

**LONG-TERM CARE INITIATIVE**  
**QS AND AS, January 4, 1998**

**Q. How is this tax policy different than the \$500 credit in the Republican Contract with America?**

This proposal is quite different -- and we think much better. First, it would give twice as much assistance (\$1,000 credit). Second, many more people would be eligible under this proposal. It would go to people who have long-term care needs or their spouses, not just to relatives who qualify as caregivers. It also would broaden significantly the definition of a "caregiver" by eliminating the "support test," which essentially excludes people with Social Security income. Our proposal also targets the dollars on middle-class families by phasing out the credit at higher income levels. Finally, it is part of a larger, well-rounded initiative that would help caregivers both financially and through real services in the new Family Caregiver Program.

We are glad, however, that Republicans have supported a similar concept, and seem to want to take credit for this proposal. It makes us optimistic that Republicans and Democrats in Congress can work together to pass this initiative and provide meaningful support for family caregivers.

**Q. Didn't the President veto a family caregivers' tax credit in 1995?**

A. The President vetoed the 1995 Republican budget, which included massive cuts to Medicare, Medicaid, education, and environmental spending. Somewhere within that budget was a long-term care tax deduction that was poorly targeted and disproportionately benefited upper income families. For obvious reasons, the President was not willing to sign the whole 1995 Republican budget to gain this poorly constructed long-term care tax proposal.

**Background:** There were actually two different proposals offered by Republicans in 1995: a **\$500 tax credit** that was introduced in early 1995 as a refundable credit for taxpayers housing certain family members (parent, grandparent) needing "custodial care" (2 + ADLs or similar level of disability due to cognitive impairment); and a **tax deduction** of \$1,000 for taxpayers housing certain family members (parent, spouse or former spouse) who are "physically or mentally incapable of caring for himself." The latter was in the Balanced Budget Act of 1995 that was vetoed by the President.

**Q. Why isn't the tax credit refundable? Doesn't this mean that low-income people are not helped by this initiative?**

A. No. Eligibility for the tax credit was carefully designed so it reaches virtually all taxpayers with significant long-term care needs. In addition, many individuals who do not pay taxes will be able to gain some benefit from this credit because their caregiver files tax returns. Finally, other aspects of the initiative announced today will benefit all people with long-term care needs, regardless of tax status. The new Family Caregiver Program targets assistance to low-income families who provide long-term care to their elderly relatives, and the Medicare long-term care information campaign will help all beneficiaries regardless of income.

**Q. Why isn't there a greater emphasis placed on private long-term care insurance in your initiative?**

A. The Federal employees' insurance initiative and the Medicare education campaign are both designed to give people information and encourage them to purchase high-quality long-term care insurance. However, even according to optimistic industry projections, if every baby boomer who could afford private insurance purchased it, less than one-third of long-term care costs would be paid for by private insurance in 2030. This initiative explicitly recognizes that long-term care will continue to be funded and provided through multiple sources and thus addresses it through a multi-faceted response.

**Q. By focusing on family caregivers, are you implying that you are not interested in expanding Medicare and Medicaid long-term care coverage?**

A. The President has a strong track record of encouraging innovative long-term care services through Medicaid. Today, 20 percent of Medicaid long-term care spending is devoted to home and community-based long-term care services -- double the percent in 1987. The President has encouraged the shift away from Medicaid's "institutional bias" by approving over 300 waivers for local home and community-based care programs and proposing to repeal the need for such waivers.

Medicare was not designed to cover long-term care, as the Bipartisan Commission on the Future of Medicare has noted. The President looks forward to the recommendations of this Commission on long-term care and other benefits. But given the financing crisis facing Medicare, it seems unlikely that the Commission will vote for a significant expansion of Medicare coverage in this area.

While Medicare and Medicaid cannot be relied on to finance all long-term care, the President will continue to support creative targeted policies, both administrative and legislative, that cost-effectively and appropriately provide for effective long-term care services.

**Q. Isn't this a drop in the bucket relative to the size of the long-term care problem?**

A. Any initiative that spends \$6.2 billion over 5 years has to be considered a significant proposal. It would make a major contribution toward helping over 2 million Americans afford and obtain much-needed long-term care services. No one in this Administration has or will suggest that this initiative on its own will address all of the problems. But it recognizes and provides meaningful support for the caregiving provided to Americans of all ages with chronic illness or disability.

**Q. Isn't this policy another attempt to distract from impeachment?**

A. Anyone who has followed this President since he has taken office will recognize his ongoing commitment to help meet the needs of American families. This initiative is a classic example of that commitment. The President has been working on it since the Spring of 1998 and, because it is a new initiative that will be included in his upcoming FY2000 budget, wanted to release it early to ensure that it receives the attention and consideration that it deserves.

**Q. How do you think Republicans will respond to this initiative? Will it pass this year?**

A. The President believes that this initiative has great potential to attract strong bipartisan support in this Congress. It addresses a set of real problems through an approach that both Republicans and Democrats can embrace. And he believes that any policy to recognize and relieve the tremendous responsibilities that caregivers shoulder should and will receive favorable consideration by both parties in the upcoming Congress.

Older Americans Act File



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary  
Administration on Aging

Washington, D.C. 20201

MAR 10 1998

Similar letter  
sent to All  
Chairs, Ranking's  
on House + Senate

The Honorable Frank Riggs  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Mr. Riggs:

As the Assistant Secretary for Aging in the Department of Health and Human Services, I would like to take this opportunity to encourage you to act swiftly on the pending reauthorization of the Older Americans Act. As you know, the most recent authorization of this important law expired on September 30, 1995.

For over 30 years, the Older Americans Act has enjoyed strong bi-partisan support. Its programs have assisted millions of older persons and their families across our country to remain independent. As our nation rapidly approaches the dawn of the 21<sup>st</sup> century, a time when there will be a doubling of the aging population, it is critical that we have a strong and comprehensive system of home and community-based care in place, which includes nutrition, supportive and access services, if we are to adequately and appropriately address the needs and demands of a longevous society.

I appreciate your continued support for the Older Americans Act, the services it provides and for your interest in the issues that impact the lives of our nation's older population.

Sincerely,

Jeanette C. Takamura  
Assistant Secretary for Aging

**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515**

June 2, 1998

The Honorable William F. Goodling  
Committee on Education and the Workforce  
2181 Rayburn HOB  
United States House of Representatives  
Washington, D.C. 20515

Dear Chairman Goodling:

We are writing to urge your support for re-authorization of the Older Americans Act (OAA) before the 105<sup>th</sup> Congress adjourns. The OAA is the most important federal social services program for seniors and has provided essential services to the nation's elderly for the last 33 years. In particular, the program has provided services to those seniors who are most vulnerable due to poverty, frailty or isolation. With the greying of America, there is an increased need for the services and programs authorized by the OAA. The over-75 age group remains the fastest growing segment of our population and will increase 36 percent by 2005.

Throughout the three decades of its existence, the Older Americans Act has served our nation's aging population well. By authorizing federal aid for supportive nutrition services, elder abuse prevention and remediation, ombudsman services, job training and employment opportunities, and a host of other assistance, the Act has helped older Americans maintain their independence and well-being. The OAA makes possible a continuum of care for our seniors who have the greatest social and economic need.

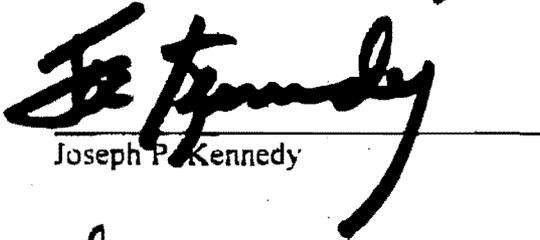
As you know, the OAA is a promise to our seniors that they can live the remainder of their lives in dignity and independence. The OAA offers a way to live, not just survive. As members of Congress and the Older Americans Caucus, we believe that many programs provided in the OAA have been extremely successful and feel that it is time for all of us to keep our commitment to the seniors of America.

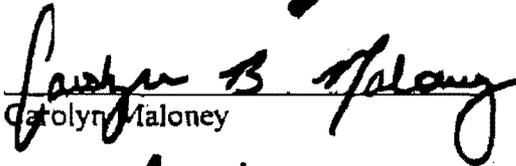
The lack of an authorization places these important services in jeopardy. While we all agree that updating the Act and providing additional flexibility for service providers could prove to benefit our nation's seniors, it is our belief that the Older Americans Act, as currently codified, is worth supporting. Given the disagreements that continue to circulate around proposed changes, and the lack of any one proposal that has overwhelming support from Congress, the Aging Network, and the seniors themselves, we urge you to consider an extension of the Older Americans Act.

As you are aware, the Aging Network has been calling for significant increases - up to 8 percent - in the Act's appropriations. This needed funding will only be possible if appropriators have clear, consistent authorizing language with a strong mandate guiding them. The Older Americans Act has always received bipartisan support. Let us ensure the future of these services on which America's seniors have come to rely

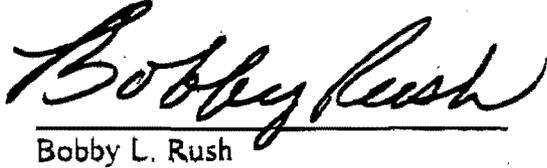
Sincerely,

  
Loretta Sanchez

  
Joseph P. Kennedy

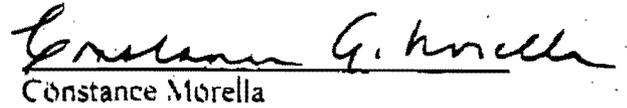
  
Carolyn Maloney

  
Sue Kelly

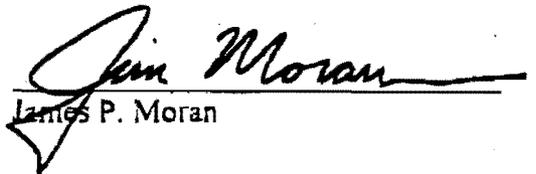
  
Bobby L. Rush

  
Eleanor Holmes Norton

  
Nancy Johnson

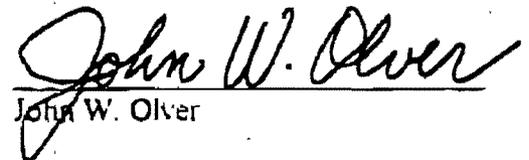
  
Constance Morella

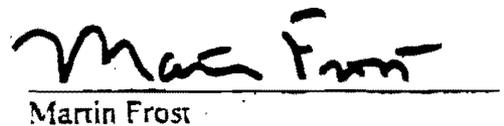
  
Ralph Regula

  
James P. Moran

  
Steve LaTourette

  
Calvin Dooley

  
John W. Olver

  
Martin Frost

*Matthew H. Martinez*  
Matthew Martinez

*Majors Owens*  
Major Owens

*Kenny Hulshof*  
Kenny Hulshof

*Neil Abercrombie*  
Neil Abercrombie

*Nick J. Rahall*  
Nick J. Rahall

*Elizabeth Furse*  
Elizabeth Furse

*Nancy Pelosi*  
Nancy Pelosi

*Robert A. Borski*  
Robert A. Borski

*Zoe Lofgren*  
Zoe Lofgren

*John Lewis*  
John Lewis

*Gerald Klaczka*  
Gerald Klaczka

*Thomas J. Manton*  
Thomas J. Manton

*Earl Hilliard*  
Earl Hilliard

*Nita Lowey*  
Nita Lowey

*Sam Farr*  
Sam Farr

*Harold Ford*  
Harold Ford

*John McHugh*  
John McHugh

*Barney Frank*  
Barney Frank

*Ted Strickland*

Ted Strickland

*Tom Lantos*

Tom Lantos

*Jose E. Serrano*

Jose Serrano

*Bob Filner*

Bob Filner

*Martin Medina*

Martin Medina

*Colin Peterson*

Colin Peterson

*Gene Green*

Gene Green

*Ken Bentsen*

Ken Bentsen

*John LaFalce*

John LaFalce

*Charles E. Schumer*

Charles Schumer

*Rosa L. DeLauro*

Rosa DeLauro

*Robert Weygand*

Robert Weygand

*James Walsh*

James Walsh

*Jerrold Nadler*

Jerrold Nadler

*Paul McHale*

Paul McHale

*Sherrod Brown*

Sherrod Brown

*Sam Gejdenson*

Sam Gejdenson

*Maurice Hinchey*

Maurice Hinchey

Carlos Romero Barcelo

Carlos A. Romero-Barcelo

Dale E. Kildee

Dale Kildee

Edward J. Markey

Edward Markey

Bud Cramer

Bud Cramer

Robert A. Underwood

Robert A. Underwood

Tony P. Hall

Tony Hall

William J. Coyne

William Coyne

Pat Danner

Pat Danner

Adam Smith

Adam Smith

Eva M. Clayton

Eva Clayton

# United States Senate

WASHINGTON, DC 20510

The Honorable Judd Gregg  
Chairman, Senate Sub-Committee on Aging

The Honorable Barbara Mikulski  
Ranking Member, Senate Sub-Committee on Aging

Dear Mr. Chairman and Senator Mikulski,

It has become increasingly clear to me that we need to take action to reauthorize the Older Americans Act (OAA). The OAA defines services vital to the dignity and self sufficiency of our senior populations. It also defines a planning and oversight mechanism that includes not only regional, state and national administrative personnel, but local community providers and the seniors themselves. Furthermore, the provisions in the special titles for Native American seniors allow them to determine their needs based on their own culture and traditions.

As you know, the OAA is a promise to our seniors that they can enter the last years of their lives with confidence that they will have a safe place. It recognizes their need for continuing independence. The OAA offers a way to live, not just survive.

The OAA makes possible a continuum of care for our seniors who have the greatest social and economic need. Services authorized by the OAA include: the congregate and home-delivered meals that promote health through good nutrition while offering socialization for those who might otherwise be alone and isolated; community-based long-term care services that help keep people in a safe environment with health monitoring, personal care and housekeeping; adult day care that provides a supervised, stimulating environment for seniors with serious physical, cognitive and mental health impairments who need a care-giver and respite for the care-givers, some of whom need to work and others who need time for themselves so they can continue in the care-giving role; senior employment opportunities for those with small pension benefits who need to supplement their income; legal services; transportation; education; research and demonstration projects in the field of aging; advocacy through an ombudsman program for those in institutional settings; as well as a variety of other important support services.

Many of our seniors can see the OAA planning and service system at work. They are participants in the processes that determine

its existence in their communities and they are the volunteers in the daily operation of many programs. Because of this, they are well informed about what will happen should the OAA vanish from public policy.

Seniors are feeling a lack of permanency in these programs that are specific to their needs. We need to reassure them through reauthorization of the OAA. Remaining involved is difficult for them when they may be making promises to their friends and neighbors that cannot be kept. They do not know what kinds of changes we may make that will cause shift in direction without their ideas and losses of the very services they think are the most important.

I believe that many programs provided in the OAA have been extremely successful. It is time for all of us to reconcile our differences and keep our commitment to the seniors of our great country.

Sincerely,

John McCain

Susan Collins

Rick Santorum

John J. Kelly

James M. Inhofe

T. Huddins

Max Cleland

Mary L. Landrau

[Signature]

Bob Crutcher

Hub Kohl

Barbara Pifer

Pat Roberts

Olympia Snow

Sam Hainlock

Paul D. Wellstone

Carl Handberg

Pat Downey

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RECEIVED  
 MAY 23 11 14 AM '98  
 U.S. HOUSE OF REPRESENTATIVES  
 WASHINGTON, D.C.

**Congress of the United States**  
**House of Representatives**  
 Washington, DC 20515

**SUPPORT A FUNDING INCREASE FOR THE OLDER AMERICANS**  
**ACT PROGRAMS**

May 22, 1998

Dear Colleague:

We urge you to join us in sending a letter (on the reverse) to Chairman Porter requesting an eight percent increase in appropriations for the Older American Act (OAA) programs. OAA programs are currently operating at inadequate funding levels. Increased costs due to inflation and higher demand for more specialized services has crippled the program's ability to successfully serve the diverse needs of our growing elderly population.

Since 1980, OAA programs experienced a 40 percent loss in their capacity to keep millions of frail older persons independent in their homes. OAA programs and services include congregate and home delivered meals and other in-home services such as home health, transportation, elder abuse protections, nursing home ombudsman, senior employment, adult day care, legal assistance, and counseling.

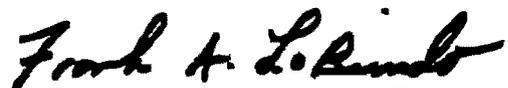
The typical recipient of Older Americans Act services is a woman over 75 years of age, living on a fixed income, who requires daily help in preparing meals or weekly transportation to a doctor. In fact, Americans over age 85 make up the fastest growing segment of our population. The number of over-85 Americans is expected to increase by 40 percent by the year 2010.

The Older Americans Act defines services vital to the dignity and self-sufficiency of our senior citizens. It is a promise to seniors that they can enter the latter part of their lives with confidence — knowing that they will not be isolated and forgotten by their communities and by their government.

We urge you to sign onto to the letter attached. If you would like to sign on or have any questions, please call Jessica with my staff at #5-6416. Thank you for your prompt attention to this important issue.

Sincerely,

  
 Rep. Peter A. DeFazio

  
 Rep. Frank LoBiondo

Slightly Revised the table on 2nd page

**PRESIDENT LAUNCHES NEW CAMPAIGN TO ENSURE THAT  
LOW-INCOME MEDICARE BENEFICIARIES RECEIVE PREMIUM ASSISTANCE**  
July 7, 1998

Today, the President announced a new outreach campaign to help millions of low-income seniors and people with disabilities get assistance in paying Medicare premiums. A study by Families USA reports that over 3 million low-income Medicare beneficiaries are not enrolled in the Qualified Medicare Beneficiary (QMB) and related programs that pay for Medicare premiums and (for some) copayments and deductibles. This assistance was expanded last year in the Balanced Budget Act. However, as this new report underscores, many eligible beneficiaries are not aware of these cost-sharing protections and others have difficulty accessing this critically needed assistance.

To address this problem, the President has requested that the Department of Health and Human Services (HHS) and the Social Security Administration (SSA) launch a multi-faceted effort to enroll eligible Medicare beneficiaries in QMB and related programs. These new initiatives, that build on existing efforts to help identify and enroll eligible beneficiaries and parallel the President's efforts on children's health outreach, include:

[I didn't make this edit/trying to keep this the same as AP one]

- **Launching unprecedented efforts to educate Medicare beneficiaries about premium assistance programs.** HHS and SSA will make unprecedented efforts to <sup>give</sup> ~~ensure that~~ beneficiaries ~~know~~ about these programs by distributing ~~clear~~, plainly written information about these programs by:
  - **Sending information to all 38 million Medicare beneficiaries** about this program in Medicare handbook or pamphlet that will be sent to all beneficiaries this fall.
  - **Informing every one of the 1.8 million new Medicare beneficiaries** about this program in the Medicare initial enrollment package that is sent to these beneficiaries.
  - **Including information describing this program and an eligibility screening worksheet on the new Medicare Internet site**, "www.medicare.gov," which is used by millions of older Americans and their families, as well as others who work with the elderly and people with the disabilities.
  - **Sending program information to more than 36 million individuals receiving Social Security benefits** in the annual cost-of-living adjustment (COLA) notices this fall.
  - **Distributing 450,000 pamphlets as well as placing posters in SSA's 1,300 field offices** where millions of beneficiaries go to enroll and ask questions about these programs.
- **Encouraging the use of a simplified application process.** In July, the Health Care Financing Administration (HCFA) will send a letter to State Medicaid agencies that includes a model, simplified application as well as examples of successful outreach and enrollment programs. HCFA will encourage states to adopt simple, user-friendly procedures such as a mail-in application.

- **Creating a Federal-State-consumer advocate task force to develop new strategies to enroll eligible beneficiaries.** Beginning this month, HHS, SSA, the National Governors' Association, and advocates of the elderly and people with disabilities will collaborate to identify and implement strategies to educate beneficiaries about this program and to make it easier to enroll.
- **Targeting eligible beneficiaries through direct mailings.** This fall, HCFA will send a letter to a targeted group of beneficiaries who are likely to be eligible for the QMB and related programs. The targeting population list will come from a list of beneficiaries supplied by SSA that the agency believes may be eligible. The letter will explain the program and encourage beneficiaries to apply.
- **Directing SSA field office employees to strengthen efforts to advise beneficiaries about QMB and related programs.** SSA will immediately send a reminder to all its workers about this program and encourage them to reach out to the millions of beneficiaries they see every day to ensure they are informed about these programs.
- **Providing the State Insurance Counseling and Assistance Programs (ICAs) with materials to assist beneficiaries in enrolling in the premium assistance programs.** ICAs provide assistance on insurance and benefits to millions of older and disabled Americans.

These new initiatives build on an ongoing commitment to target and enroll these vulnerable, low income Americans. Past efforts include:

- **HCFA:** Developed pamphlets on the programs for beneficiaries; provides training materials on identifying and assisting potential beneficiaries to providers, advocates and States.
- **SSA:** Puts information on programs in every SSA pamphlet, booklet or handout that could reach potential candidates; continuously train staff who interact with beneficiaries.

**Explanation of the QMB and related programs.** The following table shows eligibility for premium and cost sharing assistance programs, which are offered in all States.

Category	Income (Poverty)	Annual Income (1998)		Medicaid Pays For:
		Individual	Couple	
<b>QMBs:</b> Qualified Medicare Beneficiaries	0 to 100%	Up to \$8,290	Up to \$11,090	Medicare Part A & B premiums, deductibles, copayments
<b>SLMBs:</b> Specified Low-Income Medicare Beneficiaries	100-120%	\$8,291 to 9,900	\$11,091 to 13,260	Medicare Part B premium
<b>QI-1s:</b> Qualified Individuals 1	120-135%	\$9,901 to 11,108	\$13,261 to 14,888	Medicare Part B premium (Funding is limited)
<b>QI-2s:</b> Qualified Individuals 2	135-175%	\$11,109 to 14,328	\$14,889 to 19,228	Part of Medicare Part B premium (Funding is limited)

Notes: Income guidelines include a \$240 unearned income disregard and are different in AK and HI. There is also an assets limit of \$4,000 for individual and \$6,000 for couples for all groups.

**SUMMARY OF LONG-TERM CARE (LTC) TAX CREDIT OPTIONS, July 7**

#	TAXPAYER ELIGIBLE	QUALIFYING PERSON W/ CHRONIC ILLNESS	QUALIFYING OF CAREGIVER	AMOUNT/ TYPE OF CREDIT	COMMENT
1	Person with chronic illness  Caregiver of person w/ chronic illness	2 + ADLS for at least 6 months (certified) or mental impairment	Has a dependent who meets the dependency test minus the income cap of \$2,750	\$500 Partially refundable Phases out	2.5 million receive 1 million are dependents  Half are in homes
2	Person with chronic illness  Caregiver of person w/ chronic illness	3 + ADLS for at least 6 months (certified) or mental impairment	Has a dependent who meets the dependency test minus the income cap of \$2,750	\$1,000 Partially refundable Phases out	1.8 million receive  700,000 are dependents  Half are in homes

Dependency test: (1) specified relative or member of the taxpayer's household; (2) be a U.S. citizen or resident of Canada or Mexico; (3) not be required to file a joint tax return with spouse; (4) has gross income in excess of \$2,750 if not a child; (5) receive over half of his or her support from the taxpayer.

## Respite Tax Credit Policy Parameters

The following are the key policy parameters for the tax credit.

- Who is eligible for the credit:
  - Person with disabilities themselves [Treasury option 1]
  - Person who has a dependent with disabilities (family caregivers) [Treasury option 1, Johnson bill]
  - Person who has a dependent with disabilities who cares for that person at least 1,000 hours per year or pays for 1,000 hours per year of care [Treasury option 2]
- How do you define the person with disabilities:
  - Adult with 2 or more limitations in ADLs [Treasury option 1]
  - Adult who meets SSA definition of disability [Bunning Kennelly]
  - Adult who has a physical or mental impairment which results in the individual being incapable of caring for himself [Johnson bill]
- Is it restricted to community-based people with disabilities
- What is credit for
  - Any expenditures for the care of a person with disabilities [Treasury]
  - Care for a person living at home, or up to 14 days of care for a person who lives at home for a period in which they are not residing at home [Johnson bill]
- How much is the credit
  - Set amount (e.g., \$500) *- \$1.0m*
  - Back into the amount so that the bill costs no more than \$x per year

## 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 paid 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

File "8NBs"



FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: C+2

Date: 5/30/97

To: <u>Chris Jennings</u>	From: <u>Patti Unruh</u>
Fax: _____	Fax: <u>202 690-8168</u>
Phone: _____	Phone: <u>690-8607</u>

REMARKS: \_\_\_\_\_  
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**HEALTH CARE FINANCING ADMINISTRATION**  
200 Independence Ave., SW  
Room 341-H, Humphrey Building  
Washington, DC 20201

**CBO and Administration Scoring for Skilled Nursing Facility  
Proposals in the Administration's FY 1998 Budget**

Savings in billions of dollars over  
the 5-year period 1998-2002

	<u>Administration</u>	<u>CBO</u>
SNF PPS	5.8	Included in Total
SNF Consolidated Billing	0.0*	-0.1*
Extend Savings from the OBRA 1993 Freeze	1.3	Included in Total
<b>Total</b>	<b>7.1</b>	<b>7.7</b>

\*Under Administration scoring, SNF consolidated billing is -0.3 under Medicare Part A, and 0.3 under Part B. Hence the net consolidated billing savings is 0.0. Under CBO scoring, SNF consolidated billing is -0.4 under Medicare Part A, and 0.3 under Part B. The net savings are -0.1 (which is actually a cost)

**Discrepancy in Pricing**

Fee-for-Service Impact of SNF PPS	7.1
Indirect Effect of SNF PPS on Managed Care	1.9
<hr/>	
Total	9.0
Pricing Error (number from OACT)	-2.3
True Savings of Proposal for both FFS and Managed Care	6.7

**SNF Pricing Error**

The Administration's budget language sets SNF PPS rates at FY 1995 costs updated to FY 1998. However, both CBO and OACT priced the proposal based on FY 95 payments, rather than costs. Payments are generally lower than costs. The savings were calculated by comparing this lower, initial amount (payments) to the baseline. Thus, the savings are larger the way OACT originally priced the policy due to the greater difference between: 1) payments and the baseline, versus 2) costs and the baseline. OACT now believes that pricing the proposal as drafted would yield \$2.3 billion less than the \$9.0 billion total savings from both fee-for-service and the indirect effect on managed care.



The American Council of Life Insurance

# INSURANCE FACTS

Contact: Herb Perone (media) 202-624-2416, Fax 202-624-2139 or e-mail (herbperone@acli.com)  
Barbara Stucki (research) 202-624-2124, Fax 202-624-2139, or e-mail (barbarastucki@acli.com)

## COMMON MYTHS ABOUT LONG-TERM CARE INSURANCE

Long-term care insurance is an important part of planning for an uncertain future—especially in retirement. But some people are reluctant to consider buying this insurance because of common myths about its affordability, and the way long-term care is paid for in this country.

**MYTH 1: I don't need long-term care insurance because the government will care for me.**

**REALITY:** Government long-term care programs primarily pay for the poor and those who impoverish themselves.

Many Americans mistakenly believe that Medicare will pay for their long-term care needs. In reality, this program primarily focuses on acute care needs (hospital stays and physician visits). Medicare pays only for short-term, skilled nursing home stays following hospitalization. This program also limits help at home primarily to those who need skilled nursing care and rehabilitative therapy.

Medicaid, another government health insurance program, is for the poor. Middle-income individuals may qualify for long-term care under Medicaid. But increasingly strict rules regarding income and assets require that they impoverish themselves before they can become eligible for assistance. There are penalties for those who try to "game the system" by making substantial gifts of money or property to relatives or friends before trying to qualify for Medicaid.

So the vast majority of Americans, particularly middle-income families, must use their own income and assets to pay for long-term care.

**MYTH 2: I don't need long-term care insurance because my family will take care of me.**

**REALITY:** The burden on family caregivers will rise as large numbers of baby boomers survive to old age.

More than three-quarters of the care needed by frail, older people is provided by their family. While this trend is likely to continue, many social factors will place an increasing burden on family caregivers. In the past, few families needed to care for an elderly relative. Due to increasing life expectancy, 22 million households now help a family member or friend over age 50 with daily activities. This number will grow as 70 million baby boomers reach old age.

America's changing lifestyles and family structures will reduce the availability of family caregivers in the future—family sizes are smaller, family members are living further apart, and more women are working outside the home. In addition, a significant number of Americans will have no family to help them if they become disabled. The most recent U.S. Census found that about one in four baby boomers do not have any children.



**MYTH 3: I don't need long-term care insurance because I can save on my own.**

**REALITY:** It is costly and challenging to self-fund long-term care.

The high cost of long-term care already has many people worried. In the future, rapid increases in these costs will make paying for long-term care even more challenging. For example, a 45 year-old can expect to pay \$244,000 annually for nursing home care by the time he or she reaches age 85 in 2038. Home care also will become more expensive over time, so you also risk depleting your savings to pay for these services.

Protecting yourself against future long-term care costs requires a large amount of savings. A two-year nursing home stay could cost about half a million dollars by the time most baby boomers retire. To reach this goal, a 45-year-old would have to save over \$3,500 each year for 40 years—and invest it wisely to ensure an average annual return of 7 percent. A 60-year-old would have to save almost \$4,500 per year.

### Ways To Pay for Future Long-Term Care

	AGE TODAY	
	45 years	60 years
<b>OPTION 1—SET ASIDE SAVINGS</b>		
Annual savings needed	\$3,557	\$4,481
Lifetime assets needed at age 85 to pay for two years of nursing home care	\$489,446	\$235,432
<b>OPTION 2—PURCHASE PRIVATE LONG-TERM CARE INSURANCE</b>		
Annual premium contributions	\$417	\$824
Lifetime value of premiums	\$57,907	\$52,097
<b>POTENTIAL SAVINGS FROM LONG-TERM CARE INSURANCE</b>		
Annual savings	\$3,140	\$3,657
Lifetime savings	\$431,539	\$183,335

Source: American Council of Life Insurance

Note: Author's calculations are based on a two-year long-term care policy with inflation protection of 5 percent. All numbers are represented in future dollars and assume a 7 percent return.

**MYTH 4: I cannot afford to purchase long-term care insurance.**

**REALITY:** Long-term care insurance is affordable for nearly two-thirds of families.

The earlier you purchase long-term care insurance, the less expensive the premiums. Today's 45-year-old would pay about \$417 for a two-year policy and \$730 a year for a five-year policy that includes inflation protection. But a 65-year-old buying the same policies would pay about \$824 for two years of coverage and about \$2,300 for five years of coverage.

Annual premiums also vary based on the choices you make. There are options for the type of services covered by the policy (such as nursing home or home care), amount of the daily benefit, duration of the benefit period, and length of the waiting period before benefits begin. You also may purchase additional features such as inflation protection to ensure that your policy retains its value over time.

### Who Can Afford Long-Term Care Insurance?

Ages	Percent
35-39	73
40-44	71
45-49	81
50-54	72
55-59	63
60-64	47
65 +	31
Total	62

Source: American Council of Life Insurance

Note: Affordability is defined as spending no more than 2 percent of income for ages 35-44, 3 percent for ages 45-54, 4 percent for ages 55-59, 5 percent for ages 60-64 and 10 percent for ages 65+.

# SPECIAL REPORT



# United Seniors Health Cooperative

## Private Long-Term Care Insurance TO BUY OR NOT TO BUY?

Many people are concerned about the cost of long-term care when, as the result of a prolonged illness, disability, or injury, they can no longer do the ordinary tasks of everyday living such as bathing, dressing or eating or when they require regular monitoring. While long-term care is often equated with nursing homes, most care is provided at home or in community settings like adult day care or assisted living facilities.

Medicare and regular health insurance do not cover long-term care. About 40% of all nursing home expenses in this country are paid for out-of-pocket by patients and/or their families; half of all nursing home expenses are paid by Medicaid, the government program designed to subsidize individuals who cannot afford long-term care in a nursing facility. Medicare only covers a short nursing home stay, only under certain conditions and only for skilled services.

One option for covering these costs is long-term care insurance that is sold by about 100 insurance companies. The idea of protection from devastating costs sounds good, but is it really a good buy and how can you tell? This Special Report raises important questions for you to answer if you are thinking about long-term care insurance and offers help in selecting a policy.

### What are your chances of needing long-term care?

Experts estimate that a person turning 65 faces a 43% risk of entering a nursing home. Women are at higher risk because they live longer and are more likely to live alone when they are old.

After the age of 85, one out of every two of us will need help with the ordinary activities of daily living (ADLs). One of the biggest risks for older

people is Alzheimer's disease, which eventually requires full-time care. Approximately one in ten persons over age 65, and nearly half of those over 85, will get Alzheimer's disease.

### Long-term care financing: what are your options?

**Long-Term Care Insurance**—People give the following reasons for considering long-term care insurance: to preserve their assets for their spouses and heirs; to avoid being dependent on others; to be cared for at home as long as possible; to be able to get into the nursing home of their choice should they need one; to avoid Medicaid; and to have peace of mind. It is important to note that the older you are the higher the premium and if you develop a disability or illness you may not be insurable. Private long-term care insurance may be the right choice for you, but you need to consider all of the following options to determine which of these alternatives may make the most sense in your situation.

Total Length of Stay	Men	Women
NONE	67%	48%
Less than 12 months	19%	21%
1 to 5 years	10%	18%
More than 5 years	4%	13%

Source: New England Journal of Medicine, article by P. Kemper and C. Murtaugh; February 1991.



UNITED SENIORS HEALTH COOPERATIVE  
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individual deduction	1	1	1	1	1	1	1	1	0
	yes	no							
cafeteria plan	0	0	0	0	0	0	1	0	0
	no	no	no	no	no	no	yes	no	no
contribute % single	0.50	0.50	0.70	0.70	0.80	0.90	0.90	0.90	0.90
contribute % family	0.30	0.30	0.50	0.50	0.65	0.75	0.75	0.75	0.75
load disadvantage	0.00	0.20	0.00	0.20	0.20	0.20	0.20	0.20	0.20
Required savings to switch	200	200	200	200	200	200	200	200	200
total insured switchers	37,768	25,448	35,690	22,144	25,832	24,529	24,228	24,529	13,445
(% of insured)	0.44	0.29	0.41	0.26	0.30	0.28	0.28	0.28	0.16
	56,215	43,895	54,137	40,592	44,280	42,976	42,676	42,976	31,893
(% of employees)	0.53	0.42	0.51	0.39	0.42	0.41	0.41	0.41	0.30

individual deduction	1	1	1	.1
	yes	yes	yes	yes
cafeteria plan	0	0	0	0
	no	no	no	no
contribute % single	0.90	0.70	0.80	0.90
contribute % family	0.75	0.50	0.65	0.75
load disadvantage	0.20	0.20	0.20	0.20
Required savings to switch	200	200	200	200
total insured switchers	21,361	23,751	22,443	21,361
(% of insured)	0.25	0.27	0.26	0.25
total switchers including uninsured (% of employees)				

	1	1	1	0
	yes	yes	yes	no
	1	1	0	1
	yes	yes	no	yes
	0.90	0.90	0.90	0.90
	0.75	0.75	0.75	0.75
	0.00	0.00	0.20	0.20
	0	200	200	200
	40,522	26,723	21,361	11,358
	0.47	0.31	0.25	0.13
	58,969	45,170	39,809	
	0.56	0.43	0.38	

	1	1	1	1	1
	yes	yes	yes	yes	yes
	0	0	0	0	0
	no	no	no	no	no
	0.90	0.90	0.90	0.90	0.90
	0.75	0.75	0.75	0.75	0.75
	0.20	0.20	0.20	0.20	0.20
	0	200	200	200	200
	31,677	24,467	21,866	21,361	24,529
	0.37	0.28	0.25	0.25	0.28

THE WHITE HOUSE

WASHINGTON

January 3, 1999

**NEW INITIATIVE TO ADDRESS GROWING LONG-TERM CARE NEEDS AND  
SUPPORT FAMILY CAREGIVERS**

**DATE:** January 4, 1999  
**TIME:** 10:30 am to 11:00 am (Pre-brief)  
11:00 am to 11:15 am (Meet and Greet)  
11:15 am to 12:10 pm (Event)  
**LOCATION:** Oval Office (Pre-brief)  
Blue Room (Meet and Greet)  
Grand Foyer (Event)  
**FROM:** Bruce Reed / Chris Jennings

**I. PURPOSE**

You are unveiling a new long-term care initiative to support Americans with long-term care needs and the millions of family members who care for them.

**II. BACKGROUND**

You will unveil a new, four-pronged, \$6.2 billion (over five years) initiative that takes important steps to address the complex needs of Americans with long-term care needs and their family members through:

- **Supporting families with long-term care needs through a \$1,000 tax credit.** This initiative, for the first time, acknowledges and supports millions of Americans with long-term care needs or the family members who care for and house their ill or disabled relatives through a \$1,000 tax credit. This new tax credit supports the diverse needs of families by compensating for a wide range of formal or informal long-term care services for people of all ages with three or more limitations in activities of daily living (ADLs) or a comparable cognitive impairment. This proposal, which supports rather than supplants family caregiving, would provide needed financial assistance to about 2 million Americans, including 1.2 million older Americans, over 500,000 non-elderly adults, and approximately 250,000 children. It costs \$5.5 billion over five years and the credit phases out beginning at \$110,000 for couples and \$75,000 for unmarried taxpayers.

- **Creating a new National Family Caregiver Support Program.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's disease patients can delay institutionalization for as long as a year. This new nationwide program, strongly advocated by the Vice President, would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to create "one-stop-shops" that provide: quality respite care and other support services; critical information about community-based long-term services that best meet a family's needs; and counseling and support, such as teaching model approaches for caregivers that are coping with new responsibilities and offering training for complex care needs, such as feeding tubes. This program, which costs \$625 million over five years, would serve approximately 250,000 families nationwide.
- **Launching a national campaign to educate Medicare beneficiaries about the program's limited coverage of long-term care and how best to evaluate their options.** Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long-term care, and many do not know what long-term care services would best meet their needs. This \$10 million nationwide campaign would provide all 39 million Medicare beneficiaries with critical information about long-term care options including: what long-term care Medicare does and does not cover; how to find out about Medicaid long-term care coverage; what to look for in a quality private long-term care policy; and how to access information about home and community-based care services that best fit beneficiaries' needs.
- **Having the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees.** You will also call on the Congress to pass a new proposal that authorizes OPM, representing the nation's largest employer, to use its market leverage and set a national example by offering non-subsidized quality private long-term care insurance to all federal employees, retirees, and their families. This proposal, which costs \$15 million over five years, will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.

**Expected Response From Validators.** We expect aging advocacy organizations, like AARP and the Alzheimer's Association to be very supportive of your policy. The advocates appear to be impressed that your proposal recognizes the multi-faceted nature of the problems facing the nation's chronically ill and are pleased that you are focusing the initiative on all age groups rather than just the elderly. They will caution, though, that however positive this proposal is, it does not address all of the long-term care challenges facing the nation. We have assured them that we will not make such a claim; indeed, it would hurt us among independent validators as well as the Republican Congress if we were proposing a much more expansive approach.

**Role of the Vice President and Mrs. Gore.** The Vice President and Mrs. Gore are participating in this event from the Triple "R", an adult day care program that is part of a successful California statewide caregiving program and that serves approximately 30 families in the Sacramento area. The California program, one of the four model caregiver support programs that currently exist, is similar to the National Family Caregiver Support Program that the Administration is launching nationwide on January 4. The Vice President and Mrs. Gore, who will meet with a number of families with long-term care needs during your remarks, will join you via satellite at 11:40 am to discuss the experiences of these families and to validate the need for your long-term care initiative.

### **Program Participants**

*Patricia Darlak*, who will introduce you at the event, is a Maryland resident who has recently assumed the responsibility of caring for her 83 year old mother. Mrs. Darlak is a special education teacher in Maryland. Her mother was diagnosed with Alzheimer's almost 2 years ago and has been living with the Darlaks for four months. Her mother currently requires assistance with bathing, dressing, eating, and toileting. Mrs. Darlak had a great deal of difficulty finding information on how to obtain respite and adult day care services for her mother, and still has been unable to find a regular source of respite care. Presently, she drives home during her lunch break in order to check on her mother. She is very worried about the financial burden that caring for her mother creates, especially since she and her husband are still responsible for their two children, who are in college in Florida. The Darlaks would be eligible for the proposed tax credit and would benefit from the respite care, adult day care, and information and referral services provided by the proposed National Family Caregivers Support Program.

When they join you via satellite, the Vice President and Mrs. Gore will tell you about the following caregivers:

*Barbara Cepeda-Adams* is a 39 year old Hispanic woman who has cared for her father since 1994, when his Parkinson's disease made it impossible for him to continue to live by himself. Ms. Cepeda-Adams stopped working full time shortly after her father moved in with her and was forced to stop working altogether last January in order to care for him properly. Her father, Jesus Cepeda, currently requires assistance with bathing, dressing, eating, and toileting, and is unable to move around the house without assistance. Since Ms. Cepeda-Adams is no longer working, her husband has been the sole financial support for both her father and their two children, aged 6 and 10. Although Mr. Cepeda has a limited income, it does not come close to covering the expenses associated with his care. The Cepeda-Adams family has greatly benefited from the services provided by California's model statewide family caregiving resource program, and would be eligible for the new proposed tax credit.

*James Burns* has been caring for his wife Ruth since 1993, when she was diagnosed with Alzheimer's disease. He continues to work full time in order to provide for his wife's care. Currently, Ms. Burns requires assistance with bathing, eating, dressing, and toileting. She is unable to move around the house without assistance. Mr. Burns receives respite care services and has enrolled his wife in the adult day care program administered by Triple "R".

### III. PARTICIPANTS

#### Briefing Participants

You  
The First Lady  
Secretary Shalala  
Secretary Rubin  
Janice LaChance  
Bruce Reed  
Gene Sperling  
Chris Jennings

#### Program Participants (Washington, DC)

You  
The First Lady  
Secretary Shalala  
Secretary Rubin  
Janice LaChance  
Patricia Darlak

#### Program Participants (Sacramento, CA)

The Vice President  
Mrs. Gore

### IV. PRESS PLAN

Information about the new initiative has been advanced to all major national papers for Monday. In addition, Secretaries Rubin and Shalala, together with Director LaChance, will brief members of the press at the beginning of Joe Lockhart's daily briefing.

### V. SEQUENCE OF EVENTS

- **You** and the First Lady, together with Secretary Rubin, Secretary Shalala, and Director LaChance, will spend 15 minutes meeting with Patricia Darlak in the Blue Room.
- **You** and the First Lady, together with Secretary Rubin, Secretary Shalala, Director LaChance and Patricia Darlak, are announced into the Grand Foyer.
- The First Lady delivers remarks and introduces Patricia Darlak.
- Patricia Darlak delivers brief remarks and introduces **you**.
- **You** deliver remarks.
- The First Lady introduces the Vice President and Mrs. Gore via satellite.

- **You** proceed to your seat.
- The Vice President and Mrs. Gore deliver remarks. (**You** will ask follow-up questions to be provided by speechwriting).
- Upon conclusion of the discussion, the Vice President makes concluding remarks and bids farewell.
- **You** deliver concluding remarks and depart.

## **VI. REMARKS**

Your remarks have been prepared by speechwriting.

## **VII. ATTACHMENTS**

- Rationale for the long term care initiative
- Background on the California program

## BACKGROUND AND RATIONALE: THE LONG-TERM CARE INITIATIVE

Americans of all ages, particularly the elderly and their families, fear developing a need for intense, ongoing long-term care. Unlike acute care, long-term care is rarely paid for by private insurance and Medicare, and is more likely to require out-of-pocket expenditures. It also takes a huge financial and emotional toll on family and friends who provide most of this care. Because of its complexity, however, no single policy can "solve" this problem. Thus, your proposed initiative is multi-faceted, providing immediate assistance with long-term care & helping to prepare for what will surely be one of the great challenges as the baby boom generation ages.

### GROWING NEED FOR LONG-TERM CARE

- **Who needs long-term care.** People with chronic illness or disability not only need doctor, hospital and other acute care services --they also need a wide range of services to manage their health conditions and perform basic activities of daily living. For example, people with strokes may be bed-bound due to paralysis and need help with eating, moving and changing their feeding tubes. Diabetics or people with congestive heart failure may require frequent injections, medication and doctor visits. People with Alzheimer's disease often need constant monitoring and changes to their physical environment to allow them to live at home safely. Long-term care encompasses these and other services. It is probably the most complicated area of health care, since it varies based on a person's specific condition and limitations as well as access to care from institutions, health providers, families and friends.

About 5 million Americans of all ages have significant limitations (cannot perform 3 or more activities of daily living without assistance) because of illness or disability and thus require long-term care. Nearly 2 million of these people live in nursing homes; the remainder live in the community and benefit from irreplaceable and uncompensated caregiving from countless relatives and friends. In addition, millions more Americans have chronic illnesses or disabilities that are less limiting but still require long-term care.

More than two-thirds of people with long-term care needs are elderly --nearly half of all people age 85 and older need assistance with everyday activities. Older women are more likely to need long-term care than men; three-fourths of nursing home residents are women.

- **The aging of America will create a greater need for long-term care.** The sheer increase in number of elderly in the next century means more chronic illnesses. The number of people age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older will grow even faster (from 4.0 to 8.4 million). By 2050, the number of older, disabled people could double.
- **Not just a challenge for the elderly.** About 2 million people with substantial long-term care needs are younger than age 65. The rate of disability has been rising among children. In part, this reflects a little-noticed effect of the success in helping premature, sick, or disabled newborns. Their increased survival through infancy has led to a need for long-term care as they grow up. Also, many adults have long-term care needs due to lifelong health conditions (e.g., cerebral palsy) or conditions developed as adults (e.g., multiple sclerosis).

## LONG-TERM CARE SYSTEM

- **Medicare was not designed to cover long-term care.** Long-term care costs account for nearly half (44 percent) of all uncovered, out-of-pocket health expenditures for Medicare beneficiaries. When it was created in 1965, Medicare was modeled after a typical private insurance policy and thus did not include long-term care coverage.

Unfortunately, nearly 60 percent of all Medicare beneficiaries --and two-thirds of people under age 65 --do not realize that Medicare does not pay for long-term nursing home care. This means that the majority of Americans are unprepared for the financial and emotional challenges of paying for and/or providing long-term care.

- **Medicaid is already the major payer of long-term care, but historically has focused on nursing homes.** Medicaid is the largest payer of long-term care in the nation. It covers two-thirds of nursing home residents --many of whom become eligible for this income-related program because long-term care costs impoverish them. Nursing home costs average almost \$50,000 per year. About 80 percent of Medicaid long-term care costs are for nursing homes.

The remaining 20 percent of costs are for home and community-base long-term care services. The share of Medicaid long-term care spending going toward home and community-based services has more than doubled in the last 10 years. Ten years from now, Medicaid spending on these services is projected to equal spending on nursing homes. The President has encouraged the shift away from Medicaid's "institutional bias" by approving over 300 waivers for local home and community-based care programs and proposing to repeal the need for such waivers. Notwithstanding these advances, not all Medicaid beneficiaries with long-term care needs have community-based options, and many people with long-term care needs don't qualify for Medicaid at all.

- **Private insurance is relatively new, untested, and covers very few people.** Only about 4 million Americans --1.5 percent of all Americans --have private long-term care insurance. In part, this reflects the newness of the coverage, the inconsistency of benefits across policies, variable regulation, and low demand. Given their cost, even if every baby boomer who could afford private insurance purchased it, less than one-third of long-term care costs would be paid for by private insurance in 2030.
- **Families and friends provide most long-term care.** Informal caregiving is a part of family life for many Americans. About 70 percent of caregivers report it being a positive experience. Only about one-third of the 5 million people with substantial long-term care needs lives in a nursing home --virtually all of the 3 million community-based people with similar needs rely on one or more relatives or friends for help. The millions of caregivers that provide nearly full-time assistance for these people with severe needs are part of a larger group of Americans that help people with less intense long-term care needs.

However, the costs of such caregiving --in time, money, and physical and emotional strain --can be large. Two-thirds of working caregivers report experiencing conflicts that cause them to rearrange their work schedules, work fewer hours, or take an unpaid leave of absence from work. Most of the primary caregivers for the elderly are elderly themselves. Their average age is 60 years old, and half are older than 65. About one third describe their own health as "fair to poor." This presents problems since informal caregiving often requires physical work like heavy lifting, frequent bedding changes, dressing and bathing. These stresses tend to be more severe for families of people with Alzheimer's disease. Such caregivers tend to experience greater time demands, family conflict, strain, mental and physical problems, and financial hardship.

## CALIFORNIA'S STATEWIDE CAREGIVING RESOURCE PROGRAM

California is one of four states in the nation which provide model statewide family caregiving resource programs similar to the one that the Administration is launching nationwide today.

California's Department of Mental Health developed a program in 1984 to provide caregiver support services through eleven agencies statewide to provide support services for families caring for persons with Alzheimer's disease, Parkinson's disease, stroke, and traumatic brain injury. In 1996, California's Caregiver Resource Centers served over 10,000 family members and friends who care for loved ones suffering from Alzheimer's disease, stroke, Parkinson's disease, multiple sclerosis, traumatic brain injury, and other adult-onset, brain impairing diseases. The Centers' primary functions include the provision of respite care (e.g. in-home respite care, adult day services, or weekend respite camps), information, education, long-term planning, legal/financial consultations, training, and support groups.

Recent statewide assessments of this program have shown that the typical caregiver in California is 60 years old and most (76 percent) are women, and they typically provide about 10.5 hours per day of care. Depression continues to be a pervasive problem for caregivers; approximately six out of 10 caregivers in California's program have been diagnosed with depression.

LATEST DRAFT - CAN WE CALL MICHAEL  
DOYCH/OMB TO ASK ABOUT HUD?

DRAFT: December 23, 1998

MEMORANDUM

FROM:

RE: Long-Term Care Initiative

NOT  
Sufficient  
Financial

One, great fear of the elderly is developing a need for intense, ongoing long-term care. Unlike acute care, long-term care is much less likely to be paid for by private insurance and Medicare and more likely to require out-of-pocket expenditures. It also takes a huge financial and emotional toll on family and friends who provide most of this care to seniors -- as well as children and adults with chronic illness or disability. Because of its complexity, however, few lawmakers have proposed major reforms in this area. This memo describes our multi-faceted initiative for your budget. It is designed to both provide immediate assistance with long-term care and help prepare for what will surely be one of the great challenges as the baby boom generation retires. Although we have kept this initiative close to prevent leaks, key experts and aging advocates have told us they think that this initiative is thoughtful and progressive. It will also be acknowledged as the first major recognition of the invaluable role that families and friends play in long-term care.

**BACKGROUND**

**During the 20th century, the health of the elderly improved.** This century has brought great improvements to the health of older Americans. Today's elderly are expected to live more than 20 percent longer (over 3 years) than the elderly of the early 1960s. In part, this is because of less chronic illness among the elderly. One study found that the number of elderly with chronic illness is 1.2 million lower than it would have been had trends from the early 1980s had continued. In just the last 10 years, the proportion of the elderly reporting fair to poor health status declined by nearly 10 percent since 1987.

**In the 21st century, an older society -- with more, chronic health problems -- will emerge.** The year 2000 marks the first time in the history of the world where the old outnumber the young. In the U.S., the number of people age 65 years or older will double by 2030 (from 34.3 to 69.4 million). By 2030, one in five Americans will be elderly. The number of people 85 years or older will grow even faster (from 4.0 to 8.4 million). By 2030, the Census Bureau predicts that 324,000 Americans will be over 100 years old, compared to 64,000 today.

Even while the proportion of elderly with health problems declines, the sheer increase in number of elderly means increases in chronic illness. One study, using optimistic assumptions about disability declines, projects that, by 2050, the number of older, disabled people will double.

**Today, at least 6 million Americans need long-term care.** About 6 million Americans have significant limitations due to illness or disability and thus require long-term care. About two-thirds of people with long-term care needs are elderly -- nearly half of all people age 85 and older need help with daily activities. Elderly women are more likely to have long-term care needs. Three-quarters of seniors with long-term care needs live in their homes or in the community.

**Who provides long-term care.** People with chronic illness or disability not only need acute care services, but usually require help in managing their health conditions and performing basic activities of daily living. For example, people with diabetes, heart disease, arthritis, and Alzheimer's disease often need help in coordinating and monitoring medications; changing feeding tubes or maintaining other medical devices; preparing meals and eating; and moving from place to place. Such long-term care is provided by a wide range of people.

**Family and friends.** Over 70 percent of the community-based elderly with long-term care needs live with a spouse, son, daughter, or other adult -- almost all of whom provide a significant amount of unpaid help. According to a recent study, over 7 million Americans provide nearly 30 hours per week of assistance to elderly people with long-term care needs.

Informal caregiving is a long tradition in America, and the vast majority of caregivers consider it a positive experience. On average, two people help every older person with long-term care needs. This number is greater among African and Asian American families that more frequently provide informal long-term care. However, in today's world, the costs of such caregiving -- in time, money, and physical and emotional strain -- can be large. Two-thirds of working caregivers report experiencing conflicts that cause them to rearrange their work schedules, work fewer hours, or take an unpaid leave of absence from work. Most of the primary caregivers for the elderly are themselves older; their average age is over 60. About one third described their own health as "fair to poor." This presents problems since informal caregiving often requires physical work like heavy lifting, frequent bed changes, dressing and bathing. These stresses tend to be more severe for families of people with Alzheimer's disease.

**Home and community-based health care.** Home health providers, nurses, physical therapists, physicians, and other health providers often deliver long-term care in peoples homes or sites like adult day care centers. About 30 percent of paid long-term care is for home health services, and this spending is growing rapidly. Medicare's payments for home health grew at a rate of nearly 15 percent before the constraints of the Balanced Budget Act. Medicaid spending on home and community-based services is outstripping its payment growth in nursing homes -- its share of Medicaid long-term care dollars more than doubled in the last 10 years.

**Assisted living.** A wide range of facilities combine health care and housing. "Assisted living facilities" typically provide 24-hour supervision, three meals a day in a group dining room, and services such as personal care and housekeeping. About 30,000 assisted living facilities serve over 1 million people, most of whom are elderly. Although all states have some type of regulation, assisted living facilities are generally not closely monitored. More importantly, few insurers pay for this type of care. Only a few states pay for Medicaid services in these facilities.

**Nursing homes.** Nursing homes provide essential care for people whose long-term care needs are too intense for community-based care, or for people who do not have community-based support systems. About 1.6 million older Americans and people with disabilities receive care in approximately 16,700 nursing homes. About three-fourths of nursing home residents are women. A large proportion of nursing facility residents have Alzheimer's disease or other dementing diseases; one study found that over 43 percent of facility residents were diagnosed with dementia and 63 percent had some sort of memory impairment or disorientation. Medicaid pays for over two-thirds of nursing home residents because the high cost of such care (on average nearly \$50,000) usually impoverishes people. Medicare only a limited number of days of post-acute, skilled nursing facilities care. However, nearly two-thirds of beneficiaries think that Medicare pays for long-term nursing home care.

**Who pays for long-term care.** In contrast to acute care services, long-term care is primarily paid for by public programs (60 percent) and out-of-pocket (28 percent). Only about 7 percent of long-term care services is covered by private insurance. As such, long-term care expenditures account for nearly half (44 percent) of out-of-pocket health spending for Medicare beneficiaries. These estimates don't even include the value of unpaid, informal long-term care.

*Alld MCR 1*

### **LONG-TERM CARE INITIATIVE**

The elderly's fear of developing long-term care needs is justifiable given the complexity of the delivery system and its fragmented financing. However, because of the nature of the problem, no simple, single answer exists. Thus, we developed a series of policies centered on three imperatives: (1) provide immediate support and assistance for the major providers of long-term care: families and friends; (2) educate the elderly and people with disabilities about long-term care issues and options; and (3) promote directions in long-term care policy that hold promise for the twenty-first century. These cross-cutting objectives resulted in soliciting policies from four agencies: DHHS, Treasury, OPM and HUD. They are listed below.

**Support for Family Caregiving.** Our initiative, for the first time, acknowledges and supports families who care for and house their ill or disabled relatives. It does this through a tax credit to compensate for the formal and informal costs of people with significant long-term care needs and a new Family Caregivers program that provides information, education and respite services that support and improve caregiving.

**Long-term care tax credit.** This policy provides a tax credit of up to \$1,000 to people with long-term care needs or the families with whom they live. The vast majority of people with long-term care needs live with a spouse, sibling, or child -- almost all of whom provide some type of care. As such, family members who house their chronically ill or disabled relatives may also qualify for the credit. Rather than basing the credit on receipts for expenses for long-term care, this credit is a flat amount that will help offset both the direct costs (e.g., home health visits, adult day care) and indirect costs (e.g., time off from work) of caregiving. Although the credit is not refundable, most people with long-term care needs who are not filing taxes are probably receiving SSI.

About 2 million people would benefit from this credit. About 1.2 million of these people are elderly, over 500,000 are nonelderly with disabilities, and approximately 250,000 are children. The majority of people receiving the credit are caregivers and not the person with disabilities themselves. Most of the people receiving the credit have income between \$20,000 and 50,000. (Investment: \$5.5 billion over 5 years)

***Family Caregiver Support Program.*** A new Administration on Aging program will provide services to strengthen the long-term care that many Americans provide for relatives with chronic illness or disability. States will receive grants to: (1) connect families with information and local public and private services (e.g., guides on caring for people with strokes; local home health and respite services); (2) give counseling, training and peer support to teach families how to address the challenges of caregiving; and (3) provide respite care (e.g., sending attendants to families' homes, adult day care centers, and temporary care in an assisted living facility or nursing home). States will build these systems around the existing area agencies so that they serve as a "one-stop-shop" access point to provide services. This program is modeled on successful programs in Washington, Wisconsin and California. Recent studies have found that adult day care relieves caregiver stress and delays institutionalization, and that counseling and support for families of Alzheimer's disease patients can delay institutionalization for as long as a year.

Up to 250,000 families would benefit from services provided through the Family Caregiver Support Program. Although states will have some flexibility in allocating funds for the three activities, we expect that about 75,000 families will benefit from some type of respite care. (Investment: \$130 million in 2000)

**Education and Information on Long-Term Care.** Information can play a central role in helping people understand their long-term care options and navigate the system.

***Medicare Beneficiaries Long-Term Care Information Campaign.*** Beginning in 1999, Medicare will send its beneficiaries information about their health plan choices annually. Since most people who have or will develop long-term care needs are Medicare beneficiaries, this information system is an extremely efficient way to provide information on long-term care to the majority of people who will need it. This information would include: simple descriptions of what long-term care Medicare does and does not cover; how to find out about Medicaid long-term care; what to look for in a private long-term care insurance policy; and other consumer information.

All 39 million Medicare beneficiaries will get this educational material. Preliminary results from this year's test of the Medicare+Choice information suggest that beneficiaries do read extra information in the booklet (we added information on low-income protections and a large number of calls were made as a result). (Investment: \$25 million)

**Policies to Strengthen Long-Term Care in the 21st Century.** Innovation in financing and delivery of long-term care will be needed to address the challenges of our aging society.

***Offering private long-term care insurance to Federal employees.*** Private long-term care insurance is a small but growing part of the long-term care financing system. Tax preferences enacted in the Kassebaum-Kennedy legislation put in place new standards for such insurance, but this market is far from providing widespread, high-quality, affordable policies. This policy aims to encourage better private insurance by allowing OPM to offer selected private policies to Federal workers. It would set high standards and negotiate good prices with insurers -- hopefully setting an example for other employers. OPM would also conduct a similar education campaign for its workers about long-term care. The outcomes of OPM's effort could guide future policy debates over the role of private long-term care insurance.

OPM estimates about 300,000 participants. (Investment: small administrative expenses)

***Integrating health and housing options for the elderly.*** For the low-income elderly who need round-the-clock care, nursing homes may be their only option. All state Medicaid programs pay for nursing home care, but few pay for services provided in assisted living facilities. This policy provides grants to low-income housing units to convert to assisted living facilities, allowing low-income elderly to remain in this housing rather than move to nursing homes. It would give preference to housing units that develop relationships with the state to provide Medicaid-covered home and community-based services in these facilities. This innovative model will both allow the elderly to "age in place" rather than move to nursing homes and provide a cost effective alternative to nursing home care.

[get#s]

Long Term Care Savings Account  
File

## Thomas Idea: MANDATORY LONG-TERM CARE SAVINGS ACCOUNTS

**BACKGROUND:** Bill Thomas (R-Health Subcommittee Chair, Ways & Means) announced at the Medicare Commission last week his interest in creating mandatory retirement accounts for long-term care services. As part of Social Security reform, he would create these individual accounts that would be privately invested for the sole purpose of savings for predictable long-term care expenses (e.g., personal assistance). He did not offer details on how much these accounts would be, when people could begin to withdraw from them, when they could be converted for other types of uses, etc.

### PROS:

- **A significant proportion of the elderly have long-term care needs.** One in 10 people ages 65 to 75 need assistance with everyday activities, and half of people over age 85 need help.
- **At least one-fourth of long-term care expenses are paid for out of pocket.** As such, saving for long-term care helps families pay for that care when needed and lowers the reliance on Medicaid for such care. (Currently, people who exhaust their resources paying for long-term care get covered by Medicaid).

### CONS:

- **Without large subsidies for the low-income, this option mostly benefits the wealthy.** In general, people with higher income save more, benefit more from the tax treatment of savings, and pay more of their long-term care costs out of pocket. Thus, low-income people would don't benefit very much -- and presumably would be sharing in the cost of the policy.
- **Does not protect against catastrophic costs of nursing homes.** Most of the costs of long-term care are associated with institutionalization. Only 5 percent of the elderly reside in nursing homes, but the cost of nursing homes accounts for over two-thirds of all long-term care costs. Although this policy could be coupled with the purchase of adequate catastrophic long-term care insurance, such products are not widespread and it is unlikely that Medicare will move in this direction.
- **Why only long-term care?** The elderly have a wide range of health care costs -- the lack of Medicare coverage of prescription drugs may be an even greater problem than non-catastrophic long-term care expenses. Nearly one in every five dollars the elderly pay out-of-pocket is for prescription drugs. Given the cost of the mandatory individual accounts, does it make sense to either allow these accounts to be used for drugs or to use the funds for a Medicare prescription drug benefit?



Skilled Nursing Facility  
File

**Health Care Financing Administration  
 Office of Legislation**

200 Independence Avenue, SW-Room 341-H  
 Washington, DC 20201  
 Fax: (202) 690-8168 Phone: (202) 690-5444

Number of Pages: Cover + 2

Date: 10/9/98

To: <u>Chris Jennings</u>	From: <u>Bonnie Washington</u>
Fax: <u>456-7431</u>	Fax: _____
Phone: _____	Phone: _____

REMARKS: SNF PPS

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**Section 0000 Reconciliation of Skilled Nursing Facility Non-Therapy Ancillary Costs For The First Year of the Prospective Payment System.**

**(a) RECONCILIATION OF NON-THERAPY ANCILLARY COSTS.--**

**(1) TRANSITION PERIOD.--**Section 1888(e)(2)(E) (42 U.S.C. 1395yy(e)(2)(E)) is amended by adding after clause (ii) the following new clause:

**"(iii) PAYMENT ADJUSTMENT FOR NON-THERAPY ANCILLARY SERVICES.--**Upon settlement of the cost reports, for periods beginning July 1, 1998 through June 30, 1999, the Secretary shall adjust the portion of the payments made to facilities under this subsection which are attributable to covered ancillary services (other than physical therapy, occupational and speech therapy), as determined by the Secretary, to account for the difference between the payment for such services and the reasonable cost of those services. In making such adjustment, the Secretary shall--

**(I) recover from each facility the full amount of payments for such services which are greater than the reasonable costs of those services;**

**(II) make additional payments to each facility to the extent that reasonable costs exceed payments for those services. Such additional payment shall be made using only the amounts recovered under subclause (I)**

and in equal proportion to the amount of reasonable cost of each facility in excess of its payment; and

(III) make further adjustments to the additional payments made under subclause II to ensure that such payments do not result in aggregate expenditures greater than had this clause not been enacted.

(2) LIMITATION ON REVIEW.--Section 1888(e)(8) is amended by striking "and" at the end of subparagraph (B) and adding "and" at the end of subparagraph (C) and by adding the following new subparagraph--

"(D) the payment adjustment specified in subsection (2)(E)(iii)."

For Immediate Release

October 8, 1998

TEXT OF A LETTER FROM THE PRESIDENT  
TO THE MAJORITY LEADER OF THE SENATE

October 8, 1998

Dear Senator Lott:

I am writing to urge you to pass legislation to reauthorize the Older Americans Act (OAA) before the Congress adjourns this year. Failure to do so will call into question our nation's commitment to the Act and the vital services it provides to millions of older Americans.

Legislation to reauthorize the OAA has gained an impressive degree of bipartisan support. In fact, the legislation proposed by Senator McCain and Senator Mikulski is cosponsored by more than 60 Senators.

The OAA is receiving broad support because it has played such an important role in responding to the diverse needs of our nation's seniors. It provides more than 100 million meals to nearly one million vulnerable seniors each year through its meals-on-wheels program; it finances and supports an ombudsman program that helps resolve tens of thousands of problems, including abuse and neglect, affecting nursing home residents and other vulnerable populations; it provides job training for seniors who need or want to work; and, in many communities, it provides the type of adult day care that gives families a much needed respite from caregiving responsibilities.

These programs are essential to ensuring that our nation's seniors can maintain their independence. Sometimes a few basic services or programs, such as adult day care or adequate nutrition, are all that is necessary to allow seniors with limited resources to continue living in their homes and communities. Without the OAA, too many older Americans would have no choice but to turn to long-term care facilities to get the help they need. This harms those who would like to remain in their communities, significantly draining our nation's limited resources.

No political party gains -- and all Americans lose -- when we fail to work together to pass a bipartisan reauthorization of the OAA. I am committed to working with you to reauthorize this critically important legislation.

Sincerely,

WILLIAM J. CLINTON

# # #

## Options to Assist Taxpayers with Long-Term Care Needs September 11, 1998

### 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.<sup>1</sup> A taxpayer would not be eligible for the credit if he or she were a chronically ill dependent of another taxpayer. [Variant increases credit to \$1,000.]

For purposes of the proposed tax credit, a chronically ill individual could be a dependent if their gross income was below the sum of the exemption amount, the standard deduction, and the deduction for the elderly and blind (\$7,100 for a non-elderly single dependent and \$8,150

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<sup>1</sup> 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 the dependent exemption amount (\$2,750 in 1999) if not the taxpayer's child; and (5) receive over half his or her support from the taxpayer.

for an elderly single dependent; higher if blind).

Taxpayers would not have to meet the support test in order to claim a chronically ill individual as a dependent if the individual meets one of the following two requirements: (i) the individual is the parent (including stepparents and in-laws), or ancestor of the parent, or child, or descendant of the child, of the taxpayer and lives with the taxpayer for over half the year;<sup>2</sup> or (ii) the individual meets the other relationship or household membership tests and resides with the taxpayer a full year. If more than one taxpayer could claim the individual as a dependent under the proposed rule, the taxpayer with the highest adjusted gross income would be entitled to the tax credit.

A custodial taxpayer who is not required to meet the support test under the proposal may waive the tax credit to another taxpayer if the noncustodial taxpayer provides over half of the dependent's total support and meets the other current law rules for dependency.

An adult is chronically ill if he or she has been certified by a licensed doctor within the previous 12 months as being unable for at least six months to perform at least two activities of daily living without substantial assistance from another individual, due to loss of functional capacity. [Variant increases ADL test to three or more limitations.] Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence management. Substantial assistance includes both hands-on assistance (that is, the physical assistance of another person without which the individual would be unable to perform the activity of daily living) and stand-by assistance (that is, the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual when perform the activity of daily living). 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 and have difficulty with one or more ADL or instrumental ADL.

A child under 6 is chronically ill if he or she is very developmentally delayed (for example, cannot sit upright without leaning against something by ages 24 to 59 months, or cannot walk without holding onto something by ages 30 to 59 months). A child aged 6 - 17 is chronically ill if he or she is either very developmentally delayed, or has difficulty with two out of five ADLs (same as adults but excluding continence management)

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

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<sup>2</sup> Under certain circumstances, the residency test would be met even if the chronically ill individual had spent some or all of those six months in a hospital or nursing home. The dependent would be considered to be "temporarily away from the taxpayer's home," if he or she had lived in the taxpayer's home prior to entering the hospital or nursing home and had a reasonable expectation of either returning to the taxpayer's home or dying in the hospital or nursing home.

mathematical error procedures. Further, the taxpayer would be required to attach a certificate from a doctor to their tax return the first time that they apply for the tax credit.<sup>3</sup> The certificate would state that the individual was chronically ill (as defined above) and must be signed by a licensed doctor and include their Unique Physician Identification Number (required for Medicare billing). Certification would be prospective. (The IRS will need access to HCFA's files linking UPINs with doctors names and addresses.) Failure to attach a complete certificate would also be subject to mathematical error procedures. Individuals 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 additional child 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). The additional child credit replaces a portion of the child credit lost due to either nonrefundability or the tentative minimum tax limitations.

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<sup>3</sup> Non-elderly chronically ill individuals could be required to attach the certificate on a more regular basis (every three or five years).

### **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.<sup>4</sup> 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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<sup>4</sup> 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.<sup>5</sup> In general, a qualifying individual is (1) a dependent of the taxpayer who is under the age of 13<sup>6</sup>; (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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<sup>5</sup> If married, both spouses must generally be employed in order to claim the credit.

<sup>6</sup> 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 incurred for themselves, their spouses, or a dependent (including those who could be claimed as an exemption if not for the gross income test). 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 (including both hands-on and stand-by 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.

September 11, 1998

### **Long-Term Care Tax Credit Beneficiary Counts: Estimates and Explanations**

This note provides some rough preliminary estimates of the characteristics of the chronically ill population and their caregivers. Specifically, we estimated the number of individuals who are potentially eligible for long-term care tax credits by severity of disability, age, and tax status, as well as the costs of various options. The estimates are still preliminary and should not be cited publicly at this time. In particular, estimates of non-tax variables that are not readily available from other sources should be viewed as especially sensitive.

These estimates are somewhat lower than our earlier estimates because of additional data that we have recently been able to incorporate into our analysis. We start by explaining revisions and qualifications on our current estimates (i.e., why they might be revised again), and then provide the estimates.

#### **Key Caveats and Revisions**

Estimating long-term care tax credit options is extremely difficult because available data are incomplete. For example, much of the data regarding severity of disability are available only for a point in time in a given year, but we need to calculate disability status and duration of disability for an entire year. Further, there is little information regarding intra-family transfers or support networks between households that can be used to estimate different dependency relationships.

To meet these challenges, we developed on-model imputations and off-model adjustments, but they are still being refined. We have recently improved our estimates by matching data on long term care, provided by HHS and others, to the new 1995-based individual income tax model.

These model and data enhancements have caused downward revisions in the estimates of the proposals since August. For example, the estimates of the cost of the \$500 basic credit for chronically ill individuals with two or more activity of daily living limitations (ADLs) have been revised downwards: from \$3.9 billion to \$3.1 billion between FY 1999 and 2003 and from \$12.4 billion to \$9.5 billion between FY 1999 and 2008. Our estimates of the total number of chronically ill individuals benefitting from the proposal has declined from 3.4 million persons to 2.9 million persons. Estimates have been revised downwards to account for new information on the numbers of both elderly dependents and disabled filers with pre-credit income tax liability. The growth rates of the elderly disabled population in the community has also been adjusted downwards between FY 1999 and 2008.

As the model continues to be refined, further revisions are possible.

**Estimates of Potential Beneficiaries (ALL ESTIMATES ARE PRELIMINARY)**

A. Elderly vs. Non-elderly: Using data from the National Long Term Care Survey and the National Health Interview Survey, we find that there are about 3.4 million individuals living in the community who had two or more ADLs or who were cognitively impaired for three or more months when surveyed in 1994. Increasing the ADL limitation to three or more reduces this estimate to 2.6 million individuals.

Extrapolating to 1999 levels and annualizing the estimates, we estimate that there will be 4.7 million individuals living in the community for six or more months with two or more ADLs or who were cognitively impaired. Of these, 2.5 million will be aged 65 or older. Limiting the sample to individuals with three or more ADLs would reduce the total number to 3.6 million and the number of elderly disabled to 2.1 million.

There were about 1.4 million elderly individuals living in nursing homes at some point during 1995. Annualized estimates are not available. Most of these individuals would not qualify for the credit because they have little or no taxable income.

These estimates, even when finalized, should not be cited publicly.

B. Filers vs. Dependents: We estimate that 2.8 million of the 4.7 million individuals with two or more ADLs living in the community would benefit from the credit; of these, half would benefit from filing their own return, and the other half would be claimed as a dependent by another taxpayer (using the residency-based definition of dependents).

Among the 3.6 million people with three or more ADLs living in the community, the number of beneficiaries declines to 2.2 million; again, half of those would benefit from filing their own return, and the other half would be claimed as a dependent by another taxpayer.

Among year-round nursing home residents, only about 100,000 would benefit from the credit. This estimate cannot be further split between filers and dependents.

C. Differing Definitions of Dependents: The proposal would change the definition of dependency: dependents are defined as having gross income below the sum of the exemption amount, standard deduction, and the deduction for the elderly and disabled (rather than just the exemption amount). Further, the support test for dependents under present law is waived if they meet certain residency and relationship tests. Under the new definition, there are roughly 1.4 million dependents with two or more ADLs and 1.1 million with three or more ADLs who qualify for the credit.

If the current law definition of dependents were retained, there would be roughly 800,000 dependents with two or more ADLs and 600,000 with three or more ADLs who would qualify for

the credit

D. Number of Nonfilers with ADLs But Not Qualifying for Credit: There are roughly 1.1 million individuals, aged 65 or older, in homes or community with two or more ADLs (900,000 with three or more ADLs) who would not qualify for the credit. There are approximately 700,000 nonelderly individuals with two or more ADLs in homes or communities (500,000 with three or more ADLs) who would not qualify for the credit.

Estimates of year-long nursing home residents who would not benefit from the credit are not available.

The estimates on nonfilers, even when finalized, should not be cited publicly.