

## **PRESIDENT CLINTON'S LONG-TERM CARE AND DISABILITY EMPOWERMENT**

### **HEALTH CARE AGENDA**

#### **\$6.3 Billion Long-Term Care Initiative, includes:**

- \* \$5.5 billion \$1,000 Tax Credit for Chronically-Ill/Disabled of All Ages OR their Caregivers
- \* \$625 million Older Americans Act Caregiver Support Program
- \* \$110 million State Option to Eliminate Current Medicaid Institutional Bias (and allow home and community options to be expanded to nursing home coverage levels -- 300 percent of SSI limits)
- \* Medicare Long-Term Care Education Campaign to make beneficiaries aware of private and public long-term care options and limitations of Medicare coverage

#### **\$3.1 Billion Disability Empowerment Initiative, includes:**

- \* \$1.2 billion For Bipartisan Jeffords/Kennedy/Moynihan/Roth Work Incentives Improvement Act, which provides incentives for states to allow disabled workers to buy into the Medicaid program and permits continue Medicare eligibility.
- \* \$700 million \$1,000 tax credit for Work-Related Expenses.
- \* \$1.2 billion reg which increases the amount of money disabled workers can earn without losing SSDI/SSI benefits.

**VICE PRESIDENT GORE UNVEILS NEW INITIATIVE TO HELP OLDER AMERICANS  
ACCESS QUALITY HOUSING AND SERVICES TO REMAIN  
IN THEIR COMMUNITIES**

**January 21, 1999**

Today, at a forum on long-term care in Tampa, Florida, Vice President Gore is unveiling a new initiative to help older Americans and people with disabilities access quality home and community based services. This two-pronged initiative would eliminate Medicaid's current institutional bias for long-term care and would provide for a new multi-faceted approach to long-term care in the nation's public housing programs. This proposals to help older Americans get the home and community-based services they need, build on the Administration's historic long-term care initiative, which the President and Vice President announced earlier this month.

**More and more Americans need support and services to remain in their communities.** As the President pointed out this week in his State of the Union Address, the need for quality home and community-based care will only grow as the number of Americans age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of Americans aged 85 years or older, nearly half of whom need assistance with everyday activities, will grow even faster (from 4.0 to 8.4 million). Building on the Administration's long-term care initiative, the Vice President announced:

**A new proposal to enable states to expand home- and community-based care to the same income levels as for nursing homes.** Historically, Medicaid policy and practice has inadvertently discriminated against people with long-term care needs who want to live in the community by making it much easier to expand coverage to nursing homes than community-based services. To eliminate this "institutional bias," this new proposal would enable states to expand their programs to cover community-based care as well as nursing home residents with income up to 300 percent of the Social Security Income (SSI) limits, without requiring a complicated and frequently time-consuming Federal waiver. This proposal provides another incentive to enable families with long-term care needs stay in the community. It costs \$110 million over five years and is paid for in the Administration's balanced budget.

**A new multi-faceted housing initiative that restructures and modernizes public housing for the elderly by providing a wide range of services that meets the unique and varying needs of older Americans.** This \$750 million elderly housing initiative offers a range of options that meet the changing needs of the older Americans. It includes:

- A continued commitment to new construction to provide low-income seniors quality affordable housing through the highly successful Section 202 Supportive Housing for the Elderly Program.
- New efforts to help older Americans remain in their communities through assisted living facilities. For the first time, this funding enables some of the new construction to convert some or all of current 202 housing through competitive grants to assisted living facilities that many older Americans need to stay in their communities.
- New health care partnerships to assure older Americans get the services they need. To assure that older Americans get adequate services and health care in assisted living facilities, new competitive grants to are available to facilities that get a new Medicaid waiver to provide home and community-based services for Medicaid-eligible residents. This new innovative partnership will help assure that residents get the health care and services that they need to remain relatively

independent and autonomous in their communities.

- Intergenerational Learning centers. To help assure that seniors remain connected to communities, funds may be used to allow assisted living facilities build leaning centers where seniors can provide affordable child care to families or other service to their communities. This model approach is designed to ensure that older Americans can remain connected to their communities and make valuable contributions -- through sharing their skills, knowledge and energy.
- New housing vouchers: In addition, a new \$90 million to provide 15,000 housing vouchers through mandatory funding that enable seniors to choose for themselves where they want to live.

**BUILDS ON THE ADMINISTRATION'S NEW INITIATIVE TO SUPPORT AMERICANS WITH LONG-TERM CARE NEEDS AND THOSE WHO CARE FOR THEM.** This new initiative the Vice President unveiled today builds on the Administration's historic four-part, \$6.2 billion long-term care initiative that takes important steps to address complex long-term care needs through:

- (1) an unprecedented \$1,000 tax credit that compensates for formal or informal costs Americans of all ages with long-term care needs or the family caregivers who support them;
- (2) a new National Family Caregivers Support Program that provides a range of critical services for caregivers such as respite, home care services, and information and referral;
- (3) a national campaign to educate Medicare beneficiaries about the programs' limited coverage and how best to evaluate long-term care options; and
- (4) a proposal to have the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees at group rates.

770.9994

# OFFICE OF MANAGEMENT AND BUDGET

*Legislative Reference Division  
Labor-Welfare-Personnel Branch*

## Telecopier Transmittal Sheet



FROM: Bob Pellicci -- 395-4871

DATE: 1/6/99 TIME: 4 P.M.

Pages sent (including transmittal sheet): 14

COMMENTS:

*FINAL - OPM draft bill on  
LTC for Federal employees.*

TO:

*Dan Mendelson  
Chris Jennings / Jeanne Lambrew*

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.



**UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT**

WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

JAN 6 1999

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

Dear Mr. President:

The Office of Personnel Management (OPM) submits the enclosed legislative proposal entitled the "Federal Employees Group Long-Term Care Insurance Act of 1999." This proposal would authorize OPM to purchase a policy or policies from one or more qualified private-sector contractors to make long-term care insurance available to Federal employees and retirees, and family members whom OPM defines as eligible, at group rates. Coverage would be paid for entirely by those who elect it.

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

The Administration also has a more general interest in the development of a long-term care insurance program for Federal employees. At present, Medicare and supplemental Medigap insurance provide extremely limited coverage of long-term care services. Medicaid covers nursing home and some community-based services only if a person meets very low eligibility thresholds for income and assets.

Since 1995, OPM and the Department of Health and Human Services have been engaging in cooperative research on long-term care insurance products and employer-sponsored programs. Responses to questions in a 1997 OPM survey indicated there is significant interest in such protection among Federal employees. On March 26, 1998, we discussed our findings at a hearing before the House Subcommittee on Civil Service during which there was substantial support for introducing Government-sponsored group long-term care insurance, on an employee-pay-all basis. This is consistent with general practice among other employers who offer this benefit.

Honorable Albert Gore, Jr.

2

From a pool of qualified carriers, OPM will select a single or a very small number of carriers based on quality, service and price to offer a high-quality benefits package to eligible participants. This benefits package will be consistent with the most recent National Association of Insurance Commissioners standards. OPM will be open to various financing arrangements proposed by the carrier(s), such as the use of consortia or reinsurance arrangements to ensure the financial stability of the program. Our proposal would allow OPM broad flexibility to determine appropriate benefits and to contract competitively for benefits with one or more private carriers, without regard to section 5 of title 41, United States Code, or any law requiring competitive bidding. OPM needs the flexibility to capitalize on complex market factors to procure the best value for Federal enrollees. OPM will ensure that resulting contracts are awarded on the basis of contractor qualifications, price, and reasonable competition to the maximum extent practicable. Qualified carriers shall: (A) be licensed to do business in all States and the District of Columbia to offer long-term care insurance; (B) agree to provide coverage for all eligible enrollees consistent with requirements for qualified long-term care insurance contracts and issuers enacted under subtitle C of Title III of the HIPAA; (C) propose rates which in OPM's judgment reasonably reflect the cost of benefits provided; (D) maintain funds associated with the Federal employee contract separate and apart from the carriers' other funds; and (E) agree to carry all risk. The contract or contracts would be for a duration of 5 years, unless terminated earlier by OPM. OPM will issue regulations to provide for opportunities to enroll and benefit portability. With this statutory and regulatory authority, OPM will have the flexibility needed to administer the program as the market for long-term care services and protection evolves over time.

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

OPM will be responsible for the administrative costs of the program, which we estimate to be \$15 million over a 5-year period. Initial year costs include developing and implementing a program to educate employees about long-term care insurance, procuring a contract or contracts, and validating the reasonableness of rate proposals. Employee and annuitant premiums would be withheld from salary or annuity and transmitted directly to respective contractors, and those enrollees could also elect withholdings for coverage of their spouses.

Any eligible enrollees shall, at the discretion of OPM, submit premiums directly to the appropriate contractor. As with the Federal Employees Health Benefits Program, the bill would require participating contractors to provide benefits when OPM finds the individual is entitled to

Honorable Albert Gore, Jr.

3

benefits under the terms of the contract. Participating carriers would be required to reimburse OPM's expenses for adjudicating claims disputes.

OPM's proposal reflects or is slightly ahead of predominant practices among medium and large-sized employers and is consistent with Federal law and State Insurance Commissioners' requirements and guidelines for long-term care insurance products. The proposal would provide a substantial benefit to Federal employees and retirees by providing access to quality long-term care insurance products at cost-saving, group premiums. OPM views this proposal as part of our ongoing efforts to improve the package of benefits offered to Federal employees to meet the changing needs of our workforce. Accordingly, OPM urges Congress to give this proposal early consideration.

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

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

Sincerely,



Janice R. Lachance  
Director

Enclosures

**A BILL**

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

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

**Section 1. Short Title**

This Act may be cited as the "Federal Employees Group Long-Term Care Insurance Act of 1999".

**Section 2. Long-Term Care Insurance**

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

**"Chapter 90—Long-Term Care Insurance**

"Sec.

"9001. Definitions.

"9002. Contracting authority.

"9003. Minimum standards for contractors.

"9004. Long-term care benefits.

"9005. Financing.

"9006. Preemption.

"9007. Studies, reports, and audits.

"9008. Claims for benefits.

"9009. Jurisdiction of courts.

"9010. Regulations.

"9011. Authorization of appropriations.

**"§ 9001. Definitions**

"For the purpose of this chapter—

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

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

-2-

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

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

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

“(5) ‘qualified carrier’ means an insurer licensed to do business in each of the States and meeting the requirements of a qualified insurer in each of the States;

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

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

**“§ 9002. Contracting authority**

“(a) The Office may, without regard to section 5 of title 41 or any other statute requiring competitive bidding, purchase from one or more qualified carriers a policy or policies of group long-term care insurance to provide benefits as specified by this chapter. The Office, however, shall ensure that each resulting contract is awarded on the basis of contractor qualifications, price, and reasonable competition to the maximum extent practicable.

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

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

“(d) Premium rates charged under a contract entered into under this section shall

-3-

reasonably reflect the cost of the benefits provided under that contract as determined by the Office.

“(e) The coverage and benefits made available to individuals under a contract entered into under this section are guaranteed to be renewable and may not be canceled by the carrier except for nonpayment of premium.

“(f) The Office may, based on open season participation rates, the composition of the risk pool, or both, withdraw the product.

**“§ 9003. Minimum standards for contractors**

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

“(1) be licensed as an insurance company and approved to issue group long-term care insurance in all States and to do business in each of the States; and

“(2) be in compliance with the requirements imposed on issuers of qualified long-term care contracts by section 4980C of the Internal Revenue Code of 1986.

**“§ 9004. Long-Term Care Benefits**

“The benefits provided under this chapter shall be long-term care benefits which, at a minimum, shall be compliant with the most recent standards recommended by the National Association of Insurance Commissioners.

**“§ 9005. Financing**

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

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

-4-

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

“(d) An employee, annuitant, or other eligible individual, whose pay or annuity is insufficient to cover the withholdings required for enrollment, shall, at the discretion of the Office, pay the premium for enrollment directly to the carrier.

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

“(f) The costs of the Office in adjudicating a claims dispute under section 9008, including costs related to an inquiry not culminating in a dispute, shall be reimbursed by the carrier involved in the dispute or inquiry. Such funds shall be available to the Office for the administration of this chapter.

#### “§ 9006. Preemption

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

“(1) the provisions of this chapter; or

“(2) after consultation with the National Association of Insurance Commissioners, the efficient provision of a nationwide long-term care insurance program for Federal employees.

#### “§ 9007. Studies, reports, and audits

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

“(1) furnish such reasonable reports as the Office determines to be necessary to

enable it to carry out its functions under this chapter; and

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

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

**"§ 9008. Claims for benefits**

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

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

"(c)(1) Except as provided in paragraph (2), benefits payable under this chapter for any reimbursable cost incurred or service provided are secondary to any other benefit payable for such cost or service. No payment may be made where there is no legal obligation for such payment.

"(2) Benefits payable under the following programs shall be secondary to benefits payable under this chapter:

"(A) the program of medical assistance under title XIX of the Social Security Act; and

"(B) any other Federal or State programs that the Office may specify in regulations that provide health benefit coverage designed to be secondary to other insurance coverage.

**“§ 9009. Jurisdiction of courts**

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

**“§ 9010. Regulations**

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

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

“(c) The Office may not exclude—

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

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

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

**“§ 9011. Authorization of appropriations**

“There are authorized to be appropriated such sums as may be necessary for the purposes of carrying out sections 9002, and 9010.”

**Section 3. Effective Date**

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

## SECTION-BY-SECTION ANALYSIS

To accompany a draft bill

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

The first section of the bill titles the bill as the "Federal Employees Group Long-Term Care Insurance Act of 1999."

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

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

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

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

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

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

"Qualified carrier" is defined as an insurer who is licensed to do business in each of the States and who meets the requirements of a qualified insurer in each of the States.

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

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

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

In subsection (a), the Office is authorized to purchase from one or more qualified carriers a policy or policies of group long-term care insurance to provide the benefits specified by this chapter, and to do so without regard to section 5 of title 41 or any other statute requiring competitive bidding. The Office, however, will ensure that resulting contracts are awarded on the basis of contractor qualifications, price, and reasonable competition to the maximum extent practicable.

Subsection (b) allows the Office to design a benefits package or packages and negotiate final

-2-

offerings with qualified carriers. The Office will examine the reasonableness of the underlying assumptions that generate the premium rates, but the Government will not assume any underwriting liability.

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

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

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

Subsection (f) authorizes the Office to withdraw the product, based on open season participation rates, the composition of the risk pool, or both.

New section 9003 specifies the minimum standards for contractors. It provides that, in order to be a qualified contractor under this chapter, a company is required, at a minimum, to be licensed as an insurance company and approved to issue group long-term care insurance in all States and to do business in each of the States, and be in compliance with the requirements imposed on issuers of qualified long-term care contracts by section 4980C of the Internal Revenue Code of 1986.

New section 9004 specifies that the benefits provided under this chapter are required to be compliant with the most recent standards recommended by the National Association of Insurance Commissioners.

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

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

Subsection (f) requires the reimbursement of the costs of the Office in adjudicating a claims dispute under new section 9008, including costs related to an inquiry not culminating in a dispute, by the carrier involved in the dispute or inquiry. It makes such funds available to the

-3-

Office for the administration of this chapter.

New section 9006 provides for the preemption of State or local law by specifying that the provisions of this chapter preempt any such law which the Office determines is either inconsistent with the provisions of this chapter or, after consultation with the National Association of Insurance Commissioners, inconsistent with the efficient provision of a nationwide long-term care insurance program for Federal employees.

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

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

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

New section 9008 addresses claims for benefits under this chapter.

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

Subsection (b) requires the Office to adjudicate a claims dispute arising under this chapter and to mandate that the contractor pay for any benefit or provide any service the Office determines appropriate under the applicable contract. The Office will regulate the adjudication procedures and incorporate them into carrier contracts.

Subsection (c) provides, in paragraph (1), that, except as provided in paragraph (2), benefits payable under this chapter for any reimbursable cost incurred or service provided are secondary to any other benefit payable, e.g., workers' compensation, liability or no-fault insurance, for such cost or service. It also bars payment where no legal obligation exists under the terms of the contract.

Paragraph (2) of that subsection specifies exceptions to the policy in paragraph (1) so that benefits payable under the program of medical assistance under title XIX of the Social Security Act and under any other Federal or State programs specified by the Office in regulations as being designed to provide health benefit coverage which is secondary to other insurance coverage shall be secondary to benefits payable under this chapter.

-4-

New section 9009 establishes the jurisdiction of courts by authorizing a claimant under this chapter to file suit against the carrier of the long-term care insurance policy covering the claimant in the district courts of the United States, but only after exhausting all administrative remedies available to the claimant. The administrative procedures will be specified by regulation.

New section 9010 requires the Office, in subsection (a), to prescribe regulations necessary to carry out this chapter.

Subsection (b) authorizes the Office to prescribe in its regulations the time at which and the conditions, e.g., pay and duty status requirements, under which an eligible individual may enroll in the Program.

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

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

New section 9011 authorizes the appropriation of such sums as may be necessary for the purposes of carrying out the provisions of new sections 9002, and 9010. This section will provide funds for both the start-up costs and the ongoing administrative expenses of the Program.

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

PHOTOCOPY  
PRESERVATION

**FEDERAL DIARY**

Mike Causey

## The Year for Long-Term Care

**T**he Clinton administration soon will ask Congress to approve a long-term-care group rate plan for federal workers, retirees and family members. Rep. **John L. Mica** (R-Fla.) first proposed a federal long-term-care program last year. But it died because of political and philosophical differences over how much—or how little—control government would have over premiums and benefits.

Passage of some kind of long-term-care plan aimed at members of the federal family is more likely this year. That's because of increased pressure from federal workers and retirees, who want the group rate coverage, and the new White House initiative to provide tax credits to people with severe disabilities or disease or to those who take care of them.

A draft copy of long-term-care legislation drawn up by the Office of Personnel Management indicates that, if approved, it would work like this:

- The long-term-care option would be part of a much broader administration effort to achieve a "modern, performance-oriented compensation system" that includes fringe benefits including various kinds of insurance. That "total compensation" concept will be developed over the next couple of years presumably, with long-term care as the first step. Eventually, government workers' salaries would be based on a comparison of the total value of the benefits packages—not just straight salaries—of comparable jobs in the private sector.

- The Office of Personnel Management—which handles the federal retirement, health and life insurance programs—would run the long-term-care program.

- OPM would select up to three plans "based on quality, service and price to offer a single benefits package to eligible participants" in the federal employee-retiree long-term-care program.

- Workers and retirees, and eligible family members, would pay the entire cost of their long-term-care premiums.

- Premiums would be withheld from employee paychecks or retiree annuity checks. Federal workers and retirees might be able to have premiums of an eligible relative withheld from their federal checks.

- Plans chosen to participate in the federal employee-retiree long-term-care program would have to be licensed in every state, set rates approved

- Long-term care would be available to all federal workers and retirees as well as spouses or former spouses (if entitled to a civil service spousal or survivor annuity) and to parents and parents-in-law of feds.

- Premiums would be based on age at the time of enrollment. Although many younger, healthy people can buy long-term care now—at relatively low premiums—from private firms, older people or those with serious illnesses often can't afford the much higher premiums charged by long-term-care plans. OPM estimates workers or retirees would pay on average 15 to 20 percent less than if they bought individual coverage.

Long-term care is designed to fill in the gaps and pay for coverage not provided by regular health insurance. For instance, Medicare and many supplemental Medigap policies provide very limited long-term-care services. Medicaid covers nursing home and community-based services only if an individual meets near-poverty standards.

National Association of Retired Federal Employees President **Frank G. Atwater** said yesterday that long-term-care coverage for federal workers and retirees is long overdue and that the administration plan "is a step in the right direction."

Given the new emphasis on long-term care, it is no longer a question of if U.S. workers and retirees will get it, but rather when and in what form.

### Career Fair

The Agricultural Research Service will have a job fair tomorrow at 5601 Sunnyside Ave., Beltsville. Openings are for clerical and administrative staff, computer specialists and research scientists and technicians. Hours are 11 a.m. to 7 p.m., with the 5 to 7 p.m. time period reserved for current federal employees. If you don't work for Uncle Sam but would like to, get there early. For details, call 301-504-1482.

### Leave Chart

The 1999 federal employee leave chart ran in this space Monday.

But Geico is offering a free copy of its 1999 leave card to anyone calling 1-800-522-4688. The computer minded can go to the federal program

LTC event  
F/U

PHOTOCOPY  
PRESERVATION

# Parties Vie to Dominate Long-Term Care Issue

## Clinton Budget to Propose \$1,000 Tax Credit

By AMY GOLDSTEIN  
Washington Post Staff Writer

President Clinton's proposal to give tax credits and other assistance to patients who require long-term care highlights a corner of the health care system that Democrats and Republicans alike view as a trouble spot, touching off a partisan race to dominate an issue both parties hope will have broad public appeal.

Congressional Republicans were swift to praise Clinton for drawing attention to the burdens on patients with long-term illnesses—and on the relatives who take care of them at home—but portrayed the initiative as a reprise of GOP measures that the White House rebuffed a few years ago.

White House officials countered that the president's four-prong initiative, which would cost \$6.2 billion over the next five years, would provide greater financial relief than Republicans had sought to provide and would reach more people.

Yet on the day that Clinton unveiled the initiative, the largest new domestic program in the fiscal 2000 budget he will propose, members of both parties interpreted the jockeying for credit as a harbinger of its eventual success on Capitol Hill.

"It was a good idea then. It's a good idea now," said Rep. Bill Thomas (R-Calif.) chairman of the House Ways and Means health subcommittee. He and other leading Republicans, however, urged the White House to embrace longstanding GOP ideas to use the tax code to help Americans buy insurance policies covering long-term care or set aside savings for such care. And they said the initiative was less likely to attract GOP support if it required tax increases.

Nevertheless, Sen. Charles E. Grassley (R-Iowa), chairman of the Senate Special Committee on Aging, said Clinton "is promoting concepts that I would basically agree with."

Democratic leaders on Capitol Hill also suggested they would support the proposal.

In outlining his ideas at a White House ceremony yesterday, Clinton said the growing number of elderly Americans is "one of the central challenges of the coming century. . . . We must use this time now to do everything in our power not only to lift the quality of life and the security of the aged and disabled today . . . but to make sure that we do not impose that intolerable burden on our children."

Specifically, the White House is proposing a four-prong effort aimed at the 5

million Americans, three-fifths of them living outside nursing homes, who are unable to care for themselves because they have such conditions as Alzheimer's disease, stroke and severe physical disabilities.

The heart of the initiative is a \$1,000 tax credit, which the administration estimates 2 million people will claim at a cost of \$5.5 billion over five years. Either patients or the relatives on whom they depend would be eligible for the credit. The full credits would be available to single people with incomes up to \$75,000, couples with incomes up to \$110,000 and married people who file separate returns and have incomes up to \$55,000.

The Republican-backed tax credits, part of the House GOP "Contract With America," would have provided \$500 tax credits to people responsible for parents or grandparents unable to care for themselves.

The White House proposal devotes \$625 million over the next five years to provide various kinds of assistance to an estimated 250,000 family care-givers. And it includes \$15 million over five years to help about 300,000 federal workers who want to purchase long-term care insurance to locate lower-priced policies. In addition, the agency that runs Medicare, the federal health insurance program for the elderly, would be given \$10 million to teach beneficiaries that the program does not pay for long-term care and to help them learn where they might find help.

The initiative was lauded by many health care lobbyists. Some support came from constituencies such as nursing homes that would not benefit from most of its provisions but hope it will stimulate a broader discussion of financing long-term care. "I think there's going to be a beneficial ripple effect across the board," said Paul R. Willging, president of the American Health Care Association.

"Who can oppose giving help to families caring for seriously disabled loved ones? You'd really be a Grinch if you weren't going to support it," said John Rother, chief lobbyist for the AARP, who said the proposal appeared to draw a warmer initial reception on Capitol Hill than a Clinton initiative last year that would have allowed younger Americans to join Medicare.

"It's not a bad thing to have people claiming credit on both sides of the aisle for thinking of it," Rother said. "We'd be happy to give credit to each as long as they worked together to get it done."

# A small but useful start on providing long-term care

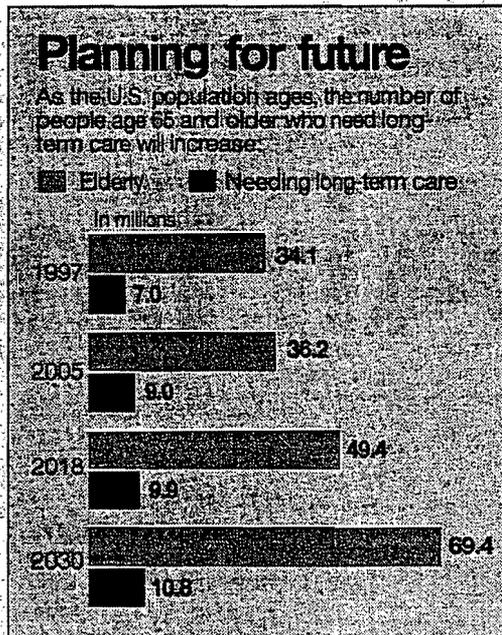
As the baby boom slouches into late middle age, it doesn't need bifocals to foresee the trouble ahead. In the next 30 years, the elderly population will hit 70 million, and a large chunk of those people, many already caring for aging parents, will be receiving long-term care themselves. Or giving it. Either way, the prospect is grim. Medicare doesn't pay for most long-term care, insurance policies are expensive, and Medicaid helps only those who first exhaust their working capital.

Even now, the requirements of long-term care are wrecking retirements and consuming victims. The average cost of nursing home care is in excess of \$46,000 a year, and for that you don't exactly get a suite at the Ritz. Quality homes providing quality care can be far more expensive. At-home care is sometimes less costly and for many, more desirable. But still, Medicaid spends upward of \$8,000 to \$9,000 a year to provide in-home and community care; so even with the tax credit, elderly households are looking at enormous out-of-pocket expenses. And that assumes a family member or friend is available to carry the burden for much of the week, often not the case.

Against all that, President Clinton this week offered a plan to buffer at least part of the current and pending crisis. His four-part, five-year, \$6 billion-plus program calls for:

- ▶ A \$1,000 tax credit for patients and their families facing long-term health needs;
- ▶ A series of state-run networks to assist those providing long-term care at home;
- ▶ Long-term care insurance for federal workers as a model for other employers;
- ▶ And a campaign to educate Medicare beneficiaries about the gaps in their coverage.

If you had to seed these ideas, they would rank in reverse order. Educating consumers about the risks and gaps in their old-age health care coverage is essential. Demonstrating alternatives for large employers is useful. And helping establish support systems for caregiv-



Source: National Academy on an Aging Society

USA TODAY

ers is compassionate.

The money helps, too, although perhaps not as much. One thousand dollars isn't cracker crumbs, and given the pressing need to resolve the Social Security underfunding crisis before taking on another expensive program, not much more is available. But the money barely touches the problem. Because it's a tax credit, for instance, it excludes people with no taxable income — roughly half the nation's elderly population; though some of those receive long-term care through Medicaid. So the 85-year-old widow of limited means, who should be the primary concern for reformers, may have to find her assistance elsewhere.

Sooner or later, every American will experience the flaws in a system that spends you down, bundles you off and then looks away. If budget priorities inevitably muffle cries for deeper reform now, they won't as the baby boom ages. With the Clinton plan as a start point, let the howling begin.

PHOTOCOPY  
PRESERVATION

## A Step Toward Long-Term Care

**T**HE PRESIDENT continues to propose incremental health care reform as distinct from the comprehensive kind that foundered at such great political cost in 1994. This year's largest venture is meant to ease the cost of long-term care. Not everyone ends up needing such care, but more people do than are insured against it. About 40 percent of people now 65 can expect to spend some time in a nursing home, and 20 percent will spend more than a year. The cost can be more crippling than the debility, and in fact many people in need of long-term care receive it at home, often from relatives. The problem will get worse as the baby boomers age and as life expectancies continue to increase.

Critics say the government lacks—and needs—a program to help people meet this likely cost. They note that Medicare doesn't do it; contrary to what most of the public continues to believe, it pays for only a very limited amount of non-acute care. The government does pay for quite a lot of long-term care through Medicaid, but that is only for people who are poor, or become poor by virtue of their illness—"spend down" until they are poor enough to qualify.

The president would use tax credits to provide a modest layer of aid on top of Medicaid. It would go to middle-income families—only people with income tax liability, but only those below certain income cutoffs—and a lot would go to people receiving and/or providing care in their homes as opposed to

those in institutions. Home care is much less costly, but part of the reason can be that its costs are understated, as when a family member has to give up wages to stay home and provide the care.

Only families of the seriously disabled could claim the credit. They could get it without documenting particular expenditures; it would be enough that they had such a person in their household. That sounds like enough of a safeguard to us. The credit of up to \$1,000 a year would hardly solve the problems of such a family. The proposal in that sense is more palliative than structural; there still would be a serious mismatch nationally between need and aid. But it would help—not least to underscore the seriousness of the problem that it would barely begin to solve.

Aides say the president will somehow find the money elsewhere in the budget, including possibly the tax code, to pay the cost of more than \$1 billion a year. He is looking for ways to finance a couple of failed incremental proposals from last year as well to provide insurance to early retirees not yet eligible for Medicare and formerly disabled people who lose Medicare and/or Medicaid when they return to work. He may likewise revive a proposal from last year to increase child care subsidies. The budget is such that none of these will be large, but they will be large enough to stir the political pot and make a modest substantive difference if enacted. That's the limited goal.

## No Business on the Street

**T**HIRTY-ONE-year-old Sabeeha Mahmood and her 4-year-old son, Khurram Haider Mahmoud, are dead—the victims of a devastating car crash that occurred in Falls Church a week ago. The driver of the other car, Samuel Z. Morton, who escaped with minor injuries, was charged with two counts of manslaughter, grand larceny for allegedly driving a stolen car and with driving while intoxicated. There is, however, one likely contributing factor to the tragedy for which no one is likely to be charged. At the time of the fatal collision, Mr. Morton, who has a long history of shoplifting and auto theft, was a D.C. Corrections Department halfway house escapee.

If ever there was a need for an official explanation of standards used to order offenders into halfway houses, Samuel Morton's case is it. Why would someone who has trouble remaining clear of the law and has just pleaded guilty to unlawful use of an auto and receiving stolen property be sent to live in a halfway house for nearly three weeks while awaiting sentencing?

Mr. Morton had already spent four of the

past seven years in jail for robbery and car theft: from August 1991 to June 1993 for attempted robbery and from March 1996 to April 1998 for unlawful use of a vehicle, destruction of property and shoplifting. Since his release from prison last spring, Mr. Morton has been arrested twice more while driving stolen cars—and that doesn't include last week's arrest.

Presented with that record, what could have prompted Superior Court Judge Linda Hamilton to send him to a halfway house with permission to leave custody every day for work until his Dec. 17 sentencing? Within a week, he had escaped simply by not returning in the evening. Two weeks later, Mr. Morton was once again in police custody, but not in response to bench warrants for his failure to show up for sentencing in the District or for failing to appear at another auto-theft trial in Arlington. This time he was in custody, accused of killing a woman and her child.

With his criminal history and recent guilty plea, why was Samuel Morton turned out on the streets? More people than Sabeeha Mahmood's grieving family want to know.

# Quick-Fix Push May Deraile Long-Term Medicare Plan

By LAURIE MCGINLEY

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—A high-level commission resumes debate today on securing Medicare's long-term future. But Congress is facing intense pressure from health-industry groups to undo recently adopted changes instead of passing new ones anytime soon.

"For the next few years, the focus in Medicare policy will be on trying to fix the problems caused by the Balanced Budget Act" rather than on fundamental reform, predicts Robert Reischauer, a Brookings Institution senior fellow and a former Congressional Budget Office director.

Health-care lobbyists from many industries are taking aim at the 1997 budget law, which reduced projected Medicare spending by \$115 billion over five years and ordered up an array of new payment systems and regulations. Health-maintenance organizations, home-care agencies and others want some of the money put back and some new rules delayed or killed. Hospitals, for their part, are trying to stave off what they fear could be further reductions in their payments.

"Everyone is lining up at the cash register," says Stuart Altman, a Brandeis University health-policy professor. "It's the sport of the year."

## Lobbying Campaign at Hand

The lobbying blitz is shaping up even as the National Bipartisan Commission on the Future of Medicare, appointed by Congress and the White House, steps up its search for ways to ensure the long-term viability of the federal health program for 39 million elderly and disabled. The 17-member panel, which includes lawmakers, health-care professionals and academics, including Mr. Altman, will meet today and tomorrow in an effort to meet a March 1 deadline for developing recommendations.

The task is daunting: Among the most politically explosive issues is whether Medicare should pay for prescription drugs, a hugely expensive benefit. One of the touchy issues on today's agenda: Whether to raise the Medicare eligibility age to 67.

Whatever the commission's recommendations, many in Washington doubt Congress will attempt a major Medicare overhaul anytime soon. For one thing, President Clinton and congressional leaders have made Social Security, not Medicare, the top candidate for entitlement overhaul. Even that may face tough sledding, considering the partisan acrimony emerging from the impeachment debate. Moreover, politicians of both parties may shy away from making difficult decisions involving Medicare's long-term future before the 2000 elections.

There is no question, however, that lobbyists will be pressing Congress to revisit the Balanced Budget Act. While wholesale changes in the law won't occur, certain provisions may be revised.

Among the most aggressive interests: HMOs, which say disgruntled beneficiaries are their most effective advocates.

More than 40 HMOs pulled out or scaled back their participation in unprofitable Medicare markets last year, forcing 440,000 people to find other HMOs or return to the traditional Medicare program, which has higher costs. That could be just the beginning, industry officials warn, if payment rates aren't ratcheted up and costly rules rewritten: Under the budget law, most health plans are getting annual increases of 2%, even though health-care costs are rising much faster.

"We're hearing around the country that 1998 might have been the tip of the iceberg," says Karen Ignagni, president of the American Association of Health Plans, which represents 1,200 HMOs and other managed-care plans. "It will only get worse unless Congress acts."

Physical therapists also are upset about the budget law, which set a new annual limit of \$1,500 a patient for outpatient rehabilitative services. The American Physical Therapy Association, which is based in Alexandria, Va., and represents 75,000 therapists, says the cap doesn't meet the needs of senior citizens who become seriously ill. The average stroke victim, the group maintains, requires 34 therapy visits, costing \$2,788.

Other supplicants will include the

PHOTOCOPY  
PRESERVATION

2

Medicare  
Commission

Medi-gap

PHOTOCOPY  
PRESERVATION

effectiveness leave office? Why should a president continue to govern without the confidence of the majority in Congress? Why should it take so much high crimes and misdemeanors for the American people to fire their man in the White House? The president's allies assert that his early resignation would demolish the constitutional standard for removing a president from office. These arguments are convincing. But constitutional revolution might mark an improvement over the current system. After all, in almost every other modern democracy, chief executives serve only as long as they retain the confidence of their legislatures. Once they lose that trust, whether by scandal, policy reversal or lackluster performance, their government collapses and new elections follow a few weeks later. Just last month, disagreements about the Middle East peace process brought down Prime Minister Benjamin Netanyahu's government in Israel. Without waiting more than a year for scheduled elections, Israeli voters can decide whether to replace Netanyahu or return him to power with a fresh mandate. How much better off would the United States be now, if the dispute over Clinton's conduct had already been decided by a direct election? Of course, the United States possesses no such parliamentary system (and it seems unlikely that two-thirds of the states will summon a new constitutional convention to create one). But just as Roosevelt altered the political system without changing the constitution, Clinton and his adversaries might erode the barriers against removing presidents from power. Like the New Deal, the result might strike some Americans as a constitutional travesty, an insult to the founding fathers. But it might also point the way toward more effective and responsive government.

**Seniors Face Large Increase in Medi-Gap Insurance Rate**

**By Robert A. Rosenblatt**  
**Los Angeles Times**

WASHINGTON The dragon of medical inflation is breathing fire again, with millions of senior citizens facing hefty increases for their Medi-gap supplemental insurance this year. United HealthCare Corp., the biggest single player in the market, is raising premium prices approximately 9 percent this year. The price increases are drastically higher than the overall rate of inflation faced by U.S. consumers, which is running at a negligible 1.5 percent. But Medi-gap, the private insurance meant to pay for what Medicare doesn't cover, is a highly sensitive barometer of actual health care costs. And the fast-moving insurance prices reflect the reality of caring for the nation's masses of elderly: They are healthy and long-lived, but it takes tremendous amounts of money to keep them that way. The resurgence of medical inflation comes at a difficult political time, when a special congressional Medicare commission is grappling with ideas to assure the financial solvency of the massive program, which covers 40 million people 65 and older and the disabled of all ages. The soaring health costs mean that any solutions the commission fashions could be overwhelmed simply by the reality of demographics.

The fastest-growing group of Americans is people age 80 and above. Healthier than their counterparts in the rest of the world, they have access to new, less-intrusive surgical techniques that make it possible to replace a hip or a knee at a more advanced age than ever before. For baby boomers and their aging parents, greater longevity is a fact of life. And the old will keep getting older. By the census of 2010, predicted Bill Beach, an economist at the conservative Heritage Foundation think tank, the fastest-growing group of Americans will be those ages 90 and above. "No one has anticipated what medical science would be able to do." But the costs of longevity are also growing. Now an average of \$15,000 a year is spent for the health care of those over 80. As they age and fall prey to a series of ailments and chronic conditions, many will need additional financial help, especially with prescription drugs, which are not covered by Medicare. Millions of people already buy supplemental Medi-gap coverage because Medicare won't give them complete coverage for hospital and doctor bills. The supplemental insurance costs about \$120 a month for the most basic coverage to nearly \$250 a month for the most comprehensive. The "high costs of Medi-gap coverage are straining the limited budgets of growing numbers of seniors," according to an article by economists Henry Aaron and Robert D. Reischauer of the Brookings Institution, a nonpartisan think tank in Washington. And the price tag could escalate.

"Costs have been relatively flat over the last few years, but they are starting to rise again," warned Bob Hussey, vice president of retirement and senior services for United HealthCare, which is the exclusive Medi-gap supplier for the American Association of Retired Persons. The average age of buyers of his company's Medi-gap coverage is 77, up from 75 a few years ago. Unlike the majority of

Americans with insurance through work who are usually limited in their selection of doctors and hospitals most Medicare enrollees are still living in a fee-for-service world. They select any doctor who participates in the Medicare system. Although health maintenance organization participation is growing rapidly, notably where drug coverage is offered, an overwhelming 85 percent of Medicare beneficiaries remain in the traditional fee-for-service system. Therefore, a significant Medi-gap price increase is a warning sign about the difficulties of paying for medical care in a steadily aging society. "More is done for patients at all stages in the health care delivery system of 1999, compared with 1965 (when Medicare was created), and that is what is driving costs," said Karen Ignagni, president of the American Association of Health Plans, the HMO trade group.

The soaring demand for Viagra, the drug that enables impotent men to have erections, has set off an intense debate over what society can afford to do for the aging population. Individual consumers, medical experts, economists and ethicists have to figure out how to "draw the line between medical necessity and lifestyles," Ignagni said. Viagra may be generating the headlines and spawning jokes on the Internet, but the debates over medical cost and efficacy go on every day in doctor's offices and hospitals and around kitchen tables.

Dr. Henry Simmons is head of the National Coalition for Health Care, which includes businesses, health care providers and corporate consumers. He argued that the "whole medical system is headed in absolutely the wrong direction." Citing increased drug advertising aimed directly at consumers, Simmons said that "newspapers and television are telling people, 'Buy this product, we can really help you,' when the drug might be of very marginal benefit." But patients want, and get, more treatments as they age. And that is precisely the time of life when most people "will have some level of chronic disease," said Dr. Rick Smith, regional elder-care coordinator for Kaiser Permanente in Northern California. High blood pressure, arthritis and coronary artery disease are among the conditions that become more common with age. The incidence of cancer also rises sharply. "If you were healthy until age 85 and you begin to get sick, you are much more prone to want aggressive things done even though they may not prolong your life," said Smith, an internist and geriatrician. "Sometimes I'm not sure what the best thing is," he acknowledged. "When a patient is beyond age 85, the efficacy of many treatments isn't proven."

Ironically, one of the handful of scientifically proven treatments to increase longevity and health among the elderly is very low-tech. It has nothing to do with Medicare, Medi-gap or any insurance program or surgery. It is simple: marriage. The federal researchers at the federal Agency for Health Care Policy and Research found that elderly people who are married live longer because they are more likely to eat breakfast, wear a seat belt, get exercise and have their blood pressure checked regularly. And they are less likely to smoke.

**Elizabeth Dole Takes Step Toward Possible Presidential Bid**

**By Ronald Brownstein and Edwin Chen**  
**Los Angeles Times**

WASHINGTON Elizabeth Dole, wife of 1996 Republican presidential nominee Bob Dole, cracked open the door to a White House bid of her own Monday, as Sen. John Ashcroft, R-Mo., a favorite of conservatives, appeared to be edging away from the race. Elizabeth Dole, in announcing her resignation as president of the American Red Cross, indicated she intends to explore the possibility of seeking next year's GOP presidential nomination. Ashcroft, meanwhile, was due to announce his political plans Tuesday in Missouri. Though aides cautioned that he has not revealed his decision to anyone outside his family, some around him said signs suggested Ashcroft would likely forgo a presidential bid and focus on defending his Senate seat in 2000. Even at this early date, the impending decisions by Dole and Ashcroft could significantly reshape the geometry of the emerging Republican race. For most of 1998, the assumption in GOP circles was that the field in 2000 would be crowded with conservative candidates competing for voters on the right and that Texas Gov. George W. Bush if he decides to run would have little competition for voters in the center. Now that equation could be essentially reversed. Though little-known nationally, Ashcroft has built substantial support among grass-roots conservatives, and if he opts not to run it opens up considerably more space for such likely conservative contenders as magazine publisher Steve Forbes and former Vice President Dan Quayle. It's the center of the GOP field that suddenly looks crowded with not only Dole and

Oregon

PHOTOCOPY  
PRESERVATION

## It's enough to make you sick

When Hillary Clinton came up with a plan four years ago to cure what she thought ailed the U.S. health-care system, Harry and Louise weren't among those cheering. Fictional characters in a series of industry-sponsored advertisements, they raised very real concerns about what Mrs. Clinton's proposed "universal coverage" would mean in practice. They didn't want Mrs. Clinton practicing big-government health care on them, and, as it turned out, neither did federal lawmakers, who did not give the plan a single vote.

Proponents of the plan blamed Harry and Louise and the industry for using scare tactics to defeat it, but consumers may want to consider what might have happened without them. Take Oregon, for example.

Five years ago, the state came up with its own universal-coverage plan. Like that of the Clintons, it promised medical coverage to poor persons who couldn't otherwise afford it. All they had to do was join health maintenance organizations, and government officials would see the patients get coverage for the care they needed. That government, in its role as Big Doctor, would decide what the patient really needed — rather than patient and doctor — seemed like a small price to pay for universal coverage.

Unfortunately, it hasn't worked out that way. The Oregon plan has turned out to be like one of those hospital gowns one can never quite close in back; it leaves patients with something less than complete coverage.

For one thing, the New York Times reports, the Oregon plan has proved so expensive that the state has had to abandon its proposal of universal coverage. To date, there are still 350,000 Oregonians left uncovered. Even higher cigarette taxes have not been enough to bring them under the plan's umbrella. Where once Oregon officials proposed to cover everyone, they have now set a target of covering all but 5 or 6 percent of the population, but even that target now seems questionable.

For another thing, participants must now pay premiums that range up to \$28 per month for services they used to get for free. The state kicks out those who don't pay.

Finally, the state set up a rationing plan that dictated the kind of medical treatment a poor person in Oregon

could receive. The plan covers things like preventive medicine, hospice care, and life-saving interventions. But you have to be healthy to merit intervention. If the government thinks the treatment may only extend one's life a week or two, it won't cover the treatment. In that case, you better sign up for physician-assisted suicide — which starting this month the Oregon plan does cover. Welcome, Dr. Kevorkian. (One is reminded of the old Monty Python skit in which a medieval character pushing a cartful of bodies wanders through a town of plague victims crying, "Bring out your dead." When a candidate for the cart announces he isn't dead yet, the pusher calmly bops him on the head, puts him on the cart and moves on.)

What's Oregon going to do now? Gov. John Kitzhaber, a former emergency room physician, is proposing tougher screening of patients, which threatens to stretch out the time needed to approve applications from a day to at least a month. He also wants to reduce the number of treatments eligible for coverage, proposing that the state would no longer pick up the tab for care of knee-ligaments damage, contact dermatitis and more. State lawmakers want to lower the income levels of persons eligible for coverage.

Said a Blue Cross & Blue Shield official who backs the overall approach of the plan, it "has never provided what's needed to take adequate care of the population. To get to the next increment, we're going to have to spend more money, and to do that is a question mark."

It doesn't take a complete government overhaul of the health-care system, as Oregon did, to make a mess of things. In a recent Heritage Foundation study of 16 states that tried to increase coverage of the uninsured through mandates and regulations on companies, the Alexandria-based Galen Institute found that those 16 had annual average growth of their uninsured populations eight times that of the other 34 as of 1996.

Higher prices, less coverage, less consumer choice — it's enough to make you sick. But that's what can happen when government decides to intrude on the free market and substitute its good intentions for those of consumers, doctors and insurers. Just ask Harry and Louise.

PHOTOCOPY  
PRESERVATION

# Republicans praise Clinton's proposed caregiver tax relief

ASSOCIATED PRESS

President Clinton proposed tax breaks and other steps yesterday to ease the financial burden on families that care for a chronically ill or disabled relative.

The proposal, carrying a price tag of \$6.2 billion over five years, drew praise from many Republican members of Congress, who said Mr. Clinton was resurrecting a GOP idea he once opposed.

"I'm delighted he has changed his tune," said Rep. Bill Thomas, California Republican and chairman of the House Ways and Means subcommittee on health. "This GOP initiative the president has adopted can make a difference." He said House Republicans made a similar proposal in their 1994 "Contract With America."

Sen. Charles E. Grassley, Iowa Republican, chairman of the Senate Special Committee on Aging, applauded Mr. Clinton and said he plans to introduce two bills this year to make long-term care more affordable.

The praise was tempered by concerns about how Mr. Clinton intends to pay for the proposals, which include a \$1,000 tax credit to compensate caregivers for such expenses as adult day care and lost wages in cases in which they must work less to be home to provide care.

In announcing his initiative at a White House ceremony, Mr. Clinton said the revenue loss from the tax cuts would be offset in a balanced budget he will submit to Congress in February. He provided no details, however.

Several members of Congress, including Rep. Phil English, Pennsylvania Republican, said the plan must not be paid for with tax increases.

"The president's idea has an excellent chance of moving forward if he does not raise taxes or propose other creative revenue-

raising schemes that have been defeated two and three times in the last several Congresses," Mr. English said.

Mr. Clinton called his plan "a critical new initiative to give care to the caregivers." He said long-term care would become an increasingly important issue in the 21st century as the baby boom gives way to a "senior boom."

Appearing with the president to provide personal testimony to the needs of family caregivers was Patricia Darlak of Waldorf, Md. She told the White House audience she is struggling to care for her mother, who is suffering from dementia. She said the cost of her mother's care is such a burden that she may have to delay her own retirement in order to pay the bills.

Mr. Clinton's initiative also proposes that the government start offering federal workers and retirees private, long-term care insurance, in the hope that other employers would follow suit. Officials estimate that 300,000 government employees would participate in the model program.

Mr. Clinton will ask Congress for \$625 million in grants to state and local agencies on aging.

Paul Willging, president of the American Health Care Association, representing nursing homes and other health care providers, called Mr. Clinton's plan a "balanced approach" that at least will stimulate debate on a topic that has gained little attention in recent years.

First lady Hillary Rodham Clinton, who appeared with the president yesterday, said help for family caregivers is long overdue.

"Everyone knows that there is not a substitute for families being able to care for their loved ones," Mrs. Clinton said. "But we sometimes forget that caregivers also need care. They, too, carry enormous burdens."

**The Washington Times**  
TUESDAY, JANUARY 5, 1999

*Donna E. Shalala*

## Care for Caregivers

Robert Kuttner—in his Jan. 8 op-ed article "One More Hoax"—alleges that President Clinton's proposed long-term care initiative is "falling so short of a real remedy as to be a hoax." He could not be more wrong. He may not think this proposal will make much of a difference, but to 2 million severely disabled Americans and their families, many who now receive little or no assistance, the difference will be substantial.

Our proposal is the first long-term care strategy in our nation's history, and it recognizes two truths. First, as the number of seniors continues to grow rapidly, so will the need for long-term care because, although we are living healthier and more active lives, with aging inevitably come the disabilities of old age. Second, it recognizes that long-term care is primarily being provided at home, often by family members.

The core of our five-year, \$6 billion initiative is a targeted \$1,000 long-term tax credit, paid for as part of our balanced budget, for people with long-term care needs or their caregivers. For some families, the tax credit will help offset some of the direct costs of long-term care, such as adult day care or home health care visits. For others, it will help offset indirect costs such as unpaid leave some caregivers must take. As the president has said, this initiative will help "give care to caregivers." But the important point is that it flexibly responds to the real needs of real families that have gone unaddressed for years.

In a very practical way, this proposal will support caregivers, who are usually women in the work force, who are trying to care for their elderly or disabled loved ones as well as their spouses and children. Like so many other American families, my own family is experiencing this. When I was home in Cleveland over Christmas, my cousins were

### Taking Exception

talking to me about one of my aunts who has Alzheimer's. My cousins are rushing home from work in the middle of the day, every day, to make sure that their mother gets the help she requires. It is very stressful. They need help. But they could find very few places that would help them, because they are middle-income and do not qualify for Medicaid services.

Although the tax credit represents the crux of our proposal to help people like my aunt and my cousins, a complicated chal-

lenge requires a comprehensive solution. Our initiative also includes a number of items that Mr. Kuttner simply dismisses or fails to mention: It would provide funds for states to create one-stop-shops where caregivers can access community resources, find guidance and obtain adult day care services. It would include an effort to inform all Medicare beneficiaries about long-term care options, since most know very little about their alternatives. (This is an education effort designed to offer seniors options and choices, not a gimmick designed to placate the insurance industry, as the writer charges.) Finally, as part of this initiative, the federal government would offer private long-term care insurance to federal employees. As the nation's largest employer, the market leverage of the federal government will influence the private sector to develop options that better meet the needs of older Americans and their families, and hopefully, more businesses will invest in long-term care coverage for their employees. Overall, our initiative is a pragmatic, comprehensive response to the growing problem of long-term care.

Kuttner also argues that the neediest elderly, whose incomes are too low to pay federal taxes, would get no benefit and would therefore be bypassed. This is simply not true. By eliminating the complicated "income support test," our proposal would make tens of thousands more low-income families eligible for help through the tax code. In addition, as I noted above, our initiative expands services for both the disabled and their caregivers who do not qualify for the credit. This initiative is really about providing comprehensive assistance, not just financial assistance, to those requiring or providing long-term care.

Our proposal also recognizes the fiscal realities that Kuttner ignores. Any program or plan we propose must be within the balanced budget framework that the president and Congress worked out in a bipartisan fashion. Although the writer feels otherwise, it is a framework that will provide a solid fiscal foundation for our children and grandchildren.

Kuttner seems to argue that since our proposed initiative is insufficient to offset all the costs or address all the needs associated with long-term care, it should not be adopted. This suggests that it would be better to do nothing to help millions of disabled Americans and their families than to do what we can. I strongly disagree.

It is true that this initiative will not address all the needs of those requiring or providing long-term care, but it is a historic first step. With the number of elderly Americans doubling by the year 2030, providing proper care for our aging and disabled citizens will be one of the central challenges of the 21st century. The president's long-term care initiative will help us meet that challenge.

*The writer is secretary of Health and Human Services.*

**FEDERAL DIARY**

Mike Causey

## The Risks of Long-Term Care Insurance

**M**any federal workers, retirees and family members are elated by the prospect of long-term care insurance coverage. Long-term care insurance would be at group rates. Spouses and parents-in-law would be eligible.

Long-term care insurance is like apple pie and motherhood. Everybody is for it. But there is a potential problem. If it happens, it could force workers to choose between coverage and either taking reduced benefits for health insurance or retirement or paying more for those benefits.

Premiums will be decided through competitive bidding. The level of government involvement in premiums and benefits has yet to be decided.

The Office of Personnel Management estimates that group rates would save many people 10 to 15 percent from what they would pay for similar coverage at nongroup rates. Many younger, healthier workers can already buy low-cost long-term care coverage. But premiums are very high for older individuals, and some employees—with major illnesses—can't get coverage.

The concept of long-term care insurance is a good one.

The danger is that Congress or the White House might use long-term care insurance as the bait to lure federal workers into a cafeteria-style benefits plan. The Clinton administration is considering such a package—not necessarily linked to long-term care insurance—as part of its plan to overhaul federal compensation. The choose-your-own benefits idea is popular with many private-sector employers. But it involves trade-offs.

The upside of the cafeteria plan is that it allows workers to tailor their benefits. Someone might, for example, elect a bare-bones health plan in return for a more generous benefit in some other area. Or an employee might choose to pay a larger share of their health premium in return for an enhanced retirement benefit.

Long-term care coverage is supposed to be a no-cost item to the government. Workers, retirees and eligible family members would pay the full premium. Those premiums could range from \$200 to \$3,000 a year, depending on the age individual when the coverage is purchased. Health would not be a factor.

But there would be costs to the government for negotiating benefits with long-term care plans and

for administering the program and collecting premiums.

Politicians in the not-too-distant future could propose that workers give up some benefits, or pay more for them, to keep long-term care. That was part of the first long-term care bill introduced years ago by then-Sen. Pete Wilson (R-Calif.). Unions liked the idea of the insurance but didn't want it linked to other benefits.

That isn't on the table now. But it could be. Which is why workers should keep an eye on legislation that would set up the long term care program.

Meantime, Sen. Barbara A. Mikulski (D-Md.) has introduced the administration's long-term care insurance bill. It is similar to the plan introduced earlier by Rep. Elijah E. Cummings (D-Md.).

Under both plans, millions of people—federal workers, retirees and relatives—would be eligible for coverage. Republicans last year endorsed a somewhat similar bill by Rep. John L. Mica (R-Fla.).

Most politicians believe Congress and the White House will reach agreement this year on a long-term care insurance plan that could be effective sometime next year.

### SFLRPs New Team

Irwin Kaplan, a labor arbitrator and mediator, is the new president of the Society of Federal Labor Relations Professionals—DC Chapter. Pat Nighswander, of the National Border Patrol Council, is vice president, and the Justice Department's Steve Muir is treasurer. To make sure that all segments of the profession are represented, the three top offices are held by a neutral, a union and a management representative.

An item here Jan. 12 noted that an Internal Revenue Service employee had retired after 39 years service and that the 33 he spent with the local appeals office may have been some kind of record. But not for overall service in the IRS.

Tony Burgess spotted the item and says we don't know the meaning of longevity. He says his father, James Burgess, may hold the overall record for IRS. He retired last year with 54 years and nine months of federal service. That will be hard to beat.

Tuesday, Jan. 19, 1999

The Washington Post

TUESDAY, JANUARY 19, 1999

# Sharpest Health Insurance Increases in a Decade Hit Small Employers the Hardest

By JENNIFER STEINHAUER

When the notice came in December that his company's health insurance premiums were going up 22 percent, Jonathan South knew what he had to do.

Mr. South, the office manager for a small Manhattan company, dropped the plan with Cigna Healthcare, one that allowed employees to go to doctors out of the network and would now have cost the company \$241 per employee each month, and signed up for a plain vanilla health maintenance plan offered by Aetna, at a cost of \$179 a month.

The company, Eric Winterling Inc., which makes costumes for Broadway shows, also cut its contribution to its employees' premiums from 50 percent to 25 percent. Half the 15 full-time employees chose to go without insurance.

All American businesses — and in many cases, their employees — are facing some of the steepest price increases for health insurance in almost 10 years, as the nation's health insurers struggle through a period of consolidation and falling profits. But small businesses like Mr. South's are feeling the brunt of it, insurance experts and business owners say.

For small employers, the increases have led to tough decisions

about whether to absorb the higher costs, pass them on to employees or not offer benefits. While the increases are more or less the same nationwide, several factors make them especially painful in New York.

The cost of doing business, especially in New York City, is significantly higher than in other areas, making the increases that much more of a burden. In addition, small businesses have no negotiating power with insurance companies, because New York has the nation's most stringent form of a practice known as community rating, in which prices for businesses with fewer than 50 employees are set strictly by geographic area.

And health-care experts and policy makers worry that the increases will worsen the problem of the uninsured, whose numbers in New York are well above the national average. As of last year, 19 percent of New York State residents under 65 were uninsured; in the city, the figure was 28 percent. In comparison, the figures were roughly 16.9 percent in the District of Columbia and roughly 11 percent in Pennsylvania. Nationally, 17.6 percent of those under 65 lacked insurance.

In January, insurance prices for businesses with more than 100 em-

## A particular problem in high-priced New York.

ployees rose about 6 percent on average around the country, experts said, while small businesses are seeing increases in the range of 10 to 13 percent, with more anticipated. New York's Insurance Department is considering requests from several companies for rate increases for small businesses ranging from 7 percent to more than 30 percent.

"Clearly small businesses are getting whacked," said Elliott Shaw, the director of government affairs for the New York State Business Council. Addressing these rising costs among small businesses has become a government concern. Yesterday, the White House said President Clinton would propose a tax credit for companies with fewer than 25 workers that established or joined purchasing alliances to buy insurance.

And Mayor Rudolph W. Giuliani last week announced two pilot programs intended to help small businesses buy insurance.

The effect of the increases will vary according to the fiscal health, and in some cases, the generosity of the companies. While the extremely tight labor market will make it difficult for employers to drop health insurance entirely, employees will see costs increase in the form of greater weekly contributions, raised deductibles and co-payments, or less generous plans.

As it is, 73 percent of the state's uninsured population consists of people who have jobs, like Sarup Arora and his employees at Party Glitters, a store in Brooklyn. "Right now, we pay cash when we go to the doctor and try not to get sick," Mr. Arora said.

Andrew Nathan, who owns the restaurant Frontiere in SoHo, regrets that he cannot offer insurance to more of his employees. He only has insurance for himself and his two managers, but the restaurant covers the full cost of the premiums, even in the face of rate increases.

"I can't turn to a restaurant manager and say 'I can't pay that,'" he said. "A restaurant manager often works an 80-hour week. They have a high rate of sickness. So insurance is a costly necessity. I would love to be able to offer it to more employees if I could be financially successful and

do it."

And many employees who are offered insurance feel they cannot afford to take it because of the amount they must contribute. "I have considered it, but basically I can't afford it," said Laurence Woodbury, the manager of Doggie-Dó, a pet grooming, boarding and retail store on the Upper East Side.

His boss, Larry Roth, pays half of the company's policy with Oxford Health Plans, which went from \$300 to \$336 a month recently. He was dismayed by the increase, Mr. Roth said, and ponders what he'll do if there is an increase next year. "I find this is the perk that is most significant to employees," he said.

Even so, Mr. Woodbury said he cannot find it in his budget to pay. "I probably don't worry about it because I probably don't think about it," he said. "I know that's not very smart. But I very rarely get ill. What worries me is getting hit by a bus."

While small businesses make up the largest employer group in the country and are a powerful lobbying voice, individually they generally hold little power with suppliers, including insurance companies.

The companies charge higher rates to small businesses because their volume is smaller, and because the risk of illness is spread out among fewer people. And with community rating, which was designed to spread that risk among employers, small businesses are barred from cutting their own deals.

Five years ago, small businesses were among the most vociferous opponents of President Clinton's failed health plan, arguing that if they were forced to offer health insurance benefits to employees, many would go broke. Led by the National Federation of Independent Businesses, they argued that they could contain costs better on their own.

And indeed in recent years, employers have faced modest increases as insurance companies fought for market share, often offering discounted rates to win business. But a recent consolidation among the managed-care companies and their realization that they could not make money offering such low premiums have caused the rates to rise sharply in the last six months.

"I think these businesses were deluded into thinking that the private

sector had discovered a panacea for medical costs," said Ted Marmor, a professor of politics at the Yale School of Management, who has written extensively on health care policy. "And this is a case of getting what they feared, partly out of the actions they took to avoid it."

The business federation does not see it that way. "Is it cause for growing concern? Absolutely," said Jim Weidman, a spokesman for the organization. "But at least now small employers can still drop insurance, and under the Clinton plan, they would be out of business. And when push comes to shove, health insur-

## Premium increases of 10 to 13 percent for some companies.

ance is a benefit. We think it is far better to have a job with no benefits than no job."

In New York City, the rise of the uninsured is a major public policy problem, and is already putting strains on the city's hospital system. As such, the Mayor's office has announced two pilot plans to address the issue. One would offer discounted rates to small business owners on managed care offered by the Health and Hospitals Corporation, which would require patients to use certain public hospitals and their doctors. The program will begin in East Harlem and parts of Brooklyn and the Bronx this winter.

The other plan, a joint venture with the New York Business Group, will form an insurance purchasing alliance for small businesses. Employers will be able to buy insurance through a central office and offer each employee a choice of many plans. The company can subsidize the least expensive option, and the worker who wants a fancier plan can pay the difference.

The advantage, said Laurel Pickering, the Business Group's managing director, is that employers will have access to many plans and will no longer have to do the administrative work, one of the highest hassles with insurance companies.

PHOTOCOPY  
PRESERVATION

The New York Times

TUESDAY, JANUARY 19, 1999



**American Health Care Association** 1201 L Street, NW, Washington, DC 20005-4014  
FAX: 202-842-3860

Facsimile Cover Sheet  
Please Deliver Immediately Upon Receipt

To: Chris Jennings

Company: \_\_\_\_\_

Fax #: 456-7431

From: Bruce Yarwood Tel #: 202-898-2858

Date: 1/4/99 Total pages (incl cover page): 4

Message: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you did not receive a complete and legible transmission, please call  
202-898-2826

The information contained in this facsimile is confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, the reader is hereby notified that any dissemination, distribution or copy of this telecopy is strictly prohibited. If you have received this telecopy in error, please notify us by telephone or facsimile and destroy the original telecopy. Thank you.

( ) Fax delivered Time \_\_\_\_\_ Operator \_\_\_\_\_

BRUCE YARWOOD

Chris

- Hue is our statement -
- Ken - how do the tax credits work -



# NEWS



American Health Care Association

Contact: Tom Burke  
202/898-2814

Immediate Release

**AMERICAN HEALTH CARE ASSOCIATION APPLAUDS  
PRESIDENT'S LONG TERM CARE INITIATIVE  
Tax Credits Key to Reforming Long Term Care Financing**

Washington, D.C. (January 4, 1999)--The American Health Care Association (AHCA) today lauded President Clinton for taking important steps in addressing the issue of providing long term care for our nation's elderly and chronically ill.

"The President and the Administration are demonstrating leadership with the introduction of this long term care initiative to assist the chronically ill and their caregivers. AHCA has long been an avid supporter of using tax credits to help ease the burden of long term care financing," said Dr. Paul Willging, president of AHCA.

As the baby boom generation ages over the next 30 years it will increase the need for long term care services and the current financing system will reach the breaking point. Adding tax incentives will help relieve pressure on individual consumers and provide access to more long term health care options.

"The Administration's plan also gives important visibility to long term care insurance. By providing this type of insurance to the federal workforce, all employers may be encouraged to examine this type of insurance for their employees," Willging said.

Willging further noted the wisdom of the President's plan, saying, "This plan goes well beyond just easing the financial burden. By providing badly needed public education about how to plan for and access long term care, the Administration takes on an important national public service."

--more--

### Long Term Care/Add One

Most Americans do not realize the importance of planning for their long term care needs. "For example," added Willging, "virtually all homeowners carry fire insurance but face only a 1 in 1,200 chance of needing to make a claim. Meanwhile, only 3% of Americans carry long term care insurance, yet nearly half of all Americans will access long term care services at some point in their lives. Americans must be educated about how to plan for these services."

AHCA considers the Administration's announcement a major step toward guaranteeing access to quality health care for all Americans, but notes it is only the first step of many which will be required to truly provide reforms to our system for providing and financing long term care.

The population growth among the elderly over the next 30 years is staggering. Decisions on how to finance long term care must be made soon in order to ensure access to the system in the future. Both the public and private sectors must cooperate, innovate and develop policies which fill this growing need.

*AHCA, a federation of 50 affiliated associations, represents over 11,000 non-profit and for-profit assisted living, nursing facility and subacute centers that provide care to more than one million elderly and disabled individuals nationally. Helpful information about long term care options can be obtained through AHCA's consumer information telephone line at 1-800-555-9414 or at the AHCA web site ([www.ahca.org](http://www.ahca.org)).*

Long Term Care File

**STATEMENT BY AARP EXECUTIVE DIRECTOR HORACE B. DEETS  
ON PRESIDENT CLINTON'S ANNOUNCEMENT OF A  
LONG-TERM CARE TAX CREDIT**

AARP is pleased that president Clinton has announced a plan to provide a tax credit to Americans who need long-term care. This is long overdue recognition to many American families who are assuming the enormous burden of providing high quality care to a family member.

As we approach the 21<sup>st</sup> Century and as the population ages and Americans live longer, the demand for long-term care will continually increase. Our nation must look for more innovative and cost effective ways to provide care for people with chronic illnesses and disabilities and to help sustain their caregivers.

For most families or spouses caring for a seriously disabled loved one, the burden they face in time and money can be overwhelming. This tax credit would help those caregivers find occasional relief, enabling them to continue to provide support.

People give and receive long-term care in a variety of ways. We already know that those who need care prefer to receive it in their own homes. The proposed long-term care tax credit would provide to middle income individuals with serious chronic illnesses or disabilities, or to their caregivers, a modest tax benefit - up to \$1,000 per year. It recognizes the need for those with chronic illness and their caregivers to have some flexibility in purchasing the services that are needed. The tax credit is one of a number of steps that we need to take toward solving the nation's long-term care problems.

This tax credit is a step in the right direction. It builds upon a similar proposal previously put forward by Republicans. AARP will continue to work with the President and members of Congress on a bipartisan basis to make sure this proposal and future efforts will help families in need.

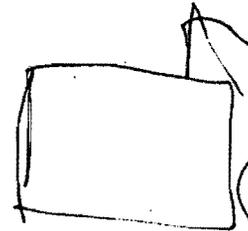
- Unkward at main line

o/m 18-252

SWW: (723) 998-1841

CA  
Caregiver  
Business

Grandmother



6156-2673

July 220

Com



For Release at 11 AM  
January 4, 1999

Contact:  
Scott Treibitz  
703/276-2772

## **Reaction To Clinton Caregiver Proposals**

**Statement of Stephen McConnell  
Senior Vice President, Alzheimer's Association**

**Spokespeople are Available for News Interviews and Talk Shows  
B-Roll Available**

"With the proposal he is putting forth today, President Clinton gives powerful recognition of the incredible role that family caregivers play in providing long-term care in this country."

"Family members are the heart and soul of our caregiving system. They provide at least 70% of the care for people who have Alzheimer's disease, and they do so at enormous personal cost -- physical, emotional and financial."

"Every family struggling today to keep a spouse or a parent or grandparent at home will understand and appreciate the importance of what the President is doing today."

"This initiative will help millions of hard working families address a real problem and should draw strong and immediate bipartisan support. The Alzheimer's Association will work aggressively with the President and Congress to see these proposals enacted into law this year."

-30-

### **CAREGIVERS STUDY**

**The Alzheimer's Association and the National Alliance of Caregiving will soon release a national report on *Caregivers of those with Alzheimer's*.**

**For details and a general overview  
contact Scott Treibitz at 703/276-2772**

## **NEWS RELEASE**

**From the National Council on the Aging**

### **NCOA Supports President's Long-Term Care Initiative**

**FOR IMMEDIATE RELEASE**

**CONTACT: Michael Reinemer, 202 479-6975, Jim Hood, 202 479-6976**

**WASHINGTON, Jan. 4, 1999** – James Firman, the President and CEO of the National Council on the Aging (NCOA), today expressed the organization's support for the new long term care initiative proposed by President Clinton and Vice-President Gore, but cautioned that it is "just the beginning."

"As the American population ages, long-term care will rapidly replace child care as a major concern of baby boomers," Firman said.

"The proposal would provide some much-needed help in alleviating the tremendous burdens that millions of families face in trying to care for loved ones who are unable to help themselves," Firman said. "Coverage for chronic illness is the biggest gap in our nation's health care system. Currently, people with long-term chronic illness are forced to exhaust their life savings before receiving any assistance. We can do better for America's families."

Clinton is proposing \$6.2 billion tax break to the millions of Americans who need long-term care and for their caregivers, in the form of a \$1,000 annual tax credit to help patients and their caregivers cope with the effects of Alzheimer's disease, strokes and other disabling conditions.

The initiative recognizes the growing number of disabled persons who are being cared for in private homes, usually by family members -- an estimated 60 percent of the five million Americans with chronic illnesses. The number is expected to grow as the population ages.

The issue is particularly important to middle-aged women, Firman noted. Women comprise more than 80 percent of the family caregivers for chronically ill older Americans. The average caregiver is a 57 year old married woman. "It's about time middle class, sandwich generation caregivers got a little help," said Firman.

NCOA applauded the intergenerational nature of the proposal and the flexibility it would provide to families to determine their own needs. "The proposal would enable a daughter, for example, to pay for about 25 visits to an adult day center for an disabled parent," Firman said. "This would provide much-needed relief and help families to stay together and keep loved ones out of institutions."

The proposal is also consistent with programs sponsored by NCOA's Center for Consumer-Directed Services, Firman said.

Clinton is also expected to ask Congress to distribute \$125 million yearly to state and local agencies for older persons, to enable them to furnish more support to caregivers, including respite care, training and stress management.

"We are also excited about the family support program included in the proposal," Firman said. "NCOA looks forward to working with the Administration on Aging to reauthorize and improve funding for services under the Older Americans Act, which provides essential home and community-based care and support for frail, lower income seniors," he added.

NCOA is an association of organizations and individuals dedicated to promoting the dignity, self-determination, well-being and continuing contributions of older persons through leadership and service, education, and advocacy. NCOA's members include professionals and volunteers, service providers, consumer and labor groups, businesses, government agencies, religious groups and voluntary organizations.

*CHRIS - JEANNE*

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

January 5, 1999

Dear Democratic Colleague:

Monday, the President proposed a long-term care initiative, which received a supportive editorial in today's Washington Post. This initiative has the potential to be a bipartisan incremental improvement in health care. I certainly hope so.

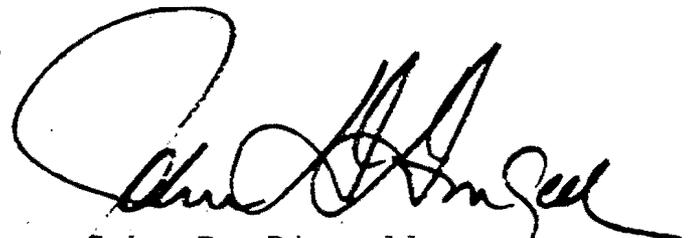
For the record, in checking the history of this issue, you may be interested in the attached chart which shows differences between the President's proposal and past proposals.

The President is clearly proposing a step forward!

Sincerely,



Charles B. Rangel  
Ranking Member  
Ways and Means Committee



John D. Dingell  
Ranking Member  
Commerce Committee

**PRESIDENT CLINTON AND VICE PRESIDENT GORE UNVEIL HISTORIC LONG-TERM CARE INITIATIVE TO SUPPORT FAMILY CAREGIVERS AND HELP ADDRESS GROWING LONG-TERM CARE NEEDS**

**January 4, 1999**

Today, President Clinton is unveiling an historic new initiative to support Americans with long-term care needs and the millions of family members who care for them. This four-part, \$6.2 billion (over five years) initiative takes important steps to address complex long-term care needs through: (1) an unprecedented \$1,000 tax credit that compensates for formal or informal costs Americans of all ages with long-term care needs or the family caregivers who support them; (2) a new National Family Caregivers Support Program that provides a range of critical services for caregivers such as respite, home care services, and information and referral; (3) a national campaign to educate Medicare beneficiaries about the programs' limited coverage and how best to evaluate long-term care options; and (4) a proposal to have the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees at group rates.

The President is being joined by the First Lady, Secretary Rubin, Secretary Shalala, and OPM Director LaChance to unveil this initiative at the White House and the Vice President and Mrs. Gore are participating from an adult day care center in California, one of four States with model statewide family caregiving resource programs.

**MILLIONS OF AMERICANS HAVE LONG-TERM CARE NEEDS**

- **More and more Americans have a range of long-term care needs.** Over five million Americans have significant limitations due to illness or disability and thus require long-term care. Approximately, two-thirds are older Americans. Also, millions of adults and a growing number of children have long-term care needs because of health condition from birth or a chronic illness developed later in life.
- **The aging of Americans will only increase the need for quality long-term care options.** The number of Americans age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older, nearly half of whom need assistance with everyday activities, will grow even faster (from 4.0 to 8.4 million).

**MULTI-FACETED INITIATIVE TO SUPPORT FAMILY CAREGIVERS AND ADDRESS GROWING LONG TERM CARE NEEDS.** The President is unveiling a four-part initiative that is designed to address the broad-based and varied long-term care needs. It will: provide immediate support and assistance for the millions of Americans who care for family members with major long-term care needs; educate the elderly and people with disabilities about long-term care issues and options; and promote new promising strategies directions for long-term care policy for the twenty-first century. The President also called on the Vice President to host a series of forums around the nation to raise awareness about the need to support family caregivers and address the growing need for long-term care options.

The long-term care proposal being unveiled today by the President and Vice President includes:

- **Supporting families with long-term care needs through an historic \$1,000 tax credit.** This initiative, for the first time, acknowledges and supports millions of Americans with long-term care needs or the family members who care for and house their ill or disabled relatives through a \$1,000 tax credit. This new tax credit supports the diverse needs of families by compensating a wide range of formal or informal long-term care for people of all ages with three or more limitations in activities of daily living (ADLs) or a comparable cognitive impairment. This proposal, which supports rather than supplants family caregiving, would provide needed financial support to about 2 million Americans, including 1.2 million older Americans, over 500,000 non-elderly adults, and approximately 250,000 children. It costs \$5.5 billion over five years and phases out beginning at \$110,000 for couples and \$75,000 for unmarried taxpayers.
- **Creating an unprecedented National Family Caregiver Support Program.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's disease patients can delay institutionalization for as long as a year. This new nationwide program, strongly advocated by the Vice President, would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to create "one-stop-shops" that provide: quality respite care and other support services; critical information about community-based long-term services that best meet a families' needs; and counseling and support, such as teaching model approaches for caregivers that are coping with new responsibilities and offering training for complex care needs, such as feeding tubes. This program, which costs \$625 million over five years, would assist approximately 250,000 families nationwide.
- **Launching a national campaign to educate Medicare beneficiaries about the programs' limited coverage of long-term care and how best to evaluate their options.** Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long-term care, and many do not know what long-term care services would best meet their needs. This \$10 million nationwide campaign would provide all 39 million Medicare beneficiaries with critical information about long-term care options including: what long-term care Medicare does and does not cover; how to find out about Medicaid long-term care coverage; what to look for in a quality private long-term care policy; and how to access information about home-and community-based care services that best fit beneficiaries' needs.
- **Having the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees.** The President also called on Congress to pass a new proposal that allows OPM to use its market leverage and set a national example by offering non-subsidized, quality private long-term care insurance to all federal employees, retirees, and their families at group rates. This proposal, that costs \$15 million over five years, will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.

## COMPARISON OF THE PRESIDENT'S LONG-TERM CARE TAX CREDIT WITH THE CONTRACT WITH AMERICA PROPOSAL

There were actually two different proposals offered by Republicans in 1995:

- **Tax credit:** \$500 refundable tax credit for taxpayers who house certain family members (parent, grandparent) who needs "custodial care" (2 + ADLs or similar level of disability due to cognitive impairment). Taxpayer must be providing at least half of the support for the person with long-term care needs. There is no upper income limit on the credit.

This was included in HR 11, The Family Reinforcement Act, but dropped from the Republican budget. JCT estimated the cost at \$8 billion over 5 years.

- **Tax deduction:** \$1,000 tax deduction for taxpayers who house certain family members (parent, spouse or former spouse) who is "physically or mentally incapable of caring for himself".

This was included in HR 2491, the Balanced Budget Act of 1995 that was vetoed by the President.

### Issues:

- **Narrow eligibility:** Neither proposal gives the credit to:
  - People with chronic illness or disabilities themselves;
  - Children and most non-elderly adults; and
  - Many caregivers since the support test essentially eliminates people receiving Social Security from eligibility.
- **Lower amount:** Although the tax credit was refundable, the amount is half of the amount under the current proposal.
- **No upper income limit** -- and the deduction actually benefits the wealthy over the lower-income taxpayers.

**ELDERCARE TAX CREDIT**  
(Title II of the Family Reinforcement Act)

A Proposal in the Contract with America

Description

This proposal provides a \$500 tax credit for taxpayers who maintain a household for certain family members who need "custodial care". The credit is refundable (i.e. if the amount of the credit exceeds the taxpayer's total liability for the year, the government pays the taxpayer the difference). The estimated 5-year cost of the credit is \$8 billion.

The person who needs care must be:

- the parent or grandparent of the taxpayer or the taxpayer's spouse (Although it is described as an "eldercare" credit, there is no specification of the age of the person needing care.)
- certified by a physician as "unable to perform without substantial assistance at least 2 activities of daily living" or "having a similar level of disability due to cognitive impairment"
- living in ("principal place of abode") the taxpayer's home for more than half the year.

The taxpayer or the taxpayer's spouse must furnish over one-half the cost of maintaining the household.

The credit takes effect in the 1996 tax year.

Issues

1. The credit provides minimal financial assistance (the equivalent of about two and a half weeks of day care and probably less home care).
2. It is not targeted. A taxpayer gets the same credit regardless of income.
3. The credit is expensive and, under budget rules, must be paid for by cuts in spending. The sponsors have not said where those cuts will be made.
4. The proposal covers only a portion of persons with this level of disability who are receiving care from family members. It does not cover care of spouses (thus excluding a large portion of Alzheimer families), children, adult children, siblings, or any other family members.
5. The proposal recognizes disability based on cognitive impairment.
6. It does not cover persons with mental impairment other than cognitive impairment.
7. It does not provide any help for persons with disabilities or chronic disease (including persons with Alzheimer's disease) who are not living with a family member.

H.R. 11  
"Family  
Reinforcement  
Act"

\$ 8 billion  
over 5 years  
(RCT)

1 **TITLE II—ELDERCARE**  
2 **ASSISTANCE**

3 **SEC. 201. REFUNDABLE CREDIT FOR CUSTODIAL CARE OF**  
4 **CERTAIN DEPENDENTS IN TAXPAYER'S**  
5 **HOME.**

6 (a) IN GENERAL.—Subpart C of part IV of sub-  
7 chapter A of chapter 1 of the Internal Revenue Code of  
8 1986 (relating to refundable credits) is amended by redес-  
9 ignating section 36 as section 37 and by inserting after  
10 section 35 the following new section:

11 **"SEC. 36. CREDIT FOR TAXPAYERS WITH CERTAIN PERSONS**  
12 **REQUIRING CUSTODIAL CARE IN THEIR**  
13 **HOUSEHOLDS.**

14 "(a) ALLOWANCE OF CREDIT.—In the case of an in-  
15 dividual who maintains a household which includes as a  
16 member one or more qualified persons, there shall be al-  
17 lowed as a credit against the tax imposed by this subtitle  
18 for the taxable year an amount equal to \$500 for each  
19 such person.

20 "(b) DEFINITIONS.—For purposes of this section—

21 "(1) QUALIFIED PERSON.—The term 'qualified  
22 person' means any individual—

23 "(A) who is—

6

1                   “(i) a father or mother, or stepfather  
2                   or stepmother, of the taxpayer, his spouse,  
3                   or his former spouse, or

4                   “(ii) a father or mother, or stepfather  
5                   or stepmother, of an individual described  
6                   in clause (i),

7                   “(B) who has been certified by a physician  
8                   as—

9                   “(i) being unable to perform (without  
10                   substantial assistance from another indi-  
11                   vidual) at least 2 activities of daily living  
12                   (as defined in paragraph (2)), or

13                   “(ii) having a similar level of disabil-  
14                   ity due to cognitive impairment, and

15                   “(C) who has as his principal place of  
16                   abode for more than half of the taxable year the  
17                   home of the taxpayer.

18                   “(2) ACTIVITIES OF DAILY LIVING.—For pur-  
19                   poses of paragraph (1), each of the following is an  
20                   activity of daily living:

21                   “(A) BATHING.—The overall complex be-  
22                   havior of getting water and cleansing the whole  
23                   body, including turning on the water for a bath,  
24                   shower, or sponge bath, getting to, in, and out

7

1 of a tub or shower, and washing and drying  
2 oneself.

3 "(B) DRESSING.—The overall complex be-  
4 havior of getting clothes from closets and draw-  
5 ers and then getting dressed.

6 "(C) TOILETING.—The act of going to the  
7 toilet room for bowel and bladder function,  
8 transferring on and off the toilet, cleaning after  
9 elimination, and arranging clothes.

10 "(D) TRANSFER.—The process of getting  
11 in and out of bed or in and out of a chair or  
12 wheelchair.

13 "(E) EATING.—The process of getting  
14 food from a plate or its equivalent into the  
15 mouth.

16 "(3) PHYSICIAN.—The term 'physician' means  
17 a doctor of medicine or osteopathy legally authorized  
18 to practice medicine or surgery in the jurisdiction in  
19 which he makes the determination under paragraph  
20 (1).

21 "(c) SPECIAL RULES.—For purposes of this section,  
22 rules similar to the rules of paragraphs (1), (2), (3), and  
23 (4) of section 21(e) shall apply.

8

1       “(d) REGULATIONS.—The Secretary shall prescribe  
2 such regulations as may be necessary to carry out the pur-  
3 poses of this section.”

4       (b) CONFORMING AMENDMENTS.—

5             (1) Paragraph (2) of section 1324(b) of title  
6 31, United States Code, is amended by inserting “or  
7 36” after “section 35”.

8             (2) The table of sections for subpart C of part  
9 IV of subchapter A of chapter 1 of such Code is  
10 amended by striking the item relating to section 36  
11 and inserting the following:

“Sec. 36. Credit for taxpayers with certain persons requiring cus-  
todial care in their households.

“Sec. 37. Overpayments of tax.”

12       (c) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to taxable years beginning after  
14 December 31, 1995.

## 15       **TITLE III—CHILD PROTECTION**

### 16       **SEC. 301. INCREASED PENALTIES FOR USE OF A COM-** 17                             **PUTER IN SEXUAL CRIMES AGAINST CHIL-** 18                             **DREN.**

19       The United States Sentencing Commission shall  
20 amend the sentencing guidelines applicable to section  
21 2252 of title 18, United States Code, to increase the of-  
22 fense level by 2 levels if a computer was used in the trans-  
23 porting or shipment of the visual depiction.

THIS SEARCH  
Next Hit  
Prev Hit  
Hit List

THIS DOCUMENT  
Forward  
Back  
Best Sections  
Doc Contents

GO TO  
New Bills Search  
HomePage  
Help

*Family Reinf. Act - \$ 8 bill*

## H.R.2491

**Balanced Budget Act of 1995 (Enrolled Bill (Sent to President))**

### **SEC. 11005. DEDUCTION FOR TAXPAYERS WITH CERTAIN PERSONS REQUIRING CUSTODIAL CARE IN THEIR HOUSEHOLDS.**

(a) IN GENERAL- Part VII of subchapter B of chapter 1 is amended by redesignating section 221 as section 222 and by inserting after section 220 the following new section:

### **'SEC. 221. TAXPAYERS WITH CERTAIN PERSONS REQUIRING CUSTODIAL CARE IN THEIR HOUSEHOLDS.**

'(a) ALLOWANCE OF DEDUCTION- In the case of an individual who maintains a household which includes as a member one or more qualified persons, there shall be allowed as a deduction for the taxable year an amount equal to \$1,000 for each such person.

'(b) QUALIFIED PERSON- For purposes of this section, the term 'qualified person' means any individual--

- '(1) who is a father or mother of the taxpayer, his spouse, or his former spouse or who is an ancestor of such a father or mother,
- '(2) who is physically or mentally incapable of caring for himself,
- '(3) who has as his principal place of abode for more than half of the taxable year the home of the taxpayer,
- '(4) over half of whose support, for the calendar year in which the taxable year of the taxpayer begins, was received from the taxpayer, and
- '(5) whose name and TIN are included on the taxpayer's return for the taxable year.

For purposes of paragraph (1), a stepfather or stepmother shall be treated as a father or mother.

'(c) SPECIAL RULES- For purposes of this section, rules similar to the rules of paragraphs (1), (2), (3), and (4) of section 21(e) shall apply.'

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS- Subsection (a) of section 62 is amended by inserting after paragraph (16) the following new paragraph:

- '(17) TAXPAYERS WITH CERTAIN PERSONS REQUIRING CUSTODIAL CARE IN THEIR HOUSEHOLDS- The deduction allowed by section 221.'

(c) CLERICAL AMENDMENT- The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following new items:

`Sec. 221. Taxpayers with certain persons requiring custodial care in their households.

`Sec. 222. Cross reference.'

(d) EFFECTIVE DATE- The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

**Subtitle B--Savings and Investment Incentives**

**CHAPTER 1--RETIREMENT SAVINGS INCENTIVES**

**Subchapter A--Individual Retirement Plans**

***PART I--RESTORATION OF IRA DEDUCTION***

**SEC. 11011. RESTORATION OF IRA DEDUCTION.**

**(a) INCREASE IN INCOME LIMITS FOR ACTIVE PARTICIPANTS-**

(1) IN GENERAL- Subparagraph (B) of section 219(g)(3) (relating to applicable dollar amount) is amended to read as follows:

`(B) APPLICABLE DOLLAR AMOUNT- The term 'applicable dollar amount' means the following:

`(i) In the case of a taxpayer filing a joint return:

**The applicable**

**'For taxable years beginning in:**

**dollar amount is:**

	1996
\$45,000	
	1997
\$50,000	
	1998
\$55,000	
	1999
\$60,000	
	2000
\$65,000	

**DRAFT: COMPARISON BETWEEN THE 1995 PROPOSALS AND THE  
PRESIDENT'S PROPOSED TAX CREDIT FOR LONG-TERM CARE**

	1995 House Budget Proposal	1995 Conference Budget Proposal	1999 President's Budget Proposal
<b>Basic Policy</b>	\$500 Credit for Caregivers of Parents with Long-Term Care Needs	\$1,000 Deduction for Long-Term Care Expenses	\$1,000 Credit for People with Long-Term Care Needs or their Caregivers
<b>Cost over 5 years</b>	\$0.9 billion (JCT)	\$0.56 billion (JCT)	\$5.5 billion (Treasury)
<b>Who Gets the Credit:</b>			
Caregivers of <u>Parents</u> with Chronic Illness & Disability	Yes	Yes	Yes
<i>If parent is financially independent or not living with caregiver</i>	No	No	Yes
Caregivers of <u>Adults</u> with Chronic Illness & Disability	No	No	Yes
Caregivers of <u>Children</u> with Chronic Illness & Disability	No	No	Yes
<u>Spouses</u> of People with Chronic Illness & Disability	No	No	Yes
<u>People</u> with Chronic Illness & Disability <u>Themselves</u>	No	No	Yes
<b>Upper income limits</b>	None	None	\$95,000 for singles, \$130,000 for couples

- The President's tax proposal is one part of a broader initiative that includes the new \$625 million Family Caregiver Program that would provide real services -- respite care, counseling, information -- to caregivers. Aging advocates strongly support this initiative both because the tax proposal is much broader and more generous and because the financial assistance is complemented by the important, new Caregiver Program.
- The President did not veto the 1995 Republican budget because of the tax proposal -- he vetoed the legislation because of its massive cuts to Medicare, Medicaid, education, and environmental spending.

## **PRESIDENT CLINTON'S LONG-TERM CARE INITIATIVE:**

### **How It Assists Non-Elderly People with Long-Term Care Needs, January 4, 1999**

Today, President Clinton is unveiling an historic new initiative to support Americans with long-term care needs and the millions of family members who care for them. This four-part, \$6.2 billion (over five years) initiative takes important steps to address complex long-term care needs through: (1) an unprecedented \$1,000 tax credit that compensates for formal or informal costs of Americans with long-term care needs or the family caregivers who support them; (2) a new National Family Caregivers Support Program that provides a range of critical services for caregivers such as respite care, information, and referral; (3) a national campaign to educate Medicare beneficiaries about the programs' limited coverage and how best to evaluate long-term care options; and (4) a proposal to have the Office of Personnel Management (OPM) serve as a model employer by offering quality private long-term care insurance to Federal employees.

Although most people with long-term care needs are elderly, a large and growing number of non-elderly Americans have chronic illnesses or disabilities and would benefit from these policies. About two million non-elderly Americans have significant limitations due to illness or disability and live in the community. The number of children with disabilities has been rising. Long-term care, provided in the most appropriate, integrated setting, can help children grow to their full potential and enable adults to live independently.

- **\$1,000 tax credit for people with long-term care needs or their family caregivers.** This new tax credit would target people of all ages with three or more limitations in activities of daily living (ADL) or severe cognitive impairments. It recognizes the diverse needs of people with disabilities and their families, compensating for the wide range of formal and informal costs of long-term care, such as personal assistance services, respite care, and reduced hours at work for the caregiver. An estimated 500,000 non-elderly adults and 250,000 children or their family caregivers would benefit from this credit.
- **National campaign to educate Medicare beneficiaries about long-term care options.** Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long term care. This \$10 million nationwide campaign would provide all 39 million Medicare beneficiaries -- including the 5 million beneficiaries with disabilities -- with critical information about long-term care options including: what long-term care Medicare does and does not cover; how to find out about Medicaid long-term care coverage; what to look for in a quality private long term care policy; and how to access information about home and community based care services that best fit beneficiaries need.
- **Offering quality private long-term care insurance to Federal employees.** This proposal allows the Federal government as the nation's largest employer to use its market leverage and set a national example by offering quality private long-term care insurance to all Federal employees, retirees, and their families. About 100,000 Federal employees with some type of disability and another 27,000 employees with severe disabilities would be eligible.

These proposals represent the President's ongoing commitment to promoting community-based long-term care, as demonstrated by his approval of over 300 Medicaid home and community-based waivers, proposal to eliminate the need for such waivers, and other administrative actions.

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

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

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

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

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

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

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

**Q. How is this initiative funded?**

- A. This initiative is fully funded through offsets in the President's proposed FY 2000 budget. The tax proposal is funded through tax offsets such as closing tax loopholes. All of these provisions will be described in the budget documents released in early February.

**Follow-up:** Isn't it irresponsible to announce specific spending proposals without announcing how these proposals will be financed?

Not at all. The President will ensure that this -- and all other new initiatives -- will be fully paid for as part of his overall balanced budget proposal. Like most budgets, the President's FY2000 budget will not contain a specific dollar-for-dollar link between new proposals and offsets. The bottom line, however, will reflect the President's long-standing commitment to a balanced budget. Moreover, not one dime will be taken away from the surplus for this initiative.

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

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

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

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

response.

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

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

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

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

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

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

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

A. Anyone who has followed this President since he has taken office will recognize his ongoing commitment to help meet the needs of American families. This initiative is a classic example of that commitment. The

President has been working on it since the Spring of 1998 and, because it is a new initiative that will be included in his upcoming FY2000 budget, wanted to release it early to ensure that it receives the attention and consideration that it deserves.

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

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

**Q. Is the Medicare buy-in, the Jeffords-Kennedy bill, etc. in this year's budget?**

A. The President will not address any other health-care initiatives today. In the coming weeks, he will unveil other proposals and initiatives in the budget. For today, we want to focus on this new and historic commitment to address Americans' long-term health care needs.

## BACKGROUND: PRESIDENT CLINTON'S LONG-TERM CARE INITIATIVE

January 4, 1999

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

### GROWING NEED FOR LONG-TERM CARE

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

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

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

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

## LONG-TERM CARE SYSTEM

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

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

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

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

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

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

## **LONG-TERM CARE INITIATIVE**

The challenges of providing and financing long-term care are clearly large and multi-dimensional. No single policy can provide the answer. As such, the President is proposing a four-part, \$6.2 billion (over five years) initiative takes important steps to address complex long-term care needs (described in detail in subsequent pages):

- **Direct financial support through a new tax credit for people with long-term care needs or their family caregivers.** This credit helps pay for the formal and informal costs associated with care for people with significant long-term care needs.
- **Direct service support through a new Family Caregivers Program** that provides information, education, counseling, and respite services directly to families that care for elderly, ill or disabled relatives.
- **Education for Medicare beneficiaries about long-term care issues and options.** Since most people who develop long-term care needs are Medicare beneficiaries, Medicare can be used to provide information on the limitations of its coverage, alternative sources of long-term care services and financing, and how best to choose the most appropriate options.
- **High-quality, affordable private long-term care insurance for Federal employees.** The Federal government would develop a model program to offer high quality, private long-term care insurance policies to its employees, retirees and eligible family members. By offering this coverage, the Federal government will both guide public policy by example and act responsibly as the largest employer in the nation.

## **TAX CREDIT FOR PEOPLE WITH LONG-TERM CARE NEEDS OR THEIR CAREGIVERS**

Eligible people with long-term care needs or their caregivers would receive a \$1,000 tax credit beginning in 2000. This would help about 2 million people, at a cost of \$5.5 billion for 2000-04.

- **Goal:** This policy offsets some of the paid and unpaid long-term care costs incurred by people with chronic illness or the families with whom they live. A large proportion of long-term care costs are not covered by insurance, and studies suggest that the value of informal, unpaid long-term care provided by families is worth billions of dollars.
- **Amount of the credit:** The credit is \$1,000. It phases out for higher income tax payers (taxpayer with modified adjusted gross income exceeding \$110,000 for couples, \$75,000 for unmarried taxpayers, and \$55,000 if the taxpayer is married but filing a separate return; same phase-out as the child tax credit). This credit cannot exceed the total amount of tax liability except, however, it may be refundable for taxpayers with 3 or more dependents.

The flat \$1,000 credit would be given on the basis of a certified need for long-term care rather than expenses for long-term care. This means that families and people with chronic illness or disability do not have to collect and submit receipts for paid home health or respite care. It also recognizes the costs associated with informal, family caregiving. For example, a wife whose husband has had a stroke would not have a receipt for her reduced hours at work, time spent bathing and feeding her husband and other real costs associated with care.

- **Eligibility:** Three types of people could receive this tax credit: (1) taxpayers with long-term care needs; (2) taxpayers whose spouses have long-term care needs; and (3) taxpayers with dependents with long-term care needs.
- **“Person with long-term care needs”:** For this credit, this includes:
  - People with 3 or more limitations in activities of daily living (ADL) (bathing, dressing, eating, toileting, transferring and continence management) who cannot perform these activities without substantial assistance from another individual due to a condition lasting for longer than 6 months, as certified by a licensed doctor in the previous 12 months.
  - People with severe cognitive impairments who require substantial supervision to be protected from threats to their health and safety due to this condition and have difficulty with one or more ADLs or one of four major instrumental ADLs.
  - Children ages 2 through 6 who have difficulty with 2 out of 3 ADLs (eating, transferring and mobility) or are under the age of 2 and require skilled caregiver in the parents’ absence or specific durable medical equipment (e.g., a respirator) for over 6 months. Within one year, HHS and Treasury will report on whether these eligibility rules are appropriate and how to improve them if necessary.

- **“Caregivers”:** Families would be eligible for the credit as caregivers if their relatives with long-term care needs can be claimed as dependents. Under current law, a “dependent” is generally an individual who does not pay taxes, is related to the taxpayer, receives more than half of his or her support from the taxpayer, and has gross income less than \$2,750. For purposes of this credit, this definition would be expanded significantly in two ways. First, individuals with long-term care needs would not have to meet the support test if they live with a taxpayer who is a close relative for at least half the year (the entire year in the case of a distant relative and other persons). Second, the limit on gross income would be raised to the sum of the exemption amount, the standard deduction, and the additional deduction for the elderly and blind (to \$8,100 for single elderly person; in general, Social Security benefits are excluded from gross income for moderate to low-income individuals). Most people with income above this limit would file taxes and receive the long-term care credit themselves

Broadening the definition of dependency for the purposes of this credit is a major change that allows many more families that house and care for relatives to receive the credit. It does so by allowing caregiving relatives of individuals with long-term care needs to claim the credit when those individuals themselves have insufficient income to pay taxes.

- **Who benefits:** About 2 million people would benefit from this credit: about 1.2 million elderly, about 500,000 nonelderly adults, and about 250,000 children. About three-fourths of people receiving the credit are expected to be spouses or family caregivers of these people with long-term care needs. Almost all recipients are middle class; about 75 percent of elderly taxpayers have income below \$50,000.
- **Cost:** About \$5.5 billion over the five-year budget window.

TAX CREDIT FOR PEOPLE WITH LONG-TERM CARE NEEDS: Examples Assuming 1999 Levels					
Elderly Single Person		Elderly Married Couple (1)		Caregiver of Elderly Person (2)	
<b>INCOME</b>					
Social Security (3)	9,420	Social Security (4)	16,086	Senior's Soc Security (3)	9,420
Pensions	13,765	Pensions	14,370	Son's Income	46,000
Interest Income	1,000	Interest Income	1,500		
<b>Total Money Income</b>	<b>24,185</b>	<b>Total Money Income</b>	<b>31,956</b>	<b>Total Money Income</b>	<b>55,420</b>
<b>Adj. Gross Income</b>	<b>14,765</b>	<b>Adj. Gross Income</b>	<b>15,870</b>	<b>Adj. Gross Income</b>	<b>46,000</b>
<b>TAX LIABILITY</b>					
Exemption	-2,750	Exemption	-5,500	Exemption	-8,250
Standard Deduction	-4,300	Standard Deduction	-7,200	Standard Deduction	-7,200
Elderly Deduction	-1,050	Elderly Deduction	-1,700	Elderly Deduction	
<b>Taxable Income</b>	<b>6,665</b>	<b>Taxable Income</b>	<b>1,470</b>	<b>Taxable Income</b>	<b>30,550</b>
Current Law Tax Liability	1,000	Current Law Tax Liability	221	Current Law Tax Liability	4,583
				Current Law Child Tax Credit	-500
<b>Proposed LTC Credit</b>	<b>-1,000</b>	<b>Proposed LTC Credit</b>	<b>-1,000</b>	<b>Proposed LTC Credit</b>	<b>-1,000</b>
<b>Proposed Law Tax Liability</b>	<b>0</b>	<b>Proposed Law Tax Liability</b>	<b>0</b>	<b>Proposed Law Tax Liability</b>	<b>3,083</b>

Dept of the Treasury; Office of Tax Analysis. (1) Only one individual needs long-term care; both are older than 65. (2) Single elderly person moves in with son, his wife & teenage son; total income (including grandfather's) roughly equals the median income for a family of 4. (3) Weighted average of benefits paid to retired workers, and widows and widowers, in 1996 adjusted for inflation. (4) Average benefits paid to retired workers and their wives in 1996 adjusted for inflation.

## NEW FAMILY CAREGIVER SUPPORT PROGRAM

A new National Family Caregivers Support Program would support families who provide long-term care to elderly relatives with chronic illnesses or disabilities through state and local area agencies on aging. This \$125 million program would help approximately 250,000 families.

- **Goal:** This policy provides support for families who care for relatives with chronic illness in hope of easing the emotional, physical and financial strain of caregiving. Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that counseling and support for families of Alzheimer's disease patients can delay institutionalization for as long as a year.
- **Eligibility:** Families -- especially low-income families -- who provide care to elderly relatives with limitations in activities of daily living would be eligible for services.
- **Services provided:** Funding would be used to help families that take care of elderly relatives with significant long-term care needs. This assistance would include:
  - Connecting families with information on caregiver resources and local services (e.g., detailed information on the condition affecting their relative; names and numbers of local home care and respite services);
  - Providing counseling, training and peer support to teach families how to face the challenges of caregiving (e.g., how to bath people who have had strokes; what exercises work best for people with severe arthritis; how to cook meals for people with diabetes; how to manage the stress of caregiving);
  - Providing and paying for respite care (e.g., attendants so that the caregiver can shop or leave the house for other reasons, adult day care centers, and temporary care in an assisted living facility or nursing home). For people providing intense long-term care, these services provide necessary, temporary relief from caregiving responsibilities, allowing them to restore balance to their lives that strengthens their ability to continue to provide assistance. Most of the funding of this program would pay for respite services.

Additionally, a competitive grant program would test innovative interventions (e.g., use of computer information for distant caregivers) and challenges for subgroups of caregivers (e.g., minority caregivers; caregivers for people with severe conditions like brain injuries).

- **Administration:** All state agencies on aging would receive a grant from the Administration on Aging for distribution to local area agencies on aging. These Federal grants would be matched by the states and states could not reduce their current spending on such services. States would develop a sliding fee scale consistent with its other programs.

- **Who benefits:** Altogether about 250,000 families could be served by this program.
- **Examples:** The following programs serve as models for this new, nationwide program:
  - **California:** Its Department of Mental Health developed a program in 1985 to provide caregiver support services through eleven agencies statewide. These agencies target families caring for persons with Alzheimer's disease, Parkinson's disease, stroke, and traumatic brain injury. Services include needs assessment, information and referral, family consultation and training, support groups, and respite care.
  - **New Jersey:** The Statewide Respite Care Program was established in 1988 to help unpaid caregivers of the stress arising from providing intensive personal assistance to a family member. Annually, over 2,000 families receive respite care provided through adult day care centers, short-term placement in the home of a trained individual, or overnight nursing home stays. One quarter of the families helped by the program are caring for someone with Alzheimer's disease; heart disease, stroke and arthritis are the next most common chronic conditions of the program's care recipients. A recent evaluation found that families helped through its adult day care had much lower feelings of worry, strain and overload, and fewer experienced depression or anger. Depression is a major problem for caregivers, not only limiting their ability to help their relative but restricting their own lives and activities.
  - **Washington:** Washington State Aging and Adult Services Administration established a program in 1989 to provide assistance to family caregivers. Through its area agencies on aging, it offers respite services to 2,800 families annually. Several thousand families receive caregiver training. Respite services are prioritized based on the caregiver's vulnerability, intensity of care provided by family members, and presence of other family and/or community supports.
  - **Wisconsin.** Since 1986, Wisconsin Bureau on Aging has funded county aging and social services offices to work with families to identify the types and amounts of assistance needed to care for relatives diagnosed with Alzheimer's disease or a related disorder. Covered services include respite care, provided in the home or in adult day care, and in-home help. In addition, assistive devices, caregiver training, and peer group supports are financed. Families share in the cost based on income. About 1,000 families benefit from funded respite care or in-home help and another 4,600 families are helped through caregiver training, information and peer group supports.
- **Cost:** The total funding is \$125 million in FY 2000 and \$625 million over five years, most of which would be distributed among all states, and a small part of which would be used for the competitive grant program. Additionally, funds would be set aside for an evaluation of these efforts -- in an effort to identify what works and doesn't work so that future efforts are best targeted.

## **LONG-TERM CARE INFORMATION CAMPAIGN FOR MEDICARE BENEFICIARIES**

A National Long-Term Care Information Campaign will be conducted to help Medicare beneficiaries and their families better understand their long-term care options. All 39 million Medicare beneficiaries would receive this information through this \$10 million initiative.

- **Goal:** This policy provides information on long-term care to Medicare beneficiaries -- who comprise most of the people who have or will develop long-term care needs. Since nearly 60 percent of beneficiaries do not realize that Medicare does not cover most long-term care, this information is critical to educating them about their coverage and directing them to financing and delivery systems.
- **Information provided:** The Health Care Financing Administration (HCFA), working with other components of DHHS, would conduct this information campaign. It would include information about long-term care coverage under the Medicare and Medicaid programs; what to look for in a private long-term care insurance policy; how to access home and community-based care; and other consumer information. Components of the campaign would include:
  - Developing and distributing printed educational materials about long-term care options and resources to beneficiaries and their families;
  - Incorporating information about long-term care options and resources into the Medicare handbooks, toll-free phone numbers and the consumer internet site, [www.Medicare.gov](http://www.Medicare.gov);
  - Enhancing training on long-term care options in organizations that provide information to beneficiaries including state health insurance assistance programs, Medicare carriers and fiscal intermediaries, area agencies on aging and Social Security Administration offices;
  - Working with groups representing the elderly, people with disabilities, the long-term care industry, employers, states and others to disseminate information to their constituencies.

In addition, HCFA would conduct pilot information campaign projects focusing on the needs of particular populations such as people with disabilities, people who don't speak English, or the rural elderly. An evaluation component would be included to identify what works best in assisting beneficiaries in making informed long-term care decisions.

- **Who benefits:** All 34 million seniors and 5 million people with disabilities are covered by Medicare would receive this information. Since a large proportion of people with long-term care needs are elderly or adults with disabilities, Medicare is an extremely efficient way to target such people.
- **Cost:** \$10 million in FY 2000.

## OFFERING PRIVATE LONG-TERM CARE INSURANCE TO FEDERAL EMPLOYEES

This proposal would authorize the U.S. Office of Personnel Management (OPM) to make private long-term care insurance available to Federal employees, retirees, and eligible family members at negotiated group rates. The cost of administration of this benefit would be about \$15 million over 5 years and an estimated 300,000 people would participate.

- **Goal:** This initiative would educate Federal employees and retirees about long-term care options and encourage the purchase of high-quality, long-term care insurance at 15-20 percent below market rates. This is one in an ongoing series of efforts in which the Federal government has taken a leadership role by both guiding public policy by example and acting responsibly as the largest employer in the nation.
- **Eligibility:** People eligible to purchase this insurance would include: Federal employees and retirees; and their spouse; former spouses who are entitled to annuities under a Federal retirement system; and parents, and parents-in-law. In its first year, OPM would run a campaign to educate possible participants about long-term care insurance and solicit and evaluate potential insurers. In the second year, it would hold an open enrollment for all eligible participants. New employees and employees electing coverage during the open enrollment period would be subject to either minimal or no underwriting. All others will be required to disclose additional information about their health status in order to acquire coverage. Once enrolled, coverage would be guaranteed renewable and could not be canceled except for nonpayment of premium.
- **Types of insurance policies offered:** OPM would select a single qualified carrier, or a very small number of carriers, to provide one or more long-term care insurance policies. This selection of carriers would be based on quality, service and price. At a minimum, carriers must be licensed under state law, compliant with the Health Insurance Portability and Accountability Act standards, and offer guaranteed renewability of their policies. OPM would set a basic benefit package consistent with the National Association of Insurance Commissioners' standards (e.g., with a minimum benefit level; inflation protection; contingent nonforfeiture) and may offer plans with additional coverage (e.g., higher reimbursement levels for nursing home care or a more flexible benefit that can be used for whatever type of service the person needs). OPM would have the flexibility to administer the program as the market for long-term care services and protections evolves over time.
- **How much participants would pay:** The full cost of premiums would be paid by the participant. OPM would negotiate group rates that it expects will be 15 to 20 percent lower than the cost of individual long-term care policies. Employee and annuitant premiums would be withheld from salary or annuity and sent directly to respective contractors.
- **Cost:** The Federal administrative costs would be about \$15 million over 5 years.