DEVORAH ADLER
Domestic Policy Council

Box 2 of 7

Files:

Long Term Care
Long Term Care
Long Term Care
Long Term Care
Long Term Care
Long Term Care
Long Term Care
Organ Donation
Organ Donation
Organ Donation
Grijalva
Medicare
BBRA
BBRA
BBRA
BBRA
BBRA
Grijalva
Grijalva
Grijalva
Grijalva
Grijalva
PBOR
PBOR
PBOR
PBOR
Risk Adjust
CHIP
Medicare
Medicare
Medicare
TANF
TANF

Enclosures filed in Oversize Attachments # 20469
NARA # 17672

NATIONAL ASSOCIATION of NUTRITION & AGING SERVICES PROGRAMS
P.O. Box 9007 • Grand Rapids, MI 49509-0007 • 616-531-9909 • FAX 616-531-3103

For immediate release
March 26, 1999

Contact: Emily Ross
(202)789-0470

NANASP COMMENDS GORE ANNOUNCEMENT ON OLDER AMERICANS ACT

The National Association of Nutrition and Aging Services Programs (NANASP), today praised Vice President Gore's announcement that the Administration will formally submit an Older Americans Act reauthorization bill. NANASP is the largest professional membership organization representing the interests of members of all levels of the aging network, dedicated to providing quality nutrition and other direct services for older Americans.

In a statement released at their Washington D.C. Board meeting, NANASP President Mary Podrabsky declared "This is another important example of leadership by the Administration on behalf of the Act in 1999. In January the President proposed the new National Family Caregiver Support Program, later his FY 2000 budget called for increases in two of the nutrition programs under the Act and today the Vice President commits to seeing reauthorization accomplished in 1999."

Podrabsky added "It is time to lift the anxiety felt by many seniors in this country about the future of the Older Americans Act. It would only be fitting to have one of the most important senior programs of the 20th century be extended to begin the 21st century."

NATIONAL SILVER HAIRED CONGRESS

For immediate release
March 26, 1999

Contact: Emily Ross
(202)789-0470

NSHC HAILS GORE ANNOUNCEMENT ON OLDER AMERICANS ACT

The National Silver Haired Congress (NSHC) today said that prospects for reauthorization of the Older Americans Act in 1999 improved dramatically with Vice President Gore's announcement that the Administration would submit its bill to Congress next week.

NSHC is a national, non-partisan, non-affiliated, grassroots organization of seniors 60 and over.

Chairman Bea Bacon said "The legislative deadlocks over the Older Americans Act these past six years need to end. This is a program which has proven to be a great value not only to the seniors it serves but also to the taxpayer as these programs and services allow seniors to remain in their homes and independent and not in nursing homes which would cost far more."

Bacon noted that at their February 1999 National Silver Haired Congress session, the top resolution adopted by the their delegates called for the reauthorization of the Older Americans Act in 1999.

11901 West 148th Street. Olathe . KS . 66062 . Phone: 913-897-2252 FAX: 913-897-2255

National Committee to
Preserve Social Security
and Medicare
10 G Street, NE, Suite 600
Washington, D.C. 20002-4215 202 216 0420
Contact: Kris Geddings 703 709-6680

NEWS

FOR IMMEDIATE RELEASE
Friday, March 26, 1999

Senior's Group Applauds White House Message on Older Americans Act Support for Family Caregivers "On Target"

As Vice-President Albert Gore announced the Administration's plans to send an Older Americans Act bill to the Congress next week, Martha McSteen, President of the National Committee to Preserve Social Security and Medicare voiced encouragement. " It is significant that the Administration at its highest levels, recognizes the importance of the Older Americans Act, and the pressing need for its passage this year," said McSteen.

The Older Americans Act is the primary federal resource for community based services for seniors. Since 1965 the Older Americans act has provided home delivered and congregate meals, employment assistance, counseling services, in-home care, protection from physical and financial abuse and other vital services to many of the most vulnerable Americans. In 1995 formal budget authority for the OAA expired under Congressional inaction.

The centerpiece of the White House proposal will be a new federal grants program providing support for the at-home caregivers of frail and homebound seniors. Ms. McSteen called this focus "on-target." "While there are about 2 million Americans in long-term care institutions, there are five times as many who need some level of assistance with daily living activities in order to remain in their own homes and communities." she said. Approximately 55 percent of those who receive care in their homes are over the age of 65.

"This work can be extremely demanding, and more often than not family caregiving responsibilities fall upon women of the household," McSteen noted. "As the fastest growing segment of the U.S. population is the 80 and older age group, it is not uncommon for 70 year old children to be charged with the care of their 90 year old parents." She concluded, "Above all, the Older Americans Act must pass this year."

--30--

NATIONAL ASSOCIATION OF
AREA AGENCIES ON AGING

N4A SUPPORTS FAMILY CAREGIVER INITIATIVES

For immediate release
March 26, 1999

Contact: Janice Jackson
N4A – 202-296-8130
jjackson@n4a.org

Washington D.C. The National Association of Area Agencies on Aging (N4A) applauds the White House's initiatives to support family caregivers of older adults. Today, Vice-President Gore will highlight long term care and the Older Americans Act (OAA) at a forum in New Hampshire.

For too long, the needs of caregivers of older adults and persons with disabilities have been overlooked. Currently, nearly one in four families in the United States is providing physical and emotional assistance to frail older adults or friends. These caregivers devote many hours each week to help their older relatives with activities of daily life, such as eating, bathing, dressing and getting around. The Administration's National Family Caregiver Support Program will provide critically needed assistance to families as they struggle to provide care to their older relatives with little or no help.

According to Janice Jackson, N4A Executive Director, "People often think 'nursing home' when they hear the phrase long term care, but the most cost-effective and preferred form of long term care is home and community-based services such as meals-on-wheels, homemaker services and friendly visitors. Yet, funding for these types of community services is woefully inadequate, particularly in comparison to the amount of federal funding that is available for much more costly nursing home care. This just doesn't make sense when families need and want services to help them in their own homes."

The National Family Caregiver Support Program will build upon the services provided through the OAA in local communities throughout the country. The nation's 655 Area Agencies on Aging and 229 Native American Aging Programs have 25 years of experience coordinating a wide array of cost-effective services to help older Americans and persons with disabilities remain independent in their own home. The Older Americans Act is long overdue for reauthorization and an increase in funding.

N4A is pleased that the Administration and some Members of Congress in both parties have recognized the key role that caregivers play in the lives of their loved ones, as well as the strengths of Area Agencies on Aging in providing community-based long term care. We look forward to working with the White House and the Congress to ensure reauthorization of the Older Americans Act and enactment of the National Family Caregiver Support Program this year.

The National Association of Area Agencies on Aging has launched a national grassroots campaign to secure the passage of the Older Americans Act and the National Family Caregiver

Support Program in this Congress. The key messages of the campaign — "Support Caregivers" and "Pass the Older Americans Act Now" — will highlight the critical need to support family caregivers through funding of home and community-based services.

N4A's national network of Area Agencies on Aging and Native American Aging Programs are dedicated to helping older Americans and their families by assisting with service choices, protecting consumers and optimizing varied funding.

The Older Americans Act, enacted in 1965, is the major vehicle for the organization and delivery of social services to older adults at the federal, state and community levels.

###

Total Pages: 11

LRM ID: RJP27

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

SPECIAL

Thursday, March 11, 1999

LEGISLATIVE REFERRAL MEMORANDUM

TO: Legislative Liaison Officer - See Distribution below

FROM: Janet R. Forsgren (for) Assistant Director for Legislative Reference

OMB CONTACT: Robert J. Pellicci
PHONE: (202)395-4871 FAX: (202)395-6148

SUBJECT: **Office of Personnel Management Testimony on HR110 Federal Employees Group Long-Term Care Insurance Act of 1999**

DEADLINE: **NOON Monday, March 15, 1999**

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. **Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

COMMENTS: Hearing is before the House Government Reform and Oversight Subcommittee on Civil Service on Thursday, March 18th. OPM Director Janice LaChance is the witness.

DISTRIBUTION LIST

AGENCIES:
52-HEALTH & HUMAN SERVICES - Sondra S. Wallace - (202) 690-7760
62-LABOR - Robert A. Shapiro - (202) 219-8201
118-TREASURY - Richard S. Carro - (202) 622-0650

EOP:
Daniel N. Mendelson
JENNINGS_C
Devorah R. Adler
Jeanne Lambrew
Sarah A. Bianchi
Bruce D. Long
Lisa B. Fairhall
Daniel LaPlaca
Barry T. Clendenin
Mark E. Miller
Anne E. Tumlinson
Joseph F. Lackey Jr.
Mark A. Wasserman
Mark D. Menchik
Janet Forsgren
Kate Donovan

LRM ID: RJP27 **SUBJECT:** Office of Personnel Management Testimony on HR110 Federal Employees Group Long-Term Care Insurance Act of 1999

RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: **Robert J. Pellicci Phone: 395-4871 Fax: 395-6148**
Office of Management and Budget
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ **(Date)**

_____ **(Name)**

_____ **(Agency)**

_____ **(Telephone)**

The following is the response of our agency to your request for views on the above-captioned subject:

_____ **Concur**

_____ **No Objection**

_____ **No Comment**

_____ **See proposed edits on pages** _____

_____ **Other:** _____

_____ **FAX RETURN of** _____ **pages, attached to this response sheet**

STATEMENT OF
JANICE R. LACHANCE, DIRECTOR
OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

on

GROUP LONG TERM CARE INSURANCE
FOR FEDERAL EMPLOYEES

MARCH 18, 1999

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR CONVENING THIS HEARING TO DISCUSS THE DESIRABILITY OF INCLUDING GROUP LONG-TERM CARE INSURANCE IN THE FEDERAL EMPLOYEE BENEFITS PACKAGE.

ON JANUARY 4, 1999, PRESIDENT CLINTON ANNOUNCED AN INITIATIVE TO IMPROVE ACCESS TO LONG-TERM CARE FOR ALL AMERICANS. H.R. 110, ENTITLED "THE FEDERAL EMPLOYEES GROUP LONG-TERM CARE INSURANCE ACT OF 1999," IS JUST ONE COMPONENT OF THE PRESIDENT'S PROPOSAL. ALSO INCLUDED ARE TAX CREDITS OF $1,000 FOR PATIENTS OR THEIR CAREGIVERS, ASSISTANCE TO STATE AND LOCAL AGENCIES FOR THE ELDERLY, AND AN EDUCATIONAL CAMPAIGN TO INFORM OLDER AMERICANS ABOUT LONG-TERM CARE.

THE BILL WOULD AUTHORIZE THE OFFICE OF PERSONNEL MANAGEMENT (OPM) TO CONTRACT FOR LONG-TERM CARE INSURANCE ON BEHALF OF THE FEDERAL GOVERNMENT, THE NATION'S LARGEST EMPLOYER. THE PROPOSED STATUTORY FRAMEWORK WOULD ENABLE THE GOVERNMENT TO OFFER AFFORDABLE COVERAGE ON AN ENROLLEE-PAY-ALL BASIS TO FEDERAL EMPLOYEES AND ANNUITANTS, AND THEIR SPOUSES, PARENTS OR PARENTS-IN-LAW, AND OTHER INDIVIDUALS OPM MAY SPECIFY. WHILE THE PROPOSED LEGISLATIVE LANGUAGE DOES NOT INCLUDE POSTAL SERVICE EMPLOYEES IN THE COVERED GROUP, A MINOR DRAFTING CHANGE WOULD MAKE THEM ELIGIBLE TO PARTICIPATE.

WE ESTIMATE THAT BY NEGOTIATING GROUP RATES WE CAN PROVIDE AN ATTRACTIVE LONG-TERM CARE PRODUCT AT A COST OF FROM 15 TO 20 PERCENT LOWER THAN A COMPARABLE, INDIVIDUALLY-PURCHASED POLICY. WE EXPECT THAT INITIALLY ABOUT 300,000 ELIGIBLE PARTICIPANTS WILL ENROLL IN SUCH A PROGRAM.

LONG-TERM CARE POLICIES ARE DESIGNED TO PROVIDE COVERAGE FOR PERSONAL CARE, HOME HEALTH CARE, ADULT DAY CARE, AND NURSING HOME CARE FOR PERSONS WITH COGNITIVE IMPAIRMENT OR IN NEED OF ASSISTANCE WITH ACTIVITIES OF DAILY LIVING. AS YOU ARE WELL AWARE, THE COST OF PROVIDING SUCH CARE CAN BE VERY EXPENSIVE.

CURRENTLY, ABOUT 70 PERCENT OF LONG-TERM CARE EXPENDITURES ARE FOR NURSING HOME CARE. HOWEVER, THERE IS INCREASED INTEREST IN COMMUNITY-BASED ALTERNATIVES THAT MANY CONSIDER PREFERABLE. MEDICARE, SUPPLEMENTAL MEDIGAP AND MAJOR MEDICAL INSURANCE POLICIES PROVIDE EITHER VERY LIMITED COVERAGE OR NO COVERAGE FOR THE KINDS OF SERVICES PROVIDED BY LONG-TERM CARE INSURANCE.

THE MEDICAID PROGRAM COVERS NURSING HOME CARE AND SOME COMMUNITY-BASED SERVICES FOR INDIVIDUALS WHO ARE NOT EXCLUDED BASED ON THEIR INCOME AND ASSETS. MEDICAID AFFORDS LITTLE HELP TO MIDDLE CLASS INDIVIDUALS WHO QUALIFY FOR BENEFITS ONLY IF THEY "SPEND DOWN" UNTIL THEY REACH POVERTY LEVEL THRESHOLDS. ALSO ABOUT FOUR-FIFTHS OF MEDICAID LONG-TERM CARE EXPENDITURES GO TOWARD HIGH COST NURSING HOME CARE RATHER THAN LESS COSTLY BUT OFTEN MORE DESIRABLE ALTERNATIVES. THE COSTS OF THE CURRENT PROGRAM ARE CERTAIN TO INCREASE RAPIDLY AS THE BABY BOOM GENERATION AGES.

IN OPM'S MARCH 26, 1998, STATEMENT TO THE SUBCOMMITTEE, WE NOTED THAT OFFERING LONG-TERM CARE INSURANCE IS CONSISTENT WITH OUR OBJECTIVE OF DEVELOPING A TOTAL COMPENSATION PACKAGE THAT WILL BE COMPETITIVE WITH THE PRIVATE SECTOR IN ATTRACTING AND RETAINING

QUALIFIED EMPLOYEES. THE EVOLUTION OF LONG-TERM CARE INSURANCE PRODUCTS SINCE THE 1980'S CULMINATED IN THE ENACTMENT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996. THAT ACT NOT ONLY GIVES FAVORABLE TAX TREATMENT TO LONG-TERM CARE INSURANCE PRODUCTS, BUT ALSO ESTABLISHES MINIMUM REQUIREMENTS FOR PRODUCTS TO RECEIVE SUCH FAVORABLE TREATMENT. AS A RESULT, LONG-TERM CARE PRODUCTS ON THE MARKET TODAY OFFER CONSUMER PROTECTIONS NOT AVAILABLE IN OLDER PRODUCTS. AS LONG-TERM CARE PRODUCTS HAVE MATURED, MORE PEOPLE HAVE PURCHASED COVERAGE. THE HEALTH INSURANCE ASSOCIATION OF AMERICA REPORTED THAT, BY THE END OF 1996, NEARLY 5 MILLION POLICIES HAD BEEN SOLD. BY NOVEMBER OF 1998, THE KIPLINGER RETIREMENT REPORT WAS NOTING THAT TO DATE ABOUT 6 MILLION POLICIES HAD BEEN SOLD.

THE RESPONSE TO LONG-TERM CARE QUESTIONS IN OUR 1997 CUSTOMER FEEDBACK SURVEY HIGHLIGHTS THE ANTICIPATED RELATIONSHIP BETWEEN THE ESTIMATED COST OF THE PRODUCT AND THE DEGREE OF CONSUMER INTEREST. SINCE PREMIUMS INCREASE WITH AGE AT INITIAL PARTICIPATION AND WITH KEY BENEFITS DESIGN FEATURES, WE WILL NEED TO GIVE CAREFUL CONSIDERATION TO A VARIETY OF FACTORS IN ORDER TO DEVELOP A VIABLE PROGRAM IN THE CONTEXT OF A TOTAL BENEFITS PACKAGE FOR THE FEDERAL WORKFORCE.

H. R. 110 PROVIDES A FRAMEWORK THAT WOULD ALLOW US, IN CONSULTATION WITH STAKEHOLDERS--INCLUDING THE INSURANCE INDUSTRY, EMPLOYEE AND RETIREE GROUPS, AND FEDERAL AGENCIES--TO DESIGN A FLEXIBLE LONG-TERM CARE BENEFIT THAT CAN EVOLVE OVER TIME AS THE MARKET CHANGES, THEREBY ALLOWING THE FEDERAL GOVERNMENT TO KEEP THE POLICY CONSISTENT WITH INDUSTRY STANDARDS. IT ALSO PROVIDES US WITH THE OPPORTUNITY TO EDUCATE POTENTIAL PURCHASERS ABOUT THE IMPORTANT FEATURES OF A SPECIFIC PRODUCT AND TO PARTICIPATE ACTIVELY IN THE CAMPAIGN TO DEMONSTRATE THE NEED FOR THIS PROTECTION.

GROUP INSURANCE PRODUCTS ARE LESS COSTLY THAN INDIVIDUAL INSURANCE BECAUSE ECONOMIES OF SCALE MITIGATE BOTH ADMINISTRATIVE COSTS AND UNDERWRITING RISKS. IF WE OFFER LONG-TERM CARE ON THE SAME BASIS AS EMPLOYERS IN THE PRIVATE SECTOR, THE DISCOUNTS AVAILABLE TO FEDERAL ENROLLEES WILL BE AT LEAST COMPARABLE.

UNDER THE AUTHORITY GIVEN OPM IN H. R. 110, WE WOULD SEEK COMPETITIVE BIDS FOR LONG-TERM CARE INSURANCE THAT MEET SPECIFIED QUALITY AND PRICE CRITERIA AND SELECT THE CONTRACTOR OR CONTRACTORS ON THAT BASIS.

UNDER H. R. 602, THE CIVIL SERVICE LONG TERM CARE INSURANCE BENEFIT ACT, OPM WOULD BE REQUIRED TO ACCEPT VIRTUALLY ANY LONG-TERM CARE INSURANCE PRODUCT THAT MEETS BASIC REQUIREMENTS. OUR PRIMARY ROLE WOULD BE TO ENSURE THAT ADEQUATE PAYROLL DEDUCTIONS ARE MADE AND TO MAKE INFORMATION AVAILABLE ON ALL OFFERINGS. THIS ALTERNATIVE GIVES THE FEDERAL POPULATION THE SAME CHOICES ALREADY AVAILABLE ON AN INDIVIDUAL BASIS IN THE PRIVATE MARKET WITH LITTLE OR NO FINANCIAL INCENTIVE TO ENROLL. SUCH AN APPROACH IS CONTRARY TO EMPLOYER BEST PRACTICES. WE WOULD NOT BE ABLE TO TAKE ADVANTAGE OF ECONOMIES OF SCALE TO SAVE MONEY, AND WE WOULD NOT BE ABLE TO PASS THE SAVINGS ON TO ENROLLEES.

IN ADDITION, ALTHOUGH EMPLOYER SUPPORT IS CONSIDERED A KEY FACTOR IN PROMOTING LONG-TERM CARE INSURANCE, OPM WOULD HAVE TO REMAIN NEUTRAL IF COMPETING PRODUCTS WITH DIFFERENT OPTIONS, BENEFITS AND PRICES ARE OFFERED.

H. R. 602 MAKES THE INCORRECT ASSUMPTION THAT PRODUCT AND VENDOR COMPETITION WILL REDUCE COSTS. SINCE ONLY ABOUT 6 PERCENT OF THE ELIGIBLE POPULATION TYPICALLY PURCHASES LONG-TERM CARE INSURANCE, SEGMENTING THE RISK POOL IS MORE LIKELY TO INCREASE, RATHER THAN

REDUCE PREMIUM RATES.

UNDER H.R. 110, OPM WOULD OFFER A LONG-TERM CARE BENEFITS PACKAGE THAT REFLECTS THE STANDARDS OUTLINED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN ITS LONG-TERM CARE MODEL REGULATION. THE COVERAGE WOULD PROVIDE FOR A VARIETY OF SERVICES AND OFFER FLEXIBLE OPTIONS TO PARTICIPANTS. A CONTINUUM OF SERVICES WOULD LIKELY INCLUDE HOME HEALTH CARE, ALTERNATIVE FACILITY CARE (SUCH AS ASSISTED LIVING), ADULT DAY CARE, AND NURSING HOME CARE.

THE SPECIFICS OF PRODUCT DESIGN WOULD BE DEVELOPED IN CONSULTATION WITH STAKEHOLDER GROUPS INCLUDING EMPLOYEE AND RETIREE ORGANIZATIONS, FEDERAL AGENCIES, AND REPRESENTATIVES OF THE INSURANCE INDUSTRY. STAKEHOLDER INPUT IS KEY TO THE DESIGN AND ACCEPTANCE OF A SUCCESSFUL FUTURE PRODUCT. YESTERDAY, WE HELD THE FIRST OF A SERIES OF MEETINGS WITH INDUSTRY REPRESENTATIVES TO BEGIN THIS DIALOGUE.

ELIGIBLE PARTICIPANTS WOULD PAY THE FULL COST OF THE BENEFIT, BASED ON AGE AT TIME OF ENROLLMENT. THIS IS CONSISTENT WITH THE PRACTICE AMONG PRIVATE EMPLOYERS WHO OFFER THIS BENEFIT. EARLY ESTIMATES

ARE THAT ANNUAL PREMIUM COSTS COULD RANGE FROM $200 TO $3,000, DEPENDING ON THE INSURED'S AGE.

AS IN OTHER FEDERAL BENEFIT PROGRAMS, H. R. 110 WOULD REQUIRE CONTRACTOR FINANCIAL AND PROGRAM ACCOUNTABILITY AND WOULD GIVE OPM THE AUTHORITY TO DETERMINE THE REASONABLENESS OF PREMIUM RATES ESTABLISHED.

WE ESTIMATE OPM'S COSTS TO ADMINISTER THE PROGRAM AT APPROXIMATELY $15 MILLION OVER A FIVE-YEAR PERIOD. INITIAL COSTS COVER THE SOLICITATION PROCESS, INCLUDING ACTUARIAL ANALYSIS TO DETERMINE THE REASONABLENESS OF RATE PROPOSALS, AS WELL AS IMPLEMENTATION OF AN EXTENSIVE EDUCATION PROGRAM FOR EMPLOYEES, RETIREES, AND OTHER ELIGIBLE PARTICIPANTS ABOUT THEIR LONG-TERM CARE OPTIONS. WE FEEL STRONGLY THAT A MAJOR FACTOR IN THE SUCCESS OF THE PROGRAM WILL BE EFFORTS TO INFORM EMPLOYEES ABOUT THE COSTS OF LONG TERM CARE, THE NEED FOR LONG TERM PLANNING, AND THE BENEFITS OF PURCHASING COVERAGE SOONER RATHER THAN LATER IN LIFE.

A LONG-TERM CARE INSURANCE PRODUCT STRUCTURED SO THAT IT COULD SERVE AS AN INDUSTRY MODEL WOULD LIKELY INCREASE EMPLOYER INTEREST IN OFFERING THIS BENEFIT TO THEIR EMPLOYEES. IT ALSO WOULD

HEIGHTEN PUBLIC AWARENESS OF THE GROWING NEED FOR INDIVIDUALS TO PARTICIPATE IN PLANNING AND PROVIDING FOR THEIR FUTURE LONG-TERM CARE NEEDS.

THE NATURE OF THE PROCUREMENT WILL DEPEND ON THE LEGISLATIVE FRAMEWORK. WE FIRMLY BELIEVE THAT THE EMPLOYER-SPONSOR MODEL OF H. R. 110 OFFERS THE BEST VEHICLE FOR DELIVERING A QUALITY PRODUCT. WE URGE YOU TO GIVE H.R. 110 EARLY CONSIDERATION. A NEW LONG-TERM CARE PRODUCT WILL GREATLY ENHANCE THE CURRENT FEDERAL EMPLOYEES' BENEFIT PACKAGE AND OFFER VIABLE OPTIONS FOR EMPLOYEES, ANNUITANTS, AND MEMBERS OF THEIR FAMILIES TO PLAN FOR THEIR LONG-TERM CARE NEEDS.

THIS CONCLUDES MY STATEMENT. I WILL BE GLAD TO ANSWER ANY QUESTIONS THE SUBCOMMITTEE MAY HAVE.

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: Chris Jennings **PHONE:** 456-5560	**FROM:** Nancy-Ann Min DePorle **OFFICE OF THE ADMINISTRATOR** **200 INDEPENDENCE AVE., S.W.** **ROOM 314G** **WASHINGTON, DC 20201** **PHONE: 202-690-6726** **FAX : 202-690-6262**

TOTAL PAGES:	**ADDRESSEE'S FAX MACHINE NUMBER:**	**DATE:**
C+20	456-5557	2/25/99

REMARKS:

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 - 0001

AUG 3 1998

Chris Jennings -
Thought you
& Jeanne
might be
interested.
Nancy-Ann

TO: Executive Council
Regional Administrators
Regional Environmental Scanning Liaisons

FROM: Barbara Cooper Barbara Cooper

SUBJECT: Environmental Scanning Report -- ***The Future of Retiree Health Coverage***

Attached is *The Future of Retiree Health Coverage*, the first of several Environmental Scanning Reports being prepared by the Office of Strategic Planning (OSP). It summarizes recent trends in retiree coverage, forecasts the near-term future of retiree coverage, and highlights issues for HCFA and other policy makers to consider.

As you know, OSP is responsible for spearheading HCFA's Environmental Scanning efforts. Scanning provides HCFA the opportunity to look outside of itself and, sometimes, beyond its usual sources of information and ideas. OSP's scanning effort involves: (1) working with the Regional Offices to collect and evaluate local information related to health systems change, safety net providers, Medigap markets, and legislative/regulatory issues; and (2) more focused projects on a small number of priority issues. In addition to this focused project on retiree health coverage, OSP is currently finishing a project on how workers compensation and auto insurers detect and deter fraud and abuse. And, we are just beginning a report on how Medicare could serve as a prescription drug purchasing consolidator to reduce the price of prescription drugs for beneficiaries. Both of these reports will be shared with you as they are completed.

Your feedback or questions on this report, or on HCFA's Environmental Scanning effort, are always welcome. Please call (or e-mail) Sharman Stephens or Mary Ellen Stahlman at (202) 690-7063 with comments.

Attachment

ENVIRONMENTAL SCANNING REPORT

THE FUTURE OF RETIREE HEALTH COVERAGE

HCFA
Health Care Financing Administration

THE FUTURE OF RETIREE HEALTH COVERAGE

Health Care Financing Administration
Office of Strategic Planning
Planning and Policy Analysis Group
(202) 690-7063

July 1998

EXECUTIVE SUMMARY

There are two major groups of retirees -- the early retirees, age 55-64, and the Medicare-eligible retirees, age 65 and older. Fifty-eight percent of early retirees are covered by employer-sponsored plans, 17 percent have no insurance coverage, and the remainder are covered by public programs or other private health insurance. Nearly all -- 97 percent -- of the 65+ population are covered by Medicare. About one third of Medicare beneficiaries supplement their Medicare coverage with employer-sponsored health insurance. An additional 30 percent purchase individual Medigap policies. Four percent have both employer-sponsored and individual Medigap coverage.

Although more than half of early retirees are covered by employer-sponsored health insurance, the availability of employer-sponsored health insurance for retirees is declining. The percentage of large firms offering health benefits to retirees under age 65 declined from 46 percent in 1993 to 38 percent in 1997. And, many early retirees do not have access to affordable health insurance through the individual insurance market. Forty percent of large firms offered health benefits to their Medicare-eligible retirees in 1993; by 1997, the number had dropped to 31 percent. Retirees over age 65 are increasingly turning to managed care options as the cost of services and selection issues drive up Medigap premiums. However, approximately one third of the Medicare beneficiaries do not have access to Medicare risk health maintenance organizations (HMOs).

In an effort to better understand what the next decade holds for retiree health coverage, HCFA staff conducted a literature review and met with representatives of unions, employers, employer groups, and consulting firms. The goal was to build a scenario about the future of retiree health benefits, and to develop an awareness of the major issues surrounding retiree health and an understanding of how those issues might affect future Medicare policy. Noteworthy findings include:

- There is interest in allowing employer groups to buy into Medicare for their pre-Medicare age retirees.
- Declining employer-sponsored retiree health insurance will force more Medicare beneficiaries to either purchase Medigap policies, join Medicare risk plans or go without supplemental coverage.
- Medicare may be under more pressure to offer additional benefits, most notably outpatient prescription drugs, as more beneficiaries pay out-of-pocket for coverage or services.
- Employers are more likely to spend their limited health care dollars on current workers rather than retirees.

- CEOs of firms offering retiree health insurance feel "on the hook" for medical inflation over the long term.

- Employees generally are in a weak bargaining position relative to employers regarding retiree health benefits. Consequently, employees may be more willing to buy into cost controlling strategies including managed care and lower levels of defined contributions from the employer to preserve some employer-sponsored health benefits. On the other hand, protracted contract negotiations, and the threat of damage to the public image of employers who reduce coverage may delay the seemingly inevitable erosion of retiree health benefits.

- Employers are increasingly helping employees "manage their expectations" regarding retiree health insurance coverage.

- Retiree health coverage is of particular concern to workers who must retire early because of the physical demands of their jobs.

- Employer concerns about a number of factors, such as financial viability and high overhead, are leading some employers to believe that managed care may not be the best long-term strategy for retiree health coverage.

The findings and literature review raise a number of issues that warrant further exploration and possible analytical work by the policy community including examining:

- Employer-based buy-in to Medicare as part of a Medicare buy-in proposal.

- Effects of declining retiree health coverage on the Medigap market.

- Providing information to pre-retirees on their future health insurance needs and cost.

- Options for assisting Medicare beneficiaries with prescription drug costs.

- Needs of pre-65 retirees.

- Input from employer groups on proposals affecting retiree health insurance.

I. INTRODUCTION

In an effort to better understand what the next decade holds for employer-sponsored retiree health coverage, HCFA staff conducted a literature review and met with representatives of unions, employers, employer groups, and consulting firms (see Appendix). The goal was to build a scenario about the future of retiree health benefits, and to develop an awareness of the major issues surrounding retiree health and an understanding of how these issues might affect future Medicare policy. This paper presents a brief overview of the major trends in retiree coverage, highlights findings from the literature review and discussions with outside groups, and presents several issues for consideration by HCFA leadership.

II. HIGHLIGHTS OF RETIREE HEALTH COVERAGE TRENDS

There are two major groups of retirees -- the early retirees, age 55-64, and the Medicare-eligible retirees, age 65 and older. These groups are covered by various combinations of public programs (Medicare, Medicaid, Veterans Administration and TRICARE[1]) and employer-sponsored or individually purchased private health insurance. Both the early retirees and the Medicare-eligible retirees are facing a similar, daunting problem: the erosion of employer-sponsored health insurance coupled with the inability of the individual market to offer affordable, comprehensive, insurance coverage for these age groups.

Early Retirees

In 1997, 22.7 million individuals (8 percent of the United States population) were between the ages of 55 and 64. The number of individuals in this age group is expected to grow, particularly after the year 2000, when the first of the baby boom generation turns 55 years old.

Fifty-eight percent of early retirees have employer-sponsored health coverage either through their own employers or that of their spouse (Table 1). Seventy-six percent of the working population in the same age group have employer coverage. Interestingly enough, early retirees are no more likely to be uninsured (17 percent of early retirees are uninsured) than the working population (18 percent of workers under age 65 are uninsured). Children have the same rate of coverage by employer-sponsored insurance -- 59 percent -- as early retirees.

Gender plays a role in whether an individual is covered by health insurance. For the 55-64 age group (either working, unemployed or retired), 15.3 percent of females are uninsured, compared with 12.3 percent of the males. In addition, women are less likely to have employer coverage

[1]TRICARE was formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Table 1

Percent Distribution by Selected Sources of Health Insurance , 1996

Age and Activity	Employer Coverage	Other Private	Total Public	Uninsured
Total ages 18-64	66%	7%	12%	19%
Working	72	6	7	18
Retired	**56**	**14**	**24**	**18**
Ages 55-64	65	10	18	14
Working	76	10	8	12
Retired	**58**	**14**	**23**	**17**
Children	59	7	25	15

Source: Employee Benefits Research Institute

than men -- 62.2 percent compared to 68.8 percent.[2]

Whether or not an individual is covered by health insurance has a bearing on the decision to retire. In 1995, the average age for retirement in organizations that provide coverage for retirees was 61 years. In organizations that do not provide an early retiree benefit, the average age at retirement was 64 years.[3] In addition, a recent study by RAND found that "men aged 51-61 with offers of post-retirement health benefits have a retirement probability 4.3 percentage points higher than those who have health insurance while working, but no health benefits after retirement."[4] Clearly, individuals with employer-sponsored retiree coverage are more inclined to retire.

Some early retirees can obtain health insurance even if their employer does not have a retiree health plan. "COBRA" benefits (enacted into law as part of the Consolidated Omnibus Budget Reconciliation Act of 1985) are available for workers who retire at age 63 ½. COBRA allows early retirees to purchase health insurance through their former employers for 18 months at 102 percent of the employer's group premium rate. Early retirees also may have coverage through a spouse's employer-based insurance policy. Finally, early retirees may purchase individual insurance. Indeed, they are more likely than the under age 55 population to purchase individual insurance.

---

[2] Paul Fronstein, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey. Employee Benefit Research Institute. December 1997.

[3] Foster Higgins National Survey of Employer-Sponsored Health Plans, 1996.

[4] Karoly, Lynn A. and Rogowski, Jeannette: Health Insurance and Labor Market Transitions of Older Workers RAND. September 1997.

It should be noted that early retirees do not fare well on the individual insurance market. Health status or age may prevent retirees from gaining access to affordable individual insurance. Depending on whether the individual is protected by provisions of the Health Insurance Portability and Accountability Act (HIPAA), or State laws prohibiting pre-existing condition exclusions, certain medical conditions may be excluded from the health insurance policy. Common conditions including headaches, kidney stones, rheumatoid arthritis, angina, or coronary artery disease may be cause for an insurance company to deny individual coverage,[5] again depending on the applicability of HIPAA or other laws.

Assuming that an early retiree may obtain health insurance through the individual market, the cost of the coverage may be too high for many individuals to afford. HIPAA does not regulate or cap how much an insurance company may charge for coverage. The average annual premium for nongroup health insurance for an individual age 60-64 is $2,785 in 1996-97 -- 9.3 percent of average family income. This is nearly double the 1996-97 nongroup health insurance premium for a policy holder aged 25-34 ($1,467 -- 4.1 percent of average family income).[6]

Medicare-Eligible Retirees

It is well known that the number of Medicare-eligibles will grow significantly as the baby-boom generation ages. In 1997, about 12 percent of the population, or 33.7 million persons, were 65 years of age or older. By the year 2017, this group is expected to grow to 47.5 million people, reaching almost 15 percent of the population.

---

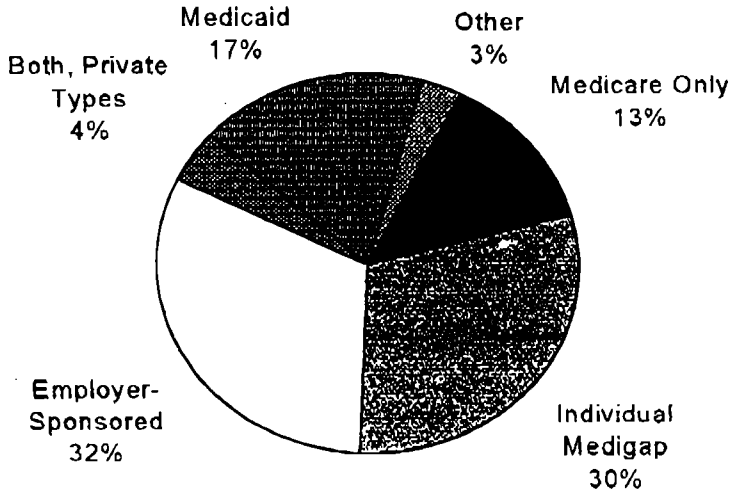
[5] Chollett, Deborah, J. and Kirk, Adele M.: Understanding Individual Health Insurance Markets. Henry J. Kaiser Foundation. March 1998.

[6] Center for Studying Health System Change: Issue Brief, Number 12. April 1998.

The majority of the 65 years of age and over population (97 percent) are covered by Medicare. Because the Medicare benefit package does not provide coverage for all types of medical care and has relatively high levels of out-of-pocket costs, a majority of Medicare enrollees (66 percent) have supplemental insurance. Thirty-two percent of beneficiaries enrolled in fee-for-service Medicare supplement their coverage with employer-sponsored health insurance, 30 percent purchase individual Medigap policies and 4 percent are covered by both employer-sponsored and individually purchased health insurance (Chart 1).

Medicare risk plans are becoming an increasingly popular option for employer-sponsored retiree health coverage. According to Mercer/Foster Higgins, 39 percent of employers offered risk plans for their retirees in 1997 -- up from 7 percent in 1993.[7] In order to make risk plans more attractive, 25 percent of employers in 1996 offered incentives to retirees to elect Medicare risk coverage (including direct rebates or rebates of the Part B premium). Interestingly enough, 24.1 percent of beneficiaries enrolled in Medicare risk plans in 1996 retained their employer-sponsored plan, individually purchased Medigap policies, or both.

Chart 1
Type of Supplemental Health Insurance Held by Medicare Beneficiaries, 1996



Source: Medicare Current Beneficiary Survey

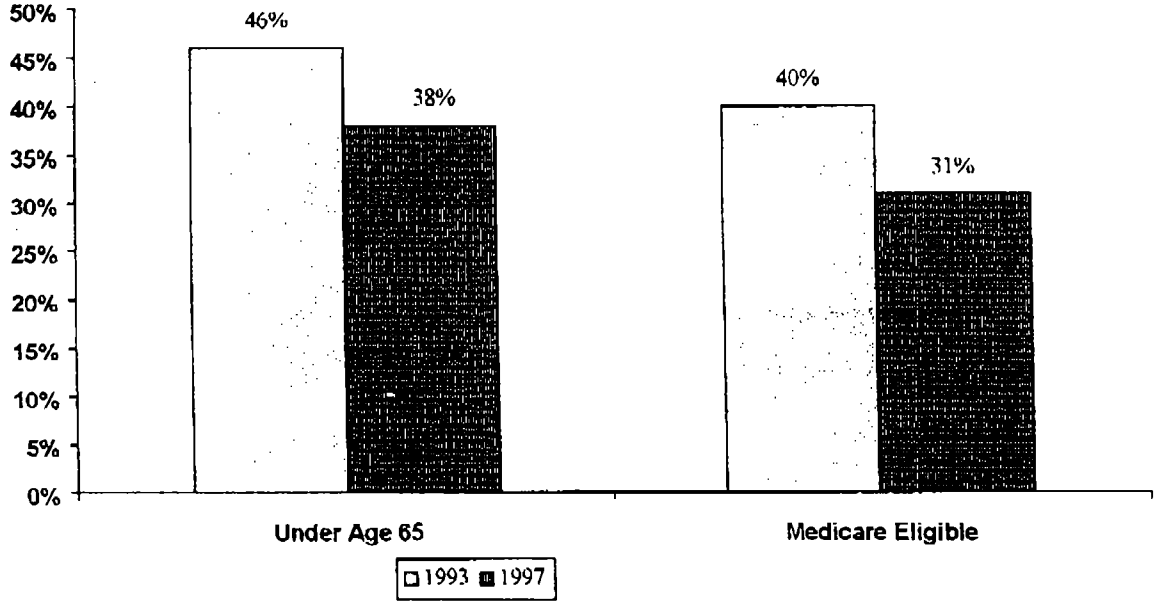
[7]Mercer/Foster Higgins: National Survey of Employer-Sponsored Plans, 1997.

Availability of Employer-Sponsored Retiree Health Coverage

The availability of employer-sponsored health insurance for retirees is declining. The percentage of large firms[8] offering health benefits to retirees declined from 1993 to 1997. In 1993, 46 percent of large firms offered retiree health insurance to individuals under age 65 (Chart 2). By 1997, the percentage dropped to 38 percent. Forty percent of large firms offered health insurance benefits to their Medicare-eligible retirees in 1993; by 1997, the number had dropped to 31 percent.

The dominant factor influencing declining employer-based offerings of retiree health coverage is

Chart 2
Percent of Large Firms Offering Retiree Health Benefits, 1993-97



Source: Mercer/Foster Higgins: National Survey of Employer-Sponsored Plans, 1997

the high cost and long term growth rates. Premiums paid by employers for health insurance were 5.4 percent of total compensation in 1987, by 1990 premiums consumed 6.8 percent of total compensation. Premiums as a percent of total compensation continued to grow until 1994 when it reached 7.5 percent. By 1995 the percentage of total compensation consumed by premiums was 7.1 percent.

[8] Large firms have more than 500 employees. According to the 1992 Economic Census, 47.3 percent of the workforce (or 41,052,195 employees) were employed by large firms. Generally, small firms do not offer retiree health insurance.

In 1990, aggregate employer-sponsored health insurance premiums grew 18 percent from the previous year.[9] In response to high premiums, employers have dropped coverage, increased cost sharing, and switched to more cost effective delivery systems including managed care. These strategies, along with slow overall economy-wide price inflation, have helped to slow employment-based outlays for private health insurance. From 1995 to 1996, aggregate employer-sponsored health insurance premiums grew only 3.6 percent.[10]

The average health plan cost is highest for retirees under age 65 ($4,985) and lowest for Medicare-eligible retirees ($1,910) (Chart 3). Of course, the benefits packages for these two groups are different. The under 65 retirees receive a full benefit package (which, in most instances, is more generous than the Medicare benefit package). The age 65 and over retirees are provided plans that coordinate with Medicare coverage or supplement the benefits provided by Medicare.

Some of the strategies that employers used to control health costs for active workers are not

Chart 3
Average Health Plan Cost per Active Employee and Retiree, 1997

Source: Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 1997

[9] HCFA, Office of the Actuary.

[10] Cowan, C.A., and Braden, B.R.: Business, Households, and Government: Health Care Spending, 1995. Health Care Financing Review, Spring 1997.

March 4, 1999

The Growing Business of Helping Elders Cope

Related Article
- In This Brand-New City, No Shortage of Elders
- Issue in Depth: **Health Care**

Forum
- Join a Discussion on **Health Care** Reform

By SARA RIMER

NEWPORT BEACH, Calif. -- When an 86-year-old woman with Alzheimer's disease broke her hip, Deborah Newquist was the person who stayed with her at the hospital here. Years earlier, she had arranged 24-hour home **care** for the woman and her bedridden husband, and she also took **care** of everything from having their house painted to getting their cat to the veterinarian.

When the husband died in November, it seemed fitting that Dr. Newquist was among the six mourners at his funeral. After eight years on the job for the couple, she had become a professional member of the family.

Dr. Newquist, whose doctorate is in medical anthropology, is a geriatric **care** manager, an occupation that did not exist when she received her master's degree in social work 24 years ago. The field was born in response to the nation's rapidly aging population and the **health care** system's complexity.

At $70 to $150 an hour, geriatric **care** managers generally don't offer hands-on **care**. Part counselors and part social workers, they help manage the healthcare, living arrangements and other affairs of their elderly clients. In doing so, they perform a role once filled by families -- not only because families are so scattered and **care** has become more complicated, but because outsiders are listened to, while children often are not -- as some **care** managers have discovered with their own families.

"The systems are so complex now that even some of us who think we know something about them get confused," said Raymond T. Coward, a gerontologist and the dean of the school of **health** and human services at the University of New Hampshire. "And families are being pulled in more ways than they have in the past. They've changed to the point where they're looking to share this responsibility with someone else."

Rona Bartelstone, a clinical social worker, started her South Florida geriatric **care** management business in a bedroom of her home in Miami 18 years ago after trying to help her grandmothers, both of whom had dementia and degenerative illnesses.

Dr. B.J. Curry Spitler got into the business in San Diego 20 years ago when she was teaching social work at San Diego State University, and a local psychiatrist asked her to help an elderly couple whose lives were falling apart as they tried to stay in their own home.

Robin Fuller was working at a Tucson law firm that specialized in the elderly when she realized there was a niche to be filled, and reinvented herself as a geriatric **care** manager.

Amy Wetter, a former dental hygienist, and her best friend, Pat Bowen, an investment specialist, went into business together after spending years coping with the medical needs, home **care**, insurance forms, estate planning and nursing homes of their parents.

"We looked at each other one day and said, 'We're intelligent, competent people, and we almost ruined our lives taking **care** of our parents,' " said Ms. Wetter, 44. "You're so emotionally involved you need help to do it."

In the case of the couple in Newport Beach, who had no children, it was their nephew, Norris Couch, 50, who lives in Austin, Texas, who found Dr. Newquist. Most often it is the children, worn out from juggling demanding jobs, children and their aging parents, who hire managers. Surveys show the overwhelming majority of the elderly want to remain independent, and in their own homes, and it often falls to the children to help them stay there.

One of Dr. Newquist's clients was an elderly widow with Alzheimer's who lived on her own in Anaheim, Calif., and had four children, three in Connecticut and one in Ohio. "They were doing a round robin," Dr. Newquist said. "They would rotate one of them at a time flying out and spending two weeks with her. They didn't want Mom to live with a stranger. But they couldn't sustain it."

After a series of telephone conference calls with the family, Dr. Newquist was able to introduce live-in caregivers. Eventually, as the woman continued to decline, she helped the family move her into an Alzheimer's **care** facility. The children continued to visit regularly.

The woman, who was 86, died last month.

Often, it takes an outsider to get the family to make emotionally fraught decisions about aging relatives. That was the case with Ms. Bartelstone's grandmothers.

"Even though my family considered me an expert in aging, because I was a child they would not take my advice," she recalled. "So after two years of talking, I got a colleague to come in and talk to them, and she got them to do what they needed to do in one meeting."

At the same time that she was dealing with her grandmothers, Ms. Bartelstone, 48, noticed that more and more adult children were calling her agency with questions about their parents.

"Most of them were not local," she said. "They did not know what services were available. Services and eligibility requirements are different, not only in every state, but in every county."

As a geriatric nurse practitioner and associate professor of nursing in Long Beach, Calif., Dr. Karna Bramble, 55, is supposed to be an expert on aging. But

when it came to acknowledging the decline of her own mother, she said, "there was an incredible amount of denial."

She was visiting her parents in San Diego four years ago when her mother, Doris Meek, who is 86, mentioned that she had gotten lost on a familiar stretch of freeway that evening. "She said, 'I think I have that Ronald Reagan disease,"' Dr. Bramble recalled. "I said, 'No, Mom, you're fine.' "

A year later, on another visit, Ms. Bramble discovered that the food she had bought for her parents the week before was rotting in the refrigerator. Her mother, who was later found to have dementia, had forgotten about preparing meals. Her father, Ray Meek, 90, a retired engineer, did not know how to cook. The couple had all but stopped eating.

"I left to buy them fresh food, and I was sitting in the car in the parking lot of the grocery store, crying," Dr. Bramble said. "That was when I knew we needed some help." She got it by contacting Dr. Spitler's firm, Age Concerns, in San Diego.

Finding someone who was familiar with the ins and outs of the local **health care** system was crucial for Diane Huckabee, 41, a bank manager in San Diego, who called Dr. Spitler after both her parents landed in the hospital near their home in Los Angeles, her mother with a stroke, her diabetic father for the amputation of a leg.

"I was in a panic: 'What do I do?' " said Mrs. Huckabee, who has two sons, 12 and 6, and a husband who works full time as an accountant. "I couldn't just quit work and go up there. My mother had an HMO, and the hospital was about to discharge her, and she had no help in the home."

Dr. Spitler recommended a **care** manager in Los Angeles who intervened with the hospital so that Mrs. Huckabee's mother, Jean Dahle, could stay until the **care** manager could arrange for home **care**.

"They know the system," Mrs. Huckabee said. "You've got to know somebody who knows somebody to figure out what to do."

Steve Barlam, a **care** manager based in Beverly Hills, not only helped Bill Bregar and his family realize that their 82-year-old mother had to move into a **care** facility because of Alzheimer's and helped find the right one, but even drove her to her new home.

"He was the only one who could do it," said Bregar, 58, an engineer in Portland, Ore. Recalling that wrenching day, Bregar said that only Barlam could get his mother into the car.

"She thinks he's great," Bregar said. "She treats him like a long-lost friend. The last time I visited her, she threw me out."

In one measure of the profession's growth, Barlam recently sold his business -- consisting of himself and five other social workers -- to a venture capital firm from San Francisco, Bank America Ventures. The idea is to create an in-home **care** and **care** management company with offices throughout California, said Barlam, who will stay on as executive vice president and continue to do geriatric **care** management.

Many managers are now advocating certification for what started out as a cottage industry. Ms. Bartelstone is the vice president of the National Academy

of Certified **Care** Managers, which was founded in Connecticut in 1994 and has been administering a certification test since 1997. She is also one of the founders of the National Association of Professional Geriatric **Care** Managers, in Tucson, which started in 1986 with 30 members and has since grown to 1,200 of the estimate 4,000 private **care** managers around the country.

Geriatric **care** managers, generally sought during a crisis, can initially cost as much as $2,000 a month, but Ms. Bartelstone points out that long-distance clients are spared the expense of last-minute plane fares, hotel rooms and lost days at work. As the crisis passes and only monitoring is needed, the cost can fall to about $200 a month. In most cases, none of it is covered by insurance.

Geriatric **care** managers are also good at assuaging the guilt of those who hire them.

"The **care** manager always reinforces my feeling that I'm doing all I can, I can't do more," said Jack Veerman, 68, an importer who lives in Manhattan and visits his 91-year-old mother in Miami once a month -- unless there is a crisis, when he makes the trip every weekend. "You don't think you're doing an adequate job, no matter what you do. It's your mother. Your memory is that she was always there for you."

Often, the **care** managers end up spending more time talking with the children than with their parents.

"They're dealing with all sorts of unresolved conflicts from childhood -- 'She liked you better.' " Ms. Bartelstone said. "They're worrying about their inheritances. They're trying to get approval. They're trying to be the perfect son or daughter. They're trying to make up for prior wrongs, or trying to get back at their parents for what they perceive is wrong. It's exhausting work, but you never get bored."

Department Of The Treasury
Office of Benefits Tax Counsel
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

April 5, 1999

To: Chris Jennings & Bruce Vladeck
Fax:

Number of pages (including this coversheet): 7

From: **William K. Bortz**
Associate Benefits Tax Counsel
Room 4017 MT
Tel: 202/622-1352 **Fax: 202/622-0236**
Internet: william.bortz@treas.sprint.com

Making Health Care More Affordable

ASSISTING TAXPAYERS WITH LONG-TERM CARE NEEDS

Current Law

Several provisions in the tax code provide assistance to taxpayers with a disabled family member or with long-term care expenses. A taxpayer can receive a child and dependent care tax credit for expenses incurred to care for a disabled spouse or dependent so the taxpayer can work. A low-income working taxpayer can qualify for the earned income tax credit if he or she resides with a disabled child (of any age). A taxpayer who itemizes can deduct expenses for qualified long-term care services if he or she is chronically ill or such expenses were incurred on behalf of a chronically ill spouse or dependent.

Reasons for Change

A long illness or a disability can impose significant burdens on individuals and their caregivers. Taxpayers who have long-term care needs or who care for others with such needs do not have the same ability to pay taxes as other taxpayers. Providing a tax credit is an equitable and efficient way of recognizing the formal and informal costs of providing long-term care.

Proposal

A taxpayer would be allowed to claim a $1,000 credit if he or she has long-term care needs. A taxpayer also would be allowed to claim the credit with respect to a spouse or each qualifying dependent who has long-term care needs.[1] The credit (aggregated with the child credit and the proposed disabled worker credit) would be phased-out for certain high-income taxpayers--that is, the aggregate credit amount would be phased out by $50 for each $1,000 (or fraction thereof) by which the taxpayer's modified AGI exceeds $110,000 (in the case of a joint return), $75,000 (in the case of a taxpayer who is not married), or $55,000 (in the case of a married individual filing a separate return).

---

[1] To qualify as a dependent, an individual must (1) be a specified relative or member of the taxpayer's household; (2) be a citizen or resident of the U.S. or resident of Canada or Mexico; (3) not be required to file a joint tax return with his or her spouse; (4) have gross income below the dependent exemption amount ($2,750 in 1999) if not the taxpayer's child; and (5) receive over half of his or her support from the taxpayer. The taxpayer may be deemed as providing over half the cost of supporting the individual if (a) no one person contributes over half the support of such individual; (b) over half the support is received from persons each of whom, but for the fact that he or she did not provide over half such support, could claim the individual as a dependent; (c) the taxpayer contributes over 10 percent of such support; and (d) the other caregivers, who provide over 10 percent of the support, file written declarations stating that they will not claim the individual as a dependent.

For purposes of the proposed tax credit only, the dependency tests of section 151 would be modified in two ways. First, the gross income threshold would increase to the sum of the personal exemption amount, the standard deduction, and the additional deduction for the elderly and blind (if applicable). In 1999, the gross income threshold would generally be $7,050 for a non-elderly single dependent and $8,100 for an elderly single dependent.

Second, the current-law support tests would be deemed to be met if the taxpayer and an individual with long-term care needs reside together for a specified period. The length of the specified period would depend on the relationship between the taxpayer and the individual with long-term care needs. The specified period would be over half the year if the individual is the parent (including stepparents and in-laws), or ancestor of the parent, or child, or descendant of the child, of the taxpayer. Otherwise, the individual must reside with the taxpayer the full year. If more than one taxpayer resides with the person with long-term care needs and would be eligible to claim the credit for that person, then those taxpayers generally must designate the taxpayer who will claim the credit. If the taxpayers fail to do so or if they are married to each other and filing separate returns, then only the taxpayer with the highest adjusted gross income would be eligible to claim the credit.

An individual age six or older would be considered to have long-term care needs if he or she were certified by a licensed physician (prior to the filing of a return claiming the credit) as being unable for at least six months to perform at least three activities of daily living (ADLs) without substantial assistance from another individual, due to a loss of functional capacity (including individuals born with a condition that is comparable to a loss of functional capacity).[2] As under section 7702B(c)(2)(B), ADLs would be eating, toileting, transferring, bathing, dressing, and continence. Substantial assistance would include both hands-on assistance (that is, the physical assistance of another person without which the individual would be unable to perform the ADL) and stand-by assistance (that is, the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual when performing the ADL).

As an alternative to the three-ADL test described above, an individual would be considered to have long-term care needs if he or she were certified by a licensed physician as (a) requiring substantial supervision for at least six months to be protected from threats to health and safety due to severe cognitive impairment and (b) being unable for at least six months to perform at least one or more ADL or engage in age appropriate activities as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services.

A child between the ages of two and six would be considered to have long-term care needs if he or she were certified by a licensed physician as requiring substantial assistance for at least six

---

[2] A portion of the period certified by the physician must occur within the taxable year for which the credit is claimed. After the initial certification, individuals must be re-certified by their physician within three years or such other period as the Secretary prescribes.

months with two of the following activities: eating, transferring, and mobility. A child under the age of two would qualify if he or she were certified by a licensed doctor as requiring for at least six months specific durable medical equipment (for example, a respirator) by reason of a severe health condition or requiring a skilled practitioner trained to address the child's condition when the parents are absent. Within five years of enactment, the Department of the Treasury and the Department of Health and Human Services would report to Congress on the effectiveness of the definition of disability for children and recommend, if necessary, modifications to the definition.

The taxpayer would be required to provide a correct taxpayer identification number for the individual with long-term care needs, as well as a correct physician identification number (e.g., the Unique Physician Identification Number that is currently required for Medicare billing) for the certifying physician. Failure to provide correct taxpayer and physician identification numbers would be subject to mathematical error procedures. Further, the taxpayer could be required to provide other proof of the existence of long-term care needs in such form and manner, and at such times, as the Secretary requires.

The credit would be coordinated with the current law child credit and the proposed disabled workers credit to allow these credits to be refundable for a taxpayer claiming three or more credit amounts.[3] As under the current-law child credit, the amount of refundable credit would be the amount that the nonrefundable personal credits would increase if the tax liability limitation of section 26(a) were increased by the excess of the taxpayer's social security taxes over the taxpayer's earned income credit (if any).

The proposal would effective for taxable years beginning after December 31, 1999.

---

[3] More than one credit amount could be attributable to a single individual. For example, a disabled worker with long-term care needs would have two credit amounts–a disabled workers credit and a long-term care credit. Similarly, a taxpayer with a child under age 17 with long-term care needs would have two credit amounts–a child credit and a long-term care credit--for that child.

Making Child Care More Affordable

INCREASE, EXPAND AND SIMPLIFY THE CHILD AND DEPENDENT CARE TAX CREDIT

Current Law

A taxpayer may be eligible for a nonrefundable tax credit if he or she pays for the care of a qualifying individual in order to work. Qualifying individuals include dependents under the age of 13 and disabled dependents or spouses. The credit is equal to a percentage of the taxpayer's employment-related expenditures for child or dependent care. A taxpayer must provide over half the costs of maintaining the household in which the taxpayer and the qualifying dependent reside. Taxpayers who do not incur out-of-pocket child care expenses are not eligible for the credit.

The credit rate depends on the taxpayer's adjusted gross income. The credit rate is phased-down from 30 percent (for taxpayers with adjusted gross incomes of $10,000 or less) to 20 percent (for taxpayers with adjusted gross incomes above $28,000). The maximum amounts of qualifying employment-related expenses for which credits can be claimed are limited to $2,400 for one qualifying individual and $4,800 for two or more qualifying individuals. Thus, the maximum credit ranges from $480 to $720 for a taxpayer with one qualifying individual and $960 to $1,440 for a taxpayer with two or more qualifying individuals.

Employees may exclude from their taxable income (and their earnings for social security tax purposes) amounts their employers provide as child and dependent care benefits, including those provided through a cafeteria plan. The exclusion is limited to $5,000 of child care expenses per year and does not vary with the number of qualifying dependents. The amount of a taxpayer's expenses eligible for the child and dependent care credit is reduced dollar for dollar by the amount of excludable benefits provided by the employer.

Reasons for Change

Many working parents cannot find affordable and safe child care. In the FY 2000 budget, the Administration is proposing a comprehensive initiative to address the child care needs of both low- and moderate-income working families. Low-income families will receive additional assistance through an expansion of the Child Care and Development Block Grant. The needs of moderate-income families can be best served through an expansion of the child and dependent care tax credit, which was last increased in 1982.

Infants require special care and attention. Infants especially benefit from bonding with their parents during their first year, although many parents cannot afford to stay at home to care for their children. To enable parents to make the best choices for caring for their youngest children, the child and dependent care tax credit should be expanded to provide additional assistance to taxpayers with infants.

Proposal

Expand basic child and dependent care credit

The maximum child and dependent care tax credit rate would be increased from 30 percent to 50 percent. Taxpayers would be eligible for the 50-percent credit rate if their adjusted gross income is $30,000 or less. For taxpayers with adjusted gross incomes between $30,000 and $59,000, the credit rate would be reduced by one percentage point for each additional $1,000, or fraction thereof, of adjusted gross income in excess of $30,000. Taxpayers with adjusted gross incomes over $59,000 would be eligible for a 20-percent credit rate. The current-law maximum amounts of employment-related expenses for which the credit can be claimed ($2,400 for one qualifying individual and $4,800 for two or more qualifying individuals) would be retained. Thus, the maximum credit would range from $480 to $1,200 for a taxpayer with one qualifying individual and $960 to $2,400 for a taxpayer with two or more qualifying individuals.

Taxpayers generally would no longer be required to provide over half the costs of maintaining the home in which the taxpayer and the qualifying individual reside to claim the child and dependent care tax credit, but would still be required to demonstrate that they resided in the same household as the qualifying individual. A married taxpayer who files a separate return, however, would still have to meet the current law household maintenance test in order to qualify for the credit.

The provision would be effective for tax years beginning after December 31, 1999. Beginning 2001, the $30,000 starting point for the phase-down range would be indexed for inflation. The maximum amounts of qualifying child and dependent care expenses that could be claimed for the credit also would be indexed, beginning in 2001.

Additional credit for taxpayers with infants

The child and dependent care tax credit would be expanded to provide an additional credit for all taxpayers with qualifying dependents under the age of one ("infants"), whether or not they incur out-of-pocket child care expenses. The additional credit amount would be equal to the applicable credit rate multiplied by $500 for an infant ($1,000 for two or more infants).

For taxpayers with infants who incur out-of-pocket child care expenses in order to work, the proposed expanded basic child and dependent care tax credit would be augmented by allowing these taxpayers to add $500 (or $1,000 if two or more infants) to these expenses. For example, a two-earner couple with an infant could qualify for a maximum child and dependent care tax credit of up to $1,450 if they incurred $2,400 or more of out-of-pocket child care expenses (50 percent x ($2,400+$500)).

Taxpayers with infants who do not incur any out-of-pocket child care expenses would also be eligible for the additional credit for infants. For example, a taxpayer with a stay-at-home spouse

who cares for their infant would qualify for a maximum credit of up to $250 (50 percent x $500) ($500 if they have two or more infants). Similarly, a two-earner couple with an infant could qualify for a credit of up to $250 even if they rely on unpaid relatives and friends to help care for their infant while they are at work.

The provision would be effective for taxable years beginning after December 31, 1999. The additional credit for taxpayers with infants would be appropriately indexed for inflation beginning in 2000.

United
Hospital Fund

Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10018

FAX COVER PAGE

To: Chris Jennings	**From:** Jim Tallon
Fax Number: 202 456-5557	**Company: UNITED HOSPITAL FUND**
Date: 3/23/99 **Total Pages:** 6	**For Information Call: (212) 494-0777**
Subject: UHF Family Caregivers Project	**Fax Number: (212) 494-0830**

Notes:

Attached is a press release regarding the United Hospital Fund's Families and Health Care Project that I mentioned to you the other day.

As you know, this project provides grants to develop innovative programs and resources to assist family caregivers, who provide ever more complex care to seriously ill and disabled family members.

Please do not hesitate to contact me if you should need more information.

News

United Hospital Fund

Shaping New York's Health Care Information, Philanthropy, Policy

Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10118
212 494-0700
Fax 212 494-0800

Contact: Linden Alschuler & Kaplan, Inc.
Billy Kenny/Lloyd Kaplan
(212) 575-4545

United Hospital Fund
Eleanor Rorer
(212) 494-0732

UNITED HOSPITAL FUND AWARDS $1.15 MILLION IN GRANTS TO DEVELOP CRITICAL RESOURCES FOR FAMILY CAREGIVERS

First Effort of Its Kind in the U.S. Addresses Urgent Need Highlighted By President Clinton's Long-term Care Proposal

NEW YORK, NEW YORK, March 23, 1999--The United Hospital Fund has awarded seven New York City hospitals $1.15 million in grants to develop innovative programs and resources to assist family caregivers. This initiative, involving many of the City's major medical centers as well as community hospitals, is the first effort of its kind in the country to address the daunting needs of family caregivers—relatives,spouses, partners, and friends—who provide extensive care at home for seriously ill or disabled family members.

National Models

These programs will serve as national models to help other medical centers and hospitals across the country better assist America's 25 million family caregivers in their efforts to provide care for their loved ones.

The grants are part of the Fund's Families and Health Care Project, which was created in 1996 to identify ways to help family caregivers, who provide services ranging from bathing and daily aid to administering intravenous therapies and tube feedings. The project has found that patient care at home

can be jeopardized by the lack of adequate training for caregivers, and that caregivers also can suffer adverse health and economic consequences from the unrelenting stress of caring for a loved one at home.

In January, the Clinton Administration further raised the awareness of this crisis by proposing a $6 billion federal initiative involving tax credits for caregivers and elderly patients and assistance to states for the development of programs to help caregivers.

The seven hospitals receiving grants to implement programs to assist family caregivers are: The Brooklyn Hospital Center, Cabrini Medical Center, Jamaica Hospital Medical Center, Maimonides Medical Center, The Mount Sinai Hospital, NYU Hospitals Center, and Peninsula Hospital. The programs at these hospitals were chosen because of their innovative approaches – and because they can serve as national models. The hospitals also will work with nursing homes, home care agencies, and other community-based partners. Descriptions of the programs and the amounts of the grants each hospital received are attached.

A Revolution in the Culture of Health Care

"The United Hospital Fund is hoping to foster a revolution in the culture of health care institutions and a re-evaluation of the roles played by families," said James R. Tallon, Jr., president of the United Hospital Fund. "We need to recognize that medical advances and cost cutting efforts have imposed a growing burden on family caregivers, and this country's health care system has not responded adequately to this change. These grants can help begin to correct that imbalance."

"Hospitals and caregivers need each other and have to develop working partnerships," said Carol Levine, director of the Families and Health Care

Project, and a caregiver herself. "These hospitals are taking the bold step of recognizing their responsibility in facilitating continuity of care and support for caregivers."

The programs utilize traditional as well as new technologies to bridge the communications gap between caregivers and hospitals. They emphasize developing better education, counseling, and support for caregivers, as well as ways to better educate, train, and inform doctors and other hospital staff about caregiver concerns. The hospitals also will look at ways to integrate caregiver needs into the hospital environment through changes in institutional culture, policies, and practices, and to help patients as they are discharged to different settings. In addition, they will examine ways to improve communication with caregivers and promote access to information through the Internet.

The seven new grants are the second phase of the Fund's $1.5 million Family Caregiving Grant Initiative, a three-year effort to develop programs and resources that address caregivers' needs. During the first phase, 16 New York City hospitals were awarded planning grants to explore ways to improve support for family caregivers. These hospitals found that responsibility for care is fragmented, making communication and continuity difficult. The hospitals themselves are set up in ways that are not conducive to helping caregivers. Staff and physicians focus on the patient, giving the caregiver only last minute and perfunctory training. The result, as one hospital found two weeks after patients were discharged, was that caregivers were not coping and were feeling depressed, stressed, and scared.

Helping Caregivers Saves Money

A growing body of research supports the belief that more responsive programs not only help caregivers, but can also save money. A recent study of

effects of comprehensive discharge planning and home follow up, including caregiver assessment and resources, published in the *Journal of the American Medical Association,* showed that patients who receive this kind of follow-up care at home were readmitted less frequently and that their total Medicare costs were half that of those who did not receive such care.

"The long-term care proposal President Clinton announced has raised awareness of the burdens family caregivers face when caring for their loved ones at home," Mr. Tallon said. "We want to capitalize on this awareness and to continue to use the Fund's resources to create an environment in which caregivers are not facing this enormous challenge alone and without adequate preparation."

Last year, the Families and Health Care Project issued a comprehensive study entitled *Rough Crossings: Family Caregivers' Odysseys through the Health Care System.* It illustrates the enormous responsibilities being placed on caregivers nationwide and presents a set of principles to guide family caregivers in developing collaborative relationships with health care providers. (Copies are available for $15 plus $3.50 for shipping and handling from the Publications Program, United Hospital Fund, 350 Fifth Avenue, 23rd Floor, New York, NY 10118-2399.)

The Families and Health Care Project at the United Hospital Fund is supported in part by grants from the Altman Foundation, The Nathan Cummings Foundation, The JM Foundation, The New York Community Trust, The William Stamps Farish Fund, and The Prudential Foundation. The project's Family Caregiving Grant Initiative is partly supported by United Way of New York City.

The United Hospital Fund is a health services research and philanthropic organization addressing critical issues affecting hospitals and health care in New York City and the nation.

###

UNITED HOSPITAL FUND
FAMILY CAREGIVING INITIATIVE IMPLEMENTATION GRANTS

Project Descriptions

Following are descriptions of the projects and amounts of the grants awarded to seven New York City hospitals:

The Brooklyn Hospital Center ($175,000) In collaboration with the Wartburg Lutheran Home for the Aging, to create a program to assist caregivers of neurologically impaired blacks in northern and central Brooklyn during the acute and chronic phases of illness.

Cabrini Medical Center ($175,000) In collaboration with Cabrini Center for Nursing and Rehabilitation and the Alzheimer's Association of New York, to create family-centered acute and long-term care environments that encourage partnerships between professional and family caregivers of patients with dementia.

Jamaica Hospital Medical Center ($100,000) To launch a program to assist the extremely isolated caregivers of traumatic brain injury patients by creating and promoting an interactive web site.

Maimonides Medical Center ($175,000) To plan and develop a Continuum of Care Initiative in collaboration with First to Care Home Care to integrate medical and support services for elderly patients and their caregiving spouses both in the hospital and after discharge.

The Mount Sinai Hospital ($175,000) To create the Caregivers and Professionals Partnership, a replicable program that offers providers, patients, and their caregivers a range of support, education, and information services.

NYU Hospitals Center ($175,000) To improve the hospital experiences of elderly patients with dementia and their caregivers by including caregivers as partners in the patient care team, by providing them with support and information during and after hospitalization, and by collaborating with them in the development of staff training programs.

Peninsula Hospital Center ($175,000) To expand the breadth and duration of family support services for caregivers of patients with traumatic brain injury.

Alzheimer's Association
1319 F Street NW, Suite 710
Washington, DC 20004
202/393-7737
202/393-2109 FAX
judith.riggs@alz.org

facsimile transmittal

To:	Chris Jennings	**Fax:**	456-5557
From:	Judy Riggs	**Date:**	03/25/99
Re:	Caregiver Initiatives	**Pages:**	4

Chris. Sorry we couldn't do the meeting today. Hope you can get people together soon and push them a bit. You probably heard about the Senate Aging Committee hearing – the Secretary did a great job!! We had over 500 Alzheimer advocates on the Hill Tuesday and they got a lot of positive feedback about both the family caregiver piece and the tax credits (as well as a lot of conversation about ltc insurance.) They also pushed on the 15% for Medicare.

We released state-by-state data on the value of caregiving, based on the Peter Arno data that was published in Health Affairs (March-April). I sent all the info to Sarah Bianci last week, but I'm attaching the state-by-state charts and the graphic we used. We think this is pretty powerful stuff to use to support your initiatives (i.e. Families ARE the ltc system in this country, overwhelming everything we spend on home health and nursing homes combined. We're DEAD if we let this system fall apart, and it doesn't take a lot to sustain it.)

ALZHEIMER'S®
ASSOCIATION
Someone to Stand by You

Estimated Value of Informal Caregiving, Number of Informal Caregivers and Caregiving Hours by State, 1997

	Mid-Range Value (millions of dollars)	Number of Caregivers	Caregiving Hours (millions)
Alabama	3,221.8	423,143	393.9
Alaska	410.0	53,852	50.1
Arizona	3,243.4	425,977	396.5
Arkansas	1,851.6	243,189	226.4
California	22,914.3	3,009,523	2,801.3
Colorado	2,853.4	374,758	348.8
Connecticut	2,476.5	325,253	302.7
Delaware	549.3	72,140	67.1
Florida	11,214.6	1,472,899	1,371.0
Georgia	5,422.7	712,203	662.9
Hawaii	874.6	114,872	106.9
Idaho	844.0	110,845	103.2
Illinois	8,651.4	1,136,260	1,057.6
Indiana	4,327.1	568,307	529.0
Iowa	2,115.6	277,860	258.6
Kansas	1,887.6	247,912	230.8
Kentucky	2,921.3	383,673	357.1
Louisiana	3,119.2	409,665	381.3
Maine	941.9	123,712	115.2
Maryland	3,803.5	499,539	465.0
Massachuse	4,645.9	610,184	568.0
Michigan	7,207.8	946,663	881.2
Minnesota	3,403.7	447,037	416.1
Mississippi	1,950.0	256,115	238.4
Missouri	3,974.1	521,950	485.8
Montana	646.5	84,904	79.0
Nebraska	1,201.4	157,768	146.9
Nevada	1,225.4	160,942	149.8
New Hampshi	870.4	114,322	106.4
New Jersey	6,059.2	795,802	740.7
New Mexico	1,216.8	159,811	148.8
New York	13,525.3	1,776,382	1,653.5
North Carolina	5,508.7	723,498	673.4
North Dakota	469.6	61,671	57.4
Ohio	8,298.3	1,089,878	1,014.5
Oklahoma	2,422.5	318,164	296.1
Oregon	2,422.1	318,200	296.2
Pennsylvania	9,155.1	1,202,411	1,119.2
Rhode Island	749.8	98,473	91.7
South Carolina	2,777.6	364,803	339.6
South Dakota	534.1	70,144	65.3
Tennessee	4,021.2	528,142	491.6
Texas	13,636.0	1,790,931	1,667.0
Utah	1,316.9	172,955	161.0
Vermont	441.0	57,916	53.9
Virginia	5,033.5	661,094	615.3
Washington	4,113.6	540,272	502.9
Washington D	419.6	55,104	51.3
West Virginia	1,401.5	184,065	171.3
Wisconsin	3,791.8	498,009	463.5
Wyoming	343.8	45,161	42.0
TOTALS	196,426.7	25,798,370	24,013.1

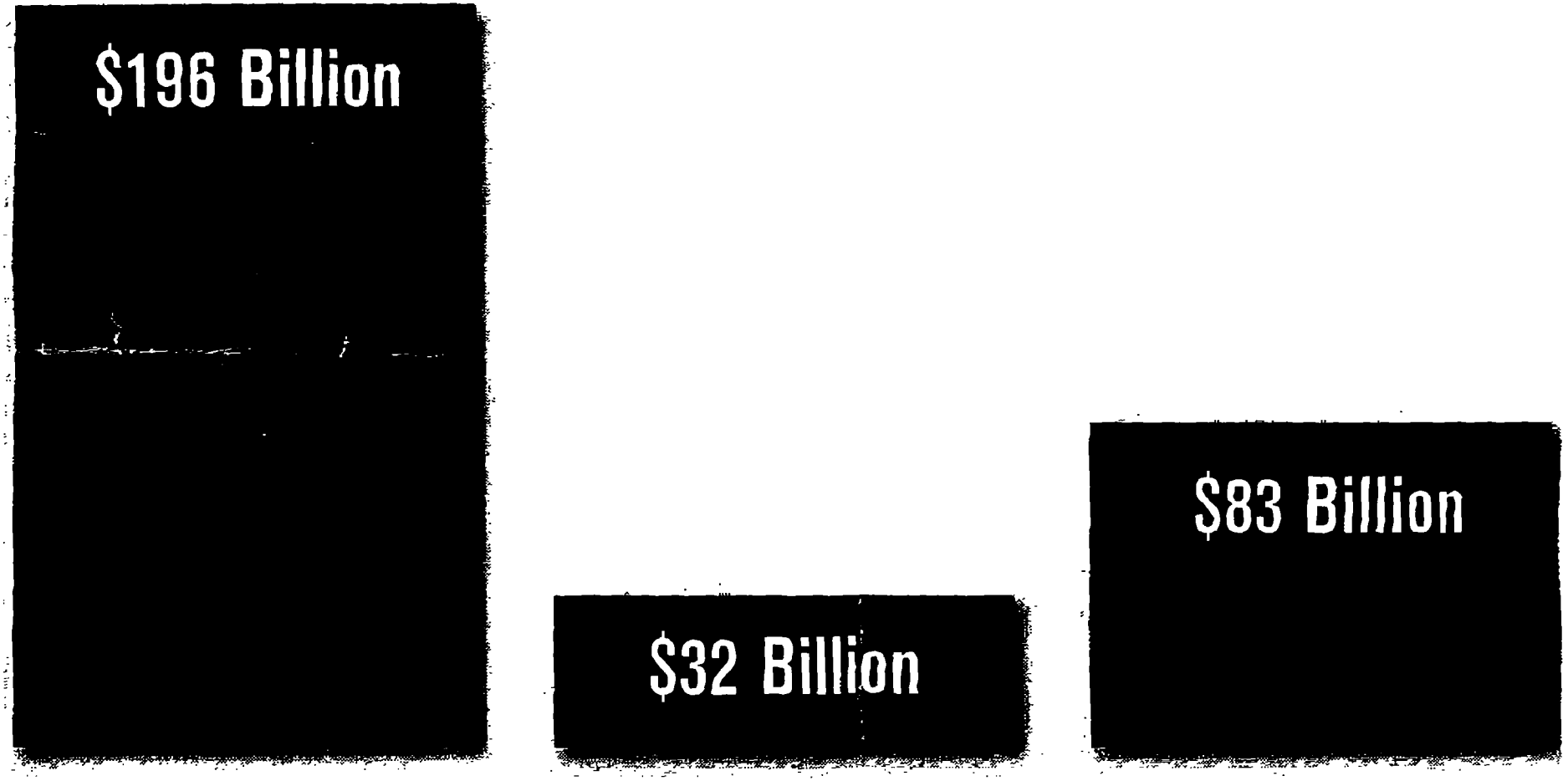
Excerpted from "Economic Value of Informal Caregiving in the United States, By State: Methodological Approach and Findings" prepared by Peter S. Arno Ph.D. and Margaret Memmott, for the Alzheimer's Association, March 9, 1999

Estimated Value of Informal Caregiving, Number of Informal Caregivers and Caregiving Hours by State, 1997

States shown in descending order.

	Mid-Range Value (millions of dollars)	Number of Caregivers	Caregiving Hours (millions)		Mid-Range Value (millions of dollars)	Number of Caregivers	Caregiving Hours (millions)
California	22,914.3	3,009,523	2,801.3	Connecticut	2,476.5	325,253	302.7
Texas	13,636.0	1,790,931	1,667.0	Oklahoma	2,422.5	318,164	296.1
New York	13,525.3	1,776,382	1,653.5	Oregon	2,422.1	318,200	296.2
Florida	11,214.6	1,472,899	1,371.0	Iowa	2,115.6	277,860	258.6
Pennsylvania	9,155.1	1,202,411	1,119.2	Mississippi	1,950.0	256,115	238.4
Illinois	8,651.4	1,136,260	1,057.6	Kansas	1,887.6	247,912	230.8
Ohio	8,298.3	1,089,878	1,014.5	Arkansas	1,851.6	243,189	226.4
Michigan	7,207.8	946,663	881.2	West Virginia	1,401.5	184,065	171.3
New Jersey	6,059.2	795,802	740.7	Utah	1,316.9	172,955	161.0
North Carolin	5,508.7	723,498	673.4	Nevada	1,225.4	160,942	149.8
Georgia	5,422.7	712,203	662.9	New Mexico	1,216.8	159,811	148.8
Virginia	5,033.5	661,094	615.3	Nebraska	1,201.4	157,788	146.9
Massachuse	4,645.9	610,184	568.0	Maine	941.9	123,712	115.2
Indiana	4,327.1	568,307	529.0	Hawaii	874.6	114,872	106.9
Washington	4,113.6	540,272	502.9	New Hampshi	870.4	114,322	106.4
Tennessee	4,021.2	528,142	491.6	Idaho	844.0	110,845	103.2
Missouri	3,974.1	521,950	485.8	Rhode Island	749.8	98,473	91.7
Maryland	3,803.5	499,539	465.0	Montana	646.5	84,904	79.0
Wisconsin	3,791.8	498,009	463.5	Delaware	549.3	72,140	67.1
Minnesota	3,403.7	447,037	416.1	South Dakota	534.1	70,144	65.3
Arizona	3,243.4	425,977	396.5	North Dakota	469.6	61,671	57.4
Alabama	3,221.8	423,143	393.9	Vermont	441.0	57,916	53.9
Louisiana	3,119.2	409,665	381.3	Washington D	419.6	55,104	51.3
Kentucky	2,921.3	383,673	357.1	Alaska	410.0	53,852	50.1
Colorado	2,853.4	374,758	348.8	Wyoming	343.8	45,161	42.0
South Carolin	2,777.6	364,803	339.6				
				TOTALS	196,426.7	25,798,370	24,013.1

$196 Billion in Services From Family Caregivers Dwarfs Cost of Other Types of Care



Source: Economic Value of Informal Caregiving in the United States, by States