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315

Gordon Evans is
sick and will not
be here today.

Supports the

HESS CS SB 315

Alaska State Legislature

SENATOR PAUL FISCHER, Chairman
SENATOR JIM DUNCAN, Vice Chairman
SENATOR AL ADAMS
SENATOR LLOYD JONES
SENATOR TIM KELLY



P.O. BOX V
ROOM 508
STATE CAPITOL
(907) 465-3762

Senate Committee on Health, Education and Social Services

TO: MEMBERS OF THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE.

FROM: SENATOR PAUL FISCHER, CHAIRMAN

DATE: JANUARY 22, 1990

RE: SB 315 - LONG TERM CARE INSURANCE.

THIS BILL IS BASED UPON A MODEL ACT DEVELOPED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. IT ESSENTIALLY ALLOWS PROVIDERS TO DELIVER LONG TERM CARE INSURANCE IN THE STATE OF ALASKA. ~~CERTAIN REQUIREMENTS MUST BE MET~~ IN ORDER TO BE ALLOWED TO DO THIS.

TO DATE, 38 STATES HAVE DEVELOPED SIMILAR VERSIONS OF THIS MODEL ACT. SEVERAL OTHER STATES HAVE THIS UNDER CONSIDERATION.

ESSENTIALLY, THIS BILL PROVIDES A METHOD FOR OUR CITIZENRY TO MEET THE NEEDS OF AN AGING POPULATION. MEDICARE CURRENTLY PROVIDES ALMOST NO COVERAGE FOR LONG TERM CARE. MOST COVERAGE FOR LONG TERM CARE COMES OUT OF MEDICAID.

THIS BILL PROVIDES A PRIVATE SECTOR ALTERNATIVE FOR INDIVIDUALS IN NEED OF LONG TERM CARE. IT WOULD ALSO HELP REDUCE PRESSURES ON THE MEDICAID BUDGET.

A ZERO FISCAL NOTE IS ATTACHED.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

January 22, 1990

SUBJECT: Long-term disability insurance - SB 315
TO: Senator Paul Fischer
FROM: Michael F. Ford *M.F.*
Legislative Counsel

The following is a section by section analysis of SB 315:

Section 1 - Purpose section.

Section 2 - Adds a new chapter to Title 21, concerning long term disability insurance.

Sec. 21.53.010 - Prohibits the sale or delivery of a long-term disability insurance policy unless the policy complies with AS 21.53.

Sec. 21.53.020 - Establishes certain disclosure and performance standards that must be included in each long-term disability insurance policy.

Sec. 21.53.030 - Establishes requirements for exclusion of a preexisting condition from coverage in a long-term disability insurance policy.

Sec. 21.53.040 - Provides that a policy cannot condition eligibility on certain prior hospital or institutional care, and that a limitation or condition not prohibited must be clearly set out in the policy.

Sec. 21.53.050 - Establishes the right of a policyholder to return the policy and to receive a refund. Requires insurers to provide an outline of coverage to a prospective applicant and establishes certain items that must be included in the outline.

Sec. 21.53.060 - Prohibits long-term disability insurance being offered under a group policy issued in another state,

Senator Paul Fischer
Page 2
January 22, 1990

unless the state in which the policy is issued has substantially similar statutory or regulatory provisions.

Sec. 21.53.070 - Provides that an insurer may not issue a long-term group disability insurance policy to an association, unless the association meets the requirements of this section.

Sec. 21.53.080 - Definitions.

Section 3 - Delayed effective date for the prohibition on prior hospital or institutional care conditions.

Section 4 - Effective date.

MFF:lmb
L9/065

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907-465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M

February 14, 1990

SUBJECT: Long-term care disability insurance -
CSSB 315(HESS)

TO: Senator Paul Fischer

FROM: Michael F. Ford *M.F.*
Legislative Counsel

The following is a sectional analysis of CSSB 315(HESS):

Section 1 - Purpose section.

Section 2

Sec. 21.53.010 - Prohibits sale or marketing unless the insurance complies with the provision of this charter and other applicable provisions of law.

Sec. 21.53.020 - Provides disclosure and performance standards for long-term disability insurance.

Sec. 21.53.030 - Establishes criteria for excluding coverage as a result of a preexisting condition.

Sec. 21.53.040 - Prohibits conditioning eligibility on prior hospital or institutional care. Allows limitations or conditions on eligibility, if not prohibited and if clearly set out in a separate paragraph of the policy.

Sec. 21.53.050 - Provides that an insured has the right to return a policy within 30 days after delivery. Requires the insurer to deliver an outline of coverage to a prospective applicant. Establishes items that must be included in the outline of coverage.

Sec. 21.53.060 - Requires a policy summary be included with an individual life insurance policy, if the policy provides long-term care disability insurance benefits. Establishes

items that must be included in the summary. Requires a report of benefits paid, if the benefits are paid by acceleration of the policy death benefit. Establishes items that must be included in the report.

Sec. 21.53.070 - Provides that group long-term care disability insurance cannot be offered to a resident of this state, under a group policy in another state, unless the state in which the policy is offered has similar statutory or regulatory provisions.

Sec. 21.53.080 - Prohibits group long-term care disability insurance being offered to an association, unless the association meets the requirements of this section.

Sec. 21.53.090 - Requires the director of the division of insurance to adopt certain regulations.

Sec. 21.53.200 - Definitions.

Section 3 - Provides that AS 21.53 applies to fraternal benefit societies.

Section 4 - Provides that AS 21.53 applies to hospital or medical service corporations.

Section 5 - Effective date.

MFF:pl
WKP2/046

SB 315: An Act relating to long-term disability insurance; and providing for an effective date.

This bill establishes a specific regulatory framework for insurance contracts that provide for long-term care benefits. It establishes certain standardized contract provisions in order to require certain minimum benefits and to facilitate public understanding and comparison shopping.

Funding of long-term care is a critical issue throughout the nation that impacts all third-party and out-of-pocket payers of medical care for older persons. "Long-term care" is the term that pertains to a continuum of care that ranges from some assistance in the home to the extreme of 24-hour skilled care in a medical facility. Our average population is getting older and is living longer, thus, increasing the likelihood of more people requiring some form of long-term care. Medicare currently provides almost no coverage for long-term care. Medicaid provides the majority of the funding for long-term care nationwide and provides for nearly all of the funding for skilled nursing service care in Alaska. Most Americans are not financially prepared to meet the cost of long-term care in their later years. This results in those people spending down both assets and income in order to qualify for public assistance primarily through Medicaid.

The insurance industry has been slow to develop insurance products to cover this risk. The most important reason for this is the lack of reliable statistical data on which to base rates, coupled with the fact that correct projection of costs far into the future is required and is extremely difficult to accomplish. Although this attitude is changing, the general population has held the misperception that there is little or no need for such coverage, and also that, if long-term care is needed, Medicare would provide the necessary benefits.

Without mechanisms such as insurance products to prefund long-term care, publicly-funded care is expected to increase, perhaps to a point beyond that which public resources can readily bear. It is important to encourage the growth of insurance products to help finance long-term care needs. However, this needs to be done in a manner that provides appropriate elements of consumer protection.

SB 315 is based on the National Association of Insurance Commissioners (NAIC) Model Long-Term Care Act. The NAIC is encouraging the adoption of this model by the various states in lieu of federal intervention. Abuses have occurred in other states with a large senior population. These abuses have received Congressional scrutiny, with indications that the federal government should regulate long-term care if the states do not.

Since the introduction of SB 315, the NAIC has amended its model act. The department supports the legislation with inclusion of the NAIC amendments.

Proposed amendments:

1. The term "long-term disability insurance" should be changed to "long-term care disability insurance" whenever it appears in the bill. This will avoid confusion with long-term disability income replacement coverage.

AS is deleted
AS 21.53.030(e) (page 3) needs to be amended in order to clarify the sponsor's intent. Subsection (e) of this section exempts group long-term care contracts from limiting the preexisting condition definition and the waiting period for benefits to that prescribed in subsections (a) and (b). The NAIC model does not exempt group contracts from these provisions. It is not clear whether the intent of this Act is to prohibit any preexisting condition or waiting period provisions, or to allow all possible provisions with any kind of definition or any length waiting period.

3. The effective date clauses (page 8) need review. *Not needed* Section 3 allows for a one-year phase-in of the requirements found in AS 21.53.040. Amendment to the NAIC model eliminates this one-year phase-in provision. The model was amended because two-thirds of the states have previously adopted the model and insurers in the marketplace do not need this lead time in other jurisdictions as contracts have already been developed to comply with these requirements.

4. AS 21.53.050 (page 4) needs to be amended to include a 30-day right to return the contract for all types of contracts providing long-term care. We recommend wording used in the amended NAIC model.

5. AS 21.53.060 (page 6) needs to be amended to have this provision apply only to stationary groups as defined in AS 21.53.100(3)(D).

HIAA
6. AS 21.53.100 (page 6) needs to be amended to include a definition of the term "insurer" to include hospital or medical service corporations and fraternal benefit associations. Also, the term "policy" should be amended to include subscriber contracts issued by a hospital or medical service corporation.

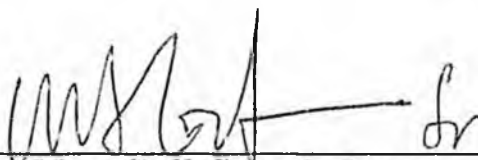
7. AS 21.87.340 needs to be amended to include a reference to AS 21.53.010-100. Otherwise, hospital or medical service corporations will not be subject to this Act.

8. AS 21.84.590 needs to be amended to include reference to AS 21.53.010-100. Otherwise, fraternal benefit associations will not be subject to this Act.

9. A new provision, perhaps AS 21.53.080, needs to be added to specifically authorize the director to adopt regulations to establish the format for the required disclosures, outlines of coverage, and for the establishment of loss ratio standards. The language for this authority is found in the NAIC model at Section 6-A and Section 6-E. Also, the NAIC model act contemplates a regulation to be promulgated following enactment of the model act.
10. A new provision, perhaps AS 21.53.055, needs to be added to reorganize long-term care benefits provided through life insurance contracts. We recommend the language used in the amended NAIC model act identified in Section 6-I and Section 6-J. Benefits can be provided via the nonforfeiture benefits or by accelerated death benefits. In other words, the amount of death benefit is reduced by any amounts utilized for long-term care benefits. Most often these types of benefits provided through life insurance contracts are provided for terminally ill people. This would also require that AS 21.53.010 be amended to provide for compliance with AS 21.45 and AS 21.18. AS 21.12.040 needs to be amended to recognize that life insurance contracts may be utilized to offer such benefits. ✓

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IJK

I have attached the sections of the Model Act referenced above for your consideration.



Larry Mercurieff, Commissioner
Date: 16 Jan 90

LM/LW/dgl6113D
11690b
Attachments

Dubin

FISCAL NOTE

REQUEST:

Revision Date: _____
Title : An Act relating to long-term disability insurance
Sponsor : HESS Committee
Requestor : Senate HESS Committee

Agency Affected : Commerce & Economic Dev. Insurance
BRU : _____
Components : Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by : Don Koch, Chief of Market Surveillance *DAC* Phone : 465-2577
Division : Insurance Date : 1-12-90
Approved by Commissioner : Larry Merculieff *LM* Date : 1/1/90
Agency : Department of Commerce and Economic Development

Distribution (by preparer) :
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to long-term disability insurance
Sponsor: HESS Committee
Requestor: Senate HESS Committee

Agency Affected: Commerce & Economic Dev. Insurance
BRU: _____
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
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EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by: Don Koch, Chief of Market Surveillance *[Signature]* Phone: 465-2577
Division: Insurance Date: 1-12-90
Approved by Commissioner: Larry Merculieff *[Signature]* Date: 1/11/90
Agency: Department of Commerce and Economic Development

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

page _____ of _____

*Adopted/Passed
out*

6-1217E
Ford
2/5/90

Original sponsor(s): HESS Committee

1 IN THE SENATE

BY THE HESS COMMITTEE

2 CS FOR SENATE BILL NO. 315 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to long-term care disability insur-
7 ance; and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE. The purpose of this Act is to promote the public
10 interest and the availability of long-term care disability insurance poli-
11 cies, to protect applicants for long-term care disability insurance from
12 unfair or deceptive sales or enrollment practices, to establish standards
13 for long-term care disability insurance, to facilitate public understanding
14 and comparison of long-term care disability insurance policies, and to
15 facilitate flexibility and innovation in the development of long-term care
16 disability insurance coverage.

17 * Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 53. LONG-TERM CARE DISABILITY INSURANCE.

19 Sec. 21.53.010. PROHIBITED SALE OR ADVERTISING. An insurer,
20 hospital or medical service corporation, or a fraternal benefit soci-
21 ety may not advertise, market, sell, deliver, or offer for delivery a
22 long-term care disability insurance policy unless the policy complies
23 with this chapter, AS 21.18, AS 21.45, the disability insurance re-
24 quirements imposed under AS 21.51, and, if a group policy, the group
25 disability insurance requirements imposed under AS 21.54.

26 Sec. 21.53.020. DISCLOSURE AND PERFORMANCE STANDARDS. An insur-
27 er, hospital or medical service corporation, or a fraternal benefit

1 (1) cancel, fail to renew, or otherwise terminate the
2 policy on the grounds of age or deterioration of the mental or phys-
3 ical health of the insured or certificate holder;

4 (2) include a provision requiring a new waiting period in
5 the event existing coverage is converted to or replaced by a new or
6 another form of disability insurance within the same company, unless
7 there is an increase in benefits voluntarily selected by the insured;
8 or

9 (3) provide coverage only for skilled nursing care, or
10 provide significantly more coverage for skilled care in a facility
11 than is provided for coverage for lower levels of care; evaluation of
12 the coverage provided under this paragraph must be based on the number
13 of days of coverage provided for lower levels of care, when compared
14 to the number of days of coverage provided for skilled care.

15 Sec. 21.53.030. PREEXISTING CONDITIONS. (a) An insurer, hospi-
16 tal or medical service corporation, or a fraternal benefit society
17 may not include, in a long-term care disability insurance policy or
18 certificate, a definition of "preexisting condition" that is more
19 restrictive than the following: preexisting condition means the
20 existence of symptoms that would cause an ordinarily prudent person to
21 seek diagnosis, care, or treatment, or a condition for which medical
22 advice or treatment was recommended by, or received from a provider of
23 health care services, within six months preceding the effective date
24 of coverage of an insured person.

25 (b) In a long-term care disability insurance policy or certifi-
26 cate an insurer, hospital or medical service corporation, or a frater-
27 nal benefit society may not exclude coverage for a loss or confinement
28 that is the result of a preex. ing condition, unless the loss or
29 confinement begins within six months following the effective date of

1 coverage of an insured person.

2 (c) The director may extend the limitation periods established
3 under (a) and (b) of this section for specific age group categories or
4 specific policy forms, if the director finds that the extension is in
5 the best interest of the public.

6 (d) This section does not prohibit an insurer, hospital or
7 medical service corporation, or a fraternal benefit society from using
8 an application form designed to elicit the complete health history of
9 an applicant, and, on the basis of the answers on the application,
10 from applying that insurer's, hospital or medical service corpora-
11 tion's, or fraternal benefit society's established underwriting stan-
12 dards. Unless otherwise provided in the policy or certificate, a
13 preexisting condition, regardless of whether it is disclosed on the
14 application, need not be covered until the waiting period described in
15 (b) of this section expires. A long-term care disability insurance
16 policy or certificate may not exclude, limit, or reduce, or use waiv-
17 ers or riders of any kind to exclude, limit, or reduce coverage or
18 benefits for specifically named or described preexisting diseases or
19 physical conditions after the waiting period described in (b) of this
20 section, unless the waiver or rider has been specifically approved by
21 the director.

22 Sec. 21.53.040. PRIOR HOSPITAL OR INSTITUTIONAL CARE CONDITIONS
23 PROHIBITED. (a) A long-term care disability insurance policy may not
24 be delivered or issued for delivery in this state if the policy condi-
25 tions eligibility

- 26 (1) on a prior hospitalization requirement;
27 (2) on the receipt of a higher level of institutional care,
28 when care is provided in an institutional setting;
29 (3) for noninstitutional benefits on a prior institutional

1 stay of more than 30 days for which benefits are paid; or

2 (4) on admission to an institutional care facility for the
3 same or a related condition within a period of less than 30 days after
4 discharge from the institution, if the policy provides benefits only
5 following institutionalization.

6 (b) A long-term care disability insurance policy may contain a
7 limitation or condition on eligibility for benefits, not prohibited in
8 (a) of this section, if the limitation or condition is clearly set out
9 in a separate paragraph of the policy or certificate.

10 Sec. 21.53.050. RIGHT OF RETURN; OUTLINE OF COVERAGE. (a) A
11 long-term care disability insurance applicant may return a policy
12 within 30 days after delivery and have the premium refunded if, after
13 examination of the policy, the applicant is not satisfied with the
14 policy. A long-term care disability insurance policy must have a
15 notice prominently printed on the first page of the policy or sepa-
16 rately attached stating that the applicant has the right to return the
17 policy within 30 days of its delivery and to have the premium refunded
18 if, after examination of the policy, the applicant is not satisfied
19 with the policy.

20 (b) An insurer, hospital or medical service corporation, or a
21 fraternal benefit society shall deliver an outline of coverage to a
22 prospective applicant for long-term care disability insurance at the
23 time of initial solicitation by a means that prominently directs the
24 attention of the recipient to the document and its purpose. In the
25 case of agent solicitations, an agent shall deliver the outline of
26 coverage before the presentation of an application or enrollment form.
27 In the case of direct response solicitations, the outline of coverage
28 must be presented in conjunction with an application or enrollment
29 form. The outline of coverage must include

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

3 (2) a statement of the principal exclusions, reductions,
4 and limitations contained in the policy;

5 (3) a statement of the terms under which the policy or
6 certificate, or both, may be continued in force or discontinued,
7 including a reservation in the policy of a right to change the pre-
8 mium; continuation or conversion provisions of group coverage must be
9 specifically described;

10 (4) a statement that the outline of coverage is a summary
11 only, not a contract of insurance, and that the policy or group master
12 policy contain governing contractual provisions;

13 (5) a description of the terms under which the policy or
14 certificate may be returned and premium refunded; and

15 (6) a brief description of the relationship between the
16 cost of care and benefits.

17 (c) A certificate issued under a group long-term care disability
18 insurance policy that is delivered or issued for delivery in this
19 state must include

20 (1) a description of the principal benefits and coverage
21 provided in the policy;

22 (2) a statement of the principal exclusions, reductions,
23 and limitations contained in the policy; and

24 (3) a statement that the group master policy establishes
25 the governing contractual provisions.

26 Sec. 21.53.060. GROUP LONG-TERM CARE BENEFITS UNDER LIFE INSUR-
27 ANCE POLICIES. (a) In addition to the requirements of AS 21.45, at
28 the time of policy delivery, a policy summary shall be included with
29 an individual life insurance policy if the policy or policy rider

1 provides long-term care disability benefits. In the case of direct
2 response solicitations, the insurer shall deliver the policy summary
3 upon the applicant's request, but regardless of request shall deliver
4 a policy summary not later than the time of policy delivery. The
5 summary must include

6 (1) an explanation of how the long-term care benefits
7 interact with other components of the policy, including deductions
8 from death benefits;

9 (2) an illustration of the amount and length of benefits,
10 and guaranteed lifetime benefits, if any, for each covered person;

11 (3) an explanation of each exclusion, reduction, and limi-
12 tation on long-term care disability benefits; and

13 (4) if applicable to the policy type,

14 (A) disclosure of the effects of exercising other
15 rights under the policy;

16 (B) disclosure of guarantees related to the long-term
17 care disability costs of insurance charges; and

18 (C) current and projected maximum lifetime benefits.

19 (b) If a long-term care disability benefit is paid under a life
20 insurance policy by the acceleration of the policy death benefit, and
21 is in benefit payment status, a monthly report shall be provided to
22 the policyholder. The report must include

23 (1) long-term care disability benefits paid out during the
24 month;

25 (2) an explanation of changes in the policy, including
26 changes in death benefits or cash values, due to long-term care dis-
27 ability benefits being paid out; and

28 (3) the amount of long-term care disability benefits re-
29 maining.

1 Sec. 21.53.070. GROUP LONG-TERM CARE DISABILITY INSURANCE.
2 Group long-term care disability insurance coverage may not be offered
3 to a resident of this state under a group policy issued in another
4 state, unless the state in which the policy is issued has statutory or
5 regulatory provisions applicable to group long-term care disability
6 insurance that are substantially similar to this chapter and the
7 director determines that the issuance of the group policy is not
8 contrary to the best interest of the public, results in economies of
9 acquisition or administration, and the benefits are reasonable in
10 relation to the premiums charged.

11 Sec. 21.53.080. ORGANIZATIONAL REQUIREMENTS OF ASSOCIATIONS. An
12 insurer, hospital or medical service corporation, or a fraternal
13 benefit society may not issue group long-term care disability insur-
14 ance to an association or a trust or the trustee of a fund estab-
15 lished, created, or maintained for the benefit of members of one or
16 more associations, unless the association or the insurer of the asso-
17 ciation files evidence with the director that the association has

- 18 (1) a minimum of 100 members;
- 19 (2) been organized and maintained in good faith for pur-
20 poses other than that of obtaining insurance;
- 21 (3) been in active existence for at least one year; and
- 22 (4) a constitution and by-laws that require
- 23 (A) the association to hold regular meetings not less
24 than annually to further purposes of the members;
- 25 (B) except for credit unions, the association to
26 collect dues or solicit contributions from members; and
- 27 (C) the members to have voting privileges and repre-
28 sentation on the governing board and committees.

29 Sec. 21.53.090. REQUIRED REGULATIONS. The director shall adopt

1 regulations regarding the sale of long-term care disability insurance
2 that provide standards for

- 3 (1) terms of renewability;
- 4 (2) initial and subsequent conditions of eligibility;
- 5 (3) nonduplication of coverage provisions;
- 6 (4) coverage of dependents;
- 7 (5) preexisting conditions;
- 8 (6) termination of insurance;
- 9 (7) continuation or conversion;
- 10 (8) probationary periods, limitations, exceptions, reduc-
11 tions, elimination periods, and requirements for replacement.

12 Sec. 21.53.200. DEFINITIONS. In this chapter,

13 (1) "applicant" means in the case of an individual long-
14 term care disability insurance policy, the person who seeks to con-
15 tract for benefits, and in the case of a group long-term care disabili-
16 ty insurance policy, the proposed certificate holder;

17 (2) "certificate" means a certificate issued under a group
18 long-term care disability insurance policy that has been delivered or
19 issued for delivery in this state;

20 (3) "group long-term care disability insurance" means a
21 long-term care disability insurance policy, subscriber's contract, or
22 fraternal benefit society certificate that is delivered or issued for
23 delivery in this state and issued to

24 (A) one or more employers or labor organizations, or
25 to a trust or to the trustees of a fund established by one or
26 more employers or labor organizations, or a combination of them,
27 for employees or former employees or a combination of them, or
28 for members or former members or a combination of them, of the
29 labor organization;

1 (B) a professional, trade, or occupational association
2 for its members or former or retired members, or combination of
3 them, if the association is composed of individuals all of whom
4 are or were actively engaged in the same profession, trade, or
5 occupation, and has been maintained in good faith for purposes
6 other than obtaining insurance;

7 (C) an association or a trust or the trustee of a fund
8 established, created, or maintained for the benefit of members of
9 one or more associations;

10 (D) a group other than described in this paragraph if
11 the director determines that the issuance of the group policy is
12 not contrary to the best interest of the public, would result in
13 economies of acquisition or administration, and the benefits are
14 reasonable in relation to the premiums charged;

15 (4) "long-term care disability insurance" means an indi-
16 vidual or group insurance policy, including group and individual life
17 insurance or annuities, a subscriber's contract, fraternal benefit
18 society certificate, or rider advertised, marketed, offered, or de-
19 signed to provide coverage for not less than 12 consecutive months for
20 each covered person on an expense incurred, indemnity, prepaid, or
21 other basis, for one or more necessary or medically necessary diagnos-
22 tic, preventive, therapeutic, rehabilitative, maintenance, or personal
23 care services that are provided in a setting other than an acute care
24 unit of a hospital, and includes a policy or rider that provides for
25 payment of benefits based on cognitive impairment or loss of func-
26 tional capacity; "long-term care disability insurance" does not in-
27 clude an insurance policy, subscriber's contract, or fraternal benefit
28 society certificate that is offered primarily to provide basic Medi-
29 care supplement coverage, basic hospital expense coverage, basic

1 medical-surgical expense coverage, hospital confinement indemnity
2 coverage, major medical expense coverage, disability income and relat-
3 ed asset protection coverage, catastrophic coverage, comprehensive
4 coverage, accident only coverage, specified disease or specified
5 accident coverage, or limited benefit health coverage;

6 (5) "policy" means a contract, subscriber agreement, rider,
7 or endorsement delivered or issued for delivery in this state by an
8 insurer, fraternal benefit society, nonprofit health, hospital or
9 medical service corporation, prepaid health plan, or health mainte-
10 nance organization.

11 * Sec. 3. AS 21.84.590 is amended to read:

12 Sec. 21.84.590. OTHER PROVISIONS APPLICABLE. In addition to the
13 provisions contained in this chapter, the following provisions of this
14 title apply to fraternal benefit societies to the extent applicable
15 and not in conflict with the express provisions of this chapter and
16 the reasonable implications of this chapter:

- 17 (1) AS 21.03
18 (2) AS 21.06
19 (3) AS 21.09.050 and 21.09.100
20 (4) AS 21.33
21 (5) AS 21.36
22 (6) AS 21.42.290 and 21.42.355
23 (7) AS 21.53
24 (8) AS 21.69.370 and 21.69.640
25 (9) [(8)] AS 21.78
26 (10) [(9)] AS 21.89.060.

27 * Sec. 4. AS 21.87.340 is amended to read:

28 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
29 provisions contained or referred to previously in this chapter, the

1 following chapters and provisions of this title also apply with re-
2 spect to service corporations to the extent applicable and not in
3 conflict with the express provisions of this chapter and the reason-
4 able implications of the express provisions, and for the purposes of
5 the application the corporations shall be considered to be mutual
6 "insurers":

- 7 (1) AS 21.03
8 (2) AS 21.06
9 (3) AS 21.09, except AS 21.09.090
10 (4) AS 21.18.010
11 (5) AS 21.18.030
12 (6) AS 21.18.040
13 (7) AS 21.18.120
14 (8) AS 21.21.321
15 (9) AS 21.36
16 (10) AS 21.53
17 (11) AS 21.69.400
18 (12) [(11)] AS 21.69.520
19 (13) [(12)] AS 21.69.600, 21.69.620, and 21.69.630
20 (14) [(13)] AS 21.78
21 (15) [(14)] AS 21.90
22 (16) [(15)] AS 21.42.345 - 21.42.365
23 (17) [(16)] AS 21.89.040
24 (18) [(17)] AS 21.89.060.

25 * Sec. 5. This Act takes effect July 1, 1990.
26
27
28
29

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2

SENATE BILL NO. 315

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

SIXTEENTH LEGISLATURE - FIRST SESSION

5

A BILL

6 For an Act entitled: "An Act relating to long-term disability insurance;
7 and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE. The purpose of this Act is to promote the public
10 interest and the availability of long-term disability insurance policies,
11 to protect applicants for long-term disability insurance from unfair or
12 deceptive sales or enrollment practices, to establish standards for long-
13 term disability insurance, to facilitate public understanding and compari-
14 son of long-term disability insurance policies, and to facilitate flexibil-
15 ity and innovation in the development of long-term disability insurance
16 coverage.

17 * Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 53. LONG-TERM DISABILITY INSURANCE.

19 Sec. 21.53.010. PROHIBITED SALE OR ADVERTISING. An insurer may
20 not advertise, market, sell, deliver, or offer for delivery a long-
21 term disability insurance policy unless the policy complies with this
22 chapter as well as the disability insurance requirements imposed under
23 AS 21.51, and, if a group policy, the group disability insurance
24 requirements imposed under AS 21.54.

25 Sec. 21.53.020. DISCLOSURE AND PERFORMANCE STANDARDS. An insur-
26 er who delivers or issues for delivery a long-term disability insur-
27 ance policy may not

28 (1) cancel, fail to renew, or otherwise terminate the
29 policy on the grounds of age or deterioration of the mental or

1 physical health of the insured or certificate holder;

2 (2) include a provision requiring a new waiting period in
3 the event existing coverage is converted to or replaced by a new or
4 another form of disability insurance within the same company, unless
5 there is an increase in benefits voluntarily selected by the insured;
6 or

7 (3) provide coverage only for skilled nursing care, or
8 provide significantly more coverage for skilled care in a facility
9 than is provided for coverage for lower levels of care; evaluation of
10 the coverage provided under this paragraph must be based on the number
11 of days of coverage provided for lower levels of care, when compared
12 to the number of days of coverage provided for skilled care.

13 Sec. 21.53.030. PREEXISTING CONDITIONS. (a) An insurer may not
14 include, in a long-term disability insurance policy or certificate, a
15 definition of "preexisting condition" that is more restrictive than
16 the following: preexisting condition means the existence of symptoms
17 that would cause an ordinarily prudent person to seek diagnosis, care,
18 or treatment, or a condition for which medical advice or treatment was
19 recommended by, or received from a provider of health care services,
20 within six months preceding the effective date of coverage of an
21 insured person.

22 (b) In a long-term disability insurance policy or certificate an
23 insurer may not exclude coverage for a loss or confinement that is the
24 result of a preexisting condition, unless the loss or confinement
25 begins within six months following the effective date of coverage of
26 an insured person.

27 (c) The director may extend the limitation periods established
28 under (a) and (b) of this section for specific age group categories or
29 specific policy forms, if the director finds that the extension is in

1 the best interest of the public.

2 (d) This section does not prohibit an insurer from using an
3 application form designed to elicit the complete health history of an
4 applicant, and, on the basis of the answers on the application, from
5 applying that insurer's established underwriting standards. Unless
6 otherwise provided in the policy or certificate, a preexisting condi-
7 tion, regardless of whether it is disclosed on the application, need
8 not be covered until the waiting period described in (b) of this
9 section expires. A long-term disability insurance policy or certifi-
10 cate may not exclude, limit, or reduce, or use waivers or riders of
11 any kind to exclude, limit, or reduce coverage or benefits for specif-
12 ically named or described preexisting diseases or physical conditions
13 after the waiting period described in (b) of this section, unless the
14 waiver or rider has been specifically approved by the director.

15 (e) Subsections (a) and (b) of this section do not apply to
16 group long-term disability insurance.

17 Sec. 21.53.040. PRIOR HOSPITAL OR INSTITUTIONAL CARE CONDITIONS
18 PROHIBITED. (a) A long-term disability insurance policy may not be
19 delivered or issued for delivery in this state if the policy condi-
20 tions eligibility

21 (1) on a prior hospitalization requirement;

22 (2) on the receipt of a higher level of institutional care,
23 when care is provided in an institutional setting;

24 (3) for noninstitutional benefits on a prior institutional
25 stay of more than 30 days for which benefits are paid; or

26 (4) on admission to an institutional care facility for the
27 same or a related condition within a period of less than 30 days after
28 discharge from the institution, if the policy provides benefits only
29 following institutionalization.

1 (b) A long-term disability insurance policy may contain a limi-
2 tation or condition on eligibility for benefits, not prohibited in (a)
3 of this section, if the limitation or condition is clearly set out in
4 a separate paragraph of the policy or certificate.

5 Sec. 21.53.050. RIGHT OF RETURN; OUTLINE OF COVERAGE. (a)
6 Individual long-term disability insurance policyholders may return a
7 policy within 10 days after delivery and have the premium refunded if,
8 after examination of the policy, the policy holder is not satisfied
9 with the policy. An individual long-term disability insurance policy
10 must have a notice prominently printed on the first page of the policy
11 or separately attached stating that the policyholder has the right to
12 return the policy within 10 days of its delivery and to have the
13 premium refunded if, after examination of the policy, the policyholder
14 is not satisfied with the policy.

15 (b) A person insured under a long-term disability insurance
16 policy issued under a direct response solicitation has the right to
17 return the policy within 30 days of its delivery and to have the
18 premium refunded if, after examination, the insured person is not
19 satisfied with the policy. Long-term disability insurance policies
20 issued under a direct response solicitation must have a notice promi-
21 nently printed on the first page or attached to the policy stating in
22 substance that the insured person has the right to return the policy
23 within 30 days of its delivery and to have the premium refunded if
24 after examination the insured person is not satisfied with the policy.

25 (c) An insurer shall deliver an outline of coverage to a pro-
26 spective applicant for long-term disability insurance at the time of
27 initial solicitation by a means that prominently directs the attention
28 of the recipient to the document and its purpose. In the case of
29 agent solicitations, an agent shall deliver the outline of coverage

1 before the presentation of an application or enrollment form. In the
2 case of direct response solicitations, the outline of coverage must be
3 presented in conjunction with an application or enrollment form. The
4 outline of coverage must include

5 (1) a description of the principal benefits and coverage
6 provided in the policy;

7 (2) a statement of the principal exclusions, reductions,
8 and limitations contained in the policy;

9 (3) a statement of the terms under which the policy or
10 certificate, or both, may be continued in force or discontinued,
11 including a reservation in the policy of a right to change the pre-
12 mium; continuation or conversion provisions of group coverage must be
13 specifically described;

14 (4) a statement that the outline of coverage is a summary
15 only, not a contract of insurance, and that the policy or group master
16 policy contain governing contractual provisions;

17 (5) a description of the terms under which the policy or
18 certificate may be returned and premium refunded; and

19 (6) a brief description of the relationship between the
20 cost of care and benefits.

21 (d) A certificate issued under a group long-term disability
22 insurance policy that is delivered or issued for delivery in this
23 state must include

24 (1) a description of the principal benefits and coverage
25 provided in the policy;

26 (2) a statement of the principal exclusions, reductions,
27 and limitations contained in the policy; and

28 (3) a statement that the group master policy establishes
29 the governing contractual provisions.

1 Sec. 21.53.060. GROUP LONG-TERM DISABILITY INSURANCE. Group
2 long-term disability insurance coverage may not be offered to a resi-
3 dent of this state under a group policy issued in another state,
4 unless the state in which the policy is issued has statutory or regu-
5 latory provisions applicable to group long-term disability insurance
6 that are substantially similar to this chapter.

7 Sec. 21.53.070. ORGANIZATIONAL REQUIREMENTS OF ASSOCIATIONS. An
8 insurer may not issue group long-term disability insurance to an
9 association or a trust or the trustee of a fund established, created,
10 or maintained for the benefit of members of one or more associations,
11 unless the association or the insurer of the association files evi-
12 dence with the director that the association has

13 (1) a minimum of 100 members;

14 (2) been organized and maintained in good faith for pur-
15 poses other than that of obtaining insurance;

16 (3) been in active existence for at least one year; and

17 (4) a constitution and by-laws that require

18 (A) the association to hold regular meetings not less
19 than annually to further purposes of the members;

20 (B) except for credit unions, the association to
21 collect dues or solicit contributions from members; and

22 (C) the members to have voting privileges and repre-
23 sentation on the governing board and committees.

24 Sec. 21.53.100. DEFINITIONS. In this chapter,

25 (1) "applicant" means in the case of an individual long-
26 term disability insurance policy, the person who seeks to contract for
27 benefits, and in the case of a group long-term disability insurance
28 policy, the proposed certificate holder;

29 (2) "certificate" means a certificate issued under a group

1 long-term disability insurance policy that has been delivered or
2 issued for delivery in this state;

3 (3) "group long-term disability insurance" means a long-
4 term disability insurance policy that is delivered or issued for
5 delivery in this state and issued to

6 (A) one or more employers or labor organizations, or
7 to a trust or to the trustees of a fund established by one or
8 more employers or labor organizations, or a combination of them,
9 for employees or former employees or a combination of them, or
10 for members or former members or a combination of them, of the
11 labor organization;

12 (B) a professional, trade, or occupational association
13 for its members or former or retired members, or combination of
14 them, if the association is composed of individuals all of whom
15 are or were actively engaged in the same profession, trade, or
16 occupation, and has been maintained in good faith for purposes
17 other than obtaining insurance;

18 (C) an association or a trust or the trustee of a fund
19 established, created, or maintained for the benefit of members of
20 one or more associations;

21 (D) a group other than described in this paragraph if
22 the director determines that the issuance of the group policy is
23 not contrary to the best interest of the public, would result in
24 economies of acquisition or administration, and the benefits are
25 reasonable in relation to the premiums charged;

26 (4) "long-term disability insurance" means an individual or
27 group insurance policy or rider advertised, marketed, offered, or
28 designed to provide coverage for not less than 12 consecutive months
29 for each covered person on an expense incurred, indemnity, prepaid, or

1 other basis, for one or more necessary or medically necessary
2 diagnostic, preventive, therapeutic, rehabilitative, maintenance, or
3 personal care services that are provided in a setting other than an
4 acute care unit of a hospital; "long-term disability insurance" does
5 not include an insurance policy that is offered primarily to provide:
6 basic Medicare supplement coverage, basic hospital expense coverage,
7 basic medical-surgical expense coverage, hospital confinement indem-
8 nity coverage, major medical expense coverage, disability income
9 protection coverage, catastrophic coverage, comprehensive coverage,
10 accident only coverage, specified disease or specified accident cover-
11 age, or limited benefit health coverage.

12 * Sec. 3. AS 21.53.040, enacted in sec. 2 of this Act, takes effect
13 July 1, 1990.

14 * Sec. 4. Except for AS 21.53.040, enacted in sec. 2 of this Act, this
15 Act takes effect July 1, 1989.

Original sponsor(s): HESS Committee

1 IN THE SENATE

BY THE HESS COMMITTEE

2 CS FOR SENATE BILL NO. 315 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to long-term care disability insur-
7 ance; and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE. The purpose of this Act is to promote the public
10 interest and the availability of long-term care disability insurance poli-
11 cies, to protect applicants for long-term care disability insurance from
12 unfair or deceptive sales or enrollment practices, to establish standards
13 for long-term care disability insurance, to facilitate public understanding
14 and comparison of long-term care disability insurance policies, and to
15 facilitate flexibility and innovation in the development of long-term care
16 disability insurance coverage.

17 * Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 53. LONG-TERM CARE DISABILITY INSURANCE.

19 Sec. 21.53.010. PROHIBITED SALE OR ADVERTISING. An insurer,
20 hospital or medical service corporation, or a fraternal benefit soci-
21 ety may not advertise, market, sell, deliver, or offer for delivery a
22 long-term care disability insurance policy unless the policy complies
23 with this chapter, AS 21.18, AS 21.45, the disability insurance re-
24 quirements imposed under AS 21.51, and, if a group policy, the group
25 disability insurance requirements imposed under AS 21.54.

26 Sec. 21.53.020. DISCLOSURE AND PERFORMANCE STANDARDS. An insur-
27 er, hospital or medical service corporation, or a fraternal benefit
28 society that delivers or issues for delivery a long-term care disabil-
29 ity insurance policy may not

1 (1) cancel, fail to renew, or otherwise terminate the
2 policy on the grounds of age or deterioration of the mental or phys-
3 ical health of the insured or certificate holder;

4 (2) include a provision requiring a new waiting period in
5 the event existing coverage is converted to or replaced by a new or
6 another form of disability insurance within the same company, unless
7 there is an increase in benefits voluntarily selected by the insured;
8 or

9 (3) provide coverage only for skilled nursing care, or
10 provide significantly more coverage for skilled care in a facility
11 than is provided for coverage for lower levels of care; evaluation of
12 the coverage provided under this paragraph must be based on the number
13 of days of coverage provided for lower levels of care, when compared
14 to the number of days of coverage provided for skilled care.

15 Sec. 21.53.030. PREEXISTING CONDITIONS. (a) An insurer, hospi-
16 tal or medical service corporation, or a fraternal benefit society
17 may not include, in a long-term care disability insurance policy or
18 certificate, a definition of "preexisting condition" that is more
19 restrictive than the following: preexisting condition means the
20 existence of symptoms that would cause an ordinarily prudent person to
21 seek diagnosis, care, or treatment, or a condition for which medical
22 advice or treatment was recommended by, or received from a provider of
23 health care services, within six months preceding the effective date
24 of coverage of an insured person.

25 (b) In a long-term care disability insurance policy or certifi-
26 cate an insurer, hospital or medical service corporation, or a frater-
27 nal benefit society may not exclude coverage for a loss or confinement
28 that is the result of a preexisting condition, unless the loss or
29 confinement begins within six months following the effective date of

1 coverage of an insured person.

2 (c) The director may extend the limitation periods established
3 under (a) and (b) of this section for specific age group categories or
4 specific policy forms, if the director finds that the extension is in
5 the best interest of the public.

6 (d) This section does not prohibit an insurer, hospital or
7 medical service corporation, or a fraternal benefit society from using
8 an application form designed to elicit the complete health history of
9 an applicant, and, on the basis of the answers on the application,
10 from applying that insurer's, hospital or medical service corpora-
11 tion's, or fraternal benefit society's established underwriting stan-
12 dards. Unless otherwise provided in the policy or certificate, a
13 preexisting condition, regardless of whether it is disclosed on the
14 application, need not be covered until the waiting period described in
15 (b) of this section expires. A long-term care disability insurance
16 policy or certificate may not exclude, limit, or reduce, or use waiv-
17 ers or riders of any kind to exclude, limit, or reduce coverage or
18 benefits for specifically named or described preexisting diseases or
19 physical conditions after the waiting period described in (b) of this
20 section, unless the waiver or rider has been specifically approved by
21 the director.

22 Sec. 21.53.040. PRIOR HOSPITAL OR INSTITUTIONAL CARE CONDITIONS
23 PROHIBITED. (a) A long-term care disability insurance policy may not
24 be delivered or issued for delivery in this state if the policy condi-
25 tions eligibility

- 26 (1) on a prior hospitalization requirement;
27 (2) on the receipt of a higher level of institutional care,
28 when care is provided in an institutional setting;
29 (3) for noninstitutional benefits on a prior institutional

1 stay of more than 30 days for which benefits are paid; or

2 (4) on admission to an institutional care facility for the
3 same or a related condition within a period of less than 30 days after
4 discharge from the institution, if the policy provides benefits only
5 following institutionalization.

6 (b) A long-term care disability insurance policy may contain a
7 limitation or condition on eligibility for benefits, not prohibited in
8 (a) of this section, if the limitation or condition is clearly set out
9 in a separate paragraph of the policy or certificate.

10 Sec. 21.53.050. RIGHT OF RETURN; OUTLINE OF COVERAGE. (a) A
11 long-term care disability insurance applicant may return a policy
12 within 30 days after delivery and have the premium refunded if, after
13 examination of the policy, the applicant is not satisfied with the
14 policy. A long-term care disability insurance policy must have a
15 notice prominently printed on the first page of the policy or sepa-
16 rately attached stating that the applicant has the right to return the
17 policy within 30 days of its delivery and to have the premium refunded
18 if, after examination of the policy, the applicant is not satisfied
19 with the policy.

20 (b) An insurer, hospital or medical service corporation, or a
21 fraternal benefit society shall deliver an outline of coverage to a
22 prospective applicant for long-term care disability insurance at the
23 time of initial solicitation by a means that prominently directs the
24 attention of the recipient to the document and its purpose. In the
25 case of agent solicitations, an agent shall deliver the outline of
26 coverage before the presentation of an application or enrollment form.
27 In the case of direct response solicitations, the outline of coverage
28 must be presented in conjunction with an application or enrollment
29 form. The outline of coverage must include

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

3 (2) a statement of the principal exclusions, reductions,
4 and limitations contained in the policy;

5 (3) a statement of the terms under which the policy or
6 certificate, or both, may be continued in force or discontinued,
7 including a reservation in the policy of a right to change the pre-
8 mium; continuation or conversion provisions of group coverage must be
9 specifically described;

10 (4) a statement that the outline of coverage is a summary
11 only, not a contract of insurance, and that the policy or group master
12 policy contain governing contractual provisions;

13 (5) a description of the terms under which the policy or
14 certificate may be returned and premium refunded; and

15 (6) a brief description of the relationship between the
16 cost of care and benefits.

17 (c) A certificate issued under a group long-term care disability
18 insurance policy that is delivered or issued for delivery in this
19 state must include

20 (1) a description of the principal benefits and coverage
21 provided in the policy;

22 (2) a statement of the principal exclusions, reductions,
23 and limitations contained in the policy; and

24 (3) a statement that the group master policy establishes
25 the governing contractual provisions.

26 Sec. 21.53.060. GROUP LONG-TERM CARE BENEFITS UNDER LIFE INSUR-
27 ANCE POLICIES. (a) In addition to the requirements of AS 21.45, at
28 the time of policy delivery, a policy summary shall be included with
29 an individual life insurance policy if the policy or policy rider

1 provides long-term care disability benefits. In the case of direct
2 response solicitations, the insurer shall deliver the policy summary
3 upon the applicant's request, but regardless of request shall deliver
4 a policy summary not later than the time of policy delivery. The
5 summary must include

6 (1) an explanation of how the long-term care benefits
7 interact with other components of the policy, including deductions
8 from death benefits;

9 (2) an illustration of the amount and length of benefits,
10 and guaranteed lifetime benefits, if any, for each covered person;

11 (3) an explanation of each exclusion, reduction, and limi-
12 tation on long-term care disability benefits; and

13 (4) if applicable to the policy type,

14 (A) disclosure of the effects of exercising other
15 rights under the policy;

16 (B) disclosure of guarantees related to the long-term
17 care disability costs of insurance charges; and

18 (C) current and projected maximum lifetime benefits.

19 (b) If a long-term care disability benefit is paid under a life
20 insurance policy by the acceleration of the policy death benefit, and
21 is in benefit payment status, a monthly report shall be provided to
22 the policyholder. The report must include

23 (1) long-term care disability benefits paid out during the
24 month;

25 (2) an explanation of changes in the policy, including
26 changes in death benefits or cash values, due to long-term care dis-
27 ability benefits being paid out; and

28 (3) the amount of long-term care disability benefits re-
29 maining.

1 Sec. 21.53.070. GROUP LONG-TERM CARE DISABILITY INSURANCE.
2 Group long-term care disability insurance coverage may not be offered
3 to a resident of this state under a group policy issued in another
4 state, unless the state in which the policy is issued has statutory or
5 regulatory provisions applicable to group long-term care disability
6 insurance that are substantially similar to this chapter and the
7 director determines that the issuance of the group policy is not
8 contrary to the best interest of the public, results in economies of
9 acquisition or administration, and the benefits are reasonable in
10 relation to the premiums charged.

11 Sec. 21.53.080. ORGANIZATIONAL REQUIREMENTS OF ASSOCIATIONS. An
12 insurer, hospital or medical service corporation, or a fraternal
13 benefit society may not issue group long-term care disability insur-
14 ance to an association or a trust or the trustee of a fund estab-
15 lished, created, or maintained for the benefit of members of one or
16 more associations, unless the association or the insurer of the asso-
17 ciation files evidence with the director that the association has

- 18 (1) a minimum of 100 members;
- 19 (2) been organized and maintained in good faith for pur-
20 poses other than that of obtaining insurance;
- 21 (3) been in active existence for at least one year; and
- 22 (4) a constitution and by-laws that require
- 23 (A) the association to hold regular meetings not less
24 than annually to further purposes of the members;
- 25 (B) except for credit unions, the association to
26 collect dues or solicit contributions from members; and
- 27 (C) the members to have voting privileges and repre-
28 sentation on the governing board and committees.

29 Sec. 21.53.090. REQUIRED REGULATIONS. The director shall adopt

1 regulations regarding the sale of long-term care disability insurance
2 that provide standards for

- 3 (1) terms of renewability;
4 (2) initial and subsequent conditions of eligibility;
5 (3) nonduplication of coverage provisions;
6 (4) coverage of dependents;
7 (5) preexisting conditions;
8 (6) termination of insurance;
9 (7) continuation or conversion;
10 (8) probationary periods, limitations, exceptions, reduc-
11 tions, elimination periods, and requirements for replacement.

12 Sec. 21.53.200. DEFINITIONS. In this chapter,

13 (1) "applicant" means in the case of an individual long-
14 term care disability insurance policy, the person who seeks to con-
15 tract for benefits, and in the case of a group long-term care disabil-
16 ity insurance policy, the proposed certificate holder;

17 (2) "certificate" means a certificate issued under a group
18 long-term care disability insurance policy that has been delivered or
19 issued for delivery in this state;

20 (3) "group long-term care disability insurance" means a
21 long-term care disability insurance policy, subscriber's contract, or
22 fraternal benefit society certificate that is delivered or issued for
23 delivery in this state and issued to

24 (A) one or more employers or labor organizations, or
25 to a trust or to the trustees of a fund established by one or
26 more employers or labor organizations, or a combination of them,
27 for employees or former employees or a combination of them, or
28 for members or former members or a combination of them, of the
29 labor organization;

1 (B) a professional, trade, or occupational association
2 for its members or former or retired members, or combination of
3 them, if the association is composed of individuals all of whom
4 are or were actively engaged in the same profession, trade, or
5 occupation, and has been maintained in good faith for purposes
6 other than obtaining insurance;

7 (C) an association or a trust or the trustee of a fund
8 established, created, or maintained for the benefit of members of
9 one or more associations;

10 (D) a group other than described in this paragraph if
11 the director determines that the issuance of the group policy is
12 not contrary to the best interest of the public, would result in
13 economies of acquisition or administration, and the benefits are
14 reasonable in relation to the premiums charged;

15 (4) "long-term care disability insurance" means an indi-
16 vidual or group insurance policy, including group and individual life
17 insurance or annuities, a subscriber's contract, fraternal benefit
18 society certificate, or rider advertised, marketed, offered, or de-
19 signed to provide coverage for not less than 12 consecutive months for
20 each covered person on an expense incurred, indemnity, prepaid, or
21 other basis, for one or more necessary or medically necessary diagnos-
22 tic, preventive, therapeutic, rehabilitative, maintenance, or personal
23 care services that are provided in a setting other than an acute care
24 unit of a hospital, and includes a policy or rider that provides for
25 payment of benefits based on cognitive impairment or loss of func-
26 tional capacity; "long-term care disability insurance" does not in-
27 clude an insurance policy, subscriber's contract, or fraternal benefit
28 society certificate that is offered primarily to provide basic Medi-
29 care supplement coverage, basic hospital expense coverage, basic

1 medical-surgical expense coverage, hospital confinement indemnity
2 coverage, major medical expense coverage, disability income and relat-
3 ed asset protection coverage, catastrophic coverage, comprehensive
4 coverage, accident only coverage, specified disease or specified
5 accident coverage, or limited benefit health coverage;

6 (5) "policy" means a contract, subscriber agreement, rider,
7 or endorsement delivered or issued for delivery in this state by an
8 insurer, fraternal benefit society, nonprofit health, hospital or
9 medical service corporation, prepaid health plan, or health mainte-
10 nance organization.

11 * Sec. 3. AS 21.84.590 is amended to read:

12 Sec. 21.84.590. OTHER PROVISIONS APPLICABLE. In addition to the
13 provisions contained in this chapter, the following provisions of this
14 title apply to fraternal benefit societies to the extent applicable
15 and not in conflict with the express provisions of this chapter and
16 the reasonable implications of this chapter:

- 17 (1) AS 21.03
18 (2) AS 21.06
19 (3) AS 21.09.050 and 21.09.100
20 (4) AS 21.33
21 (5) AS 21.36
22 (6) AS 21.42.290 and 21.42.355
23 (7) AS 21.53
24 (8) AS 21.69.370 and 21.69.640
25 (9) [(8)] AS 21.78
26 (10) [(9)] AS 21.89.060.

27 * Sec. 4. AS 21.87.340 is amended to read:

28 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
29 provisions contained or referred to previously in this chapter, the

1 following chapters and provisions of this title also apply with re-
2 spect to service corporations to the extent applicable and not in
3 conflict with the express provisions of this chapter and the reason-
4 able implications of the express provisions, and for the purposes of
5 the application the corporations shall be considered to be mutual
6 "insurers":

- 7 (1) AS 21.03
8 (2) AS 21.06
9 (3) AS 21.09, except AS 21.09.090
10 (4) AS 21.18.010
11 (5) AS 21.18.030
12 (6) AS 21.18.040
13 (7) AS 21.18.120
14 (8) AS 21.21.321
15 (9) AS 21.36
16 (10) AS 21.53
17 (11) AS 21.69.400
18 (12) [(11)] AS 21.69.520
19 (13) [(12)] AS 21.69.600, 21.69.620, and 21.69.630
20 (14) [(13)] AS 21.78
21 (15) [(14)] AS 21.90
22 (16) [(15)] AS 21.42.345 - 21.42.365
23 (17) [(16)] AS 21.89.040
24 (18) [(17)] AS 21.89.060.

25 * Sec. 5. This Act takes effect July 1, 1990.
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Draft: December 5, 1989

Adds Prohibition Against Post-Claims Underwriting, pp. 8-10

Adds Standards for Home Health Care Benefits, p. 2, 10

Adds Requirement to Offer Inflation Protection, p. 11

LONG-TERM CARE INSURANCE MODEL REGULATION

Table of Contents

Section 1.	Purpose
Section 2.	Authority
Section 3.	Applicability and Scope
Section 4.	Definitions
Section 5.	Policy Definitions
Section 6.	Policy Practices and Provisions
Section 7.	Required Disclosure Provisions
<u>Section 8.</u>	<u>Prohibition Against Post Claims Underwriting</u>
<u>Section 9.</u>	<u>Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies</u>
<u>Section 10.</u>	<u>Requirement to Offer Inflation Protection</u>
Section 8: <u>11.</u>	Requirements for Replacement
Section 9: <u>12.</u>	Discretionary Powers of Commissioner
Section 10: <u>13.</u>	Reserve Standards
Section 11: <u>14.</u>	Loss Ratio
Section 12: <u>15.</u>	Filing Requirement
Section 13: <u>16.</u>	Standard Format Outline of Coverage

Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Long-Term Care Insurance Model Act], to promote the public interest, to promote the availability of long-term 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 hereof, 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. "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 their health status.
- B. "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.
- A: C. "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.

- B: D. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
- G: E. "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.
- D: F. 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 "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 7 of this regulation.
- (1) No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable." However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates:
- (a) That renewal will jeopardize the insurer's solvency; or
 - (b) That:
 - (i) The actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and
 - (ii) The policies will continue to experience substantial and unexpected losses over their lifetime; and
 - (iii) The projected loss experience of the policies cannot

be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and

(iv) The insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.

(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 "noncancellable" 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. No policy may be delivered or issued for delivery in this state as long-term care insurance if such 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 self-inflicted 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 (a) exclusions and limitations for payment for services provided outside the United States and (b) 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 such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term 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 which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which 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 and/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:
 - (1) 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 long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which 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. Such 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, any 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.

Section 7. Required Disclosure Provisions

- A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such 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 which 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 which 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, such premium charge shall be set forth in the policy, rider or endorsement.
- C. Payment of Benefits. A long-term care insurance policy which 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 such terms and an explanation of such 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, such 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 such 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."

Section 8. Prohibition Against Post-Claims Underwriting

- A. All applications for long-term care insurance policies or certificates except those which 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 which 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 such 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 which 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.

Section 9. Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

A. A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

- (1) By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;
- (2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community 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 requiring that the insured/claimant have an acute condition before home health care services are covered;
- (6) By limiting benefits to services provided by Medicare-certified agencies or providers.

B. 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 B 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 40 visits amount to an illusory home health care benefit.

Section 10. Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder 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];
- (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; or
- (3) Covers a specified percentage of actual or reasonable charges.

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:

- (1) Life insurance policies or riders containing accelerated long-term care benefits, nor
- (2) Expense incurred long-term care insurance policies.

D. Insurers shall include the following information in or with the outline of coverage:

- (1) 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.
- (2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75, and 85 for benefit increases.

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. It is suggested that a minimum of five percent (5%) (compounded) annual cost increase be used as a base for determining future costs and premiums. 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.

Section 8: 11. Requirements for Replacement

- A. Question Concerning Replacement. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.
- B. 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 such 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**

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 ten (10) ~~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.

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. 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.
3. 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 you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

- C. 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**

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.

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. 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.
3. [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)

Section 9: 12. 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 long-term care insurance policy or certificate upon a written finding that:

- A. The modification or suspension would be in the best interest of the insureds; and
- 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 10: 13. 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 such 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 must

also be established in the case when such 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 11: 14. Loss Ratio

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, 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 enumeration of the thirteen items includes factors traditionally not allowed in calculating rates. Because of the desire to foster development of the long-term care product, the drafters' intention is that the consideration of these factors will provide sufficient latitude to achieve the sixty percent loss ratio.

Section 12: 15. 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 13: 16. 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.

- A. The outline of coverage shall be a free-standing document, using no smaller than ten point type.
- B. The outline of coverage shall contain no material of an advertising nature.
- C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.
- D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.
- E. 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]

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).
2. 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!
3. 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.]
4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's 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.
5. 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.]

6. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen 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. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions/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 (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. 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:

- (a) That the benefit level will not increase over time;
 - (b) Any automatic benefit adjustment provisions;
 - (c) 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;
 - (d) 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;
 - (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]
9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.
- [(a) Describe the policy renewability provisions;
 - (b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;
 - (c) Describe waiver of premium provisions or state that there are not such provisions;
 - (d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]
10. 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.]
11. PREMIUM.
- [(a) State the total annual premium for the policy;
 - (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]
12. ADDITIONAL FEATURES.
- [(a) Indicate if medical underwriting is used;
 - (b) Describe other important features.]

Draft: Dec. 5, 1989

Eliminates Prior Stays on Home Health Care Benefit, pp. 6-7

LONG-TERM CARE INSURANCE MODEL ACT
PROPOSED AMENDMENTS

Table of Contents

Section 1.	Purpose
Section 2.	Scope
Section 3.	Short Title
Section 4.	Definitions
Section 5.	Extraterritorial Jurisdiction - Group Long-Term Care Insurance
Section 6.	Disclosure and Performance Standards for Long-Term Care Insurance
Section 7.	Administrative Procedures
Section 8.	Severability
Section 9.	Effective Date

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 6I.

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 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 protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

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 by-laws 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 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; non-profit 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 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 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; or
 - (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 any ~~limitations or conditions for eligibility other than these~~ prohibited --above --in --Paragraph --(1) post-confinement.

post-acute 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.

(a) ~~A long-term care insurance policy containing a benefit advertised, marketed or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.~~

(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 ~~for which benefits are paid.~~

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.

(2) 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 days after discharge from the institution.

Drafting Note: The Dec. 1988 amendment to this section will eliminated the three-day prior hospitalization screen for new long-term care insurance policies. Some states may wish to consider a "dual-option" alternative to the total prohibition against the prior hospitalization screen, based on the state's particular demographic, geographic and market characteristics. If so, the following provision is such an alternative: "No long-term care insurance policy which conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this State unless the insurer or other entity offering that policy also offers a long-term care insurance policy which does not condition eligibility of benefits on such a requirement."

Editors Note: Section 6D(2) is language from the original model act which did not prohibit prior institutionalization. The drafters intended that Section 6D(2) 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 long-term 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 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 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 Section 4(E)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 long-term 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 contain 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 8. 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 9. 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 10. Effective Date

This Act shall be effective [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 19, 655, 677-680, 700 (adopted).
1987 Proc. II 15, 23, 632-633, 727, 730-734 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652, 661-665 (amended and reprinted).
1989 Proc. I 9, 24-25, 703, 754-755, 789-793 (amended).
1989 Proc. II (amended and reprinted).

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HIAA

Health Insurance Association of America

THE CONSUMER'S GUIDE TO
**LONG-TERM
CARE
INSURANCE**

Selecting the health insurance that's right for you can be very complicated. There can be confusing words, exclusions and differing costs for various coverages to understand.

Recently there has been yet another form of insurance introduced to the American people. It is long-term care insurance. While many people think that Medicare insurance will cover the cost of long-term care, such as care in nursing homes, it actually pays for such coverage only in certain cases. Even if you have purchased private supplemental insurance, sometimes called Medigap, it does not cover long-term care either. Because there has been limited insurance for this care in the past, people have had to pay for their own care with their own resources or become impoverished in the process and qualify for Medicaid.

This booklet will explain what long-term care is and how long-term care insurance works. It also provides a handy checklist you can use to compare policies before you buy.

You owe it to yourself to examine carefully all aspects relating to this coverage and its cost. Many of the different types of policies available will be suitable for you and will meet your needs. Some may be suitable for others, but may not be suitable for you. This booklet will tell you in plain language most of what you need to know.

Long-term care refers to more than nursing home care.



What is long-term care?

Long-term care is the kind of assistance you could need if you ever have a chronic illness or disability that lasts a long time and you are unable to care for yourself. Long-term care does not refer only to nursing home care. It can be provided in your own home if you need help with activities such as bathing, walking or doing chores.

There is a range of services available in the community to meet long-term care needs besides the nursing home. These services include: visiting nurses, home health aides, friendly visiting, meals on wheels, chore services and respite care that is available for caregivers who need an occasional break from daily responsibilities.

Some or all of these services may be available in your community. You may want to check with the Area Agency on Aging, listed in the telephone book, for help in locating these types of long-term care services.



What are the chances that you will need long-term care?

By 2000, more than 8 million Americans aged 65 or more probably will need some form of long-term care due to disability or chronic illness. Most people can be cared for at home. Family and friends are the sole caregivers for 70 percent of these elderly.

Those aged 85 or older are the most at risk for needing long-term care. In fact, statistics show that, at any given time, 22 percent of those age 85 and older are in a nursing home. One study showed that in 1985, 2.3 million people who were 65 years old and older spent at least part of a year in a nursing home. An additional 4 million elderly people received care in their homes.

At the same time, it is estimated that two out of five people aged 65 or more risk entering a nursing home. Half of them will need to stay about six months or less; and half will need to stay an average of 2.5 years. Only a small number stay longer than 5 years.



What are the costs associated with long-term care?

Long-term care can be very expensive. Recent figures indicate that a year in a nursing home costs an average of \$25,000. Depending on where you live it could cost more than that.

Home-based care (help with dressing, bathing, household chores) provided by an aide just three times a week for a year can easily cost \$440 each month, or \$5,300 a year. If you require someone to assist you in administering oxygen or medication, for example, skilled nursing visits can cost even more with three visits per week for a year running as much as \$8,200 per year.



Who pays for it?

Neither Medicare nor private Medicare supplemental insurance (or the health insurance you may have through your employer) will pay for most long-term care expenses. Medicare supplemental insurance (Medigap) is private insurance that is designed to help cover some of the gaps in Medicare coverage—but not long-term care. Even the new Catastrophic Care Amendments to Medicare do not cover long-term care. Many people think that this new expansion of Medicare insurance will cover the cost of nursing home care or home health care, but it actually pays for such coverage only in extremely limited circumstances.

Medicare pays for nursing home care in limited situations.

Medicare will help pay for long-term care under these conditions only:

- Skilled nursing care is covered for up to 150 days per calendar year. You must meet restrictive eligibility criteria and a physician must show that nursing home admission is necessary. Under the new law, in 1989 there is a \$25.50 copayment per day for the first through the eighth day of a nursing home confinement. After the eighth day there is no copayment required.
- Part-time skilled home health care is covered but only for short-term unstable conditions. You must be homebound and certified by a doctor that care is necessary. Also, the home health agency must participate in Medicare. The new law allows more frequent use of the benefits under limited circumstances.

Your care will not be covered if what you need is custodial care, or if you need prolonged home health care on a daily basis. (See Glossary for definition of intermediate care and custodial care.)

It is not surprising then that Medicare pays for less than 2 percent of the nation's annual nursing home bill. Medicare supplemental policies generally do not cover services in addition to Medicare, but rather are designed to pay the costs Medicare does not cover such as hospital deductibles or physician copayments. More than half of nursing home care expenses are paid out-of-pocket by individuals and their families.

Medicaid is a major payer of nursing home care, accounting for 42 percent of all payments to these facilities. Medicaid is a federal-state welfare program meant to provide help with medical expenses to the aged, blind and disabled poor. Many people who begin paying for nursing home care out of their own pockets are often impoverished soon after entering a nursing home. They then turn to Medicaid to pay part or all of their nursing homes expenses.

Recent changes to Medicaid allow your spouse to keep at least \$786 per month and at least \$12,000 in assets in 1989, if you should

People can lose most of their assets after entering a nursing home.

become Medicaid-eligible for nursing home care. These amounts will increase annually.

It is difficult to know what kind of care you may need or what the costs will be. But knowing that you will be responsible for the majority of expenses, you need to know what kind of insurance coverage you should consider. The rest of this booklet describes features of private insurance policies and provides a convenient worksheet you may use in evaluating insurance policies.



What kind of insurance is available?

Long-term care insurance is a relatively new type of private insurance. More than 100 companies offer private long-term care insurance today and that number is rising as more insurance companies seek to fill this growing need.

Almost all policies now available are called indemnity policies, meaning they pay a set amount, usually a fixed dollar amount per day for nursing home or home health care. No policy, however, provides full coverage for all expenses. In addition, many policies do not increase the indemnity amount as the cost of care increases over time. Several newer policies do offer increased benefits over time to allow for increased costs.

Long-term care coverage also is offered as part of individual life insurance policies. Under this arrangement, a certain percentage of the policy's death benefit is paid for each month the policyholder requires long-term care.

Each policy is priced differently. In 1987, individual policy premiums ranged from about \$250 a year in premiums to more than \$2,500 depending on several factors:

Age

The younger you are when you buy a policy, the lower the premium. Most policies are sold on an entry-age level basis, so that the premium should

*Private
long-term
care
insurance
can fill
a growing
need.*

remain at that level and not increase with age, unless there is an increase for everyone that has the same kind of insurance.

Elimination or deductible periods

These are defined as the number of days you must be confined in a facility or the number of home care visits you must receive before policy benefits begin. For example, if the policy you select has an elimination period of 20 days for nursing home care or home health visits, your policy will begin paying you benefits on the 21st day. Usually the longer the elimination or deductible period, the lower the premium.

Indemnity value and duration of benefits

These vary from policy to policy, but in general the more money the policy will pay or the longer the benefit period, the more the policy costs. For example, a policy that pays \$100 a day for up to five years of nursing home care will cost more than a policy that pays \$50 a day for three years.

***Policies
can cover
round-the-
clock care
and help
with
daily
activities.***



What kind of coverage is provided?

Long-term care policies usually pay for skilled, intermediate or custodial care in a nursing home. Generally, skilled care refers to round-the-clock treatment by a registered nurse under a doctor's supervision. Intermediate care refers to occasional nursing and rehabilitative care under the supervision of skilled medical personnel. Custodial care primarily meets personal care needs in activities of daily living such as help in bathing or eating that can be provided by someone without professional medical skills.

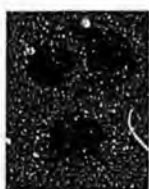
Most policies will pay for expenses in facilities that are licensed by the state to provide skilled and intermediate care and participate in Medicaid and Medicare, and meet the policy's definition of skilled, intermediate or custodial care.

Many long-term care policies require hospitalization before covering any portion of a

nursing home stay. This is increasingly not the case, however. A few require that the policyholder receive skilled or intermediate care before they will pay for custodial care or allow that custodial care be covered only if it is provided in a skilled or intermediate nursing home.

Also, policies usually cover home health care services such as skilled or nonskilled nursing care and homemaker and home health aides, although many policies require a prior nursing home or hospital stay before they will cover home health care benefits. This, too, is changing. Newer policies do not base benefit eligibility for nursing home or home health care benefits on a prior hospitalization requirement.

Therefore, it is very important to make sure the coverage you seek is provided in the policy. Also, make sure you understand the conditions under which your policy will pay for nursing home or home health care.



What kinds of limits are there?

All policies contain limitations and exclusions in addition to age, elimination or deductible periods, and the amount and duration of benefits. The purpose of these provisions is to help maintain reasonable premiums that would cover anticipated costs should that become necessary.

Other limitations for consideration are:

Preexisting conditions

An insurance company generally requires that a certain period of time passes before the policy pays for care related to a health problem you may have already had when you became eligible for coverage. Such health problems are called preexisting conditions. At this time, most companies use a six-month preexisting condition limitation period. (For these policies, if you need to use long-term care benefits within six months

Make sure the benefits you want are covered.

(Continued on page 10)

Long-Term Care Policy Checklist

The following checklist will help you compare policies you may be considering.

Policy A Name: _____

Policy B Name: _____

	Policy A	Policy B
1. What services are covered? <ul style="list-style-type: none"> <input type="checkbox"/> Skilled care <input type="checkbox"/> Intermediate care <input type="checkbox"/> Custodial care <input type="checkbox"/> Home health care <input type="checkbox"/> Other care 		
2. How much does the policy pay per day for: <ul style="list-style-type: none"> <input type="checkbox"/> Skilled care <input type="checkbox"/> Intermediate care <input type="checkbox"/> Custodial care <input type="checkbox"/> Home health care <input type="checkbox"/> Other care 		
3. Does the policy offer a means for increasing benefits to account for expected future costs? If so, how? Is there an additional premium?		
4. Does the policy have a maximum lifetime benefit? If so, what is it? <ul style="list-style-type: none"> <input type="checkbox"/> Nursing home <input type="checkbox"/> Home health 		

5. Does the policy have a maximum length of coverage per "spell of illness" of maximum benefit period? If so, what is it?

- Nursing home
- Home health

6. How long do I have to wait before preexisting conditions are covered?

7. Is Alzheimer's disease covered?

8. How many days is the elimination or deductible period before benefits begin?

9. Does this policy require:

- Physician certification of need
- A functional assessment
- A prior hospital stay for:
 - Nursing home care
 - Home health care
- A prior nursing home stay for home health care
- Other

10. Can the policy be cancelled?

11. Will the policy cover you if you move to another area?

12. What is the age range for enrollment?

13. What does the policy cost?

- per month
- per year

of the effective date of coverage due to a preexisting condition, you may be denied coverage.

Eligibility

For most individual policies, you will be unable to buy a policy after a certain age. Each company sets its own age limit, usually around age 79. Most policies are available only to those over the age of 50. These age limitations refer only to the ability to purchase long-term care insurance, not to the age you are when you use the benefits.

Renewability

Most policies sold on an individual basis are guaranteed renewable and cannot be cancelled. This renewability provision normally is found on the first page of the policy and tells under what conditions the policy can be cancelled and under what conditions premiums may be raised.

Exclusions

Policies may not pay for long-term care related to inorganic mental or nervous conditions, alcoholism, mental retardation, or certain other health conditions or situations. Alzheimer's disease and other related cognitive impairments, leading causes for nursing home admissions, generally are covered. Check policy provisions carefully to determine what exclusions apply.

*Don't
be afraid
to ask an
insurance
agent if
something is
unclear.*



What should you look for in a long-term care policy?

Be sure to read policies you are considering carefully and compare them. Ask for a summary of the policies' benefits or a disclosure form outlining the policies' features. Don't be afraid to ask your insurance agent about anything unclear. There is no single solution for everyone, but your financial plans should include consideration of your long-term care needs.

Glossary

The following definitions of commonly used long-term care terms are meant to provide a general definition of each term but may differ somewhat from those found in long-term care policies, in Medicare or by actual nursing homes.

- **Conditionally renewable**—An insurance company agrees to continue to insure a policyholder as long as it continues to insure all people in the state holding the same kind of policy.
- **Coinsurance**—A percentage of allowed expenses that an insured person is required to pay, e.g., 20 percent of "reasonable" charges under Medicare.
- **Custodial care**—Care that is primarily for meeting personal needs such as help in bathing, dressing, eating or taking medicine. It can be provided by someone without professional medical skills or training but must be according to doctor's orders.
- **Deductible or elimination period**—This amount is the initial sum that must be paid for services covered under an insurance plan before benefits are paid by the insurance company. It is usually expressed in terms of days in long-term care insurance policies (e.g., 20 days).
- **Disclosure form**—A description of benefits, exclusions and provisions of a policy that facilitates understanding of the plan and comparison among plans.
- **Exclusion**—Any condition or medical expense for which the policy will not pay.
- **Guaranteed renewable**—An insurance company agrees to insure a policyholder for life as long as the premium is paid and for a fixed premium unless there is an across-the-board rate increase.
- **Home health care**—Care received at home such as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers or choreworkers.

■ **Individual insurance**—Insurance underwritten and sold on an individual basis.

■ **Intermediate care**—Occasional nursing and rehabilitative care that can be performed by, or under the supervision of, skilled medical personnel only. Care must be based on doctor's orders.

■ **Intermediate care facility**—A nursing home that is licensed by the state and one that may be certified by Medicaid to provide intermediate care. It may provide custodial care as well.

■ **Medicaid**—A joint federal-state program that provides payment for health care services to those with low incomes or with very high medical bills relative to income and assets. It provides benefits for long-term nursing home care once income and assets have been "spent down" to eligibility levels. It also provides some home health services.

■ **Medicare**—The federal program providing people aged 65 and older, some disabled persons and those with end-stage renal disease with hospital and medical insurance. Active employees covered under their employers' plans do not qualify. It provides only very limited benefits for nursing home and home health services under narrowly defined circumstances.

■ **Medigap**—Medicare supplemental insurance is private insurance that supplements or fills in many of the gaps in Medicare coverage, such as deductibles and coinsurance amounts. It does not, however, provide benefits for long-term care.

■ **Preexisting condition exclusion**—An exclusion of benefits for medical conditions that a policyholder had before applying for health or long-term care insurance.

■ **Skilled nursing care**—Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. Care must be based on doctor's orders.

■ **Skilled nursing facility**—A nursing home that is licensed by the state and one that may be certified by Medicare and/or Medicaid to provide skilled care. It also may provide intermediate and custodial care.

Questions we hear most often



What does long-term care insurance cover?

Generally, today's policies cover skilled, intermediate and custodial care in state-licensed nursing homes. They also cover home health services provided by state-licensed and/or Medicare certified home health agencies.



How much do policies pay?

Almost all policies pay a fixed amount per day, or an indemnity, that is independent of a particular nursing home or home health agency rate. Policyholders are usually offered a choice of indemnity amounts ranging from \$40 to more than \$100 per day. Generally, the higher the indemnity, the higher the premium. In most cases, the indemnity for home health care is 50 percent of the nursing home rate.



What about five years from now, when costs probably will rise?

The cost of nursing home care varies widely and depends on factors such as geographic location, and staffing and personnel requirements. The average cost of a year in a nursing home is \$25,000 and rising steadily.

Most policies currently do not automatically adjust the benefit amount upward to account for higher costs expected in the future. Make sure you understand whether the policy you are examining offers protection against future, increasing costs. If the policy does offer protection, make sure you understand how the provision works. While these types of policies are more expensive, more companies are offering them.

Do these policies cover Alzheimer's disease?

Policies generally cover Alzheimer's disease specifically or "organic mental and nervous disorders," which generally include Alzheimer's disease and related disorders.

What are the real chances of entering a nursing home?

A Brandeis University study indicates that persons aged 65 or more face a 40 percent chance of entering a nursing home for any length of time. For those who do, 40 percent will stay three months or less.

What do policies cost?

Policy premiums are based on the age of the purchaser. The premium remains at one level for as long as you own the policy, although premiums can be increased if they are raised for all individuals who hold a policy just like yours. Premiums, in general, cannot be increased because of your age or if your health deteriorates. At age 50, a policy offering a \$60 per day nursing home indemnity and a 20-day deductible period costs around \$300 per year, at age 65, about \$675 and at age 79 or 80, about \$2,100 per year.

How does the preexisting condition limitation work?

Preexisting conditions are conditions that warranted medical attention prior to the policy's effective date. Benefits for preexisting conditions will be paid if you require long-term care after buying the policy, usually after a period of six months. What this means is that if you buy a policy and need services for a preexisting condition within six months of purchase, it will not pay. If everyone who already needed long-term care purchased a policy, premiums would not be affordable for healthy persons.



What else do I need to know?

Insurance policies are legal contracts; make sure you understand what you are buying. If you are not satisfied with an agent's answers, ask for a phone number or an address of someone you can contact in the company itself. Good agents want you to know what you are buying. Community consumer organizations such as the Better Business Bureau, which is listed in your telephone book, might also help answer your questions.



Who offers long-term care insurance?

You may obtain a list of all companies offering long-term care policies by writing to:

Health Insurance Association of America
P.O. Box 41455
Washington, DC 20018

Additional Reading

Additional publications about health care coverage and long-term care are available from other organizations.

American Association of Homes for the Aging

Suite 400
1129 20th Street, N.W.
Washington, DC 20036
Telephone: 202/296-5960

Brochures describing continuing care retirement communities.

American Association of Retired Persons Health Advocacy Services

1909 K Street, N.W.
Washington, DC 20049
Telephone: 202/872-4700

Booklets and pamphlets on long-term care choices for older Americans.

American Health Care Association

1202 L Street, N.W.
Washington, DC 20005
Telephone: 202/842-4444

Various pamphlets about long-term care facilities.

Council of Better Business Bureaus

Suite 800
4200 Wilson Boulevard
Arlington, VA 22203
Telephone: 703/276-0100

Written materials on home care and nursing homes.

National Consumers League

Suite 516
815 15th Street, N.W.
Washington, DC 20005
Telephone: 202/639-8140

Consumer's guide to life care communities has health and ambulatory fact sheets on Medicare.



Health Insurance Association of America
1025 Connecticut Avenue, NW
Washington, DC 20036-3998
(202) 223-7780

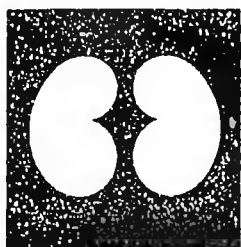
What Legislators Need to Know About Long-Term Care Insurance



National Conference
of State Legislatures



Foundation for
State Legislatures



What Legislators Need to Know About Long-Term Care Insurance was written by David Landes, health care program manager, National Conference of State Legislatures (NCSL).

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May 1987

Introduction

Long-term care insurance is an emerging private financing mechanism for long-term care services—those services required due to a chronic illness or a condition lasting over a prolonged period of time. Currently, through the Medicaid program, government payment for long-term care is available only for the poor. Individuals not qualifying for Medicaid generally use their own assets until they are exhausted. State governments are searching for ways to reduce the burden of Medicaid expenses and to halt the financial drain on individuals. Long-term care insurance and other private financing mechanisms for long-term care represent a group of possible solutions to the problem.

State governments are also responsible for insurance regulation and consumer protection. Having begun to assess the need for regulation of long-term care insurance, states are finding that such regulation raises some difficult issues. Because long-term care insurance is relatively new, insurers consider it a financially risky

venture. Some state attempts to protect consumers and regulate the insurance market raise the possibility that insurers may withdraw from the state rather than operate under conditions of increased financial risk. Each state must balance the need to protect consumers against the possibility of losing any potential benefits of long-term care insurance. States also may want to take action promoting the purchase of long-term care insurance.

This booklet discusses the potential importance to states of long-term care insurance, describes general policy characteristics, and summarizes state actions to both regulate and promote long-term care insurance. It is intended as a resource for both legislators and others involved in long-term care financing and public policy formulation.

What Are Long-Term Care Question and Long-Term Care One: Insurance?

Long-Term Care

Long-term care refers to a broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to chronic illness or condition and who are expected to need such services over a prolonged period of time.¹

As used in this booklet, *long-term care* does not include short-term rehabilitative care, whether provided in nursing homes, other institutional settings such as extended care or rehabilitation units of acute care hospitals, or individuals' own homes. In contrast to acute care, long-term care typically requires less technical and intensive medical treatment. Nurses, nurses aides, rehabilitation and other specialists, and persons providing homemaker services play key roles. Physicians are less prominent than in acute care.

There are three different levels of long-term care:

- *Skilled nursing care* includes nursing and rehabilitative services given by skilled health personnel on a daily basis, under the supervision of a physician;
- *Intermediate care* is the same as skilled nursing care except that procedures may be performed on an occasional basis; and
- *Custodial/personal care* includes assistance in activities of daily living that are provided by persons without medical skills.²

Although there is general agreement on the existence of the three levels of care, insurers, government officials, and other groups all define the three levels differently.

All three levels of long-term care can be provided in nursing homes or in patients' own homes. The cost for each type of care, however, may vary by the setting. In 1984, approximately 20 percent of persons receiving long-term care resided in nursing homes, with the remainder living at home. Of those in their own homes, 75 percent were maintained solely through the efforts of unpaid caregivers such as family, friends, and volunteer community workers.³

The elderly (over age 65) population, the primary users of long-term care services, will increase in the future. By the year 2000, the number of elderly (over age 65) persons will have increased by 37 percent over the number in 1980.⁴ As a percentage of total population, the elderly will increase from 11.3 percent in 1980 to 13.1 percent by 2000.⁵ Increasing longevity will swell the over-85 age group, those elderly most likely to need long-term care. The number of persons over age 85 in the year 2000 will be 129 percent higher than the number of persons in the same age group in 1980.⁶ It is estimated that on any given day in 1978 22 percent of those over 85 resided in nursing homes, compared with 7 percent of the age 75 to 84 population and only 2 percent of the age 65 to 74 population.⁷

The need for long-term care services will reflect the growth in the elderly population. The number of elderly persons with limitations of activity due to chronic conditions is projected to increase 38 percent between 1978 and 2003 assuming current mortality rates.⁸ Should mortality rates

continue to decline, the increase could be as high as 64 percent." Nursing home utilization is projected to rise by between 62 percent and 125 percent in the same time period, depending on whether mortality rates remain constant or decline.¹⁰

Long-Term Care Insurance

Long-term care insurance is insurance intended to cover long-term care services. The definition of long-term care used in this publication excludes short-term rehabilitative or acute care services. Consequently, the definition of long-term care insurance excludes insurance intended primarily to cover short-term care, such as Medicare supplemental insurance covering Medicare deductible and coinsurance payments. (See Question Four for a complete discussion of the Medicare nursing home benefit.) Existing long-term care insurance policies cover long-term care services exclusively, but long-term care insurance eventually may be sold as part of a more comprehensive health or life insurance package.

Policies now on the market have the following general characteristics:

- Coverage for nursing home care (almost always skilled nursing care, sometimes intermediate or custodial level care) and sometimes for home health care services. Benefits are paid up to a specified maximum number of days, home visits, or dollars, and often are contingent on a prior stay in a nursing home or hospital.
- Indemnity benefit payments. Policyholders receive a specified amount of money per day or per home visit, regardless of the actual expenses incurred. Policyholders then are responsible for paying providers of care, making up the difference between insurance receipts

and charges incurred out of their own funds. Some policies escalate the amount of the indemnity payment each year the policy is in force, charging a higher premium for this option.

- Benefit or coverage limitations. Long-term care required for certain conditions, such as alcoholism or mental illness, may be excluded entirely from coverage. Care for other medical conditions diagnosed or treated before the policy is purchased ("pre-existing conditions"), such as heart disease or stroke, may be covered only after a waiting period of between three months and one year. Policyholders generally pay for a minimum number of nursing home days or home health visits before benefit payments can begin ("elimination periods").

Should current policies achieve satisfactory results, insurers can be expected to broaden their offerings to include policies with wider coverage and fewer exclusions and limitations.

Estimates of the number of insurers offering long-term care policies range as high as 35.¹¹ At least one policy is available in every state. Between 130,000¹² and 200,000¹³ policies are estimated to be in effect.

Long-term care insurance helps consumers pay for long-term care by spreading the risks and the costs over large numbers of persons. There also exist two types of asset accumulation programs (not discussed further in this publication) that help consumers generate funds to pay for long-term care services by themselves:

- Asset accumulation programs targeted to health care. These include life insurance with pre-death long-term care benefits and "individual medical accounts" ("medical IRAs") that allow individuals to save their own money to pay for future health care expenditures. These are largely proposals at this time. Only one state, Colorado, has enacted legislation recognizing individual medical accounts,¹⁴ and no insurers currently offer life insurance with long-term care benefits.

- Asset accumulation programs not targeted to health. These include life insurance cash value savings, pension accumulations, and reverse annuity/mortgage programs that allow individuals to convert their equity in real property or other assets into monthly income. These programs supply unrestricted income that individuals may use for any purpose, including health care. All are widely available except for reverse annuities/mortgages, which are available only in certain states and localities.

Accumulated assets also could be used to purchase long-term care insurance rather than long-term care services directly.

Question Two: Why Is Long-Term Care Insurance an Important Issue for State Legislators?

Long-term care insurance has the potential to reduce state Medicaid expenditures by decreasing the number of persons who are forced to rely on Medicaid to pay their nursing home and home health care costs. A major study of private financing of long-term care, conducted by ICF Incorporated for the U.S. Department of Health and Human Services, estimated that long-term care insurance could reduce Medicaid nursing home expenditures by between \$3 billion and \$9 billion annually over a 35-year period (depending on the

assumptions used to estimate how many persons would purchase long-term care insurance).¹⁵ These dollar amounts represent reductions of between 8 and 23 percent in annual Medicaid nursing home expenditures.¹⁶ Another study, done by The Brookings Institution using different assumptions, estimated a maximum average 5 percent reduction in Medicaid expenditures in the years 2016 to 2020.¹⁷ Reductions might increase, however, in subsequent years.

Medicaid expenditures are one of the fastest growing components of state budgets. Between 1975 and 1981, state-only Medicaid costs increased from 5.6 percent of all state expenditures to 7.7 percent.¹⁸ Long-term care expenditures are a significant component of Medicaid expenditures. Nursing home care is the second largest expense in the national Medicaid budget after hospital care, accounting for 37 percent of total state-funded Medicaid expenditures in 1985.¹⁹ Between 1980 and 1985, total Medicaid nursing home expenditures increased from \$9.8 billion to \$14.7 billion, a 10 percent annual increase, growing faster than any other part of the Medicaid budget except hospital care.²⁰ The predicted increase in the over-65 population and the especially large increase in the over-85 population are expected to accelerate the rise in Medicaid expenditures.

The present, near-exclusive reliance on Medicaid and private financing for long-term care raises additional public policy concerns about access to care and family impoverishment. In 1985, payments out of personal funds accounted for 53 percent of all long-term care services purchased in nursing homes while Medicaid covered 42 percent.²¹ Medicaid recipients may find it difficult to gain admission to Medicaid-certified nursing homes because their operators prefer patients who pay privately, generally at rates higher than those Medicaid pays. This is especially true for patients requiring intensive and technically difficult care and in states where bed supply has been strictly controlled by certificate of need programs.

Medicaid recipients are excluded entirely from nursing homes that choose not to be Medicaid certified. Medicaid emphasizes institutional long-term care, and many state programs provide only limited home health care. Finally, the pressure on legislatures to reduce state budgets makes Medicaid recipients vulnerable to future benefit cuts.

Private-pay patients incur nursing home charges that average \$67 per day, or nearly \$25,000 annually.²² Many exhaust their resources. One study, using computer simulations, estimated that between 40 and 72 percent of the persons entering nursing homes as private-pay patients would spend down to Medicaid eligibility levels within six months of admission.²³ Between 55 percent and 82 percent would do so within one year of admission.²⁴ For elderly couples with one spouse in a nursing home, the depletion of assets for long-term care also impairs the remaining spouse's ability to live independently. This problem of spousal impoverishment has been of special concern to state legislators, and states have begun searching for ways to limit the amount of assets that must be spent before becoming eligible for Medicaid.

Question Three: What Types of Long-Term Care Insurance Policies Are Available?

Long-term care insurance is a relatively new phenomenon, and policy offerings will be refined continually over the next few years. While policies on the market differ in a number of ways, they share some general features.

Benefits

Nursing Home Care

Coverage for nursing home care is the principal component of almost all long-term care insurance policies. Generally, a specified dollar amount per day is paid for a maximum number of days (most frequently three or five years) in a state-licensed nursing home. Some policies impose lifetime maximum limits on total days of care paid for or total reimbursement dollar amounts or both. Almost all policies cover skilled nursing care. Some also cover intermediate or custodial level care. Benefit payments often differ by type of facility or level of care.

Most policies include provisions designed to reduce induced demand—the tendency of policyholders to use more services because insurance pays some or all of the costs. These provisions may require, for example, that covered nursing home care be preceded by a minimum length of stay in a hospital (usually three days), or that care be certified by a physician as “medically necessary.” Elimination or deductible periods before benefit payments begin serve a similar purpose. Policyholders are discouraged from unnecessary

nursing home use, since they must pay the initial charges themselves until benefit payments begin. Elimination periods also screen out nursing home stays intended more for short-term rehabilitation or posthospital recovery.

Adverse selection—the tendency of high-risk or already-ill persons to seek insurance—is reduced by applicant screening, which all insurers writing individual policies have the right to do. Many policies exclude coverage for alcoholism, mental retardation, or mental illness not of organic origin. For insurers, these exclusions represent high-risk coverages since they are difficult to define in an insurance policy and use of services is difficult to manage effectively. Other pre-existing conditions (conditions diagnosed or treated prior to purchase of the insurance), such as a recent stroke or diagnosed Alzheimer’s disease—the existence of which could encourage already-sick individuals to seek insurance, generally are covered only after a waiting period, typically six months.

Home Health Care

Some policies cover home health care. Home health coverage is not universal because insurers are less able to protect themselves against adverse selection and induced demand. There is no general agreement on the services included in home health care and the need for such care is more difficult to judge objectively. Policies covering home health care differ in the scope of covered services. Some cover only those services provided by licensed health care personnel: rehabilitation services such as physical, speech, and occupational therapy; and nursing services

such as injections, wound dressing, and intravenous fluid administration. Policies with broader coverage also may include personal care services intended to assist with activities of daily living: bathing, routine physical exercise, walking, eating, and monitoring of medication use.

All policies limit the number of home health visits or days of home health care covered. Most policies include provisions to guard against adverse selection and induced demand similar to those applied to nursing home benefits. Use of home health benefits may be contingent on a prior nursing home stay, for example.

Payment Mechanisms and Premiums
Individuals who have purchased long-term care insurance have done so at about the same time they perceived the need—in middle to late life. Policies typically have a minimum age of 55 or 60.²⁵ If clients would purchase at a younger age, insurers could reduce annual premiums since they would have a longer payment period to build up funds to pay benefits. However, since even elderly individuals often do not see the need to purchase long-term care insurance (see Question Four), purchase by younger individuals does not appear likely without employer-sponsorship or changes in public attitudes.

Long-term care insurance premiums vary depending on the policyholder's age. "Level premium" policies have premiums that are determined by the policyholder's age at the time of purchase and remain the same as long as the policy remains in effect. "Graduated premium" policies increase the annual premium as the policyholder ages. Premiums for these policies are lower for younger individuals than those of the level premium policies but are higher for older persons. In addition to age, scope of covered services, the length of elimination periods before benefits can begin, the length of time benefits will be paid, and the amount of the daily benefit payment all influence the premium amount. Insurers often reserve the right to increase

premiums for whole classes of policyholders based on changes in benefit utilization. A comparison of nine relatively comprehensive policies published in March 1986 showed that monthly premiums ranged from \$28 to \$37 at age 55 to from \$106 to \$148 at age 75.²⁶

Most long-term care policies are sold on an individual, rather than a group, basis. Experts generally agree that premiums would decrease with a shift to group long-term care insurance. Group insurance covers larger numbers of persons allowing insurers to spread the risks more broadly and offering greater protection from adverse selection. Most group insurance, however, is employer based, and numerous obstacles exist to offering long-term care insurance as a component of employers' benefit packages.²⁷ Younger employees generally are not interested in long-term care insurance, preferring more immediately useful benefits such as longer vacations. Court decisions and existing legislation may restrict an employer's ability to alter benefits of current retirees, limiting the freedom to reallocate funds to new benefits for active workers. Tax laws do not provide favorable tax treatment for the expenses of pre-funding retiree health benefits such as long-term care insurance. Finally, accounting standards soon may require companies to show unfunded retiree health benefits as balance sheet liabilities. Long-term care insurance benefits for retirees ultimately could cost much more than expected given the difficulty of accurately estimating future expenses of providing such care. Despite these obstacles, some employers are considering long-term care insurance benefits for employees.

Combining Long-Term Care Insurance with Other Forms of Insurance

While existing long-term care insurance policies cover long-term care exclusively, there is no reason why long-term care insurance could not be part of a broader life or health insurance policy. An experimental program offering both acute care and long-term care services on a capitated basis is being tested in four locations (Long Beach, California; Portland, Oregon; Minneapolis, Minnesota; and Brooklyn, New York), with technical assistance paid for by the U.S. Department of Health and Human Services. Labeled "social" health maintenance organizations (S/HMOs), these are traditional medical HMOs that also provide long-term care (nursing home, home health) and social services (homemaker and case management services) to Medicare beneficiaries for limited amounts of time. S/HMOs combine insurance and service provision in a single entity. Since S/HMOs must provide all necessary services for a set monthly fee, they have a strong incentive to provide services in the most cost-effective manner. This could mean substituting less expensive nursing home care for hospital care, and home care for nursing home care, wherever possible. The S/HMO structure also should help control induced demand. Since the S/HMO controls access to care, it should be able to manage and coordinate service use and reduce inappropriate utilization. Since these experimental programs only began operation in 1985, it is too early to judge their success. Should they succeed, however, capitated systems will offer another mechanism for combining long-term care financing and services with acute care and Medicare supplemental benefits in a managed care environment.

Life care communities, in which persons are guaranteed a lifetime residence and long-term care services in return for an initial payment and continuing monthly fees, are a form of long-term care insurance. Some life care communities provide nursing home and home health services using their own employees; others contract with outside entities for the provision of services. In 1984, between 55,000 and 100,000 persons nationwide were believed to reside in life care communities.²⁸

Long-term care insurance also could be incorporated into a life insurance policy. Policyholders generally would begin paying premiums at a younger age than current long-term care insurance purchasers. Policy benefits would be similar to those available under existing life insurance policies, except that a long-term care insurance coverage option would be available at the time the policyholder chose to begin benefit payments. A number of insurers are developing such policies. A first step in this area is the Office of Personnel Management's recent proposal that certain older federal employees be allowed to convert a portion of their life insurance to long-term care insurance.

Question Four: What Are the Barriers to the Expansion of Long-Term Care Insurance?

Barriers to the expansion of long-term care insurance exist both among potential purchasers and among insurers. Elderly consumers often do not see a need for long-term care insurance or believe they already are covered in the event they need to use long-term care services. At the same time, many insurers view long-term care insurance as risky and potentially unprofitable, given the nature of the product and the absence of historical experience on which to calculate premiums. Governmental actions (discussed in Question Five) also have influenced the availability of long-term care insurance.

Consumer Disinterest Toward Long-Term Care Insurance

Among the over-55 population, the rate of purchase of long-term care insurance is

Of a potential market of approximately 50 million persons over age 55 in 1985, only 0.3 to 0.4 percent had such coverage. If long-term care insurance is to become a viable financing mechanism for long-term care, the reasons for this low rate of purchase must be understood.

Market research data do much to explain consumers' low level of interest. The findings of two surveys are especially relevant: the Long-Term Care Insurance Survey, a 1987 six-state survey of 1,403 elderly persons done by the National Center for Health Services Research; and the American Association of Retired Persons (AARP) Survey of 1,009 AARP members nationwide, done by the Gallup Organization in 1984.²⁹

The research data indicate that many of the beliefs and expectations of the elderly that discourage purchase of long-term care insurance are incorrect. A common misconception concerns the probability of needing long-term care services in later

life. Long-Term Care Insurance Survey results indicate that older persons may underestimate the likelihood of needing nursing home care. While 24 percent of the respondents believed that the average person in their age group was "very likely" to require long-term care in the future, only 15 percent believed it "very likely" that they themselves would ever need long-term care.³⁰ By contrast, some researchers estimate the likelihood the average person age 65-69 will ever use at least one day of nursing home care to range from 31 percent for men to 52 percent for women.³¹

Survey results also show that the elderly are not thoroughly familiar with existing insurance benefits, believing that Medicare will pay for most long-term care services. Among respondents to the AARP Survey who believed they would need long-term care, 79 percent believed Medicare would pay all or part of their nursing home charges.³² In fact, Medicare coverage criteria are very stringent: no more than 100 days of skilled nursing care in a Medicare-certified skilled nursing facility following a three-day minimum hospital stay, and then only when a physician certifies that the patient requires skilled nursing care. Consequently, the average covered nursing home length of stay for Medicare patients in 1980 was less than 30 days, compared with an average length of stay for all patients of 456 days.³³ Medicare pays in full only the first 20 days of nursing home care; the beneficiary must pay the first \$65 (in 1987) in charges for each of the remaining 80 days. As a result, Medicare's role in long-term care delivery is insignificant. Medicare accounted for only 2 percent of total payments to nursing homes in 1985.³⁴ Only about 30 percent of

all licensed nursing homes in the United States were certified to accept Medicare patients in that year.⁴⁵

Additional data confirm the relative lack of knowledge about insurance coverage. Only 33 percent of the Long-Term Care Survey respondents were considered to have "solid" knowledge of their Medicare benefits, based on answers to a set of six Medicare-related questions.³⁶ AARP Survey respondents overestimated their insurance coverage for long-term care; 35 percent believed their insurance policies covered long-term care, when in fact they did not.³⁷

Underlying attitudes toward long-term care also may play a role in consumers' reactions to long-term care insurance. A more psychologically oriented study found that individuals viewed contingency planning for long-term care as "an overwhelming, solutionless problem."³⁸ Study participants felt they were unable to plan for the future because they had little control over future events and because they had little credible information about the costs of long-term care and ways to meet those costs.

Some have argued that the availability of Medicaid may discourage the purchase of long-term care insurance since older persons willing to "go on welfare" will not buy the insurance. There are contradictory findings on attitudes toward welfare. The AARP Survey showed that 62 percent of the respondents considered it acceptable for someone (not necessarily themselves) to accept Medicaid benefits when all other assets had been exhausted.³⁹ This attitude was more common among younger respondents. Only 19 percent of the elderly in the Long-Term Care Insurance Survey, however, indicated that the availability of Medicaid would prevent them from purchasing long-term care insurance.⁴⁰

A 1984 study of 1,000 members of the "prime life" generation, those age 50 to 64, showed disparate attitudes about responsibility for payment of nursing care after

age 65. While 35 percent of the respondents believed individuals had that responsibility, 31 percent believed the responsibility rested with government. Twenty percent indicated that responsibility should be shared.⁴¹

Another consumer-related deterrent to the growth of long-term care insurance has been the relatively high cost of premiums compared with the average income of the elderly population. Many of the elderly have relatively low incomes, leaving little after costs of food and shelter have been met. What discretionary funds are available for health care usually go for Medigap insurance and noncovered items such as pharmaceuticals and eyeglasses. Thus, some elders may not have enough income to pay long-term care insurance premiums.

Insurer Disinterest in Long-Term Care Insurance

Until recently, there was relatively little interest in long-term care insurance among insurance companies and few policies were available. Insurers generally regarded long-term care by its very nature to be an uninsurable risk, for a number of reasons:

- Individuals' future use of long-term care services is difficult to predict because the factors that influence such use are difficult to measure and quantify. Medical and physical conditions alone do not determine use of long-term care services. Of two persons with the same level of physical or medical disability, only one actually may seek formal long-term care services. Personal preference, availability of family and other social support networks, financial status, and other variables all influence a person's decision to seek long-term care services. Insurers cannot measure these factors accurately and thus find it difficult to calculate the risk of individuals' using long-term care and to determine appropriate premiums.
- Long-term care itself is difficult to define for insurance purposes. Should routine help with bathing

and dressing at home be considered long-term care services? What about nursing home care provided during a three-month recovery from a broken hip? Lack of a clear definition of long-term care makes it difficult to calculate risks to the insurer accurately.

- Adverse selection is more difficult to control in the case of long-term care because of the difficulty of predicting who will use long-term care services. The lower cost of insurance compared with the actual cost of health care, however, can be maintained only if adverse selection is controlled and a relatively small proportion of policyholders actually use benefits. Insurers' failure to limit adverse selection may result in financial losses since long-term care is relatively expensive and also may force premiums up to unaffordable levels.
- Induced demand increases the use of long-term care services. This problem would be most severe for noninstitutional services, where judging appropriateness of services is most difficult. As with adverse selection, uncontrolled induced demand would result in greater than expected utilization of services and possible financial losses for insurers.
- Establishing policy coverages and corresponding premiums in the present for benefits that may be paid far in the future can be risky without reliable historical data. An individual purchasing a policy at age 55 may not collect benefits until age 75 or 80. Future changes in circumstances, such as use of more nursing home care and less home health care, can have a large negative impact on insurers in the future.

Indeed, one of the greatest barriers to insurer participation has been the lack of reliable data on which to base product development and premium-setting decisions. Two types of data in particular are lacking: data on the need for, and use of, long-term care services in the population as a whole, especially in an

insured environment; and studies of attitudes and desires of the elderly population.

The first type of data—information on the use of nursing home and home health services by various population groups over time—is needed for pricing long-term care insurance products. Insurers also need more information on the factors that cause persons in need to seek long-term care services so they can calculate the risks of service use accurately and price the premiums accordingly. Such data are not readily available now.

The potential value of the second type of data is illustrated by the AARP Survey. In that survey, 77 percent of the respondents said they would prefer a long-term care plan covering home health care to one covering nursing home care.⁴² Yet, home health care benefits are not universal. Such studies are indispensable if products acceptable to the buying public are to be brought to the market.

Reducing Barriers to Long-Term Care Insurance

A number of steps must be taken if the barriers among consumers and insurers are to be reduced. Education and information programs will be needed to increase consumers' awareness and understanding of current long-term care financing mechanisms and the potential role of long-term care insurance. Among insurers, recent events already have stimulated interest in the long-term care insurance concept. Insurance companies have recognized the older population as a potentially profitable new market due to its increasing numbers and affluence (see Question Seven). Insurers are beginning to recognize that while long-term care may be a difficult risk to insure, there may be ways to counteract adverse selection, induced demand, and other uncertainties that threaten the financial viability of long-term care insurance. Finally, insurance companies and government will need to begin collecting the necessary market research and utilization data. The end result should be policies constructed and priced to better meet the expressed needs of consumers.

Question Five: What Have States Done to Regulate the Sale and Content of Long-Term Care Insurance Policies?

To date, few states have enacted laws regarding the sale or content of long-term care insurance policies specifically. Several others have seen some legislative activity but no significant enactments. Still others have initiated studies in the legislative or executive branches to make recommendations regarding long-term care insurance. States with studies in progress or completed are Alaska,⁴³ Arizona,⁴⁴ California, Connecticut, Florida, Georgia,⁴⁵ Hawaii,⁴⁶ Massachusetts,⁴⁷ North Carolina, Texas, and Virginia (citations are given for completed studies only).

The states have primary responsibility for overseeing most activities in the insurance market. The McCarran-Ferguson Act of 1944 affirms the primacy of the states in regulating the insurance industry and limits federal government activity. Generally, state regulation is performed by agencies of the executive branch using statutorily delegated authority to promulgate necessary rules and regulations.

Consumer protection has been the driving force behind state actions to regulate long-term care insurance. State regulation has focused on two areas: the manner in which policies are sold to consumers and the financial attributes of policies and insurers ("performance-based" aspects of the insurance policies); and the specific provisions contained in the policies being sold ("product-based" aspects).

The National Association of Insurance Commissioners (NAIC) recently published a Long-Term Care Insurance Model Act intended to serve as a basis for state regulation of long-term care insurance. The model act relies on both performance-based and product-based regulation.⁴⁸

The following discussion of state regulatory actions is not intended to be a complete listing. Rather, it describes sample enactments and proposals representing approaches to long-term care insurance regulation. Provisions of the model act also are discussed.

Regulating Performance-Based Aspects of Long-Term Care Insurance

Insurance regulators in all states are empowered to promulgate regulations protecting purchasers of insurance. As a result, numerous performance-based requirements intended to protect all purchasers, including those who buy long-term care insurance, already exist. These generally cover:

- Authorization of insurance companies to sell insurance in a state;
- Licensure of insurance salesmen;
- Approval of specific policy wording and format for understandability;
- Disclosure of policy benefits and limitations;
- Specification of conditions under which buyers may return previously purchased insurance (termed "free look" provisions);
- Review of advertising and marketing materials;

- Required notification of rate changes;
- Imposition of financial solvency and reserve requirements to assure that insurance companies can meet future obligations to policyholders.

In addition to these generic consumer protections, some states have enacted or proposed specific measures applicable to long-term care insurance. A common action, derived from existing insurance regulation, is the establishment of minimum loss ratios for policies. A loss ratio is the proportion of premium income from a particular type of policy projected to be ultimately paid back to policyholders in the form of benefits. The lower the loss ratio, the more premium income the insurance company retains for operating expenses and profit. Establishment of a minimum loss ratio attempts to assure that premiums will be fairly and reasonably related to the cost of benefits by making certain that a minimum portion of every premium dollar received will be paid out in benefits. Connecticut and Minnesota have established minimum loss ratios for long-term care insurance by statute: 55 percent and 60 percent, respectively, for individual policies, and 60 percent and 65 percent, respectively, for group policies. Maine and Washington have elected to give authority to insurance regulators to set minimum loss ratios by regulation.⁴⁹ The model act allows regulators to prescribe minimum loss ratios as long as they are specifically for long-term care insurance.

Minimum loss ratios have been opposed by the insurance industry because the proposed ratios generally are higher than the industry believes is warranted, given the level of risk and uncertainty in pricing involved. Because long-term care insurance is relatively new, insurers argue, there is no experience on which to base judgments about appropriate loss ratios. Also, imposition of unreasonable loss ratio requirements during the next 10 to 20 years of long-term care insurance "start up" could prevent insurers from building up the reserves necessary to pay future claims. Low loss ratios will occur because the majority of today's purchasers will not begin to claim benefits until 10 or 20 years

from now, and insurers will be collecting premiums in anticipation of future benefit payments but paying relatively little in benefits. Insurers claim that the result would be long-term financial losses and that they might have to withdraw from the market rather than run the risk of selling potentially unprofitable policies.

Limiting insurers' ability to cancel policies has been another common legislative action. Minnesota and Washington prohibit cancellation of policies except in the case of nonpayment. South Dakota has considered, but not passed, similar legislation. The model act prohibits cancellation of policies for reasons of age or health status.⁵⁰ Advocates of noncancellation provisions argue that it is unfair to allow policyholders to pay premiums for years only to have the policies cancelled in later life when benefits are most likely to be paid.

In another type of consumer protection action, Washington prohibits sale of long-term care insurance policies to persons already receiving Medicaid assistance. This action was taken in an effort to stop the unethical practice of knowingly selling insurance policies to persons who do not need them.

Regulating Product-Based Aspects of Long-Term Care Insurance

As with performance-based regulation, the goal of product-based regulation has been consumer protection. Product-based regulation has caused more controversy, however, than performance-based regulation because its potential impact on market development and on the financial condition of insurers is greater.

Product-based regulation has focused on requiring minimum benefits for long-term care insurance policies and prohibiting inclusion of certain provisions. Examples of minimum benefit provisions either approved, or considered but not approved, include:

- **Minimum daily payments for nursing home or home care.**
In Minnesota, the statutorily prescribed minimums are \$40 to \$60 per day for nursing home care and \$20 to \$25 per day for home care.⁵¹ Other unsuccessful state proposals would have tied the minimum payments to other indicators. New Jersey would have required that the daily home care benefit equal 75 percent of the daily nursing home benefit.⁵² Kansas would have mandated that the daily nursing home benefit be no less than 75 percent of actual charges.⁵³
- **Coverage of specific services.**
Kentucky requires that skilled, intermediate, and custodial care all be covered by at least one policy offered by each insurer. A number of states have proposed that specific services be covered, such as respite care ("short-term" long-term care intended to give family members a break from attending elderly relatives at home) and home care. Maryland indirectly addresses long-term care coverage by requiring health insurers to offer optional coverage for Alzheimer's disease, the later stages of which require long-term care, and any other care required by the elderly and mandated by the insurance commissioner.⁵⁴
- **Minimum numbers of nursing home days or home care visits**
Kansas and New Jersey considered, but did not pass, such provisions. Kansas proposed a two-year minimum for nursing home benefits; New Jersey, a three-year minimum.

Some states have enacted, or have considered but not enacted, prohibitions on certain policy provisions. These include:

- **Prohibiting deductible or copayment amounts above specified levels.**
Minnesota limits copayments to 20 percent of actual charges. Kentucky requires insurers to offer at least one policy with copayments no more than 25 percent of actual charges.
- **Prohibiting exclusion from coverage of pre-existing conditions for longer than specified maximum times.**
Generally, medical conditions that were diagnosed or treated within a specified time immediately prior to commencement of the policy are excluded from coverage for a specified time period immediately following commencement of the policy. Washington law specifies that only medical conditions that were diagnosed or treated within one year prior to policy commencement can be excluded, and then only during the first six months following commencement. The model act uses standards of "two years before commencement-two years after commencement" for policyholders under age 65 and "six months before commencement-six months after commencement" for older policyholders. An unsuccessful South Dakota proposal would have limited the definition of pre-existing conditions to only those for which treatment was received within six months prior to the effective date of the policy. This proposal would have prohibited exclusion of coverage for conditions present but not treated in the six-month period.
- **Prohibiting the requirement of a prior stay in a hospital as a condition of nursing home benefit payments.**
Kentucky has enacted this prohibition and also proscribes requiring prior care at the skilled nursing level as a condition of

payment of benefits for intermediate level nursing home care.⁵⁵ Kansas and New Jersey considered, but did not enact, such a provision.⁵⁶

The practices targeted by these prohibitions are those used by insurance companies to protect themselves from adverse selection and induced demand. The public, however, sometimes sees them as ways of unfairly preventing policyholders from claiming benefits to which they are entitled.

States that have acted to regulate the content of long-term care insurance policies have taken a variety of approaches in allocating responsibility between the legislative and executive branches of government. Kentucky, Minnesota, and Washington have enacted relatively extensive and specific statutes, leaving less discretion to regulators.⁵⁷ On the other hand, Maine statutes delegate all regulatory authority to regulators.⁵⁸ Some states, such as Arkansas and Wisconsin, have enacted no statutes, but insurance regulators have used existing authority to promulgate long-term care insurance regulations.

Regulation of policy content has been controversial. Proponents argue that the state is obligated to protect consumers from the sale of insurance policies that do not provide meaningful benefits. The elderly, the primary target of long-term care insurance marketing, are particularly vulnerable to deceptive and misleading sales practices. They are not always well informed about the long-term care delivery and financing system or its associated costs. The highly publicized fraud and abuse associated with Medigap policies are cited as a reminder of what can happen when states fail to safeguard the interests of the elderly population. For all these reasons, proponents claim, it is necessary to set minimum benefit levels and prohibit certain provisions, thus preventing the sale of inadequate policies that do not provide the coverage for which consumers believe they have paid.

Opponents of product-based regulation claim that state prescription of policy content limits the flexibility of insurers to adapt their offerings to changing market conditions. Persons desiring relatively low benefit levels or only one kind of coverage, such as nursing home or home health care, will be forced to pay higher premiums for coverage they do not want. Low-income persons may have to do without insurance entirely because they cannot afford the higher premiums insurers must charge for the state-mandated minimum benefits. A second argument is that development of long-term care insurance currently entails excessive financial risk and that imposition of minimum benefit levels and other regulatory requirements will discourage insurance companies fearful of future financial losses. The end result will not be consumer protection but nonavailability, or limited availability, of long-term care insurance.

The States' Experience with Long-Term Care Insurance Regulation

The experience of states that have attempted to regulate long-term care insurance indicates that insurers are highly sensitive to some statutory or regulatory requirements that pose potential financial risks. In general, the insurance industry has supported performance-based regulation. The Industry Advisory Committee on Long-Term Care of the National Association of Insurance Commissioners supported a position of "regulatory flexibility," but with consumer protection safeguards.

Most problems have arisen when states have acted to regulate policy content. An extreme example occurred in Wisconsin. The insurance commissioner, motivated by complaints from policyholders failing to receive benefits to which they believed they were entitled, decided that existing regulations did not protect consumers

sufficiently. He concluded that the most effective way to reduce the number of complaints was to require all policies to provide a minimum level of benefits and to prohibit certain policy provisions limiting benefits. Consequently, the commissioner issued a relatively stringent set of regulations that, among other things, prohibited use of a prior hospital stay as a precondition for payment of nursing home benefits and required insurers to pay for all days of care certified only as "necessary," rather than as "medically necessary." To the insurers, this meant paying benefits for long-term care services that might be necessary for nonmedical reasons, such as social isolation, in addition to those services required due to illness or accident. These requirements increased the likelihood of induced demand since the need for long-term care due to nonmedical factors is difficult to judge objectively or to predict with any reliability. The result was that all but one insurer discontinued sales of long-term care policies in the state, and this insurer did not market this policy actively. The state now has promulgated a revised set of regulations.

Whether Wisconsin and other states are better off with more stringent regulations and fewer insurers or more liberal regulations and more insurers, is a question for each to decide individually. Wisconsin policymakers apparently concluded at the time that it was preferable to have a small number of "good" policies available rather than a large number of policies that did not meet policyholders' expectations. In other states, the opposite may be the case. What the Wisconsin experience demonstrates is that states face difficult tradeoffs in considering proposals to regulate long-term care insurance.

States must balance consumer protection against insurers' avoidance of markets where they perceive inordinate financial risk. State studies of long-term care insurance have emphasized finding a middle ground where consumers are adequately protected and insurers still are willing to offer a variety of coverage. The Arizona and Georgia study commissions recommended no restrictions on long-term care insurers beyond already-existing consumer protections. Although the Massachusetts study called for minimum benefits, they were similar to those already offered in many existing policies. The authors also suggested requiring some policy features but avoided conditions they considered especially onerous to insurers, attempting to leave them free to experiment with new policy features. The National Association of Insurance Commissioners has published a model act intended to balance the interests of consumers and insurers.⁵⁹ The model act approach has the advantage of assuring uniformity of both performance-based and product-based requirements from state to state.

Federal Support of State Efforts

Despite lack of direct involvement with insurance, the federal government is interested in long-term care insurance. There have been numerous suggestions for extension of Medicare coverage to long-term care, and long-term care insurance is a potential private sector substitute. Also, budgetary reductions in Medicaid could result from widespread acceptance of long-term care insurance. The federal government has supported a number of research efforts and feasibility studies on long-term care insurance. The recently passed Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, Section 9601) established the Task Force on Long-Term Health Care Policies to develop recommendations regarding consumer protection, consumer education, and promotion of long-term care insurance. The task force's report will be completed by August 1987.

Question Six: What Have States Done to Encourage the Sale of Long-Term Care Insurance?

States have taken little concrete action to encourage purchase of long-term care insurance. State actions that have been taken have been of two types: requiring insurers to offer long-term care insurance, and encouraging market development through incentives and consumer education. State actions involving requirements have mandated that all insurers offering health insurance also offer coverage for some long-term care services, either as a standard benefit or as an option. Kentucky requires all insurers—individual and group insurers, HMOs, and Blue Cross plans—issuing health policies to make available at least one long-term care policy.⁶⁰ Unsuccessful bills in Kansas, Massachusetts, and New Jersey have contained similar requirements. While this kind of requirement may increase the number of insurers offering long-term care coverage, policies offered might not be appealing to consumers. Critics argue that most insurers, fearing financial losses in long-term care insurance, will design unattractive policies with limited benefits and high premiums. Others may withdraw from the state. The upshot would be only a small increase in the number of policies sold and public dissatisfaction with long-term care insurance.

Other states have focused on encouraging long-term care insurance. New York has sought to promote policy availability by giving the superintendent of insurance power to "modify or suspend" certain statutory or regulatory requirements for experimental long-term care insurance policies.⁶¹ Other states have taken more specific actions. These include:

- Preferential Tax Treatment for Long-Term Care Insurance Premiums
Tax incentives to encourage particular actions are a common

strategy in many situations. In 1986, Colorado enacted an income tax deduction for long-term care insurance premium payments for policies meeting specified minimum benefit criteria.⁶² An unsuccessful Hawaii proposal would have allowed a tax credit equal to twice the amount of long-term care insurance premiums.⁶³ Tax incentives were rejected by Arizona's study commission, however, which argued they might hinder development of other incentive programs that would accomplish the same objective without reducing state tax revenues. No action has been taken at the federal level to give preferential treatment to premium expenses on federal income taxes.

- Premium Tax Reductions for Companies Selling Long-Term Care Insurance Policies

Reductions in premium taxes for long-term care insurance policies could encourage purchasers if part of the savings were passed on in the form of lower premiums. Lower taxes on long-term care insurance premium income also would encourage insurers to sell more long-term care policies since the premium income would be taxed at a lower rate. Colorado has been the only state to take this step, enacting a one percentage point tax reduction on long-term care insurance premium income.

■ **Consumer Education About Long-Term Care Insurance**

Consumer education programs on long-term care insurance are a frequently mentioned market development strategy. Such programs encourage wise buying and address consumer misconceptions about long-term care and its costs. Long-term care insurance studies in Arizona and Georgia have emphasized the importance of consumer education. The Washington state Insurance Commissioner's Office has established a separate senior citizens' program unit to oversee the state-sponsored Senior Health Insurance Benefit Advisors (SHIBA) program. Working through trained elderly volunteers, the SHIBA program conducts public meetings and media campaigns to educate elderly consumers about a range of insurance-related topics, including long-term care insurance. Topics covered include Medicare and Medicaid eligibility and program benefits, as well as comparison of available long-term care insurance policies. SHIBA also publishes a number of consumer guides for the elderly.

Additional materials from which states might draw in formulating consumer education programs are also available. A report prepared for the Massachusetts insurance commissioner contains a draft "Guide to Long-Term Care Insurance" describing Medicare and Medicaid benefits, materials to aid prospective purchasers in evaluating the adequacy of benefits, and a proposed disclosure statement to be given to purchasers explaining policies in uniform language.⁶⁵ The report done for the National Association of Insurance Commis-

sioners by an advisory committee of insurance industry representatives also contains a model consumer education booklet.⁶⁵ The booklet discusses topics similar to those covered by the Washington program. It also has a list of "Questions to Ask [About Long-Term Care Insurance]" and a glossary of long-term care terms. The American Association of Retired Persons also has prepared a consumer's guide to long-term care entitled "Making Wise Decisions For Long-Term Care."⁶⁶

■ **Removing Barriers to Long-Term Care Insurance Availability**

State laws written prior to the advent of long-term care insurance sometimes create unintentional barriers. Failure to define long-term care insurance as a separate category of insurance may cause it to be considered a form of disability, Medigap, or other supplemental insurance. The result may be the application of inappropriate regulatory criteria and discouragement of interested insurers. Minnesota prohibited sale to Medicare beneficiaries of all health or accident insurance except Medigap policies in an attempt to eliminate the sale of duplicative insurance policies to the same person. This prohibition made the sale of long-term care policies effectively illegal, however, an obstacle that was removed recently.

In some states, statutory definitions of group insurance may not include the insurance offered by HMOs and Blue Cross plans, making it impossible for them to offer long-term care insurance on a group basis. The public, however, may best be served by a wider selection of policies.

Legislators may want to review state statutes and reconsider those that restrict development of long-term care insurance. An unsuccessful

South Carolina proposal would have required the Department of Insurance to conduct a review of state regulations to be sure none discouraged long-term care insurance. The Arizona study commission conducted such a review and concluded that no additional laws or statutory revisions were necessary to encourage long-term care insurance. Review of the NAIC model act also may be useful in this regard.⁶⁷

■ **State Catastrophic Coverage for Long-Term Care Insurance Purchasers**

While not yet introduced as legislation, a proposal from the Massachusetts Special Commission on Elderly Health Care is noteworthy.⁶⁸ Under the proposal, the state would agree to assume financial responsibility for persons who purchase Medigap and long-term care insurance with specified minimum benefits, but who exhaust their benefits while receiving long-term care. No asset "spend-down" or other financial requirements would be imposed. Consumers would be encouraged to purchase long-term care insurance since they would be guaranteed future state protection without having to spend down their own funds when their insurance benefits ended. The state would benefit from substitution of private insurance coverage for Medicaid and postponement of Medicaid responsibility for payment. Whether this program is to be implemented through Medicaid or through some other program will depend on interpretation of existing Medicaid program regulations. The advantages and disadvantages of

such a plan in terms of access, quality of care, and cost to both consumers and the state are yet to be explored fully. A successful program of this nature, however, might hasten the spread of long-term care insurance by creating a large customer base and stimulating market entry by more insurers.

■ **State Participation as a Long-Term Care Insurer**

States could act as insurers when private insurance is not widely available. An unsuccessful California proposal would have created a Long-Term Care Association within state government to issue a long-term care insurance policy offering benefits specified in the statute.⁶⁹ The policy was intended specifically to supplement policies already available to consumers. It would have covered intermediate, personal, and home care, but not skilled nursing care, which generally is covered by policies now on the market.

■ **Long-Term Care Insurance Benefits for State Employees**

An additional proposal is for states to purchase long-term care insurance for their own employees and retirees. As pointed out in Question Three, however, legal and practical obstacles must be overcome if employers, including the states, are to offer long-term care insurance.

Question What Is the Future of Long-Term Care Insurance?

Long-term care insurance has a definite role to play in financing long-term care. The demand for long-term care services will increase in the coming years, and government and personal funds alone may be inadequate to pay the costs. A range of new funding mechanisms will be necessary, and long-term care insurance is important among these. Although it has achieved wide visibility only recently, there is growing interest on the part of insurers, consumers, and government. All three groups have incentives to promote its use, but all three groups must take action if long-term care insurance is to play a significant, meaningful part in the nation's long-term care financing scheme.

Insurers

Insurers see a new market for insurance in the growing over-55 age group. Between 30 and 40 companies currently offer long-term care insurance policies. Many more are developing policies for introduction in the next few years. Over 20 Blue Cross plans also are considering offering long-term care coverages. All this activity clearly indicates that insurer interest in long-term care insurance will continue to grow.

But the increased interest among insurers is accompanied by widespread uncertainty about the ultimate financial viability of long-term care insurance. Long-term care is difficult to insure by its very nature. There is little agreement on exactly what constitutes long-term care or on the definitions of the three levels of care. The probability that persons will use long-term care ser-

vices is not easily calculated, and adverse selection and induced demand are difficult to control. In addition to the inherent difficulties in insuring long-term care, there exist little historical data on which to calculate risks and price premiums. All these factors increase insurers' financial risks.

Insurers temper their interest with words of caution:

Long-term care insurance is in an embryonic state of development and as yet, it is not known which policy designs might work best. Established carriers are entering this market but products are in an evolutionary stage. The challenge of insurers is to establish benefit levels and premium charges in products which minimize insurance induced demand for services and adverse selection, which avoid stimulating increased provider charges, and which provide meaningful benefits to consumers.⁷⁰

Consumers

Existing long-term care financing alternatives do not always meet the needs of consumers well, so they have been motivated to seek other ways of financing long-term care. Individuals needing such care now must become Medicaid recipients immediately, or they must deplete most or all of their own assets on long-term care expenditures. Medicaid, however, provides little financial support for those desiring home health care, and consumer choice in selection of a nursing home is restricted. Those who must spend down their own funds suffer the loss of self-esteem accompanying the loss of self-sufficiency. Noninstitutionalized spouses may become impoverished paying the expenses of spouses receiving long-term care.

The lack of interest in long-term care insurance up to now may mean that the financial and other burdens of long-term care are not evident to consumers. Potential purchasers may be underestimating the risks of needing long-term care and may not be completely knowledgeable about the limitations of Medicare and Medigap insurance policies. Effective consumer education programs gradually might diffuse these misconceptions and help potential policyholders better assess the risk of needing long-term care and the role private insurance might play. Consumers need specific information regarding available long-term care financing options, planning for future needs, and the costs of long-term care. Long-term care insurance cannot reach its full potential without educated and aware consumers.

Affordability is also an obstacle to consumer acceptance. While the cost of long-term care insurance always will be too costly for many of the elderly, studies indicate that a larger proportion of the future elderly population will be able to afford long-term care insurance as it is presently sold. One study predicts that the proportion of elderly households with annual real incomes greater than \$20,000 will increase from 21 percent in 1980 to 31 percent in 1995.⁷¹

One solution to the affordability problem is purchase of long-term care insurance at an earlier age, when premiums are lower. A second possible solution may be group insurance, which offers lower premiums because risk is spread over a larger number of persons and adverse selection is reduced. Life insurance and similar capital accumulation vehicles incorporating long-term care insurance options, should they appear on the market, also might be less expensive than currently available exclusively long-term care policies because the premium payments would be spread over a longer time period of time. Barriers to consumer acceptance must be overcome, however, for these more inclusive options to be effective.

The need for consumer protection in long-term care insurance is a recurring theme. Consumer groups, legislators, and govern-

ment leaders alike have emphasized the importance of insuring that policyholders receive benefits commensurate with premiums paid, and that consumers fully understand the policies they purchase. The question here is what measures are needed to insure that consumers are protected adequately. AARP, speaking on behalf of its members, has taken the following position:

[States] should encourage the development of a range of private, long-term care insurance products by eliminating legal and regulatory barriers that impede this development. At the same time, states should protect consumers' interests by such actions as prohibiting fraudulent advertising, developing a buyer's guide, and providing public education about long-term care insurance.⁷²

State Government

To governments, long-term care insurance offers the possibility of reduced Medicaid expenditures. This option is especially attractive in a time of declining federal financial support and resistance to tax increases. Long-term care insurance alone will not solve the problem of increasing Medicaid budgets, however. Researchers estimate that, at most, a 23 percent maximum decrease in total annual Medicaid expenditures can be expected because of long-term care insurance. Others estimate the impact to be as low as 5 percent annually, on average. Thus, a need always will exist for public funding of long-term care. Long-term care insurance is only one of a number of private and public financing mechanisms that must be developed to create a more accessible, flexible, and efficient long-term care financing system.

At the same time that government seeks to promote the purchase of long-term care insurance, it also must act to assure fair and principled marketing of these policies. Government actions to protect consumers

may focus on the manner in which policies are sold (such as disclosure provisions and "free looks") or their contents. Because the content-related requirements may influence the financial viability of policies, insurers have objected to many of these measures. In some cases, insurers have left states rather than sell policies, leaving little insurance available. State legislatures will have to reconcile the requirements of consumer protection and insurer encouragement, finding a solution that meets each state's unique needs.

The preamble to Georgia Senate Resolution 314 of 1983, creating the Senate Private Long-Term Care Insurance Study Committee, sums up the states' perspective on long-term care insurance:

- it is projected that one-tenth of the population of Georgia will be age 65 or over by the end of 1985; and
- it is a public policy goal of this state that every senior citizen should have access to quality care; and
- Medicare covers only a maximum of 100 days of care in a skilled nursing facility, provides no coverage for intermediate facility care, and only limited coverage of home health services; and
- most Medigap policies only pay for the deductibles and coinsurance required by Medicare for skilled nursing facility care between the twenty-first and one hundredth day; and

. . . . coverage for comprehensive long-term care services and home health services is offered on a limited basis by only a few companies; and

. . . . long-term expenses may have devastating financial consequences for senior citizens, often forcing them to liquidate assets and exhaust savings until they become eligible for benefits under the Georgia Medical Assistance program; and

. . . . the lack of availability of private insurance for long-term care has resulted in tax supported programs having to bear more than their share of the costs of nursing home services; and

. . . . the health care marketplace is in a state of uncertainty and transition regarding Medicare and coverage for comprehensive long-term care.

States must be concerned about the needs of the growing elderly population and seek ways to meet the financial demands of long-term care. The states' own resources may not be enough, and long-term care insurance should be investigated as one possible alternative.

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