term care insurance policy in exchange for a commitment to protect some level of assets. A less ambitious

alternative step in this direction would be to create a new optional benefit in which states could choose to contribute to a backup pool (perhaps with federal matching funds like with Medicaid) with reciprocity arrangements for participating states. The key to either of these approaches is that the stop loss incentive is removed from its direct link to Medicaid which would eliminate concerns about variability across states and over time. It could also serve to allow for some combination of income and assets to be protected. The recent movement toward product standardization under the tax qualification requirements of the Kassebaum-Kennedy legislation might serve to facilitate agreements on the qualifying features.

*Next steps in program development*

A key question in research and program development is identifying the problem which needs to be solved. Even among those actively involved in the development and implementation of the Partnership program, there is disagreement about the nature and scope of the long term care financing problem. The original goals of the Partnership program centered on helping consumers take more personal responsibility for paying for long-term care by increasing the value and affordability of long-term care insurance. The intervention needed to be at least budget neutral and work from existing state and Federal financial and administrative structures so as to allow for incremental learning and acceptance. Furthermore, the program needed to be an effective vehicle for educating consumers about the risks of long-term care, as well as the availability and benefits of quality long term care insurance coverage for individuals with middle and modest income and assets.

This is an ambitious set of goals, particularly since they did not completely coincide with the goals of some of the key partners, the insurers and agents. Throughout the development and implantation of the Partnership, program tax clarification was the primary public policy goal of the long-term care insurance industry. It was viewed as a way to show that the government supported the role of private

insurance in protecting against this risk. Equally important was that tax clarification signaled that the government was not going to pursue a broad based new entitlement. However, since these were also reasons for supporting the Partnership program, a cooperative working relationship has emerged, with potential for further development.

As the market matures and the effect of the Kassenbaum-Kennedy legislation becomes clear, it is likely that there will be a renewed interest in finding ways to reach the broader market. The lessons learned in the Partnership program will be valuable to that renewed interest. At least two possible options fit within the framework of incrementalism. One option is to revise the product design to make it as identical to that offered in the market as possible, given the goals of the program. This would relieve the burden of creating and receiving approval for two separate products. The other option is to develop selective partnering strategies along with distribution channel innovations that emphasize lifetime protection as the top priority in a marketing approach.

Bottom up marketing would convey that everyone needs some protection against the risk of long-term care and should buy as much as possible, using their resource base as a guide. This message would be targeted to groups of potential purchasers of middle and modest means at risk of impoverishment if they needed long-term care. Prospective purchasers would be coached to make their purchase decision by assessing the level of resources that they would like to have at their disposal while still qualifying for Medicaid's help.

As the next steps unfold, some version of both these strategies may be tried. However, without the repeal of the OBRA '93 restrictions on Partnership style asset protection, it may difficult to stimulate the multi-state interest necessary to justify the commitment of resources by insurers and their agents to support these alternative marketing strategies. But there is growing recognition that States need flexibility in dealing with the pressures on the Medicaid system and that private long-term care insurance is a needed alternative to public financing. The National Governor's

Association has recently called for elimination of federal barriers to public-private insurance partnerships like those in the RWJF states and the expansion of authority to all states to implement such programs (National Governors Association, 1997).

Next steps also involve investigation of strategies that do not depend on direct links to Medicaid. For example, the growing interest in managed care for both Medicare and Medicaid eligible populations has promoted greater recognition of the potential value of integrating acute and long-term care. Minnesota, Colorado, Florida, New York, and Wisconsin to name a few are launching programs to develop managed care programs for those eligible for both Medicare and Medicaid. These programs have as their goal better more cost-effective care through the integration of provider systems and the coordination of care. Though the initial focus is on public pay clients the delivery system development lessons are equally relevant to long-term care insurance links that might be made with Medicare managed care products as the private market alternative for those not eligible for Medicaid.

## VI. Conclusion

Strategies for enhancing the market for private long-term care insurance abound. The menu of options originally suggested as the impetus for the Partnership program remains relevant today (Meiners, 1988). It was broken into the following four distinct but related targets but related categories.

The first category focused on general public policy interventions. It includes educational campaigns to enhance public awareness, regulatory review to encourage market flexibility while promoting consumer protection, support for improved data development and sharing to minimize uncertainty, and coordination of public cost and care management mechanisms (e.g., pre-admission screening, utilization review, case management, benefit coverage and rate regulation) with those of the private market. The second category focused on consumers. It includes tax credits or deductions, deductible or co-pay subsidies, and inflation protection in addition to liberalized asset spend down requirements. The

third category focused on insurers and mentioned premium tax relief and public reinsurance. The fourth category focused on special population and noted buy-in of Medicaid eligible and special risk pool subsidies.

The dilemma we face in moving forward with long-term care reform is that different approaches - universal social insurance versus means testing - makes compromise difficult (Meiners and McKay, 1990; Mahoney and Meiners, 1994). During the development of the Clinton long-term care plan, there was clear tension between the preference for universal social insurance and the realities of budget constrains. The Clinton Plan, on the one hand, supported private action through tax clarification and national insurance regulations. On the other hand, the Plan proposed a home and community care benefit that leaves the impression that government programs will be sufficient to meet individual needs even though the details really suggest a "capped entitlement" to states, a more limited policy. There was considerable concern on the part of the states regarding the proposal's implementation, given their fiscal constraints.

To have effective private financing options, a clear delineation of where the public role ends and personal responsibility begins is required. This is especially the case if individuals are expected to plan for and bear some of their risk of chronic disability. If planning does not occur, more people will be dependent on public support. There is a need to commit to a vision for the future, because long-term care is a risk that will require pre-funding if it is to be affordable either privately or publicly. Incremental solutions would seem to make sense both in terms of the cost and the experience necessary for solid progress to be made.

## VII. Key Concepts

* Public/private partnerships
* The Partnership for Long term Care
* Dollar for dollar models
* Total asset models

* National partnership

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