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Long-Term Care: The President's FY2001 Budget Proposals and Related Legislation

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Summary

In his FY2001 budget, President Clinton proposed a multi-faceted long-term care initiative. Its principal components include a new tax credit (up to \$3,000 when fully phased-in) for persons with substantial disabilities and their families, grants to states for caregiver services through the Older Americans Act (OAA), long-term care insurance for federal workers, and conversion of some federally assisted housing to assisted living units. Similar proposals were included in the FY2000 budget.

The President's initiative raises questions that some say need attention by policymakers. One is whether family caregiving can be sustained by targeting tax benefits and making support, respite, and counseling services more widely available. While federal assistance for long-term care is primarily for nursing homes, most long-term care is provided by families in the home. About 37 million caregivers provide unpaid care – usually without public assistance – to family members of all ages with functional or cognitive impairments. The need for caregivers and the demands they face are expected to grow substantially in the future.

A second question is what role private long-term care insurance can play. Some believe it can supplement public programs and support options for family caregiving, at least for some people. One objective of the President's initiative is to promote employment-based long-term care insurance by establishing a model program for federal employees.

The President's proposals continue an incremental approach to long-term care when some believe that a more comprehensive strategy is needed. The \$3,000 tax credit, the most costly element of the package, in particular has been criticized. While it would compensate families for their caregiving efforts and out-of-pocket expenses, some analysts say it is not well targeted. Most lower income families without tax liability would not be eligible for the credit; for those that are, it would cover only a small portion of their often significant expenses.

Different approaches are found in the patient protection legislation passed by the House (H.R. 2990) and Senate (S. 1344), in conference. These bills would authorize a new tax deduction (not limited to itemizers) for individuals who purchase long-term care insurance, and allow employment-based long-term care insurance to be included in cafeteria plans and flexible spending accounts. H.R. 2990 would also authorize an additional dependency exemption for taxpayers who provide care to elderly family members. These tax benefits have also been included in the Senate amendment to the FY2001 Labor-HHS-Education Appropriations legislation (H.R. 4577).

The House and Senate have passed legislation (H.R. 4040) that would establish a group long-term care insurance program for federal employees, retirees, members of the uniformed services, and certain family members. Similar proposals for an OAA caregiver grant program have been approved by the House Education and the Workforce Committee (H.R. 782) and the Senate Health, Education, Labor and Pensions (HELP) Committee (S. 1536).

Contents

Introduction	1
The Need for Long-Term Care	2
Federal Role	3
Public and Private Spending and Unpaid Family Care	4
The President's Initiative and Related Legislation	5
Tax Credit for Long-Term Care Needs	5
Proposal	5
Cost and Coverage	6
Major Issues	6
Legislation	7
Caregiving Grants to States under the Older Americans Act	8
Proposal	8
Cost and Coverage	9
Major Issues	9
Legislation	9
Long-Term Care Insurance for Federal Workers	10
Proposal	10
Cost and Coverage	11
Major Issues	11
Legislation	11
State Option to Liberalize Medicaid Income Eligibility	12
Proposal	12
Cost	13
Major Issues	13
Legislation	13
Nursing Home Quality Improvements	13
Proposal	13
Cost	13
Major Issues	14
Legislation	15
Housing and Services Initiative	15
Proposal	15
Cost of the HUD Proposal	16
Major Issues	16
Legislation	16
Some Other Legislation	16

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Introduction

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care as a result of chronic illness or frailty. It includes home and community-based services as well as services provided in nursing homes and other institutions. In his FY2001 budget, President Clinton has proposed a multi-faceted long-term care initiative, including a \$3,000 tax credit (when fully phased-in) for families of individuals needing care, Older Americans Act grants to states for caregiver services, and an insurance program for federal workers. Similar proposals were included in his FY2000 budget.

This report summarizes and analyzes the President's initiative and identifies 106th Congress legislation modeled on its various aspects. It also discusses House and Senate legislative activity on long-term care, some of which takes a different approach. Legislative action includes the following:

- Patient protection legislation passed by the House (H.R. 2990) and Senate (S. 1344) and now in conference would authorize a new tax deduction (not limited to itemizers) for individuals who purchase long-term care insurance and allow employment-based long-term care insurance to be included in cafeteria plans and flexible spending accounts. The House bill would also authorize an additional dependency exemption for taxpayers who provide care to elderly family members; the Senate bill would also authorize a study of long-term care needs and policies;
- The Senate amendment to the FY2001 Labor-HHS-Education Appropriations legislation (H.R. 4577) would authorize the new tax deduction, cafeteria plan and flexible spending account changes, additional dependency exemption, and long-term care study included in H.R. 2990 and S. 1344;
- Older Americans Act legislation reported by the House Committee on Education and the Workforce (H.R. 782) and approved by the Senate Health, Education, Labor and Pensions (HELP) Committee (S. 1536) would authorize caregiving programs similar to those proposed by the Administration in its reauthorization proposal submitted to Congress in 1999; and

- Federal employee long-term care insurance legislation (H.R. 4040) has passed both the House and Senate, and the measure now awaits the President's signature. The legislation authorizes a group long-term care insurance program for federal workers and retirees (including active and retired members of the uniformed services) as well as certain family members.

This report does not discuss other long-term care strategies that Congress might consider, such as new social insurance initiatives or block grant approaches for long-term care services.

The Need for Long-Term Care¹

The need for long-term care is measured by assessing a person's need for assistance from others to perform basic daily activities, referred to as activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, toileting, transferring from a bed or chair, bathing, dressing, and continence. IADLs include such things as meal preparation, cleaning, grocery shopping, managing money, and taking medicine.

It is estimated that about 5.2 million persons age 65 and older, and 3.5 million persons aged 18-64 currently receive assistance either in the community or in nursing homes due to ADL or IADL limitations.² Most of these persons receive care in home and community-based settings, not in nursing homes. Legislation to finance long-term care services frequently limits eligibility to persons having limitations in a specific number of ADLs, and, for the cognitively impaired, persons with a similar level of disability. This approach allows policymakers to target people with greatest need and to control costs. Long-term care insurance policies, a limited but growing market, also use ADL limitations to trigger payment of benefits.

The need for long-term care is expected to grow substantially in the future. While estimates vary, increases in longevity and in the number of older persons are certain to affect the demand for services. Rapid growth in the number of people over age 85 presents special challenges because the "old-old" have the greatest risk of needing care. The demand for home and community-based services in particular may grow due to the recent Supreme Court decision in *Olmstead v. L.C.*, advocacy efforts of younger persons with disabilities, and continuing demand for improvements in the quality of institutional care. (In *Olmstead*, the Court held that title II of the

¹ For an overview about long-term care, see *Long-Term care Chart Book: Persons Served, Payers, and Spending*, a document (CD00122) prepared jointly by The Urban Institute CRS.

² Spector, William D., John A. Fleishman, Liliana E. Pezzin, and Brenda C. Spillman, *The Characteristics of Long-Term Care Users*. Prepared for the Committee on Improving Quality in Long-Term Care, Institute for Medicine, 1998. Estimates are based on the National Health Interview Survey (NHIS) Disability Supplement, 1994 (for community residents) and the 1996 Medical Expenditure Panel Survey (for nursing home residents). *Note*: estimates of the number of persons who need assistance as a result of impairment vary depending upon the number and types of ADL and IADL limitations and other factors used for measurement. Therefore, other research may show slightly different estimates.

Americans with Disabilities Act (ADA) requires states to place individuals with mental disabilities in community settings rather than institutions when the state's treatment professionals have determined that community placement is appropriate, community placement is not opposed by the individual with a disability, and the placement can be reasonably accommodated.)³

Federal Role

A number of federal programs directly or indirectly assist either persons with long-term care needs or their caregivers:

- *Medicaid* provides coverage for nursing home care and a wide range of home and community-based services for persons of all ages who meet income, asset, and categorical eligibility criteria under federal and state law. Many people qualify for Medicaid's long-term care benefits by depleting most of their assets and income to pay for their care.
- *Medicare* pays for medically necessary, part-time skilled nursing and rehabilitation therapy services at home; these must be reauthorized by a physician at least every 60 days. It also pays for up to 100 days in a skilled nursing facility for individuals with an immediate prior hospitalization who need full-time skilled nursing care or rehabilitation therapies. Medicare otherwise does not cover long-term care services for beneficiaries who have chronic care needs or require assistance with daily living activities.
- The *Social Services Block Grant (SSBG)* program provides a range of home and community-based services to low-income persons of all ages who meet state-defined eligibility requirements; but home care services must compete with a variety of other services for funding.
- The *Older Americans Act (OAA)* supports home and community-based services to persons aged 60 and over.
- *Tax benefits* for long-term care include a limited deduction for long-term care expenses and insurance premiums (provided the taxpayer itemizes deductions), tax-exempt insurance benefits, and the dependent care tax credit.
- The *Supplemental Security Income (SSI)* program is the federal cash assistance program for low income aged, blind, and disabled; states may supplement the basic federal program. Aged and disabled persons eligible for this assistance may use the supplemental payments to pay for care in board and care and other assisted living facilities that provide personal care to persons with limitations in ADLs/IADLs.
- The *Department of Veterans Affairs (DVA)* provides a wide range of long-term care to the Nation's veterans, including nursing home, domiciliary, home health care, and assistance to caregivers.

³ For further information, see CRS Report RS20246, *The Americans with Disabilities Act (ADA): Supreme Court Decisions*, by Nancy Lee Jones.

Other federal programs or benefits that recognize the caregiving needs of persons with disabilities or their caregivers include the *Family and Medical Leave Act*; the *Senior Companion Program (SCP)* which supports volunteer assistance to frail older persons; and various targeted state grant programs such as *Public Health Service* demonstration grants to develop model services programs for persons with Alzheimer's disease and *Rehabilitation Act* grants for the older blind. Some believe that federal programs are fragmented and reach only a portion of the population in need due to restrictive income eligibility requirements, conflicting administrative requirements, and limited funding.

Many observers believe that federal programs do not significantly support the care most people want, that is, home and community-based services. However, Congress has chosen an incremental approach to expanding federal support for community-based services, principally through the Medicaid home and community-based waiver authority enacted in 1981. Services provided under the waiver authority, however, are not uniformly available and its expenditures are dwarfed by Medicaid support for nursing home care.

During the early 1990s, various proposals, such as the Pepper Commission on Long-Term Care, and the Administration's long-term care plan in its Health Security Act,⁴ recommended significant expansion of publically-supported home and community-based care. Many believe that a strategy that combines both public support and private financing, through long-term care insurance for example, is needed to meet future long-term care needs.

Public and Private Spending and Unpaid Family Care

Estimates prepared for the Department of Health and Human Services (DHHS) show that in the year 2000 total national spending for institutional and home care services for the elderly alone will exceed \$98 billion.⁵ Medicaid and Medicare together are expected to pay about \$55 billion (56%) of the total. Most of the rest, 40%, is estimated to be paid out-of-pocket by recipients of care or their caregivers. Almost three-quarters of total long-term care spending for the elderly is for institutional services. By the year 2025, these estimates show that total public and private expenditures will be over \$207 billion.

Despite substantial public spending for long-term care, families provide the bulk of long-term care services to family members with physical and cognitive disabilities. About 37 million caregivers provide informal, or unpaid, care to family members of all ages. Typically, this care is provided by adult children to elderly parents. About two-thirds of the functionally impaired elderly rely *exclusively* on informal assistance. Research has documented the enormous responsibilities that families face in caring for

⁴ The Pepper Commission. U.S. Bipartisan Commission on Comprehensive Health Care. *A Call for Action. Final Report 1990*. September 1990, and the Health Security Act, introduced as H.R. 3600/S. 1757 in 1993.

⁵ Preliminary estimates prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (ASPE/DHHS), by The Lewin Group, Inc. April 2000. Other estimates sometimes differ.

relatives who have significant impairments. For example, caregivers of the elderly with certain functional limitations provide an average of 20 hours of unpaid help each week. Unpaid work, if replaced by paid home care, would cost an estimated \$45 billion to \$94 billion annually.⁶ Many argue that while public programs should not and cannot replace family caregiving, targeted public initiatives might do more to assist families sustain their efforts.

The President's Initiative and Related Legislation

The President's FY2001 initiative contains the following elements:

- a \$3,000 income tax credit (when fully phased-in) for families of individuals with long-term care needs;
- a \$125 million for caregiver services under the Older Americans Act;
- group long-term care insurance program for federal employees;
- option for states to liberalize Medicaid income eligibility for persons who need home and community-based care;
- steps to improve quality of care in nursing facilities; and
- \$100 million for capital grants and operating subsidies for assisted living housing units administered by the Department of Housing and Urban Development (HUD).

These elements as a package touch on a number of major issues related to long-term care, such as expansion of support for family caregivers, use of a flexible cash approach through the tax credit, and recognition of the importance of coordinating federal housing assistance with supportive services programs. The proposal continues the incremental approach to financing long-term care services that Congress has taken in the past. In contrast, a more comprehensive approach was taken by the Administration as part of its proposed Health Security Act in 1993.⁷

Tax Credit for Long-Term Care Needs

Proposal. The largest component of the President's proposal is a new federal income tax credit for families of individuals with long-term care needs. The credit could be claimed by the individual who needs care, by the person's spouse, or by someone who can claim that person as a dependent (using expanded dependency tests)

⁶ Doty, Pamela. *Caregiving: Compassion in Action*. U.S. Department of Health and Human Services, 1998. p.13. This estimate is based on elderly persons who need assistance with ADL or IADL limitations.

⁷ In the Health Security Act (introduced as H.R. 3600/S. 1757 in 1993), the Administration proposed a state grant program for home and community-based long term care services for persons requiring assistance in three or more ADLs, the severely mentally ill, the mentally retarded, and chronically ill children who are dependent on medical technology. The proposal was estimated to cost \$38 billion in FY2003.

Individuals age 6 or older (with different standards applying to young children) would be considered to have long-term care needs if they were certified by a licensed physician as being unable for at least 6 months *either*:

- to perform at least three ADLs without substantial assistance, *or*
- to perform at least one ADL without substantial assistance or to engage in age appropriate activities, provided they have severe cognitive impairment that requires supervision to be protected from threats to health and safety.

The maximum credit would be \$3,000 for each individual with long-term care needs. It would be phased in as follows: \$1,000 in 2001, \$1,500 in 2002, \$2,000 in 2003, \$2,500 in 2004, and \$3,000 in 2005 and thereafter. (In his FY2000 budget, the President proposed a \$1,000 credit.) The credit would be combined with the child credit (\$500 per child under age 17) and a proposed \$1,000 credit for workers with disabilities). to form a new family care credit. This combined credit would be phased out for higher income taxpayers, beginning with modified adjusted gross incomes of \$110,000 for married couples filing jointly and \$75,000 for single individuals. Where the phase-out range ends would depend on the number of qualifying individuals, either eligible children or individuals with long-term care needs.

In the case of one or two qualifying individuals, the combined credit would not be refundable; thus, it would not be available to lower income taxpayers with no tax liability. In the case of three or more qualifying individuals, the combined credit could be refundable, depending on the taxpayer's income tax liability.

Cost and Coverage. The proposed credit would be effective for taxable years beginning after December 31, 2000. The Joint Tax Committee estimates that it would cost \$10.8 billion through fiscal year 2005 and \$32 billion through fiscal year 2010.

Major Issues. The tax credit would provide recognition for families' long-term care costs, both monetary and personal, and it would provide some tax relief. However, some analysts question what practical difference \$3,000 would make for families that pay home care or nursing home expenses (the latter which average over \$41,000 per year) or that provide care themselves, sometimes giving up their jobs. Since the credit does not seem proportional to these costs, there could be pressure to increase the amount of the credit, if it were enacted. Some analysts argue that the federal government could use the same resources to help families in other ways, such as increasing funding to expand home care services under the auspices of the OAA and the SSBG programs or expanding home care services under a new program.

The credit would not help all families with long-term care needs. Lower income families without tax liability would not be eligible (unless they had three or more qualifying individuals), nor would families with incomes higher than the phaseout ceilings. Some of the former might qualify for Medicaid, which provides more generous assistance. However, some families might qualify for *both* Medicaid and the credit (e.g., nursing home residents who have a spouse with a tax liability), while others qualify for *neither* (e.g., lower income families with assets exceeding Medicaid income eligibility ceilings). These patterns may strike some people as unfair. Similarly, while higher income families can more readily pay for long-term care, there

are some who may have difficulty, particularly if care is required for many years. It might be noted that the credit could be claimed even if all long-term care expenses were covered by insurance, either public or private. In this respect it differs from other tax subsidies that generally are based on out-of-pocket expenses.

Other questions include whether the tax credit should use a three-ADL test or two-ADL test; whether only licensed physicians should be allowed to certify that individuals have long-term care needs (the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits certification for private insurance by licensed social workers or nurses, as is also true for Medicaid); and what additional administrative burdens might be placed on the Internal Revenue Service (IRS) in implementing the credit, particularly to prevent fraud and other abuses. In addition, the proposed credit would add to the complexity of the federal income tax system.

Legislation. A number of bills have been introduced that would authorize a tax credit for caregiving similar to the President's proposal. Included among these are S. 10 (Senator Daschle), S. 1160 (Senator Grassley), S. 2096 (Senator Bayh), S. 2225 (Senator Grassley and Senator Graham), H.R. 2085 (Representative Hooley), and H.R. 2102 and H.R. 3872 (both by Representative Johnson of Connecticut). Representative Smith of New Jersey has introduced two tax credit bills, H.R. 275 and H.R. 4029. A bill by Representative Stark (H.R. 2458) would authorize a \$1,000 refundable tax credit. In addition, numerous bills have been introduced to expand the dependent care tax credit (DCTC) which already benefits some families with long-term care needs.⁸

A different approach to tax benefits for long-term care is taken in the managed care (health care patient protection) legislation passed by the House (H.R. 2990) and Senate (S. 1344). Both bills would authorize a new tax deduction (not limited to itemizers) for individuals who purchase long-term care insurance, and both would allow employment-based long-term care insurance to be included in cafeteria plans and flexible spending accounts. The House bill would also authorize an additional dependency exemption for taxpayers who provide care to elderly family members; the Senate bill would also authorize a study of long-term care needs and policies.⁹

The long-term care tax benefits in H.R. 2990 and S. 1344 were included in the Senate amendment to the FY2001 Labor-HHS-Education Appropriations legislation (H.R. 4577). The Senate minimum wage legislation (part of H.R. 833, formerly S. 625, dealing with bankruptcy reform) would also authorize a tax deduction not limited to itemizers for individuals who purchase long-term care insurance.

⁸ The DCTC is a nonrefundable credit for employment-related expenses incurred for the care of a dependent child, or a dependent or spouse with disabilities. For additional information on the DCTC bills, see CRS Report RL30021, *Child Care issues in the 106th Congress*, by Karen Spar and Melinda Gish.

⁹ Provisions authorizing the above-the-line deduction, inclusion in cafeteria plans and flexible spending accounts, and an additional personal exemption had also been included in the Taxpayer Refund and Relief Act of 1999 (H.R. 2488) that the President vetoed on September 23, 1999.

Caregiving Grants to States under the Older Americans Act¹⁰

Proposal. The President's FY2001 budget requests \$125 million for caregiver support services to be funded under Title III-B of the Older Americans Act (State and Community Programs on Aging, Supportive Services and Centers). Caregiver services would include respite, adult day care, home care services and others identified by state and area agencies on aging. Title III-B is a generic service program that funds a wide range of services for older persons. Services are to be targeted on persons with the greatest social and economic needs, with particular attention to low income minority older persons.

The FY2001 budget proposal is similar to the President's FY2000 budget request and the Administration's Older Americans Act reauthorization proposal submitted to Congress last year. However, it does not contain the following specific elements that are included in the reauthorization proposal. That proposal would establish a new National Family Caregiver Support program as a separate new part under Title III of the OAA. The program would provide grants to states for the following services:

- information to caregivers about available services;
- assistance to caregivers in gaining access to services;
- individual counseling, organization of support groups, and caregiver training;
- respite services to provide families temporary relief from caregiving responsibilities; and
- supplemental services (such as adult day care or home care services, for example), on a limited basis, that would complement care provided by family and other informal caregivers.

Under the reauthorization proposal, older persons, whose caregivers would be eligible for services, would be those who:

- are unable to perform at least two activities of daily living (ADL) without substantial human assistance, including verbal reminding, or supervision, or
- due to a cognitive or other mental impairment, require substantial supervision because of behavior that poses a serious health or safety hazard to the individual or other individuals.

Priority would be given to older persons and their families who have the greatest social and economic need, with particular attention to low income minority individuals. In addition, the Administration's legislative proposal would allow states to elect to establish cost-sharing policies for individuals who would receive respite and supplemental services provided under the program, that is, persons could be required to pay for services received.

¹⁰ For additional information, see CRS Report RL30055, *Older Americans Act: 106th Congress Legislation*, by Carol O'Shaughnessy.

Cost and Coverage. The Administration has proposed \$1.25 billion over 10 years for the grant program. About 250,000 families would receive some services each year depending on a number of factors, such as actual appropriations, the number of persons who meet eligibility requirements and also apply for services, capabilities and readiness of service providers, and state spending for specific services (since they have the option of pending their allotments in several ways).

Major Issues. The caregiver grant program would provide needed assistance to the burgeoning caregiver population and would supplement existing caregiver efforts. Enactment of the legislative proposal has been affected by controversy surrounding the reauthorization of the Older Americans Act which expired in FY1995. Despite attempts by both the 104th and 105th Congresses, the Act was not reauthorized due to controversy about the legislation related to issues on the community service employment program authorized under Title V of the Act and proposals for cost-sharing of services under Title III of the Act. (Funding for the Act has been continued by appropriations legislation since FY1996.)

The House Education and the Workforce Committee reported reauthorization legislation (H.R. 782) in September 1999 that included a caregiving program similar to that of the Administration. Although the bill was scheduled for House floor action in October, the bill was withdrawn due to controversy about some aspects of the bill unrelated to the caregiver proposal.

Because of controversy surrounding the reauthorization and unclarity of whether the reauthorization will actually be enacted by the 106th Congress, this year the Administration included funds for caregiver support as part of the budget request for an *existing* Older Americans Act program (supportive services and centers). Many of the caregiving services are similar to those already provided by state and area agencies under the Title III-B supportive services program. However, House and Senate action on FY2001 appropriations legislation has not included funding for the program because it has not been specifically authorized.

Legislation. The Administration's Older Americans Act reauthorization proposal, which includes the caregiver proposal, has been introduced by request as H.R. 1637 (Representative Martinez) and as S. 1203 (Senator Mikulski).

H.R. 782 and S. 1536, which would reauthorize the Older Americans Act, contain caregiver programs similar to that of the Administration's FY2000 budget and legislative proposals. H.R. 782 (Representative Barrett) was approved by the House Committee on Education and the Workforce on September 15, 1999; it would authorize \$125 million for these programs. H.R. 782 was scheduled to be considered by the House under "suspension of the rules" (which requires a two-thirds majority vote for passage) on October 4, 1999. However, the bill was not taken up due to controversy about the community service employment program. S. 1536 was approved by the Senate Committee on Health, Education, Labor and Pensions (HELP) on July 21, 2000. It contains a caregiver proposal that is also similar to the Administration proposal.

Both H.R. 782 and S. 1536 would authorize cost-sharing by participants for certain caregiver services. S. 1536 would also authorize caregiver services to older

persons who provide services and support to persons with mental retardation and related developmental disabilities, and to older persons who care for their grandchildren.

Under the Administration's proposal, funds for the caregiver program would be allotted to states on a formula based on a state's proportional share of the total population of aged 60 and older. H.R. 782 would allot funds to states based on a state's share of the total population aged 70 and over. However, persons under age 70 would be eligible for caregiver services. S. 1536 takes a different approach. It would allot funds to states based on its share of the population aged 60 and over as well as segments of that population in older age categories, its elderly poor population, and its nonwhite population. In addition, it would also base allotments on a measure of a state's relative total taxable resources (TTR).

Under both bills, the federal matching share for the specified caregiver services would be 75%, with the remainder to be paid by states.

In addition, other bills include the caregiver proposal. S. 10 (Senator Daschle), S. 707 (Senator Grassley), and H.R. 1341 (Representative Martinez) would authorize the caregiver proposal, but, unlike the Administration's bill, they would not authorize cost-sharing by participants toward the cost of caregiver services funded by the program. Like S. 1536, S. 707 would authorize caregiver services to older persons who provide services and support to persons with mental retardation and related developmental disabilities.

Long-Term Care Insurance for Federal Workers

Proposal. On January 4, 1999, the President announced that the federal government would set an example for other employers by offering a voluntary program under which group long-term care insurance would be available to civilian federal personnel and retirees as well as their spouses and certain other family members. The House and Senate have passed legislation to establish such a program.

In general, long-term care insurance policies pay for care required by policy holders who become unable to perform certain ADLs or who suffer from cognitive impairment. Benefit features of policies vary: in-home care as well as care by nursing facilities may be covered; the purchaser may elect high or low daily benefit rates or cost reimbursement limits; benefits payments may be adjusted to account for inflation; and benefits may be paid for different time periods, such as 1 year, 3 years, or for life. Premiums for specified benefit packages are priced on the basis of the age of the policy holder at the time of purchase.

Employer-sponsored group long-term care insurance is a relatively new concept in employee benefits. Group policies are estimated to cost 15% to 20% less than those purchased by individuals, generally because of lower marketing costs and commissions associated with selling to a group. The President's proposed program would require that premiums be paid fully by policy holders with no government cost sharing. Policies purchased by young or middle-aged employees are more affordable than those purchased at older ages, and, although benefits may not be needed for years or decades, long-term care insurance provides protection for individuals and

their families from financial strain or from depletion of resources and reliance on Medicaid or other public programs. Thus, employment-based private insurance purchased by workers today is one facet of a strategy to address long-term care for the large elderly population of the future.

Cost and Coverage. The Administration estimates that the administrative costs incurred by the Office of Personnel Management (OPM) in running a long-term care insurance program would be \$15 million over 5 years. About 300,000 individuals are expected to participate.

Major Issues. During congressional consideration of alternative program designs, some questioned whether the federal government should initiate a new employee benefit for which government cost-sharing might be sought in the future. However, most of the debate centered on the administrative design of the program, including whether OPM should manage competition among carriers by selecting one or a small number of firms to participate in the program through a competitive bidding process, or whether competition should occur at the employee/retiree level with all qualified firms marketing their product directly to the active and retired workforce.

Another issue was the extent to which OPM should specify the features of benefit packages, such as eligibility criteria and covered services. Other issues included whether there should be coverage of active and retired military personnel, and the extent to which premium costs for each individual should be “medically underwritten” to reflect the purchaser’s health status.

Legislation. The Administration’s proposal was introduced as H.R. 110 (Representative Cummings), S. 57 (Senator Mikulski), and as part of S. 10 (Senator Daschle). Several other bills were introduced in the House and the Senate. All of the bills based eligibility for the insurance on eligibility for the Federal Employees Health Benefits Program (FEHBP), though they vary with regard to coverage of postal workers, members of the armed and uniformed services, and relatives. They also varied with respect to benefit design, underwriting, and OPM regulatory authority.

In the second session of the 106th Congress, bipartisan consensus formed around H.R. 4040 (introduced by Representative Scarborough) and an identical Senate bill S. 2420 (Senator Grassley). An amended version of the former bill passed both the House and Senate on July 27, 2000. The Administration has indicated that the bill is compatible with the President’s objectives. The legislation would cover most groups eligible for participation in the Federal Employees Health Benefits Program (FEHBP), active and retired members of the uniformed services, and spouses and certain relatives of workers and retirees could elect coverage also. It authorizes OPM to select one or more insurance carriers and to negotiate 7-year contracts; requires that underwriting standards be the same for active employee or annuitant participants and their spouses (but does not specify any other underwriting standards); and requires that OPM’s administrative costs be paid from the Employees’ Life Insurance Fund and be reimbursed by participating carriers. The legislation does not specify benefit

packages except that they must meet the tax qualification requirements of the Internal Revenue Code.¹¹

State Option to Liberalize Medicaid Income Eligibility

Proposal. The Administration's FY2001 budget has proposed a change in current law that would equalize Medicaid income eligibility for home and community-based and institutional care settings by allowing states to apply the same income eligibility standard to both settings. This is the same as its FY2000 proposal. Current Medicaid law allows a state to apply more liberal income eligibility standards to persons who need nursing home care than it can use for persons who may have the same care needs, but who reside in the community and prefer care in home and community-based settings. States may make eligible for institutional care persons who have income up to 300% of the income eligibility standard for Supplemental Security Income (SSI) (in 2000, this level is \$1,532 per month).

This more liberal income standard does not generally apply to home and community-based care, with one exception. Only in cases where states have received approval from the Health Care Financing Administration (HCFA) to establish section 1915(c) home and community-based waiver programs are they allowed to waive Medicaid income eligibility standards that would otherwise apply, and use a more liberal income eligibility standard. Section 1915(c) of Medicaid law allows states to waive certain federal requirements so that they may have flexibility to provide home and community-based services to persons who would otherwise need institutional care. Services that may be provided under this authority include a variety of services such as case management, homemaker, personal care, adult day health, habilitation, and respite services, among others.

In addition to allowing states to use the more liberal income eligibility standard, under the waiver program, Section 1915(c) allows states to waive Medicaid requirements that (1) services be provided on a statewide basis and (2) services be comparable for all covered groups. Therefore, under an approved home and community-based waiver program, states may provide home- and community-based services in certain geographic areas and not others, and may provide a package of services targeted at specified groups, such as the elderly, the developmentally disabled, or the mentally ill.

Under the President's proposal, states would be permitted to make persons who are determined to need institutional care and who have incomes up to 300% of the SSI level eligible for certain Medicaid non-institutional care services, such as home health and personal care services, *without* seeking a HCFA waiver. The proposal would allow states to extend this more liberal income standard to persons who need home and community-based services, such as personal care services, so long as they otherwise need institutional care.¹² Persons who would be unable to qualify for

¹¹ For more information, see CRS Report RS20644, *Long-Term Care Insurance for Federal Personnel*, by Carolyn Merck.

¹² Medicaid does not require that persons receiving non-waiver home and community-based
(continued...)

Medicaid home health or personal care services solely because their income is too high could be eligible if states chose to liberalize the income eligibility standard for non-institutional care. Such persons could be covered under a state's Medicaid plan, rather than the Section 1915(c) waiver program.

Cost. The Administration estimates that this proposal would cost \$15 million in FY2001. Amounts spent would partly depend on the number of states that chose to use the more liberal income standard for home and community-based services.

Major Issues. Under the proposal, states would be allowed to apply a more liberal income eligibility standard to both institutional and home and community-based long term care settings. Thus, persons who need the level of care provided in an institution, but who could be provided personal care services at home, for example, could qualify under a more liberal income standard set by the state. Therefore, the proposal would respond to the expressed preference of persons with substantial disabilities to receive care at home.

The proposal does not waive the Medicaid statewideness and comparability of services requirements. This means that if states chose to liberalize the income eligibility standard for noninstitutional care, they would be required to provide such care to all persons in the state and provide a comparable package of services to all covered persons. This could substantially increase state Medicaid costs and deter states from choosing the option.

Legislation. Last year, the Administration forwarded to Congress its legislative proposal on the Medicaid eligibility change.

Nursing Home Quality Improvements

Proposal. As part of the HCFA FY2001 budget request, the Administration has proposed various activities to continue current HCFA activities to improve quality of nursing home care. These activities include imposing immediate sanctions on homes found to have deficiencies that affect patient care; conducting weekend inspections; increasing numbers of patients evaluated to determine facilities' ability to detect and prevent bed sores, dehydration and malnutrition; and inspecting facilities with serious quality of care violations more frequently. This proposal builds upon the President's nursing home initiative in the FY2000 budget.

Cost. The FY2001 budget request for the nursing home initiative is \$61.6 million. This includes \$29.7 million for survey and certification of facilities; \$6.1

¹² (...continued)

services (such as home health or personal care) meet certain functional eligibility criteria to qualify for institutional care. Each state determines functional eligibility criteria that apply to these services. The President's proposal would require that to qualify for non-waiver home and community-based services under the higher income eligibility standard, persons would have to be so disabled that they would otherwise be eligible for institutional care. This proposed new option would be similar to the Section 1915(c) program which requires that persons served through the waiver program qualify for institutional care.

million for federal administration; \$19.5 for nursing home surveys of Medicaid facilities, and other activities to improve quality; and \$2 million for research designed to transition nursing home residents to community-based care with attendant services. The request also includes \$4.3 million for operation and maintenance of a national abuse registry; this activity would be financed through fees charged to users of the registry.

Major Issues. Federal and state governments spend an enormous amount of funds to pay for the care of the 1.6 million residents in the Nation's 17,000 nursing homes. CBO projects that in FY2000 Medicaid and Medicare payments for nursing home care will be \$49 billion, with three-quarters paid by Medicaid. Despite major reform of the nursing home quality of care requirements in 1987 by the Omnibus Budget Reconciliation Act of 1987 (OBRA87), a decade later, oversight and enforcement of quality of care standards continue to be of major concern. Recent reports by the General Accounting Office (GAO) and by DHHS's Office of the Inspector General (OIG) have again highlighted quality of care and enforcement issues.¹³

Standards for nursing home quality are established by federal law and regulation. Oversight of nursing homes and enforcement of standards are a joint federal and state government responsibility. While HCFA is ultimately responsible for enforcing compliance with the standards, it contracts with state survey agencies to conduct surveys, or periodic inspections, of nursing homes that participate in Medicare to assure their compliance. States are responsible for enforcing compliance by nursing homes that participate in Medicaid.

In its report this year, GAO reviewed findings of surveys of nursing homes to assure that homes are in compliance with legislative and regulatory standards. The surveys showed that more than one quarter of nursing homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury. The most frequent violations were inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide adequate care. Moreover, sanctions initiated by HCFA (which may include fines or civil monetary penalties) were never implemented and were not found to be an adequate incentive to assure compliance with standards by nursing homes.

The OIG report echoed the GAO findings that serious quality of care problems persist. It also identified a number of other issues. These included inadequate levels of nursing home staff, inadequate resources for the nursing home ombudsman

¹³ U.S. General Accounting Office. *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*. GAO/HEHS-99-46. Washington, D.C., March 1999. U.S. Department of Health and Human Services. Office of Inspector General. *Quality of Care in Nursing Homes; An Overview*. OIG-02-99-00060. Washington, D.C., March 1999.

program (authorized under the Older Americans Act),¹⁴ and a lack of evaluation of the reform effort required by OBRA87.

Legislation. Appropriations legislation for HCFA may address the budget request.

Housing and Services Initiative¹⁵

Proposal. The Administration has proposed continuation and expansion of activities to improve housing and long-term care options for the elderly and for persons with disabilities as part of the Department of Housing and Urban Development (HUD) budget.

Capital Grants for Conversion of Existing Section 202 Housing to Assisted Living Units. Section 202 of the Housing Act of 1959 authorizes a combination of capital advances and rental assistance to supply a stock of congregate housing facilities for low income elderly and persons with disabilities. Capital advances are provided to private nonprofit organizations and consumer cooperatives to aid in financing the construction, acquisition, or rehabilitation of a structure to be used for supportive housing for the elderly. Project rental assistance is provided through 5-year renewable contracts between HUD and the project owners. Under these contracts, HUD agrees to pay the operating costs not covered by the tenant rents. Tenants pay 30% of their income as rent. Supportive services provided in housing projects under this program are to be tailored to meet the needs of the elderly persons living in the units. Services may include meals, transportation, housekeeping, personal assistance, and other services as needed.

Many older persons living in existing Section 202 housing projects have “aged in place,” that is, they may have entered the facility in relatively good health, but over time, have experienced illnesses that lead to frailty or inability to function without some personal care assistance. If the health of Section 202 housing residents declines so that they cannot live relatively independently, they must apply for nursing home care. Because the existing Section 202 housing program is primarily a financing mechanism for “bricks and mortar” and for rent subsidies for low income persons, it is limited in its ability to provide care for residents who simply need personal care or housekeeping assistance on a continual basis, but not the level of care provided in a nursing home.

In the FY2000 budget, the President proposed a change in the Section 202 housing program to recognize the “aging in place” phenomenon among elderly residents. The proposal recommended the use of capital grants to convert existing Section 202 housing units to assisted living units. Assisted living facilities provide more oversight and supervision of residents than under the Section 202 program,

¹⁴ The purpose of the program is to investigate and resolve complaints of residents of nursing homes and board and care facilities. For further information, see CRS Report 96-399 EPW, *Older Americans Act: Long-Term Care Ombudsman Program*, by Carol V. O’Shaughnessy.

¹⁵ For further information, see CRS Report RL30247, *Housing for the Elderly: Legislation in the 106th Congress*, by Susan VanHorenbeck.

including 2 meals a day and 24-hour staff. Authorization for assisted living conversion capital grants was incorporated into the FY2000 HUD appropriations legislation (P.L. 106-74). In addition, the legislation included \$50 million for this purpose.

The FY2001 proposal continues the direction started last year. The President has proposed \$50 million for conversion of existing Section 202 housing units to assisted living, the same amount provided last year. In addition, the proposal would encourage the development of new assisted living facilities by providing \$50 million in operating subsidies for a 5-year period. The proposal would allow the use of Section 232 Federal Housing Administration (FHA) mortgage insurance to underwrite the cost of loans to develop the facilities. The operating subsidies would be available at market rent levels up to 150% of fair market value.

Cost of the HUD Proposal. The Administration is requesting \$100 million for HUD assisted living subsidies, including \$50 million for conversion of existing Section 202 housing units to assisted living, and another \$50 million for operating subsidies for assisted living units that might be developed by housing developers.

Major Issues. The Administration's proposal recognizes an important component of the long-term care services system that is usually not considered in any discussion of home and community-based care; namely, providing a combination of housing and personal care assistance to the frail elderly and persons with disabilities. While assisted living facilities would provide more oversight to frail elderly and persons with disabilities than that provided by Section 202 housing programs, facilities would still need to access other funds to provide direct health and social services to persons needing more assistance than is normally provided by the facilities. Provision of these services would depend upon availability of funds from state-administered programs, such as the Medicaid home and community-based waiver program, the Social Services Block Grant Program (SSBG), and the Older Americans Act.

Legislation. Additional funding for converting Section 202 housing units to assisting living units presumably will be considered in any action on the FY2001 HUD appropriations legislation. In addition, allowing use of Section 232 FHA mortgage insurance to produce new facilities may also be considered.

Some Other Legislation

Well over 100 bills have been introduced in the 106th Congress to address long-term care needs. In addition to the ones cited above, others that might be mentioned include those listed below. More can be identified by searching under the term "long-term care" in the Legislative Information System available to congressional offices at [<http://www.congress.gov>].

- S. 2066 (Senator Cleland) and H.R. 4316 (Representative Lewis) would exclude income from U.S. savings bonds from gross income if used to pay long-term care expenses

- H.R. 745 (Representative Stark) would amend Medicare to include coverage of substitute adult day care services.
- H.R. 746 (Representative Stark) would amend Medicare to provide coverage of home health care case manager services.
- H.R. 1716 (Representative Bilirakis) would provide for a study of long-term care needs in the 21st century.
- S. 1935 (Senator Harkin) would provide for coverage of community attendant services and supports under the Medicaid program.