Order Code RS20992
Updated January 22, 2003

CRS Report for Congress
Received through the CRS Web

Long Term Care: 107th Congress Legislation

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Summary

The need for long-term care is expected to grow substantially in the future, straining both public and private resources. Total spending on long-term care services for people of all ages was over $151 billion in FY2001, with over 48% paid by Medicaid and about 22% paid out-of-pocket by recipients of long-term care and their families. Steady expansion will be required simply to meet the needs of the growing elderly population, expected to double by 2030. While most care is provided by family members, most public funding is for institutional care. Home and community-based services, which can help heavily burdened families, are unevenly available. The U.S. Supreme Court decision in *Olmstead v. L.C.* focused federal and state attention on development of policies that would expand home and community-based care for people with disabilities.

Most bills introduced in the 107th Congress would have continued incremental refinements of the current system that have characterized congressional activity in recent years. Enacted legislation included H.R. 2559 (P.L. 107-104), which exempted premiums for the long-term care insurance program for federal employees from state and local taxes, and H.R. 3487 (P.L. 107-205), the Nurse Reinvestment Act, which addressed the need for greater supply and improved quality of long-term care personnel. The House passed H.R. 4946, which would have allowed a limited above-the-line deduction for long-term care insurance premiums and an additional personal exemption for families of individuals with long-term care needs. The bill expired at the end of the 107th Congress. This report will not be updated.

Background

The need for long-term care — supportive and health services for persons who have diminished capacity for self-care — is expected to grow substantially in the future. About two-thirds of the people receiving long-term care are over age 65, a group expected to double in size by 2030. Even faster growth rates are anticipated for people over age 85, the age group most likely to need care, between 2030 and 2050.

In FY2001, over $151 billion was spent on long-term care services for persons of all ages, about 12.2% of total personal health care expenditures ($1.24 trillion). Of total long-term care spending, Medicaid provided $73.1 billion (over 48%), largely for institutional care. Long-term care recipients and their families paid $33.2 billion (22%) from their own income and assets. Medicare accounted for slightly more than 14%. Private health insurance accounted for almost 13% with the balance from other programs. The over $151 billion does not include informal caregiving provided by families and other caregivers. One study estimated that the economic value of these services may range from $140 billion to as high as $389 billion in 2000.[1]

While expenditures for long-term care will surely increase in the future, whether they will climb commensurately with the number of elderly is less certain. Research has shown that the prevalence of disability among the elderly has declined over the last 20 years.[2] If this trend continues, the elderly of the future may be healthier than today, which may reduce some of their need for care. On the other hand, increased longevity, particularly past age 85, when frailty becomes common, will result in higher demand for services. Increased demand for care may drive up prices, though it might also result in more efficient ways of providing services. While future need is difficult to predict, total public and private spending for long-term care for the elderly alone could double from 2000 to 2025.[3]

These two trends — growing need and rising expenditures — present policy makers with difficult choices. Options may be limited because the ratio of people age 18-64 to those 65 and over is projected to fall from 4.6 in 2000 to 2.7 in 2030, indicating that there will be far fewer workers to support the retired population. This will make it difficult to maintain Medicare and Social Security at current levels, let alone expand other programs to meet long-term care needs.[4] In attempting to balance needs and costs, Congress might consider one of the following general approaches:[5]

- *Assistance to family caregivers*: Help families to pay for their own care through incentives for private long-term care insurance and/or enhanced lifetime savings; and/or expand existing grant programs that assist family caregivers (i.e., the Older Americans Act caregiver program);
- *Home and Community-Based Services*: Develop social and health services that allow people to receive more care outside of institutions;
- *Social Insurance*: Expand public financing for a broad range of long-term care options, either by extending Medicare and/or Medicaid

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[1] *Arno, Peter S. et. al. The* Economic Value of Informal Caregiving. Paper presented at the American Association for Geriatric Psychiatry, 2002.

[2] Manton, Kenneth G. and XiLiang Gu. *Changes in the Prevalence of Chronic Disability in the United States, Black and Nonblack Population above 65 from 1982 to 1999.* Proceedings of the National Academy of Sciences, May 22, 2001.

[3] The Lewin Group, Inc. *The Long-Term Care Financing Model*. For DHHS, 2000.

[4] See CRS Report RS20885, *Benefits for the Aged and the Federal Budget: Short- and Long-Term Projections*.

[5] See CRS Report RS20784, *Long-Term Care: What Direction for Public Policy?*

coverage or by establishing a new prepaid public insurance program; and/or
- *Joint Public-Private Strategies*: Integrate various components of the previous three approaches in a manner that strikes a balance between private responsibility and shared public concern.

Many analysts see problems with the current system that need attention. Most long-term care is provided by families, but most public funding is for institutional care. Medicaid, the largest public payor, spent $75.3 billion on long-term care in FY2001 with 71% of that for institutional care. Nursing homes provide care to a very disabled population: the average age of residents is 85 and over 80% have limitations in three or more activities of daily living. However, elderly persons are more likely to receive long-term care from family members without reimbursement. Many believe that families should receive more assistance in their efforts to maintain their disabled family members at home and that federal policy should be changed to provide more home and community-based services which most people prefer. However, striking the balance between encouraging families to provide needed assistance and relieving personal costs and sacrifices is difficult.

Additional pressures for expanded home and community-based care may occur as a result of the U.S. Supreme Court opinion in *Olmstead v. L.C.* In its 1999 decision, the Court held that the Americans with Disabilities Act (ADA) requires states to transfer individuals with mental disabilities from institutions to less confining community settings when a state treatment professional has determined the latter are appropriate, the community setting is not opposed by the individual with a disability, and the placement can be reasonably accommodated by the state.[6] A January 2000 Health Care Financing Administration (now Centers for Medicare and Medicaid) notice to state Medicaid directors indicated that the decision was applicable to all individuals with disabilities, not just those with mental disabilities.

In recent years, Congress has followed an incremental strategy for long-term care, making numerous small changes in programs and tax benefits. In 1996, it clarified the tax treatment of long-term care insurance and expenses (the Health Insurance Portability and Accountability Act, P.L. 104-191). In 2000, it established a long-term care insurance program for federal workers and retirees, (P.L. 106-265) and a new state grant program to support caregivers (the National Family Caregiver Support program, under the Older Americans Act, P.L. 106-501). Through hearings and other oversight, Congress has also been concerned about the quality of care provided by nursing homes and assisted living facilities, nursing and paraprofessional staff shortages, consumer protection for long-term care insurance, and affordable housing options.

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Tax Benefits for Long-Term Care Insurance. Under current law, premiums for long-term care insurance may be claimed as an itemized deduction to the extent the sum of the premiums and other unreimbursed medical and long-term care expenses

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[6] See CRS Report RS20588, *Olmstead v. L.C.: Implications and Subsequent Judicial, Administrative, and Legislative Actions.*

exceeds 7½% of adjusted gross income (AGI). The deductible amount is limited by age; in 2002, the limit ranges from $240 for persons age 40 or less, to $2,990 for persons over age 70. (These age limitations do not apply to employer-paid insurance, which is tax-exempt to the worker.) Relatively few people can take advantage of this deduction since their standard deduction is larger.

As part of the FY2003 budget, the President proposed an "above-the-line" deduction, phased in over 4 years, for long-term care insurance premiums up to the current allowed age limits. (An above-the-line deduction is not limited to taxpayers who itemize their deductions, and generally benefits all taxpayers who have a tax liability.) On July 25, 2002, the House approved a more limited above-the-line deduction (an amended version of H.R. 4946), which would have been phased in by 2012. Under the proposal, the deduction would have been reduced for taxpayers with modified adjusted gross incomes in excess of $20,000 ($40,000 for married couples filing jointly) and eliminated for those with incomes in excess of $40,000 ($60,000 for married couples). H.R. 4946 also included an additional personal exemption for families providing long-term care (described below) and additional consumer protections for long-term care insurance. No further action on the bill was taken before the end of the 107th Congress.

Other bills proposing an above-the-line deduction for long-term care insurance included H.R. 831 (Johnson of Connecticut), the identical S. 627 (Grassley), and H.R. 4002 (Susan Davis). An alternative tax benefit, a tax credit, would have been authorized by S. 24 (Specter).

Expanded tax benefits for long-term care insurance would reduce its effective cost and result in more people purchasing it. Proponents see the benefits as a way of encouraging families to assume greater financial responsibility for long-term care and helping them pay expenses largely by themselves. Greater use of insurance would offset Medicaid and other direct public costs in the future. Opponents question how large a role private insurance could play and whether public funds should be used to subsidize insurance which is purchased primarily by middle income families (some of whom would buy it anyway) in order to pass on larger estates to heirs. They also have concerns about whether there is adequate consumer protection for this insurance, given its complexity and the possibility that future premiums may change unexpectedly.

In other action on insurance, on December 27, 2001, the President signed H.R. 2559 (P.L. 107-104) which exempts premiums for the long-term care insurance program for federal employees and retirees from state and local taxes. Open season for the federal program, which is administered by the Office of Personnel Management (OPM), ran from July 1, 2002, through December 31, 2002.

Assistance to Family Caregivers. Proposals take different approaches to assist family caregivers. They include both tax relief measures to compensate for long-term care expenses, and state grant programs to provide services to families. Current tax law provides some tax benefits for families of individuals with long-term care needs: the dependent care tax credit is available for expenses incurred so taxpayers can go to work; the head of household filing status may be used by single taxpayers caring for a dependent relative; and the itemized deduction for medical expenses (subject to the 7½% AGI floor) includes qualified long-term care expenses. The Economic Growth and Tax Relief

Reconciliation Act of 2001 (P.L. 107-16) that President Bush signed on June 7, 2001 increased the qualified expense limits and credit rates for the dependent care tax credit.

In his FY2003 budget, President Bush proposed an additional personal exemption for taxpayers maintaining a household for family members with long-term care needs. An additional exemption, which would have been phased in from 2003 to 2011, was included in H.R. 4946 that the House passed on July 25, 2002. Tax credit bills introduced in the 107th Congress included S. 9 (Daschle), S. 464 (Bayh), and the identical S. 627 (Grassley), H.R. 831 (Johnson of Connecticut), H.R. 2575 (Murtha), and H.R. 4002 (Susan Davis). S. 383 (Snowe) proposed an above-the-line deduction for home health care and adult day and respite care expenses of dependents with Alzheimer's disease or related organic brain disorders.

The National Family Caregiver Support Program (enacted in 2000 under the Older Americans Act) provides grants to state agencies on aging to fund a range of services to assist family caregivers. In FY2002, Congress provided $141 million for the program. For FY2003, the President requested $141.5 million; the Senate Appropriations Committee had approved $160.5 million in the 107th Congress. The program was funded under a continuing resolution into the108th Congress.

Home and Community-Based Services. Some bills in the 107th Congress would have expanded public coverage of home and community-based services, either through amendments to Medicaid or Medicare, or through new programs. For example, S. 24 (Specter) and S. 1298 (Harkin)/H.R. 3612 (Danny Davis) would have required states to provide as a covered Medicaid service, community attendant services and supports for persons who require the level of care provided in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR) (though the bills differ in some respects). Community attendant services would assist individuals in performing activities of daily living (ADLs) and may be provided in home or community settings, including the workplace. S. 1298 and H.R. 3612 would have expanded states' federal Medicaid matching payments for services to improve community supports for persons with disabilities. These bills are similar in some respects to bills, referred to as MiCASA (Medicaid Community Attendant Services Act), which received congressional attention in previous Congresses.

Other bills would have expanded Medicare's coverage of long-term care. H.R. 4954, the House-passed version of Medicare coverage for prescription drugs, passed by the House on June 28, would have required the Secretary of DHHS to demonstrate the effectiveness of providing adult day care services as a substitute for a portion of Medicare's home health care benefit for eligible beneficiaries. Similarly, other bills would have amended Medicare to allow adult day care substitution, but without first conducting a demonstration (S. 2655, Rockefeller, H.R. 3585, Kleczka, and S. 1619, Santorum). Other bills would have expanded Medicare coverage for a variety of home and community-based services with eligibility based on the presence of limitations in ADLs (for example, H.R. 913, Engel, and H.R. 1200, McDermott).

Quality of Care. Issues related to the quality of care have received congressional attention for many years. The Senate Special Committee on Aging has conducted a series of hearings documenting serious lapses in quality of institutional care stemming in part

from weaknesses in the enforcement of nursing home quality regulations. Deficiencies are in part attributed to lack of adequate nurse and nurse aide staffing and training.

During the 107th Congress, some Members expressed concern about reports that the demand for registered nurses, licensed practical nurses, nurse aides and other paraprofessional personnel exceeds supply. The Senate Health, Education, Labor and Pensions (HELP) Committee held hearings on this issue in April 2001. The Health Resources and Services Administration (HRSA/DHHS) projects that demand for RNs and LPNs in nursing homes will increase by 44% and 48% respectively between 2000 and 2020. The demand for RNs and LPNs in home health agencies (HHAs) is expected to increase by 44% and 54% during the same period. The aging of the population will intensify the demand for long-term care personnel.[7] Nursing aides and homemaker/home health aides, who provide the bulk of care across many long-term care settings, generally receive low wages and limited, if any, benefits, and have little opportunity for upward mobility, but nonetheless carry out emotionally and physically challenging tasks. As a result, long-term care jobs have high turnover rates which present significant challenges for long-term care administrators.

Proposals to address the need for greater supply and improved quality of long-term care personnel (S. 1864, Mikulski; H.R. 3487, Bilirakis), were passed by the respective houses on December 20, 2001. The conference agreement on H.R. 3487 (the Nurse Reinvestment Act) was signed by the President on August 1, 2002 (P.L. 107-205). Among other things, this legislation requires the Secretary of DHHS to establish a National Nurse Service Corps where persons agree to serve as nurses for at least 2 years at health care facilities (including nursing homes and home health agencies) with critical nursing shortages in return for scholarships for nursing school. It also authorizes the Secretary to make grants for nurse education, practice, and retention to increase care to underserved populations including the elderly, and grants to train personnel to provide geriatric care, including nurse and certified nurse assistants.

Other bills introduced (H.R. 1436 (Capps)/S. 706 (Kerry) would have provided enhanced federal matching payments to nursing facilities and home health agencies that implement continuing education and other training programs for nurse and nurse aides. H.R. 1897 (Engel) would have authorized grants to nursing facilities and home health agencies for nurse recruitment and retention. H.R. 118 (Holt) would have authorized competitive grants for states to test innovative ways of recruiting and retaining nursing home staff and to improve their education and training, among other things. Another bill (H.R. 2677, Waxman) would have required the Secretary of DHHS to establish minimum staffing standards for nursing homes. H.R. 3331 (Schakowsky) would have amended Medicare and Medicaid to require specific nurse and nurse aide staff/patient ratios.

Other bills would have addressed quality of care provided by facilities. For example, H.R. 2677 and S. 1054 (Kohl) would have required background checks of nursing home personnel for violations of criminal law or past incidences of abuse of residents. H.J.Res.13 (Stark) called for a White House Conference to develop national recommendations regarding the care assisted living facilities provide.

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[7] See CRS Report RL31090, *Long Term Care: Nursing and Paraprofessional Workforce Issues*.