

Attachment 2

Assisting Low-Income Taxpayers with Long-term Care Needs Through Tax System

Option 1:

For purposes of the proposed tax credit, taxpayers would not have to meet the support test in order to claim a chronically ill individual as a dependent if the individual meets the following two requirements: (i) the individual is the parent (including stepparents and in-laws), or ancestor of the parent, of the taxpayer and (ii) the individual lives with the taxpayer for over half the year.¹ If more than one taxpayer could claim the child as a dependent under the proposed rule, the taxpayer with the highest adjusted gross income would be entitled to the tax credit.

A custodial taxpayer who is not required to meet the support test under the proposal may waive the tax credit to another taxpayer if the noncustodial taxpayer provides over half of the dependent's total support and meets the other current law rules for dependency. As under the basic option, an individual could not claim the credit if he or she is a qualifying individual of another taxpayer (e.g., an incapacitated mother who lived with her daughter could not claim the credit on her own tax return).

Pros:

- Recognizes that taxpayers who reside with chronically ill parents are probably providing significant in-kind services, even though they may not be paying for parents' expenses.
- Eliminates burdensome record-keeping in order to prove support.
- Based on a FY 1998 budget proposal to simplify dependency exemptions for children.

Cons:

- Adds to complexity of tax system by creating new definition of dependency. Duplicate claims by confused taxpayers are likely.
 - A taxpayer who provides most of the financial support for his or her parent qualifies for a dependent exemption. However, the parent lives with the taxpayer's sibling, making the taxpayer ineligible for the tax credit. But because the taxpayer is used to conventional dependency tests, he or she erroneously claims the tax credit (as does the taxpayer's

¹ Under certain circumstances, the residency test would be met even if the chronically ill individual had spent some or all of those six months in a hospital or nursing home. The dependent would be considered to be "temporarily away from the taxpayer's home," if he or she had lived in the taxpayer's home prior to entering the hospital or nursing home and had a reasonable expectation of either returning to the taxpayer's home or dying in the hospital or nursing home.

sibling). Much to their dismay (and annoyance), both siblings receive notices from the IRS as a result.

- By eliminating both the gross income and support tests, a taxpayer might be eligible to claim the credit on behalf of a parent whose income exceeds his or her own and may even be greater than the proposed income thresholds for the credit.
 - The elimination of the support test could be coupled with the retention of the gross income test. The gross income test could be modified, allowing taxpayers to claim the credit for a dependent whose gross income was below the tax threshold. But another deviation from current law rules will add complexity to the tax code.
- Many parents and caregivers may live apart. Thus, the option still will not provide any benefit to adult children who care for their parents but do not live with them.
- Excludes taxpayers who reside with and care for relatives or friends who are not their parents. The residency test exemption could be expanded to include other relatives or friends who lived with the taxpayer a full year, but these relationships may be more difficult for the IRS to verify.
- Elimination of support test increases likelihood that chronically ill individual receives Medicaid benefits, while their son or daughter receives the tax credit. Additional complicated coordination rules would be required to explicitly deny eligibility for the credit for individuals receiving Medicaid benefits.

Option 2:

Same as option 1 but with following additions: Taxpayers who do not meet residency or support tests can be deemed to be parent's caregiver by State Units on Aging (SUA) or Area Agencies on Aging (AAA). A caregiver would be defined as someone who provides 20 or more hours of care a week for a chronically ill parent for over half the year. Care would be defined to include assistance with two out of the six activities of daily living or to provision of substantial assistance to an individual with a severe cognitive impairment.

Certification would be retrospective. Before providing certification, the SUA or AAA office would be required to interview the chronically ill individual, the individual's physician, and/or neighbors. Before the end of the tax year, the SUA or AAA would provide both the taxpayer and the IRS with certification of caregiving. The taxpayers would be required to attach the certificate to the tax return.

Pros:

- Provides credit to caregivers, with tax liability, who do not live with chronically ill individual

but provide assistance.

Cons:

- State and area aging offices do not have sufficient experience or staff to verify caregiving responsibilities. They also may not have the computer programming resources to provide the IRS with information that can be used in a timely manner to verify eligibility. But without reliable, independent reporting by an independent third-party, abuse is likely.
- Increases administrative burden for chronically ill individual, their caregiver, the state and district aging offices, and the IRS. In particular, the two certification requirements (of the chronic illness by the doctor and of the caregiver by the aging office) will be very burdensome for both the caregiver and the chronically ill individual.
- May raise unfunded mandate issues.
- Despite the added complexity, many needy individuals would receive no benefit from this option. For example, neither the low-income chronically ill individual or his equally low-income caregiver will benefit from this option.

Option 3:

Taxpayers could not claim individuals as dependents for the tax credit unless they met all the current law dependency tests (including the gross income and support test). However, the credit would be refundable.

Pros:

- Most direct way of providing assistance to low-income families through the tax system.
 - Does not differentiate between taxpayers who pay for support of chronically ill individual from those who provide day-to-day care through in-kind services.
 - Does not differentiate between those who are cared for by taxpayers from those who receive care from other low-income individuals.
 - Also benefits low-income individuals with chronic illness who live alone and are not receiving any assistance from friends and relatives.
- In certain respects, less complicated than other options. A new definition of dependency would not be created only for purposes of this tax credit.
 - Caregivers of nondependents may benefit indirectly from the proposal, because the

chronically ill individual may choose to share the credit with them or may, in fact, use the credit to hire outside help and thus provide the caregiver with a respite.

Cons:

- Individuals would be eligible for a flat check of \$1,000 even if they had zero income. This is different from the EITC which is phased-in as earned income increases. The IRS does not have experience administering a negative income tax, and the effects on compliance are not known.
 - There is also another key difference between the EITC and the proposed credit that can affect enforcement. Since the EITC is based on wage income and wage income is subject to a well-established comprehensive independent reporting system, the IRS has procedures and experience in distinguishing between real and fraudulent claims. But if someone submitted a claim for the proposed credit with no income, a false physician's certificate, and a borrowed social security number, the IRS would have little independent information to determine that the claim was bogus before the money was paid out.
- Previous proposals to make credits refundable have led to Congressional counter-attacks on the earned income tax credit (EITC). The imminent release of new GAO report on EITC compliance problems may make the credit particularly vulnerable to attack at this time (even though the report is generally a rehash of old news).
- Adds new filers to tax system. Many elderly, disabled individuals who have no reason to file a tax return would be required to file in order to obtain the tax credit.
 - Some low-income claimants may not file a tax return for years before they become eligible for the proposed credit, and the IRS no longer sends them forms and tracks their addresses. If they subsequently became eligible for the proposed credit, the IRS would not know how to reach them in order to provide them with tax return forms and information about the credit.
- Could become magnet to refund anticipation loan industry. While legitimate, this industry raises concerns because its profits are derived by charging high interest rates on loans to low-income populations who are anxious for their tax refund checks.
- Without complicated coordination rules, chronically ill individual could receive both Medicaid benefits and the refundable tax credit.
 - On the other hand, the refundable tax credit would reduce SSI benefits (and thus possibly affect eligibility for Medicaid), unless explicitly excluded from income.

SENT TO KARL

August 4, 1998

TO: Karl et al.
FROM: Chris and Jeanne
RE: **SIMPLIFYING YOUR WORK (We think)**

We just went through all of the options and think that we can take some options off the table. We have come around to your thinking: that trying to broaden the dependency test as we discussed with the AoA / Option 2 variant last Friday may be too difficult. Thus, there are probably only two options that we should present to Principals.

1. 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 -- last Friday's Option 1.
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. After thinking about it, we realized that once we open the door to nonfilers, the issue of institutionalization comes back (right?)

For both, we would want estimates of number of people helped and costs at both 2-plus and 3-plus ADLs.

We also would like to know the implications of broadening the work-related impairment expenses definition as Bob Williams discussed last Friday. The HSA might be a model.

Please call with questions.

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

The NEC and DPC have been working with Treasury and other agencies to develop policies that provide financial support to taxpayers with significant long-term care needs or their caregivers. There are currently two options under consideration. **All estimates are still rough and preliminary, pending the addition of new information on disabilities to the tax model.**

There are Two Options Currently Under Discussion

Option 1

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), would mitigate the effects the AMT, and would begin to phase out at \$110,000 (\$75,000 if the taxpayer is unmarried).

This option would replace the current dependency support test with a residency test. In particular, taxpayers would not have to demonstrate that they provide over half a chronically ill individual's support if the individual meets the following three requirements: (i) the individual meets a relationship test; (ii) the individual lives with the taxpayer for over half the year (if the taxpayer's parent or child) or a full year otherwise; and (iii) the individual's gross income is below the income tax threshold (roughly the poverty level for a nonelderly person or 200 percent of poverty for an elderly person).

- With a maximum credit of \$1,000, this option would cost roughly **\$6.2 billion** through 2003 and **\$18.9 billion** through 2008. It would benefit roughly **2.6 million** chronically ill individuals.
- Dropping the residency test but restoring the support test (and eliminating any gross income test) would lower the cost to **\$5 billion** through 2003 and **\$15 billion** through 2008 and would reduce the number of beneficiaries to **2.1 million**.

Option 2

Taxpayers could not claim individuals as dependents for the tax credit unless they met all the current law dependency tests (including the support test). However, the credit would be refundable.

- With a maximum credit of \$1,000, this option would cost roughly **\$9.0 billion** through 2003 and **\$26.5 billion** through 2008 if both nursing home residents and SSI recipients were ineligible. It would benefit roughly **2.9 million** chronically ill individuals. The estimates assume that a system could be established to prevent SSI recipients from claiming the credit. But such a system does not currently exist and would likely require additional legislative

changes and administrative costs to establish.

- Allowing nursing home residents, who are not on Medicaid, to claim the refundable credit would increase the costs to **\$10 billion** through 2003 and **\$30.5 billion** through 2008.

The Options Incorporate Several Policy Calls

- Our primary focus has been on the population with severe disabilities: they either need hands-on or stand-by assistance with 3 or more activities of daily living (ADLs) or have a severe cognitive impairment (including limitations with 1 or more ADLs or instrumental ADLs).
 - Under option 1, reducing the ADL test to 2 limitations would cost **\$7.5 billion** and aid **3.4 million** chronically ill individuals.
- Because of the difficulty in administering a credit that depends on the type of institution in which care occurs and the small cost saving that arise from excluding nursing home residents, the nonrefundable options do not restrict the population based on the location of care.
- The options include children under 17. Excluding this group would save roughly **\$.7 billion** under options 1 and 2 through 2003.

Pros and Cons of Options 1 and 2

Option 1 Pros:

- Provides assistance to chronically ill taxpayers or their taxpaying caregivers.
- Modifying the support test recognizes that taxpayers who reside with chronically ill relatives are probably providing significant in-kind services, even though they may not be paying for their relatives' expenses. It also eliminates burdensome record-keeping in order to prove support.
- Modifying the support test is also based on a FY 1998 budget proposal to simplify dependency exemptions for children.

Cons for Option 1:

- Adds to complexity of tax system by creating new definition of dependency. Duplicate claims by confused taxpayers are likely.
- Provides no benefit to adult children who care for their parents but do not live with them or

pay for most of their expenses.

- Non-dependent chronically ill individuals who live alone or with a spouse would not benefit from this option.

Pros for Option 2:

- Provides assistance to low-income, chronically ill families who do not pay taxes.
- Full refundability may be less complicated than other options (though for revenue reasons, this option restricts credit eligibility in other ways that may add to complexity). For example, a new definition of dependency would not be created only for purposes of this tax credit.

Cons for Option 2:

- Individuals would be eligible for a flat check of \$1,000 even if they had zero income. This is different from the EITC which is phased-in as earned income increases. The IRS does not have experience administering a negative income tax, and the effects on compliance are not known.
 - There are other key differences between the EITC and the proposed credit that may make the latter more difficult to administer. Since the EITC is based on wage income and wage income is subject to a well-established comprehensive independent reporting system, the IRS has procedures and experience in distinguishing between real and fraudulent claims. Further, most EITC claimants have a reason, other than the EITC, to file a tax return (for example, claiming a refund of overwithheld taxes). But if someone submitted a claim for the proposed credit with no income, a false physician's certificate, and a borrowed or stolen social security number for an elderly person who hasn't had to file a return in years, the IRS would have little independent information to determine that the claim was bogus before the money was paid out.
- Previous proposals to make credits refundable have led to Congressional counter-attacks on the earned income tax credit (EITC). The imminent release of new GAO report on EITC compliance problems may make the credit particularly vulnerable to attack at this time (even though the report is generally a rehash of old news).
- Adds new filers to tax system. Many elderly, disabled individuals who have no reason to file a tax return would be required to file in order to obtain the tax credit.
- Could become magnet to refund anticipation loan industry who charge high interest rates on loans to low-income populations anxious for their tax refund checks.

- Denying eligibility to nursing home residents (both private payors and Medicaid recipients) and SSI recipients will be administratively cumbersome (at best) and difficult to enforce.
 - IRS will not know if a chronically ill individual is at home or in a nursing home, unless an audit is initiated. But the IRS will generally not be able to identify a questionable return for audit based on the information reported on the tax return.
 - The IRS generally does not know who is receiving SSI or Medicaid, and the states must rely on the SSI or Medicaid beneficiary to report receipt of tax refunds. Enforcing a firewall between tax credit recipients and SSI and Medicaid beneficiaries will require, at a minimum, states to report information on SSI and Medicaid receipt in a timely fashion to the IRS so that it can be used during processing. This will probably require new funding for the necessary automation requirements and time.
- Nursing home residents who pay for their own care also incur significant costs, and it would be inequitable to deny them eligibility for the tax credit.

Payfors

The attached list gives some possible ways of paying for the long-term care proposal.

- The first three items are relatively noncontroversial and not included in the FY99 Budget. The first two were all included in the Senate's version of the IRS Restructuring legislation.
 - The FTC item is supported in the Senate and anathema to Chairman Archer.

Several issues need to be noted with the **liquidating REIT** proposal.

- There is an enormous baseline scoring difference between Treasury and the JCT on the liquidating REIT proposal. The JCT scores it as raising nearly \$5 billion through 2003. Treasury scores it as raising roughly \$500 million through 2003.
 - Using liquidating REITs as a payfor could possibly lead to the charge that under the President's scoring, the long-term care initiative is not fully paid for.
- By next January, both the JCT and Treasury may score the liquidating REIT proposal as raising even more money than the current JCT estimate (because the erosion of the tax base caused by liquidating REITs will be fully reflected in the respective baselines).
 - Given Y2K and IRS Restructuring concerns, the long-term care initiative would have a 1/1/2000 effective date. If Congressional action on the proposal did not take place until next year, the baseline scoring difference between the JCT and Treasury would likely not exist.

Possible Revenue Offsets
[\$ in millions]

		<u>1998-2003</u>	<u>1998-2008</u>
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



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUL 29 1998

File Long Term Care
Johns -
your copy

Bob

The Honorable Newt Gingrich
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Long-Term Care Patient Protection Act of 1998".

The bill would amend the Medicaid statute (title XIX of the Social Security Act) to remove certain restrictions on the provision of feeding and hydration assistance to residents in Medicaid nursing facilities. Under current law, the only paid staff who are permitted to assist residents with eating and drinking are nurse aides and licensed health professionals. This restriction can result in a shortage of personnel available to assist residents during mealtimes. The bill would allow staff other than those mentioned above to assist residents with eating and drinking, provided that they comply with Federal and State feeding and hydration assistance training and competency evaluation requirements. The bill would make corresponding amendments to the provisions of the Medicare statute (title XVIII of the Social Security Act) that set forth requirements for skilled nursing facilities.

The bill would also amend the Social Security Act to provide for background checks on applicants for employment in Medicare and Medicaid long term care facilities. The bill would authorize the establishment of a national registry that would collect information about abusive nursing facility workers from all States, and would make the information available to State and Federal agencies and nursing facilities. Nursing facilities would be required to (1) search the national registry to determine whether an applicant has committed acts of patient or resident abuse; and (2) if the registry did not contain information about the applicant, request States, in conjunction with the Attorney General, to perform a criminal background check of the applicant. The bill would prohibit Medicare and Medicaid long-term care facilities from knowingly employing abusive workers.

The Department intends to issue interim final regulations to implement the provisions of the bill within 180 days after the enactment of the bill.

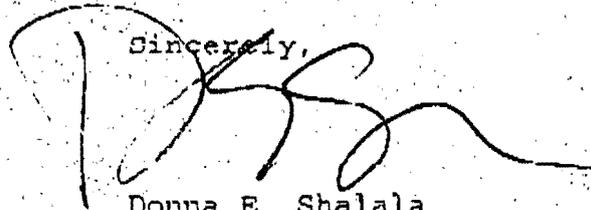
Page 2 - The Honorable Newt Gingrich

The draft bill would affect both direct spending and receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. The Office of Management and Budget estimates that the net pay-as-you-go effect of this legislative proposal would result in negligible costs for the period FY 1999-2003.

We urge the Congress to give the draft bill its prompt and favorable consideration.

The Office of Management and Budget has advised that there is no objection to the submission of this legislative proposal to the Congress, and that its enactment would be in accord with the program of the President.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. Shalala', written over the word 'Sincerely,'.

Donna E. Shalala

Enclosure

7-30-98 9:22AM DMS/OC/LG/LEGISLATION 202 355 6148# 3/28

A BILL

To amend titles XI, XVIII, and XIX of the Social Security Act to permit paid staff other than nurse aides and licensed health professionals to provide feeding and hydration assistance to residents in nursing facilities participating in the Medicare and Medicaid programs (and to provide special training requirements for such staff), and to establish a program to ensure that such facilities do not employ individuals who have a history of patient or resident abuse or have been convicted of certain crimes.

1 *Be it enacted by the Senate and House of Representatives of*
2 *the United States of America in Congress assembled, that this Act*
3 *may be cited as the "Long-Term Care Patient Protection Act of*
4 *1998".*

5 **SEC. 2. SPECIAL REQUIREMENTS FOR INDIVIDUALS PROVIDING FEEDING**
6 **AND HYDRATION ASSISTANCE TO NURSING FACILITY RESIDENTS**
7 **AND SKILLED NURSING FACILITY PATIENTS.**

8 (a) **MEDICAID PROGRAM.**—Section 1919 of the Social Security
9 Act is amended—

10 (1) in subsection (b)—

11 (A) in paragraph (5)(F)—

12 (i) by striking the period and inserting "
13 or"; and

14 (ii) by adding at the end the following new

1 clause:

2 "(iii) who is described in paragraph
3 (8) (B)."; and

4 (B) by adding at the end the following new
5 paragraph:

6 "(8) REQUIRED TRAINING OF FEEDING AND HYDRATION
7 ASSISTANTS.—

8 "(A) IN GENERAL.—A nursing facility must not use
9 on a full-time or other paid basis any individual as a
10 feeding and hydration assistant in the facility unless
11 the individual—

12 "(i) has completed a feeding and hydration
13 assistance training and competency evaluation
14 program approved by the State under subsection
15 (c) (8), and

16 "(ii) is competent to provide feeding and
17 hydration services.

18 "(B) FEEDING AND HYDRATION ASSISTANT DEFINED.—In
19 this paragraph, the term 'feeding and hydration
20 assistant' means any individual who assists residents
21 in a nursing facility to eat or drink but does not
22 otherwise provide any nursing or nursing-related
23 services to such residents, but does not include an
24 individual—

25 "(i) who is a licensed health professional
26 (as defined in paragraph (5) (G)) or a registered

1 dietician,

2 "(ii) who volunteers to provide such services
3 without monetary compensation, or

4 "(iii) who is a nurse aide (as defined in
5 paragraph (5) (F)).";

6 (2) in subsection (e), by adding at the end the
7 following new paragraph:

8 "(8) SPECIFICATION AND REVIEW OF FEEDING AND HYDRATION
9 ASSISTANCE TRAINING AND COMPETENCY EVALUATION PROGRAMS.—The
10 State must—

11 "(A) specify those training and competency
12 evaluation programs that the State approves for
13 purposes of subsection (b) (8) and that meet the
14 requirements established under subsection (f) (10),
15 which shall at a minimum include training concerning—

16 "(i) recommended amounts of food and
17 hydration,

18 "(ii) methods of providing food and
19 hydration, and

20 "(iii) recognition of symptoms of
21 malnutrition and dehydration; and

22 "(B) provide for the review and reapproval of such
23 programs, at a frequency and using a methodology
24 consistent with the requirements established under
25 subsection (f) (10) (B).

26 The failure of the Secretary to establish requirements under

1 subsection (f) (10) shall not relieve any State of its
2 responsibility under this paragraph."; and

3 (3) in subsection (f), by adding at the end the
4 following new paragraph:

5 "(10) REQUIREMENTS FOR FEEDING AND HYDRATION ASSISTANCE
6 TRAINING AND EVALUATION PROGRAMS.—For purposes of
7 subsections (b) (8) and (e) (8), the Secretary shall
8 establish—

9 "(A) requirements for the approval of feeding and
10 hydration assistance training and competency evaluation
11 programs; and

12 "(B) requirements respecting the minimum frequency
13 and methodology to be used by a State in reviewing such
14 programs' compliance with the requirements for such
15 programs."

16 (b) MEDICARE PROGRAM.—Section 1819 of such Act is amended—

17 (1) in subsection (b)—

18 (A) in paragraph (5) (F)—

19 (i) by striking "or" at the end of clause

20 (i);

21 (ii) by striking the period at the end of
22 clause (ii) and inserting ", or"; and

23 (iii) by adding at the end the following new
24 clause:

25 "(iii) who is described in paragraph

26 (8) (B)."; and

1 (B) by adding at the end the following new
2 paragraph:

3 "(8) REQUIRED TRAINING OF FEEDING AND HYDRATION
4 ASSISTANTS.—

5 "(A) IN GENERAL.—A skilled nursing facility must
6 not use on a full-time or other paid basis any
7 individual as a feeding and hydration assistant in the
8 facility unless the individual—

9 "(i) has completed a feeding and hydration
10 assistance training and competency evaluation
11 program approved by the State under subsection
12 (e) (6), and

13 "(ii) is competent to provide feeding and
14 hydration services.

15 "(B) FEEDING AND HYDRATION ASSISTANT DEFINED.—In
16 this paragraph, the term 'feeding and hydration
17 assistant' means any individual that assists residents
18 in a skilled nursing facility to eat or drink but does
19 not otherwise provide any nursing or nursing-related
20 services to such residents, but does not include an
21 individual—

22 "(i) who is a licensed health professional
23 (as defined in paragraph (5) (G)) or a registered
24 dietician,

25 "(ii) who volunteers to provide such services
26 without monetary compensation, or

1 "(iii) who is a nurse aide (as defined in
2 paragraph (5) (F)).";

3 (2) in subsection (e), by adding at the end the
4 following new paragraph:

5 "(6) SPECIFICATION AND REVIEW OF FEEDING AND HYDRATION
6 ASSISTANCE TRAINING AND COMPETENCY EVALUATION PROGRAMS.—The
7 State must—

8 "(A) specify those training and competency
9 evaluation programs that the State approves for
10 purposes of subsection (b) (8) and that meet the
11 requirements established under subsection (f) (8), which
12 shall at a minimum include training concerning—

13 "(i) recommended amounts of food and
14 hydration,

15 "(ii) methods of providing food and
16 hydration, and

17 "(iii) recognition of symptoms of
18 malnutrition and dehydration; and

19 "(B) provide for the review and reapproval of such
20 programs, at a frequency and using a methodology
21 consistent with the requirements established under
22 subsection (f) (8) (B).

23 The failure of the Secretary to establish requirements under
24 subsection (f) (8) shall not relieve any State of its
25 responsibility under this paragraph."; and

26 (3) in subsection (f), by adding at the end the

1 following new paragraph:

2 "(8) REQUIREMENTS FOR FEEDING AND HYDRATION ASSISTANCE
3 TRAINING AND EVALUATION PROGRAMS.—For purposes of
4 subsections (b) (8) and (e) (6), the Secretary shall
5 establish—

6 "(A) requirements for the approval of feeding and
7 hydration assistance training and competency evaluation
8 programs; and

9 "(B) requirements respecting the minimum frequency
10 and methodology to be used by a State in reviewing such
11 programs' compliance with the requirements for such
12 programs."

13 **SEC. 3. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING**

14 **FACILITY RESIDENTS.**

15 (a) **NURSING FACILITY AND SKILLED NURSING FACILITY**
16 **REQUIREMENTS.—**

17 (1) **MEDICAID PROGRAM.—**Section 1919(b), as amended by
18 section 2(a), is amended by adding after paragraph (8) the
19 following new paragraph:

20 "(9) **SCREENING OF NURSING FACILITY WORKERS.—**

21 "(A) **BACKGROUND CHECKS ON APPLICANTS.—**Subject to
22 subparagraph (B) (ii), before hiring an individual, a
23 nursing facility shall—

24 "(i) give the individual written notice that
25 the facility is required to perform background
26 checks with respect to applicants;

1 "(ii) require, as a condition of employment,
2 that such individual—

3 "(I) provide a written statement
4 disclosing any conviction for a relevant
5 crime or finding of patient or resident
6 abuse;

7 "(II) provide a statement signed by the
8 individual authorizing the facility to
9 request the search and exchange of criminal
10 records;

11 "(III) provide in person a copy of the
12 individual's fingerprints; and

13 "(IV) provide any other identification
14 information the Secretary may specify in
15 regulation;

16 "(iii) initiate a check of the registry under
17 section 1120F in accordance with regulations
18 promulgated by the Secretary to determine whether
19 such registry contains any disqualifying
20 information with respect to such individual; and

21 "(iv) if such registry does not contain any
22 such disqualifying information—

23 "(I) request that the State initiate a
24 State and national criminal background check
25 on such individual in accordance with the
26 provisions of subsection (e)(9); and

9

1 " (II) furnish to the State the
2 information described in subclauses (II)
3 through (IV) of clause (ii) not more than 7
4 days (excluding Saturdays, Sundays, and legal
5 public holidays under section 6103(a) of
6 title 5, United States Code) after completion
7 of the check against the registry initiated
8 under clause (iii).

9 "(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

10 "(i) IN GENERAL.—A nursing facility may not
11 knowingly employ any individual who has any
12 conviction for a relevant crime or with respect to
13 whom a finding of patient or resident abuse has
14 been made.

15 "(ii) PROBATIONARY EMPLOYMENT.—After
16 complying with the requirements of clauses (i),
17 (ii), and (iii) of subparagraph (A), a nursing
18 facility may provide for a probationary period of
19 employment (not to exceed 90 days) for an
20 individual pending completion of the check against
21 the registry described under subparagraph (A)(iii)
22 and the background check described under
23 subparagraph (A)(iv). Such facility shall
24 maintain supervision of the individual during the
25 individual's probationary period of employment.

26 "(C) REPORTING REQUIREMENTS.—A nursing facility

1 shall report to the State any instance in which the
2 facility determines that an individual has committed an
3 act of resident neglect or abuse or misappropriation of
4 resident property in the course of employment by the
5 facility.

6 "(D) USE OF INFORMATION.—

7 "(i) IN GENERAL.—A nursing facility that
8 obtains information about an individual pursuant
9 to clauses (iii) and (iv) of subparagraph (A) may
10 use such information only for the purpose of
11 determining the suitability of the individual for
12 employment.

13 "(ii) IMMUNITY FROM LIABILITY.—A nursing
14 facility that, in denying employment for an
15 applicant, reasonably relies upon information
16 about an individual provided by the State pursuant
17 to subsection (c)(9) shall not be liable in any
18 action brought by the individual based on the
19 employment determination resulting from the
20 incompleteness or inaccuracy of the information.

21 "(iii) CRIMINAL PENALTY.—whoever knowingly
22 violates the provisions of subparagraph (D)(i)
23 shall be fined in accordance with title 18, United
24 States Code, imprisoned for not more than 2 years,
25 or both.

26 "(E) DEFINITIONS.—As used in this paragraph—

"(i) the term 'conviction for a relevant crime' means any State or Federal criminal conviction for—

"(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

"(II) such other types of offenses as the Secretary may specify in regulations;

"(ii) the term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (g) (1) (C) or a Federal agency that an individual has committed—

"(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

"(II) such other types of acts as the Secretary may specify in regulations; and

"(iii) the term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse."

(2) MEDICARE PROGRAM.—Section 1819(b), as amended by section 2(b), is amended by adding after paragraph (8) the following new paragraph:

"(9) SCREENING OF NURSING FACILITY WORKERS.—

"(A) BACKGROUND CHECKS ON APPLICANTS.—Subject to subparagraph (B) (ii), before hiring an individual, a

1 skilled nursing facility shall—

2 "(i) give the individual written notice that
3 the facility is required to perform background
4 checks with respect to applicants;

5 "(ii) require, as a condition of employment,
6 that such individual—

7 "(I) provide a written statement
8 disclosing any conviction for a relevant
9 crime or finding of patient or resident
10 abuse;

11 "(II) provide a statement signed by the
12 individual authorizing the facility to
13 request the search and exchange of criminal
14 records;

15 "(III) provide in person a copy of the
16 individual's fingerprints; and

17 "(IV) provide any other identification
18 information the Secretary may specify in
19 regulation;

20 "(iii) initiate a check of the registry under
21 section 1128F in accordance with regulations
22 promulgated by the Secretary to determine whether
23 such registry contains any disqualifying
24 information with respect to such individual; and

25 "(iv) if such registry does not contain any
26 such disqualifying information—

1 "(I) request that the State initiate a
2 State and national criminal background check
3 on such individual in accordance with the
4 provisions of subsection (e) (7); and

5 "(II) furnish to the State the
6 information described in subclauses (II)
7 through (IV) of clause (ii) not more than 7
8 days (excluding Saturdays, Sundays, and legal
9 public holidays under section 6103(a) of
10 title 5, United States Code) after completion
11 of the check against the registry initiated
12 under clause (iii).

13 "(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

14 "(i) IN GENERAL.—A skilled nursing facility
15 may not knowingly employ any individual who has
16 any conviction for a relevant crime or with
17 respect to whom a finding of patient or resident
18 abuse has been made.

19 "(ii) PROBATIONARY EMPLOYMENT.—After
20 complying with the requirements of clauses (i),
21 (ii), and (iii) of subparagraph (A), a skilled
22 nursing facility may provide for a probationary
23 period of employment (not to exceed 90 days) for
24 an individual pending completion of the check
25 against the registry described under subparagraph
26 (A) (iii) and the background check described under

1 subparagraph (A) (iv). Such facility shall
2 maintain supervision of the individual during the
3 individual's probationary period of employment.

4 "(C) REPORTING REQUIREMENTS.—A skilled nursing
5 facility shall report to the State any instance in
6 which the facility determines that an individual has
7 committed an act of resident neglect or abuse or
8 misappropriation of resident property in the course of
9 employment by the facility.

10 "(D) USE OF INFORMATION.—

11 "(i) IN GENERAL.—A skilled nursing facility
12 that obtains information about an individual
13 pursuant to clauses (iii) and (iv) of subparagraph
14 (A) may use such information only for the purpose
15 of determining the suitability of the individual
16 for employment.

17 "(ii) IMMUNITY FROM LIABILITY.—A skilled
18 nursing facility that, in denying employment for
19 an applicant, reasonably relies upon information
20 about an individual provided by the State pursuant
21 to subsection (e) (9) shall not be liable in any
22 action brought by the individual based on the
23 employment determination resulting from the
24 incompleteness or inaccuracy of the information.

25 "(iii) CRIMINAL PENALTY.—Whoever knowingly
26 violates the provisions of subparagraph (D) (i)

shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

"(F) DEFINITIONS.—As used in this paragraph—

"(i) the term 'conviction for a relevant crime' means any State or Federal criminal conviction for—

"(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

"(II) such other types of offenses as the Secretary may specify in regulations;

"(ii) the term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (g) (1) (C) or a Federal agency that an individual has committed—

"(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

"(II) such other types of acts as the Secretary may specify in regulations; and

"(iii) the term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse."

(b) STATE REQUIREMENTS.—

(1) MEDICAID PROGRAM.—

1 (A) EXPANSION OF STATE REGISTRY TO COLLECT
2 INFORMATION ABOUT NURSING FACILITY EMPLOYEES OTHER THAN
3 NURSE AIDES.—Section 1919, as amended by section 2(a),
4 is amended—

5 (i) in subsection (e)(2)—

6 (I) in the paragraph heading, by
7 striking "NURSE AIDE REGISTRY" and inserting
8 "NURSING FACILITY EMPLOYEE REGISTRY";

9 (II) in subparagraph (A)—

10 (aa) by striking "By not later than
11 January 1, 1989, the" and inserting
12 "The";

13 (bb) by striking "a registry of
14 all individuals" and inserting "a
15 registry of (I) all individuals"; and

16 (cc) by inserting before the period
17 ", and (II) all other nursing facility
18 employees with respect to whom the State
19 has made a finding described in
20 subparagraph (B)";

21 (III) in subparagraph (B), by striking
22 "involving an individual listed in the
23 registry" and inserting "involving a nursing
24 facility employee"; and

25 (IV) in subparagraph (C), by striking
26 "nurse aide" and inserting "nursing facility

employee"; and

(ii) in subsection (g) (1)—

(I) in subparagraph (C)—

(aa) in the first sentence, by striking "nurse aide" and inserting "nursing facility employee"; and

(bb) in the third sentence, by striking "nurse aide" each place it appears and inserting "nursing facility employee"; and

(II) in subparagraph (D), by striking "nurse aide" each place it appears and inserting "nursing facility employee".

(B) STATE AND FEDERAL REQUIREMENT TO CONDUCT BACKGROUND CHECKS.—Section 1919(e), as amended by section 2(a), is amended by adding at the end the following new paragraph:

"(9) STATE AND FEDERAL REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

"(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b) (9) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b) (9) (A) (ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b) (9) (F)), shall submit such request and information

1 to the Attorney General and shall request the Attorney
2 General to conduct a search and exchange of records
3 with respect to the individual as described in
4 subparagraph (B).

5 " (B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY
6 GENERAL.—Upon receipt of a submission pursuant to
7 subparagraph (A), the Attorney General shall direct a
8 search of the records of the Federal Bureau of
9 Investigation for any criminal history records
10 corresponding to the fingerprints or other positive
11 identification information submitted. The Attorney
12 General shall provide any corresponding information
13 resulting from the search to the State.

14 " (C) STATE REPORTING OF INFORMATION TO NURSING
15 FACILITY.—Upon receipt of the information provided by
16 the Attorney General pursuant to subparagraph (B), the
17 State shall—

18 " (i) review the information to determine
19 whether the individual has any conviction for a
20 relevant crime (as defined in subsection
21 (b) (9) (E)); and

22 " (ii) report to the nursing facility the
23 results of such review.

24 " (D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND
25 CHECKS.—

26 " (i) AUTHORITY TO CHARGE FEES.—

"(I) ATTORNEY GENERAL.—The Attorney General may charge a reasonable fee, not to exceed \$50 per request, to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b) (9) for conducting the search and providing the records. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation, until expended.

"(II) STATE.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b) (9), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

"(ii) TREATMENT OF FEES FOR PURPOSES OF COST REPORTS.—An entity may not include a fee assessed pursuant to this subparagraph as an allowable item on a cost report under this title or title XVIII.

"(E) REGULATIONS.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the

1 Secretary, may promulgate such regulations as are
2 necessary to carry out the Attorney General's
3 responsibilities under this paragraph and subsection
4 (b) (9), including regulations regarding the security,
5 confidentiality, accuracy, use, destruction, and
6 dissemination of information, audits and recordkeeping,
7 and the imposition of fees.

8 "(F) REPORT.—Not later than 2 years after the
9 date of enactment of the "Long-Term Care Patient
10 Protection Act of 1998", the Attorney General shall
11 submit a report to Congress on the number of requests
12 for searches and exchanges of records made under this
13 section and the disposition of such requests."

14 (2) MEDICARE PROGRAM.—

15 (A) EXPANSION OF STATE REGISTRY TO COLLECT
16 INFORMATION ABOUT SKILLED NURSING FACILITY EMPLOYEES
17 OTHER THAN NURSE AIDES.—Section 1819, as amended by
18 section 2(b), is amended—

19 (i) in subsection (c) (2)

20 (I) in the paragraph heading, by
21 striking "NURSE AIDE REGISTRY" and inserting
22 "SKILLED NURSING CARE EMPLOYEE REGISTRY";

23 (ii) in subparagraph (A)—

24 (aa) by striking "By not later
25 than January 1, 1989, the" and inserting
26 "The";

1 (bb) by striking "a registry of
2 all individuals" and inserting "a
3 registry of (I) all individuals"; and

4 (cc) by inserting before the period
5 ", and (II) all other skilled nursing
6 facility employees with respect to whom
7 the State has made a finding described
8 in subparagraph (B)";

9 (III) in subparagraph (B), by striking
10 "involving an individual listed in the
11 registry" and inserting "involving a skilled
12 nursing facility employee"; and

13 (IV) in subparagraph (C), by striking
14 "nurse aide" and inserting "skilled nursing
15 facility employee"; and

16 (ii) in subsection (g) (1)—

17 (I) in subparagraph (C)—

18 (aa) in the first sentence, by
19 striking "nurse aide" and inserting
20 "skilled nursing facility employee"; and

21 (bb) in the third sentence, by
22 striking "nurse aide" each place it
23 appears and inserting "skilled nursing
24 facility employee"; and

25 (II) in subparagraph (D), by striking
26 "nurse aide" each place it appears and

1 inserting "skilled nursing facility
2 employee".

3 (B) STATE AND FEDERAL REQUIREMENT TO CONDUCT
4 BACKGROUND CHECKS.—Section 1819(e), as amended by
5 section 2(b), is amended by adding at the end the
6 following new paragraph:

7 "(7) STATE AND FEDERAL REQUIREMENTS CONCERNING CRIMINAL
8 BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

9 "(A) IN GENERAL.—Upon receipt of a request by a
10 skilled nursing facility pursuant to subsection (b)(9)
11 that is accompanied by the information described in
12 subclauses (II) through (IV) of subsection
13 (b)(9)(A)(ii), a State, after checking appropriate
14 State records and finding no disqualifying information
15 (as defined in subsection (b)(9)(E)), shall submit such
16 request and information to the Attorney General and
17 shall request the Attorney General to conduct a search
18 and exchange of records with respect to the individual
19 as described in subparagraph (B).

20 "(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY
21 GENERAL.—Upon receipt of a submission pursuant to
22 subparagraph (A), the Attorney General shall direct a
23 search of the records of the Federal Bureau of
24 Investigation for any criminal history records
25 corresponding to the fingerprints or other positive
26 identification information submitted. The Attorney

1 General shall provide any corresponding information
2 resulting from the search to the State.

3 "(C) STATE REPORTING OF INFORMATION TO NURSING
4 FACILITY.—Upon receipt of the information provided by
5 the Attorney General pursuant to subparagraph (B), the
6 State shall—

7 "(i) review the information to determine
8 whether the individual has any conviction for a
9 relevant crime (as defined in subsection

10 (b) (9) (E)); and

11 "(ii) report to the skilled nursing facility
12 the results of such review.

13 "(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND
14 CHECKS.—

15 "(i) AUTHORITY TO CHARGE FEES.—

16 "(I) ATTORNEY GENERAL.—The Attorney
17 General may charge a reasonable fee, not to
18 exceed \$50 per request, to any State
19 requesting a search and exchange of records
20 pursuant to this paragraph and subsection
21 (b) (9) for conducting the search and
22 providing the records. Such fees shall be
23 available to the Attorney General, or, in the
24 Attorney General's discretion, to the Federal
25 Bureau of Investigation, until expended.

26 "(II) STATE.—A State may charge a

1 skilled nursing facility a fee for initiating
2 the criminal background check under this
3 paragraph and subsection (b) (9), including
4 fees charged by the Attorney General, and for
5 performing the review and report required by
6 subparagraph (C). The amount of such fee
7 shall not exceed the actual cost of such
8 activities.

9 "(ii) TREATMENT OF FEES FOR PURPOSES OF COST
10 REPORTS.—An entity may not include a fee assessed
11 pursuant to this subparagraph as an allowable item
12 on a cost report under this title or title XIX.

13 "(E) REGULATIONS.—In addition to the Secretary's
14 authority to promulgate regulations under this title,
15 the Attorney General, in consultation with the
16 Secretary, may promulgate such regulations as are
17 necessary to carry out the Attorney General's
18 responsibilities under this paragraph and subsection
19 (b) (9), including regulations regarding the security,
20 confidentiality, accuracy, use, destruction, and
21 dissemination of information, audits and recordkeeping,
22 and the imposition of fees.

23 "(F) REPORT.—Not later than 2 years after the
24 date of enactment of the "Long-Term Care Patient
25 Protection Act of 1998", the Attorney General shall
26 submit a report to Congress on the number of requests

1 for searches and exchanges of records made under this
2 section and the disposition of such requests."

3 (c) ESTABLISHMENT OF NATIONAL REGISTRY OF ABUSIVE NURSING
4 FACILITY WORKERS.—Title XI of the Social Security Act is amended
5 by adding after section 1128E the following new section:

6 "NATIONAL REGISTRY OF ABUSIVE NURSING FACILITY WORKERS

7 "Sec. 1128F. (a) IN GENERAL.—The Secretary shall establish
8 a national data collection program for the reporting of
9 information described in subsection (b), with access as set forth
10 in subsection (c), and shall maintain a database of the
11 information collected under this section.

12 "(b) REPORTING OF INFORMATION.—Each State shall report the
13 information collected pursuant to sections 1819(e)(2)(B) and
14 1919(e)(2)(B) in such form and manner as the Secretary may
15 prescribe by regulation.

16 "(c) ACCESS TO REPORTED INFORMATION.—

17 "(1) AVAILABILITY.—The information in the database
18 maintained under this section shall be available, pursuant
19 to procedures maintained under this section, to—

20 "(A) Federal and State government agencies;

21 "(B) nursing facilities participating in the
22 program under title XIX and skilled nursing facilities
23 participating in a program under title XVIII; and

24 "(C) such other persons as the Secretary may
25 specify by regulation,

26 but only for the purpose of determining the suitability for

1 employment in a nursing facility or skilled nursing
2 facility.

3 "(2) INFORMATION.—The information in the database
4 shall be exempt from disclosure under 5 U.S.C. 552.

5 "(3) FEES FOR DISCLOSURE.—

6 "(A) IN GENERAL.—The Secretary may establish or
7 approve reasonable fees for the disclosure of
8 information in such database. The amount of such a fee
9 shall be sufficient to recover the full costs of
10 operating the database. Such fees shall be available
11 to the Secretary or, in the Secretary's discretion, to
12 the agency designated under this section to cover such
13 costs.

14 "(B) AVAILABILITY OF FEES.—Fees collected
15 pursuant to this subsection shall remain available
16 until expended, in the amounts provided in
17 appropriation acts, for necessary expenses related to
18 the purposes for which the fees were assessed.

19 "(C) TREATMENT OF FEES FOR PURPOSES OF COST
20 REPORTS.—An entity may not include a fee assessed
21 pursuant to this subsection as an allowable item on a
22 cost report under this title or title XIX."

23 **SEC. 4. EFFECTIVE DATE.**

24 The provisions of and amendments made by this Act shall be
25 effective on and after the date of enactment, without regard to
26 whether implementing regulations are in effect.

Secretary Shalala's FY 2000 Long-Term Care Budget Initiative

OVERVIEW

Secretary Shalala's FY 2000 Long-Term Care budget initiative aims to achieve three goals:

- to reduce the institutional bias in state Medicaid programs and increase the availability of consumer responsive home and community based services;
- to increase assistance available to family and other informal caregivers who support people with chronic illness and disability; and
- to remove barriers and create opportunities within Medicaid for people with disabilities who want to work so that they have secure health care coverage and access to P.A.S.

The HHS package proposed here includes changes in laws and policies, research and demonstration, and technical assistance activities.

RELATIONSHIP TO WHITE HOUSE INITIATIVE

HHS is anxious to work with the White House staff and the Department of Treasury and OPM to develop a coordinated, comprehensive long-term care strategy that addresses a range of services for the elderly and people with disabilities. We are pleased to have the opportunity to work with Treasury in designing the tax credits/exemptions and estimating their impact. Similarly, we will continue to work with OPM as the federal employees private long-term care insurance benefit is developed.

SECRETARIAL LONG-TERM CARE INITIATIVE: 3 ELEMENTS

Secretary Shalala's long-term care initiative includes the following two elements:

1. *Activities to Expand and Enhance Community Services.* A series of research and demonstration, technical assistance, and policy changes to address the institutional bias in Medicaid and offer consumers more opportunities and choices for home and community based services and support family caregivers; and
2. *Health and Long-Term Care Coverage for people with disabilities who work.* A strategy to aggressively promote the continuation and expansion of Medicaid benefits for people with disabilities who work.

These two elements are in addition to the comprehensive nursing home strategy that was rolled out by the President on July 21.

In addition, long-term care initiative activities will be coordinated with chronic disease prevention initiative activities, where there is potential for joint activities toward similar or

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related ends. In particular, there will be close coordination with the IHS Elder Health Care proposal (FY 2000 IHS budget request of \$5 million) which has as one of its three focus areas the provision of expertise and technical assistance to tribal groups on developing home and community based elder care programs.

ELEMENT 1: ACTIVITIES TO EXPAND AND ENHANCE COMMUNITY SERVICES.
HHS proposals to decrease institutional bias and expand home and community based services and support family caregivers (Total cost of Element 1: \$1.125 billion discretionary, \$556 million entitlement, over five years). Element 1 includes four components.

1A. We propose to establish the "Bridge to Independence Program," to support states in reducing their reliance on nursing homes and increasing the availability of home and community based services. The program will consist of:

- (a) a national technical assistance and resource center;**
- (b) a capacity building grant program to assist 20 states in building stronger foundations for effective and efficient community based services systems; and**
- (c) performance awards for participating states that successfully demonstrate their ability to reduce institutional use and expand consumer responsive home and community services systems.**

The first component of the "Bridge to Independence" initiative is the development of a national technical assistance center, funded through the AoA budget, and administered in cooperation with HCFA, ADD and ASPE. Beginning in FY 2000, the national TA and resource center will be a vehicle that states and Indian tribes can draw on to help them solve concrete problems around financing, capitation, case management, quality, consumer direction and the many other real problems faced by states trying to develop and expand home and community based services in a cost effective manner. The center will:

- identify innovative practices across states, tribes, and communities;
- share information and experience;
- conduct data analysis activities;
- plan and host forums, seminars and workshops;
- develop and support teams of state experts to visit and assist other states; and,
- conduct specific training sessions at the request of states and tribes.

The second component of the new program is the implementation of new state grant program in 20 states to support organizing, operating and providing innovative home and

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community based services that are consumer directed and cost effective. Grants funds may be used by states to bring together the stakeholders—consumers, providers and policy and program people (including both state and tribal officials) to identify reform principals and goals, to identify consumer needs, to obtain specialized expertise where it is most needed, i.e., to develop alternative financing designs, risk adjustment schemes, assessment protocols and to provide gap filling services not normally provided within their state plans or other services not provided statewide to all Medicaid recipients; for example, counseling and training for people who want to manage their own attendant care, upgraded assistive devices to support independent living, creating new residential services etc. The product of the grant will be a state blue print for home and community based systems change and practical experience in testing new service modalities supported by the principal stakeholders. A percentage of the funds allocated to the grant program will be set aside and targeted for Indian tribes to conduct the same activities; tribes will compete for the set aside funds.

The third component is the **development and implementation of performance awards** to reward participating states and tribes that demonstrate major gains in infrastructure development, collaboration across stakeholders, expanded participation in a high quality, cost effective system of home and community based services and reduced nursing home use. Selected states which meet performance criteria after two years will be awarded performance grants to be used to implement new aspects of their system design or to expand services to new populations.

The total investment for the "Bridge to Independence" would be \$375 million over five years, placed in the AoA budget, but jointly administered by HCFA, AoA, ADD and ASPE. The \$375 million would be divided as follows: \$5 million for the National TA Center; \$300 million for the new state grant program; and \$70 million for the performance awards (each over five years). The FY 2000 total will be: \$75 million.

1B. Through a newly established National Family Caregiver Support Program, provide families with assistance to support their efforts in caring for their elderly disabled relatives with chronic conditions. The Administration of Aging will establish a national caregiver support program that offers assistance to families and other informal caregivers caring for people with chronic illness and disability. The program will:

- (a) create family caregiver support system through formula grants to states;**
- (b) foster innovation through state incentive grants awarded on a competitive basis;**
- (c) enhance ongoing program performance through evaluation and caregiver education about chronic diseases in collaboration with ASPE, CDC and OPHS.**

A multifaceted support system will be established in each state for family caregivers, who provide the overwhelming majority of all personal assistance to those with chronic illnesses and disabilities. All states will put in place five basic program components, financed by the formula grant and/or with funding from other sources. These components include:

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- information for caregivers about resources that will help them in their caregiving roles;
- assistance to families in locating services from a variety of private and voluntary agencies;
- caregiver counseling, training and peer support to help them better cope with the emotional and physical stress of dealing with the disabling effects of a family member's chronic condition;
- respite care in its many forms--provided in one's home, adult day care center or over a weekend in a nursing home or residential setting such as an assisted living facility; and
- limited supplemental services to fill in a service gap that can not be filled in any other manner.

To foster continuous program innovation, states will also compete for incentive grants that will integrate research, demonstrations and evaluations to test new approaches which will: examine differences in the types and amount of support needed by families caring for persons with specific chronic diseases and for younger persons with disabilities; better identify caregivers in crisis to prevent elder abuse; reach caregivers from diverse racial and ethnic backgrounds; approaches to supporting the efforts of Indian tribes; and promote employer caregiver support

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Long-term care R/b

LONG-TERM CARE POLICY OPTIONS

JULY 24, 1998

WHY CONSIDER LONG-TERM CARE POLICIES NOW

- **Increasing interest in long-term care as the baby boom generation ages**
 - The number of elderly Americans -- including those age 85 years and older -- will double by 2030.
 - The need for long-term care rises with age. Nearly half of all people age 85 and older need assistance with everyday activities.
- **Heightened interest in helping people with disabilities receive personal assistance and other long-term care services**
 - Task Force on Employment of Adults with Disabilities
 - Bills (e.g., MiCASA, Kennedy-Jeffords) to expand options for home & community care
- **Not likely to be significantly addressed by Medicare Commission**
 - No desire for large, new entitlement expansion
 - Any new benefit likely to be prescription drugs
- **Congressional Republicans are sending signals that they support using FEHBP, MSAs and other tax incentive proposals to assist the elderly and people with disabilities**

WHAT ARE THE PROBLEMS WITH THE LONG-TERM CARE SYSTEM

- **Little private insurance for long-term care**
 - The Kassebaum-Kennedy law provided important tax clarifications that have contributed to increased marketing and sales of private long-term insurance. However, few businesses offer policies, they remain expensive, and few people recognize the need for this insurance. Only 6 percent of the elderly and a very small percent of baby boomers have private long-term care insurance.
 - Even if every baby boomer who could afford private insurance purchased it, less than one-third of long-term care costs would be paid for by private insurance in 2030.
- **The financial and non-financial burden of long-term care can be devastating**
 - About \$25 billion was paid out-of-pocket on formal nursing home and about \$6 billion on home health care in 1996. Long-term care expenditures account for nearly half (44 percent) of all out-of-pocket health expenditures for Medicare beneficiaries.
 - In addition, a significant amount of long-term care is provided informally, by families and friends. One in three (52 million) Americans voluntarily provide unpaid informal care each year to one or more ill or disabled family members or friends.
- **Personal assistance and other types of home and community-based care are especially important to the 30 million working-age Americans with disabilities.**
 - Despite its institutional bias, Medicaid is the primary health insurer of personal assistance and other home and community-based services. However, in most cases, Medicaid does not cover people with disabilities earning more than about \$20,000/year.

OVERVIEW OF POLICY OPTIONS

- **Private long-term care insurance**
- **Tax incentives for the chronically ill, their caregivers and people with disabilities**
- **Public program options**

PRIVATE LONG-TERM CARE INSURANCE: NEW LONG-TERM CARE OFFERING FOR FEDERAL EMPLOYEES

- Legislation could give OPM the contracting authority to offer Federal active workers, annuitants, and spouses private long-term care insurance.
- Workers, not the Federal government, would pay the full cost. However, participants would have the advantage of lower prices, due to the large number of Federal employees, and assurance of high quality products. People could choose a:
 - “Core” policy, that includes the inflation protection, nonforfeiture protection (among others) and meets financial solvency tests, or an
 - “Enhanced” policy, that includes the core plus options like more generous nursing home coverage, a cash benefit, or adding a parent to the policy.
- Premiums would be based on the age of the insured. New employees could enroll when hired; retirees and spouses could enroll at any time with premiums based on health status.
- Rough estimates of participation would be about 300,000
- Cost: Roughly \$40 million in administrative costs over 5 years.

TAX CREDITS FOR PEOPLE WITH CHRONIC ILLNESS OR DISABILITIES OR THEIR CAREGIVERS

- **Credit to offset long-term care costs for the chronically ill or their caregivers**
 - Lower credit, broader definition of chronic illness: \$500 credit for people with cognitive impairment or chronic illness lasting more than 6 months that results in 2 or more activities of daily living (ADL) limitations or their caregivers. People receiving credit: 2.5 million. Cost: \$3.9 billion over 5 years
 - Higher credit, narrower definition of chronic illness: \$1,000 credit for people with chronic illness lasting more than 6 months that results in 3 or more ADL limitations or their caregivers. People receiving credit: 1.8 million. Cost: \$5.4 billion over 5 years
 - Disabled children (using a restrictive definition of “disabled”) could be added to the options above; this would cost \$400 million and \$700 million respectively.
 - Number of families with dependent receiving the credit could be broadened (e.g., give credit to all taxpayers who have chronically ill relatives living with them).
 - Could target to community-based people with chronic illness or disabilities
- **Credit for work-related expenses for people with disabilities**
 - Tax filers who are handicapped would receive a non-refundable credit of 50 percent of the first \$10,000 of impairment-related work expenses. People receiving credit: about 300,000. Cost: \$600 million over 5 years

PUBLIC PROGRAM OPTIONS

- **Return to work options for people with disabilities (Kennedy-Jeffords alternative)**
 - Medicaid buy-in option: Expand eligibility and provide incentive grants for states to take up this option that allows people with disabilities to buy into Medicaid. Costs: \$500 to 800 million over 5 years
 - Medicare extension: Pay Part A premium for people leaving the SSDI work program. Costs: \$300 million over 5 years
- **Policies to remove Medicaid institutional bias**
 - Allow states to use the “300 percent of SSI” rule for both nursing home residents and people using home and community-based care. Costs: \$500 million over 5 years
 - “Date certain”-like demonstration: Develop, test and evaluate a program for states to help people who live in nursing homes successfully transition to the community Costs: \$56 million over 5 years
 - “Bridge to Independence” grants: Fund a national technical assistance center and grants and awards to states to develop and test new community service models and promote state mentoring, with Indian set-asides. Costs: \$375 million over 5 years
- **Grants to provide support for people who provide informal long-term care**
 - National family caregiver support program: Grants to states to assist families who care for elderly relatives with 2 or more ADL limitations and/or severe cognitive impairment (e.g., provide information, arrange for respite services) Costs: \$750 million over 5 years

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

#	TAXPAYER ELIGIBLE	QUALIFYING PERSON W/ CHRONIC ILLNESS	QUALIFYING OF CAREGIVER	AMOUNT/ TYPE OF CREDIT	COMMENT
1	Person with chronic illness Caregiver of person w/ chronic illness	2 + ADLS for at least 90 days (certified) or mental impairment	Has a dependent who meets the dependency test minus the income cap of \$2,750	\$500 Partially refundable Phases out	Not linked to any type of LTC payments or service
2	Person with chronic illness Caregiver of person w/ chronic illness	3 + ADLS for at least 90 days (certified) or mental impairment Not institutionalized for over half the time when LTC is needed Provides LTC in home or community for qualifying person	Has a dependent who meets the dependency test minus the income cap of \$2,750 Provides LTC in home or community for qualifying person	\$1,000 Non-refundable Phases out	LTC is part of definition of who is eligible, not amount of credit
3	Person with chronic illness Caregiver of person w/ chronic illness	3 + ADLS for at least 90 days (certified) or mental impairment	Has a dependent who meets the dependency test minus the income cap of \$2,750	75% of costs of LTC services Credit capped at \$1,500 Non-refundable Phases out	Amount of credit is linked to LTC expenditures

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

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Sperling
Reed
Jennings
Bowles

Long-Term Care

THE WHITE HOUSE
WASHINGTON
August 31, 1998

THE PRESIDENT HAS SEEN
9/1/98

MEMORANDUM FOR THE PRESIDENT

FROM: PHILLIP CAPLAN *PC*

SUBJECT: Long-term care initiative

The attached Sperling/Reed/Jennings memo seeks your approval of a package of recommendations on a long-term care initiative. At your request, NEC/DPC ran a policy process to explore how such a package could be added to the Administration's tax cut package. The initiative would be fully paid for by postponing or modifying some of our tax cut proposals, or adding additional offsets.

All of your advisors agree on the components of the initiative, which include:

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outlined*

Long-term care tax credit: broad-based, non-refundable \$500 tax credit for people with long-term care needs (defined as those having two or more limitations, e.g. bathing, dressing, toileting, etc.), or for families who house and care for such relatives. The credit would be given on the basis of illness, rather than expenses, in order to capture people who receive unpaid long-term care and would help 3.4 million people and cost \$3.9 billion over five years. The memo includes a discussion of whether the credit should be (i) larger (\$1000) and cover less people, and/or (ii) refundable, but your advisors agree on the credit as outlined.

Tax credit for impairment-related work expenses for people with disabilities: \$5000 tax credit for personal and medical care expenses incurred at the workplace -- such expenses are often a precondition for the disabled to leave home for work.

Private long-term care insurance for federal workers: there would be no government contribution for this coverage, but OPM would set standards for the plans and sort them into benefit classes to facilitate informed choice. This would be viewed as a small but symbolic step.

Approve Disapprove Discuss

OK

Timing: There is a question of whether to announce this package in mid- to late-September, or to hold it for sometime later (NEC/DPC prefer to hold the \$5000 impairment-related tax credit component for the State of the Union). While announcing the package soon would put you in a leadership position on this issue, it could also generate momentum for the Republican tax cut efforts; Hill Democrats think that inaction on the tax cut front is a good thing at this point. The memo includes a lengthy discussion of whether to announce now or wait, but bottom line: your advisors will come back to you on the timing issue in a couple of weeks once they have a better sense of how it would play on the Hill.

THE WHITE HOUSE

WASHINGTON

August 11, 1998

THE PRESIDENT HAS SEEN

9/1/98

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MEMORANDUM FOR THE PRESIDENT

FROM: GENE SPERLING
BRUCE REED
CHRIS JENNINGS

SUBJECT: LONG-TERM CARE INITIATIVE

cc. THE VICE PRESIDENT, ERSKINE BOWLES, ROBERT RUBIN,
JACK LEW, SYLVIA MATTHEWS, JANET YELLEN, MARIA
ECHAVESTE, JOHN PODESTA, RON KLAIN, LARRY STEIN,
RAHM EMANUEL, PAUL BEGALA, ELENA KAGAN

Per your request, an interagency NEC/DPC process examined long-term care policy options, specifically how long-term care options could be added to our tax cut package. This memo summarizes our recommendations on both the best policy and the advisability of announcing such an initiative in August or September or waiting until the State of the Union.

We developed a long-term care initiative that both assists people who provide or pay for long-term care and encourages workers to purchase high-quality, private long-term care insurance. The centerpiece of the initiative is a broad-based, non-refundable tax credit for people with long-term care needs or for families who house and care for such relatives. The credit could help defray the costs of formal care (e.g., home health care) and informal care (e.g., assisting parents who are bed-ridden). Second, to complement the ongoing work of your Task Force on the Employment of Adults with Disabilities, we could introduce a tax credit of up to \$5,000 for impairment-related work expenses incurred by disabled individuals. Third, we could announce support for offering private long-term care insurance to Federal employees, which would have virtually no costs and bipartisan support. The long-term care tax options cost a total of \$4 billion over 5 years and \$14 billion over 10 years, and would be fully funded by savings from postponing or modifying our budget revenue proposals, plus a few offsets that were in the Senate IRS bill, but that were not included in the final bill, or in your FY 1998 budget.

The timing of an announcement of a long-term care initiative in a modified tax package depends on a number of factors that will be discussed later in the memo.

BACKGROUND

This policy initiative is motivated by an interest to address long-term care and issues facing the chronically ill, particularly the elderly.

Unlike Social Security and Medicare, long-term care has received little attention. Republicans have begun to raise policy options (e.g., MSAs for long-term care in their Patient Protection Act), but not aggressively. Along with the lack of coverage of prescription drugs, the poor coverage of long-term care represents a major concern for the elderly and their families. Medicare pays for only a limited amount of long-term care, and private insurance even less -- only 10 percent of home health care and 5 percent of nursing home care. As a result, long-term care costs account for nearly half of all out-of-pocket health expenditures for Medicare beneficiaries.

Concern about long-term care costs is not limited to the elderly and people with disabilities. Their children, other relatives and friends provide a large amount of formal and informal long-term care. According to an HHS study that has not yet been released, one in three Americans voluntarily provide some unpaid informal care to an ill or disabled family member or friend. Over 90 percent of people with three or more limitations in activities of daily living (ADLs) living in the community receive some kind of informal care, most often from a spouse or relative. This means that middle-class families may find themselves caring both for their parents and their children.

A second motivation for this initiative is to make our targeted tax cut package include a more progressive, senior-focused tax option. Most people with long-term care needs have lower incomes. For example, the poverty rate for the elderly with two or more limitations in ADLs is twice as high as the rate for all elderly.

POLICIES

The proposed long-term care initiative would consist of three policies: two new tax credits plus offering quality private long-term care insurance to federal workers. Savings to pay for this initiative would come from new offsets and savings from postponing or modifying our existing tax cut proposals.

1. Long-term care tax credit

The centerpiece of the long-term care initiative would be a tax credit for people with long-term care needs or the families who house and care for such relatives. A \$500, non-refundable credit would cost \$3.9 billion over 5 years and \$12.4 billion over 10 years (according to preliminary Treasury estimates) and would help a total of 3.4 million chronically ill individuals (described below). People with long-term care needs are defined as having two or more limitations in ADLs (bathing, dressing, eating, toileting, transferring and incontinence management) lasting for longer than six months or severe cognitive impairment, as certified by a doctor. Virtually all people who meet these criteria need some type of long-term care. The credit would be given on

the basis of illness rather than expenses because, otherwise, it would not help people who receive unpaid long-term care. For example, a wife who cares for her husband herself rather than paying someone to do it would not receive a credit if it were based on receipts for long-term care expenses. This approach is also easier to administer than alternatives. About 1.7 million chronically ill individuals would directly get this credit on their own tax returns.

Certain families with "dependents" with long-term care needs could also receive the credit. Under current law, adults can be claimed by tax filers as dependents if they are related, have very low income, and receive at least half of their support from the tax payer (among other criteria). Adult dependents are generally not required to file tax returns themselves. For the purpose of this credit, we would broaden the definition of a "dependent" to include a person who needs long-term care (described above), lives with the family member, and generally does not have any income tax liability. Because by definition they live in the community, dependents are rarely nursing home residents. Simply stated, this allows families (other than spouses) who house and care for relatives needing long-term care to apply for the credit on their behalf. This improves the ability of the credit to help people who do not have enough income to file tax returns, although it does not help the elderly with no tax liability living alone or outside of their relatives' homes. Another 1.7 million families would get the credit in this way.

Over half of the chronically ill individuals benefiting from this credit are elderly, since the need for long-term care increases with age. Preliminary conversations with aging advocates suggest that this tax credit would be well received. However, private long-term care insurers could oppose the credit for fear that it will decrease interest in insurance since people may think that the credit protects them against long-term care costs.

Key Issues

Should the credit be refundable? A large proportion of people with long-term care needs are low-income and do not have tax liability. Refundability could improve the effectiveness of this policy at reaching its target population.

Pro:

- An additional several hundred thousand people would benefit from the credit if it were refundable, and, for those with a low tax liability, they would get the full amount of the credit.

Cons:

- It adds complexity to the policy because it creates a need to exclude certain groups. A large number of non-filers with long-term care needs are already receiving assistance through SSI and Medicaid if in a nursing home. Because a refundable credit would count against their eligibility for these programs, it makes sense to exclude them from the credit. However, this would be difficult, administratively and politically.
- It could jeopardize the initiative. Although we have been successful in our support for

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the refundability of the E.I.T.C. despite the strong Republican opposition, adding another refundable credit could risk the passage of the initiative and potentially undermine support for existing refundable credits as well.

- This proposal, as a refundable credit, may not be administrable at acceptable levels of compliance and intrusiveness.

Should we give a larger credit to few people or a smaller credit to more people? If we make the definition of needing long-term care stricter (i.e., three or more ADL limitations as opposed to two), fewer people would be eligible but we could increase the credit amount within the budget constraints.

Pros:

- Raising the credit amount to \$1,000 would make the amount more meaningful. For example, it is enough to purchase a few hours of respite care per week.
- Eligibility based on two or more limitations in ADLs could be more subject to fraud, since it is a less strict standard.

Con:

- Even with \$500 credit and the broader definition of needing long-term care, the policy helps a subset of the people who need long-term care or their families. According to one estimate, about 50 million Americans provide some type of informal long-term care to family and friends.
- Because most people meeting the stricter definition (three plus limitations in ADLs) are ill enough to require institutionalization, even a \$1,000 may be perceived as being too small relative to the larger costs incurred by these people and their family.

*Business
of 1995
from 1991
Revised*

2. Tax credit for impairment-related work expenses for people with disabilities

To complement the work of the Task Force on Employment of Adults with Disabilities, people with disabilities could receive a new tax credit of up to \$5,000 for their impairment-related work expenses. This credit could be used to offset expenses for personal care in the workplace, for example, which is often a pre-condition for leaving home for work. A similar credit was in the Health Security Act and a Republican "return-to-work" proposal this year. It costs about \$500 million over 5 years, \$1.2 billion over 10 years, and helps about 300,000.

Key Issue

Should this credit remain as part of the long-term care initiative or be saved for a separate announcement? Although this credit can be considered a long-term care policy, it also fits in the context of return-to-work policies for people with disabilities and could be announced by itself or in the State of the Union.

THE PRESIDENT HAS BEEN

9/1/98

Pro:

- Omission of a policy for people with disabilities within a long-term care initiative would be noticed. There is a heightened attention to disability issues both in Congress and the community, and especially close attention is being paid to Administration actions. Even the aging advocates support including people with disabilities to avoid this criticism.

Cons:

- The disability community seems happy with the Administration's work on the Jeffords-Kennedy legislation, so that an additional policy at this point may not be needed.
- Since we do not exclude people under age 65 from the long-term care tax credit, we would be helping people with more severe disabilities even if we dropped this specific credit. The overlap between the two credits, however, may be low.

3. Offering private long-term care insurance to Federal workers

The third piece of the initiative is the small but symbolic non-tax option to offer Federal employees and annuitants a range of high-quality private long-term care insurance policies. There would be no Federal contribution for this coverage, but Office of Personnel Management (OPM) would set standards for the plans and sort them into benefit classes (e.g., "core" policy plus several types of "enhanced" policies) to facilitate informed choice. A seriously flawed bill to allow a open-ended long-term care insurance option was introduced by Representative Mica (R-FL) last week. Democratic members of the Civil Service Subcommittee, plus some Republicans (e.g., Connie Morrella), have expressed interest in a substitute. Proposing an alternative would add to our series of policies for Federal workers that demonstrates our leadership as a responsible employer.

Key Issues. None on policy grounds, although it is not a tax policy like the others. However, your advisors recommend that we act on this as soon as possible to preempt the Republicans from claiming the policy.

4. Offsets

This long-term care initiative would cost about \$4 billion over 5 years and \$14 billion over 10 years. It could be offset by modifying our existing tax package and adding a few new policies. First, we would postpone the effective date of our proposed tax initiatives until January 1, 2000. Given the Year 2000 problem, we would probably have to do so regardless. Second, we would scale back the child and dependent care credit (make it a 40 percent credit as opposed to 50 percent and slow the phase-down). Third, we would add two new policies that were in the Senate IRS package, but weren't included in the final bill and that were in your FY 1998 budget. The first is to modify the Foreign Tax Credit carryover rules; the second is to reform the treatment of Foreign Oil and Gas Income and dual capacity taxpayers.

THE PRESIDENT HAS SEEN
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Key Issues. None on policy grounds, although like any offsets, they are not universally liked.

RECOMMENDATIONS. Your advisors (Chief of Staff, Office of the Vice President, NEC, DPC, CEA, Legislative Affairs, Treasury and OMB) generally agree on all of the components of this long-term care initiative. On the issue of refundability of the long-term care tax credit, we recommend against it. In particular, NEC, DPC Treasury and Legislative Affairs fear that making the credit refundable could spur an overall attack against refundability and jeopardize the gains that we have made on the E.I.T.C. It does, however, leave us somewhat vulnerable to criticisms that it is regressive. We suggest responding to this concern by stating that we are willing to work with Congress to make this credit more progressive. There is also agreement choose a broader definition of eligibility (two plus limitations in ADLs) even though we would have to lower the credit to make it affordable. This could help broaden the base of support for the initiative. Finally, even though the credit for people with disabilities could be part of the long-term care package, we recommend making it a separate announcement. NEC/DPC think that this credit might be best announced in the State of the Union, since it is likely to be recommended by the Task Force's November report and such an announcement would be viewed as acting on that recommendation.

Long-term care tax credit:

- Include refundable credit
- Include non-refundable credit (RECOMMENDED)
- Do not include in the package

Tax credit for impairment-related expenses for people with disabilities:

- Include tax credit for people with disabilities
- Do not include in the package (RECOMMENDED)

Offering private long-term care insurance to federal employees:

- Include in package (RECOMMENDED)
- Do not include in the package

Discuss some or all options further

ISSUES RELATED TO THE TIMING OF AN ANNOUNCEMENT

Assuming that the long-term care initiative and modified tax cut package are acceptable on policy grounds, the next question is about timing of an announcement. The following outlines the pros and cons of announcing this initiative in August or early September.

Pros:

- **Secures ownership of the long-term care issue.** A strong, affirmative long-term care message would not only be popular amongst the elderly, people with disabilities and most

advocacy groups, but it would probably be well received by validators who think that this is the great, untouched baby-boom issue. This could complement and affirm your leadership on major, societal issues facing the country in the next century.

- **Provides an alternative to private long-term care insurance and MSAs as the only solution to the problem.** In September, the Republicans will probably take up the Mica federal employees' private long-term care insurance proposal and the Senate Patient Bill of Rights legislation that expands MSAs to include long-term care expenses. The mainstream advocates are concerned about the singular focus on private long-term care insurance and MSAs, since they will not come close to covering the costs of long-term care. Even the insurance industry, in its most optimistic projections, does not foresee that private insurance will cover even half of long-term care costs in thirty years. However, in the absence of alternatives, some may feel some pressure to support the Republicans' proposals.
- **Confirms our support for responsible tax cuts.** Presenting a tax cut package with explicit offsets would reaffirm that we support tax cuts, so long as they are paid for. As such, it could complement our Save Social Security First message. These credits also are attractive alternatives to some of the Republican proposals, since they focus on the elderly and people with disabilities who have lower income.

Cons:

- **Could provide impetus for an unacceptable tax cut this year.** The proposal would come at a time when Congressional Democrats, especially in the House, see the Social Security First message as strong and simple. They would probably perceive a new tax package as clouding that message. Also, Gingrich has been musing about settling for a tax cut this year of \$70 billion or even less, so that our announcement of a revised tax package of about \$30 billion could be read as a sign that we are willing to deal with the Republicans on their tax package in September and make our rule of not using the surplus less clear as well. Finally, given that our revenue raising provisions are unpopular on the Hill, an announcement with an attractive set of options could increase the chances of a tax cut that taps the surplus.
- **Democrats may prefer marriage penalty regardless.** The new package could have somewhat limited value for Congressional Democrats because it does not include marriage penalty relief, which is their main concern.
- **May appear political and not receive the attention and validation that it deserves.** Since it is unusual to propose policies with budget implications outside of the State of the Union and Budget process, the timing of the announcement, rather than the substance of it, may be what the press focuses on.

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RECOMMENDATIONS. Your advisors generally do not recommend an August or early September announcement. The importance of this initiative to your overall policy agenda would probably be obscured by a media focused on the timing. Moreover, Republicans could seize on the announcement to generate momentum in September for their tax package or one that uses the surplus. It appears, at this point, that Democrats think that inaction on the tax front is a good outcome for them.

~~However, we think that the question of timing should be revisited in mid-September.~~ At that point, we will have a better sense of the potential ramifications of the announcement for Congress. We can also assess when and how we can make this announcement so it clearly gets the attention it deserves and puts you in a leadership role on this important issue.

- Announce in August or early September
- Revisit timing decision in mid-September (RECOMMENDED)
- Discuss further