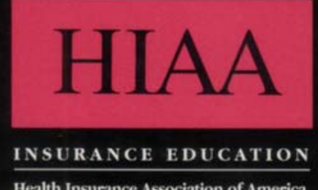

INSURANCE EDUCATION

Health Insurance Association of America

LONG-TERM CARE: KNOWING THE RISK, PAYING THE PRICE

LONG-TERM CARE: KNOWING THE RISK, PAYING THE PRICE

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Chapter 1

WHAT IT IS, WHO NEEDS IT, AND WHO PROVIDES IT

1 Introduction
2 What Is Long-Term Care?
3 Who Needs and Uses Long-Term Care?
9 How and Where Is Long-Term Care Provided?
12 Care Needs of the Under-Age-65 Population
12 Summary
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■ Introduction

Concern about long-term care needs is a relatively recent phenomenon due to a growing population in need of such care. As people get older, the chances that they may need long-term care increase significantly. For example, those aged 85 are four times as likely to enter a nursing home as those aged 65.[1] Life-prolonging advances in medicine and more healthy diets result in more and more families who must cope with a member unable to function independently due to a chronic condition. At the turn of the century, the average life expectancy was 40 years. In 1930, when those who turned 65 in 1995 were born, life expectancy was approximately 60 years. People born in 1995 can expect to live to the age of 73, females to almost 80 years on average.[2]

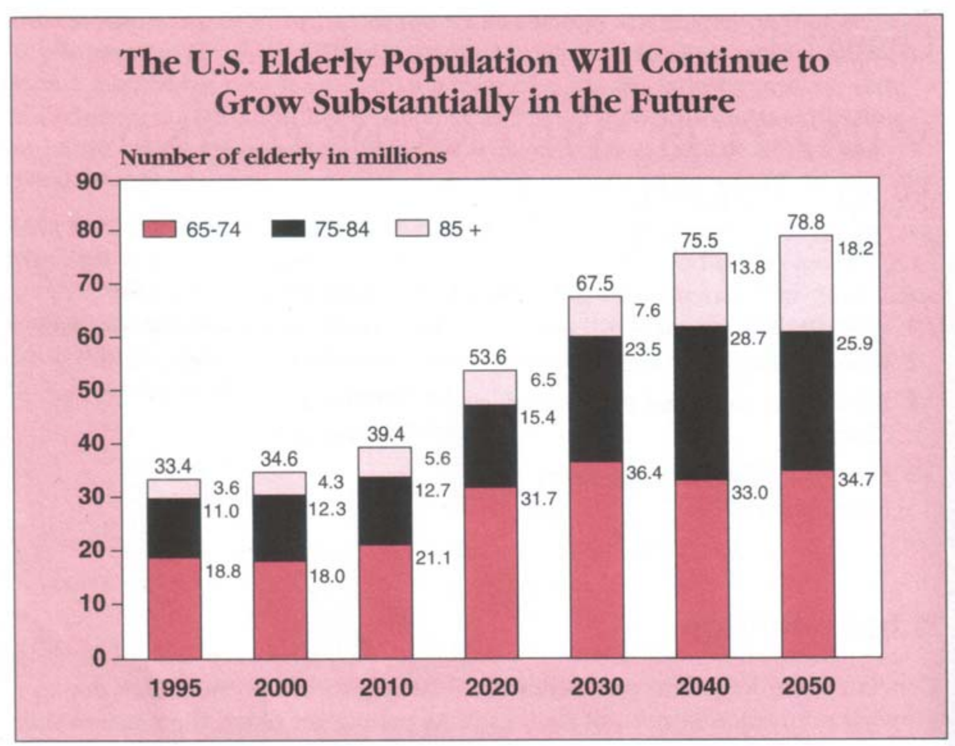

Figure 1.1

SOURCE: U.S. Department of Commerce, Bureau of the Census, Population Projection of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050, Series P25-1130, 1996.

The need for long-term care will continue to grow. As those people in the demographic bulge labeled the baby boom get older, the number of individuals zed 85 and over will more than quintuple between 1995 and 2050 (3.6 million to 18.2

million) (see Figure 1.1). In 2050, persons aged 85 and over will constitute 4.8 percent of the total population, compared with 1.4 percent in 1995.[3] Many experts question whether our current delivery and financing system can adequately cope with the sheer numbers likely to require long-term care in the future.

This chapter describes long-term care services, the population in need of these services. and the nature of current care options. The chapter focuses primarily on the elderly population, although it should be noted that one-third to threequarters of the total population with disabilities are not elderly, depending on which definition of disability is used.[4] Later chapters describe the financing of long-term care and emerging trends in the provision of such services.

■ What is Long-Term Care?

Long-term care encompasses a broad range of services available to individuals with a chronic illness or other disabling condition over a prolonged period of time. These services primarily focus on supportive functions that provide assistance with daily activities in order to minimize, rehabilitate, or compensate for loss of functioning due to a disability. Long-term care services can include assistance with (1) basic functions, such as bathing, getting dressed, getting out of bed. going to the toilet, and eating (services that provide assistance with these basic functions are called "personal care services"); (2) household chores, such .is meal preparation and cleaning; (3) life management, such as shopping, money management, and taking medications; and (4) transportation. Long-term care can also include a need for high-tech medical interventions, such as ventilators and intravenous drug therapy. These services can be provided by unpaid family members or friends (informal caregivers) or by specially trained and/or Licensed professionals (formal caregivers).

In the past, the distinction between long-term care and the traditional acute care model often followed the setting for care. Acute care happened in hospitals and physicians' offices, while long-term care occurred in nursing facilities and the home. With the rapid changes in medical technology and the increase of managed care, people once cared for only in hospitals have been moved to less intensive settings. Therefore, the setting for care no longer differentiates the type of care provided to the extent it once did -nursing homes increasingly provide high-tech intensive care. Chemotherapy treatments can now be delivered in the home. In addition, the range of settings in which long-term care is provided has proliferated with the development of adult day care centers, adult foster care, assisted living facilities, and independent living centers. Therefore. a more practical distinction between acute care and long-term care is that long-term care focuses on coping with rather than curing impairment.

For the purpose of this text, we will use the following definitions:

Acute care. Acute care involves a finite episode of care and the intensive interventions whose purpose is to cure the patient and/or restore him/her to previous levels of functioning to the extent possible.

Subacute care. Subacute care describes higher acuity patients, typically patients with complex needs who require skilled care in settings other than in a hospital. It also describes a new and developing type of organized care that focuses on achieving specified, measurable outcomes using a special physical plant and/or professional resources.[5]

Long-term care. Long-term care includes health, social, and/or personal care services required on a long-term basis by persons with chronic illness, disability, or mental retardation. Supervising someone in the completion of tasks or reminding him/her to complete tasks can be another component of long-term care particularly for persons with cognitive impairment.

Obviously there is some overlap among the definitions. Subacute care has risen out of a more recent trend toward moving people out of hospitals into nursing homes, where possible, to reduce hospital costs.

■ Who Needs and Uses Long-Term Care?

The combination of the disabling effects of chronic conditions and the individual's ability to compensate for these deficits determines who needs long-term care services. For example, individuals may have very different losses of functioning following strokes of similar magnitudes. One individual may actively pursue therapies to regain lost motor functioning and require assistance with only a few tasks for a relatively short period of time. A second individual may be dealing with depression, in addition to lost motor functioning, and as a result, respond poorly to therapy and decline into near total dependency. Similarly, some individuals may take advantage of assistive technologies to function independently while others may be unable to adapt to these technologies. Thus, similar precipitating events may require different long-term care services due to differences in an individual's ability to compensate.

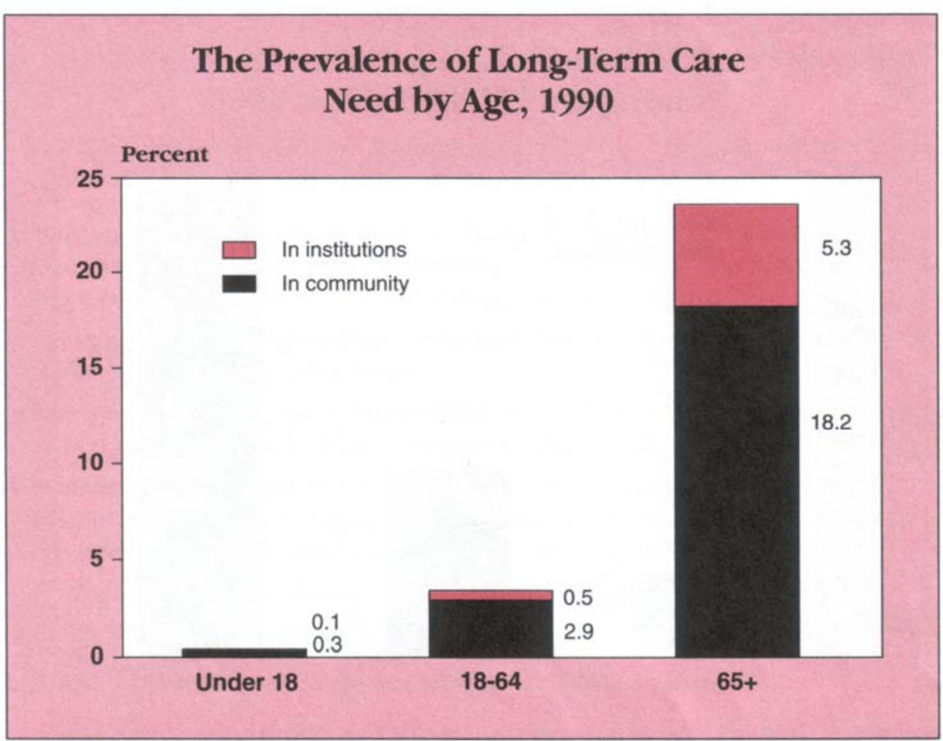

Figure 1.2

SOURCE: ASPE Research Notes, Population Estimates of Disability and Long-Term Care, February 1995.

Researchers use several measures of the need for or use of long-term care services-incidence, prevalence, and continuance. Incidence is a measure of the rate of

occurrence of the need for or use of long-term care services, usually over the course of a year (e.g., the percentage of persons who become disabled or will begin using long-term care annually). Prevalence is a measure of the percentage of persons in need of or using long-term care at a point in time (e.g., the percentage of persons with a disability or in a nursing home at the start of a year). Continuance is a measure of how long individuals need or use longterm care services. Figure 1.2 presents the prevalence of disability by age. Figure 1.3 is a further breakdown for those aged 65 and older.

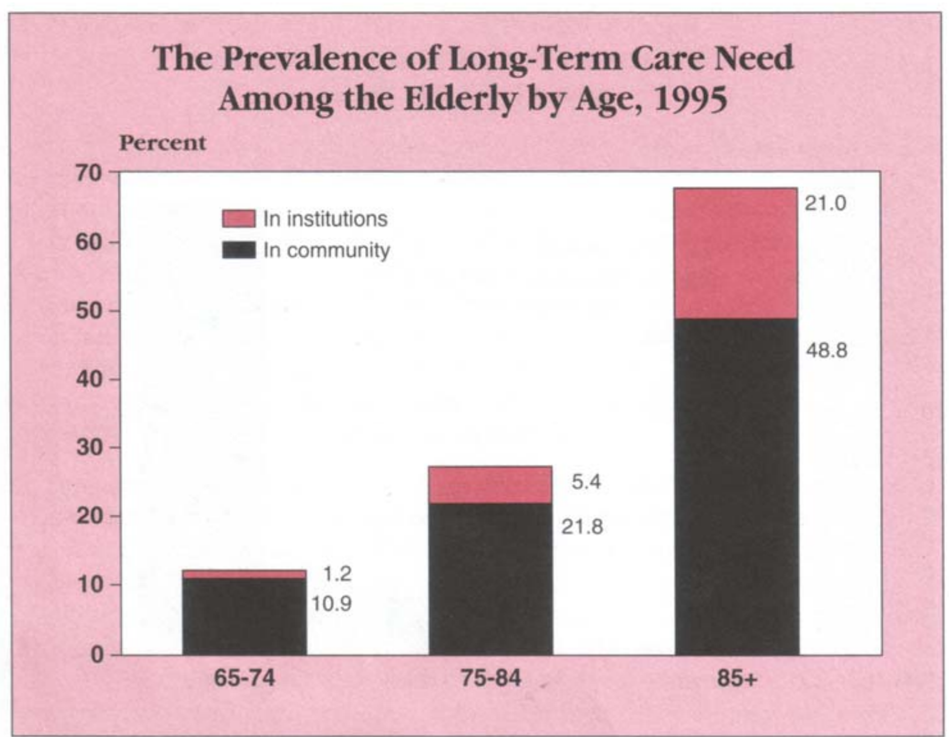

Figure 1.3

SOURCE: Lewin-VHI based on data from the 1987 National Medical Expenditure Survey, Institutional Sample; the 1989 National Long-Term Care Survey; and the 1989 Current Population Survey.

Level of disability is often used as a measure for the need for long-term care. However, not all individuals with a disability require long-term care services and a much smaller subset receive paid long-term care services. Informal caregivers, generally unpaid family and friends, provide the majority of long-term care services. In 1989, over 90 percent of elderly individuals with a functional impairment living in the community received some form of long-term care services. Approximately 65 percent received informal care only, 25 percent received informal and formal care, and less than 10 percent received formal care only.[6]

The availability of family and community support, as well as funding sources, often determines who receives paid long-term care services. Research has consistently shown that, in addition to functional need, the use of paid long-term care services increases as the availability of informal supports decreases.[7] The use of some types of community-based long-term care services, particularly adult day care and assisted living, depends upon their availability. Finally, the ability to pay for these services affects whether individuals use paid care.

Who Determines Need?

Determination of need for, and use of, long-term care varies for different programs and funding sources. The third chapter on government programs highlights the differences in determining eligibility across states and for different government funding sources. The fourth chapter on private long-term care insurance discusses some of the differences in determining benefit eligibility for different policies. Under programs that are funded by the government or other third parties, the types of gatekeeper mechanisms used, such as assessment tools and case or care managers, strongly influence who will receive paid services. In addition to gatekeeping mechanisms to determine the need for care based on level of functional or cognitive impairment, Medicaid uses income and asset tests to determine who will be eligible for reimbursement under the pro?-am. Both public and private payers define the services covered, and this has a direct impact on which services and providers are selected. Generally, if the individual or the family pays for services, the individual determines the need for and amount of paid care.

Functional and Cognitive Indicators of Need

Functional impairment relates to physical deficits, while cognitive impairment refers to the loss or deterioration of one's intellectual capacity. Researchers and others use several measures of functional and cognitive impairment, including activities of daily living (ADLs), instrumental activities of daily living (IADLs), and standardized tests and behavioral indicators. Researchers originally developed ADLs in the early 1960s as a tool for assessing the likelihood that an individual in an institution would regain functioning. By the early 1980s, ADL impairment had become the preferred method for assessing the functional status of older populations living in the community.[8] ADLs have also been used by clinicians to estimate the type of care needed.

Studies generally examine from five to seven ADLs. Most researchers agree that to following five core ADLs best describe functional impairment.[9]

- *Bathing* - turning on water faucets, setting temperature and water level, transferring into tub or shower, washing the whole body, transferring out of the tub or shower, drying off completely, and emptying tub;
- *Dressing* - getting clothes from closet and drawers, dressing self, including fasteners, braces, and prostheses;
- *Transferring* - changing the body from one surface or plane to another, such as bed to chair, chair to chair, chair to standing;
- *Toileting* - moving self to bathroom when urge to void occurs, arranging clothes, transferring to toilet, cleansing self, transferring off toilet, rearranging clothing, washing hands, and moving out of bathroom; and
- *Eating* - getting food and drink from a container into the body for nourishment, including cutting meat, buttering bread, and using fingers or utensils.

In addition, some studies have examined other ADLs, including:

- *Grooming* - washing face and hands, combing hair, brushing teeth, shaving, putting on makeup;

- *Mobility inside and outside the house* - moving from one location to another, walking or wheeling; and
- *Continence* - voluntary control over bowel or bladder.

The developers of the original Katz ADL scale that included bathing, dressing, toileting. transferring, eating, and continence considered these items hierarchical. That is, these abilities tended to be lost in a certain order - the reverse order from that in which one acquires them as a child. A person with increasing impairment could be expected to lose independence in dressing and bathing first. then transferring and toileting, and feeding and continence last. A person dependent in all his/her ADLs would tend to regain independence in feeding and continence first, transferring and toileting second, and dressing and bathing last.[10]

Many national surveys have examined IADLs in addition to ADLs. These measures are designed to assess a broader range of functioning than ADLs by examinng activities that require a greater degree of skill, judgment, and independence. Because of this, people tend to have more difficulty performing IADLs than they do ADLs. And the vast majority of people having difficulty with ADLs also have difficulty with their IADLs.

There are more IADLs than ADLs and there is greater variation in which IADLs are included across assessment instruments. Some of the IADLs assessed in the literature include the following:

- shopping for personal items;
- managing money;
- using the telephone;
- meal preparation;
- medication management;
- doing heavy housework; and
- doing light housework.

IADLs provide important measures of need for support/assistance to live independently, but they cannot be as objectively measured as ADLs. IADLs encompass both cognitive and physical function, but they also can include cultural/ social biases (e.g., some men may have never prepared their own meals, while some women may have never managed their own money).

ADL and IADL measures appear to be sound measures of impairment that perform well at evaluating certain functions. These measures have been found to be both reliable (the same result will be obtained if the measure is given again) and valid (they actually assess functional impairment).[11] [12] ADL dependency is correlated with use and cost of home- and community-based care.[13] Dependency with ADLs is a stronger determinant of nursing service time than other measures of health (e.g., diagnosis).[14] In addition, these measures strongly predict institutionalization and death (see Kovar and Lawton, 1994, for a review).[15]

Depending on how ADLs are defined and which IADLs are included, they can be applied to many of the cognitively impaired. For example, if the definition of impairment in an ADL includes the need for someone to supervise an individual in the completion of the task or remind him/her to complete the task, many individuals with

cognitive impairment would be included. Also, certain IADLs, such as money management and medication management, require higher levels of cognitive functioning. Therefore, including failure to perform these IADLs in the criteria for disability would capture some individuals with cognitive impairment.

Researchers and those determining program/insurance eligibility identify cognitive impairment through (1) the need for supervision or cuing (prompting) for ADLs or IADLs; (2) standardized tests; (3) displays of disruptive behavior, such as wandering or stealing; and (4) clinical assessments and judgment regarding whether an individual might be a danger to self or others. Researchers have not reached a consensus on the most appropriate methods for assessing and measuring cognitive impairment. The currently accepted standardized tests primarily memory (e.g., "Delayed Word Recall," the "Short Portable Mental Status Questionnaire," and Folstein's "Mini-Mental Examination"). Broader measures that assess `thinking" by encompassing mental functions necessary for organization. planning, insight, judgment, self-control, and self-regulation, such as Fogel's measure of executive cognitive functioning, may be more appropriate for identifying cognitive impairment.[16]

Approximately 7.5 million of the 33.6 million persons aged 65 or older in 1995 hi e an ADL or an IADL impairment. Approximately 30 percent of these have a cognitive impairment. Among those with impairments, 81 percent live in the community, while 19 percent reside in nursing homes. Those in nursing homes have higher levels of impairment (see Figure 1.4).

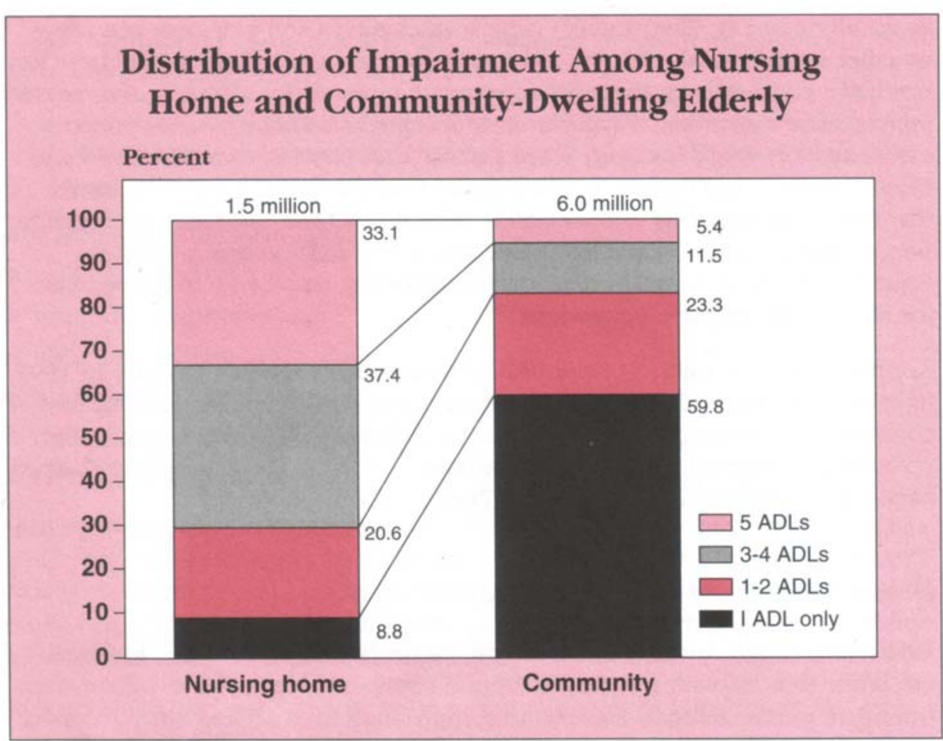

Figure 1.4

SOURCE: Lewin-VHI based on data from the 1987 National Medical Expenditure Survey, Institutional Sample, and the 1989 National Long-Term Care Survey.

Other Characteristics of Those at Risk

Elderly individuals with ADL or IADL impairments tend to be older, less well off white females with few family supports available. Many of these characteristics relate

to one another. For example, individuals aged 85 and older are more to have impairment because of declining health associated with their ages. They also tend to be single women with lower incomes because they hive been widowed. Table 1.1 presents the sociodemographic characteristics of those in nursing homes and those in the community with ADL or IADL impairment compared with those without disabilities.

Table 1.1

Sociodemographic Characteristics of Persons by Residence and Disability Status, 1995

	In nursing homes with functional impairment	Living in community with functional impairment	Without disabilities
Number of persons (in millions)	1.5	6.0	26.1
Total (%)	100.0%	100.0%	100.0%
Age			
65–74	15.5	35.7	66.4
75–84	37.8	38.3	29.5
85+	46.7	26.0	4.1
Sex			
Male	28.2	31.6	43.6
Female	71.8	68.4	56.4
Race			
White	92.0	90.4	89.4
Black and other	8.0	9.6	10.6
Marital status			
Married	18.0	47.0	57.0
Single	82.0	53.0	43.0
Living arrangement			
Live alone	NA	25.0	40.0
Live with others	NA	75.0	60.0
Income below poverty level	NA	22.0	9.0

SOURCE: Lewin-VHI. Based on data from the 1987 National Medical Expenditure Survey, Institutional Sample, the 1989 National Long-Term Care Survey, and the 1989 Current Population Survey.

The Use of Paid Long-Term Care Services

Many factors contribute to whether an individual uses paid long-term care services and how long he/she uses services, including level of impairment, availability of providers (both formal and informal), and ability to pay for services. On all. 22 percent of the elderly had an ADL or IADL impairment in 1995. Am-ing those individuals with ADL or IADL impairments, 44 percent used paid long-term care services. As indicated earlier, those with higher levels of impairment use paid long-term care services more often than those with lower levels of impairment (see Table 1.2).

The extent of long-term care service use varies substantially. Based on the estimates from one computer model using national data, Table 1.3 shows the expected lifetime use of nursing home care and home care services for individuals turning age 65.* The

* These estimates are for individuals turning age 65 in 1990 and are based on projections of the Brookings-ICF Long-Term Care Financing Model. In general, these figures compare favorably with other estimates, such as those from Kemper and Murtaugh, 1991.[17]

expected use of care is generally illustrated in one of two ways-the percent of all elderly who use a certain level of care or the percent of users of care who use a certain level of care. Note that the table illustrates the percent of all *elderly* who use certain levels of care.

Table 1.2

Percentage of Elderly by Measure of Functional Impairment and Their Use of Paid Long-Term Care Services

	Proportion of elderly with impairment	Proportion of elderly with impairment using paid long-term care services
IADLs only	11%	26%
1–2 ADLs	5	47
3–4 ADLs	4	71
5 ADLs	3	79

NOTE: Paid long-term care services include both nursing home care and home care.
SOURCE: Lewin-VHI. Based on the 1989 National Long-Term Care Survey and Liu and Manton, 1994.

Table 1.3

Distribution of Lifetime Long-Term Care Use

Nursing home care	Percent of elderly turning age 65	Home care	Percent of elderly turning age 65
Any use	48.6%	Any use	71.8
Under 1 month	9.9	30 visits or fewer	14.7
1–3 months	6.5	31–60 visits	6.6
3–6 months	4.8	61–90 visits	10.6
6 months–1 year	5.7	91–182	12.1
1–2 years	6.0	183–365 visits	11.2
2–3 years	3.6	366–730 visits	7.8
3–5 years	5.3	731 visits or more	8.8
5 years and over	6.8		

SOURCE: Lewin-VHI. Based on the Brookings-ICF Long-Term Care Financing Model.

The table illustrates that elderly persons are more likely to use home care than nursing home care (72 percent versus 49 percent). The average lifetime nursing home use is one year and the average home care use is a little over 200 visits.
However the table shows that many users receive care only for a short period of time, while a small proportion of the elderly use substantial amounts of long term care services. For example, 51.4 percent of all elderly won't use any nursing home care. Of the 48.6 percent who do use such care, over 50 percent can expect to use less than one year of care during their lifetime, while 14 percent, can expect to use five or more years of care. Similarly, for home care, 28.2 percent of those turning age 65 are not expected to use home care. Of the 71.8 percent who are expected to use care, almost half (45 percent) are expected to use fewer than 90 visits during their lifetime, while 12 percent can expect to use more than 730 visits.

■ How and Where is Long-Term Care Provided?

As indicated earlier, long-term care is provided in a variety of settings-from nursing facilities with highly skilled staff to residential communities with few staffing requirements to community-based facilities, such as adult day care centers, to a

person's home, where care can be provided by individuals with varying skill levels, who may not be paid. The specific requirements for certification or licensure and the availability of each of the settings vary by state. Below, we provide a generic outline of each of these alternatives.

Nursing Home Care

States license nursing homes and the federal government certifies them for Medicare and Medicaid payments. Facilities may provide different levels of care. The amount of medical care provided and the skill of the staff generally distinguish the three levels:[*]

Skilled nursing care. Generally includes around-the-clock medical care.

Intermediate nursing care. Generally involves daily, but not 24-hour, care supervised by registered nurses and ordered by a physician.

Custodial care. Helps meet such basic needs as bathing, dressing, eating, transferring, toileting, mobility, and continence. Skilled medical workers are generally not required.

All three levels generally provide care to persons with cognitive impairment, but intermediate and custodial care tend to have higher percentages of persons with cognitive impairment than do skilled nursing facilities.

The existence of both state licensing and the requirements that must be met for Medicaid and Medicare certification means that nursing homes are highly regulated. As a result, the quality of care provided in these institutions is regularly monitored. Licensure and certification attempt to ensure that residents receive high-quality care from qualified providers.

As indicated in Table 1.1, approximately 1.5 million elderly resided in a nursing home at a point in time in 1995.

Residential Community Care

Residential community care settings provide domiciles in which people receive assistance with their ADLs and IADLs. Residential communities are a small, but growing, segment of the long-term care delivery system. These settings have a variety of names, including assisted living facilities, adult family/foster homes, congregate homes, continuing care retirement communities, and board and care homes. Most of these settings provide similar types of care. The particular name used for a facility is generally dependent on state licensing provisions and the size of the facility. States are responsible for the oversight of these facilities, and generally there are fewer regulations for them than for nursing homes because the care and services they provide are less medical in nature than those in a nursing home.

Assisted living facilities. Provide personal care to residents needing aroundthe-clock assistance with ADLs. These facilities can be the most viable alternative to a nursing

---

[*] The Medicaid program no longer distinguishes between skilled and intermediate care and requires 24-hour nurse availability for all Medicaid-certified nursing facilities. Medicare provides only limited coverage for skilled nursing care by a registered nurse under the direction of a physician, and/or physical, occupational, or speech therapist.

facility for an individual with heavy care needs. Not all states license assisted living facilities. Currently approximately 40,000 to 65,000 providers serve about 1 million elderly.[18]

Board and care homes. Provide a room, meals, personal care services, and 24-hour protective oversight. These homes tend to be small (20 or fewer residents), are typically privately operated, and are known by many different names in different states, such as adult/foster homes.

Congregate homes. Offer independent living with some central facilities and services that can include transportation, recreation, social, and health services. (Although empirical data for board and care homes and congregate homes are not available, such homes appear to be expanding dramatically, especially in states like Oregon that cover them under their Medicaid home- and communitybased waivers.)

Continuing-care retirement communities. Offer both full housing and a range of health care, social, and other services for substantial initial costs plus monthly fees. The American Association of Home and Services for the Aging estimates that there were 350,000 residents in 1,174 CCRCs in 1994.

Home- and Community-Based Care/Services

Community-based care includes services designed to help individuals to remain independent in their own homes. These include (1) centralized service sites, such as senior centers, congregate meal sites, and adult day care; (2) transportation services; and (3) services provided in the home, such as delivered meals, nursing, therapy, home health aide, and homemaker/chore services. Some of these sources of care tend to be the least regulated and monitored among longterm care alternatives.

Senior centers. Provide social and support services to all adults; some include special programs for those with impairments.

Congregate meals. Provide regular, nutritionally balanced meals at a central site for those unable to prepare meals on their own.

Adult day care. Provides a variety of health, social, and related supported services in a protective setting for functionally impaired adults. The National Institute on Adult Day Care estimates that there were 3,000 adult day care centers in 1994.

Transportation. Permits those with special transportation needs and those without other sources of transportation to get to where they need to go.

Delivered meals. Provide regular, nutritionally balanced meals at the home of an individual who is unable to prepare meals on his/her own.

Nursing services. Tend to be medically oriented, such as wound care, and delivered by licensed professionals; provided in the home or community.

Therapy services. Tend to be rehabilitative in nature and include physical, speech, and occupational therapies; provided in the home or community.

Home health aide services. Usually assist persons with functional impairments with personal care needs, such as bathing, and are provided in the home or community.

Homemaker/chore services. Provide assistance with basic household tasks, such as cooking and laundry.

Informal care provided by family and friends can also be considered community-based care. In fact, families and friends provide the vast majority of care received by elderly persons with impairments. Among elderly individuals with an impairment who are receiving assistance, unpaid caregivers provided assistance on average 28 hours per week and paid caregivers provided assistance four hours per week.[19] Even among the one-quarter of informal care recipients who received both unpaid and paid care, paid care averaged only 16 hours per week.[20]

The growing number of elderly persons and those likely to require long-term care will place increasing demands upon the long-term care delivery system. In the future, the availability of paid supports may need to increase. Although research conducted in the early 1980s suggests that informal support has not declined, many speculate that as members of the baby boom age, there may not be sufficient informal support available.[21]

■ Care Needs of the Under-Age-65 Population

Although this chapter has focused on persons aged 65 and over, more than 40 percent of persons with disabilities who could potentially require long-term care services are under age 65.[22] These individuals require many of the same services provided to the elderly population. They also may require additional services to develop or relearn life skills and become more integrated into the community at large. Also advocates for younger people with disabilities have effectively lobbied to ensure there is maximum independence in selecting needed services and providers of service. As a result, this population receives much more care in the community than in institutions. The primary conditions causing a need for assistance with an ADL or IADL differ somewhat among those aged 18 to 64 compared with those aged 65 and over (see Table 1.4).

Table 1.4

Top Five Conditions Causing ADL or IADL Impairments, by Age

Age 18–64	Age 65 and over
1. Bad back	1. Arthritis
2. Mental retardation	2. Coronary heart disease
3. Mental illness	3. Visual impairments
4. Coronary heart disease	4. Stroke
5. Respiratory conditions	5. Respiratory conditions

SOURCE: ASPE Research Notes, Population Estimates of Disability and Long-Term Care, February 1995. Data based on an analysis of the 1990 Survey of Income and Program Participation (SIPP).

■ Summary

As the U.S. population ages, policymakers, individuals, and families must confront many difficult issues regarding how to meet the long-term care needs of a growing number of people. Rapid changes in the delivery system for long-term care over the past decade indicate that the market for services has attempted to respond to a need for more flexible and varied models for providing care. One of the biggest challenges facing providers and consumers in the future will be ensuring that as the continuum of care includes more and more options, quality care is provided in all settings.

hanya untuk kalangan sendiri

■ Key Terms

- Activities of daily living (ADLs)
- Acute care
- Adult family/foster homes
- Assisted living
- Average life expectancy
- Baby boom
- Board and care homes
- Cognitive impairment
- Community-based care
- Congregate homes
- Congregate meals
- Continence
- Continuing care retirement communities (CCRCs)
- Custodial care
- Formal caregivers
- Functional impairment
- Incidence
- Informal caregivers
- Instrumental activities of daily living (IADLs)
- Intermediate nursing care
- Prevalence
- Senior centers
- Skilled nursing care
- Subacute care

Chapter 2

WHO PAYS, HOW MUCH?

14 Introduction
16 Long-Term Care Costs
17 The Long-Term Care Financing System
19 Summary
20 Key Terms

■ Introduction

Increases in health care spending have historically outpaced inflation. The largest gap between the increase in health expenditures and the increase in inflation occurred following the introduction of the Medicare and Medicaid programs in 1965. The annual increase in health expenditures exceeded the annual increase in inflation by 7.9 percentage points during the 1965 to 1970 period. Since 1970, the difference between the increase in health expenditures and inflation has been between 4.6 and 6 percentage points (see Figure 2.1).

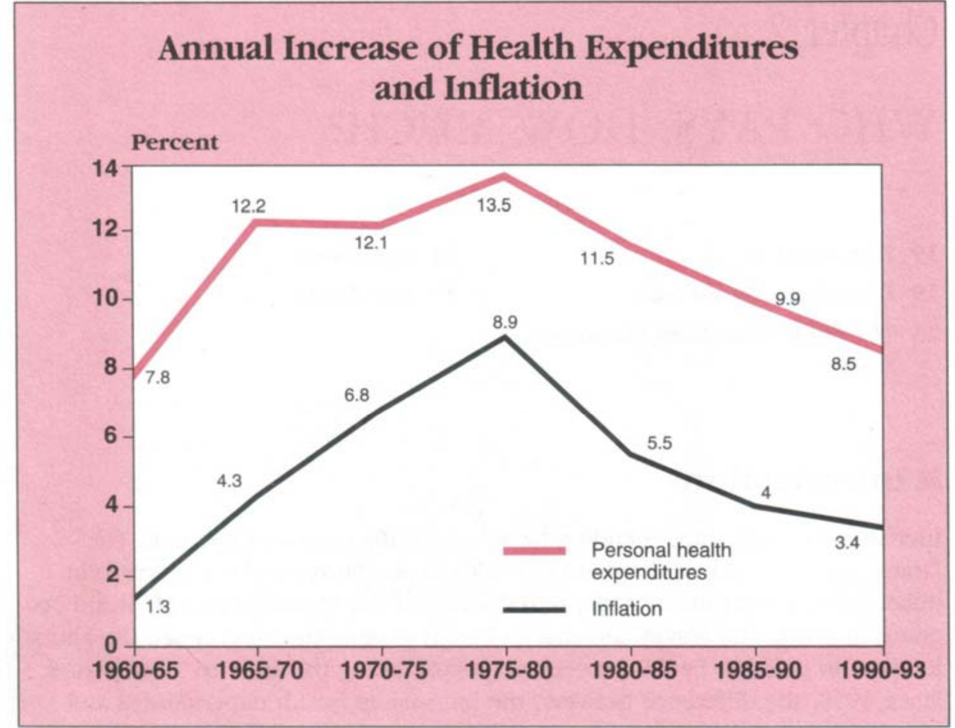

Figure 2.1

SOURCE: Unpublished data from the Health Care Financing Administration, Office of the Actuary, 1995, and the Economic Report of the President, February 1995.

Long-term care expenditures make up a relatively small, but growing, portion of personal health care expenditures (see Figure 2.2). As the population has grown older and the demand for long-term care services has risen, long-term care expenditures as a proportion of total personal health care expenditures has increased from less than 4 percent in 1960 to over 11 percent in 1993 (see Figure 2.3). Long-term care expenditures are expected to increase at a rapid pace because of the growth in the number of elderly persons, combined with significant expansions in the home care

sector. Total long-term care expenditures are expected to be $248 billion in 1993 dollars in the year 2020, up from $108 billion in 1993.[23] This chapter discusses the cost of long-term care services and how these costs are financed.

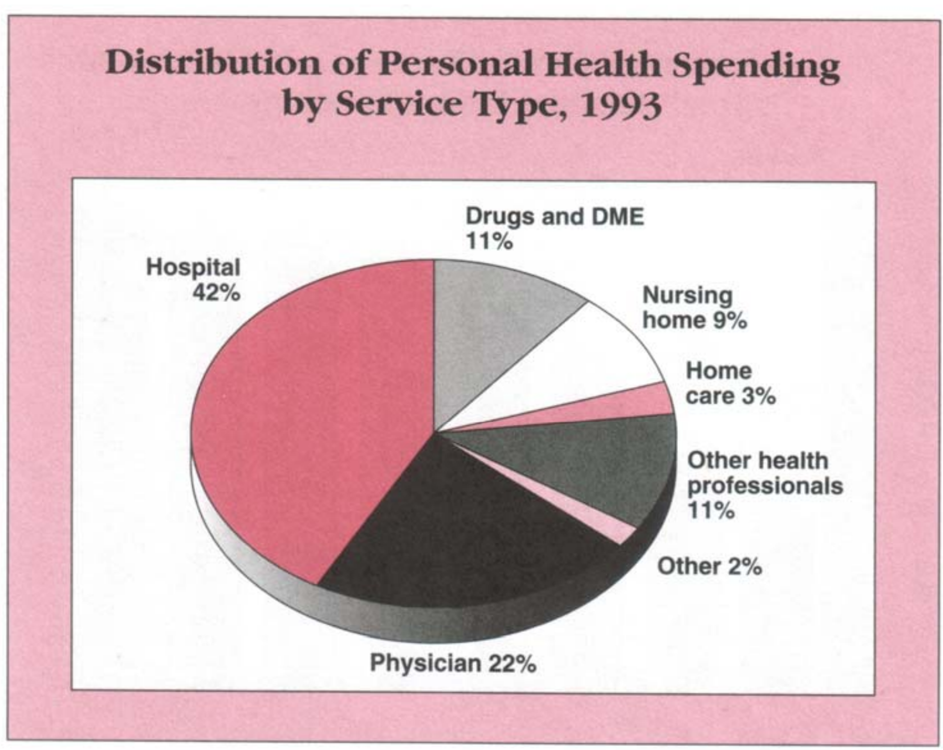

Figure 2.2

SOURCE: Unpublished data from the Health Care Financing Administration, Office of the Actuary, 1995.

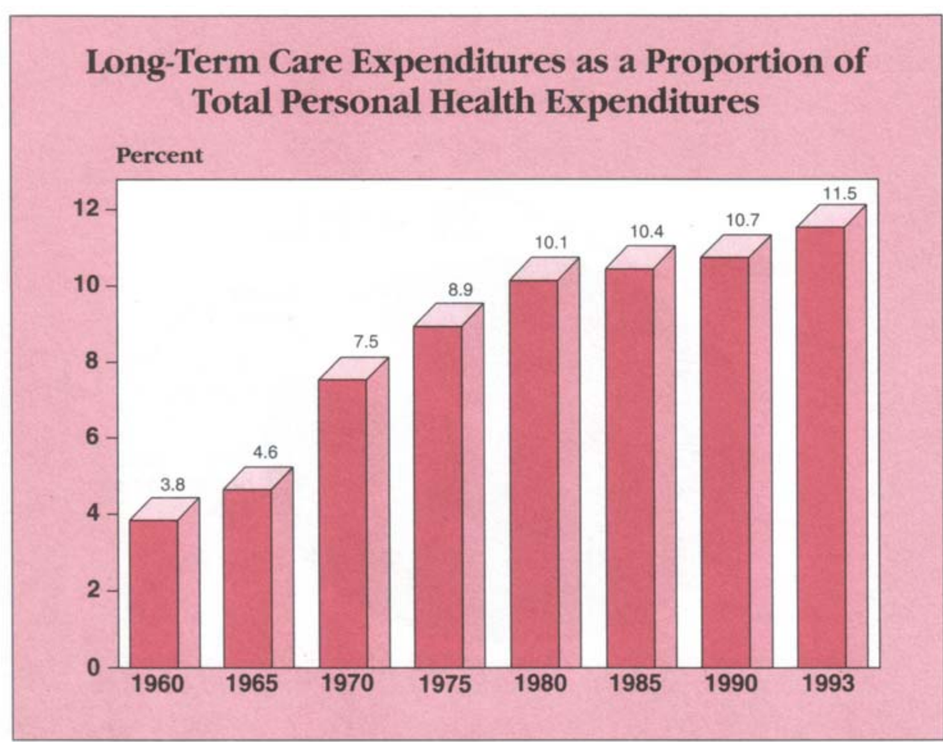

Figure 2.3

SOURCE: Unpublished data from the Health Care Financing Administration, Office of the Actuary, 1995.

■ Long-Term Care Costs

Long-term care services generally cost less than acute care services on a per unit basis (e.g., per day or per visit), but due to the prolonged periods that individuals require this care, individuals can easily incur catastrophic costs. For example, according to the American Hospital Association, hospital care averaged $750 per day in 1995 and the average hospital stay lasted 7.8 days. Thus, among the nearly 20 percent of the elderly who had a hospital stay, the average total cost was $5,850 per stay with approximately $330 paid out-of-pocket. On the other hand, nursing home care for private pay patients averaged nearly $110 per day in 1995.* If the 4 percent of individuals aged 65 and over who entered a nursing home in 1995 experience the average length of stay of just over two years, the average cost will be $88,000, with approximately $43,100 paid out-of-pocket.

The out-of-pocket cost of long-term care services to any given individual varies based on:

- the level of care (i.e., skilled, intermediate, or custodial);
- the setting in which care is delivered (i.e., nursing facility, residential facilities, or home);
- who provides the care (i.e., nurses, home health aides, unlicensed professionals, or families and friends);
- the payment source of care (i.e., Medicare, Medicaid, private insurance);
- how much care is received; and
- the area of the country.

Table 2.1

Variations in Long-Term Care Costs

Setting of care[1]	
Average nursing facility per diem, 1995	$ 95
Average home care visit rate, 1995	60
Provider of care[2]	
Medicare average charge per visit, 1992	
All visits	75
Nursing care	88
Home health aide	58
Physical therapy	90
Speech therapy	93
Occupational therapy	93
Medical, social services, & other	120
Payment source[3]	
Average nursing home private pay[4] per diem, 1995	110
Average nursing home Medicaid per diem, 1995	88
Geographic variation[5]	
Net patient revenue per nursing home resident day, 1993	
National average	74
Lowest state (Arkansas)	55
Highest state (Alaska)	211

[1]Lewin-VHI estimates.
[2]Health Care Financing Review: Medicare and Medicaid Statistical Supplement, HCFA Pub. No. 03348, February 1995.
[3]Lewin-VHI estimates.
[4]Prviate pay includes out-of-pocket and private insurance.
[5]HCIA and Arthur Anderson, 1995 Guide to the Nursing Home Industry, 1995.

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* As discussed in the previous chapter, a large proportion of users of care have relatively short stays and a small proportion of users have very long stays. We note, also, that the average per diem of $110 for private pay nursing home care reflects an overall average across levels of care. Those staying for a prolonged period of time would likely receive care at a custodial level, with a lower than average per diem cost.

Table 2.1 provides data demonstrating these variations. Nursing home prices have increased faster than inflation over most of the past two decades (see Figure 2.4). With the exception of 1980, when inflation was particularly high, nursing home revenue per day (a proxy for nursing home charges) has outpaced general inflation.

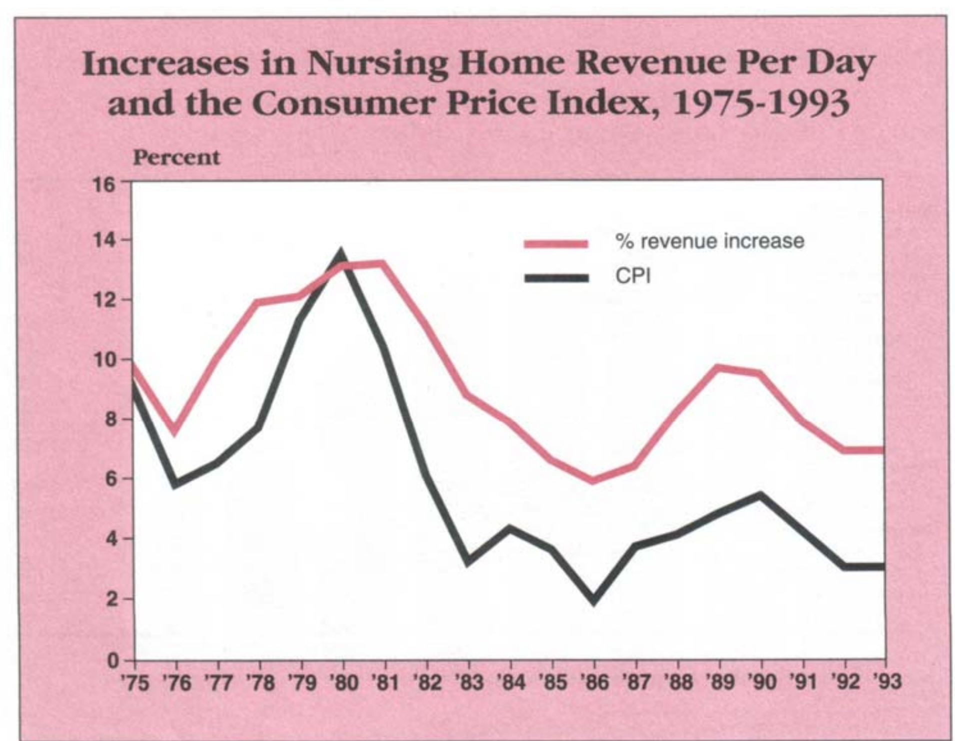

Figure 2.4

SOURCE: Office of National Health Statistics, Office of the Actuary, Health Care Financing Administration and the Congressional Budget Office.

Many elderly cannot afford the high cost of long-term care because they have relatively modest incomes and assets. In 1992 dollars, median income among the elderly was $21,305 for those aged 65 through 69, $18,928 for those aged 70 through 74, and $13,904 for those aged 75 and over.[24] [*]

■ The Long-Term Care Financing System

There is a real difference between the financing of acute care and long-term care services. Both private health insurance and Medicare are 'well designed to cover the cost of acute health care services, but neither is designed to cover the cost of long-term care services. The financing of health care services has a direct impact on the availability and use of services. Overall, Medicare and outof-pocket payments made up the majority (66 percent) of the financing sources for health care among the elderly in 1993 (see Figure 2.5). Acute care services, including hospital care, professional services, and prescription medications, made up 72 percent of health expenditures among the elderly. Long-term care services provided in nursing facilities and the home constituted the remaining 28 percent (see Figure 2.6).

The role each source of financing plays within the acute and long-term care systems differs dramatically. For the elderly, over one-half of funding for acute care services

[*] The median level reflects the point at which 50 percent of households have income above and below this level

in 1993 came from the Medicare program. Private insurance, including Medicare supplement insurance, paid 16 percent and out-of-pocket payments constituted 14 percent. In contrast to acute care, most funding for long-term care services was provided by Medicaid (35 percent) and out-of-pocket payments (42 percent) (see Figure 2.7).

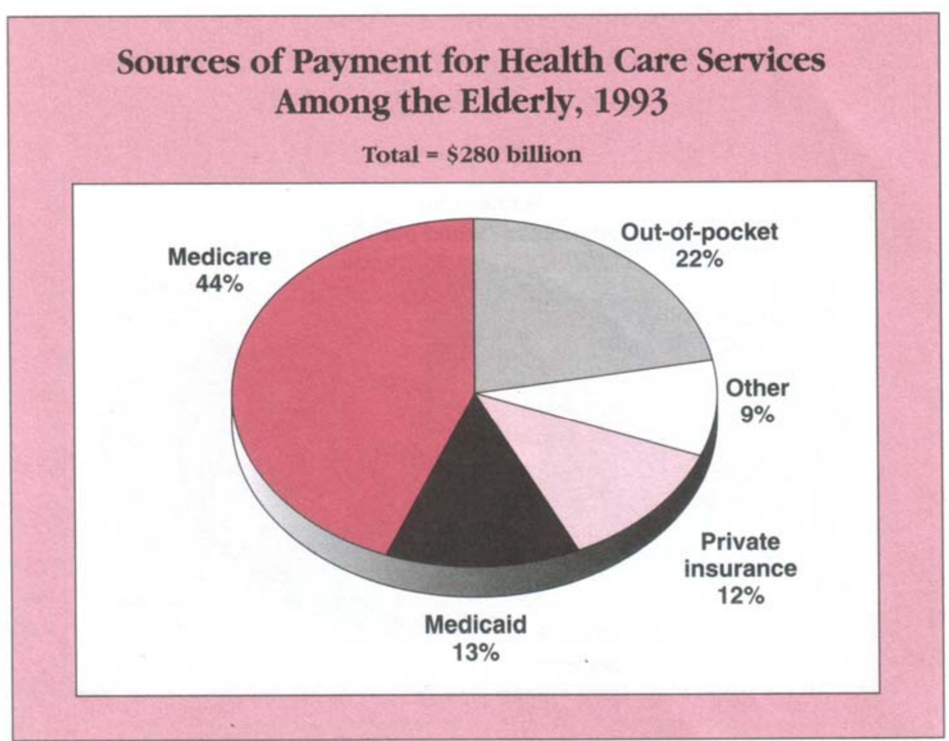

Figure 2.5

SOURCE: Lewin-VHI estimates.

The lack of third-party financing for long-term care means that those in need of this care can face catastrophic costs. As indicated in the previous chapter, a 65year-old has about a 20 percent chance of spending a year or more in a nursing home at an annual cost of roughly $40,000 (in 1995 dollars) before he/she dies. Seven percent will stay five or more years at a cost of $200,000 or more. Given the lack of public and private coverage, individuals and families with catastrophic costs often end up spending all their assets and relying on Medicaid to pay for their long-term care. This process is called "spend-down" to Medicaid and is discussed in more detail in Chapter 3.

The infrequent occurrence and high costs of long-term care expenditures make long-term care an insurable risk across a broad population base. However, as the expenditure data indicate, private insurance covers a very small portion of long-term care expenditures. The lack of private insurance is due in part to the relative newness of the private long-term care insurance market and limited demand. Many elderly incorrectly believe that Medicare or their Medicare supplemental policies will cover long stays in a nursing home.

Despite this, insurance remains a logical and efficient method of preparing for and funding long-term care expenses. Insurance takes advantage of risk-pooling, spreading the risk of long-term care costs across users and nonusers alike. Spreading these expenses reduces the highest possible costs borne by one family. Methods of pooling risk include both public (social insurance) and private (long-term care insurance) options.

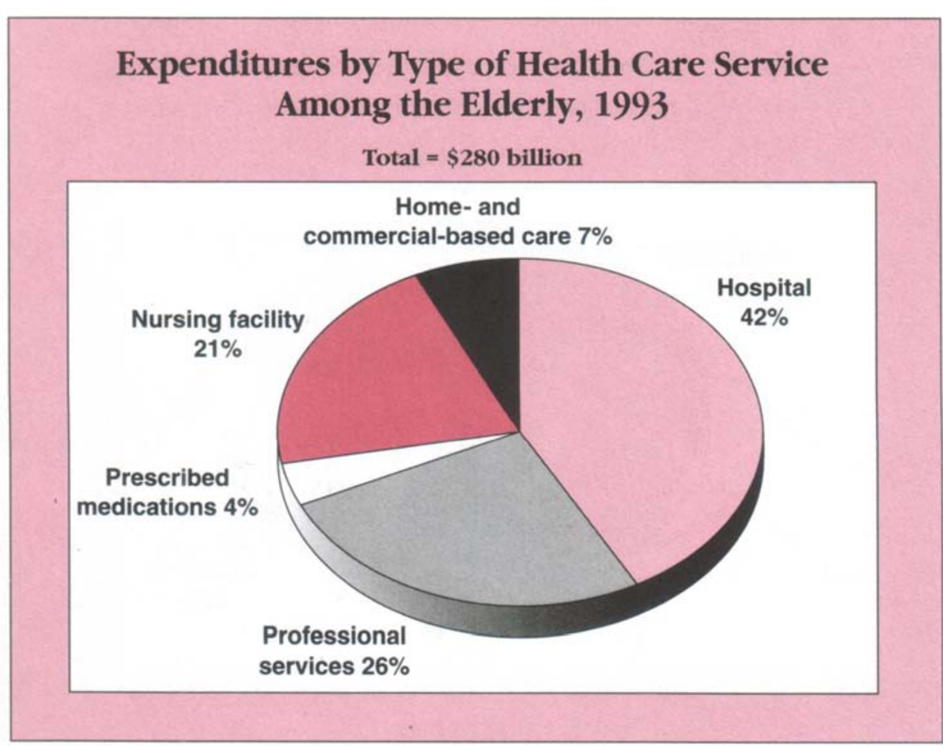

Figure 2.6

SOURCE: Lewin-VHI estimates.

■ Summary

Although long-term care expenditures constitute a relatively small percentage of total personal health expenditures, this proportion is expected to increase. At a time when the cost of medical care in general is very much a problem for the federal and state governments, and for employers and individuals alike, the prospect of a dramatic increase in the need for and use of long-term care services makes financing solutions all the more difficult. Long-term care will affect the health-and the wealth-of the nation. Certainly the cost of long-term care will attract the attention of state and federal governments as they attempt to shape programs to effectively meet people's needs, within increasingly tight budgets. Individuals too must address the issue of long-term care and its potential impact on them as they develop their own financial security plans.

The costs of long-term care services to an individual depend on a number of different factors, including the level of care needed, the setting in which the care is delivered, who provides the care, how much care is received, and the area of the country. The costs borne solely by an individual receiving long-term care services can be substantial because insurance coverage is only a recent phenomenon in the private sector and not provided in the public sector. However, the relatively infrequent occurrence and high level of long-term care expenses constitute a classic insurable risk across a broad population base.

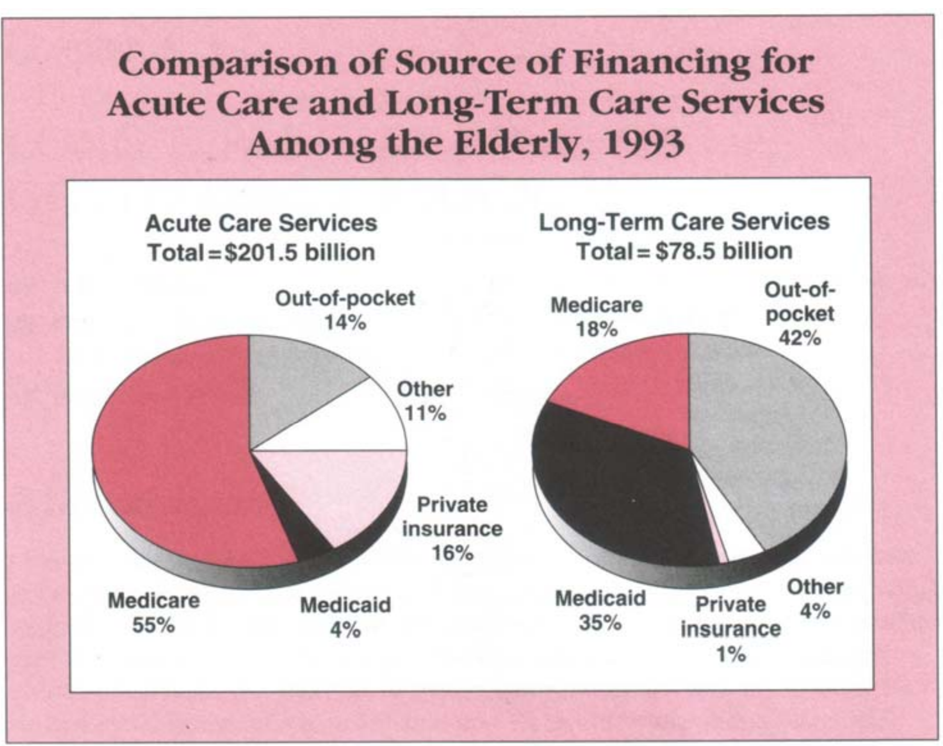

Figure 2.7

SOURCE: Lewin-VHI estimates.

■ Key Terms

Long-term care expenditures
Medicaid
Medicare
Personal health care expenditures
Spend-down

Chapter 3

LONG-TERM CARE BENEFITS OF GOVERNMENT PROGRAMS

21 Introduction
21 Overview of Public Programs That Finance Long-Term Care
31 Issues and Trends
34 US. Long-Term Care Programs in International Perspective
35 Summary
35 Key Terms

■ Introduction

Over the past thirty years, the public sector has become a major source of financing for long-term care (LTC) services in the United States. In 1993, total national expenditures for institutional long-term care services (i.e., nursing home care and care in intermediate care facilities for the mentally retarded) and medically oriented home health services (i.e., in-home nursing, aide, and therapy services) totaled $90.4 billion, of which $55 billion (61 percent) was publicly financed.[25] Although these figures suggest that government is the principal source of funding for long-term care services, it is important to note that the figures do not include spending on home care services that are primarily "social" rather than medical (i.e., personal care attendant, companion, and homemaker/chore service). Nor do they include spending on supervised residential care settings other than Medicare/Medicaid-certified facilities. Private expenditures for such services are known to be sizable, but reliable estimates are not available.

This chapter discusses the extent to which various government programs provide benefits for long-term care services. Table 3.1 lists the major federal programs that finance long-term care services.

■ Overview of Public Programs That Finance Long-Term Care

Medicare

Title XVIII of the Social Security Act, "Health Insurance for the Aged and Disabled," is commonly known as Medicare. The program complements the retirement, survivors, and disability insurance benefits provided under other titles of the Social Security Act. It is administered by the Health Care Financing Administration (HCFA). When initially enacted in 1965, Medicare was available only to persons aged 65 and older. In 1973, legislation extended coverage to other groups: (1) persons entitled to disability benefits for 24 months or more; (2) persons with end-stage renal disease requiring dialysis or kidney transplant; and (3) certain noncovered persons who elect to buy into the program through the payment of premiums.

As of 1993, 36.3 million Americans-of whom 32.4 million were aged 65 or older-were entitled to Medicare coverage under either Part A (the Hospital Insurance program) and/or Part B (the Supplemental Medical Insurance program).[26] Part A is financed through a payroll tax or through premiums for those who lack the Social Security work credits to qualify for premium-free Part A coverage. Part B is financed

by a combination of general revenue tax financing and monthly premiums. In 1995, the Medicare Part B premium was $46.10 per month for most beneficiaries.[27]

Table 3.1

Major Federal Programs Financing Long-Term Care Services

Law	Year enacted	Target LTC population	Covered LTC services
Medicare (Title XVIII of Social Security Act)	1965	Age 65 and older, disabled (24 months of Soc. Sec. disability benefits) End-stage renal disease	Short stay nursing home, home health care (skilled nursing therapies, home health aides)
Medicaid (Title XIX of Social Security Act)	1965	Low-income aged Low-income disabled	Nursing homes, intermediate care facilities for MR/DD, adult day care, personal care attendant services, respite, homemaker services (varies by state)
Social Services Block Grant (Title XX of Social Security Act)	1974	Children, aged, mentally or physically handicapped	Community-based service (varies by state); homemaker, chore, adult day care, and adult foster care
Older Americans Act	1965	Aged (over 60)	Nutrition services, home-delivered meals, supportive services: transportation, outreach, information and referral, legal, in-home services State ombudsman programs Social/recreational
Supplemental security income (SSI) (Title XVI of Social Security Act) and state supplemental payments (SSP)	1972	Low-income aged (over 65) Low-income blind Low-income disabled	Cash payments mainly for residential settings other than nursing homes (at state option)
Department of Veterans Affairs	1963 1972 1975 1980	Veterans	Nursing homes Outpatient care/visits Special housing placement Personal care Adult day care Hospice

SOURCE: Health Insurance Association of America.

Although Medicare does cover most of the hospital, physician, and ancillary costs associated with the medical treatment of chronic illness, it was never designed to cover long-term care. At the same time, one of the few innovations of the original Medicare legislation was to incorporate coverage for post-hospital rehabilitative and convalescent care provided in qualified nursing homes (originally termed extended care facilities, later named skilled nursing facilities) or in the beneficiary's own home. Such benefits were not generally available in insurance programs prior to that time. Unfortunately, Medicare's provisions for short-term, post-acute services in a skilled nursing facility and home health care gave rise to persistent confusion about Medicare's coverage of long-term care needs. Many elderly persons and their families continue to be ill-informed about the limits of Medicare coverage and mistakenly believe that Medicare will finance long-term nursing home care and long-term assistance with functional disabilities in the home.

Skilled Nursing Facility (SNF) Coverage

Medicare coverage of nursing home care is limited to 100 days of "skilled nursing facility" (SNF) care, following a hospital stay of at least three days. However, after the first 20 days, Medicare SNF patients become liable for substantial co-payments ($92.00 per day in 1996) set at one-eighth of the in-patient hospital deductible and

equal to about 85 percent of the average daily nursing home charge for private-pay patients.

From 1972 to 1988, expenditures for Medicare SNF accounted for only 1 to 2 percent of total Medicare payments. In 1989, however, such payments suddenly rose to 3 percent of total Medicare payments. This change reflected the enactment of the Medicare Catastrophic Coverage Act (MCCA) of 1988, which marked the most significant expansion of the Medicare program since its inception. The MCCA eliminated the three-day prior hospitalization stay for SNF coverage, expanded the permissible length of stay to 150 days, and dramatically reduced the potential maximum beneficiary co-payment from $5,400 to $204. These expansions were in effect for only one year. Protests by higher-income elders against an income tax surcharge they were required to pay to help finance these benefit expansions caused Congress to repeal the act in 1989, effective January 1, 1990.

Despite the repeal, SNF payments nevertheless began to grow again in 1991. These payments rose from $1.8 billion in 1990 to $4.4 billion in 1993-a 140 percent increase. In 1993, 31 out of every 1,000 Medicare enrollees used SNF services-up from 22 per 1,000 in 1990. It is believed that these increases occurred because the benefit expansions under the MCCA induced more nursing homes to seek Medicare certification for the first time or, in the case of facilities already participating in Medicare, to expand the number of Medicarecertified beds. Many nursing homes added professional staff and began to provide more skilled nursing and rehabilitative services. Most of these facilities and beds remained in the program even after the 1989 repeal of the SNF benefit expansions.

Home Health Coverage

Medicare covers home health care provided by Medicare-certified home health agencies. In order to qualify, beneficiaries must be homebound and must require the services of either a registered nurse or a physical therapist. So long as beneficiaries require one or more of these "skilled" services, they may also receive other professional and nonprofessional covered services, including medical social work services, occupational therapy, respiratory therapy, home infusion therapies, and home health aide services. Although home health services are supposed to be provided only on a part-time or intermittent basis, visits may occur daily for up to 21 consecutive days and, under special circumstances, even longer. There are no co-payments required from beneficiaries and no limit to the number of visits. Virtually all Medicare financing of such services is provided under Medicare Part A.

Medicare coverage of home health care originally paralleled the SNF benefit (i.e., 100 visits following a hospital stay of at least three days). However, beginning in 1980, when Congress removed the visit limit and prior hospital requirements, the boundary between "post-acute" and "long-term" home health coverage has become increasingly blurred. Thus, whereas the Medicare SNF benefit has, over time, intensified its focus on short-term, post-hospital convalescent and rehabilitative care, the Medicare home health benefit has evolved in the opposite direction: toward serving more beneficiaries who have not had a recent prior hospital stay and increasing the provision of nonprofessional aide services. In recent years the trend has been attributed primarily to liberalizations in coverage and eligibility that occurred in 1989 in response to a successful class action suit, *Duggan v. Bowen.*

These trends can be seen in the dramatic changes in Medicare home health expenditures and utilization that occurred between 1988 and 1993. Home health expenditures grew by 400 percent-from $1.9 billion to $9.7 billion. In 1993, home health services represented 7.5 percent of all Medicare expenditures.

The total number of home health visits grew by 335 percent over the 19881993 time period. The number of persons served per 1,000 Medicare enrollees also increased dramatically-from 49 in 1988 to 79 in 1993-while the average number of visits per person served more than doubled-from 24 to 57.

Much of this increased use of home health services was associated with beneficiaries who had more than 100 visits during the year. Medicare beneficiaries with 100 or more visits per episode now account for 62.6 percent of all home health visits-as compared with 25.1 percent in 1987. The distribution of Medicare home health visits by type of visit has also changed. Visits for home health aide services increased from 26.9 percent of all visits in 1988 to 47.4 percent in 1993, whereas the percentages of skilled nursing and therapy visits declined.

In 1995, HCFA established the Home Health Initiative, whose purpose was to carry out a comprehensive assessment of policy, quality assurance, and operational elements of the home health benefit and recommend improvements where needed. HCFA is also experimenting with a per-episode prospective payment system that seeks to create incentives for home health agencies to deliver services with greater cost efficiency. This voluntary demonstration project began to enroll home health agencies in July 1995 and will last three years.

Medicaid

Medicaid is a means-tested entitlement program that is jointly financed and administered by the federal government and the states. Eligibility for Medicaid is discussed later in this chapter. Funding is from general revenues. Two types of long-term care-nursing facility and home health services-are among the core set of benefits that must be covered under all state Medicaid programs. States have the option of electing to offer other noninstitutional long-term care services, including assistance with activities of daily living (personal care services), adult day health care, targeted case-management, and home- and community-based long-term care "waiver" services. Generally, a state can add or remove most optional services from its Medicaid program by filing a state plan amendment with its federal regional office. However, to be allowed to provide a broad range of home- and community-based services as cost-effective alternatives to nursing home care, authorized under special "waiver" authority first enacted in 1981, states must apply to and obtain approval from the central office of the Health Care Financing Administration.

Medicaid-Covered Services and Expenditures

Medicaid expenditures on long-term care have long been dominated by spending on nursing facility services. Preliminary data for FY 1995 indicate that Medicaid spent $9.9 billion on home- and community-based services as compared with $40 billion on institutional care, including both nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs/MR). Even though spending on nursing home and related institutional services continues to dominate total Medicaid long-term care spending, the growth rate in spending for home care is much higher than that for institutional services. During 19931994, total Medicaid long-term care

expenditures grew 8.6 percent, whereas Medicaid noninstitutional spending grew 26 percent and Medicaid spending for home- and community-based care waiver services grew 35 percent. As of 1993, Medicaid data indicated that, nationwide, there were 1.1 million Medicaid recipients of home health care services and 1.6 million Medicaid recipients of nursing home care.[28]

Medicaid is the largest public payer for home- and community-based (HCBC) long-term care in most states. Indeed, the dependency of most states on Medicaid as the primary payer for such services has intensified in recent years. Throughout the 1980s and early 1990s, states generally found that there were many benefits to be reaped from taking advantage of federal matching funds available through Medicaid to expand public funding for home- and communitybased long-term care. This occurred despite concerns that states had about creating an entitlement program whose future growth might be difficult to control and their frustrations at becoming subject to various federal Medicaid statutory and regulatory requirements. In particular, states have found the application process for Section 1915(C) waivers (named after the section of the Social Security Act that authorizes such programs) for home- and community-based longterm care to be onerous and somewhat restrictive. Since 1981, when the waivers first became available, 395 waivers have been approved in 49 states. Two hundred and five are still in existence, of which 95 serve aged and disabled Medicaid recipients. Another of the optional services that a state may offer under its Medicaid plan to support home- or community-based care is personal care services-assisting with activities of daily living. Over this same time period, states' use of the Medicaid personal care services optional benefit also expanded greatly. Thirty-three states now offer personal care services.
In 1990, Congress enacted an additional mechanism for financing home care under Medicaid (known as the "Frail Elderly" provision.) A capped pool of funding was established for states to provide home- and community-based services to severely disabled elders. Because of concerns about inadequate funding and too much regulation, as of October 1995 only Texas had actually implemented a program.

Table 3.2 shows expenditure patterns on long-term care services financed by Medicaid over the period 1987-1995. As Table 3.2 indicates, the growth rate for home- and community-based waiver services has consistently outpaced that of other long-term care services. The period of greatest expenditure growth rate for all long-term care services, including institutional services, was 19891992. The major increase in expenditures for the personal care option between 1993 and 1994 was due primarily to California's decision to begin financing a significant portion of its In-Home Supportive Services via Medicaid. (It was previously supported by the Social Services Block Grant (SSBG) and state general revenues.) (Social Services Block Grants are discussed later in this chapter under "Other Public Programs.") Conversely, the decrease in personal care expenditures between 1994 and 1995 is largely explained by cutbacks in New York's program (which has long been responsible for two-thirds or more of national expenditures under the personal care services option).

As a percentage of total Medicaid spending, expenditures for long-term care services (including both institutional and noninstitutional) have declined substantially since the mid-1980s. In 1987, long-term care expenditures accounted for 45 percent of all Medicaid spending. In 1995, they accounted for only 33 percent of total Medicaid expenditures. This reflects the higher growth rates in nondisabled and the under-age-65 disabled Medicaid populations in recent years-groups whose Medicaid expenditures are concentrated in acute services.

Eligibility for Medicaid-Financed Long-Term Care Services

Eligibility Rules. Medicaid eligibility rules are extraordinarily complex and also differ across states. Individuals who apply for Medicaid long-term care coverage must qualify on the basis of both functional disability/medical need criteria and financial eligibility standards. Functional disability and medical need criteria that determine whether an individual is considered to be appropriately placed in a nursing home or in home- and community-based long-term care are particularly variable across states. A recent survey[29] found that states usually employ one of three types of criteria to determine whether applicants for Medicaid-funded nursing home care actually require nursing facility care: medical necessity only, medical/functional criteria, and comprehensive criteria that include consideration of social and environmental factors, such as availability of informal caregivers or adequacy of housing in the community. Medical-necessity-only criteria are extremely restrictive in that they require applicants to demonstrate a need for licensed nurse or therapy services that occur with such frequency or unpredictability of timing that they must be provided in a facility setting. Medical/functional criteria are less restrictive, and comprehensive criteria are the least restrictive and most inclusive. This variability in criteria is one reason there is variability in the number of nursing home beds per 1,000 elderly population across states.

Medicaid financial eligibility requirements are more standardized but still vary across states in certain key respects. Briefly, individuals are generally considered financially eligible for Medicaid-covered service if they have income and assets low enough to qualify for cash assistance. Thus, aged and disabled persons who receive or who are eligible to receive Supplement Security Income (SSI) payments are almost always automatically eligible for Medicaid-covered long-term care services.

In addition, states may choose, but are not required, to provide coverage to the "medically needy," persons whose medical expenses exceed their income and savings. In states that offer medically needy coverage, any nursing home resident whose monthly income is insufficient to cover monthly nursing facility charges can qualify for Medicaid coverage for the shortfall-provided that the individual has no savings or other assets above allowable levels. In states that do not offer medically needy coverage, nursing home residents who have "spent-down" their savings can still qualify for Medicaid if their monthly income does not exceed a "special needs cap" set at 300 percent of SSI cash assistance levels ($1,410 in 1996 dollars). Medicaid recipients in nursing homes must contribute all of their monthly income toward the cost of nursing home care, with the exception of a small personal needs allowance (which, by federal law, must be at least $30 per month but may be higher at state discretion).

Although definitions of allowable and exempt assets vary somewhat across states, Medicaid recipients are generally permitted to retain up to $2,000 in savings as well as some forms of property. In the majority of states that follow SSI cash assistance rules to determine Medicaid eligibility, Medicaid recipients, including those residing in nursing homes, may retain the following assets:

- life insurance with a face value of less than $1,500I personal property (such as clothing and jewelry) up to reasonable limits;
- prepaid burial insurance;
- burial space;
- an automobile, within certain limits; and

- a home, regardless of its value, provided it is the individual's principal place of residence. (Nursing home residents may continue to claim a home as their principal residence by making a declaration of "intent to return," regardless of their actual likelihood of eventual discharge from the nursing home back to the community.)

Table 3.2

Medicaid Expenditures for Long–Term Care Services, 1987–1995 (Thousands of Dollars)

	1987	1988	Percent change	1989	Percent change	1990	Percent change	1991	Percent change
Personal care	$ 1,178,031	$ 1,291,663	9.6	$ 1,656,998	28.3	$ 1,864,565	12.5	$ 2,109,662	13.1
HCBS waiver	451,061	632,859	40.3	943,300	49.1	1,246,722	32.2	1,606,904	28.9
Home health	439,655	523,805	19.1	656,553	25.3	813,505	23.9	1,041,228	28.0
CSLA	0	0	0.0	0	0.0	0	0.0	0	0.0
ICF	7,599,393	8,225,635	8.2	8,902,074	8.2	10,111,868	13.6		
SNF	5,966,181	6,418,806	7.6	6,766,109	5.4	7,874,090	16.4	20,823,502	15.8
ICF–MR	5,501,832	5,887,953	7.0	6,628,208	12.6	7,639,157	15.3	8,170,386	7.0
Total long-term care	21,136,153	22,980,721	8.7	25,553,242	11.2	29,549,907	15.6	33,751,682	14.2
Total Medicaid	46,955,851	51,647,062	10.0	58,642,495	13.5	69,754,495	18.9	88,211,139	26.5

	1992	Percent change	1993	Percent change	1994	Percent change	1995	Percent change	ACRG 1987–1995 (%)
Personal care	$ 2,349,443	11.4	$ 2,470,056	5.1	$ 2,995,988	21.3	$ 2,880,361	–3.9	11.8
HCBS waiver	2,152,786	34.0	2,778,984	29,1	3,754,159	35.1	4,681,821	24.7	34.0
Home health	1,258,595	20.9	1,445,382	14.8	1,643,475	13.7	1,922,772	17.0	20.3
CSLA	20,577	NA	5,977	–71.0	24,906	316.7	35,130	41.1	NA
ICF									
SNF	24,358,396	17.0	26,117,195	7.2	28,125,805	7.7	30,454,119	8.3	22.6
ICF–MR	8,706,396	6.6	9,290,697	6.7	9,172,064	–1.3	9,495,561	3.5	7.1
Total long-term care	38,846,193	15.1	42,108,291	8.4	45,716,397	8.6	49,469,764	8.2	11.2
Total Medicaid	114,159,641	29.4	125,050,821	9.5	136,639,351	9.3	151,658,931	11.0	15.8

SOURCE: HCFA 64 data, Office of State Agency Financial Management. (Compiled by Brian Burwell, MEDSTAT, Cambridge, MA, 1996).

Incidence of Spend-Down to Medicaid Eligibility

The cost of nursing home care varies considerably both within and across states, but the average annual private pay cost of nursing home care is estimated at approximately $40,000. Given the high cost of nursing home care, persons who, prior to nursing home admission, were not poor enough to qualify for cash assistance payments-including some considered to be middle class or well-off financially-can

become eligible for Medicaid through the process of "spending-down" their income and assets, especially if their nursing home stays last several years.

For technical reasons, it is no easy task to determine with any great precision the number or percentage of nursing home residents who "spend-down" to Medicaid eligibility. Many studies have been conducted in an attempt to measure spend-down. Experts agree that it is preferable to study the risk of nursing home admission and subsequent spend-down to Medicaid eligibility from the perspective of "lifetime probability" among a given age cohort-an approach that takes into account the fact that some individuals will have multiple nursing home admissions and discharges. Even after multiple admissions are considered. however, spend-down estimates vary widely depending on which population is studied. For example, the spend-down rate for persons admitted as private pay patients who eventually become Medicaid eligible is 47 percent for current residents and 31 percent for all discharged residents. However, if the number of all persons initially admitted as private pay patients is compared with all nursing home patients, regardless of payment source, the spend-down rate is 20 percent for current residents and 14 percent for discharged residents.[30]

Spousal Impoverishment Protections

In 1988, Congress changed the rules determining Medicaid eligibility for persons in nursing homes who have a noninstitutionalized spouse. The intent behind the changes-termed "spousal impoverishment protections" -was to prevent spouses living in the community from being required to contribute the income and savings they needed to maintain their standard of living in the community toward the cost of the institutionalized spouse's nursing home care.

The 1988 legislation required Medicaid to count all assets held by either spouse, divide them equally, and permit the noninstitutionalized spouse to retain a minimum amount of $15,348 (as of 1996) or 50 percent up to a maximum of $76,740 (as of 1996). The minimum and maximum amounts are indexed annually. The noninstitutionalized spouse is also allowed to keep at least 133 percent of the federal monthly poverty level for a couple ($1,254 in 1996) and may also be eligible for an excess shelter allowance (to a maximum of $664 in 1996).

Asset Transfers

By the mid-1980s, there was anecdotal evidence that some people were successfully transferring assets in order to become eligible for Medicaid long-term care coverage without "spending-down." Data on the extent of this practice were not available.

During this same period, there was the development of growth in the wellpublicized "Medicaid estate planning" industry, which helps clients find and negotiate loopholes in Medicaid eligibility laws and regulations. The extent to which Medicaid estate planning has actually resulted in many elders transferring assets in order to obtain Medicaid coverage for nursing home care is a matter of conjecture and controversy. However, with increasing concern about the financial burden of Medicaid on the federal government and the states, policymakers and program administrators are strengthening their efforts to block diversion of benefits intended for low-income families to provide inheritance protection for the families of middle- and upper-income nursing home residents. In 1993, Congress enacted legislation that sought to close most of the loopholes in the law that permitted Medicaid estate planning to occur and required all states to implement estate recovery to recoup Medicaid

expenditures on nursing home care from the estates of deceased beneficiaries. This is discussed further in Chapter 7.

Medicaid/Private Long-Term Care Insurance Partnerships

Six states (California, Connecticut, Indiana, Iowa, Massachusetts, and New York) have the authority under federal Medicaid law to establish "public/private partnerships" to provide asset protection against Medicaid spend-down to individuals who purchase qualified private long-term care insurance policies. The purpose of the program is to encourage individuals to fund their own long-term care with high-quality long-term care insurance. Although the details of such partnerships vary from state to state, the basic concept calls for individuals who purchase qualified private long-term care insurance plans to be rewarded by at least partial exemption from "spend-down" requirements for Medicaid eligibility should they eventually exhaust their private long-term care insurance coverage. In the four states that have initiated such programs-California, Connecticut, Indiana, and New York-more than 15,000 policies had been issued by May 1996.

In addition to the number of partnership policies issued, it is believed by many that the introduction of state-approved long-term care insurance and the publicity surrounding the introduction of partnership policies have a positive effect on all long-term care policies offered in the state.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 closed several loopholes that had enabled people to become eligible for Medicaid without spending down. This made the asset protection feature under partnership plans more attractive. However, at the same time, the law required states that enacted partnership plans after the date the act was passed to recover payment for Medicaid services from the estate of the recipient. In effect, it limited asset protection to the period of time the insured was living. The inability to pass on an estate to heirs greatly reduced the attractiveness of the partnership concept. As a result, state interest in establishing public-private partnerships waned considerably.

Other Public Programs

In addition to Medicaid, there are several other sources of federal and/or state funding for home- and community-based long-term care services. These include: the Social Services Block Grant (SSBG), formerly known as Title XX; Title III of the Older Americans Act; state-only programs (including long-term-care-related state supplemental payments to federal Supplemental Security Income (SSI) cash-assistance-eligible elderly and disabled persons); and Department of Veterans Affairs programs (see Table 3.1).

Social Services Block Grant

The origins of the Social Services Block Grant (SSBG) can be traced to a 1956 amendment of the Social Security Act (SSA) that authorized a dollar-for-dollar match of state funds to social services. Amendments to the SSA enacted in 1962 encouraged provision of social services specifically to the aged. In 1974, Title XX (of the SSA) was enacted to consolidate federally funded social services. The federal/state matching fund formula required that states provide 25 percent of funding. In 1981, federal funding was capped and Title XX became the Social Services Block Grant.

During the 1970s, Title XX was the main source of federal funding for homeand community-based long-term care services. Most of the spending for services to the frail elderly went for homemaker/chore services. During the 1980s, states began to rely more heavily on Medicaid as the principal federal source of funding for home- and community-based services. This was because funding opportunities via Medicaid expanded while SSBG funds became more scarce and were needed to serve other populations (e.g., child day care for AFDC and other low-income families).

Since 1981, direct cuts and inflation have reduced the SSBG by nearly one-third in real terms. Total federal funding under the SSBG was $2.8 billion in 1993; however, reliable estimates of SSBG expenditures on home care are not available. States that have traditionally used significant portions of their SSBG allocations (more than 10 percent) to finance home care services include Indiana, Michigan, Texas, Virginia, Washington, and Wisconsin.[31]

The Older Americans Act

The Older Americans Act (OAA) was enacted in 1965. Title III of the OAA established state and substate agencies to plan and coordinate services to the elderly. Services are defined very broadly to include health, continuing education, welfare, recreation, homemaker services, counseling and referral, transportation, housing, supportive services, nutrition services, and multipurpose senior centers. Federal Title III funds are allotted to state units on aging, which in turn allocate funds throughout each state to local Area Agencies on Aging (AAAs), which make provisions for the delivery of services within their respective planning and service areas. Title III, OAA grantees are required to match federal dollars (either in cash or in kind) at a 25 percent rate for program administration and a 15 percent rate for program activities.

The OAA has not been a major source of funding for long-term care services. However, it has been and remains the major source of funding for services promoting access to the community, such as senior centers and transportation for both the well and frail elderly. Recently, the Area Agencies on Aging have emerged as focal points of efforts to help people find the most cost-effective long-term care services. In some instances these "single entry points" are also used as gatekeepers for referral, assessment, and case management activities. In FY 1991, over half of Title III, OAA funds were spent on nutritional services - $360 million for congregate meals and $87.6 million for home-delivered meals (i.e., Meals on Wheels). Another $290.2 million went toward supportive services (including information and referral, transportation, employment services, legal assistance, counseling, health education, and screening). In contrast, only about $6.8 million was spent on in-home aide and attendant services for the frail elderly. The other major categories of Title III expenditures were for elder abuse programs ($2.9 million) and ombudsman services ($2.4 million) to monitor care provided in nursing homes and to respond to complaints about nursing home care received from residents or their families.

State-Funded Programs

State expenditures for long-term care that are independent of Medicaid or OAA and SSBG programs take the following three forms:

- ***Special payments for residential care facilities.*** These most often take the form of special state supplemental (SSP) payments that augment federal SSI benefits targeted to older or younger disabled persons living in supervised residential

settings such as board and care homes. A handful of states actually run their own specialized residential facilities (e.g., Alaska's "Pioneer Homes" for the elderly).

- ***Stand-alone programs that provide home- and community-based services to the elderly or disabled,*** Occasionally, these programs take the form of cash allowances (e.g., Colorado's Home Care Allowance). More often, however, they are programs that provide services similar to those provided to Medicaid eligibles under home- and community-based waivers-the difference being that the state-only funding can be used to purchase services for individuals who are not financially eligible for Medicaid. Indeed many have incomes or assets well above the financial eligibility threshold for Medicaid or SSBG-funded services (e.g., Oregon's Project Independence). Programs of this type usually require beneficiaries to make income-related copayments. In other cases, state funding may be targeted toward providing services needed by Medicaid recipients that Medicaid does not cover.
- ***Programs targeted toward family caregivers***. These are generally programs that provide respite services or that reimburse caregivers for out-ofpocket expenses associated with caring for an elderly or disabled family member at home (e.g., spending on durable medical equipment, continence pads, or prescription drugs). Occasionally, these programs provide cash allowances to family caregivers (e.g., to parents of disabled children) to cover special needs at the caregiver's discretion.

Department of Veterans Affairs Home Care Programs

The Department of Veterans Affairs (VA) operates about 117 nursing facilities of its own, generally affiliated with VA medical centers. In addition, the VA pays the cost of nursing home care for certain veterans in non-VA nursing homes. The VA also operates a range of programs for disabled veterans who live in their own homes or in residential care settings other than nursing homes. About 78 VA medical centers operate home care programs that provide primary medical care and supportive services to veterans in their own homes. The VA also operates a small number of adult day care centers, a community residential program for about 11,000 veterans, a respite care program, an aide and attendants program (which provides a cash allowance to low-income disabled veterans or, in some circumstances, to spouses or parents of veterans who are similarly impaired), and a senior companion program.

■ Issues and Trends

The following are some of the significant issues and trends that may be expected to influence the evolution of government's role in long-term care over the next several years.

Interstate Variation in Access to Long-Term Care Services

Despite the extensive involvement that the federal government has had in financing long-term care since the 1960s-through Medicare, Medicaid, the SSBG, and Title III of the Older Americans Act-it remains true that there are 50 different state policies on long-term care rather than a single cohesive national policy. Access to publicly funded long-term care benefits depends very much on the state (and sometimes even the county) where an individual lives.

State policies can have a substantial impact on private demand for long-term care and vice versa. States with generous Medicaid reimbursement rates for nursing facilities tend to encourage growth in nursing home bed supply and consequent overutilization of nursing homes. States such as Minnesota and Wisconsin have found that, once overbuilding of nursing home beds has occurred, the trend toward overutilization of nursing homes is extremely difficult to reverse. And, high Medicaid payment rates mean even higher private pay rates. The result is that private pay nursing home residents are more likely to rapidly deplete their resources and, ultimately, to spend-down to Medicaid eligibility-a pattern that is particularly evident in New York.

Demographic differences across states influence how much priority states give to long-term care policy. Paradoxically-or perhaps not so paradoxically given the nature of the fiscal pressures that states experience-states with comparatively low percentages of elderly in their populations often provide more generous publicly funded services, particularly home- and community-based services, than do those states with high percentages of elderly or high elderly population growth rates.

Growing Public Support for Residential Alternatives to Nursing Home Care: Assisted Living Facilities, Adult Foster Care

Growth in availability of nursing home beds per 1,000 elderly is falling behind growth in the elderly population who need care. Most states have imposed "certificate of need" requirements intended to limit new nursing home bed construction. Under these programs, developers must obtain prior permission from state government authorities before constructing new nursing facilities or before expanding the capacity of existing nursing facilities.

New forms of housing with services for the elderly are proliferating. This phenomenon results not only from government constraints on nursing home growth but also because of consumer demand for residential alternatives that have more amenities and offer a more home-like-or, at least, more hotel-like - atmosphere than do most nursing homes. Although the growth of "upscale" continuing care retirement communities and assisted living facilities is clearly a private pay phenomenon, some states (e.g., Oregon, Washington) have been active in promoting the development of assisted living facilities and other residential alternatives to nursing facilities as a matter of public policy.

Unlike coverage of nursing facility care, Medicaid coverage of alternative residential settings only extends to the personal assistance services provided; room and board costs are explicitly excluded. Very low income residents may, however, obtain public assistance in financing room and board costs in adult foster care homes, assisted living facilities, or other types of board and care from SSI and state supplements to SSI.

Movement toward Consumer-Directed "Personal Assistance Services"

There is a growing desire among clients of government programs and their advocates to have more autonomy in managing their personal assistance (i.e., home- and community-based long-term care) services. This raises questions about the need for many of the regulatory requirements that some have long championed as important to quality assurance. In response to this desire, in 1993, Congress eliminated the federal statutory requirements that attendant services financed under the Medicaid personal

care services option be prescribed by a physician and supervised by a registered nurse. Advocates for consumerdirected services want clients of public programs to be able to hire, fire, train. schedule, supervise, and pay or participate in paying their personal care attendants. In practice, this means that clients be permitted to hire independent providers and be able to recruit whomever they choose, including family, friends. and neighbors, with few restrictions (such as prior training or licensure requirements) being imposed. Although only a few states (e.g., California, Michigan) currently permit such an approach in their primary home- and communitybased long-term care services programs, most states now have at least one program (sometimes and often targeted exclusively toward the younger disabled) that is designed to permit their clients to manage their own services.

Efforts to Integrate Acute and Long-Term Care Services in Managed Care Models

Proposals to integrate acute and long-term care services through various types of "managed care" are receiving increasing attention from both federal and state Medicaid officials as a strategy for reducing health care costs and providing better care.[32] [33] A main goal of such proposals is to provide acute care services more efficiently so that savings can be used to expand the provision of longterm care (especially home- and community-based) services.

To date there is little experience with the integration of acute and long-term programs. Of the 19 states recently identified as having enrolled Medicaid-eligible elderly persons or persons with disabilities in risk-based managed care, only seven included some form of long-term care services.[34] Only Arizona included comprehensive long-term care services, including nursing facility coverage, in a statewide program. It is important to note that only the Medicaid services have been capitated; the acute care services-where cost savings for the elderly are likely to accrue-remain covered through Medicare fee-for-service.

The two federal demonstration projects that have been most aggressive in providing a comprehensive array of acute and long-term care services-the Social HMO (SHMO) and Program of All Inclusive Care for the Elderly (PACE) models-are both limited in the size and type of population served.[35] The integration of the financing and delivery of acute and long-term care services is discussed further in Chapter 9.

Policymakers face many critical design issues in developing and implementing managed care models capable of integrating acute and long-term care services. Some of these are highly technical (e.g., how to set risk-adjusted capitation rates), and there is little experience on which to base these decisions. Minnesota recently received Medicaid and Medicare waivers to develop an integrated system, but it will be years before useful findings can be expected to emerge from this experiment. In view of these uncertainties, the advocates of the frail elderly and the younger disabled who depend on Medicare and/or Medicaid have expressed considerable concern about the potential impact of the Medicare/Medicaid managed care and acute/long-term care services integration trends on their constituencies.[36]

■ U.S. Long-Term Care Programs in International Perspective

While long-term care financing reform has been stalled in the United States due to a lack of consensus in regard to health care financing proposals generally, several other advanced industrial countries have forged ahead in making major changes over the past few years. Several contrasting trends are evident in these reform efforts.[37] One is toward "block granting" of funds and moving control away from the central government toward local authorities. This trend has been most evident in Britain and the Scandinavian countries, where it has been accompanied by increased targeting of services to the severely disabled and increased privatization of home care services delivery (i.e., permitting private agencies to provide services that previously could be provided only by government-employed nurses and nonprofessional "home helpers").

The 1993 Community Care Act legislation in Britain did away with the centrally administered social security-based allowances for nursing home care that had been available on a means-tested basis. These funds were transferred in the form of a "block grant" to the local authorities, who already had responsibility for administering home help services and placements in nonmedical "local authority" homes for the aged. The intent was to redirect financial incentives away from institutional to community care. Implementation of the community care reforms has been underway for approximately two years. Early evidence suggests that demand for community care at the local level exceeds available funding, with the result that numerous local authorities have had to impose moratoria on taking on new clients and have developed long waiting lists. At the same time, there is little evidence to date of substantial reduction in use of institutional care.

A second trend involves growing reliance on private insurance. Because there appears to be little likelihood that greatly expanded public funding for longterm care services could be made available, British policymakers are currently giving very serious consideration to providing incentives for the purchase of private long-term care insurance policies. These incentives may take the form of developing public sector/private long-term care insurance policies along lines similar to the Medicaid/private long-term care insurance partnerships that have been developed in four states in the United States. In contrast, Germany has taken a centralizing approach to long-term care reform by adding coverage for long-term care services-both home- and community-based care and, on a phased-in basis, nursing homes-to its social security-based national health insurance system. This required the imposition of a new payroll tax, to which employers and employees must contribute equally. When the new long-term care insurance coverage was first proposed, employers fought the new tax that would be required to pay for it, claiming that the tax would have the effect of making German businesses less competitive in international markets. Ultimately, labor unions won over business by trading off existing workers' benefits. That is, German workers lost one paid holiday annually in order to fund social security-based long-term care insurance coverage.

Finally, a third trend can be seen in the growing popularity of cash allowances that disabled elders (as well as younger disabled persons) and their families can use either to purchase services or to subsidize family care giving. In Germany, individuals who qualify for long-term care insurance coverage in the community can elect to receive either services or a discounted cash payment. The value of the services or the cash payment to which they are entitled varies according to the severity of their disability. The Netherlands also has recently reformed its long-term care financing system

(which is essentially a national health insurance approach) to permit those who qualify for benefits and who are residing in the community to have access to cash allowances. Austria's system of public longterm care financing-put in place several years ago-consists entirely of disability-related cash allowances that are locally administered. The allowances may be used either for nursing home or community-based services. France was scheduled to introduce locally administered cash payments called "independence allowances" for the disabled elderly in January 1996. The plan called for the allowances to be made available initially to elders with severe disabilities living in the community, with eligibility extended eighteen months later to persons with similar levels of disabilities who were living in residential care settings. However, the public employees' strike in the fall of 1995 and the related political turmoil in regard to proposals to cut social benefits for public employees resulted in a postponement of the independence allowances.

■ Summary

The main criticisms of the U.S. government's long-term care programs and policies are that (1) public funding disproportionately supports institutional as opposed to home- and community-based services and (2) they do little to help middle-income families cope with the high cost of formal long-term care services.

Neither of these weaknesses seems likely to be overcome in the near future. Despite the increase in federal and state spending on home- and communitybased care during the 1980s, nearly three-quarters of all government spending on long-term care services during 1993 was for nursing home care. There is no political consensus on either the level of assistance or the method of helping middle-income families protect themselves against catastrophic long-term care costs.

Over the near term, it is unlikely that there will be significant government expansion in the area of long-term care. Instead, government policies will focus on ways to decrease the rate of Medicare and Medicaid spending.

■ Key Terms

Adult foster care
Assisted living facilities
Block granting
Cash allowances
Community-supported living arrangements
Comprehensive criteria
Consumer-directed services
Estate recovery
Functional eligibility standards
Health Care Financing Administration (HCFA)
Home and community based care (HCBC)
Home health agencies
Interstate variation
Means-tested entitlement program
Medicaid
Medicaid estate planning
Medicaid financial eligibility requirements
Medical/functional criteria
Medical necessity
Medicare
Medicare Catastrophic Coverage Act (MCCA)
Medicare Part A
Medicare Part B
Older Americans Act (OAA)
Omnibus Budget Reconciliation Act (OBRA)
Personal care services
Public/private partnerships
Residential alternatives
Skilled nursing facility (SNF)
Social Services Block Grant (SSBG)
Spend-down
Spousal impoverishment protections

Chapter 4

AN EVOLVING PRODUCT

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■ Introduction

Long-term care insurance policies are designed to offer consumers protection against the potentially catastrophic costs of long-term care. Policies vary in scope of coverage, levels of benefits available, and cost.

Over the past decade, long-term care insurance has emerged as a viable product because it meets consumer demands in a way that traditional forms of insurance do not. Coverage is available as individual policies, association group policies, and employer-sponsored group policies.

Statistics reveal that people buy long-term care insurance for a variety of reasons. They buy to avoid dependence, to guarantee the availability of affordable services when needed, to protect assets, and to preserve their standard of living should care be needed (see Figure 4.1).

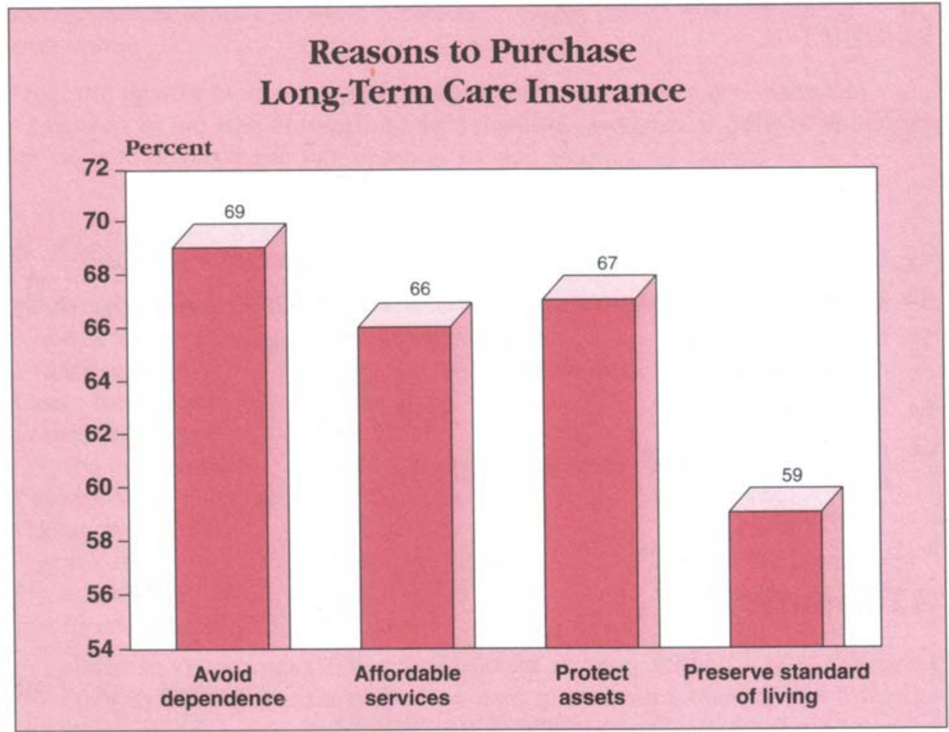

Figure 4.1

SOURCE: LifePlans, Inc., Survey of Buyers, 1994.

Over time, the understanding of what long-term care is has changed from simply being confined to a nursing home to including care by a wide variety of facilities and

providers. As the perception of what long-term care is has changed, so, too, have the expectations of long-term care insurance.

The purpose of this chapter is to present an overview of how the insurance industry has responded to these expectations. We will briefly review some of the reasons for the burgeoning need, review the policy development issues that have been addressed over the past decade, trace the evolution of long-term care insurance, and note differences between individual and employer-sponsored group long-term care insurance.

At the end of the chapter, you will learn of the scope of the long-term care insurance industry as measured by the number of companies currently writing long-term care insurance and the amount of insurance written.

The Emerging Need

Converging trends could create changes in the way Americans receive longterm care. At a time when more people are living longer, recent changes in family structure could mean that fewer families are able to provide the care traditionally given to their older members. At the same time that the demand and need for care is on the increase, public programs are hard pressed to fund existing benefits, let alone take on new ones.

Demographic Realities

The demographic influences are compelling. People are living longer and the number of older people continues to increase. Significantly, the "baby boomers," those born between 1945 and 1964, have passed through their school years, entered the work force, and are planning for retirement (or should be). By the year 2015, people in this population bulge will begin to enter their 70s.

Medical advances, nutrition, and informed wellness practices have helped lengthen the American life span. However, these influences have not necessarily produced healthier older people. At the same time, health care costs have increased at a more rapid rate than retirement income, despite the improved financial health of those aged 65 or older. Thus we face a growing number of older people, who become frail and disabled in later life and who are not prepared to pay the cost of needed care.

Socioeconomic Trends

In the past, it was the woman's responsibility to take care of the family. Whether it was a daughter taking care of her parents or a wife taking care of her husband (and perhaps his parents), it was clearly understood that care giving was the job of the female.

Today, more and more women have joined the work force, making it difficult for them to carry out the care-giving role, but not removing them from it. Also, families have become more geographically dispersed. Divorce has separated women from their husbands and in-laws. And families are smaller. All of these trends lead to the conclusion that care giving will, at a minimum, be more difficult in the future.

Further pressure is created by the trend toward later childbirth, which results in many women caring for their children and their parents at the same time. People in this situation are often referred to as members of the "sandwich generation." All of these factors make traditional care giving much more difficult than in the past.

Public Programs

At this time, there is little probability the government will establish a social insurance program for long-term care. The public sector is hard pressed to provide for the growing older population under current programs, and citizens are not receptive to further tax increases. This situation is exacerbated by the fact that the baby boom was followed by a "birth dearth." Our nation is facing a dramatic increase in older people unsupported by a commensurate increase in the numbers of working men and women to pay the taxes to support public programs. Thus, we face the need for private solutions and the expectation that private long-term care insurance and proper planning will be a major part of the solution.

Lack of Coverage

You learned in Chapter 3 that government programs do not provide meaningful long-term care benefits to most people. What many people don't realize is that neither do traditional forms of private insurance. While the combination of public and private insurance is quite effective in providing the benefits they were designed to provide, the simple fact is that neither public nor private programs were designed for long-term care. Medical insurance was created to handle the short-term needs of acute care, such as periods of hospitalization, surgery, physicians' care, and X-rays. And Medicare and Medicare supplement insurance, which were specifically designed for those aged 65 and over, cover acute care expenses and not those related to long-term care. Long-term care financing was never part of the plan for public or private programs before long-term care insurance came along.

Consumer Demand for Broader Coverage

As it became clear that neither public nor private programs provided appropriate benefits for long-term care, people began seeking better solutions.

Over the past decade, it has been consumers, represented by consumer advocacy groups and supported by health policy experts and regulators, who have been a driving force in encouraging insurance companies to provide insurance policies that better meet the unique needs of long-term care. Furthermore, consumers view confinement to a nursing home as a last resort and have made their demand for alternatives loud and clear. They want flexibility in coverage so they can elect to receive care in a variety of care settings: assisted living facilities, adult day care centers, and at home. And they want a variety of caregivers, including nurses, therapists, nutritionists, and home health aides.

■ Policy Development Issues

Long-term care insurance resulted from consumer demand and a response by the insurance industry. When the industry recognized long-term care insurance as a feasible and attractive new market, it committed resources to develop and market the product. As experience has accumulated and difficult issues have been addressed, long-term care insurance has evolved. Now people can select from a broad array of benefits that better meet their needs and financial security goals.

Insurance Concept

Insurance is based on the fundamental theory that people will pay a price for sharing a risk with others rather than assuming it all themselves. If enough people share in the cost of a risk, the per person cost will be brought to an affordable level. In such an arrangement each person is willing to pay something, trading against the possibility of paying a much larger amount if the loss happens to him/her. At the same time, he/she is accepting the possibility of incurring no loss at all. The insurance company, which insures a sufficient number of people to adequately spread the risk and ensures that no one participant has a greater chance than another of receiving the benefit, receives an additional fee for these services. Put another way, after a person meets the underwriting criteria and pays the premium, a policy is issued that guarantees certain benefits will be paid in return for the premium. The amount of the premium reflects the average expected claims, plus the expense of marketing, administration, and profit to the insurer.

Certain basic assumptions underlie the insurance theory. Each person should have a similar risk of loss. There need to be sufficient numbers insured to spread the risk effectively and predictably. The amount an individual receives from insurance should not exceed the loss he/she incurs.

Initially, the insurance industry questioned how well the need for long-term care fit the insurance model. This uncertainty resulted in highly restrictive policies in the early years, beginning in the mid-1970s. However, it is now clear that with proper underwriting, proper definition of the risk insured, proper data on the use of long-term care, and large enough numbers to stabilize the risk, the risk of needing long-term care fits the insurance model quite well.

It is the goal of the long-term care insurance industry to provide the broadest, least restrictive coverage-but within acceptable risk parameters. In addition, the industry wishes to offer such benefits at a reasonable price, but one that produces an appropriate return to the company. Obviously, achieving all these objectives concurrently is no easy task. The development of more reliable data on long-term care risk has enabled companies to develop more effective underwriting and pricing strategies to better achieve these goals.

Although there are many variations among long-term care insurance policies, such a policy is generally structured in the following manner. Once a person meets the policy's eligibility criteria (benefit trigger), the policy pays for certain services defined in the policy (covered services), following a period during which the individual pays for the services out-of-pocket (elimination period). The amount of benefits paid for each day of services (daily benefit amount) is paid until the policy maximum is reached (benefit maximum). This benefit maximum is defined by the daily benefit amount and the period of time chosen (benefit period).

What might be called "first generation" policies were considered costly yet, at the same time, extremely limited. Coverage was tied to acute medical care following a period of hospitalization. Usually only skilled nursing facility coverage was provided.

Early policies developed as they did because there was very little demand for coverage and it was not yet recognized by insurers as an attractive market. Actuaries and underwriters had legitimate concerns: the insurable event, "moral hazard," anti-selection, and the lack of reliable data, to name a few. (A more complete discussion of

the actuarial and underwriting functions is found in Chapter 5.) The result was that little was allocated to product development and marketing and a very limited policy was offered.

Medicare Model

Long-term care insurance developed initially as a new kind of Medicare supplement insurance, augmenting the limited coverage that Medicare provided for nursing home care. Just as Medicare supplement insurance filled in the gaps left by Medicare for acute care, long-term care insurance was conceived to fill the gaps left by Medicare for nursing home care. Thus the early policies were, like Medicare, for skilled care only, in Medicare-approved facilities, after three days in a hospital and within 30 days of discharge from the hospital. These policies were extremely restrictive in their coverage.

Change Influences

As consumers' interest in long-term care insurance grew and insurance companies increasingly saw long-term care insurance as a feasible market opportunity, companies began to design policies that reflected the unique characteristics of long-term care. Changes included more appropriate benefit triggers that incorporated the various levels of care and a wide range of sites of care, including home care and other community-based alternatives. At the same time, some of the limitations and exclusions were modified or eliminated.

Benefit Eligibility

Early long-term care insurance policies based benefit eligibility on a hospital stay of three days. A second eligibility criterion, also borrowed from Medicare, was what is called "medical necessity." This criterion required that a physician certify that care was needed due to a medical condition. Neither standard served the consumer or the insurance company effectively. Benefit triggers were needed that specifically tracked the need for long-term care, that could be objectively defined, and that were not subject to abuse.

Early Benefit Triggers

The problem with requiring a prior three-day hospitalization was that, as consumers argued, real needs for care occurred without, or instead of, hospitalization. Insurers were not totally satisfied with the requirement either. They feared that it would encourage people to elect a stay in a hospital in order to get their nursing home care covered. This concept of "stepping-down" in care (requiring that hospital care precede nursing home care) was followed by other stepdown requirements in the early policies. Intermediate and custodial care were covered only if they followed skilled nursing home care, and home care was covered only if it followed nursing home care.

These step-down requirements were very unpopular with consumers, who rightly maintained that the path of care needs did not always flow "down" in this fashion, but just as likely flowed "up," from home health care to more and more skilled levels of care. "Medical necessity" was a standard neither consumers nor insurance companies liked because it was prone to individual interpretation. The bottom line was that both insurers and consumers needed eligibility standards that were measurable and predictable. At the same time, consumers demanded coverage at home, because this

was the preferred site for care. Greater and greater flexibility was called for, and consumers expressed the need for coverage wherever effective care could be provided.

Activities of Daily Living

In response to the demand for better eligibility requirements, companies turned to an evaluation process used to determine eligibility for public programs. This assessment tool measured someone's need for care based on the ability to perform the activities of daily living (ADLs). Considerable research shows that this measure is objective, that volumes of data exist to support it, and that it truly correlates with one's need for care.

ADLs generally include bathing, dressing, transferring, toileting, eating, and, sometimes, continence. Limitations in these activities are often called "dependencies." While limitations in ADLs do provide a better benefit trigger, policies differ widely in how the trigger works. The policies differ in the following ways:

- how many and which ADLs are included;
- how many dependencies are required to trigger benefits;
- whether an individual needs substantial help or just some help;
- whether dependency is for one or two days a week or must be constant; and
- whether dependency on another person is necessary or dependency on some sort of equipment is enough.

The ADL definition is rarely a competitive feature discussed with a prospect at the time of sale, yet the variations between one policy and another could make quite a difference at claim time and in the premium charged. Therefore, while the use of limitations in ADLs was a vast improvement over prior triggers, the variety of ways in which limitations in ADLs are used by insurance companies tends to confuse the consumer. The National Association of Insurance Commissioners (NAIC) has amended the Long-Term Care Insurance Model Regulation to establish a minimum standard for use of ADLs as a benefit trigger (see Appendix C, Section 24). This standard should result in a more consistent use of ADLs in the future.

Cognitive Impairment Test

Another area of attention in benefit eligibility has been cognitive impairment. Consumer groups began to push for coverage of illnesses characterized by dementia-Alzheimer's disease and senile dementia-as they were major causes for needing care. Consumers were concerned that the use of ADL limitations missed people who could perform the activities of daily living but didn't because of cognitive impairment or who required constant supervision to perform such activities. Policies now cover people who need care due to cognitive impairment, and cognitive impairment is a separate benefit trigger.

■ Evolution of Policy Characteristics

Long-term care insurance has evolved from its early, limited form to current policies that offer a breadth and depth of coverage specifically designed to meet people's long-term care needs. The evolutionary process has enabled consumers, insurers, and regulatory entities to learn and react; with this balance of influences, the resulting

policies can be defined and explained in specific terms of benefits, premiums, eligibility, exclusions, and options.

Benefits

Just as effective benefit triggers have evolved, so too has the range of benefits. The following discussion is designed to give the reader an appreciation for the scope of benefits now available.

Daily Benefit Limits

Generally, the daily benefits that a policy will pay are stated in terms of nursing home coverage. The benefit limit is largely a matter of consumer choice, ranging from about $40 per day to $300 per day. In the early days of long-term care insurance, companies offered fairly low daily benefit amounts, in order to limit their exposure. As the market expanded, so too did the benefits being offered. Charges for nursing homes vary widely by type of care and geographic location. In large cities, such as New York, nursing homes charge $200 to $300 a day. For nursing home coverage, a wide range of daily benefit maximums is needed.

The home care benefit is often stated as a percent of nursing home coverage (e.g., 50 percent). But some policies offer home care benefits independently of nursing home amounts, and consumers can select an amount appropriate to their needs and location.

Not only is there a range of daily benefit amounts from which to choose; two kinds of benefits have evolved: service-based and disability-based. Coverage under a service-based, or sometimes called reimbursement-based, policy is designed to reimburse a person who has paid for a service covered under the policy. Thus, payment is based on satisfying the benefit trigger and using covered services. Within the service-based concept, there are two kinds: those that pay the policy amount regardless of the cost of the service and those that reimburse the cost of the service up to the daily benefit amount.

Disability-based, or sometimes called per diem-based, policies are designed to pay an insured if he/she meets the benefit trigger, regardless of service use. The disability-based approach is used for home care and sometimes for nursing home-equivalent benefits.

Covered Charges

Nursing home care. Many people think of nursing homes when they think of long-term care, and nursing-home confinement often is the best way of providing needed care. Certainly, the cost of a long nursing home confinement presents the greatest potential for a catastrophic loss. The nursing homes used for such long-term care needs are generally not the skilled nursing homes designed for shorter periods of skilled or subacute care. Rather they are those that provide for one's personal care needs; they are referred to as intermediate or custodial nursing homes. Unlike early policies that provided coverage for a limited period of skilled nursing home care, current long-term care policies include coverage of the full range of facility-based care.

Community-based care. Because most people see nursing home confinement as a last resort, more and more community-based care options are emerging. These options

form a continuum of care, from minimum personal care requirements to the maximum needs that only a skilled nursing home can meet. These options include:

- ○ Adult day care centers, where seniors are dropped off for the day, staffed by nurses and aides who provide a range of health care.
- ○ Assisted living facilities that give older couples and singles an opportunity to live in an apartment-like atmosphere with minimal help. A program of assistance is normally provided by a staff of qualified caregivers and may include nursing care and supervision.

As new modes of care are developed and endorsed by consumers, insurance companies have found ways to incorporate them into policies. However, because the definitions and requirements of these facilities can vary widely, so too can the benefits provided. State-by-state variations in licensing requirements for such facilities make it difficult for insurance companies to develop one definition that can be used in all jurisdictions.

Home care. Most people prefer to receive care in their own homes. Nursing care provided by RNs, LPNs, OTs (occupational therapists), and PTs (physical therapists) satisfies medical needs. Care provided by other qualified home health aides satisfies personal care, or ADL-support needs. Care provided by less skilled personnel satisfies the household needs of individuals who need help with cooking, shopping, and cleaning. Policies initially covered only the medical needs; most expanded to cover personal needs; and some expanded to cover household needs.

Other Benefits

Some long-term care policies include other benefits. Coverage of durable medical equipment and home modifications are good examples of benefits that meet a real need, because installing a ramp or stairway elevator in a home can make the difference between someone staying at home or entering a nursing home.

Some policies also cover ambulance needs, prescription drugs, and other benefits. Other forms of coverage include:

- ○ ***Respite care benefit.*** Designed to pay for brief periods of formal care to give relief to informal caregivers.
- ○ ***Hospice care benefit***. Designed to provide benefits for care that focuses not on curing but on meeting the emotional needs of terminally ill patients and their families and on helping patients cope with pain.
- ○ ***Alternate care benefit.*** Designed to provide reimbursement for the services of providers not covered by the policy where it better meets the individual's needs.

In the future we are likely to see new forms of care developed. Insurance companies will need to determine whether and how to provide coverage for them.

Benefit Duration

Benefit duration options have also expanded. Some early policies had a benefit duration of as little as six months. (The NAIC Long-Term Care Insurance Model includes a one-year minimum that has been adopted by most states.) With current policies, consumers can select a benefit duration from among several options, ranging from one to seven years and generally an opportunity to buy lifetime benefits. Although an estimated 65 percent of people aged 65 and older will never enter a

nursing home, for the 35 percent who do, there is a 14 percent chance that the stay will be five years or more. Offering a full range of benefit durations gives consumers the opportunity to select a policy that best meets their needs. Some policies use a separate benefit period for nursing home and home care, and some set an integrated dollar maximum. The latter serves as a "pot of money" that can be used for nursing home or any covered service.

Elimination Period

An elimination period (also known as a deductible period or benefit waiting period) is defined as the number of days that services are received before insurance benefits begin. In the early days, elimination periods reflected coverage available under Medicare-20 days and 100 days. In response to the demand for additional choices, companies have added other options, for example, 30, 60, 90, 180, and even 0 days.

Some policies only require the insured to meet the elimination period once in a lifetime, so that if a second period of care occurs, no elimination period is then required. Other policies require that the policyholder meet the elimination period for each episode of care.

Care Management Benefit

Just as people are concerned about receiving benefits to cover the cost of their care, many don't know what care is available or how to determine what care is most appropriate. As a result, some policies include a care management benefit that provides an assessment of an individual's care needs, of his/her family and community support, and of his/her financial position and then recommends a plan of care. Consumers have found this assessment particularly helpful in guiding them toward the most appropriate care. Some policies may include a benefit that provides for periodic reassessments as needs change over time. Such a benefit is particularly helpful in support of a plan with an integrated dollar maximum as it helps the individual manage the benefits available in the most costeffective manner.

Exclusions and Limitations

Every long-term care policy contains certain coverage exclusions and limitations. While first-generation policies were often highly restrictive, current policies reflect greater flexibility. Some policies, for example, have eliminated preexisting condition limitations. And as stated earlier, Alzheimer's disease and other dementia are no longer excluded.

Pre Existing Conditions

Pre-existing conditions are those conditions that an individual had prior to applying for insurance. It is standard practice in health insurance to exclude coverage for pre-existing conditions so that people don't apply for insurance after they have been diagnosed with an illness that will require care. In the case of long-term care insurance, pre-existing-condition limitations took on a special meaning because some carriers abused this policy design feature. These carriers did a less than thorough job of underwriting policies at the time of issue but were extremely thorough at the time a claim was made. In that way, they were able to rescind coverage (and return the premium) if a claim was presented and there were pre-existing conditions identified at that time.

This practice, post-claims underwriting, was unacceptable to consumers and the majority of insurance companies, and subsequently defined as a prohibited practice in the NAIC Long-Term Care Insurance Model Regulation (see Appendix C, Section 9). This prohibition has been adopted by most states.

Standard Exclusions

Other standard health insurance exclusions were made part of most long-term care policies. These included care that was needed:

- due to acts of war;
- for which reimbursement is available under a government program (where such exclusion is permitted);
- for self-inflicted injury;
- outside the United States;
- due to alcohol or drug disorders; or
- due to mental and nervous disorders.

This last exclusion created strong consumer reaction, and insurers have had to clarify the fact that the exclusion did not refer to Alzheimer's disease and other related dementia, prime causes of catastrophic long-term care costs. Usually the policy exclusion reads "mental and nervous disorders of inorganic origin," and virtually all policies specifically state that Alzheimer's is covered.

Additional Benefits

Two additional benefits have emerged as standard choices in response to consumer concerns: inflation protection and nonforfeiture of benefits upon termination of an established policy.

Inflation Protection

As people prepare for the future, the potential impact of inflation on the cost of all goods is a concern. Because of the substantial time period between the purchase of long-term care insurance and the likely need for care, the impact of inflation can be substantial. An increase of 5 percent per year will double the cost of care in just 15 years. The younger the individual is when he/she purchases long-term care insurance, the greater the potential impact of inflation on the cost of care.

Early policies were sold to people in their late 70s, and inflation was not as great a concern as it is today (especially as the target market has expanded to younger ages). Inflation protection is an option now offered to respond to increases in the cost of care.

The most common approaches to help offset the increasing cost of care are:

- A provision that automatically increases benefits a fixed percent (such as 5 percent) per year. A level premium is charged. Two variations of this approach are:
  - The increase may be compounded or simple. The compounded approach increases benefits 5 percent each year over the prior year's benefit, whereas the simple approach increases the benefit each year by the same dollar amount

(e.g., 5 percent of the initial benefit). The compounded approach provides greater benefits, tracks inflation better, and costs more than the simple approach. Figure 4.2 compares the benefits produced by the two approaches.

- The increase may be annually for the lifetime of the policy or it may be limited. Limits on the increase may be (a) a multiple of the original benefit amount (e.g., two times the original benefit), (b) for a specified period of time (e.g., twenty years), or (c) until the insured reaches a certain age (e.g., 85).
- A benefit that gives the individual the option to purchase additional benefits periodically, usually tied to increases in the cost of care. Under such an arrangement, each time an additional amount is selected, an additional premium is added to the initial premium; the additional premium reflects both the additional benefit and the age at which it is purchased. The combined amount becomes the new annual premium. Often such a benefit also provides that if the policyholder waives the option to purchase additional benefits a specified number of times, the option will no longer be available.

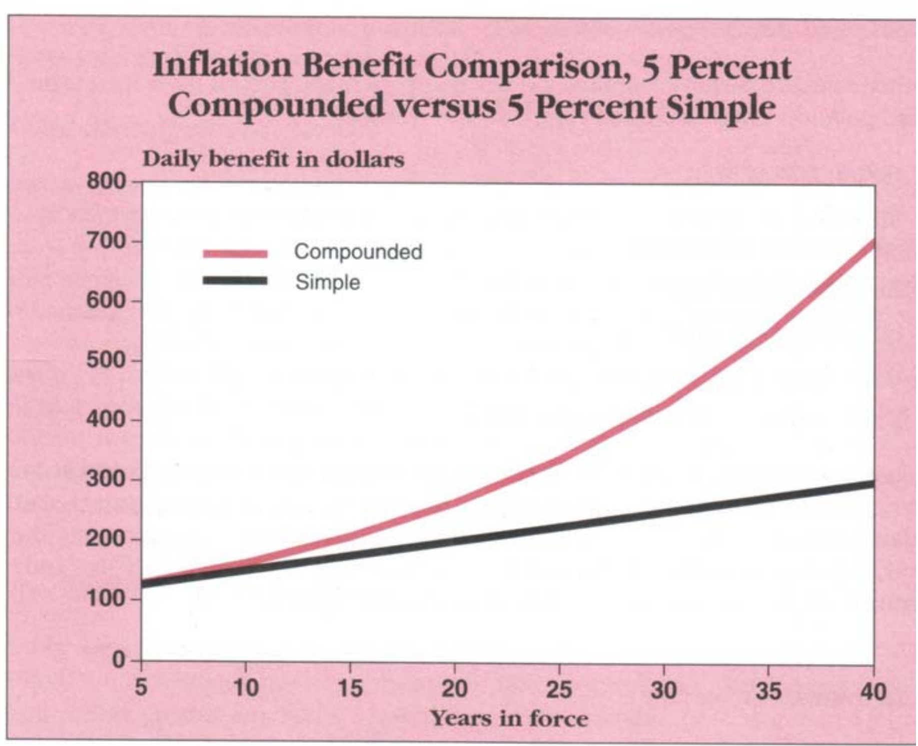

Figure 4.2

The initial premium for an inflation benefit that is guaranteed to increase a certain amount annually is greater than for one that provides a periodic increase, especially when purchased at a younger age. However, as time goes on, the periodic premium approach becomes greater, substantially so over many years. Figure 4.3 illustrates the difference between the two approaches for an individual who purchases at age 55.

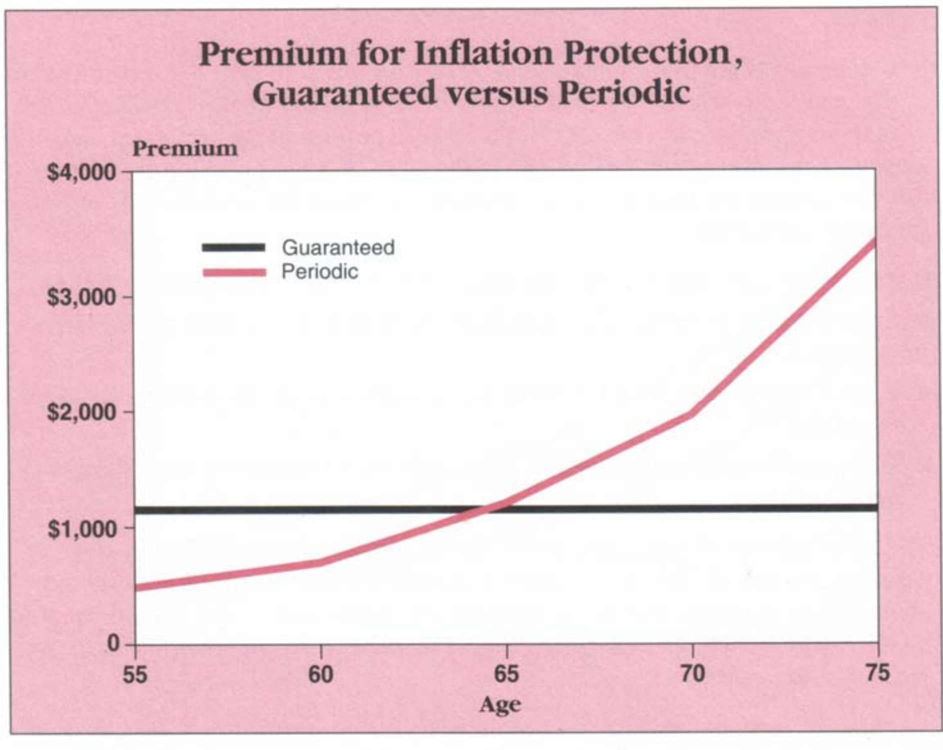

Figure 4.3

Nonforfeiture

Nonforfeiture is another benefit offered. Its purpose is to give the individual an option to ensure that he/she will receive value from the policy if he/she decides to terminate the policy. This feature is important for long-term care insurance because of the prefunding inherent in its level premium; it is especially important the longer a policy is in effect. There are several kinds of nonforfeiture, including:

- Extended term, which continues the policy in force for a specified period.
- Reduced paid-up, which pays a reduced benefit level over the policy's benefit period.
- Return of premium, which returns all, or a portion, of the premium paid for the policy.
- Shortened benefit period, which pays a full daily benefit but for a shortened period of time.

The actual period of time, amount of benefit, or premium mentioned above is based on the age at which the policy is purchased, the length of time the policy has been in effect, and the amount of any claims paid under the policy. The nonforfeiture benefit can be quite expensive, depending on what kind it is and the age of the purchaser.

As of October 1995, seven states had mandated that companies offer a nonforfeiture benefit: Connecticut, Florida, Maryland, Montana, New York, Oklahoma, and Wyoming. Some consumer advocates insist that all policies should include nonforfeiture as a mandated benefit, not as an option. Such a provision was recently included in the NAIC Long-Term Care Insurance Model Act and Regulation. The debate continues, however, because of the significant extra premium involved and

true disagreement over the value of the benefit. The fact that a variety of nonforfeiture benefits exists adds to the difficulty of resolving this debate.

■ Premiums

Long-term care insurance premium is generally charged on an entry-age level basis. Premiums vary widely by age, benefits chosen, and, in some companies, by health history. An examination of Figure 4.4 illustrates the premium for one pattern of benefits on two bases: one is a level benefit and one a 5 percent guaranteed annual increase in benefits (compounded). Note that for the level benefit the premium for someone aged 65 is more than twice that of someone aged 55. The premium for someone aged 75 is more than twice that of someone aged 65. And the premium for someone aged 80 is more than 50 percent that of someone aged 75. In other words, for this pattern of benefits, rates nearly double every ten years. Figure 4.4 illustrates premium by age.

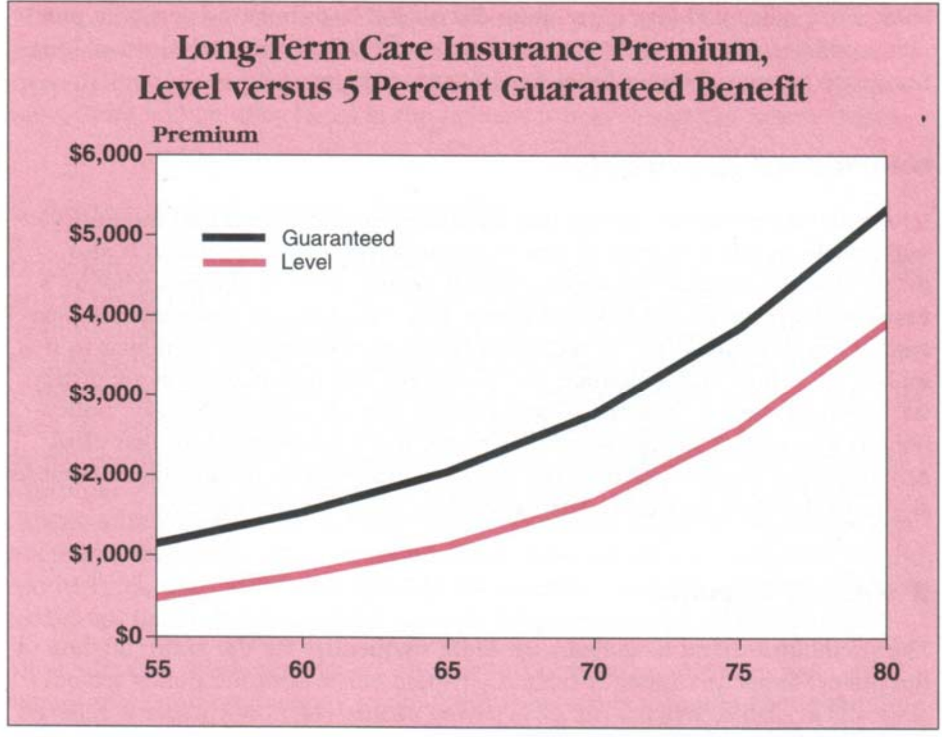

Figure 4.4

Benefits chosen can also cause the premium to vary widely. With the choices of benefit duration, daily benefit amount, elimination period, inflation option, nonforfeiture benefit, and other options, the range of premiums from the least expensive to the most expensive can be tremendous.

Lastly, health history can affect the premium. Some companies underwrite certain risks that would not be insurable at standard rates but can be covered at higher rates, called substandard rates. Substandard rates are most often a stated additional percentage of the base premium for the policy.

Some companies will give a premium discount if both husband and wife purchase policies. The discount is designed to both reflect the lower cost of longterm care for married couples and help market the product.

Guaranteed Renewability

"Guaranteed renewable" means that an insured is guaranteed that the policy will remain in effect as long as timely premium payments are made. It also means that the contract provisions cannot change without the policyholder's expressed written consent. And it means that the premium payments are guaranteed not to increase for an individual because of something particular to that individual. It does not guarantee that premiums will not increase at all; if they do, however, they will increase for an entire class of individuals-say, policyholders in a particular state-because of the overall experience of that class. Any premium increases of this type must be approved by the insurance commissioner of the state, based on data proving the need for the increase.

Waiver of Premium

The premium is payable annually (or more frequently) for the entire lifetime of the policy. Single premium or limited payment versions of the policy are not generally available. When a policy is paying claims, the policyholder is relieved from paying premiums. This is called waiver of premium.

■ Impact of Regulatory Requirements

Regulatory requirements are discussed more fully in Chapter 6; however, it is important to recognize here that much policy variation occurs because of state regulation of insurance.

National Association of Insurance Commissioners

Because states write their own laws and regulations regarding insurance, a good deal of variation exists among the states. A unifying force is the NAIC, the National Association of Insurance Commissioners, which produces model legislation on all forms of insurance for individual state consideration. The NAIC Long-Term Care Insurance Model Act and Regulation were developed over time and have been amended as the industry developed; however, states continue to write laws different enough from the model law to cause significant variations from one state to another. For example, one company may have as many as 35 different state variations in its contract wording, with many different levels of premiums resulting from the different contract requirements. So not only are there differences among companies in the policies they write; for any one company, there will be differences in the policies it provides in the various states.

■ Accelerated Death Benefits

At the same time that long-term care insurance was evolving, so too was a new benefit under life insurance policies: accelerated death benefits. They are currently available under individual and, increasingly, group insurance policies. Accelerated death benefits can be divided into two types based on the nature of the benefit trigger. Some are considered mortality benefits and they are regulated by specific regulations that apply to accelerated benefits. The NAIC has developed the Accelerated Benefits Model Regulation (Appendix B) to provide regulatory guidance for such policies. These are discussed further in Chapter 7. Others, which include the need for long-term

care as a benefit trigger, are considered morbidity benefits and are regulated as long-term care insurance. At the end of 1993, there were over 280,000 life insurance policies containing accelerated death benefits that used the need for long-term care as a benefit trigger.

All accelerated death benefits are designed to provide people who meet the benefit trigger an opportunity to tap into life insurance benefits during their lifetimes. Thus, accelerated death benefits add flexibility to a life insurance policy. Most policies limit the amount or portion of the life insurance benefit that can be accelerated.

Those policies with an accelerated death benefit that uses the need for longterm care services as a benefit trigger are well suited to provide needed financing of long-term care. However, in order to effectively provide such financing, the policy must have a sufficient face amount to allow for an adequate level of benefits. The insured must recognize that benefits used for long-term care reduce the amount of life insurance available to his/her beneficiary.

Generally, there is a premium charged for long-term care and specified disease accelerated death benefits. For the others, the cost is assessed at time of use, the benefit is discounted, or there is an administrative fee.

Because of the flexibility that accelerated death benefits add to life insurance policies, they are likely to become a common feature of such policies. It should be remembered that the predominant reason for life insurance is to provide for one's beneficiaries and that money used for long-term care cannot be used for any other purpose. It can be an excellent supplement to a private long-term care policy.

■ Group Long-Term Care Insurance

Employers have long made available to their employees an array of financial security products. They have now become quite interested in the issue of longterm care and long-term insurance. In addition to employer-sponsored contracts, there are other kinds of group long-term care coverage, including association membership and provider-sponsored coverage. (For a comparison of individual and employer-sponsored long-term care policies sold, see Table 4.1).

Table 4.1

Long-Term Care Insurance Products by Percentage of Companies, Percentage of Policies Sold, and Average Age of Buyer

LTC product*	Percent of companies** (n=118)	Percent of policies sold (n=3.42 million)	Average age of buyer in 1993
Individual and group association	76.5%	79.8%	67.5
Employer-sponsored	18.3	11.9	42.5
Long-term care as part of life insurance policy	24.3	8.3	34.4

*Does not include information on continuing care retirement communities.
**Does not total 100% because some companies sell their LTC product in more than one type of market.
SOURCE: Health Insurance Association of America, Long-Term Care Market Survey, 1995.

Characteristics of Group Insurance

Group long-term care insurance is primarily employee-paid, voluntary coverage with level premiums (not term). To date, most plans have been sold without an employer contribution toward payment of long-term care premiums. However, in the market survey released by the HIAA in March 1996, HIAA noted that of the reported 1,028 employer-sponsored long-term care plans sold through the end of 1994, one insurer had sold plans to 429 employers who paid all of the employee premium. Most of those employers had under 100 employees, and the plan itself was a basic one that allowed employees to purchase additional coverage with their own resources. The main difference is that the employer or association is the policyholder, not the employee or member. The participants hold a certificate of insurance. Underwriting, at least for the employee, is generally streamlined. Some companies guarantee long-term care insurance to employees who are actively-at-work (guaranteed issue).

The other important factor in group long-term insurance is that regulation of group insurance is slightly different. Because employers are thought to provide a watchful eye on behalf of the employee, the same level and type of regulation is not required. Often the group long-term care policy only has to be filed in the state in which the employer is located ("situs state"). The need for different regulation for group long-term care insurance is discussed more fully in Chapter 6.

Employer-Sponsored Insurance

In addition to employees, the employees' spouses, parents, and parents-in-law are generally eligible under an employer-sponsored program. Sometimes grandparents are eligible as well. Under some plans, the employee must elect coverage in order for other eligible family members to be insured.

As the contract holder, the employer governs many rights normally exercised by the individual policyholder. For instance, the employer can approve contract changes, where an individual policyholder would normally have that right.

An important issue under employer-sponsored long-term care insurance is portability. Because the premium is based on the age of the insured at the time of purchase and there is prefunding, it is extremely important that the individual

be able to keep insurance in effect on the same rate basis should the individual leave the employer. Employer-sponsored long-term care programs generally provide that the individual can remain insured under the group plan after termination of employment on the same rate basis. Under some plans the individual is given the right to convert to an individual policy at a premium rate that reflects his/her age when initially insured under the employer-sponsored plan.

The other kind of portability that is of concern in group long-term care insurance is when an employer wishes to move its program from one insurance carrier to another. This kind of portability is possible with group long-term care insurance, but it is more complicated than for other forms of group insurance because of the build-up of reserves that result from the entry-age level premium. The original contract must anticipate the transfer of these reserves to a new carrier on some sort of equitable basis.

Limited Choice of Options

Generally, there are fewer options offered to employees under an employersponsored plan. The options to be offered are determined by the employer.

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) are self-contained facilities designed to cater to elderly individuals who want to live in an environment that can effectively meet their long-term care needs. For example, they have the choice of taking their meals at home or together with other members of the community. They also can receive care in their apartments if they become frail and need help. They may eventually need additional care, which can be provided in their apartments or even in a nursing home that is integral to the same site. Thus, the elderly in CCRCs can have all their needs met in familiar surroundings without leaving their friends in the community. This approach is attractive to many elderly people because it allows them to "age in place."

Various levels of insurance are offered by CCRCs to give residents an opportunity to protect against the potential cost of long-term care. The American Association of Homes and Services for the Aging divides CCRCs into three categories, based on the level of insurance available to residents to pay the cost of long-term care:

- 6 percent of CCRCs provide care at little or no cost beyond the monthly fee.
- 26 percent provide care at little or no cost beyond the monthly fee until they reach a stated amount, after which the individual pays some or all of the cost.
- 38 percent provide emergency and short-term care, but the full cost of longterm nursing is paid by the resident.[38]

Private long-term care insurance can be paid to residents living in CCRCs of the latter two categories.

■ Industry Scope

Companies Offering Long-Term Care Policies

Of the over 1,000 insurance companies selling health insurance in the United States, only approximately 120 companies sell long-term care insurance. (See Figure 4.5 for a statistical summary of companies selling long-term care insurance.)

This number has been somewhat stable for a few years, though the actual companies involved have changed. The number includes both small regional companies and companies with a national market.

Market Size

As of the end of 1994, more than 3.8 million policies had been sold, a small but growing market with a 25 percent or higher annual growth rate. Growth has been particularly dramatic in the employer-sponsored group market and the accelerated death benefit market. (Figure 4.6 summarizes the current market size and the growth trends.)

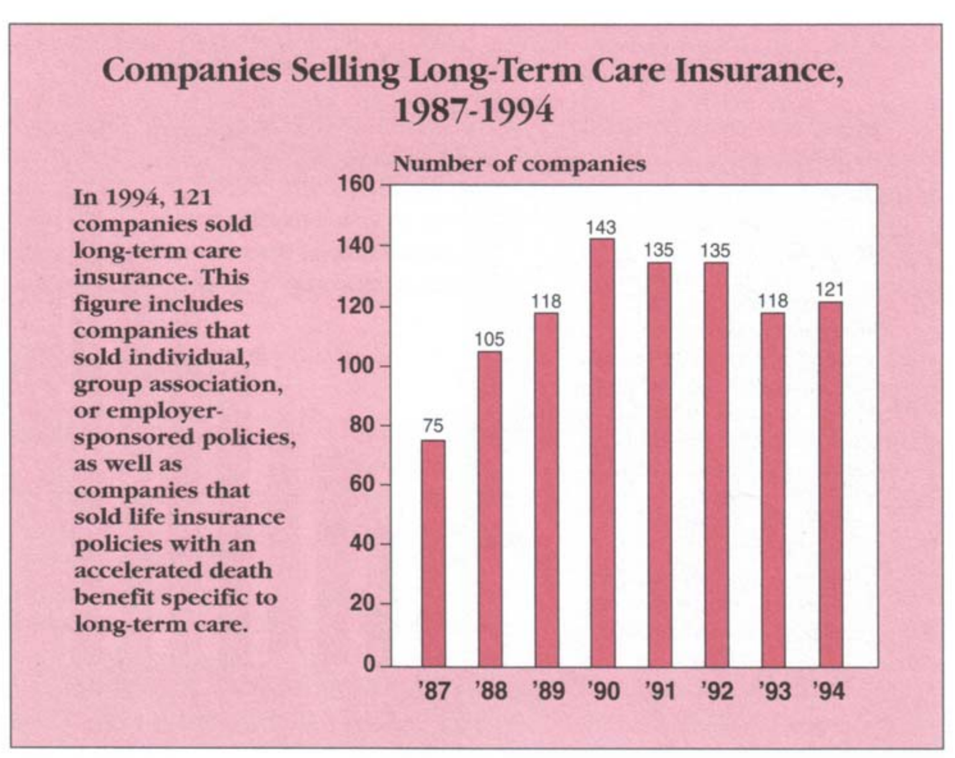

Figure 4.5

SOURCE: Health Insurance Association of America, Long-Term Care Market Survey, 1995.

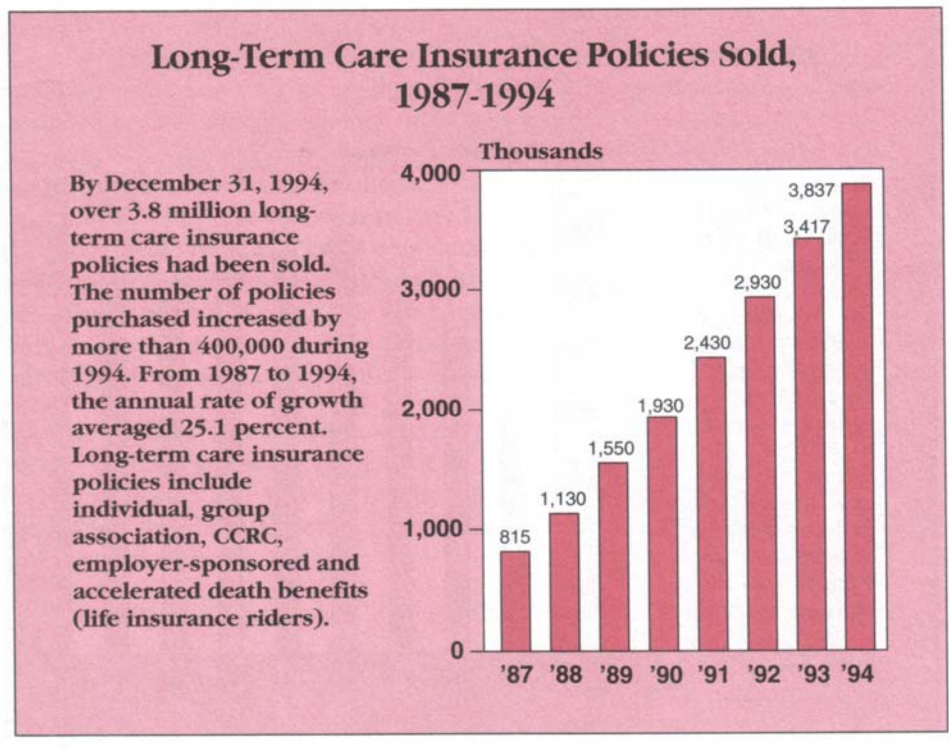

Figure 4.6

SOURCE: Health Insurance Association of America, Long-Term Care Market Survey, 1995.

■ Summary

In the near term, it seems quite clear that existing public programs will not be expanded to provide comprehensive long-term care coverage for all those in need. Those people who can afford to pay for their own care will be expected to do so; they should consider the risk-shared approach offered by long-term care insurance as a way to finance their care.

Long-term care insurance-an example of the insurance industry's response to a consumer need-was developed through the efforts of a number of forces: regulators, state and federal health policy experts, consumer advocacy groups, and the insurance industry. Although long-term care insurance has taken quantum leaps over the last decade, it continues to evolve as data are collected and analyzed and insurers are able to replace assumptions with fact.

Three trends are likely to continue for the foreseeable future:

- An increase in individual responsibility for paying for one's own care.
- A desire by individuals to choose the settings and providers of care.
- Continued efforts to provide quality care at the lowest cost within the entire health care industry.

Monitoring trends in provider settings and services and in consumers' needs and preferences will be critical to keeping the benefits offered under long-term care policies on target. The desire for more home-like care and the need to seek the most cost-effective way of providing appropriate care suggest that there will be an increase in noninstitutional alternatives. Insurers will need to modify policies to be responsive to these changes.

■ Key Terms

Accelerated death benefits
Activities of daily living (ADLs)
Alternate care benefit
Alzheimer's disease
Anti-selection
Association group policies
Benefit maximum
Benefit period
Benefit trigger
Care giving
Care management benefit
Cognitive impairment
Community-based care
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Chapter 5

MARKETING AND OPERATIONS

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■ Introduction

In the preceding chapter you learned that early long-term care insurance was quite limited, modeled after typical medical insurance products, and designed to cover acute care costs. That form of insurance has now evolved to the point that it specifically addresses the unique characteristics of long-term care and meets the specific needs of consumers. Long-term care insurance would not have grown to its current form if insurance companies had not found ways to adapt their traditional marketing and operations functions to effectively support this new product.

This chapter will discuss the objectives of the various insurance functions as they relate to long-term care insurance. It will discuss how, while the objectives may be the same as those for other lines of business, the techniques employed to support long-term care insurance needed to be changed. First, we Rill briefly review the individual and group markets, identifying the characteristics of the buyer and the product purchased.

The Individual Market

Long-term care insurance is primarily sold through one-on-one contact between a prospective buyer and an insurance agent. Although the direct response marketing of long-term care insurance-through the mail and on the telephone - has met with some success where there is a close affinity between the consumer and the insurance company or plan sponsor, it is the one-on-one sales approach that has been most effective to date. There are two prominent reasons for the success of that approach.

- Because long-term care insurance is new and entails many available options, a good deal of education is needed before one considers purchase.
- Long-term care insurance is relatively expensive (an average policy costs about $1,500 per year) and is not purchased without a good deal of deliberation.

In short, long-term care insurance must be sold. Individual insurance accounts for the major portion of the 3.8 million policies that had been purchased by the end of 1994.

Who buys individual long-term care insurance? Tables 5.1 and 5.2 show the characteristics of those who buy and the policies purchased. A review shows that the typical buyer is older (long-term care insurance is generally marketed to people between the ages of 50 and 85), female, and of moderate or middle income. Buyers tend to be planners; they know that they can't rely on government programs to pay for their care, and they want to be assured that they can have access to the quality care of their choice.

Table 5.1

Individual Long-Term Care Insurance Buyer and Product Characteristics

Buyer characteristics		Product characteristics	
Average issue age	69	Nursing home and home care	61% (33% nursing home only)
Gender	61% female	Daily benefit amount	
Annual income	61% < $35,000	Nursing home	$85
Assets	51% < $75,000	Home care	$78
Average monthly savings	$316	Benefit duration	
		Nursing home	5.1 years
		Home care	3.4 years
		Average annual premium	$1,505

SOURCE: Health Insurance Association of America, Who Buys Long-Term Care Insurance?, 1995.

Table 5.2

Employer-Sponsored Long-Term Care Insurance Buyer Characteristics

Average issue age	43
Gender	56% female
Household income	61% > $50,000
Assets	40% > $50,000

SOURCE: Health Insurance Association of America, Who Buys Long-Term Care Insurance?, 1995.

The Group Market

Although the employer-sponsored group market represents a small portion of long-term care insurance, it has seen tremendous growth in recent years. An HIAA study[39] shows that individuals insured under employer-sponsored programs grew from 20,000 at the end of 1988 to 440,000 at the end of 1994. The employers that offer these programs range from quite small (under 100 employees) to those with over 25,000 employees. In a procedure similar to other employer-sponsored programs, the employer decides on the benefit choices to be made available to the employees and the employees decide whether to participate and, if so, which benefits to select. However, unlike many other employer-sponsored plans, the employer rarely contributes toward the cost of long-term care insurance.

Historically, it is important to realize that there have been real advantages to providing welfare benefits through the employer. Some (but not all) of these advantages apply to employer-sponsored long-term care insurance. Common advantages of traditional employer-sponsored products include the following:

- Marketing and administrative costs are less.
- Communication and education are facilitated.
- With sufficient enrollment, insurance can be guaranteed issue and costs are lower.
- Employers are more sophisticated buyers and afford some consumer protection.
- Often there are employer contributions with pre-tax dollars.

As indicated, not all of these advantages apply to long-term care insurance. Perhaps the most important difference is that there has been little interest among employers in

funding employees' long-term care policies. Many employers are looking for ways to contain the cost of employee benefits, and may not be willing to make additional contributions to a long-term care program. However, recent tax changes may stimulate some additional interest on the part of employees (discussed in more detail in Chapter 6.)

Why have employers sponsored long-term care insurance programs? Although employers generally have not contributed toward the cost of long-term care insurance programs, they do believe that introducing such programs encourages employees to take greater responsibility for their financial security. Such programs can be implemented at a minimal cost to the employer. They also fulfill an employee's desire to have a plan available to help provide financial security.

The primary differences between the buyer of long-term care insurance in the individual market and the employer-sponsored group market is the age of the buyer (average age 69 versus 43).[40] And because many people in the individual market are retired, they tend to have a lower income than active employees.

It is difficult to make a good comparison of benefits selected because, before an employee makes a selection, the employer has narrowed the choices. The pattern of benefits selected under employer-sponsored plans reflects both the effects of the employer's choices and those of the employee. The younger age of the target market under employer-sponsored plans has an impact on both the benefits offered and the benefit selected. Inflation protection is essential if one purchases at an early age. In addition, at an early age it may make more sense to buy the periodic upgrade approach to providing inflation protection rather than the initially more expensive 5 percent guaranteed approach.

■ Marketing

The basic objectives of the marketing functions that support long-term care insurance are the same as those that support other products. However, because of the unique characteristics of long-term care insurance, companies have found that the techniques used to achieve those objectives have had to be changed.

The following is a statement of the objectives for marketing health insurance:

> Health insurance companies utilize the marketing process to form a communication link between the consumer's need for protection and the coverage provided by the insurance products offered for sale. The marketing process is successful when it achieves three results:
>
> 1. The consumer is made aware of a need for protection against the high cost of health care and/or the impact of income loss during a disability.
> 2. The consumer believes that the product offered by the insurer will satisfy the perceived need.
> 3. The sale is made.
>
> The insurer must market products that provide the type of protection best suited to meet the needs of a wide spectrum of consumers. Consumers, on the other hand, must be convinced of the advantages to be gained by paying money now for protection in the future.[41]

If, in number one, we substitute the phrase "long-term care" for "health care and/or the impact of income loss during a disability," this statement applies equally well to the marketing of long-term care insurance. The objectives are the same.

There are several reasons why long-term care insurance marketing brings new challenges to the industry:

- The data sources for long-term care use and costs are not readily available in a form that lends itself to pricing insurance products.
- There is a lack of familiarity with long-term care and long-term care insurance among consumers and within the insurance industry.
- People are accustomed to having their employer pay for a substantial portion of their health care products, rather than purchasing health-related products entirely on their own.
- Long-term care and its objectives differ from those of most medical care. It involves caring rather than curing.
- Just as long-term care insurance is evolving at a rapid pace, so too is the regulation of it.
- People who use long-term care tend to be much older. It is not a risk that generally concerns younger people.
- Most people view long-term care as nursing home care and do not believe it is a service they will ever need.

Thus, long-term care insurance presents insurance companies with not only a new set of risks but also a host of marketing challenges.

The Sales Function

Individual Long-Term Care Insurance

Long-term care and long-term care insurance are new not only to consumers and insurance company employees but also to agents. This, coupled with the predominantly older age of buyers, presents a challenge to the sales function.

Not all agents have a product or market focus that lends itself to long-term care insurance. Agents who already have a client base made up predominantly of older people, or who specialize in the broader area of financial planning, have a clientele that is more likely to be interested in long-term care insurance. The same may be true for agents who specialize in Medicare supplement insurance.

While the need for most products that agents sell is apparent, the need for long-term care insurance is not. It is also a topic that conjures up a picture of being confined to a nursing home-a topic most people would rather avoid. Before customers will consider the purchase of long-term care insurance, they need to learn about the risk of needing care, what care is available, and how much it costs.

Because long-term care insurance is new and is undergoing change, agents need to be assured that the insurance company is committed to supporting it. This means keeping the product and pricing competitive and up-to-date and developing effective education and training programs to keep the agent informed about issues that have an impact on the product. Tools to identify those people who are most likely to buy long-term care insurance would be very helpful as well.

While effective communication between the insurance company and agent is important to the support of all products, it is imperative with a new and somewhat complicated product like long-term care insurance.

The one-on-one sales approach has so far been the most effective way to sell long-term care insurance. It provides the opportunity to answer the variety of questions that inevitably arise as a prospective buyer begins to consider the product. It also ensures that the individual will focus on the issue, at least for the length of the visit.

Regulators have viewed this unmonitored, one-on-one approach as presenting a potential risk to the consumer. Further, since the purchasers are usually elderly, regulators view them as a particularly vulnerable segment of the population. In order to reduce the possibility that the consumer will be misinformed, the National Association of Insurance Commissioners has added certain requirements to the Long-Term Care Insurance Model Regulation. These include a 30day free-look provision, a requirement that prospective buyers receive an outline of coverage, and a shopper's guide. (These provisions are also required in order for a policy to qualify for favorable federal tax treatment, as discussed in Chapter 6.)

The point is, that while long-term care insurance is a product that must be sold, it is difficult to sell. Only agents who believe they can effectively serve this market with an insurance company's full support will invest the time and effort to sell it.

Direct Response Marketing

Direct response marketing is used by some companies to sell long-term care insurance. With direct response marketing, the goal is to reach a large number of people through direct mail or by advertising through newspapers or on the radio or television. It is often used to sell relatively inexpensive, easy-to-understand products. Although long-term care insurance is neither inexpensive nor easy to understand, direct response marketing of it has met with some success. This is especially true where there is a strong affinity between the potential customer and the insurer or, when marketing to members of an association, the sponsoring group.

There are several reasons that direct response marketing is particularly successful in that situation. First, where there is such an affinity there may be an established means of communication between the insurer or sponsor and the individual, as well as an element of trust. The individual is more likely to read information received from a familiar and trusted source. In some instances the individual may have already purchased other insurance from this group. Second, the insurer or sponsor may have access to data about the target group (e.g., age, sex, occupation, and income). This information enables the insurer to better target its marketing effort to those most likely to purchase.

Although long-term care and long-term care insurance are not widely understood, many people seem eager to learn about it. This interest causes many who receive an initial mailing to request information about long-term care insurance. Converting interest into a sale seems to work best when the individual is exposed to a limited number of plan choices rather than a broad array of options. Knowing the characteristics of the target market helps the insurer to present the most attractive options.

Direct response marketing is not inexpensive. Developing effective marketing materials and doing mass mailings costs a good deal of money. Therefore, as with all

forms of marketing, it is important to focus the marketing effort on those most likely to buy.

Group Long-Term Care Insurance

Because employees generally must pay for 100 percent of their policies, the employee must be sold, much as in the individual market. It is imperative to the success of the program that the employer not only endorse the program but be committed to it. This includes making payroll deductions, making space available to hold employee seminars, and giving people time off to attend. Some industry specialists believe that mandatory attendance at such seminars is most effective.

The approach used in selling long-term care insurance to the employer is similar to that used with other employer-sponsored products. It is done either directly by the insurer or through a benefit consultant. As with other employersponsored products, the employer usually issues a request for proposal (RFP); however, often the process is more interactive than with other forms of insurance. Rather than setting forth the benefits that must be included, the RFP is generally accompanied by a list of questions on a broad range of topics related to the product and the insurance company is asked why it uses one approach rather than another. An example might be, "Do you use a service-based or disability-based benefit, and why?"

The sales process used with the employee employs a combination of tools, such as seminars, videos, brochures, and a dedicated 800 number that people can call to obtain information about the product. The method will depend, to an extent, on the size of the particular employee group to whom the plan is offered and the employer's normal way of communicating with its employees on benefit matters.

A recent study[42] profiled the top four insurance companies writing employersponsored long-term care insurance. It found, based on the three highest and three lowest enrollments, that employee salary level is the best predictor of enrollment success. Higher-salaried groups produced better results than lowersalaried groups. The study confirmed that active sponsorship on the part of the employer was also extremely important and that the use of telephone and electronic enrollments produced better results than paper-based enrollments.

Market Research

With any new product, lack of data is a problem. Long-term care insurance is no exception. Few companies have sufficient data of their own to develop a precise view of market or product trends. Certainly they don't have the same level of information that supports their other products. Most companies turn to external sources to fill the void. Consulting firms that specialize in long-term care insurance can offer a broader perspective of market and product trends. Also industry groups, such as the HIAA, the Life Insurance Market Research Association (LIMRA) and the Life Office Management Association (LOMA) all are excellent sources of information. Two publications by the HIAA are of particular interest. A buyer/nonbuyer survey that has been conducted twice has been helpful in analyzing why people do, or do not, buy the product. The most recent survey, "Who Buys Long-Term Care Insurance," was released in 1995. The other publication, an annual survey of the long-term care insurance market most recently released in 1996, defines the scope of the current private longterm care insurance market, covering the period from 1987 to 1994.

Individual companies have studied the long-term care market with a variety of quantitative and qualitative marketing techniques. They have used focus groups and in-depth interviews of buyers, potential buyers, agents, and employer representatives to obtain product or market information. Research has focused primarily on purchase motivations of buyers, barriers to purchase among nonbuyers, product development, and communications. Research has also been devoted to evaluating the effectiveness of enrollment techniques, pre-testing of communications materials, and customer satisfaction.

Marketing Material

Insurance companies have long developed material to support and sell their products. With long-term care insurance, such material must fulfill both an educational and marketing role. Before people will consider purchase of a longterm care policy, they must learn what long-term care is, its cost, and their risk of needing it. They must be made aware that traditional medical insurance and Medicare do not provide protection and that Medicaid provides coverage only to low-income people or those who exhaust their resources first. Only then are they likely to be interested in the product. The challenge is to present clear information in a way that people will read it and be ready to take the next step-and to do so in an economical and rational manner. Companies have used numerous vehicles to deliver the information, including brochures, seminars, and videos.

■ Underwriting

Individual Underwriting

The goal of underwriting is to approve those applicants for coverage who fall within the parameters of risk assumed in developing the premium rates and decline those who do not. This goal is the same as for other insurance products.

Criteria

Long-term care insurance cannot be underwritten in the same way as other health insurance, however. Initially, companies based their underwriting criteria on those used for more traditional forms of insurance. The result was that some people who were good risks were declined and some who were poor risks were accepted. This was a poor result for the consumer, the agent, and the insurance company.

Under traditional forms of health insurance, underwriters use an attending physician's statement (APS) to determine medical history and to decide whether the applicant will be insured. Although this may be an effective tool for some health insurance products, it was not the sole solution for screening applicants for long-term care insurance. More information was needed, because long-term care use depends not so much on the presence of a condition but on how likely it is that the condition will have an impact on the individual's independence. This is especially important for long-term care insurance where, as indicated earlier, the average issue age is 68, an age at which the applicant already may have one or more diagnosed conditions. Loss of independence could result from an accident or an illness or just from the aging process. There may be no medical expenses involved.

Cognitive impairment was found to be a major source of claims that could last a long time. Research revealed that an early predictor of cognitive impairment was use of a face-to-face interview technique, during which certain questions about everyday life are asked. Such an approach is often used for the very oldest applicants.

Standardized tests that are effective in evaluating one's ability to perform ADLs and IADLs or one's cognitive impairment are currently used to underwrite longterm care insurance. Information used by the underwriter includes that obtained from the application, medical records, and in-person or telephone interviews.

The presence of an effective measure is not the total answer. For instance, a face-to-face interview may be an extremely effective method of obtaining information, but it is also quite expensive. It is important to establish underwriting guidelines as to when a particular underwriting method is employed so that each method is used in a cost-effective manner.

Other factors considered in underwriting include marital status, self-reported health status, and whether the individual, although of an advanced age, still lives a very healthy and active life-style.

Some companies will approve people who are a poorer-than-normal risk on a substandard basis. Generally, this means that they will be accepted but at a higher premium rate than for those who fall within normal risk parameters.

Communications

Underwriting is more than the assessment of risk. It requires excellent communication skills in order to keep the consumer and the agent informed during the underwriting process. It also requires an appreciation for the public relations implications involved in the underwriting function. A late decision, approval on a substandard basis, or a decline must each be handled courteously and diplomatically.

Employer-Sponsored Underwriting

Primarily for larger employers, actively-at-work employees may be offered insurance on a guaranteed issue basis or will be asked to fill out an abbreviated application form. This form of underwriting may apply to the spouse of the employee as well. For retired employees, the employee's parents, and parentsin-law (who are also usually eligible to participate under an employer-sponsored program), full underwriting is required. Because there is generally no employer contribution and a low level of participation is expected, there is a greater opportunity for anti-selection. (Anti-selection is discussed later in this chapter.) Therefore, individual underwriting is more common with employer-sponsored long-term care programs than with more traditional employer-sponsored programs. A survey by LIMRA in July 1994 found the following participation rates for voluntary, employer-sponsored products: life insurance, 36 percent; longterm disability insurance, 48 percent; dental insurance, 43 percent; and longterm care insurance, 8 percent.[43]

■ Actuarial

Perhaps no function is more critical to a new product, such as long-term care insurance, than the actuarial function. Pricing for an insurable event and the type and amount of services used, on a prefunded basis, all presented new challenges to the

actuary. For other products, actuaries generally have insured data on an industrywide basis and for their specific company. However, data initially available for long-term care were based on general population statistics and had to be adjusted to be useful for an insured population. This involved making a number of assumptions. State regulations also had an impact on pricing and reserving standards for this new product.

Insurable Event

Actuaries were concerned about many of the characteristics of this emerging product. One major concern was the insurable event. Insurance is based on the concept that what is insured against is something outside the control of the insured individual. The event in this case, entering a nursing home or receiving formal, paid care at home, was believed to be somewhat within the control of the insured and his/her family.

Data

A second concern was the lack of reliable data with which to price the product. Medicare and Medicaid data existed; however, they were different from insured data. Because people are eligible for these programs regardless of health status, the data didn't reflect the effects of underwriting. Benefit triggers for Medicaid benefits vary from state to state. Data were collected in an inconsistent manner that did not lend itself to product pricing. For example, state Medicaid data tended to focus on nursing home stays and episodes of care rather than lifetime use of care. Even with the availability of several government nursing home studies, actuaries still had to make a number of assumptions to convert the data to a form useful in pricing insurance.

Home health care, in particular, was (and still is) a challenge. It is well known that 90 percent of those needing care at home receive all or a portion from family or friends. It is anticipated that any data regarding past home care use are grossly understated for the purpose of insurance pricing as people will use more formal, paid care if it is paid for by insurance, as explained below.

"Moral Hazard"/Induced Demand

The tendency to choose care when it is covered by insurance that would not have been chosen if insurance were not in effect is called "moral hazard." The potential for moral hazard was a significant concern for actuaries who initially priced the product. It is true that if people have insurance that covers home care, and they meet the benefit trigger, they are more likely to use formal care than if they had to pay for it out-of-pocket. Also, the availability of private insurance dollars will likely increase the use and number of home health care providers. The impact of this induced demand on consumers and providers is generally reflected in pricing.

Anti-Selection

The risk of anti-selection is also of concern to the actuary. This risk is based on the fact that no amount of underwriting is 100 percent effective. Individuals know something about their risk of needing long-term care that the insurance company does not. Thus, actuaries assume that the insured pool will be more likely to need care than the general population.

The use of more objective underwriting criteria and benefit triggers, and the availability of somewhat better data, have certainly improved the ability to price the

product. However, a good deal of uncertainty still exists. Over time, experience will replace the many assumptions that are currently made to price this product. But experience for a product such as long-term care insurance will take a long time to develop. Many people buy a policy years before they are likely to need care, and some of those people who do receive benefits under the policy will have extended periods of care. Therefore, it will be many years before experience for this product evolves.

Nature of Coverage

Pricing is also complicated by the fact that long-term care insurance is written on a level, prefunded basis and that the event being insured may be 40 years in the future. In addition to estimating when and for how long a covered service will be used, the actuary must consider the rate of mortality and of lapse and an assumed interest rate.

Determining how long the policy will be in effect and whether it terminates due to death or lapse has an impact on pricing. Lapse rates are a special problem to the industry. Consumer advocates and some regulators fear that insurance companies will encourage policyholders to lapse their policies in order to receive a windfall from the release of their prefunded reserves. Use of a high assumed lapse rate tends to reduce the price, if it is assumed to occur after the policy has been in effect for a sufficient period of time. A high lapse rate also suggests that the product won't be in effect when people most need it, a risk of great concern to regulators and consumer advocates. A low assumed lapse rate will produce a higher rate and may put the product at a competitive disadvantage. A study by the HIAA found that the lapse rate of long-term care policies was the same as or less than that of other products. However, even a lapse rate of 5 percent, over a long period of time, suggests that a fairly large percent of people will not have the coverage when they are most likely to need it. Some insurance companies have instituted programs to minimize lapse. One example is to offer a policy with a lower, more affordable premium at the time a policyholder lapses.

The assumed interest rate has quite an impact on the premium because of the reserve developed under a level premium product. Such premium is greater than necessary to cover the risk in the early years developing reserves (on which interest is credited) for the later years when the premium is less than necessary to cover the risk. The long-term nature of the policy makes incorporating a high rate of interest in the development of rates quite risky.

As with all insurance coverage, the actuary must constantly seek an appropriate balance between competitiveness and financial stability.

Reporting and Filing Requirements

The NAIC Long-Term Care Insurance Model Regulation specifies the reserving and loss ratio requirements for long-term care insurance. Additionally, there are special reports that must be completed for long-term care insurance in preparing the annual statement. There is a further provision that insurers report annually certain lapse and replacement information, the number of applicants who don't meet the companies' underwriting standards, and all policy rescissions.

To qualify for favorable tax treatment, companies must report certain lapse and replacement information and maintain such records on an agent-specific basis. Companies must also report the number of claims denied annually. The federal government can impose a tax of $100 per policy for each day these and other

requirements are not met. Of course, as with all provisions of the model, these are guidelines for the states, and insurers need not adopt them until they are adopted by a particular state.

■ Administration

The administration function includes policy issue and policyholder services, premium billing and collection, terminations and conversions, paying commissions, and compliance with state regulations. The goal is to provide prompt, effective service at the lowest possible price. This cannot be achieved without an administration system that can meet the needs of this dynamic product.

It is difficult to build a system that accommodates easy access to information and constant change. However, that is exactly what is needed to effectively support long-term care insurance. Consumers need access to customer service representatives who can answer the variety of questions they have about policy features and about the status of a claim or application. Because the representatives often are dealing with older, retired people, and because there is so much about long-term care and long-term care insurance that people do not understand, there are numerous questions and the telephone calls tend to be longer.

State variations also have a heavy impact on the policy issue function. Companies must implement procedures to ensure that policies reflecting the unique requirements of each state are appropriately issued, and that policyholder service representatives have a means of accessing the appropriate state requirements to effectively serve policyholders.

Policy upgrades are relatively frequent as this product evolves. With each upgrade, there is the question of how the new benefits will be offered to existing policyholders. Will they be offered on a guaranteed issue basis or will underwriting be required? Also, because of the entry-age level premium, there is the question of whether the price of the policy with the new benefits will reflect the individual's age when the policy was originally issued or reflect the reserve build-up under the original policy on some other equitable basis. Insurance companies also provide for a decrease in benefits to accommodate the needs of policyholders. Such a decrease is often an option presented to an insured as an alternative to lapse. Administrative systems need to be sufficiently flexible to handle these activities.

If an insurance company does not have a sufficiently flexible system, it may be confronted with the choice of not offering an important competitive feature or of doing so at a prohibitive cost. The variety of options and state requirements makes policy issue quite complex. Although this is also true for other coverages, it has been especially difficult to anticipate changes in this product as it emerges. The volume of administrative and system changes is expensive for an emerging product to support.

Compliance

Ensuring that the policies offered in each state meet its laws and regulations is a difficult task for most products. The compliance process has been particularly cumbersome for launching long-term care insurance. Having a variety of different requirements makes it extremely difficult to develop policies and supporting material on a uniform, cost-effective basis. It also makes it more difficult to provide necessary

material to consumers, to train employees, and to maintain accurate administrative systems. The compliance process has been an impediment to companies entering the market and has made it difficult for some to continue offering the product. The NAIC Long-Term Care Insurance Model Regulation has changed at least once a year for the last ten years. States have passed different versions of the regulation and at different points in time. This makes compliance very difficult. A 1993 study by the HIAA found that among the 22 companies that stopped writing long-term care insurance in 1991, the most prominent reason was that "they could not keep up with changes in product design and state regulations."

Employer-sponsored long-term care insurance includes many of the features of the individual product. The conversion or continuance of coverage requirements are an added feature. Because of the prefunding involved, such insurance requires different handling than traditional products. Also, because of the impact that insuring a large new client can have, there are bound to be peaks and valleys in work activity, which creates a need for creative resource allocation.

■ Claims Administration

The objective of claims administration is the prompt payment of all valid claims. If further information is needed to process the claim, all such information should be promptly requested with a clear statement of why it is needed. If a claim must be denied, this too must be done promptly and with a clear explanation to the policyholder.

Effective claim administration relies on clear, enforceable contract language and objective, reliable criteria for determining the insured event. An assessment of limitations in activities of daily living and cognitive impairment is a vast improvement over earlier benefit triggers, such as "medical necessity."

Claims examiners need to be trained to understand the unique characteristics of long-term care and how it differs from other forms of health insurance. In order to ensure that claims reviewers make consistent decisions, a claim manual is developed by individual insurance companies to give guidelines on how to handle unique situations and to record policy interpretations as they develop.

Some long-term care policies include a care management benefit. In such instances, part of the claims review process is the development of a plan of care by a care manager. The role of the care manager differs from the role of those associated with traditional medical products. In the latter, care management tends to act as a gatekeeper to receiving care. For long-term care, care management tends to be more instructive and is often optional. This is a particularly important benefit that helps people identify and select appropriate care from the options available in their communities. The use of care management can be extremely effective in managing an ongoing claim to ensure that the proper level and cost of care are being delivered.

Assignment of benefits is common to long-term care insurance, as it is to other health coverages, and is often preferred by policyholders and providers of care. Where assignment of benefits is used, the insured individual may not see the bill for service. Where benefits are assigned, the insurance company generally employs some method of ensuring that the care being provided, and its cost, are appropriate.

An important consideration for all companies in establishing an organization to support its long-term care product is to determine which functions should be independent functions dedicated to long-term care insurance and which should be integrated with functions that already exist to support existing products. In some instances an insurance company may find it appropriate to use an outside source to provide services, such as care management, rather than to develop that function internally.

■ Fraud

An issue of growing importance to both public and private insurance programs is fraud. Our purpose here is not to provide a full discussion of fraud and other forms of abuse.[*] Rather, the reader should be aware of the current status of health care fraud because it has direct implications for long-term care insurance as it evolves.

Why is fraud of interest to the insurance industry? Estimates are that fraud and other forms of abuse add from 3 to 10 percent to the national health bill. With the annual cost of health care estimated to be one trillion dollars, this comes to between $30 billion and $100 billion each year. Certainly a problem of this magnitude requires the attention of the insurance industry and society in general.

Different kinds of fraud include:

- falsified claims,
- misrepresentation on insurance applications,
- altered bills or bills for unrendered services,
- misappropriation of funds,
- fee forgiveness, after benefits have been paid,
- hyper-itemization/excessive fees,
- questionable treatment/services,
- overutilization, and
- fee splitting.

Fraud can be difficult to prove. For instance, one would need to prove that `overutilization' occurred with the intent to do harm. Instances of abuse experienced by Medicare, and the prevalence of older people targeted for other kinds of fraud, suggest the need for active state and federal regulation and enforcement of all aspects of purchasing, selling, and using long-term care insurance.

■ Summary

Developing a functional organization to support long-term care insurance is no easy task. Each function is required to learn new skills or to adapt old skills to a new product. The balance between current costs and potential future benefits is continually challenged. Although there are advantages to having a separate function dedicated to long-term care insurance, there are also benefits to integrating it with those that

[*] An HIAA text covering all aspects of health care fraud is available.

support an existing product. Each company must also determine which services are best done internally and which should be done externally. There is no one best answer. It will depend on such things as the current organizational structure, product mix, and the growth rate of the longterm care insurance business.

■ Key Terms

Administrative system	Fraud	Policy upgrades
Anti-selection	Induced demand	Pricing
Buyer characteristics	Marketing	Reliable data
Claims administration	Marketing material	Reporting requirements
Claims manual	Market research	Sales
Compliance	Moral hazard	Underwriting
Direct marketing	One-on-one sales	

Chapter 6

REGULATION

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■ Introduction

The insurance industry is one of the most regulated industries in the United States. The essence of insurance is the exchange of a written promise to pay a benefit if a particular event occurs for the payment of a premium. The insurance regulator helps to protect the policyholder by making sure that the insurer is solvent and that the products it sells meet certain standards. This function is particularly important for long-term care insurance-where benefit payments typically take place years after a policy is issued.

■ Regulation of Long-Term Care Insurance

Most insurance is regulated on the state level as a result of PL 15, the McCarran-Ferguson Act. This act provides that federal law applies to the insurance business only to the extent that it is not regulated by state law. McCarranFerguson does recognize that the federal government retains exclusive control over matters of national interest such as employer-employee relationships and fair labor standards.

Insurance contracts are quite detailed and difficult to understand. Government supervision of insurance protects the insured by (1) ensuring that policies do not contain unreasonable restrictions and limitations and (2) ensuring that benefits are reasonable compared with the premium charged. In summary, the primary purpose of the regulation of insurance is to protect the consumer.

In developing a new product, such as long-term care insurance, the key challenge is to develop regulations that afford protection to the consumer, offer the consumer a broad range of options, and, at the same time, foster a positive environment for product development and market expansion. Insurance companies and regulators face the following trade-offs:

- ○ Individual choice versus broad consumer protection;
- ○ Assurance that the average consumer receives value from products versus meeting the special needs of particular classes of consumers;
- ○ Comprehensive regulation of the market versus development of regulations to alleviate specific problems;
- ○ Establishing general, goal-oriented standards versus requiring specific provisions to meet the objectives; and

- Rules that take into account market impact versus rules developed independent of market effects.

Insurers and regulators continue to work together to find an appropriate balance between these trade-offs to ensure that the consumer is adequately protected but, at the same time, to ensure that there is sufficient opportunity for innovation and flexibility to enable long-term care insurance to evolve.

The degree of control over insurance matters can vary from one state to another. However, the methods used to control the industry are similar and can generally be divided into three categories.

Statutes. Laws enacted by the state legislature and referred to as "insurance code."

Formal regulations. Specific rules established by state insurance departments under authority conferred by statutes.

Informal regulations. Can include insurance department bulletins, official letters, or guidelines.

In addition, all three branches of government-legislative, administrative, and judicial-participate in the regulation of insurance. Administratively, each state has an insurance department that is headed by an insurance commissioner, who may be elected or appointed. The insurance department is involved in day-to-day dealings with insurers and enforces and executes the state's insurance laws. All state insurance commissioners are members of the National Association of Insurance Commissioners (NAIC).

■ NAIC Role in Regulation of Long-Term Care Insurance

The NAIC is a nonprofit, unincorporated association composed of the chief regulatory insurance officer of each state, the District of Columbia, and the four U.S. territories. A primary function of the NAIC is to develop uniform model laws for insurance products that states can adopt. In order to promote standardization of long-term care insurance regulation and to define an acceptable minimum level of regulation, the NAIC unveiled its first version of the Long-Term Care Insurance Model Act in 1986. This act provided insurance companies and state regulators minimum standards for long-term care insurance legislation. The following year, a model regulation was issued providing greater specificity for implementation of the act. Both have been amended several times since then. The most current versions of the model act and regulation are found in Appendixes A and C of this textbook. As is the case with all NAIC models, states have been encouraged, but not required, to implement statutes and regulations based on these models. The NAIC Senior Issues Task Force, charged with exploring emerging issues and concerns, continues to seek ways of further encouraging the adoption of NAIC long-term care insurance models. Section 1 of the model act sets forth the following objectives:

- Promote the public interest;
- Promote the availability of long-term care insurance policies;
- Protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices;
- Establish minimum standards for long-term care insurance;

- Facilitate public understanding and comparison of long-term care insurance policies; and
- Facilitate flexibility and innovation in the development of long-term care insurance coverage.

While regulators and insurance companies may agree on overall principles, there is often a difference of opinion regarding how to put the principles into practice or what the optimum solution to a given problem might be. Often there is no one best solution. Generally speaking, the insurance industry contends that the appropriate role of state regulators is to promote consumer choice through market competition and to foster consumer protection through regulations governing education, disclosure, marketing, and policy provisions that ensure consumers' basic long-term care insurance needs are met. Many regulators and consumer advocates, however, view mandating certain policy provisions as an appropriate way to ensure consumer protection-a position generally opposed by the industry because they add to the cost of the premium and exceed the industry's standard of meeting "basic" needs.

An example of a benefit about which a basic disagreement exists between the insurance industry and regulators is inflation protection. Everyone agrees that a person should consider the impact of inflation on the future cost of long-term care in deciding how to finance it. By mandating the inclusion of an inflation protection feature, regulators are assured that everyone who purchases a longterm care policy will be afforded this protection. The insurance industry, on the other hand, believes that the consumer is better served by being offered an inflation benefit, at an increased cost, and by being allowed to decide whether this benefit is the way he/she wishes to provide for future increases in the cost of care.

Table 6.1a

Key Provisions in NAIC Long-Term Care Insurance Model Act

Key provision	Year instituted
Definition of LTC insurance	1986
including cognitive impairment	1990
Extraterritorial jurisdiction	1986
Guaranteed renewability	1986
Uniform free look of 30 days	1989
Six-month pre-existing condition	1987
Outline of coverage	1988
Prior hospitalization/institutionalization requirements prohibited	1988
Penalties	1990
Incontestability period	1993
Mandated nonforteiture	1993

SOURCE: Health Insurance Association of America.

Prior to the development of the model act and regulation, few states had laws specifically governing long-term care insurance. By 1991 almost all states had implemented some version of the model act and 38 states had some version of the model regulation. Despite that progress, states have come under attack from federal policymakers and consumers for their failure to remain current with the yearly updates to the NAIC models. However, studies* have shown that, despite state

* Although it is difficult to correlate the introduction of long-term care insurance regulations ,with product changes, the NAIC Long-Term Care Insurance Model Act and Regulation clearly have influenced product design

variation with the NAIC models, a large segment of the insurance industry has kept pace with the changes in the model act and regulation. Virtually all of the largest sellers and many other companies offer long-term care insurance that currently meets the majority of the NAIC requirements, regardless of whether a specific state has enacted the latest provisions of the models.

As you review the key NAIC provisions relating to long-term care insurance listed in Tables 6.1a and 6.1b, it is important to recall the discussion in Chapter 4 of the unique characteristics of long-term care insurance and how it differs from other forms of insurance.

Table 6.1b

Key Provisions in NAIC Long-Term Care Insurance Model Regulation

Key provision	Year instituted
Policy definitions	1987
Prohibition against exclusion of coverage for Alzheimer's disease	1987
Loss ratio requirements	1987
Guaranteed renewability	1987
Replacement requirements	1987
Filing requirements	1987
Continuation/conversion	1988
Outline of coverage	1988
Post-claims underwriting restrictions	1989
Minimum standards for home health care	1989
• Requirement to cover community-care benefits	1991
• Prohibition against exclusion of personal care and adult day care services	1991
• Minimum benefit levels for home care	1991
Requirement to offer inflation protection	1989
• Minimum of 5% compounded annually	1990
• Mandatory inflation benefits except with signed waiver at time of application	1991
• Prohibit limits on benefit increases based on age, claims, status, or duration of policy	1991
• Disclosure on premium increases	1991
Delivery of shopper's guide	1990
Reporting requirements related to sales practices, advertisement, claims/premium experience	1990
Agent licensing	1990
Standards for marketing	1990
Prohibited marketing practices	1990
Prohibition on attained age rating or durational rating	1991
Unintentional lapse	1992
Loss ratios extended to group	1992
Association group requirements	1992
Nonforfeiture benefit standards	1993
Premium rate restrictions	1994
Suitability requirements	1995
Benefit triggers	1995

SOURCE: Health Insurance Association of America.

State Adoption of NAIC Models

Since 1993, HIAA has been monitoring each state's level of compliance with the most current NAIC Long-Term Care Insurance Model Act and Regulation. To measure state compliance with the model act and regulation, HIAA compares each state's statutory and regulatory requirements with key provisions from the most current NAIC Long-Term Care Insurance Model Act and the Model Regulation. These "key" provisions are viewed as most significant to regulators, insurers, and consumers. The 29 key provisions shown in Tables 6.1a and 6.1b include: the definition of long-term care insurance, requirements on limitations or coverage, 30-day free-look period, outline of coverage, group continuation and conversion, prohibiting post-claims underwriting, home health care standards, inflation protection, suitability, agent compensation limits (optional), mandated nonforfeiture, rate stabilization, and benefit

triggers. Broadly speaking these provisions can be divided into two categories: those directed toward assisting the consumer (e.g., disclosure requirements and minimum standards) and those directed toward the insurance company and its conduct (e.g., marketing practices and post-claims underwriting).

State compliance with the specific provisions of the model act and regulation varies widely. As of October 1995 all 50 states had adopted laws and regulations relating to long-term care insurance. Most states have adopted a majority of the provisions identified (see Figure 6.1). Thirty-seven states have adopted at least half of the provisions analyzed (i.e., 15 provisions). By further analyzing the data, HIAA found that six states comply with at least 80 percent of the 29 provisions, 24 states comply with between 60 percent and 79 percent, and 20 comply with less than 60 percent of the provisions. The states that have the highest levels of adherence to these key provisions are Oklahoma, Missouri, North Dakota, Ohio, Connecticut, and Kentucky. The states that have the lowest levels of compliance are West Virginia, Alaska, Hawaii, New Hampshire, and New Jersey. The District of Columbia had yet to enact any law or regulation specific to long-term care insurance.

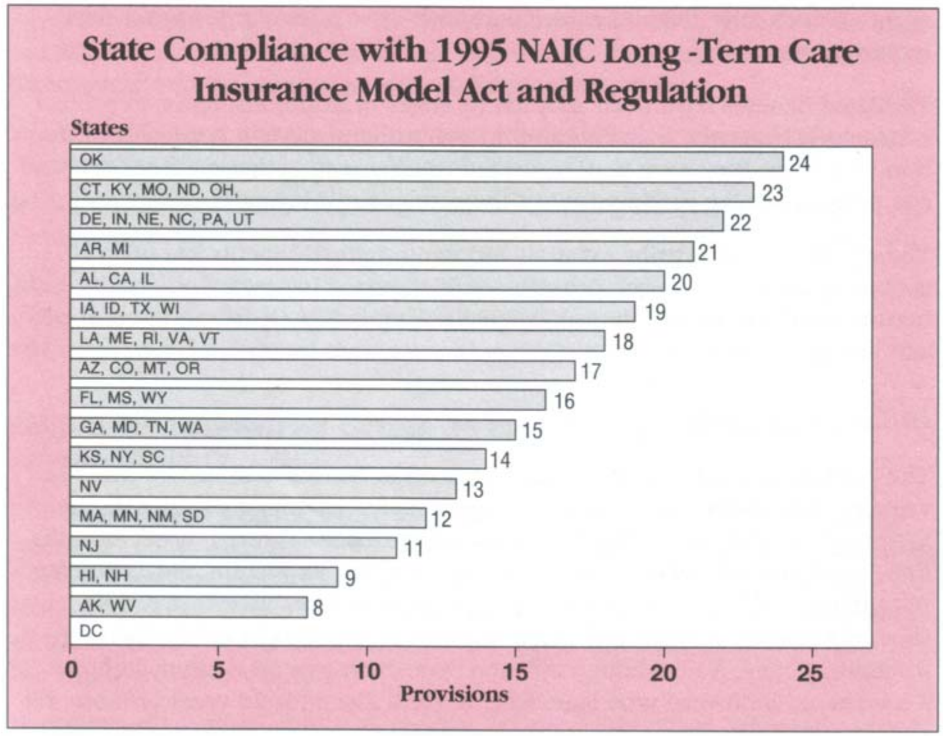

Figure 6.1

SOURCE: Health Insurance Association of America, 1995.

Some provisions have been widely adopted. Most states have incorporated (without much variation from the NAIC language) requirements on: no prior institutionalization, guaranteed renewability, definition of long-term care insurance, pre-existing condition limitations, and 30-day free-look period.

The NAIC provisions least adopted are requirements on the following: premium rate restrictions, mandatory nonforfeiture benefit, benefit triggers, suitability, and agent compensation. (The latter is an "optional" provision in the model regulation.) These are among the more recent and controversial provisions. The older the provision, the more likely that a state has complied with it.

hanya untuk kalangan sendiri

■ Areas of Regulatory Controversy

There is a high level of consensus among insurance companies, agents, and regulators regarding insurance regulation. Virtually all parties agree with the consumer protection goals set forth at the beginning of this chapter. Regarding specific regulatory provisions, however, there has been less agreement. Some of the more controversial issues are discussed below.

Optional Benefits Versus Mandated Benefits

Insurance companies, agents, and regulators are widely divided on the issue of benefit mandates. The majority of agents and companies oppose requiring inflation and nonforfeiture benefits, mandating that long-term care insurance policies provide coverage for nursing home and home care, and leveling of agent commissions. Regulators and consumer advocates often support these requirements.

Mandated benefits have been adopted by states in health insurance to protect consumers. Mandated benefits can improve patient care and consumer protection. However, they have been a major contributor to increased premiums and can price insurance products out of the reach of some people.

The question of mandating inflation and nonforfeiture benefits has been a major source of controversy between regulators and insurers. The cost of each benefit is substantial and the value is highly dependent on factors such as age and income.

Inflation Benefits

The primary rationale for an inflation protection benefit is to ensure that the value of the benefits provided by a long-term care policy keeps up with the increase in service costs. Depending on the age of the insured, however, inflation protection can increase the premium between 50 percent and 125 percent for a traditional indemnity policy. There is general agreement that people should consider the impact of inflation when they purchase a long-term care insurance policy. And although inflation protection may be a rational choice for a 55-year-old individual who is unlikely to file a claim for 20 years or more, for a 75 year old, who may be more likely to use insurance benefits within several years of purchasing the policy, the need for inflation protection is not as great. The NAIC model regulation requires that consumers be offered the option of purchasing inflation protection (Section 11).

Nonforfeiture Benefits

The issue of nonforfeiture benefits arises from the prefunding method used by long-term care policies. Premiums, based on age at purchase, are designed to be level through the life of the policy. This means premiums charged in the early years are greater than is actually required to cover the risk. The excess is set aside as a reserve to cover later years when the level premium is less than sufficient to cover the risk. The purpose of a nonforfeiture benefit is to ensure that the policyholder does not lose the value of the reserve. In other words, the extra premium paid for including a nonforfeiture benefit can be viewed as insurance against the policyholder's loss of these reserves.

Not everyone wishes to pay a larger premium to ensure that he/she receives some value from his/her policy if it lapses. Some people would rather pay a lower premium and risk lapse. The difference in premium can be substantial, over 50 percent at some

ages. The NAIC model act (Section 8) and model regulation (Section 23) require that policies provide a "shortened benefit period." There were two primary reasons for mandating its inclusion:

- to provide some benefit to consumers who unintentionally lapse after paying premiums for several years, and
- to prevent insurance companies from encouraging lapse rates to keep premiums down.

Each side of the argument has merit. Certainly, there is general agreement that insurance companies should not induce lapse to create a windfall through a release of reserves beyond that assumed in developing premium.

Employer-Sponsored Group Programs - Regulatory Distinctions

The regulation of long-term care insurance was primarily designed to address individual policy concepts and focus on agent-solicited sales and marketing practices. Because the employer-sponsored group market differs in several respects from the individual market, the regulations are sometimes inappropriate. Some of the regulatory requirements often identified as unnecessary or unhelpful in the employer market include:

- outline of coverage requirements that frequently duplicate information contained in employer-prepared material;
- marketing standards that are inconsistent with the use of employee meetings and other employer-sponsored enrollment techniques; and
- distribution of a "shopper's guide" that is directed at the elderly market, where agent-solicited sales are common, but is not necessarily appropriate for sales to younger, active employees.

Some of the distinctions to consider when developing regulations for employersponsored long-term care plans are the following:

- The target market for employer group plans is different-primarily active employees under age 65.
- The sales process is different. Individual one-on-one sales do not generally occur. In many cases agents are not part of the process nor are commissions generally paid.
- Employers already provide "disclosure" information, including marketing material, group insurance certificates, and summary plan descriptions as required by the Employee Retirement Income Security Act (ERISA). (Note: Not all employer plans are subject to ERISA fiduciary duties-for example, state government plans are exempt.) This is the kind of information employees are used to receiving from their employer for other employer-sponsored plans.
- Employers are skilled at evaluating and selecting insurance plans and carriers for their employees and at evaluating a plan's ongoing performance. This high level of examination clearly gives the employee a form of consumer protection not provided in an individual purchase situation.
- Employees may already be afforded many of the protections that regulators are interested in providing.

Given these distinctions, it is important for regulators to evaluate whether requirements designed for the individual market should apply to the employersponsored group market.

Enforcement and Oversight

While good laws and regulations are required, equally important is the enforcement and oversight of such laws. Because the market is still under development, state attention to the newly developing long-term care insurance regulatory process is often out of proportion to the size of the marketplace in a given state. Substantial variation exists across states in insurance department resources; this is also true for resources dedicated to long-term care insurance products. Based on incomplete responses to an American Association of Retired Persons survey several years ago, it was estimated that total state insurance department staffing ranged from a low of 21 to a high of 812. Staff assigned to long-term care insurance ranged from one to 50 employees.

Few departments assign staff exclusively to long-term care insurance product regulation. Carriers have noted a number of barriers to marketing in certain states that are attributable to resource shortages. These include the long lag time in product approval, overwhelming paperwork, and poor communication between insurance companies and regulatory staff. These problems are only exacerbated by the frequency with which the NAIC updates its model act and regulation, resulting in refiling of policies for state approval to maintain competitiveness.

To overcome these obstacles, some have recommended additional funding for staff, staff training programs, and improved technology such as automated systems to track consumer complaints. Carriers, agents, and regulators agree on the need to reduce the frequency of NAIC changes, which have occurred every y ear-and sometimes twice a year-since the model was developed in 1986. This reduction could improve the timeliness of the regulatory process and give consumers a greater number of product choices. The recently passed federal legislation, discussed below, will put additional pressure on states to review and approve new long-term care policy filings.

■ Federal Legislative and Regulatory Environment

There has been high-level interest in the development of private long-term care insurance by both the legislative and executive branches of the federal government since the mid-1980s. Some examples of government attention include:

- ○ Numerous research and policy studies funded by the U.S. Department of Health and Human Services to examine the feasibility of private insurance in funding long-term care. The most notable study was conducted by The Brookings Institution and published in 1988. Caring for the Disabled Elderly, Who Will Pay? became a starting point for policy discussions regarding the viability of private long-term care insurance.
- ○ A 1986 congressionally established Task Force on Long-Term Health Care Policies to assess the viability of private long-term care insurance as a means of financing long-term care.
- ○ The inclusion of long-term care financing concerns in a report addressing catastrophic health care costs prepared for President Reagan by U.S. Health and Human Services Secretary Otis Bowen. (The report led to the passage of the so-

called Medicare catastrophic legislation, which was later repealed by Congress. It did not, however, include long-term care provisions.)

- A congressionally established commission-the Pepper Commission-established by Public Law 100-360 to recommend legislation that would ensure health care and long-term care coverage for all Americans. The final report was issued in September 1990.
- The inclusion of private long-term care insurance provisions in President Clinton's Health Security Act proposed in 1994. The provisions addressed both consumer protection standards and federal tax law clarifications.

Other national initiatives included a program launched by the Robert Wood Johnson Foundation in 1987 that awarded grants to several states. The grants funded research and data collection needed to design ways to pair private longterm care insurance with state Medicaid eligibility for the purpose of reducing state and federal spending on Medicaid long-term care services. In addition, the first national private long-term care insurance conference was held in 1983. It was cosponsored by several organizations, including the National Governors' Association, the Health Insurance Association of America, and the American Health Care Association.

Along the way, there were numerous congressional hearings on long-term care financing in general and private long-term care insurance in particular. Congressional interest was focused on two broad questions:

- What role could private long-term care insurance play in helping to pay the nation's long-term care bill?
- Was the design of long-term care insurance adequate to provide good protection for consumers? Should federal laws be established to protect consumers and policyholders, primarily older Americans?

Congressional interest in regulating private long-term care insurance was motivated by several factors. To some, it seemed a logical extension of regulating Medicare supplement insurance. Others concluded that states had not acted swiftly enough or with enough uniformity in regulating the new product. Many believed that the elderly were a vulnerable population that needed special protection. Some in the insurance industry believed the only way to convince Congress to clarify the tax status of long-term care insurance was if federal consumer protection standards were also established.

Passage of the Kassebaum-Kennedy Bill: H.R. 3103

In August 1996, President Clinton signed "The Health Insurance Portability and Accountability Act of 1996," known as the Kassebaum-Kennedy Bill (H.R. 3103). The primary purpose of the legislation was to help ensure that individuals would not lose their medical coverage or be subject to new pre-existing condition periods when they changed or lost their jobs. The bill also included an increased health insurance premium deduction for the self-employed, provisions to reduce fraud and to simplify administrative systems, and a demonstration project for medical savings accounts. Finally, the bill included long-term care insurance consumer protection standards and provisions clarifying the federal tax treatment of the policies.

Consumer Protection Provisions

Generally, the law established consumer protection standards that were contained in the 1993 NAIC Long-Term Care Insurance Model Act and Regulation. There are two types of consumer protection standards: requirements imposed on the insurance policy and requirements imposed on the company issuing the policy. Requirements imposed on the policies themselves include:

- The stipulation that policies be guaranteed renewable or noncancellable.
- A six-month limit on the length of the pre-existing condition exclusion period. (And a look-back period limited to six months.)
- Specific limits on coverage that can be excluded. (However, coverage of Alzheimer's disease must be included in the policy.)
- Continuation or conversion requirements for individuals covered under group policies.
- A designated individual, other than the policyholder, to receive a notice of policy termination due to nonpayment of premium, and a requirement that the policy be reinstated if proof of cognitive impairment or loss of functional capacity is provided to the insurer.
- Prohibitions against post-claims underwriting.
- Minimum standards for home health and community care benefits.
- A requirement to offer an inflation protection feature that increases benefits at a compounded annual rate of 5 percent (other inflation protection benefits can also be offered).
- Prohibitions on requiring a prior hospital stay in order to qualify for nursing home coverage and on requiring a prior nursing home stay in order to qualify for home health care coverage.
- A requirement to offer a nonforfeiture benefit that includes at least one of the following: reduced paid up; extended term; shortened benefit period; or a similar form approved by the Secretary of the Treasury.

The second category of consumer protection standards focuses on requirements that must be met by the issuer of the policy. The law imposes an excise tax for noncompliance with these standards equal to $100 per policy for each day the requirement(s) is not met. These consumer protection standards include:

- Establishing a process and a form to follow at the time of application to ensure an individual is not replacing a current long-term care insurance policy inappropriately.
- Requiring that insurers report information on lapse rates, replacement sales, and claims denied on an annual basis. An explanation of claims denial must be given within 60 days of a policyholder's written request.
- Requiring insurers to file advertisement materials with a state.
- Establishing marketing procedures and other marketing standards to prevent such sales practices as "twisting," high pressure sales tactics, and cold lead advertising.

- Requiring an agent to "make reasonable efforts to determine the appropriateness" of a recommended purchase of a policy.
- Providing a prospective purchaser of an individual policy with a uniform "outline of coverage" that provides a summary of the policy's benefits and limitations in a standardized format to allow comparisons with other policies.
- Providing a prospective purchaser of an individual policy with a copy of the NAIC shopper's guide or a guide developed or approved by the state insurance commissioner.
- Requiring group certificates to include a description of the policy's principal benefits and exclusions, as well as a statement that the group master policy determines governing contractual provisions.
- Providing a full refund of a premium up to 30 days after purchase of a policy. In addition, applications must be approved within 30 days and denied applicants must have their premiums returned within 30 days of application.
- Requiring disclosure and reporting for those accelerated death benefits subject to governance under the long-term care insurance model act and regulation.
- Requiring a definition of the incontestability period and conditions under which a policy can be rescinded.

States may impose more stringent consumer protection standards than those outlined above and policies will still qualify for tax-favored treatment. The Secretary of the Treasury is charged with determining if policies comply with the consumer protection provisions in the law.

Benefit Eligibility

In addition to the provisions outlined above, policies may base benefit eligibility only on activities of daily living (ADLs) or severe cognitive impairment. Specifically, benefits can be triggered based on at least two ADLs from the list of the following: bathing, dressing, transferring, toileting, continence, and eating. Policies must include at least five of these six ADLs. Before receiving benefits, an individual must be certified as being ADL-impaired for at least 90 days.

An individual can qualify as being cognitively impaired if "substantial supervision" is needed to "protect the individual from threats to health and safety due to severe cognitive impairment." The bill also allows the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to develop a similar benefit eligibility test. States may not require less restrictive benefit eligibility criteria.

Additional Policy Requirements

To qualify for favorable tax treatment, policies must include the consumer protection standards reviewed above (or more stringent ones required by a state), and follow the benefit eligibility criteria outlined above. In addition:

- Policies may only pay for "qualified long-term care services," which include "necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services" (There is an exception to this for per diem policies. See Chapter 4 for a discussion of per diem-based policies.);

- Services must be required by a "chronically ill" individual (defined as someone meeting the benefit eligibility described above);
- Services must be provided based on a plan of care prescribed by a licensed health care practitioner;
- Policies must be guaranteed renewable and may not include a cash surrender value,
- Policies must offer a nonforfeiture benefit as described above; and
- Policies must coordinate with Medicare payments (i.e., not pay for services covered under Medicare or Medicare supplement policies). (Per diem-based policies, because they pay independent of service use, are not required to coordinate.)

Tax Clarifications

If policies and insurers follow the requirements outlined above, H.R. 3103 permits such policies to receive the following tax treatment:

- In most cases, benefits are excluded from taxable income, that is, they are tax-free. (Benefits paid by per diem-based policies are tax-free up to $175 a day, indexed for inflation.) There is a new requirement for insurers to report to the Internal Revenues Service the amount of long-term care insurance benefits paid.
- Insurance premiums and out-of-pocket spending for long-term care services qualify as medical expense deductions subject to the 7.5 percent adjusted gross income limitation. There are limits on the premium deduction, based on age.
- Self-employed individuals can deduct long-term care insurance premiums from their income, beginning with 40 percent in 1997 and ultimately reaching 80 percent of the premium in 2006.
- Employer contributions to an employee's premium are excluded from taxable income of the employee. Long-term care insurance cannot be offered, however, as part of a cafeteria plan.
- Employers can deduct the cost of operating a group plan as a business expense. (It is uncertain at the time this book goes to press if employer contributions are deductible.)
- The federal tax treatment of insurer reserves is reconciled with the NAIC minimum reserving requirements-that is, companies are permitted to use the one-year preliminary term reserve method.

All of the above tax clarifications are effective January 1, 1997, except for the last one. The tax treatment of reserves becomes effective January 1, 1998. Policies sold prior to January 1, 1997, that complied with state standards at the time of their sale are "grandfathered," that is, they are treated as long-term care insurance policies. States will approve new policies designed to meet the federal law's requirements as part of their overall responsibility of regulating insurance.

H.R. 3103, while presenting many challenges to insurers regarding implementation issues and questions, also offers great opportunities. Passage of the law was sought by the insurance industry and others for several years. Many believe it will stimulate the marketplace and result in increased group and individual sales. Increased market interest is thought to result from making the policies more financially attractive

through the tax changes. However, others believe that increased market interest will be due, in part, to the educational value the tax changes present to the public. Many consumers will learn about long-term care insurance for the first time by learning about the new tax law and its treatment of long-term care insurance.

■ Summary

Since the mid-1980s, there has been great interest by both the state and federal governments in the developing long-term care insurance industry. State legislative interest has focused on regulating this new form of health insurance, and the National Association of Insurance Commissioners has led this initiative.

The federal government has focused more broadly on the public policy question of how to improve the financing of long-term care. It has also been concerned, however, about the adequacy and viability of private long-term care insurance. Recent federal legislation establishing consumer protection standards and favorable tax treatment represents a significant federal initiative addressing long-term care financing.

Although it is too early to assess, the establishment of federal laws may slow the rate of state-by-state regulatory changes that have been the norm since the late 1980s and result in greater regulatory uniformity across the states.

■ Key Terms

- Consumer protection standards
- Enforcement and oversight
- Inflation protection
- Kassebaum-Kennedy (H.R. 3103)
- Mandated benefits
- McCarran-Ferguson Act
- NAIC Long-Term Care Insurance Model Act
- NAIC Long-Term Care Insurance Model Regulation
- National Association of Insurance Commissioners (NAIC)
- Nonforfeiture
- Outline of coverage
- Post-claims underwriting
- Rate stabilization
- Suitability
- Tax clarifications
- 30-day free-look period

Chapter 7

SUPPLEMENTAL SOURCES OF FINANCING

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■ Introduction

The nature of the long-term care risk-a relatively small chance of incurring a substantial level of expenses-makes private long-term care insurance an attractive means of protection to a wide spectrum of the population. However, it may be either unaffordable or unavailable to some individuals, or the policy selected may not cover the entire cost of care. In these cases, and for those who have decided not to purchase long-term care insurance or who have not yet decided how to fund their long-term care needs, other avenues for funding all, or a portion, of long-term care will have to be pursued. As the reader proceeds through this chapter, it will be helpful to view the financing mechanism being discussed from two perspectives:

- How well it fits into a long-term financial plan.
- How effective it is at the time the individual needs care.

This chapter discusses the following supplemental sources of financing:

Accelerated death benefits (ADBs). These provisions in a life insurance policy were created to allow early access to death benefits, generally because of a terminal illness or the development of a specified disease. Although there are some ADBs specifically triggered by the need for long-term care, ADBs usually are designed to add flexibility to the use of life insurance protection.

Viatical settlements. These fairly new contracts allow terminally ill individuals access to death benefits. Because the viators must be terminally ill, viatical settlements, as presently structured, do not provide long-term financing for chronic illness.

Home equity conversions. These contracts provide homeowners access to the equity in their homes. These arrangements may be excellent for converting assets to income. However, they are not reliable sources for funding the full cost of long-term care as discussed in greater detail below.

Charitable remainder trusts. These trusts were designed to leverage charitable gifting. Although they may provide additional income, they are not available to many people and are not reliable avenues for funding long-term care needs.

Medicaid qualifying trusts. Originally, these trusts allowed individuals access to Medicaid without spending down their assets. The government has significantly limited the use of these trusts so that they do not, except in very specific circumstances, provide funding for long-term care.

Personal savings programs. Personal savings for long-term care must be specifically earmarked for that purpose. However, few people can use this approach as the sole source of financing.

Although these strategies are useful for managing various financial situations, if the main objective is long-term care financing they should not be considered as the primary solutions. Supplemental savings are advisable, however, for any long-term care financing plan.

■ Accelerated Death Benefits

Accelerated death benefits (ADBs) provide cash advances, while the insured is living, against all or a portion of the death benefit of a life insurance policy. The amount of the benefit varies according to the provisions of the insurance contract and the conditions triggering benefits. ADBs were introduced into the United States in the 1980s and have evolved substantially since then. Their primary use has been to extend the life of insureds (e.g., in the form of organ transplants), for imminent death situations (e.g., AIDS), or for people who need long-term care. Many companies offer ADB riders for policies already in force, as well as for newly written policies. Although they add flexibility to life insurance policies, for most people, they are not effective ways of financing longterm care needs. In 1994, 215 companies provided some form of accelerated death benefits. In 1991, the National Association of Insurance Commissioners (NAIC) issued an Accelerated Benefits Model Regulation providing guidelines for ADBs. Like all NAIC Models, these are only guidelines and not mandatory for states to adopt. A copy of the model regulation is included in Appendix B.

Benefit Triggers

The NAIC ADB model regulation provides for any one of four qualifying events to trigger accelerated death benefits. The model treats these as mortality, not morbidity, risks and they are therefore regulated as life, not accident or health, insurance.

Most policies will include only a single event that triggers benefits. The NAIC model triggers are:

Terminal illness. A condition that limits the insured's life expectancy. The policy will specify a number of months of expected life required to trigger the ADB. This feature provides flexibility for those insureds facing imminent death due to conditions such as cancer, end-stage renal failure, and AIDS. Depending on the insurer, the number of months required may range from six to 24, although recent federal legislation defines terminal illness as a condition expected to result in death within 24 months.

Extraordinary life preserving measures. A medical treatment or surgery, such as a vital organ transplant, without which the insured would die. The 1994 American Council of Life Insurance (ACLI) survey of ADBs found only a few companies offering this provision. However, with the increasing number of organ transplants, this provision may become a significant added benefit to a life policy.

Specified disease. A medical condition that quickly shortens life expectancy unless extensive medical treatment is provided. This provision is most often used by those afflicted with AIDS, life-threatening cancer, heart disease, endstage renal failure (i.e., extensive dialysis), or stroke.

Permanent confinement to a nursing home. Any condition that requires continuous and permanent confinement in the expectation of ultimate death, in an eligible

institution. As noted earlier, this permanent confinement is considered a mortality event and regulated as life insurance. It is not considered longterm care.

Another accelerated death benefit provided under life insurance policies does specifically address long-term care. It is triggered by the need for extended confinement in a care facility or the need for extended home health care. This provision, although attached to a life policy, is considered a morbidity risk and therefore is not regulated as life insurance and is not included under the Accelerated Benefits Model Regulation. Instead, such life insurance riders are included under the NAIC LTC Insurance Model Act and Regulation as discussed in Chapter 4.

The ACLI 1994 survey on ADBs also found that 83 percent of the ADB features written as part of individual policies specify only one type of condition, or benefit trigger, for which they will accelerate benefits. The remaining products provide payment of benefits when one of two conditions occur. For example, a policy may include a provision to accelerate benefits in the event of terminal illness or if the policyholder must be permanently confined to a nursing home.

Most accelerated death benefits (84 percent) are structured as riders. Of the balance, 11 percent incorporate the benefit in the policy. Four percent have some type of noncontractual arrangement.

The study found that ADB provisions occur most often in universal life policies. However, they also may be written as part of traditional whole life, term, and single premium policies.

Insurer Financing Methods

The insurer may finance ADBs in one of three ways:

Premium charge. The insurer charges an additional premium for the benefit. The amount is based on actuarial calculations.

Discount provision. The insurer pays the present value of the face amount to the insured. This approach accounts for the interest lost in advancing the death benefit.

Interest provision. The insurer treats the ADB as a loan against the policy's face value, accruing interest charges on the amount of the accelerated benefits advanced. The amount of the loan plus interest is settled against the proceeds of the insurance payment upon the insured's death.

The method of charging varies depending on the benefit trigger. As a rule, insurers charge an additional premium when specified disease benefit triggers are used. They generally use other financing methods for other triggers. According to the 1994 ACLI Update Survey, only 25 percent of insurers required an additional premium, while 25 percent had no charge, 25 percent used the present value of the face amount, and 23 percent considered the advanced amount as a loan and therefore charged interest. Table 7.1 illustrates the methods for charging for ADBs in individual policies. This is a significant change from the results of the 1990 survey, which indicated that 90 percent of the insurers charged an additional premium. More than half (54 percent) of the companies surveyed charged an administrative fee that was levied when the accelerated payouts were made.

Table 7.1

Method of Charging Policyholders for Accelerated Death Benefits by Product Type, Individual Products

	Long-term care	Dread disease	Terminal illness	Other	Total
	(%)	(%)	(%)	(%)	(%)
No charge	—	—	28	75	25
Additional premium	100	100	10	25	25
Discounted benefit	—	—	30	—	25
Lien approach	—	—	28	—	23
Other/combination	—	—	3	—	3
(Base)	(21)	(12)	(175)	(4)	(212)

SOURCE: Accelerated Death Benefits: 1994 Update, A Joint Report of ACLI and LIMRA International.

Tax Treatment

Federal law signed by President Clinton, H.R. 3103, amended the internal revenue code to allow amounts received under a life insurance contract, by reason of the insured being either terminally or chronically ill, to be excluded from taxable income (as are life insurance proceeds paid to beneficiaries). A terminally ill person is defined as having been certified by a physician as having an illness or a condition reasonably expected to result in death within 24 months. The definition of a chronically ill person is the same as that defined in Chapter 6 regarding standards for tax-favored long-term care policies (i.e., an individual who is unable, without substantial assistance, to perform two out of at least five activities of daily living).

Concluding Observations

It is important to remember that while accelerated death benefits may add significant flexibility to life insurance products, they are not replacements for long-term care coverage.

Insurance benefits cannot be used twice. If there is a need to meet financial obligations through life insurance proceeds on the insured's death, the ability to do so is obviously lessened if the accelerated death benefits are used prior to death. If there is no need for life insurance, it may not be prudent to continue to pay premiums for an unnecessary life policy just to keep the ADB, which may not be needed for 20 or more years. However; for those individuals who may not qualify for long-term care coverage due to ill health, it may be advisable to keep a life insurance policy with an ADB rider in force.

■ Viatical Settlements

With a viatical settlement, individuals with terminal illness sell their life insurance policies, at a discount, to private companies or individuals. Because the individual selling the policy must be terminally ill, this approach is obviously not appropriate for financing long-term care.

The term "viatical" is from the Latin "viaticum" meaning "provisions for a journey." The amount received for the policies will vary according to the number of months of life expectancy of the terminally ill policyholder. For example, a person with six months anticipated life expectancy may receive 75 to 80 percent of the policy's face

value. According to the Viatical Association of America, most people today who are viaticating are 25- to 50-year-old policyholders who have contracted AIDS.

There are essentially two types of arrangements for viatical settlements: through funders or brokers. Funders invest in the policies. Working directly with the individuals, evaluating the policyholder's health situation, they make an offer to buy the policy. If the offer is accepted, they then repackage the policy and sell it to investors. Viatical brokers do not invest in the policies themselves but work on behalf of viators to find purchasers for their policies.

In 1995, the Security and Exchange Commission (SEC) ruled that viatical settlements are securities and thus require registration. The SEC maintains that if a firm solicits individual investors and represents viatical settlements as investments, the firm is selling an unregistered security. The SEC also ruled that if an agent refers a client to a viatical settlement firm, he/she is considered to be selling insurance and therefore is not currently affected by the SEC rulings.

Following the SEC decision in 1995, the National Association of Insurance Commissioners (NAIC) issued a model regulation covering viatical settlements-the Viatical Settlements Model Regulation. If adopted by states, viatical companies would be licensed by state insurance departments. Full disclosure would be required, especially regarding tax implications. Additionally, viators would need to be informed that the sale of their death benefits may disqualify them for public assistance, such as Medicaid.

To support the guidelines, Standard and Poors has developed criteria to rate securities issued by viatical settlement companies. Among the items S and P uses as its criteria are a fair market value for the policy, the company's track record, and the licensing status of the companies offering to purchase. So far, approximately 20 states have passed regulations on viatical settlements. A few states, such as Oregon and Vermont, require insurance licenses for those selling such arrangements.

Tax Treatment

H.R. 3103, discussed earlier under the tax treatment of accelerated death benefits, also permits proceeds paid out under viatical settlements to be excluded from taxable income of the insured, as long as the viatical provider meets certain requirements specified in the law. (Generally, these requirements follow the provisions in the NAIC Viatical Settlements Model Act and Regulation.) The definition of terminal illness for viatical settlements is the same as that used for accelerated death benefits for terminal illness described earlier in the chapter.

Concluding Observations

Viatical settlements are designed for use by the terminally ill. As such, they are not designed to cover long-term care needs. They may be a last resort, however, for someone who does not require life insurance protection and who has no other resources to pay for care needed near the end of life.

■ Home Equity Conversions

For many older homeowners, the major, and perhaps only, significant asset they have available is the equity they have built in their homes. Home equity conversions are effective ways for homeowners to tap into this equity.

Historically, the only methods for converting this asset to cash were to sell the home or to obtain a conventional home equity mortgage. Often, neither alternative was particularly viable. The former involved leaving the security of a lifetime residence. The latter involved submitting to mortgage payments again. A home equity conversion is a method of gaining access to the equity in the home, without the conventional mortgage payment. These loan structures may be very useful for those with long-term care needs. In fact, a survey completed by the American Association of Retired Persons (AARP) in 1991 indicated that most individuals responding to the survey were interested in home equity conversions to provide liquidity to pay for health care.

Currently, there are more than 125 lenders across the United States who offer some form of home equity conversions. In addition, Fannie Mae has introduced a new reverse mortgage program, allowing homeowners to tap into an even more significant portion of their home equity than was available before.

Table 7.2 outlines the three basic types of home equity conversions: reverse mortgages, special purpose loans, and sale plans.

Reverse Mortgages

Unlike traditional mortgages where homeowners are reducing debt and building equity in their homes over time, in a reverse mortgage, homeowners are increasing debt and decreasing equity in their homes. These loans are offered by public, private, and federally insured lenders; however, offerings vary from state to state.

There are three broad classifications of multipurpose reverse mortgages available. The most basic reverse mortgage is the fixed-term uninsured plan, which provides monthly cash to a borrower for a selected period of time (say, three to ten years). This plan may be appropriate for homeowners who need to supplement their monthly incomes for a known, specific period of time with the expectation of selling their homes at the end of that period. The time period for long-term care, however, is unknown. Therefore, an individual using a fixedrate uninsured plan to pay long-term care costs may be required to sell his/her home to pay off the loan, even though the need still exists.

Another form of reverse mortgage is the reverse annuity mortgage (RAM). In a RAM, part of the loan amount is used to purchase an annuity, so even if the borrower sells or moves from the home, he/she will continue to receive the annuity payments. The loan, however, must be paid off when the owner dies, sells, or moves from the home. This plan, currently available on a limited basis, may be structured with an immediate annuity, which makes payments as soon as the RAM commences, or as a deferred annuity, which will make payments at a predetermined time in the future.

Table 7.2

Types of Home Equity Conversions

Reverse mortgages			Special purpose loans			Sale plans	
FHA insured	**Reverse annuity**	**Uninsured**	**Deferred pay plan**	**Property tax deferral**	**Split term loans**	**Sale leaseback**	**Life estate**
Loans: Monthly for a fixed term or as long as in home **FHA limit: $151,000** **FNMA limit: $203,000**	**Loans:** Monthly for life; line of credit; monthly plus line of credit	**Loans:** Monthly for a fixed term	**Loans:** One-time lump sum for specific repairs Low income required	**Loans:** Annual advances to be used only for property tax deferral Low income required	**Loans:** Monthly payments for a fixed period Low income required	**Loans:** Cash downpayment plus monthly purchase payments Ownership not retained	**Loans:** One-time lump sum or monthly payments for life
Repayment terms: At death, move or sell	**Repayment terms:** At death, move or sell	**Repayment terms:** When the loan advances stop	**Repayment terms:** When borrower leaves the home	**Repayment terms:** When borrower leaves the home	**Repayment terms:** When borrower leaves the home	**Repayment terms:** N/A	**Repayment terms:** N/A
Loan costs: Interest-fixed or adjustable plus insurance premium, service fee	**Loan costs:** Cost of annuity plus other charges depending on how it is structured	**Loan costs:** Interest at a fixed rate	**Loan costs:** Low interest	**Loan costs:** 6–8% Fixed by law	**Loan costs:** Low interest	**Loan costs:** N/A Seller transfers ownership to buyer and pays rent to buyer	**Loan costs:** N/A Seller transfers ownership to buyer at death

The third type of reverse mortgage, the FHA-insured reverse mortgage, also referred to as HECMs (home equity conversion mortgages), is sponsored by the federal government. The Federal Housing Administration (FHA) of the U.S. Department of Housing and Urban Development (HUD), which began offering reverse mortgages in 1989, provides for the most flexibility for payment, using the following options:

Term. Receive equal monthly payments for a fixed period.

Tenure. Receive equal monthly payments for as long as borrower lives in the home as a principal residence.

Line of credit. Draw amounts of the borrower's choosing up to a maximum amount.

Modified term. Set aside a portion of loan proceeds as a line of credit and receive the rest in the form of monthly payments.

Modified tenure. Set aside a portion of loan proceeds as a line of credit and receive the rest in the form of equal monthly payments for as long as the home is the principal residence.

Insurance, a part of the FHA contract, provides the homeowner protection in the event the loan balance becomes greater than the value of the home. The FHA creates a reserve fund, using premiums collected for the insurance, to cover losses that may occur. Under this plan, the borrower is not required to make a repayment as long as he/she remains in the home. As with the other reverse mortgages, the loan must be repaid when the borrower dies or sells or moves from the home.

Since 1989, only about 12,000 FHA-insured reverse mortgages have been structured. It is anticipated that the participation will increase dramatically with the entrance of Fannie Mae into the reverse mortgage arena. Fannie Mae is the Federal National Mortgage Association, which packages and insures mortgages for sale as securities. Fannie Mae's new reverse mortgage program, referred to as the Home Keeper, allows a borrower to select similar payment options but with higher loan limits than available under FHA-insured reverse mortgages.

HECM loan limits are $151,000, while the Fannie Mae Home Keeper loan maximum is currently $203,000.

Costs of Reverse Mortgages

Costs for securing reverse mortgages vary according to the structure of the contract. It is important to calculate the total loan cost, including all fees and startup costs for each option, to determine which is actually the most cost efficient to purchase. The following illustration demonstrates the impact of selecting a lump sum payout versus a monthly payment.

Mr. Gerry and Mrs. Schultz each owns a home worth $100,000, and each applies for a reverse mortgage. Each has a choice of accepting a $35,000 lump sum payment or a monthly payment of $350. Mr. Gerry selects the lump sum. Mrs. Schultz would like to have a monthly payment to offset her monthly long-term care costs. The total loan cost includes all costs of structuring the loan, both start-up and ongoing interest costs. Therefore, should Mrs. Shultz die after two years, the impact of start-up costs on the overall cost of the loan is substantial. As shown in Table 7.3, at the end of two years, Mr. Gerry's total loan cost is 16 percent, but Mrs. Shultz's is a whopping 55 percent.

Table 7.3

Reverse Mortgage Illustration: Lump Sum versus Monthly Payments after Two Years

	Mr. Gerry	Mrs. Schultz
Total cash received	$35,000	($350/month for 2 years) $8400
Start-up costs	4,700	4,700
Total interest 9%	7,524	1,706
Total loan costs	12,224	6,406
Total amount owed	47,224	14,806
Total loan cost rate as a percentage of funds received	16%	55%

NOTE: $100,000 fair market value of the home.

Special Purpose Loans

Among the various loans available in the public sector are deferred payment plans (also known as deferred payment loans (DPLs)), property tax deferrals (PTDs), and split-term loans. Many local government agencies offer DPLs. They provide a one-time, lump-sum payment that must be used to repair or improve the home. These programs usually specify what types of repairs are allowed, such as installation of ramps, grab bars, and rails. These loans have low interest and usually do not have the fees and premiums connected with private sector reverse mortgages.

In many states, local governments offer property tax deferral loans, which provide annual advances that can only be used to pay property taxes. As long as the borrower lives in the home, the loan does not require repayment. These programs may not be available on a statewide basis and eligibility varies from locale to locale. In most cases, however, the applicant must be over 65 and have a low to moderate income level.

A few state housing financing agencies (HFAs) offer a split-term loan arrangement, providing monthly payments for a fixed period of time. The loan does not have to be repaid as long as the borrower remains in the home. Also, the loans, when available, usually require that the applicant be in the low or moderately low income bracket.

Sale Plans

Sale plan options such as sale leaseback and life estate plans allow consumers to sell all or part of the equity in their homes and still live in them. These arrangements are usually negotiated privately.

Under a sale leaseback, the buyer purchases the home, often with third-party financing. The seller then leases the home from the buyer, in order to remain in the home.

Under a life estate plan, the buyer purchases a remainder interest in the home and assumes ownership on the death of the seller. As with the sale leaseback, the seller receives a lump sum payment and monthly installments of principal and interest. The 1986 Tax Reform Act and OBRA '93 seriously reduced the tax advantages associated with these structures.

Concluding Observations

Reverse mortgages can be an effective method of allowing homeowners to tap into the equity in their homes without moving. Freeing up this equity may provide funds that could be used for long-term care, especially home care services.

The effectiveness of reverse mortgages clearly depends on the amount of the loan, the severity of impairment, and whether community-based or institutional long-term care services are needed. Sale leaseback is least effective for those who need nursing home care for a long period of time.

Special purpose loans are good ways of tapping the equity in a home but are generally too restrictive to rely on for total long-term care financing. At best, they can help individuals remain in their own homes and receive communitybased care, providing they have the necessary informal support and are not too frail. Changes in the federal tax law with respect to sales leaseback and life estates make them generally

unattractive to buyers and sellers for all purposes, including the financing of long-term care needs.

■ Trusts

Trusts may provide some strategies for gaining access to partial funding for long-term care needs. Primary examples are charitable remainder trusts and Medicaid Disability Trusts.

Charitable Remainder Trusts

Charitable remainder trusts may allow individuals to use their own assets for long-term care with an added benefit of reducing taxes. Persons with highly appreciated assets, such as low basis stock, may find it advantageous to gift the stock to a trust, benefiting their favorite public charities. For tax purposes, the gift is valued at fair market value and the grantor receives a tax deduction based on that amount. The payments to the grantor from the charity are also based on the current market value.

A charitable remainder annuity trust (CRAT) provides for prorated annual fixed payments that total 5 percent of the initial fair market value of the trust. A charitable remainder unitrust (CRUT) must pay a fixed percentage of the annually reappraised value of the trust. A CRUT provides the opportunity for increased payments if the trust portfolio grows in value. It also carries the risk of a decrease in payments, depending on the current value of the trust. In any event, the charity receives whatever is left in the trust at the grantor's death.

This strategy is limited to fairly affluent people with a specific kind of asset. Few people have such assets available to them, and it is difficult to include the future value of a stock in one's long-range plan. However, for those few who have such assets available, it can be a useful strategy to restructure assets for a long-term care need.

Mrs. Boone owns 6,000 shares of XYZ stock that her father left her 30 years ago. The stock has a basis of $1 per share, but the current market value is $100 per share. If Mrs. Boone were to sell the stock, she would realize a capital gain of $99 per share and would, based on today's tax rates, pay a capital gains tax of 28 percent, or $166,320 in taxes. If she invests the remainder and receives 5 percent after taxes, Mrs. Boone will receive $21,684 in income. Mrs. Boone has chronic arthritis and is confined to a nursing home. If she gifts the stock to a charitable remainder unitrust for the ultimate benefit of the Salvation Army, her favorite charity, she will receive a tax deduction, based on the current value (or 30 percent of $600,000), and the first year her payments will be at least 5 percent of the current value (i.e., the payments will be $30,000), a significant increase in her cash flow. At her death, the Salvation Army will receive the remainder of the trust. The $30,000 annual payments will help pay for her care in the nursing home.

Medicaid Trusts

Medicaid was originally designed to meet the needs of lower-income individuals with limited resources to pay for their own medical costs. Due to the high cost of nursing home care, over time some individuals learned how to divest themselves of their assets in order to qualify for Medicaid coverage. The continuing strain on Medicaid long-term care spending led Congress to tighten Medicaid eligibility loopholes. Prior to 1986, irrevocable special needs trusts were used to remove assets without spending

down and still preserve Medicaid eligibility. In 1986 Congress defined these as Medicaid Qualifying Trusts and disqualified them. The 1993 Omnibus Budget Reconciliation Act (OBRA) tightened the loopholes further and created a Medicaid Disability Trust-the only type of trust exempt from rules regarding trusts and Medicaid eligibility. All other irrevocable trusts currently created with the intent to remove assets without spending down run the risk of being disqualified.

One risk these trusts have involves the look-back period. Medicaid eligibility currently requires a 60-month look-back period for assets the applicant has transferred to a trust. The look-back period, beginning on the first day that the applicant requests support, is the period of time that Medicaid can review and disallow all financial transactions. Trusts under five years old at the time of request for support may result in the individual being permanently denied support.

Another risk involves estate recovery. Prior to OBRA '93, Medicaid could only recover its expenditures if an individual's estate went through probate. OBRA '93 expanded the definition of a person's "estate" to include "any other assets to which the individual immediately prior to death had any legal title." This definition provides more opportunities for Medicaid to recover expended funds.

There are two types of Medicaid Disability Trusts. Both are limited to individuals who are disabled. The first allows for a trust to be established for a disabled person under age 65 by a parent, grandparent, or legal guardian. If Medicaid benefits are paid on behalf of the individual, any amount remaining in the trust at the individual's death is recoverable by the state up to the amount of such benefits.

Under the second type of trust, the individual must be disabled, the trust must be managed by a nonprofit association, and a separate account must be maintained for each beneficiary. Upon the beneficiary's death, the state must be reimbursed for the Medicaid benefits paid on behalf the beneficiary.

Clearly, the intent of OBRA '93 was to dramatically limit the ability of individuals to shelter assets in order to qualify for Medicaid-covered long-term care.

■ Self Insurance

The earlier sections of this chapter address external sources and strategies for financing the costs of long-term care. This last section addresses self insurance, or the use of discretionary income and investment assets.

Existing Assets

For individuals with personal investment assets more than adequate to meet all of their personal goals (e.g., support of a spouse or passing of an estate to children), self insurance may be a viable solution. There is, however, a caveat. Individuals who expect to self-insure must understand the risk involved and the limitations of their personal resources.

Because we are living longer, it is important to factor in the impact of inflation on expenses over time. Further, because it is difficult to know whether or when someone may require long-term care assistance, it is hard to "save for it."

An individual needs an adequate level of assets to set aside for the sole use of long-term care (in today's dollars, approximately $200,000 to fund a five-year nursing

home stay). These assets should be invested in a manner likely to assure real growth (i.e., after inflation) at a rate that will keep up with the increasing costs of long-term care.

Savings

As discussed in earlier chapters, long-term care lends itself to being an insurable event-a small likelihood of incurring catastrophic costs. As such, saving for long-term care costs is not generally efficient. Consider this example.

Robert Wells elects to save for long-term care. He begins saving $8,000 per year at age 45. Assuming an average total return of 7 percent, by age 75, Robert would have $756, 000 to pay for his long-term care costs. Current costs for long-term care are $110 per day or $40,000 annually. Robert calculates that using current inflation projections of medical costs of 5 percent, he will need $173,800 annually for long-term care in 30 years or $748,000 for 5 years of care. Robert feels he has enough set aside for his long-term care needs. At age 68, Robert is diagnosed with chronic arthritis, a disability that requires custodial care. Robert's savings are $427,000; nursing home costs now are $123,000 annually. Robert's savings will cover less than four years of care.

Annuities

Private annuities are usually structured with an individual's children to provide an income stream to the parent. Insurance company-sponsored annuities may be fixed, applying a constant rate of return, or may be variable, based on equity investments within the contract. A fixed annuity does not adjust with inflation, and fixed payments will not keep up with the growing costs of long-term care. Variable contracts bear the risk of the volatility of equities and a variable return over time. As with all forms of financing long-term care, including long-term care insurance, the impact of increases in the cost of care must be considered in developing a financing plan.

In addition, because annuities are based on an average life expectancy, an annuity holder who annuitizes because of a condition requiring long-term care may be underpaid for the investment if his/her condition is likely to result in a shorter-than-average life expectancy. Further, a 75-year-old man or woman purchasing an immediate annuity today in order to cover the cost of five years of long-term care at $40,000 annually would need a lump sum payment of over $175,000.

Therefore, although annuities are an excellent means of producing an income stream during retirement, they may not be an effective means of funding one's total long-term care costs.

■ Summary

Although life insurance policies containing accelerated death benefits can provide financing for at least some of the cost of long-term care, they are limited in that they greatly reduce life insurance protection. Viatical settlements are restricted to those who are terminally ill, not those who are chronically disabled.

Home equity conversions offer an effective way for long-time homeowners to tap into this equity, and are expected to become more popular with the entrance of Fannie Mae into the market.

While personal resources may be restructured to allow individuals liquidity to finance long-term care needs, they are unlikely to be adequate. And, many types of trusts make individuals ineligible for Medicaid nursing home coverage. These options must be evaluated carefully and realistically.

Emerging Issues

Several government initiatives on the horizon could have an impact on private financing for long-term care. From 1997 to 2000, a four-year demonstration program will be conducted, on a national basis, testing the concept of medical savings accounts (MSAs). Up to 750,000 taxpayers employed by small employers (under 50) and the self-employed are allowed to purchase high-deductible health plans and make contributions to MSAs. Such contributions are deductible from the taxpayer's income, and employer contributions are excludable from taxable income to the taxpayer. Withdrawals to pay for medical expenses, including long-term care insurance, are excluded from taxable income. Given that the MSA fund can accumulate over time, it offers a new source of funding for long-term care insurance, at least for those individuals participating in the four-year demonstration program. Obviously, if the program expands after 2000, it will have an even bigger impact.

Congress continues to examine ways to slow the growth in Medicare and Medicaid spending (as discussed in Chapter 3). Potential reductions in Medicaid spending would clearly affect the elderly, who may be dependent on the program to help pay their long-term, care expenses. Given the need to reduce spending, it is very unlikely that the tightening of Medicaid eligibility, as witnessed in the OBRA '93 provisions, will be reversed. It is more likely that pressures will continue to ensure that middle- and upper-income elderly do not abuse the original intent of the program.

■ Key Terms

Accelerated death benefits (ADBs)
Charitable remainder annuity trust (CRAT)
Charitable remainder trust
Charitable remainder unitrust (CRUT)
Deferred payment loans (DPLs)
Extraordinary life preserving measures
Federal National Mortgage Association (also known as Fannie Mae)
Fixed-term uninsured plan
Home equity conversions
Home equity conversion mortgage (HECM)
Home Keeper
Life estate plans
Line of credit
Medicaid Disability Trust
Medicaid Qualifying Trust
Modified tenure
Modified term
NAIC Accelerated Benefits Model Regulation
NAIC Viatical Settlements Model Regulation
OBRA '93
Permanent confinement to a nursing home
Property tax deferrals (PTDs)
Reverse annuity mortgage (RAM)
Sale leaseback
Special purpose loans
Specified disease
Split-term loans
Tenure
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Viatical settlements
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Chapter 8

CONSUMER ISSUES

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■ Introduction

Deciding whether to buy long-term care insurance and, if so, when, from which company, and which benefits is a complex process. It is important that the insurance industry understand not only the risks they assume but those assumed by their customers. When people buy long-term care insurance they buy a promise from the company to pay benefits. Private long-term care insurance will continue to grow only by consistently fulfilling its promise to the consumer.

Consumers must assess the risk of needing long-term care some time in the future, know what long-term care services are available and their costs, assess their personal choices of care setting, evaluate their financial situations and consider the availability of family and community support.

■ The Purchase Decision

Understanding the risk of needing care and the potentially catastrophic costs certainly helps the consumer see the need to plan for the cost of care. No one can predict with any degree of certainty whether he/she will need care or, if so, when or how much. But people can become better informed about the potential need for care. The estimates of the likelihood of someone aged 65 entering a nursing home or needing home care during his/her lifetime were illustrated in Chapter 1.

However, in addition to considering the risk to the population in general, a consumer should consider other factors that may make him/her more or less likely to need care. And everyone has a different tolerance for accepting risk. In the final analysis, it may be the answers to the following questions about risk that determine whether and how much insurance to buy:

- How would I feel if I didn't buy insurance and I had to use most, if not all, of my savings to pay for long-term care?
- How would I feel if I bought insurance and paid $1,500 to $2,000 a year for 20 or 30 years, never needed long-term care, and therefore never received benefits from the policy?

Buying insurance and selecting a policy is an individual decision. There is no answer that is right for everyone. However, in order for consumers to make a decision that is best for them, it is essential that they analyze the situation in a rational manner and make their decisions based on fact.

Hurdles to the Purchase of Long-Term Care Insurance

Although everyone knows that he/she will eventually die, many people do not recognize the risk of needing long-term care before they die. Normally, people do not want to think about aging, the prospect of diminished capacity, and the need to rely on someone else, let alone the possibility of being confined to a nursing home. People, therefore, either don't know the risk of needing care or just assume it won't happen to them.

Some people assume that government programs will cover the cost of their care. But, as discussed in prior chapters, neither government programs nor traditional forms of health insurance provide adequate coverage for people with even a moderate level of assets and income.

Even when people understand that neither public nor private health insurance plans will pay for long-term care, they postpone planning for it. Other people don't understand long-term care insurance or are unfamiliar with the buying process. People who fail to plan for the possibility of needing long-term care are no less likely to need it. But they may find themselves in the position of spending all of their assets on care and then needing to rely on Medicaid.

In addition to those people who ignore the need for care, there are those who are fearful at the prospect of needing care. Some have bought policies that they really can't afford or that are far beyond what is needed to protect limited assets. Long-term care insurance can significantly help people pay for the cost of care. However, it is not a product for everyone. It should be bought only by those who can afford it.

Reasons to Purchase

A 1995 study commissioned by HIAA.[44] shows that people have many reasons for buying long-term care insurance. When given eight reasons for buying longterm care insurance, those who had purchased a policy listed them in the following order, ranked by the percent who thought it was a "very important" reason:

- I can preserve my financial independence and avoid having to rely on others. (69 percent)
- I do not have to use up my savings or income to pay for nursing home or home health services. I can preserve my assets. (67 percent)
- I will be able to afford needed health care services. (66 percent)
- Helps ensure an adequate income remains for my spouse if I need costly services. (59 percent)
- Gives me the freedom to choose the nursing home or home care services I prefer. (59 percent)
- The government will not cover the care I may need in the future. (54 percent)
- I will not have to depend on Medicaid, the public medical assistance program for the needy. (50 percent)
- I want to leave an estate to family/friends. (43 percent)

While protecting assets and income are prominent among the reasons for purchase, so too is an interest in financial independence, a desire not to rely on Medicaid, and a desire to select one's own care.

Who Should Buy Long-Term Care Insurance?

Without long-term care insurance, people either pay for needed care from income and assets, rely on family or friends to provide care, or qualify for government assistance through Medicaid. Only people with very limited financial resources qualify for Medicaid. As stated in Chapter 2, approximately 42 percent of the cost of long-term care for the elderly is paid for out-of-pocket by individuals or their families. According to the HIAA buyer study, most people buy long-term care insurance to preserve financial independence and to protect assets for spouse or family. People who do not have a meaningful level of assets or income will quickly become eligible for Medicaid and do not need to purchase long-term care insurance. Couples with substantial assets clearly should consider long-term care insurance to protect assets for the surviving spouse. Otherwise, virtually all assets, except for the assets protected by Medicaid spousal impoverishment limits, explained in Chapter 3, could be used to pay for long-term care expenses. Single people don't face the same risk, but may wish to leave an inheritance to children or others or may want to ensure maximum flexibility in selecting their care options. For such individuals longterm care insurance is an appropriate choice.

Just as long-term care is expensive, so too is long-term care insurance. One way of measuring the need for long-term care is to assess one's level of assets. If people don't have sufficient assets to protect, and they have relatively little income, they should not spend limited income to pay for insurance. Financial planners suggest various levels of assets be used as a threshold in determining whether to purchase long-term care insurance. One suggests that a single person should have at least $40,000[45] or more in liquid assets in order to consider long-term care insurance. The actual level selected may differ from person to person. The important thing is for the individual to be satisfied that there are sufficient assets to protect. For instance, an individual who wants to ensure that he/she has a choice of caregivers or who has a strong aversion to relying on public assistance programs may decide to purchase long-term care insurance, whereas a person with the same level of assets, but without those concerns, may not.

Risk of Needing Care

In Chapter 1, the lifetime risk of needing care was discussed and illustrated in Table 1.3. It showed that the estimated risk of a 65-year-old entering a nursing home at some point in his/her life is about 48.6 percent, according to one study-more for women and less for men. However, almost half of those who enter a nursing home do so for a short time, less than three months, for a recuperative period following a period of hospitalization or until death. Therefore, a better measure for those who are considering the purchase of a long-term care policy is the risk of needing a long stay in a nursing home. It is the potential cost of a prolonged stay in a nursing home that causes most people to buy insurance protection. As illustrated in Chapter 1,, for people turning age 65, about 20 percent will spend one or more years in a nursing home, 12 percent will spend three or more years in a nursing home, and 7 percent will spend five or more years in a nursing home.

Similar estimates for lifetime home care use suggest that for people turning age 65, just over 70 percent will need some home care during their lifetimes; however, 40 percent will need 90 or more visits, 16 percent will need 365 or more visits, and 9 percent will need 731 or more visits. Generally speaking, elderly people who use home care fall into one of two categories: short-term and longterm users. Short-term users are mostly people who require post-hospital care for an acute illness from which they either recover, die, or enter a nursing home within a few weeks or months. Long-term users tend to have chronic physical or cognitive impairments and often need care for a period of five to ten years.

So it is not so much the risk of needing care as the risk of needing a prolonged period of care that should be considered in determining the need for long-term care insurance.

Individual Risk Factors

Of course, the risks discussed above are estimates based on general population statistics. While they are instructive, they cannot be used to predict any one person's need for care. Another ingredient to consider is the impact that an individual's own circumstances can have on the risk of needing care. There are several factors that can have an impact on whether, when, for how long, and what kind of care will be needed. These factors include:

- current age,
- current health status and lifestyle,
- family history, and
- availability of family assistance.

Although people under age 60 generally do not focus on issues related to long-term care, the possibility of needing care at a younger age, while rare, does exist. The risk of needing care is extremely low until age 60 when it begins to increase moderately until the mid-70s when the risk begins to increase dramatically.

Despite the low risk, there are several reasons a person may wish to buy longterm care insurance prior to age 60. First, if insurance is purchased at an early age the annual premium will be less, and even though it will be paid for a longer period of time the lower annual premium will be carried into retirement when funds are more limited. This approach is a kind of prefunding during one's working years in order to lower the cost of long-term care insurance during retirement. A second reason is that if one purchases at an earlier age one is more likely to qualify for insurance. A third reason might be to take advantage of an attractive program offered by an employer. Of course, in making a decision to buy, the individual must consider the other, possibly more important, uses for these funds. It is important to begin accumulating funds for retirement or to have other substantial assets before buying a long-term care policy.

A person's health status and life-style can have a substantial impact on the need for long-term care. Certainly people with chronic or degenerative medical conditions, such as juvenile onset diabetes, rheumatoid arthritis, Alzheimer's disease, or Parkinson's disease are more likely than the average person to need long-term care and possibly at an earlier age. Of course, once a person is diagnosed with such a condition, he/she is unlikely to qualify for insurance. A person who eats well, exercises, and generally lives an active and healthy life-style is more likely to live

longer and to continue to be independent than a person who eats poorly, is overweight, smokes or uses alcohol to excess, and leads a sedentary life.

Family health history also plays a role in one's longevity and the need for care. If an individual's parents and older relatives all tend to live long and healthy lives, that person is likely to follow suit. However, if the reverse is true, this too can have an impact on an individual's longevity and need for care.

Family Care Giving

A study comparing the long-term care needs of people in a nursing home with those at home[46] found that the factor that most affected the need, type, and duration of care was the availability of a family member to serve as caregiver. If a person has a caregiver, usually a spouse, the likelihood of needing a long stay in a nursing home is less. If nursing home care is needed, it is needed for a shorter period of time because having a caregiver can delay the need for formal care.

Approximately 30 percent of married people who enter a nursing home will stay for more than a year, compared with over 40 percent of unmarried people.[47] Three times as many men over age 75 are married as are women over age 75. Women generally survive their husbands. Therefore, women have a greater likelihood of a stay in a nursing home. According to a study on caregivers, 70 percent of older disabled people living in the community receive all their care from family or friends. Spouses are the caregivers 35.6 percent of the time, followed by daughters at 32.6 percent, and sons at 17.1 percent. Over one-third (36 percent) of older people needing assistance live with their children.[48]

However, taking care of another person exacts a tremendous toll on the caregiver. It is both physically and emotionally draining. Sometimes the caregiver suffers physical problems as the result of giving care, and not everyone can provide care. There have been a number of changes in family structure that suggest a future decline in the ability of family members to provide care. More divorce, women working outside the home, smaller families, and the disbursement of family members across the country all will have an impact on family care giving.

The availability of a caregiver can make a nursing home stay unnecessary or of a shorter duration. It also makes long-term care at home more likely. Whereas the need for care is more a function of a person's health history and status, lifestyle, and his/her family's health history, the type of long-term care provided tends to be related to the availability of caregivers.

Attitude Toward Risk

Each individual has a level of risk that he/she feels comfortable with. Part of the determination of whether to buy long-term care insurance and, if so, how much is governed by an individual's tolerance for risk. Some people may decide to buy a policy with a long elimination period and no limit on benefit duration while others may select no elimination period but a two-year benefit duration. There is no best answer for everyone. Each individual must make his/her own decision. After making that decision, it is important for people to consider a variety of scenarios, from needing no care to needing a long period of care, and determine whether they are satisfied with their selections.

In summary, before deciding whether to buy long-term care insurance, consumers need to learn about the risk of needing care, the services available (including informal care), and the cost of services and to assess their own care preferences and financial situation. Although all this information is helpful in planning for the potential costs of long-term care, it should be recognized that the situation that exists just prior to the purchase decision may change substantially by the time care is needed. For instance, a person can't be sure that a particular person will be available to provide informal care. That individual may have moved out of the area, died, or become frail and incapable of providing needed care.

■ Selecting the Best Policy

Over 100 insurance companies sell long-term care insurance. There is no one best policy that meets everyone's needs. Most companies offer a broad array of benefits. The richer the benefits selected, the more expensive the policy. This section discusses factors an individual should consider in selecting an insurance company and a policy that meets his/her needs.

Choosing a Company

In real estate it is said that the three most important considerations are "location, location, location." Similarly in long-term care insurance the three most important considerations should be "the company, the company, the company." Long-term care insurance is a new and evolving product. Most people who purchase today cannot expect to use it for many years. There are many unknowns in the development of this product, and the care delivery system is undergoing constant and significant change. An individual pays an entry-age level premium with prefunding, making it difficult to change insurers. It is therefore important to buy from a company that has a commitment to the product and the financial resources to keep its promises today and into the future.

The best advice is to buy from a reputable company, one that is financially strong and one that you trust. There are several services that rate the financial strength of insurance companies. These include A.M. Best, Standard and Poors, Duff and Phelps, and Moody's. Consumers can find information from these sources in the reference section of many public libraries. Although a high rating at the time of purchase provides no guarantee that the company will stay healthy, the odds are that a company that is consistently rated higher is a better selection than a company with a consistently lower rating. Rating services assess the financial strength of selected companies, so not all companies will be rated by all the services.

It is believed by some that the company one chooses should have substantial assets; a figure of $1 billion is sometimes mentioned as the appropriate amount of assets.

There are at least two sources in each state where a consumer can learn about insurance companies and the products they sell. The state insurance department is responsible for approving all individual long-term care policy forms used within the state. Some states offer consumers information about insurance products, and some will provide information about any complaints reported to the state. States also have health insurance counseling and advocacy programs run by the state insurance department or the state office on aging.

The Sales Process

Once a consumer has selected a few companies, the next step is to obtain information about the products they offer. This will generally be done through a meeting with an insurance sales representative. He/she may be an insurance agent, financial planner, or attorney. It is important to constantly keep in mind that insurance companies and their sales representatives are in the business to sell insurance. Their goal during the meeting will be to convince the consumer of the need for insurance and that the policies of the company or companies he/she represents offer the best value. The consumer's goal is to obtain objective information about long-term care and long-term care insurance. It is important that the consumer enter the meeting prepared. The consumer must specify the information he/she wants to have from the representative in advance of the meeting.

Consumers can learn more about long-term care insurance by doing research in their local libraries. Many articles have been written about the subject. Also the American Association of Retired Persons (AARP), state insurance departments, and area agencies on aging can provide information to assist the consumer in learning about and selecting a long-term care insurance policy. The consumer should be aware that just as a sales representative wants to sell long-term care insurance, consumer advocates may also have an agenda. For instance, some prefer government, not private, financing of long-term care. This preference could color their discussion and evaluation of private long-term care insurance policies available. The point is that the consumer should obtain as much objective information as possible in preparation for a meeting with the insurance representative and should address information from all sources with a healthy skepticism.

It is often helpful to discuss the prospect of buying long-term care insurance with a trusted friend or relative who is particularly well versed in financial matters. This may be a son or daughter as adult children often are the ones who will handle financial matters should the need for long-term care arise. The consumer may choose to have that individual attend the meetings with the sales representative as well.

Once the consumer is well informed about long-term care and long-term care insurance, meetings with a few representatives should be scheduled. The meetings will take time. The consumer should expect each representative to make an initial presentation about the need for long-term care insurance and the special features of the particular policy he/she is selling. It is likely that each will also want information about personal finances, family support, and health status. It is important that the consumer be prepared to ask questions as well. After the first meeting a second meeting will generally be scheduled to propose a specific policy from a recommended company and at a stated premium designed to meet the consumer's needs. The consumer should be prepared with any questions that have arisen since the first meeting.

Following the second meeting the representative will leave information to help the consumer evaluate the proposal. It is important to make sure that this information includes a copy of the actual policy being recommended, because it is the policy, and not the marketing materials or any statement by the sales representative, that defines the promise to pay benefits.

Most people who sell insurance are extremely helpful and want to assist people to select an insurance product that meets their needs. However, long-term care insurance

has had its share of reported abuses. These have been, most commonly, misrepresenting the facts about the risk of needing care, giving incorrect information about Medicaid eligibility, and encouraging people with limited resources to buy insurance or to buy more insurance than they can afford. A person who enters the sales process well informed is much better able to make a sound decision.

State insurance regulations and federal laws defining tax-favored policies are directed at protecting the consumer throughout the sales process. Designed to ensure that the consumer will have the information and the time he/she needs to make an objective decision, the laws include supplying the consumer with the NAIC shopper's guide that helps the individual to select among policies, an outline of coverage that describes the benefits and limitations in a standardized non-sales language format, and, once the policy is received, a 30-day free look, during which time the consumer can decide to return the policy with a full premium refund.

Selecting Benefits

Just how do people select, from the broad array of benefits available, the pattern of benefits that best suits their needs? Although almost everyone might prefer to select the richest benefit package available, the level of benefits selected obviously has a dramatic impact on price. The final decision is almost always a matter of balancing benefits against cost. This section discusses the major benefits offered by most long-term care insurance policies. First, however, we discuss the scope of coverage included in the policy, such as the setting and type of care included, care management, and other special features. We then discuss how to determine how much insurance to buy-the daily benefit amount, inflation protection, an elimination period, a maximum benefit amount, and coinsurance.

Perhaps a good first step is to ensure that the plan provides coverage for the kinds of services you want. Some people may want to select an extremely comprehensive nursing home benefit and no home care benefit, assuming that a family caregiver will be available for home care. There is a risk in making this decision, as the family member may not be available when care is needed or may be too frail to provide it. In addition, the inclusion of a home care benefit enables the individual to supplement informal care if it is available, which could make it possible to be cared for at home for a longer period of time. (Of course, some people just believe that their limited premium dollars are better spent on a comprehensive nursing home benefit.)

Does the policy provide all levels of nursing home and home care? Are assisted living facilities covered? And, if so how? Not all policies include all forms of care. This becomes increasingly important as new modes of care are added to the continuum of care. Does the policy pay for the cost of home modification? Another benefit that might be considered is a respite care benefit. This is designed to provide formal care periodically so that an informal caregiver can get a much needed break.

In addition, many people are interested in a managed care benefit that provides professional help in locating quality care options. This information and referral benefit is extremely helpful where an integrated benefit maximum is provided, where a disability-based benefit is provided, or where the services of a wide variety of caregivers are covered, as it can help the individual to effectively manage the use of benefits. Very often people don't know the range of care options available in their area nor those most suitable for their care. The care manager can develop a care plan and ensure that ongoing care is appropriate and cost effective.

In selecting a policy it is important that the consumer be satisfied with the scope of benefits provided.

■ How Much Insurance to Buy

It is important to buy enough insurance to meet one's needs, but it is also important to buy insurance that is affordable. Consumers must consider not only the cost at time of purchase but also its affordability over time. Retirees are on a relatively fixed budget and may not be able to afford increases in their premiums. Long-term care insurance premiums are entry-age level and guaranteed renewable. This means that the premium is designed to be level through the life of the policy and the company can neither raise the premium for any one individual nor alter the terms of the policy. However, the company does have a limited right to increase rates for an entire class of people, subject to the approval of the insurance department.

The consumer should recognize the possibility of rate increases when selecting a policy. In determining the level of premium that an individual can afford, perhaps including a margin for potential rate increases is one of the contingencies he/she should consider. Otherwise, if the premium should increase, it is possible that just as the need becomes greatest the premium could become unaffordable. Alternatively, the individual may have to use assets to pay the premium, which will draw down on the very thing the person bought insurance to protect. Instead of a premium increase, some companies will permit the policyholder to select a lower level of benefits. This feature gives the policyholder flexibility in the event of a premium increase.

The earlier a consumer buys, the lower the annual premium will be, so an individual who purchases during the working years can carry this lower annual premium into retirement.

No one knows whether, when, or how much long-term care will be needed. Therefore, it is difficult to determine how much insurance to buy. The process is a constant balance between the desire for comprehensive benefits and their cost. Once a pattern of benefits is selected, the individual will need to assess the affordability of the premium. If the amount of the premium is more than he/she wishes to pay, the purchaser will need to modify the benefits. There are several ways of reducing the cost of a long-term care insurance policy. These include:

- adjusting the daily benefit maximum,
- adjusting the elimination period,
- adjusting the duration of benefits, and
- selecting fewer options

Daily Benefit Maximum

A good place to start in choosing a policy is to select the daily nursing home benefit amount. This should be an amount that approximates the cost of care in the area in which the consumer would expect to use care. The cost of care varies dramatically from one area to the next. Generally, daily nursing home benefits range from $40 to $300 per day. While most policies provide a home care benefit equal to 50 percent of the nursing home daily benefit amount, some permit the buyer to select the level of

the home care benefit independent of the nursing home benefit, giving the individual greater flexibility in designing his/her plan.

Companies also offer a choice of two types of benefits from which to choose. One is a service-based (or reinbursement-based) benefit, which reimburses the insured for service use. This type of benefit will pay in one of two ways. Either it will pay a specific amount per day if the individual uses a covered service or it will pay the amount of the covered service, but not more than the daily benefit maximum. The second type is a disability-based (or per-diem based) benefit, which pays the daily benefit amount for home care if the person satisfies the benefit trigger. There is no requirement for service use. This benefit gives the individual maximum flexibility in the use of benefit dollars. He/she could use the money to pay for a caregiver not specifically covered in the policy or for any other purpose. It gives the policyholder an assurance of available benefits as new forms of long-term care services evolve. Thus far, this approach, which is more expensive, is not as prevalent as the service-based benefit.

Inflation Protection

It is important that an individual consider the potential impact of inflation on the cost of care in determining his/her long-term care financing needs. For an older person this is important, but for a younger buyer it is imperative. If the cost of care increases only 5 percent per year, the $110 daily cost of a nursing home in 1995 becomes $220 per day in 2010 and $440 per day in 2030. That sounds like a long way off, but the year 2030 is when a person who bought long-term care insurance in 1995, at age 50, will be 85.

Without inflation protection, the value of someone's long-term care benefit could be dramatically reduced. This could result in the policy not meeting the original objective of protecting assets. Even if insurance is purchased at an older age, when inflation is not as likely to have as great an impact, it should be considered. The relative cost of inflation protection at an advanced age should be less.

The primary types of inflation protection and their costs were discussed in Chapter 4. The initially more expensive, 5 percent guaranteed increase may be more attractive to some than the periodic approach. It has the disadvantage of a substantially higher initial premium, but the premium remains level over time. This may be more attractive to someone who wants to prefund the cost of long-term care insurance during his younger, working years and lock in a lower, level premium that can be carried into retirement. On the other hand, another individual may wish to keep her premium as low as possible and keep her options open as to how she will fund her care during retirement.

Individuals who select an inflation benefit that provides increases on a simple rather than compounded basis or one that limits the amount of increase to a specified age or dollar amount must recognize that, while less expensive, each approach may lead to benefits lagging behind increases in the costs of care. No matter what pattern of benefits is selected, people should periodically review the adequacy of the policy in view of changes in the services available and their costs.

Duration of Benefits

The next step is to decide for how long benefits will be paid. This involves deciding when you wish benefits to start (the length of the elimination period) and for how long

they are to continue (the maximum duration of benefits or benefit maximum). People in essentially the same financial situation may select different benefits depending on their attitude toward risk, their desire to select their own care, and their aversion to relying on public programs.

People are familiar with the process of using deductibles to reduce the cost of other insurance; medical, automobile, and homeowners insurance are examples. They make the decision to self-insure the amount of the deductible. The same can be done with long-term care insurance by selecting an elimination period.

Policies are available that provide options from a zero elimination period to a six-month elimination period. The longer the elimination period, the lower the price. But the consumer must remember that the average daily cost for a nursing home for a private pay patient during 1995 was $110. Although selecting a six-month elimination period results in a lower premium, it subjects the consumer to the potential of self insuring (paying out of pocket) about $20,000.

How long does an individual want the policy to pay benefits? As discussed earlier, at age 65 there is a 12 percent chance that a person will incur a nursing home stay of three years and a 7 percent chance of a nursing stay of five years or more; for 16 percent, 365 or more home visits will be incurred, and for 9 percent, 731 or more visits will be incurred. Knowing this, some people will select three years, some five, and some may decide to select unlimited coverage. One strategy might be to select a long duration, which increases the cost, but to offset the increase in premium by selecting a longer elimination period. Or, a person may decide a better way to decrease the cost is to reduce the daily benefit amount, thereby picking up a coinsurance instead of selecting a longer elimination period. The point is, there are trade-offs and individuals will find different approaches to achieve their desired results.

Sometimes, instead of the maximum being expressed as a number of days it will be expressed in terms of a dollar amount. This is especially true where an integrated benefit amount is incorporated in the policy. The integrated maximum provides one maximum dollar amount that can be used for any covered service. It acts like a "pot of money" that the insured can use as he/she sees fit. When an insured selects such a benefit it is important that the inflation protection benefit chosen apply to the maximum benefit as well as to the daily benefit amount. Otherwise the individual's daily benefit will increase but the stated dollar maximum won't last as long. In most policies there is a separate maximum for nursing home and home care.

Coinsurance

In addition to being able to choose from different levels of coinsurance (a policy may reimburse 80 percent or 100 percent of covered charges), an individual who selects a policy that reimburses 100 percent also may select a daily benefit maximum that approximates the full cost of care or some portion of it. It is important for consumers to recognize that they will need to plan on paying out of pocket not only for care received during the elimination period but also for the ongoing cost of care to the extent it exceeds the daily benefit payable. If the cost of care exceeds the benefit by $20 per day, that amounts to $600 per month or about $7,200 per year in coinsurance in today's dollars. The insured must feel comfortable about being able to pay that amount as it increases over time.

Affordability

Once these key decisions are made, it is a good idea for consumers to assess the cost of the plan they have selected before going on to other benefits. It's worthwhile for the consumer to sit down with paper, pencil, and pocket calculator and determine the impact of his/her selection. Let's assume a policy was selected with a $100 per day nursing home benefit, a 60-day elimination period, and a five-year benefit maximum. And let's assume that the annual premium is $1,500. The first question to answer is "Is the premium affordable?" If a person still has substantial amounts of life or disability insurance in effect, he/she may wish to reassess those needs as well. As people age, their responsibilities tend to decrease; so too do their life and disability insurance needs. A decrease in the amount paid for these coverages could be used to offset the cost of longterm care insurance.

Once the consumer has determined the affordability of the policy, it is helpful to go through a calculation similar to the following to determine the affordability of care with the policy selected:

- Calculate the monthly amount of discretionary income that could be used to pay for long-term care. Because most long-term care insurance policies waive the premium while benefits are being paid, this amount (as well as the premium for any other insurance that may be waived) can be used to pay for care.
- Estimate the monthly cost of long-term care.
- Calculate the amount that must be paid during the elimination period.
- Calculate the amount over and above the amount paid by the policy that must be paid for long-term care.

If an individual has $200 per month in disposable income that can be used for long-term care expenses and the cost of care is $120 per day, the cost to that individual could be as much as $7,200 ($120 x 60) during the elimination period, plus $600 per month ($20 x 30), once benefits are payable, for excess charges over the daily benefit maximum. Over a five-year period, the charges would be over $225,000, the benefits would be about $182,500, and the individual would pay about $43,000 out of pocket. The consumer has to be able to look at this outcome and be satisfied with it. He/she should also ask, "What if my nursing home stay had been seven years?" (a situation that would result in another $87,000 out-of-pocket expenses) and "Do I have sufficient assets to afford it?" He/she could be paying a premium for years and end up relying on Medicaid anyway. Two people in identical situations could, at this point, come to two different conclusions. One could conclude that the odds of having a five-year stay, let alone a longer one, are not that great, and be perfectly happy with his/her selection. Another person might conclude that a longer elimination period and a lifetime benefit period would better ensure that he/she would be able to choose his/her care and never have to rely on Medicaid.

As discussed in Chapter 6, the NAIC Long-Term Care Insurance Model Regulation addresses the issue of "suitability," to ensure that consumers not buy longterm care insurance without evaluating the cost and their ability to pay (see Appendix C, Section 21).

Nonforfeiture

Another option consumers should consider is the nonforfeiture benefit. The various approaches to providing this benefit were described in Chapter 4. The purpose of a nonforfeiture benefit, regardless of approach, is to ensure the policyholder of some value if he/she should terminate premium payments at a future date.

The amount of the benefit depends on the age at purchase and the length of time the policy is in force. There generally is no benefit if the policy terminates in the first few years.

Of course, few people who purchase long-term care insurance expect to terminate it. The question each individual must consider is whether to pay an additional premium to ensure that some long-term care benefit will be available should he/she terminate premium payment at some future date. The amount of additional premium varies considerably by type of nonforfeiture available and age at purchase.

There are those who believe that a nonforfeiture benefit should be included in all long-term care insurance policies. Advocates of this position argue that because the level, prefunded premium requires consumers to pay a greater than needed premium in the early years, this "reserve" should be credited to them if they should terminate. Further, it is argued that some insurance companies use higher-than-expected lapse assumptions to produce a lower rate than their competitors. If lapses should prove to be lower, it may be necessary to increase premiums (depending on the accuracy of other rating assumptions).

Others believe that the consumer should have a choice of whether to include a nonforfeiture benefit at an increased cost. They argue that the lapse rates for this product are no greater than for other products and that the lapses that do occur tend to occur in the early years when relatively little premium has been paid and when little or no benefit would be available. Because, according to the HIAA, only about 8 percent of those who purchase a policy with a nonforfeiture benefit would ever use it and the additional cost ranges between 30 and 200 percent, some ask whether it is appropriate for all policyholders to pay for it.

As stated in Chapter 4 the NAIC has incorporated a mandatory nonforfeiture in the Long-Term Care Insurance Model Act and Regulation. It requires the inclusion of a nonforfeiture benefit using the shortened benefit. To date, no state has required that companies include a nonforfeiture benefit in their policies; although, some have required that companies offer a nonforfeiture benefit.

■ Summary

The primary concern of a consumer in almost any purchase is value. This is true of long-term care insurance. The difference is that with long-term care insurance the proxy for value is the promise that the insurance company makes at time of purchase. The real value is measured by the way the insurance company ultimately keeps its promise: the prompt payment of valid claims. For most people this will not be for years after the date of purchase.

In addition to their own continued financial stability, buyers of long-term care insurance take on a number of risks:

- ○ Reduction in the company's financial strength.

- The risk of premium increases.
- Product obsolescence.

The future of long-term care insurance will to depend on how well it helps consumers protect their financial security.

■ Key Terms

Affordability
Asset protection
Benefit maximum
Choice of care
Coinsurance
Disability-based (per diem) benefit
Elimination period
Family care giving
Family history
Financial independence
Health status
Individual risk factors
Inflation protection
Integrated benefit maximum
Life-style
Managed care benefit
Nonforfeiture benefit
Outline of coverage
Periodic upgrade
Representative
Risk factors
Scope of benefits
Service-based (reimbursement) benefit
Shopper's guide (NAIC)
Suitability
30-day free look

Chapter 9

FUTURE DIRECTIONS

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■ Introduction

As we approach the 21st century, the social, financial, and service-delivery implications of a rapidly aging population will be brought to the fore. Both the graying of the population-over the last 10 years alone, the number of persons aged 65 and over in the United States increased by almost 21 percent-and the graying of the federal budget-expenditures on aging-related programs are in excess of 30 percent of the budget-have contributed to a change in the perception about the needs of elders as well as about public obligations toward meeting those needs. Due in large part to federal benefit programs, there have been dramatic improvements in the aggregate economic status of elders; for example, poverty rates among elders have declined from 30 percent in the 1960s to about 12 percent today.

Yet, rightly or wrongly, this tremendous success has also fueled perceptions among some that the elderly now consume "too many" public resources, which may limit our ability to serve other needy people in our society. Some also maintain that expenditures on entitlements benefiting all elders, rather than just needy elders, may compromise the competitiveness of the U.S. economy. Put another way, a growing number of policymakers view programs for the elderly as "fair game" in attempts to deal with American economic and social problems.[49] For this reason and others, many now believe that new models of long-term care financing and service delivery are needed to ensure that society can meet both the needs of elders and the health and long-term care needs of other groups.

That the need and demand for long-term care services will dramatically increase is clear. The first baby boomers will begin to retire in about 14 years. At that time, roughly 6.6 million elders will be over the age of 85.[50] Many of these individuals will be single, which increases the chance that they will require formal (paid) rather than informal (unpaid) long-term care services. Smaller family size, the increase in the average age at which couples choose to have children, and increases in age-adjusted life expectancy among elders will all result in additioinal competing demands on both formal and informal support networks.

Long-term care presents a substantial financial risk to individuals and their families as well as to state and federal governments. The average annual cost of a nursing home stay in 1995 was about $40,000 whereas among users of home health care, annual out-of-pocket costs total more than $370 per month.[51] [52] Total long-term care expenditures now exceed $100 billion annually. Medicaid pays about 44 percent of all long-term care costs, Medicare 16 percent, and individuals and their families about 33 percent.[53] For many states, long-term care expenditures represent the fastest growing part of their Medicaid budget. Thus, consumers and the governments alike are

exploring options for reducing financial exposure to long-term care costs and reducing overall expenditure growth in public programs.

Providers of long-term care are not immune to the changing demands and expectations of consumers nor to the requirements imposed by changes in financing and reimbursement policy. Alternative models of care are emerging, and traditional providers have come to play new roles in the service delivery system. Today's nursing home looks different from that of twenty years ago and, in just a few years, may look different still. Growth in assisted living facilities, continuing care retirement communities, and subacute care units in nursing homes has led to a blurring of the lines between acute and long-term care services, between informal and formal care giving, and between institutional and home-based care. While payers of care have in part been responsible for many of these changes, they too are having to rethink the way they pay for and manage care.

In this chapter we present information about a number of key emerging trends in long-term care. We focus on issues related to long-term care financing, new models of long-term care service delivery, and shifts in consumer expectations and preferences. Taken together, changes occurring in these areas point to a rapidly transforming long-term care landscape. Three major trends are likely to occur over the coming years:

Long-term care financing responsibility is likely to shift away from the federal government to states, individuals, and their families. As states attempt to control public expenditures, individuals and their families will face greater risks for incurring long-term care expenditures.

Providers are responding to changes in reimbursement and financing policy. shifts in consumer preferences, and market competition by adding new services to the continuum of care and by exploring ways to integrate and manage acute and long-term care services.

Consumers are increasingly aware of their vulnerabilities and are thinking more seriously about how to plan and pay for their future long-term care needs as well as how to independently navigate the long-term care system.

■ Emerging Trends in Long-Term Care Financing

Increased Role for States

Much of the public policy debate over the past few years has been focused on how the federal government could reduce the rate of growth of entitlement programs like Medicare and Medicaid. Expenditures on both programs have increased markedly over the past few years. For example, an examination of recent growth in Medicare expenditures suggests that while hospital and physician payments are increasing at only a very modest rate, Medicare payments for home health care and nursing home care are growing 20 percent to 30 percent per year.[54] Moreover, between 1990 and 1993, total public spending on home care has increased on average from 50 percent to 62 percent; Medicare's share has risen from 27 percent to 44 percent.[55]

Yet, these trends are very likely to change in the near future. The federal-state partnership represented by the current Medicaid program will continue to undergo fundamental change with respect to underlying philosophy and funding levels. In the area of long-term care financing, the responsibility of states vis-a-vis the federal

government will likely grow. Funding caps-either global or individual-on federal dollars allocated to Medicaid mean that states may be given greater latitude to meet consumers' needs, albeit with fewer resources. The shift in financing responsibility will profoundly affect many of the more than two million elders who use nursing homes every year. Moreover, anticipated changes in Medicare reimbursement policy for home health care, where payment would be paid in one sum for an episode of care rather than on a feefor-service basis, could result in fewer individuals with long-term care needs being served by the program. This too will increase pressure on state home health care programs.[56] Clearly, states will face tremendous challenges in trying to meet the long-term care needs of their citizens over the next decade.

As states are confronted with fewer federal dollars and increased responsibility for paying for long-term care, they too are going to have to find ways to target resources and control expenditures. Many state policymakers are already thinking about how to work with the private sector to share long-term care financing responsibilities. A survey of state agencies on aging and state Medicaid agencies reveals a strong desire to work with the private sector to help address the long-term care financing "squeeze." Survey respondents indicated a belief that state costs could be reduced if more informal or family care giving was encouraged and if there was greater support for private long-term care insurance, employer-sponsored elder care programs, and residential care alternatives.[57] Figure 9.1 shows the number of state agencies indicating that a particular private sector approach would likely result in a reduction in government expenditures.

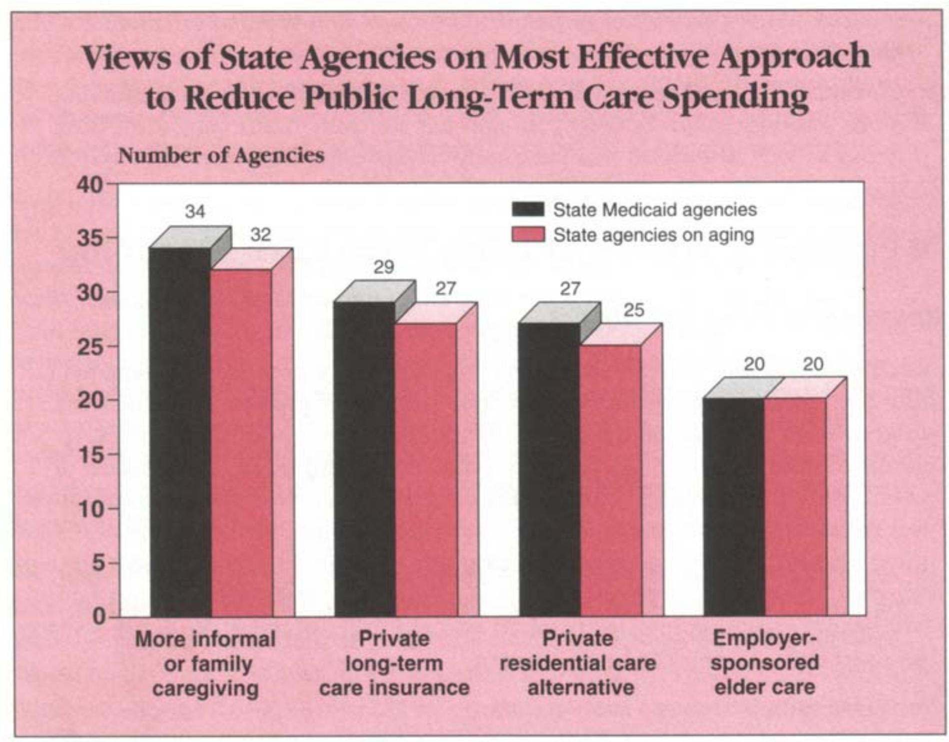

Figure 9.1

SOURCE: General Accounting Office, 1994.

Public-Private Long-Term Care Financing Partnerships

One approach to encouraging development of the long-term care insurance market is represented by the Robert Wood Johnson Foundation Partnership Programs. A number of states, including California, Connecticut, Indiana, and New York, have implemented state-sponsored programs whereby individuals are provided an incentive to purchase state-certified long-term care insurance policies. If an individual exhausts his/her insurance benefits, then Medicaid either pays benefits without regard to the asset levels of the individual or views the insurance payments as equivalent to depleting assets for the purposes of Medicaid eligibility. In total, by the end of 1995, about 10,000 people had purchased policies under the Partnership Programs.[58] Most sales have occurred in California and New York, which indicates that some partnership models may be more attractive than others and/or that the market in those two states may be more amenable to long-term care insurance sales given the service delivery system, consumer awareness, and regulatory requirements.

These programs represent the first "real-world" public-private long-term care financing partnerships. However, because a primary benefit of the partnership program is to give individuals access to Medicaid, interest in the program may be minimal among some consumers; many people, after all, buy private insurance to avoid having to depend on Medicaid.[59] [60] This perceived welfare "stigma" may have something to do with the relatively modest growth in sales of partnership policies. To date, the benefits of such programs are that they have increased awareness about long-term care catastrophic costs and that they give individuals who may otherwise spend down to Medicaid eligibility levels a way to protect assets and pay for care, thus decreasing reliance on scarce public dollars.

Although not an obvious public-private partnership, favorable tax treatment and tax incentives for the purchase of long-term care insurance also represent a type of public-private model. As discussed in Chapter 6, the long-term care insurance tax clarifications contained in recent federal legislation help to send a clear message that it is important for individuals to plan ahead for their longterm care needs and that insurance is a legitimate mechanism by which individuals could assume greater personal responsibility for such needs. This may give a "psychological" nudge to the market. Moreover, it gives consumers some financial relief in effectively funding their own care and some financial relief in their tax burden for Medicaid.

■ Emerging Trends in Long-Term Care Service Delivery

The long-term care services industry is in the midst of a radical transformation characterized by both opportunity and challenge. In fact, some of the most innovative and exciting trends in health care are in the area of long-term care service delivery. Perhaps the most important trends with the most far-reaching consequences are the (1) growth in models that integrate acute and long-term care in the context of a managed care environment and (2) growth in new services provided by traditional and new long-term care providers designed to "fill in the service continuum."

Models of Managed Care and Integration

Around the country, there are many innovative models that combine the financing and delivery of acute and long-term care services. The belief underlying all such models is

hanya untuk kalangan sendiri

that if a single organization is responsible and at risk for managing the "total care" of the individual, and is in charge of the "total health dollar," the match between client need and services will be optimized at the lowest possible cost for a given level of quality. Put another way, better outcomes will be produced if trade-offs are made between acute and long-term care and between medically oriented and socially oriented services; this, in part, is a result of improved communication and coordination among those individuals and institutions responsible for providing care. What follows is a brief description of a number of these models.

The Social Health Maintenance Organization (SHMO)

The Social HMO is a federally sponsored demonstration project that is being conducted at four U.S. sites serving more than 16,000 enrollees. Already more than a decade old, the basic model adds community care services and shortterm nursing home care to a Medicare HMO's acute care plan. The program focuses on providing a broad cross-section of the Medicare eligible population with acute care and limited community-based long-term care coverage. It does not provide care of a more long-term or custodial nature. The purpose of the program is to administratively combine acute care, long-term care, and behavioral/social health services into an integrated health service delivery system. The HMO is reimbursed by Medicare, Medicaid, and private premiums on a prepaid, capitated funding basis. A case manager helps ensure that enrollees are placed in the least restrictive, most cost-effective, care environment.

Already in the beginning stages of its second generation, the SHMO heavily emphasizes a geriatric service model with a case management approach. The model will be designed to identify individuals who are at high risk for both illness and disability, rather than just long-term care needs. Six new sites have been offered planning grants to begin the process of building on the first generation models. The fact that more than 19 organizations applied to participate in the program indicates a growing interest in the model across a variety of HMO organizations. Because the initial sites have (for the most part) demonstrated financial feasibility-and a growing number of HMOs are taking Medicare risk contracts-it is likely that these models will expand as the market continues to become more competitive.

Program of All Inclusive Care for the Elderly (PACE)

The PACE program, also federally sponsored, represents an innovative public approach to providing long-term care services to frail elders eligible for Medicaid. The distinguishing features of the PACE approach are integrated funding and provider financial risk through capitated Medicare and Medicaid reimbursements, integrated service delivery with heavy emphasis on adult day care, case management through multidisciplinary teams, and nursing home-eligible clients choosing to receive long-term care services in the community.[61] The program objective is to provide an alternative to institutional care by maintaining people in their homes and communities for as long as is medically and economically feasible. Currently there are between 10 and 15 sites in various stages of development serving between 78 and 351 clients per site.

The PACE program assembles acute and long-term care services into a contracted service network, and the full range of services is included in the benefit package. Management systems coordinate service provision under a full-risk, capitated, prepaid financing model. The PACE program differs from the SHMO in that it focuses services only on those individuals who are nursing-home eligible, it covers all long-

term care costs for members, all PACE members are eligible for Medicaid, and PACE sites integrate acute and long-term services through a multidisciplinary team based in adult day centers that all members attend.[62] Thus far, enrollment rates suggest that target clients may not be as enthusiastic about participating in the program as was anticipated; moreover, the client selection process suggests that some "skimming" may be occurring.[63] For these reasons, changes in the program may be warranted to ensure that the model can be viable and attractive to state and federal sponsors as well as to consumers.

The Florida Robert Wood Johnson Long-Term Care Initiative

Although still in its planning phase, the Florida Robert Wood Johnson (RWJ) initiative seeks to encourage the development of long-term care HMOs. To this end, Medicaid and Medicare payments would be combined into a single funding stream to eliminate fragmentation of services and cost shifting. Individuals would be entitled to the benefit package provided by traditional Medicare HMOs, and the long-term care HMO would be at risk for co-payments, deductibles, and services, including a specified amount of nursing home care, home care, and other community services. The new long-term care HMO system would deliver care through existing acute care provider networks and through the state's existing network of elder service providers. The hope is that pooling these funding sources at the provider level will provide more flexibility in service delivery, leading to more efficiency.

The trend toward programs that put the provider at risk for both acute and long-term care is likely to continue. In part, this is because long-term care services can sometimes substitute for more costly acute care services. Thus, an atrisk provider who has an integrated financing and delivery system has tremendous opportunities to increase profitability through service substitutions. Although, historically, elders have been reluctant to join HMOs, this trend is changing. Greater numbers of HMOs are enrolling elderly members under Medicare risk contracts, and it is just a matter of time before they begin to experiment more aggressively with providing a broader set of benefits.

Managed Care and Provider Networks

Increasingly, long-term care providers are positioning themselves to become part of integrated service delivery networks. The goal is to participate in a network of services that spans the continuum of care, stretching from the hospital and the nursing home to the home.[64] Managed care is really about establishing networks of providers who will offer quality-controlled services at predetermined levels of reimbursement. To date, most managed care contracts have been between nursing home providers and HMOs and preferred provider organizations (PPOs). However, many managed care networks want to offer members an array of long-term care services. This means that other long-term care providers as well as nursing homes themselves are entering the arena of assisted living, home health care, and adult day care.

Inclusion of long-term care in a managed care network accomplishes a number of objectives. First, it helps traditional HMOs, hospitals, or nursing homes differentiate themselves from competitors. Second, there is a belief that many acute care services could be provided in less costly long-term care settings without sacrificing quality. Thus, there is the potential for service efficiencies and improved financial performance. For their part, long-term care providers are eager to become part of more integrated provider networks because they can increase their profitability by

working with HMOs, PPOs, and hospitals and they can market to a new population of potential clients.

Developing such networks is not without problems. It is difficult to manage care across so many delivery sites, and a great deal of management sophistication is required to understand how services and individuals can best be matched. Also, agreeing on standards and philosophy of care across different organizations and provider-types is particularly challenging. Unless all participating organizations share in financial risk, it will be difficult to ensure that patients and costs are not shifted to inappropriate levels of care. Further, there is a significant risk that by integrating acute and long-term care services, the latter will become over-medicalized and unnecessarily more costly. Long-term care providers that have to add more medically oriented services will also need to upgrade their staffs and equipment. To be part of an integrated delivery network also requires an increase in administrative staff, who must ensure smooth communication and information flow between participating provider entities. This is a costly endeavor.

Finally, there must be the appropriate technologies or clinical protocols to guide the network manager in determining how to manage care cost effectively and maintain quality. Much remains to be learned in this area. In sum, the key to a successful managed care network is the coming together of high quality and like-minded providers who have an ability to attract and retain a sufficient market share.

Clearly, the alliances, joint ventures, and mergers that are taking place across the entire health care system influence the subsystem of long-term care providers. Consumers' demands for more "one stop shopping," coupled with reimbursement pressure on providers to deliver services more efficiently, has laid the groundwork for greater integration and managed delivery systems. The Congressional Budget Office has projected that enrollment among elders in managed care could reach 25 percent by the year 2002. Seniors' concerns about greater freedom of choice as well as their traditional reluctance to embrace HMOs and managed care organizations must be overcome. Changes in Medicare reimbursement policy as well as the growing number of new retirees who have had experience with HMOs and managed care suggest that even among the elderly population, over time, such networks are likely to be the rule rather than the exception. Even among long-term care insurers-who traditionally have few links to provider networks-there is a move afoot to incorporate elements of care management into product designs. Such trends are likely to dominate both the public and private long-term care sectors for the coming decade.

Filling in the Continuum of Care

As traditional long-term care providers become part of integrated provider networks, they are also "spreading out" along the continuum of care. For example, traditional nursing homes have reached out to embrace both sides of the continuum that stretches from limited supervision in the home to subacute specialties in skilled nursing homes.[65] There has been a redefinition of long-term care to include everything from subacute care to assisted living and board and care. Two of the most important trends in "continuum-filling" have been in the area of subacute care and assisted living.

Subacute Care Services

Subacute care refers to medical or rehabilitative services provided to patients who may no longer require inpatient hospitalization but who do require a level of care

commensurate with ongoing medical supervision. Patients who continue to reside in an inpatient hospital due to a lack of alternative placement, but who no longer require acute care services, may be classified as "subacute." Since 1983, hospitals have been reimbursed under a diagnostic-related grouppayment system. This has served to encourage hospitals to release patients as quickly as possible, which has led to dramatic declines in hospital length of stay and resulting increases in the number of individuals receiving post-acute (i.e., subacute) care in supportive care settings.[66]

Many nursing home and home health care providers view the pressure on hospitals to discharge patients "quicker and sicker" as an important opportunity to serve an unmet need. As such, many nursing homes have enhanced their service capacity and added subacute care units to the portion of their facility that is Medicare certified because nursing homes can receive Medicare payments for the provision of subacute care services. This is important because pre-tax profit margins for subacute care providers are two to three higher than those for traditional providers; some estimate that potential annual revenue of the subacute care industry could exceed $10 billion.[67] [68] Thus, to many, subacute care represents the nursing home industry's future and the catalyst to a major transformation of the skilled nursing home to a more "low-tech" hospital setting. Providers are now offering post-surgical and other medical services once available only in hospitals, and at a much lower cost-from $250 to $900 per day compared with hospital charges that may exceed $1,500 per day. The rates charged for subacute care are much higher than skilled nursing rates.

In addition to Medicare reimbursement policy-which pays for medical services delivered in settings such as the nursing home-the increase in managed care enrollments has also fueled growth in the subacute industry. Total enrollment in Medicare managed care risk arrangements was about 2.3 million in 1995.[69] Because subacute services represent a lower cost alternative to hospital care, they are strong candidates for inclusion in comprehensive managed care strategies. States also have an interest in shifting long-term Medicaid-covered nursing home residents who qualify for skilled care into subacute units so as to spend federal (i.e., Medicare) rather than state dollars. Finally, patients themselves may be more interested in leaving the hospital for more care in a less institutionallike setting.

Even as some are predicting that within the next decade subacute care beds will come to represent as much as 25 percent of the nursing home bed count, others caution against the overuse of subacute care. There still remains considerable confusion about what actually constitutes subacute care, how to define its true costs, whether the outcomes of care provided in subacute settings are better or worse than in hospital settings, whether long-term care providers are adequately staffing-up to provide appropriate services, and whether managed care organizations will use subacute care as a way to reduce costs without regard to quality or as a way to provide cost-effective care for the same level of quality. How this relatively new service ultimately fits into the continuum of care will dramatically influence both provider and payer behavior over the next decade.

Assisted Living

The growth in subacute services represents an attempt by long-term care providers to expand services to the more medical side of the health care continuum. At the other end of the continuum, an array of other market opportunities have presented themselves to traditional long-term care providers. One of the more important and

growing new services is the assisted living facility, which is a bridge between boarding homes and skilled nursing facilities. In general, assisted living facilities can be categorized into one of three broad types: (1) public housing; (2) units in continuing care retirement communities; (3) free-standing facilities.

Assisted living facilities typically offer a combination of housing, health care, personal assistance, and supportive services. Yet, there are substantial variations in the range of services that assisted living facilities provide and in the type of populations they serve. For the most part, individuals living in assisted living facilities are medically stable and do not require 24-hour nursing care. Most facilities do provide or arrange for some level of personal care services for those individuals who may require them.

Although there is no definitive estimate of the number of assisted living facilities in the United States, a 1992 survey by the American Health Care Association determined that 10 percent of its members operated such facilities. Estimates of the number of these facilities vary from between 40,000 to 65,000; up to one million elders live in an assisted living facility.[70 71] Assisted living has developed into a $10 billion per year industry. The growth in assisted living facilities reflects the consumer's demand for supportive living environments that closely parallel a home-like atmosphere. In addition, some claim that the growth in the subacute market may have begun to leave a vacuum in the provision of traditional, low-technology, facility-based long-term care that assisted living beds are designed to fill. Figure 9.2 shows the diversity in property type represented by the assisted living industry.

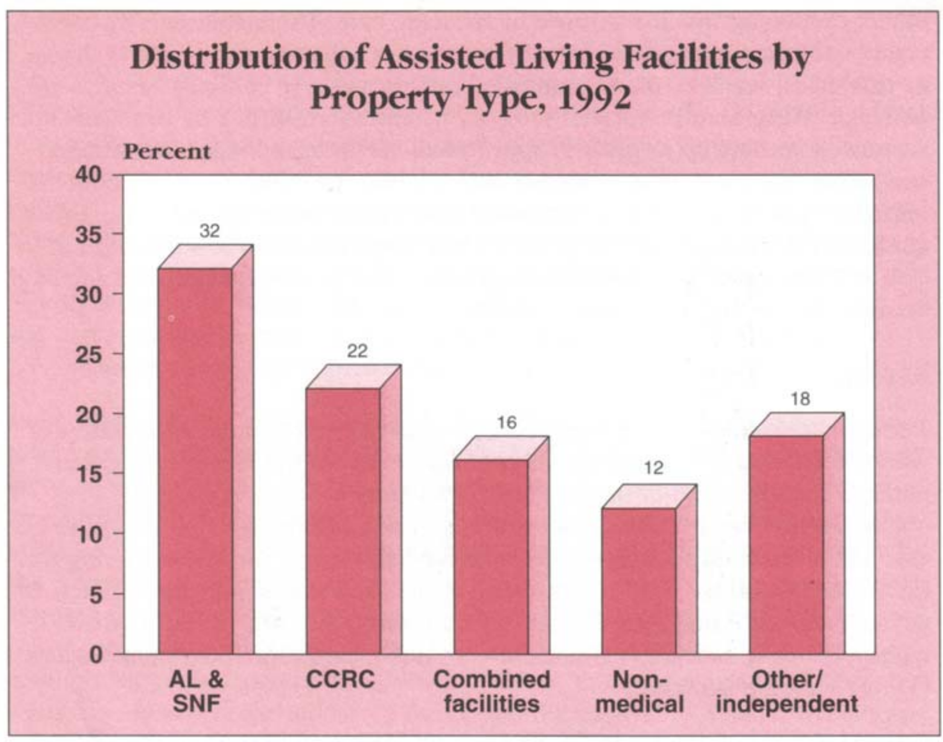

Figure 9.2

NOTE: AL is assisted living facility; SNF is skilled nursing facility; and CCRC is continuing care retirement community.
SOURCE: Coopers & Lybrand L.L.P., 1994.

What little evidence there is suggests that frail elders residing in assisted living settings are happier than nursing home residents, that they may avoid premature institutional placement, and that caregivers of assisted living tenants may exhibit

higher levels of satisfaction when compared with those of institutionalized elders.[72] For some individuals, there is likely to be a cost savings as assisted living is substituted for nursing home care. Assisted living costs can range from 30 percent up to 100 percent of skilled nursing care costs.[73] These facilities may also achieve economies of scale in the delivery of home health care to frail elders that are difficult to achieve when frail elders live in their own homes. Because elders overwhelmingly prefer to reside in their own homes or in congregate living situations rather than in a nursing home, to the extent that a "noninstitutional feel" is maintained in these facilities, they are likely to continue to grow and expand.

The growth of assisted living facilities presents new opportunities for providers-and new challenges for payers. Traditional long-term care providers can capitalize on a popular new living arrangement for which there is likely to be a growing demand. On the other hand, because of the wide variability in definitions about what actually constitutes assisted living, it is difficult to know if and how services provided in these setting should be reimbursed. Already, longterm care insurers are grappling with whether assisted living should be viewed as a nursing home benefit or a home health care benefit. The lack of uniform standards and licensure makes it difficult to know how to cover and define these services in a way that ensures (1) equitable and appropriate use of benefits and (2) reliably priced policies. As shown in Figure 9.3, the issue is of growing importance because a significant proportion of insurance claimants reside in assisted living facilities.

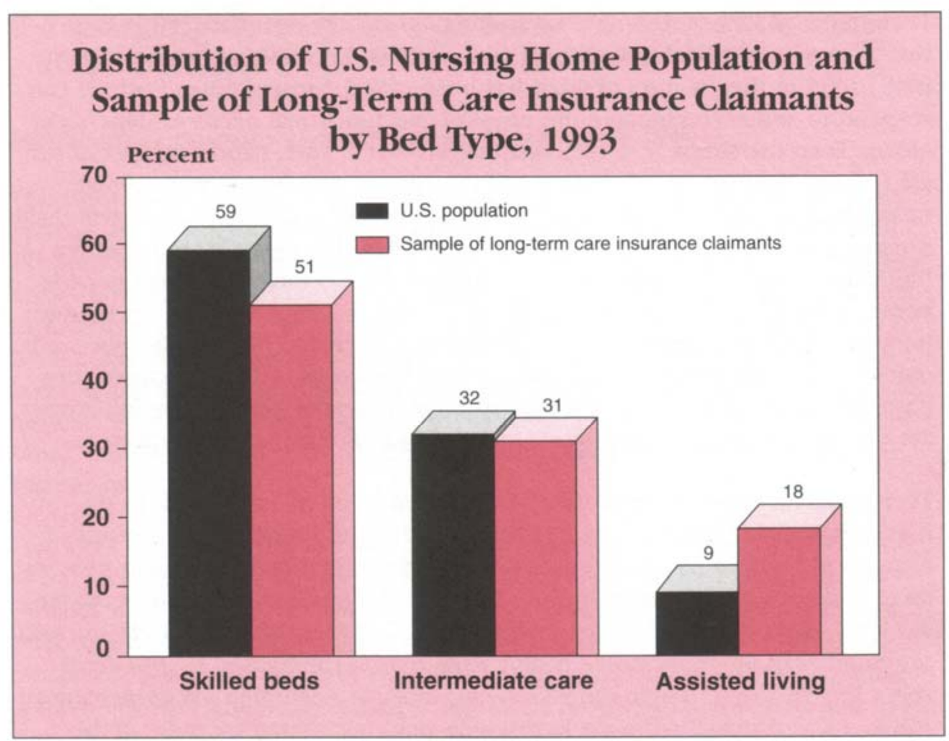

Figure 9.3

SOURCE: LifePlans, Inc., assessment of sample of long-term care insurance claimants and Marion Merrell Dow Managed Care Digest, Long-Term Care Edition, 1993.

Technological innovations also are making assisted living an attractive alternative to more traditional institutional care options. Technology can be particularly useful in the creation of what has been called "smart houses," which can respond to and accommodate the physical and functional needs of dependent elders. Even the simple low-tech adaptations-grab bars, handrails, special single faucets, lighting

modifications, and emergency response systems-make tasks easier to perform and reduce the likelihood of accidents.[74] They will make assisted living and traditional home environments that much more attractive to frail elders who may otherwise be at high risk for needing traditional nursing home care and will likely come to dominate the housing environment of many people. Information technologies also promise to ensure that individuals can be quickly linked to services as the need arises. Networks of "smart houses" can be part of larger formal and informal support networks. All of these initiatives are designed to help to keep individuals living in home-like environments.

Technological improvements have also spurred tremendous growth in the home health care industry and in two very different directions. As a result of changes in Medicare administrative policy and hospital reimbursement policies, there has been rapid growth in both high- and low-tech home health care services for Medicare beneficiaries. For example, between 1988 and 1993 the average number of Medicare home health visits per user increased by 34-from about 23 visits to 57 visits; skilled nursing services accounted for 44 percent of this increase.[75] Unskilled home health aide visits accounted for most of the remainder of this increase.

The reemergence of a growing "low-tech" home health care industry is also evident in states such as California, which has a rich network of independent providers (unlicensed individuals or agencies) to provide in-home personal care and homemaker services. Also, some private long-term care insurance policies reimburse the costs of home care provided by friends and relatives of a disabled insured. Although this trend may expand the availability and attractiveness of unskilled home health care service, it also poses quality of care challenges to consumers and payers alike.

Taken together, the trend toward greater integration of acute and long-term care services and the addition of new services to the continuum of care portend dramatic change in the way that long-term care is delivered and paid for. The nursing home of the past will continue to evolve in two polar directions: into more sophisticated medical facilities and into more home-like places to live. Barriers between service levels are diminishing, and the flow between service settings and the match between needs and services will increasingly become "seamless."

■ Emerging Trends in Consumer Preference and Expectations

Individual versus Government Responsibility

The 1990s have witnessed a growing societal view that there are limits to the abilities of the federal government to solve the nation's social ills. Public opinion polls have shown increasing distrust and skepticism of all types of organizations-government and corporate entities alike. Simultaneously, there has been an increased political and public emphasis on the role of families and individuals in addressing the nation's social problems. A public opinion poll conducted in the mid-90s found that, in most cases, the majority of the public believe the responsibility to fix a wide range of social issues lies not with the government alone, but should be shared equally with individuals, community groups, and businesses.[76]

The 1994 election of the first Republican Congress in 40 years symbolizes this trend. Likewise, the complete overhaul of the nation's welfare program, Aid to Families with Dependent Children, is another prime example. For the first time, there will be time

limits on the number of years individuals can receive cash assistance. Whenever possible, individuals will be encouraged to work. Public opinion is consistent with legislative actions. A recent public opinion poll sponsored by the Washington Post, the Kaiser Family Foundation, and Harvard University found, that regardless of race, nine out of 10 people surveyed said that individuals "need to take more individual responsibility and become less dependent on government."[77]

Regarding the specific public policy issue of who should pay for long-term care in this country, the trends appear to be parallel. A recent survey of the population aged 55 and older found that 74 percent believe it is more likely that individuals will have to rely on themselves to plan and pay for long-term care over the next few years. The same survey found that 58 percent do not believe it is the federal government's responsibility to pay for the long-term care needs of all people. Finally, 48 percent said it is very unlikely that the states or the federal government will have a new long-term care program for all individuals over the next 10 years (see Figure 9.4).

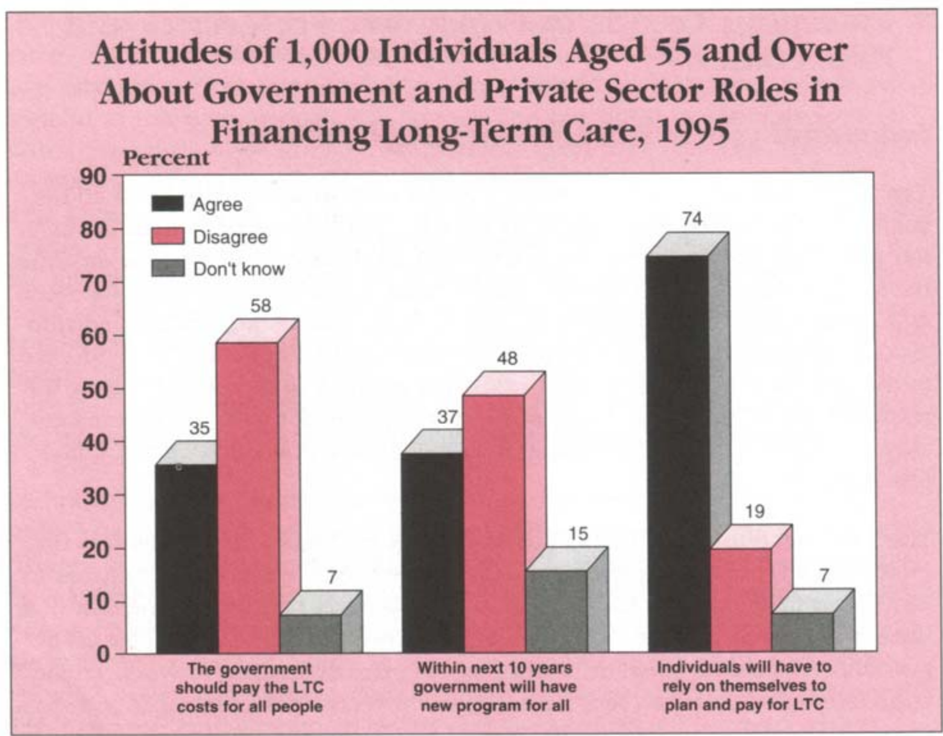

Figure 9.4

SOURCE: Health Insurance Association of America, Who Buys Long-Term Care Insurance?, 1995.

Also, as shown in Figure 9.5, only one-third of individuals favor a universal entitlement program for long-term care and about half of all elders believe that the government should target benefits only to the most needy. Most people do not believe it is the responsibility of the federal government to pay for the longterm care needs of everyone without regard to personal resources. These results are particularly significant because the surveyed age cohort would benefit most quickly from the implementation of a universal entitlement program. Thus, among the general elderly public,' there is a growing realization that the private sector will need to play a more important role in financing care. The demand for savings and risk-pooling mechanisms like insurance is, therefore, likely to increase in the years ahead.

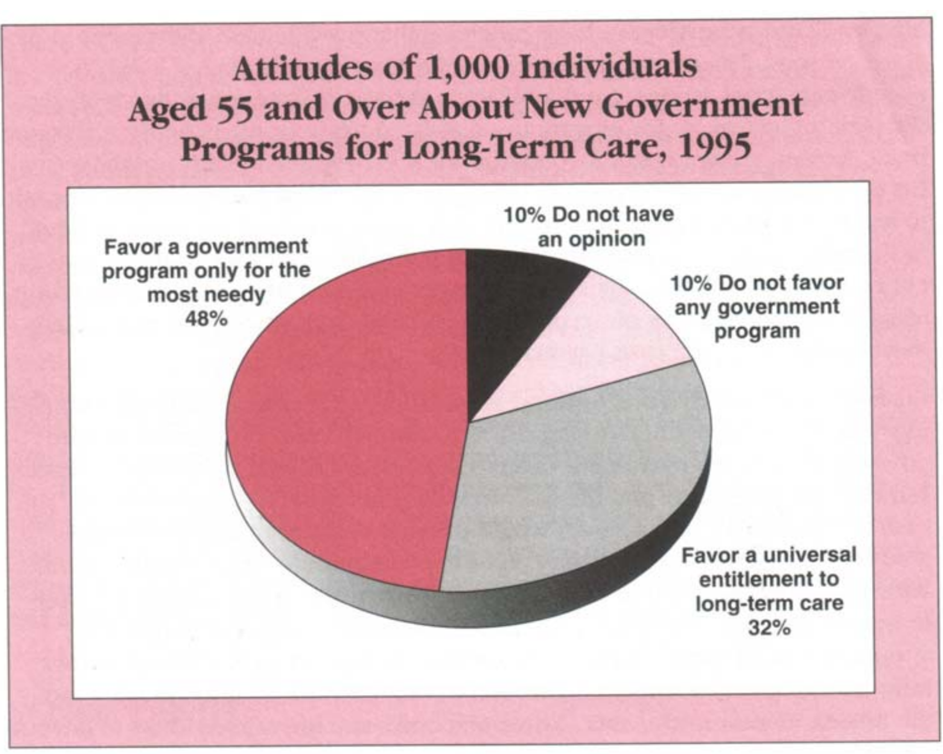

Figure 9.5

SOURCE: Health Insurance Association of America, Who Buys Long-Term Care Insurance?, 1995.

Consumer Directed Long-Term Care

As consumers rely less and less on the government to pay for long-term, care, they are also less likely' to accept many of the constraints on their behavior that are the hallmark of government programs. In other words, when people spend their own resources on long-term care-either directly or through participation in risk-pooling programs-they expect to be able to make their own choices about how to do so. Thus, cash benefits (or greater flexibility in how expenses are reimbursed) may become more common in long-term care insurance policies and programs. Aside from direct cash payments to policyholders who are disabled, recent private sector innovations involve offering consumers the opportunity to purchase a level of benefits-say, $100,000-that can be spent either in the nursing home or at home with home health care. This "pot of money" or integrated benefit concept, coupled with care management to assist the consumer use benefits effectively, is another step in a continuing trend of offering consumers more choice, more flexibility, and better value for the premium dollar. Put simply, insurers are coming to the conclusion that maximizing consumer sovereignty is particularly important in long-term care because of the variety of available services.

The idea of providing cash to disabled individuals is not, however, confined to the private market. A number of states, such as Colorado, California, Wisconsin, Maryland, and Pennsylvania, have programs that provide cash allowances to disabled persons. The cash can be used to purchase services from a home care agency or referral service, from a friend or relative to care for or live with the disabled individual, or for moving to an assisted living or other housing arrangement. Service receipt is not a condition for receiving the benefit (disability status is). When given the choice, for the same price, most individuals prefer cash to service benefits.

Perhaps one of the most well-developed programs is found in Germany. There, for example, disabled individuals can choose to receive either services prescribed by a case manager or a monthly cash payment that is roughly half of the costs of needed services; well over 80 percent of disabled individuals opt for the cash payment option.[78]

Currently the Robert Wood Johnson Foundation is funding a "cash and counseling" initiative whose primary purpose is to develop new information to help policymakers, state government officials, and others decide if and how to establish cash payments and provide for counseling in regard to long-term care. The cash component of the program would provide disabled individuals with a monthly cash allowance, and the counseling component would furnish people with consumer information and assistance in choosing and arranging for longterm care support. The major purported benefits of a cash and counseling approach include empowerment of consumers, support of families and other informal caregivers, a unified model for serving persons of different ages and disabilities, administrative ease, lower unit costs and lower total costs to government, and encouragement of consumer-directed chronic care systems.

As states experiment with how best to pay for long-term care, such programs may become more attractive because they make it easy to forecast costs, reduce liabilities associated with direct contracting and provision of services to consumers, and lower administrative expenses. Insurers are also likely to continue to develop products that maximize consumers' ability to make decisions about the level and type of care needed to meet their needs. They are also including more information in their long-term care plans to help educate, inform, and direct consumers. For consumer-directed care to work, however, consumers will need to be educated about the options available in their communities and to know how and when to access services.

■ Summary

Many emerging trends in long-term care financing and service delivery are mutually supportive. For example, as traditional long-term care providers add new services to the continuum of care, managed care organizations are helped in their effort to find lower cost alternatives to more expensive levels of care.

There are, however, trends in managed care that may be antithetical to trends in consumer preferences. For example, as greater numbers of managed care networks are established, can consumer-directed long-term care still work? Will the emphasis on care management mean that consumers have less input into decisions about their care or will care-giving institutions instead maximize consumer decision-making as a way to ensure and enhance market share? What will be the primary goal of consumer-directed long-term care? Will it be to select the least expensive care or will other values, such as reducing the stress and burden on informal caregivers, determine the use of formal care? Also, if managed care organizations are to benefit from new services in the continuum of care, the capitation paid to them must be adequate to ensure that nonmedical, more personally oriented services are not driven out of the service basket. Will the integration of acute and long-term care lead to the "medicalization" of long-term care and result in higher costs? These and other issues will be played out in the context of a public system that is "downsizing" and a private system that is gearing up to assist consumers who are trying to navigate their way through a dynamic and shifting service delivery system. As the country moves into

the 21st century, such a context presents tremendous opportunities and challenges to the public and private sectors alike.

■ Key Terms

- Assisted living
- Consumer-directed long term care
- Consumer preference
- Continuum of care
- Entitlement programs
- Funding caps
- Individual responsibility
- Long-term care service delivery
- Managed care
- Program of All Inclusive Care for the Elderly (PACE)
- Provider networks
- Robert Wood Johnson Foundation Partnership Programs
- Shift in financing responsibility
- Social HMO
- Subacute Care

Appendix A
LONG-TERM CARE INSURANCE MODEL ACT

(Model Regulation Service-1993)

From the NAIC *Model Laws, Regulations and Guidelines.* Reprinted with permission of the National Association of Insurance Commissioners.

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Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Comment: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Comment: The Task Force recognizes the viability of a long-term care product funded through a life insurance vehicle, and this Act is not intended to prohibit approval of this product. Section 4 now specifically addresses this product. However, states must examine their existing statutes to determine whether amendments to other code sections such as the definition of life insurance and accident and health reserve standards and further revisions are necessary to authorize approval of the product.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

Note: See Section 61.

Comment: This section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the "Long-Term Care Insurance Act."

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this Act.

B. "Applicant" means:

   (1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

   (2) In the case of a group long-term care insurance policy, the proposed certificate holder.

C. "Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that:

(a) The association or associations hold regular meetings not less than annually to further purposes of the members;

(b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) The members have voting privileges and representation on the governing board and committees.

Thirty (30) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

Section 5. Extraterritorial Jurisdiction - Group Long-Term Care Insurance

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4E(4), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Drafting Note: By limiting extraterritorial jurisdiction to "discretionary groups," it is not the drafters' intention that jurisdiction over other health policies should be limited in this manner.

Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

A. The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

Comment: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

B. No long-term care insurance policy may:

(1) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

C. Preexisting condition:

(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in Sections 6C(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization:

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2)

(a) A long-term care insurance policy containing post- confinement, postacute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(b) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

Drafting Note: The amendment to the section is primarily intended to require immediate and clear disclosure where a long-term care insurance policy or rider conditions eligibility for non-institutional benefits on prior receipt of institutional care.

(3) No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

Editors Note: Section 6D(3) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(3) would be eliminated after adoption of the amendments to this section which prohibit prior institutionalization. States should examine their Section 6 carefully during the process of adoption or amendment of this Act.

E. The Commissioner may adopt regulations establishing loss ratio standards for longterm care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to return - free look:

Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act, the applicant is not satisfied for any reason.

G.

(1) An outline of coverage shall be delivered to a prospective applicant for longterm care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(a) The Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group 'master policy contains governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded; and

(f) A brief description of the relationship of cost of care and benefits.

H. A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

Comment: The above provisions are deemed appropriate due to the particular nature of long-term care insurance, and are consistent with group insurance laws. Specific standards would be contained in regulations implementing this Act.

I. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care; and

(4) If applicable to the policy type, the summary shall also include:

(a) A disclosure of the effects of exercising other rights under the policy;

(b) A disclosure of guarantees related to long-term care costs of insurance charges, and

(c) Current and projected maximum lifetime benefits.

J. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

K. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Section 7. Incontestability Period

A. For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

C. After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

D.

(1) No long-term care insurance policy or certificate may be field issued based on medical or health status.

(2) For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

Section 8. Nonforfeiture Benefits

No long-term care insurance policy or certificate may be delivered or issued for delivery in this state unless the policy or certificate provides for nonforfeiture benefits to the defaulting or surrendering policyholder or certificateholder. The commissioner shall promulgate a regulation specifying the type or types of nonforfeiture benefits to be included in such policies and certificates and the standards for the benefits.

Section 9. Authority to Promulgate Regulations

The commissioner shall issue reasonable regulations to establish minimum standards for marketing practices, premium rate stabilization, agent compensation, agent testing, penalties and reporting practices for long-term care insurance.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

Section 10. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 11. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 12. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intention of this section is to authorize separate fines for both the insurer and the agent in the amounts suggested above.

Section 13. Effective Date

This Act shall be effective [insert date].

Legislative History (all references are to the *Proceedings of the NAIC*).

1987 Proc. 111, 19, 655, 677-680, 700 (adopted).
1987 Proc. 1115, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. 19, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. 19, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. 1113, 23-24, 468, 476-477, 479-484 (amended and reprinted).
1990 Proc. 16, 27-28, 477, 541-542, 556-561 (amended and reprinted).
1991 Proc. 19, 17, 609-610, 662, 666-671 (amended and reprinted).
1993 Proc. 18, 136, 819, 844, 845 (amended).
1993 Proc. 1st Quarter 3, 34, 267, 275, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 458 (amended).

Appendix B

ACCELERATED BENEFITS MODEL REGULATION

(Model Regulation Service-July 1991)

From the NAIC Model Laws, Regulations and Guidelines. Reprinted with permission of the National Association of Insurance Commissioners.

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Section 1. Purpose

The purpose of this regulation is to regulate accelerated benefit provisions of individual and group life insurance policies and to provide required standards of disclosure. This regulation shall apply to all accelerated benefits provisions of individual and group life insurance policies except those subject to the Long-Term Care Insurance Model Act, issued or delivered in this state, on or after the effective date of this regulation.

Section 2. Definitions

A. "Accelerated benefits" covered under this regulation are benefits payable under a life insurance contract:

(1) To a policyowner or certificateholder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider; and

(2) Which reduce the death benefit otherwise payable under the life insurance contract; and

(3) Which are payable upon the occurrence of a single qualifying event which results in the payment of a benefit amount fixed at the time of acceleration.

B. "Qualifying event" shall mean one or more of the following:

(1) A medical condition which would result in a drastically limited life span as specified in the contract, for example, twenty-four (24) months or less; or

(2) A medical condition which has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die; or

(3) Any condition which usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life; or

(4) A medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:

   (a) Coronary artery disease resulting in an acute infarction or requiring surgery;

   (b) Permanent neurological deficit resulting from cerebral vascular accident;

   (c) End stage renal failure;

   (d) Acquired Immune Deficiency Syndrome; or

   (e) Other medical conditions which the commissioner shall approve for any particular filing; or

(5) Other qualifying events which the commissioner shall approve for any particular filing.

Section 3. Type of Product

Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks. They are life insurance benefits subject to [insert sections referencing life insurance provisions].

Section 4. Assignee/Beneficiary

Prior to the payment of the accelerated benefit, the insurer is required to obtain from any assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payout. If the insurer making the accelerated benefit is itself the assignee under the policy, no such acknowledgement is required.

Section 5. Criteria for Payment

A. Lump Sum Settlement Option Required.

   Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.

B. Restrictions on Use of Proceeds.

   No restrictions are permitted on the use of the proceeds.

C. Accidental Death Benefit Provision.

   If any death benefit remains after payment of an accelerated benefit, the accidental death benefit provision, if any, in the policy or rider shall not be affected by the payment of the accelerated benefit.

Section 6. Disclosures

A. Descriptive Title.

   The terminology "accelerated benefit" shall be included in the descriptive title. Products regulated under this regulation shall not be described or marketed as long-term care insurance or as providing long-term care benefits.

B. Tax Consequences.

A disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

C. Solicitations.

(1) A written disclosure including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant. The description shall include an explanation of any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant prior to or concurrently with the application. Acknowledgment of the disclosure shall be signed by the applicant and writing agent.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a notice that a full premium refund shall be received if the policy is returned to the company within the free look period.

Drafting Note: States may wish to consider a 30-day free look period for direct response solicitation.

(c) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.

(2) If there is a premium or cost of insurance charge, the insurer shall give the applicant a generic. illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant prior to or concurrently with the application.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant at the time the policy is delivered.

(c) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.

(3) Disclosure of Premium Charge.

(a) Insurers with financing options other than as described in Section 10 A(2) and (3) of this regulation shall disclose to the policyowner any premium or cost of insurance charge for the accelerated benefit. These insurers shall make a reasonable effort to assure that the certificateholder is aware of any additional premium or cost of insurance charge if the certificateholder is required to pay such charge.

(b) Insurers shall furnish an actuarial demonstration to the state insurance department when filing the product disclosing the method of arriving at their cost for the accelerated benefit.

(4) Disclosure of Administrative Expense Charge. The insurer shall disclose to the policyowner any administrative expense charge. The insurer shall make a

reasonable effort to assure that the certificateholder is aware of any administrative expense charge if the certificateholder is required to pay such charge.

D. Effect of the Benefit Payment.

When a policyowner or certificateholder requests an acceleration, the insurer shall send a statement to the policyowner or certificateholder and irrevocable beneficiary showing any effect that the payment of the accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. The statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of an accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policyowner or certificateholder and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder or notify the certificateholder under a group policy to reflect any new, reduced in-force face amount of the contract.

Section 7. Effective Date of the Accelerated Benefits

The accelerated benefit provision shall be effective for accidents on the effective date of the policy or rider. The accelerated benefit provision shall be effective for illness no more than thirty (30) days following the effective date of the policy or rider.

Section 8. Waiver of Premiums

The insurer may offer a waiver of premium for the accelerated benefit provision in the absence of a regular waiver of premium provision being in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

Section 9. Discrimination

Insurers shall not unfairly discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy. Insurers shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

Section 10. Actuarial Standards

A. Financing Options

(1) The insurer may require a premium charge or cost of insurance charge for the accelerated benefit. These charges shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be reflected in the experience rating.

(2) The insurer may pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:

(a) The current yield on 90 day treasury bills; or

(b) The current maximum statutory adjustable policy loan interest rate.

(3) The insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:

(a) The current yield on 90 day treasury bills; or

(b) the current maximum statutory adjustable policy loan interest rate.

The interest rate accrued on the portion of the lien which is equal in amount to the cash value of the contract at the time of the benefit acceleration shall be no more than the policy loan interest rate stated in the contract.

B. Effect on Cash Value.

(1) Except as provided in Section 10B(2), when an accelerated benefit is payable, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.

(2) Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums and any accrued interest can be considered a lien against the death benefit of the policy or rider and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans could also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

C. Effect of Any. Outstanding Policy Loans on Accelerated Death Benefit Payment.

When payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment may not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

Section 11. Actuarial Disclosure and Reserves

A. Actuarial Memorandum

A qualified actuary should describe the accelerated benefits, the risks, the expected costs and the calculation of statutory reserves in an actuarial memorandum accompanying each state filing. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner upon request.

B. Reserves

(1) When benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves shall be determined in accordance with the Standard Valuation Law. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a Member in good standing of the American Academy of Actuaries. Mortality tables and interest currently recognized for life insurance reserves by the NAIC may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary must follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate should be sufficient to cover:

(a) Policies upon which no claim has yet arisen.

(b) Policies upon which an accelerated claim has arisen.

(2) For policies and certificates which provide actuarially equivalent benefits, no additional reserves need to be established.

(3) Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability such excess must be held as a non-admitted asset.

Appendix C

LONG-TERM CARE INSURANCE MODEL REGULATION

(Model Regulation Service-October 1995)

From the NAIC Model Laws, Regulations and Guidelines. Reprinted with permission of the National Association of Insurance Commissioners.

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Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC LongTerm Care Insurance Model Act], to promote the public interest, to promote the availability of longterm care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite sections of law enacting the NAIC Long-Term Care Insurance Model Act and establishing the commissioner's authority to issue regulations].

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Drafting Note: This regulation, like the NAIC Long-Term Care Insurance Model Act, is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these plans, organizations and arrangements (e.g., contract, policy, certificate, subscriber, member) may be substituted for, or added to, the corresponding terms used in this regulation.

Section 4. Definitions

For the purpose of this regulation, the terms "long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "policy" and "certificate" shall have the meanings set forth in Section 4 of the NAIC Long-Term Care Insurance Model Act.

Drafting Note: Where the word "commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To the extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated into this section.

Section 5. Policy Definitions

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

B. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

H. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

J. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

L. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

N. "Skilled nursing care," "intermediate care," "personal care," "home care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. "Transferring" means moving into or out of a bed, chair or wheelchair.

Q. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to or incorporation of the individual state law may be required in structuring each definition.

Comment: This section is intended to specify required definitional elements of several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

Section 6. Policy Practices and Provisions

A. Renewability. The terms "guaranteed renewable" and "noncancelable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 9 of this regulation.

(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancelable."

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancelable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally selfinflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(6) This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

Drafting Note: Paragraph (6) is intended to permit exclusions and limitations for payment for services provided outside the United States and legitimate variations in benefit levels to reflect differences in provider rates.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the longterm care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

(1) Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

   (a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

   (b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

(8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another longterm care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and Replacement

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

F. Premium Rate Restrictions

(1) The initial premium charged an insured covered by a long-term care policy shall not increase during the initial four (4) years in which the policy is in force.

(2) Except as provided in Paragraph (4) of this subsection, any premium rate increases after the initial four-year period are subject to the following restrictions:

(a) For insureds age eighty (80), and over, the premium charged may not increase more than ten percent (10%) in the aggregate during any five-year period;

(b) For insureds age sixty-five (65) to age eighty (80), the premium charged may not increase more than fifteen percent (15%) in the aggregate during any five-year period; and

(c) For insureds under the age of sixty-five (65), the premium charged may not increase more than twenty-five percent (2'5%) in the aggregate during any four-year period.

(d) The premium charged to an insured shall not increase due to either:

(i) The increasing age of the insured at ages beyond sixtyfive (65); or

(ii) The duration the insured has been covered under the policy.

(3) Policies that provide for inflation protection shall be subject to the restrictions in Paragraphs (1) and (2) of this subsection; however, the purchase of additional coverage shall not be considered a premium rate increase for purposes of determining compliance with Paragraph (2) at the time additional coverage is purchased. The premium charged for the purchase of additional coverage shall be subject to Paragraph (2) for any subsequent premium rate increases where no additional purchases of coverage are made.

(4) The commissioner may amend, for universal application, the premium rate restrictions imposed by this subsection, in appropriate circumstances, including but not limited to the following:

(a) State or federal law is amended, materially affecting the insured risk;

(b) Unforeseen changes occur in long-term care delivery, insured morbidity or insured mortality; or

(c) Judicial interpretations or rulings are rendered regarding policy benefits or benefit triggers resulting in unforeseen claim liabilities.

(5) Nothing in Paragraph (4) shall limit the commissioner's authority pursuant to other sections of the insurance code of this state.

(6) Except as provided in Paragraph (7), the provisions of this Subsection F shall apply to any long-term care policy or certificate issued in this state on or after the effective date of this amended regulation.

(7) For certificates issued on or after the effective date of this Subsection F, under a group long-term care insurance policy as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this amended Subsection F shall not apply.

Section 7. Unintentional Lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. .

(1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand

that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice,'

The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

B. Reinstatement. In addition to the requirement in Subsection A, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Section 8. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is

charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

Section 9. Prohibition Against Post-Claims Underwriting

A. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B. .

(1) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

(a) A report of a physical examination;

(b) An assessment of functional capacity;

(c) An attending physician's statement; or

(d) Copies of medical records.

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

Section 10. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

A. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) By excluding coverage for personal care services provided by a home health aide;

(6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(8) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) By excluding coverage for adult day care services.

C. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

D. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection C permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than 365 benefit days and less than a $25 daily maximum benefit constitute illusory home health care benefits.

Section 11. Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in [Section 4E(4) of the Act) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in Subsection A above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. .

(1) Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase

benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Drafting Note: It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

E. Inflation protection benefit increases under a policy which' contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. .

(1) Inflation protection as provided in Subsection A(1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.

(2) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans , ………………..….. and I reject inflation protection.

Section 12. Requirements for Application Forms and Replacement Coverage

Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by (insert reference to Section 4(E)(1) of the Model Act], the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

(a) If so, with which company?

(b) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

____________________________________ _______________

(Applicant's Signature) (Date)

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse. or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an

otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

Section 13. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above.

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

F. For purposes of this section, "policy" shall mean only long-term care insurance and "report" means on a statewide basis.

Section 14. Licensing

No agent is authorized to market, sell, solicit or otherwise contact a person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of longterm care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.

Section 15. Discretionary Powers of Commissioner

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific longterm care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds;

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C. .

(1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Drafting Note: This provision is intended to provide the commissioner with limited discretion and flexibility to accommodate specific and innovative long-term care insurance products which are shown to be in the public's best interest. This provision is intended to be used sparingly for this purpose.

Section 16. Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with [cite the standard valuation law for life insurance, which contains a section referring to "special benefits" for which tables must be approved by the commissioner]. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) Definition of insured events;

(2) Covered long-term care facilities;

(3) Existence of home convalescence care coverage;

(4) Definition of facilities;

(5) Existence or absence of barriers to eligibility;

(6) Premium waiver provision;

(7) Renewability;

(8) Ability to raise premiums;

(9) Marketing method;

(10) Underwriting procedures;

(11) Claims adjustment procedures;

(12) Waiting period;

(13) Maximum benefit;

(14) Availability of eligible facilities;

(15) Margins in claim costs;

(16) Optional nature of benefit;

(17) Delay in eligibility for benefit;

(18) Inflation protection provisions; and

(19) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with [cite law referring to minimum health insurance reserves, the NAIC version of which requires reserves using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner].

Section 17. Loss Ratio

Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

A. Statistical credibility of incurred claims experience and earned premiums;

B. The period for which rates are computed to provide coverage;

C. Experienced and projected trends;

D. Concentration of experience within early policy duration;

E. Expected claim fluctuation;

F. Experience refunds, adjustments or dividends;

G. Renewability features;

H. All appropriate expense factors;

I. Interest;

J. Experimental nature of the coverage;

K. Policy reserves;

L. Mix of business by risk classification; and

M. Product features such as long elimination periods, high deductibles and high maximum limits.

Drafting Note: The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section 18 above which removes the word "individual": (1) reflects the fact that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

Section 18. Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 5 of the Long-Term Care Insurance Model Act, it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Section 19. Filing Requirements for Advertising

A. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

Section 20. Standards for Marketing

A. Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

(7) For long-term care health insurance policies and certificates, use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to Section 6 A(3) of this regulation.

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. .

(1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in [insert citation to Section 4E(2) of the NAIC Long-Term Care Insurance Model Act], when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding longterm care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the insurance department the following material:

(a) The policy and certificate,

(b) A corresponding outline of coverage, and

(c) All advertisements requested by the insurance department.

(3) The association shall disclose in any long-term care insurance solicitation:

(a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(b) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall also:

(a) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(b) Actively monitor the marketing efforts of the insurer and its agents; and

(c) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Drafting Note: The materials specified for filing in this section shall be filed in accordance with a state's filing due dates and procedures.

(7) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.

(8) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of [insert citation to corresponding section of state Unfair Trade Practices Act].

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to long-term care insurance policies and certificates.

Section 21. Suitability

A. This section shall not apply to life insurance policies that accelerate benefits for longterm care.

B. Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) Train its agents in the use of its suitability standards; and

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

C. .

(1) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(2) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

(3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(4) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Agents shall use the suitability standards developed by the issuer in marketing longterm care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Section 22. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Section 23. Nonforfeiture Benefit Requirement

A. No policy or certificate may be delivered or issued for delivery in this state unless the policy or certificate provides for nonforfeiture benefits to the defaulting or lapsing policyholder or certificate holder.

This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Drafting Note: It should be noted that there may be certain situations where it is appropriate to exempt public-private partnerships from the mandatory inclusion of nonforfeiture benefits.

(1) For purposes of this section, attained age rating is defined as a schedule of premiums starting from the issue date which increases with increasing age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this section, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection B.

(4) No policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(a) The end of the tenth year following the policy or certificate issue date; or

(b) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

B. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

C. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

D. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

E. Premiums charged for a policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements of Section 17 treating the policy as a whole.

Section 24. Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B.

(1) Activities of daily living shall include at least the following as defined in Section 5 and iur the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting; and

(f) Transferring;

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.

D. For purposes of this section the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in this section shall be effective [insert date 12 months after adoption of this provision] and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the Long-Term Care Insurance Model Act] that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

Section 25. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of [Section 6G of the Long-Term Care Insurance Model Act] [cite provision of law requiring the Commissioner to prescribe the format and content of an outline of coverage] in prescribing a standard format and the content of an outline of coverage.

H. The outline of coverage shall be a free-standing document, using no smaller than tenpoint type.

I. The outline of coverage shall contain no material of an advertising nature.

J. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

K. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

L. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy) [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your

policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancelable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

[For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

[Describe waiver of premium provisions or state that there are not such provisions;]

[State whether or not the company has a right to change premium, and if such right exists, describe clearly and concisely each circumstance under which premium may change.]

TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return-"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.)

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONGTERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

That the benefit level will not increase over time;

Any automatic benefit adjustment provisions;

Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

PREMIUM.

[(a) State the total annual premium for the policy;

If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

Section 26. Requirement to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under [cite for Section 6 of Long-Term Care Insurance Model Act].

Section 27. Penalties

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intent of this section is to authorize separate fines for both the company and the agent in the amounts suggested above.

OPTIONAL PROVISION

Section [ ]. Permitted Compensation Arrangements

An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Drafting Note: The NAIC recognizes that long-term care insurance is in an evolutionary stage. The product market needs to be able to develop in order to be responsive to the needs of consumers. In addition, since long-term care insurance and long-term care insurance regulations are continually changing, a state should consider the fact that not all replacements are improper.

The NAIC also recognizes that currently, long-term care insurance products are being primarily sold to the senior citizen market, a market that has been identified as being susceptible to abusive marketing practices. In response, the NAIC has adopted consumer protection amendments in its model regulation for Medicare supplement insurance. The Medicare supplement insurance model regulation limits agents' compensation in order to address the potential for marketing abuses resulting from the large difference between first year and renewal commissions.

If a state believes that there is evidence that the long-term care insurance market is experiencing similar abuses, it may wish to consider adopting the optional agent compensation provision above.

In considering these agent compensation limitations, states should recognize the emerging nature of the long-term care insurance market. Long-term care insurance is evolving along both health insurance indemnity and life insurance lines. A state may want to consider that, since life insurance products usually contain nonforfeiture and cash value accumulation features and are normally targeted to a younger age group than long-term care indemnity products, such life insurance products could be exempted from these compensation limitation requirements.

The compensation provision such as provided above should not be enacted in lieu of the penalty and other consumer protection provisions contained in the regulation, but in addition to them.

APPENDIX A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF
FOR THE REPORTING YEAR 19[ ]

Company Name: ____

Address: ____

____

Phone Number: ____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: ____

____

____

____

____

____
Signature

____
Name and Title (please type)

____
Date

Appendix B

Long Term Care Insurance
Personal Worksheet

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long term care insurance can be expensive, and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

Premium

The premium for the coverage you are considering will be [$ _____ per month, or $ ____ per year,] [a one-time single premium of $.________________]

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up by an average of ____ %]. [The company has not raised its rates for this policy.]

Drafting Note: The issuer shall use the bracketed sentence or sentences applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage.

[☐ Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

Drafting Note: The issuer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

Income

Where will you get the money to pay each year's premiums?

☐ Income ☐ Savings ☐ Family members

What is your annual income? (check one)

☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000] ☐ $[30-50,000] ☐ Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Turn the Page

Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

□ Under $20,000 □ $20,000-$30,000 □ $30,000-$50,000 □ over $50,000

How do you expect your assets to change over the next ten years? (check one)

□ Stay about the same □ Increase □ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

□ The information provided above accurately describes my financial situation.	□ I choose not to complete this information

Signed: ________________________________ ________________________________
(Applicant) (Date)

[□ I explained to the applicant the importance of completing this information.

Signed: ________________________________ ________________________________
(Agent) (Date)

Agent's Printed Name: ____]

[**Note**: In order for us to process your application, please return this signed statement to (name of company), along with your application.]

[My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed: ________________________________ ________________________________
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Appendix C

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does not pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Appendix D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No**. I have decided not to buy a policy at this time.

______________________________ ______________________________

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

Legislative History (all references are to the Proceedings of the NAIC).

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GLOSSARY

A

ACCELERATED DEATH BENEFIT A provision in some life insurance policies that gives the policyholder the option to have a portion of the proceeds paid before death when certain conditions are met. These conditions may include terminal illness, permanent confinement to a nursing home, a need for longterm care services, or catastrophic illness. Proceeds paid under this provision reduce the amount of death benefits payable.

ACTIVITIES OF DAILY LIVING (ADLs) The basic functions one must perform to live independently. They include bathing, dressing, transferring (such as from bed to chair), toileting, continence, and feeding.

ACUTE CARE Care that has recovery as its primary goal. It generally requires the services of a physician, nurse, or other skilled professional. It is usually provided in a hospital and is usually short term.

ADMINISTRATION ON AGING (AOA) Federal agency under the Secretary of Health and Human Services (HHS) responsible for administering the programs under the Older Americans Act of 1965, as amended. Serves as the federal body for programs and services for older adults.

ADULT DAY CARE Community-based, daytime program for functionally impaired adults that provides a variety of health, nutrition, social, and related services in a protective setting to those who are otherwise being cared for by family members. Its purpose is to enable individuals to remain at home and in the community and to encourage family members to provide for them by offering the family members relief from the burden of constant care.

ADVERSE SELECTION Tendency of people who are poorer-than-average risks to apply for or maintain insurance. Also called anti-selection.

ALZHEIMER'S DISEASE A progressive, irreversible disease involving degeneration of the brain cells. It leads to impairment or loss of mental functions, such as orientation to person, place, or time; short- and long-term memory; and the ability to reason. Person could cause harm to self or others.

ANTI-SELECTION See "Adverse Selection."

AREA AGENCY ON AGING (AAA) Local agencies established under the authority of the Older Americans Act of 1965, as amended. These agencies are designated and monitored by each State Unit on Aging and are responsible for planning, advocacy, and coordination of community-based services to persons aged 60 or older (or to their spouses or to certain disabled individuals).

ASSESSMENT Evaluation of a person's level of physical or mental function, the type and extent of services available and needed, and the finances available to pay for these services.

ASSISTED LIVING FACILITIES Residential care facilities for those who tend to be older and frail and who need some assistance but are not so impaired as to need nursing home care. They generally provide congregate meals, periodic housekeeping and linen services, transportation and preventive health services, and help with personal care. Assisted living facilities are also called board and care homes or residential health care facilities.

B

BABY BOOMERS People who were born between 1945 and 1964.

BENEFIT Amount payable by the insurance company when the insured suffers a loss covered by the policy.

BENEFIT MAXIMUM Amount of money or number of days of care beyond which a long-term care policy will not pay benefits.

BENEFIT PERIOD Period of time that begins when the insured becomes eligible for benefits and ends when the insured has been out of claim status for a given period of time, such as 90 days.

BENEFIT TRIGGER Criteria used to determine eligibility for benefits. Triggers may be based upon limitations in ADLs and/or degree of cognitive impairment.

BOARD AND CARE HOMES See "Assisted Living Facilities."

C

CAREGIVER Person providing care to someone with chronic illness or disability. The caregiver, who can be unpaid (family, friend, or volunteer) or paid, provides care in the home or community.

CARE PLAN Written plan of care developed after an assessment of a person with chronic disease or disability. The plan outlines a person's needs and the services and care options (both type and amount) to meet them. It is used to ensure that the care and services are provided and coordinated.

CASE MANAGEMENT Systematic process of assessment, planning, service coordination, and/or referral and monitoring through which the multiple service needs of people are met. Its dual goal is to contain costs and promote more effective intervention to meet patient needs.

CASH SURRENDER VALUE BENEFIT A type of nonforfeiture benefit that returns to the policyholder a portion of the reserves when the policy lapses. The amount returned varies based on the individual's age, when the policy is issued, and the length of time the policy was in effect. The amount is reduced by any benefits paid under the policy.

CATEGORICAL PROGRAM A program characterized by narrowly defined objectives, processes, and administration. An example is congregate meals.

CHORE SERVICES Heavy housecleaning, minor home repairs, yard work, and other infrequent tasks related to home maintenance.

CHRONIC ILLNESS Irreversible presence of disease or impairment requiring care, rehabilitation, or observation; may require long-term care.

COGNITIVE IMPAIRMENT Problems with attention, memory, or other loss of intellectual capacity that require supervision to help or protect the impaired person. Depending on the cause, such impairment may be permanent or temporary. Alzheimer's disease is an example of cognitive impairment.

COINSURANCE The portion of covered charges that a policyholder must pay. If the insurance company reimburses 80 percent of covered charges, the policyholder's coinsurance is 20 percent.

CONGREGATE MEALS Meals provided to older persons at a site such as a senior center, congregate housing complex, adult day care center, or community center. The intent is to offer a nutritious meal while reducing the isolation experienced by many older people. This program constitutes the single largest categorical program funded under the federal Older Americans Act of 1965, as amended.

CONTINUUM OF CARE The full range of interrelated services, from homeand community-based programs to institutionalization, that may be needed by individuals at various stages of disability.

CONVERSION Policy provision that entitles an individual to elect to convert coverage to an individual policy when coverage under a group policy terminates.

COORDINATION OF BENEFITS Method of integrating benefits payable under more than one insurance policy so that the benefits paid from all sources do not exceed 100 percent of allowable expenses. Many private policies coordinate with Medicare so that the carrier is not responsible for benefits payable by Medicare.

COVERED EXPENSES Those expenses that an insurer will consider for payment under the terms of an insurance policy.

CUSTODIAL CARE Assistance with personal needs, such as bathing, dressing, and eating, that can be provided by persons without medical training.

D

DEATH BENEFIT A benefit payable in the event of the death of the insured to his/her beneficiary or estate.

DEDUCTIBLE Amount of covered expenses (or number of days of care) the insured must incur before benefits are payable under the policy.

DISABILITY CRITERIA Measures of the extent of functional and/or cognitive impairment to determine need for care. (See "Benefit Trigger".)

E

ELIMINATION PERIOD Period of time after an individual meets the criteria for benefits during which no benefits are payable. Also called deductible period or benefit waiting period.

ENTITLEMENT PROGRAM A government program under which individuals are eligible for benefits so long as they meet specific criteria.

EXCLUSION Any condition or expense for which a policy will not pay.

EXTENDED TERM INSURANCE A nonforfeiture option that provides that, when premium payments cease, full benefits are continued, but only for a specific period of time. The duration of coverage depends upon the individual's age when the policy is issued, the length of time the policy was in effect, and any benefits paid under the policy.

F

FREE-LOOK PERIOD Period of time, usually 30 days after sale, during which the policyholder may return the policy for any reason and receive a full refund.

FUNCTIONAL IMPAIRMENT Limitations of physical or mental functioning that may affect an individual's capacity for independent living. (See "Activities of Daily Living".)

G

GATEKEEPER Means of controlling access to services to ensure appropriate and cost-effective care. (See "Case Management".)

GUARANTEED ISSUE Guarantees plan participation without providing evidence of insurability if elected during a limited period and/or under certain circumstances (e.g., the employee is actively-at-work). Common in group policies.

GUARANTEED RENEWABLE Provision that an insurer cannot terminate insurance nor alter a policy so long as premium is paid on a timely basis. The insurer does have a limited right to increase premium rates by class of policyholder.

H

HEALTH MAINTENANCE ORGANIZATION (HMO) Organization that provides for a wide range of comprehensive health care services for a specific group at a fixed periodic prepayment.

HOME EQUITY CONVERSION A mechanism through which people are able to convert a portion of the equity in their homes to cash.

HOME HEALTH CARE Wide range of services provided at home or in another residential setting. Services may include part-time skilled nursing care, speech therapy, physical or occupational therapy, personal care by home health aides, and homemaker services.

HOMEMAKER SERVICES Basic services provided at home to help a person with a chronic illness or disability to be as independent as possible. These services may include housekeeping, cooking, transportation, and shopping.

HOSPICE Program of care provided to terminally ill patients and their families. It emphasizes emotional needs and coping with pain and death rather than cure.

I

INCIDENCE Refers to how often an event occurs for a given class of risk. An example would be the annual rate at which people of a given age enter a nursing home.

INDEMNITY BENEFIT A benefit that pays a defined amount regardless of the charges incurred.

INFLATION PROTECTION Policy provision that provides that benefits increase over time, either automatically or at the option of the policyholder, to help offset future increases in service costs.

INFORMAL CARE Unpaid care, usually provided by family or friends, to assist a person with a chronic illness or disability to be as independent as possible.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) Activities beyond the most basic level to maintain a person's independence. They include the ability to do housework, prepare meals, manage money, take medicine as prescribed, and use the telephone.

INSURANCE An arrangement whereby people pay a defined periodic amount (premium) to an insurance company in exchange for a guarantee that, should the individual incur a specified loss, the insurance company will pay the benefit guaranteed in the policy.

INTERMEDIATE CARE Occasional nursing and rehabilitative care performed by, or under the supervision of, skilled medical personnel, generally in a nursing home.

L

LAPSE Termination of an insurance policy because of nonpayment of premium within the required period.

LIFETIME RESERVE Under Medicare, the one-time 60 extra days of hospital coverage available to individuals who have a hospital stay that exceeds the 90day limit during a benefit period.

LONG-TERM CARE Medical, social, and/or personal care services required over a long period of time by a person with a chronic illness or disability. Services are designed to help the person maintain as much independence as possible and may be provided at home, in the community, or in a nursing home.

LOSS RATIO The ratio of claims to premium (the dollar value of all claims divided by the total amount of premium dollars).

M

MEANS TEST A measure of income and assets used to determine eligibility for benefits under some government programs.

MEDICAID (TITLE XIX OF THE SOCIAL SECURITY ACT) State programs providing health care to persons regardless of age, whose assets and/or income are below

a certain level. This program operates under federal guidelines and receives matching funds from the federal government under the Social Security Act.

MEDICAL NECESSITY A benefit trigger used under traditional medical care policies to determine whether a charge can be accepted as a covered expense. Also often used under earlier long-term care policies.

MEDICARE (TITLE XVIII OF THE SOCIAL SECURITY ACT) Federal medical insurance program that provides benefits for hospital and physician care and limited skilled nursing care in a nursing home or at home. It is provided to those aged 65 or older, to those under 65 who are disabled and have received Social Security disability income benefits for 24 months, and to those who have end-stage renal disease (kidney failure).

MEDIGAP INSURANCE Private medical insurance policies that are designed to fill in the gaps left by Medicare deductibles and coinsurance.

MODEL LAW AND REGULATION Model insurance laws and regulations are developed by the National Association of Insurance Commissioners (NAIC) to serve as a model or standard for adoption by individual states. Model laws are designed to promote both a level of minimum standards and standardization from state to state, and to facilitate the ability of states to appropriately regulate new and evolving insurance products.

MORBIDITY Frequency and severity of sickness and accidents in a welldefined class of people.

MORTALITY Measure of death from various causes in a well-defined class of people.

N

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) Organization of state insurance commissioners that voluntarily promotes some degree of uniformity in the regulation of insurance and prevents unnecessary duplication of effort by both the regulatory authorities and insurance companies.

NONCANCELLABLE Provision that a policy may not be canceled or altered nor the premium changed by the insurance company so long as premiums are paid on a timely basis.

NONFORFEITURE BENEFITS Benefits that accrue to the insured when a policy terminates due to nonpayment of premium. These may take one of several forms. The amount of nonforfeiture benefits depends on the individual's age when the policy is issued, the length of time the policy was in effect, and any benefits paid under the policy.

O

OLDER AMERICANS ACT OF 1965, AS AMENDED Federal law establishing a network of state and community-based programs and services for older Americans. Primarily, it fosters provision of preventive services such as congregate and home-

delivered meals and certain supportive services. Priority is given to minorities and persons with the greatest economic and social needs.

OUTLINE OF COVERAGE Brief description of important features of a policy, including benefits and limitations, delivered at the time of solicitation.

P

PER-DIEM BENEFITS Benefits that pay a flat dollar amount for each day of benefit eligibility. Use of licensed providers may not be required.

POST-CLAIMS UNDERWRITING The practice of being more diligent at obtaining information on health status or functional capacity when a claim is filed than during the underwriting of a policy in order to deny the claim or rescind the policy.

PRE-EXISTING CONDITION A medical condition (either physical or mental) that existed before the effective date of the policy. If the condition existed within a specified period (often six months) before the policy went into effect, charges for care relating to that condition are often not covered for a period of six months following the policy's effective date.

PREMIUM The amount periodically paid by the insured to keep the policy in effect.

R

REDUCED PAID-UP A nonforfeiture benefit that pays a percentage of the daily benefit, such as 30 percent after 10 years, increasing to 75 percent after 25 years.

REHABILITATION Process of restoring disabled people to maximum physical, mental, and vocational independence and productivity consistent with any residual limitations. It is achieved by identifying and developing one's capabilities, by environmental modification, or by skills training.

RESCISSION Voiding of an insurance contract from date of issue by the insurer because of material misrepresentation on the application.

RESPITE CARE Temporary relief for family members or friends who are caring for an older or disabled person at home. Respite care is often provided by volunteers, home health care providers, or adult day care centers or in a nursing home.

RETURN OF PREMIUM (ROP) A nonforfeiture benefit that returns a portion of the premium to the insured in the event the policy lapses. The amount of such benefit is based on the individual's age when the policy was issued, the length of time the policy was in effect, and any benefits paid under the policy.

REVERSE ANNUITY MORTGAGE An arrangement under which an individual exchanges the equity in a home for a lifetime annuity. (See "Home Equity Conversion".)

S

SHORTENED BENEFIT PERIOD A nonforfeiture benefit that provides full daily benefits, although for a shorter period than was initially purchased, if the person meets the criteria for payment of benefits after the policy has lapsed. The period of coverage will depend on the age of the individual when the policy was issued, the length of time the policy was in effect, and any benefits paid under the policy.

SKILLED CARE Twenty-four hour nursing and/or rehabilitative care that requires the services of skilled medical personnel, generally in a nursing home.

SKILLED NURSING FACILITY Institution that provides a planned program of observation, medical care, and treatment under the direction of a physician and continuous 24-hour nursing care under the regular supervision of a registered nurse.

SPEND-DOWN Depletion of assets to pay for long-term care after which a person becomes eligible for Medicaid.

STANDARD RISK Person insured based on standard underwriting criteria without a need for modifying a policy by adding exclusions, changing benefits, or increasing premiums.

SUBACUTE CARE Care provided to patients who need skilled care in settings other than a hospital; subacute care focuses on achieving measurable outcomes.

SUPPLEMENTAL SECURITY INCOME Government cash assistance program for low-income people qualified by age, blindness, or disability.

T

TWISTING Unwarranted replacement of a policy. The unfair marketing practice of inducing a person to lapse or to convert an existing policy and to adopt a new one without providing significant added value.

U

UNDERWRITING Process by which an insurer determines whether, and on what basis, it will accept an application for insurance.

UPGRADE Formal process by which an insurer allows policyholders with an earlier generation product to purchase a new policy, generally without meeting some of the standard requirements. For example, underwriting requirements may be waived and the premium for the enhancements may be based on the insured's age when the original policy was issued.

V

VIATICAL SETTLEMENT A contract that enables an individual who is terminally ill to receive a sum of money in exchange for the right to death benefits under a life insurance policy.

W

WAIVER OF PREMIUM Provision that ensures that insurance will remain in effect, under certain circumstances, when the insured stops paying premium while benefits are being received.

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