

#2006-13
May 2006

**COMPARING LONG-TERM CARE INSURANCE POLICIES: BEWILDERING
CHOICES FOR CONSUMERS**

by

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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Foreword

Private long-term care insurance is a critical component of our nation's overall system of paying for long-term services and supports. For those who can afford the premiums, private long-term care insurance helps to ensure one's choice in the setting of services and the selection of providers. It also helps purchasers protect their assets, rather than having to deplete them paying for services.

Why have relatively few Americans purchased this insurance? One reason is the cost of premiums; other reasons include uncertainty about whether benefits will be paid in the future and a pervasive denial of the future likelihood of needing long-term services. Beyond these reasons, however, is another concern. Many consumers who consider making a purchase find they are confused and bewildered by the array of choices and the seeming impossibility of comparing one policy with another.

Unlike many other types of purchases, it is not enough for consumers to simply compare prices for a comparable number of years of coverage. Long-term care insurance policies have myriad variables that may be only poorly understood, if at all, by potential purchasers. Yet the unwary buyer may find that the wrong choice results in less coverage or higher out-of-pocket costs. Choosing the "cheaper" policy may also result in steep rate hikes and expensive gaps in benefits down the road.

To learn more about these complexities, the AARP Public Policy Institute (PPI) asked California Health Advocates to examine and report on the variables in private long-term care insurance policies that make it difficult for consumers to make educated comparisons between policies. We hope that the findings reported in this paper will be useful to policymakers as they consider needed steps that could, possibly, help to make these products more accessible to potential purchasers.

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Executive Summary

Introduction and Background

The cost of long-term care is an important factor in retirement planning. It also affects state and federal governments, given the major role of Medicaid in paying for care. Yet, as Medicaid eligibility rules are tightened, the implication for consumers is that long-term care insurance (LTCI) may be their best option for financing care. LTCI will allow them to maintain their independence and have a choice of high-quality providers, it is said; at the same time LTCI will enable consumers to avoid dependence on scarce public resources. Whether LTCI can accomplish these goals for most Americans, and whether the purchase of this product will substantially relieve the pressure of future demands on public benefits, remains to be seen.

Comparing one long-term care policy with another is a challenge, even for professionals. Consumers will find very little independent and objective help or guidance to assist them during the decision-making process, and nothing that will help them easily compare one policy with another.

Purpose

The purpose of this report is to

- Identify the critical issues that make the comparison of LTCI policies difficult for consumers, and
- Offer public policy recommendations that would improve the ability of consumers to make educated decisions about the purchase of LTCI.

The author identified critical issues that consumers face when they consider purchasing LTCI. Such issues include types of policies, benefit amounts and duration of coverage, location and license status of providers, inflation protection, length of waiting period before benefits begin, and premium costs. Yet, simply understanding these issues will not resolve the difficulties that consumers face. The intent of this report is to offer recommendations to policymakers that would make the system more comprehensible.

Critical LTCI Issues for Consumers

Type of Policy

Consumers may have a variety of options among which to choose when they consider purchasing long-term care coverage, including

- Individual versus group policies;
- Partnership policies that link LTCI and Medicaid; and
- Products that combine LTCI with life insurance or an annuity.

Policy Coverage

A typical LTCI policy will offer benefits for some combination of nursing home care, assisted living, and home and community care. Consumers can choose from

- Comprehensive policies that usually provide benefits for services at all levels of institutional, home, and community-based care;
- Facility-only policies limited to care in institutional settings; and
- Home-care-only policies.

Policy Features

Consumers face decisions on

- A daily benefit amount the policy will pay for services in each care setting covered by the policy;
- The length and definition of a waiting period or deductible, if any, before benefit payments will begin;
- The duration of benefit payments over the life of the policy;
- Inflation protection and, if selected, what type to choose; and
- Nonforfeiture protections.

Premiums and Premium Increases

Consumers may not know that their premiums can change. Consumers are often told, correctly, that the premiums for LTCI are “level,” and that they, as individuals, can’t be singled out for an increase because of their age or health. However, while companies cannot raise premiums because of *individual* circumstances such as age or health, they *can* raise premiums for entire *classes* of individuals (e.g., all policyholders age 75 and older) based on the company’s experience in paying benefits.

Currently, companies have to justify premium increases to state insurance departments, but states have limited authority to deny those increases. The current National Association of Insurance Commissioners (NAIC) rate stability requirements, which include a contingent benefit on lapse, are expected to moderate or eliminate future premium increases. But those requirements apply only to new policies sold after a state has adopted these provisions, leaving companies free to increase premiums for policies previously sold. To date, fewer than half the states have adopted the NAIC’s rate stability provisions.

Standardization and Other Regulatory Issues

Although some minimal standardization has already occurred, the ability of consumers to measure and compare how several LTCI policies will pay for their care is hampered by the complexity of these products. Few of the elements of an LTCI policy are standardized, such as a waiting period and how it is calculated. The definitional issues that cause difficulties for consumers in measuring and comparing LTCI policies include

- How many activities of daily living (ADLs) trigger benefits;
- Which family members will *not* qualify as care providers for benefit payment; and
- What type of assisted living facility qualifies for benefits.

Other policy variables include

- How a daily benefit amount is calculated;
- When premium payments might be waived;
- What constitutes a home-modification benefit;
- What alternate plans of care cover;
- How medical underwriting is handled; and
- What risks are inherent in limited-term policies.

As a result, consumers face a bewildering array of LTCI policies. These products contain an assortment of benefits and features, and come in policy designs that vary from one company to another, leading to significant product differences within a single state.

Agent Training

The advice that agents give consumers can have long-lasting effects, such as the consequences of not purchasing inflation protection for a policy purchased long before the consumer needs its benefits. Some agents represent a single company and are limited to selling that company's products, and a sales quota may influence the particular product they offer a consumer. For agents who represent several companies, sales commissions may be a factor in the product they encourage a consumer to buy.

Although many agents are unfamiliar with long-term care and the insurance products they sell, most states do not require training specific to LTCI. The NAIC is in the process, however, of adopting a provision that will require companies in states that enact the regulation to use only those agents who have completed eight hours of training specific to LTCI.

Consumers may be able to take advantage of information and counseling through the federally funded State Health Insurance assistance Programs (SHIP), but only if they know these programs exist and how to reach them. Many of the SHIPs can help people one-on-one to evaluate their suitability for the product they are considering and help them understand what the policy covers and how the benefits work.

Conflicting Regulatory Frameworks

At least four different regulatory frameworks might be applied to the sale of LTCI policies in a given state, plus any state-specific requirements. These include

- The federal Health Insurance Portability and Accountability Act (HIPAA) requirements for tax-qualified LTCI policies (which references selected provisions of the 1993 NAIC Model Act and Regulation).

- The current NAIC Model Act and Regulation, updated most recently in 2000, but undergoing additional revisions as this report is written.
- The NAIC Interstate Compact (for those states that join the Compact), which is in the process of enactment. It is similar to the current NAIC Model Act and Regulation, but it will not be *required* to mirror the NAIC Model.
- The LTCI Partnership standards, which reference selected provisions of the 2000 NAIC Model and exceed HIPAA requirements.

Conclusions and Recommendations

The need for long-term care is unpredictable—which is why long-term care is a good candidate for insurance. The issue, in this case, is whether the consumer can determine if the premium is fairly priced, based on sound actuarial experience. The recommendations that follow will not solve all the difficulties that consumers face. However, they offer guidance to policymakers on how they could begin to make it easier for consumers to make sound decisions.

Recommendations:

- *Standardize policy benefits, features, and provisions.*
- *Require all insurers to offer at least the same benefit packages that are offered through the Federal Long-Term Care Insurance Program.*
- *Require LTCI policies that pay benefits for multiple types of care to make the total value of all purchased benefits available to the policyholder in any covered setting.*
- *Expand funding for the federally funded SHIPs so that more consumers could take advantage of the information and counseling they provide.*
- *Require companies to offer an option for paying family caregivers, with appropriate monitoring.*
- *Revise the NAIC formula for contingent benefit on lapse (a partial benefit to consumers who drop their policies when premiums escalate) to provide more protection to purchasers.*
- *Revise federal HIPAA standards to parallel the national standards that will apply to new LTCI partnership policies; require that existing partnership programs also conform to the new standards so that there will be a more consistent regulatory framework than currently exists.*
- *Regularly update federal HIPAA standards to include the most recent provisions of the NAIC Model Act and Regulation.*

Introduction and Background

The cost of long-term care (LTC) is an important factor in retirement planning. It also affects state and federal governments, given the major role of Medicaid in paying for care. Yet, as Medicaid eligibility rules are tightened, there is increased pressure on consumers to consider long-term care insurance (LTCI) as their best option for financing care. LTCI will allow them to maintain their independence and have a choice of high-quality providers, it is said, while enabling them to avoid dependence on scarce public resources. Whether LTCI can accomplish these goals for most Americans, and whether the purchase of this product will substantially relieve the pressure of future demands on public benefits, remains to be seen.

Fewer than 10 million Americans have bought an LTCI policy since those products were first tracked in 1987, and only about 7 million of those policies remain in force today (America's Health Insurance Plans [AHIP] 2004). The federal government and many states offer limited tax incentives to purchase LTCI, and sales have grown steadily over the last decade. Despite this growth, sales continue to lag behind industry expectations.

In 2003, most, if not all, of the 4.2 percent growth in the LTCI market could be attributed to enrollment in the new Federal Long-Term Care Insurance Program (FLTCIP) (Glickman 2004). Yet, even though the federal government conducted a fairly extensive education campaign to encourage participation, only 5 percent of active civilian employees enrolled during its first three years, similar to the trend of low participation rates observed in other group offers of LTCI (GAO 2006). This low take-up rate may reflect a more general difficulty in selling these products.

Insurance companies and agents believe that consumers don't understand their need for coverage, or are in deep denial of their own potential need for care. Some consumers incorrectly believe that Medicare will pay for their future LTC costs. Those who delay making a decision to purchase private insurance may find themselves shut out of the market for coverage because people with preexisting medical conditions often are excluded from coverage by medical underwriting.

Consumer advocates argue that current LTCI policies, while considerably better than earlier products, are just too difficult to understand, with the number and complexity of the choices making it hard for consumers to obtain the right set of benefits at the right price. The complexity of the decision-making process can have a paralyzing effect on consumer behavior.

Comparing one long-term care policy with another is a challenge, even for professionals (Glickman 2004). Consumers will find very little independent and objective help or guidance to assist them during the decision-making process, and nothing that will help them easily compare one policy with another (Friedland and Lewis 2004). Generally, a consumer has only the advice of an agent (who often has a financial interest in making a

sale), various marketing materials, and an “Outline of Coverage” (an abbreviated description of the policy) on which to rely for an understanding of their choices.

Purpose

The purpose of this report is to identify the critical issues that make the comparison of LTCI policies difficult for consumers and offer public policy recommendations that would improve the ability of consumers to make educated decisions about LTCI.

This paper addresses

- Critical variables in LTCI policies;
- Interstate variations in provider licensing and their effect on the ability of consumers to receive benefits;
- Factors that would help consumers compare policy differences and ways of making this information accessible to consumers;
- The merits of standardizing all or some features of LTCI policies; and
- Public policy decisions that further the goal of helping consumers to have the knowledge to make better decisions about LTCI coverage.

The report identifies critical choices that consumers face when they consider purchasing an LTCI policy:

- Types of policies;
- Amount and duration of coverage;
- Purchase of inflation protection;
- Length of the waiting period before benefits begin; and
- Cost of the premium.

The report and appendices cite language from actual LTCI policies to illustrate choices that may create confusion for consumers. Yet, simply understanding these issues will not resolve the difficulties that consumers face. The intent of this report is to offer recommendations to policymakers that would make the system more comprehensible.

Critical LTCI Issues for Consumers

When purchasing an LTCI policy, consumers must make a number of decisions about variables ranging from the type of policy to the nature of the benefits, duration of coverage, and waiting periods before payments will be paid. Consumers must make these decisions that affect the cost of the premiums they will pay without knowing whether they will even need care in the future or, if they do, what kind of care. How can consumers make informed choices about which policy options to choose? How can they then compare policies to make sure they are making the best choice? Selecting the right policy is especially important in buying LTCI because premiums are generally “locked in” for the life of the policy. If a purchaser does subsequently decide to change policies, in most cases the new premium will be higher, as a result of the purchaser’s advanced age. In addition, if the purchaser has become disabled or developed a health condition, he or she is unlikely to qualify for new coverage. The following section describes some of the choices that consumers face.

Types of LTCI Policies

One choice a consumer must make is to decide what type of insurance product to buy. Depending on the type of policy one chooses, there may be a significantly different type of benefit structure, which adds an additional layer of complexity in deciding which policy to purchase.

Individual and Group Coverage

A common choice for most consumers is an individual, freestanding LTCI policy with only long-term care benefits. Anyone can apply for an individual commercial LTCI policy, but some people are also eligible for a group product sponsored by a public or private employer, an association, or a faith-based organization. Group policies may be less expensive or have less stringent medical underwriting.

Partnership Policies

People living in one of four states (Connecticut, Indiana, New York, and California) can also choose a partnership policy, which will allow them to retain a specified amount of their assets if they qualify for Medicaid after using up all their insurance benefits. Some companies selling partnership policies in those four states also sell an individual commercial product that competes with their own partnership offering. At the time of this writing, Congress had recently passed the Deficit Reduction Act of 2005, which expanded the partnership option to all interested states. It is anticipated that many new partnership programs will be adopted, because at least 21 states already have enacted enabling legislation (National Association of Health Underwriters [NAHU] 2006).

To illustrate the potential confusion, a consumer might be able to choose among six entirely different LTCI programs, depending on the individual's own or a spouse's eligibility for one or more group products or programs. Choices might include (1) the federal LTCI program for current or former federal workers, (2) a state public employee program, (3) a private employer-sponsored LTCI program, (4) an association- or faith-sponsored group coverage, (5) an individual, commercially sold LTCI product, or (6) a partnership policy. These products are very different from each other, making it nearly impossible to compare and make informed choices among them.

Combination Products

Consumers can choose a policy that offers LTC benefits combined with a life insurance or annuity policy.

- A ***life insurance*** policy accelerates payment of the death benefit, providing funds to pay for care as specified in the policy. A life policy can also include a rider for LTCI benefits that are similar to those in stand-alone LTCI policies. The benefits of an LTCI rider are typically paid only after the accelerated payment for the death benefit has been exhausted.
- An ***annuity*** can also include a rider for LTCI. The LTCI rider benefits are paid only after the cash value in the annuity has been exhausted.

Both an annuity and an accelerated life insurance death benefit usually provide a very long elimination (waiting) period before the benefits of an LTCI rider are triggered. Some of these products require the payment of a single lifetime premium up front, or a premium paid over a specified number of years, after which no further premiums are required. Congress is considering tax provisions to make these blended products more attractive.

Some consumers, particularly younger persons who may worry about paying premiums for several decades for benefits they may never use, are drawn to combination products like these. While sales of these products are not particularly strong, younger purchasers may begin to demand the blended benefits of a combination policy as a hedge against an uncertain future.

Policy Coverage

A typical LTCI policy will offer benefits for some combination of nursing home care, assisted living, and home and community care. Consumers can choose to limit benefits to certain types of care or choose a comprehensive package of benefits. Products are commonly marketed three different ways:

- ***Comprehensive policies*** usually provide benefits for services at all levels of institutional, home, and community-based care.
- ***Facility-only policies*** pay only for care in institutional settings (nursing homes), although some may also include care for assisted living, depending on how that kind of care is defined in the policy.
- ***Home-care-only policies*** provide benefits only for home care and some community-based care (such as adult day care), depending on the requirements in the state where they are sold.

Facility-only policies are often purchased by people who are concerned about the catastrophic costs of nursing home care and who cannot afford or do not want more comprehensive coverage. The policy defines the institutions where benefits will and will not be paid.

On the other hand, consumers who buy home-care-only policies often say they never want to be in a nursing home and think they can avoid a nursing home stay if they have home-care benefits. These policies may also cost less than policies with more comprehensive benefits, but they can provide a false sense of security if the insured person is unable to be cared for at home. One major issue that may arise with home-care-only coverage concerns the eligibility of the home-care provider to receive payment. Home-care policies define the agencies and personnel whom the company will pay to provide services and usually exclude family members, such as spouses, children, or other relatives. Other companies exclude only immediate family members or other people who live with the insured person.

The exclusion section of a policy is frequently the only place where this information can be found, often in the very last pages of a policy and expressed in arcane legal language. The exclusion may also require consumers to look up the definition of “Family Member” or “Immediate Family” to determine how far down the family relationship chain the ban extends. (For an example of the relative exclusion definition in a California LTCI policy, see Appendix A.)

Coverage of Assisted Living in LTCI Policies—State law may require that assisted living be included in a facility-only policy, or allow insurers to include assisted living in those policies if they wish. Some home-care-only policies may also contain benefits for assisted living if the state requires such inclusion or if an insurer voluntarily includes the benefit.

However, the term “assisted living” does not have a common definition in the states or in LTCI policies. A policy will define the places where assisted living benefits will be paid. Those definitions may conflict with, or fail to match, the requirements in other states for the kind of care described in the policy. In some cases, those requirements may not be met by every place that provides assisted living services within a single state.

A General Electric Capitol Assurance policy issued in Iowa illustrates the uncertainty about exactly where these policies will pay benefits. The language relating to the assisted living benefit begins—

An Assisted Living Facility is a facility, not excluded below, that satisfies the Conditions below and is engaged primarily in providing continual (24 hours a day, every day) assistance and supervision to at least 10 resident inpatients due to their inability to perform Activities of Daily Living or Severe Cognitive Impairments.

The remainder of the page describes the conditions under which benefits will be paid and those places that are excluded from consideration. The definition of when benefits will be paid is elsewhere in the policy. Aside from the complexity of the benefit description, state-licensed assisted living facilities with fewer than 10 beds will not meet the definition in this policy.

Consumers who have policies with these definitions may not be able to use their assisted living benefit if they move to another state with a different definition of assisted living. In addition, if the policy requires the facility to be licensed and the state in which the consumer seeks benefits does not license assisted living facilities, the policyholder may not be able to use the benefit in that state.¹

¹ See *Van Houten v. General Electric Capital Assurance Company (GE)*, in which GE denied benefits for assisted living on the grounds that the facility was not licensed by the state. At the time, the state of New York did not license such facilities.

Regulation of Cross Border Issues

The NAIC is amending its Model Regulation to require that care covered in the state of purchase will also be covered in any other state. However, this change will do nothing for consumers who purchased their policy before their state adopted this change, or in states that fail to adopt the change for policies sold in the future.

Policy Features

Each purchaser, or his or her agent, constructs an individualized benefit package, with most of the decisions heavily influenced by the cost of the premium. Couples must decide whether to insure both spouses separately with identical or different benefits and costs, or to purchase a single policy with a pool of benefits from which each spouse can draw. The danger of this approach is that one spouse could deplete the benefit pool, leaving the other spouse with no benefits. There also may be complications if spouses subsequently divorce.

Both spouses are frequently offered a discount if they are accepted for coverage by the same company. If one spouse is rejected, or has a health condition, the company will cover only at a higher premium cost, the discount may be reduced, or it may vanish completely.

Benefit choices include

- The daily benefit amount the policy will pay for care in each place covered by the policy;
- The length of a waiting period or deductible, if any, before benefit payments will begin;
- The duration of benefit payments over the life of the policy;
- Inflation protection and, if selected, what type to choose; and
- Nonforfeiture protections.

The 1996 enactment of the Health Insurance Portability and Accountability Act (HIPAA) established the first and only set of national minimum standards for federally tax-qualified LTCI. Products must meet many provisions of the 1993 NAIC Model Act and Regulation and comply with the federal HIPAA standard for benefit eligibility to qualify for a potential tax subsidy for purchasers—that is, the potential tax deductibility of LTCI premiums and the exclusion from taxable income of benefits paid out by a policy. Some 90 percent of LTCI policies sold today meet these “tax qualified” standards.

LTCI policies require the insured to meet a specific level of disability in activities of daily living (ADLs) before he or she is eligible to receive (or “triggers”) benefits. HIPAA sets benefit eligibility at severe cognitive impairment or no less than two ADLs (using a list of no less than five ADLs). Consumers often fail to understand these terms and how they are applied. Although most policies use the HIPAA standard for the number of ADLs required to trigger eligibility, the tools that companies use to *assess*

people for ADL disability vary from one company to another. Moreover, the company may require that the eligibility assessment be done in-person, by phone, by a physician's medical statement, or by medical records obtained as part of the claims process.

The Daily Benefit

Once eligibility is established, LTCI benefits can be paid out in a variety of ways:

- Reimbursement for services paid out at specific daily, weekly, or monthly amounts;
- Reimbursement limited to specific costs and services that are capped at specific daily, weekly, or monthly amounts;
- Payment in percentages or periodic lump-sum amounts based on other components of the underlying insurance product, such as the accelerated death benefit of a life insurance policy; or
- Paid as a cash benefit once the disability trigger is met, regardless of use of services.

Applicants for an LTCI policy typically select their benefits from a menu of choices. The daily benefit amounts offered can range from as little as \$50 daily to \$300 or more. The daily benefit they choose is usually based on the current cost of nursing home care, and the benefit chosen is the highest amount the policy will pay for nursing home care. The amounts that will be paid for other types of care covered by the policy can be the same amount as the nursing home benefit, a percentage of the nursing home benefit, or a smaller daily amount. The policy spells out in detail the specific circumstances under which each selected benefit will be paid.

The premium charged will depend on the daily benefit chosen and how it will be paid, as well as the individual's age, gender, and, in some cases, current health condition. If applicants feel the resulting premium is too high, they can make some adjustments to their previous choices or decide that LTCI is too expensive and abandon the application.

Variations in the Payment of Daily Benefits

Some policies pay the daily benefit amount regardless of actual care costs. Others will pay only the cost for the actual care, but limited to 100 percent of the daily benefit amount chosen. For example, if the daily cost of care is \$100 but the maximum daily benefit purchased was \$150, some companies will pay only \$100, the actual cost of the care. In some older policies, the "excess" benefit may be lost; however, some newer policies use a "pool of money" approach. With a "pool of money" policy, the daily benefit is multiplied by the number of years of coverage purchased. This pool of benefits may then be spent at any rate for any combination of services in the policy. For example, a policy that pays \$150 per day for three years would yield a total benefit pool of \$164,250. Provided the policy covers both nursing home and home-care benefits, the total pool of money might be spent more slowly if the consumer uses home care or more quickly if the beneficiary opts for a private room in a nursing home.

Waiting Periods

Perhaps the most confusing acronyms and ambiguous terms in LTCI policies pertain to the waiting period. Once a person has met the policy's disability trigger for eligibility, the period of time before benefits begin is inconsistently referred to as an elimination period, a waiting period, or a deductible.

If care in a nursing home currently costs \$150 a day and a consumer chooses a 100-day elimination period, she will pay \$15,000 before the company begins paying on the 101st day. If she does not stay in the nursing home for the full 100 days, the company will pay nothing for her nursing home stay, but may eventually pay something for home care if she qualifies and that benefit is included in her policy.

In addition, the cost of long-term care services is subject to inflationary increases. Today's \$15,000 elimination period is likely to grow to \$30,000 or more when a policy is purchased decades before care may be needed. Many people also mistakenly believe that Medicare will pay for all or at least part of the elimination period they have chosen if they need nursing home care. However, Medicare requires that an individual need daily *skilled* nursing care in a nursing home before the program pays for a portion of a nursing home stay. Many people need only personal care services that LTCI policies, not Medicare, are designed to cover. Even if Medicare *does* pay for LTC services, the policy may or may not count those days toward the elimination period.

Other confusing elimination period issues for consumers include the following:

- Few consumers understand that they must receive *paid* care (i.e., not care from a relative) to get credit toward their elimination period. Some consumers think it does not matter who provides the care during the elimination period, and that paid care is only required once benefits begin.
- Most consumers do not know how a company credits days of care toward their waiting period. Many companies count only the days on which the person actually *receives* paid care, called a "service day" elimination period. For instance, if a person received formal, paid home care benefits three days during a week, some companies would count only those three days toward the elimination period, not the entire seven days the person was qualified to receive benefits.
- Some companies count the entire week if the individual receives at least three days of home and community care during the week. Other companies will count every day a person is *qualified* to receive benefits toward the elimination period, regardless of the days when care was actually received, called "calendar day" elimination periods.

To illustrate the difficulties that consumers can face in figuring out the terms of their policy's elimination period, two examples of language taken directly from LTCI contracts are provided in Appendix B.

Most LTCI policies contain numerous other benefits, including premium waivers, home modification, bed reservation, adult day care, respite care, hospice care, and many variations of case and care assessment and management. Understanding and comparing even a few of these benefits along with the major issues discussed previously presents a major challenge for consumers.

Duration of Coverage

- Most companies offer a *variety of durational choices*, ranging from one year of coverage to lifetime benefits.

For instance, a policy sold by AFLAC pays for three years of nursing home care, two years of assisted living, and 400 home-care visits (AFLAC policy A-27025-CA by American Family Life Assurance Company). A person could exhaust the home-care benefit fairly quickly but be unwilling to leave home to use the other benefits the policy provides. Conversely, people who need nursing home care might not ever be able to access the home-care or assisted living benefits, even though the cost of both are included in the premium paid for the policy.

- Policies that use a “pool of money” approach offer much more flexibility.

Policies using this construction allow consumers the flexibility of receiving care in the most appropriate place at the time, without restricting them to just one part of the benefit package. This method also allows an extended time period over which benefits can be paid by using lower cost benefits as long as possible, while still maintaining coverage for higher-cost benefits as long as money is still left in the “pool.”

Many consumers want lifetime coverage, but because the premium for such coverage is often out of reach, most people settle for a shorter period of time. In 2000, the average policy covered \$109 per day for 5.5 years for nursing home care. Most policies (77 percent) were comprehensive policies that paid for benefits in the home, community, or institutional settings (Health Insurance Association of America [HIAA] 2000).

Inflation Protection

The optional benefit for inflation protection is designed to offset inflationary increases in the cost of care over time, helping the daily benefit amount to keep pace with the cost of services. Without inflation protection, the chosen daily benefit will lose value in relation to the cost of care, and the consumer’s out-of-pocket costs will grow larger each year once services begin. Younger purchasers who don’t choose this protection run a particular risk of having a benefit insufficient to fund the cost of their care decades later. In 2000, only 41 percent of purchasers selected inflation protection (HIAA 2000), although this percentage may be increasing as more people begin to recognize its importance.

Instead of purchasing built-in inflation protection, some persons select a higher daily benefit than the current cost of care. Consumers who choose this strategy pay a higher premium in the early years for a benefit that will decrease in value over time as service costs increase. They also pay for a daily benefit that is more than what the company may

actually pay until later. While the cost of care is likely to grow to meet the higher daily benefit, at some point costs may exceed that threshold, leaving the consumer with a static benefit and steadily rising out-of-pocket costs.

Inflation protection is typically offered in two ways: (1) built-in protection, where both the amount of the inflation protection and its cost are built into the initial annual premium; and (2) an option to purchase increased protection at periodic intervals, with a corresponding increase in premium based on the age of the policyholder (but with no additional medical underwriting) at the time the option is exercised.

- *Built-in Automatic Inflation Protection:* In this version, the initial daily benefit increases by some percentage of simple or compounded interest on an annual basis.

The NAIC Model Regulation requires agents to *offer* a 5-percent compounded benefit, but they can also offer any other configurations allowed under state law. Most companies offer a 5-percent simple or compounded increase annually, although some may offer additional choices at a lower or higher percentage. The rate of increase is predetermined and may or may not track actual changes in the cost of LTC. Consumers may not realize that simple inflation protection will increase the value of their benefit much more slowly than will compounded inflation adjustments.

The cost of this optional benefit is built into the initial premium, so after the consumer makes that decision at purchase, the annual premium is not affected in future years. The certainty of this type of inflation protection allows consumers to better budget their cost of coverage into the future, when they are likely to have a fixed income and be vulnerable to any unexpected increases.

- *Periodic Offer of Inflation Protection:* This method of inflation protection allows purchasers to postpone a decision and the cost for some period of time, letting them increase their daily benefit amount at periodic intervals.

While the purchaser cannot be turned down for this optional benefit within the timeframe it is offered, the cost of the premium increase for this type of inflation protection will be based on his or her current age and added to the existing premium when the option is exercised. Companies typically offer this option every three to five years. Although a consumer can turn the offer down once or even twice, there is usually a limit after which the option can no longer be exercised.

Consumers may not understand the value of inflation protection, nor the potential cost of deferring this benefit, at the time they purchase their LTCI policy. As a consumer gets older, the price for exercising this option may become too high, leading to the eventual loss of any further inflation protection and a static benefit.

Nonforfeiture Benefit

When they purchase their policy, consumers can usually buy a *nonforfeiture* benefit that will return some portion of their premium if they decide to drop their coverage, depending on certain events and when they occur. Choosing a nonforfeiture benefit

significantly increases the premium. (See Table 1 below.) However, it provides the consumer with a guarantee of getting some return for his or her premiums, should LTC services eventually be needed.

In other cases, a company may use the NAIC contingent benefit on lapse (CBL), sometimes referred to as contingent nonforfeiture. This feature is triggered when consumers who did not buy a nonforfeiture benefit at purchase stop paying their premiums following notice of a rate increase. CBL means that the insured person retains some policy benefits that are equal to all the premiums they have paid at the time a premium increase occurs and the policy lapses. Unlike the advance purchase of a nonforfeiture benefit, this feature does not require a person to select this benefit and pay an additional premium; however, it is available only in states that require this protection or from companies that voluntarily offer it. The nonforfeiture benefit under CBL is triggered when the cumulative amount of all premium increases exceeds a certain percentage based on the policyholder's age.

Appendix C illustrates the increase in premiums at selected ages that would be required to trigger the CBL, according to the NAIC Model Regulation. As an example, a person age 75 who purchased her policy at age 65 with an annual premium of \$2,000 a year would have paid at least \$20,000 in premiums over that 10-year period. If she dropped the policy after her premium increased 30 percent, either in a single increase or in cumulative increases, she would be eligible for CBL. She would have a credit equal to the premiums she had paid (\$20,000) as a benefit against future long-term care costs that would have been covered by the policy.²

However, \$20,000 today would pay for less than four months of nursing home care in most parts of the country. Policyholders who had paid less in premiums when they exceeded the percentage of increased premium for their age group would have less than this amount as a credit toward their future care. While CBL does provide a small amount of benefit if people are no longer able to afford their LTCI coverage, it can be devastating for consumers to be priced out of their LTCI policy, particularly when they are close to the age when they may need to use the benefit.

Premiums and Premium Increases

Premiums for LTCI policies are particularly hard for consumers to compare. Premiums for a freestanding LTCI policy are based on

- Selection of a daily benefit amount;
- Length of an elimination period;
- Duration of coverage;
- Type of coverage;
- Inflation protection; and
- Gender and age.

² This example would not apply in states that don't require CBL, or when companies don't provide this protection voluntarily.

Younger people certainly pay much lower premiums than older people because their risk of needing long-term care is much less likely at age 40 than at age 80. Table 1 illustrates the average premiums paid for a policy in 2002.

Table 1
Average Annual Premiums, 2002

\$150 Daily Benefit, 90-Day Elimination Period, 4 years of coverage				
Age	Base Plan	With 5% Compounded Inflation Protection (IP)	With Nonforfeiture Benefit (NB)	With IP and NB
40	\$422	\$890	\$537	\$1,117
50	\$564	\$1,134	\$715	\$1,474
65	\$1,337	\$2,346	\$1,646	\$2,862
79	\$5,330	\$7,572	\$6,479	\$8,991

Source: AHIP 2004.

Each company determines the premiums it will charge using a different set of assumptions and criteria. Consumers are accustomed to shopping for the best price for most goods and services, but LTCI is one product where a higher price may offer the best protection against future premium increases. The lowest-priced policy may be one that is underpriced and especially vulnerable to premium increases. Some industry analysts maintain that many LTCI policies were underpriced in the past as an explanation for why companies have had to increase the premiums that consumers initially agreed to pay (Conning Research and Consulting 2003).

Consumers may not know that the premiums for the benefits and features they choose can change. They are often told, correctly, that the premiums for LTCI are “level,” and they can’t be singled out for an increase because of their age or health. However, while companies cannot raise premiums because of *individual* circumstances such as age or health, they *can* raise premiums for entire *classes* of individuals (e.g., all policyholders age 75 and older) based on their experience in paying benefits. While LTCI is guaranteed renewable for life, it may not be affordable for life.

In states using the Suitability Standards of the 2000 NAIC Model Regulation,³ insurers are required during the application process to divulge all rate increases for any LTCI policies they sold anywhere in the last 10 years. Such a requirement may provide some warning to applicants of the possibility of a later increase. Whether warned or not, the imposition of an increase in the future can lead to a loss of coverage if it is more than the person can afford to pay.

In fact, premiums have been climbing as companies have been faced with an unexpected drop in investment earnings and higher retention rates than anticipated (Conning Research and Consulting 2003; Lane and Austin 2003). Insurance companies assume that a certain percentage of purchasers will die or let their policies lapse before they qualify for benefits. When this happens, the company retains those premiums without having to pay benefits. If fewer purchasers let their policies lapse, the company may face higher-than-anticipated claims for benefits.

³ The Suitability Standards call for insurers to obtain financial and other information from applicants to screen out applicants who are inappropriate purchasers of LTCI based on their income and other factors.

Resulting rate increases of 40 percent, singly or cumulatively, have taken many consumers by surprise and caused at least some people to let their coverage lapse (California Department of Insurance 2003). Rate increases are usually unnecessary when insurance companies are able to set appropriate premiums by estimating

- The cost and number of future claims;
- The number of people who will lapse their policies;
- Return on investment income; and
- Other expenses.

With careful estimates, if increases are needed later, they are usually small and infrequent. However, when insurance companies get one or more of the above assumptions wrong, or they rely on the ability to increase premiums in future years, the result may be a substantially underpriced product (Conning Research and Consulting 2003). Future rate increases will not only be necessary, they are likely to be large and occur more than once. Since LTCI can be an expensive product to begin with, the pressure on companies to keep initial premiums low and affordable is intense. Lower-priced products are more likely to be more attractive to consumers who do not know the potential impact of buying a policy with a lower-priced premium.

The NAIC rate stability requirements in the 2000 Model were developed to moderate or eliminate future premium increases, but those requirements apply only to new policies sold after a state has adopted these changes, leaving companies free to increase premiums for policies previously sold. These requirements include disincentives to underprice policies, actuarial certification that initial rates are reasonable, and stronger consumer protections and disclosures. To date, fewer than half the states have adopted the NAIC's 2000 Model Regulations (Kofman and Thompson 2004). While companies have to justify premium increases to state insurance departments, states have limited authority to deny those increases.

In addition, consolidation within the LTCI industry is some cause for concern because it concentrates the nation's privately insured risk within just a few companies (Forbes 2003). At least nine of the top-selling companies have left the market since 2000, either ceasing to sell LTCI or putting all their long-term care business up for sale (Forbes 2003; McBirney 2004). One consulting actuary estimates approximately \$2.5 billion in premiums is now being paid annually to companies that no longer sell this product (McBirney 2005).

Rate increases by one company can create a public relations problem for all companies selling LTCI. A 1998 North Dakota class action lawsuit was filed on behalf of elderly policyholders who had received rate increases totaling 700 percent over seven years. The situation received widespread publicity, culminating with testimony before Congress on "low balling" of rates by some companies (Kanner 2000). Some other companies had been steadily imposing double-digit increases over the last few years, forcing many older people to drop their coverage when they couldn't pay the higher costs.

The manner in which a company establishes its premiums and the likelihood of future increases are not elements consumers can compare when shopping for LTCI. Previous

premium increases are their only frame of reference, and then only if that information is available prior to purchase or at the point of sale.

Standardization and Other Regulatory Issues

The Case for Standardization

Policymakers often suggest that LTCI be standardized along the same lines as Medicare supplemental insurance policies. A report by Weiss Ratings (2001) noted the many parallels between LTCI policies today and Medigap policies before Congress standardized those policies in 1992. Creating a series of standard benefits packages could make the product easier to understand and compare.

Although some minimal standardization has already occurred, it is unlikely to be very meaningful for consumers trying to compare policies. For example, the California Public Employees Retirement System (CalPERS) limits member choices of daily benefit amounts and durations of coverage to several standardized combinations, which still results in more than 83 different permutations. Individuals eligible for the CalPERS LTCI program have a limited number of product designs and durations from which they can choose:

- They can choose one year or two years of benefits in a CalPERS Partnership or three years of coverage or lifetime benefits for the non-Partnership options.
- If they can't afford lifetime benefits but are uncomfortable with no more than three years of benefits, they can find an unlimited number of choices in the commercial market, where they can choose any number of years that fits their needs.
- They can choose a partnership policy outside of CalPERS that offers more years of coverage.

The FLTCIP created a few standard packages its members could select during the initial stages of the program, but allowed a full range of choices for those who wanted to tailor benefits to their own needs. However, none of these “standardized” options make it easier for a consumer to make comparisons between, say, a CalPERS policy, an individual policy offered by one or more private insurers, and an FLTCIP policy.

Colorado is the only state that has actually standardized LTCI policies. According to some state officials, the program has been under attack by industry forces since it started in 1997. Colorado requires companies to file and offer two policies—basic and standard—that are designed by the state. Both policies must be offered to consumers along with any others a company sells. Initially, the two plans were a three-year nursing home-only policy, and a five-year nursing home and home-care policy. With revisions in 2002, the basic and standard plans are now substantially the same. Both cover a full range of institutional, home, and community care. The basic plan is a three-year policy; the standard plan is a five-year policy.

The presence of a standardized product in the marketplace gives Colorado consumers a benchmark product to measure against. However, there have been few sales of the standardized policies in Colorado.

Standardization Issues: Definitions and Other Variables

Defining terms

The ability of consumers to measure and compare how one LTCI policy will pay for their care with another LTCI policy is hampered by the complexity of these products. Few of the elements of an LTCI policy are standardized, such as a waiting period and how it is calculated. Consumers must guess what the language in each company's policy means. A range of additional variables that compound the difficulty of consumers making educated decisions include the following definitional issues:

- ***Activities of Daily Living:*** While most policies adhere to the HIPAA definitions, the NAIC Model Regulation allows companies to interpret these definitions in different ways. A company might also decide to tighten its interpretation as claims increase, shutting out claims the company might have paid previously.
- ***Family member exclusions:*** The issue of family members who will not qualify as care providers for benefit payment is not addressed in the NAIC Model. Companies can exclude any relative—from either side of the family, down to second cousins—or they can exclude only those family members who live with the insured person. In some cases, family members who are only remotely related and who are professionally qualified caregivers are precluded from qualifying by the terms of the policy, even though they may be the most competent and the most desirable caregiver.
- ***Assisted living:*** It is difficult for consumers to determine how the definition of an assisted living benefit relates to the facilities that provide that kind of care, in their state or in any state to which they might move.

Other critical policy variables

- ***Daily benefit amounts:*** Some companies limit the benefits for home care by tying the daily benefit amount to a maximum hourly rate that will be paid to a home health aide. The computation of the daily benefit can then be manipulated in favor of the company if the hourly rate is set low and the benefit does not inflate. For example, a company could write a policy with a daily benefit of \$100 with an hourly rate of \$12.50. Not only is the hourly rate very low for an aide, most home care visits are four hours in length, less than the maximum daily benefit promised. Consumers may not understand the mechanics of a benefit written this way or the out-of-pocket cost that will come with it.
- ***Waiver of premiums:*** Many companies waive premiums after some period of benefits payments. But consumers cannot easily determine when those premiums are waived, for what services the waiver applies, and whether the company will retain any prepaid premiums or will return the excess premium at some point.

- **Home modification benefit:** Many companies provide this type of benefit to allow consumers to make their homes adaptable to their needs and allow them to stay at home when they need long-term care. But consumers may not know what the benefit pays for and how much it will pay. Companies write this benefit in a variety of ways, and it may pay as little as \$500. Consumers often assume the home modification benefit to be more significant than it is.
- **Alternate plan of care:** Many LTCI policies include an alternate plan of care and promise to pay for services or care in places not covered by the policy. This provision can help pay benefits many years, or even decades, later if the places or providers of care change. However, this is often at the complete discretion of the insurance company. An alternate plan of care has the potential of being an illusory promise if the benefit is not clearly written and useful to the insured. It should ensure that consumers are able to take advantage of the evolution of care and technology.
- **Medical underwriting:** Companies can defer medical underwriting and rely on the yes/no answers on an application, which many agents fill out and an applicant only signs. Insurers that don't medically underwrite up front can rely on the unlimited right in most states to challenge an application accepted many years earlier with an allegation of medical information that is discovered through the claims process. This practice is called *post-claims underwriting* by regulators and advocates, but it may be called fraud prevention by some companies. Although post-claims underwriting is prohibited in Section 11 of the NAIC Model Regulation, companies have an unlimited right to rescind a policy for fraud in most states.

Insurers do have the right to prevent fraudulent claims against their company. Good underwriting at the time of application should screen out people in the early stages of Alzheimer's disease or those who have other obvious health conditions. A yes/no question on the application about whether they think they might have or be developing the disease is unlikely to achieve the same result.

- **Limited-term policies:** These policies are purchased by people who agree to pay very high premiums for a fixed period of time, such as 10 years, after which the policy is paid up and no further premiums are required. In other cases, where both spouses are insured by a single pool of benefits, such an LTCI policy may also include a paid-up feature following some event, such as the death of one spouse.

People in many states who buy a limited-term policy with a paid-up feature have no lapse protection if they give up their policy due to a premium increase of any size during the fixed period in which they are paying premiums. The CBL in the NAIC Model does not currently address limited-term LTCI policies, although work is being done on a calculation that would provide a benefit if the policy lapses due to a premium increase. That protection will only be available, however, in policies sold after the date of adoption of the provision in a particular state.

Agent Training

Most consumers rely on an agent when buying LTCI. They trust agents to understand this complex insurance and to help them select the benefits they need. That trust may be misplaced when agents have little or no training to sell LTCI.

Most states have failed to establish any standards that specifically apply to agents selling LTCI, and even fewer require them to take specific training in LTCI before selling this type of insurance (Friedland and Lewis 2004; NAIC 2000). Many career agents do seek out specialized training and receive designations as experts in their field from a variety of training courses and organizations. Many other agents, however, are not well trained to understand and sell the most appropriate LTCI coverage, putting consumers at risk of receiving misinformation and/or buying insurance that does not meet their needs.

Consumers have no way to evaluate one designation over another, or to know whether a designation indicates expertise on the part of the agent. While insurance companies provide extensive information about their products to agents, it is often related to marketing and sales rather than detailed information about how a policy works.

Moreover, purchasing LTCI needs to be part of overall financial planning for retirement. Agents need to understand the role of LTCI in the overall picture of protecting financial security and improving a person's LTC options if disability should strike. Agents may give bad advice, such as purchasing LTCI with a reverse mortgage, because they don't adequately understand the financial implications—or because they simply don't care as long as they get the commission. If agents don't understand LTC and the details of products they are selling, consumers can buy the wrong policy or the wrong set of benefits. Some agents may promise benefits that are not available in the policy they are selling simply because they don't understand how a policy will be used, or they misunderstand the relationship of the benefits to long-term care services.

The advice agents give consumers can have long-lasting effects. For instance, agents sometimes don't offer inflation protection or don't recommend its purchase because of the added premium cost. Yet this protection is critical for consumers who aren't expected to use their benefits for years to come. Adding inflation protection does add cost to the premium, but affordability needs to be balanced across all the elements of an LTCI policy. Consumers must understand at the point of sale, for instance, that lack of inflation protection will gradually reduce the value of their benefit and will result in steadily increasing out-of-pocket costs for them at the point that they begin to use benefits.

An agent may encourage the purchase of a policy that is at the limit of a consumer's affordability without taking into account future life changes such as the death of one spouse, which can reduce the income of the living spouse and result in an unaffordable premium. Consumers might spend thousands of dollars of limited income to pay for an LTCI policy that they could lose shortly before they need to claim those benefits. From the perspective of public policy, a worst-case scenario may be when a consumer receives a tax benefit for purchasing an LTCI policy, lapses that policy, and then turns to public

benefits for help with the cost of long-term care. In those cases, taxpayers have paid twice: once for the tax subsidy and again for the care.

Some agents represent a single company and are limited to selling that company's products. Those agents may have a quota to meet or be expected to sell one of the company's products over another. Other agents represent several companies and can sell many different products. However, commissions may be a factor in the product the agent will encourage a consumer to buy, particularly when the company is paying large commissions or bonuses to gain market share. For example, one company was paying a commission of 130 percent of the first-year premium during a time when other companies were paying 60 to 75 percent (Forbes 2003). In other cases, an agent might submit an application to a company that specializes in accepting substandard business (accepting health conditions, for example, that other companies won't cover), exposing purchasers to almost certain premium increases later if premiums are not high enough to cover the additional risk.

The NAIC recently adopted a provision intended to improve agent training. It requires companies selling LTCI to use only agents who have completed eight hours of training specific to LTCI. A qualifying course may not include training related to marketing or a specific company's products. Like other NAIC provisions, however, it applies only in states that voluntarily adopt this measure.

Consumers may also be able to take advantage of information and counseling through the federally funded State Health Insurance assistance Programs (SHIP), but only if they know one of these programs exists in their state and how to reach it. California law requires companies to notify consumers of the availability of the SHIP and provide its toll-free number on the outline of coverage. Many of the SHIPs can help people one-on-one to evaluate their suitability for the product they are considering and help them understand what the policy covers and how the benefits work.

Conflicting Regulatory Frameworks

There are at least four different and overlapping regulatory frameworks that might be applied to the sale of LTCI policies in a given state, in addition to state-specific requirements:

- HIPAA requirements for tax-qualified LTCI policies (which reference selected provisions of the 1993 NAIC Model Act and Regulation);
- The current NAIC Model Act and Regulation, updated most recently in 2000, if adopted by a state (under additional revision as this report is written);
- The NAIC Interstate Compact (for those states that join the Compact), which is in the process of enactment. It is similar to the current NAIC Model Act and Regulation, but it will not be *required* to mirror the NAIC Model; and
- LTCI Partnership standards, which reference selected provisions of the 2000 NAIC Model and exceeds HIPAA requirements.

These regulatory systems are outlined in more detail in Appendix D. In addition to these overarching principles, there is a patchwork of state regulations that can have a profound effect on consumer protections and policy characteristics from one state to another.

Confusing Choices

Consumers have a bewildering array of LTCI policies from which to choose. These products contain an assortment of benefits and features, and come in policy designs that vary from one company to another, leading to significant product differences within a single state. In addition, an assortment of riders can be added that enhance, change, or modify the benefits of the base policy.

Conclusions and Recommendations

The need for long-term care is unpredictable—which is why long-term care is a good candidate for insurance. Consumers cannot know in advance what might cause their need for care or whether they will be able to afford care in the setting of their choice. It may seem unreasonable to pay premiums for benefits they may never receive. Yet this is a basic tenet of many types of insurance: paying to protect against a circumstance that one hopes never to experience. The issue, in this case, is whether the consumer can determine whether the premium is fairly priced, based on sound actuarial experience, and whether the policy will pay benefits as expected. The recommendations that follow will not solve all the difficulties that consumers face. However, they could begin to make it easier for consumers to make sound decisions.

Recommendation:

- ***Standardize policy definitions, benefits, features, and provisions.***

If these policy components were standardized, a tool could be developed to help consumers compare one LTCI policy with another. Consumers would also have a better chance of selecting an appropriate package of benefits and understanding how their policy works if common parts of the policy were standardized and could be easily compared. No such tool, beyond the most rudimentary, currently exists because it is impossible to design one that will compare policies, provisions, and practices that vary so greatly.

While standardizing *components* of an LTCI policy is desirable, creating standard benefit *packages* does not seem to be an appropriate solution, because the selection of an LTCI policy is so dependent on the financial circumstances of the purchaser. This kind of standardization could leave some people, who might fall between the cracks of a few standardized packages, without the ability to buy the protection they need.

Recommendation:

- ***Require all insurers to offer at least the same benefit packages that are offered through the Federal Long-Term Care Insurance Program.***

This would, at least, make it easier for consumers to compare a set of public, private, and federal LTCI policies, and could help move the nation toward more standardized terms, definitions, and benefits. Additional benefit packages could still be offered.

Recommendation:

- *Require LTCI policies that pay benefits for multiple types of care to make the total value of all purchased benefits available to the policyholder in any covered setting.*

A comprehensive LTCI policy with a “pool of money” feature allows a consumer the most flexibility in getting LTC in the most appropriate and desirable setting covered by the policy. Inflexible payment options can result in a consumer being unable to use all benefits purchased, even if he or she meets the policy’s disability criteria. A home-care-only policy should be purchased only if applicants are fully aware that they could be exposed to the high cost of nursing home care and other types of care not covered in a home-care-only policy, and if they have substantial resources to pay for institutional services in the event they are needed.

Recommendation:

- *Expand funding for the federally funded State Health Insurance assistance Programs (SHIP) so that more consumers could take advantage of the information and counseling they provide.*

Many of the SHIPs can help people one-on-one to evaluate whether their income, assets, and other characteristics make them suitable purchasers for the product they are considering. In addition, these programs can help consumers understand what the policy covers and how the benefits work, without having a vested interest in making a sale.

Recommendation:

- *Require companies to offer a standardized option for paying family caregivers with appropriate monitoring.*

Many consumers prefer to receive services from family members who are able to provide this type of care. LTCI policies that offer this option are generally more expensive, and the NAIC regulations do not address this issue. Having a standardized benefit option would make it easier for consumers to compare whether it is worthwhile to purchase a policy that will allow them to pay family members.

Recommendation:

- *Revise the NAIC formula for contingent benefit on lapse to provide more protection to purchasers.*

The current CBL requires consumers to absorb substantial premium increases before a benefit is triggered (see Appendix C), particularly if they purchased their policy while young. The NAIC rate stability requirements should limit the number and amount of future increases, making it less likely those percentages will ever be reached. People who lapse before the approved percentage is reached get nothing in return for the premiums they paid.

Recommendation:

- *Revise HIPAA standards to parallel the national standards that will apply to new LTCI partnership policies, and require that existing partnership programs also conform to the new standards.*

The failure of state regulators and the NAIC to insist on more comprehensive standards for LTCI leaves an incomprehensible morass of differences for consumers to sort through when considering the purchase of a policy. Rather than stimulating innovation, this industry free-for-all creates paralysis for consumers and problems for regulators, and depresses sales. Now that Congress has approved new minimum standards for Partnership policies that can be offered in every state, there is an opportunity for the NAIC to build on those minimum standards, enhancing the quality of all products and moving closer to a common standard. However, accomplishing this goal will require willingness by both state regulators and the NAIC to make these changes to improve the product and the marketplace for consumers.

Recommendation:

- *Regularly update federal HIPAA standards to include the most recent provisions of the NAIC Model Act and Regulation.*

It is critical that both the insurance industry and state regulators make changes in their current practices to improve the marketplace for consumers. As LTCI continues to evolve and change, the regulatory environment needs to keep pace with these changes by developing appropriate standards.

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APPENDIX A

PAYING BENEFITS FOR CARE PROVIDED BY FAMILY MEMBERS:

DEFINITION OF EXCLUDED “RELATIVES”

The definition of a relative who cannot provide care for which an LTCI policy would pay is unusually specific and comprehensive in a Kanawha LTC policy from California, as the following example illustrates:

Relative means a member of Your family who is not a Licensed Health Care Practitioner including: You, Your spouse, Your son or daughter or a descendant of either; Your stepson or stepdaughter; Your brother, sister, stepbrother or stepsister; Your father or mother, or an ancestor of either; Your stepfather or stepmother; the son or daughter of Your brother or sister; the brother or sister of Your father or Mother; Your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law. The term Relative does not include a Licensed Health Care Practitioner.

Source: Kanawha Insurance Company LTC Policy Form #80650 1/97 CA

APPENDIX B

DEFINITION OF AN ELIMINATION PERIOD

The following language is from a G.E. Capital policy from Florida:

Elimination Period: The number of days that You must receive Covered Care before benefits are payable under those Benefits that are subject to the Elimination Period. The Schedule states:

- the number of days in the Elimination Period, and
- the Benefits to which the Elimination Period applies.

The Elimination Period can be satisfied by days for which payment would otherwise be made under those Benefits to which the Elimination Period applies. It can also be satisfied by days for which You receive payment under the Home Care Benefit in accordance with a Plan of Care developed by a Privileged Care Coordinator. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Elimination Period for this Policy.

Source: General Electric Capital Assurance Company, Policy Form Number FLH 03-01315

The following language is from CalPERS Evidence of Coverage:

Deductible Period (also called an **Elimination Period**) means the total number of consecutive number of calendar days that must elapse before the benefits covered by this **Agreement** are payable. The **Deductible Period** begins on the first day You receive covered **Formal Long Term Care Services** after You become a **Chronically Ill Individual** and have met the *Conditions for Receiving Benefits*. You are not required to continue to receive covered services to satisfy the **Deductible Period**, but You must continue to be a **Chronically Ill Individual** and to meet the *Conditions for Receiving Benefits* for the number of days shown on the **Schedule of Benefits** in order to satisfy the **Deductible Period**.

Source: CalPERS Comprehensive Plan, Evidence of Coverage PR-LTC-042003

APPENDIX C

NAIC CONTINGENT BENEFIT ON LAPSE

Age of person at time of LTCI purchase and cumulative amount of premium increase that triggers nonforfeiture benefit

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30–34	190%
35–39	170%
40–44	150%
45–49	130%
50–54	110%
55–59	90%
60	70%
65	50%
70	40%
75	30%
80	20%
85	15%
90 and over	10%

APPENDIX D

CONFLICTING REGULATORY MECHANISMS FOR LTCI

Listed below are the four major frameworks that states might use in regulating LTCI in addition to any state-specific requirements.

HIPAA

HIPAA established the first national floor of standardized requirements for LTCI policies. To be considered tax-qualified (and, therefore, have the potential to deduct a portion of premiums and receive tax-preferred status for benefits received), the benefit eligibility threshold must meet the HIPAA disability trigger. This trigger requires that the individual be disabled in two or more activities of daily living (ADLs), such as eating, bathing, or dressing, or have a cognitive impairment. The threshold for receiving benefits cannot be more generous than those allowed under HIPAA without losing the designation of a “tax-qualified” policy. Before HIPAA, it was not uncommon for LTCI policies to qualify an individual for coverage based on the somewhat loosely defined term “medical necessity,” generally an easier standard to achieve. In other areas of regulation, HIPAA did not preempt states from enacting stronger standards.

HIPAA incorporated numerous aspects of the 1993 NAIC Model Act and Regulation, including

- Prohibition of post-claims underwriting,
- Regulation of replacement policies,
- Guaranteed renewability,
- Specification of minimum benefit triggers, and
- Disclosure requirements.

These minimum standards have not been updated since HIPAA was enacted, although the NAIC has made several changes to its Model Law and Regulation in the interim, and some states have enacted additional changes. As a result, the only national standards used are now more than 10 years out of date.

NAIC Model Act and Regulation

Nearly half the states have adopted the 2000 NAIC Model Act and Regulation, which has updated numerous consumer protection standards not required by HIPAA. Most notable are the rate stability provisions, including the contingent benefit on lapse that is detailed in Appendix C. The NAIC continues to modify its recommendations in response to issues in the marketplace. There is no requirement that states adopt these recommendations. Therefore, a consumer who moves from one state to another may not realize that the consumer protections in effect in the state in which his or her policy was purchased may not be enforceable in another state.

The NAIC Interstate Compact

Each state has an elected or appointed chief insurance official who is responsible for a state agency that regulates insurance. Each state also has some requirements that insurance companies must meet for each LTCI product they sell in that state. Companies must comply with the unique requirements of a state before they can receive approval to sell an insurance product. Companies have found this process burdensome and have also complained that the approval process is unnecessarily lengthy and expensive.

Companies took their complaints to Congress, and in response to the threat of a takeover of insurance regulation by the federal government, the NAIC adopted an Interstate Insurance Product Regulation Compact. The NAIC is creating a separate organization that will apply a single, uniform set of filing requirements and processes for insurance products, including LTCI, that can be approved for sale in participating states. The product standards do not standardize benefits, definitions, terms, or conditions of an LTCI policy.

States that join the Compact will allow companies to sell LTCI policies that have been filed and approved under the product standards of the Compact. According to the NAIC Web site, 23 states have adopted the Compact as of April 2006, and legislation is pending in 14 other states. The Compact becomes binding on member states when 26 states have enacted the enabling legislation, or when states representing more than 40 percent of the premium volume have done so.

The Compact agreement sets up a commission with rulemaking authority similar to that of a state insurance department. The commission is the exclusive entity for approving products filed under the Compact agreement, and its decisions are binding on the states that join. Products approved as part of the Compact can then be sold in member states, bypassing the member state's standards as well as its filing and approval process.

Once a state has joined the Compact, it cannot apply its own state requirements to LTCI products approved through the Compact agreement. Insurance companies have the flexibility, however, to choose to file their LTCI product with the Compact, or they can choose to file it under a member state's own requirements. The commission can also allow a company to self-certify that it meets the Compact's product standards.

The commission will decide whether to accept or reject subsequent changes to the NAIC Model Act or to make any other changes to the product standards of the Compact states. Current Compact product standards for LTCI are very similar to the existing NAIC Model Act and include some standards that are currently under consideration for NAIC adoption, but the process for updating or making future changes to the Compact's product standards is at the discretion of the commission.

LTCI Partnership Standards

The passage of the Deficit Reduction Act of 2005 added an additional layer of complexity. This legislation included authority for any state to enact an LTCI partnership program in which purchasers may protect a certain level of assets, should they deplete their private insurance benefit and subsequently seek Medicaid. Any new partnership policies will have to meet a different set of minimum federal standards that goes beyond the HIPAA standards, but incorporates neither all provisions of the 2000 NAIC Model, nor all provisions of the Interstate Compact. Not only does the regulatory environment for new partnership policies differ from the HIPAA, NAIC, and Compact standards, new partnership programs will have different standards from those pertaining to the original four partnership states.