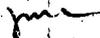


Long-Term Care 8/6

September 9, 1998

TO: Len Burman, Mark McClellan

FROM: Chris Jennings, Jeanne Lambrew 

RE: REVIEW OF LONG-TERM CARE TAX CREDIT ESTIMATES

Len, welcome. This is the first of what surely will be many overly demanding requests with very little time to respond. We look forward to working with you.

We are hoping to schedule a meeting on Friday afternoon to review the estimates of the long-term care tax credit options that you all developed in July and early August. We specifically wanted to go over:

- For both the 2 plus and 3 plus ADL eligibility groups:
 - Split between the elderly and non-elderly
 - Split between tax filers / spouses with ADL limitations and those who are claimed as dependents
 - Number of those claimed as dependents who only qualify by broadening the definition of dependency (beyond waiving the \$2750)
 - Number of nonfilers meeting the eligibility criteria who do not get the credit, split between elderly and nonelderly.
- Assuming the set of offsets discussed in August, what is the maximum credit per filing unit that we could afford for both the 2 plus and 3 plus ADL eligibility groups
- What are the 5 and 10 year costs for the 2 plus ADL eligibility group if the credit were:
 - \$750
 - \$1000
- Can we get year-by-year, line-by-line, Treasury and JCT estimates of the offsets

We have already requested and received many of these estimates, but given the pressure at the time, we wanted to give you all a chance to revisit, revise, update etc as necessary.

Please call with questions, and thanks.

0605

Five and Ten Year Revenue Estimates
of LTC Credit for Two or Three ADLS
Effective 1/1/2000

(\$ billions)

	2000-2003	2000-2008
2 + ADLS		
\$500 credit	-3.1	-9.5
<i>\$700 credit</i>	-4.3	-13.0
\$750 credit	-4.6	-13.9
\$1000 credit	-5.9	-18.1
3 + ADLS		
\$500 credit	-2.4	-7.5
\$750 credit	-3.6	-10.9
<i>\$850 credit</i>	-4.0	-12.1
\$1000 credit	-4.6	-14.2
<hr/>		
August 8 estimates		
2+ADLS		
\$500 credit	-3.9	-12.4
\$1000 credit	-7.5	-23.5
3+ ADLS		
\$500 credit	-3.3	-10.0
\$1000 credit	-6.2	-18.9
<hr/>		
sept9model	98/09/11	

Italicized credits (\$700 2ADL and \$850 3ADL) yield five year but not necessarily ten year estimates close to the "pay for".

Long-term Care Tax Preferences

SUMMARY

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

CONCERNS

- **Providing additional subsidies for long-term care insurance does not make sense.** Because of the very important Medicaid backstop, long-term care insurance can be more a form of asset protection than a vehicle for getting more long-term care services to people. If additional Federal resources are to be spent on long-term care, these resources should be targeted to expanding long-term care services to those with the greatest physical and financial need rather than spent subsidizing the insurance market.
- **Current law subsidies are already very generous.** Compared with saving for long-term care needs at age 90 by depositing earnings in a taxable savings account at age 45, employer-provided long-term care insurance results in a subsidy of 64 percent in one example. Subsidies would be even larger for policies purchased at a younger age or for employees who are in a higher tax bracket during their working years than in the example (28 percent).
- **It may be very costly to jump-start health insurance market.** Long-term care insurance is not a wise buy for most individuals because the cumulative value of the stream of premiums in real terms would be relatively high compared with the assets that the insurance is designed to protect. As a result, subsidies would have to be very large to jump-start the long-term care insurance market.
- **Expanding tax preferences for long-term care is unlikely to substantially reduce Medicaid expenditures.** Expansion of long-term care insurance may not save enough Medicaid money to warrant large tax expenditures. Individuals that buy long-term care insurance may buy policies covering only a year or two of long-term care services. Seventy percent of projected nursing home use for 80 year-old individuals occurs after the first year of nursing home residence. Many individuals that purchase long-term care insurance would otherwise have assets that could contribute toward long-term care expenses for one, or more, years. As a result, Medicaid savings are likely to be very small, yet tax benefits even under current law could be quite large.
- **Some individuals could fall prey to insurance companies.** A not so insignificant number of individuals, especially those who have less ability to make complicated

financial decisions, could fall prey to insurance companies. Many individuals with few assets might purchase long-term care insurance and not be able to maintain premium payments. For example, lapse rates for one major insurance company were as high as 60 percent resulting in the majority of purchasers paying premiums but being without coverage during their high risk years. Other individuals that continue to make the payments would do better by saving instead of paying premiums and using the savings and Medicaid to pay for long-term care.

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

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

- **Current law already allows penalty-fee withdrawals from IRAs for long-term care expenses under special circumstances.** Medical expenses, including long-term care expenses, for individuals with expenses above 7 ½ percent of adjusted gross income, for long-term unemployed individuals, and for individuals that are 59 ½ years of age or older are exempt from early withdrawal penalties. It would not be sensible to give long-term care services, which are more difficult to distinguish from everyday needs (e.g. housekeeping) than medical care, more tax preferences than medical care (e.g. cancer treatment). Similarly, it would be unwise to expand penalty-free withdrawals to cover all medical care expenses. IRAs were intended for retirement, not for unlimited medical spending.
- **IRAs should be protected for retirement cash needs.** IRAs are intended to encourage saving for retirement needs. Using IRA funds to pay for long-term care premiums may result in some healthy individuals finding themselves without the resources needed to meet everyday retirement needs. Deductible IRAs were designed to lock up funds until retirement. The list of penalty-free special purpose withdrawals should not be expanded further. It will already be difficult to avoid going further down this slippery slope.

Possible Option [I would prefer not to offer any options. We have not yet discussed this proposal and may not want it at all. On the other hand, even if we like this proposal, we may want to keep it in our back pocket. Or does this proposal keep the WH from pushing something bigger? (I doubt it.) Even if we have a narrow proposal like this, wouldn't it

be likely to grow on the Hill. JUST SAY NO.]

- **Clarify the tax treatment of nonqualified long-term care insurance.** Despite these general objections to expanding tax preferences for long-term care insurance, there is a need for clarifying the tax treatment of nonqualified long-term care insurance.

Qualified long-term care insurance receives special tax treatment. Both the definition of qualified long-term care and the special tax treatment is carefully prescribed in the law. Generally, an individual must meet a stricter standard of impairment under a qualified policy than under a nonqualified policy. The law was intentionally designed in this way to target tax benefits to those most in need. Qualified long-term care insurance payments are not includable in taxable income. In addition, qualified long-term care insurance premiums are deductible to the extent that they exceed 7 ½ percent of adjusted gross income and are excludable from income if provided by an employer.

Currently there is no special tax treatment of popular nonqualified long-term care insurance payments. [**Technically nonqualified long-term care insurance payments should be included in taxable income.**] However, in practice few individuals include these payments in taxable income. Under the proposal, a new category of "nonqualified" long-term care insurance would be defined, to cover a broad class of policies that are limited to long-term care insurance but that may include individuals that have relatively minor impairments (for example have only one limit in activities of daily living such as incontinence). Insurance payments from these "nonqualified" plans would not be includable in taxable income. However, premiums for nonqualified plans would not be deductible for income tax purposes nor excludable if paid by an employer. As a result, "nonqualified" plans would receive more favorable tax treatment than under the current vague law, but less favorable tax treatment than qualified plans targeted to those with more severe limitations. Insurance payments from plans that neither met the definition of qualified nor "nonqualified" would explicitly be includable in taxable income.

Long-term Care Subsidies: An Example

- HIPAA changed the law to enable employers to provide long-term care insurance on an extremely tax-preferred basis. Consider the following example of an individual who is in the 28 percent tax bracket while working and in the 15 percent bracket during retirement.
- In order to pay for \$100 of future long-term care services at age 90, a 45 year-old employee could allocate after-tax earnings toward those services. An employer would have to pay \$13.10 in wages and payroll taxes. The employee would then pay income taxes on the earnings and deposit the remainder into a taxable savings account. Assuming an interest rate of seven percent, the funds would grow at an after-tax rate of return reaching \$85 by age 90. This individual could then purchase \$100 in long-term care services, using \$85 from the account and \$15 from reduced taxes (assuming that other medical expenses exceed $7\frac{1}{2}\%$ of adjusted gross income).
- Alternatively, an employer could purchase insurance for a 45 year-old employee. Suppose \$100 of benefits is expected to be paid out at age 90. The one-time premium at age 45 would be \$4.76. Because insurance premiums would accumulate at a tax-free rate of return, there would be enough funds to provide \$100 of long-term care services when the retired employee reached age ninety.
- By providing long-term care insurance through an employer, the cost would be 36% ($\$4.76 / \13.10) of what an individual would have to earn to be able to provide an equivalent amount of long-term care services. In this example, an employee could receive a subsidy of 64%. Subsidies would be greater for individuals whose employer begins to contribute at an earlier age than in this example. Subsidies would also be greater for employees that are in higher tax brackets during their working years.

Long-Term Care/FETMBP File

Jeanne: Are we all with all
of this?
Total Pages: 15

LRM ID: RJP306

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

Thursday, August 6, 1998

LEGISLATIVE REFERRAL MEMORANDUM

SPECIAL

TO: Legislative Liaison Officer - See Distribution below
FROM: *Janet R. Forsgren*
Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT: Robert J. Pellicci
PHONE: (202)395-4871 FAX: (202)395-6148
SUBJECT: Office of Personnel Management Draft Bill on Federal Employees Group
Long-Term Care Insurance Act of 1998
DEADLINE: Wednesday, August 19, 1998

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: OPM draft bill designed to implement the Administration's proposal for long-term care insurance for Federal employees.

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LRM ID: RJP306 SUBJECT: Office of Personnel Management Draft Bill on Federal Employees Group Long-Term Care Insurance Act of 1998

**RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM**

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or

(2) sending us a memo or letter

Please include the LRM number shown above, and the subject shown below.

TO: Robert J. Pellicci Phone: 395-4871 Fax: 395-6148
 Office of Management and Budget
 Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)
 _____ (Name)
 _____ (Agency)
 _____ (Telephone)

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

Honorable Albert Gore, Jr.
President of the Senate
Washington, DC 20510

Dear Mr. President:

The Office of Personnel Management (OPM) submits the enclosed legislative proposal entitled the "Federal Employees Group Long-Term Care Insurance Act of 1998." This proposal would authorize OPM to purchase a policy or policies from one or more qualified private-sector contractors to make long-term care insurance available to Federal employees and retirees, and family members whom OPM defines as eligible, at group rates. Coverage would be paid for entirely by those who elect it.

In keeping with our mission to provide Government-wide human resource management leadership, one of OPM's objectives is to achieve a modern, performance-oriented compensation system which includes a benefits package that will enable Federal agencies to attract and retain well-qualified employees. As the large baby boom generation with its improved longevity projections begins to plan for retirement, large- and medium-sized employers are beginning to respond to their employees' concerns by sponsoring group long-term care insurance. Long-term care, which includes assistance with daily living activities in a variety of settings, can be very expensive. Insurance products for this purpose have been evolving since the 1980s. In the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Congress recently authorized tax treatment similar to that for medical insurance to promote access to good quality long-term care insurance contracts.

The Administration also has a more general interest in the development of a long-term care insurance program for Federal employees. It hopes to demonstrate the potential for private insurance to help contain costs under the Medicare and Medicaid Programs. At present, Medicare and supplemental Medigap insurance provide extremely limited coverage of long-term care services. Medicaid covers nursing home and some community-based services only if a person meets poverty guidelines for income and assets. Projected increases in the population over age 85 will likely raise costs for, and create pressure to expand, publicly-funded health programs if reasonable alternatives do not exist.

Since 1995, OPM and the Department of Health and Human Services have been engaging in cooperative research on long-term care insurance products and employer-sponsored programs. Responses to questions in a 1997 OPM survey indicated there is significant interest in such protection among Federal employees. On March 26, 1998, we discussed our findings at a hearing before the House Subcommittee on Civil Service during which there was substantial

Honorable Albert Gore, Jr.

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support for introducing Government-sponsored group long-term care insurance, on an employee-pay-all basis. This is consistent with general practice among other employers who offer this benefit.

Our proposal would allow OPM broad flexibility, similar to that available under the Federal Employees Health Benefits (FEHB) Program, to determine appropriate benefits and to contract for benefits with one or more private carriers, without regard to section 5 of title 41, United States Code, or any other law requiring competitive bidding. Qualified carriers must: (A) be licensed by law in all States and the District of Columbia to offer long term care insurance; (B) agree to provide coverage for all eligible enrollees consistent with requirements for qualified long term care insurance contracts and issuers enacted under subtitle C of Title III of the Health Insurance Portability and Accountability Act of 1996; (C) propose rates which in OPM's judgment reasonably reflect the cost of benefits provided; and (D) maintain funds associated with the Federal employee contract separate and apart from the carriers' other funds. Contracts would be for a duration of 5 years, unless terminated earlier by OPM. Regulations of OPM will provide for opportunities to enroll and benefit portability. This flexibility will enable OPM to negotiate program improvements as the market for long-term care services and protection evolves over time.

The program would be available to Federal employees and retirees, and their spouse, former spouse who is entitled to annuity under a Federal retirement system, parents, and parents-in-law. All participants other than active employees would be underwritten (i.e., asked questions about health status for premium-setting purposes) as is standard practice with products of this kind. Coverage made available to individuals would be guaranteed renewable and could not be canceled except for nonpayment of premium. Though each participant would be responsible for paying the full amount of premiums, based on age at time of enrollment, group rates will save an estimated 15-20 percent off the cost of individual long-term care policies.

Employee and annuitant premiums would be withheld from salary or annuity and transmitted directly to respective contractors, and those enrollees could also elect withholdings for coverage of their spouse. Any other eligible enrollees shall, at the discretion of OPM, submit premiums directly to the appropriate contractor. As with the FEHB Program, the bill would require participating contractors to provide benefits when OPM finds the individual is entitled to benefits under the terms of the contract. OPM would have access to the trust funds available for the operation of Federal employee benefits programs to cover its administrative expenses associated with making long-term care insurance available. Participating carriers would be required to reimburse OPM's expenses for adjudicating claims disputes.

In all of its features, OPM's proposal is consistent with mainstream public policy. It reflects or is slightly ahead of predominant practices among medium- and large-sized employers and is consistent with Federal law and State Insurance Commissioners' requirements and guidelines for long-term care insurance products. At virtually no cost to the Government, the proposal would

Honorable Albert Gore, Jr.

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provide a substantial benefit to Federal employees and retirees by providing access to quality long-term care insurance products at cost-saving, group premiums. Accordingly, OPM urges Congress to give this proposal early consideration.

The Office of Management and Budget advises that there is no objection to the submission of this proposal and that enactment of this legislation would be in accord with the program of the President.

A similar letter is being sent to the Speaker of the House.

Sincerely,

Janice R. Lachance
Director

Enclosures

A BILL

To amend title 5, United States Code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Section 1. Short Title

This Act may be cited as the "Federal Employees Group Long-Term Care Insurance Act of 1998".

Section 2. Long-Term Care Insurance

Subpart G of part III of title 5, United States Code, is amended by adding at the end the following new chapter:

"Chapter 90—Long-Term Care Insurance

"Sec.

"9001. Definitions.

"9002. Contracting authority.

"9003. Minimum standards for contractors.

"9004. Long-term care benefits.

"9005. Financing.

"9006. Preemption.

"9007. Studies, reports, and audits.

"9008. Time limit for filing claims.

"9009. Effect of other statutes.

"9010. Jurisdiction of courts.

"9011. Regulations.

"§ 9001. Definitions

"For the purpose of this chapter—

"(1) 'annuitant' means an individual referred to in section 8901(3);

"(2) 'employee' means an individual referred to in subparagraphs (A)-(D),

and (F)-(I) of section 8901(1); but does not include an employee excluded by regulation of the Office under section 9011;

“(3) ‘other eligible individual’ means the spouse, former spouse, parent or in-law of an employee or annuitant, or other individual specified by the Office;

“(4) ‘Office’ means the Office of Personnel Management;

“(5) ‘qualified carrier’ means an insurer meeting the requirements of a qualified insurer in each of the States and the District of Columbia;

“(6) ‘qualified contract’ means a contract meeting the conditions prescribed in section 9002; and

“(7) ‘State’ means a State or territory or possession of the United States, and includes the District of Columbia.

“§ 9002. Contracting authority

“(a) The Office may, without regard to section 5 of title 41 or any other statute requiring competitive bidding, purchase from one or more qualified carriers a policy or policies of group long-term care insurance to provide benefits as specified by this chapter.

“(b) The Office may design a benefits package or packages and negotiate final offerings with qualified carriers.

“(c) Each contract shall be for a uniform term of 5 years, unless terminated earlier by the Office.

“(d) Premium rates charged under a contract entered into under this section shall reasonably reflect the cost of the benefits provided under that contract.

“(e) The coverage and benefits made available to individuals under a contract entered into

under this section are guaranteed to be renewable and may not be canceled except for nonpayment of periodic charges.

“§ 9003. Minimum standards for contractors

“At the minimum, to be a qualified carrier under this chapter, a company shall—

“(1) be licensed to issue group long-term care insurance in all States and the District of Columbia; and

“(2) be in compliance with the requirements imposed on issuers of qualified long-term care contracts by section 7702B of the Internal Revenue Code of 1986.

“§ 9004. Long-Term Care Benefits

“The benefits provided under this chapter shall be group long-term care benefits which, at a minimum, shall be sufficient to enable each contract to meet the standards for a qualified long-term care insurance contract in section 7702B(b) of the Internal Revenue Code of 1986.

“§ 9005. Financing

“(a) The amount necessary to pay the total charge for enrollment of an enrolled employee shall be withheld from the pay of each enrolled employee.

“(b) Except as provided by subsection (d), the amount necessary to pay the total charge for enrollment of an enrolled annuitant shall be withheld from the annuity of each enrolled annuitant.

“(c) The amount necessary to pay the total charge for enrollment of a spouse may be withheld from pay or annuity, as appropriate.

“(d) An annuitant whose annuity is insufficient to cover the withholdings required for enrollment, the spouse of such an annuitant, or any other eligible individual, shall, at the

discretion of the Office, pay the total charge for enrollment directly to the carrier.

“(c) Each carrier participating in the Program established by this chapter shall maintain the funds related to this Program separate and apart from funds related to other contracts and other lines of business.

“(f)(1) The funds established under sections 8348(a), 8714(a), and 8909(a) are available without fiscal year limitation to pay the expenses of the Office in administering this chapter.

“(2) The costs of the Office in adjudicating a claims dispute under section 9008, including costs related to an inquiry not culminating in a dispute, shall be reimbursed by the carrier involved in the dispute or inquiry.

“§ 9006. Preemption

“The provisions of this chapter shall supersede and preempt any State or local law which is determined by the Office to be inconsistent with—

“(1) the provisions of this chapter; or

“(2) after consultation with the National Association of Insurance Commissioners, the efficient provision of a national long term care insurance program.

“§ 9007. Studies, reports, and audits

“(a) Each qualified carrier entering into a contract under this chapter shall—

“(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter; and

“(2) permit the Office and representatives of the General Accounting Office to examine such records of the carrier as may be necessary to carry out the purposes of this chapter.

“(b) Each Federal agency shall keep such records, make such certifications, and furnish the Office, the carrier, or both, with such information and reports as the Office may require.

“§ 9008. Claims for benefits

“(a) A claim for benefits under this chapter shall be filed within 4 years of the date on which the reimbursable cost was incurred or the service was provided.

“(b) The Office may prescribe a maximum age by which a claim for benefits under this chapter shall be filed.

“(c) The Office shall adjudicate a claims dispute arising under this chapter and shall require the contractor to pay for any benefit or provide any service the Office determines appropriate under the applicable contract.

“(d) Benefits payable under this chapter for any reimbursable cost incurred or service provided are secondary to any other benefit payable for such cost or service. No payment may be made where there is no legal obligation for such payment.

“§ 9009. Effect of other statutes

“No provision of law outside of this chapter may provide coverage or any benefit under this chapter to any individual who would not otherwise be eligible for such coverage or benefit.

“§ 9010. Jurisdiction of courts

“A claimant under this chapter may file suit against the carrier of the long-term care insurance policy covering such claimant in the district courts of the United States, after exhausting all available administrative remedies.

“§ 9011. Regulations

“(a) The Office shall prescribe regulations necessary to carry out this chapter.

“(b) The regulations of the Office may prescribe the time at which and the conditions under which an eligible individual may enroll in the Program established under this chapter.

“(c) The Office may not exclude—

“(1) an employee or group of employees solely on the basis of the hazardous nature of employment; or

“(2) an employee who is occupying a position on a part-time career employment basis, as defined in section 3401(2).

“(d) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, former spouses, and other eligible individuals under this chapter, and any requirements for continuation or conversion of coverage.

Section 3. Effective Date

The amendments made by this Act shall take effect on the date of enactment of this Act, except that no coverage may be effective until the first day of the first pay period in October which follows by more than 1 year the date of enactment of this Act.

SECTION-BY-SECTION ANALYSIS

To accompany a draft bill

"To amend title 5, United States code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes."

The first section of the bill titles the bill as the "Federal Employees Group Long-Term Care Insurance Act of 1998."

Section 2 of the bill amends title 5, United States Code, to provide for the establishment and operation of the Program by adding a new chapter 90.

New section 9001 provides the definitions used in the administration of the Program. Included are the following:

"Annuitant" is defined by reference to the definition in section 8901(3), which is used in the Federal Employees Health Benefits (FEHB) Program.

"Employee" is defined by reference to the FEHB Program definition, specifically, subparagraphs (A)-(D) and (F)-(I) of section 8901(1), but expressly does not include an employee excluded by regulation of the Office of Personnel Management under new section 9011, which requires the Office to prescribe regulations to carry out the purposes of the Program.

"Other eligible individual" is defined as the spouse, former spouse, parent, or in-law of an employee or annuitant, or other individual specified by the Office.

"Office" is defined as the Office of Personnel Management.

"Qualified carrier" is defined as an insurer who meets the requirements of a qualified insurer in each of the States and the District of Columbia.

"Qualified contract" is defined as a contract meeting the conditions prescribed in new section 9002, which provides the contracting authority for the Program.

"State" is defined as a State or territory or possession of the United States, and includes the District of Columbia.

New section 9002 provides the contracting authority for the Office to use in establishing and operating the Program.

In subsection (a), the Office is authorized to purchase from one or more qualified carriers a policy or policies of group long-term care insurance to provide the benefits specified by this chapter, and to do so without regard to section 5 of title 41 or any other statute requiring competitive bidding.

Subsection (b) allows the Office to design a benefits package or packages and negotiate final offerings with qualified carriers.

Subsection (c) specifies that a contract shall be for a uniform term of 5 years, unless terminated

earlier by the Office.

Subsection (d) requires the premium rates charged under a contract entered into under this section to reasonably reflect the cost of the benefits provided under that contract.

Subsection (c) guarantees that the coverage and benefits made available to an individual under a contract entered into under this section are renewable and may not be canceled except for nonpayment of periodic charges.

New section 9003 specifies the minimum standards for contractors. It provides that, in order to be a qualified contractor under this chapter, a company is required, at a minimum, to be licensed to issue group long-term care insurance in all States and the District of Columbia, and be in compliance with the requirements imposed on issuers of qualified long-term care contracts by section 7702B of the Internal Revenue Code of 1986.

New section 9004 specifies that the benefits provided under this chapter are required to be, at a minimum, sufficient to enable each contract to meet the standards for a qualified long-term care insurance contract in section 7702B(b) of the Internal Revenue Code of 1986.

New section 9005 addresses the financing of the Program. Subsections (a) through (d) make it clear that the total cost of coverage under the Program is to be borne by the enrollee, with separate provisions for withholding from the pay of an employee or the annuity of an annuitant for coverage of the employee or annuitant or spouse, as well as, at the discretion of the Office, requiring payment directly to the carrier by an annuitant or spouse when the annuity is insufficient to cover the withholdings, and also mandating direct payment by any other eligible individual.

Subsection (e) requires each carrier participating in the Program established by this chapter to maintain the funds related to this Program separate and apart from funds related to other contracts and other lines of business.

Paragraph (1) of subsection (f) makes available the Civil Service Retirement and Disability Fund established under section 8348(a), the Employees' Life Insurance Fund established under section 8714(a), and the Employees Health Benefits Fund established under section 8909(a), without fiscal year limitation, to pay the expenses of the Office in administering this chapter. This would provide a method of addressing not only the initial costs of implementing a new program, but also the ongoing operating costs of the Office. No startup appropriations would be required.

Paragraph (2) of that subsection requires the reimbursement of the costs of the Office in adjudicating a claims dispute under new section 9008, including costs related to an inquiry not culminating in a dispute, by the carrier involved in the dispute or inquiry.

New section 9006 provides for the preemption of State or local law by specifying that the

provisions of this chapter preempt any such law which the Office determines is either inconsistent with the provisions of this chapter or, after consultation with the National Association of Insurance Commissioners, inconsistent with the efficient provision of a national long-term care insurance program.

New section 9007 addresses the requirements for studies, reports, and audits relating to the Program.

Subsection (a) requires each qualified carrier entering into a contract under this chapter to furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter, and also requires each such carrier to permit the examination, by the Office and by representatives of the General Accounting Office, of such records as may be necessary to carry out the purposes of this chapter.

Subsection (b) requires each Federal agency to keep such records, make such certifications, and furnish the Office, or the carrier, or both, with such information and reports as the Office may require.

New section 9008 addresses claims for benefits under this chapter.

Subsection (a) requires a claim for benefits to be filed within 4 years of the date on which the reimbursable cost was incurred or the service was provided.

Subsection (b) authorizes the Office to prescribe a maximum age by which a claim must be filed.

Subsection (c) requires the Office to adjudicate a claims dispute arising under this chapter and to mandate that the contractor pay for any benefit or provide any service the Office determines appropriate under the applicable contract.

Subsection (d) provides that benefits payable under this chapter for any reimbursable cost incurred or service provided are secondary to any other benefit payable for such cost or service. It also bars payment where no legal obligation exists.

New section 9009 expressly limits the effect of other statutes by specifying that no provision of law outside this chapter may provide coverage or any benefit under this chapter to any individual who would not otherwise be eligible for such coverage or benefit.

New section 9010 establishes the jurisdiction of courts by authorizing a claimant under this chapter to file suit against the carrier of the long-term care insurance policy covering the claimant in the district courts of the United States, but only after exhausting all administrative remedies available to the claimant.

New section 9011 requires the Office, in subsection (a), to prescribe regulations necessary to

carry out this chapter.

Subsection (b) authorizes the Office to prescribe in its regulations the time at which and the conditions under which an eligible individual may enroll in the Program.

Subsection (c) bars the Office from excluding an employee or group of employees solely on the basis of the hazardous nature of employment, and from excluding an employee who is occupying a position on a part-time career employment basis, as defined in section 3401(2).

Subsection (d) requires the Office to include in its regulations provisions for the beginning and ending dates of coverage of employees, annuitants, former spouses, and other eligible individuals under this chapter, as well as any requirements for continuation or conversion of coverage.

Section 3 of the bill provides that the amendments made by the Act shall take effect on the date of enactment of the Act, allowing the immediate commencement of the establishment of the Program. However, section 3 also provides that no coverage may be effective until the first day of the first pay period in October which follows by more than 1 year the date of enactment of the Act. This is designed to provide adequate time for the negotiation of contracts, the preparation of materials, and the mammoth task of educating millions of potential enrollees about this Program.

LRM ID: RJP306

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

Thursday, August 6, 1998

LEGISLATIVE REFERRAL MEMORANDUM

SPECIAL

TO: Legislative Liaison Officer - See Distribution below
FROM: Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT: Robert J. Pellicci
SUBJECT: PHONE: (202)395-4871 FAX: (202)395-6148
Office of Personnel Management Draft Bill on Federal Employees Group
Long-Term Care Insurance Act of 1998

DEADLINE: Wednesday, August 19, 1998

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: OPM draft bill designed to implement the Administration's proposal for long-term care insurance for Federal employees.

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LRM ID: RJP306 SUBJECT: Office of Personnel Management Draft Bill on Federal Employees Group Long-Term Care Insurance Act of 1998

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or

(2) sending us a memo or letter

Please include the LRM number shown above, and the subject shown below.

TO: Robert J. Pallicci Phone: 395-4871 Fax: 395-6148 Office of Management and Budget Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date) _____ (Name) _____ (Agency) _____ (Telephone)

The following is the response of our agency to your request for views on the above-captioned subject:

- ___ Concur
___ No Objection
___ No Comment
___ See proposed edits on pages ___
___ Other: ___
___ FAX RETURN of ___ pages, attached to this response sheet



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

Honorable Albert Gore, Jr.
President of the Senate
Washington, DC 20510

Dear Mr. President:

The Office of Personnel Management (OPM) submits the enclosed legislative proposal entitled the "Federal Employees Group Long-Term Care Insurance Act of 1998." This proposal would authorize OPM to purchase a policy or policies from one or more qualified private-sector contractors to make long-term care insurance available to Federal employees and retirees, and family members whom OPM defines as eligible, at group rates. Coverage would be paid for entirely by those who elect it.

In keeping with our mission to provide Government-wide human resource management leadership, one of OPM's objectives is to achieve a modern, performance-oriented compensation system which includes a benefits package that will enable Federal agencies to attract and retain well-qualified employees. As the large baby boom generation with its improved longevity projections begins to plan for retirement, large- and medium-sized employers are beginning to respond to their employees' concerns by sponsoring group long-term care insurance. Long-term care, which includes assistance with daily living activities in a variety of settings, can be very expensive. Insurance products for this purpose have been evolving since the 1980s. In the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Congress recently authorized tax treatment similar to that for medical insurance to promote access to good quality long-term care insurance contracts.

The Administration also has a more general interest in the development of a long-term care insurance program for Federal employees. It hopes to demonstrate the potential for private insurance to help contain costs under the Medicare and Medicaid Programs. At present, Medicare and supplemental Medigap insurance provide extremely limited coverage of long-term care services. Medicaid covers nursing home and some community-based services only if a person meets poverty guidelines for income and assets. Projected increases in the population over age 85 will likely raise costs for, and create pressure to expand, publicly-funded health programs if reasonable alternatives do not exist.

Since 1995, OPM and the Department of Health and Human Services have been engaging in cooperative research on long-term care insurance products and employer-sponsored programs. Responses to questions in a 1997 OPM survey indicated there is significant interest in such protection among Federal employees. On March 26, 1998, we discussed our findings at a hearing before the House Subcommittee on Civil Service during which there was substantial

Honorable Albert Gore, Jr.

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support for introducing Government-sponsored group long-term care insurance, on an employee-pay-all basis. This is consistent with general practice among other employers who offer this benefit.

Our proposal would allow OPM broad flexibility, similar to that available under the Federal Employees Health Benefits (FEHB) Program, to determine appropriate benefits and to contract for benefits with one or more private carriers, without regard to section 5 of title 41, United States Code, or any other law requiring competitive bidding. Qualified carriers must: (A) be licensed by law in all States and the District of Columbia to offer long term care insurance; (B) agree to provide coverage for all eligible enrollees consistent with requirements for qualified long term care insurance contracts and issuers enacted under subtitle C of Title III of the Health Insurance Portability and Accountability Act of 1996; (C) propose rates which in OPM's judgment reasonably reflect the cost of benefits provided; and (D) maintain funds associated with the Federal employee contract separate and apart from the carriers' other funds. Contracts would be for a duration of 5 years, unless terminated earlier by OPM. Regulations of OPM will provide for opportunities to enroll and benefit portability. This flexibility will enable OPM to negotiate program improvements as the market for long-term care services and protection evolves over time.

The program would be available to Federal employees and retirees, and their spouse, former spouse who is entitled to annuity under a Federal retirement system, parents, and parents-in-law. All participants other than active employees would be underwritten (i.e., asked questions about health status for premium-setting purposes) as is standard practice with products of this kind. Coverage made available to individuals would be guaranteed renewable and could not be canceled except for nonpayment of premium. Though each participant would be responsible for paying the full amount of premiums, based on age at time of enrollment, group rates will save an estimated 15-20 percent off the cost of individual long-term care policies.

Employee and annuitant premiums would be withheld from salary or annuity and transmitted directly to respective contractors, and those enrollees could also elect withholdings for coverage of their spouse. Any other eligible enrollees shall, at the discretion of OPM, submit premiums directly to the appropriate contractor. As with the FEHB Program, the bill would require participating contractors to provide benefits when OPM finds the individual is entitled to benefits under the terms of the contract. OPM would have access to the trust funds available for the operation of Federal employee benefits programs to cover its administrative expenses associated with making long-term care insurance available. Participating carriers would be required to reimburse OPM's expenses for adjudicating claims disputes.

In all of its features, OPM's proposal is consistent with mainstream public policy. It reflects or is slightly ahead of predominant practices among medium- and large-sized employers and is consistent with Federal law and State Insurance Commissioners' requirements and guidelines for long-term care insurance products. At virtually no cost to the Government, the proposal would

Honorable Albert Gore, Jr.

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provide a substantial benefit to Federal employees and retirees by providing access to quality long-term care insurance products at cost-saving, group premiums. Accordingly, OPM urges Congress to give this proposal early consideration.

The Office of Management and Budget advises that there is no objection to the submission of this proposal and that enactment of this legislation would be in accord with the program of the President.

A similar letter is being sent to the Speaker of the House.

Sincerely,

Janice R. Lachance
Director

Enclosures

A BILL

To amend title 5, United States Code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America

in Congress assembled.

Section 1. Short Title

This Act may be cited as the "Federal Employees Group Long-Term Care Insurance Act of 1998".

Section 2. Long-Term Care Insurance

Subpart G of part III of title 5, United States Code, is amended by adding at the end the following new chapter:

"Chapter 90—Long-Term Care Insurance

"Sec.

"9001. Definitions.

"9002. Contracting authority.

"9003. Minimum standards for contractors.

"9004. Long-term care benefits.

"9005. Financing.

"9006. Preemption.

"9007. Studies, reports, and audits.

"9008. Time limit for filing claims.

"9009. Effect of other statutes.

"9010. Jurisdiction of courts.

"9011. Regulations.

"§ 9001. Definitions

"For the purpose of this chapter—

"(1) 'annuitant' means an individual referred to in section 8901(3);

"(2) 'employee' means an individual referred to in subparagraphs (A)-(D),

and (F)-(I) of section 8901(1); but does not include an employee excluded by regulation of the Office under section 9011;

"(3) 'other eligible individual' means the spouse, former spouse, parent or in-law of an employee or annuitant, or other individual specified by the Office;

"(4) 'Office' means the Office of Personnel Management;

"(5) 'qualified carrier' means an insurer meeting the requirements of a qualified insurer in each of the States and the District of Columbia;

"(6) 'qualified contract' means a contract meeting the conditions prescribed in section 9002; and

"(7) 'State' means a State or territory or possession of the United States, and includes the District of Columbia.

"§ 9002. Contracting authority

"(a) The Office may, without regard to section 5 of title 41 or any other statute requiring competitive bidding, purchase from one or more qualified carriers a policy or policies of group long-term care insurance to provide benefits as specified by this chapter.

"(b) The Office may design a benefits package or packages and negotiate final offerings with qualified carriers.

"(c) Each contract shall be for a uniform term of 5 years, unless terminated earlier by the Office.

"(d) Premium rates charged under a contract entered into under this section shall reasonably reflect the cost of the benefits provided under that contract.

"(e) The coverage and benefits made available to individuals under a contract entered into

under this section are guaranteed to be renewable and may not be canceled except for nonpayment of periodic charges.

“§ 9003. Minimum standards for contractors

“At the minimum, to be a qualified carrier under this chapter, a company shall—

“(1) be licensed to issue group long-term care insurance in all States and the District of Columbia; and

“(2) be in compliance with the requirements imposed on issuers of qualified long-term care contracts by section 7702B of the Internal Revenue Code of 1986.

“§ 9004. Long-Term Care Benefits

“The benefits provided under this chapter shall be group long-term care benefits which, at a minimum, shall be sufficient to enable each contract to meet the standards for a qualified long-term care insurance contract in section 7702B(b) of the Internal Revenue Code of 1986.

“§ 9005. Financing

“(a) The amount necessary to pay the total charge for enrollment of an enrolled employee shall be withheld from the pay of each enrolled employee.

“(b) Except as provided by subsection (d), the amount necessary to pay the total charge for enrollment of an enrolled annuitant shall be withheld from the annuity of each enrolled annuitant.

“(c) The amount necessary to pay the total charge for enrollment of a spouse may be withheld from pay or annuity, as appropriate.

“(d) An annuitant whose annuity is insufficient to cover the withholdings required for enrollment, the spouse of such an annuitant, or any other eligible individual, shall, at the

discretion of the Office, pay the total charge for enrollment directly to the carrier.

"(c) Each carrier participating in the Program established by this chapter shall maintain the funds related to this Program separate and apart from funds related to other contracts and other lines of business.

"(f)(1) The funds established under sections 8348(a), 8714(a), and 8909(a) are available without fiscal year limitation to pay the expenses of the Office in administering this chapter.

"(2) The costs of the Office in adjudicating a claims dispute under section 9008, including costs related to an inquiry not culminating in a dispute, shall be reimbursed by the carrier involved in the dispute or inquiry.

"§ 9006. Preemption

"The provisions of this chapter shall supersede and preempt any State or local law which is determined by the Office to be inconsistent with—

"(1) the provisions of this chapter; or

"(2) after consultation with the National Association of Insurance Commissioners, the efficient provision of a national long term care insurance program.

"§ 9007. Studies, reports, and audits

"(a) Each qualified carrier entering into a contract under this chapter shall—

"(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter; and

"(2) permit the Office and representatives of the General Accounting Office to examine such records of the carrier as may be necessary to carry out the purposes of this chapter.

"(b) Each Federal agency shall keep such records, make such certifications, and furnish the Office, the carrier, or both, with such information and reports as the Office may require.

"§ 9008. Claims for benefits

"(a) A claim for benefits under this chapter shall be filed within 4 years of the date on which the reimbursable cost was incurred or the service was provided.

"(b) The Office may prescribe a maximum age by which a claim for benefits under this chapter shall be filed.

"(c) The Office shall adjudicate a claims dispute arising under this chapter and shall require the contractor to pay for any benefit or provide any service the Office determines appropriate under the applicable contract.

"(d) Benefits payable under this chapter for any reimbursable cost incurred or service provided are secondary to any other benefit payable for such cost or service. No payment may be made where there is no legal obligation for such payment.

"§ 9009. Effect of other statutes

"No provision of law outside of this chapter may provide coverage or any benefit under this chapter to any individual who would not otherwise be eligible for such coverage or benefit.

"§ 9010. Jurisdiction of courts

"A claimant under this chapter may file suit against the carrier of the long-term care insurance policy covering such claimant in the district courts of the United States, after exhausting all available administrative remedies.

"§ 9011. Regulations

"(a) The Office shall prescribe regulations necessary to carry out this chapter.

"(b) The regulations of the Office may prescribe the time at which and the conditions under which an eligible individual may enroll in the Program established under this chapter.

"(c) The Office may not exclude—

"(1) an employee or group of employees solely on the basis of the hazardous nature of employment; or

"(2) an employee who is occupying a position on a part-time career employment basis, as defined in section 3401(2).

"(d) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, former spouses, and other eligible individuals under this chapter, and any requirements for continuation or conversion of coverage.

Section 3. Effective Date

The amendments made by this Act shall take effect on the date of enactment of this Act, except that no coverage may be effective until the first day of the first pay period in October which follows by more than 1 year the date of enactment of this Act.

SECTION-BY-SECTION ANALYSIS

To accompany a draft bill

"To amend title 5, United States code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes."

The first section of the bill titles the bill as the **"Federal Employees Group Long-Term Care Insurance Act of 1998."**

Section 2 of the bill amends title 5, United States Code, to provide for the establishment and operation of the Program by adding a new chapter 90.

New section 9001 provides the definitions used in the administration of the Program. Included are the following:

"Annuitant" is defined by reference to the definition in section 8901(3), which is used in the Federal Employees Health Benefits (FEHB) Program.

"Employee" is defined by reference to the FEHB Program definition, specifically, subparagraphs (A)-(D) and (F)-(I) of section 8901(1), but expressly does not include an employee excluded by regulation of the Office of Personnel Management under new section 9011, which requires the Office to prescribe regulations to carry out the purposes of the Program.

"Other eligible individual" is defined as the spouse, former spouse, parent, or in-law of an employee or annuitant, or other individual specified by the Office.

"Office" is defined as the Office of Personnel Management.

"Qualified carrier" is defined as an insurer who meets the requirements of a qualified insurer in each of the States and the District of Columbia.

"Qualified contract" is defined as a contract meeting the conditions prescribed in new section 9002, which provides the contracting authority for the Program.

"State" is defined as a State or territory or possession of the United States, and includes the District of Columbia.

New section 9002 provides the contracting authority for the Office to use in establishing and operating the Program.

In subsection (a), the Office is authorized to purchase from one or more qualified carriers a policy or policies of group long-term care insurance to provide the benefits specified by this chapter, and to do so without regard to section 5 of title 41 or any other statute requiring competitive bidding.

Subsection (b) allows the Office to design a benefits package or packages and negotiate final offerings with qualified carriers.

Subsection (c) specifies that a contract shall be for a uniform term of 5 years, unless terminated

earlier by the Office.

Subsection (d) requires the premium rates charged under a contract entered into under this section to reasonably reflect the cost of the benefits provided under that contract.

Subsection (c) guarantees that the coverage and benefits made available to an individual under a contract entered into under this section are renewable and may not be canceled except for nonpayment of periodic charges.

New section 9003 specifies the minimum standards for contractors. It provides that, in order to be a qualified contractor under this chapter, a company is required, at a minimum, to be licensed to issue group long-term care insurance in all States and the District of Columbia, and be in compliance with the requirements imposed on issuers of qualified long-term care contracts by section 7702B of the Internal Revenue Code of 1986.

New section 9004 specifies that the benefits provided under this chapter are required to be, at a minimum, sufficient to enable each contract to meet the standards for a qualified long-term care insurance contract in section 7702B(b) of the Internal Revenue Code of 1986.

New section 9005 addresses the financing of the Program. Subsections (a) through (d) make it clear that the total cost of coverage under the Program is to be borne by the enrollee, with separate provisions for withholding from the pay of an employee or the annuity of an annuitant for coverage of the employee or annuitant or spouse, as well as, at the discretion of the Office, requiring payment directly to the carrier by an annuitant or spouse when the annuity is insufficient to cover the withholdings, and also mandating direct payment by any other eligible individual.

Subsection (e) requires each carrier participating in the Program established by this chapter to maintain the funds related to this Program separate and apart from funds related to other contracts and other lines of business.

Paragraph (1) of subsection (f) makes available the Civil Service Retirement and Disability Fund established under section 8348(a), the Employees' Life Insurance Fund established under section 8714(a), and the Employees Health Benefits Fund established under section 8909(a), without fiscal year limitation, to pay the expenses of the Office in administering this chapter. This would provide a method of addressing not only the initial costs of implementing a new program, but also the ongoing operating costs of the Office. No startup appropriations would be required.

Paragraph (2) of that subsection requires the reimbursement of the costs of the Office in adjudicating a claims dispute under new section 9008, including costs related to an inquiry not culminating in a dispute, by the carrier involved in the dispute or inquiry.

New section 9006 provides for the preemption of State or local law by specifying that the

provisions of this chapter preempt any such law which the Office determines is either inconsistent with the provisions of this chapter or, after consultation with the National Association of Insurance Commissioners, inconsistent with the efficient provision of a national long-term care insurance program.

New section 9007 addresses the requirements for studies, reports, and audits relating to the Program.

Subsection (a) requires each qualified carrier entering into a contract under this chapter to furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter, and also requires each such carrier to permit the examination, by the Office and by representatives of the General Accounting Office, of such records as may be necessary to carry out the purposes of this chapter.

Subsection (b) requires each Federal agency to keep such records, make such certifications, and furnish the Office, or the carrier, or both, with such information and reports as the Office may require.

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New section 9009 expressly limits the effect of other statutes by specifying that no provision of law outside this chapter may provide coverage or any benefit under this chapter to any individual who would not otherwise be eligible for such coverage or benefit.

New section 9010 establishes the jurisdiction of courts by authorizing a claimant under this chapter to file suit against the carrier of the long-term care insurance policy covering the claimant in the district courts of the United States, but only after exhausting all administrative remedies available to the claimant.

New section 9011 requires the Office, in subsection (a), to prescribe regulations necessary to

carry out this chapter.

Subsection (b) authorizes the Office to prescribe in its regulations the time at which and the conditions under which an eligible individual may enroll in the Program.

Subsection (c) bars the Office from excluding an employee or group of employees solely on the basis of the hazardous nature of employment, and from excluding an employee who is occupying a position on a part-time career employment basis, as defined in section 3401(2).

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Section 3 of the bill provides that the amendments made by the Act shall take effect on the date of enactment of the Act, allowing the immediate commencement of the establishment of the Program. However, section 3 also provides that no coverage may be effective until the first day of the first pay period in October which follows by more than 1 year the date of enactment of the Act. This is designed to provide adequate time for the negotiation of contracts, the preparation of materials, and the mammoth task of educating millions of potential enrollees about this Program.

LONG-TERM CARE TAX OPTIONS

ELIGIBILITY	\$500 CREDIT		\$1,000 CREDIT	
	Non-refundable *	Refundable	Non-refundable *	Refundable
More Disabled: 3+ ADLs	\$3.7 billion / 5 \$11.3 billion / 10 2.9 million people	\$5.1 billion / 5 \$15.1 billion / 10 3.2 million people	\$6.8 billion / 5 \$20.7 billion / 10 2.9 million people	\$9.6 billion / 5 \$28.3 billion / 10 3.2 million people
Less Disabled: 2+ ADLs	\$4.4 billion / 5 \$13.2 billion / 10 3.7 million people	\$6.5 billion / 5 \$19.1 billion / 10 4.1 million	\$8.1 billion / 5 \$24.7 billion / 10 3.7 million people	\$12.4 billion / 5 \$36.5 billion / 10 4.1 million

NOTES

Most of these estimates are not Treasury numbers but extrapolated based on Treasury estimates

* This credit is partially refundable, meaning that if the filer has three or more dependents, then the credit is refundable.

All options include the up to \$5,000 credit for work-related impairment expenses. This credit helps 300,000 and costs \$600 million over 5, about \$1.8 billion over 10 years.

Treasury has strong concerns about refundable credits.

LONG-TERM CARE TAX OPTIONS

ELIGIBILITY	NON-REFUNDABLE *		REFUNDABLE	
	\$500 CREDIT	\$1,000 CREDIT	\$500 CREDIT	\$1,000 CREDIT
More Disabled: 3+ ADLs	People getting credit: 2.9 million		People getting credit: 3.2 million	
	\$3.7 billion / 5 \$11.3 billion / 10	\$6.8 billion / 5 \$20.7 billion / 10	\$5.1 billion / 5 \$15.1 billion / 10	\$9.6 billion / 5 \$28.3 billion / 10
Less Disabled: 2+ ADLs	People getting credit: 3.7 million		People getting credit: 4.1	
	\$4.4 billion / 5 \$13.2 billion / 10	\$8.1 billion / 5 \$24.7 billion / 10	\$6.5 billion / 5 \$19.1 billion / 10	\$12.4 billion / 5 \$36.5 billion / 10

NOTES

Most of these estimates are not Treasury numbers but extrapolated based on Treasury estimates.

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Treasury has strong concerns about refundable credits.

Possible Revenue Offsets
 (\$ in millions)

		1998-2003	1998-2008
Modify Foreign Tax Credit carryover rules*	/1	1,925	3,391
Liquidating REITs (see attached discussion)	/1	4,900	8,600
Constructive ownership (Kennelly)*		150	300
Subtotal		6,825	11,991
Superfund AMT tax*		3,800	5,000
Superfund excise tax*		3,600	5,000
10-cent tobacco excise tax (could be scaled down or up) +		7,500	15,000
Subtotal		14,900	25,000

* = JCT scoring

+ = rough guess

1. Used in the Senate's version of IRS Restructuring

C. 2
 7.4
 14.2

3+

What can we
 Buy for \$126/10
 Disability: \$26/10
 LTC = \$106
 OPTION 1 / OPTION 2
 1. \$500 Credit / \$350 Refundable

Bonnie says that
she has not
heard anything,
But we've
been quiet
because of
concerns about
opening up
CHIP.

It's Caution

Long Term Care R6

August 5, 1998

TO: Gene
FROM: Jeanne
RE: LONG-TERM CARE MEETING TOMORROW

The goal of this small meeting is to (1) reduce the number of options for the tax credit to two or three, possibly for discussion at a meeting with Erskine or memo (whichever way you think best to make a decision); (2) begin to discuss offsets. We do not have the final numbers or paper from Treasury, but will get it to you as soon as we have it.

LONG-TERM CARE TAX CREDIT

As we discussed at the last meeting, there were three issues:

- **How many people with chronic illness are non-filers:** Treasury estimates that about half of people receiving the credit under the original Treasury option are non-filers. This is a major equity problem.
- **Is the best way to capture non-filers to allow them to be claimed as dependents for relatives who are filers, or to make the credit refundable.** Obviously, the most direct way to get the credit to people who need long-term care is to make it refundable. We have heard through the grapevine that this will cost well over \$10 billion over 5 years. The alternative is to broaden the number of non-filers who can be claimed as dependents (e.g., replace the current "support test", which says that a person can only be a dependent if their relative is providing at least half of all support, with a "residency test" which is much less strict). Although this still omits people with chronic illness, it can more easily be claimed as a "caregiver" credit.
- **How many people receiving the credit are institutionalized:** As Jack said, this would matter if we were trying to target the funds better. It turns out that few of the people receiving the credit under Treasury's original option were institutionalized. However, the risk increases as we add non-filers either as dependents on tax filers' claims, or if the credit is refundable.

With these issues in mind, we expect Treasury to present two options:

- **Option 1 (variant on Treasury option):** \$1,000 partially refundable credit, with two changes to the dependency test: waiving the gross income limit and replacing the support test with a residency test.
- **Option 2: Refundable credit:** \$1,000 fully refundable credit with no change in the dependency test but excluding people who have resided in a state certified nursing facility for at least 6 months in the tax year.

For both, we have asked for estimates of number of people helped and costs at both 2-plus and 3-plus ADLs. We may have to consider other ways to target the credit if we find that the refundable option is desired but too expensive.

WORK-RELATED EXPENSES FOR PEOPLE WITH DISABILITY

We also strongly support this credit, since it will be seen as a meaningful, well-targeted credit by the disability community. We have asked Treasury to revise some of the definitions in the option, but it looks good.

OFFSETS

I think that you have asked for a presentation of any options; I have asked as well.

Please call with questions.

INFORMATION FOR MEETING

	2+ ADLS	3+ ADLS
Baseline number of eligibles		
Filers		
Dependents		
Non-filers		
Community-based		
Institutionalized		
Option 1: Broadening the dependency test		
5-Year Revenue Effect		
Number of people receiving credit		
Filers		
Dependents		
Option 2: Refundability		
5-Year Revenue Effect		
Number of people receiving credit		
Filers		
Dependents		
Non-filers (if possible, also the number excluded who are institutionalized)		

Long Term Care File

August 5, 1998

TO: Karl A. A.

FROM: Chris and Jeanne

RE: TAX OPTIONS ON LONG-TERM CARE

Good morning. As you know, there is a meeting in Gene's office at 5:15 with a core group to discuss how we narrow the options on the tax credit proposal. There may also be a discussion of offsets (did Gene talk to you about this? I'll find out).

A couple comments on the options. First, you are including children in your cost estimates? Chris thinks that we decided that there is no logical reason to exclude them, but we should know the break-out of their expenses just in case.

Second, about waiving the gross income limit if we use the residency test: given that your paper suggests that, for the elderly, tax liability begins when income exceeds about 200 percent of poverty, why don't we use that standard rather than 100 percent of poverty?

Third, on policy grounds, we think it is very important to broaden the work-related impairment expenses definition to include the personal assistance and other expenses needed to get to work. Do you have a revised cost estimate for this? Do you agree with the policy? If so, it is one less thing to discuss.

Fourth, and most importantly, to make the meeting be a decision meeting about the options, it is REALLY important that we have the cost and coverage numbers ahead of time so that we have a chance to think about them. The attached table is the information that we need to make informed choices. Please let one of us know if this is a problem.

Thanks for all your hard work -- we understand that this has made for a busy summer, but we're getting close to the end (of summer, that is -- just kidding).

POSSIBLE SOURCES AND USES FOR LONG-TERM CARE POLICIES

(Most are CBO estimates, 5-year numbers)

LONG-TERM CARE POLICIES		OFFSETS	
Offering private long-term care insurance to Federal employees	About \$40 million	OPM budget modifications	(to review)
Tax credit Long-term care People with disabilities	\$4-5 billion \$600 million	Republican Pt Protection Act offsets Democrat Pt Bill of Rights offsets: Tobacco tax	\$1 billion \$4 billion? ??
Kennedy-Jeffords: Medicaid option Medicare option	\$600-800 million \$200-300 million	Medicare fraud Centers of excellence Medicare Secondary Payer Market price for drugs EPO SSA fraud Overpayments for SSI Shaw-like additions	\$300 million \$400 million \$600 million \$100 million \$170 million \$125 million
Grant options	\$200-800 million	[not likely to be needed]	

Targeting Individuals with Significant Long-term Care Needs Through Tax System

Basic option under discussion

Under the basic option, taxpayers would receive a \$500 or \$1,000 tax credit if they are incapacitated or have an incapacitated spouse or dependent. Because the proposed credit is envisioned as an expansion of the \$500 child credit, it would be partially refundable for those with three or more qualifying individuals (including children under 17 and incapacitated taxpayers, spouses, and dependents), mitigate the effects the AMT and would begin to phase out at \$110,000 (\$75,000 if the taxpayer is unmarried).

There are (at least) three targeting issues that must be resolved

DPC has made two requests for additional information to be used in determining how to better target the credit toward individuals with significant long-term care needs. These requests would have very different impact on the costs and scope of the proposal.

- The first would narrow the targeted group of credit beneficiaries based on type of care (for example, exclude people in nursing homes) in order to provide a larger per capita credit.
- The second would expand the targeted group of credit beneficiaries to include more low-income individuals (in particular, taxpayers with no tax liability or taxpayers who do not file).

There has been very little discussion regarding a third targeting criteria that also affects the costs and scope of the proposal. Treasury has developed and estimated options for the credit, using two very different definitions of chronic illness. Treasury is providing more background information regarding the specifications of these definitions, so that this issue can be discussed at the same time as the other targeting issues raised by DPC.

Targeting based on type of care

The inter-agency group has previously considered restrictions that would make the credit available only if the disabled person did not received care in an institutional setting for more than six months of the taxable year. Tax Policy has raised equity and administrative concerns with this restriction.

In response to a request from DPC staff, we have gathered some data (**Attachment 1**) to provide a more detailed picture of the disabled based on the type of care they receive.

Targeting based on economic needs

The basic option has been criticized for not providing sufficient assistance to low-income taxpayers. Some of this objective was initially addressed by broadening the definition of dependents used in the basic option. Adult dependents generally do not include individuals with gross (or taxable) income above \$2,750 (1999 level). Many disabled elderly may have other

sources of taxable income that prevent them from being claimed as a dependent, even though they do not have sufficient income to have a positive income tax liability of their own. By lifting the gross income test, the basic option allows these individuals to be claimed as a dependent by the taxpayer who supports them.

Even with this modification, some low-income individuals may not benefit from the proposal. In some cases, it may be because they cannot be claimed as anyone's dependent. Taxpayers must provide over half of a dependent's support. While expenditures for housing and food count as part of support, other types of care (such as dressing and bathing the disabled individual) are more difficult to value and are usually not counted as part of the taxpayer's support of a dependent. Thus, a taxpayer may not be able to claim her mother, for whom she provides day-to-day care, as a dependent, if the mother pays for most of her living expenses out of her own savings and income (including social security benefits). Other low-income disabled individuals will not benefit from a change in the definition of a dependent because they receive care from low-income individuals who do not have a tax liability, or they are not receiving assistance from any caregiver at all.

Attachment 2 discusses three options to broaden the credit so that more low-income taxpayers might become eligible for the credit. These options would:

- Replace the current dependency support test with a residency test.
- Use Administration on Aging offices to certify caregivers.
- Make the basic credit refundable.

Implicit in these choices is another targeting issue -- whether or not Medicaid beneficiaries should be eligible for the tax credit. Under the current option, most will not be because they generally cannot have a tax liability and be eligible for Medicaid. Further, they are unlikely to be claimed as a dependent by another taxpayer. Even though Medicaid is not included in support, it is unlikely that another taxpayer could be providing over half of their total support without adversely affecting their Medicaid eligibility. The three options under discussion would make it more possible for Medicaid recipients to benefit from the tax credit, in the absence of additional, possibly difficult-to-administer restrictions.

Targeting based on severity of chronic illness

The options estimated by Treasury have been based loosely on two alternative definitions. The first definition is derived from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The second definition is based on the 1995 National Association of Insurance Commissioners (NAIC) model for long-term care insurance legislation.

- Under HIPAA, a chronically ill individual can be defined as someone who requires

substantial hands-on or standby assistance with two (or more) out of six activities of daily living (ADLs), including bathing, dressing, toileting, transferring, continence, and eating. In addition, a chronically ill individual may require substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

- Hands-on assistance means the physical assistance of another person without which the individual would be unable to perform the ADL.
 - Stand-by assistance means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while performing the ADL.
 - A severe cognitive impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar measures of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.
 - Substantial supervision means continual supervision by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her own safety.
- Following the 1995 NAIC model, the most restrictive definition of a chronically ill person would be someone who requires hands-on assistance with three (or more) out of six ADL's or has a level of cognitive impairment such that the individual is a "danger to himself or herself or to others."

Questions raised by these definitions include:

- How many ADLs should be used to trigger eligibility for the credit?
- Which ADLs should be used to trigger eligibility?
- How should cognitive impairment be defined?
- If the credit is extended to minor children, how should chronic illness be defined? (Currently, options require children to have difficulty with two out of five ADLs (same as adults but excluding continence) or to be 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).

Attachment 1
Targeting Individuals with Significant Long-term Care Needs Through Tax System:
Data Issues

In order to make informed choices about the long-term care tax credit proposals, more information is needed regarding the characteristics of the chronically ill population and their caregivers. Specifically, Treasury has been asked to provide information regarding the number of individuals by severity of disability, type of care, and tax filing and liability status. For the reasons discussed in the appendix, we cannot provide this information in precisely the form that has been requested at this time. But in the discussion below, we present other data that can be used to infer answers to the key questions.

1. How many individuals receive care at home or in the community?

Using data from the National Long Term Care Survey and the National Health Interview Survey, we estimate that there were about 3.4 million individuals living in the community or at home who had two or more activities of daily limitations 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; if this group was further restricted to include only those who received hands-on assistance, the estimate would fall to 2.0 million. (See Table 1)

These estimates provide a measure of home and community care at a specific point in time during 1995. The estimates must be adjusted to derive the total potential beneficiary group. Under the current basic option, eligibility for the credit would be based on having been chronically ill for at least half the year, as well as on annual income. Thus, the estimates of individuals in home and community care must be annualized. Several factors need to be taken into account in annualizing these estimates:

- The shorter the average expected duration of care at a specific point in time, the larger the total number of potential beneficiaries on an annual basis.
- To the extent that the duration of care is generally less than six months, the total number of potential beneficiaries would be reduced.

2. How many individuals are nursing home residents?

Two surveys conducted independently in 1995 show similar counts for the number of elderly nursing home residents. As shown in Tables 2 and 3, there were approximately 1.4 million elderly individuals living in nursing homes when surveyed by two different studies in 1995. Most of these individuals had at least two ADL limitations, and over 80 percent had three or more ADL limitations.

These numbers should not be added to the estimates of the individuals in home and community care to derive measures of the total beneficiary population:

1
(20.00)
Risk of
disability
(= 1.4 million)
home

- Because elderly individuals move from home and community care to nursing homes, there is probably some overlap between the various surveys.
- Again, these data are for a single point in time during 1995, and the year-long numbers (if they were available) would be somewhat different.

Other data and information can be combined with these data to estimate the number of potential nursing home residents for half the year.

- A non-trivial number of nursing home residents have stays of relatively short duration.
 - Spillman and Kemper found that among the elderly who died in 1985 and who had ever resided in a nursing home, one-third had spent less than three months in a nursing home, and about 43 percent had lived in a nursing home for less than six months. (See Table 4)
 - Kemper and Muragh found that about 30 percent of nursing home residents had a total lifetime use of under three months, and 51 percent were in nursing homes for less than one year.

3. How many chronically ill individuals have a positive income tax liability before tax credits?

To benefit from a nonrefundable tax credit, taxpayers must have a positive tax liability. This means that their taxable income, prior to taking into account exemptions and deductions, must be positive.

To have an income tax liability, a childless individual must generally have income roughly above the poverty level. But, an elderly individual can have much higher income before generating a tax liability because social security benefits will not be taxable at low and moderate levels of income and supplemental security income benefits are never includable in taxable income. It's probably fair to say that a single elderly individual could have social security benefits and other forms of income and not have a tax liability until the combined income exceeded 200 percent of poverty. Assuming a \$1,000 credit, they would not be entitled to the full amount until their income was nearly 300 percent of poverty. (See hypothetical examples 1 through 4.)

Even at higher levels of income, a chronically ill individual may not be able to benefit from the tax credit. Because the tax credit is stacked after itemized deductions, moderate-income taxpayers may find that their tax liability is already wiped out by high medical or long-term care expenses even before the tax credit is computed. (See hypothetical example 5). The credit, itself, begins to phase-out at \$75,000 for an unmarried individual and \$110,000 for a married couple filing jointly.

We anticipate that many elderly long-term care recipients may not benefit directly from the proposed credits because they do not have an income tax liability. This is particularly true of nursing home residents.

- Many nursing home residents are Medicaid recipients. About 38 percent of elderly nursing home residents are on Medicaid at time of admission. As others spend down, the share of nursing home residents on Medicaid increases to 56 percent. To qualify for Medicaid, most elderly will have to meet income tests that, almost by definition, reduce the chance that they have an income tax liability to qualify for the full or any credit. (See Table 3)
 - SSI beneficiaries qualify as categorically needy, but their income will generally be below poverty.
 - The medically needy elderly may qualify with higher income, but they are still required to have income below, at most, 133 percent of the maximum payment received by a similarly situated family under AFDC.
 - The third group of Medicaid beneficiaries is relatively new and was authorized under the Balanced Budget Act of 1997. Under the 1997 Act, States are permitted to allow individuals to "buy into" Medicaid by paying a needs-based sliding scale premium if their income is up to 250 percent of poverty.
- About one-third of nursing home residents pay for care out of private means when they enter a facility. (See Table 3) Even amongst this population, it is unlikely that they will be able to benefit greatly from the proposal because the tax credit will be "stacked" after itemized deductions.
 - With average nursing home costs of \$30,000 (and, according to at least one source, nearing \$40,000 currently), an elderly nursing home resident would have to have taxable income above that amount in order to take advantage of the credit. If the nursing home resident has other medical expenses and state and local income and property taxes, his or her income must be still higher in order to benefit from the tax credit.
 - Over time, the number of nursing home residents who pay out of private means falls, declining to about 25 percent as the length of stay increases.

These hypotheticals demonstrate that it is unlikely that many nursing home residents will be able to qualify for the credit. For these reasons, our preliminary estimates of the tax credit proposals include only a small proportion of nursing home residents who were not community long-term care residents in the tax year. Individuals receiving long-term care at home or in the community constitute the overwhelming majority of those estimated to be assisted by the tax credit options.

4. How many elderly recipients may not have a tax liability but are not claimed as dependents by others?

The hypotheticals, shown above, reinforce concern that many chronically ill individuals living at home or in the community may not be able to benefit from the proposed credit because they do not have a tax liability. Other data suggest that relatively few of the chronically ill are likely to be claimed as a dependent by another taxpayer and thus indirectly benefit from the credit.

Not surprisingly, most dependents are children. Out of 80 million dependent exemptions claimed by taxpayers in 1995, only 2 million were for dependent parents, and an additional 3 million were claimed for individuals who were neither the taxpayer's child or parent. To increase the likelihood that a low-income adult can be claimed as a dependent, we have already proposed dropping the dependents' gross income test from the eligibility criteria for the proposed credit. But even with the modification, the number of chronically ill individuals claimed as dependents, for purposes of this credit, is likely to be small.

Some have suggested that many elderly individuals may not be claimed as dependents for the credit because they are self-supporting. Under the current support test rules, the taxpayer must provide over one-half of the support of a dependent. For example, social security benefits count as support provided by the recipient, making it difficult to claim a social security beneficiary as a dependent. If the chronically ill individual owns his or her own home, the imputed rental value of the home also counts as self-support. The taxpayer may have to provide support in excess of the imputed rental value of the home and/or the social security benefits received by the chronically ill individual in order to claim the individual as a dependent and benefit from the credit. Yet, we know that relatively few adults receive significant financial support from individuals with whom they do not live:

- According to the 1988 Survey of Income and Program Participation, 1.7 million parents received financial support from their children who lived separately. Average support payments were \$1,330. Of these, 1.5 million lived in a private home; 101,000 lived in nursing home. In total, about 5.4 million adults received financial support from other adults who did not live with them.

We have been asked to consider whether a change in the definition of dependents could be considered as a way to expand the scope of the credit. However, data on the elderly disabled and their living and care arrangements (see Table 5) show that changes in the dependency definition may not suffice because many elderly disabled live on their own and, if possible, rely on their own spouse (not an adult child) for care.

- Over half of the elderly disabled who live with another individual live with their spouse. Of the 583,000 elderly disabled who live with their spouse, three-quarters rely on their spouse as the primary caregiver.

- Over 300,000 elderly disabled (22.5 percent of the elderly disabled) live alone. Of these, only 133,000 actually receive unpaid care from a son or daughter.

Allowing taxpayers to claim elderly disabled individuals who live with them would not increase the number of dependents significantly:

- Out of 1.4 million disabled elderly living in the community, only about one-third (481,000) live with adults other than their spouses. In the majority of cases, this appears to be the disabled individual's son or daughter.

Alternatively, an outside caregiver could be certified. But, the data suggest that the number of legitimate individuals, for whom assistance would be desired, is small, while the number of taxpayers who might try to take advantage of the provision could be much higher.

- Ideally, one might want to provide assistance to those who might be providing in-kind services for elderly disabled persons who live alone. The data suggest that there are only about 241,000 elderly disabled individuals who live alone and rely on unpaid, outside care.
- Depending on how the proposal was specified, a revenue estimate of a change in the dependency requirements might be significantly larger as taxpayers change their living or care arrangements or lie about their living and care arrangements in order to claim the credit. For example, there are 169,000 elderly disabled who live with a spouse and other adults; of these, over half rely on the spouse as the primary caregiver. Depending on the change in the dependency rules, some of these individuals could be claimed by the other adults in the household, even though they did not provide either financial or in-kind services to the disabled individual.

5. How does the definition of cognitive impairment affect the beneficiary population?

Table 6 compares two different definitions of cognitive impairment:

- Under the first definition, an individual is considered severely cognitively impaired if he or she incorrectly answers five or more questions on the Short Portable Mental Status Questionnaire (SPMSQ). This definition increases the number of chronically ill by between 900,000 and a million.
- Under the second definition, cognitively impaired individuals must also have difficulty with one activity of daily living or one instrumental activity of daily living. This reduces the number of individuals, who qualify on the basis of cognitive impairment only, by roughly one-half.

The current estimates use a definition of cognitive impairment closer to the second definition. But as Table 6 indicates, the definition of cognitive impairment will have significant impact on

estimates of the proposal. Further guidance would also be helpful regarding the definition of cognitive impairment.

Appendix: Measuring the Revenue Effects of Long Term Care Proposals

The Individual Tax Model (ITM) is an important tool developed by OTA to aid in estimating changes in Federal receipts. The ITM is a large microdata simulation model. The microdata aspect of the model refers to the fact that it contains data on the income, deductions, health expenditures, and other characteristics of individual tax filing units and families. The model can simulate the taxes paid under both current law and proposed changes in law.

Long-term care proposals present new challenges. For example, the nonfiling, institutionalized population is not represented in the two main data sets that are the traditional base of the ITM (tax returns and the CPS). While there have been numerous surveys and studies done in the area of long-term care, much of the data regarding severity of disability and place of care are available only for a point in time in a given year and must be annualized in order to be used in combination with tax return data. Overlaps in samples (for example, between samples of individuals in home-based care and nursing home residents) must somehow also be identified and removed. In order to be matched or imputed to the ITM, the surveys must also contain information that can be linked to data on tax returns or the CPS, or again, assumptions must be made.

Some of the long-term care proposals have also raised questions regarding living arrangements and support, both cash and in-kind and both within and between households. At best, tax return and CPS data can measure cash payments received by members within a household, and the relationships between members of a household, family, or tax filing unit. There are very few data that provide much insight into intra-family transfers or support networks between households.

To meet these challenges, on-model imputations and off-model adjustments have been developed and currently are being refined. In addition, we are currently completing work on a new 1995-based ITM that will contain estimates of the non-filing, and to some extent, institutionalized population. Incorporation on this model of the data on long term care, provided by HHS and other sources, will significantly improve the precision of estimates.

For these reasons, we have identified our revenue estimates for the current options as rough and preliminary. It is particularly difficult at this point to pinpoint estimates for inputs (such as people counts) into the preliminary revenue estimates. The data reviewed in this paper, however, should give the reader some sense of the magnitude of the effects of the proposed changes.

Table 1
 Numbers of Persons in Home or Community-Based Long-Term Care
 At Point in Time, 1994

	1994 (thous.)
<u>Age 65 and over 1/</u>	
Two or More Activities of Daily Living Limitations or Cognitively Impaired 2/	
hands-on and standby	1,917
hands-on only	1,625
Three or More Activities of Daily Living Limitations or Cognitively Impaired 2/	
hands-on and standby	1,622
hands-on only	1,372
<u>Age 18-64 3/</u>	
Two or More Activities of Daily Living Limitations 4/	
hands-on and standby	1,482
hands-on only	1,161
Three or More Activity of Daily Living Limitations 4/	
hands-on and standby	962
hands-on only	667

1/ Source: ASPE tabs of 1994 National Long Term Care Survey.

2/ Out of six ADLs (bathing, dressing, toileting, transferring, continence, and eating).
 Continence included only if needs assistance with continence.

Cognitively impaired includes those with four or more questions wrong on the
 Short Portable Mental Status Questionnaire (SPMSQ) and (1) either one ADL or
 or one of the four instrumental ADLs (telephoning, medicine management, money
 management or meal preparation). Three months or more duration

3/ Source: ASPE tabs of 1994 National Health Interview Survey, Disability
 Component Phase II.

4/ No real measure of cognitive impairment in the 1994 NHIS. There is a "supervision only"
 variable that probably captures some persons who are cognitively impaired
 and can perform all ADLs without assistance but may need cueing.
 Adding these individuals, aged 18 - 64, increases the estimates by about 5,000.

Table 2

Number of Nursing Home Residents Age 65 and Over
 By Degree and Type of Disability
 At Time of Interview, 1995 1/
 (Thousands)

Number of ADL Limitations 2/	Total	With Dementia, Mental Illness, Or Behavioral Problem
0	33	16
1	95	56
2	122	70
3 or more	<u>1,159</u>	<u>685</u>
Total	1,410	827

1/ Source: ASPE tabs of February 1998 TABS Current Residents

2/ Receives assistance (personal, assistive devices) eating, bathing, dressing, toileting, transferring, walking.

Note: Advance Data indicates that 40.5 % received assistance in 4 or more ADLs (eating, bathing, dressing, transferring or using toilet room).

Table 3

Elderly Nursing Home Residents by Source of Payment
At Time of Admission and in Month Before Interview 1/
1995
(Thousands)

	Primary Source At Admission	Primary Source in Month Before Interview: 2/			
		Private	Medicare	Medicaid	Other
All sources	1,385	401	176	772	36
Private	448	335	10	100	*
Medicare	353	58	150	141	*
Medicaid	526	*	14	507	*
Other	58	*	*	24	26

* means not significant.

1/ Source: Advance Data, NCHS Characteristics of Elderly Nursing Home Residents, Number 289.

2/ Medicaid is the secondary payer for 8.4 percent (116,000) of elderly residents at time of interview.

Addendum: Selected demographic characteristics

Married	230
Female	1,043
Age	
65-74	242
75-84	586
85+	557

Table 4
 Life Time Nursing Home Use
 Among Persons Aged 65 and Over At Time of Death in 1985 and
 Who Ever Used Nursing Home 1/

Months in Nursing Home	Total		Private Pay Throughout	
	Persons (thousands)	Persons (percent)	Persons (thousands)	Persons (percent)
Less than 3	160	32.5	90	56.5
3 - 6	50	10.2	27	53.5
6 - 12	52	10.6	24	47.1
12 - 24	56	11.4	25	44.0
24 - 60	91	18.5	31	33.6
60 or more	83	16.9	21	25.7
All	492	100.0	218	44.3

1/ Derived from Spillman B. and Kemper P., "Lifetime Patterns of Payment for Nursing Home Care,"
Medical Care Vol. 33, # 3 p.280-96, 1995.

Addenda: 16 percent of all persons have one or more year of nursing home care and private pay throughout

Table 5
 Numbers of Disabled Elderly in Home or Community Care
 By Living Arrangements and Source of Care 1/

Living Arrangments and Type of Care	Number of Disabled Elderly 2/	% of Disabled Elderly
Lives in community with spouse only	413,677	30.1%
Paid help (includes government subsidized)	188,093	
Paid out-of-pocket	89,720	
Unpaid help	394,870	
Spouse is primary caregiver	336,233	
Someone else is primary caregiver	58,638	
Both paid and unpaid help	175,890	
Lives in community with spouse and other adult	169,214	12.3%
Paid help (includes government subsidized)	57,098	
Paid out-of-pocket	25,751	
Unpaid help	167,032	
Spouse is primary caregiver	90,144	
Someone else is primary caregiver	76,888	
Both paid and unpaid help	56,078	
Lives with other adult(s) (not spouse)	481,403	35.1%
Paid help (includes government subsidized)	192,389	
Paid out-of-pocket	96,964	
Unpaid help	460,417	
Son or daughter is primary caregiver	309,165	
Someone else is primary caregiver	151,252	
Both paid and unpaid help	178,053	
Lives alone	308,538	22.5%
Paid help (includes government subsidized)	181,814	
Paid out-of-pocket	120,543	
Unpaid help	240,736	
Son or daughter is primary caregiver	132,440	
Someone else is primary caregiver	108,266	
Both paid and unpaid help	134,203	
Total disabled	1,372,832	100.0%

1/ ASPE tabulations from 1994 National Long-Term Care Survey.

2/ Three or more activity of daily living limitations out of six (bathing, dressing, eating, toileting, transferring, and incontinence management), with need for hands-on assistance, lasting three or more months or severe cognitive impairment lasting 3 months or longer.

Severe cognitive impairment is defined as four or more errors on the Short Portable Mental Status Questionnaire (SPMSQ) and at least one ADL limitation (out of five, bathing, dressing, eating, toileting, transferring) or one instrumental ADL limitation (out of four, medication management, money management, telephoning, and meal preparation) or a serious behavioral problem (such as wandering).

Table 6

Alternative Estimates of Number of Persons in Home or Community-Based Long Term Care
At Point in Time, Aged 65+ in 1990 1/
(Thousands)

	ADL Criteria Only 2/	Plus	Cognitive Impairment Defn. A 3/	Or	Cognitive Impairment Defn. B 4/
<u>Hands-on Assistance Only</u>					
2 ADLs	1,007		1,947		1,457
3 ADLs	630		1,657		1,174
<u>Hands-on or Standby Assistance</u>					
3 ADLs	1,157		2,076		1,588

1/ Source: Jackson M., Burwell B, Clark R, & Harahan M. "Eligibility for Publicly Financed Home Care" American Journal of Public Health, June, 1992.

Authors' estimates based on 1984 National Long Term Care Survey.

2/ one out of five core activity of daily living limitations (eating, toileting, transferring, dressing, bathing).

3/ Score of 5+ wrong answers on the Short Portable Mental Status Questionnaire (SPMSQ).

4/ Score of 5+ wrong answers on the SPMSQ and one ADL or one out of three instrumental ADLs (disability in money management, medication management, or telephoning).

Hypothetical Example 1:
 Income Tax Liability of Elderly Disabled Single Individual
 Under Current Law and Basic Option (\$1,000 max. credit)

Money Income: Social Security Benefits Only
 1999 Level

	Current Law	Option	Change
Income			
Social Security 1/	8,612	8,612	
Pensions	0	0	
Interest	<u>0</u>	<u>0</u>	
Total Money Income	8,612	8,612	
% of Poverty Level	107%	107%	
AGI			
- Exemption	-2,750	-2,750	
- Standard Deduction	-4,350	-4,350	
-Deduction for Elderly	<u>-1,050</u>	<u>-1,050</u>	
Taxable Income	0	0	
Pre-Credit Tax Liability			
-Long-Term Care Credit	<u>0</u>	<u>0</u>	
Post-Credit Tax Liability	0	0	0

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1/ Based on average monthly benefit paid in December, 1996 and adjusted for inflation.

Hypothetical Example 2:
Income Tax Liability of Elderly Disabled Single Individual
Under Current Law and Basic Option (\$1,000 max. credit)

Money Income: Social Security Benefits + Retirement Savings
1999 Level

	Current Law	Option	Change
<u>Income</u>			
Social Security 1/	8,612	8,612	
Pensions	5,500	5,500	
Interest	<u>1,950</u>	<u>1,950</u>	
Total Money Income	16,062	16,062	
% of Poverty Level	200%	200%	
AGI	7,450	7,450	
- Exemption	-2,750	-2,750	
- Standard Deduction	-4,350	-4,350	
-Deduction for Elderly	<u>-1,050</u>	<u>-1,050</u>	
Taxable Income	0	0	
Pre-Credit Tax Liability	0	0	
-Long-Term Care Credit	<u>0</u>	<u>0</u>	
Post-Credit Tax Liability	0	0	0

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1/ Based on average monthly benefit paid in December, 1996 and adjusted for inflation.

Hypothetical Example 3:

Income Tax Liability of Elderly Disabled Single Individual
Under Current Law and Basic Option (\$1,000 max. credit)

Money Income: Social Security Benefits + Retirement Savings
1999 Level .

	Current Law	Option	Change
Income			
Social Security 1/	8,612	8,612	
Pensions	8,250	8,250	
Interest	<u>3,250</u>	<u>3,250</u>	
Total Money Income	20,112	20,112	
% of Poverty Level	250%	250%	
AGI			
AGI	11,500	11,500	
- Exemption	-2,750	-2,750	
- Standard Deduction	-4,350	-4,350	
-Deduction for Elderly	<u>-1,050</u>	<u>-1,050</u>	
Taxable Income	3,350	3,350	
Pre-Credit Tax Liability			
Pre-Credit Tax Liability	503	503	
-Long-Term Care Credit	<u>0</u>	<u>-503</u>	
Post-Credit Tax Liability	503	-0	503

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1/ Based on average monthly benefit paid in December, 1996 and adjusted for inflation.

Hypothetical Example 4:
 Income Tax Liability of Elderly Disabled Single Individual
 Under Current Law and Basic Option (\$1,000 max. credit)

Money Income: Social Security Benefits + Retirement Savings
 1999 Level

	Current Law	Option	Change
Income			
Social Security 1/	8,612	8,612	
Pensions	11,000	11,000	
Interest	<u>4,500</u>	<u>4,500</u>	
Total Money Income	24,112	24,112	
% of Poverty Level	300%	300%	
AGI	15,500	15,500	
- Exemption	-2,750	-2,750	
- Standard Deduction	-4,350	-4,350	
-Deduction for Elderly	<u>-1,050</u>	<u>-1,050</u>	
Taxable Income	7,350	7,350	
Pre-Credit Tax Liability	1,103	1,103	
-Long-Term Care Credit	<u>0</u>	<u>-1,000</u>	
Post-Credit Tax Liability	1,103	103	1,000

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1/ Based on average monthly benefit paid in December, 1996 and adjusted for inflation.

Hypothetical Example 5:
 Income Tax Liability of Elderly Disabled Single Individual
 With Nursing Home Itemized Expenses
 Under Current Law and Basic Option (\$1,000 max. credit)

Money Income: Social Security Benefits + Retirement Savings
 1999 Level

	Current Law	Option	Change
<u>Income</u>			
Social Security 1/	8,612	8,612	
Pensions	10,000	10,000	
Interest	<u>10,000</u>	<u>10,000</u>	
Total Money Income	28,612	28,612	
% of Poverty Level	356%	356%	
AGI	20,000	20,000	
- Exemption	-2,750	-2,750	
- Itemized Deductions 2/	<u>-20,000</u>	<u>-20,000</u>	
Taxable Income	0	0	
Pre-Credit Tax Liability	0	0	
-Long-Term Care Credit	<u>0</u>	<u>0</u>	
Post-Credit Tax Liability	0	0	0

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- 1/ Based on average monthly benefit paid in December, 1996 and adjusted for inflation.
- 2/ Assumes nursing home expenses of \$21,500. Medical expenses in excess of 7.5 percent of AGI can be deducted.