



**CALIFORNIA HEALTH ADVOCATES**  
Medicare: Policy, Advocacy and Education

**TESTIMONY of CALIFORNIA HEALTH ADVOCATES**  
**House Energy & Commerce Committee**  
**Long-Term Care Insurance: Are Consumers Protected for the Long Term?**  
**Subcommittee on Oversight and Investigations Hearing**  
**July 24, 2008**  
**Washington D.C.**

**Promises Made, Promises Denied: Consumers of Long-Term Care Insurance Experience Denied Claims and Premium Increases**

**INTRODUCTION**

California Health Advocates (CHA) is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of California's Medicare beneficiaries. We provide support, including technical assistance and training, to the network of California's Health Insurance Counseling and Advocacy Programs (HICAP). HICAP is California's federally funded State Health Insurance Assistance Program (SHIP) that assists California's Medicare beneficiaries and their families. CHA also provides statewide technical training and support to social and legal services agencies and other professionals helping Californians with questions about Medicare, Medigap, and long-term care. Our experience with many health and insurance related issues is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting older consumers and their families.

I served on the Consumer Standards Working Group, the founding committee for developing the Partnership for Long-Term Care in California during the early 1990's. I also served as a funded consumer representative to the National Association of Insurance Commissioners (NAIC) for 15 years where I successfully advocated for many of the consumer protections added to the NAIC Model Act and Regulation for Long-Term Care Insurance, some of which reflected specific protections of California law. It has been twenty years since I have been called to talk about long-term care insurance before a Congressional committee and I greatly appreciate that this committee is taking a renewed interest in these issues.

**I. BACKGROUND**

The need for long-term care is completely unpredictable. It may result from a traumatic injury or major disabling illness at any age, or when an aging body or mind fails. Few people can predict what condition will trigger care, the range or intensity of services they will need, or, whether institutional care will be their only option because of the severity of their condition.

This is an emotional, financial, and often a legal crisis for family members struggling to find, arrange, and pay for care. Each family patches together their own set of services based on whatever information they have or are able to find from whatever is available in their community. Increasingly long-term care is also becoming a cost factor for businesses when employees are caregivers for one or more family members.

Long-term care includes a wide assortment of services provided in a multitude of settings including care at home, in community settings, in nursing facilities, and more recently in wide variety of assisted living arrangements. Individual needs can range from supervision and cueing of daily tasks, to complete assistance with everyday personal care services. While some skilled care services may be needed the most common need is daily assistance with the ordinary tasks of daily living, usually provided by family members and other unskilled workers. The cost of these services along with the cost of institutional care is the primary cause of catastrophic out-of-pocket spending for people requiring long-term care, and often leads to personal impoverishment and subsequent reliance on state Medicaid programs.

Individuals are often solicited to buy this insurance to avoid becoming dependent on Medicaid, and policymakers are often convinced that this insurance will reduce Medicaid expenditures. Claims are often made that consumers deliberately hide or transfer their assets specifically to qualify for state Medicaid benefits. In response, there have been a variety of changes and restrictions in federal law pertaining to transfers of personal resources, Medicaid look-back periods, and estate recovery actions. However, the Government Accountability Office (GAO) in its report “Medicaid Long-Term Care” found that few people who applied for Medicaid covered nursing home care in the three states studied, had engaged in such activity.<sup>1</sup>

Insurance for this type of care can be purchased individually, through an association or faith-based organization’s sponsorship, or through the sponsorship of a private or public employer. The federal government created the Federal Long-Term Care Insurance Program (FLTCIP) for the federal family of employees, active duty military, retirees, and qualified family members in 2002. Although long-term care insurance was formerly sold only to people in their 60’s and 70’s, it has more recently been marketed and sold to younger people through the employer group market<sup>2</sup> who will be paying premiums for several decades to cover the cost of their care in later years.<sup>3</sup>

Yet many older consumers who bought long-term care insurance years or even decades ago may no longer have their policy when they need care because of increases in the premiums they originally promised to pay. Other consumers have had their claim denied, often because older policies contain out of date requirements for claiming benefits, and don’t reflect changes in long-term care services and providers.

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<sup>1</sup> GAO-07-280 Medicaid Long-Term Care, March 2007.

<sup>2</sup> Employers rarely pay the premium for this coverage, and often offer employees a stripped down bare bones policy at low premium cost. Employees are often offered the opportunity to upgrade by adding missing features such as inflation protection, but may not understand the significance of those missing features or be willing to pay the higher cost of adding them to their policy.

<sup>3</sup> The cost of long-term care insurance for working people 30 to 50 years of age often competes with the cost of other necessary protections such as retirement savings, life insurance, and disability income.

If commercial long-term care insurance is to successfully help finance long-term care and reduce future reliance on Medicaid, then far more product standards need to be developed to avoid future problems. In addition, regulatory oversight needs to be increased to ensure that agents fairly represent the products they sell, and that insurance companies keep the promises they make to consumers decades before they need care.

Furthermore, if states enter into newly authorized Partnership arrangements with insurance companies, promising Medicaid asset protection to consumers who buy state-sanctioned products, then states have an even greater responsibility to ensure: 1) people understand the parameters and limitations of these public-private partnerships, and 2) companies and agents meet mandatory standards for marketing and sales, product design, rate stability, and claims payment.

Within the following sections are illustrations of real life examples that have come to my attention within the last five months, an unusual number in such a short period of time. In almost every case the consumers described here bought their policies in the late 1980's or early 1990's reflecting the long time period that is typical between the purchase of these policies and the use of their benefits. Purchasers of today's policies may have a similar experience decades from now depending on how much long-term care services and providers resemble those described in the policies they buy today.

## **II. STATE AND NATIONAL STANDARDS**

Like all commercial insurance, long-term care insurance is regulated by the states. However, there is inconsistent regulatory authority from one state to another over insurance products offered for sale in each state, the premiums companies charge, and premium increases they impose. Although the National Association of Insurance Commissioners (NAIC) Model Act for Long-Term Care Insurance and Model Regulation to implement the Model Act serve as an advisory regulatory foundation for state laws and regulation, many state legislatures change or refuse to adopt certain provisions of those Models, if they adopt them at all.<sup>4</sup>

In some cases legislative members may retain their business connection as a licensed insurance agent or other professional member of the insurance industry while simultaneously serving in their state legislature. Regulatory authority and oversight as a result may be very strong in some states and minimal in others. Product standards also vary between the states, again depending on members of state legislatures and their willingness to impose standards on insurance companies and agents that contribute heavily to their political campaigns. Because long-term care insurance is such a tiny portion of each state's over all insurance market it may not receive a great deal of attention from state insurance regulators.

The Health Insurance Portability and Accountability Act (HIPAA) created tax benefits for long-term care policies meeting certain standards, and for the first time established a set of national standards for these policies, regardless of the quality of state laws.<sup>5</sup> More recently the Deficit Reduction Act (DRA) gave states the option to grant Medicaid asset protection by waiving certain spend down requirements and estate recovery actions for purchasers of approved policies through newly established Partnership programs.<sup>6</sup>

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<sup>4</sup> The NAIC adopted the first Model Act for Long-Term Care insurance in 1986 followed by the Model Regulation in 1987.

<sup>5</sup> The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191).

<sup>6</sup> The Deficit Reduction Act (DRA) of 2005 (P. L.109-171).

Yet in each case, federal law used an older version of the NAIC Models that lacked some newer amendments such as suitability requirements, left out some key requirements or protections, and even specifically exempted others such as rate stability requirements.

While the NAIC Models provide a regulatory framework for this type of insurance they provide no guidance on a number of issues. Issues that are addressed in the Models are achieved only by consensus of the NAIC members who are often subject to industry pressure in their own state. Rather than incorporating the strongest standards from around the country for any particular issue, the NAIC process must achieve consensus of a working group, heavily attended by industry representatives. For instance, the Model Regulation allows insurers the unlimited right to challenge medical information provided on an application simply by alleging fraud on the part of the applicant, setting up a catch-22 for people who develop dementia later.<sup>7</sup> The NAIC considered a two-year limitation for challenging information submitted on an application several years ago in several hotly debated sessions, but the idea was ultimately rejected. However, California law has for 15 years restricted companies to a two-year period following the issuance of a policy, and the Florida legislature also recently adopted a two-year limitation.

While the NAIC Models offer states an advisory regulatory model, states often pick and choose the issues they wish to incorporate into their state law or rule. Even when a state does adopt a change it is not retroactive. Therefore policies sold prior to a change will not comply with those changes, and consumers who bought those policies will not benefit from it. Uniform national standards for long-term care insurance are only accomplished when federal law requires compliance with a specific standard in order to gain some benefit of federal law. This was the case when HIPAA created federally tax-qualified policies based on compliance with specific provisions of the NAIC Model Act and Regulation. However, HIPAA did create retroactivity of federal tax benefits by allowing consumers who had previously purchased long-term care insurance to have the same tax benefits,<sup>8</sup> and also established for the first time some national standards for this type of insurance, regardless of the quality of state law.<sup>9</sup>

As standards have continued to develop, companies have continued to collect premiums on previously issued policies, some sold decades earlier, with outdated restrictions and few, if any, consumer protections. For instance, policies sold during the 1980's, and even well into the 1990's in some states, included a requirement for a three-day hospital stay before nursing home benefits would be paid.<sup>10</sup> Since hospitalization and acute care needs have little if anything to do with a need for long-term care many people with these older policies are unable to collect benefits for nursing home care because they don't have a prior hospital stay and are admitted directly into long-term care facilities from their home.<sup>11</sup> Yet companies have continued to collect premiums for these policies for decades, and then deny benefits later.

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<sup>7</sup> See e.g.: <http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2004/06/13/BUGL574S4G1.DT>

<sup>8</sup> If a long-term care policy was purchased under the laws of a state prior to the passage of HIPAA it qualified as a federally tax qualified policy, regardless of whether it met the required standards expressed in federal law.

<sup>9</sup> As long as the policy met the requirements of HIPAA it qualified as a federally tax-qualified policy, regardless of whether any of those standards had been incorporated into state law.

<sup>10</sup> By 1990 the NAIC Model, and many states, prohibited the use of a three-day hospital stay to qualify for nursing home benefits.

<sup>11</sup> People often ask why a doctor can't simply admit the person to a hospital to meet the requirements of the policy; however hospitals are unlikely to allow doctors to admit a Medicare patient when their stay would not meet current Medicare rules for payment.

Some people have continued paying their premiums even while in a nursing home because they were told that if they do go into a hospital anytime during their nursing home stay the company will then pay the promised nursing home benefits. While a person may have a hospital stay while confined to a nursing home, people are often more likely to use up their assets and become eligible for Medicaid than be admitted into a hospital while confined in a nursing home.

Example of outdated restrictions in older policies:

Edith bought her long-term care policy in 1986 in California from AIG Life Insurance Company. She was diagnosed with Alzheimer's disease in 2001 and made a claim against the policy for home care benefits in 2005 after paying premiums for 19 years. Her policy required a three-day hospital stay, which Edith had had, but it also required that she be in a nursing home within 30 days of that hospital stay, and that skilled nursing benefits be collected for at least 14 days before the company would then pay for any home care. The condition causing hospitalization had to be the same condition requiring the nursing home stay and her home care. Since Edith did not have a nursing home stay following her hospitalization the company refused to pay her any home care benefits.

Unfortunately Edith's strategy of establishing a private source of payment for any care she might need later in life failed to meet her objective. Edith bought her policy before California prohibited this kind of requirement and since each requirement of her insurance contract had not been met the insurance department was unable to assist her. Edith is using her own resources to pay for care at home, and hopes she will die before she needs nursing home care, a cost which she cannot pay and will require her to apply for Medicaid if she has no insurance benefits to pay for care. She is considering whether she should continue paying the premium for her policy.

### **III. CONSUMER EXPECTATIONS: PROMISES MADE, PROMISES BROKEN**

Denied claims open a window into the world of unmet consumer expectations, and reveal how insurance companies interpret contracts and apply various requirements. Recent press reports<sup>12</sup> of large numbers of denied claims for long-term care insurance policies highlighted this issue and spurred the NAIC to conduct a survey of the states to determine the extent of the problem.<sup>13</sup> While the actual volume and number of these denied claims is in dispute between state regulators and the industry,<sup>14</sup> each denied claim often reveals an issue that is not addressed in state law or in the NAIC Models.

Market conduct examinations of insurance company practices by states are useful for finding faulty patterns in claims handling and processing by a company. However, these examinations may not focus on individual contract issues resulting in a disputed claim, thus allowing companies to continue making an unreasonable interpretation or application of contract terms. Each of the denied claims described in the following section illustrates an issue that is not addressed in the NAIC Models and for which better consumer protections are required.

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<sup>12</sup> "Aged, Frail and Denied Care by Their Insurer," Charles Duhigg, New York Times, 3/26/07.

<sup>13</sup> NAIC Long Term Care Data Call & Analysis Report, May 9, 2008.

<sup>14</sup> Disputes have arisen in part due to differences in definitions of complaints, methodology of categorizing a complaint, and collection of data in the various states.

Many people bought long-term care insurance during the 1980's and 90's with restrictions and requirements that have to be met now when they need care, often decades after purchase. As claims under those older policies are made and denied more and more families of those purchasers, now in their late 80's and 90's, are contacting their state insurance department to complain about the difference between what their family member thought they were buying and what the insurance company say they would pay. Often those families are left with no benefits to pay for care. In some cases they seek help from the courts to get their claims paid, in other cases they drop their policy losing the premiums they've paid over many years. When a long-term care policy has lapsed the reserves set aside to pay any future claims are released and become available to the insurance company.

### **Assisted Living Care: Lack of Standard Definitions and Requirements**

Assisted living was an uncommon alternative to nursing home care decades ago, and few if any long-term care policies included a benefit for it until the mid 1990's. Assisted living services are delivered in various and inconsistent ways across the states. Some states license these facilities, some certify providers, and some states do neither. The definition of assisted living varies between states and between providers. Even when a policy provides a specific benefit for assisted living, insurance companies often refuse to pay those benefits by challenging the status, design, staffing or services of a facility or arrangement, particularly when a policy has been issued under the laws of one state and used in another.

Examples of definitional issues and assisted living:

General Electric Capital Assurance Company (now Genworth) denied assisted living benefits described in a policy issued in New York, because at the time of the claim, the state of New York did not license assisted living arrangements.<sup>15</sup> In a more recent example Mrs. KC, who bought her AMEX (now Genworth) long-term care policy in California in 1992, was denied her assisted living benefits because the state licensed assisted living home her family chose has only six beds and not the ten beds required in her policy. Her family chose that particular assisted living home because of its individualized dementia services but is now faced with the choice of moving her back to a larger facility, and losing the individualized services they value so highly, and which have made a marked difference in Mrs. KC's day-to-day life. Mrs. KC has paid approximately \$50,000 in premiums since purchasing her policy for benefits she is now unable to collect because of a difference of four beds.

The NAIC recently adopted changes to their regulation intended to address the issue of assisted living benefits being claimed in a state different from the state of purchase.<sup>16</sup> However, even with those changes consumers can still be denied assisted living benefits because the structure and duties of the provider may not match the language of the policy, or the assisted living arrangement may not have a specific number of beds. Definitional differences in existing policies will still cause problems for consumers even if a state adopts the NAIC changes, and any changes a state makes will only affect policies issued after those changes take effect.

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<sup>15</sup> See *Van Houten v. General Electric Capital Assurance Company (GE)*.

<sup>16</sup> NAIC Model Regulation: Section 5 - Policy Definitions; Section 6 - Policy Practices and Provisions; and Appendix C.

## **Home Is Where You Live: Definitions of “Home” and Home Care Benefits**

In many cases people who live in congregate living arrangements, ranging in size from a few beds to facilities with multiple levels of care, occupy individual rooms or units and receive long-term care services the same as they would have if they still lived in their own apartment or single family home. Some companies define a home very narrowly, and routinely refuse to pay benefits for home care when it is received in any place other than the person’s single-family residence. Others companies will pay benefits for care received in another person’s home, or in some congregate living arrangements that are clearly not providing around the clock care. Older long-term care policies often provide benefits for care in a person’s home that could potentially be used in congregate living arrangements that may also provide assisted living services.

Examples of conflicts between assisted living care and where it is received:

Mrs. M. K. bought a Pioneer Insurance Company (now Conseco) long-term care insurance policy in 1990 that only pays for care at home and has no other benefits.<sup>17</sup> She did however have the foresight to purchase an 8 percent compounded inflation protection benefit, a very rare benefit to be offered or purchased in 1990 which illustrates the seriousness with which she attempted to plan for her future care. Despite Mrs. K’s prudent planning her claim for benefits has been denied. Now 84 years old, Mrs. K has dementia and is living in a state licensed assisted living home in California that is also licensed to provide specialized services to residents with dementia. Mrs. K is getting the same personal care services she could receive if she were living in her single family home, but in this home she has round the clock supervision, specialized activities for people with dementia, and socialization with other people who have the same condition. This assisted living home is not licensed to provide skilled nursing care nor is it a skilled nursing facility.

Yet the company refuses to pay her home care benefits arguing that this assisted living home meets the definition in the policy of a licensed skilled nursing facility and is therefore excluded as a place of care, and that the personal care services described in the policy which Mrs. K is getting are not being provided by a licensed home health agency as required by the policy but instead are provided by the staff of the assisted living home. However, nowhere in the policy is a person’s home defined, nor is there a definition of where policy benefits will be paid.

In a different example, Mrs. N bought her Conseco Home Care Only policy in another state in 1997 and later moved to California. When she needed home care recently at age 92 her daughter contacted the company, an assessment was made, and she was approved for home care benefits. The company however, refused to pay the policy’s benefits because her personal care services at home were not supervised by a home health agency. Furthermore they argued that her provider is not licensed by California to provide her care. However, the provider she was using at the time the assessment was made did not have a state license because California does not issue a license to deliver personal care services,

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<sup>17</sup> Conseco recently settled a multi-state market conduct examination related to long-term care claims practices and procedures, complaint handling, and sales and marketing practices in which almost 40 states participated, led by Pennsylvania, Illinois, Indiana, Texas and Florida. See also California Department of Insurance Order to Show Cause and Notice of Hearing File No. 05048841 in regard to long-term care insurance claims, for engaging in unfair acts or practices of the Fair Claims Settlement Practices, and unfair acts and deceptive practices of the California Insurance Code.

State certification is only required when services are paid by Medicare or Medicaid. The delivery of personal care services, such as assistance with dressing, bathing, eating, and other tasks, does not require the services or oversight of a licensed skilled care provider that typically charges higher fees and increases the cost of care. Since the policy was issued in another state California has no authority in regard to this claim. The other state was contacted and the company has now issued a check for the services she has already received as an “administrative exception.” The company will in the future though, require her to receive services under the supervision of a state licensed Home Health Agency and from a state licensed provider, which will dramatically increase her cost of care without providing her with any additional services, reducing the number of hours her benefits will cover.<sup>18</sup>

### **Alternate Plan of Care, Or Illusory Benefit?**

Over the last two decades some companies began including a benefit for an “alternate plan of care” to assure consumers that the policy benefits would adapt to their future care needs. This benefit promises that when care is needed the company may consider paying benefits in an alternative setting, or for benefits not covered under the policy. Yet exercising this option is completely at the discretion of the company, which, as shown by at least one company, often makes this benefit illusory.

Examples of failure to provide alternate care or services:

Mr. and Mrs. M replaced their existing AMEX long-term care policies in 1988 with two new policies from Continental Casualty Company specifically because the new policies included a benefit for an alternative plan of care in addition to benefits for nursing home care. These two highly educated elders believed the benefit described in the new policy was superior to their existing policies, and would allow them the flexibility to receive benefits in whatever setting best met their needs, an impression reinforced by the policy language and the agent who sold the policy to them. Eighty nine year old Mr. M recently needed assistance in caring for his wife who has dementia, and filed a claim for the policy’s long-term care benefits. The claim was denied with the explanation that benefits could not be paid for services received in their home under the alternate plan of care benefit, and policy benefits would only be paid when Mrs. M, now 86 years old, is confined to a nursing home. Mr. and Mrs. M have paid approximately \$98,000 in premiums for their two policies since 1988 and will apparently receive no benefits unless they each enter a nursing home, regardless of the alternate plan of care promise made to them.<sup>19</sup> In the meantime Mr. M continues to try to provide care for his wife at home, adamantly refusing to send her away to a nursing home.

Mr. and Mrs. R also bought two of these policies for nursing home care from Continental Casualty Company and the company actually paid for Mr. R’s care at home in 2002 under the alternate plan of care benefit. But this year when Mrs. R needed care at home under exactly the same policy and alternate plan of care benefit the company refused saying it was at the option and discretion of the company to provide this benefit and the company was no longer providing this flexibility in benefit payments.

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<sup>18</sup> California has a large community of documented women immigrants who specialize in caring for elderly people in their homes or other community settings at lower cost than home health agencies that are authorized to provide Medicare and Medicaid covered services.

<sup>19</sup> California law has no specific requirements related to an alternate plan of care, and the California insurance Commissioner has no authority to order a company to pay a disputed claim.

#### IV. RATE INCREASES

During the last ten years a number of companies have increased the original premiums consumers agreed to pay. Some increases affecting policyholders across the country have led to class action lawsuits in protest against these increases.<sup>20</sup> While companies do have the right to increase premiums for this type of insurance, several factors lead consumers to believe that won't happen. For example, these policies are guaranteed renewable, which means that companies can't cancel a policy for any other reason than failure to pay premium. Also, premiums for this type of insurance are characterized as "level premiums" meaning that most states don't allow companies to base a premium increase on the age or health condition of an insured person individually and can only be increased for a "class" of purchasers.<sup>21</sup> Sales and marketing of these policies emphasize these two factors leading most consumers to believe that the premiums will be level for life. Sadly that has not been the case and some consumers have been forced to give up their coverage late in life and near the time they would need to use their benefits.

The California Department of Insurance, under a legislative mandate, maintains a database of premium increases for every company that has sold long-term care insurance in the state since 1990.<sup>22</sup> Companies must submit data annually of any premium increases imposed on policies sold in California, and any other state as well. This information allows consumers and others to research company practices and discover the amount of cumulative increases over time.

Companies explain these increases as a necessary business practice to account for mistakes made when calculating the amount of the initial premium and point to unexpected increases in claims or lower than expected numbers of lapsed policies. Seldom do companies mention deliberate under pricing to gain market share, or lower than expected earnings on their reserves, which can be "unpredictable, and the pricing structure of LTCI products with inflation coverage are especially vulnerable to relatively small changes in investment return" according to John L Timmerberg, writing in Actuary Magazine.<sup>23</sup> Rarely are companies required to share in the pain of their pricing mistakes and made to absorb some of the losses. Instead state regulators, who have the will and the authority, will sometimes approve a lower amount than requested as evidenced by this excerpt from a Penn Treaty 11/29/07 letter to a policyholder.

*This rate increase represents a 35% increase in annual premium which has been approved by the Indiana Department of Insurance.<sup>24</sup> Based on current actuarial projections, we requested an aggregate 74% increase, which is greater than the amount currently approved. Therefore we anticipate filing an additional request in the future, the amount of which will be determined by actuarial analysis at that time.*

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<sup>20</sup> See e.g.: [http://www.lidi.louisiana.gov/whats\\_new/Penn%20Treaty/NAIC%20Class%20Settlement.pdf](http://www.lidi.louisiana.gov/whats_new/Penn%20Treaty/NAIC%20Class%20Settlement.pdf). See also: <http://www.insurance.missouri.gov/consumer/faq/conseco.htm>, Milkman v. Conseco Senior Health Insurance Company, case no. 03775 (PA, 2000); and Hanson v. Acceleration Life et al., case no. A3:97-152 (ND, 1999).

<sup>21</sup> A class is usually determined by the company or by state law, but is generally all the purchasers of a certain type of policy, or group of policies, sold within a state.

<sup>22</sup> Senate Bill (SB) 2111, codified at section 10234.6 of the California Insurance Code; see also <http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/ltc-rate-history-guide/rate-history-long-term-care.cfm>.

<sup>23</sup> See: <http://www.soa.org/library/newsletters/the-actuary-magazine/2005/june/lon2005june.aspx>.

<sup>24</sup> Indiana is one of the original Partnership states and it is unknown whether this rate increase affected any Penn Treaty Partnership policyholders.

In other cases a state may make a company spread a large increase over several years in their state. The effect of a cumulative increase, however, causes as much pain as one large increase and often deceives policyholders as to the extent of the increases they face. If fewer people lapse than the company expected as a result of a premium increase, that factor alone may change the rate increase calculations and result in yet another increase request.<sup>25</sup> In any event, older purchasers must absorb those increases on a fixed income, or abandon the investment they made in planning for the cost of their future care.

While the NAIC in 2000 adopted a new method of setting initial premiums and later requests for premium increases, it will be decades before regulators will know if the new method has been successful in mitigating future increases. About half the states have adopted the rate stability portion of the Model Regulation to reflect the new requirements for more accurate pricing. As a result, companies have had to increase initial premiums to reflect those new requirements. In addition, data for some risks covered by long-term care insurance is changing or just beginning to develop. According to a 2005 article in Actuary Magazine, there is very little data about assisted living claims for companies to use for pricing that benefit.<sup>26</sup> Consumers buying policies with benefits for assisted living may face higher premiums in the future as companies gain more experience with those claims.

## **V. MAKING PREMIUMS CHEAPER**

Since competition, and ultimately market share, for the long-term care insurance industry is often based more on the cost of a premium than actual benefits, companies have begun to offer stripped down versions of previous policies by deleting expensive features or benefits such as a waiver of premium that has been a standard benefit in most policies for decades. These benefits are then offered as “enhancements” at extra premium cost. Consumers rarely understand the value of this feature, and may be unwilling to pay extra to add it to a low cost policy. They will then be faced with continuing to pay an annual premium, whatever the cost, at the same time they are collecting benefits, or that they may need to use some of their benefits to fund their premiums, reducing the benefit amount they may have to pay for their care.

Another method of reducing the initial cost of premiums is to attach a deductible of a large dollar amount that perversely increases annually in the same fashion as the method of inflation protection a policyholder chooses, forcing consumers to pay an ever increasing cost before benefits ever begin. In addition, some companies have begun to offer a daily benefit based on a percentage amount, usually 80 percent. A twenty percent co-payment might seem reasonable to a working age person who is accustomed to paying a co-payment for their medical benefits, but this co-payment tied to the future inflated cost of long-term care, along with an equally unclear method of calculating the percentage of the company’s benefit payment, can be very large.

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<sup>25</sup> The calculations used to price a premium increase include a projected number of policyholders who will lapse their policies, often referred to as a “shock lapse.” Each lapsed policy eliminates any future claims the company is obligated to pay, which is also part of the premium increase calculation the company needs for a profitable block of business. When more people than expected keep their policies, the company will have greater claims exposure, driving up the amount of the premium increase needed.

<sup>26</sup> *ibid.*

The NAIC added a provision to the Model Regulation previously enacted in California that allows consumers to reduce the benefits they bought in return for a lower premium following a premium increase, or at any other time after purchase. This will help people keep some amount of coverage in force at a premium cost close to what they have been paying. In another action the NAIC adopted a Contingent Benefit on Lapse, allowing a person subjected to cumulative premium increases of a certain percentage based on their current age, to lapse their policy and maintain benefits equal to the premiums they have paid. There are however no requirements about how companies are to maintain contact with a previously insured person or how those previously insured people will know to claim those benefits.

Example:

Mrs. T.R. recently needed home care services. Her family thought she had insurance for this kind of care in the past, but didn't find a policy. They did find a notice that describes her right under a class action lawsuit to cancel her coverage and retain approximately \$39,000 in benefits. The local HICAP in California, part of the federally funded SHIP network, is working with the family to determine what, if any, action she might have taken after receipt of this letter, and what benefits she may have, if any.

## **VI. WAYS TO REDUCE CONSUMER CONFUSION**

The text in this section is excerpted from our 2006 research report for AARP's Public Policy Institute, Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers.<sup>27</sup>

Consumers who consider buying long-term care insurance are bewildered by the complicated nature of these policies and the inability to compare one policy with another. Comparing one long-term care policy with another is a challenge, even for professionals. Consumers will find very little independent and objective help or guidance to assist them during the decision-making process. Few elements of a policy are standardized leaving consumers unable to measure and compare how several LTCI policies will pay for their care. Benefits may appear to be the same, but the details of those benefits make it impossible to do a side-by-side comparison among several products. Agents are often not well trained to understand how these policies work, or to help a consumer make a comparison between one policy and another. An unwary consumer who relies on choosing the policy with the lowest premiums may have fewer benefits, expensive gaps in benefits, higher out-of-pocket costs than expected, and the potential for a steep increase in premiums later.

Long-term care insurance products contain an assortment of benefits and features, and come in policy designs that vary from one company to another, leading to significant product differences within a single state despite what appear to be similarities of benefits. In addition, an assortment of riders can be added that enhance, change, or modify the benefits of the base policy. If policy components were standardized, a tool might be developed to help consumers compare one LTCI policy with another. Consumers would also have a better chance of selecting an appropriate package of benefits and understanding how their policy works. No such tool, beyond the most rudimentary, currently exists because it is impossible to design one that will compare policies, provisions, and practices that vary so greatly, even within a single state.

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<sup>27</sup> See: [http://www.aarp.org/research/longtermcare/insurance/2006\\_13\\_ltc.html](http://www.aarp.org/research/longtermcare/insurance/2006_13_ltc.html).

While standardizing *components* of an LTCI policy is desirable, creating standard benefit *packages* does not seem to be an appropriate solution, because the selection of an LTCI policy is so dependent on the needs and the financial circumstances of the purchaser. This kind of standardization could leave some people, who might fall between the cracks of a few standardized packages, without the ability to buy the protection they need, or with buying the wrong set of benefits for their circumstances. The NAIC Models represent a regulatory framework that Congress could utilize to begin moving towards standardization of some components of these policies.

## **VII. PARTNERSHIP PROGRAMS**

Amid concerns about increasing Medicaid payments for long-term care services and the growing numbers of people who exhaust their assets and turn to Medicaid for help, Congress enacted the Deficit Reduction Act (DRA) that allows states to ignore assets above the Medicaid limit and waive asset recovery when people buy state approved long-term care policies as part of a public-private Partnership program.<sup>28</sup> This arrangement is often referred to as “asset protection,” a formal agreement between the state Medicaid program, the insurer issuing the policy, and the purchaser.

A Partnership program, in theory, allows consumers to shelter certain amounts of their personal assets from the state Medicaid program by buying a state certified long-term care insurance policy that will pay for their care in the future. In return the state promises that if the individual later qualifies for Medicaid benefits, each dollar of insurance benefits paid will protect one dollar of their assets from the state’s spend down requirements and later estate recovery actions. State Medicaid programs may benefit if a person uses their insurance benefits instead of Medicaid, or delays accessing Medicaid until their insurance benefits are exhausted. However, much of the success of a Partnership program depends on the standards a state establishes and the regulatory oversight it provides.

States need to build a solid foundation for their public-private partnership, ensure strong standards for participating companies and products, and provide strong oversight of the program and the consumers it serves. Partnership status should be limited to high quality dependable products that meet strict state standards, and to companies that are willing to comply with those standards to ensure that they will deliver on their promise of future benefits, and that the asset protection consumers have been promised will apply when they use those benefits.

States should consider the following specific issues when offering a Partnership program:

**Marketing:** Commercial insurance companies and their sales agents clearly have a compelling and valuable marketing advantage when a state Medicaid program enters into a long-term care insurance Partnership program. This is because an insurance policy that is endorsed by the state makes it instantly both attractive and credible, and sets it apart from other long-term care insurance policies. While sales opportunities for these products begin immediately the effect, if any, on a state’s Medicaid program will not be known for many years, perhaps decades.

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<sup>28</sup> Deficit Reduction Act of 2005 (DRA), PL 109-171. See Section 6021 that amends Section 1917(b) of the Social Security Act to provide for Qualified State Long-term care Insurance Partnership programs. See: <http://www.dehpg.net/LTCPartnership/map.aspx>.

To ensure that companies and sales agents don't exploit their connection to the state government, states need to develop strong standards for marketing and sales conduct. Consumers must be protected from overzealous advertising and misleading sales promotions, particularly seniors who may be a prime market for agents selling a state approved product, and one that the state may even promote and encourage its residents to buy. Bonuses, incentives and other sales reward programs are often used to increase sales of long-term care insurance and will compete with a state's interest in appropriate marketing and sales of these state endorsed products.

Taking advantage of the halo of state endorsement, sales agents may also include other insurance products in the same sales session, such as annuities and burial insurance. States should fully consider the effect of cross selling other insurance products to prospective purchasers of Partnership policies.

In addition, careful consideration should be given to the state's role in the promotion, marketing and sale of a commercial product that may be in conflict with their role as a government agency and draw public criticism.<sup>29</sup> Such a relationship with the private market will require careful monitoring of these products and the people who sell them to maintain the integrity of the program and ensure consumer confidence in the program.

**Medicaid eligibility, benefits, and asset protection in the state of purchase:** The relationship between commercial insurance products and a public benefits program through a Partnership agreement is a complicated arrangement, with many opportunities for confusion. Written descriptions and explanations of a Partnership program and the interaction between a commercial insurance policy and a state's Medicaid program should be drafted by the state Medicaid office with verbatim use required by agents and companies. Consumers will need an official explanation of Medicaid eligibility requirements, Medicaid benefits, asset protection accumulation and application, and estate recovery actions in their own state and some information about other states, in the event that they use their policy in a state different than the state of purchase.

Additionally, consumers need to be aware that states can change their Medicaid program at any time, and that they will have to meet the eligibility requirements in place at the time they apply for benefits in the state of purchase, or the one they move to later. Consumers also need to understand that asset protection reciprocity is not assured, that benefits available under Medicaid in their own state may not be covered in another state, that another state may apply a different standard to their protected assets, and that states can withdraw from active Partnership participation at any time.<sup>30</sup>

**Agent Training:** The DRA has no requirement in regard to agent training for qualified Partnership programs. It is our belief that agents should be required to take no less than eight hours of training on long-term care insurance and an additional 8 hours on Partnership products to ensure that they have the knowledge to accurately present information about these products and their interaction with a state's Medicaid program.

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<sup>29</sup> See e.g.: "States Draw Fire for Pitching Citizens On Private Long-Term Care Insurance", Wall Street Journal, Jennifer Levitz and Kelly Greene, 2/26/08.

<sup>30</sup> Reciprocity standards issued by the Department of Health and Human Services allows states with Partnership programs to apply their own Medicaid rules to a Partnership policy purchased in another state. States may opt out of reciprocity, or participation in a Partnership program, at any time. See Reciprocity Standards Draft 2 at <http://www.dehpg.net/LTCTPartnership/generic.aspx?idir=federal%20guidance%20documents>.

This is the standard required in California before an agent can sell a Partnership policy. No less than four hours of continuing education during each licensing period, usually two years, should be required to ensure that agents have the most current information about state's Medicaid program and the state's Partnership program.

The state Medicaid program should actively participate in setting standards for these trainings, and monitor the training materials used to teach agents about the state Medicaid program and its interaction with commercial insurance products. In addition, the state insurance department should review and approve training instructors and their courses. This approval would verify to the state Medicaid agency that agents completing these trainings will have a thorough working knowledge of the Partnership products and a state's Medicaid program. It would also ensure that the agent certification requirements under federal law are met.

Recent amendments to the NAIC Model Act imposes training requirements for agents selling long-term care insurance and specifies the content of training courses, but delegates the responsibility for certifying that knowledge and understanding of agents to the insurance companies whose policies they sell.<sup>31</sup> Federal law, however, ultimately places that burden on the state insurance department and the state Medicaid agency.<sup>32</sup>

In addition, agents and companies selling these policies to some extent represent the state when selling a Partnership policy. The active involvement of state agencies in setting the training standards and approving instructors and courses will help ensure the quality and accuracy of their representation and the products they are endorsing.

Selling a long-term care Partnership insurance policy places a greater burden of accountability on agents to guarantee that state endorsed policies are sold appropriately to people who can benefit from them, and that they are *not* sold inappropriately to people who can ill afford to pay for them over their lifetime.

## **VIII. PARTNERSHIP PRODUCT STANDARDS**

The DRA established certain standards that qualified Partnership policies must meet, building on previous standards established by HIPAA for tax-qualified policies. States can create higher standards than those in federal law as long as these standards don't exceed those for other long-term care policies sold in the state, or conflict with federal law. This flexibility allows states to upgrade their product standards and consumer protections, thus

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<sup>31</sup> The NAIC Long-Term Care Insurance Model Act Producer Training Requirements Section 9.C (2): Insurers subject to this Act shall maintain records with respect to the training of its producers concerning the distribution of its Partnership policies *that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B (2)(a) as required by Subsection A (1) and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state.* These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request. (Emphasis added)

<sup>32</sup> Sub-chapter B, Sec. 6021(V) The State Medicaid agency under section 1902(a)(5) "provides information and technical assistance to the State insurance department on the *insurance department's role of assuring that any individual who sells a long-term care insurance policy under the Partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.*" (Emphasis added)

ensuring their residents are adequately protected when buying these state-endorsed Partnership policies.

Four specific areas of product standards and their limitations are discussed below: inflation protection, suitability standards, rate stability, and notice of SHIP availability.

**Inflation Protection:** The federal standards of the DRA allow insurers a great deal of flexibility. For instance, federal law requires “annual compounded inflation protection” for purchasers 60 years of age or younger and “some type of inflation protection” for people between the ages of 61 and 76 years of age. However, it is doubtful that Congress envisioned the myriad of methods and combinations of inflation protection the insurance industry could construct within this broad statutory language.

A July 19, 2006 letter from Senator Charles Grassley, Chair of the Senate Committee on Finance, and Congressman Joe Barton, Chair of the House Committee on Energy and Commerce to Dennis Smith, Director of the Medicaid branch of the Centers for Medicare and Medicaid Services (CMS) expressed their joint displeasure with one method of inflation protection that CMS would allow. Since then the Department of Health and Human Services has designed data elements that companies issuing qualified Partnership policies must report, as required by the DRA, to allow the federal government to track various components of this public-private partnership. The sheer number of data elements pertaining just to inflation protection reflects the potential for a dizzying array of combinations and methods of providing this protection.

Since federal law neither prescribed the amount of compounded inflation protection that was required nor whether the company, or the covered person, had to continue inflation protection over the life of the policy, the potential exists, for example, of a company selling a policy with 2 percent compounded inflation protection that lasts only until a person is 61 years old and then replacing that method with an option of purchasing another form of this protection at additional cost that will end or expire during the term of the policy.

This is just one example of how an inflation protection benefit can be manipulated in a way that is dangerous for both unsuspecting consumers and the state. Long-term care insurance policies without adequate inflation protection put a state Medicaid program at risk of spending its own dollars when a person’s insurance benefit falls further and further behind the cost of care with each succeeding year. To prevent this, states can limit the number and variations of inflation protection that can be offered in their state, and require that companies offer only certain limited combinations, as long as the minimums are not below those required by federal law and they apply to all long-term care policies sold in the state.

The failure of federal law to define and require adequate inflation protection leaves consumers at risk for steadily building an unaffordable co-payment liability that will come due when they need care. States should carefully consider the effect on their state Medicaid program if consumers arrive on the day of care with a monthly co-payment that consumes a large part of their income, a benefit that lags significantly behind the increasing cost of care, and results in tapping assets they planned to protect.

**Suitability Standards:** The DRA did not address the issue of suitability of benefits and premiums for consumers who buy Partnership policies. Section 24 of the NAIC Model Regulation for Long-Term Care Insurance requires companies to develop and train their

agents on standards of suitability. The Model does not specify those standards but leaves it up to companies to develop their own. We believe the state Medicaid program in consultation with consumer groups and companies should develop the standards to be applied to the sale of Partnership policies. Partnership products are unique with respect to the need to consider income and assets along with the likelihood of future eligibility for Medicaid. Suitability standards might also help agents understand how to better tailor benefits to the needs of Partnership purchasers.

Agents, companies, and states also need to acknowledge that not everyone can afford a long-term care policy, and not everyone needs a Partnership policy. Consumer groups are justifiably concerned that some moderate income consumers will spend a large percentage of their income to protect small amounts of assets that may already be exempt under federal spousal impoverishment law for purposes of Medicaid eligibility, or that these policies will be inappropriately sold to people who have neither the income to pay for them over time, nor significant assets to protect.

**Rate Stability:** The NAIC requirements for initial rate filings and rate increase requests are not included in the DRA and were not included previously in HIPAA. The lack of rate regulation has resulted in erratic and sometimes dramatic premium increases. Indeed, premium increases by some companies that issued long-term care insurance policies have made headlines across the country. Having rate stability in long-term care insurance, Partnership policies is crucial to the premise that purchasers will still have their policies when care is needed.

State Medicaid agencies need to carefully think through how premium increases may affect the state's program. The worst of all possible situations is for consumers to spend large amounts of money over many years paying for coverage that may not be there when they need it. Taxpayers in the meantime will have subsidized those premiums through the federal tax code,<sup>33</sup> and subsidized Medicaid benefits for individuals who are unable to continue paying for their policy and subsequently qualify for that program.

## **CONCLUSION AND RECOMMENDATIONS**

The surge of baby boomers who may live into their 80's and beyond and their future needs for care coupled with a growing shortage of health care workers combine to present many planning challenges for providing and paying for the long-term care services this population will need.

Today the quality of a long-term care insurance policy a consumer buys, the premium increases they experience, and their ability to resolve disputed claims depends on the state they live in. The unwillingness of state legislatures to enact better standards and consumer protections shouldn't be the determining factor of whether consumers have access to high quality products. Federal law could mandate additional minimum standards by directing the NAIC to form a working group to develop those standards and amend the NAIC Models, as was the case with Medigap standardization under OBRA 90. That process when mandated by federal law with participation by federal agencies, consumer groups, industry and regulators can work to accomplish common goals.

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<sup>33</sup> The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) allows certain amounts of premiums paid for these policies, based on the age of the taxpayer, to be deducted as a medical expense. Many states allow a similar deduction for state income taxes.

States sometimes argue against the creation of national standards by claiming local conditions differ from one state to another. While that may be true with regard to services and providers, consumers deserve quality products and consumer protections regardless of the state they live in. States should play a traditional, primary role in enforcing federal standards, in establishing standards above the federal minimum, and in monitoring performance of companies.

Examples of standards needed:

- Require notification of the availability of free counseling by the federally funded State Health Insurance assistance Programs (SHIP) in company advertising materials, outlines of coverage, including the contact information for the local program.
- Require agents selling long-term care insurance to provide the local SHIP contact information at the time of solicitation.
- Begin standardizing various elements of long-term care policies to limit consumer confusion such as:
  - Definition of family members who cannot be reimbursed;
  - Definition of waiting periods and how those are applied;
  - Definition and operational rules for an alternate plan of care;
  - Definition of a person's home to include the home of others; and various congregate living arrangements that are clearly not institutional in nature.
- Require a two-year limitation on contestability. Companies through adequate underwriting should be able to screen out fraudulent applications and those with evidence of a health or cognitive condition.
- Develop operational rules for the 90-day certification required by HIPAA to clarify that it cannot be used to delay the beginning of a deductible or waiting period.
- Require annual notification to former policyholders of their contingent benefit information, along with required reporting to states and tracking by states.
- Develop a clear requirement that a policy benefit payable in the state of issue is payable in any other state without regard to structural differences in providers (i.e. number of beds), or state requirements for providers.
- Establish a reasonable range of inflation protection methods, amounts, and benefits to ensure consistency with state and federal standards.
- Regularly update federal HIPAA and DRA standards to include the most recent provisions of the NAIC Model Act and Regulation and to keep pace with an evolving market and product.

- Require policies to make the total value of all benefit periods available in any covered setting.
- Require that policies approved through the NAIC Interstate Compact use the latest version of the NAIC Model Act and Regulation and incorporate and apply any changes to those Models as they occur.
- Tighten the responsibility of states with respect to Partnership programs, as previously outlined.

Thank you for the opportunity to provide these comments. Respectfully submitted by:

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