



ISSUE BRIEF

AMERICAN ACADEMY of ACTUARIES

Federal Tax Incentives for Long-Term Care Insurance: Actuarial Issues and Public Policy Implications

Due to the same demographic changes that threaten the financial health of Social Security and Medicare, the public funding of long-term care services will face increasing pressure in the years to come. A tax policy that provides incentives for private long-term care insurance is one way to ease that pressure and increase the availability of long-term care coverage to those who need it. Possible options for tax incentives include:

- *Providing above-the-line income tax deductions and/or tax credits*
- *Providing deductions through cafeteria plans and flexible spending accounts*
- *Allowing premium payments without penalty from IRA, 401(k), and similar tax-deferred retirement accounts.*

Possible strategies to limit losses in tax revenues include:

- *Setting maximum caps for the amount of tax incentive*
- *Adding income phase-out amounts to target lower income taxpayers*
- *Setting an age cap on tax incentive eligibility*
- *Limiting tax incentives for a specific number of years.*

This issue brief discusses the actuarial and public policy implications of using federal tax incentives to encourage the purchase of private long-term care insurance.

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Introduction

Most people are aware of the future funding crises awaiting Social Security and Medicare. Medicaid faces an equally gloomy picture primarily due to rapidly increasing rates of long-term care (LTC) expenses, currently the second largest cost component (behind hospital care) of Medicaid.

The Congressional Budget Office (CBO) estimated that the aggregate direct cost of LTC for the elderly aged 65 years and older was \$123 billion in 2000, with another \$45-94 billion of LTC provided without charge by family members, friends, and community organizations.¹ The CBO projected that constant-dollar direct costs of LTC will grow 2.6 percent per year during 2000-2040, attaining levels 2.8 times higher by 2040. This is one-third faster than the growth in real GDP for the same period projected by the Social Security Board of Trustees.²

The CBO further projected that Medicaid and Medicare would jointly pay about 60 percent of each year's direct cost, assuming that private LTC insurance (LTCI) payments would increase by a factor of 7.2 during 2000-2020.¹ Without this assumption, the CBO projected that Medicaid and Medicare's share would gradually increase from 60 percent to 72 percent by 2020, with additional increases thereafter.

Given:

- the large existing and projected federal budget surpluses,
- the large savings to Medicaid that could result from substantial growth in private LTCI, and
- the potential for private LTCI to fund in advance a significant portion of future LTC costs;

many have argued that new tax incentives should be enacted to stimulate the growth of private LTCI. This issue brief discusses the actuarial issues and public policy implications of federal tax incentives designed to accomplish this goal.

Background

Private LTCI provides advance funding of LTC costs. This differs from the predominately pay-as-you-go approach underlying Medicaid and Medicare. This section briefly describes the funding of these programs, summarizes the difficulties facing pay-as-you-go, and outlines the case for increased advance funding through private LTCI.

Medicaid is funded on a pay-as-you-go basis from general tax revenues with shared federal and state contributions; eligibility for Medicaid benefits is means-tested. Medicaid covers a broad range of institutional and home/community-based LTC services, accounting for 60 percent of publicly financed LTC for the elderly.¹

Medicare is federally funded with various combinations of pre-funding and pay-as-you-go mechanisms. Medicare's Hospital Insurance (HI) program is financed using a partially pre-funded trust fund system with most revenues obtained from dedicated payroll taxes. Medicare's Supplementary Medical Insurance (SMI) program is financed using a pay-as-you-go trust fund system with most revenues obtained from a combination of monthly premiums charged to beneficiaries and general federal tax revenues.

The Medicare Board of Trustees projected that HI will exhaust its assets by 2029.³ Beyond 2015, general tax revenues will be needed to pay interest on HI's Treasury bonds and, starting in 2021, to redeem the bonds. The net effect will be that the financing of HI, and hence all of Medicare, will be indistinguishable from pay-as-you-go financing after 2015.

Eligibility for Medicare benefits is non-means tested and is generally automatic for persons aged 65 and older; about 12 percent of Medicare beneficiaries are disabled non-elderly persons.

LTC services under Medicare are of two types — home health agency (HHA) and skilled nursing facility (SNF) services. HHA services are primarily covered under SMI; SNF services are covered under HI.

Increases in aggregate costs of LTC will result from the aging of the U.S. population. In 2000, there were 4.0 workers for each Medicare beneficiary.³ This ratio will decrease to 2.3 workers per beneficiary by 2030, with further gradual decreases to 2.0 workers per beneficiary by 2075. Demographic changes will strain the financing of Medicare and Medicaid.

The primary appeal of increased private LTCI is the prospect of pre-funding a substantial part of the inevitable societal burden predicted for the baby-boom generation's need for LTC. A further appeal is that a substantial share of the funding responsibility will shift from the government to the individual.

The current blend of private LTCI and public LTC systems could become more effective with additional tax incentives. Tax incentives for private LTCI could be provided to individuals and employers with the expectation that the cost to the federal government would be better managed. Participation in the private system would be more likely for those who can afford it. While such tax incentives would increase the ownership of private LTCI, there would continue to be a segment of the population that is not adequately insured through either the private or public system due to personal choice or lack of education about LTC needs and costs. For these individuals, additional programs could be developed using government subsidies and tax credits.

Several conclusions can be drawn:

1. Public financing of LTC services at both the federal and state levels is primarily pay-as you-go.
2. The pay-as-you-go approach will put increasing pressure on payroll and income taxes as the number of workers per Medicare beneficiary declines.
3. The projected increase in aggregate LTC costs motivates consideration of advance funding through private LTCI.

Public Policy Objectives

Federal tax policy is necessarily intertwined with public policy considerations. The use of federal tax policy to create incentives for the purchase of private LTCI could be based on one or more of the following public policy objectives:

1. The societal burden for LTC as the baby-boom generation ages will be great and must be pre-funded now or paid for as the costs are incurred later at a much higher price spread over fewer available funding sources.
2. Individuals should plan for and pre-fund future LTC costs.
3. Education, awareness, and understanding of LTC needs and the potential role for private LTCI are currently very limited and need to be expanded for the long-term public welfare.
4. Government expenditures and programs for LTC should be based primarily on criteria of need, coverage, and cost.
5. Pre-funding will minimize government risk for future unexpected and uncontrolled expenditures, while maximizing availability and quality of care for the truly needy.

Existing Tax Incentives for Private LTCI

Given the impetus to pre-fund future LTC costs, the question is how to best accomplish this goal. Congress has indicated, through passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996,⁴ that private insurance is an acceptable method of pre-funding LTC costs.

Under HIPAA, premiums for qualified LTCI policies were given favorable tax treatment similar to that of accident and health insurance premiums. HIPAA provided that:⁴

1. Employer premium contributions for qualified LTCI are excludable from employee income, except for contributions under a cafeteria plan or flexible spending account/arrangement. Employers may deduct their qualified premium contributions as trade or business expenses.
2. Self-employed individuals may deduct qualified LTCI premiums as health insurance expenses, under special rules with specified maximum caps.
3. Tax-free distributions from medical savings accounts may be used to pay qualified LTCI premiums up to specified maximum caps.
4. Qualified LTCI premiums not covered by provisions 1-3 are deductible from income, as itemized medical expenses, to the extent that such expenses exceed 7.5 percent of adjusted gross income, with specified maximum caps.

The maximum caps for the annual amount of qualified LTCI premium eligible for the tax favored treatment in provisions 2-4 are indexed for inflation and increase with attained age, currently ranging from \$230 for policyholders up to age 40 to \$2,860 for policyholders beyond age 70.⁴

Because of the restrictions in provisions 1-4, only a small percentage of taxpayers can utilize any of these tax incentives. Other tax incentives, including full deductibility via an "above the line" tax deduction mechanism, were not adopted in order to minimize lost tax revenue. Nonetheless, HIPAA clarified the tax-free receipt of qualified LTCI proceeds and increased public awareness of private LTCI.

Even though the number of private LTCI policies purchased has increased about 70 percent, to 8 million policies,⁵ since the passage of HIPAA, the percentage of the population covered by LTCI is still small. Currently, less than 10 percent of the population aged 65 and over has purchased private LTCI coverage.⁶ Therefore, recent budget surpluses have led Congress to seriously consider additional tax incentives to further promote private LTCI purchases.

Possible Tax Incentives for Private LTCI

There are numerous possibilities for providing tax incentives that will encourage the purchase of LTCI. Below we identify three major options and their advantages/disadvantages:

1. *Providing above-the-line income tax deductions and/or tax credits.*
An above-the-line 100 percent federal tax deduction has the advantage of reducing taxable income by the full amount of the annual LTCI premium. However, for an equivalent cost to the Treasury, a tax credit can be structured to deliver more value to the less economically advantaged, to increase penetration levels for those who most need to pre-fund their LTC costs.
2. *Providing deductions through cafeteria plans and flexible spending accounts.*
The general rule that a qualified LTCI contract is treated as an accident or health insurance contract is suspended for cafeteria plans and flexible spending accounts/arrangements. As a result, LTCI premiums cannot be paid with pre-tax dollars under such plans. This option would seem to be a very effective means to encourage pre-funding of LTC costs. It has been omitted in the past primarily due to the large anticipated tax loss.
3. *Allowing premium payments without penalty from IRA, 401(k), and similar tax-deferred retirement accounts.*
This option could be an effective mechanism for redirecting retirement savings toward pre-funding of LTC costs. The short-term tax loss could be relatively small if the transferred funds would otherwise be held in place; the long-term tax loss could be substantially offset by future Medicaid savings. However, this mechanism may have the unintentional effect of reducing needed retirement savings.

Strategies for Limiting Tax Losses

Various strategies could be developed to limit losses in tax revenues associated with the proposed tax incentives. Below we identify four major options and their advantages/disadvantages:

1. *Setting maximum caps for the amount of tax incentive.*
Caps are designed to limit costs associated with tax incentives. However, care must be exercised to avoid minimizing the incentive effects or targeting the wrong groups. For example, the current LTCI premium deductibility caps increase with age, minimizing the incentives for younger workers while maximizing the tax loss among the elderly. For an equivalent cost to the Treasury, the caps could be restructured to maximize the number of LTCI purchases.
2. *Adding income phase-out amounts to target lower income taxpayers.*
These are designed to deliver more value to the less economically advantaged, but they may also be used to limit costs associated with tax incentives. However, unless this approach is coupled with effective prohibitions of Medicaid estate planning techniques for artificial impoverishment, it could be self-defeating in an environment where the wealthy do not appear to have incentives to pre-fund their LTC costs.
3. *Setting an age cap on tax incentive eligibility.*
This option would direct the incentives toward the younger working-age population where they are most likely to have the maximum impact on the number of LTCI purchases. This option could be coupled with a caregiver tax credit to increase the impact for the elderly as well.
4. *Limiting tax incentives for a specific number of years.*
Many people act on incentives with large short-term impacts. By limiting the tax incentives to the first few policy years, the incentives could be maximized and the costs minimized. However, this mechanism could be self-defeating if it leads to increased lapse rates when the tax incentives expire.

Tax Policy

Tax subsidies provide two very important incentives to encourage the purchase of LTCI. First, the tax savings make the insurance more affordable. Second, the existence of a tax subsidy leads to publicity and education, making the public more aware of the option of pre-funding the LTC risk.

Politics plays a major role in setting tax policy. Even in good economic times, politicians need to decide how

tax incentives are distributed. Although members of the two major political parties generally recognize the desirability of LTCI coverage, significant disagreements remain over who to target for incentives and how to do it. For example, some advocates prefer tax deductions, which tend to favor individuals in higher tax brackets, while others prefer tax credits, which tend to favor those in lower tax brackets. Consideration has also been given to tax credits for caregivers, although such credits may have little impact on individuals choosing to be caregivers or on individual decisions to pre-fund future LTC costs.

Surveys have determined that the majority of the public does not have an adequate understanding of LTC, while only 20 percent have given substantial thought to preparing for the financial implications of LTC.⁷ Individuals buying any form of personal insurance are prompted by recognizing the need to prepare for the occurrence of an untimely event such as an accident, illness, or death.

LTCI is no different. Those buying often have had personal experience as a caregiver or are aware of the costs and difficulties of dealing with LTC needs. Nonbuyers, especially those over age 55, are more than twice as likely as buyers to think the government will pay for LTC costs.⁸ They are less informed about the financial risks as well as the likelihood of needing LTC.

The major reasons for owning LTCI are to avoid using assets to pay for LTC, to avoid being dependent on family members or friends for care, and to assure that adequate care and choices will be available and affordable when needed.⁸

The most significant barrier to purchasing a policy among nonbuyers is cost. Eighty percent of nonbuyers would be more interested in purchasing LTCI if premiums could be deducted from federal income tax.⁸ The same would hold true if LTCI proceeds could be credited against assets in the determination of Medicaid eligibility, as is currently done through a handful of state public-private partnership plans. Buyers pay an average premium of \$1,677 per year, with somewhat lower payments for younger buyers and somewhat higher payments for older buyers.⁸ On average, nonbuyers indicate they are willing to pay \$924 per year for coverage, although this price varies substantially among individuals and moves with the perceived value of the insurance.⁸ About 15 percent of nonbuyers would be willing to pay the \$1,677 per year premium paid, on average, by buyers, indicating that the demand for LTCI is price elastic. While consumers do not have a specific price point for purchase, the effective reductions in out-of-pocket costs, combined with improved policy benefits and better understanding of LTC needs and costs, would induce more purchases, especially by those who are closest to affording the coverage now and are most likely to spend down to Medicaid eligibility in the future.

There is a logical tie-in between LTCI and retirement savings vehicles in that both are driven by the needs of an aging population. Savings are needed to fund the living expenses of retirees while LTCI is needed to protect their savings.

A parallel may exist in the use of tax incentives to promote and develop the respective markets for these products. By way of comparison, Individual Retirement Accounts, expanded by tax legislation in 1981, resulted in significantly increased retirement savings participation.⁹ When tax legislation in 1986 limited these tax incentives, participation was dramatically reduced. When these tax incentives were again expanded in 1997 participation increased dramatically.¹⁰

Similarly, the 1981 clarifications of the 1978 legislation governing 401(k) retirement plans induced a huge increase in retirement savings participation as more and more employers have offered these plans.^{9, 10} These examples demonstrate the willingness of the general population to participate voluntarily in pre-funding their own retirement needs based on government tax incentives and employer participation in their sponsorship.¹¹

Implications for Medicaid

Medicaid is currently the largest source of funding for LTC expenses. Indeed, the majority of Medicaid expenditures for the elderly is spent on nursing facility services. Because of this, extraordinary pressure has been exerted to minimize Medicaid's per-diem reimbursements to nursing facilities.

Currently, Medicaid's per diem rates average 20-30 percent below the rates paid by private-pay residents, with substantial variation within and between states.¹² These reimbursement levels are so low it has been argued that residents who pay with their own funds or private insurance are substantially subsidizing the costs of care for Medicaid residents.

It has been further argued that low Medicaid reimbursement rates have combined with legislative require-

ments for equivalent care for both private pay and Medicaid residents to threaten the financial viability of the entire nursing home industry.

The demographic trends indicate a significant worsening of this situation as the baby-boom generation ages. However, a parallel growth of LTCI coverage could mitigate this effect. LTCI provides benefits at private pay levels, allowing more nursing facility beds to be filled at profitable rather than subsidized levels. It also prevents or delays individuals from moving into the Medicaid eligible category.

Likewise, to the extent that LTCI becomes a significant source of nursing facility payments, the Medicaid system will be able to better target its expenditures to the truly needy, providing better care and avoiding or minimizing current and future funding crises. For example, minimum standards of appropriate care for Medicaid patients could be legislated and enforced, probably at higher levels than currently.

Some advocates have further argued that private pay patients should be allowed to pay for higher levels of care, thus encouraging further purchases of LTCI. Under this approach, Medicaid funding could be spread over a smaller and more slowly growing population of the truly needy, strengthening the whole system and possibly allowing further upgrades in Medicaid patient service levels.

The current upward trend in Medicaid LTC expenditures has resulted, in part, from increased eligibility due to trusts, family partnerships, and other Medicaid estate planning strategies. Elder law attorneys and tax planners frequently use these strategies with their clients when the need for LTC service is imminent, despite legislative efforts to curb this practice. The counterbalancing effect of increased LTCI market penetration could offset this source of growth in Medicaid expenditures.

Tax Losses and Medicaid Savings

The major tax incentive provided in recent legislative proposals such as the Taxpayer Relief Act of 2000 is a tax deduction for LTCI premiums.¹³ The Joint Committee on Taxation (JCT) estimated the LTCI tax loss under that proposal to be \$11.4 billion for FY2001-2010, with an annual cost of \$1.9 billion in FY2007 when fully phased-in.¹⁴ These estimates did not include offsetting Medicaid savings resulting from additional LTCI participation. Due to prohibitions against overlapping coverage and the payment priority of private LTCI as secondary to Medicare, additional offsetting savings for Medicare would be minor and are not considered here.⁴

Two methods of estimating the Medicaid savings yield very different results: 25 cents¹⁵ vs. 81 cents¹⁶ of each federal tax dollar lost. Both methods recognize delays in timing before the expected Medicaid savings are realized. The first method counts only Medicaid savings directly attributable to additional LTCI purchases stimulated by the tax incentive; the second method counts Medicaid savings among all LTCI policyholders. Although there is no consensus as to which method is preferable, it is important to note that the CBO would score a proposal by estimating the Medicaid savings attributable to additional LTCI purchases stimulated by the tax incentive, not over all LTCI policyholders. However, the CBO would underestimate the long-run savings to Medicaid, because it uses a 10-year budget window and savings due to new purchases would accrue after that time frame.

Advocates of the first method argue that one should not count Medicaid savings attributable to LTCI purchases that would have occurred without the tax incentive. This argument, developed in the early 1990's during a period of federal budget deficits, reflects the view that all tax losses must be offset by other tax increases or spending cuts. Advocates of the second method argue that full accounting for all Medicaid savings accurately reflects the net costs of LTCI tax incentives. This argument, developed during the current period of federal budget surpluses, reflects the view that without tax incentives the purchasers of private LTCI are implicitly subsidizing Medicaid by effectively removing themselves from the pool of potential Medicaid beneficiaries. The differences between the two methods are substantial.

To illustrate, assuming an average annual LTCI premium of \$1,677 and a 20 percent average tax deduction, the unadjusted annual tax loss would be \$335 per policy. After accounting for Medicaid savings, the adjusted annual tax loss would be \$252 or \$64, depending on the adjustment method. Alternatively, assuming the total annual tax loss of \$1.9 billion in FY2007 cited above, the adjusted annual tax loss would be \$1.4 billion or \$0.4 billion, depending on the adjustment method.

Some advocates argue that the public policy objectives can be best accomplished by choosing tax incentives that encourage the largest number of people to pre-fund their future LTC costs, while minimizing the tax loss, however computed. Others maintain that greater efficiency can be obtained by tax incentives that target those with minimal income and assets, since they are the ones most likely to eventually use scarce Medicaid resources.

Tax incentives could be coupled with other changes to magnify the positive effects. For example, expansion of a federally funded education campaign could increase awareness of both the problem and its solution.

Additionally, Medicaid laws could be changed to minimize artificial impoverishment and maximize estate recovery. Some advocates argue that further changes should be made in the Medicaid laws to allow higher levels of care for non-Medicaid financed patients.

Such proposals could be designed to increase public awareness and identify steps that could be taken by individuals to pre-fund their future LTC costs.

Conclusion

Publicly funded LTC under Medicaid and Medicare is primarily financed on a pay-as-you-go basis. Because of the lack of advance funding, demographic changes will significantly strain the financing of these programs. The goal of private LTCI is to fund LTC costs in advance. Cost is the primary impediment to both LTCI tax-incentives and LTCI purchases. Appropriate recognition of Medicaid savings would reduce the net cost to the federal government of LTCI tax incentives, making the passage of some form of incentive more politically feasible. New tax incentives would reduce the effective cost to the consumer of LTCI policies, making it more likely that such policies would be purchased. In turn, the LTC costs of a larger portion of the elderly would be pre-funded and the rate of growth of future Medicaid LTC expenditures would be lower. In addition, because of advance funding within LTCI, most future federal budget surpluses redirected via tax incentives towards private LTCI would continue as national savings.

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² *2001 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Trust Funds* (p. 88), Washington, DC, March 19, 2001. <http://www.ssa.gov/OACT/TR/TR01/index.html>

³ *2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (pp. 16 and 23), Washington, DC, March 19, 2001. <http://www.hcfa.gov/pubforms/tr/>

⁴ Joint Committee On Taxation, *Description of Federal Tax Rules and Legislative Background Relating to Long-Term Care*, March 26, 2001. <http://www.house.gov/jct/x-18-01.pdf>

⁵ Extrapolated from: Susan A. Coronel, *Long-Term Care Insurance in 1997-1998*. HIAA, Washington, DC, March 2000. <http://membership.hiaa.org/pdfs/LTC9798.pdf>

⁶ American Council of Life Insurers, *Life Insurance Fact Book* (p. 62). ACLI, Washington, DC, 2000.

⁷ National Council on Aging, What Americans of all ages don't know about long-term care. *Perspectives on Aging* Vol. XXIV, No. 3 (July-September 1996), pp. 5-12. NCOA, Washington, DC, 1996.

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⁹ American Council for Capital Formation, *Issue Brief: Savings Incentives Work*. ACCF, Washington, DC, November-December 1995. <http://www.accf.org/NovDec95.htm>

¹⁰ Joint Committee on Taxation, *Present Law and Background Relating to Tax Incentives for Savings*, February 11, 1998. <http://www.house.gov/jct/x-11-98.htm>

¹¹ John Sabelhaus and Ken Ayotte, *The effect of tax-deferred savings plans on household wealth accumulation: Evidence from the Survey of Consumer Finances*. CBO, Washington, DC, March 1998. <ftp://ftp.cbo.gov/RePEc/papers/19994.pdf>

¹² Walter M. Cadette, *Financing Long-Term Care, Replacing a Welfare Model with an Insurance Model* (p. a16). Public Policy Brief No. 59, The Jerome Levy Economics Institute of Bard College, Blithewood, NY, 2000. <http://www.levy.org/>

¹³ Joint Committee on Taxation, *Summary Of Provisions Contained In H.R. 5542, The "Taxpayer Relief Act Of 2000," As Incorporated By Reference In The Conference Agreement For H.R. 2614*, October 31, 2000. <http://www.house.gov/jct/x-110-00.pdf>

¹⁴ Joint Committee on Taxation, *Estimated Revenue Effects of the "Taxpayer Relief Act of 2000"*. October 26, 2000. <http://www.house.gov/jct/x-109-00.pdf>

¹⁵ Joshua M. Wiener, Laurel H. Illston, and Raymond J. Hanley, *Sharing the Burden* (pp. 16 and 98). The Brookings Institution, Washington, DC, 1994.

¹⁶ Marc A. Cohen, personal communication June 13, 2001, based on updated data in endnote 8 using methods described in Marc A. Cohen and Maurice Weinrobe, *Tax Deductibility of Long-Term Care Insurance Premiums*. Health Insurance Association of America, Washington, DC, March 2000. <http://membership.hiaa.org/pdfs/000308LTC.pdf>



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