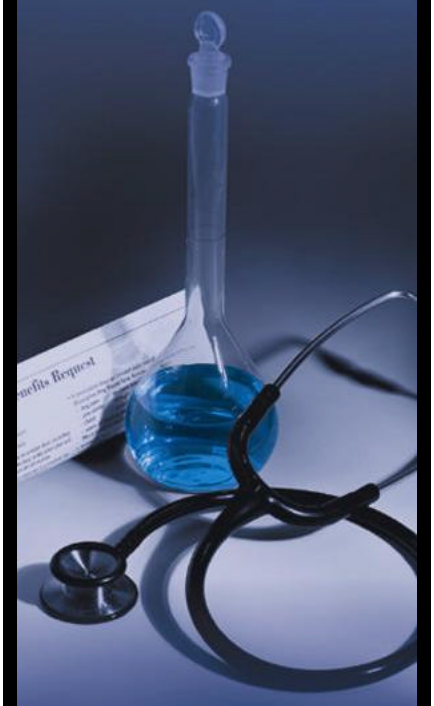

KPMG Consulting

# Design & Test of Evidence-Based Communications Strategies to Increase Consumer Understanding & Awareness of Long-Term Care Options

**ENVIRONMENTAL SCAN: LEGISLATIVE & REGULATORY BRIEF**

**Contract No. 500-96-0006**

## Final Report

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The *Legislative and Regulatory Brief* was authored by Keith Cherry, Amy Bradshaw, Rachel Quinn, and Kelly Dobson of Barents Group of KPMG Consulting Inc. Eileen Tell of the Long Term Care Group, Inc. and Brian Burwell of The MEDSTAT Group provided extensive comment. We would also like to thank the Health Care Financing Administration and our Project Officer, Ted Chiappelli, for his support and assistance throughout this effort. The opinions expressed in this report are the authors' and do not necessarily reflect the views of the Health Care Financing Administration or of the authors' respective organizations.

# EXECUTIVE SUMMARY

## Overview

Any communications campaign around long-term care must recognize the policy environment that frames issues in the eyes of lawmakers and the public. This framework is likely to influence the campaign throughout its life: from planning and implementation to sustaining support for the effort.

This brief is a preliminary look at the policy environment as it relates to long-term care. Long-term care issues are viewed here through a national lens, with the brief examining legislative and regulatory activity over the past two years (1999-2000) in two key areas: financing and delivery of long-term care services (including tax issues related to long-term care); and consumer protection and education. This memo is considered preliminary in two respects: first, the MEDSTAT team will continue to monitor long-term care public policy debates over the duration of its 30-month project, with a particular eye to any relevant new policy directions under the Bush Administration. Furthermore, the MEDSTAT team will focus more intently on relevant state and local issues as it assesses pilot sites for the project. The brief concludes by summarizing the most prominent long-term care legislative and regulatory activity of the last two years, in addition to highlighting unresolved issues. Finally, implications for a long-term care communications campaign are discussed.

## Financing and Delivery of Long-Term Care Services

Given the important role that public programs (Medicaid and, to a lesser extent, Medicare) play in paying for long-term care services, it is perhaps not surprising that financing is a significant long-term care issue for federal policymakers. In the past two years, the most prominent policy debates have been in response to changes mandated by the Balanced Budget Act (BBA) of 1997. As it became clear that reductions in Medicare expenditures would be much greater than expected under the BBA's **prospective payment system (PPS)** for both skilled nursing facility (SNF) and home health (HH) care, Congress sought to remedy the situation with several giveback bills and to delay **payment cuts for home health agencies**. In addition to scrutinizing payments to providers, policymakers expanded the potential universe of people who may receive long-term care services via Medicare or Medicaid. In particular, provisions like the **Ticket to Work and Work Incentives Improvement Act of 1999** make it easier for persons with disabilities to work without losing their eligibility for Medicare or Medicaid. Services and supports for persons with disabilities also became a significant policy issue with the advent of ***Olmstead v. L.C.***, in which the U.S. Supreme Court ruled that the institutionalization of a person with a physical and/or mental disability who could be and wants to be treated in a community-based setting is a violation of the Americans with Disabilities Act (ADA). The Court's decision generated a flurry of compliance activity on the part of the federal and state governments.

Beyond Medicare and Medicaid policy, lawmakers have recognized the role of private insurance in financing long-term care. After at least a decade of interest by both Republicans and Democrats, the 106th Congress, with a push from the Clinton Administration and the Office of Personal Management (OPM), passed a bill that will effectively make the federal government the largest employer sponsor of group coverage for long-term care. The **Long-Term Care Security Act** offers current and retired federal employees and military personnel and their families voluntary long-term insurance options that cover a range of services at group rates, including home healthcare, adult day care and nursing home care.

Finally, policymakers have debated tax incentives for the purchase of long-term care insurance and to ease the financial burdens of caregiving. These debates have come on the heels of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which was significant in clarifying the tax treatment of long-term care insurance. Under HIPAA, a portion of premiums for a tax-qualified plan can be deducted in some instances. Some lawmakers want to go beyond HIPAA and have proposed **expanding the tax deductibility of premiums**. To create tax breaks for both buyers and non-buyers of long-term care insurance, former President Clinton advocated in both 1999 and 2000 for a **tax credit for the formal or informal care of people with functional limitations** in at least three of the six basic activities of daily living (e.g., bathing, dressing, toileting, transferring, continence, and eating). On the other hand, President Bush favors creating a new **personal tax exemption** for households where family members provide care to an aging spouse, parent, or relative.

**Consumer Protection and Education**

Protection and education of long-term care consumers has come into the federal policymaking arena as the long-term care insurance market has developed and the stakes of financing long-term care have become clearer. While regulation of long-term care insurance is predominantly under state purview, members of Congress have shown some interest in state **compliance with model laws set forth by the National Association of Insurance Commissioners (NAIC)** and in protecting consumers of federally qualified policies from **unexpected and extreme rate hikes**. The NAIC has urged Congress to reference some of its new consumer protections on nonforfeiture and suitability, but leave rate stability issues to state regulators. To date, consumer education from the federal government about long-term care has been focused primarily on nursing home fraud and abuse. However, both Congressional members and former President Clinton have recognized the need for broader consumer education about long-term care. For his part, Clinton included two educational components in the long-term care initiative that was part of his budget proposal for federal fiscal year 2000. One of Clinton's proposals led to the creation of the Administration on Aging's **National Family Caregiver Support Program**; his other initiative spurred the Health Care Financing Administration's (HCFA) project to design and test communication strategies to **increase consumer understanding and awareness of long-term care**.

**Conclusions**

A review of legislative and regulatory initiatives reveals, for the most part, bi-partisan efforts at incremental reform. This pace and approach leaves important long-term care issues looming on the federal landscape, a landscape fraught with the uncertainty of a new Administration and of changes in important Congressional leadership posts. Despite this uncertainty, recent legislative and regulatory activity suggests some possible implications for the project. Specifically:

- Long-term care issues have been raised in such a way that they probably have not touched the general public to a great extent. Although policymakers have addressed long-term care issues, they have done so in a mostly piecemeal and esoteric fashion (e.g., changing Medicare payment systems) that does not easily lend itself to broader public discussion.
- Because of initiatives like Olmstead and Ticket to Work, certain groups of persons with disabilities may be exceptionally receptive to planning messages. Furthermore, there may be opportunities for the MEDSTAT team to piggyback outreach on initiatives related to Olmstead and Ticket to Work.
- Presuming they come up in the 107th Congress, issues like premium deductibility and tax incentives for caregiving may create a "news peg" for generating media coverage in project pilot sites. The HCFA project can help consumers take a step back to the information sources they need to consider long-term care insurance and other facets of long-term care.
- The National Family Caregiver Support Program, while focused on people in immediate need of services, may also create partnership opportunities and media interest in long-term care issues.
- The OPM insurance initiative under the Long-Term Care Security Act will be an important model for educational strategies. These strategies will articulate the "government line" on long-term care and will presumably take federal government employees and retirees from a low level of awareness to a decision-making stage.
- As evidenced by active lobbying and coalition-building in the past two years, the long-term care and insurance industries will almost certainly have a vested interest in HCFA's long-term care communications campaign. This interest could be cultivated in a way that boosts the campaign's message, without necessarily allying HCFA with industry groups.
- Members of Congress, with an increasing awareness of long-term care issues, may be supportive of pilot programs in their districts and of a federal long-term care communication campaign in general.
- State legislative and regulatory activities, especially around long-term care tax incentives and state-sponsored long-term care insurance programs, merit close attention in the project's pilot sites. State activities may provide an important undercurrent of public awareness and education about the need to plan for long-term care.

# ENVIRONMENTAL SCAN: LEGISLATIVE AND REGULATORY BRIEF

## Overview

Any communications campaign around long-term care must recognize the policy environment that frames issues in the eyes of lawmakers and the public. This framework is likely to influence the campaign throughout its life. In the planning stage, the policy agenda of a campaign sponsor (such as the Health Care Financing Administration (HCFA)) will certainly influence the policy goals, target audiences, and messages of a communications campaign. As the campaign is implemented, political discourse will, to some degree, amplify or obscure the campaign's messages. Consumers may be more or less receptive to the campaign's messages, depending on the long-term care issues that are in the public forum and the degree to which they are visible. Finally, the political environment will help determine the ultimate fate of a government-sponsored campaign: whether it will continue and grow or whether it will succumb to higher priorities.

This brief is a preliminary look at the policy environment as it relates to long-term care. Long-term care issues are viewed here through a national lens, with the brief examining legislative and regulatory activity over the past two years in two key areas: financing and delivery of long-term care services (including tax issues related to long-term care); and consumer protection and education. This memo is considered preliminary in two respects: first, the MEDSTAT team will continue to monitor long-term care public policy debates over the duration of its 30-month project, with a particular eye to any relevant new policy directions under the Bush Administration. Furthermore, the MEDSTAT team will focus more intently on relevant state and local issues as it assesses pilot sites for the project. This assessment is likely to be important, since states jointly administer the Medicaid program that pays for over a third of long-term care services, have significant responsibility for regulating insurance products (including long-term care insurance), and have been inclined to adopt tax-incentives related to long-term care insurance or to offer group coverage for civil servants.

The brief concludes by summarizing the most prominent long-term care legislative and regulatory activity of the last two years, in addition to highlighting unresolved issues. Finally, implications for a long-term care communications campaign are discussed.

## Methodology

Legislative and regulatory initiatives for the period 1999-2000 were identified primarily through a review of the public policy/trade press and major electronic databases of legislative and executive branch materials. Databases included, but were not limited to, Lexis-Nexis and THOMAS (a service of the Library of Congress), the Health Insurance Association of America's Hi-Wire service tracking state and federal legislation and regulation affecting the insurance industry, NILS, and ODEN (an on-line resource for laws and regulations specific to long-term care insurance). When possible, full text of legislative and regulatory initiatives was analyzed (rather than relying on secondary research).

# FINANCING AND DELIVERY OF LONG-TERM CARE SERVICES

This section discusses the role of the government as both a purchaser and regulator in the long-term care marketplace. Both of these roles occur predominantly with respect to the Medicaid and Medicare programs, which together cover a greater percentage of long-term care expenditures than any other source (public or private).

## Paying for Long-Term Care

On an aggregate, patients and their families are responsible for paying for about 33 percent of all nursing home expenses and 20 percent of all home care expenses (see Table 1). Most of the balance is paid for by Medicare, when certain conditions of care are met, or by Medicaid, on behalf of individuals who meet income and asset requirements for that program.

**Table 1. Spending for Nursing Home and Home Health Care, 1998**

| Payment Source | Nursing Home/ICFMRs | Home Health Care |
|---|---|---|
| Medicare | 11.8% | 35.6% |
| Medicaid | 46.2% | 17.1% |
| Out-of-Pocket | 32.5% | 20.5% |
| Private Health Insurance | 5.4% | 13.7% |
| Other | 4.1% | 13.0% |

Source: Office of the Actuary, National Health Statistics Group, Personal Health Care Expenditures, HCFA, DHHS, 2000.

## Medicaid and Medicare Coverage

The past two years have seen relevant changes in both Medicaid and Medicare coverage. To begin to understand the significance of these changes it is important to have at least a basic understanding of the different roles that Medicaid and Medicare play in financing long-term care services.

Medicaid is by far the larger payer of the two programs, with Medicaid payments for long-term care services totaling $62.3 billion in FY 1999.[1] Approximately 75 percent of Medicaid long-term care expenditures are for institutional services, either for nursing homes or intermediate care facilities for persons with developmental disabilities. The remaining 25 percent of Medicaid expenditures for long-term care services are for community-based services. Of these Medicaid expenditures for home and community-based services, roughly three-quarters are for services to mentally retarded and developmentally disabled populations.[2]

[1] Burwell, B. *Medicaid Long-term Care Expenditures in FY 1999*. The MEDSTAT Group: Cambridge, MA. April 25, 2000.

[2] Harrington, et. al. *Medicaid Home and Community Based Waiver Participants, Services and Expenditures, 1992-1997*. University of California: San Francisco, CA. November 1999.

Medicare, on the other hand, provides only limited coverage of nursing home services. Medicare covers in full the first 21 days in a Medicare-certified skilled nursing facility, following discharge from a hospital stay of at least three days. For days 22 through 100, Medicare will pay expenses over and above a $99 per day co-payment.

Medicare provides relatively broad home health care coverage, but Medicare-covered home care visits are primarily structured to meet a beneficiary's medical needs. The Medicare home health care benefit provides assistance with beneficiary's long-term care needs (e.g. assistance with bathing, dressing, eating, etc.) only to the extent that they are incidental to treatment for a medical condition.

Although Medicare long-term care expenditures are significantly lower than those of Medicaid, Medicare long-term care costs have increased tremendously over the last decade. However, because of the newly implemented prospective payment systems for skilled nursing care and home health care (see below), Medicare expenditures for long-term care services have abated.

*Payments to Medicare Providers*. As mandated by the Balanced Budget Act (BBA) of 1997, HCFA replaced its retrospective payment system with a **prospective payment system (PPS)** for both skilled nursing facility (SNF) and home health (HH) care. Unlike the previous cost-based reimbursement system, which encouraged over-utilization of services, the PPS bases reimbursement on the average cost to provide care to a certain category of patient, determined in these cases by patient acuity and adjusted for regional differences. The SNF PPS implementation began in July 1998 and the HH PPS began in October 2000.

In addition to the implementation of the HH PPS, the BBA mandated a **15 percent reduction in payment** for home health agencies. The reduction was originally set to go into effect on October 1, 1999, but was delayed, first until October 1, 2000 and then again to October 1, 2001.

Estimates from the Congressional Budget Office indicated that the BBA would reduce Medicare expenditures by $116 billion from 1998 through 2002. Revised estimates indicate, however, that the figure will probably be about $227 billion. The home health industry will be especially hard hit, with reductions projected to be $69 billion over five years (four times the amount originally projected). Under the threat of severe reductions in payments to providers, Congress sought to remedy the situation with several giveback bills.

The **Balanced Budget Refinement Act of 1999**, passed as part of an omnibus appropriations bill for federal fiscal year 2000, provided $16 billion in givebacks over five years and $27 billion over ten. Payments for SNFs in 2001 and 2002 were increased by 20 percent for the 15 resource utilization groups (RUGs) for medically complex patients and by four percent for all others. The bill also mandated the development of a prospective payment system for long-term care and psychiatric hospitals to be implemented no later than October 1, 2002. Until implementation, the long-term care[3] and psychiatric hospitals will receive an increase in payments: 1.5 percent for fiscal year 2001 and a two percent increase for fiscal year 2002.

[3] The term "long-term care hospital," as defined in section 1886(d)(1)(B)(iv) of the Social Security Act, refers to a hospital with an average length of stay greater than 25 days.

Several additional giveback bills were proposed last year and in late October 2000, the House approved a bill, co-sponsored by 44 House Republicans and one Democrat, providing over $30 billion to Medicare providers. Democrats, however, were not satisfied with the bill and then-President Clinton threatened to veto the measure, arguing that it provided too much relief for managed care organizations and not enough for providers such as hospitals and home health agencies. Various provider groups put considerable pressure on House and Senate leaders to pass the **Benefits Improvement and Protection Act of 2000 (BIPA)** and, in December, it was ultimately enacted as the final item of business for the Congressional term. The measure will provide $32 billion in relief, with hospitals receiving an estimated $14 billion, managed care organizations $12 billion, and the remainder divided among SNFs, home health agencies, and other providers. Additionally, the bill will eliminate consolidated billing for non-Part A stays, eliminate the one percent reduction in the market basket for SNFs, and increase the nursing component of the RUGs.

Several bills calling for the elimination of the 15 percent reduction in payments to home health agencies were introduced in the 106th Congress, but did not pass despite significant bipartisan support.

*Medicare Modernization*. Medicare modernization was an issue both in the Congress and on the Presidential campaign trail over the past two years. This debate focused primarily on creating a prescription drug benefit within the Medicare program. The scope of long-term care or continuing care benefits did not figure significantly into the modernization debate. However, a bill introduced in July 2000 by Rep. Pete Stark (D-California), sought to establish a comprehensive national policy on chronic illness care. The **Chronic Illness Improvement Act of 2000 (**HR 4981) proposed expanding Medicare coverage to include services for the prevention and early detection of chronic illnesses, developing prototypes of coordinated care for two subpopulations of the chronically ill, and establishing national goals and measures related to chronic care. The bill died in committee.

*Repeal of the Boren Amendment*. HCFA recently engaged in rulemaking to provide state guidance on the repeal the **Boren Amendment**, which was pursuant to the BBA. The now-excised Boren Amendment required states to set Medicaid nursing home reimbursement rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards" (Section 1902(a)(13) of the Social Security Act). Some observers note that, to date, a good economy and modest increases in overall Medicaid expenditures have allowed most states to maintain their current nursing home reimbursement rates. The real test will occur with a downturn in the economy, when states trying to cut Medicaid costs will face opposition from the nursing home industry.

*Eligibility Expansions*. Recently, policymakers expanded the potential universe of people who may receive long-term care services via Medicare or Medicaid. In particular, these provisions have focused on persons with disabilities.

With overwhelming support in both chambers, Congress passed the **Ticket to Work and Work Incentives Improvement Act of 1999**, which allows disabled individuals receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) to work without losing their eligibility for Medicare or Medicaid.[4] Under the measure's provisions, disabled individuals with Medicare may retain premium-free Part A coverage for up to eight and a half years after returning to work and those covered by Medicaid may return to work and purchase Medicaid coverage if their earnings would disqualify them.

In implementing the law, the Department of Health and Human Services announced two sets of grant opportunities. Under the six-year, $250 million Demonstration to Maintain Independence and Employment, states may provide health care coverage to working individuals with deteriorating health conditions. For example, Mississippi, one of the first states awarded a grant, will use $27 million in grant funds to provide comprehensive health coverage to up to 500 workers with HIV/AIDS. Through the second initiative, Medicaid Infrastructure Grants, states may allow disabled individuals to purchase health coverage through Medicaid. Twenty-four states and the District of Columbia were awarded grants during the first round of awards in October 2000.

In addition to the Ticket to Work initiative, the Social Security Administration recently announced an **increase in Substantial Gainful Activity (SGA) income limits**, effective January 1, 2001, allowing more disabled individuals to earn income and keep their benefits. As part of the changes, a disability beneficiary may earn up to $740 per month, rather than $700 per month, and remain eligible for Social Security disability benefits. In addition, a new rule makes **alterations to the trial work period (TWP)**, which allows beneficiaries to work for up to nine months without affecting their benefits. Previously, any month during which a disability beneficiary earned over $200 counted as a trial month. Under the new rules, a beneficiary may earn up to $530 without being considered to be in a trial work period.

More recently, in a January 10, 2001 State Medicaid Director (SMD) letter, HCFA announced a rule change that permits additional **state options for using section 1902(r)(2) of the Social Security Act** to provide health and long-term care coverage to select groups of individuals. Basically, the rule change allows states more flexibility in deciding which types of income are excludable for certain categories of individuals. The SMD letter outlines several potential applications of the new rule and shows the potential effects that the rule change could have on expanding eligibility for medically needy individuals, assisting beneficiaries to move out of institutions and into a home or community based setting, and allowing disability beneficiaries to work without losing benefits. The OMB estimates the cost of the rule to be $960 million over five years (although total cost is dependent on the extent to which states exercise their flexibility).

*Expansions in Medicaid Home and Community-Based Services*. Since 1981, the **1915(c) home- and community-based waiver program** has allowed states to receive federal matching funds for alternative long-term care services that are not otherwise covered under the Medicaid statute as long as these services are targeted to individuals who meet functional criteria for placement in

[4] The Act passed in the House with a vote of 418 to 2 and in the Senate 95 to 1.

an institutional setting. The Medicaid Home and Community-Based Services (HCBS) waiver program experienced rapid growth during the 1990s.[5]

The debate over moving disabled and chronically ill beneficiaries from institutional settings to home or community-based ones has developed over decades. Proponents argue that people typically prefer care in less intensive settings and that this care is less expensive. The latter is a somewhat contentious point. While a comparison of Medicaid expenditures clearly indicates that the per capita cost of providing home or community-based services is far lower than that for institutional care,[6] increasing access to services and care in less intensive settings may not decrease expenditures if a "woodwork effect" results. This refers to the notion that many people who would not have sought institutional care may seek the often-desired home and community-based services, thus coming out of the "woodwork." Thus, cost is not the only justification for providing better access to these services.

At the same time that home- and community-based waivers have become more popular, the movement to community care has advanced on other fronts. Most notable of these is the case of ***Olmstead v. L.C***. In July 1999, the U.S. Supreme Court ruled that the institutionalization of a person with a physical and/or mental disability who could be and wants to be treated in a community-based setting is a violation of the Americans with Disabilities Act (ADA). The Court requires states to "administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons" and to make "reasonable modifications to avoid discrimination on the basis of disability unless the public entity can demonstrate that making modifications would fundamentally alter the nature of the service, program, or activity."

The Court's decision has generated a flurry of activity on the part of the federal and state governments. HCFA has provided guidance to states regarding interpretation of Olmstead, as well as vehicles to facilitate compliance. For example, a January 10, 2001 SMD letter outlines several new federal grant opportunities to assist states in meeting the requirements of the ruling. These initiatives include funding to provide outreach and support to individuals transitioning to community-based care, to develop partnerships between states and disability and aging communities, to improve systems that support chronically ill or disabled individuals living in the community, and to develop or improve community-based attendant services.

**Employee/Group Coverage**

The aging workforce, coupled with the fact that most health insurance in the United States is provided through the workplace,[7] has created attention to employee and group sponsorship of

[5] Spending between 1993 and 1999 increased at an annual rate of almost 25 percent and 1999 expenditures approached $10.4 billion. (See Lutzky, S. *Review of the Medicaid 1915(c) Home and Community Based Services Waiver Program Literature and Program Data*. Washington, DC: Health Care Financing Administration, June 15, 2000.)

[6] In 1997, Medicaid spent $42.5 billion to provide nursing home and other institutional care to one million beneficiaries and only $13.5 billion providing home and community-based services for nearly two million people. (See Stone, R. *Long-Term Care for the Disabled Elderly: Current Policy, Emerging Trends and Implications for the 21st Century*. January 2000. www.milbank.org/0008stone/index.html.)

[7] Culter, J. "Research and Other Developments of Interest in Employer Group Long-Term Care Insurance," *ASPE Research Notes*, April 1999 (www.aspe.hhs.gov/daltcp/projects.htm).

long-term care insurance. Acknowledging the potential role of employers in providing long-term care insurance, the federal government has sponsored research to better understand the existing employer group market as well as to investigate roles for itself as the sponsor of a long-term care insurance plan for federal employees, retirees and their families.

*Research on Employer Group Long-Term Care Insurance*. In April 1999, the Office of Disability, Aging and Long-Term Care Policy (DALTCP) within the Office of the Assistance Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services (HHS) sponsored research to further understand the employer/group market for long-term care insurance and to help design group products that could be made available to federal employees. The purpose of the research was to help guide policymakers, employers (including the federal government), and consumers to make informed decisions about how to structure and market long-term care insurance to employees. Survey findings were published in a final report in May 2000 and supported employer/group long-term care insurance market as a "promising idea" for protecting millions more Americans from long-term care costs since a majority of adults already receive some insurance benefits through their employer. Findings highlighted the potential impact a long-term care insurance offering to federal employees could have on increasing the size of the employer market.[8] The "current practices" portion of the report found that, among other things, companies considered educating employees about the benefits very important.

*Long-Term Care Security Act*. As mentioned above, the second component of DALTCP's initiative was to explore potential models for long-term care insurance benefits for federal employees. This research initiative was important in educating policymakers as they lobbied on the Hill to pass the landmark **Long-Term Care Security Act**. After at least a decade of interest by both Republicans and Democrats, the 106th Congress, with a push from the Clinton Administration and the Office of Personal Management (OPM) Director Janice Lachance, passed a bill that will effectively make the federal government the largest employer sponsor of group coverage for long-term care.

On September 19, 2000, after a number of different versions of the bills were proposed in the House and the Senate, President Clinton signed the Long-Term Care Security Act into law (Public Law No. 106-265). The Long-Term Care Security Act (former HR 4040) offers current and retired federal employees and military personal and their families on a volunteer basis long-term insurance options that cover a range a range of services at group rates, including home healthcare, adult day care and nursing home care. It also extends long-term care insurance coverage to Tennessee Valley Authority employees who were placed in the wrong retirement system in the 1980s.

The Long-Term Care Security Act came to fruition after debates over what the government's role should be in administering and regulating long-term care insurance. The Clinton Administration and Democrats favored involving OPM as the administrator and purchaser of the

[8] Lutzy, S., Corea, J. Alecxih, L. *A Survey of Employers Offering Group Long-Term Care Insurance to Their Employees*. Prepared by the Lewin Group for the Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (DALTCP): Washington, DC, May 31, 2000. (www.aspe.hhs.gov/daltcp/reports/ltinfres.htm).

long-term care plans. In January 1999, Rep. Elijah Cummings (D–Maryland) sponsored the Federal Employees Group Long-Term Care Insurance Act (HR 110), the Clinton's Administration's version of the long-term care bill for federal employees and retirees which would allow OPM to negotiate with insurance carriers to obtain an attractive benefit package at rates lower than those offered in the individual market.

On the other hand, Republicans initially wanted to limit OPM's role. Before sponsoring his successful HR 4040 long-term care proposal, Rep. Scarborough sponsored the Civil Service Long-Term Care Insurance Benefit Act (HR 602) in February 1999, which allowed an unrestricted number of insurers to offer a variety of long-term care insurance products, but did not give OPM a role in negotiating premiums or the types of policies allowed under the program. After facing opposition from Democrats and the National Association of Retired Federal Employees (NARFE), Scarborough modified his proposal so that it gave OPM purchasing power. In the Senate, Sen. Charles Grassley (R-Iowa) and Sen. Barbara Mikulski (D-Maryland) introduced S 2420, a bill identical to HR 4040, with more than 150 cosponsors. After many markup sessions and the incorporation of S 2420 into HR 4040, the legislation was passed by unanimous consent in both chambers of Congress. The Long-Term Care Security Act had overwhelming bipartisan support because it included key elements of past bills proposed by both Democrats and Republicans.

Although policyholders will be responsible under the Long-Term Care Security Act for paying their whole premium, the government's purchasing power will enable them to achieve low pricing so federal employees and retirees will have the opportunity to insure this risk, instead of having to pay for long-term care out of pocket or "spend down" to go on Medicaid. Specifically, the legislation allows the OPM to use its purchasing power to negotiate savings of 15 to 20 percent on commercial long-term care insurance rates and to ensure that such products meet high quality standards. In addition, the Act directs OPM to ensure that federal employees and retirees are aware of the value of purchasing long-term care insurance. A prominent public education and marketing campaign prior to the offering of the insurance is a key component of the OPM program. OPM expects the initial educational and marketing campaign in 2002 to include satellite broadcasts, cable television shows, CD-ROMs, website calculators, and other initiatives. The OPM long-term care program will take effect no later than October 2002. Start-up costs for the program are estimated at $30 million, with an annual $1 million for contract maintenance.

While the federal government has become the largest and most visible employer to sponsor group long-term care insurance, over 2,100 employers currently offer long-term care insurance as a voluntary benefit available to employees, retirees and their families.[9] Among these are several large public employers. For example, state-sponsored long-term care insurance plans are in place or actively being developed in sixteen states.[10] Many observers hope that federal government, as the country's largest employer, will serve as a model to other employers in both

[9] Lutzky, S., Corea, J., and Alecxih, L. 2000.

[10] Alaska, California, Colorado, Florida, Hawaii, Indiana, Kansas, Maryland, Minnesota, North Carolina, Ohio, Oregon, Texas, Virginia and Washington offer or have plans to offer state-sponsored long-term care insurance plans. Additional state-level activity around sponsoring long-term care insurance programs is expected to continue, especially given the success of these public sector programs (e.g., CalPERS Long Term Care, State of Minnesota, and others).

the public and private sector, causing more rapid growth in long-term insurance offerings to employees as awareness of the need for coverage grows among employers and workers. Currently, group insurance policies (and private insurance in general) finance only a small part of long-term care services because relatively few people are covered by private policies.

**Relevant Tax Issues**

In the past two years, federal policymakers have debated tax incentives for the purchase of long-term care insurance and to ease the financial burdens of caregiving. These debates have come on the heels of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which was significant in clarifying the tax treatment of long-term care insurance. Under HIPAA, plans are divided into two categories: non-tax qualified and tax-qualified. Benefits received from tax-qualified long-term care policies are excluded from taxable income, much like the benefits received through major medical coverage. Furthermore, a portion of premiums for a tax-qualified plan can be deducted as a health care expense if such expenses exceed 7.5 percent of the taxpayer's adjusted gross income and returns are itemized. HIPAA also provided tax-favored treatment for employers who sponsored long-term care policies.

Specifically, individuals who qualify for a premium deduction can deduct up to a specified amount of the premium they pay for long-term care insurance. The amount is based on their age and is adjusted each year for inflation. The amounts for the 2000 tax year are as follows.

**Table 2. 2000 Deductions for Premiums of Tax-Qualified Long-Term Care Insurance Plans**

| Age | Deductible – 2000 Tax Year |
|---|---|
| Age 40 or less | $220 |
| Age 41-49 | $410 |
| Age 50-59 | $820 |
| Age 60-69 | $2,200 |
| Age 70 or more | $2,750 |

Self-employed individuals are allowed to deduct 60 percent of the premiums for tax-qualified long-term care plans, up to these age-specific amounts. The percentage of premium cost that a self-employed individual can deduct will increase from 60 percent to 70 percent for the year 2002 and will be 100 percent for 2003 and thereafter.

*Premiums*. Since HIPAA, there have been more aggressive efforts to encourage the purchase of long-term care insurance. For example, in 1999 Congress passed legislation that would have phased-in a **100 percent deduction** (for both itemizers and nonitemizers) for the health and long-term care insurance costs of individuals not participating in employer-subsidized health plans. In addition, the legislation and would have permitted employers to offer **long-term care insurance under cafeteria plans and flexible spending arrangements**. The provisions were part of an omnibus tax bill (HR 2488) vetoed by then-President Clinton.

A stand-alone bill containing similar long-term care insurance provisions was introduced in 2000 by Sens. Charles Grassley (R-Iowa) and Bob Graham (D-Florida) and Reps. Nancy Johnson (R-Connecticut) and Karen Thurman (D-Florida) and endorsed by both AARP and the Health Insurance Association of America (HIAA). The **Long-Term Care and Retirement Security Act of 2000** (S 2225 in the Senate and HR 3872 in the House) did not see much progress, but full deductibility provisions were included in House and Senate managed care reform bills that reached conference. Key differences among the provisions included whether the deduction would be immediate or phased in and how the provision would apply to persons eligible for employer-sponsored long-term care insurance.

During his candidacy, President Bush spoke out in favor of offering a tax deduction for the full cost of private insurance premiums, regardless of whether a taxpayer itemizes deductions. Under Bush's proposal, employer-subsidized premiums would not be eligible.

*Caregiving*. To create tax breaks for both buyers and non-buyers of long-term care insurance, former President Clinton advocated in both 1999 and 2000 for a **tax credit for the formal or informal care of people with functional limitations** in at least three of the six basic activities of daily living (e.g., bathing, dressing, toileting, transferring, continence and eating). In 1999, he called for a $1,000 tax credit, and in 2000 he rallied for a $3,000 credit, phased in beginning in 2001 at $1,000 and rising in $500 increments. Full benefits for his 2000 proposal would have been limited to couples earning $150,000 or less and single taxpayers earning $75,000 or less. The Clinton proposal was contained in the failed Long-Term Care and Retirement Security Act of 2000 (described above).

To ease caregiving burdens, President Bush favors creating a new **personal tax exemption** (valued at $2,750 for each family member under care) for households where family members provide care to an aging spouse, parent, or relative. Congress has signaled support for this type of exemption in the past, including it in an omnibus tax bill (HR 2488) vetoed by former President Clinton in 1999.

*State Tax Initiatives*. Twenty-two states have tax incentives for individuals who purchase private long-term care insurance.[11] Among these states, seven promote the purchase of long-term care by offering a tax credit. The credit ranges from 15 percent of premium paid in Oregon to 100 percent of premium paid in Utah. Some states impose a cap on the credit (e.g., $500 in Maryland and $100 in Minnesota). The remaining states offer a tax deduction. Most states follow rules similar to the federal tax deduction provisions provided by HIPAA, although some states are more generous. Many other states are currently considering credits or deductions to encourage long-term care insurance purchase.

[11] These are Alabama, California, Colorado, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, New York, North Carolina, North Dakota, Ohio, Oregon, Utah, Virginia, West Virginia, and Wisconsin.

# CONSUMER PROTECTION AND EDUCATION

This section discusses efforts around consumer protection and consumer education on long-term care issues. To date, most of this activity has been focused on purchasers or potential purchasers of long-term care insurance.

**Marketing Long-Term Care Insurance or Long-Term Care Services**

At the national level, there has not been major legislative or regulatory activity in the past two years related to the sales or marketing of long-term care insurance or services. This is not surprising since regulation of insurance and many health services take place at the state level. Therefore, this section focuses mainly on how consumer protections are being regulated at the state level and the federal government's response to these activities.

The National Association of Insurance Commissioners (NAIC) formulates model laws and regulations regarding long-term care insurance. It then encourages states to adopt these as the basis for their regulatory oversight of long-term care insurance policy provisions and practices. State compliance with the NAIC model varies, although states are continually updating their long-term care insurance regulations to meet or exceed the standards proposed by NAIC.

As of April 1998, all 50 states had adopted laws and regulations relating to long-term care insurance. Most states have adopted a majority of the key NAIC provisions related to consumer protection. Forty-one states have adopted at least half of these key provisions. Nine states are 80 percent in compliance with all the key NAIC provisions and 25 states are 60 to 70 percent in compliance. Important consumer protection features which state regulations have adopted almost in their entirety pertain to requirements on: no prior hospital stay; guaranteed renewability; free-look period; pre-existing condition limitations; basic policy definitions; and delivery of an outline of coverage and shopper's guide to prospective buyers.

An important area of concern is ensuring that only consumers for whom it is appropriate to purchase insurance do so. To address this, the NAIC developed suitability guidelines for purchase, based on an individual's financial situation and other criteria. Only 14 states have not adopted any laws or regulations to require insurers to follow suitability guidelines. About 19 states have adopted or exceeded the most recent NAIC guidelines with respect to suitability. Another 14 states have less stringent requirements, but still require insurers to determine the appropriateness of the sale.

Class action lawsuits involving long-term care policyholders have been brought in response to a variety of concerns, most notably around rate stability issues. For example, a class action suit filed in North Dakota several years ago contended that insurers did not properly explain to the purchasers that a level premium policy could result in premium increases for the entire class of policyholders and did not appropriately determine the initial premium rate for the policy.

These activities has sparked the recent NAIC activity focused on expanding consumer protection with respect to an insurance company's ability to raise rates and requirements for fuller

disclosure to consumers about any past rate increases the company may have had. The NAIC recently adopted new provisions regarding consumer protection and disclosure specifically on the area of rate stability and the history of past rate increases disclosure (e.g., requiring that insurers allocate almost all proceeds from rate increases to pay benefits, requiring insurance agents to inform policy holders of the company's history of rate increases). Some states have already begun to adopt these model provisions into their regulations. Similarly, the NAIC has developed and several states have adopted provisions requiring policies to provide a contingent nonforfeiture benefit to all insurers in the event of an extreme rate increase.

To investigate consumer protections, the Senate Aging Committee held a hearing September 13, 2000 featuring testimony from representatives from NAIC, the General Accounting Office, a lawyer who has filed several class-action lawsuits on behalf of policyholders, and insurance industry representatives. NAIC testimony urged Congress to reference some of its new consumer protections on nonforfeiture and suitability, but leave rate stability issues to state regulators.

In 2000, Sen. Chuck Grassley (R-Iowa), chairman of the Senate Special Committee on Aging, expressed his interest in requiring that long-term care insurance plans billed as federally qualified plans include a provision that protects consumers of these policies from unexpected and extreme rate hikes. These and other consumer protection measures may be raised as Congress takes up the issue of full deductibility of long-term care insurance premiums, as it is likely to do this session.

**Consumer Education**

To date, consumer education from the federal government about long-term care has been focused primarily on nursing home fraud and abuse. However, both Congressional members and former President Clinton have recognized the need for broader consumer education about long-term care. For his part, Clinton included two educational components as part of the long-term care initiative included in his budget proposal for federal fiscal year 2000. One of these components is the recently-enacted **National Family Caregiver Support Program** (Public Law No. 106-501). The $125 million state grant program will be administered through the Administration on Aging (AoA) and executed primarily through Area Agencies on Aging. The program is intended to serve family caregivers and older individuals who are relative caregivers (e.g., for grandchildren or adult children with disabilities), especially those in greatest social and economic need. Services shall include: (1) information to caregivers about available services; (2) assistance to caregivers in gaining access to the services; (3) individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles; (4) respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and (5) supplemental services, on a limited basis, to complement the care provided by caregivers.

Clinton's second education component resulted in **HCFA's pilot project to inform the public about long-term care**. According to a summary of Clinton's federal fiscal year 2000 budget proposal, the intent of the project is to move toward "a national campaign to educate Medicare beneficiaries about how best to evaluate long-term care options." At the time Clinton unveiled his four-part long-term care initiative, the new national campaign was described as providing "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."[12] A background brief on the Presidential initiative suggests that campaign components would include producing printed material; incorporating information into Medicare handbooks, toll-free phone numbers and HCFA's consumer Internet site (www.medicare.gov); enhancing training to 'information intermediaries' such as state health insurance assistance programs (SHIPs), Medicare carriers and fiscal intermediaries, area agencies on aging, and Social Security offices; and working with groups representing consumers, industry, employers and states to disseminate information.[13,14]

Members of the 106th Congress expressed their priorities for consumer education in both resolutions and proposed legislation. For example, a set of resolutions in 1999 indicated the need for the federal government to inform the public about the financial risks associated with the need for long-term care, about the fact that Medicare does not cover most long-term care costs, and that Medicaid coverage requires the exhaustion of assets. SCR 22 and HCR 8 (sponsored by Sen. Christopher Dodd (D-Connecticut) and Rep. Christopher Shays (R-Connecticut), respectively) also indicated that the federal government should encourage employers to offer long-term care insurance as a benefit to employees and encourage the purchase of individual policies.

Other legislation detailed specific educational activities. HR 2102, sponsored by Rep. Nancy Johnson (R-Connecticut) proposed that the Commissioner of Social Security use annual statements from the **Social Security Administration (SSA) to provide information** to employers about the tax benefits of offering qualified long-term care insurance coverage to employees and encouraging employers to offer coverage under qualified long -term care insurance contracts to their employees. S 2935, sponsored by Sen. Bob Graham (D-Florida), would have mandated an employer-centered **campaign conducted by the Secretary of Labor, in conjunction with the Secretary of Health and Human Services and the Administrator of the Small Business Administration**. One of the most detailed legislative proposals for long-term care outreach was HR 4498, sponsored by Rep. Judy Biggert (R-Illinois). Biggert's proposal called for the Department of Labor to raise public awareness of the long-term care

[12] "President Clinton and Vice President Gore: Strengthening Families that Need Long-Term Care." Press release. January 4, 1999.
[13] "Background: President Clinton's Long-Term Care Initiative." Press release. January 4, 1999.
[14] A January 1999 poll commissioned by the American Health Care Association, a trade organization, found that 82 percent of baby boomers support a national campaign to educate Medicare beneficiaries about the program's limited coverage for long term care and how to evaluate their options. (See "Baby Boomer IQ Test, Fact Sheet on Long-Term Care." AHCA press release. April 7, 1999 (www.ahca.org/brief/nr990407.htm).

basics, vehicles for long-term care financing, and the shortcomings of Medicare and Medicaid coverage of long-term care. HR 4498 would have boosted funding to state health insurance assistance programs (SHIPs) for the purposes of educating consumers and would have solicited the help of HCFA and AoA for promotion efforts.

# CONCLUSION

## Prominent and Unresolved Issues

A review of legislative and regulatory initiatives reveals, for the most part, bi-partisan efforts at incremental reform. Though federal action in the past two years has been fairly circumscribed, it has been important: policymakers have addressed BBA-dictated changes to provider payments and have expanded the potential universe of people eligible for benefits under Medicaid and Medicare (particularly persons with disabilities). Perhaps most importantly, in terms of the potential for increasing awareness about long-term care, legislation has been enacted to offer long-term care insurance to government employees. With this act, long-term care insurance will become much more visible to employers and, ultimately, to 13 million people in the civil service.

By all indications, long-term care issues will not disappear from the federal landscape. In particular, Congress and President Bush seem poised to expand tax deductibility of long-term care insurance premiums and to agree on some sort of tax relief for caregiving. Debated in the last Congress, these measures may continue to gain momentum as policymakers realize the limited effects of their first real foray into long-term care insurance regulation, the HIPAA.

Beyond the issue of tax relief, uncertainties abound. The new Administration has not expanded on the subject of long-term care other than to favor greater deductibility of premiums and a caregiver exemption; Department of Health and Human Services Secretary-elect Tommy Thompson has indicated long-term care as one of his top priorities, but it is difficult to predict how his experience in Wisconsin (where he began to pilot a program to create a single, county-level point of entry for long-term care services) will come to bear in Washington. Furthermore, aging activist Sen. Charles Grassley (R-Iowa) will hand leadership of the Senate Special Committee on Aging to Sen. John Breaux (D-Louisiana). It is difficult to say if Grassley's new post as chair of the Senate Finance Committee will divert his attention from aging issues. Other important changes in Congressional leadership include the appointment of Rep. William Thomas (R-California) as chair of the House Ways and Means Committee. Thomas leaves a six-year stint as head of the House Ways and Means Health Subcommittee, which will now be led by Rep. Nancy Johnson (R-Connecticut).

With a new Administration, a new Congress, and what many regard as a looming long-term care crisis, one could argue that the time is right for a more concerted and comprehensive look at long-term care issues. In fact, the Department of Labor's Advisory Council on Employee Welfare and Pension Benefit Plans-Working Group on Long-Term Care issued a report in January calling for a White House conference to develop a national policy on long-term care that articulates a coordinated strategy that is responsive to all of the many dimensions of the problem. The report further stated that the President should issue an executive order to establish a Long-Term Care Interagency Coordinating Council including representation from the Department of Labor, the Department of Health and Human Services, the Department of the Treasury, and the Office of Personnel Management (and perhaps the Veterans Administration and Social Security

Administration). The council would have the responsibility to coordinate the development and implementation of initiatives consistent with structuring of a national policy on long-term care.

**Implications for the Project**

Recent federal legislative and regulatory activity has several implications for the project. Specifically:

- Long-term care issues have been raised in such a way that they probably have not touched the general public to a great extent. Although policymakers have addressed long-term care issues, they have done so in a mostly piecemeal and esoteric fashion (e.g., changing Medicare payment systems) that does not easily lend itself to broader public discussion.
- Because of initiatives like Olmstead and Ticket to Work, certain groups of persons with disabilities may be exceptionally receptive to planning messages. Furthermore, there may be opportunities for the MEDSTAT team to piggyback outreach on initiatives related to Olmstead and Ticket to Work.
- Presuming they come up in the 107th Congress, issues like premium deductibility and tax incentives for caregiving may create a "news peg" for generating media coverage in project pilot sites. The HCFA project can help consumers take a step back to the information sources they need to consider long-term care insurance and other facets of long-term care.
- The National Family Caregiver Support Program, while focused on people in immediate need of services, may also create partnership opportunities and media interest in long-term care issues.
- The OPM insurance initiative under the Long-Term Care Security Act will be an important model for educational strategies. These strategies will articulate the "government line" on long-term care and will presumably take federal government employees and retirees from a low level of awareness to a decision-making stage.
- As evidenced by active lobbying and coalition-building in the past two years, the long-term care and insurance industries will almost certainly have a vested interest in HCFA's long-term care communications campaign. This interest could be cultivated in a way that boosts the campaign's message, without necessarily allying HCFA with industry groups.
- Members of Congress, with an increasing awareness of long-term care issues, may be supportive of pilot programs in their districts and of a federal long-term care communication campaign in general.
- State legislative and regulatory activities, especially around long-term care tax incentives and state-sponsored long-term care insurance programs, merit close attention in the project's pilot sites. State activities may provide an important undercurrent of public awareness and education about the need to plan for long-term care.

# APPENDIX: STATE LEGISLATION ENACTED IN 2000[15]

Following is a summary of the state legislation enacted in 2000 pertaining to long-term care. These bills illustrate the variety of long-term care subjects addressed at the state level. Sixteen bills pertained to the topic of individual and/or employer tax credits, deductions, or related incentives for the purchase of private long-term care insurance. Another 14 bills pertained to the policy standards and provisions that long-term care insurance policies must adhere to in that state, including state adoption of updated provisions of the National Association of Insurance Commissioners (NAIC) model laws with respect to long-term care.

A number of states enacted laws establishing a long-term care insurance plan for its employees and retirees, or laws authorizing that this issue be explored. State-specific studies of the long-term care services and options available were also authorized. Other topics addressed in newly enacted long-term care laws address regulating long-term care insurance offered as a rider to a life insurance policy, requirements regarding insurance policy filings, agent training, education, advocacy and caregiver support.

| State | Bill # | Topic | Summary |
|---|---|---|---|
| AK | S00008 | LTC Study | Create task force to study LTC needs in Alaska |
| AL | H00170 | LTC Standards | Updates LTC regulations to be substantially similar to NAIC model. Primary areas impacted include contingent nonforfeiture, claim payment speed, and notification of denial of claims. |
| AL | Bulletin 5-0 | LTC Model Law | Proposes a rule concerning LTC insurance. The department's intention is to implement HB 170 which is the NAIC model act, with the exception of Section 14 (agent licensing). |
| AL | Bulletin 8-0 | LTC Model Law | Explains the LTC Insurance Minimum Standards Act, which becomes effective 8/1/00. Schedules a hearing to discuss proposed revisions, including sections for contingent nonforfeiture and standards for benefit triggers. |
| AZ | S01077 | Tax | Increases appropriation into the state's LTC Fund and strikes the proposed tax incentive for LTC insurance. |
| AZ | S01099 | LTC Study | Studies feasibility of LTC insurance to state employees. |
| CA | S00475 | Rate Guide | Mandates that the Department of Insurance will prepare annual rate guide for LTC insurance starting in December 2000. |
| CA | S00738 | Partnership | Makes California Partnership program permanent and revises some of the criteria for DoI review of policies. |
| CA | S00870 | LTC Standards | Revises standards for LTC insurance policies. Mandates certain benefits like RCF at 70% of NH; RCF benefit trigger same as home care; TQ plans at 2/6 ADLs for NH benefits; modifies some aspects of the mandated offer of a NF option; require BIO upgrade offer be continued on claim; requires appeal section to appear in policy; bars policy from a mental/nervous exclusion. |
| CA | S00898 | LTC Standards | Requires group policies to be non-cancelable or guaranteed renewable. Requires prior approval of all policies and rates, including rate increases. |
| CA | S475/ S2111 | Rate Guide | Requires the commissioner to create annually, a consumer rate guide. |
| CO | H01246 | Tax | Creates state income tax credit of 25% of premium for individuals filing single with federal taxable income of $50,000 or less or up to $100,000 for |

[15] The summary, provided by the Long-Term Care Group, is current through January 24, 2001.

| State | Bill # | Topic | Summary |
|---|---|---|---|
| | | | joint filing. Credit is capped at $75 or $150 respectively |
| CO | Amended Reg | LTC Standards | Adopted amendments to Regulation 4-6-5 re. the basic and standard LTC plans |
| CT | H05123 | LTC as a Life Rider | Allows Life/LTC policies and regulates them. |
| FL | H01993 | LTC Study | Authorizes a task force to study LTC service issues and options. |
| HI | H00170 | Tax | Establishes individual tax deduction for LTC like federal law. |
| HI | S00131 | LTC Standards | Updates LTC insurance standards per NAIC. Mandates offer of NFO at certificate level. Contingent NF required if NFO not elected. Mandates offer of inflation, but offer can be made to policyholder for employer group. Requires 60% loss ratio. Requires advertising filing for review and approval to the extent it may be required by state law. Requires disclosure group sponsor royalty if applicable. Must cover hospice, adult residential care home (ARCH) and extended care ARCH. |
| ID | H00014 | LTC Standards | Mandates offer of NF at certificate level for discretionary groups, otherwise offer can be at policyholder level. Mandates contingent NF if NF option not elected. Adopts extra-territoriality provision of NAIC model. |
| IL | Bulletin 10-0 | ALF | The department is requesting that insurers providing LTC benefits submit an amendment form for policies marketed before ALFs were developed, giving the policyholder the opportunity on an accept/reject basis, the ability to add this feature. The amendment would address the level of care being provided, make consideration for payment based on specific benefit triggers, and allow the payment for ALFs be provided under terms of the contracts. |
| IN | S00007 | Tax | Provides adjusted gross income tax deduction for LTC. |
| KS | H02780 | LTC Study | Establishes a task force on LTC services to study services provided by the public and private sectors to citizens of the state, and the laws and rules and regulations relating to such services. |
| LA | H00595 | Filing Requirements | Requires insurance policy form to include certificate, EOC or similar agreement. The form must be filed and approved by Commissioner. |
| MA | Bulletin 1-0 | Agent training | Requires insurers to provide appropriate LTC training to agents and file required information on agent training with DOI. |
| MA | E00013 | LTC Study | Requires a comprehensive assessment of long-term care in the Commonwealth of Massachusetts, including but not limited to a projection of needs, an examination of access to LTC, financing of LTC, and quality of LTC provided in a variety of settings, along with the development of a comprehensive plan and a set of recommendations for developing and preserving adequate LTC capacity in the Commonwealth for the next 5 years. |
| MD | Bulletin 6-0 | Tax | Describes tax credit for employer provided LTC insurance. Employer may claim credit of 5% of their costs to provide LTC insurance, up to the lesser of $5,000 or 100 x the number of participating employees. |
| MD | S00171 | Tax | Gives one-time credit against state income tax for LTC insurance premiums if covered by TQ LTC after July 1, 2000. Credit capped at $500. Can claim 100% of premium paid for self, spouse, parents, children, up to $500 cap. State will monitor legislation to see how many people claim credit and evaluate impacts, if any, on Medicaid program as result of more private insurance purchase. |
| ME | S00140 | Standards | Adopts latest version of NAIC model for LTC. Mandates offer of NFO and include contingent NF if option not elected. Offer can be made to the group policyholder. |

| State | Bill # | Topic | Summary |
|---|---|---|---|
| MN | H00878 | State LTC Plan | Authorizes state to administer group LTC plan for state employees, either self-funded or insured. |
| MO | S0008 | Tax | Allows premium deduction up to 50% from state taxable income. |
| MO | S00173 | Tax | Same as above. |
| MT | S0005 | Policy Statement | Implores Congress to include LTC under Medicare. |
| ND | S02046 | Partnership | Repeals Partnership. |
| ND | S02180 | LTC Standards | Amends rules re: incontestability for LTC. |
| NE | L00323 | LTC Standards | Updates rules re: incontestability for LTC. Mandates offer of nonforfeiture . |
| NH | H01589 | Genetic Testing | Removes LTC insurance from exemption from genetic testing provisions which prohibits insurers from requiring genetic testing |
| NM | H00004 | Study/Tax | Requests executive branch report to Legislature re: progress on addressing LTC insurance tax credits to promote private sector purchase. |
| NV | S00370 | Partnership | Authorizes Medicaid to include Partnership-type program in its state plan. Would provide Medicaid eligibility after 3 years of LTC benefit from private insurance for those with household income below $200,000. |
| NY | A11006 | Tax | Amends tax laws relating to insurance and LTC insurance. |
| OH | H00403 | Consumer Guide | Requires commissioner to publish a LTC Consumer Guide. |
| OR | H02080 | Tax | Establishes state income tax credit of 15% or $500 of premiums paid. Employers can credit $500/employee. Establishes LTC education program. |
| OR | S05526 | Advocacy | Appropriates funds to LTC ombudsman program. |
| OR | Bulletin | Tax | Warns agents not to induce insureds to replace coverage just to take advantage of state tax credit for LTC for policies sold after January 1, 2000. |
| SD | H01010 | Policy Statement | Urges Congress to inform public of LTC costs and promote insurance. |
| TX | Bulletin 8-0 | LTC Standards | Adds 3/6 ADL trigger as option to the current 2/6 ADL standard for LTC policies under certain conditions: (1) insurer also offers a 2/6 ADL option; (2) insurer gets written rejection of 2/6 ADL choice; and (3) prominent disclosure in marketing and policy of differences between 2 and 3 ADL trigger benefits. Insurers can afford a "2-tiered" benefit trigger within the same policy (e.g., 2 ADLs for non-facility care and 3 ADLs for facility care) as long as they also offer a 2/6 product and it is rejected and the benefit payable with 2 vs 3 ADL losses are prominently disclosed. Applies both to individual and group. |
| TX | Bulletin 16-0 | LTC Model Law | Proposes rule necessary to implement H1586 from the 1999 Legislature. Establishes individuals eligible for LTC coverage, and requires inclusion of a provision stating the conditions under which the LTC coverage will become effective for an individual who becomes insured subsequent to the issuance of the policy/certificate. For all LTC plans in TX. |
| TX | Bulletin 24-0 | LTC Model Law | Gives notice that the proposed rule necessary to implement H1586 has been adopted without change (in regards to 28 TAC 3.3806). |
| TX | S01128 | State LTC Plan | Requires Texas Retirement System (TRS) to contract with one or more carriers to provide LTC insurance to state employees. |
| TX | H01586 | LTC Standards | Expands the requirement for the DOI to set standards for LTC insurance . |

| State | Bill # | Topic | Summary |
|---|---|---|---|
| TX | H01924 | Risk Pool | Exempts LTC insurance from the assessment of the Texas Health Insurance Risk Pool. |
| TX | H03089 | State LTC Plan | Prohibits state from implementing group LTC plan for employees unless development costs are incidental. Lets college or university join in the program. |
| TX | S00374 | LTC education | Requires Dept of LTC Services to develop information programs re: LTC costs, Medicaid eligibility limits, and LTC insurance. |
| UT | S00009 | Tax | Establishes income tax credit for LTC insurance premiums. |
| VA | H01546 | Tax | Amends prior legislation re: tax treatment for LTC. Allows state income tax deduction for premiums only if insured did not claim a similar deduction for federal income tax purposes. |
| VA | H00156 | Study | Continue the LTC Subcommittee to evaluate LTC financing. |
| VA | S00220 | State LTC Plan | Authorizes Board of VA Retirement System to develop, implement, and administer a LTC insurance program. |
| VA | S00464 | Policy Statement | Add coordination of LTC policy to duties of Secretary of Health. |
| VA | H01458 | State LTC Plan | Allows local governments and school board to participate in LTC insurance programs (or other insurance benefits) made available to them by Dept of Personnel and Training. |
| VA | H01511 | LTC Standards | Updates state LTC regulations per NAIC model: (1) incontestability; (2) mandate offer of nonforfeiture as well as inclusion of contingent nonforfeiture if NFO declined; (3) require policies to carry prominent statement re. tax qualified vs. non-qualified; (4)prohibits field issuance; (5) prohibits insurer from recovering benefit payments already made if policy is rescinded; (6) requires Joint Commission to study NAIC reporting and disclosure requirements for LTC in other states. |
| VA | S00517 | State LTC Plan | Same as H01458 above. |
| VA | H00923 | LTC Standards | Requires the return of unearned premium in event of policy cancellation within 30 days of cancellation effective date. Does not apply to group plans, or plans that cover the duration of a person's life if premium is paid as a single installment. |
| VT | Propose Revision of Bulletin HCA-102 | LTC Standards – Nursing home only | States that carriers can't sell NH only in Vermont. If they have a NH only policies in force that were issued on or after 7/1/89, they must notify policyholder prior to next anniversary that they have the option to purchase a comprehensive policy. Insurer must provide information about other sources of comprehensive products if insurer doesn't offer one. If insured elects to maintain nursing home only policy, insurer must maintain the same premium unless the policyholder elects to upgrade and is approved. If not previously submitted, carrier must submit letter to DOI on or before 15 months from bulletin date. Letter must state the number of NH only policies currently in force and the number of policyholders of NH only policies choosing to purchase more comprehensive coverage, if available. The bulletin provides the shell of the letter to be used. |
| WA | S05766 | Policy Statement | Describes role of LTC ombudsman. |
| WA | H02454 | Informal Caregiver Support | Creates family caregiver LTC information and support services to help families. Provides info re. public and private LTC support services through Dept. of Social and Health Service contracts with local AAAs, to the extent of available funding. |

| State | Bill # | Topic | Summary |
|---|---|---|---|
| WV | H04354 | Tax | Taxpayers can deduct premiums for TQ LTC from their federal taxable income for purposes of state income tax calculation. Can include premiums paid for self, spouse or parent(s). |
| WV | H02693 | Tax | Provides uncapped tax deduction for LTC premiums. |