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THE URBAN INSTITUTE

NEW FEDERALISM
ISSUES AND OPTIONS FOR STATES

A product of "Assessing the New Federalism," an Urban Institute Program to Assess Changing Social Policies

Repeal of the "Boren Amendment": Implications for Quality of Care in Nursing Homes

Joshua M. Wiener and David G. Stevenson

From 1980 to 1997, federal law directly linked Medicaid nursing home rates with minimum federal and state quality of care standards. As part of the Omnibus Reconciliation Act of 1980, the "Boren amendment" required that Medicaid nursing home rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards" (Section 1902(a)(13) of the Social Security Act). State Medicaid officials overwhelmingly came to oppose the amendment as impossible to operationalize, believing that they were forced by the courts to spend too much on nursing homes at the expense of other services.

As states gain freedom to cut nursing home reimbursement, it becomes more important to understand whether and how these changes might affect quality of care in nursing homes.

The federal Balanced Budget Act of 1997 repealed the Boren amendment, giving states far greater freedom in setting nursing home payment rates. The nursing home industry warned that Medicaid reimbursement levels already are too low, and that further reductions would adversely affect quality of care. Indeed, poor-quality nursing home care is gaining increasing attention. For example, in response to a recent General Accounting Office report identifying glaring quality of care deficiencies in California nursing homes, the U.S. Senate Special Committee on Aging held critical hearings on nursing homes and their regulators, and President Clinton unveiled tougher enforcement standards.[1]

Despite nursing home industry claims that low payment rates inhibit quality of care, Medicaid rates for nursing facility care are a logical target for states trying to reduce the growth rate of long-term care expenditures. Nursing home care accounted for 20 percent of Medicaid expenditures in 1996. Whereas the financial effect of reforms such as expanding home and community-based services and integrating acute and long-term care is uncertain, with savings likely to occur some time in the future, the impact of nursing home rate reductions on state budgets is predictable, immediate, and potentially large. Similarly, with nearly 70 percent of nursing home residents dependent on Medicaid to pay for their care, it is hard to overstate the importance of Medicaid to the nursing home industry.[2]

As states gain freedom to cut nursing home reimbursement, it becomes more important to understand whether and how these changes might affect quality of care in nursing homes.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

Assistant Secretary for Public Affairs

Phone: (202)690-7850 **Fax: (202)690-5673**

To: Chris Jennings & Sarah Bianchi

Fax: 456-5557 Phone: _____

Date: 12/14 Total number of pages sent: 3

Comments:

FYI re: disabilities event, our ADAPT talking points.

Melissa

FOR INTERNAL USE ONLY
November 13, 1998

Questions and Answers About ADAPT

ADA Most Integrated Setting Requirement

Basic Statement:

"Secretary Shalala has agreed to meet with representatives of ADAPT to discuss ways to achieve a better use of resources, within the context of a balanced budget, on behalf of persons with disabilities. This is a process that will take time and care, and we want to involve all of the stakeholders."

Background:

The Department has always supported the intent of the Americans with Disabilities Act in calling for "most integrated setting" for delivery of services to those with disabilities, and we expect that this will be a key subject of the meeting. At the same time, the legal implications of the Amost integrated setting" requirements are still being worked out in the courts.

Further, we recognize that states confront legitimate issues in moving toward changes in their services for those with disabilities. Thus, our purpose is not to create a new mandate on states, but to work cooperatively with all interested parties to determine the best use of resources, within a balanced budget, consistent with the ADA law.

Questions and Answers to be used with the public:

Q. What is HHS's interpretation of the November 3 letter to ADAPT?

A. Secretary Shalala has agreed to meet with representatives of ADAPT to discuss ways to achieve better use of resources, especially Medicaid funding, on behalf of persons with disabilities. The Department has always supported the Americans with Disabilities Act principle of "most integrated setting" for delivery of services to those with disabilities, and we expect that this will be a key subject of the meeting. At the same time, the exact meaning of the ADA in this respect is still being worked out in court and elsewhere. And further, we recognize that states confront legitimate issues in moving toward changes in their services for those with disabilities. Thus, our purpose is not to create a new mandate on states, but to work cooperatively with all interested parties to determine the best use of resources, within a balanced budget, consistent with the ADA law.

Q. But what does the letter really mean? Does it mean HHS has pledged to bring about the kind of home and community based services mandate that ADAPT has long been demanding?

A. Secretary Shalala has committed to a meeting with ADAPT. The exact agenda is still to be worked out, but we want to work with all of the involved parties to achieve the best use of resources, within the context of a balanced budget, on behalf of people with disabilities. In the coming months, we hope to be meeting with advocates as well as state Medicaid program representatives to discuss the many legal and other issues that are involved.

Q. The letter says that the plan will result in state compliance with the requirements of the ADA. So aren't you already committing to new mandates?

A. Obviously, the federal and state governments will be bound by the ADA. However, the legal interpretation of the ADA, and its implications for state Medicaid programs, are still evolving. Our hope is that we can help in the translation of the ADA goals into programs at the state level that will do better in enabling people with disabilities to live in their communities. We're confident that the states share that

goal, but it's not an end that will be achieved overnight.

Q. Doesn't the letter clearly commit FY 2000 funds to pay for state compliance with ADA?

A. HHS is in the process of developing policies its FY 2000 budget proposals in consultation with OMB. However, budget negotiations are ongoing and decisions will ultimately be made by Congress as well as the Administration.

In addition, the legal requirements that will stem from the ADA are still being interpreted, notably in various court cases. What we are committed to is a careful, good-faith process, involving all stakeholders to move toward achieving the goals we share. We want to achieve the best use of resources to meet the needs of people with disabilities, consistent with a balanced budget and with the law as it develops under the ADA.

Questions and Answers for additional background information; sections that are explicitly not to be used in discussions with the public are italicized and in brackets:

Q. What is the Amost integrated setting" requirement?

A. Title II of the Americans with Disabilities Act requires that public programs administer services to individuals with disabilities in the most integrated setting appropriate to their needs. The Amost integrated setting" requirement applies to all of a state agency's programs, including those that may be funded only with state funds. ADA, as interpreted by the Department of Justice, required each state to conduct a self evaluation to ensure, among other things, that policies, practices, and procedures promote, rather than hinder integration. The self evaluation requirement applies to state Medicaid programs.

The Amost integrated setting" varies greatly from individual to individual. People with disabilities may receive long-term care services in a range of settings, from highly integrated regular homes and apartments in regular communities, through a range of staffed settings, up to segregated environments, such as nursing homes and institutions.

Interpretations of the most integrated setting requirement as it relates to Medicaid long-term care services also vary widely. Some advocates interpret it to mean that any individual who receives or is eligible to receive nursing home or institutional services has a right to choose, instead to get community based services B in essence an entitlement to community based care. On the other end of the spectrum, some state Medicaid and long-term care officials point out that the Medicaid law mandates nursing home services for persons in need over age 21; home and community based services are optional. Ultimately, the most integrated setting is determined for each individual based on his or her individual situation.

Whether either of these interpretations, or some middle ground, prevails, will likely ultimately be determined by the Courts. Consumers and their advocates are initiating ADA lawsuits on behalf of individuals seeking community based services.

COVER SHEET

FAX

To: Chris Jenning/Cynthia Rice
Fax #: 456-5557 / 7431
Subject: Bridge Funding
Date: December 16, 1998
Pages: 3, including this cover sheet.

COMMENTS:

Attached is paper we discussed. If you have any questions, give me a call tomorrow morning,

From the desk of...

Seth Harris
Counselor to the Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

(202) 219-6181
Fax: (202) 219-8924

Two Alternative Strategies

Alternative #1: Find PAYGO Offsets to Fund the BRIDGE Program

•One strategy is to fund the BRIDGE program with either mandatory or discretionary funds using the authority provided under JTPA and the Workforce Investment Act, as has been discussed over the last several weeks, which would require PAYGO offsets.

•Given the tightness of the budget with respect to finding PAYGO offsets for either increased mandatory or discretionary expenditures, it is necessary to consider an alternative strategy that would not require PAYGO offsets.

Alternative #2: Place Funding of the BRIDGE Program Off Budget

•This alternative would add the BRIDGE program in its entirety to Kennedy-Jeffords, including the administration of the grants through DOL and the local workforce development boards, and would explicitly provide authority to charge these funds for BRIDGE to the SSA trust funds as is done for the Title IV grant program on work incentives counseling.

•A significant advantage of this approach is that it would place the funding for BRIDGE off budget and would eliminate the need to find offsets for the funding.

•The approach would require the BRIDGE program to be focused exclusively on recipients of SSDI and SSI. A good case can be made that this is the part of the out-of-the-workforce disability community that we should care the most about given the large amounts of money going into benefit payments.

•A disadvantage of this alternative is that the overall BRIDGE objective of integrating and coordinating services for all persons with disabilities would not be achieved.

•Another disadvantage is that the charging of the BRIDGE grant funds to the SSA trust funds would be a bigger departure from tradition than the Title IV grant program in Kennedy-Jeffords, and Congress may reject the approach. The Title IV grant programs goes beyond the traditional use of trust funds to pay for cash benefits and for the reimbursement of return-to-work services provided to SSDI and SSI individuals, but does retain the notion of direct services to SSDI and SSI recipients.

•Finally, SSA is only beginning to consider this approach and may have significant concerns about assuring accountability of funds, particularly when the grant administration involves DOL and local workforce development systems and the funding must be used only for SSDI and SSI recipients. Further discussions with SSA, OMB, and DOL would be required before pursuing this alternative.

December 16, 1998

The BRIDGE Program and Kennedy-Jeffords Title IV Grant Program

Background

•Discussion at an NEC meeting last Thursday focused on achieving the objectives of the BRIDGE program by using the Senate substitute for H.R. 3433 (Kennedy-Jeffords) as a statutory basis for establishing the BRIDGE program, on the presumption that the grant program in Title IV of Kennedy-Jeffords is very similar to the BRIDGE proposal and can be easily revised to achieve the BRIDGE objectives.

•The strategy would be to announce the BRIDGE program as part of the FY 2000 budget, with resources similar to those in Kennedy-Jeffords and then work with the Senate to tweak the Senate bill to make it more like the BRIDGE proposal. The principal advantage of this approach is that the Senate substitute provides funding for a grant program that is "off budget" and requires no PAYGO offsets.

The Problem

•The strategy discussed at the NEC meeting will not work for both substantive and constituency reasons.

•The Title IV grant program would achieve only a small part of the overall objectives of the BRIDGE proposal. The BRIDGE proposal essentially has two parts: (1) front-end counseling and information-provision to adults with disabilities seeking employment; and (2) systems change through the integration of employment-related services for adults with disabilities. The Title IV grant program makes funds available only for the training and hiring of specialists who would counsel people with disabilities on available work incentives programs.

•Thus, the Title IV grant program would have to be significantly revised and expanded in order to achieve overall objectives of BRIDGE. Also, Title IV contemplates very small grants ($50,000 - $300,000) befitting the program's narrow purpose. BRIDGE grants would be capped somewhere in the vicinity of $5 million dollars. A significant expansion in funding for grants would be needed to pay for the second part of BRIDGE: systems change grants to achieve service integration/coordination that are administered through DOL and the local workforce development system.

•Any attempt to absorb the Title IV grant program into a larger BRIDGE proposal in Kennedy-Jeffords that would have money flowing through DOL would present significant constituency problems in the disability community, given that the grant program has been designed to provide money directly to institutions independent living centers serving people with disabilities and any attempt to change this would be a political nightmare.

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Controlling the Supply of Long-Term Care Providers at the State Level

Joshua M. Wiener
David G. Stevenson
Susan M. Goldenson
The Urban Institute

Occasional Paper Number 22

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division

Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

FROM: Bob Pellicci -- 395-4871

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

Pages sent (including transmittal sheet): 14

COMMENTS:

FINAL - OPM draft bill on LTC for Federal employees.

TO: Dan Mendelson
Chris Jennings / Jeanne Lambrew

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

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

JAN 6 1999

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

Dear Mr. President:

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Janice R. Lachance

Janice R. Lachance
Director

Enclosures

A BILL

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

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

Section 1. Short Title

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

Section 2. Long-Term Care Insurance

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

"Chapter 90—Long-Term Care Insurance

"§ 9001. Definitions

"For the purpose of this chapter—

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

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

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

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

"(4) 'Office' means the Office of Personnel Management;

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

"(6) 'qualified contract' means a contract meeting the conditions prescribed in section 9002; and

"(7) 'State' means a State or territory or possession of the United States, and includes the District of Columbia.

"§ 9002. Contracting authority

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

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

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

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

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

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

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

"§ 9003. Minimum standards for contractors

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

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

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

"§ 9004. Long-Term Care Benefits

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

"§ 9005. Financing

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

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

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

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

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

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

"§ 9006. Preemption

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

"(1) the provisions of this chapter; or

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

"§ 9007. Studies, reports, and audits

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

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

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

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

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

"§ 9008. Claims for benefits

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

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

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

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

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

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

"§ 9009. Jurisdiction of courts

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

"§ 9010. Regulations

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

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

"(c) The Office may not exclude—

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

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

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

"§ 9011. Authorization of appropriations

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

Section 3. Effective Date

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

SECTION-BY-SECTION ANALYSIS

To accompany a draft bill

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Office for the administration of this chapter.

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

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

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

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

New section 9008 addresses claims for benefits under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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NFCA

RESPONSE TO PRESIDENT'S LONG-TERM CARE PROPOSALS

STATEMENT BY SUZANNE MINTZ
PRESIDENT AND CO-FOUNDER
NATIONAL FAMILY CAREGIVERS ASSOCIATION
JANUARY 6, 1999

"The National Family Caregivers Association, the nation's most broadly-based organization of hands-on family caregivers, warmly welcomes the President's far-reaching long-term caregiving initiatives announced January 4.

"For years family caregivers have been the invisible majority providing the day in and day out care for America's long-term health care recipients. The President's dramatic announcement of a broad range of initiatives on caregiving finally recognizes family caregivers and includes them in the national discussion of the issues that will affect each American family in the century ahead.

"Family caregivers provide 80 - 90% of all long-term care services. Recent studies have shown a conservative market value of their services is $194 billion a year. Family caregivers underpin our healthcare system in an irreplaceable way. We are very pleased to see that the President and Vice President recognize this and are moving toward providing some meaningful assistance for family caregivers of chronically ill and disabled persons, regardless of age.

"We support all initiatives that recognize and support family caregivers. NFCA believes we can trust families to do what is right for their loved ones. We appreciate that many of the administration's proposals, such as a tax credit for family caregivers, acknowledge that families need to be in control of making decisions about the type of help and services they require. This is vital because each caregiving circumstance in so very different.

Membership surveys show that most NFCA caregivers provide "intense" levels of assistance with more than two activities of daily living. NFCA was founded in 1993 to support, educate, and empower all of the nation's more than 25 million family caregivers who care for chronically ill or disabled loved ones.

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NEWS RELEASE

January 4, 1999 **FOR IMMEDIATE RELEASE**

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AAHSA APPLAUDS PRESIDENT' LONG TERM CARE PROPOSALS

WASHINGTON, DC -- The American Association of Homes and Services for the Aging applauds President Clinton for opening a national discussion on the future of financing the long-term care expenses of millions of elderly and persons with disabilities.

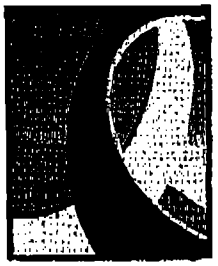
"Paying for long-term care is a national problem, straining both the financial and caregiving abilities of many American families," said AAHSA Interim President Alan Rosenbloom. "The President's proposal begins to close the gap between the cost of long-term care and what most families are able to pay, but it is crucial that we begin the process of seeking broader reforms as our society ages."

The centerpiece of the President's proposal is a $1,000 tax credit for caregivers in order to give them respite from taking care of a loved one. Also, the President's proposal would encourage the further growth of private long-term care insurance through offering it to federal employees and retirees.

"AAHSA has long promoted long-term care insurance as part of any broad solution to the nation's long-term care financing problem," said Rosenbloom. "Hopefully, more employers will offer private insurance as an employee benefit if the federal government takes such a leadership role."

"This is not a problem we will ever solve by just improving our present programs," says Rosenbloom. "We must look closely at Medicare,

-more-



Medicaid, Social Security, HUD senior housing programs, and Older Americans Act programs to begin thinking of them as resources contributing to a complete system that provides real long-term care security in the future."

AAHSA pledges to continue working diligently with members of Congress and the Administration to help develop such a system.

AAHSA is the national association of not-for-profit long-term care and senior housing providers. Its members include over 5,000 nursing homes, assisted living facilities, continuing care retirement communities, senior housing and home and community-based service organizations. AAHSA's website is: www.aahsa.org.

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THE LONG TERM CARE CAMPAIGN

FOR IMMEDIATE RELEASE
January 6, 1999

Contact: Jon Dauphiné, Chief Program Officer
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STATEMENT BY THE LONG TERM CARE CAMPAIGN'S CHIEF PROGRAM OFFICER, JON DAUPHINÉ, ON PRESIDENT CLINTON'S PROPOSED LONG TERM CARE PACKAGE

The Long Term Care Campaign (LTCC), a coalition of 150 older adult, disability, religious, consumer, labor and other groups that has been fighting for improved long term care services since 1987, lauds President Clinton's plan to provide tax credits to Americans struggling with long term care costs and to take other steps to help those who need long term care.

The President's proposal is an important new initiative that addresses a part of the overwhelming burden that long term care currently imposes on our nation's families. With nursing home care now averaging over $46,000 per year, and home care ranging from $55 to $200 per visit, the financial costs of long term care are staggering, and the emotional toll on the families whose loved ones need care is equally high. As a nation, we are desperately in need of solutions that help families to afford long term care services, that support and sustain family caregivers, and that assist Americans to prepare for a problem that almost half of us will eventually face personally.

We are pleased that President Clinton's proposal recognizes the enormous burden that long term care needs currently impose on families and that it is likely to stimulate a national dialogue on long term care that is sorely needed. For too long, our policymakers have debated health security (Medicare) and retirement security (Social Security), while ignoring the long term care issue, which is crucially and inextricably linked to both. The LTCC looks forward to working with the Administration and Congress on a nonpartisan basis to stimulate continued dialogue and to encourage comprehensive solutions.

The LTCC and its members, which include AARP, Alzheimer's Association, and Paralyzed Veterans of America, will continue working together to ensure that quality long term care services are accessible and affordable for all American families.

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NEWS

FOR IMMEDIATE RELEASE
January 4, 1999

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NARFE SUPPORTS WHITE HOUSE, OPM PLANS TO ENHANCE LONG-TERM CARE SUPPORT AND ACCESS

NARFE has announced it will support legislation proposed by the White House this morning that will enhance access to long-term care for federal annuitants and other Americans.

"NARFE welcomes both of these proposals," said NARFE National President and Chief Executive Officer Frank G. Atwater. "The plans meet the criteria supported by resolutions passed at NARFE's National Convention and offered by NARFE in Congressional hearings held last year. And while both proposals are just that – proposals – we find the fact that there is a recognition that federal retirees need to have long-term care available a positive step in the right direction and will support legislation to implement them."

According to Atwater, the Office of Personnel Management (OPM), the Department of Health and Human Service's Assistant Secretary for Policy and Evaluation (HHS/ASPE), and the White House assembled a plan that would make private long-term care insurance available to federal employees, retirees and dependents at negotiated group rates. OPM would negotiate and administer its long-term care plan, but those who participate would pay the entire cost of this insurance.

As part of the initiative, the White House also proposed an annual $1,000 tax credit for long-term care recipients and caregivers; a new national family caregivers support program that provides respite, home care services, information and referral services; and a national campaign to educate Medicare beneficiaries about long-term care options.

Atwater added that NARFE is particularly pleased that the proposals would help ease the financial burden on Alzheimer's sufferers and those who care for them. NARFE actively supports the Alzheimer's Association, and has thus far contributed over $3 million to Alzheimer's research.

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NARFE, one of America's oldest and largest associations, was founded in 1921 with the mission of protecting the earned rights and benefits of America's active and retired federal workers. NARFE has a membership of some 430,000 men and women.

start inviting on Friday

press conf. prompt

Jeff

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

	1995 House Budget Proposal	1995 Conference Budget Proposal	1999 President's Budget Proposal
Basic Policy	$500 Credit for Caregivers of Parents with Long-Term Care Needs	$1,000 Deduction for Long-Term Care Expenses	$1,000 Credit for People with Long-Term Care Needs or their Caregivers
Cost over 5 years	$0.9 billion (JCT)	$0.56 billion (JCT)	$5.5 billion (Treasury)
Who Gets the Credit:			
Caregivers of Parents with Chronic Illness & Disability	Yes	Yes	Yes
If Parents have Social Security Income	No	No	Yes
Caregivers of Adults with Chronic Illness & Disability	No	No	Yes
Caregivers of Children with Chronic Illness & Disability	No	No	Yes
Spouses of People with Chronic Illness & Disability	No	No	Yes
People with Chronic Illness & Disability Themselves	No	No	Yes
Upper income limits	None	None	$95,000 for singles, $130,000 for couples

- The President's tax proposal is one part of a broader initiative that includes the new $625 million Family Caregiver Program that would provide real services -- respite care, counseling, information -- to caregivers. Aging advocates strongly support this initiative both because the tax proposal is much broader and more generous and because the financial assistance is complemented by the important, new Caregiver Program.

- The President did not veto the 1995 Republican budget because of the tax proposal -- he vetoed the legislation because of its massive cuts to Medicare, Medicaid, education, and environmental spending.