



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

SUMMARY OF LONG-TERM CARE PROVISIONS UNDER THE HEALTH SECURITY ACT

March 1994

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

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Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This discussion paper was prepared by DALTCP as a follow-up document to Health Care Reform activities. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

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The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services.

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Medicare has guaranteed acute health coverage for older Americans and many younger people with disabilities for almost three decades. However, when Medicare beneficiaries experience a chronic illness or disability which results in a need for long-term care, no similar guarantees are present. Several million Americans of all ages with chronic disabilities require help with routine daily living tasks such as bathing, dressing, toileting, eating, shopping, taking medications, or managing money. The great majority rely solely on their families and friends. There is widespread consensus that this system of informal caregiving must be reinforced, particularly if it is to meet the challenges of a rapidly aging society.

The present system of financing long-term care is inadequate. Medicare coverage of long-term care services is quite restrictive, usually limited to a short period following a hospital stay for an acute illness or injury. The fledgling private market for long-term care insurance pays less than 2% of the nation's long-term care bill and has yet to prove that it can provide reliable and affordable protection to the majority of Americans.

By default, the Medicaid program, designed to provide health care coverage for the poor, has become the national long-term care program. But Medicaid is only available to people who are very poor or who have exhausted virtually all personal resources paying for their own care. Medicaid is also heavily biased toward the purchase of expensive institutional care. As a result, Medicaid nursing home expenditures are threatening the budgets of many State governments. We know that both older and younger people with disabilities overwhelmingly prefer services in their own homes and communities. To be responsive to the consumers of long-term care, funding of home and community-based services must be expanded; more attractive, less expensive residential options must also be developed.

The need for secure coverage for long-term care poses a serious challenge for health care reform. The Health Security Act is an important step toward correcting some of the most severe deficiencies of the long-term care system.

First and foremost, it greatly increases Federal funding for home and community-based services and, in doing so, takes a giant step toward buttressing the family caregiving system. Second, it significantly enhances the potential of the private insurance market to offer affordable, reliable and high quality long-term care insurance products. Third, it provides all people who are concerned about protecting themselves against the need for long-term care with more choices ... more choices about what services are most needed, where services should be provided and who should actually deliver them.

The long-term care component of the Health Security Act encompasses six key elements:

- New home and community-based services (HCBS) program.

- Improvements in long-term care coverage under Medicaid.
- Private long-term care insurance standards and tax incentives
- Tax incentives that help individuals with disabilities to work.
- Demonstration study of acute and long-term care integration
- Long-term care system performance review.

In addition to this comprehensive summary of the long-term care provisions of the Health Security Act, a separate document which explains the cost estimates for the long-term care provisions is also available.

I. NEW HOME AND COMMUNITY-BASED SERVICES (HCBS) PROGRAM

The Health Security Act significantly expands home and community-based services (HCBS) for individuals with severe disabilities without regard to income or age. The expanded HCBS program is a Federal/State partnership.

The HCBS program complements other sources of financing for home and community-based services. For example, it does not reimburse for services covered under the nationally guaranteed benefit package or Medicare, both of which provide comprehensive coverage for acute medical services, as well as limited post acute services such as home health, extended care, and rehabilitation.

Eligibility: The Secretary of the Department of Health and Human Services (HHS) will issue regulations establishing uniform eligibility criteria and assessment protocols. States will use the standard protocol(s) developed by the Secretary to initially screen people and assess eligibility for the new program; protocols may vary across eligibility categories. Eligibility must be redetermined at least every 12 months (unless the individual's condition is unlikely to change).

To be eligible, an individual must be in one of the following categories, and be expected to remain eligible for at least 100 days. Generally, the first three categories apply to individuals of all ages; the final category applies only to children under age six. There is no individual entitlement to services under this program.

- Requires hands-on or stand-by personal assistance, supervision or cues in three or more of five activities of daily living (ADLs): eating, dressing, bathing, toileting and transferring in and out of bed.
- Presents evidence of severe cognitive or mental impairment as indicated by a set score on a standard mental status protocol (or protocols) specified by the Secretary of HHS, and demonstrated a need for service as evidenced by:
 - One or more ADL dependencies, **or**
 - One or more instrumental activity of daily living dependencies (IADL) related to the mental or cognitive impairment, **or**
 - Displays symptoms of one or more serious behavioral problems which create a need for supervision to prevent harm to self or others.
- Has severe or profound mental retardation.

- Is a child under the age of six who otherwise requires hospital or institutional care for a severe disability or chronic medical condition.

Covered Services/Benefits: To obtain benefits under the program an individual must be determined eligible and must receive a standardized needs assessment and an individualized plan of care based on the assessment. The care plan must be approved by the individual or his or her representative. The care plan specifies how services will be provided and how services not reimbursed under the new HCBS program will be obtained. States may take informal services into account in allocating services and benefits. States are not required to provide all services specified in a plan of care.

The statute provides States with considerable flexibility to design community-based service systems which respond to the diverse needs of the eligible population and which reflect the unique needs and circumstances of individual States and communities. States define services to be covered under the State plan and any limitations on services.

Each State must develop a State plan which includes services that respond to the needs of individuals in each of the four eligibility categories. Specific services may be targeted to certain categories of eligible individuals. At a minimum, a State's array of services must include personal assistance for every eligible category of participant. Personal assistance services include hands-on and stand-by assistance, supervision, and cuing to perform ADLs. States may expand this definition to include other benefits and services. Both agency-administered and consumer-directed personal assistance services must be available. Consumer-directed services permit consumers to hire, train and fire their own providers.

Other services may include but are not limited to: case management, homemaker and chore assistance, home modifications, respite services, assistive technology, adult day services, habilitation and rehabilitation, supported employment, and home health services. Room and board are not covered. States may offer vouchers or cash directly to consumers or capitate benefits to health plans or other providers.

HCBS may be delivered in a person's own home, a range of community residential arrangements, or outside the home. Services may not be provided in licensed nursing homes or intermediate care facilities for the mentally retarded (ICFs/MR).

Co-insurance: All eligible individuals with incomes above 150% of the Federal poverty level pay coinsurance to cover a portion of the cost of all services they receive according to a sliding scale. People with incomes between 150% and 200% of the Federal poverty standard pay 10% of the service costs; between 200% and 250%, people pay 20%; and, if a person's income is over 250% of poverty, the individual is responsible for paying 25% of the cost of services. States have the option of imposing nominal cost sharing on individuals with incomes below 150% of the Federal poverty level.

State Administration: To participate in the HCBS program, each State must have an implementation plan approved by the Secretary of HHS and developed with participation from individuals with disabilities and their representatives. The plan:

- Designates an agency (or agencies) to administer the program.
- Defines services to be provided under the program in addition to personal assistance, and any limits on services.
- Demonstrates how the needs of people in each eligibility category will be met.
- Specifies how the State allocates resources during and after the seven year program phase-in. Resources may not be allocated based on the beneficiary's financial status, age, geographic location, disability level, or residential setting.
- Specifies how the State administers the program, including how it will manage available Federal and State funds during and after the phase-in to serve each category of eligible individuals.
- Specifies how the State monitors, ensures, and improves quality.
- Specifies how the State coordinates services under the plan with other health and long-term care services outside the plan including Medicare; Medicaid; Maternal and Child Health Services and Social Services Block Grant Programs; programs under the Older Americans Act, the Developmental Disabilities and Assistance Bill of Rights Act, and Individuals with Disabilities Education Act; health plans; and any other public program that provides services to individuals with disabilities.
- Provides assurances that Medicaid recipients of HCBS as of the date the new HCBS program is enacted will continue to receive an appropriate level of care either under the new program, Medicaid or through other State programs.
- Provides assurances that the proportion of low-income individuals with severe disabilities served in the new program, through Medicaid or other State programs, is at least as great as the proportion of low-income individuals in the State.
- Provides results of negotiations between the State and employee labor unions of hospitals and other facilities regarding the impact of the new program on the work force and methods to redeploy workers.

Quality Assurance: States are responsible for ensuring the health and safety of persons receiving services under the HCBS program and for specifying, monitoring and enforcing minimum standards for agency providers (including competency requirements

for agency employees providing direct services). States must survey program participants to determine whether they received services identified in the service plan and whether they were satisfied with these services. Consumer choice regarding services and providers must be honored as much as possible. States must also specify the role of the long-term care ombudsman and Protection and Advocacy Agency within their overall system for assuring quality. In addition, the State advisory groups are expected to play a strong role in assuring and enhancing quality in the program.

Consumer Involvement in Governance: The Secretary of HHS will establish a Federal advisory group, made up of a majority of consumers and their representatives, as well as providers, Federal and State officials, and local community implementing agencies to advise the government and the States on all aspects of the new long-term care program.

In addition, each State will be required to establish a similarly constituted group. This advisory group will consult with the State before the State plan is developed and advise the State on guiding principles and values, policy directions and specific components of the plan. The group will continue to consult with State officials throughout plan development, and during implementation and evaluation of the program. The members of the advisory group will participate in public hearings on the plan and ensure public comments are addressed. The group is also required to submit, as a component of the State plan, detailed comments on all aspects of the plan, including its level of consumer responsiveness.

National Budget¹: The key components of the budget and financing for the program include:

- HHS establishes a national budget for the HCBS program, based on the estimated cost of providing HCBS to persons with severe disabilities and program administration. This budget consists of public funds and copayments, made by participants. The Federal matching rate (FMAP + 28%) was chosen so that States would spend approximately the same amount under the new program as they would have spent under current law for the eligible population. The amount of new Federal funds is based on the difference between the Federal portion of the national budget and projected Federal Medicaid expenditures for persons with severe disabilities. The amount of new State funds required for full participation is based on the difference between the State portion of the national budget and projected State expenditures for persons with severe disabilities, including both Medicaid and State-only funds.
- After the seven year phase-in, the budget increases annually, consistent with the rate of increase in the CH and the growth in the number of persons with severe disabilities in the national population.

¹ A separate document, "*Cost Estimates for Long-Term Care Provisions under the Health Security Act*" explains all aspects of the budget, allocation and estimating process for the long-term care provisions of the Health Security Act. [<http://aspe.hhs.gov/daltcp/reports/hcrctest.htm>]

- States will be allocated a maximum Federal budget based primarily on the number of persons with severe disabilities in each State.
- The program will be paid for through Federal and State funds, with copayments from recipients. The Federal share of public funds in the national budget ranges from 78% to 95% depending on State per capita income and States will pay 5% to 22%.
- Medicaid HCBS components continue as under current law for low-income people with lesser levels of disability. States may elect to serve persons with severe disabilities either under Medicaid or under the new program.
- States are entitled to their share, once their State plan is approved.

State Allocation Formula: The budget for each State will equal: (# of persons with severe disabilities * 80% of national average budget per eligible * wage adjustment) + co-insurance adjustment. It is calculated as follows:

- **Number of persons with severe disabilities in each State.** This estimate is computed by applying national age-sex-income specific prevalence rates to the corresponding population in each State.
- **National average budget per eligible.** This is computed by dividing the total expenditures under the program (Federal, State, copayment) by the number of persons with severe disabilities. State allocations are adjusted to reflect co-insurance payments and to account for low-income persons who are not required to pay co-insurance.
- **Wages in each State.** The wage index will be calculated by dividing average hourly wages for service workers other than household or protective services in a State by the national average wages for this category of workers.

Phase-In: The program will be phased in over a seven year period. During the phase-in period, the maximum Federal dollars which can be allocated to each State for the new program will be equal to the sum of: (1) the State's proportionate share of new Federal dollars in each year of the phase-in; and (2) the State's proportionate share of the Federal Medicaid offset amount for HCBS for persons with severe disabilities. State matching funds are required, but States are not required to spend up to the maximum allotment.

1. The new Federal dollars will be capped at the following amounts:
 - fiscal year 1996--\$4.5 billion;
 - fiscal year 1997--\$7.8 billion;
 - fiscal year 1998--\$11.0 billion;

- fiscal year 1999--\$14.7 billion;
- fiscal year 2000--\$18.7 billion;
- fiscal year 2001--\$26.7 billion;
- fiscal year 2002--\$35.5 billion;
- fiscal year 2003--\$38.3 billion.

The Federal dollars will be allocated to States during the phase-in period in the same proportion as the allocation of Federal dollars by State when the program is fully phased in.

2. In addition to the new Federal dollars, in each year of the phase-in, the Federal budget for the new HCBS Program may be increased by an amount equal to the Federal Medicaid savings due to enrolling Medicaid recipients with severe disabilities in the new HCBS program (**this adjustment is called the Medicaid offset**). Based on information collected from the States, the Secretary of HHS may increase the Federal portion of the **national** budget by the amount of the Federal Medicaid offset for HCBS demonstrated by the States. The Medicaid portion of the national budget is distributed to the States according to the same formula as the new Federal dollars.

Updating the Allocation Formula: The components of the State allocation formula will be updated based on the following schedule and sources of information:

- Prevalence rate of severe disability--every ten years based on the most recent and reliable national and/or State estimates of the number of persons with severe disabilities.
- Population estimates by State--annually based on data from the Current Population Survey (CPS).
- Wage index--every ten years based on data from the Decennial Census.
- Co-insurance index--annually based on data from the CPS.
- Average spending per eligible--annually based on rate of growth in the national health care budget, not including the population growth component.

Federal and State Matching Requirements: The Federal matching rate will be 28 points higher than the current FMAP rate, but in no case lower than 78% or higher than 95%. States are prohibited from using other Federal dollars to match the Federal share under the new program--L Current restrictions under Medicaid on use of donations and taxes apply.

Administrative Costs: The costs of administering the program including the eligibility determination process and care planning are included under the national budget. Differential Federal administrative match rates will be established as follows:

- 50% for administrative activities such as budgeting, State program management, and contracting.
- 90% for administrative activities related to the eligibility determination process; e.g., preliminary screening and assessment. Care planning activities are treated as a service or benefit and matched accordingly.
- 90% during the phase-in period for the design, development, and installation of client tracking systems, mechanical claims processing and other information retrieval systems required by the Secretary of HHS for program administration and evaluation purposes. Once the new program is fully implemented, the Federal administrative match rate for the operation of these systems and continued information retrieval activities will be 75%.

After the seven year phase-in period is completed, States will not be permitted to spend more than 10% of their budget for the new program on administrative expenditures.

II. IMPROVEMENTS IN LONG-TERM CARE COVERAGE UNDER MEDICAID

All current rules and requirements are retained for Medicaid community care programs including personal care; home and community-based waivers; frail elderly programs; community supported living arrangements; targeted case management; and home health services, clinic services and rehabilitation services finished to an individual as a result of a need for long-term care.

States must ensure that the proportion of low-income individuals served between the new HCBS program and their continuing Medicaid program equals or is greater than the proportion of low-income individuals residing in the State.

A. Improvements To Medicaid Coverage for Institutional Care

The Health Security Act provides the following improvements for institutional care under Medicaid:

- States will establish a medically needy program for all residents of nursing homes.
- Residents of nursing homes and ICFs/MR will be able to retain at least \$50 per month as a personal needs allowance. The current minimum allowance is \$30. This increase will be paid with Federal funds.
- States may permit single residents of nursing homes and ICFs/MR to retain up to \$12,000 in personal assets in determining eligibility for Medicaid coverage. The current limit is approximately \$2,000.
- Nursing home and ICF/MR applicants and residents (or their representatives as appropriate) must be informed of the array of home and community-based long-term care services available in the State under Medicaid, the new home care program, and any other public HCBS programs operating in the State for which the individual may be eligible. All other aspects of institutional care including nursing facility services, ICFs/MR, and IMDS continue as under current law.

B. Medicaid Commission

The Health Security Act establishes a 15 member Medicaid Commission for approximately one year. The Commission will study Medicaid reform including block grant payment systems for covered services, integration of acute and long-term care services, establishing a global budget for institutional and community-based long-term care, and other matters. One year following enactment of the Act, the Commission will report its findings to the Secretary of HHS and National Health Board.

III. PRIVATE LONG-TERM CARE INSURANCE STANDARDS AND TAX INCENTIVES

The Health Security Act contains a variety of provisions to help consumers who wish to protect themselves against long-term care costs to purchase high quality, affordable long-term care insurance products. Under the bill's provisions:

- The Federal Government will establish uniform standards for long-term care insurance policies.
- The Secretary of HHS will award grants to States to improve their enforcement of Federal and State regulatory requirements.
- A new program of consumer education will be initiated to inform people about their risks of needing long-term care, and the strengths and limitations of various insurance products.
- Tax incentives will be made available to make long-term care insurance more affordable.

A. Insurance Standards

Advisory Council: Under the Health Security Act, a five member Long-Term Care Insurance Advisory Council will be established, appointed by the Secretary of HHS, to monitor the development of the private long-term care insurance market and disseminate information to insurers, providers, consumers, and regulatory agencies. \$1.5 million is authorized for the Advisory Council in fiscal year 1995, and \$2.5 million in subsequent years. In addition, the Advisory Council will develop for consideration by the Secretary:

- Uniform terms, definitions, and formats for policies.
- A standard outline of coverage.
- A standardized assessment process.
- Insurer and State dispute resolution procedures.
- Agent training and certification requirements.

- Limits on agent commissions and other compensation.
- Prohibited sales practices.

The Advisory Council will also consider the need for Federal requirements regarding:

- Long-term care insurance premiums and amounts by which premiums may increase.
- Upgrades in long-term care insurance coverage.
- Standardizing levels of functional or cognitive impairment needed to trigger long-term care insurance coverage.
- The insurance aspects of continuing care retirement communities.

Regulations: The Secretary of HHS will publish a timetable for promulgating Federal regulations for long-term care insurance. Regulations must be established no later than three years after the appointment of the Advisory Council.

Effective Six Months After Enactment: The Health Security Act provides that certain requirements become effective six months after enactment of the Act (without regard to the publication of regulations) including:

- Prohibitions on pre-existing conditions exclusions under most circumstances.
- Requirements that policies providing nursing facility coverage include coverage in all licensed, and some other, facilities.
- Prohibitions against treating persons with Alzheimer's disease or other conditions (or other dementias), mental illness, mental retardation, or AIDS differently from those with other conditions.
- Prohibitions regarding certain insurer sales practices.
- Requirements concerning the right to cancel within 30 days and receive a full refund.
- Requirements concerning the insurer's right to cancel under certain circumstances.
- Requirements that policies include a renewal statement.
- Prohibitions against selling replacement coverage that provides less coverage than the initial policy.

- Requirements that policies specify the level of functional or cognitive impairment that will trigger benefits and include procedures to determine when these levels are met.
- Requirements that insurers promptly pay or deny claims, provide a written explanation of the action taken, and establish an appeals process for claims denial.

Interim Requirements: In addition, until the Secretary of HHS promulgates regulation the Health Security Act allows insurers to be found in compliance if certain standards established by the National Association of Insurance Commissioners are met including, for example:

- The provision of an outline of coverage to applicants that specifies conditions of coverage, describes benefits, and other requirements.
- Requirements that insurers provide annual reports to State insurance commissioners regarding lapse and replacement rates.
- Prohibitions on conditioning benefits on prior hospitalization or institutionalization, or receipt of a higher level of care.
- Minimum standards for home health and community care benefits.
- Inflation protection and premium charges for this protection.
- Prohibitions against post-claims underwriting and consequences of providing misinformation on the insurance application.
- Specific limitations on agent compensation.
- Requirements concerning policies sold through employer or membership organizations.
- Requirements that policies be guaranteed renewable or noncancelable.

Other Requirements: In addition, Other requirements included in the Health Security Act would become effective when the Secretary of HHS promulgates regulations including:

- Mandatory nonforfeiture benefits in the event a policy lapses.
- Possible requirements for standardized benefit eligibility triggers.

- Use of a uniform assessment process completed by qualified individuals who meet Federal requirements.
- A statement in the outline of coverage of the tax treatment of premium's and benefits.
- A comparison of available public and private long-term care insurance alternatives.
- Possible mandatory or optional premium rates and increases.
- Federal requirements concerning "substantial equivalence" for continuation or conversion of group policies.

B. State Implementation and Enforcement Assistance

The Health Security Act authorizes matching grants to States to promote monitoring and enforcement of Federal long-term care insurance requirements. To receive these grants, States must establish regulatory Programs that ensure compliance with Federal standards and meet certain procedural requirements to:

- Review, certify, and recertify policies sold in the State.
- Monitor compliance of insurers and policies with Federal standards.
- Require insurers to annually report information.
- Monitor sales practices.
- Monitor administration of benefits (including eligibility determinations and disposition of claims).
- Investigate and resolve consumer complaints.
- Include certain sanctions for noncompliance with Federal requirements.
- Provide to insurers information on eligibility and benefits for public and private long-term care insurance programs (including Medicare) and coverage under each regional alliance.
- Provide technical assistance to insurers in order to comply with Federal requirements.

In addition to establishing Federal long-term care insurance requirements, the Secretary of HHS approves State programs that meet all Federal standards.

The Health Security Act authorizes appropriation of \$10 million for each of fiscal years 1996 and 1997, \$7.5 million for fiscal year 1998, and \$5 million for each fiscal year thereafter for Federal grants to promote monitoring and enforcement of Federal requirements. States are entitled to receive payment up to the allotment for each fiscal year for 50% of incurred enforcement expenditures. States are prohibited from using any Federal funds as the State's share.

The Secretary of HHS is to:

- Review and determine whether State regulatory programs comply with requirements.
- Notify States failing to comply with Federal standards.
- Provide States with an opportunity to correct noncompliance and may require States within a reasonable period of time to develop and implement a corrective action plan.
- Withdraw approval of State regulatory programs that fail to correct noncompliance by the date specified by the Secretary of HHS. No insurer may sell insurance in a State without an approved regulatory program. Within one year of enactment of the Health Security Act (or longer if necessary in States requiring legislation) insurers violating this requirement are subject to civil money penalties up to the greater of \$10,000 or three times any commission.

C. Consumer Education Grants

The Secretary of HHS is authorized to make grants to States, national organizations, and regional alliances for programs providing consumer information, counseling, and other assistance. The goals of the grant program include the provision of information in the following areas:

- Risks of needing and costs of long-term care.
- Lack of long-term care coverage under Medicare, Medigap, and health insurance.
- Limitations of long-term care coverage under State programs.
- Availability, variations in costs and coverage, and common features of private long-term care insurance policies and pitfalls to avoid when purchasing these products.

The Health Security Act authorizes \$10 million each fiscal year 1995-1997 for grants to States and \$1 million each fiscal year for grants to eligible organizations.

D. Tax Treatment of Long-Term Care Insurance and Services

Long-Term Care Services: The Federal tax code current provides a deduction for medical care expenses for people who spend over 7.5% of their adjusted gross income. Generally, the treatment of long-term care insurance benefits is unclear under current law. To the extent that long-term care is not treated as medical care, employer-provided long-term care coverage is now taxable to the employee.

The Health Security Act expands the definition of medical care under the tax code to include qualified long-term care insurance. This will permit long-term care expenses incurred by a person with a disability to be treated as deductible medical expenses subject to the 7.5% floor. To be eligible for this deduction an individual must be unable to perform at least two ADLs without substantial assistance or be severely cognitively impaired. The provision would apply to taxable years beginning after December 31, 1995.

Long-Term Care Insurance: Favorable tax treatment is also provided by the Health Security Act to encourage people to buy, qualified private long-term care insurance. If individuals purchase Supplemental (not qualified) policies, these tax benefits do not apply to the Supplemental Policy.

Under the Act, premiums paid for a qualified long-term care policy are deductible as a trade or business expense or as an itemized deduction subject to the 7.5% of adjusted gross income floor; the value of employer-provided coverage under the policy is not taxable to an employee; and benefits under the policy are not taxable to the recipient. However, funding the purchase of the policy on a tax-favored basis through a cafeteria plan is not permitted.

A qualified long-term care insurance policy would be required to:

- a. Satisfy certain regulatory standards set forth in the Health Security Act;
- b. Condition eligibility for benefits on being unable to perform at least two ADLs or on suffering severe cognitive impairment;
- c. Not allow immediate prefunding or cash values; and
- d. Limit benefits to \$150 per day (indexed for medical inflation) without regard to actual incurred long-term care expenses.

The provision would apply to policies issued after December 31, 1995. A transition rule would permit existing long-term care insurance policies to be "changed for qualified long-term care insurance policies.

Accelerated Death Benefit Riders: Under current laws, insurance contracts have been developed that provide for payment of death benefits under a life insurance policy, as a result of terminal illness, prior to an insured's death. Generally, the accelerated death benefit is equal to all or a portion of the death benefit, discounted for the remaining life expectancy (generally 12 months or less) of a terminally ill individual.

The Health Security Act provides insurers with standards needed to design and market insurance contracts that provide for payment of benefits prior to an insured's death without subjecting policyholders to taxation on the additions to cash value within the life insurance contract.

The Health Security Act allows an accelerated death benefit rider to be sold in conjunction with a life insurance contract without causing disqualification of the contract as a life insurance contract. This protects the policyholder from taxation on the inside buildup in the life insurance contract.

The Health Security Act would expand the definition of a life insurance contract to include a qualified accelerated death benefit rider on the contract and would treat the rider as a qualified additional benefit. Also, the addition of an accelerated death benefit rider to a life insurance contract would not be treated as a modification or material change of the contract.

The provision would apply to contracts issued after December 31, 1995.

IV. TAX INCENTIVES THAT HELP INDIVIDUALS WITH DISABILITIES TO WORK

Many Individuals with disabilities want to work, but face the prospect of high out-of-pocket costs for buying assistance with daily activities. The Health Security Act provides incentives to these individuals which will assist them in their efforts to become, and remain, part of the work force.

A nonrefundable tax credit will be made available to individuals who work and who, by reason of a medically determinable Physical impairment that has lasted (or can be expected to last) for at least 12 months, would be unable to engage in substantial gainful activity without personal assistance services. The amount of the credit will be based on: (i) the level of specified personal assistance expenses; (ii) the individual's earned income; and (iii) the individual's (and his or her spouse's) adjusted gross income. For taxpayers with adjusted gross income of less than \$50,000, the credit would be equal to 50% of up to \$15,000 in personal assistance expenses (or 50% of earned income, if the individual's personal assistance expenses exceed his or her earned income)--for a maximum credit of \$7,500. The rate of the credit, and accordingly the maximum possible credit, would be phased down for taxpayers with adjusted gross income between \$50,000 and \$70,000 (with no credit available for taxpayers with adjusted gross income over \$70,000).

The credit is be effective for taxable years beginning after December 31, 1995.

V. DEMONSTRATION STUDY OF ACUTE AND LONG-TERM CARE INTEGRATION

The Secretary of HHS will establish a demonstration program to test the effectiveness of various approaches to financing and providing integrated acute and long-term care services for chronically ill or disabled persons who meet the eligibility criteria in this part.

Except as permitted by the Secretary of HHS, each demonstration approved under this section must offer the following services and benefits:

- Benefits included in the comprehensive benefit package.
- Benefits relating to the transition from acute to long-term care including: assessment and consultation; medical rehabilitation; inpatient transitional care; home health care and home care; and, caregiver support and self-help technology.
- Long-term care benefits including: adult day care; personal assistance services; homemaker and chore services; home-delivered meals; respite services; nursing facility services in specialized care units; services in other residential settings; and, assistive devices and environmental modifications.
- Specialized habilitation services (for participants with developmental disabilities).

The Secretary of HHS will establish eligibility criteria for individuals receiving benefits in demonstrations. The criteria will include individuals:

- Eligible for the new home care program.
- Entitled to benefits under Medicare Parts A and B.
- Entitled to Medicare who are also Medicaid recipients or SSI beneficiaries.

An entity conducting a demonstration is entitled to receive such payment amounts as the Secretary of HHS provides including risk-based and nonrisk-based by government programs, third parties, program enrollees or any combination of these payments. Amounts paid by the Secretary may vary by project and by enrollee.

The Secretary of HHS will publish a request for applications under this section no later than one year after the Act is enacted, and will authorize no more than 25 demonstrations, each to last for seven years from the date of the award.

The Secretary of HHS will evaluate the demonstration projects and make interim and final reports to Congress. The final report will contain recommendations regarding whether to include some or all of the tested models for integrated services in the comprehensive benefit package or in Medicare.

The Health Security Act authorizes for the costs of these demonstrations \$7 million for fiscal year 1996 and \$4.5 million for each of the six fiscal years thereafter. Of these amounts, no less than \$1 million will be set aside to study the feasibility of systems to provide integrated care for non-aged populations.

Funds are also authorized for costs of benefits which no public or private program obligated to pay. The amounts authorized for this purpose are \$50 million for the first fiscal Year in which grants are awarded and in each of the four following years.

VI. LONG-TERM CARE SYSTEM PERFORMANCE REVIEW

The overall performance of the long-term care components of the President's Plan will be assessed in terms of quality, access, and availability of long-term supports for individuals with disabilities. Seven years from the date of implementation of the long-term care reform plan (or by 2003 whichever is sooner), the Secretary of HHS will submit to Congress an interim report of the effectiveness of the new long-term care program. A final report to Congress is required two years later.

The reports will address States' effectiveness in delivering services, access to and quality of services, the performance of the private sector in offering affordable and adequate long-term care insurance, costs of insurance, and the effectiveness of the programs to integrate long-term, and acute care and social services.