TAX CREDITS AND CARE FOR THE ELDERLY: THE PUBLIC POLICY ISSUES

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FOREWORD

This report has been prepared in response to H.R. No. 13, H.D. 1 and H.R. No. 14, H.D. 1 which were adopted during the 1989 Regular Session. House Resolution No. 13, H.D. 1 requests an examination of state tax credits to encourage individuals to purchase long-term care insurance. House Resolution No. 14, H.D. 1 requests an examination of credits to relieve families that care for the elderly who are ill.

Two years ago the Bureau submitted a report that addressed many of the same issues relating to long-term care insurance and state tax credits. This report supplements the previous study and re-examines the role of tax credits in the area of long-term care. Developments during the past two years have not altered the original report's primary finding that public information and education are probably the most important activities of state and local government in the area of long-term care for the elderly.

This report examines the public policy issues from the perspective of long-term care programs and in terms of the State's tax system, and finds that, under current conditions, neither long-term care policies nor tax policies would be supported by enactment of the tax credits suggested in H.R. Nos. 13 and 14. Instead, the report recommends using State resources to develop a comprehensive long-term care data base and, where appropriate, direct funding of the care needs documented by the data.

The population projections and related demographic statistics on long-term care reveal two factors that both public officials and program advocates should bear in mind. First, while the elderly are the largest portion of the population needing long-term care services, a number of other groups such as the developmentally disabled, mentally ill, and the growing number of AIDS patients also have significant and costly long-term care needs. Secondly, the fact that the elderly are projected to be the fastest growing segment of the population over the next 20 to 30 years creates a potential for inter-generational conflict over programs for the elderly and the ways they are funded. The time frame and magnitude of this population shift are dramatically illustrated by the series of population pyramids presented in Chapter 2. Questions about the fairness and costs of public services that use age as a key eligibility criterion can be expected to increase in coming years.

Readers should also bear in mind that major revisions to the medicare Catastrophic Coverage Act of 1988 are currently before Congress.

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INTRODUCTION

Long-term care for the elderly is a national problem. It crosses all age, income, ethnic and professional lines, as well as all political boundaries. While there is agreement that individuals, businesses and government each have a part in the delivery of long-term care for the elderly, the nature and extent of that participation is still the subject of much debate. Efforts to resolve the policy and technical issues include state and federal task forces charged with developing policy and program recommendations, and a number of special studies and demonstration projects funded by the private sector as well as government.

This report examines two proposals to use state income tax credits to support specific areas of long-term care; credits to encourage individuals to purchase long-term care insurance (H.R. No. 13, HD 1 (Appendix A)), and credits to provide relief to families that care for the ill elderly (H.R. No. 14, HD 1 (Appendix B)). Both resolutions, which were adopted by the House of Representatives of the State of Hawaii during the 1989 regular session, request the Legislative Reference Bureau (Bureau) to study the respective proposals. Both proposals raise the issue of the relationship between program policy and fiscal or tax policy, and for this reason their examination has been combined in one report.

Chapter 2 presents statistical and demographic data on the impaired elderly, their caregivers, and how their care is currently financed. Material in this chapter is based upon existing state and national data and a number of studies conducted by researchers in the field of long-term care.

The State's policy and plan for long-term care of the elderly is reviewed in Chapter 3, with related research and legislation discussed in Chapter 4. The long-term care plan developed by the Hawaii Executive Office on Aging is the primary source of this material.

Chapter 5 reviews long-term care insurance policies including the type of coverage generally offered and its costs. This chapter uses the findings of Mattson & Co.'s 1989 report to Hawaii's insurance commissioner, Consumer Reports' May 1988 survey, and the analysis conducted to develop the Brookings-ICF Long-Term Care Financing Model.

Hawaii's tax policies and the tax provisions of other states that relate to long-term care are summarized in Chapters 6 and 7. The material on other states is based on responses to a questionnaire sent to the tax departments of states that have special long-term care income tax provisions.

Examples of alternative approaches that have been suggested by researchers and policy advisors are presented in Chapter 8. Some of the alternatives are under consideration or being

tested as demonstration projects in other jurisdictions while others are purely conceptual at this time.

Each chapter concludes with a section on findings that are the basis for the report's conclusions and recommendations as presented in Chapter 9.

CHAPTER 2

LONG-TERM CARE DEMOGRAPHICS

The Elderly

Eleven per cent (114,000) of Hawaii's resident population was 65 years of age or older in 1988. By the year 2010 the total for this group is projected to increase to 188,000 and represent 13% of the State's population - an increase of 65% over the 22-year period. Increased life expectancies and the aging of the "baby boomers" will raise the median age of Hawaii's population from 32 to 35 over this period, and more than double the number of persons age 75 and older.

RESIDENT POPULATION[1]
(In Thousands)

AGE	1988	% OF TOTAL	1990	2000	2010	% OF TOTAL	% CHANGE 1988-2010
TOTAL	1098.0	100	1137.0	1285.0	1436.0	100	31
UNDER 65	985.0	89	1012.1	1123.7	1247.5	87	27
65-74	72.0	7	79.2	85.4	96.4	7	34
75-84	42.0*	4*	36.5	58.9	63.8	6*	119*
85+			10.0	17.0	28.0		
TOTAL 65+	114.0	11	125.7	161.3	188.2	13	65

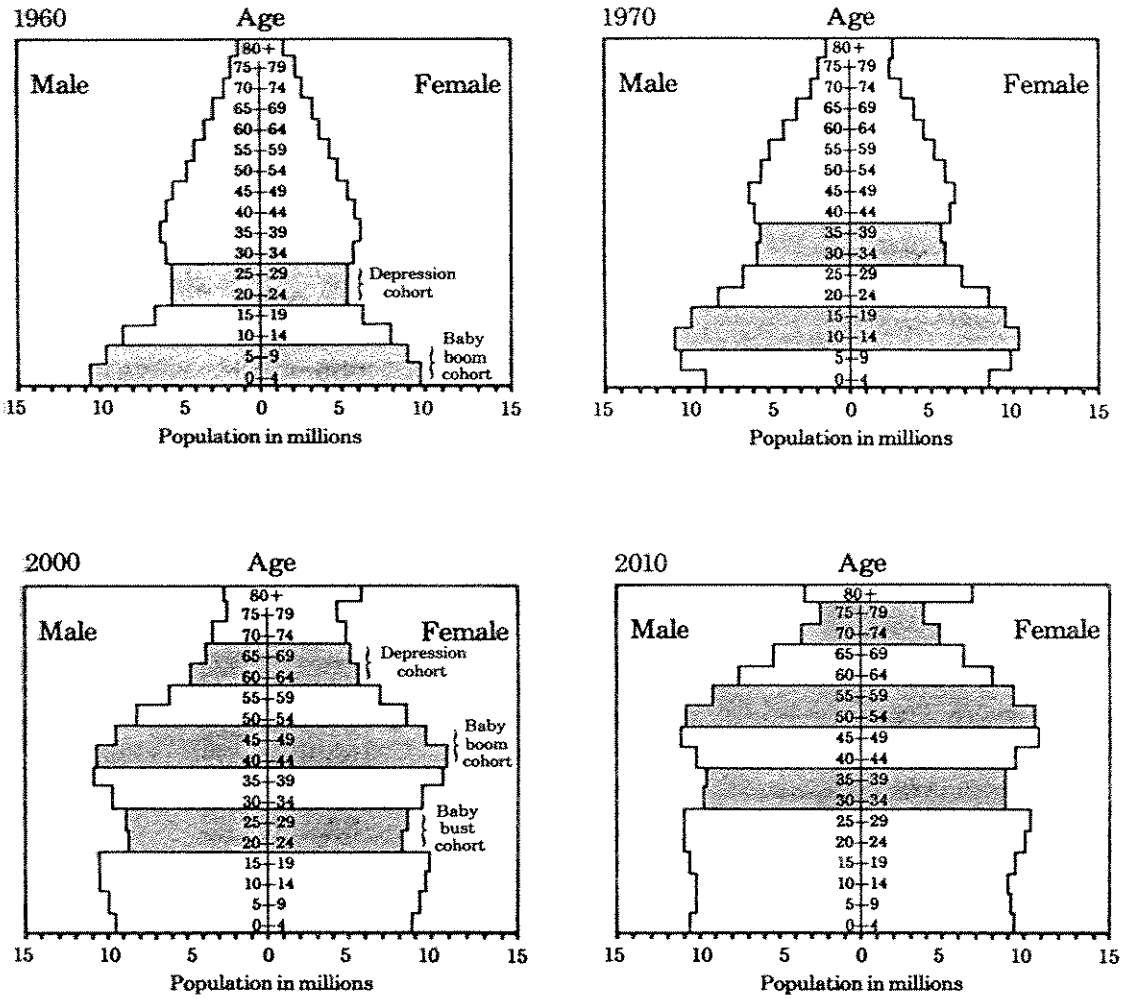
* Includes those age 85 and older.

The aging of the population is not limited to Hawaii. It is a well documented national trend, and its magnitude is dramatically illustrated in the traditional population pyramid. By the year 2030 the pyramid will, in fact, closely resemble a square (see Figure 1).

Hawaii individual income tax returns for 1986 showed claims for 86,000 age exemptions where the taxpayer and/or the taxpayer's spouse was age 65 or older. (The elderly who are dependents of non-elderly taxpayers are not eligible for the age 65+ exemption.) Income reported by the State's elderly taxpayers was $827 million or $9,616 per elderly exemption. This figure does not include social security and most pension and retirement benefits because such income is not taxable in Hawaii and need not be reported. Salaries and wages accounted for 28% of reported income, and "passive" income from dividends, interest and capital assets/property income accounted for another 56%. The average adjusted gross income (AGI) for taxpayers age 65 and older was nearly $14,000, while the average for all taxpayers was $19,600.[2]

FIGURE 1

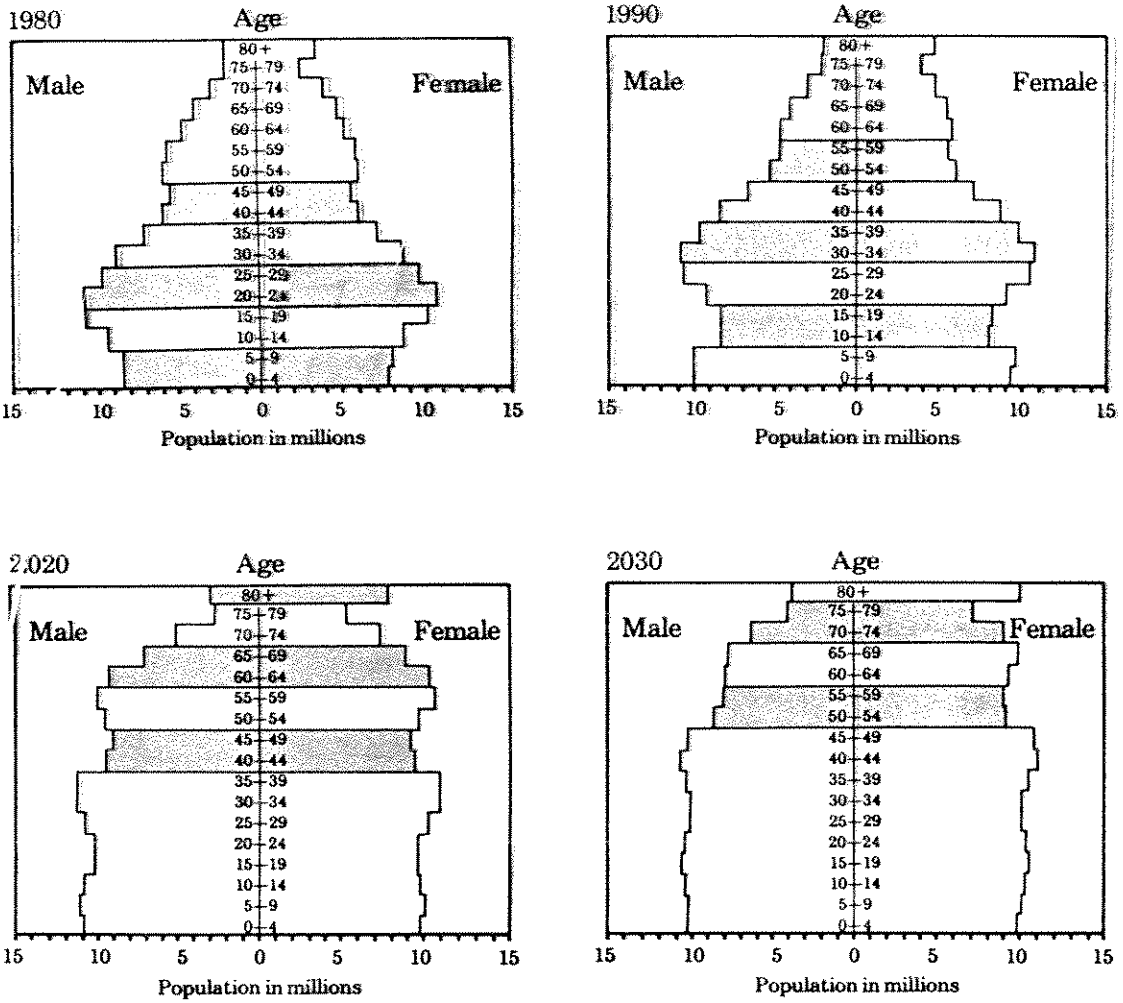
Population Pyramids, by Age and Sex,
United States 1960 - 2030



Depression cohort persons born 1930-39

Baby boom cohort persons born 1950-59

Baby bust cohort persons born 1970-79



Sources: Adapted from L. Bouvier, "America's Baby Boom Generation: The Fateful Bulge," *Population Bulletin*, vol. 35, no. 1 (Population Reference Bureau, Inc., Washington, DC, 1980); 1960-1970; U.S. Bureau of the Census, *1970 U.S. Census of Population: General Population Characteristics, United States Summary*, vol. 1, PC(1)-B1, 1972, Table 52; and 1980-2050; Special unpublished tabulations prepared by L. Bouvier for the Select Commission on Immigration and Refugee Policy, 1980.

Note: 1980-2050 projections assume a total fertility rate rising to 2.0 births per woman by 1985 and constant thereafter; life expectancy at birth rising to 72.8 years for males and 82.9 years for females by 2050; net immigration constant at 750,000 persons per year.

The 1986 distribution of adjusted gross income among returns claiming age exemptions showed a major clustering at the lower AGI brackets. Age exemptions for returns reporting AGI of $20,000 or less totaled 72,000, which accounts for 84% of the 86,000 age exemptions claimed. Fewer than 4,000 age exemptions were claimed on returns reporting AGI exceeding $50,000.

ADJUSTED GROSS INCOME OF
HAWAII RESIDENT TAXPAYERS AGE 65 AND OLDER[3]
1986 Tax Year

ADJUSTED GROSS INCOME	NUMBER OF AGE EXEMPTIONS	% OF TOTAL
$0-9,999	55,974	65
$10,000-19,999	15,943	19
$20,000-29,999	6,277	7
$30,000-30,999	2,690	3
$40,000-49,999	1,308	2
$50,000 & OVER	3,728	4
TOTAL AGE 65+ EXEMPTIONS CLAIMED	85,920	100

A study conducted for the Social Security Administration in the mid-1980's found that, nationally, the mean annual household income of the elderly from both taxable and non-taxable sources was $23,000 and net worth $110,000.[4]

Similar findings were reported for a 1983 survey of consumer finances conducted by the Federal Reserve Board. Mean annual income of $21,800 and financial assets of $65,300 were reported for households where the head of household was between the ages of 65 and 74. This compared with incomes of $26,300 and assets of $27,400 for all households surveyed.[5]

The Long-Term Care Population

Long-term care has been defined as "the help needed to cope, and sometimes to survive, when physical or mental disabilities impair the capacity to perform the basic activities of everyday life, such as eating, toileting, bathing, dressing, and moving about."[6] These basic activities are broken into two classes called "instrumental activities of daily living" (IADL's) and "activities of daily living" (ADL's). IADL's include household tasks such as cleaning, cooking, and shopping. ADL's are personal care activities such as bathing, eating, toileting, and dressing.[7]

Long-term care needs occur in all age groups and at all economic levels. An estimated 12% of Hawaii's population (127,000 persons in 1985) are classified by the Community Long Term Care Branch of the Hawaii Department of Human Services as "disabled," i.e., having "... a physical or mental impairment which substantially limits one or more of such person's life activities" including a record for such an impairment or being regarded as having one.[8] This total includes the developmentally disabled, chronically mentally ill, and catastrophically ill as well as the disabled elderly.

The Disabled Elderly

The Long Term Care Branch estimates that, in 1985, persons age 65 and older with activity limitations numbered 76,000 and represented a significant majority of the State's disabled population. Some 14,000, or 15% of the elderly with activity limitations, were estimated to be eligible for medicaid. Projections to the year 2000 show the State's disabled population increasing to 152,000 and the number of elderly with activity limitations rising to 106,000, of whom 22,000 will be medicaid eligible[9] (see Appendix C).

According to Hawaii's Executive Office on Aging (EOA), 15% of those between the ages of 60 and 74 suffer from moderate to severe impairments, while the comparable rate for the age 75+ group is 34%.[10] Given these figures, Hawaii residents age 65 and older with moderate to severe impairments can be estimated to be 25,000 for 1988. This is slightly more than one-fifth (22%) of those age 65 and older, and represents 2% of the State's total resident population for that year. This estimate indicates that, of the total number of elderly with activity limitations, approximately one-third are impaired to the extent that care services are probably needed.

NUMBER OF ELDERLY WITH MODERATE TO SEVERE IMPAIRMENTS[11]
1988 and 1990 Estimates

AGE	1988	1990
65-74	11,000	12,000
75+	14,000	22,000
TOTAL	25,000	34,000
IMPAIRED AS A % OF ALL 65+	22%	27%

The EOA estimates are supported by national figures showing that while 76% of the elderly are fully independent, the probability of having an IADL or ADL impairment increases from less than 13% in the age 65-69 group to over 55% for those over age 84.[12]

Informal or Home Care for the Elderly

The EOA reports that an estimated 80-85% of long-term care in Hawaii is provided informally by family and friends[13] indicating that some 20,000 to 21,000 of the moderately to severely impaired are cared for in this manner.

NUMBER OF MODERATELY/SEVERELY IMPAIRED ELDERLY RECEIVING INFORMAL CARE
1988 and 1990 Estimates

	1988	1990
LOW ESTIMATE	20,000	27,000
HIGH ESTIMATE	21,000	34,000
IMPAIRED ELDERLY RECEIVING INFORMAL CARE AS A % OF ALL 65+	18%	21-23%

Analysis of 1985 national survey data shows that one-third of the dependent elderly live with their spouse, 24% live alone, and 21% live with others. Twenty-three per cent are residents of nursing homes or board and care facilities.[14]

NUMBER OF MODERATELY/SEVERELY IMPAIRED ELDERLY BY PRIMARY SOURCE OF CARE

(Based on 1985 National Living Arrangement Data)

LIVING ARRANGEMENT	1988	1990
WITH SPOUSE	8,000	11,000
WITH OTHERS	5,000	7,000
ALONE	6,000	8,000
INSTITUTION/OTHER	6,000	8,000
TOTAL	25,000	34,000

Assuming that living arrangement correlates with the source of care and that Hawaii follows the national pattern, a rough estimate can be made that the primary caregivers for Hawaii's non-institutionalized impaired elderly are spouses (40%) and other family or close friends in a household environment (25%).

A series of national surveys found the following with regard to informal caregivers:

- 68% of informal caregivers are 45 years of age or older,
- 72% of caregivers are female (60% are wives or daughters of the disabled person and 12% are other females),
- 61% of children who are caregivers share a household with the care recipient,
- 33% of all informal caregivers are employed outside the home, and
- 57% of caregivers reported no additional expense incurred as the result of their care activities, and nearly 80% reported care expenses of $50 or less per month.[15]

While the majority of informal caregivers reported care costs of $600 or less per year, costs of up to $10,000 per year have been cited.[16] When home care is provided wholly or in part by paid caregivers or includes formal medical services, out-of-pocket expenses will be significantly greater than is the case when care is primarily household or personal care provided by family members.

In 1987, the City and County of Honolulu Office of Human Resources' Elderly Affairs Division surveyed caregivers through the Caregiver-to-Caregiver newsletter. The 115 usable responses received reflected a response rate of 4% of the 3,100 questionnaires distributed and is too small to be statistically significant. However, it does indicate a local pattern similar in many respects to the findings of national caregiver surveys.[17]

The average age of caregivers was 60 and three-fourths were female. About one-half of care recipients were parents of the caregiver and 39% were spouses. When asked what would be most helpful, two-thirds said emergency help in case the caregiver gets sick, and 45% said respite service. Only 21% said financial assistance would be helpful. However, 46% responded favorably to a tax credit that would, in fact, be financial assistance.[18]

Nearly 70% of care recipients were age 75 or older and 80% lived with the caregiver. Nearly 90% reported that skilled care procedures were not required. The most common ADL limitations reported were bathing and dressing/grooming. Fifty per cent reported eight or more IADL limitations from a list that included transportation, shopping, housework, getting around outside, laundry, cooking, handling finances, taking medicine, and using the telephone.[19]

Institutional Care for the Elderly

Those with multiple or severe impairments are more likely to be cared for in an institution and to be age 75 or older. Data on nursing home utilization in Hawaii show that 80% of the State's long-term care beds are occupied by persons in this age group.[20] Thus, of Hawaii's 3,750[21] nursing home beds in service or approved as of September 1987, some 3,000 are

serving the portion of the elderly population with the highest probability of need for institutional care. In 1986, the average length of stay in Hawaii's long-term care beds ranged from 95 days on Molokai to 419 days on Oahu.[22]

Occupancy rates for Hawaii's long-term care facilities have consistently been quite high and are expected to remain so in the future (see Table 1). These rates indicate full utilization of the State's long-term care beds, and may mask a significant level of unmet demand. Staff shortages, rather than insufficient physical plant, are cited as the primary factor behind current and future unmet care needs - both institutional and non-institutional.[23] Low pay, lack of employment benefits, and low job status make careers in long-term care unattractive to many who might otherwise consider entering the field.[24]

Nationally, characteristics of the elderly in nursing homes include the following:

- older women are twice as likely as older men to be in a nursing home,
- the most frequently experienced ADL limitations of nursing home residents are bathing and dressing,
- 63% of nursing home residents experienced disorientation or memory impairment,
- more than one-half of nursing home residents were admitted from either a hospital or another nursing home,
- similarly, 60% of those discharged from a nursing home are transferred to a hospital (49%) or another nursing home (11%),
- 30% of those discharged transfer to a private residence.[25]

Annual costs of nursing home care vary widely depending upon the level of services provided. Average costs in the western states range from $21,170 for skilled care to $10,585 for residential care.[26] In Hawaii, the average is $36,000, with typical costs running between $30,000 and $35,000.[27] Figures of up to $40,000 have been cited.[28]

TABLE 1

Occupancy Rates by Counties
State of Hawaii 1981 - 1986

	1981	1982	1983	1984	1985	1986
LONG TERM CARE						
Oahu	94.4	96.0	95.4	97.3	97.2	90.5
Hawaii	95.3	82.9	94.6	95.2	95.3	93.8
Kauai	101.2	99.8	94.5	96.3	91.1	83.0
Tri-Isle	93.2	94.9	96.8	92.6	97.0	97.3
Maui	94.4	95.4	97.5	95.0	97.0	97.6
Molokai	78.3	92.5	97.6	55.8	96.8	89.3
Lanai	68.8	77.5	66.6	95.1	84.9	*

*data not available

Source: Statistical Report, Department of Health, State of Hawaii, 1986, p. 83.

Financing Long-Term Care for the Elderly

Medical Care: Most medical services for the disabled elderly are financed either by medicaid or medicare. Medicaid is a means-tested welfare system designed to deliver medical care to the poor without regard to age, including physician-prescribed nursing-home care.[29] In 1985, medicaid accounted for just under one-half of nursing home expenditures in the United States with out-of-pocket spending covering the other half. About 1% was covered by long-term care insurance.[30] Medicaid coverage of home care may be available under special state-initiated waiver programs. (Hawaii's Long Term Care Branch of the Department of Human Services provides medicaid-funded home care services for some 350 medically needy of all ages under the Nursing Home Without Walls Program.)[31]

Medicare is the general public health insurance program for the elderly and is designed to cover the cost of physicians, hospitals and specific related services such as physical and occupational therapy when prescribed by a physician. It covers the cost of some non-institutional care if it is medically necessary.[32] Medicare payments represented only 2% of nursing home payments in 1985.[33] This will probably increase under the new federal Catastrophic Coverage Act that includes physician-prescribed nursing home care for up to 150 days per year, effective January 1, 1989.

Long-term care: Long-term care other than care that is medically necessary is not funded under medicare. Medically necessary long-term institutional care is eligible for medicaid funding if the individual meets the low-income requirements of the program. Since most long-term care is not primarily medical, it must be financed with private funds. Thus, virtually all non-medical

home and custodial care, and nursing home services for persons other than the poor is privately financed.

Findings

Eleven per cent or 114,000 of Hawaii's resident population is age 65 or older. By the year 2010 a projected 65% increase will bring this total to 188,000.

A majority of the elderly are economically independent with financial resources comparable to the general population. In 1986, Hawaii income tax returns filed by persons age 65 or older show 84% with adjusted gross income (AGI) of $20,000 or less, with average AGI of $14,000 as compared with $19,600 for all taxpayers. AGI significantly understates the financial resources of the elderly because it does not include social security, most pension and retirement benefits, or the value of accumulated assets. National data show the elderly with an average income of $21,000 to $22,000 and assets valued in excess of $75,000.

An estimated 25,000 of Hawaii's 114,000 persons age 65 or older are moderately to severely impaired. Of this group, 14,000 are age 75 or older. Some 20,000 to 21,000 impaired elderly are cared for informally by family or friends. More than 3,000 are cared for in the 3,750 long-term care beds available in the State's skilled nursing and intermediate care facilities.

Hawaii's long-term care beds have been and are expected to continue to be fully utilized, with typical occupancy rates well above 90%. Chronic high occupancy may reflect a significant level of unmet demand for institutional care. An acute lack of properly trained staff is the primary factor behind unmet demand, and low pay, poor employment benefits, and low job status make the field unattractive to many.

Statistically significant data on informal caregivers and recipients in Hawaii are not available. National surveys show the majority to be women, age 45 and older, who are relatives of the impaired person. One-third of informal caregivers are also employed outside the home. Informal caregivers report minimal direct costs attributable to their care activities.

Data indicate that 40% of primary caregivers are the spouse of the impaired person and 25% are other family or friends. The latter figure may be higher in Hawaii.

National surveys indicate that women are twice as likely as men to be in a nursing home. Most nursing home residents were admitted from a hospital or another nursing home and will be discharged to another facility rather than to a private home. These persons usually experience disorientation or memory impairment, and require assistance in bathing and dressing. The average length of stay in Hawaii's long-term care beds ranged from 95 days (Molokai) to 419 (Oahu) in 1986.

The costs of institutional care vary depending upon the types of care required. Annual averages in the western states range from $10,000 to $21,000. Hawaii's average is $36,000 per year.

Medically necessary care provided in an institutional setting is generally covered by medicaid or medicare, as are some medically necessary services provided in custodial facilities or in the home.

Many long-term care needs are for assistance with bathing, dressing and transportation, shopping, cleaning, and similar activities of daily life, and are not primarily medical unless associated with a specific illness or other medical event. The cost of care to meet these needs is not covered by medicaid or medicare.

CHAPTER 3

LONG-TERM CARE POLICY FOR THE ELDERLY

The State Constitution

Article IX, section 4, of Hawaii's constitution states that:

> The State shall have the power to provide for the security of the elderly by establishing and promoting programs to assure their economic and social well-being.

State Law

The State's purpose, policies, and responsibilities regarding the elderly are set forth in chapter 349, Hawaii Revised Statutes. This chapter establishes the Executive Office on Aging (EOA) within the Office of the Governor, designates the EOA as the single state agency responsible for programs affecting senior citizens, and directs all state and county agencies serving the elderly to coordinate their activities with the EOA.

Among the goals specifically identified as state and county responsibilities with regard to the elderly are:

- The best possible physical and mental health which science can make available, without regard to economic status.
- Full restorative services for those who require institutional care.
- Efficient community services which provide social assistance in a coordinated manner and which are readily available when needed.[1]

The law provides that the elderly, state and local government, and the community at-large are to work in partnership to "make available comprehensive programs which include a full range of health, education, and social services to our older residents who need them."[2] The policy statement also specifies that the programs shall, "...pending the availability of such programs for all older residents, give priority to the elderly with the greatest economic and social need."[3]

The State Plan for Long-Term Care

The EOA is the State's advocate for the elderly. Among its duties is the development, implementation and updating of a comprehensive state master plan for the elderly. The Long Term Care Plan for Hawaii's Older Adults - A First Step in Planned Care,[4] identifies the policies and goals for long-term care that are a key element of the master plan. Within the long-term care plan, the issue of financing is a priority consideration. Specifically, the plan states that the finance-related issues are:

- how to impel the federal government to recognize that the long-term care of elders is a national issue requiring federal leadership in the form of substantive initiatives;

- how to best finance both community-based and institutional long-term care costs using a mixed funding approach which:

  - is fiscally responsible,
  - provides adequate coverage,
  - stimulates private sector and personal initiatives, and
  - assures the appropriate use of Medicaid funding;

- how best to generate public revenues for governmental initiatives in long-term care;

- how to encourage private sector involvement in a partnership with the public sector in the financing of long-term care;

- how best to control long-term care costs in both community-based and institutional settings; and

- how best to protect members of the older adult gap group from personal/spousal impoverishment due to long-term or catastrophic illness.[5]

The plan's policy objectives with respect to financing are aimed at protecting individuals from impoverishment due to long-term care costs while conserving limited state funds. These objectives are:

- ensuring that the federal government develop a national long-term care program;

- shifting the focus of finance and other mechanisms so that community-based and home care services are developed and covered to sufficient quantity;

- supporting family caregiving efforts;

- stimulating public-private sector partnership around financing options; and

- increasing public awareness about long-term care issues and costs to permit ample opportunity for individual planning and action.[6]

While advocating the development of a national policy to address long-term care costs, the plan also recommends development of a state funding mechanism that:

...may take the form of:

- a payroll-based tax to undergird a long-term care fund which would pay for private insurance coverage or for long-term care costs, including community-based and home care;

- a universal long-term care insurance plan for older adults in the state, using an incremental approach, if necessary, beginning with the coverage of retired state workers and/or members of large organizations through group coverage;

- inheritance tax credit to estates for gifts made to a state-administered long-term care fund for home care;

- a tax credit for matching corporate contributions for voluntary employee purchase of long-term care insurance;

- loans to present and retired state workers from the state retirement fund at sub-market rates to qualified homeowners for the purpose of home modification to keep older adults at home;

- tax relief for the purchase of medical or long-term care IRA's (individual retirement accounts); and/or

- a state lottery with proceeds earmarked for long-term care.[7] (Emphasis added.)

The plan encourages the State to institute policy options to encourage development of community-based and home care and to acknowledge the fact that they are the preferred methods of care of older adults. The alternatives identified include:

- tax relief to families providing care at home;
- tax credit for the purchase of long-term care insurance, including community-based and home care;
- extend the tax credit, which is currently available, for household and dependent care expenses to include impaired older persons who are considered non-dependent relatives of caregivers;
- tax incentives to encourage employers to include long-term care provisions and programs in employee benefit packages;
- the enactment of legislation to establish the use of a sliding fee scale for publicly funded services to stimulate an availability of services to all in need, regardless of income;
- the amendment of the State's medicaid plan to include community-based long-term care services and programs such as case management, personal care, and others.[8]

Findings

By statute, public policy with respect to the elderly in Hawaii:

- identifies the need for a full range of comprehensive programs to serve the elderly;
- places responsibility for "... performance, development, and control of programs, policies, and activities on behalf of the elderly"[9] with the governor's executive office on aging; and
- gives priority to those in the greatest economic and social need.

The Executive Office on Aging's Long-Term Care Plan reflects this policy. The plan states that community-based and home care are preferred by the elderly and urges state support for their development. It identifies financing as a priority concern, long-term care insurance as a method to pay for some of the long-term care needs of some elderly, and state tax credits as one of several possible incentives for the purchase of long-term care insurance and as a way to support family caregiving efforts.

The plan recommends that a state funding mechanism for long-term care be developed. However, the alternatives identified are not presented as a financing plan for long-term care, nor is implementation being recommended by the EOA. They are a list of separate options that,

upon further consideration, may be found to be appropriate methods for financing long-term care.

CHAPTER 4

RELATED RESEARCH AND LEGISLATION

Hawaii's long-term care plan is supported by other research activities and specific legislation at both state and federal levels. This chapter provides an overview of the recent activities in the areas of long-term care insurance and informal family care.

Hawaii

The Legislative Reference Bureau's report, Assuring Dignity in Long-Term Care for the Elderly,[1] examined the issue of long-term care, and the roles of medicare, medicaid, and private financing mechanisms in funding long-term care. The report focused on private long-term care insurance, and the advantages and disadvantages of using state tax credits to stimulate the development and purchase of properly regulated policies.

The report's analysis of long-term care insurance products found that:

- long-term care insurance, while not a panacea, offers a viable and immediate alternative to dependency on medicaid for institutional care,
- the long-term care insurance policies available in 1987 were institutionally biased (i.e., covered institutional care while offering little or no coverage for home or community-based care), and could hinder the development of community-based care alternatives, and
- although still evolving, long-term care insurance is more established than alternatives such as social health maintenance organizations, and tax-deferred individual medical accounts.[2]

The report further found that a state personal income tax credit for long-term care insurance premiums:

- would result in revenue losses that would increase because claims would be cumulative each year,
- could benefit the elderly at all income levels,
- could benefit the elderly with no tax liability or those for whom a policy is too expensive if the credit were not limited to insureds, and could be an incentive for relatives of the elderly to purchase coverage for them, and

- may be a desirable way to inform the public about long-term care issues.[3]

The report pointed out that state financial support for consumer awareness efforts can be provided either directly through specific program appropriations, or indirectly through tax incentives such as credits or deductions, or both - a decision that rests with the legislature.[4] It recommended that, first, with or without a tax credit, the State should assume a more active role in consumer education, and that funds should be provided to the Executive Office on Aging to develop and plan a comprehensive public education program on long-term care for the elderly.[5] Second, any tax credit should be established only in conjunction with appropriate guidelines (such as the National Association of Insurance Commissioners 1986 model legislation) for the sale of acceptable policies. Should a credit be enacted, the report recommended that:

- the value of the credit not exceed 50% of the premium paid,
- taxpayers be allowed to claim credits for more than one policy and for policies purchased to insure another,
- a dollar ceiling for the credit on each policy be established (e.g., 50% of the average for policies that meet minimum qualifying standards),
- a maximum (e.g., $1,000) be established for the total credit any taxpayer may claim for the tax year,
- a provision be included allowing excess credits to be carried over for the next tax year, and
- the credit be designed with an income limitation and a declining percentage of premium costs allowed as income rises.[6]

The third and final recommendation was to consider tax incentives that encourage the development of community-based non-institutional forms of long-term care including those families caring for the frail elderly at home.[7]

Related Legislative Actions: Act 253, Session Laws of Hawaii 1987, adopted the National Association of Insurance Commissioners' long-term care model legislation. The law establishes disclosure standards and gives the insurance commissioner power to enforce compliance. This measure was replaced by Act 335, SLH 1989.

An appropriation was made to EOA in 1988 to implement a demonstration public-awareness program on long-term care insurance.[8]

The 1989 regular session of the Legislature adopted Senate Concurrent Resolution No. 137 and House Resolution No. 13, H.D. 1, requesting the Legislative Auditor and Legislative

Reference Bureau (Bureau), respectively, to examine earmarking of excise tax collections on medical services to provide funds for long-term care insurance. H.R. No. 13, H.D. 1, further requested a study of state tax credits to stimulate the purchase of long-term care insurance.

House Resolution No. 14, H.D. 1, also adopted in 1989, requests the Bureau to estimate the number of persons eligible for a tax credit for care of the frail elderly at home, and to examine alternative methods to provide relief to informal caregivers.

The Bureau's report, Employer-Assisted Dependent Care,[9] examined the State's role in meeting dependent care needs of Hawaii's labor force. The report found that both Hawaii and federal income tax laws allow employers to establish Dependent Care Assistance Plans (DCAP's) for their employees. These plans offer significant tax savings to those with qualified work-related dependent care expenses, and may be used for the care of elderly dependents as well as children. The expenses must be incurred in order to allow the taxpayer to be employed, and the dependent must be:

- under age 15[10] and eligible to be claimed as the taxpayer's personal deduction,
- a dependent who could be claimed as a personal deduction except for having gross income of $1,900 or more, but is physically or mentally unable to care for one's self, or
- a spouse who is physically or mentally unable to care for one's self.[11]

Similar provisions apply to the child and dependent care tax credits that are also available under both Hawaii and federal tax laws.[12]

The report recommended that the State (1) encourage the use of DCAP's by establishing a DCAP informational and technical assistance program for private employers,[13] and (2) offer salary reduction DCAPs as a voluntary employee-funded fringe benefit to state employees.[14]

Related Legislative Actions: Act 63, Session Laws of Hawaii 1989, allows the State and counties to establish cafeteria plans within the meaning of section 125 of the Internal Revenue Code for state and county employees. DCAPs are among the programs that can be offered under cafeteria plans.

Acts 321 and 322, Session Laws of Hawaii 1989, amended the state dependent care tax credit by:

- allowing credits that exceed tax liability to be refunded to the taxpayer,

- increasing from $10,000 to $22,000 the amount of adjusted gross income (AGI) above which the percentage credit is to be reduced by 1% for each $2,000 of additional AGI, and

- increasing the maximum percentage of eligible care expenses from 15% to 25% and the minimum from 10% to 15%.

Act 321 also established a new "medical services excise tax credit" equal to 4% of all medical expenses allowed as deductions under section 213 of the Internal Revenue Code (medical, dental, etc.). The maximum credit in any tax year is $200 per return, $400 for claimants age 65 or older, or $600 when the claimant and spouse are age 65 or older. Credits in excess of tax liability are to be refunded. The cost of capital improvements, prescription drugs or prosthetic devices are not eligible expenses, and the medical expenses claimed must have been subject to the general excise tax. The credit is effective until December 31, 1991.

Mattson & Co.'s January 1989 Report on the Feasibility of Providing Long-Term Care Insurance for Enrollees of the Hawaii Public Employees Health Fund[16] examined long-term care insurance products currently available, specifically those offered to state employees in Alaska and Maryland, and the related public policy issues. The report presented proposed bid specifications and funding recommendations.

While noting that the suggested program is clearly feasible, since similar programs have been established by two other states, the report did not recommend whether Hawaii should offer long-term care insurance to its public employees. The following policy issues were raised as factors that may make establishing the program premature:

- quality of care,

- lack of facilities,

- need for public education regarding long-term care,

- need for a multi-faceted approach to financing long-term care of which insurance is only one element,

- need to coordinate any state efforts with federal programs and possible changes in those programs that are currently under consideration by Congress, and

- the assessment that a number of currently available long-term care insurance products do not adequately meet consumers' needs.[17]

The report recommended 100% employee-funded premiums, but noted that precedent exists for employer-employee cost sharing of certain fringe benefits of state and county worke

Related Legislative Actions: Act 334, Session Laws of Hawaii 1989, authorized the board of the public employees health fund to provide and administer a voluntary long-term care insurance plan for employee-beneficiaries and their spouses. During the first three months of enrollment, public employees retirement system retirees will be eligible to enroll. The plan shall provide not less than twelve consecutive months coverage for one or more medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services in a setting other than an acute care hospital unit. The Legislature appropriated $72,700 to implement the plan. The plan is to be financed entirely by employee contributions.

National

In September of 1987, the Department of Health and Human Services' Task Force on Long-Term Health Care Policies submitted its Report to Congress and the Secretary. The Task Force concluded that long-term care insurance can provide financial protection to individuals and may reduce medicaid expenditures for some by preventing them from becoming dependent upon medicaid. It also found that properly designed policies could increase the care options available and become an integral part of a person's financial plan. The Task Force did not take a position on the public sector's role in direct financing of long-term care, including social insurance. However, there was a consensus that increased public spending is not likely in the immediate future, and that private insurance offers the best means, at present, for financing long-term care.[18]

Critical factors in the further development of private long-term care insurance identified by the Task Force include:

- consumer awareness of the absence of long-term care coverage under existing health programs, the long-term care coverage that is available, and the potential costs of long-term care,
- consumer protection through regulation of insurance products,
- market development by developing a data base to assist insurers design and price policies that meet long-term care needs and allow development of new policies as needs change,
- market development through employer-sponsored long-term care insurance, and
- tax incentives that address tax treatment of industry reserves, employer-sponsored plans and vested retirement funds.[19]

The highest priority recommendations of the Task Force addressed these issues as follows:

1. Inform consumers that Medicare, Medigap, and acute health care insurance do not cover long-term care.

2. Encourage states to adopt the national association of insurance commissioners model long-term care insurance act.

3. Promote the availability of long-term care insurance through employment.

4. Develop long-term care insurance financing through vested pension funds.

5. Use federal and state tax codes to encourage the purchase of long-term care insurance.

6. Encourage new approaches to determine eligibility for long-term care insurance benefits.

7. Encourage greater cooperation in the collection and sharing of long-term care data.[20]

The report's recommendations for tax incentives relate to the federal tax code. The specific recommendations for industry incentives are that reserves and related investment earnings held by insurers be treated the same as the reserves and earnings of other insurance products.[21] Similarly, premiums and benefits of long-term care insurance should be treated the same as medical insurance premiums and benefits.[22]

To encourage employer-sponsorship of long-term care insurance as an employee fringe benefit, the report recommended that:

- long-term care insurance should be a permitted section 125 cafeteria plan benefit,

- incentives for employers to pre-fund health and long-term care benefits that were eliminated by the Deficit Recovery Act of 1984 should be restored, and

- transfers from over-funded pension plans to retiree welfare plans should not be taxed.[23]

Individuals should be allowed to make tax-free transfers from their pension and retirement vehicles (IRA's, life insurance, annuities, post-retirement income, etc.) to buy long-term care insurance.[24]

The Task Force encouraged states to enact tax provisions that conform to the proposed federal incentives.

The Medicare Catastrophic Coverage Act of 1988[25] does not cover long-term care. However, acute hospital care, 150 days of medically necessary physician-prescribed skilled nursing home care and, in limited situations, certain home health care services are now eligible for either full or substantial medicare financing. The extended coverage is funded with a new premium on medicare Part A beneficiaries.[26]

The Catastrophic Coverage Act of 1988 also liberalized the asset and resource restrictions on medicaid eligibility[27] that had required some individuals and their spouses to "spend down" to the point of impoverishment in order to be eligible for medicaid nursing home coverage.[28] The Act requires the Secretary of the Treasury to study federal tax incentives to encourage individuals to purchase long-term care insurance. Recommended statutory changes were to have been presented to Congress by November 30, 1988.[29]

Caring for the Disabled Elderly, Who Will Pay[30] is a comprehensive study of the issues and options for long-term care financing that confront today's policy makers. The authors developed a demographic model[31] to project the size and key characteristics of the nation's elderly population, and used it to test a variety of financing alternatives for long-term care.

The study concluded that:

- the need for long-term care is a natural part of the aging process,
- risk pooling is appropriate for financing long-term care,
- both public and private resources will be required to pay for long-term care,
- the primary source of public sector financing should be a social insurance program rather than a means-tested welfare program, and
- there are a variety of ways public and private sector financing can be interfaced to finance long-term care efficiently.[32]

The report's basic recommendations were that, (1) private insurance and other forms of risk-pooling be encouraged and expanded, and (2) medicaid be replaced with public insurance.[33] Hawaii's Executive Office on Aging has contracted to have a similar model developed specifically for Hawaii's elderly.

The Robert Wood Johnson Foundation has undertaken the Program to Promote Long-Term Care Insurance for the Elderly. The Foundation has awarded planning grants to eight states to design demonstration programs that will allow them to gather experience in insuring long-term care. The states participating in the program are Massachusetts, Connecticut, Wisconsin, Indiana, New Jersey, New York, California and Oregon. The University of Maryland Center on Aging is providing direction and technical assistance. This is a multi-year program.

The first planning grant was awarded September 1987, and most are scheduled for completion by the end of calendar 1989. The demonstration project(s) in each state will begin after completion and review of the results of the planning phase.[34]

Findings

A number of studies conducted in the past few years have examined specific issues relating to long-term care including long-term care insurance and aspects of home care. The studies agree that:

- long-term care insurance is a new and rapidly changing product,
- too few policies have been issued and those that have have been in force for too brief a period to allow definitive evaluation at this time,
- the states should regulate and monitor long-term care insurance,
- a strong educational effort is needed to inform the public about long-term care issues generally, including the advantages and disadvantages of the long-term care insurance policies currently on the market,
- while government should encourage the development of long-term care insurance, direct public funding of long-term care insurance or endorsement of specific policies is not recommended,
- long-term care insurance has the potential to assume a much greater share of long-term care costs, particularly for institutional care, and
- a number of long-term care policies do not meet consumer needs, particularly with regard to home and community-based care.

Both nationally and in Hawaii, the research on long-term care insurance has not been balanced by corresponding efforts in the area of informal home and community-based care.

The Hawaii legislature has enacted a number of measures that are responsive to the recommendations of researchers and policy advisors with regard to long-term care. The insurance commissioner has been given the recommended regulatory and monitoring powers, a major public information program was directly funded, and the State as an employer will be offering group long-term care insurance to its employees. Funds have been appropriated to the EOA to develop a long-term care financing model, and to survey Hawaii's state workers with regard to long-term care.

In the area of taxation, the State provides dependent care tax credits and the 1989 legislature increased both the maximum credit and the income limits of the program. A new credit to offset the general excise tax on medical services was established on a temporary basis, and the authority to establish cafeteria plans for dependent care expenses of state workers has been enacted. Both state and federal tax savings are available to employers who sponsor eligible dependent care assistance plans and to their employees.

CHAPTER 5

LONG-TERM CARE INSURANCE

> [L]ong-term care insurance means any insurance policy or similar health benefits plan which is designed for or marketed as paying benefits for the care of a policyholder who, due to chronic illness or infirmity, is unable to perform activities of daily living for an extended period of time. Such covered care includes health care services such as nursing home care, personal care, and home health care or related services which may include home and community-based services, or both. Long-term care insurance does not include medicare supplement insurance policies, as defined under section 431-771, Hawaii Revised Statutes, which are designed primarily as supplements to reimbursements under Medicare for hospital, medical, or surgical expenses.[1]

Long-term care insurance is a new insurance product that is still being developed. In 1985, some 125,000 policies were in effect nationwide and the field was dominated by two insurers.[2] By 1986, the number of policies had increased to 200,000[3] and, by mid-1987, the federal Task Force on Long-Term Health Care Policies was able to identify 423,000 that had been sold.[4] The Congressional Research Service (CRS) reported an estimated 1.1 million persons covered under individual long-term care policies and an additional 20,000 under employer-sponsored plans by the end of 1988.[5] Today, most major insurance companies offer long-term care policies, although some are issued on a limited basis.[6] Some 40 companies are registered to sell long-term care insurance in Hawaii, and coverage is also available as a rider to some health insurance policies.

This chapter relies on three recent studies that have surveyed long-term care insurance policies.[7] As summarized in chapter 4, Mattson & Co.'s report examined the group long-term care insurance coverage available to public employees in Maryland and Alaska, as well as a representative group of policies available to individuals. (See Appendix D for the policy summaries and the details of typical specimen policies from the Mattson report.)

In May 1988, Consumer Reports evaluated and rated long-term care insurance policies. Data was requested from 81 companies offering or planning to offer long-term care insurance. Both group and individually offered policies were included in the analysis.[8]

The third major review of long-term care insurance policies was conducted by Alice Rivlin and Joshua Wiener as part of their comprehensive analysis of long-term care financing. They examined thirty-one policies available during 1986 with attention given to premium costs, exclusions or restrictions on purchasing policies and length of coverage.[9]

While these surveys were conducted at different times, used different sample sizes, and were conducted for different purposes, they all identified certain key aspects of the long-term care policies available in today's market. (Readers should refer to the original reports for specific details.) The reports show that a "typical" long-term care insurance policy includes the following provisions:

Premiums

- Premiums are based on the age of the insured at the time of purchase, with lower premiums for younger applicants. The premium remains the same as the insured ages.

- Premiums vary depending upon the specific coverage selected. The more limited the coverage the lower the premium.

- Premiums are waived when the insured has been under nursing home care for a specific period, usually 90 days.

- The Rivlin study reported average annual premiums for a low-option policy of $318 and an average of $684 for high-option coverage for applicants age 65.[10]

- The Consumer Reports evaluation reflected premiums for a person age 65 ranging from just under $200 per year to over $1,000.[11]

Coverage

- Coverage is restricted to care that is medically necessary as prescribed or recommended by a physician.

- Policies are designed to pay benefits when specific services are provided in an institution, usually a licensed skilled-nursing home. Medically necessary home or custodial care when following a specified number of days in a skilled nursing home is increasingly available.

- Benefits are a fixed dollar amount per day paid directly to the insured (indemnity benefits) without regard to the actual cost of the service provided. Policies offer a range of from $25 to $100 per day for care in a skilled nursing facility with lower daily benefits for lower levels of care (intermediate and custodial).

- Coverage does not start until a "deductible" period of care has elapsed. Payment for this period is the responsibility of the beneficiary.

- Coverage may require that care in a skilled nursing facility be preceded by a minimum number of days in an acute care hospital and, similarly, that home or custodial care be preceded by skilled nursing care. (This mandatory care sequence provision is less common than was the case in policies issued a few years ago.)

- A maximum number of days for a continuous period of care limits the coverage. This is often 2 years or more.

- Coverage is available for Alzheimer's patients.

Eligibility

- Whether for group or individual policies, applicants must answer a series of questions on their medical history and condition when applying for long-term care insurance. A company may also require a personal interview with an insurance agent.

- There are no true group policies on today's market and insurers retain the right to refuse coverage to high risk individuals.

- Applicants with pre-existing medical conditions can purchase a policy, but must complete a period free of treatment for that condition before coverage becomes effective. This waiting period is usually at least three months and may be up to a year.

- Once the policy is issued, renewal is guaranteed so long as the coverage is offered in the insured's state and the insured's premium payments are current.

Industry Issues

The insurance industry is aware that a significant market exists or can be developed for long-term care insurance. However, in designing and marketing products, insurers have tried to avoid "adverse selection" where only high-risk individuals purchase coverage. Concern also has been expressed that "moral hazard" will occur. "Moral hazard" refers to situations where demand for the insured benefit increases simply because coverage has been purchased. A number of the coverage provisions of existing policies are specifically designed to reduce or control these factors.[12]

Another problem facing both the industry and others involved in long-term care is the lack of data upon which to base analyses and projections of need, use, and costs. The industry has not had sufficient experience with long-term care policies to develop reliable actuarial data. This data base is essential for policy pricing, coverage design, and basic research.

Findings

Long-term care insurance policies are based on a physician-driven medical model. They equate long-term care needs with health care needs. Health care is physician-controlled and relies on services provided in an institutional setting. The bias of long-term care insurance on coverage for care in skilled nursing home facilities is a reflection of the medical model rather than responsive to identified long-term care needs. Thus, a number of long-term care needs are not covered by most policies or covered only after an acute medical event has occurred.

Because of its bias toward institutional care, long-term care insurance in its present form could finance a greater share of nursing home care (currently about 1%).[13] However, it will not help shift demand to a home or community-based care system, and may, in fact, contribute to a "moral hazard" situation where demand for nursing home services is actually stimulated.

The concerns of the insurance industry regarding adverse selection and moral hazard are reflected in the eligibility and coverage restrictions of their long-term care policies. From the insureds' perspective, this means that those least likely to claim benefits are those most likely to be granted coverage.

A number of insurance companies offer long-term care policies with premiums ranging from $500 to $600 per year for applicants around age 65. This represents 5% of a $12,000 income and can be considered "affordable" for many elderly persons. However, as age increases, and with it the probability of requiring long-term care, so does the cost of new insurance coverage. In order for long-term care insurance to be effective and affordable, an individual should be insured at an age when premiums are lower, and coverage must be maintained for the rest of their life. (If a policy is allowed to lapse, the person must reapply and, if eligible, pay premiums based on their age at the time of re-application, and the "value" of years of coverage forfeited.)

CHAPTER 6

STATE TAX POLICY

The State's policy of support for long-term care for the elderly raises the issue of how much and in what manner public funds should be allocated to the effort. The elderly care programs join the competition for limited public funds, and the elements of fiscal and tax policy come into play.

Tax credits to encourage the purchase of long-term care insurance (H.R. No. 13, HD 1) and to relieve persons who provide informal care to the frail elderly in their homes (H.R. No. 14, HD 1) reflect this situation, and should be evaluated not only in terms of their potential for implementing the State's policy toward long-term care but also in light of existing tax policy in Hawaii.[1]

Hawaii's first tax review commission[2] identified the basic tax policy goals as:

> ...the fairness of taxes (equal treatment of equal taxpayers), simplicity of the tax system, efficiency of the tax structure in generating revenue with a minimum of economic dislocation, and the ability of revenues to meet future expenditure needs.[3]

The commission recognized that these goals may often be in conflict. A simple tax may not be fair, a fair tax may not be easily administered, and an administratively efficient tax may generate too much or too little revenue. These policy goals are widely accepted in the field of public finance and taxation and, in fact, differ very little from the principles of taxation identified by Adam Smith[4] in the eighteenth century.

Principles and Concepts of Taxation

Tax policy is based on a few fundamental concepts and principles:

Vertical equity: Appropriate treatment of households at different levels of economic well-being. This is inherently a value judgment. Taxes are characterized as progressive, proportional, or regressive according to whether payments rise, are constant, or fall as a proportion of income as income rises.

Horizontal equity: Equal treatment of equals. Households with the same income and wealth receiving the same services should pay the same taxes. This principle is violated by provisions such as those

that enable homeowners to pay much lower income taxes than renters who are equally well off.

Neutrality: Taxes should not bias economic choices made by individuals and businesses because in competitive markets those actions will tend to produce an efficient allocation of resources. This principle must be qualified under certain conditions, such as if markets are not competitive or if economic choices entail social benefits or costs. These conditions can be characterized as "market imperfections."

Administrative costs: Taxes should not be extremely difficult or expensive for governments to administer relative to the revenue they produce.

Compliance costs: The computation of tax liability, including the filling out of forms and keeping of records, should not place great burdens on taxpayers.[5]

The issue of equity can be approached from two perspectives:

The ability to pay: The ability to pay principle states that taxes should be distributed among taxpayers in relation to their financial capacities... a regressive tax means that the ratio of tax payments to income declines as income rises...a proportional tax means the ratio states the same...a progressive tax means the ratio of tax payments rises as income rises.[6]

The benefit received: Under the benefit received principle, taxes are regarded as "prices" and distributed in accordance with the...benefits received by taxpayers from government goods and services.[7]

Tax Expenditures or Tax Preferences

The process of taxation causes a redistribution of income by taking more money from some than from others and, ideally, reflects society's consensus on the best way to distribute the costs of government.[8] "Fine tuning" a tax system to achieve a fair distribution of costs is accomplished by adjusting the tax base with deductions or exemptions, and altering tax liability through tax rates and tax credits.

The income redistribution power of taxation can also be used to support social policy.[9] The term "tax expenditure" was coined by Stanley S. Surrey when he was Assistant Secretary of the United States Treasury for Tax Policy[10] to describe this use of taxing power.

> **The term "tax expenditure" refers to the fact that many of the provisions of the U.S. tax laws are intended, not as necessary structural parts of a normative tax, but rather as tax incentives or *hardship relief provisions.*** These provisions are thus really spending measures. Direct outlays could be designed that are equivalent in their effects to the tax expenditure provisions that favor certain groups or that encourage certain forms of activity and favor certain sources of income; ... It is being increasingly recognized that unless attention is paid to tax expenditures, a country does not have either its tax policy or its budget policy under full control (emphasis added).

Tax expenditures intended as incentives are a type of subsidy. When targeted at consumers they become "user subsidies," and if targeted at producers or providers they serve as "provider subsidies." Thus a tax credit to encourage individuals to purchase long-term care insurance would be a user subsidy granted as a tax expenditure.

Tax experts usually oppose tax expenditure proposals for two reasons. First, they distort the resource allocation process of the budget by removing the activity from the general competition for public funds and from the periodic review that is part of the budget process. Second, tax expenditures or, as Hawaii's First Tax Review Commission called them, narrow tax preferences, raise questions of equity and efficiency about the tax system as a whole, and stimulate requests from those with competing interests for similar favored tax treatment.[12]

Guidelines for Analysis

The National Conference of State Legislatures' State Tax Policy & Senior Citizens - A Legislator's Guide recommends that the following questions be raised about any proposal to help senior citizens through tax relief.

- How much does it cost?
- Why should the elderly receive special treatment?
- Is tax relief or a direct expenditure program more appropriate?
- Which tax should have the highest priority? That is, which tax is most onerous from the viewpoint of senior citizens and thus the one toward which the most relief should be directed?
- How should the benefits of tax relief be distributed? Should they be targeted? Is an exemption, a deduction, or a credit the most appropriate device for providing relief?[13]

Hawaii's Tax System

The taxing power in Hawaii is highly centralized at the state level with state general and special fund tax revenues accounting for more than 80% of total state and county tax collections.[14] Earmarking of state tax revenues in Hawaii is the exception, with only 8% of tax revenues being deposited in special funds in 1987.[15] Income and general excise tax collections dominate the state tax system accounting for two-thirds of all general fund tax revenues and 57% of total state tax revenues.[16]

Historically, the Legislature established and has retained a progressive tax system with individual tax liability reflecting taxpayers' ability to pay.[17] The individual income tax is progressive with graduated rates that increase as income rises. The regressive impact of the general excise tax has been recognized and addressed by means of tax credits rather than tax exemptions or deductions.[18] The benefit of credits is targeted at low income taxpayers with a sliding scale system that reduces the amount of credit as income rises.

The newly enacted medical services expense tax credit is specifically intended to refund the general excise tax paid on medical services that are subject to the tax. The probability that the elderly have higher medical expenses than most non-elderly taxpayers is recognized by a higher maximum credit for those age 65 and older.

Hawaii has also used tax credits as incentives and to provide relief for non-tax burdens, i.e. as "tax expenditures." The child passenger restraint system credit was established to encourage the purchase of a specific item - not to correct tax inequities. Similarly, the lifeline telephone service credit (claimed directly by telephone utilities) refunds lost revenues to the utility equal to the revenue loss and administrative costs of reduced phone rates for low-income handicapped and elderly residents.[19] These credits are not offered under the federal income tax law. The dependent care expense credit provides relief from expenses that are not attributable to taxation.

The state income tax conforms closely with the federal tax code. This simplifies taxpayer compliance requirements and increases administrative efficiency. Hawaii's tax relief provisions for dependent care comply with those of the Internal Revenue Code. This includes the dependent care tax credit and state income tax benefits for those participating in employer-sponsored dependent care assistance plans that meet federal requirements.

Findings

The basic goals of tax policy are fairness, simplicity, efficiency with minimum economic dislocation, and the ability to provide adequate revenues.

Taxes can exert an influence on the fiscal behavior of taxpayers. However, there is no indication that taxes influence activities that are driven by non-economic factors.

Taxing powers should not be used to provide incentives or relief for non-tax activities. Direct funding through the budget process ensures that program needs are subject to periodic review and are balanced with competing demands for public funds.

Hawaii's tax system is highly centralized and progressive. Tax credits have been established to compensate for those features that have been identified as unfairly impacting low income individuals. The system is characterized by the "ability to pay" principle reflected in graduated income tax rates and inversely graduated tax credits. The major use of the "benefit received" approach is the state highway fuel tax and vehicle weight fees. These revenues are derived from highway users and are earmarked for highway purposes.

Hawaii's income tax law includes credits that (1) relieve tax inequities, (2) are user-subsidy incentives for the purchase of certain items, and (3) provide economic relief for certain non-tax expenses. Credits in the second and third categories are tax expenditures and could be funded directly rather than through the tax law.

The state income tax law conforms closely with the Internal Revenue Code, including the provisions for dependent care.

CHAPTER 7

TAX PROVISIONS OF OTHER STATES

Forty-two states and the District of Columbia tax personal income.[1] Of these, six have incentive or relief provisions that relate to long-term care.[2] In addition to these programs, more than one-half of the states, including Hawaii, offer dependent care tax credits for employment-related dependent care expenses. These credits are usually a percentage of the federal dependent care tax credit.

Except as noted, the following summaries are based upon the claims forms and instructions of each state, and the responses of their tax directors to a Bureau questionnaire (see Appendix E).

Arizona

Taxpayers in Arizona who paid nursing home, supervisory care facility, foster care, home health care, or medical expenses for a person age 65 or older may **itemize deductions** for such costs. The care recipient does not have to be a relative of the taxpayer.

Taxpayers may also claim the elderly person as a dependent and be granted a **personal exemption** ($1,275 in 1988) if the taxpayer paid:

- at least 25% of annual nursing home, supervisory care facility, foster care home, or home health costs; or
- at least $800 for other medical costs.

Claims data on the program are not available. The program was enacted as an amendment to a nursing home regulation bill in 1981. The measure was enacted in an effort to reduce nursing home costs and to stimulate private sector participation in long-term care costs and services. In a study[3] analyzing the Arizona and Idaho programs' effectiveness as incentives, program participants were identified, and two rounds of interviews conducted over a three-year period immediately following enactment. Of the 78 elderly identified as program participants in Arizona, the average age was 86, and 80% were female. Sixty-six per cent had incomes of $5,000 or less, and the overall severity of disabilities (ADL and IADL impairments) was significantly greater than is found in the elderly population generally.

Eighty per cent of the caregivers in Arizona were children of the program participants, 82% were female, and 72% were over age 55. Only 3% were non-relatives. Fifty-nine per cent reported income of $20,000 or more. More than three-quarters of the Arizona claimants

indicated that the tax provision was of real importance with a higher proportion of the more affluent holding this view. This can be attributed to the fact that the deduction must be itemized and has no ceiling, thus offering greater tax savings to higher income claimants.[4]

Citation: Arizona Rev. Stat. §§43-1062 (deduction), and 43-1023 (exemption).

Idaho

A resident taxpayer in Idaho who maintains a household with one or more dependents age 65 or older (the taxpayer/claimant provides more than one-half of each dependent's support) may claim a tax **credit** of $100. A maximum of three credits is allowed. In lieu of the credit, a tax **deduction** of $1,000 is allowed for a family member who is age 65 or older or who is developmentally disabled. The taxpayer must maintain a household for the dependent and provide more than one-half of their support. These provisions were first available for the 1981 tax year. The deduction is rarely claimed because the credit is always more beneficial.[5]

IDAHO CLAIMS EXPERIENCE
TAX CREDITS FOR ELDERLY DEPENDENTS

TAX YEAR	NO. OF CLAIMS	REVENUE LOSS
1981	Not Available	Not Available
1982	" "	59,873
1983	641	59,044
1984	708	66,974
1985	763	66,879
1986	691	67,072
1987	677	62,157

Idaho also allows taxpayers to itemize up to $1,000 in personal care expenses for dependents who are immediate family members. The care services must have been provided in the taxpayer's or care recipient's home, not reimbursed by medicaid, medicare or private insurance, prescribed by a physician, and supervised by a registered nurse.

The analysis of the tax incentive effects of the Idaho program relied on interviews with 398 elderly beneficiaries and their caregivers. Thirty-four per cent of the care recipients were age 85 or older, 78% were female, and 82% had incomes of less than $5,000. Care recipients reported a significantly higher level of disability than was found in the general elderly population.

Caregivers in Idaho were all relatives of the recipient and 94% were children or stepchildren. Forty-five per cent were age 55 or older, and 55% were female. Fifty-eight per cent of the caregivers reported income of less than $20,000. More than one-half were employed outside the home, and nearly one-half spent 2 to 3 hours daily providing personal assistance to

the recipient. Sixty-nine per cent provided $1,000 or more in general living expenses, but only 12% paid $500 or more in medical costs.[6]

Citation: Idaho Code §63-3022E (deduction) and 63-3025D (credit).

Iowa

Resident taxpayers in Iowa may **deduct** itemized expenses of up to $5,000 for in-home care of a grandchild, child, parent or grandparent who is unable to live independently due to physical or mental disability, and is eligible for public assistance. Expenses that may be deducted include food, clothing, transportation and medical costs not otherwise deductible. Only those expenses that are not reimbursed may be deducted.

The Iowa deduction has been available since the 1983 tax year. Data on the number and amounts reported are not available.

Citation: Iowa Code, §422.9(2)(e) 1989.

North Carolina

North Carolina taxpayers may claim a **deduction** of up to $3,000 for payments made for the care or maintenance of one or both parents. The parent must be age 65 or older and have disposable income of $9,000 or less from sources other than gifts and inheritances. The parent cannot be claimed as a dependent of the taxpayer, must be a resident of the State, and not in a public or private institution for more than one-half the year. Expenses allowed are those generally permitted for care of dependents. Any monetary gifts from the parent to the taxpayer in excess of $100 must be subtracted from the amounts itemized.

The North Carolina department of taxation is currently sampling returns for data on this provision. However, no claims data is available at present. The deduction has been available since the 1985 tax year.

Citation: General Statutes of North Carolina, §105-147(28).

Oregon

A tax **credit** of 8% (up to a maximum of $250) of the expenses of home care of a person age 60 or older is allowed in Oregon if the care is provided in order to keep the elderly person from being placed in a nursing home. The claimant's household income must be less than $17,500 and the elderly person's household income must be less than $7,500. The amount paid by the claimant for the elderly person's care, less $500, is considered gift income to the elderly

person. Household income includes taxable and non-taxable income of both husband and wife. The elderly person must further be eligible for but not receiving assistance under Oregon's Project Independence or from the State's Adult and Family Services Division. They may not reside in a nursing home or mental institution, and must have disabilities so severe as to normally require institutional care.

The credit has been available since the 1980 tax year but is rarely claimed. Project Independence served 4,600 elderly residents of Oregon in fiscal years 1988 and 1989, and the credit is not available for program participants. Oregon does not maintain data on use of the credit.

Citation: Oregon Revised Statutes, §§316.147, 316.148, and 316.149; Oregon Administrative Rules, §150-316.148.

South Carolina

Taxpayers in South Carolina may claim a tax **credit** for expenses paid to support themselves or another in a licensed skilled nursing or intermediate care facility (in any state). Expenses claimed as medical deductions on federal schedule A or reimbursed from public sources may not be used to compute the credit. The amount of the credit is 20% of eligible costs up to a maximum of $300. There are no age or income restrictions for the credit.

The credit has been available since the 1987 tax year for which 245 claims were filed with revenue loss of $70,000.

Citation: Code of Laws of South Carolina, §12-7-1235.

Findings

Six states have specific tax provisions for long-term care. Five offer tax deductions for defined expenses, and two have tax credits.

Each of the programs is unique. However, all have restrictions that limit eligibility through age and income requirements, allowable expenses, the relationship of the claimant to the care recipient, or ceilings on the maximum tax benefit allowed.

Arizona and South Carolina offer tax relief for institutional costs, while the other four limit their programs to taxpayers assisting persons in a non-institutional setting.

No significant administrative costs, or problems regarding equity or compliance were reported by the states' tax administrators.

Two states maintain records on the number and amounts of claims. Idaho has between 600 and 700 claims per year totalling around $67,000 for its tax credit for home care. South Carolina had 245 claims for a total of $70,000 under its deduction for nursing home costs paid by individuals.

CHAPTER 8

ALTERNATIVES

This chapter summarizes a few of the long-term care alternatives that have been proposed or are being tested as demonstration programs. The material is presented as a sampling of current efforts and does not constitute a recommendation for or against further consideration by the Legislature.

It must be remembered that the goals of these approaches reflect the perspective of the sponsoring entity, and are not necessarily compatible with those of others involved with long-term care. State and federal government officials look to containing medicaid costs. Thus, they view success as shifting costs of services to the private sector or replacing them with alternatives that are less costly to the government. The elderly and their advocates look for alternatives to institutionalization because it is considered the least desirable choice for personal and psychological reasons. The elderly also seek to protect the assets they have earned during their lifetimes. The insurance industry sees a potential market but can meet demand only to the degree that allows a reasonable profit. Long-term care institutions search for funding that is reliable and adequate, and assurances that a properly trained labor force will be available.

National Social Insurance

A number of researchers propose that long-term care be treated as an insurable risk and funded under a general social insurance program just as medicare covers acute health care services. Under these proposals all would contribute and earn the right to benefits. Cost sharing and deductibles are recommended to control demand. Alice Rivlin and Joshua M. Wiener[1] propose that private insurance either provide protection that supplements a medicare-type public program, or be substantially expanded and asked to fund a specified period of nursing home care (1 to 2 years) with medicare stepping in when care needs extend beyond the privately insured period.

The Indiana Program

In 1987 Indiana established a long-term care program that: offers incentives and assistance for individuals to purchase approved long-term care insurance, including eligibility for coverage under medicaid without an income test; provides counseling services with regard to long-term care; and assists certain persons with premium costs for private long-term care insurance.

This program is conditioned upon the state of Indiana receiving a medicaid waiver. The program is assisted by a grant from the Robert Wood Johnson Foundation, and is among the

Council of State Governments' suggested state legislation for 1989.[2] As of September 1988, Indiana was still awaiting the medicaid waiver.

Citation: Burns Indiana Stat. Ann., §12-1-25.

Estate Recovery

A 1988 report by the Office of the Inspector General of the United States Department of Health and Human Services found that, "Although Medicaid covers only about one-third of poor people over age 65, many elderly recipients retain sizable estates which pass to the heirs without reimbursement of public costs." The Tax Equity and Fiscal Responsibility Act allows states to establish estate recovery and lien provisions to recover certain medicaid costs. For example, a program could require a lien on certain assets as a condition of medicaid eligibility while allowing families to retain and manage the assets while the elderly person is receiving long-term care. The liens could be conditioned to avoid impoverishment of a surviving spouse or other dependent individual, and still allow the state to recover some of its medicaid costs eventually.[3] (Section 346-29.5, Hawaii Revised Statutes, relating to real property liens provides for liens of this nature in Hawaii.)

Volunteer Service Credits

The 1987 report of Connecticut's Governor's Commission on Long-Term Care Financing included a proposal to support a volunteer service credits demonstration program. The objective of the concept was to expand home and community-based long-term care by allowing volunteers to "bank" the time spent helping an elder and to "withdraw" assistance in the future when needed. The commission identified three basic components for a volunteer service credits program:

- it should be implemented by an existing organization such as a labor union, religious group, or fraternal association,
- a system to record and track credits earned and used must be developed, and
- the types of services covered including their exchange value be specified.

The intent of the program is to expand the network of informal caregivers beyond the immediate friends and family by establishing a value and system of exchange for the time and services of informal caregivers. Such a program could be organized as a cooperative or non-profit organization.[4]

Longlife Insurance

Thomas E. Getzen has proposed a new insurance product called "longlife insurance". Longlife insurance is the financial equivalent of a life care community without the bricks and

mortar, and would provide comprehensive financial support throughout retirement. According to Getzen's analysis, a couple at age 60 could pay an initial lump sum of $9,885 followed by monthly premiums of $119. Their benefits would be $50 per day after the first 45 days in a hospital, skilled nursing facility or nursing home. Home health benefits would be $40 per visit after the first 30 days. Starting at age 76, the couple would receive $750 per month without regard to their health or care needs. The initial lump sum and premiums could be taken as distributions from employee retirement benefits. Upon the insured's death a guaranteed-return-of-premium clause would return to the estate the portion of all initial and monthly premiums in excess of benefits.

The program limits adverse selection. The deferral of annuity payments and the reduction of annuitants through death would be sufficient to fund the program. It is estimated that two-thirds of retirees could afford longlife insurance - 79% of couples, 57% single males and 47% single females.

Getzen's proposal is based on known mortality and nursing home utilization rates, and conservative rate of return assumptions for invested deposits and premiums.[5]

Blue Cross/Blue Shield Custodial Care Insurance

In November 1987, Blue Cross/Blue Shield of the Rochester, New York area began limited marketing of a custodial care policy. It does not have prerequisites such as prior hospitalization, and covers care in the home, adult day health care centers, and nursing homes. Benefits are a percentage of costs with no dollar maximum rather than fixed indemnity payments. A case management approach is used to ensure that the most appropriate custodial services are provided. The policy has a 100-day deductible for nursing home care (no deductible for lower levels of care) and pays 75% of care costs in facilities that have contracted with the insurer (50% in other facilities). Premiums range from just under $60 per month to $238. Applicants must pass a medical screening test.

The policy holder selects coverage for 3, 4 or 5 years. Benefits are based on 365 "service days" per year of coverage. As each type service is used the appropriate number of service days is deducted from the total available. Care in a less intensive setting than a nursing home is charged as only one-half a service day, thus significantly expanding coverage and creating an incentive to use home or day care when possible.[6]

Employer-Sponsored Programs[7]

IBM offers a nationwide information and referral service to help employees find care for their elderly family members. Up to three years unpaid leave with continued health benefits and guaranteed re-employment is also available.

AT&T and two of its largest labor unions recently negotiated an elder care package that includes, generous leave provisions, counseling and referral services, flexible spending accounts

(Dependent Care Assistance Plans), and direct funding assistance for elderly care programs nationwide.

Stride Rite shoe manufacturing company is expanding its child care center to include adult day care for employees' elderly parents.

Several companies, including First Interstate Bancorp and American Express are offering long-term care insurance to their employees. Information and counseling services are available to employees of Travelers, Johnson & Johnson, and several other major U.S. firms.

CHAPTER 9

FINDINGS AND RECOMMENDATIONS

Tax Credit Incentive for the Purchase of Long-term Care Insurance

H.R. No. 13, H.D. 1, requests an estimate of the number of persons who would be eligible for a tax credit for long-term care insurance premiums; the feasibility of making the credit inversely graduated with a maximum of $500 for those with adjusted gross income under $20,000; the impact on medicaid costs; an examination of other financing mechanisms; and a determination of institutional and non-institutional services.

Findings and Conclusions

1. **Number of persons Eligible.** Based on statewide population estimates, the number of insurable persons age 65 or over is estimated to be:

1988 - 80,000
1990 - 91,000

These figures assume that the moderately to severely impaired (22%) and those age 85 and older (8%) are uninsurable. Those who are dependents of another for tax purposes are included.

Using data on taxpayers who claim the age 65+ personal exemption the estimate is:

1988 - 76,600

This figure excludes the elderly who do not file state income tax returns and those who are dependents of another for tax purposes. The uninsurable are also excluded using the same assumptions of 22% and 8%.

Both estimates reflect the maximum number of persons who would be eligible without regard to:

- income - some could not afford insurance,
- the person actually paying the premiums - a non-elder might purchase coverage for someone 65 or older, and
- other factors making a person uninsurable - some insurers rely on factors other than age and general disability when considering applicants.

Both estimates assume that only one person would be allowed a credit for premiums covering an eligible elder, and that premiums covering persons under age 65 would not be eligible for the credit.

2. **Feasibility of an Inversely Graduated Credit.** H.R. No. 13, H.D. 1, outlines an inversely graduated tax credit of $500 per policy premium for AGI under $20,000 to $0 credit when AGI exceeds $60,000.[1]

The following table shows that an estimated 84% of persons claiming the age 65+ personal exemption have adjusted gross income of less than $20,000, and only 4% have AGI in excess of $50,000. (The department of taxation data does not break down AGI data at the $60,000 level.) Thus, if the AGI limits were to apply only to the insured elder and not to the purchaser of the policy, and if the credit were limited to the elderly age 65+, the maximum credit of $500 would be available to an estimated 56,600 taxpayers. A cut-off at $50,000 would exclude some 3,000 taxpayers, and 8,000 would be eligible for a partial credit (AGI) between $20,000 and $49,999).

STATE RESIDENT TAXPAYERS AGE 65 AND OLDER

ADJUSTED GROSS INCOME	NUMBER OF AGE 65+ EXEMPTIONS 1986 ACTUAL	NUMBER OF AGE 65+ EXEMPTIONS 1988 EST.*	LESS UNINSURABLE 1988 EST.**	PER CENT OF TOTAL
$0-9,999	55,974	62,892	44,024	65
$10,000-19,999	15,943	17,914	12,540	19
SUBTOTAL	71,917	80,806	56,564	84
$20,000-29,999	6,277	7,053	4,937	7
$30,000-39,999	2,690	3,022	2,115	3
$40,000-49,999	1,308	1,470	1,029	2
SUBTOTAL	10,275	11,545	8,081	12
$50,000+	3,728	4,189	2,932	4
TOTAL	85,920	96,540	67,577	100

* 6% per year increase.
** 22% due to existing impairments plus 8% due to age 85+.

Source: Developed from Table 9, p. 45, Hawaii Income Patterns Individuals, 1986, Department of Taxation, State of Hawaii, March 1989.

Recent surveys of long-term care insurance premiums show a number of policies available in the $600-700 range for applicants age 65 with costs rising as the age of the applicant increases. (See Rivlin, $684 average for age 65 "high-option" coverage. See also Consumer Reports, May 1988.) Well over one-half of those age 65+ are between 65 and 74 years of age. Assuming that there is a fairly even distribution by age and by income among those age 65 to 74, a $500 credit would cover over 80% of a $600 annual premium for some 27,000 taxpayers.

3. **Effect on Medicaid Costs.** The effect of long-term care insurance on state medicaid costs cannot be determined. While researchers agree that the potential exists for long-term care insurance to assume a greater share of institutional costs, only 1% of these costs are currently being reimbursed by private insurance. Insurers avoid issuing policies to those more likely to use covered benefits, and the flat rate indemnity type coverage currently offered may not cover actual costs of the insured person. (During the preparation of this report, no case was found in Hawaii of nursing home costs being covered by long-term care insurance.) The fact that only low-risk persons are insurable means that several years of coverage will be required before statistically significant claims experience could be accumulated and analyzed to document the impact on medicaid.

In order to shift the cost of institutional long-term care from medicaid to private insurance the particular coverage that will accomplish the goal must be defined and be both profitable to insurers and attractive to potential purchasers. (See discussion of the Indiana program in Chapter 8.) An approach of this type will not reduce the total costs of institutional care.

4. **Alternative Incentives.** Chapter 8 provides an overview of some of the alternatives that have been proposed and demonstration projects being developed in other jurisdictions. While there is general agreement that long-term care insurance has the potential to assume a greater share of long-term care costs of the elderly, the costs, coverage and underwriting restrictions of the majority of available policies leave serious questions as to whether government should actively encourage individuals to invest in these products. Research indicates that the present priority should continue to be a strong public information effort and development of the population and demographic data required by insurers and researchers.

5. **Earmarking and Other Financing Mechanisms.** The legislative auditor's report on earmarking the general excise tax on health services will address the issue of dedicated revenues to finance specific programs.

6. **Institutional and Non-institutional Services.** The current system for identifying and delivering long-term care services has been shaped by the physician-driven medical model. The major public programs (medicare and medicaid) and most long-term care insurance products are designed to identify and respond to care that is medically necessary. However, medical needs are only one part of the long-term care continuum and it is both unrealistic and costly to rely on physicians and other medical professionals to direct all aspects of an individual's long-tem care.

The identification and delivery of non-medical long-term care needs is poorly developed relative to medically necessary needs.

Recommendations

1. The Legislature should not establish a tax credit incentive for long-term care insurance premiums at this time. Offering a credit based on a single years' premium will not ensure that coverage is maintained. Any user-subsidy should be provided directly so that continued coverage will be assured, and specific policies can be regularly evaluated to determine if they support the State's long-term care goals.

2. The Legislature should continue to fund the information program(s) of the Executive Office on Aging and the Insurance Commissioner to counsel groups and individuals on the advantages and disadvantages of long-term care insurance.

3. Government agencies and insurers must work together to identify the specific data needs and to develop the data bases for insurance product design and evaluation, as well as for public policy analysis.

4. The definition of long-term care services, whether provided in an institution or the community, should be shaped by factors that reflect the entire continuum of long-term care need. Consideration might be given to focusing more on the length of time a service will be required rather than the specific service. Programs should also be designed to deliver long-term care needs identified by professionals in non-medical fields. The Executive Office on Aging should be the lead agency to coordinate the public and private sectors in this task.

5. The Insurance Commissioner should maintain records on the long-term care insurance policies available in Hawaii including:

- the number of policies in effect,
- the number of applications for coverage granted and denied including the reasons for denial,
- the amounts of benefits paid and number of policyholders receiving benefits, and
- the conditions for which benefits are being paid.

Tax Credit Relief for Families Caring for the Elderly

H.R. No. 14, H.D. 1, requests an estimate of the number of persons eligible for a tax credit for families caring for the elderly who are ill; and alternatives, other than tax credits, to provide relief to these families.

Findings

1. Number of Persons Eligible. The following are rough approximations rather than reliable estimates. An accurate estimate of persons eligible for the suggested tax credit requires statistically reliable population estimates for both caregivers and care recipients, and the basic parameters of the program under consideration. The assumptions upon which the approximations are based are not recommendations.

Maximum - the primary caregivers for all impaired elderly receiving informal care are eligible:

1988 - 20,000 to 21,000
1990 - 27,000 to 34,000

Intermediate - limited to those caring for the impaired elderly in the caregiver's home:

1988 - 12,000 to 13,000
1990 - 18,000 to 20,000

Low - excludes any caregiver who is the spouse of the impaired elder:

1988 - 4,000 to 5,000
1990 - 7,000 to 9,000

These figures are based upon the demographic data presented in Chapter 2 and assume that:

- only one credit is allowed for a care recipient, i.e. only the primary caregiver is eligible for the credit,
- the credit does not have an income ceiling for either the caregiver or the care recipient,
- caregivers need not be an immediate relative of the care recipient,
- the care recipient need not be a tax dependent of the caregiver,
- "elderly" means age 65 or older,
- "ill" means moderately to severely impaired and is not limited to purely medical conditions,

- "care" means the help needed when physical or mental disabilities impair the capacity to perform the basic activities of daily life, includes both skilled and unskilled assistance, and covers both monetary contributions or gifts and care services when provided directly by the caregiver.

Persons eligible for the credit would tend to be age 45 or older, and nearly all would be spouses (unless specifically excluded by the program) or children of the impaired person. They would probably be caring for the person in their home and providing unskilled care to assist in activities of daily living rather than skilled nursing, therapy or medical services. Their out-of-pocket expenses would be less than $50 per month.

2. General Findings.

Long-Term Care Demographics: An estimated 25,000 of Hawaii's 114,000 persons age 65 or older are moderately to severely impaired. Of this group, 14,000 are age 75 or older. Between 20,000 and 21,000 of the impaired elderly are cared for informally by family or friends.

Data on informal caregivers and recipients in Hawaii are not available. National surveys show the majority to be women, age 45 and older, who are relatives of the impaired person. One-third of informal caregivers are also employed outside the home. Informal caregivers report minimal direct costs attributable to their care activities.

Data indicates that 40% of primary caregivers are the spouse of the impaired person and 25% are other family or friends. The latter percentage may be higher in Hawaii.

Many long-term care needs are for assistance with bathing, dressing, transportation, shopping, cleaning, etc. and are not primarily medical unless associated with a specific illness or other medical event.

Long-Term Care Policy: The Executive Office on Aging's long-term care plan states that community-based and home care are preferred by the elderly and urges state support for their development. It identifies financing as a priority and state tax credits as a possible way to support family caregiving efforts.

Little research has been conducted on home and community-based care for the impaired elderly.

In Hawaii, recent legislation has expanded the dependent care tax credit for employment-related expenses, and has enacted a temporary medical services tax credit to offset the general excise tax on medical services. The elderly are allowed higher maximum benefits under the medical services credit. Both state and federal tax savings are available to those participating in employer-sponsored dependent care assistance programs.

State Tax Policy: The basic goals of tax policy are fairness, simplicity, efficiency with minimum economic dislocation, and the ability to provide adequate revenues.

Taxes can exert an influence on the fiscal behavior of taxpayers. However, there is no indication that taxes influence activities that are driven by non-economic factors.

Taxing powers should not be used to provide incentives or relief for non-tax activities. Direct funding through the budget process insures that program needs are subject to periodic review and are balanced with competing demands for public funds.

Tax Provisions of Other States: Six states have specific tax provisions for long-term care. Five offer tax deductions for defined expenses, and two have tax credits.

Each of the programs is unique. However, all have restrictions that limit eligibility through age and income requirements, allowable expenses, the relationship of the claimant to the care recipient, or ceilings on the maximum tax benefit allowed.

Arizona and South Carolina offer tax relief for institutional costs, while the other four limit their programs to taxpayers assisting persons in a non-institutional setting.

Two states maintain records on the number and amounts of claims. Idaho has between 600 and 700 claims per year totaling around $67,000 for its tax credit for home care. South Carolina had 245 claims for a total of $70,000 under its deduction for nursing home costs paid by individuals.

Conclusions

Until an accurate profile of family caregivers is available, programs that effectively implement and fund the State's policy of support for informal and community-based care for the impaired elderly cannot be designed.

State tax credits for these caregivers would be contrary to accepted tax policy and, based upon the limited data available, would not significantly relieve the major burdens they experience.

The experience of other states offers little, if any, guidance in this matter.

The development and evaluation of alternative programs to relieve family caregivers is similarly constrained by the lack of data in this area. However, a general pattern of the development of care needs is suggested by recent research. This is a pattern in which, as a couple ages, they are able to meet their combined care needs to a large extent. For as long as possible, these care efforts reflect traditional sex roles with the wife responsible for household and personal care tasks, and the husband responsible for financial management and business affairs with adjustments made as specific disabilities and care needs develop. The husband will

pre-decease the wife and, without a second person to share necessary tasks, she will require institutional long-term care.

Recommendations

1. The Legislature should appropriate funds to the Executive Office on Aging to conduct a survey and needs assessment of Hawaii's informal caregivers. The results of this effort should be used by the EOA to design programs that will meet the documented needs.

2. The Legislature should defer further consideration of tax credits for family caregivers unless the results of the survey and needs assessment show that:

- a majority of informal caregivers are experiencing significant financial hardship as a result of their care activities, and

- the tax system provides the most effective and efficient method for identifying such caregivers and delivering appropriate amounts of financial relief to them.

3. The Executive Office on Aging should give priority to the development and strengthening of programs that:

- help men develop household and personal caregiving skills that have traditionally been the responsibility of wives and daughters, and

- ensure that widowed elders have access to personal support and programs that help them develop the skills and resources necessary to continue living independently after the death of their spouse.

FOOTNOTES

Chapter 2

1. Hawaii, Department of Business and Economic Development, 1988 unpublished data; 1990, 2000 and 2010, The State of Hawaii Data Book 1988 (Honolulu: 1988), p. 39.

2. Hawaii, Department of Taxation, Hawaii Income Patterns, Individuals 1986 (Honolulu: 1989), pp. 22-24.

3. Ibid., p. 45.

4. Thomas E. Getzen, "Longlife Insurance: A Prototype for Funding Long-Term Care", Health Care Financing Review, Winter 1988, Vol. 10, No. 2 (Baltimore: U.S. Department of Health and Human Services, Health Care Financing Administration), p. 51.

5. Ibid.

6. Alice M. Rivlin and Joshua M. Wiener, Caring for the Disabled Elderly, Who Will Pay (Washington: Brookings Institution, 1988), p. 3.

7. William J. Scanlon, "A Perspective on Long-Term Care For the Elderly", Health Care Financing Review, 1988 Annual Supplement (Baltimore: U.S. Department of Health and Human Services Health Care Financing Administration), p. 7.

8. Hawaii, Sixth Annual Report, *Community Long Term Care Branch* (Honolulu: Department of Human Services, Report to the Fifteenth Legislature 1989 Session), pp. 9-12.

9. Ibid.

10. Hawaii, Executive Office on Aging, Long Term Care Plan for Hawaii's Older Adults - A First Step in Planned Care (Honolulu: Revised July 1988), p. 7.

11. Ibid.

12. Scanlon, p. 9.

13. Executive Office on Aging, p. 9.

14. Scanlon, p. 9.

15. Maryanne P. Keenan, Changing Needs for Long-Term Care: A Chartbook (American Association of Retired Persons, Public Policy Institute), pp. 52-59.

16. Russell Nanod, "Russell's Corner", Hawaii FiftyPlus, Vol. 2, No. 13, July 7, 1989 (Honolulu), p. 8.

17. Honolulu, (City and County) Elderly Affairs Division, "Caregiver Survey" (Undated), p. 1.

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20. Hawaii, State Health Planning and Development Agency, State of Hawai'i Long-Term Care Bed Projection By County for 1990 (Honolulu: Department of Health, 1988), p. 11.

21. Ibid., p. 8.

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23. Interviews with Jeanette Takamura, Ph.D., Director, Executive Office on Aging, State of Hawaii, May 17, 1989; Alan Matsunami, Long Term Care Branch, Department of Health, State of Hawaii, July 28, 1989; Carolyn Richardson, Ed.D., Vice President Operations, Healthcare Association of Hawaii, August 8, 1989; and Lynda B. Johnson, M.P.H., Executive Director, Hawaii Long Term Care Association, August 23, 1989.

24. Executive Office on Aging, p. 35.

25. Keenan, pp. 72-80.

26. Ibid.

27. Average from Executive Office on Aging, October 24, 1989 transmittal to Samual B. K. Chang: range from interview with Lynda B. Johnson, M.P.H., Executive Director, Hawaii Long Term Care Association, August 23, 1989.

28. Nanod and interview with Carolyn Richardson, Healthcare Association of Hawaii, August 8, 1989.

29. Jane G. Gravelle and Jack Taylor, "Tax Options for Financing Long-Term Care for the Elderly", Congressional Research Service, Library of Congress (Washington: 1989), p. 1.

30. Rivlin, p. 7.

31. Interview with Alan Matsunami, Long Term Care Branch, Department of Human Services, State of Hawaii, July 28, 1989.

32. Rivlin, p. 9.

33. Ibid., p. 7.

Chapter 3

1. Hawaii Rev. Stat., sec. 349-1(a).

2. Ibid., sec. 349-1(b)(1).

3. Ibid., sec. 349-1(b)(2).

4. Hawaii, Executive Office on Aging, Long Term Care Plan for Hawaii's Older Adults - A First Step in Planned Care (Honolulu: Revised July 1988).

5. Ibid., p. 24.

6. Ibid., pp. 36-37.

7. Ibid., pp. 37-38.

8. Ibid., pp. 38-39.

9. Hawaii Rev. Stat., sec. 349-3(1).

Chapter 4

1. Susan K. Claveria, Assuring Dignity in Long-Term Care for the Elderly, Legislative Reference Bureau, Report No. 2 (Honolulu: 1987).

2. Ibid., pp. 39-40.

3. Ibid., p. 41.

4. Ibid.

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6. Ibid., pp. 42-43.

7. Ibid., pp. 43-44.

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9. Nell A. Cammack, Employer-Assisted Dependent Care, Legislative Reference Bureau, Report No. 10 (Honolulu: 1988).

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13. Ibid., p. 51.

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15. Hawaii Rev. Stat., sec. 235-55.6.

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17. Ibid., p. 114.

18. U.S., Department of Health and Human Services, Task Force on Long Term Health Care Policies, Report to Congress and the Secretary (Washington: 1987), p. 11.

19. Ibid., p. 2.

20. Ibid., p. 3.

21. On March 21, 1989, the Internal Revenue Service ruled that long-term care insurance policies were based on recognized mortality and morbidity tables, and that reserves qualified as life insurance reserves (Revenue Ruling 89-43).

22. Report to Congress, pp. 8-9.

23. Ibid.

24. Ibid.

25. Pub. L. No. 100-360, 100th Cong. (July 1, 1988).

26. "Medicare Catastrophic Coverage Act of 1988," Health Care Financing Review, Winter 1988, Vol. 10, No. 2 (Baltimore: U.S. Department of Health and Human Services, Health Care Financing Administration), p. 131.

27. Ibid., p. 146.

28. The State Legislature passed H.B. No. 1401, H.D. 1, during the 1989 regular session, conforming Hawaii asset and resource requirements to the new federal provisions. The measure was vetoed by the Governor on June 16, 1989, with the message stating, "This bill is unnecessary because medicaid eligibility standards are established through administrative rules. The State is bound to follow the federal law in establishing medicaid eligibility and the federal law changes frequently. By retaining the eligibility standards in the administrative rules process, the State maintains the necessary flexibility for conforming its standards to federal changes."

29. "Medicare Catastrophic Coverage Act of 1988", Health Care Financing Review, p. 134. The draft report was under administrative review as of 8/89.

30. Alice M. Rivlin and Joshua M. Wiener, Caring for the Disabled Elderly, Who Will Pay (Washington: Brookings Institution, 1988).

31. Brookings-ICF Long-Term Care Financing Model.

32. Rivlin, pp. 28-29.

33. Ibid., p. 239.

34. It should be noted that the intent of this effort is to promote the use of long-term care

insurance, not to evaluate or explore alternative approaches.

Chapter 5

1. Susan K. Claveria, Assuring Dignity in Long-Term Care for the Elderly, Legislative Reference Bureau, Report No. 2 (Honolulu: 1987), p. 17. Section 431-771, Hawaii Revised Statutes, is now section 431:10A-301.

2. Ibid.

3. Ibid.

4. Alice M. Rivlin and Joshua M. Wiener, Caring for the Disabled Elderly, Who Will Pay (Washington: Brookings Institution, 1988), p. 59.

5. Jane G. Gravelle and Jack Taylor, "Tax Options for Financing Long-Term Care for the Elderly", Congressional Research Service, Library of Congress (Washington: 1989), p. 5.

6. Rivlin, p. 59.

7. An independent survey of long-term care insurance products is beyond the scope of this report, and policies introduced in the past one year to 18 months are not covered in the discussion presented in this chapter.

8. Consumer Reports, "Who Can Afford A Nursing Home?", Vol. 53, No. 5, May 1988.

9. Rivlin, Chapter 4.

10. Rivlin, p. 60.

11. Consumer Reports, pp. 303-307.

12. Claveria, p. 22.

13. Rivlin, p. 59.

Chapter 6

1. The issue of earmarking funds for long-term care will be addressed in the legislative auditor's response to S.C.R. No. 137 (1989).

2. Hawaii Const. art. VII, sec. 3. A tax review commission must be appointed at five-year intervals to evaluate the State's tax structure, and submit recommendations on revenue and tax policy to the legislature.

3. Hawaii, Tax Review Commission, Report of the First Tax Review Commission to the Thirteenth Legislature State of Hawaii (Honolulu: 1984), p. 1.

4. Adam Smith, Wealth of Nations, book v, Chap. ii.

5. Steven D. Gold (ed.), Reforming State Tax Systems (Denver: National Conference of State Legislatures, December 1986), pp. 6-7.

6. J. Richard Aronson and Eli Schwartz (ed.), Management Policies in Local Government Finance (Washington: International City Management Association in cooperation with the Municipal Finance Officers Association, 1975), p. 43.

7. Ibid., p. 44.

8. Ibid., p. 42.

9. Gold, p. 7.

10. Oliver Oldman and Ferdinand P. Schoettle, State and Local Taxes and Finance, Tax, Problems and Cases (Mineola, N.Y.: The

Foundation Press, Inc., 1974), p. 886.

11. Ibid., pp. 123-124.

12. Hawaii, Tax Review Commission, p. 12.

13. National Conference of State Legislatures, State Tax Policy & Senior Citizens - A Legislator's Guide (Denver: 1985), pp. 19-20.

14. Tax Foundation of Hawaii, Government in Hawaii 1988, A Handbook of Financial Statistics (Honolulu: 1988), p. 22.

15. Ibid., p. 19. However, the Tax Foundation notes that the educational facilities special fund enacted in 1989 will nearly double the percentage of earmarked state revenues (October 25, 1989 letter to Samuel B. K. Chang).

16. Ibid.

17. Hawaii, Tax Review Commission, p. 2.

18. The State's tax credits for individuals are designed to offset the regressive impact of the general excise tax on low-income individuals. They are incorporated in the state individual income tax for administrative efficiency and taxpayer convenience.

19. Hawaii, Department of Taxation, Tax Credits Claimed by Hawaii Residents 1986 (Honolulu: 1988), pp. 22-24.

Chapter 7

1. Tax Foundation of Hawaii, Government in Hawaii 1988 A Handbook of Financial Statistics (Honolulu: 1988), p. 26.

2. In 1986, Colorado enacted a tax deduction for long-term care insurance premiums and a 1% reduction in the insurance premiums tax rate for certified policies. The Colorado Income Tax Act of 1987 repealed these provisions before they took effect. (Letter from Stan Williams, Tax Supervisor, Colorado Department of Revenue, to Samuel B. K. Chang, Director, Legislative Reference Bureau, August 3, 1989.)

3. Michael C. Hendrickson, "State Tax Incentives for Persons Giving Informal Care to the Elderly", Health Care Financing Review, 1988 Annual Supplement (Baltimore: U.S. Department of Health and Human Services, Health Care Financing Administration), p. 124.

4. Ibid., pp. 124-126.

5. Response of Daniel D. John, Tax Policy Administrator, Idaho Department of Revenue and Taxation, to the Bureau July 1989 questionnaire.

6. Hendrickson, pp. 124-126.

Chapter 8

1. Alice M. Rivlin and Joshua M. Wiener, "Who Should Pay for Long-Term Care for the Elderly", The Brookings Review, Summer 1988, pp. 3-9.

2. Council of State Governments, Suggested State Legislation - 1989 (Lexington, Ky.: 1989), Volume 48, pp. 157-159.

3. Betty Wiseman, "Medicaid, Good News for Spouses, But Bigger Bills for States", State Government News (Council of State Governments: March 1989), Vol. 32, No. 3, p. 18.

4. Connecticut, Report of the Governor's Commission on Private and Public Responsibilities for Financing Long-Term Care for the Elderly, How Will We Pay?, 1987, pp. 31-32.

5. Thomas E. Getzen, "Longlife Insurance: A Prototype of Funding Long-Term Care", Health Care Financing Review, Winter 1988, Vol. 10, No. 2 (Baltimore: U.S. Department of Health and Human Services, Health Care Financing Administration), pp. 47-56.

6. U.S., Congress, House, Select Committee on Aging, Hearing on Providing and Financing Long-Term Care for the Elderly, 100th Cong., 2d Sess., January 21, 1988, Greece, N.Y., pp. 82-86.

7. Honolulu Sunday Star-Bulletin and Advertiser, June 4, 1989, p. A-21.

Chapter 9

1. The text of H.R. No. 13, H.D. 1, reads as follows:

   The feasibility of making such a credit inversely proportional to the gross adjusted income of the taxpayer, with credit ranging from $500 per policy for those in the zero to $19,999 tax bracket to no credit for those with over $60,000 in taxable income. (Emphasis added.)

   Adjusted gross income has been used in the report's analysis. The analysis further assumes that the income limits apply to the insured rather than to the individual who pays the premiums.

Appendix A

HOUSE OF REPRESENTATIVES
FIFTEENTH LEGISLATURE, 1989
STATE OF HAWAII

H.R. NO. 13 H.D. 1

HOUSE RESOLUTION

REQUESTING A STUDY ON LONG-TERM CARE.

WHEREAS, the elderly persons of this State through hard work, vision, and love of these islands have made Hawaii the place it is today, with a quality of life enjoyed by all of the State's people and envied throughout the world, and it is these individuals who deserve in their latter years lives filled with dignity, caring, and respect; and

WHEREAS, one of the greatest concerns of the ever-increasing population of older people is the devastating expense of institutional long-term care, which at a private facility can impoverish a family in only two years or less and if provided by a government facility via public assistance, will mean that a similarly high cost must be borne by the taxpayers; and

WHEREAS, the purchase of long-term care insurance is currently also expensive and usually beyond the means of most people, even though many with low but taxable incomes are able to pay part of the cost for such insurance, while those with low, nontaxable incomes needing the same protection are unable to pay any of the cost, and individuals from both groups could have assets that would have to be spent down to the point of impoverishment in order to qualify for public assistance; and

WHEREAS, a mechanism is needed that will provide relief to individuals and to the taxpayers of the State from the burden of long-term care costs in a manner that will be fair to all groups by giving special incentives to buy long-term care insurance to those with taxable incomes less than a specified amount and also providing purchase incentives to those whose personal income tax returns show no taxable income; and

WHEREAS, in addition to incentives to purchase long-term care insurance, other efforts must be made to improve access to long-term care and to clarify terminology in this emerging area; now, therefore,

BE IT RESOLVED by the House of Representatives of the Fifteenth Legislature of the State of Hawaii, Regular Session of

1989, that the Legislative Reference Bureau is hereby requested to conduct a study of long-term care insurance, which shall include, but not be limited to:

(1) An estimation of the number of persons eligible for a tax credit for long-term care insurance premiums;

(2) The feasibility of making such a credit inversely proportional to the gross adjusted income of the taxpayer, with credit ranging from $500 per policy for those in the zero to $19,999 tax bracket to no credit for those with over $60,000 in taxable income;

(3) The extent to which long-term care insurance can affect Medicaid costs to the State;

(4) The consideration of alternatives that do not utilize tax credits but which provide other incentives for the purchase of long-term care insurance;

(5) An examination of the concept of earmarking the four percent excise tax on health services to fund institutional and nonistitutional long-term care services, and an analysis of other possible financing arrangements, such as subsidies to providers, benefits to individuals, and the expansion of existing programs *such as Medicaid; and*

(6) A determination of which services should be included within the scope of institutional care and within the scope of noninstitutional care;

and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau report its findings and recommendations to the Legislature at least twenty days prior to the convening of the Regular Session of 1990; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Director of the Legislative Reference Bureau and the Director of the Executive Office on Aging.

Appendix B

HOUSE OF REPRESENTATIVES
FIFTEENTH LEGISLATURE, 1989
STATE OF HAWAII

H.R. NO. 14 H.D. 1

HOUSE RESOLUTION

REQUESTING A STUDY ON ESTABLISHING TAX CREDITS FOR FAMILIES CARING FOR THE ELDERLY.

WHEREAS, the elderly persons of this State through hard work, vision, and love of these islands have made Hawaii the place it is today, with a quality of life enjoyed by all of the State's people and envied throughout the world, and it is these individuals who deserve in their latter years lives filled with dignity, caring, and respect; and

WHEREAS, one of the greatest concerns of the ever-increasing population of older people is the devastating expense of institutional long-term care, which at a private facility can impoverish a family in only two years or less and if provided by a government facility via public assistance, will mean that a similarly high cost must be borne by the taxpayers; and

WHEREAS, it is also a burden on those families who care for the elderly who are ill at home because of the physical, emotional, and intellectual strain on family care-givers to provide round-the-clock care and meet the high cost of medical care and medication; and

WHEREAS, the purchase of long-term care insurance is currently expensive and usually beyond the means of most people, even though many with low but taxable incomes are able to pay part of the cost for such insurance, while those with low, nontaxable incomes needing the same protection are unable to pay any of the cost, and individuals from both groups could have assets that would have to be spent down to the point of impoverishment in order for them to qualify for public assistance; and

WHEREAS, a mechanism is needed that will provide relief to individuals and to the taxpayers of the State from the burden of long-term care costs a manner that will be fair to all groups by giving tax credits to families caring the elderly who are ill; now, therefore,

BE IT RESOLVED by the House of Representatives of the Fifteenth Legislature of the State of Hawaii, Regular Session of 1989, that the Legislative Reference Bureau is requested to conduct a study of offering tax credits to families caring for the elderly who are ill, including, but not limited to:

(1) The estimated number of persons eligible for a tax credit of this nature; and

(2) Alternatives that do not utilize tax credits but which provide relief to those families providing care for the elderly who are ill;

and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau report its findings and recommendations to the Legislature at least twenty days prior to the convening of the Regular Session of 1990; and

BE IT FURTHER RESOLVED that a certified copy of this Resolution be transmitted to the Director of the Legislative Reference Bureau and the Director of the Executive Office on Aging.

Appendix C

Table 2
Long Term Care/Community Long Term Care Branch* Target Populations
Statewide Projections

	1985		1990		1995		2000		2005	
	LTC	CLTCB	LTC	CLTCB	LTC	CLTCB	LTC	CLTCB	LTC	CLTCB
Aged ①	67,751	13,968	82,837	17,079	95,253	19,629	106,467	21,952	118,48	24,400
Disabled ②	126,936	12,964	136,608	13,361	145,380	14,538	152,136	15,214	157,200	15,720
Developmentally Disabled (DD)	9,520	952	10,243	1,024	10,904	1,090	11,410	1,141	11,789	1,179
Chronically Mentally Ill (CMI)	6,630	663	7,243	724	7,793	779	8,238	824	8,598	860
Catastrophically Ill ③	Not Available	Not Available	1,465	775	1,561	828	1,637	871	1,695	905

*Consists of the long term care population which is projected to be Medicaid eligible and therefore could be appropriate for CLTCB services

① Comprised of residents age 65+ who are either in institutions or living in the community with limitations in their activity

② There is some overlap of persons in this population/group with other population groups due to the broad *definition used for disabled*

③ Includes AIDS population projected using a conservative 25% conversion rate

SOURCE: Numbers are based on information from DPED, DOH, *DD Council, Commission on the Handicapped*

Appendix D

John Hancock

Daily Benefits:	
Nursing Home	$60, $80, $100
Home Health	$30, $40, $50
Adult Day Care	Under Home Health Benefit
Qualifying Period:	90 days consecutive confinement.
Waiver of Premium:	After 90 days of confinement.
Portable/Convertible:	Benefits and rates are portable.
Guaranteed Renewable:	Yes.
Lifetime Maximum:	1460 times nursing home benefit selected.
Eligibility:	Active employees, retirees, spouses and parents to age 79.
Underwriting:	Non-Medical based on functional capacity.
Participation:	Must have a minimum of 750 eligibles.
Cost/Month:	80/day Nursing Home Benefit
Age:	
45	$ 20.05
55	$ 31.44
65	$ 72.75
75	$180.71

Hartford

Daily Benefits:	
Nursing Home	$20-$100
Home Health	50% of nursing home benefits for 26 weeks or number of weeks confined.
Adult Day Care	No adult day care available.
Qualifying Period:	20, 30, 60, 90, 100, or 180 day elimination period.
Waiver of Premium:	90 days after confinement.
Portable/Convertible:	No.
Guaranteed Renewable:	No.
Lifetime Maximum:	2, 3, 4, or 5 years.
Eligibility:	Active employees, retirees, spouses, and their spouses, and parents age 79.
Underwriting:	Everyone must complete medical information.
Participation:	No minimum number for group of significant size.
Cost/Month	$50/day Nursing Home Benefit.
Age:	
45	$ 10.95
55	$ 19.68
65	$ 46.48
75	$118.54

Travelers

Daily Benefits:	
Nursing Home	$50-$100
Home Health	$25-$50
Adult Day Care	$25-$50
Qualifying Period:	120 days of covered services - Lifetime aggregate.
Waiver of Premium:	After 120 days in a nursing home.
Portable/Convertible:	Portable for coverage and rates.
Guaranteed Renewable:	by class.
Lifetime Maximum:	1500 times the daily nursing home care benefit selected.
Eligibility:	Active employees, spouses, retired employees and their spouses, and parents ages 18 to 80.
Underwriting:	Everyone must complete an enrollment form with medical questions.
Participation:	No minimum.
Cost/Month:	$50/day Nursing Home Benefit
Age:	
18-24	$ 3.25
35-39	$ 6.30
50-51	$ 16.50
65	$ 64.60
75	$147.20

The Independence Plan

Underwritten by: Life Insurance Company of North America

Daily Benefits:	
Nursing Home	80% of usual, customary, and reasonable to $125,000
Home Health	100% of usual customary and reasonable to $150,000
Adult Day Care	
Qualifying Period:	48 hours of hospitalization then confinement within 30 days or 21 days of skilled nursing home.
Waiver of Premium:	After 90 days in a nursing home.
Portable/Convertible:	Benefits and rates portable.
Guaranteed Renewable:	Yes.
Lifetime Maximum:	$125,000 for Nursing Home Benefits, $150,000 for Home Health Care.
Underwriting:	All employees medically underwritten.
Participation:	No minimum.
Other:	Extra $5,000 for Alzheimer patients. $10,000 benefit with no hospitalization for Home Health Care with some criteria.
Cost/Month:	High option.
Age:	
50	$ 14.92
55	$ 20.50
65	$ 48.00
75	$118.08

LONG-TERM CARE POLICY COMPARISON--INDIVIDUAL POLICIES

Terms & Provisions	Aetna	Mutual	AMEX	CNA	AARP
General Contract Provisions					
Age Limits - Purchase	50-84	18-84	50-84	60-84	50-79
Age Limits - Benefits	None	None	None	None	None
Daily Benefit Options	$40-120	$40-100	$30-100	$40-80	$50
Benefit Period Options (yrs)	4-6	4 **	2-6	3/5	3
Elimination Period Options (days)	20-100	0-100	20/100	15/30/90	90
Renewability	Guaranteed	Guaranteed	Guaranteed	Guaranteed	Guaranteed
Waiver of Premium	Yes	Yes	Yes	Yes	-
Pre-Existing Conditions (days)	180	90	180	360	-
Inflation Adjustment Option	Yes	Yes	Yes	Yes	Yes
Premium Type	Level	Level	Level	Level	Level
Alzheimer's Covered	Yes	Yes	Yes	Yes	Yes
Organic Medical Disorders Covered	Yes	Yes	Yes	Yes	
Nursing Home Benefits					
Levels of Care Covered	All	All	All	All	All
All Levels Covered @ Same Benefit	Yes	Yes	Yes	Yes	
Level of Care Required @ Admission	Custodial	Custodial	Custodial	Custodial	
Number of Days Required in Hospital	0-3	0	0/3	0/3	0
No. of Days Allowed Between Hospital Discharge & Nursing Home Admission	30	0	90	30	N/A
Number of Skilled Days Required	0	0	0	0	0
Type of Facility Required	Skilled	Skilled			
Other	*				
Maximum Consecutive Stay (yrs)	4-6	4 yrs	6 yrs	5 yrs	3 yrs
Maximum Lifetime Benefit (yrs)	4-6	4 yrs	6 yrs	7 yrs	3 yrs
Home Health Care Benefits					
Maximum Benefit Available (yrs)	2	2**	***	2	750 visits
No. of Days Required in Nursing Home	30	20-100	N/A	15	-0-
No. of Days Required in Hospital	0-3	0	0/3	3	-0-
No. of Days Allowed between Hospitals Discharge & Home Healthcare	0	0	90	30	N/A
No. of Days Allowed Between Nursing Home Discharge & Home Healthcare	0	0	0	30	N/A
Benefit Available as Extra Rider Only	Yes	No	No	Yes	

LONG-TERM CARE POLICY COMPARISON--INDIVIDUAL POLICIES (continued)

Terms & Provisions	Aetna	Mutual	AMEX	CNA	AARP
Monthly Premium for $60/Day 3 Day Hospital 3 Year Benefit - 20 Day Elimination			4 Yr Plan	30 Day Elim.	$50 Day/ 90 Days
Age 55	15.20	No Rates	20.10	No Issue	No Rates
Age 65	38.85	No Rates	49.80	30.90	No Rates
Age 75	119.75	No Rates	126.30	72.10	No Rates
Monthly Premium for $60/Day 0 Day Hospital 3 Year Benefit - 20 Day Elimination					
Age 55	19.80	28.99	39.00	No Rates	20.00
Age 65	56.80	43.95	83.40	No Rates	55.00
Age 75	209.75	94.95	225.00	No Rates	135.00

*Different if custodial
**365 Days (for ages 80-84)

Individual:

General Definitions:

Injury:

Bodily injuries caused by an accident, independent of all other causes. The accident must occur while coverage is in effect.

Sickness:

Sickness or disease manifesting itself after the Effective Date of this contract.

We, Us, Our:

The Insurance Company.

You, Your:

The Owner named in the application.

Activities of Daily Living:

These activities are a measure of the Insured's need for long-term care. The attending physician must certify, in writing, those activities which the Insured is unable to perform. The activities include the following:

1. eating;
2. dressing;
3. bathing;
4. walking;
5. getting in and out of bed;
6. taking medications; and
7. using the toilet.

Adult Day Care Center:

An organization that provides a program of adult day care and that fully meets all of the following tests:

1. It is established and operated as an Adult Day Care Center in accordance with any applicable state or local laws.
2. Its staff includes all of the following:
   a. A full-time director;
   b. One or more registered graduate nurse (R.N.) in attendance during operating hours for at least 4 hours a day;
   c. Enough full-time staff members to maintain a client-to-staff ratio of 8 to 1 or better;
   d. A dietitian;
   e. A licensed physical therapist;
   f. A licensed speech therapist; and
   g. A licensed occupational therapist.
3. It operates at least 5 days a week for a daily minimum of 6 hours and a daily maximum of 12 hours.

4. It maintains a written record of medical services given to each client.

5. It has established procedures for obtaining appropriate aid in the event of a medical emergency.

Nursing Care Facility:

A facility which meets all of the following standards:

1. It is licensed by the state in which it is located.

2. It is a separate facility or a distinct part of another facility physically separated from the rest of such facility.

3. It provides Skilled or Custodial Nursing Care to individuals who are not able to care for themselves due to sickness or injury and who require nursing care.

4. Its primary function is to provide, for a charge, room and board and nursing care. The care must be performed under the direction of a licensed physician, registered graduate professional nurse (R.N.), or licensed practical nurse (L.P.N.).

5. It is not, other than incidentally, a hospital, a home for the aged, a retirement home, a rest home, a community living center, or a place mainly for the treatment of alcoholism, mental illness or drug abuse.

Skilled Nursing Care:

Care which uses professional nursing methods and procedures administered by licensed health care personnel. This care consists of one or more of the following:

1. intravenous injections;

2. tubal or intravenous feedings;

3. oxygen therapy;

4. catheterization; and

5. administration of medications.

It is performed under the orders of a licensed physician by a registered graduate professional nurse (R.N.) or licensed nurse (L.P.N.) and is available on a 24-hour basis.

Custodial Nursing Care:

Care which is designed to provide personal assistance with the Activities of Daily Living which the Insured is not able to perform.

Other Coverage:

All health care coverage. This coverage may be provided by any other insurance or welfare plan or prepayment arrangement, or by any federal, state or other governmental health care plan or law (except Medicaid under Title XIX of the Federal Social Security Act).

Physician:

A duly licensed practitioner of the healing arts who is practicing within the scope of that license.

Reasonable Charge:

An amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar medical condition in the locality where the charge is made.

Waiting Period:

The Waiting Period is the number of days shown in the Schedule during which the Insured would otherwise qualify for coverage.

A separate Waiting Period is not applied to each type of care; only one Waiting Period applies whether the Insured is confined in a nursing home or receiving home health or adult day care services.

If the Insured has not incurred covered expenses for home health or adult day care or been confined to a Nursing Care Facility for 6 consecutive months, the Insured must satisfy a new Waiting Period.

The days counted in the Waiting Period do not have to be consecutive. No day will be counted toward the Waiting Period if it was prior to the Effective Date of the Contract.

Benefits:

The carrier will pay the benefits described in this section if, as a result of covered injury or sickness, the Insured's physician certifies that care and treatment are medically necessary, are delivered in the least intensive health care setting required, and that the care and treatment are based on a physician's plan in accordance with accepted standards

of medical practice. Certification will be required periodically, but not more than once every 31 days. No benefits shall be payable for care received during the Waiting Period. The most the carrier will pay for all services received on one day will be the Daily Limit.

Lifetime Maximum:

The total of all benefits payable under this contract during the Insured's lifetime will not exceed the amount stated in the Schedule. Increases to the initial Daily Limit from the two Benefit Inflator Options, if selected, will not be applied toward the Lifetime Maximum.

Home Health Care Benefit:

The benefits are payable up to the Daily Limit. The amount payable is 80% of covered home health care expenses incurred by the Insured for each day the Insured is not able to perform three or more of the Activities of Daily Living.

Covered home health care expenses include reasonable charges for:

1. Services of an agency which is licensed by the state to provide:

   a. home health care; or

   b. home health aide services; or

   c. hospice services.

2. Nursing care provided by a licensed nurse (R.N., L.P.N., L.V.N.).

3. Care provided by a licensed physical, respiratory, occupational, or speech therapist.

4. Nutrition counseling provided by or under the supervision of a registered dietitian.

Adult Day Care Center Benefit:

The benefits are payable up to the Daily Limit. The amount is 80% of the reasonable charges for covered Adult Day Care Center expenses incurred by the Insured for each day the Insured receives covered adult day care services at an Adult Day Care Center.

The Adult Day Care must be an organized program of therapeutic and rehabilitative care provided in an Adult Day Care Center. Such care must be ordered in writing by a physician and be structured according to a written plan of

care developed just for the Insured.

Skilled Nursing Care Benefit:

If the Insured's physician certifies that the Insured requires Skilled Nursing Care in a covered Nursing Care Facility, the benefits are equal to the Daily Limit shown in the Schedule for each day the Insured is confined and incurs a charge for the day of confinement.

Custodial Nursing Care Benefit:

If the Insured's physician certifies that the Insured requires Custodial Nursing Care in a covered Nursing Care Facility and the Insured is not able to perform three or more of the Activities of Daily Living, the benefits are equal to the Daily Limit shown in the Schedule for each day the Insured is confined and incurs a charge for the day of confinement.

Exclusions:

The carrier will not pay the benefits of the contract for that portion of any expense which is:

1. for care or treatment for which no charge is normally made to the Insured;

2. for care or treatment where the person performing the service is the Insured's spouse, child, parent, sibling, spouse's child, or spouse's parent;

3. for care or treatment received outside the United States;

4. caused by declared or undeclared war or any act thereof;

5. caused by any attempt at suicide, within the first 2 years, while sane or insane; or intentionally self-inflicted injury;

6. payable under any Other Coverage;

7. caused by mental or nervous disorder, alcoholism, or drug abuse without demonstrable organic disease. This exclusion does not apply to senile dementia, including Alzheimer's Disease.

Premium Payment:

The first premium payment is due, in full, within 30 days after the Effective Date. Premiums, after the first, may be paid annually, semi-annually, quarterly or for any other

period which the carrier and you agree upon. They must be paid on or before the date they are due or during the grace period. They must be paid to the carrier at its office or to one of the carrier's authorized representatives. Renewal premiums will be due on the day after the end of each term for which premiums have been paid.

Premium Change:

On each due date, the premium will be based on the Insured's age and classification when the contract was issued and on the table of rates in effect on that due date for this contract. The carrier will notify you at least 30 days in advance of the last day for timely payment of the premium of any change in the premium due which is caused by a change in the table of rates.

Waiver of Premium:

If on any premium due date you have benefits due for that date, the carrier will waive that premium. Any premium paid, which would have been waived, will be refunded.

Grace Period:

The carrier will allow a 31 days grace period after the due date for payment of any premium after the first. During this period, this contract will be in full effect. If any premium past due is not paid during this period, this contract will, except as stated in the "Reinstatement" provision, end. The carrier will refund any unearned premium paid when the carrier receives proof at its office of death.

Reinstatement:

If any premium is not paid, the carrier's later acceptance of premium without requiring an application for reinstatement will restore this contact as of the date the carrier accepts the premium. If the carrier requires an application and gives a conditional receipt for the premium, the contract will be restored on the date the carrier approves your application. Lacking such approval, the contract will be resorted on the 45th day after the date of the conditional receipt unless before then the carrier has notified you in writing of its disapproval.

Your restored contract will provide you the same benefits that you had before you failed to pay premium when a loss is caused by: (a) an injury sustained after the date the contract is restored; or (b) a sickness which starts more than 10 days after that date. In all other respects, you have the same rights that you had before you failed to pay premium, subject to any rider attached to, or to any endorsement made on, this contract at the time it is

restored.

Entire Contract; Changes:

The entire contract between the carrier and the applicant consists of the contract, all attached pages, and the written application. All statements made in the application are considered to be to the best knowledge and belief of the applicant and not as promises of truth. Unless it is in the written application, the carrier will not use any statement to avoid this contract or to reduce or to deny a claim. No change in this contract shall be valid until approved by one of the carrier's officers and unless that approval is endorsed or attached to the contract. No person other than one of the carrier's officers can, for it, alter or waive any terms or provisions of this contract.

Contest:

1. Misstatements of the Applicant--After coverage under this contract has been in effect during the Insured's lifetime for two years, the carrier will not contest the coverage or reduce or deny a claim based on the statements made in the application.

2. Pre-existing Conditions--After coverage under this contract has been in effect during the Insured's lifetime for 6 months, the carrier will not reduce or deny a claim for a loss that starts after those 6 months because it was caused by a pre-existing condition which was not admitted in the application. For any other condition which was fully described in the application, the carrier will not reduce or deny a claim for a loss that starts after the Effective Date of a coverage unless that condition is excluded by name or specific description. A pre-existing condition is: (1) A condition for which medical advice or treatment was received during the months prior to the Effective Date of the coverage; or (2) a condition which produced symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment during the same period of time.

Notice of Claim; Claims Forms:

The carrier must receive written notice of claim at its office within 60 days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possibly. When the carrier gets the notice, it will send out forms for filing proof of loss. If the carrier does not send the forms within 15 days after receiving written notice, its requirements will be met if the carrier receives written proof of the event and type and

extent of the loss within the time stated in "Proofs of Loss."

Proofs of Loss:

The carrier must receive written proof of loss within 90 days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. But, unless the person making the claim is legally incapacitated, proof must be given within one year from the time it is otherwise due.

Payment of Claims; Time of Payment of Claims:

The carrier will, on receiving proof of a covered loss, pay you the benefits due. For continuing losses, the carrier will pay the benefits due, monthly, on receipt of due proofs of loss. Any accrued benefits, unpaid at your death, will be paid to your estate. If, at the time of payment:

1. benefits are payable to your estate; or

2. any benefit is payable to a person who is a minor or who is not able to give a valid release; the carrier may pay the benefit, up to $1,000.00 ($3,000.00 in Florida), to any relative of yours, by blood or by marriage, who the carrier thinks is entitled to the benefit. The carrier will be discharged to the extent of any such payment made in good faith.

Physical Examination:

To assist the carrier in evaluating a claim, the carrier reserves the right, at its expense, to examine the Insured when and as often as the carrier thinks is reasonable.

Ownership:

The Applicant for this contract will be the original owner. You, while this contract stays in effect, may exercise all rights given in this contract.

Assignment:

Ownership of any benefit provided under the contract may be transferred by assignment. No assignment is binding on the carrier until it receives a copy of the written assignment at its office. The carrier will not determine if an assignment is valid. Proof of interest must be filed with any claim under a collateral assignment.

Legal Actions:

No legal action may be brought to recover on the contract within 60 days after written proof of loss has been given, as required, or after 3 years (in Kansas, five years; in South Carolina, six years; and in Florida, the time period stated in the statute of limitations) from the time proof of loss is required.

Age:

If the Insured's date of birth or age was misstated in the application, all benefits are what the premium paid would have purchased at the correct age. If, according to the correct age, the carrier would not have issued a coverage, the carrier will not pay any benefits, but the carrier will refund all premiums paid. The coverage will be considered void. If, as a result of misstatement of age, the carrier accepted premium for coverage beyond the date on which coverage would have ended according to the correct age, no benefits will be paid, but the carrier will refund premiums for the period beyond that date. The coverage will be considered to have ended on that date. Proof of age may be filed at any time at our office. Age means age at last birthday.

Non-Participating:

This contract will not share in the carrier's surplus earnings.

Appendix E

JULY 1989 QUESTIONNAIRE

LONG-TERM CARE TAX INCENTIVES/RELIEF

STATE _____

TYPE OF PROGRAM: TAX CREDIT _____; DEDUCTION _____;

OTHER (DESCRIBE) _____

LEGAL CITATION _____

FIRST TAX YEAR AVAILABLE _____

ESTIMATED ANNUAL ADMINISTRATIVE COSTS (Most Current) _____

CLAIMS EXPERIENCE (All years for which data are available)

TAX YEAR	NUMBER OF CLAIMS	REVENUE LOSS ($)

CONTACT PERSON _____ : PHONE ( ) _____

COMMENTS

We will appreciate any comments and observations you have on the program, specifically with regard to tax administration, compliance or equity issues.