Long-Term Care Innovation (B) Subgroup:
Federal Policy Options to Present to Congress

The following is a list of federal policy changes that have been raised by various stakeholders, submitted to all Subgroup members. The Subgroup believes these federal policy changes could help to increase private LTC financing options for consumers. The federal laws primarily identified by stakeholders that would require changes include the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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Option 3: Remove the HIPAA requirement to offer 5% compound inflation with LTCI policies and remove the requirement that DRA Partnership policies include inflation protection and allow the States to determine the percentage of inflation protection. In an LTCI policy with inflation protection, the LTC benefit increases each year at a specified rate; the aim of inflation protection is to ensure that the value of the benefit keeps up with inflation. Inflation protection substantially increases LTCI premiums. For tax-qualified policies and those governed by the NAIC Model Regulation, a 5% inflation protection option must be offered, although a purchaser may choose not to take it. However, if the purchaser is

Option 6: Support innovation by improving alignment between federal law and NAIC models (HIPAA and DRA). HIPAA and the DRA require that LTC policies comply with specific provisions of outdated versions of the NAIC model act and regulation. The NAIC regularly updates its models, and this may result in confusion as the NAIC models evolve while federal law continues to reference old models. Therefore, it may make sense for federal law to reference and require compliance with pertinent provisions of the "current" version of the NAIC model for newly issued contracts (with appropriate transition rules to address model amendments) rather than require compliance with specific provisions of a specific version of the model. This would allow federal law to evolve as the NAIC, a collaborative body with active involvement of consumer and industry representatives, updates the models as needed. This would increase the flexibility of federal law to adapt to the evolving LTC market and regulatory requirements, and reduce confusion and possible inconsistencies between state and federal law.

Option 7: Create a more appropriate regulatory environment for Group LTCI and worksite coverage (HIPAA and DRA). Ideas for consideration could include addressing concerns that may prevent an employer from providing LTCI on an opt-out basis by a) providing a safe harbor to limit the employer's fiduciary liability and b) allowing an employer to offer expanded "catch-up" contributions; and/or permitting LTCI to be available for purchase through cafeteria plans.

Option 8: Establish more generous federal tax incentives. Ideas for consideration include allowing a full federal tax deduction for LTCI premiums (rather than for expenses over 7.5-10% of Adjusted Gross Income) each year an LTCI policy is in force and/or allowing purchases of LTCI under cafeteria plans and from FSAs (consideration may be given to whether tax incentives should be income-based or means tested to focus on lower and middle-income Americans who may not otherwise purchase a LTCI policy); and/or allowing shorter maximum benefit plans (<1 year) to be tax qualified to incent market expansion through lower-priced, shorter duration products.

Option 9: **Explore adding a home care benefit to Medicare or Medicare Supplement and/or Medicare Advantage plans.** Medicare provides extensive acute care coverage but more limited post-acute coverage (home health and sSBT2 0 612 7ne or Med3.41 1 0 0 1 2-overa-

of adding either something akin to a long term care benefit or, less extensive, new home and community based benefits either to Medicare (which would affect supplemental carriers) or to Medicare Advantage and/or Medigap plans. If new benefits were provided in supplemental coverage it could make those products more expensive, though that increased cost might be offset by savings from delaying or preventing the use of more expensive institutional care. [Note: this would require federal changes to Medicare, changes to the NAIC models governing Medigap benefits, and adoption48oinstI of more expen