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LONG-TERM CARE INSURANCE: PROTECTING CONSUMERS FROM HIDDEN RATE HIKES

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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LONG-TERM CARE INSURANCE: PROTECTING CONSUMERS FROM HIDDEN RATE HIKES

WEDNESDAY, SEPTEMBER 13, 2000

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:36 a.m., in room SD–608, Dirksen Senate Office Building, Hon. Charles Grassley, (Chairman of the Committee) presiding.

Present: Senators Grassley, Burns, and Bayh.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. Welcome, everybody. Those of you who are regular attendees at the Aging Committee, we promise to give you a break after Congress adjourns, but otherwise we have a very busy schedule this month of four or five hearings. We want to make sure that this committee does the job that it should do of protecting our senior citizens and seeing that the laws are faithfully executed and that the money we spend from the Congress of the United States for senior citizens is spent in the right way.

We are kind of here on a private sector matter as much as a public sector matter for this particular hearing, but it is also very important because if we are going to have successful programs for our seniors, and particularly the baby-boomers who are going into retirement, 77 million of them in the year 2010, and think in terms of that being the biggest demographic shift in the history of our country, we are going to have to have that sort of a relationship.

So today we are going to look at the growing industry of long-term care insurance and discuss some things that we would like to see corrected within the industry. But more importantly, this meeting can be interpreted, as well, as making all of us more conscious of products that are out there, and also to encourage the industry to be more vigorous in this effort as we hope a piece of legislation that we got passed for Federal employees to have in their insurance program—and this was signed by the President this summer—that long-term care insurance can be offered as part of the Federal benefit package.

So I want to say good morning to all of you, and thank you for your interest in everything that goes on with this committee, but particularly this issue. As a strong proponent of long-term care insurance, I can say that it is critical for Americans to become aware and even more familiar with this product.

At this point, we have about 3 million Americans who have long-term insurance. Well, that is good news, but the better news is that at least one big company is running TV commercials about the issue, trying to get more people involved with it, obviously wanting to sell their product. And I think the increased popularity is a very good development.

People want long-term care insurance for two main reasons. One is they see if they would ever go from a nursing home from friends and relatives that have been there that it is very, very expensive, and they want to be prepared for that. It can cost about $50,000 a year. Most people obviously don't have the cash to pay for that. Of course, Medicare pays very little, and for Medicaid to pay for it, people have to impoverish themselves.

Furthermore, most seniors are reluctant to rely upon their adult children to help them cover the costs, although we know that there are a lot of family caregivers, even through help at nursing homes, that we surely don't want to discourage. But for an adult to rely upon that—most of them don't want to, and if they did, maybe children wouldn't have the capability of doing it. I say this because it is typical of my generation of Americans and older not wanting to be a burden to their children.

Second, besides the fact that it is very expensive, long-term care insurance can help preserve quality of life. Most people want to avoid nursing homes. I have never met one person in my life that ever said, I am just dying to get into a nursing home. Long-term care insurance can help them do that.

Most products offer alternative services to nursing home care, and then that fits in with our continuum of care policies that we want to—not denigrating nursing homes in any way, but to keep people out of nursing homes as long as we can for the benefit of quality of life, as well as the benefit of a lower-cost care that is available—adult day care services, home health care services, assisted living.

Assisted living comes in a lot of different names—independent living. I suppose each entrepreneur in that area has a different title that maybe signifies the same thing, but it is somewhere in between when people can't be independent in their own home or independent with home health care and family caregiving that then they go to something in between them and nursing homes.

We have some of these policies, besides paying for these services that I have already talked about, that even pay for home care by a family member, and that is something through tax changes that we hope to get adopted yet this year, that we even encourage family caregiving through a tax credit for that purpose. But some policies recognize this as well.

These issues that I have talked about—nursing home care being expensive, and preserving the quality of life—were common considerations for more than 2,000 North Dakotans who bought long-term care policies from Acceleration Life Insurance Company just a few years ago. Unfortunately, they didn't count on the large and rapid increases in the premiums they were paying for the policy. These increases were so large and rapid that these policyholders were forced to drop their policies with nothing to show for them.

I want to give you an example of a man by the name of Harold Hanson, a typically independent North Dakotan, now 96, a former rancher, lives alone and still cooks for himself. In 1987, he bought an insurance policy with a premium of $1,498. By 1996, that policy had gone up to $6,158.

So concerned about the rising costs, Mr. Hanson wrote letters trying to stop the steep increases, and he wasn't successful. He concluded that he couldn't afford the policy. The company kept everything that he had paid over the years in premiums. Ultimately, he and other policyholders filed suit and won their suit. We will hear more about that case in testimony from witnesses today.

What is wrong with this example and probably other examples we could give you is very simple. People should get what they pay for and they should know what potholes lie ahead of them as they go down this road of trying to seek some independence and risk aversion and risk management that they are trying to do through the purchase of this kind of insurance.

It is one thing if you sign up for insurance coverage knowing that your rates might drastically increase. It is quite another thing if you didn't know and you were left out in the cold, because all of these things, if you don't know about them, has to be a bad practice by any industry, in this particular industry the salespeople that were involved in selling this product. It is especially bad when people are using their limited incomes to take responsibility for financial obligations during their old age, as Mr. Hanson is an example of.

My interest now is building greater accountability to consumers from those insurance companies who might jack up rates without saying so. And shopping for a product can be a very daunting task. Each feature requires a decision. The list is long—inflation protection, non-forfeiture, guaranteed renewability, a waiting period, maximum length of coverage, maximum lifetime benefits, per diem payments, and probably all the above and more.

The difficulty of these decisions is compounded by the impossibility of knowing exactly what, if any, services you may need. Despite these complexities, the price is the key factor in most people's decision to purchase. That may not be the way it ought to work out, but it seems like that is a very important factor.

Lately, regulators and companies are doing more to disclose information about rate-setting practices. For instances, the State of California made companies give consumers the history of rate increases for any of the products that they were selling.

The National Association of Insurance Commissioners recently adopted new model regulations requiring greater protection for long-term care insurance consumers. The National Association of Insurance Commissioners has sent their proposal out to all the States for consideration and adoption.

I am raising this issue in Congress because we are considering legislation to give tax incentives to individuals who buy long-term care policies, and I am the principal sponsor of that legislation. A Federal tax break would stimulate long-term care insurance sales. It also would indicate to consumers that such policies are safe and Government-endorsed.

As the sponsor of that legislation and as a strong believer that private long-term care insurance should be part of everyone's planning for retirement, I believe I have a special responsibility to ensure that consumers are protected when they buy a policy. A Federal tax break amounts to a Government seal of approval, and an insurance policy should be worthy of that seal of approval.

Long-term care insurance is a great concept and it will help a lot of our people, and we have to take that concept and make sure that we get a good product out of that concept.

I am going to introduce witnesses after I hear from—I think I am going to go Democrat, Republican, so I will go with Senator Bayh and then the Senator from Montana.

Senator Bayh.

STATEMENT OF SENATOR EVAN BAYH

Senator BAYH. Well, thank you, Mr. Chairman. You are most gracious. It is good to be with you and our colleague, Senator Burns. And particularly since Senator Burns arrived before I did, it is kind of you to give me my turn next. I want to thank you for your leadership in convening these hearings, and your leadership over several years on what is a very important issue to many constituents in my State and across America.

Let me be brief in my comments. I am looking forward to hearing from the witnesses. I guess I should say brief at least by the standards of the U.S. Senate, which sometimes can be a little longer than would take place in the ordinary context.

This is an issue of great interest to me. Obviously, it is of great importance to the elderly in Indiana and elsewhere. I was just looking at some statistics. 12.8 million Americans indicate the need for long-term care, and that will be growing as the population ages.

Many of our constituents who are not currently elderly find themselves in the uncomfortable squeeze of providing for children, saving for their kids' college education, putting something away for retirement, and also thinking about the challenges of long-term care.

This is especially ironic given the lack of information. We held hearings—and I want to thank you for that, Mr. Chairman—at our State fair on Senior Citizens Day. They were well attended. We did that last year, as well as this year. Based upon that experience and others, there seems to be a great lack of information on this whole subject, which is why these hearings are particularly important.

Many people are surprised to learn that Medicare does not cover long-term care. They are unaware of the fact that they must spend down their assets and essentially descend into poverty before the Government will come to their assistance in this area. And as a result of the lack of information, I believe, Mr. Chairman, only about 7 percent of the American people, perhaps fewer, are currently planning for this need by purchasing the long-term insurance to help provide for this eventuality.

That is why I share your commitment to doing something about this. The idea of a long-term care tax credit, I think, makes a great deal of sense to provide for caregivers at home. Also, a deduction for the premiums for the purchase of insurance, I think, makes a great deal of sense. These are tax cuts that will not only help to

alleviate the financial burdens of families, but they accomplish a societal good as well.

So I thank you for your leadership in conducting these hearings. I am looking forward to hearing from our witnesses today, and I strongly support your endeavors and those of other Senators. As a matter of fact, I have some similar legislation of my own in this area to help alleviate the financial burdens of seniors and middle-aged citizens who are looking at the prospect of long-term care insurance and the needs that it will help to meet.

Thank you, Senator, and thank you, also, Senator Burns.

The CHAIRMAN. Thank you.

Senator Burns.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Senator Bayh I know you will relay all the information that I will need.

Senator BAYH. Is that what happens to us newcomers?

Senator BURNS. Yes. I will give you a test after it is over.

I have got another hearing over in Commerce that is also very important. We are talking about the pollution of the mind over there today, and so I have got to get back over there. But I did want to drop by here and pick up the material, and especially the testimony that is going to be offered by our witnesses today because this is also very important.

In Montana, I think one year in a nursing home costs about $50,000, and I fear that we are on a treadmill. I don't know how this is all going to play out. We want all the new technology of health care and of pharmaceuticals our lives, and yet we are living longer and so that drives up the cost of insurance, and also drives up the cost of nursing homes. We are on a treadmill and I don't know whether we are getting anywhere or not on trying to solve these long-term health care situations.

I am going to cosponsor the bill that has been put forth by our chairman. We know the problem. There is no single silver bullet as you look at the situation of taking care of our aging. And I am in that category now, so I am pretty interested in it. I plan on supporting the approach that Senator Grassley has taken. I think it is important for families who take care of folks.

You know, we have come a long way. I am old enough to remember that my grandparents were taken care of by their kids in their homes. They didn't go to nursing homes. I only remember two of my grandparents, but both of them lived with their family and so we have come a long way from that.

We have also come a ways from the fear of the old county farm. There was a county farm out there that mom and dad said, now, if you don't take care of yourself and save for the future to take care of yourself, that is where you are going to end up. That was sort of an incentive for all of us to kind of put a little money aside and plan on insurance or saving. There just wasn't somebody who was going to take care of us and we knew that we would have to provide for ourselves. I think probably Senator Grassley's approach to this is a step in the right direction. So we know the problem and we are all very, very concerned about it because length of life now is much longer than ever before.

So I thank the chairman for holding these hearings. I am going to read the testimony and then if I have anything to ask about it, I will ask you on the floor, Senator Bayh. So I appreciate that very much. I have got to go back to the Commerce hearings this morning, so thank you very much for making this allowance for me.

[The prepared statement of Senator Burns follows along with prepared statement of Senator Blanche Lincoln:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Mr. Chairman, thank you. And thank you to those of you who are here to testify and observe these proceedings. I appreciate you taking time out of your schedules to be here today.

The marvels of modern health care and better medicine have meant that Americans are living longer and healthier lives than ever before. This fact adds more stress to the financial side of the aging process, however. And as our society ages, more senior citizens are purchasing long-term care insurance to protect them from the extremely expensive costs of residency at a skilled nursing facility or other institution.

I wholly applaud and support those seniors who attempt to provide for their future care by purchasing a long-term care policy. However, during the last weeks of August I traveled Montana speaking with senior citizens about aging issues and heard a lot about the costs of long-term care. Too many Montanans who wish to purchase long-term care insurance are forced to do without it because of prohibitive costs. I hope that we will be able to conduct a positive, constructive discussion of how we can educate and protect senior citizens and expand their access to long-term care insurance.

Some will contend that Medicare coverage of long-term care is the answer. I worry that the addition of a benefit of that type would only hasten Medicare's demise and would leave us in a worse position in the long run than we are in now. As it currently sits, most elderly Montanans are effectively forced to sell off all of their assets and deplete their life savings before Medicaid will begin to assume even partial responsibility for the cost of long-term care, which is currently averaging about $50,000 per year in Montana. This sell-off is a difficult event for people who have worked all their lives to create a small nest egg. The assumption of a long-term care patient into Medicaid in turn drains Medicaid of limited resources.

I believe that long-term care insurance is the best answer for the future crunch in this arena. By planning ahead for their needs, senior citizens can assume greater control over the care they receive if and when they require round-the-clock care, protect their life's work from liquidation due to high out-of-pocket costs, and shield their children and grandchildren from having to pay for their care.

It is better for government to help people help themselves than for Big Brother to simply step in and do it his way. That is why I am supportive of tax deductions of long-term care insurance premiums and tax credits for those who require long-term care. I would like to offer to Senator Grassley my cosponsorship of the Long-Term Care and Retirement Security Act of 2000 and extend my assistance in getting this important legislation passed.

I am very interested in the recommended revisions to long-term care regulations as suggested by the National Association of Insurance Commissioners. While I in no way wish to violate a State's right to regulate the insurance industry within its borders, I believe that the NAIC is off to a good start here. We need to protect the long-term care insurance consumer.

By 2025, Montana will have the third highest concentration of senior citizens in the nation. The fact of the matter if that my state needs to prepare for this growth in our aged population. While we cannot prevent aging, we can prepare for it. I am hopeful that this hearing and this legislation will help senior citizens in Montana and around the nation prepare for their own needs in their old age.

PREPARED STATEMENT OF SENATOR BLANCHE LINCOLN

As Baby Boomers begin to retire and life expectancies increase, the need for long-term care insurance grows more important. I am pleased that the President and Congress are beginning to recognize this benefit as a part of seniors' retirement plans. With Senate and House approval of H.R. 4040, which establishes a long-term care insurance program for federal employees, members of the uniformed services, and civilian and military retirees, the federal government provides an example for the private sector to offer this coverage for their employees.

However, insurance companies must be forthright in their advertising and consumers must be aware of the options associated with buying long-term care insurance, including premium increases, covered benefits, and the best time to buy a policy. In March of last year, the Special Committee on Aging discussed long-term care provided by family caregivers. Today's hearing moves the long-term care discussion to the next phase—the pitfalls individuals must know in order to provide for their own long-term care.

I appreciate the witnesses' testimonies before the Committee and look forward to them shedding more light on this vital topic.

The CHAIRMAN. Thank you.

Now, would Ms. Sebelius and Dr. Scanlon come to the table, please?

The first witness will be Kathleen Sebelius. She is the Vice President of the National Association of Insurance Commissioners. She is the elected Commissioner of Insurance for her State of Kansas, in her second term. She is going to discuss these National Association of Insurance Commissioners proposed model regulations that I have already referred to in my opening statement.

People who attend the hearings of this committee regularly recognize the name of Dr. Scanlon, Director of the Health Financing and Public Health Division of the United States General Accounting Office, because he has testified almost at every meeting this committee has ever had. We rely upon him quite a bit for independent judgment and investigation, and he is going to discuss for us the current trends within the long-term care insurance industry.

Before you start, Ms. Sebelius, let me have a conversation with Senator Bayh.

If we have a vote at 11, and we never know for sure if we will, would it be possible for one of us to vote and then the other one stay and keep the meeting going that way, or do you have to leave when you leave to vote and not be able to come back?

Senator BAYH. Chairman Grassley, I would be happy to help you in this regard.

The CHAIRMAN. OK, thank you.

Senator BAYH. That is what we call a no-brainer. The chairman asks if—— [Laughter.]

But I appreciate your presenting us an option. Thank you, Mr. Chairman. [Laughter.]

The CHAIRMAN. Thank you.

Ms. SEBELIUS.

STATEMENT OF KATHLEEN SEBELIUS, COMMISSIONER OF INSURANCE, STATE OF KANSAS, AND VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, TOPEKA, KS

Ms. SEBELIUS. Thank you, Chairman Grassley, and Senator Bayh. It is good to see you.

My name is Kathleen Sebelius. I am the elected Insurance Commissioner for Kansas, and serve as the Vice President of the NAIC, the National Association of Insurance Commissioners, and also have chaired the Health Committee of that Association. I want to thank you for giving us the opportunity to testify about some of the Association's activity on long-term care insurance and what the States are doing to protect consumers.

As you both are well aware, this product is relatively new in the insurance world, dating back to the 1980's, so we really don't have a long history with it. NAIC first moved into the arena of developing a model act and regulation in 1986, and we have updated them numerous times over the years.

As you know, when HIPAA was passed, Congress included in the definition of tax-qualified long-term care insurance policies a number of the features of the 1993 NAIC model, and included those consumer protections. Since HIPAA was passed, we have continued to update and add additional consumer protections to the model, and we think that it would be appropriate for Congress to take a look at our recent enhancements as you deal with the possibility of giving tax credits, tax benefits, and tax incentives to Americans to purchase long-term care coverage.

The specific protections we want to bring to your attention are suitability of the product, contingent benefit upon a lapse if a consumer can no longer afford to pay it and enhanced consumer disclosures.

Suitability really deals with whether an applicant is actually able to afford the policy, now and in the future, and whether the benefits are right for a consumer. It is an important issue in helping consumers to decide whether to purchase long-term care coverage. The current version of our model has things like personal worksheets that factor in income and expenses and savings to determine whether or not a policy is appropriate.

Nonforfeiture benefits really deal with the situation of a rate increase and a consumer who is really caught in the trap of not being able to afford these future payments. Under our model, an insurance company, at the point of sale needs to offer nonforfeiture protection. It costs more money, but guarantees that the policy would be in place.

If the consumer can't afford or chooses not to take that protection, the company must instead provide what we are calling contingent nonforfeiture, which is a benefit without any additional premium. What contingent nonforfeiture does is if the premium goes up by a certain amount since the consumer bought the policy, then the consumer gets three choices. The consumer can pay a higher premium and keep the same level of coverage. The consumer can pay the same amount of premium and actually reduce the benefits, but the consumer keeps protections in place as a safety net. Third, the consumer is given the option of having the payments that have

been made so far constitute a paid-up policy and the benefits are reconstituted and stay with the consumer as protection.

So we feel that contingent nonforfeiture at least ensures that, unlike the situation which you described in North Dakoa with Mr. Hanson, the consumer doesn't lose the money they have put into the policy up until that point, in spite of the fact that they cannot afford any future premiums.

The NAIC has also adopted enhanced consumer protection amendments which require insurance companies to disclose rate histories for the past 10 years. I brought with me, Mr. Chairman, the kind of long-term care book a lot of insurance departments have. This happens to be the Kansas long-term care rate book, which is available in print form and also on our Web site.

One of the things we require all the companies to do is give us the history of rate increases, and we make it very simple for a consumer to go to the back of the book, check the rates, and also check what the rating history has been. Consumers need to know if a company has a history of increasing rates, and that becomes one of the important questions.

Consumers also need to know about rate stability issues and our model requires mandatory disclosure to consumers about potential future rate increases. Although under a long-term care policy a company can't single out one individual and raise rates, it can raise the rates of an entire class of business. That does cause rate increases and consumers need to be aware of that possibility.

Last month, as the Chairman has already indicated, our colleagues around the country unanimously adopted these new consumer protections, and we are working right now in the States to get those into place and to require companies to follow these new guidelines. However, capturing them in a new congressional bill and as a tax incentive would be a huge step forward.

We have also established new rating practices. This has been one of the problems. The situation that the Chairman gave about North Dakota is a good example of a company who enters the market with what is in the long run an inadequate rate, only to turn around and have to increase that rate.

Frankly, the choices aren't good. If you say to companies, you can't increase the rate, and they don't have the money coming in the door to pay the benefits, then you have got an insolvent company. In that case, Mr. Hanson is no better off with an insolvent company than with a substantial rate increase.

We want to make sure that companies are filing adequate rates at the front end. So a whole series of changes have been made: to eliminate what we regard as phony initial loss ratio requirements and to require companies to do an actuarial certification of the rate into the future; to impose limits on expense allowances and increases; to require reimbursement of unnecessary rate increases to policyholders; to allow policyholders the right to switch policies without underwriting to escape a rate spiral; and to authorize the commissioner to ban companies that persistently file inadequate premiums so there is a real penalty.

We, again, are going to include these amendments at the State level. While we would urge Congress to strongly consider the enhanced consumer protections as part of the tax code amendments,

we would also urge you to leave the rating issues to the States. Frankly, there is no Federal rating bureau at this point, and stabilizing rates is really, I think, best left at the State level. We assure you that commissioners around the country are working on those issues as we speak.

Mr. Chairman, I would stop there and turn to Dr. Scanlon.

[The prepared statement of Ms. Sebelius follows:]

Testimony of the
National Association of Insurance Commissioners

Before the
Special Committee on Aging
United States Senate

Regarding
Long-Term Care Insurance:
Protecting Consumers from Hidden Rate Hikes

September 13, 2000

Kathleen Sebelius
Commissioner of Insurance, State of Kansas
Vice President, NAIC

I. Introduction

Good morning, Mr. Chairman and Members of the Committee. My name is Kathleen Sebelius. I am the elected Insurance Commissioner for the state of Kansas. Also, I am the Vice President of the National Association of Insurance Commissioners (NAIC) and the chair of the NAIC's Health Insurance and Managed Care (B) Committee. I would like to thank you for providing the NAIC[1] with the opportunity to testify about long-term care insurance and what the NAIC and the states are doing to regulate this relatively new product and respond to recent consumer issues.

The members of the NAIC understand that Congress is considering several pieces of legislation affecting long term care insurance. Our experiences in regulating long-term care insurance policies and protecting consumers can be helpful to you in developing such legislation. We look forward to continuing our cooperative federal-state effort in this area.

II. Background

A. In General

Developed in the early 1980s, long-term care insurance is a relatively new product compared to other insurance products. Originally, long-term care insurance was a policy that just covered nursing home costs. However, over the years, it has evolved into a more sophisticated product that may cover home care services and adult day care.

Even with this progress, long-term care insurance still poses several concerns that have yet to be resolved. Due to its newness, it is challenging for insurers to set rates since many of the policies sold years ago may not have had claims filed. Second, long-term care insurance has experienced rate increases because fewer insureds have lapsed than anticipated. Regardless of when an individual buys long-term care insurance (the average age is in the sixties), if an individual is on a fixed income, the ability of the individual to handle an increase in premiums is likely to decrease over time. Finally,

[1] The NAIC, founded in 1871, is the organization of the chief insurance regulators from the 50 states, the District of Columbia, and four of the U.S. territories. The NAIC's objective is to serve the public by assisting state insurance regulators in fulfilling their regulatory responsibilities. Protection of consumers is the fundamental purpose of insurance regulation.

there is the concern regarding whether consumers, who may be told their rates cannot increase due to age or physical condition, understand that they are part of a class whose rates can increase.

The members of the NAIC believe there needs to be increased and ongoing consumer education in all aspects of long-term care insurance, including: (1) who is a suitable candidate to buy long-term care insurance; (2) what issues consumers should consider when shopping for this product including benefits, exclusions, restrictions and cost of various policies; and (3) the potential for future rate increases. The NAIC has been very active in this area, publishing a consumer handbook, "*A Shopper's Guide to Long-Term Care Insurance,*" and working to include additional consumer protections in the NAIC model laws and regulations.

B. NAIC Model Act and Regulation

The NAIC has been closely monitoring the development of long-term care insurance since the product's inception. The NAIC developed its Long-Term Care Insurance Model Act and Regulation ("NAIC Model Act and Regulation") (Attachments A and B) in the 1980s with the intent of promoting the availability of coverage, protecting applicants from unfair or deceptive sales or enrollment practices, facilitating public understanding and comparison of coverages, and facilitating flexibility and innovation in the development of long-term care insurance. The NAIC has been updating the models ever since as the market and the product mature.

For the most part, the NAIC Model Act and Regulation apply to all long-term care insurance policies and life insurance policies that accelerate benefits for long-term care. The Model Act and Regulation establish:

- Policy requirements: (a) requiring a standard format outline of coverage; (b) requiring specific elements for application forms and replacement coverage; (c) preventing cancellation of coverage upon unintentional lapse in paying premiums; (d) prohibiting post-claims underwriting; (e) prohibiting preexisting conditions and probationary periods in replacement policies or certificates; and (f) establishing minimum standards for home health and community care benefits in long-term care insurance policies.

- Benefit requirements: (a) requiring the offer of inflation protection; (b) requiring an offer of nonforfeiture benefits; (c) requiring contingent benefit upon lapse if the nonforfeiture benefit offer is rejected; and (d) establishing benefit triggers for non-qualified and qualified long-term care insurance contracts.

- Disclosure requirements.

- Suitability requirements: (a) explaining and reviewing a personal worksheet with applicants; and (b) requiring that insurers deliver a shopper's guide to buying long-term care insurance to applicants.

- Insurer requirements: (a) reporting requirements; (b) licensing requirements; (c) reserve standards; (d) loss ratios standards where applicable; (e) filing and actuarial certification requirements; and (f) standards for marketing.

- Penalties.

The NAIC models have been used as guides in most states in developing legislation and regulations, and these models have been developed with the combined efforts of state regulators, industry and consumers.

III. Consumer Protections Added to the NAIC Model Act and Regulation Since HIPAA

As you know, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) created tax-qualified long-term care insurance policies and specifically cited the NAIC's 1993 models for establishing policy requirements and consumer protections for these qualified plans. Since that time, the NAIC has updated its models in a variety of ways to include additional consumer protections and to recognize the changes in the market.

A. Suitability and Nonforfeiture Benefits

Two of the most significant consumer protections added since the 1993 version was adopted are the provisions on suitability and nonforfeiture benefits.

1. Suitability

The first major change was in the provisions determining the suitability of a long-term care insurance policy for an individual. Suitability is an important issue in deciding whether long-term care insurance is appropriate for any particular individual. The consumer and the insurer must determine: (1) whether the applicant will be able to afford the policy even if the premiums do not go up (income goes down or becomes fixed); (2) whether the applicant will be able to afford the policy if the premiums do increase; and (3) whether the benefits included in a policy are appropriate for the particular individual.

In the 1993 version of the NAIC Model Act and Regulation, the suitability provision was entitled "Appropriateness of Recommended Purchase" and was one sentence long. In the current version, this same section had been renamed as "Suitability", and it is a more comprehensive section that requires insurers: (1) to develop suitability standards; (2) to train their agents on the issue; and (3) to obtain more information from the applicant. The insurers are required to examine: (1) an applicant's ability to pay for the proposed coverage and any other pertinent financial information related to the purchase of the coverage; (2) the applicant's goals or needs with respect to long-term care; and (3) the values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement any existing insurance (if any). A highlight of the current version is a personal worksheet that the applicant should complete in order to determine whether a long-term care insurance policy is appropriate for the applicant. The worksheet factors in income, expenses, savings and investments. The insurer must request that the applicant fill out the personal worksheet.

2. Nonforfeiture Benefits

A second protection added to the 1993 version was nonforfeiture benefits. These are benefits that are triggered when there is a lapse or non-payment in a long-term care policy. At such time, the policy would convert to one with a shortened benefit period providing paid-up, long-term care insurance

coverage after lapse. In addition, the standard nonforfeiture credit would be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits.

In 1993, the NAIC models included mandatory nonforfeiture benefits. The requirement that these benefits be included in the policy was not well received by the industry and Congress did not include these mandatory benefits in HIPAA. The NAIC's current version does not require inclusion of mandatory nonforfeiture benefits in the policy, but instead requires the insurer to offer nonforfeiture benefits to the consumer as an option to the policy (for an additional premium). If the consumer refuses these optional benefits, then the insurer will not include them in the policy; however, the insurer instead must provide "contingent benefit upon lapse" or a "contingent nonforfeiture" benefit (without any added premiums).

"Contingent nonforfeiture" is an alternative to nonforfeiture benefits and is triggered if the individual's rate increases by a certain accumulative percentage from the time the individual bought the policy (issue age). The current version of the NAIC's model regulation includes a chart showing issue age and the percent increase that triggers contingent benefit upon lapse. Once triggered, the consumer has three choices: (1) pay the higher premium for the same level of coverage; (2) pay the same amount of premium, but have a decrease in the level of benefits to the individual; or (3) convert the coverage to a paid-up status (no more premiums) with a shortened benefit period. This mechanism gives options to consumers when there is a substantial increase in rates. In addition, a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits.

B. Rating Practices and Consumer Disclosures

With the growth of long-term care insurance and the many changes in the market, the issue of rate stability for long-term care insurance has become a big concern for regulators, lawmakers, consumers and industry. Under a long-term care insurance policy, a company cannot raise an individual's rates, but it can raise the rates of an entire class directly increasing an individual's rates. Not only is the rate increase itself a concern, but disclosure to consumers about the potential for future rate increases is also a concern. In response to these concerns, two NAIC working groups developed a plan to address these two issues, with the input of regulators, insurance companies and consumer groups. Last month on August 17, 2000, the nation's insurance commissioners by unanimous vote adopted amendments to

the model regulation that would assist in stabilizing rates and enhancing protections for and disclosures to consumers regarding rate increases. (Attachment C).

1. Rating Practices / Rate Stabilization

To further protect consumers from rate increases, the NAIC adopted rating practices amendments. These amendments establish a new rating process that encourages insurers to establish adequate initial premiums or be penalized in the future for rate increases. A company must show why it needs a rate increase. The goal is to increase the likelihood that the premium rates offered by a company will be adequate over the life of a policy, rate increases will be less likely, only justified increases will occur, and necessary increases will be smaller and less frequent.

The amendments would: (1) eliminate the initial loss ratio requirements; (2) require companies to provide actuarial certifications regarding adequacy of all rates; (3) impose limits on expense allowances on increases; (4) require reimbursement of unnecessary rate increases to policyholders; (5) authorize review by the commissioner of companies' administration and claim practices; (6) provide policyholders with the option to escape the effect of rising rate spirals by guaranteeing the right to switch to currently sold insurance without underwriting; and (7) authorize the commissioner to ban from the market place for five years companies that persist in filing inadequate initial premiums. An executive summary of these key provisions is attached. (Attachment D).

Under the previous NAIC model regulation, companies were required to use a 60% fixed loss ratio, which is the ratio of claims to premiums, as a basis to calculate rates for long-term care insurance policies. This fixed loss ratio method effectively established a cap on premiums that a company could charge, artificially limited initial premiums, and created an incentive for insurers to increase claims so they could receive higher expenses. This method often lead to future rate increases.

Under the new amendments, there would not be a fixed loss ratio requirement on initial rate filings, but there would be penalties imposed in the future if there are rate increases. If a rate increase is filed, 58% of the initial premiums and 85% of the increased portion of the premiums must be available to cover claims on a lifetime present value basis. If a carrier has demonstrated a persistent practice of filing inadequate initial premium rates, the commissioner could: (1) prohibit an insurer from filing and marketing comparable coverage for a period of up to five years; or (2) require that the carrier offer all

other similar coverages and limit marketing of new applications to the products subject to recent premium rate schedule increases. Because of these penalties, an incentive exists for companies to price their policies adequately in the first instance.

The amendments also propose a mechanism to handle rate changes due to changes in state laws or regulations or due to increased and unexpected utilization affecting the majority of insurers of similar products. Under these "exceptional increases," there is a 70% loss ratio requirement on that rate increase of the present value of projected additional premiums.

2. Consumer Protection / Disclosure Amendments

Another concern regarding rating practices is whether consumers, who may be told their rates cannot increase due to age or physical condition, understand that they are part of a class whose rates can increase. The NAIC has adopted additional enhanced consumer protection amendments, which primarily focus on disclosures to consumers regarding potential future rate increases for all long-term care insurance policies, other than for policies where the insurer does not have the right to raise the premium (sometimes called "noncancellable" policies).

These amendments require: (1) an insurer to disclose rate increase histories for the past 10 years; (2) an insurer to supply the applicant with a list of information including a statement that the policy may be subject to rate increases in the future and an explanation of the policyholder's options in the event of a premium rate increase; (3) an applicant to sign an acknowledgement of the potential for rate increases; (4) producers who sell long-term care insurance to be adequately trained in all aspects of the product; (5) agents to provide copies of the disclosure forms and provide an explanation of contingent benefit upon lapse during the marketing of long-term care insurance coverage; and (6) the outline of coverage to state who consumers may contact if they have questions. The amendments also update the disclosure forms and personal worksheets regarding potential rate increases. An executive summary of these key provisions is attached. (Attachment D).

3. Follow-up to the Amendments

As a follow-up to these new changes, the NAIC's Accident and Health Working Group is developing educational materials for insurance department personnel as guidance for applying this new system and

in reviewing rate and form filings. An education seminar to explain these changes was held this past Saturday, September 9, at the NAIC's Fall National Meeting. Additional education programs on these changes are expected in the future. The state insurance departments will now be working to have the changes adopted into state law and/or regulation. Industry representatives have said they are willing to help the state regulators get these changes passed through the legislatures in those states that cannot accomplish it by regulation.

In addition, the Accident and Health Working Group is drafting a compliance manual, which would allow regulators with experience reviewing long-term care polices to lend guidance to other regulators. Regulators, interested parties and NAIC staff are currently involved in the drafting process. A first draft was exposed for comment this past weekend at the NAIC Fall National Meeting.

IV. Working with Congress in Implementing Changes for Tax-Qualified Plans

Because of the recent amendments made to the NAIC models[2], the models now provide additional state law protections for non-tax-qualified policies that are not current requirements for federally tax-qualified plans, including provisions on contingent benefit upon lapse, suitability, rate stabilization, and premium rate increase disclosures. In the past, Congress has incorporated protections for federally tax-qualified long-term care insurance policies by referencing the NAIC Models. However, we caution that some of the most recent changes are best accomplished at the state level.

The contingent nonforfeiture benefit and suitability requirements are two consumer protections that can be implemented easily at the federal level. We recommend that Congress amend the tax code to include contingent nonforfeiture as a mandatory consumer protection in tax-qualified plans. In particular, the NAIC believes that contingent nonforfeiture is a vital consumer protection. We applaud you, Mr. Chairman, for the inclusion of this protection in your stand-alone long-term care legislation, S. 2225, the Long-Term Care and Retirement Security Act of 2000. We also would support its

[2] In addition to the changes described above, the NAIC amended its models to recognize and accommodate federally tax-qualified long-term care insurance policies as provided for under HIPAA. Under previous versions of the models, tax-qualified policies would not have been allowed under state law. The amendments affirmatively allow for and address these types of policies within the model act and regulation. The amendments allowing such policies under state law were adopted by the full NAIC membership at the Spring National Meeting on March 13, 2000.

addition to any patient protection legislation that includes long-term care insurance provisions. Currently, both the House and Senate patient protection bills contain provisions relating to the tax treatment of long-term care insurance. If the final patient protection conference report includes tax provisions on long-term care insurance, we believe contingent nonforfeiture benefits and suitability provisions should be added to the conference report as consumer protection requirements for tax-qualified polices.

Although the suitability provisions and the nonforfeiture benefits can be implemented immediately, there are some issues that are best left to the states to enact, and rating issues is one of them.

Congress must carefully consider whether to implement the rating practices/rate stability amendments for tax-qualified plans through federal legislation. There are several issues that need to be addressed before implementation of these amendments. If the rating practices amendments are implemented immediately at the federal level, the sale of tax-qualified policies would be illegal in most states because of the 60% initial loss ratio requirement that is currently in effect. The insurance industry is quite concerned about the market disruption that could occur. We agree that this is a legitimate concern.

Another reason to leave the rating issue to the states is because currently there is no rating process found in federal law except for the Medicare Supplement Program (Medigap) and that is limited to establishing a loss ratio standard. It is unclear how the federal government would or could regulate rates for long-term care insurance. This is an area where the states need to be involved. Cooperative efforts by the federal government, the states and the NAIC are needed in order to regulate this product effectively and to enforce consumer protections. Therefore, we request that Congress defer implementing the rating practices amendments at the federal level and give the states the opportunity to implement these changes for all long-term care policies, not just tax-qualified policies. If the states fail to accomplish this task within a reasonable time, then Congress could revisit the issue.

If, however, Congress decides to implement the rating practices/rate stability amendments for tax-qualified plans as part of federal legislation, we would request that there be a transition period before the amendments become effective. Such a period is necessary in order to allow the states to amend their laws and regulations and to implement these changes before any preemption of state law occurs. There is precedent for such an arrangement. Over the years, Congress has made many amendments to

the Social Security Act affecting Medigap insurance. Generally, Congress has allowed the NAIC nine months to amend its model regulation to reflect those changes, and the states an additional year after that (two if statutory revision is required and the state legislature does not meet in the first year) to change state requirements to conform to the Social Security Act. Realistically, we believe that three years would be a reasonable time for the states to enact the rating practices revisions. These revisions represent a substantial departure from current practice and regulatory requirements, and as such are substantially more complicated than and less familiar than the Medigap amendments. The one year period provided for in federal legislation regarding Medigap would simply not be enough time in this instance.

V. Conclusion

Long-term care insurance is a relatively new product compared to other insurance products. The NAIC has been closely monitoring the development of long-term care insurance since the product's inception, and developed its Long-Term Care Insurance Model Act and Regulation to provide an array of protections to consumers of this product. The NAIC has been updating the models consistently over the years as the market and the product mature.

HIPAA created tax-qualified long-term care insurance policies and specifically cited the NAIC's 1993 models for establishing policy requirements and consumer protections for these qualified plans. Two of the most significant consumer protections added since the 1993 version was adopted are the provisions on nonforfeiture benefits and suitability. We agree with you, Mr. Chairman, and your colleague on the House side, Representative Nancy Johnson, that the contingent nonforfeiture benefit should be added as a requirement for tax-qualified plans, and we suggest that the new suitability protections be added as well.

Our more recent amendments regarding rate stability are more complicated. These amendments radically alter the regulatory landscape by eliminating initial loss ratio requirements in favor of instituting a system that creates incentives for insurers to adequately price their products so that any rate increase over the life of the product will not be necessary. Given the unique aspects of insurance rate regulation, this important new aspect of consumer protection should be left to the states. If, however, Congress decides to implement these amendments for tax-qualified plans as part of federal

legislation, we would request that there be a transition period before the amendments became effective to give the states ample opportunity to change their laws before any preemption took effect.

We look forward to continuing to work with the Congress on the important issue of consumer protection for long-term care insurance. Thank you for the opportunity to testify before you today.

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LONG-TERM CARE INSURANCE MODEL ACT

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Section 1. Purpose

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

Drafting Note: 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.

Drafting Note: 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 6J.

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

Section 3. Short Title

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

Section 4. Definitions

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

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

B. "Applicant" means:

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

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

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

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

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

E. "Group long-term care insurance" means a long-term care insurance policy that 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 the 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 trustees of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

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

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

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

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

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

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

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

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

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

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

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-

term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

G. (1) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(a) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(c) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in [insert reference to state law equivalent to Section 4G(1)(e) of the Long-Term Care Insurance Model Act];

(e) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund

on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(f) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(2) "Qualified long-term care insurance contract" or "federally tax-qualified long term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

Drafting Note: The definition of "qualified long-term care insurance contract" has been added to assist states in regulating long-term care insurance policies that are federally tax-qualified. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 7702B of the Internal Revenue Code, as amended, provide a definition of this term and clarify federal income tax treatment of premiums and benefits. Treasury Regulations 1.7702B-1 and 1.7702B-2, and Notice 97-31 issued by the Internal Revenue Service, further address these issues.

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.

Drafting Note: 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;

(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" that is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

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

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

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting

standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6C(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6C(2).

D. Prior hospitalization/institutionalization.

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

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

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

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

(2) (a) A long-term care insurance policy containing post-confinement, 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.

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

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

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

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

E. The commissioner may adopt regulations establishing loss ratio standards for 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 (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4E(1) of this Act, the applicant is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within thirty (30) days of the return or denial.

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 that 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 shall 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 shall be presented in conjunction with any application or enrollment form.

(d) In the case of a policy issued to a group defined in Section 4E(1) of this Act, an outline of coverage shall not be required to be delivered, provided that the information described in Section 6G(2)(a) through (f) is contained in other materials relating to

enrollment. Upon request, these other materials shall be made available to the commissioner.

Drafting Note: States may wish to review specific filing requirements as they pertain to the outline of coverage and these other materials.

(2) The outline of coverage shall include:

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

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

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

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

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

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

(g) A statement that discloses to the policyholder or certificateholder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

H. A certificate issued pursuant to a group long-term care insurance policy that 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.

Drafting Note: 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. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.

J. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that 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 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;

(4) A statement that any long-term care inflation protection option required by [cite to state's inflation protection option requirement comparable to Section 11 of the Long-Term Care Insurance Model Regulation] is not available under this policy;

(5) 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; and

(6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with [cite to state's basic illustration requirement comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation] or into the life insurance policy summary which is required to be delivered in accordance with [cite

to state's life insurance policy summary requirement comparable to Section 5 of the Life Insurance Disclosure Model Regulation].

K. 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. The 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.

L. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

(1) Provide a written explanation of the reasons for the denial; and

(2) Make available all information directly related to the denial.

M. Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

Section 7. Incontestability Period

A. For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is *both* material to the acceptance for coverage *and* which pertains to the condition for which benefits are sought.

C. After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

D. (1) No long-term care insurance policy or certificate may be field issued based on medical or health status.

(2) For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

F. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by [cite to state's life insurance incontestability clause]. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Section 8. Nonforfeiture Benefits

A. Except as provided in Subsection B, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

B. When a group long-term care insurance policy is issued, the offer required in Subsection A shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in Section 4E(4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

C. The commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection A.

Section 9. Authority to Promulgate Regulations

The commissioner shall issue reasonable regulations to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

Section 10. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 11. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 12. Penalties

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intention of this section is to authorize separate fines for both the insurer and the agent in the amounts suggested above.

Section 13. Effective Date

This Act shall be effective [insert date].

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

1987 Proc. 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 13, 23-24, 468, 476-477, 479-484 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 556-561 (amended and reprinted).
1991 Proc. I 9, 17, 609-610, 662, 666-671 (amended and reprinted).
1993 Proc. I 8, 136, 819, 844, 845(amended).
1993 Proc. 1st Quarter 3, 34, 267, 275, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 458 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 823-824 (amended).
1997 Proc. 1st Quarter 54, 55, 56, 57, 700, 701-704 (amended).
1998 Proc. 1st Quarter (amended).
1999 Proc. 4th Quarter (amended).

LONG-TERM CARE INSURANCE MODEL REGULATION

Table of Contents

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, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted.

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.

Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;
2. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

3. Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

Drafting Note: The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a new category of long-term care insurance called Qualified Long-Term Care Insurance. This regulation is intended to provide requirements for all long-term care insurance contracts, including qualified long-term care insurance contracts, as defined in the NAIC Long-Term Care Insurance Model Act and by Section 7702B(b) of the Internal Revenue Code of 1986, as amended. The amendments to this regulation made in recognition of Section 7702B do not require nor prohibit the continued sale of long-term care insurance policies and certificates that are not considered qualified long-term care insurance contracts.

Section 4. Definitions

For the purpose of this regulation, the terms "long-term care insurance," "qualified 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. In addition, the following definitions apply.

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.

A. (1) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

(a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(2) Except as provided in Section 20, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Drafting Note: The commissioner may wish to review the request with other commissioners.

B. "Incidental," as used in Section 20J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

Drafting Note: The phrase "value of the benefits" is used in defining "incidental" to make the definition more generally applicable. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

C. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

D. "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in [insert reference to Section 4E(1) of the NAIC Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Section 5. Policy Definitions

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

B. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

E. "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

F. "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

H. "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

I. "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

J. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

K. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

L. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

N. "Skilled nursing care," "intermediate care," "personal care," "home care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

P. "Transferring" means moving into or out of a bed, chair or wheelchair.

Q. All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to or incorporation of the individual state law may be required in structuring each definition.

Drafting Note: 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.

Drafting Note: The U.S. Treasury Department may, at some time in the future, develop additional or different policy definitions intended to satisfy the requirements of Section 7702B of the Internal Revenue Code of 1986, as amended, for qualified long-term insurance contracts. States should consider developing a mechanism to allow definitions that may be developed by the federal agency to be used in qualified long-term care insurance contracts.

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 9 of this regulation.

(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(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.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(5) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

B. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or intentionally 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) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(8) This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

Drafting Note: Paragraph (8) is intended to permit exclusions and limitations for payment for services provided outside the United States and legitimate variations in benefit levels to reflect differences in provider rates.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the 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 that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(b) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

(8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and Replacement

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage

to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

F. (1) The premium charged to an insured shall not increase due to either:

(a) The increasing age of the insured at ages beyond sixty-five (65); or

(b) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 26, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 26, the initial annual premium shall be based on the reduced benefits.

G. Electronic Enrollment for Group Policies

(1) In the case of a group defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" as defined by [insert reference to state law comparable to Section 2W of the NAIC Insurance Information and Privacy Protection Model Act], is maintained.

(2) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Section 7. Unintentional Lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to

those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

B. Reinstatement. In addition to the requirement in Subsection A, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Drafting Note: The language in Subsection B addressing the provision of proof of cognitive impairment or less of functional capacity has been amended to more precisely clarify the original intent in adopting the reinstatement provision.

Section 8. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

(2) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term

care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

G. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other

specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 29E(3) that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 29E(3) that the policy is not intended to be a qualified long-term care insurance contract.

Section 9. Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

Drafting Note: One method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (2) if the premium rate or rate schedule is changed;

(5) (a) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(d) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall

include the disclosure of that rate increase in accordance with Subparagraph (a) of this paragraph.

(e) If the acquiring insurer in Subparagraph (d) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (d), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (d).

Drafting Note: Section 10 requires that the commissioner be provided with any information to be disclosed to applicants. Information about past rate increases needs to be reviewed carefully. If the insurer expects to provide additional information (such as a brief description of significant variations in policy provisions if the form is not the policy form applied for by the applicant or information about policy forms offered during or before the calendar years of forms with rate increases), the commissioner should be satisfied that the additional information is fairly presented in relation to the information about rate increases.

Drafting Note: It is intended that the disclosures in Section 9A be made to the employer in those situations where the employer is paying all the premium, with no contributions or coverage elections made by individual employees. In addition, if the employer has paid the entire amount of any premium increases, there is no need for disclosure of the increases to the applicant for a new certificate.

Drafting Note: States should be aware of and review situations where a group policy is no longer being issued but new certificates are still being added to existing policies.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsection B(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in Appendices B and F to comply with the requirements of Subsections A and B of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least [forty-five (45) days] prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

Section 10. Initial Filing Requirements

A. This section applies to any long-term care policy issued in this state on or after [insert date that is 6 months after adoption of the amended regulation].

B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a long-term care insurance form available for sale.

Drafting Note: States should consider whether a time period other than 30 days is desirable. An alternative time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) A copy of the disclosure documents required in Section 9; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is

sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

Drafting Note: When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided could demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection C based on a standard age distribution; and

(e) (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Drafting Note: It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

C. (1) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(2) In the event the commissioner asks for additional information under this provision, the period in Subsection A does not include the period during which the insurer is preparing the requested information.

Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not address fully the questions that triggered the request for the actuarial demonstration.

Section 11. Prohibition Against Post-Claims Underwriting

A. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B. (1) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

(3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

(a) A report of a physical examination;

(b) An assessment of functional capacity;

(c) An attending physician's statement; or

(d) Copies of medical records.

D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

E. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

Section 12. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

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

(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(5) By excluding coverage for personal care services provided by a home health aide;

(6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(8) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(9) By excluding coverage for adult day care services.

B. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

C. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Drafting Note: Subsection C permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy. The subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. It is suggested that fewer than 365 benefit days and less than a $25 daily maximum benefit constitute illusory home health care benefits.

Section 13. Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at

least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in [Section 4E(4) of the Act] other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in Subsection A above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. (1) Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Drafting Note: It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increases to attained age, or for a period such as at least 20 years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

E. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. (1) Inflation protection as provided in Subsection A(1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in

this subsection. The rejection may be either in the application or on a separate form.

(2) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

Section 14. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by [insert reference to Section 4(E)(1) of the Model Act], the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

(a) If so, with which company?

(b) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

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

_____ _____

(Applicant's Signature) (Date)

D. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the

date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of [cite to state's life insurance replacement regulation similar to the NAIC Life Insurance and Annuities Replacement Model Regulation]. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

Section 15. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above.

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

Drafting Note: The definition of claim denied used in this reporting form is for HIPAA reporting purposes only, and is not intended to be applied to any other regulatory issues, such as market conduct examinations.

G. For purposes of this section:

(1) "Policy" means only long-term care insurance;

(2) Subject to Paragraph (3), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(3) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(4) "Report" means on a statewide basis.

H. Reports required under this section shall be filed with the commissioner.

Section 16. Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by [insert reference to state law equivalent to the NAIC Producer Licensing Model Act].

Section 17. 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;

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 18. Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with [cite the standard valuation law for life insurance, which contains a section referring to "special benefits" for which tables must be approved by the commissioner]. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) Definition of insured events;

(2) Covered long-term care facilities;

(3) Existence of home convalescence care coverage;

(4) Definition of facilities;

(5) Existence or absence of barriers to eligibility;

(6) Premium waiver provision;

(7) Renewability;

(8) Ability to raise premiums;

(9) Marketing method;

(10) Underwriting procedures;

(11) Claims adjustment procedures;

(12) Waiting period;

(13) Maximum benefit;

(14) Availability of eligible facilities;

(15) Margins in claim costs;

(16) Optional nature of benefit;

(17) Delay in eligibility for benefit;

(18) Inflation protection provisions; and

(19) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with [insert reference to state law equivalent to the most recent version of the NAIC Minimum Reserve Standards for Individual and Group Health Insurance Contracts].

Drafting Note: HIPAA applies the reserve method to qualified long-term care contracts that is applied to all insurance contracts except life insurance contracts, annuity contracts, or noncancellable accident and health contracts.

Section 19. Loss Ratio

A. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10 and 20.

B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-

term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(1) Statistical credibility of incurred claims experience and earned premiums;

(2) The period for which rates are computed to provide coverage;

(3) Experienced and projected trends;

(4) Concentration of experience within early policy duration;

(5) Expected claim fluctuation;

(6) Experience refunds, adjustments or dividends;

(7) Renewability features;

(8) All appropriate expense factors;

(9) Interest;

(10) Experimental nature of the coverage;

(11) Policy reserves;

(12) Mix of business by risk classification; and

(13) Product features such as long elimination periods, high deductibles and high maximum limits.

C. Subsection B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(3) The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;

(4) Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Drafting Note: The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section 19 above which removes the word "individual": (1) reflects the fact that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

Section 20. Premium Rate Schedule Increases

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, "shall provide notice" may be changed to "shall request approval." States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing is in compliance with the provisions of this section;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including

reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to

benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims , without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater

than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms "adequately match the projected experience" include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product.

It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further

deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(1)(a) and (c)

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall:

(i) Be subject to the approval of the commissioner;

(ii) Be based on actuarially sound principles, but not be based on attained age; and

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4B, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and

(c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];

(3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];

(b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and

(c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 21. Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to [cite state law equivalent 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 22. Filing Requirements for Advertising

A. Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health

care service plan or other entity for at least three (3) years from the date the advertisement was first used.

B. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

Section 23. Standards for Marketing

A. Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that:

(a) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(b) Excessive insurance is not sold or issued.

(2) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(3) Provide copies of the disclosure forms required in Section 9C (Appendices B and F) to the applicant.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

(5) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this Subsection A.

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to

the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 6 A(3) of this regulation.

(8) Provide an explanation of contingent benefit upon lapse provided for in Section 26D(3).

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

C. (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in [insert citation to Section 4E(2) of the NAIC Long-Term Care Insurance Model Act], when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the insurance department the following material:

(a) The policy and certificate,

(b) A corresponding outline of coverage, and

(c) All advertisements requested by the insurance department.

(3) The association shall disclose in any long-term care insurance solicitation:

(a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(b) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall also:

(a) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(b) Actively monitor the marketing efforts of the insurer and its agents; and

(c) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

(d) Subparagraphs (a) through (c) shall not apply to qualified long-term care insurance contracts.

Drafting Note: The materials specified for filing in this section shall be filed in accordance with a state's filing due dates and procedures.

(7) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.

(8) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of [insert citation to corresponding section of state unfair trade practices act].

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to long-term care insurance policies and certificates.

Section 24. Suitability

A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) Train its agents in the use of its suitability standards; and

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

C. (1) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(2) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

(3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(4) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who

declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Section 25. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Section 26. Nonforfeiture Benefit Requirement

A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act]:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

D. (1) After rejection of the offer required under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%

86	14%
87	13%
88	12%
89	11%
90 and over	10%

(4) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the

standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection F.

(4) (a) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(b) Notwithstanding Subparagraph (a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(i) The end of the tenth year following the policy or certificate issue date; or

(ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would payable if the policy or certificate had remained in premium paying status.

G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

H. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 19 treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection D(3), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(1) The nonforfeiture provision shall be appropriately captioned;

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) The nonforfeiture provision shall provide at least one of the following:

(a) Reduced paid-up insurance;

(b) Extended term insurance;

(c) Shortened benefit period; or

(d) Other similar offerings approved by the commissioner.

Section 27. Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

B. (1) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting; and

(f) Transferring;

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.

D. For purposes of this section the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in this section shall be effective [insert date 12 months after adoption of this provision] and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert

reference to Section 4E(1) of the Long-Term Care Insurance Model Act] that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

Section 28. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

A. For purposes of this section the following definitions apply:

(1) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) (a) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or

(ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Drafting Note: With respect to the activities of daily living (ADL) benefit trigger, HIPAA provides that tax-qualified contracts must take into account at least five of the six ADLs specified in Section 27B. This model regulation requires that eligibility for payment of benefits be no more restrictive than requiring a deficiency in the ability to perform not more than three ADLs, of the six listed. Thus, in this regard, a contract that complies with this regulation will also be tax-qualified. States do not need to alter their regulations from this model regulation with respect to the ADL trigger for tax-qualified contracts.

(b) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

(3) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

(4) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

Drafting Note: Terms used in the definition of a "chronically ill individual," such as substantial assistance, loss of functional capacity, substantial supervision and severe cognitive impairment, are not defined by the Internal Revenue Code of 1986, as amended, although the meaning of the terms has been addressed by Treasury Department and Internal Revenue Service guidance. The requirement that an insured be certified as a chronically ill individual at least once every 12 months by a licensed health care practitioner does not preclude an insurer from requiring more frequent assessments of an insured's condition in order to determine whether benefits are payable under a contract. However, states are also free to limit an insurer's ability to perform more frequent assessments without affecting the tax-qualified status of the contract.

Qualified long-term care insurance contracts that pay benefits upon a loss of functional capacity must include a provision for triggering benefits that is different from that found in Section 24 of this model regulation. The Internal Revenue Service has stated that the 90-day requirement under this benefit trigger does not establish a waiting period before which benefits may be paid or before which services may constitute qualified long-term care services.

Under Section 7702B of the Internal Revenue Code, as amended, only "licensed health care practitioners" can certify that an insured is a chronically ill individual. This term includes only physicians (within the meaning of Section 1861(r)(1) of the Social Security Act), registered professional nurses and licensed social workers.

Section 7702B does not preclude a contract from specifying a subset of "licensed health care practitioners" who can perform certifications, e.g., only physicians within the meaning of Section 1861(r)(1) of the Social Security Act that are approved by the insurance company. The Secretary of the Treasury may in regulations expand the types of individuals who are considered "licensed health care practitioners."

Section 7702B(c)(2) states that an individual will be considered chronically ill if he or she is certified by a licensed health care practitioner as having a level of disability similar (as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services) to the level of disability described in Section 7702B(c)(2)(A)(i) (Section 28C(1) of this regulation). At present, the Secretary of the Treasury has prescribed no such standard. Federal tax law does not require a qualified long-term care insurance contract to include this benefit trigger in the contract. In addition, this model

regulation does not mandate inclusion of this undefined benefit trigger in policies at the present time. If the Treasury Department prescribes an additional benefit trigger in the future, consideration will be given at that time to making appropriate amendments to this regulation.

B. A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Drafting Note: The federal tax requirements for the term "qualified long-term care services" has been added to assist states in regulating qualified long-term care insurance contracts, which are defined in Section 7702B(b) of the Internal Revenue Code of 1986, as amended. The Internal Revenue Code of 1986 is subject to amendment by Congress and to interpretation by the Treasury Department, the Internal Revenue Service and the courts.

Since a qualified long-term care insurance contract can provide insurance coverage "only" for qualified long-term care services, and such services are ones required by a "chronically ill individual," benefits from such a contract can only be provided to an individual who is chronically ill. Federal tax law does not, however, prohibit the provision of coverage of some, but not all, qualified long-term care services. Thus, a contract may cover only nursing home services or limit benefits to those performed by eligible providers consistent with the requirements of federal tax law. Likewise, the federal tax law does not preclude a contract from specifying the need for hands-on assistance for purposes of determining whether the insured can perform an activity of daily living. Under this regulation, however, benefit triggers requiring greater degrees of impairment than the minimum standard established by federal tax law are permitted only to the extent otherwise consistent with this regulation and the model act.

C. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

Drafting Note: Section 7702B of the Internal Revenue Code of 1986, as amended, includes a provision for triggering benefits that is different from that found in Section 27 of this model regulation. The definitions used in the triggering of benefits in Section 7702B (substantial assistance, loss of functional capacity, substantial supervision and severe cognitive impairment) have been defined in guidance promulgated by the Department of the Treasury.

D. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

E. Certifications required pursuant to Subsection C may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary

with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

F. Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Section 29. 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 that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

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. FEDERAL TAX CONSEQUENCES.

   This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

   OR

   Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

   (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(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.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. 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.]

7. 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.

8. 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.]

9. BENEFITS PROVIDED BY THIS POLICY.

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

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

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

   (d) Eligibility for Payment of Benefits

   [Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

   [Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers 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.]

10. LIMITATIONS AND EXCLUSIONS.

    [Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

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

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

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

11. 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.]

12. 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.]

13. 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.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Section 30. Requirement to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under [cite for Section 6 of Long-Term Care Insurance Model Act].

Section 31. Penalties

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Drafting Note: The intent of this section is to authorize separate fines for both the company and the agent in the amounts suggested above.

OPTIONAL PROVISION

Section [ ]. Permitted Compensation Arrangements

A. An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a long-term care insurance policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

C. No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Drafting Note: The NAIC recognizes that long-term care insurance is in an evolutionary stage. The product market needs to be able to develop in order to be responsive to the needs of consumers. In addition, since long-term care insurance and long-term care insurance regulations are continually changing, a state should consider the fact that not all replacements are improper.

The NAIC also recognizes that currently, long-term care insurance products are being primarily sold to the senior citizen market, a market that has been identified as being susceptible to abusive marketing practices. In response, the NAIC has adopted consumer protection amendments in its model regulation for Medicare supplement insurance. The Medicare supplement insurance model regulation limits agents' compensation in order to address the potential for marketing abuses resulting from the large difference between first year and renewal commissions.

If a state believes that there is evidence that the long-term care insurance market is experiencing similar abuses, it may wish to consider adopting the optional agent compensation provision above.

In considering these agent compensation limitations, states should recognize the emerging nature of the long-term care insurance market. Long-term care insurance is evolving along both health insurance indemnity and life insurance lines. A state may want to consider that, since life insurance products usually contain nonforfeiture and cash value accumulation features and are normally targeted to a younger age group than long-term care indemnity products, such life insurance products could be exempted from these compensation limitation requirements.

The compensation provision such as provided above should not be enacted in lieu of the penalty and other consumer protection provisions contained in the regulation, but in addition to them.

APPENDIX A

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE OF _____ FOR THE REPORTING YEAR 19[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____

_____

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX B

Long Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state.

The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?
☐From my Income ☐From my Savings\Investments ☐My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)☐Under $10,000 ☐$[10-20,000] ☐$[20-30,000]
☐$[30-50,000] ☐Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
☐No change ☐Increase ☐Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐From my Income ☐From my Savings\Investments ☐My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
☐From my Income ☐From my Savings\Investments ☐My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
☐Under $20,000 ☐$20,000-$30,000 ☐$30,000-$50,000 ☐Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐Stay about the same ☐Increase ☐Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ ☐	The answers to the questions above describe my financial situation. **Or** I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed:_____ _____
(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed:_____ _____
(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed:_____ _____]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

APPENDIX C

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of _____
For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____
_____
Company NAIC Number: _____
Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long Term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]**: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____])

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments**:

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

* Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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

1988 Proc. I 9, 20-21, 629-630, 652, 656-661 (adopted).
1989 Proc. I 9, 24-25, 703, 754-755, 791-794 (amended).
1989 Proc. II 13, 23-24, 468, 476-477, 484-493 (amended and reprinted).
1990 Proc. I 6, 27-28, 477, 541-542, 545-556 (amended and reprinted).
1990 Proc. II 7, 16, 600, 617, 649 (amended).
1991 Proc. I 9, 17-18, 609-610, 662, 672-687 (amended and reprinted).
1992 Proc. I 86, 95, 914, 954, 963, 967-982, 987 (amended and reprinted).
1992 Proc. II 9, 11, 672, 687, 696 (amended).
1993 Proc. I 8, 136, 819, 843-844, 846-848 (amended).
1993 Proc. 1st Quarter 3, 34, 267, 274, 276 (amended).
1994 Proc. 1st Quarter 4, 39, 446-447, 451, 457-459 (amended).
1994 Proc. 4th Quarter 17, 26, 713-714, 722, 731, 737, 739-761 (amended and reprinted).
1995 Proc. 2nd Quarter 2, 36, 553, 651, 653-659 (amended).
1996 Proc. 2nd Quarter 10, 33, 731, 812, 825 (amended).
1997 Proc. 1st Quarter 54, 55, 56, 57, 700, 704-714 (amendments on life/long-term care).
1997 Proc. 1st Quarter 759, 771-772 (discussed amendments on personal worksheet).
1997 Proc. 2nd Quarter 25-26, 676 (amendments on personal worksheet adopted).
1998 Proc 1st Quarter (amended).
1999 Proc. 4th Quarter (amended).
2000 Proc. 2nd Quarter (amended).

Attachment C

Adopted: 8/17/00
Rating Practices and Consumer Protection
Revisions to Model 641
Adopted by the Executive Committee and Plenary

LONG-TERM CARE INSURANCE MODEL REGULATION

Table of Contents

Appendix A. Rescission Reporting Form
Appendix B. Personal Worksheet
Appendix C. Disclosure Form
Appendix D. Response Letter
Appendix E. Sample Claims Denial Format
Appendix F. Potential Rate Increase Disclosure Form

* * * *

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Drafting Note: This regulation, like the NAIC Long-Term Care Insurance Model Act, is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these plans, organizations and arrangements (e.g., contract, policy, certificate, subscriber, member) may be substituted for, or added to, the corresponding terms used in this regulation.

Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;
2. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or
3. Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

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. In addition the following definitions apply:

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.

A. (1) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

(a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(2) Except as provided in Section 20, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Drafting Note: The commissioner may wish to review the request with other commissioners.

B. "Incidental," as used in Section 20J, means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue

Drafting Note: The phrase "value of the benefits" is used in defining "incidental" to make the definition more generally applicable. In simple cases where the base policy and the long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

C. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

D. "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in [insert reference to Section 4E(1) of the NAIC Long-Term Care Model Act] are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

* * * *

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 9 of this regulation.

(1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(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.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(45) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within

the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

* * * *

Section 8. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

(1) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable~~the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

(2) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

* * * *

Section 9. Required Disclosure of Rating Practices to Consumers

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve (12) months after adoption of the amended regulation].

B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

Drafting Note: One method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(a) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (2) if the premium rate or rate schedule is changed;

(5) (a) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(b) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(d) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four (24) month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph (a) of this paragraph.

(e) If the acquiring insurer in subparagraph (d) above files for a subsequent rate increase, even within the 24 month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph (d), the acquiring insurer must make all disclosures required by Paragraph 5, including disclosure of the earlier rate increase referenced in subparagraph (d).

Drafting Note: Section 10 requires that the commissioner be provided with any information to be disclosed to applicants. Information about past rate increases needs to be reviewed carefully. If the insurer expects to provide additional information (such as a brief description of significant variations in policy provisions if the form is not the policy form applied for by the applicant or information about policy forms offered during or before the calendar years of forms with rate increases), the commissioner should be satisfied that the additional information is fairly presented in relation to the information about rate increases.

Drafting Note: It is the intention that the disclosures in Section 9A be made to the employer in those situations where the employer is paying all the premium, with no contributions or coverage elections made by individual employees. In addition, if the employer has paid the entire amount of any premium increases, there is no need for disclosure of the increases to the applicant for a new certificate.

Drafting Note: States should be aware of and review situations where a group policy is no longer being issued but new certificates are still being added to existing policies.

C. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsection B(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

D. An insurer shall use the forms in Appendices B and F to comply with the requirements of Subsections A and B of this section.

E. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least [forty-five (45) days] prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

Section 10. Initial Filing Requirements

A. This section applies to any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

B. An insurer shall provide the information listed in this subsection to the commissioner [thirty (30) days] prior to making a long-term care insurance form available for sale.

Drafting Note: States should consider whether a time period other than 30 days is desirable. An alternative time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) A copy of the disclosure documents required in Section 9; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

Drafting Note: When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided could demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection C based on a standard age distribution; and

(e) (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Drafting Note: It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

C. (1) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(2) In the event the commissioner asks for additional information under this provision, the period in Subsection A does not include the period during which the insurer is preparing the requested information.

Drafting Note: The commissioner may wish to have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not address fully the questions that triggered the request for the actuarial demonstration.

* * * *

Section ~~14~~16. Licensing

A. ~~No agent~~A producer is not authorized to ~~market,~~ sell, solicit or negotiate with respect to long-term care insurance except as authorized by [insert reference to state law equivalent to the NAIC Producer Licensing Model Act]. ~~otherwise contact a person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.~~

* * * *

Section ~~17~~19. Loss Ratio

A. This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10 and 20.

~~A~~B. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the

long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(1) Statistical credibility of incurred claims experience and earned premiums;

(2) The period for which rates are computed to provide coverage;

(3) Experienced and projected trends;

(4) Concentration of experience within early policy duration;

(5) Expected claim fluctuation;

(6) Experience refunds, adjustments or dividends;

(7) Renewability features;

(8) All appropriate expense factors;

(9) Interest;

(10) Experimental nature of the coverage;

(11) Policy reserves;

(12) Mix of business by risk classification; and

(13) Product features such as long elimination periods, high deductibles and high maximum limits.

~~B~~C. Subsection ~~A~~ B shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of [cite to state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(3) The policy meets the disclosure requirements of Sections 6I, 6J, and 6K of the NAIC Long-Term Care Insurance Model Act;

(4) Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation; and

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Drafting Note: The loss ratio reporting form for long-term care policies that was adopted in 1990 provides for reporting of loss ratios on group as well as individual policies. The amendment to Section ~~18~~ 19 above which removes the word "individual": (1) reflects the fact

that loss ratios should be reported on all policies, and (2) establishes a 60% loss ratio for both group and individual policies. States may wish to apply a higher standard than 60% to group policies.

Section 20. Premium Rate Schedule Increases

A. This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is twelve (12) months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [thirty (30) days] prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, "shall provide notice" may be changed to "shall request approval." States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

(a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(b) The premium rate filing is in compliance with the provisions of this section;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commisioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;

(b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate

increase, the insurer will need to file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims , without the inclusion of active life reserves, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to Health Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

(a) Premium rate schedule adjustments; or

(b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms "adequately match the projected experience" include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product.

It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection H of this section; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(1)(a) and (c)

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(a) The offer shall:

(i) Be subject to the approval of the commissioner;

(ii) Be based on actuarially sound principles, but not be based on attained age; and

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4B, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and

(c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];

(3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6I, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by [cite state's life insurance illustrations law similar to the NAIC's Life Insurance Illustrations Model Regulation];

(b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and

(c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].

(5) An actuarial memorandum is filed with the insurance department that includes:

(a) A description of the basis on which the long-term care rates were determined;

(b) A description of the basis for the reserves;

(c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(d) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(f) The estimated average annual premium per policy and the average issue age;

(g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

* * * *

Section ~~20~~23. Standards for Marketing

A. Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that:

(a) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

~~(2)~~(b) ~~Establish marketing procedures to assure e~~Excessive insurance is not sold or issued.

~~(3)~~(2) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer. This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(3) Provide copies of the disclosure forms required in Section 9C (Appendices B and F) to the applicant.

* * * *

(8) Provide an explanation of contingent benefit upon lapse provided for in Section 26D(3).

* * * *

Section ~~23~~26. Nonforfeiture Benefit Requirement

A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act]:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits.

The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

D. (1) After rejection of the offer required under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%

64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(4) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and

(c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection F.

(4) (a) The nonforfeiture benefit ~~and the contingent benefit upon lapse~~ shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(b) Notwithstanding Subparagraph (a), ~~except that~~ for a policy or certificate ~~with a contingent benefit upon lapse or a policy or certificate~~ with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(i) The end of the tenth year following the policy or certificate issue date; or

(ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would payable if the policy or certificate had remained in premium paying status.

G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

H. The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section ~~17~~ 19 treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Ssubsection D(3), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

* * * *

Section ~~25~~29. Standard Format Outline of Coverage

* * * *

E. Format for outline of coverage:

* * * *

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(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 right exists, describe and concisely each circumstance under which premium may change.]~~

APPENDIX B

Long Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out ~~this worksheet~~the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) _____

The premium for the coverage you are ~~thinking about buying~~ considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. ~~[The last rate increase for this policy in this state was in [year], when premiums went up by an average of _____%]. [The company has not raised its rates for this policy.]~~ [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).]

Drafting Note: ~~The issuer shall use the bracketed sentence or sentences applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage. The issuer may include rate information for up to two policy forms if the issuer has not changed rates on either policy form or for prior policies providing essentially similar coverage.~~ A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state.

The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase.

The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?
☐From my Income ☐From my Savings\Investments ☐My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer ~~shall~~ is not required to use the bracketed sentence ~~unless~~ if the policy is fully paid up or is a noncancellable policy.

~~How will you pay each year's premium?~~
~~☐From my Income ☐From my Savings\Investments ☐My Family will Pay~~

~~**Income**~~

What is your annual income? (check one)☐Under $10,000 ☐$[10-20,000] ☐$[20-30,000]
☐$[30-50,000] ☐Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
☐No change ☐Increase ☐Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐From my Income ☐From my Savings\Investments ☐My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days Approximate cost $ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
☐From my Income ☐From my Savings\Investments ☐My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth ~~(your savings and investments)~~? (check one)
☐Under $20,000 ☐$20,000-$30,000 ☐$30,000-$50,000 ☐Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐Stay about the same ☐Increase ☐Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ ~~The answers to the questions above describe my financial situation.~~	☐ ~~I choose not to complete this information.~~

☐ The answers to the questions above describe my financial situation.
or
☐ I choose not to complete this information.
(Check one.)

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____ _____
(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent) (Date)

Agent's Printed Name: _____]

[~~Note:~~ In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

APPENDIX F (all new)

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long Term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]**: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____])

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

* **Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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processing or demonstrate that appropriate processing is in effect. This is intended to eliminate lax administration and claims handling practices as a cause of continued rate increases. This will force companies to review claims more closely and not pay inappropriate claims, which contribute to the need to increase premiums.

5. Option to escape rate spirals by converting to currently sold insurance provided.

Any time after the first rate increase, for other than an exceptional rate increase, if the majority of policyholders subject to the increase are eligible for contingent benefit upon lapse, and if the commissioner determines that a rising rate spiral exists, as demonstrated by significant number of policyholders dropping their insurance, the commissioner may require the company to offer to replace existing coverage, without underwriting, with a comparable product currently being sold. This is a type of pooling. It provides policyholders trapped in a rising rate spiral the opportunity to switch from the troubled policy to a more stable current policy without the insured being subject to any underwriting.

6. Commissioner authorized to ban companies from the market place.

If the Commissioner determines that a company has persistently filed inadequate initial premium rates, the commissioner may ban the company from the marketplace for up to five years. This penalty will essentially put the company out of business in the state. It is intended as a last resort for the commissioner when all else fails.

7. Actuarial certifications required.

For all rate filings the company is required to provide an actuarial certification that no rate increases are anticipated. Actuaries signing such certifications are subject to existing standards of professional actuarial practice. This puts the burden on the company, rather than the state, to secure actuarial certification.

8. Effective Date

For initial rate filings, the proposal would apply to any long-term care policy issued in this state six months after adoption of the amended regulation.

For premium rate schedule increases, the applicability varies for individuals and for groups. For individuals, the proposal would apply only to any long-term care policy issued in this state six months after the effective date of the amended regulation. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy that is in force on the effective date, the provisions shall apply on the policy anniversary following the date that is 12 months after adoption of the amended regulation.

III. Consumer Protection Amendments

The consumer protection amendments primarily focus on disclosures to consumers regarding potential future rate increases for all long-term care insurance policies, other than for policies where the insurer does not have the right to raise the premium (sometimes called noncancellable policies).

Key Provisions

1. Disclosure of rate increase histories required.

Companies must provide consumers with a rate increase history for the past 10 years. This is intended to inform consumers of past company practices and to deter companies from increasing premiums. Special conditions are established for companies that are acquiring closed blocks of business from other companies. These exceptions are to prevent insurers from being discouraged from buying bad blocks of business.

2. List of information required to be supplied to applicants.

These amendments add a new Section 9 to the model, which lists extensive information that must be supplied to an applicant so that the applicant is aware that the policy may be subject to rate increases in the future. In addition to the rate increase history of the insurer (see # 1 above), the insurer must supply the following information to the applicant at the time of application or enrollment: (a) a statement that the policy may be subject to rate increases in the future; (b) an explanation of the policyholder's options in the event of a premium rate increase; (c) the premium rate applicable to the applicant that will be in effect until a request is made for an increase; and (d) a general explanation for applying premium rate adjustments.

3. Signed acknowledgement of potential rate increases required.

The amendments require an applicant to sign an acknowledgement at the time of application that the insurer has made the required disclosures about possible rate increases and about the insurer's rate increase history. The insurer shall use Appendices B and F to comply.

4. Updates to Appendices

Appendix B, the *Long-Term Care Personal Worksheet*, has been revised, and a new Appendix F, the *Long Term Care Insurance Potential Rate Increase Disclosure Form*, has been added. Appendix B has been revised to require a specific acknowledgement by the consumer that the policy may be subject to rate increases in the future along with adding information on inflation protection and elimination periods. Appendix F includes information about potential rate increases, options for the consumer when there is a rate increase, and the contingent benefit upon lapse benefit that will be triggered by a substantial rate increase.

5. Licensing of Agents

Amendments were made to the licensing section of the model so that this section was in compliance with the NAIC Producer Licensing Model Act. Although the model does not state the outcome of the working group discussions, states are encouraged to add more questions on long-term care insurance to their health insurance exams, rather than creating a separate test and running into conflicts with NARAB.

6. Training of Agents and Standards for Marketing

Amendments to the Standards for Marketing section of the model impose a requirement on insurers that they develop procedures to assure that producers selling the product are adequately trained in all

Attachment D

Executive Summary of Amendments to the Long-Term Care Insurance Model Regulation

I. Background

Two working groups developed the following amendments to the Long-Term Care Insurance Model Regulation (model regulation). The Accident and Health Working Group of the Life and Health Actuarial (Technical) Task Force drafted the rating practices amendments, and the Long-Term Care Working Group of the Senior Issues (B) Task Force developed the consumer protection amendments. Each working group had the input of regulators, industry and consumer groups during the process. These two sets of amendments were combined into one draft at the 2000 Summer National Meeting in Orlando, considered by the appropriate working groups and task forces, and approved by the Health Insurance and Managed Care (B) Committee on June 13, 2000. The amendments were adopted and finalized by the Executive and Plenary Committees (full membership) during a conference call on August 17, 2000.

II. Rating Practices Amendments

The amendments are designed to guarantee rate stability and level premiums over the life of a policy. The goal is to increase the likelihood that premium rates offered by companies will be adequate over the life of the policies, that rate increases will be less likely, that only justified increases will occur, and that necessary increases will be smaller and less frequent.

Key Provisions

1. Initial loss ratio requirements eliminated.

The current 60 percent loss ratio requirement on initial rate filings is eliminated. This enables companies to set more conservative initial premiums.

2. Limits put on expense allowances on increases.

All rate increases are subject to an 85 percent (70 percent for exceptional increases) loss ratio on the increase and, once an increase is requested, 58 percent on the initial premium. The 85 percent severely limits the amount of premium available for commissions and profit. It provides a powerful incentive for companies to charge adequate initial premium.

3. Unnecessary rate increases reimbursed.

For each rate increase, the insurer must file its subsequent experience with the commissioner. If the increase appears excessive, the commissioner may require the company to reduce premiums or take other measures to ensure that premium increases that turn out to be unnecessary are returned to policyholders.

4. Review of administration and claim practices authorized.

If the majority of policyholders subject to the increase are eligible for contingent benefit upon lapse, the company must file a plan, subject to commissioner approval, for improved administration or claims

aspects of the product. Agents also must provide copies of the disclosure forms and provide an explanation of contingent benefit upon lapse during the marketing of long-term care insurance coverage.

7. Standard Form Outline of Coverage

The amendment requires the outline of coverage to state that the consumer may contact the state Senior Health Insurance Assistance Program (SHIP) if the person has general questions regarding long-term care insurance and may contact the insurance company if the person has specific questions regarding the long-term care insurance policy or certificate.

8. Effective Date

The new Section 9, "Required Disclosure of Rating Practices to Consumers," applies to any long-term care policy or certificate issued in this state six months after adoption of the amended regulation.

For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy that is in force on the effective date, the provisions of Section 9 shall apply on the policy anniversary following the date that is 12 months after adoption of the amended regulation.

IV. Future Action

1. Education Seminars for States

The NAIC will hold a four-hour education seminar to explain these changes on Saturday, September 9 in Dallas at the Fall National Meeting. In addition, the NAIC is planning on holding education programs on these changes in January 2001. These education programs are necessary in order for regulators to be able to explain the changes and have the changes adopted into state law and/or regulation. Industry has said it is willing to help the regulators get these changes passed through the legislatures in those states that cannot accomplish it by regulation. Industry wants to pass the changes quickly.

2. Compliance Manual

The Accident and Health Working Group will be drafting a compliance manual, which would allow regulators with experience reviewing long-term care polices to lend guidance to other regulators. A draft of the compliance manual is anticipated by the 2000 Fall National Meeting. Regulators, interested parties and NAIC staff will be drafting the compliance manual.

3. Use as a Model for Federal Legislation

Congress is interested in the NAIC's work on this issue. The majority and minority staff of the Senate Special Committee on Aging would like to use these amendments to draft federal legislation affecting tax qualified long-term care policies. In addition, the committee would like to hold a hearing on this issue and have the NAIC testify on a panel.

The CHAIRMAN. Thank you very much.
Now, Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman and Senator Bayh. It is a pleasure to be back again. The agenda of this committee has been dealing with critical issues for the elderly, and it is gratifying for us to be asked to provide you with information that may be helpful in your consideration of these issues.

I am pleased in particular to be here today as you discuss the importance of consumer protections regarding long-term care insurance. The financing of long-term care is already a challenge for individuals needing such care and for the public sector. The challenge will be attenuated as the 76 million baby-boomers age. Over the next 30 years, the number of elderly individuals is expected to double, and the number of elderly needing long-term care will probably grow even more as more baby-boomers are expected to reach 85 and beyond when the prevalence of long-term care needs increase drastically.

The confluence of the aging baby-boom generation, longer life expectancies, and evolving options for providing and financing long-term services will require substantial public and private investment and development of sufficient capacity to serve the growing number of disabled elderly. Many have hoped that private long-term care insurance could play a significant role in meeting this challenge. It is a hope that has not been realized to date.

Before I discuss some of the reasons why this has occurred, I would like to provide you with a sense of the magnitude of the issues that we face.

Spending on long-term care for the elderly this year totaled $123 billion, more than 10 percent of all health care spending. Medicaid and Medicare continued to pay nearly 60 percent of these costs. Medicaid funds go primarily for nursing homes and other institutional care, but home- and community-based services represent a growing share.

Today, about as many Medicaid beneficiaries receive in-home services as are in nursing homes. While Medicare has not usually been perceived as a financer of long-term care, the program has come to play a significant role through its home health benefit. However, the sharp curtailment of home health spending and use following the payment changes in the Balanced Budget Act raises questions about how much Medicare will be spending for long-term care in the future. However, the new Medicare prospective payment system for home health to be implemented next month should make funding available for a significant increase in services.

While public programs pay the majority of long-term care expenditures, the burdens borne by individuals and their families must not be overlooked. Out-of-pocket costs equal $43 billion, or about 30 percent of the total. These costs, however, do not measure the many hidden costs of long-term care, as an estimated two-

thirds of the disabled elderly living in the community rely exclusively on their family and other unpaid sources of care.

Private long-term care insurance has been viewed as a possible means of both reducing the catastrophic financial risks for the elderly and relieving some of the financing burden currently falling on public programs. However, after approximately two decades, private long-term care insurance represents a rather small fraction of long-term care spending, about $5 billion.

Fewer than 10 percent of the elderly, and even fewer near elderly, have purchased a policy. Although these numbers are increasing, its market share pales in comparison to the two-thirds of the elderly who have private Medicare supplemental insurance for expenses not paid for by Medicare, such as copayments, deductibles, and prescription drugs.

What has impeded the success of long-term care insurance? Questions do exist about the affordability of policies and the value of coverage relative to premiums being charged. While determining whether a policy is affordable is subject to differing judgments, some studies estimate that long-term care insurance is affordable to only about 10 to 20 percent of elderly individuals.

A policy purchased when a person is in their 40's or 50's has a much lower premium than one purchased later, but those premiums are going to have to be paid for a longer period of time. A policy with inflation protection could cost a 65-year-old $2,000 a year, compared to a premium of between $500 and $800 for a 50-year-old.

Concerns about premiums relative to the value of policies may be another factor deterring purchasers. Premiums for similar policies for the same individual can vary widely, raising questions about what is a good deal. For example, a 65-year-old in Wisconsin could pay between $850 and over $2,000 per year for a policy with similar terms from different carriers.

If long-term care insurance is to have a more significant role in how chronic health care needs are addressed, policies offered must be viewed by consumers as good, affordable products that are easily understandable. Considerable progress has been made since the days when long-term care insurance was first offered to better assure that available policies offer greater value to consumers, covering a meaningful array of benefits, not containing undue restrictions or charging excessive premiums.

Considerable credit goes to the National Association of Insurance Commissioners and to the States for their efforts to achieve this. But some credit also should be given to those insurers that chose to compete in this market by offering better products.

Such steps are important. Consumers are at a disadvantage in purchasing long-term care insurance. It is a product where 20, 30, or even 40 years may pass between the purchase and the need for benefits time in which how long-term care is delivered and individual circumstances could change drastically. Having only products available now that are likely to remain valuable and assuring purchasers have adequate information to make appropriate choices are critical protections for consumers.

This committee in the past has focused on the importance of good, reliable, comprehensive information to protect consumers en-

rolling in Medicare+Choice plans. Without such information, individual consumers face risks of being harmed by purchases they do make. Also, we lose the opportunity to take advantage of quality-based competition to improve what consumers have available. Without information, good products do not drive out bad ones. The situation is similar for long-term care insurance. Protecting and informing consumers is key, or the role of long-term care insurance that some envision may not be realized.

Thank you very much. I would be happy to answer any questions that you have.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
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September 13, 2000

LONG-TERM CARE INSURANCE

Better Information Critical to Prospective Purchasers

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-00-196

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the challenges the baby boom generation and society face in planning for and financing its future long-term care needs, and the role that private long-term care insurance may play in meeting those challenges. Long-term care includes an array of health, personal care, and social and supportive services provided in a range of settings including nursing homes, assisted living facilities, and people's own homes. While much care is provided by family members, paying for purchased services presents a significant financial burden for many individuals and for public health care programs. Of the nation's approximately 35 million elderly people aged 65 and older, an estimated 5.2 million—or over one-seventh—have some form of long-term physical or mental disability for which they require assistance, such as help with bathing, dressing, eating, preparing meals, or taking medicines. For those needing nursing home or other extensive continuous care, the costs can be substantial. On average, nursing home care currently costs $55,000 annually, with many nursing home residents paying much of that out of their own pockets.

Long-term care financing will be an increasing concern as the 76 million baby boomers age and begin, in just over a decade, to turn 65 and become Medicare eligible. Over the next 30 years, the number of elderly individuals is expected to double as the baby boom generation enters its senior years. Similar growth is expected for the number of individuals needing long-term care. With baby boomers living longer and greater numbers reaching age 85 and older, this generation is expected to have a dramatic effect on the number of people needing long-term care services and will challenge these individuals, their families, and public programs to finance and furnish that care.

My remarks today focus on (1) the increased demand the baby boom generation will likely create for long-term care, (2) an overview of current spending for long-term care of the elderly, including recent changes in Medicaid and Medicare financing of long-term care, and (3) the potential role of private long-term care insurance in helping finance this care, including who buys this insurance, its affordability, and the critical need for consumer information and protections. My comments are based on our previous work and other published and ongoing research. A list of related GAO products follows my statement.

In summary, estimates of the magnitude of the baby boomers' future long-term care needs vary, with estimates of the number of disabled elderly when the baby boom generation becomes elderly ranging from 2 to 4 times the current number. Estimates of cost are even more imprecise due to the uncertain effect of several important factors, including how many will be needing care, the types of care they will need, and the availability of public and private sources to pay for that care. Nonetheless, the confluence of the aging baby boom generation, longer life expectancies, and evolving options for providing and financing long-term care services will require substantial public and private investment in long-term care and the development of sufficient capacity to serve the growing number of disabled elderly.

Spending for long-term care for the elderly, including post-acute and chronic care in nursing homes and home care, is an estimated $123 billion this year. Medicaid and Medicare will pay for nearly 60 percent of these services, contributing $43 billion and $29 billion respectively. Medicaid funds go primarily to nursing homes and other institutional settings of long-term care, but home and community-based services represent a growing share of Medicaid spending and recipients. Medicare primarily covers acute care services, and thus plays a lesser role in financing nursing home care—by paying only for short-term stays following a hospitalization—but has grown to play a significant role in covering long-term care through its home health benefit. Recent federal legislative changes in response to rapid and inexplicable growth in spending for long-term care services in Medicare have already resulted in a reduction in home health spending, but it remains uncertain how much Medicare will be spending for long-term care services in the future. In part, this is because the new Medicare prospective payment system provides incentives to control home health services, but it also is based on an increased number of visits per user than currently provided, thereby making funding available for a large expansion of home health services. Public programs pay for the majority of long-term care expenditures, but out-of-pocket costs paid by individuals and their families are substantial, representing 30 percent of total long-term care expenditures ($43 billion in 2000). These amounts, however, do not include many hidden costs of long-term care because nearly 60 percent of the disabled elderly living in the community rely exclusively on their families as caregivers and other unpaid sources for their care.

Private long-term care insurance has been viewed as a possible means of reducing catastrophic financial risk for the elderly needing long-term care and of relieving some of the financing burden currently falling on public long-term care programs. Given concerns about the long-term financial solvency of the Medicare program, the additional financial stress created by the forthcoming eligibility of the baby boom generation, and the potential costs of proposed new benefits for prescription drugs, congressional interest in stimulating long-term care financing through private means has grown. Several recent congressional initiatives, including establishing a program to make group long-term care insurance available to federal employees and proposals to provide tax subsidies to individuals purchasing long-term care insurance, aim to expand the role of private long-term care insurance. Yet private long-term care insurance represents a small fraction of long-term spending—about $5 billion. Less than 10 percent of the elderly and an even lower percentage of near-elderly individuals have purchased long-term care insurance, although these numbers are increasing. Questions remain about the affordability of policies and the value of the coverage relative to the premiums charged. If long-term care insurance is to have a more significant role in addressing the baby boom generation's upcoming chronic health care needs, the policies offered must be viewed by consumers as good, affordable products that are easily understandable. To that end, the National Association of Insurance Commissioners has recently strengthened its model regulation for long-term care insurance, including recommending that states enact laws requiring additional disclosure to consumers about the potential for future policy rate increases and better ensuring that long-term care insurers accurately price their policy premiums.

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BACKGROUND

Long-term care includes many types of chronic care services needed because of physical or mental disability. Individuals needing long-term care have difficulty performing some functions involved in normal daily living, such as bathing, dressing, toileting, eating, and moving from one location to another without assistance. They may also have mental impairments, such as Alzheimer's disease, which may require supervision and assistance with tasks such as taking medications. Although a chronic physical or mental disability may occur at any age, the older an individual becomes, the more likely a disabling condition will develop or worsen. Nearly one-seventh of the nation's current elderly population—an estimated 5.2 million—have a limitation in either activities of daily living (ADL), instrumental activities of daily living (IADL), or both. More than one-third of these have limitations in 2 or more ADLs.

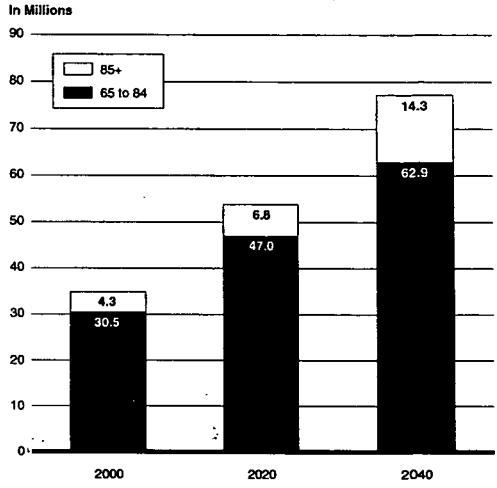
Long-term care for the elderly has often been misunderstood to mean only institutional care provided by nursing homes for individuals with chronic care needs, but it is more than that. Nearly 80 percent of the elderly requiring assistance with ADLs or IADLs live at home or in community-based settings, while more than 20 percent live in nursing homes or other institutions. The majority of long-term care is provided by unpaid family caregivers to elderly individuals living either in their own homes or with their families. However, a growing minority receives paid assistance from various sources. For example, Medicare pays for home care for a small percentage of beneficiaries who received home health services for longer-term care. In addition alternatives to nursing home care, such as assisted living arrangements, are developing. An estimated 1 million individuals live in residential settings, such as assisted living facilities, that have long-term care services available. As the baby boom demand for long-term care grows, so must the capacity for providing long-term care in individuals' homes and other appropriate settings.

THE BABY BOOM GENERATION WILL GREATLY EXPAND DEMAND FOR LONG-TERM CARE

The baby boom generation, about 76 million people born between 1946 and 1964, will contribute significantly to the growth in the number of elderly individuals who need long-term care and the increased amount of resources required to pay for it. The oldest baby boomers are currently in their fifties. In 2011, the first of the baby boomers born in 1946 will turn 65 years old and become eligible for Medicare. The Medicaid program, which pays for many health care services for low-income elderly, including nursing home care, will also begin to feel their impact. The effect on long-term care demand is expected to grow even more after 2030 when the first baby boomers reach 85 years of age, the age at which the need for long-term care services is greatest.

Today's elderly comprise 12.7 percent of our nation's total population. That percentage will increase by nearly one-third to 16.5 percent in 2020. At that time, one in six Americans will be 65 years old or older and will represent nearly 20 million more seniors than today. By 2040, the number of seniors aged 85 years and older, the age group most likely to require long-term care, will more than triple to 14 million (see fig. 1).

Figure 1: Estimated Number of Elderly Individuals in 2000, 2020, and 2040



Source: U.S. Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups and Sex With Special Age Categories: Middle Series," selected years 2000 to 2040, January 2000.

Besides their numbers, the extended life spans of the baby boom generation will have an impact on long-term care. Life expectancy has grown over the last decades, increasing more than 6 years since 1965 when life expectancy at birth was 70.2 years to 76.5 years in 1997. With aging individuals who reach 65 today expected, on average, to live to 80.9 years for males and 84.2 years for females, many baby boomers can expect to survive well into their eighties. The increasing proportion of baby boomers who will live to 85 and beyond will be most likely to need long-term care services.

Estimating the exact number of baby boomers who will need long-term care services is complicated by several factors. While experts agree that population aging will increase the number of disabled elderly needing long-term care over the next several decades, no consensus exists on the size of that increase. Long-range estimates of the magnitude of the baby boomers' long-term care needs vary with estimates of the number of disabled elderly ranging from 2 to 4 times the current number. Conclusions differ concerning the effects of better health care and healthier lifestyles on the baby boomers' need for long-term care. Some researchers contend that medical advances have increased life expectancy but have not changed the age at onset of illness and therefore the need for

long-term care may have increased. Others contend that better treatment and prevention could decrease the number of years long-term care is needed. How these factors will translate into the need for long-term care services and actual spending also will depend on the types of care used and the public and private resources devoted to purchasing long-term care.

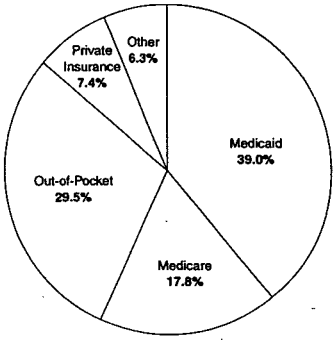
Baby boomers in general are expected to be wealthier in retirement than their parents. Those who are single, have less education, or do not own homes, however, may not do as well. While many baby boomers will have greater financial resources, they will have fewer social resources because a smaller proportion of this generation will have a spouse or adult children to provide unpaid caregiving. The geographic dispersion of families and the large percentage of women who work outside the home also may reduce the number of unpaid caregivers available to elderly baby boomers, thus creating greater need for purchased long-term care services.

For women of the baby boom generation, long-term care needs are an especially significant concern. More than 7 out of 10 unpaid caregivers are currently women, three-quarters of nursing home residents 65 years and older are female, and two-thirds of home health care users are female. Given their longer life expectancies and the fact that married women usually outlive their spouses, many women face a higher risk of needing long-term care and not having a spouse to serve as a caregiver.

LONG-TERM CARE EXPENDITURES ESTIMATED TO DOUBLE IN 25 YEARS

Over the next 40 years, between 2000 and 2040, the Congressional Budget Office estimates that long-term care expenditures for the elderly, adjusted for inflation, will grow annually by 2.6 percent. In 1998, long-term care spending for nursing home and home health care was estimated at more than $117 billion. Individuals needing care and their families paid for almost 30 percent of these total expenditures out-of-pocket, Medicaid and Medicare funded 57 percent, private health insurance accounted for about 7 percent, and other sources paid the remaining 6 percent (see figure 2). These amounts, however, do not include the many hidden costs of long-term care, because an estimated 60 percent of the disabled elderly living in their community rely exclusively on their families as caregivers and other unpaid sources for their care. CBO estimates $123 billion in total long-term care spending for the elderly in calendar year 2000, projecting that these expenditures will reach $207 billion in 2020 and $346 billion in 2040. Based on these projections, long-term care expenditures would roughly double in 25 years.

Figure 2: Elderly Long-Term Care Expenditures, by Source of Payment, 1998



Source: Office of the Actuary, National Health Statistics Group, Personal Health Care Expenditures, HCFA, Department of Health and Human Services, 2000.

Medicaid

Medicaid, a joint federal-state health financing program for low-income individuals, continues to be the largest public funding source for long-term care. Within broad federal guidelines, states design and administer Medicaid programs that include coverage for certain mandatory services, such as skilled nursing facility care, and other optional coverages, such as home and community-based services. Although most Medicaid long-term care expenditures are for nursing home care, in the last two decades there has been a shift to more home and community-based care. The result is a significant change in the proportion of people with the need for long-term care that are receiving Medicaid-financed services and in the average costs of those services. By fiscal year 1998, the number of Medicaid recipients receiving home health or home and community-based services was similar to the number of Medicaid recipients receiving nursing facility services.

State Medicaid programs have, by default, become the major form of insurance for long-term care, but only after individuals have become nearly impoverished by "spending down" their assets. Medicaid eligibility for many elderly results from having become poor as the result of depleting assets to pay for nursing home care, the average price of which is $55,000 per year.[1] In most states, nursing home residents without a spouse must

[1]The MetLife Mature Market Institute survey also found that nursing home costs vary widely by region of the country, from nearly $33,000 per year in Hibbing, Minnesota to more than $100,000 per year in Manhattan.

have less than $2,000 in countable assets to become eligible for Medicaid coverage. About two-thirds of nursing home residents in 1998 relied on Medicaid to help pay for their care, and just over half (58 percent) of Medicaid expenditures for long-term care were for institutional care in nursing homes.[2]

States historically limited coverage of in-home services under Medicaid due to concern about the potential cost of covering services for the large number of disabled who were being cared for by their families. However, as part of the Omnibus Budget Reconciliation Act of 1981, the Congress established the home and community-based service waiver program. The waiver program gave states the option of applying for Medicaid waivers to fund home and community-based services for people who met Medicaid eligibility requirements for nursing home care. These waivers also gave states the ability to restrict the number and costs of eligible individuals to be served under Medicaid in home and community-based settings. All states now have home and community-based waivers, and more than 200 waiver programs served more than 450,000 individuals nationwide in fiscal year 1998. Medicaid expenditures for home and community-based waivers have increased an average of 25 percent per year from 1993 to 1999, reaching a level of $10.5 billion in 1999.

Medicare

During the 1990s, costs for both skilled nursing facility services and home health care became the fastest growing components of Medicare spending, although changes introduced by the Balanced Budget Act of 1997 (BBA) have significantly altered this situation. In contrast to Medicaid, which is estimated to pay about 46 percent of total nursing home and other institutional care expenditures in 2000, Medicare plays a relatively small role, paying only about 12 percent of total nursing home and other institutional care expenditures. Medicare primarily covers acute health care costs, and therefore limits its nursing home coverage to short-term, post-acute stays of up to 100 days per spell of illness following hospitalization. Medicare nursing home spending increased from $1.7 billion in 1990 to $10.4 billion in 1998.

Since 1989, Medicare became a significant funding source of home care, financing $10.4 billion in care—or more than one-third of the home care purchased for the elderly—in 1998. Court decisions and legislative changes in coverage guidelines essentially transformed the Medicare home health benefit from one focused on patients needing acute, short-term care after hospitalization to one that also served chronic, long-term care patients. By 1994, only about one-fourth of home health visits covered by Medicare occurred within 60 days following a hospitalization. As a result, Medicare, on a de facto basis, has financed an increasing amount of long-term care through its home health care benefit. Both the number of beneficiaries receiving home health care and the number of visits per user more than doubled from 1989 to 1996. From 1990 to 1997, the average annual growth rate for Medicare home health care spending was 25.2 percent—more

[2]An additional 17 percent of Medicaid long-term care expenditures were for intermediate care facilities for people with mental retardation, with the remaining quarter of Medicaid long-term care expenditures for noninstitutional care provided through home health, personal care services, and home and community-based service waivers.

than 3 times the growth rate for Medicare spending as a whole. The increase in the use of these services cannot be explained by any increase in the incidence of illness among Medicare beneficiaries.

In response to concerns about the growth in spending for Medicare services, including skilled nursing facility and home health services, Congress enacted the BBA which included provisions to slow growth. The Act required prospective payment systems to be implemented for Medicare services provided through home health care agencies and skilled nursing facilities, replacing the retrospective, cost-based reimbursement that did not provide adequate incentives to control costs. The skilled nursing facility prospective payment system began to be implemented in July 1998 and will be completely phased in by 2001. Even though nursing home use has continued to increase during the phase-in of the new payment system, a temporary increase in Medicare payments to nursing homes caring for certain high-cost patients, pending the inclusion of a refined case-mix adjustment for payments to nursing homes, was enacted in response to complaints from the industry that payments were inadequate.

For home health, rather than immediately introducing a prospective payment system, an interim home health care payment system was implemented in October 1997, pending development of a case-mix adjusted prospective payment system. Between 1997 and 1998, Medicare home health spending fell by nearly 15 percent, while home health visits dropped sharply by 40 percent, and this decline continued in 1999.[3] The home health prospective payment system (PPS), scheduled to be in place by October 1 of this year, is expected to be a more appropriate payment tool than the interim payment system because it is designed to more closely align payments with patient needs.[4] The PPS rates are based on a higher number of home health visits per user than those currently being provided. As a result, the new payment system can support a large expansion of services. However, PPS incentives are intended to reward efficiency and control use of services. Because criteria for what constitutes appropriate home health care do not exist, it may be difficult for Medicare to ensure that patients receive all necessary services. How home health agencies respond to the PPS and its incentives could have major implications for the amount of future Medicare funding for home health care and the services provided.

PRIVATE LONG-TERM CARE INSURANCE REPRESENTS A VERY SMALL BUT GROWING SHARE OF LONG-TERM CARE EXPENDITURES

While many baby boomers will have more financial resources in retirement than their parents and may be better able to absorb some long-term care costs, long-term care will represent a catastrophic cost for a relatively small portion of families. This type of

[3]See Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending (GAO/HEHS-00-176, Sept. 8, 2000).

[4]See Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments (GAO/T-HEHS-00-160, July 19, 2000).

situation can be ideal for a private insurance program because it spreads risk among many individuals. Private long-term care insurance has been viewed as a means of both reducing potential catastrophic financial risk for the elderly needing long-term care and relieving some of the financing burden currently falling on public long-term care programs. Some observers also believe private long-term care insurance could provide individuals greater choice in selecting services to satisfy their long-term needs. However, less than 10 percent of elderly individuals and even fewer near-elderly individuals have purchased long-term care insurance to protect against the financial risks of the potential high costs of future care. The National Association of Insurance Commissioners reported that in 1998 approximately 4.1 million persons were insured through long-term care insurance policies, compared with 1.7 million persons in 1992.[5] In contrast, about two-thirds of the elderly—about 23 million individuals—have private Medicare supplemental insurance policies to cover other non-Medicare covered expenses such as copayments, deductibles, and prescription drug costs.

Private long-term care insurance is still a little known product with insurance providers seeking to build a larger market. Barriers to purchasing long-term care policies still exist. Many baby boomers continue to believe they will never need such coverage. A recent survey of the elderly and near elderly found that only about 40 percent believe that they or their family will be responsible for paying for their long-term care. Some mistakenly believe that public programs, including Medicaid and Medicare, or their own health care insurance will provide comprehensive coverage for the services they need. This lack of awareness decreases people's perceived need for protection, thus decreasing demand for long-term care insurance. Others may be concerned about whether they can afford such insurance now or in the future when their premiums may increase and their retirement incomes may have decreased.

Some employers offer their employees a voluntary group policy option for long-term care insurance, but this market remains small and is offered predominantly by large employers. Usually employers do not pay for any of the costs of these policies, but group policies have lower administrative costs than individually-purchased policies which can result in lower premiums for those employees choosing to purchase a policy. The American Council of Life Insurance reported in 1998 that only 29 percent of long-term care insurance policies in force were group policies. Studies estimate that 6 to 9 percent of eligible active employees took advantage of employer-provided group long-term care insurance where it was available. The House and Senate have recently passed legislation that would offer group long-term care insurance to federal employees and retirees beginning by fiscal year 2003, an initiative that, if enacted, would likely establish the largest group offering of long-term care insurance and could significantly expand this market.[6]

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[5]The accuracy of these policy numbers is dependent upon the accuracy of the information filed by the insurers themselves with the National Association of Insurance Commissioners.

[6]The House and Senate passed the Long-Term Care Security Act, H.R. 4040 and S. 2420, on July 27, 2000. The legislation awaits further action.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) extended tax deductibility of some premiums and tax exemptions for certain benefits to qualified long-term care insurance policies. Qualified policies have to satisfy certain requirements including consumer protection standards.[7] The consumer protection standards are deemed satisfied if a policy complies with the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Act. As of July 1998, the Health Insurance Association of America reported that all 50 states (which have primary responsibility for regulating insurance policies) required policies adhere to at least 3 NAIC long-term care insurance standards. These three standards require policies to not require prior institutionalization as a condition for coverage, to have an outline of coverage provided by the policy, and to be guaranteed to be renewable and non-cancelable. In addition, all but one state adheres to the NAIC definition of long-term care insurance (policies providing coverage for at least 12 months for necessary services provided in settings other than acute care hospital units), and all but two states adhere to the pre-existing conditions standard. Overall, 14 of the 19 HIPAA long-term care insurance standards had been adopted by at least 35 states as of July 1998.

Long-Term Care Insurance Affordability of Concern to Many Elderly Individuals

Questions exist about the affordability of policies for many elderly and near-elderly, and the value of the coverage relative to the premiums charged. The affordability of long-term care insurance has a large effect on its marketability, and is a key factor in individuals' decisions to purchase and retain a long-term care insurance policy. Although assessing whether individuals can afford a policy is a subjective judgement, some studies estimate that long-term care insurance is affordable for only 10 to 20 percent of elderly individuals. Affordability is even more difficult for married couples who must each purchase coverage. While some insurers offer discounts to married couples when both purchase long-term care coverage, elderly couples are likely to pay at least several thousand dollars annually for long-term care coverage. Individuals who consider and then decide against purchasing long-term care insurance cite skepticism about whether private policies will provide adequate coverage. Those who do find long-term care insurance affordable may later decide it is not affordable because their financial circumstances have changed or the premiums have increased. An industry group estimates that only 55 to 65 percent of all long-term care insurance policies sold as of June 1998 remain in force.

Insurers try to convince individuals that it is prudent to decide to buy long-term care insurance early in life rather than later because policy premiums are based largely on an

[7]A qualified long-term care insurance plan is defined as a contract that covers only long-term care services; does not pay for services covered under Medicare; is guaranteed to be renewable; does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policy holder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Also, payments received from a qualified plan are considered medical expenses and are excluded from gross income for determining income taxes. Per diem policies that pay on the basis of disability rather than reimbursing for services used are subject to a cap of $180 per day per person in 1998. Out-of-pocket expenses for long-term care are allowed as itemized deductions along with other medical expenses, if they exceed 7.5 percent of adjusted gross income.

individual's age when the policy is purchased. A policy purchased when a person is in his or her 40s or 50s has much lower premiums than a policy purchased later in one's life; however, those premiums will be paid over a longer period. A person purchasing a long-term care policy with inflation protection at age 65 may pay premiums as high as $2,000 annually for the policy. If an individual waits until age 79 to purchase a policy, the premiums are typically about 2.5 times higher than if the same policy had been purchased when the individual was 65 years, and about six to ten times higher than if the policy was purchased at age 50.

The unfamiliarity and uncertain value of long-term care insurance may deter some individuals from purchasing a policy. A low premium at age 45 may seem high for a risk that may not be realized for 40 years. Individuals need to determine if they can afford the long-term care policy premium both now and in the future when their retirement income may be lower and their policy premiums may have increased. Concerns about premiums relative to the value of policies may be a factor, especially when premiums for a similar policy for the same individual can vary widely. For example, a 65-year-old in Wisconsin could pay $857 to $2061 per year for a long-term care insurance policy from different carriers with similar terms.[8]

Consumer Information and Protection Is Necessary, Especially If Private Insurance Is to Assume a Larger Role in Financing Long-Term Care

While consumers deserve complete and accurate information about any insurance product they purchase, sales of long-term care policies are not likely to increase significantly unless consumers have adequate and understandable information to assess them. If long-term care insurance is to have a role in addressing the baby boom generation's upcoming long-term care needs, individuals need to be able to understand clearly what they are buying at the time of purchase and what changes, if any, they may face in their policy's coverage or premiums in the future. We have previously reported on a number of problems in the long-term care insurance market, including those related to disclosure standards, inflation protection options, clear and uniform definitions of services, eligibility criteria, grievance procedures, nonforfeiture of benefits, options for upgrading coverage, and sales commission structures that potentially create incentives for marketing abuses.[9]

Long-term care insurance policies are not standardized by law as are Medicare supplemental (Medigap) policies, making comparisons among different policies difficult. Although long-term care policies provide many options for individuals to choose among to create a policy to meet their perceived needs and financial situation, these choices can complicate the purchasing decision. If people do not fully understand their options, they may not make the best choices. Further, for some prospective purchasers,

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[8]Annual premiums for individual basic long-term care insurance policies marketed in Wisconsin with $100 per day nursing home benefit, $50 per day home health benefit, lifetime benefits, a 90 or 100-day elimination period, and no optional benefits as of October 1999.

[9]Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993).

the cost of some options, such as inflation protection, can compromise the affordability of the policy.

Several checklists exist to help individuals considering a policy purchase determine the options they should buy to create a policy that best fits their needs. However, the specific policy information required to make these reasoned decisions may not be readily available, and the decisions themselves may be too daunting. Among the questions an individual should try to answer when purchasing a long-term care insurance policy are:

- What is the probability that long-term care services will be needed in the future and for how long will they be needed?
- How much coverage can the individual afford, will the premium remain affordable over time, and will the coverage provide sufficient services?
- Should the policy cover only nursing home care, or also home care, or other alternatives such as assisted living?
- Should the individual purchase a less expensive policy that has a waiting period before the policy begins paying for services received?
- What level of coverage for specific services should be purchased? For example, what per day amount (such as $100 or $130 per nursing home day) should be stipulated for nursing home care? For home health, what per month or per visit amount is adequate? Should total coverage be provided for 3 years, 5 years or for lifetime coverage?
- Should inflation protection be purchased (for an additional 25 to 40 percent of the premium) to preserve more of the policy's future value?
- Should optional nonforfeiture protection be purchased (for an additional 10 to 100 percent of the premium) to allow the purchaser to retain some coverage if he or she stops making premium payments?

Particularly important for many consumers is a clear understanding of the current price of the policy and whether that price is subject to future increases. This concern was highlighted by a recent class action lawsuit involving long-term care policyholders in North Dakota, which was brought against two insurers who sold individual, guaranteed renewable, level premium policies. To the policyholders, level premium policies meant that the amount of their premiums at the time of purchase would remain at the same level. They believed that the premiums would not increase as long as they held their policies, which they were guaranteed could be annually renewed. To the insurers, level premiums meant an individual's policy premiums would not be increased unless the entire class holding the same type of policy had a premium increase. After the insurers stopped selling these policies to new purchasers in 1990, premiums for existing policyholders began increasing—for some by more than 700 percent. For example, one female policyholder's annual policy premium at purchase was $829.86 and increased to

$6,638.42. As a result, some policyholders were unable to afford the increases and were forced to drop their policies at a time when their age made buying another policy very expensive. Others at high risk of needing coverage had to continue paying very high premiums to maintain their policies. The class action suit contended that the insurers did not explain to purchasers that a level premium policy could result in premium increases for an entire class of policyholders and did not appropriately determine the initial premium rate for the policy. In 1999, the class action in North Dakota was settled along with class actions in several other states for monetary payments to former policyholders, premium rate reductions for those still holding policies, and agreement by two insurers to have no future rate increases for these policies.

In August, the National Association of Insurance Commissioners amended its Long-Term Care Insurance Model regulation to strengthen consumer disclosure to address problems such as those highlighted by the class action suit. In states that adopt the Model regulation amendments as part of their insurance regulations, insurers will have to provide written information to prospective purchasers explaining

- that a policy's premium may increase in the future,
- why premium increases may occur,
- what options a policyholder has in the event of an increase, and
- what the 10-year rate history for their policies has been.

Consumers will also have to specifically acknowledge that they understand their policy's premiums may increase, and insurers must explain any contingent benefit available to policyholders who let the policy lapse due to a substantial rate increase. Additionally, the NAIC adopted amendments to better ensure that long-term care insurers accurately price their policy premiums to be sufficient over the lifetime of the policy, so as to minimize the need for future premium increases. As a further consumer protection, these amendments require insurers to reimburse policyholders when any rate increase is found to be unnecessary and allow state insurance commissioners to ban insurers from the long-term care market if they have a pattern of offering initial policy purchasers inadequate premium rates.

CONCLUDING OBSERVATIONS

In conclusion, the aging of the baby boomers will lead to a very large increase in this nation's elderly population in the next 3 decades, and an even greater increase in the number of individuals aged 85 and over who are likely to need long-term care services. Recent Congressional proposals, including the passage of legislation that would authorize a new federal employees' long-term care insurance offering and proposed tax subsidies for the purchase of private long-term care insurance, aim to increase the role private insurance plays in financing long-term care. Increased consumer information about and confidence in long-term care insurance and the availability of affordable, reliable products are also crucial components of private insurance if it is expected to play a larger role in financing future generations' long-term care needs.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or Members of the Committee might have at this time.

GAO CONTACTS AND ACKNOWLEDGMENTS

For more information regarding this testimony, please contact William J. Scanlon or Kathryn G. Allen at (202) 512-7114. John Dicken and Opal Winebrenner also made key contributions to this statement.

RELATED GAO PRODUCTS

Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending (GAO/HEHS-00-176, Sept. 8, 2000).

Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging (GAO/HEHS-00-94, Aug. 18, 2000).

Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments (GAO/T-HEHS-00-160, July 19, 2000).

Low-Income Medicare Beneficiaries: Further Outreach and Administration Could Increase Enrollment (GAO/HEHS-99-61, April 9, 1999).

Long-Term Care: Baby Boom Generation Presents Financing Challenges (GAO/T-HEHS-98-107, March 9, 1998).

Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993).

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Senator BAYH [presiding]. Thank you very much, Mr. Scanlon.

This could get to be habit-forming. I get to lead the committee at least for a moment.

I have a couple of questions for each of you before Senator Grassley's return. They have just called votes, so he is going over to vote now. It is on the China trade issue. Then when he returns, I will have to depart, and for that I apologize, but the schedule around here is unpredictable.

Kathleen, I would like to first thank you for being here. Anyone who is familiar with Kansas and public service in Kansas knows that the Sebelius family has been a major part of Kansas public service for many, many years, and I want to welcome you and thank you for your service to the people of your State.

Let me begin by asking, the recent rate increases that have been relatively substantial—what has been driving that? Is it the fact that it is a new product and they had difficulty pricing it? Is it the fact that the costs of providing the care have been escalating? Is it both and other factors? What, in your opinion, is behind this?

Ms. SEBELIUS. I think it may be all of the above. There is no doubt that the products at this point offer a vast array of services that were not really contemplated in the early 1980's. It was initially seen as exclusively nursing home coverage, and now demands have increased greatly for an array of home health services and in-home services which often may be less expensive than nursing home services, but may be triggered at an earlier time and used for a longer period of time.

I also think, because of the relative newness of the product, there were a lot of companies who didn't have adequate experience, who offered very rich benefit packages and frankly did not adequately rate them. From a regulator's point of view, we didn't have a lot of experience with determining what were appropriate or inadequate rates.

Some companies have never increased their rates. Others have made numerous changes. While that is not the only indicator of a good or a bad company, I do think it is an important question to ask. I think the industry is generally supportive of trying to make sure at the front end that rates are adequate. What they don't like to see is a company coming in with lower rates, getting a big market share, and then turning around and bumping those rates so consumers drop out of the market or have to shift to another company.

Industry has been very supportive of the changes that we are trying to make in terms of getting those rates adequate at the front end, making sure that actuarial certification is used to project out. You are buying a product and may not use it for 20 or 25 years, so you are projecting health care costs, nursing home costs, length of life, chronic disease costs, and all kinds of factors, which is a little bit tricky to do as you look into the future.

Senator BAYH. One of the steps you were recommending in terms of dealing with what happens when people may be at risk of getting priced out of the policies, at least if I understood your testimony correctly, was to ask companies to offer an option which would essentially, if I understood you correctly, give people a fixed

cost over the period of the policy. Was that something you were encouraging as an option?

And if I understood you correctly, another one of the options was in the case of some types of life insurance, if you had paid in, you would have some residual value.

Ms. SEBELIUS. Yes. I think the latter is what we are really talking about in the contingent nonforfeiture. A lot of people cannot afford for the length of the policy to add a nonforfeiture benefit, which would guarantee that they don't lose the value they have put in, and they opt not to buy that at the front end.

We think policies should include a contingent nonforfeiture which is really triggered by a percentage rate increase. If that rate increase is substantial, rather than saying to the consumer the only option is you are out of the market, you are given a couple of options.

One is to say I have paid $30,000, $20,000, $15,000 during the time I have been paying benefits and I want that total amount of money that I have paid converted into benefits that I will use in the future and I don't ever want to pay a premium again.

Another option is to say I can only afford my current $1,000 premium, and I can't go to $1,500. What are the benefits that I can get for that $1,000? So you reduce the benefit package but keep the premium level. The third option is just to pay the increase and go on with the policy.

We think that feature, which includes some protection—you don't lose your money and you get some optional choices—is very important and should be one of the tax-qualified benefits that Congress strongly considers.

Senator BAYH. That sounds like it makes a lot of sense particularly for a product where, according to Mr. Scanlon's testimony, we really need to encourage more middle-aged people to buy into this product when the price is lower and they can afford it. But it is hard to project out, as you were saying, 20 to 30 years your ability to pay or what is going to happen to the price of the product.

Has the industry indicated what allowing this residual value, consumers to retain that, would do to the price of the product, if anything?

Ms. SEBELIUS. Well, the industry was very much involved in the collaborative effort to come up with these new regulations, and I think they are very supportive of the regulations being put into place as quickly as possible throughout the country. I know you are going to hear from representatives of the Health Insurance Association of America and others, but our experience was they were very much partners in trying to make this product much more stable in the future, to enhance consumer confidence and to see these regulations as ones that will promote these goals.

I think as Dr. Scanlon said, people have to feel secure that this product actually will deliver the benefits they paid for. So we see these ratings issues and the consumer protections as ways to enhance consumer confidence that this is a product that will be there as part of their old age planning.

Senator BAYH. Thank you, Kathleen. It sounds like you have really done some good work here.

I see the yellow light is on, but given the circumstances we will continue before we call the next panel. I would like the chairman at least to have a chance to ask you a question or two.

Doctor, you used Wisconsin as the example of how widely premiums can vary for what essentially is the same product. Is there adequate competition in this segment of the insurance market? Normally, a robust, competitive market with access to lots of information is good for consumers. Do we have that in this area, or are there some barriers to full, robust competition?

Dr. SCANLON. In this, as well as in many other markets, even though there may be a significant number of people selling a policy, information is not widely enough available to individuals when they are contemplating the purchase of a policy. Policies are able to be sold at many different prices and they don't converge to a single price.

Senator BAYH. What can we do about that?

Dr. SCANLON. Some of the rate information that is being provided in Kansas is an example of something that can be done about that. I guess the issue would be consumers' access to this information, how do we best promote the education of consumers to both the issue of the need for insurance as well as what types of insurance is going to be accessible, and then second how do we give them information about specific policies that might be available.

Ms. SEBELIUS. Senator, if I might, I think not only do most States have these kinds of materials available, but the National Association of Insurance Commissioners also captures this kind of information. I think 45 to 50 of the States have very good Web sites. So it is free information and it is relatively easy to obtain.

Educating people that the information is available is an ongoing challenge, and we may try to get some more information from you about the Indiana State Fair experience that you had. I go home tomorrow and spend 2 days at the Kansas State Fair, but having a hearing like the one you described sounds like a good way to get this information out in a more accessible form.

Senator BAYH. I would be happy to share our experience. It was really very successful. We have a Seniors Day at our fair, and so there was a natural forum for disseminating some of this information. And I again salute you for the good work that you have done. It is kind of ironic. The information is available. We just need to find ways to notify the public that it is there.

Doctor, in your testimony, if I heard you correctly, you said that only about 10 percent—I was slightly off in my opening comments; I said 7—about 10 percent of Americans——

Dr. SCANLON. I said less than 10.

Senator BAYH. Less than 10, OK.

Dr. SCANLON. We were both in agreement.

Senator BAYH. Thank you. Always good to know that.

Less than 10 percent, and then you indicated that between 10 and 20 percent, the surveys indicate, can afford it.

Dr. SCANLON. These are studies that have looked at the premiums that are associated with policies and individuals' incomes and assets, and they have estimated that between 10 and 20 percent of the elderly can afford it.

Senator BAYH. Just the elderly, not the middle-aged?

Dr. SCANLON. Not persons of near elderly or middle-aged.

Senator BAYH. Well, let's focus on the elderly for just a moment. Again, in my opening comments I mentioned briefly what they call the sandwich generation, middle-aged people who are trying to raise children on the one hand, perhaps care for an elderly relative on the other, thinking about their own retirement. There are so many financial burdens, it is tough to convince them to set aside something for a need 20, 30 years from now, but the facts are compelling that it is clearly in their best interests to do.

But focusing on the elderly for a moment, since those are the statistics that you mention, it strikes me that clearly affordability is going to be an issue for many people. In your opinion, making the premiums fully deductible, as Senator Grassley and I have suggested, how much would that help?

Dr. SCANLON. It helps some, but at the same time we need to recognize that when one is retired, one's taxable income declines dramatically. So therefore the advantages of a tax deduction are much less than it would be for individuals who are working age where the deduction may be more valuable and it may encourage them to buy policies.

Senator BAYH. Are there any statistics on what percentage of the middle-aged can afford the policies?

Dr. SCANLON. Typically, the studies have not focused on the middle-aged. I am not aware of any.

Senator BAYH. It is 10 to 20 for the elderly?

Dr. SCANLON. Ten to 20 for the elderly, yes.

Senator BAYH. So clearly there is a big problem with affordability there. Do you have any intuition with regard to the middle-aged, or would you prefer not to speculate here?

Dr. SCANLON. I think that for the middle-aged it is going to be a much, much higher percentage.

Senator BAYH. It strikes me that that would intuitively be the case.

Dr. SCANLON. Right. We are talking about incomes that are much higher. We are talking about premiums that are much lower.

In the case of the elderly, the studies have typically chosen a share of income between 5 and 10 percent to define affordability. I mean, the interesting fact is that the average premium among purchasers is about 13 percent of income. So perhaps people, even though by the studies' benchmark, are not finding this affordable, they are finding it valuable enough to still purchase.

Senator BAYH. Well, any additional thoughts you would like to share about what we can do to address the issue of affordability, I would be very interested. I mean, clearly, the facts are overwhelming that it is in people's long-term best interest to buy these when the premiums are smaller. Yet, that is when the affordability is at its least.

So it seems from a public policy standpoint, in addition to disseminating information, making for informed consumers and a robust, competitive market, we need to arm them with the financial wherewithal to participate in the market. And we had hoped that that is what the deductibility would at least be a step in the right direction toward accomplishing.

Dr. SCANLON. It is definitely a step in the right direction. I mean, certainly giving preferential tax treatment is something that enhances the value of this and makes it more affordable to a larger group of people.

The reality, though, as you indicated earlier, is that most Americans have not focused on the issue of what their need for long-term care is likely to be and how it is going to be financed, and that is something that we have a very great difficulty in thinking about how to overcome.

Senator BAYH. Unfortunately, we are going to need to recess. I am going to have to leave or I am going to miss this vote. So we are going to call a brief recess until Senator Grassley's return. So I want to thank you both. Dr. Scanlon and Kathleen, thank you for your leadership and for your testimony here today. And I would be delighted to share our experience and to benefit from yours. Thank you.

We will stand in brief recess until the vote is concluded.

[Recess.]

The CHAIRMAN. I would call the recess of the committee to a close. I will ask questions of this panel. The situation is that there are two votes in the Senate. I have cast this vote. Usually, the first vote will take 20 or more minutes, and then there is a 10-minute vote on the second issue. So, hopefully, I will be done asking this panel questions and then we will be able to have a short recess for the second panel while I vote.

I am going to start with you, Dr. Scanlon. First of all, to both of you, thank you very much for your testimony and particularly for you coming a long distance to be with us, but also to represent the 50 commissioners of insurance as well.

Your testimony, Dr. Scanlon, I think highlights two major functions of long-term care insurance. One, it allows for reduction of potential catastrophic risk for elderly needing long-term care, and it can, of course, relieve the financial burden on public programs that pay for long-term care.

Could you give us some examples of the long-term care costs that an individual or family might face?

Dr. SCANLON. Today, the average cost of nursing home care in this country is about $55,000 a year, and that is, of course, an average. So individuals, depending upon where they live, could be paying considerably more for nursing home care.

Many people—and this is a much harder number to estimate because data are so scarce—many people incur costs while remaining at home, in addition to being served by their family members. It would not be surprising to know that someone who did not have sufficient family to provide many services could end up spending more than a hundred dollars per week for the cost of their care.

The CHAIRMAN. Yes, and the next point I would like to have you make, but I would also like to have Commissioner Sebelius comment on it as well, is do you know if there is any indication that the long-term care private insurance policies that are in force have to any great extent reduced the financial burden that is currently on the Medicaid program?

Dr. SCANLON. There have been no studies of this and I don't think that we can anticipate that there has been a significant im-

pact just because of the number of policies that have been sold; also, the fact that policies are sold with the anticipation that they are going to be used at some point not in the immediate future, but sort of the longer-term future. So I don't think that it has a significant impact on Medicaid.

The CHAIRMAN. How about from your perspective?

Ms. SEBELIUS. Well, Senator, the only statistics I have seen dealing with that would indicate that at least right now if you took the Kansas nursing home population, about 10 percent of the residents in nursing homes are there by virtue of private insurance, or their payers are private insurance. So it is still a substantially small number.

Probably, 55 to 60 percent are actually Medicaid recipients and the rest are paying out-of-pocket costs, at least for a period of time. Whether or not that 10 percent would be part of the Medicaid population, is not something that we have determined. My guess is some of them certainly would be included, and certainly some of the out-of-pocket payers will rapidly move into that Medicaid population—as they spend down their assets. There is no doubt I think it has some significant impact.

The CHAIRMAN. Dr. Scanlon, your agency has previously reported to Congress on a range of issues related to long-term care insurance. How does this issue relate to other aspects of long-term care that the General Accounting Office has studied? Is this topic equally important, or what is the significance to consumers?

Dr. SCANLON. It is equally important in many respects because the consumers of these policies are making a very significant purchase, and a purchase that if the policy turns out to serve many of their needs will make a huge difference when they actually incur long-term care needs. It is therefore important that we do what we can to ensure that policy purchases are based on sound information and people make the appropriate choices.

I also think we shouldn't underestimate what the role might be of increasing the empowerment of consumers in the long-term care market. If we have consumers who have more available resources, they will be able to be more choosy about the services they receive, and that suppliers of services will need to compete more vigorously than they have in the past on the basis of quality of care, which has been, of course, a major concern of ours.

The CHAIRMAN. Commissioner Sebelius, I want to go back to something that Senator Bayh raised, and that is the extent to which your organization, and you probably as an individual commissioner as well, turn to the topic of rating practices and rate stability.

Your testimony indicates that your organization was acting in response to the growth of long-term care insurance and the many changes that are out there in the market. But I would like to have you elaborate on what the cause of concern was of specifically the 50 commissioners, not just you, getting behind this and investigating. And then you have your proposal that is the end result of that, I assume.

Ms. SEBELIUS. Yes, Senator. Again I go back to Mr. Hanson from North Dakota, whom you discussed at the beginning of the hearing. I think that kind of consumer dilemma caused commissioners to

take a very serious look at the overall rate stability of long-term care insurance which you buy at one point in your life and then use often 20 to 30 years later.

What we were concerned about was that too many companies filed rates at one level, particularly if they tended to be less expensive than some of their competitors, and were able to get more of the market share, only to turn around and increase those rates, leaving a lot of consumers in a very difficult situation of not being able to continue paying for the policy that they had made an investment in.

What our proposal is designed to do is require companies to file adequate rates at the front end, with the hope that it will cause rate stability, so that if a consumer buys a product figuring that he or she can pay $1,000 as he or she turns 80 and 85, that that $1,000 premium stays in place. We have made a whole series of adjustments that require actuarial certification out into the future of the rates that they are filing.

We impose limits on expense allowances. One of the things that we saw happening is that if a company increased a rate, they would take 30 to 40 percent of that new rate and be able to pay expenses. We say that you can't have any more than 15 percent out of any rate increase in the future, so there is no enhanced incentive to do that. We allow policyholders to switch policies to get into a more affordable policy without any kind of penalty, and we give the commissioner more authority to actually ban companies who persistently come into the market low and then increase their rates. We think that these rate enhancers will really help to ensure consumer confidence, on the one hand, and also make the rates more stable at the front end.

The CHAIRMAN. Again, Commissioner Sebelius, could you briefly describe the process that your organization followed in developing these model regulations? For instance, how does the work of the Long-Term Care Committee inform the final model act that gets voted on by the full organization?

Ms. SEBELIUS. Well, any of our model bills or model regulations, Senator, are the result of a collaborative effort. We have numerous meetings. Our processes are all in the open, and not only are representatives of the insurance industry very much a part of that process, but also a wide variety of consumer representatives participate. On any draft model we have hearings, and open comment periods, and we discussed the draft in order to get further recommendations from regulators and interested parties.

What passed unanimously by the commissioners in August was really the result of about a year of that kind of collaborative effort in very open proceedings, and we received input from key members of the industry, who are selling the products, as well as some of the consumer groups, who are particularly focused on senior issues and aging issues. I think the end result of the regulation has broad-based support of people who are very knowledgeable about this area.

Again, we would urge Congress to consider the inclusion of the consumer protection benefits in any sort of tax enhancement that you are going to take a look at because it allows that process to be jump-started if tax-qualified policies have to include those fea-

tures in order to get a tax deduction. Clearly, it moves the market rapidly, more rapidly than we can do it by including those in the 50-State level. But, again, we would urge the Senate to give us at the State level the flexibility to move forward rapidly on these rating issues.

The CHAIRMAN. Not disagreeing with you, but why on the one hand consumer protection through Federal law, but not the rate protection through Federal law?

Ms. SEBELIUS. Well, because rates really aren't terribly well designed at a Federal level. It costs a different amount of money in Kansas to fund a long-term care policy than it may in New York or California. There is a different population, different statistics, and our market is different.

The CHAIRMAN. Would there be any way that somewhere between the Federal Government doing what you don't want us to do and the position of some advocacy groups for seniors or for consumers that maybe some States won't adequately do it the way your national association wants to do it—is there some sort of broad Federal guideline we could give that would at least get States that might be reluctant to protect their consumers rate-wise to get some minimal protection?

Ms. SEBELIUS. I think it would be feasible to fashion some kind of a prospective regulatory requirement that sort of sets a floor and gives a period of time for States to include the kinds of regulations that we have described here. That has happened in the HIPAA arena and in other areas where you say to States, "we think these kinds of things are important, we are taking your word for it that it is important, and we would like to see States enact them" and then revisit the issue to make sure that States have uniformly put them in place.

Then it places the responsibility on the regulators around the country to put those LTC requirements at the top of the agendas and to move forward as rapidly as possible. This regulation came out in August. We have already got the first hearing scheduled in Kansas in 2 months. So some of us are moving very rapidly to put them in place, but that timetable may be different around the country.

The CHAIRMAN. It might be that you could help us in two ways, one with some technicality of the language, and, second, working with us and with your organization, help us so we don't get all your fellow commissioners lobbying Congress against doing that.

Ms. SEBELIUS. Well, I think, Senator, we would be delighted to work with you and the appropriate staff and develop some language that could be very promotional and I think effective in trying to get these regulations in place around the country as quickly as possible.

The CHAIRMAN. Can you explain what low-balling is and then tell us what your organization—whether it has data or any information that could tell us how widespread the problem of low-balling is? In other words, commonality of a problem. Has it been great for consumers to lapse on paying premiums because they can no longer afford them at a higher price?

Ms. SEBELIUS. Mr. Chairman, I think in response to your first question, "low-balling" is, I assume, the terminology used to de-

scribe a rate that is filed arguably with inadequate long-term projections, so a company has to turn around and raise the rate later.

I don't know if you were here when I showed Senator Bayh, but I brought along the Kansas Long-Term Care Shoppers Guide which we update every year. One of the things that we require companies to do is give a rate history. That is also part of the consumer protection provisions that we would urge you to include in any tax-qualified policy. I think consumers need to know which companies have raised rates and which companies have not, and what that history has looked like.

I can't tell you off the top of my head, Senator, about how many total consumers have dropped policies. We can probably get that information for you. I do know there is a higher lapse rate in long-term care insurance than any other insurance product on the market, and that is a serious concern to insurance commissioners.

The CHAIRMAN. Why don't you submit that, then, in writing to us?

Dr. Scanlon, your testimony discussed the importance of accurate, accessible data for consumers. You gave an example of a consumer's lack of understanding of the term "level premium." Yet, in this case level premiums did not prevent consumers from facing steep increases in premiums.

Could you further comment about the importance of consumer information? But, first, could you explain the real meaning of the term "level premium?"

Dr. SCANLON. It is a term that applies to the case that you heard of involving Mr. Hanson, where there is an assumption that a level premium means that the premium remains constant over the life of a policy. And what it actually means instead is that the premium will not be increased for a single individual, but can be increased for a class of individuals within a State. This is the kind of experience that we are talking about generally.

One of the factors in terms of buying a policy is that you are faced with terminology such as this, which, if it is not clearly explained, it is easy to make a mistake and make a decision that you are not going to be able to live with for the longer term. If you knew that you could only pay $1,000 a year and made a policy purchase on that assumption and then the rate increases, in the past you have been subject to losing your investment in that policy because you may not receive any vesting of benefits for the future.

It is defining for consumers terms that may have on first blush one meaning, and making sure consumer's understand that the terms are not necessarily meant to convey that but convey something different. Particularly in areas such as this, it is very important for consumers to understand what the financial implications of a policy are going to be.

The CHAIRMAN. Comment, Commissioner?

Ms. SEBELIUS. Yes, Senator. The staff just reminded me that in our model, the newest update, an insurer can't use the term "level premium" unless it will never increase those rates, period, because we do find that term to be very confusing to consumers. Consumers assume that it means that they will pay the same rate into the future.

We also have, as part of the consumer protections, some greatly enhanced disclosure requirements that walk a consumer through what can happen, explain how rate increases can apply, and actually require a consumer's signature when the product is being sold to ensure that the consumer has heard the information, understands it, and signs off on it. We also think additional agent training is critical as a part of this whole process, so we have people selling the product who can adequately explain to a consumer what is likely to happen during the lifetime of the product.

The CHAIRMAN. So you try to promote a common understanding and nationwide use of certain terminologies and an understanding of those terminologies?

Ms. SEBELIUS. Right, and the term that you indicated, "level premium," we thought was being greatly misused and misunderstood. So we have told the insurers that they can't use that term any longer in describing long-term care insurance unless they will never raise the rate on this policy.

The CHAIRMAN. For both of you, could you foresee that an insurance company might voluntarily adopt your insurance commissioners organization proposals?

Ms. SEBELIUS. I think a number of insurance companies are moving or have moved in that direction. As I said, they were very supportive of putting these changes in place. I think for the majority of the market, their fear concerns companies who have inadequate rates, lower prices, less than well-trained staff, but have the ability to secure large portions of the marketplace by looking like they offer a better deal than their competitors.

So they are very much supportive of efforts to stabilize the market, to make sure that people are on a level playing field, and to ensure that consumers understand what is going on, so they can make real choices.

The CHAIRMAN. And you, Dr. Scanlon.

Dr. SCANLON. I agree, Mr. Chairman. There are insurance companies that actually have led in this area in terms of trying to improve products because they would rather compete on the basis of quality than by misleading consumers and encouraging sales that way.

If you looked at the history of rates for individual companies and individual policies, while you may see a number that have gone up, there also are rates that have come down over time as insurers realized through their experience that they can afford to offer lower rates. I think this is an issue that you will hear about later, about the tension between the actuaries and the marketing departments of insurance companies, that the actuaries really may be protective of the company and the consumer in terms of overestimating what the costs might be initially, but then are willing to change that over time.

The CHAIRMAN. Back to an earlier question, even though the NAIC adopted the policy that the term "level premium" shouldn't be used because it confuses, unless States adopt that sort of provision, won't it remain a term that would be abused?

Ms. SEBELIUS. That is true, Senator, but the adoption of the model regulation just occurred in August. The new model regulation went into place, and we are doing everything we can to get the

States to adopt it. I just came from one of our quarterly meetings in Dallas and we have done the first consumer and regulator education program on the new regulation. We had 50 representatives of insurance departments around the country at the Dallas meeting to tell them how important it is to get these regulations into place quickly.

We are going to follow up at our next quarterly meeting in Boston and do it again. We are sending memos to the commissioners. We are doing a lot of internal promotional work to try and keep this on the radar screens of regulators around the country and get these regulations enacted as quickly as possible.

The CHAIRMAN. Would adoption of a proposal by a State or an insurer make their products more marketable, either one of you?

Ms. SEBELIUS. I am sorry. Adoption of this——

The CHAIRMAN. Of the proposal that you have out there for the insurance commissioners and the States to adopt.

Ms. SEBELIUS. Well, I think what it can help do certainly at a State level is build consumer confidence. In terms of making products more marketable, one of the issues for consumers is if they are going to put out their hard-earned dollars on this or any other product they are betting on a promise that it will be there when they need it.

The more that we can assure consumers that the rates are stable, I think it will enhance the marketplace.

The CHAIRMAN. On the question of economic impact, would the enactment of the NAIC proposal have any effect on premiums either up or down?

Ms. SEBELIUS. There is no doubt that for some companies having adequate rates at the front end and having to certify that on an actuarial basis will increase the front-end rates. But, frankly, I think that will help to stabilize the market in the long term because no one typically is healthier or wealthier at 80 than they are at 55. So if the rates are filed on an adequate basis at the front end, I think we are then ensuring that consumers will have those products in the future.

The CHAIRMAN. Dr. Scanlon, for an independent judgment of this process that Commissioner Sebelius says that her 50 commissioners are in trying to get these regulations adopted, can you speculate on what we could expect in terms of adoption by the States of recently approved NAIC model regulations for rate stability and disclosure? Is there any way of making any prediction based upon the past record of States adopting NAIC proposals?

Dr. SCANLON. I can indicate a little about the past record, but I think in terms of extrapolating that to the future for this particular proposal would be speculation.

In the past, well over the majority of States have adopted the majority of the provisions of the model act and regulation. There are a few of the provisions that relatively few States have adopted. Maybe Commissioner Sebelius could give an indication for us as to why that might be the case.

The issue is in terms of the newness of these provisions. The question is what has the reception of the States been to date, as well as the likely reception in other sorts of forums, and then from

that what the prediction should be. The commissioner may be able to help us with that as well.

The CHAIRMAN. This is my last question for you, Commissioner Sebelius. From the standpoint of someone who is shopping for long-term care insurance, is a person better off buying a product that reflects rate-setting practices required by the NAIC's proposal, and if so, could you give an example?

Ms. SEBELIUS. Well, again, I think that if States put into place the kind of rate adequacy proposals that are contemplated by the new regulations, a consumer will have enhanced protections knowing that when they choose a product, there will be, first of all, protections for them if there has to be a rate increase. They will not lose every dime they put into the premium, which happens too often now. But, second, hopefully there won't be a rate increase because the premiums will be filed at an adequate level at the front end.

The CHAIRMAN. I said it was the last question. I think I ought to ask you to speculate on how you think the time for the adoption of most of the States of the model regulations that we have talked about.

Ms. SEBELIUS. Well, we are very hopeful that States will move rapidly, and that is why we are focusing on educational efforts, memos and other methods to get regulators' attention.

As you know, Senator, with the passage of Graham-Leach-Bliley, there is no shortage of immediate issues that State regulators are trying to address to meet a variety of congressional mandates on everything from agent licensing to privacy regulations. So there is a lot on the plate, but we feel very strongly that these are critical issues not only for the marketplace, but certainly for consumers. These regulations are being strongly promoted by both the industry and consumer groups, so hopefully this can get done very rapidly.

The CHAIRMAN. Thank you very much, both of you, for your testimony.

We are in the middle of a second vote. I am going to introduce the second panel and then recess. The second panel doesn't have to come to the table right now and sit there for the next 6 or 7 minutes that I will be gone.

Our first witness on the second panel is Allan Kanner, an attorney from Louisiana. He will discuss a lawsuit and will provide information he has learned from this experience.

Our next witness is Charles Kahn, President of the Health Insurance Association of America, a person I have worked with on some of this legislation very closely, and his organization, and appreciate the cooperation we have had for this hearing as well as for that on the legislation.

Our final witness is Chairman of the American Council of Life Insurers' Long-Term Care Insurance Committee, and General Director of Long-Term Care, Contracts and Legislative Services, of John Hancock Life Insurance Company, David Martin.

So I will recess. It takes me about 6 or 7 minutes.

[Recess.]

The first comment somebody is going to make in the audience is that it took longer than 6 or 7 minutes, and you are right.

In order of introduction, I think that would be my left to my right. So would you please begin, then? Hopefully, we will be able to put each person's complete testimony in the remarks and then we would ask you to summarize in the minutes that have been allotted to you, I think 5 minutes.

STATEMENT OF ALLAN KANNER, ALLAN KANNER AND ASSOCIATES, P.C., NEW ORLEANS, LA

Mr. KANNER. Good morning. Thank you for having me. My name is Allan Kanner, and for the past couple of years it has been my privilege to represent tens of thousands of elderly Americans throughout the United States who have been fighting various insurance companies.

The fight, which is far from over, has been for people like Harold Hanson, a 96-year-old farmer from Reeder, ND. Harold, like most of us, has responsibly throughout his life bought insurance for a variety of products. Harold is a farmer. He has bought crop insurance, car insurance, homeowners insurance, and health insurance. But his long-term care insurance turned out to perform radically different, in ways he never could have anticipated.

Within a 6-year period, as you noted, his long-term care insurance premium and those of thousands of others went from about $1,400 a year to $6,100. He spent $21,000 on long-term care insurance, and in the end he got nothing. He was forced to drop his coverage. The money was forfeited to the company, and he was just in the end that much closer to public assistance.

I attached some exhibits which included Mr. Hanson's letter to a State insurance commissioner. I will just read about two sentences from that. He says, "I have paid in over $21,000 in premiums. I am 91 years old"—he wrote it in 1996—"in good health, live alone, do my own cooking, housework, driving. I have an aunt still living. She is 104. I could very easily live to be over 100 and not use the policy, but be broke paying the premium. With the amount I have invested in the policy, I hate to give it up. Are the raises justifiable? Sincerely." The insurance commissioner in North Dakota and in the majority of States, then, now, and frankly in the future under NAIC regulations, could do nothing to stop these rate increases or to guarantee rate stability.

I want to lay out some basic principles that I have learned in working on these cases, and some of the horror stories I have learned from elderly Americans all over America

First, and I think this is something all the experts agree on, long-term care insurance is only worth buying if it remains affordable until needed. The single biggest reason why policies are rate-unstable is there isn't adequate data out there. The utilization data isn't there. That is a fact. There isn't any generally accepted data like you see in worker's comp, in auto, life insurance, mature data that is shared by actuaries, a common basis of understanding.

What is happening is people like Harold Hanson, in effect, are kind of guinea pigs. These companies are getting the data from their experiences, and as a result of all of these studies maybe in the future the companies will have some valuable data. But the cost of the mistakes for most companies are being borne by people like Harold.

I want to be clear. There are very responsible insurance companies out there. There are some companies that have never had a rate increase. These are companies that have been selling policies for long-term care slowly, cautiously, wisely, building up experience data, assuming some losses, you know, making up the difference. But in the long run they have got the reputation and the quality product that I think is badly needed in this country.

I think that rating practices could be a lot stronger. There really isn't a lot the States do at this point to check high rates or low rates because you don't have that common base of good data. So this is very important: don't buy a guaranteed renewable policy unless it can remain affordable. And right now, most companies will not guarantee you an affordable policy. Some companies voluntarily do keep their policies affordable, and I think in the long run those companies are going to be the winners.

Second, with respect to long-term care, it is important to get it right the first time. Somebody like Harold Hanson, after 5 or 6 years he is going to be older, he is going to be sicker. It is going to be a lot tougher to qualify for another policy, and that policy will probably be even more expensive.

The elderly can't afford mistakes. They are on very limited budgets. Somebody like Harold Hanson, that $21,000 would have done a lot more for him in his bank account than it would have done for him having given it to Acceleration Life or one of the other companies.

Third, Harold's policy and most long-term care policies are limited-benefit policies. That means there is a cap on how much you can get under these policies.

Maybe I can just jump ahead to some suggestions because I know you have limited time. You said earlier people didn't want to end up in nursing homes, and I want to tell you briefly about Nellie McIlroy. She was about 96 when this lawsuit started. She didn't go into a nursing home. She had Alzheimer's, and you know it is one of those things. Carl McIlroy, her son, one of her clients—every year, he kept saying if she gets any worse, we are going to have to put her in the home.

And they had made a substantial investment in their policy, year after year. And you know how it is. You know, you think when you can't handle anymore with an Alzheimer's patient, you put up with more and more and more. And these people ended up paying more to their long-term care insurance company than they ever would have gotten in benefits. And I would like to see you avoid that in the future.

I very much commend what this committee is trying to do and your efforts with respect to long-term care and an array of elderly issues. I think you should consider, if it is at all possible, limiting the deduction to companies that will put firm limits on the amount of rate increases. Companies don't need to have rate increases. A number of companies are doing well in this field without rate increases.

I think another thing that you just need to look at briefly is the whole idea of consumer disclosure. There has been a lot of talk about giving consumers more information. I think, by the same token, that you want consumers to take more responsibility. Com-

panies should take more responsibility. I think companies should ask people at the front end, making the deal, how much can you possibly afford. If you can't afford more than this, don't buy this policy. That is not happening now.

When you give out the deduction, I think what you are doing is you are going to condition people, individuals, consumers to act more responsibly. I think that is very laudable. I would like to see the companies also act responsibly, and together I think we can solve some of these problems.

Thank you.

[The prepared statement of Mr. Kanner follows:]

TESTIMONY BEFORE THE
UNITED STATE SENATE
SPECIAL COMMITTEE ON AGING
SEPTEMBER 13, 2000

by

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on

LONG TERM CARE INSURANCE

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A. INTRODUCTION

I want to thank Senators Grassley and Breaux, and the hardworking staff of the Senate Special Committee on Aging, for their outstanding record on elderly issues, for holding this hearing to focus attention on the vital issue of ending abuses in the long term care insurance industry and ensuring a solid foundation exists for the Long-Term Care and Retirement Security Act of 2000 or any comparable legislations, and for giving me this opportunity to discuss my views on this issue.

From 1998 until the present, I have been lead counsel for plaintiffs in the class action lawsuit, *Hanson v. Acceleration Life Insurance Company*, Civ. No. A3:97-152 (D.N.D.), which has now been successfully settled. My average client in that case is about 92 years old and has suffered an approximate 700% rate increase in the cost of their long term care ("LTC") insurance policy between 1989 and 1996. Most of my clients live on fixed incomes and were unable to afford these increases which for some people went from about $700 to $10,000 per annum. State insurance departments were powerless to stop these unconscionable increases, and repeatedly expressed their frustrations to policyholders throughout the United States. Most of my clients were forced to lapse or drop coverage which was sold as "guaranteed renewable for life".

I commend defendants in *Hanson* for reaching a mutually satisfactory settlement of that matter which was ultimately approved without a single objection by any class member by the Honorable Karen Klein, Magistrate Judge, U.S. District Court for the District of North Dakota. My comments today address the fact that what happened in the *Hanson* case is not a one time event, that there are other bad LTC policies in the marketplace, and that this situation is unacceptable and threatens an important public interest in protecting the elderly from fraud. However, my comments are not intended to disparage all LTC insurers, but only those few which have systematically preyed on the elderly. Nevertheless, the problem is not limited to a few fly-by-night companies, and the problem persists today.

In addition, based on my experience representing victims of fraudulent practices, my view is that the National Association of Insurance Commissioners ("NAIC") Long-Term Care Insurance Model Regulations (as approved August 17, 2000) does nothing to help existing LTC policyholders, and does almost nothing to prevent unscrupulous vendors from committing *Hanson*-style frauds and taking advantage of the elderly with future policies.

B. THE ISSUE IS HOW BEST TO HELP THE ELDERLY AND THEIR FAMILIES TAKE MORE RESPONSIBILITY FOR THEIR LONG TERM CARE NEEDS

My clients in LTC cases like *Hanson* are the people who are making financial sacrifices in order to take responsibility for their long-term care needs. As a society, we should applaud and encourage this sort of conduct, and Senator Grassley has consistently championed responsible personal planning in this context. At the onset, these sacrifices in the form of premium payments (and lost opportunity costs, e.g., leaving the money in a savings account) were manageable. What

is most terrible about cases like *Hanson* is that the most responsible people--the people trying to buy protection for their LTC needs--were the victims.

The limited resources of the elderly should not be squandered on the purchase of insurance products that contain excessive and unnecessary charges, or that fail to provide benefits commensurate with premiums charged, or that do not remain affordable until needed, or that otherwise lack quality. The last thing anyone wants is to see the elderly or their families, especially those who are responsible enough to prepare for their LTC needs, move closer to poverty with effectively worthless coverage and nothing to show for their LTC payouts.

Fraudulent practices by some in the LTC insurance industry cause additional damages by undermining public confidence in those valuable and already underutilized insurance products sold by responsible companies. As Senator Breaux has said, "New services that meet the needs of our growing senior population are necessary and exciting. But the facilities are market driven and are susceptible to a bottom-line mentality that can lead to consumer fraud and abuse."[1]

A few things are clear to me from my involvement in *Hanson* and other cases. First, there are some companies that consciously engage in low ball pricing. Second, in other insurance companies, there is a tension between the marketing people and actuarial people on the LTC issue. The marketing people see a tremendous demographic opportunity; the actuarial people see a lack of generally accepted data, including data regarding utilization rates. Experience shows that the resulting product is often poor priced from a rate stability point of view. Third, good companies are also being victimized by the fraud of a few bad companies in that bad products also tend to squeeze legitimately priced products out of the marketplace, and damage the ability of legitimate companies to grow market share.[2]

These issues are especially important as the Congress considers whether to create additional tax incentives to stimulate the sale of potentially defective LTC insurance products. Private LTC insurance is undeniably one means for lessening the growing burden of claims on limited public resources. The public interest clearly supports the efforts of this Committee and, at least, the spirit behind the Long-Term Care and Retirement Security Act of 2000. However, the federal tax system

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[1] TIME (August 30, 1999), Vol. 154, No.9.

[2] *E.g., LTC Abuses: Can The Industry Act in Time?* BEST'S REVIEW (Oct. 1990) (attacking the marketing of LTC policies and the claims' practices of some LTC companies).

Consumers, especially elderly consumers on fixed incomes, are price sensitive and will buy "lowball" priced policies and marketing people know it. Useful information about planned or future rate increases is also withheld to encourage sales and renewals.

Fraud is not simply a private sector issues. As this Committee knows, the level of fraud, waste or abuse in some federally administered programs remains a serious problem. *E.g.*, Pound, *Program Billed Medicare Improperly*, USA TODAY, (March 21, 2000), p.1 (questionable charges found in rehab program administered by HCFA, which contracts with insurance companies to pay claims to outpatient facilities).

should not be used to encourage the purchase of bad LTC insurance products, or to lessen the level of critical scrutiny any consumer brings to his or her evaluation of whether LTC insurance products serve his or her needs. Obviously, the proposed tax deduction will be used aggressively to market these products.

C. FACTUAL BACKGROUND OF *HANSON*

The *Hanson* class action originally arose because over 2,000 of North Dakota's senior citizens purchased long-term care or nursing care ("LTC") insurance policies from Acceleration Life Insurance Company ("Acceleration") and its licensed agents (collectively referred to as "defendants") between 1984 and 1990.[3]

The stories of Harold Hanson, Nellie McIlroy and Gladys Schimke are illustrative. My client, Harold Hanson was born on December 3, 1904 and is currently 96 years old. He resides in Reeder, North Dakota, where he has lived since he was three years old. He was in the cattle business for most of his life and his family has a ranch near Reeder that his grandson maintains. Mr. Hanson's wife, Dexter, has passed away and he lives alone, and does all of his own cooking and housework.

In 1987, he purchased a long term care policy with a premium of $1,498.00 per year. In 1991 the premium was increased to $1,717.24 and by 1996 the premium was $6,158.13. When the insurance company began raising his rates, he wrote letters to the North Dakota Department of Insurance and was told that the Department could not stop the rate increases. He decided to drop the policy because it was too expensive, even though the company kept all of his prior premium payments.

Commissioner Glenn Pomeroy, used Mr. Hanson's letters in his legislative efforts to argue for increased authority to prevent this sort of thing from happening again. However, despite these efforts, effective legislation on the state level has still not been passed. This underscores the fact that NAIC recommendations are not always enacted on the state level.

My client, Nellie McIlroy was born on September 28, 1905 and is currently 94 years old. She was born and raised in Tolna, North Dakota. She was a school teacher, wife and mother of four. She and her husband Dean ran a grain and cattle farm in Glenburn North Dakota. Ms. McIlroy is now a widow and, despite serious problems, lives with her son Carl and his wife.

Mrs. McIllroy purchased a long term care policy in 1987 for $829.86. In 1992 her premiums were $1,860.96 in 1995 they were $3,386.96 and in 1997 they were $6,638.00. Several years ago,

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[3] *Hanson v. Accelerated Life Ins. Co.*, No. A3-97-152, at *3 (D.N.D. Mar. 16, 1999); available at <http://www.ndd.uscourts.gov/dndopions.html/A3_152_118htm>. LTC is only one of a number of "over-age" insurance products, which also include medical supplement, major medical and/or hospital indemnification policies, that were sold (generally in tandem) by defendants to the plaintiff class, and renewed annually thereafter by plaintiffs.

Mrs. McIlroy was diagnosed with Alzheimer's Disease. However, her family does not want to put her into the nursing home, so the children pitch in each year to make the premium payment which increased dramatically each year until the settlement of the law suit led to a reduction of Mrs. McIllroy's premium.

Gladys Schimke was born on March 30, 1915. She purchased a long term care policy in 1987. At that time her premium was $834.87 per year. Mrs. Schimke's premiums began to increase in 1990. In 1997 her premium was $2,411.20 at which time she dropped the policy because the premium was too high for her to pay.

Under the terms of the subject LTC policies (Forms 520, 521 and 522), as long as the insureds paid the premium, the policy was "guaranteed renewable" each year. As commonly understood, this means you can keep the policy for the rest of your life. According to Section 45-06-05-04(1)(b) of the North Dakota Administrative Code:

> 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.[4]

Acceleration admitted in the actuarial memorandum underlying these policies that the policies were supposed to be "level premium" policies, *i.e.*, the premium would remain constant for every year that the policy was renewed.[5] However, the policies contained a provision which read as follows:

> PREMIUM RATES-CHANGES
> We may change the premium rates. A change will apply to all contracts with the same form number as yours which are in force in the state you live in. A change will apply on the next due date after

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[4] N.D. ADMIN. CODE § 45-06-05-04(1)(b) (1994). This is similar to the provisions in most states.

[5] Level premiums are actuarily possible because the benefits under the policies are capped, unlike many true health policies. In a properly designed level premium policy, the policies are rated such that the premiums paid in the first years of the policy are in excess of what is needed to pay the commissions, administrative costs and claims (if any) so that there will be remaining funds to invest. As the years pass and the pool grows older and claims increase, the premiums paid are less than the yearly cost of running the block. However, the pool is supported by the current premiums as well as the accumulated earnings from the premiums paid in the first years. In order for a level premium policy to meet its intended purpose it must be priced in a manner which accounts for the age of the policy holders, it must be underwritten in a way to avoid high risks or excessive, early claims and the premiums paid by the customers must be reserved and managed properly in order to pay claims throughout the years. If the policy is priced correctly and the premiums remain level, both healthy risks and unhealthy risks will remain in the pool thus providing continuing premiums to help support the block as a whole and keep the loss-ratio to a minimum.

> we give you at least 30-days written notice at your last known address.

The plaintiffs charged that the *Hanson* defendants intentionally created a "low ball" priced policy and then used this language, especially the phrase "We may change the premium rates," as, in effect, a "blank check" to improperly justify the exorbitant rate increases that led to the lawsuit. The LTC policies at issue in *Hanson* operated in fact as rising premium policies, caused in part by an escalating "death spiral." Such a policy is indisputably inappropriate for elderly people on fixed incomes because LTC insurance is worthless unless the insured can afford to keep it until it is needed. In effect, even though the policy was "guaranteed renewable," the up to 700% rate increases made it impossible to keep.

A core element of the *Hanson* plaintiffs' complaint was that the LTC policies were sold as coverage that customers could realistically maintain for the rest of their lives or until needed. This is the plain understanding of the promise that the policy is "guaranteed renewable for life." This required the policies to have essentially level premiums. The *Hanson* plaintiffs also claimed that the defendants knew at the time of sale and renewal that the policy premiums would increase dramatically to unaffordable levels and that the defendants not only intentionally withheld this information from new customers and renewal customers, but they affirmatively and falsely told customers in form renewal letters that these policies were "competitive" and "one of the best policies available in your state." Likewise the risk of rate increases and future unaffordability of the policies was not raised in the brochure at the time of application when the first premium check was written. Instead, when the policy arrived, it stated that premiums "may" increase, omitting the fact that rate increases were planned and inevitable. The policies also stated that they were "guaranteed renewable for life," suggesting falsely that they would be affordable for life.

Due to the fact that premiums rose over 700% between 1989 and 1996, less than 200 North Dakota citizens were paying the annual premium on these policies at the time of the *Hanson* litigation. According to the North Dakota Department of Insurance ("NDI"), this was the worst LTC policy sold in North Dakota. Those who were still paying the premiums did so because they were trapped and were too old to switch coverage.

Essentially, the *Hanson* plaintiffs claimed the LTC policies purchased by North Dakota citizens were fraudulently sold because they were, in effect, defective products. In addition, the facts underlying these defects were fraudulently withheld from the plaintiff class to enable defendants to continue to sell, and annually renew, these policies.

The class action law suit was originally filed in October of 1997 on behalf of North Dakota purchasers of long term care policies from Acceleration Life Insurance Company and Commonwealth Life Insurance Company. A class was certified in February 1999 and a trial was set for October 1999. During the course of the litigation, the attorneys representing the class uncovered numerous internal documents from the companies that showed that the companies knew of the problems with the polices early on and made a conscious decision to pass on the mistakes of their underpricing and poor underwriting on to the policyholders. The companies also made efforts

to keep this information from the policyholders and actually encouraged policy renewals knowing that they were going to raise the premiums to unaffordable levels. When questioned by policyholders as to the reasons for the rate increases, the companies told them that it was due to high claims and hid the fact that it was actually due to the companies' poor pricing and inadequate underwriting practices.

A few days before trial, after the class had won most major pre-trial motions, the insurance companies made a settlement offer. This settlement, which was supervised by the Magistrate Judge, included available relief to over 13,000 purchasers of the long term care policies at issue in the litigation nationwide. The settlement terms included $12.6 million in cash which resulted in significant cash payments to all claimants, an immediate roll back of premiums for all current policy holders valued at $2.1 million, and a ban on any future rate increases. Some claimants were paid as much as $8,879.09. As a result of the settlement in October, 1999, claimants were paid in July 2000. Had the case been tried successfully, an appeal (again, if successful) would have delayed payments at least until 2002. The settlement does not count as an admission of any wrongdoing by any of the settling defendants, and, if anything, their actions in working to settle the mater should be commended. However, without the litigation, nothing would have been done for these consumers.

D. SOURCES OF SUBSTANTIVE TROUBLE FOR LTC POLICIES

Based on the record in *Hanson*, a review of public filings and discovery in pending litigation, it is clear that, the success of a "guaranteed renewable for life" LTC insurance is dependent on the underlying actuarial, financial and underwriting assumptions on which the policy is structured. By success, I mean the ultimate ability of the policy to pay benefits over time at the initial premium rates.

The important point is that there is inadequate data to price LTC insurance with the same certainty as there is for other insurance products (e.g., life insurance) that consumers are familiar with that shape their reasonable expectations about how an insurance product will perform.

It is also important to focus on actuarial, financial and underwriting problems because of the role they play in facilitating bad policies. The single most important reason for the rate stability problems we see in LTC insurance is the lack of generally accepted or standardized utilization rates for actuaries pricing LTC.[6] This problem was well known in the industry[7] and is one reason some

[6] Standardized tables for reserving, which are different than utilization rates, became generally accepted around 1996.

[7] As far back as October, 1985, the Society of Actuaries, acknowledged that data was limited and insurers should proceed cautiously:

> There is also a major data problem. The main sources of data that are now available come from national surveys and other public sources like Medicaid programs which are not applicable to any insured population that any company is likely to assemble. The

critics refer to LTC insurance as experimental.[8] This lack of a sound actuarial foundation (as compared to pricing life insurance) is not addressed in the NAIC proposals and should concern consumers.[9]

The next important factor in rate stability is underwriting practices. Underwriting refers to the process by which the insurance company screens applicants to determine who is entitled to buy the policy. The stricter the medical criteria, the less likely it is that there will be early claims for benefits, and the more time accumulated premiums payments can grow until needed, and the lower

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> remedy may be to offer insurance policies on an experimental and limited basis in order to gather the data that is necessary to be able to proceed further.

1985 Proceedings, p.15 (Statement of Gordon Trapnell). Yet no company has ever labeled a LTC product as "experimental." On the other hand, some companies have elected to absorb the risk of rate increases to facilitate the development of sound and profitable products over time.

By 1993, an even broader array of problems with LTC products were being recognized:

> *Pricing assumptions for LTCI have none of the traditional bases for comfort; claims costs are estimated primarily from data on the general population, not the insured population; persistency rates are little more than a good guess; underwriting has just started up the learning curve; and claims handling is more than only a step or two behind.* In addition, the relative success of underwriting and claims activities is unknown, the contract language has yet to be tested in court, and much of the tax code surrounding this product is undefined and uncertain.

Gary Corliss, *Reinsurance: The Key To LTC*, BEST'S REVIEW, Vol. 94, No. 2 (June, 1993) (Life/Health Insurance Edition).

This lack of data or product maturity need only adversely impact the consumer if (1) he or she is not told about the experimental nature of the product; and/or (2) the insurer decided to pass on the cost of its risk of miscalculations in the form of rate increases without the customers' informed consent. This lack of disclosure, and practice of passing costs back to the consumer, accompanied too many of the older policies and persists to this day.

[8] Some companies use their own experience as a data set. This is kept generally confidential and is not subject to peer review. Others have used med supp data which was found to be problematic--e.g., utilization rates for LTC, say, post op are not comparable to the LTC of Alzheimer patients. *Supra*, note 7 (1985 Proceedings).

[9] Claim practices are also important to price stability. However, what we see in these abusive cases is companies engaging in claims underwriting. In other words, they take premium dollars from anyone, until a claim is made. Then they deny coverage on the grounds, that the insured withheld information. This practice occurred in *Hanson*, but the Department intervened in times to protect the insureds' coverage. However, the cost of that coverage (for people who never should have gotten the coverage in the first place) was passed on to the other insureds (as opposed to making the company pay for its mistake).

the number of claims for benefits.[10] Given that the most likely applicant is the person who believed themselves in need of coverage soon, the importance of good underwriting cannot be overstated.

An example of an actuarial assumption that is often intentionally abused is the lapse rate. One common trick seen in intentional underpricing cases is the assumption of an extremely high lapse rate — *i.e.*, the number of people who will voluntarily drop the policy each year which number may or may not be combined with a mortality assumption. For example, a lower price follows from the fact that it is assumed that the pool of insureds shrink at a 40% per annum rate. (Why anyone would market or buy such a product is unclear.) If, however, the pool of insureds shrinks at only 5% per annum, additional premium income in the form of rate increases will be needed. Thus, if the actuarial memorandum underlying the policy assumes that a significant number of insureds will lapse after making a number of payments but prior to collecting benefits, the actuarial memo could justify a lower premium for those who are likely to complete their payments, because future claims under the policy would be diminished by the lapses and, in the case of a non-forfeiture policy, the pre-lapse payments would be available to pay the claims of the remaining policyholders. The higher the assumed lapse rate, the lower the initial premium.[11]

An example of a financial assumption is rate of return on future investments. If the memorandum assumed a high rate of return on investments, it would justify a lower premium by increasing the pool of money available to pay benefits. Likewise, assuming unrealistically low administrative costs in the future when claims are being made will lead to erroneous premium settings.[12]

Intentional or inadvertent miscalculations on any of these assumptions, or improper underwriting, or both, could lead to the need for future rate increases. Unfortunately, the policies with the erroneous assumptions would have the lowest premium price and would enjoy a competitive advantage in the marketplace. All other things being equal, if two policies promise the same

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[10] Meaningful underwriting should be conducted, which means something more than field underwriting (except perhaps in the case of relatively young customers and certain group policies). Every applicant 75 years of age or older should have an Attending Physician Statement (APS) attached to their application. This should remain in their file as a permanent record. This is because the agent is the one who conducts the field interview is motivated by the commission, whereas the company must be concerned with whether this person even qualifies medically for the policy in order to protect the group as a whole.

Underwriting mistakes should not be passed on to other policyholders, *i.e.* if the insurance company accepts applicants who are not medically qualified and they file a claim within a short time of taking out the policy, the fact that the amount of claims is increasing should not be considered when the company files for a rate increase.

[11] The loss-ratio concept, which is designed to ensure that over time 60% of every premium dollar goes to pay for benefits, is also easily manipulated. For example, by projecting future losses on dubious assumptions, an insured can justify a rate increase, even though its loss ratio is well below 60%. With respect to new policies, the new model NAIC rules will eliminate the loss-ratio concept at the time of initial filing, but not for rate increases.

[12] Other factor examined in pricing or rate calculations are utilization (current and future), cost trends, reserving commissions and profits.

benefits, experience tells us that the lower priced product will be purchased. To the extent consumers are not purchasing insurance in a transparent market, but rather are choosing among options selected by agents, the commission structure will also give some policies a competitive advantage.

E. PRICING AND INFORMATIONAL PROBLEMS

The greatest source of trouble in LTC insurance is a too low initial price followed by unaffordable rate increases.[13] Inadequate early premiums almost guarantee astronomical rate increases in the future, nullifying a promise of "guaranteed renewable for life."[14] By contrast, adequate premiums (after 40% deductions for commissions and expenses) combined with sound underwriting, create the reserves plus interest over time that ultimately pay the lion's share of the legitimate claims of policyholders. If the initial premium is inadequate (or the underwriting is substandard, or both) rate increases will be necessary to pay future claims, unless the issuing company is willing to bear the risk of loss associated with erroneous pricing.

Price variations for virtually identical products should generally be disturbing as indicating that at least some policies are not grounded on sound actuarial principles.[15] The following charts indicate some of these current price disparities:[16]

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[13] Most insurance regulators try to assure that initial rates are not too high. It is very difficult to police rates that are too low. *See also*, Gary Corliss, *The State of Long Term Care Insurance: 1998*, D&H ADVISOR (1998):

> Rate increases, which were considered anathema for a level lifetime premium product, are becoming more common.

[14] This happens for two reasons. First, future rate increases are needed to pay claims when reserves have not built up. Second, as rates increase, an anti-selection spiral begins in which those least likely to need the benefits of the policy are priced out, leaving in effect a higher risk pool of insureds who will make more claims than originally projected. If that adverse impact is great enough, the policy goes into a "death spiral."

[15] Some variations might be explainable by better corporate ratings or superior underwriting. Nevertheless, these disparities should concern the actuaries at the companies selling the lower priced products. Unfortunately, consumers rarely see price comparisons or get information about the value of various policy features.

[16] The charts are based on the work of Martin Weiss, Weiss Ratings Inc., West Palm Beach, FL @www.insure.com/health/ltc/policycosts.html. For purposes of this comparison, these policies share similar care benefits, consisting of

> 100 percent nursing home coverage
> 100 percent community-based facility coverage
> 100 percent home care coverage
> 60-day deductible period
> Four-year maximum benefit period
> $100 daily benefit
> Tax qualification

These prices do not include non-forfeiture benefits or inflation protection. Long term care insurance policies vary widely in

CHART 1
LONG TERM CARE PREMIUM COSTS

Avg. Annual Premium At Issue Age:

Company	40	50	60	70	80
UNUM Life Ins. Co.	$400.48	$548.72	$1,070.21	$2,191.38	$5,079.77
Pyramid Life Ins. Co.	$215.70	$472.00	$940.90	$1,795.00	$5,345.70
Southern Farm Bureau Life Ins. Co.	$212.00	$375.00	$850.00	$2,226.00	$6,832.00
Gen. Electric Capital Asr. Co.	$466.05	$496.51	$830.70	$1,925.35	$5,511.63
John Hancock Mutual Life Ins. Co.	$311.50	$420.40	$784.24	$1,739.10	N/A
Travelers Life & Annuity Co.	$339.28	$469.14	$784.12	$1,772.59	N/A
Physicians Mutual Ins. Co.	$286.85	$450.84	$756.40	$1,582.11	$3,937.58
Fortis Co. Inc.	$367.05	$406.94	$658.72	$1,593.37	N/A
Continental Casualty Co.	$303.01	$406.94	$658.72	$1,463.83	N/A
Penn Treaty Network America Ins. Co.	$109.00	$312.00	$604.08	$1,462.32	$4,161.72

The problem of price differentials among policies, and of "low ball" pricing tactics of some companies is part of a larger informational problem for buyers of LTC products. No one would knowingly buy, or be allowed to buy, an underpriced LTC product,[17] or a LTC product where the actuarial risk is shifted back to the consumer, or a LTC product that would become unaffordable before it is needed. Appropriate information for the elderly and their families about the benefits and risks of a LTC policy are essential to ensure an informed consumer and to avoid bad situations that harm otherwise prudent individuals or would undermine public confidence in this type of product generally.

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the coverage they provide, and consumers are wise to do some research before purchasing any long term care insurance policy.

It should also be noted that such comparison have been criticized as apples-to-oranges comparisons. I do not think that is true of all such comparisons, but if it is, it suggests that a consumer could rarely make sense of the offerings in the marketplace. *Long Term Care Insurance: Risks To Consumers Should Be Reduced*, GAO-HRD-92-14 (Dec. 26, 1991).

[17] Appropriate underwriting criteria would generally disqualify applicants who were about to file claims.

Yet such information is hard to come by for consumers. Many agents acknowledge the difficulty of explaining the risks and benefits of these products to customers.[18] This limits the number of agents selling the product.[19] More troubling, many state insurance departments too often refuse to turn over key information about complaints or rate increases.

F. THE TEMPTATION

It is easy to see now that the graying of America tempted many companies to provide elder care products before acceptable actuarial data became available:

> Demographic indications in the 1970s led the first enterprising companies into the field, and subsequent population patterns suggest a burgeoning market. The life expectancy of the average American man is projected to increase from 70 to 87 years, while the average American woman, who is expected to live until age 92, will add 14 years to her lifespan. Individuals turning 65 this year have a 40% chance of residing in a nursing home, and 10% of these will live in such a facility for five more years. Fully 90% of those needing assistance require help at home, and more than 7 million Americans struggle every year to remain there. With nursing home costs averaging $20,000 to $30,000 and home care costs reaching $10,000 annually, the need for coverage is tremendous.
>
> Actuaries deal with these facts when pricing long-term-care coverages, but they continue to work with a lack of claims information on either an insured or uninsured basis.
>
> Despite the risks, carriers have been entering the LTC market steadily since 1985: More than 140 companies offer LTC coverage products today. There have been departures as well, including that of United Equitable Life in 1987, one of the first insurers to enter and dominate the market. Aetna Life, American Republic Insurance Co. and AIG Life followed.[20]

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[18] Barry J. Fisher, *Rate Viability in LTC Insurance: Is There Cause For Concern?* BROKER NEWS, (Dec. 1999), p.13; Gary Corliss, *The State Of Long Term Care Insurance: 1998*, D&H ADVISOR (1998):

> LTC insurance agents screamed for someone to provide them with knowledge and products about which they could make cogent and absolute statements.

[19] Agents who market primarily to seniors have been tainted in the minds of some by the misconduct of a number of over-zealous Medicare Supplement agents.

[20] Gary Corliss, *Reinsurance, supra.*

This growing market provides a significant economic opportunity for responsible vendors. Unfortunately, some insurance companies have opted to develop cheap products to gain sales with the idea of passing the costs of poor actuarial assessments or bad underwriting back to the elderly consumers.

G. IS IT EVEN INSURANCE?

One of the most troubling aspects of this problem is whether LTC insurance even deserves the name. Insurance involves the "transferring or spreading" of a policyholders' risk.[21] "The primary requirement essential to a contract of insurance is the assumption of a risk of loss and the undertaking to indemnify the insured against such loss."[22] The contract ("policy of insurance") and, its language cannot be construed so as to frustrate its essential purpose. Thus, insurance companies attempts to construe the contract to shift the risk back to the insureds with unlimited rate increases should be rejected as contrary to the notion of insurance and the implicit representations of expertise in risk management contained in this product. Simply stated, selling insurance means assuming an actuarial risk in return for a fixed payment. According to the Supreme Court,

> The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk. "It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a significant fraction of the possible liability upon it."[23]

People buy LTC insurance with the common goal of exchanging the gamble of going it alone -- whereby he or she could either escape all loss whatsoever or suffer a loss that might be devastating - - for the opportunity to pay a fixed and certain amount into the fund knowing that this amount is the maximum he or she will lose on account of the particular type of risk insured against.

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[21] *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

[22] 1 COUCH ON INSURANCE, § 1.9 (3 ed. 1997); "the usual purpose of insurance is to shift risk from an individual or other entity that is risk averse, and so would prefer to substitute a cost certain (a fixed insurance premium) for the risk of incurring a larger cost, to an entity that by pooling independent risks can minimize the overall risk to itself." *Adams v. Plaza Finance Co., Inc.*, 168 F.3d 932 (7th Cir. 1999); *see also, State of South Dakota, Division of Insurance v. Norwest Corp.*, 581 N.W.2d 158 (S.D. 1998):

> The essence of an insurance contract is the shifting of the risk of loss from the insured to the insurer. "Shifting the risk" can be defined as "the transfer of the impact of a potential loss from the insured to the insurer." *Id.* at 161 (internal citations omitted).

[23] *Group Life & Health Insurance Company v. Royal Drug Company*, 440 U.S. 205 (1979)(quoting 1 G. Couch, Cyclopedia of Insurance Law § 1:3 (2d ed. 1959). The Supreme Court also recognized the indispensable nature of risk in insurance in *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959).

The business of insurance is appropriately limited to companies which hold themselves out as actuarial experts in evaluating covered risks and appropriately pricing those risk. The business involves expertise[24] and affects the public interest,[25] and so is well recognized as being something more than a pure commercial contract.[26] A product is an insurance product only if it shifts the risk of loss from the insured to the insurer,[27] which in turn manages its risk by creating a sufficiently large pool of insureds over which to spread the risk, by reinsuring all or part of the risk, and by investing premiums now to help pay claims later. This expert task is undeniably in the public interest.

H. NATURE OF THE MARKETPLACE

There are two unfortunate dynamics in the LTC marketplace. First, on the demand side, too few people are informed about the limitations of Medicare/Medicaid, social security and their already existing health insurance to provide for their long term care needs. This means that less desperate and lower risk people (generally, the young-old) avoid the product while higher risk people

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[24] This expertise by the insurer is reasonably expected and relied upon in the marketplace. This expertise combined with the use of "form contracts" explains the well known fact that most consumers do not understand their insurance contract.

[25] *E.g., Cataldie v. Louisiana Health Service and Indemnity Co.*, No. 83-C-1750, 456 So.2d 1373 (1984) ("Insurance is a business affected with the public interest . . .").

[26] A contract for insurance is one for indemnity against loss, and it is personal. *German Alliance Insurance Co. v. Ike Lewis*, 233 U.S. 389, 411 (1914). "The effect of insurance – indeed, it has been said to be its fundamental object– is to distribute the loss over as wide an area as possible." Referring to fire insurance, the Court expounded on the public interest as follows:

> [T]he loss is spread over the country, the disaster to an individual is shared by many...Contracts of insurance, therefore, have greater public consequence than contracts between individuals to do or not to do a particular thing whose effects stops with the individuals . . .
>
> * * *
>
> We have shown that the business of insurance has very difinite [sic] characteristics, with a reach of influence and consequence beyond and different from that of the ordinary businesses of the commercial world, to pursue which a greater liberty may be asserted. The transactions of the latter are independent and individual, terminating in their effect with the instances. The contracts of insurance may be said to be interdependent. They cannot be regarded singly, or isolatedly, and the effect of their relation is to create a fund of assurance and credit, the companies becoming the depositories of the money of the insured, possessing great power thereby, and charged with great responsibility.

German Alliance Ins. Co. v. Ike Lewis, 233 U.S. at 389, 413-414 (1914). Insurance "is of the greatest public concern." *Id.* at 415. The states generally agree. For example, the North Dakota Supreme Court has also recognized the public interest implicit in the business of insurance. *Bekken v. Equitable Life Assur. Soc. of United States*, 293 N.W. 200, 210 (N.D. 1940).

[27] *E.g., People v. Dollar Rent-A-Car Systems, Inc.*, 211 Cal.App.3d 119, 259 Cal. Rptr. 191 (Ct. App. June 1, 1989) (contract "was misrepresented as 'insurance' . . . [i]n truth, upon execution of the contract, the renters became absolutely liable for damages. . .").

(generally, the old-old) tend to want it more. This situation both drives honest prices up to often unaffordable levels (given the relatively higher risk pool), and makes the old-old vulnerable to fraudulent sales practices.

The risks associated with the fact that the old-old rather than young-old will be disproportionate consumers was also recognized early on by the Society of Actuaries:

> Let me say a few comments about some of the many markets that there are within this field. The most obvious market are the already old, the already frail, by which I mean mostly people over age 80 but also in their 70's when they go through the period of retirement in which they are active and able to enjoy life and start reaching the period in which they become more and more aware of their limitations and what the future holds for them.
>
> The experience so far has been that people are mostly interested in buying nursing home insurance when they get into their late 70's and that it is extremely difficult to get their attention to their potential need for this at an earlier age. The last thing they want to think about is going to a nursing home when they are in their 50s and 60s. It's very much like the similar phenomenon in insurance like the difficulty of persuading any employee under age 40 that they may retire someday and, therefore, that the pension is worth any money to them. This seems to be projected even further into the age span. The lack of publicity, the lack of information that is generally available to promote the need for these services and the nature of the aging process seem to reinforce the difficulty that you have in persuading people that there's a real need.[28]

The other side of the LTC marketplace is the fact that, while there are many insurance companies willing to sell the product, the channels of distribution are highly limited today to

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[28] *Id.* pp.15 - 16 (Statement of Gordon Trapnell); *see also*, U.S. Administration on Aging, (2/28/00):

> For instance, the strict income limits of the Medicaid program are not widely known or understood. In general, Baby Boomers were less aware than seniors about long term care insurance and few individuals had purchased insurance. Among those who are considering this option, questions were raised about affordability and the best age to purchase.

Another excellent source on public attitudes on Long Term Care comes from the University of Maryland Center on Aging. *See*, Mark R. Meiners, Research Bulletin R-589.

relatively few managing general agents ("MGA"). This situation causes some insurance companies to compete in relatively unwholesome ways to secure a prominent place on the shelf.[29]

In addition, there are a number of well known reasons why a seemingly rational insurance company would intentionally or knowingly underprice a product. First, low-ball pricing is rational where the proponent of the policy is more interested in the agency or administrative income, or has reinsured the risk away, or both. For instance, in *Hanson v. Acceleration Life Insurance Company*,[30] the LTC policy was developed by a super salesman with a network of MGAs. He then persuaded a company to front his policy for a fixed percentage of the premium after promising to reinsure 100% of the risk. Clearly, his primary goal was to maximize commission income for himself, and his MGAs. Second, some companies are anxious to acquire market share[31] to lower administrative costs. Third, some companies will price a policy as a loss leader in a bundle of elderly insurance products.

All LTC policies should be guaranteed renewable for life in a meaningful way. The key concepts are affordability and suitability. The proponents of a policy should make an affordability showing at the front end prior to approval rather than being allowed to plead solvency concerns at the back end and/or exploit the weak regulatory loss-ratios standards at the time of rate increases.

I. RECENT NAIC PROPOSALS

1. Introduction

The NAIC's proposed model regulations do nothing to ensure that LTC insurance is safe in the long run, or that consumers are fairly informed of the risks of rate increases. They are only a work in progress. Indeed, it is generally agreed on many important issues that these proposals still require a Guidance Manual which remains to be drafted in the future. This fact reflects an unfortunate rush to get some rate stabilization rules out, perhaps, for this very hearing:

> NAIC Vice President and Kansas Commissioner Kathleen Sebelius said that adoption of the model was important not only to strengthen state insurance regulation, but also to ensure that regulators can fully

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[29] *E.g.*, Gary Corliss, *The State of LTCI*, D&H ADVISOR. (Jan/Feb. 1997).

To date the primary successful distribution source has been the brokerage system, and carriers have chased this limited commodity with commissions ratcheting upward regularly.

[30] Civ. No.A3:97-152.

[31] *E.g.*, Fisher, *"Rate Viability in LTC Insurance: Is There Cause for Concern?"* BROKER NEWS (12/99), pp. 13, 20 ("a few 'bad players' who introduce low-ball premiums to increase market share, only to raise rates shortly thereafter").

participate in Congressional hearings on tax qualified long-term care policies scheduled to take place next month.[32]

The incomplete nature of the proposed regulations raises question about their likely impact, if implemented as written nationwide. Two examples from the disclosure rules suffice to make the general point. First, § 9.B(2) now requires "[a]n explanation of potential future premium rate revisions, and the policyholder's or certificate-holder's option in the event of a premium rate revision." This could be a good rule to ensure that consumers make informed choices, but a great deal depends on how it is ultimately interpreted and enforced. Second, § 9.B.(5)(a) now requires "[i]nformation regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state. . . ." Again, this rule only goes to information about past rate increases and not other, perhaps more pertinent, information regarding the known and quantifiable risk of future rate instability for the particular insurance product. Its usefulness, again, depends on how the rule is interpreted and enforced. However, § 9.B.(5)(c) appears to create an undesirable disclosure loophole for "blocks of business acquired from other non-affiliated insurers."[33]

In addition, the proposal only applies to future policies sold after the various states consider and promulgate these regulations. § 20.A.(1); § 3. This provides no help to existing policyholders, and people who purchase these policies in the interim period, and people who live in states that opt not to implement these regulations.

2. Ratings Practice

The NAIC proposal is unlikely "to guarantee rate stability and level premiums over the life of a policy." There are no absolute limits on rate increases. In addition, these proposals ignore the goal of developing substantive criteria that will only result in the approval of policies for sale that are unlikely to increase premiums. The dual goals of enabling people to retain coverage and encouraging other people to purchase coverage are never advanced by any form of rate increase.

Only two things will "guarantee" rate stability, and neither the use of sound actuarial data nor objective limits on rate increases are mandated by the NAIC. In other words the core problem is not treated.

First, rate stability depends on a sound actuarial foundation. To my knowledge no one takes the position that there is enough good data today to accurately price LTC insurance. However, the NAIC seems to acknowledge this point indirectly by acknowledging a distinction between types of

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[32] Jim Connolly, *LTC Rate Model Adopted By NAIC*, NATIONAL UNDERWRITER (8/21/2000).

[33] This exception is ostensibly justified "to prevent insurers from being discouraged from buying bad blocks of business." Fair enough. However, there has to be a plan to fix the problem--rate increases or capital contributions or rewriting the block--and this should be disclosed at the earliest possible time to the consumers who may buy the policy and the insureds who are renewing their policies.

rate increases. Specifically, a distinction is drawn between regular "rate increases" and "exceptional increases" § 4.A; § 20. The distinction seems to turn on the cause of the increase. Exceptional increases are linked to new legal requirements, § 4.A.(1)(b), and new actuarial data, § 4.A.(1)(b). Such increases seem superficially fair, if explained initially to the purchaser and if limited to truly unforeseeable developments. However, there is no requirement that these changed circumstances be truly unforeseeable to the actuary. This problem is exacerbated by the fact noted above that the insurer is not expressly obligated to identify for the customer known or foreseeable risk factors that could lead to future rate increases. In addition, the exceptional increase allowed may still be greater than the new facts or law warrant. § 20.C.(1) ("Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits"). Yet there need be no showing of 30% extra administrative cost associated with that foreseeable or unforeseeable increase (over and above the existing administrative expenses priced into the original premium).

Second, rate stability can also be achieved by firm limits on rate increases which, in effect, would mean that the insurer would have to cover the risk of its actuarial mistakes from its own capital. The NAIC ignores absolute rules--e.g. no rate increases for the first five years, no rate increases in excess of some percent, etc.

Regulators are rarely able to discern that a policy is priced too low (as opposed to being priced too high). More troubling, most states allow automatic (or "deemer") rate increases whenever the company's loss ratio exceeds a certain percentage, commonly 60%, meaning that more than 60¢ of every premium dollar are going to pay benefits.[34] This makes meaningful regulation of rate increases virtually impossible.[35]

It is true that the old loss-ratio concept is no longer necessarily a part of the initial price setting process, although it continues to be utilized for rate increases. Some had thought this tended to lead to a lower initial price separate and apart from competitive market forces. This view misses three points. First, the pressure on initial price due to competition is real. Second, as indicated, utilization data is not standardized. Third, the problem is that low ball pricing and rate instability is often accomplished by other non-ratio deceits, such as unrealistic lapse rate assumptions and bad underwriting. This loss ratio change does little then to improve the status quo. Although, strictly

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[34] The 60-40 "loss ratio" concept is a well recognized life insurance regulatory device that appears to have been improperly transposed in the LTC area. *E.g.*, Gary Corliss, *The State of LTCI*, D&H ADVISOR (Jan./Feb. 1997):

> LTCI is a new coverage. Traditional logic suggests that reserves and capital/surplus requirements should be greater for LTCI than for other more traditional insurance products. *E.g.*, Gary Corliss, *The State of Long Term Care Insurance*: 1998, *supra*:
>
> State regulators started way behind everyone else and tried to alter their regulations and practices to fit into a new reality.

[35] Nevertheless, insurance companies attempt to avoid civil liability by hiding behind regulatory rate approval or inaction. The vehicle for this excuse is an improper attempt to move the filed rate doctrine into the insurance context. Allan Kanner, The Filed Rate Doctrine and Insurance Fraud Litigation, 76 NORTH DAKOTA LAW REVIEW 1 (2000).

speaking, elimination of the loss ratio requirement does allow companies of good faith to set more conservative initial premiums, this ignores the fact that conservative companies in the past repeatedly managed to develop good policies, despite this rule. The loss-ratio rule is not the problem and did not cause the fraud; it simply failed to help regulators stop or identify poorly priced policies. Moreover, for companies desiring to get market share by underpricing competitors, this change creates no deterrent.

The limits on expense allowances and profits on rate increases do continue to use the loss ratio concepts, and are a move in the right direction. However, it is not clear why a company that has priced a policy too low (in the case of a non-exceptional increase) should receive any portion of the additional premiums for commission and profit. The first priority should be to stabilize the block of business by identifying some combination of rate increases (and/or capital contributions by the insurer) to achieve that end; otherwise, a cycle of increases is started. Forcing a company to dig into its own pocket, instead of the pockets of the elderly who relied on, and paid for, the company's expertise, would provide an even more powerful incentive for companies to charge an adequate initial premium.

Reimbursement of unnecessary rate increases is a good idea, but misses the boat for many people. If people are forced to lapse by a rate increase, they get no money back. They are simply older and probably sicker, which means that affordable coverage from other companies simply is not available to them. It also begs the question of how, if at all, the states will police this.

Companies already have powerful economic incentives to administer well. In my experience, bad claims practices do not cause increased premiums. Instead, bad underwriting leads to foreseeable claims by people who never should have been in the group in the first place. Currently, most states require the company to honor the claim of someone who did not hide their medical condition at the time of sale. I have seen market conduct exams dealing with the problem of mass denial of claims. This should not change, but the tenor of the NAIC proposal suggests the contrary. What is troubling is when a company engages in "claims underwriting" which now arguably appears to be tacitly approved by the NAIC, or tries to pass the added costs of these claims to the other insureds in the form of rate increases. A company should bear the economic risk of bad underwriting and bad administration, since the customer has already paid the company for these services in his or her premium.

The idea of taking a bad block of business and pooling it with a non-closed block of business is generally a good idea, although arguments about the triggering events for action could delay its implementation. However, there are some other open questions. First, do the significant number of policyholders who lapsed get an opportunity to opt in, or is that benefit limited to those policyholders who have continued to pay the increasing premium? Second, what rate is to be charged for that new policy? Third, who bears the financial risk that the more stable current policy may be destabilized by this change?

The idea of banning "bad" companies from the marketplace has been rejected in numerous other contexts. However, this sort of corporate death penalty will likely suffer from the same

enforcement problems that we currently see with lesser sanctions. Most states already have the power to stop approving new insurance products from a bad company or to take the license of a bad company that does not play by the rules.

Actuarial certifications are already used with new filings and rate increase filings, and most reputable actuaries would follow existing actuarial standards, which provide in substance that no hidden rate increases is planned. This leaves us in essentially the same position. Some actuaries will sign off on bad policies.

State regulatory ability to adopt appropriate regulations, monitor compliance with those regulations and police fraud is likewise tempered by their responsibility to see that insurance companies remain solvent enough to pay all claims. Too often the company that knowingly or negligently engaged in low ball pricing points to prospective financial problems of its own creation as the justification for future rate increases. Unfortunately, state regulators do a bad job of worrying about solvency at the time of initial filing (as opposed to waiting until it is too late and a rate increase is being sought).

3. Consumer Awareness

In addition, there is the disclosure question: When is the customer told about known problems with some of these assumptions. Obviously, insurers should make meaningful disclosures at the time of purchase[36] and thereafter before annual renewals. The importance of timely and meaningful disclosure is increased by the fact that as an insured ages it becomes both more difficult and more costly to buy substitute coverage.

Disclosure must also be substantively meaningful. Boilerplate language that premiums "may" go up does little to provide meaningful information to the consumer (or independent agent) about the possible range of rate increases and the attendant risk factors.

Little is being done to ensure that consumers have substantive knowledge as opposed to getting a form disclosure. What consumer really understands the difference between coverage that is "guaranteed renewable" or "noncancellable"? § 8.A.(1). In addition, systemic marketing abuses such as pressure sales are ignored.

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[36] In litigation, companies deny any obligation to disclose or claim that minimum regulatory disclosures bar any stricter common law standards. For example, in one case, an insurer (Conseco) has taken the position that it has no duty to disclose risks prior to the initial sale. "[Conseco does] not owe any such duty [to disclose] prior to policy inception because an insurer is not a fiduciary to the insured, and is not in a confidential relationship with the insured before the contract of insurance is issued." Because there is "no duty to disclose, it is immaterial whether [Conseco] had knowledge at the time that Plaintiffs were considering their purchase of long-term care insurance of the purported fact the premiums would increase because of the allegedly inherent defects in the LTC-6 policy." Conseco's Demurrers to First Amended Complaint (8/22/00), Memorandum pp. 5-6, *Blau, et al. v. American Travellers, et al.*. This litigation context claim of lack of duty is inconsistent with the public interest associated with the business of insurance.

Rate increase history disclosure is a good idea in general. As indicated above, the incomplete nature of the regulations and lack of a Guidance Manual makes it difficult to assess the eventual impact of these regulations.

The § 9 requirement of more information is good. However, most policies currently contain language that rates may be increased. This point is not driven home given the general expectation of company expertise and rate stability. In other respects, § 9 is currently too vague to assess its likely impact.

The timing of disclosure is less than adequate if it first comes in the policy, as opposed to the application and advertising material. § 8.A (limited to "policies"); § 9. In my opinion, a better disclosure would relate to rate increases — by the issuing company and companies it has acquired or divested — on all prior and current LTC policies. These and other disclosures should appear on the application. This is more meaningful than disclosures about the risk of rate increases on the contract (as some states require) and/or suitability worksheets (often filled out by agents) which are no substitute for better information and clearer warning on the initial application regarding (i) the risk of future rate increases, (ii) the history of rate increases, and (iii) the companies' experience with LTC. In addition, I would also require insurance companies in their billing statements and in their renewal letters to provide meaningful notice of future anticipated rate increases and problems. Currently, regulators are often told that a proposed rate increase is not enough (and that more may be needed), but consumers are not. This is highly relevant to the decision to buy or renew. More important, many policies are sold in one push and the block is closed before the rate increase begin.

The signed acknowledgment of potential rate increases without a disclosure of risk factors is less than worthless. First, is the risk 1% or 50% that rates "may" go up? Is this truly informed? Does the customer know the company lacks adequate utilization data, or that this policy might perform very differently from other policies? Second, this would enable a company that was selling experimental coverage to say the customer's consent (as opposed to its intent and undisclosed knowledge at the time of sale) is the only issue and should bar any recovery. Third, it shifts blame to agents who can honestly tell the client that this is just legal boilerplate or something similar. Fourth, and most important, it begs the question of corporate responsibility. A better way of reaching this sort of result would be something like this: **I UNDERSTAND THAT MY (MONTHLY/QUARTERLY/ANNUAL) PAYMENT FOR THIS POLICY IS $_____. YOU UNDERSTAND THAT I CAN ONLY AFFORD (OR I AM ONLY WILLING TO PAY) $____ PER MONTH FOR MY LONG TERM CARE INSURANCE. I UNDERSTAND THAT MY RATES WILL NOT BE RAISED BEYOND THAT AMOUNT.** This sort of statement will alert the conscientious company to the limited ability of the customer to pay for future discovered shortcomings in the insurance companies current actuarial analysis.

Training of agents and setting standards for marketing is always important. But ask yourself this, why do companies put self-serving and exculpatory language on insurance contracts that expressly disavows any responsibility for what was said by the agent during the sales process?

The emphasis on disclosures misses the point that pressure sales tactics may be occurring and would likely override formalistic disclosures. The relatively high initial lapse rates of between 30-40% on some of those policies suggest pressure sales tactics are occurring in some cases. The companies are in the best position to police their agents.

J. PERSONAL RECOMMENDATIONS

In addition, there is some question about whether the market will ever perceive this as a valuable stand alone product in sufficiently large and diverse numbers to allow meaningful risk spreading, especially after twenty years of largely unsuccessful marketing efforts:

> We think there is an awful lot of problem with trying to market just a long-term care benefit and if you try to offer a free-standing long term-care product to people there's going to be a great potential to adverse selection and moral hazard. One of the ways to cut down is to offer it as part of a much more comprehensive marketing strategy to say, "This is a total health plan for you, the older person". It has all kinds of services, not just long-term care. It's also clear to me that people who need long-term care will find you anyway but that clearly marketing a health product which has all the benefits including long-term card is preferential to marketing just a long-term care product.[37]

By the same token, from a real cost and actuarial view, the best LTC product may be a subpart of an integrated product that combines other protections such as life, medical, Medigap, disability and/or annuities.[38]

The question then becomes what form that integrated product should take. Certainly, it should be one that does not waste income on unnecessary marketing compensation such as excessive commissions. It should also be modeled on something people do feel comfortable with.

The solution may be to empower elderly consumers and their families to deal with this bundle of health care issues in a privately held medical savings account, modeled on the popular IRAs, that the holder can either manage independently, or in tandem with a traditional insurance provider willing to develop reasonable vehicles for helping the elderly and their families to manage

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[37] 1985 Proceedings, pp. 28-29 (Statement of Dennis Kodner). With stronger regulation, public confidence in LTC insurance could increase. Likewise, certain group initiatives (such as the one for government employees) might change this perception.

[38] Gary Corliss, *The State of LTC Insurance*, (1997), *supra*.

their money better, and select their care options in cost a effective manner.[39] My recommendation is expanding the utility and desirability of the concept of private medical savings accounts that can be used by the individual for his or her needs as well as those of immediate family members (parents and children). To accomplish this, some people may need to abandon current assumptions about medical savings accounts, and limitations on the development of these accounts.

Under my proposal, 100% of what people invest on behalf of themselves or their family will grow on their behalf to be used when needed in a flexible manner (as opposed to insurance where a substantial amount of money is lost in "transaction costs"). We know from experience with IRAs and 401(K)s that more and more people are willing to save to provide future needs in tax-free accounts. [40] To ensure that more rather than less money is saved, you have to allow for current deductions for such investments, for tax-free growth of these accounts and for tax-free transfers of these funds to spouse, parents, or children on death. You also allow for these products to be used to help parents as well as children, who consume a significant percentage of LTC services. Unlike existing LTC insurance products, which generally are sold with fixed limits on daily care costs and policy maximums, medical savings accounts could potentially provide a higher level of coverage and thus minimize the need to use limited public resources which will still occur in many cases with people who have LTC coverage. Medical savings accounts can also be more flexible and adaptable to new varieties of care along the continuum of care alternatives, especially the development of home care and community alternatives that maximize care for the elderly while minimizing stresses on the

[39] A different proposal is offered by John C. Goodman, *Prescription Drugs for Seniors: The Roth IRA Solution*, (National Center for Policy Analysis: March 16, 2000), www.ncpa.org.

[40] Compare this to the relatively low interest in LTC. E.g., Kevin Gough, Conning & Co., *Long-Term Care Insurance, Baby Boom or Bust?* (penetration of senior market is between 5-7%). This study attributes this primarily to two facts: (i) lack of awareness of need or limitations of federal programs, and (2) the current heavy reliance on a relatively small number of MGAS and brokers who specialize in the senior market. This trend may be changing due to increased group sales, especially among governmental employees.

family.[41] These monies can also be used to pay the significant out-of-pocket expenses not covered by public programs or private insurance.[42]

Insurance companies could profitably compete for the business of helping families develop saving strategies, manage these funds, and where necessary, provide supplemental coverage for certain defined risks, as well as the 5 to 10 year period in which these accounts need to grow.[43]

Medical savings accounts are obviously not for everyone and not for every situation. They certainly favor the currently healthy and young-old, as well as the wealthy. However, these people are future claimants on public monies, and their savings can be used for their parents and children as well. These accounts do little directly for those high risk people who are likely to file claims in the near term, although they may do quite a lot for their families who would rather provide home care than institutionalization. Some high risk state pools may be necessary for these high risk people.[44] However, needs based coverage for some Americans is not inconsistent with encouraging individuals of all ages to use their own resources to protect their families and themselves.[45]

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[41] "Both the levels of care and the mix of long-term care services available concomitant with the improving health and increased use of assistive devices, social conditions, and desire for independence among older adults may shift care for older patients to a community-based approach." JAMA, (1/26/00) Vol. 283, No.4.

The Balanced Budget Act of 1997 hurt the homecare industry, with over 2,500 agency closures according to the National Association for Home Care. This was due to increasing governmental regulations, such as the surety bond requirements, the Interim Payment System, and Operation Restore Trust. A Prospective Payment System is slated for implementation in FY 2000, and with the latest requirements to transmit patient outcome data via a uniform data set, known as OASIS, or the Outcome Assessment Information Set, homecare agencies have been put on notice to perform in all aspects of survival—both clinical and financial management. LTC NEWS & COMMENT (2/00), Vol. 10, No.6, p.1.

[42] The average Medicare beneficiary spent $2,430 out-of-pocket for healthcare in 1999, according to new report by AARP. Premiums for private insurance (such as Medigap and Medicare+ Choice) represent 27% of this amount, whileB premium weighed in with 19%. Prescription drugs comprised 17% of average out-of-pocket expenses. These out-of-pocket do not include payments for long-term care nursing home care or home healthcare.

Persons with lower incomes spent a greater percentage of their income for medical care, than those with higher incomes. "Out-of-pocket Spending on Health care by Medicare Beneficiaries Age 65 and Older: 1999 Projections," December 1999, AARP.

[43] This is not to write off the LTC insurance industry. Rather it is to incentivize them to create new and valuable products to justify the approximately 40¢ of each premium dollar that they currently keep for their expertise, their overhead and their agent's commissions. For example, the insurance industry still has a useful role because it can pool risks, especially the risk of a long stay. However, the idea of giving tax credits to people to buy LTC, even, assuming fraudulent pricing could be effectively policed (say, by creating standardized policies akin to the 10 Medigap plans), seems less efficient than medical savings accounts.

[44] *See also, Medicaid Long-Term Care: Successful State Efforts To Expand Home Services While Limiting Costs*, GAO/HEHS-94-167 (Aug. 11, 1994).

[45] Average net worth of the elderly, as well as all families, has grown significantly between 1995 and 1998. *Recent Changes In U.S. Family Finances: Results From The 1998 Survey of Consumer Finances*, Board of Governors, Federal Reserve (January 2000) (mean net worth of elderly increased 26%).

K. CONCLUSION

People of all ages need long-term care because they suffer serious chronic illnesses that lead to disability. However, the elderly and especially women are most in need of long-term care services. As the population ages and Americans live longer, the demand for long-term care will increase exponentially during the 21st century. We must look for innovative and cost-effective ways to provide care and to help caregivers. The older population is diverse, their needs are diverse, and the solutions must be diverse.

And by diverse, I mean that private alternatives and solutions must be created and supported, because public programs are neither big enough nor efficient enough to handle the problem of long-term care. Certainly, the public cannot afford to pay for all of these services and we should encourage the private sector to help meet these growing needs. On the other hand, the resources of the elderly and their families are limited and should not be wasted by fraud or on LTC insurance products that do not work.

Ultimately, what we see in the case of LTC is that both sellers and consumers are doing a bad job of evaluating risk. The consumers, except for the highest risk subclass, are generally ignoring the very real need to provide for LTC costs for themselves and their parents. The problem of the highest risk people is that, while they want LTC protection, they are the least qualified for LTC as seen by the problem of anti-selection bias. The people in their 50's who should be buying LTC insurance in greater numbers are not interested or operate under the delusion that Medicaid will pay for it. At the same time, the insurance industry in many cases is not showing the consumers that it is adding value at this point, and some of its members are clearly acting inappropriately if not fraudulently.

I am concerned about permitting tax deduction for long term care premiums because it subsidizes the purchase of potentially fraudulent products and risks causing the taxpayer to pay twice: once for the deduction, and again to pay for the LTC care of the defrauded individual from public monies. If appropriate safeguards existed, the question for this Committee would then be whether to encourage more LTC insurance or to invest in medical savings accounts, or both, matters of which are beyond my expertise.

Safeguards mean at least avoiding fraud. But it should also include protection against exorbitant commissions. Why should taxpayers subsidize 40%-60% commissions? These commissions encourage some agents to recommend the wrong policies initially or to switch policies later.[46] Maybe the deduction should be limited to the net amount of money actually being reserved by the company to pay the claims. Why should taxpayers subsidize anything else?

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[46] The NAIC currently recommends that states require LTC companies to report lapse rates, and replacement rates by agents (*i.e.*, twisting).

However, if we choose to allow tax dollars to be used for long-term care insurance in the form of credits, there must be strong consumer protections to ensure that these tax dollars are well spent, and that the costs of care do not come back to the public because the policyholders (now out the monies paid for premiums) have been forced to lapse their coverage due to rate increases.

The CHAIRMAN. Thank you, Allan.
Now, Charles.

STATEMENT OF CHARLES N. KAHN III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. KAHN. Thank you, Mr. Chairman. I appreciate the opportunity to appear here today to discuss the longstanding efforts of HIAA member companies to help Americans protect against the financial catastrophe that all too often results when people require long-term care.

In my testimony I will emphasize three points: first, the need to address this Nation's looming long-term care crisis; second, the capacity of long-term care insurance to help reduce the risk from this crisis for many Americans; and, finally, the insurance industry's commitment to protecting the consumer who purchases long-term care insurance.

As the GAO pointed out, long-term care needs loom large. It is the largest unfunded liability facing our Nation as America's baby-boomers head toward retirement. Despite the undisputed importance of having protection from the potential cost of long-term care, Americans generally have not protected themselves.

Whether Americans think Medicare will protect them, which is obviously not the case, or whether they just believe they are immune from ever needing a nursing home, which now costs over $50,000 a year, as was pointed out here, or the services of continuous home health, it is crucial that all of us who are aging get the message, and get the message now.

However, to most effectively get this message across, as well as to make such protection more affordable to families and ourselves, Congress should take practical steps now that will help us help ourselves. Private long-term care coverage provides the means for individuals to protect themselves and their families.

Fortunately, many Americans have chosen to protect themselves. The number of long-term care policies purchased has increased by 500,000 annually since 1986. Coverage is affordable for middle-class Americans, but action is necessary to jump-start the recognition by Americans that they should act to protect themselves and their loved ones.

In March, HIAA joined with the AARP in calling for Federal legislation to enact both an above-the-line deduction for long-term care insurance premiums and a tax credit of up to $3,000 to defray the costs for those requiring long-term care and their caregivers. I want to thank you, Mr. Chairman, as well as Senator Graham of Florida and Representatives Nancy Johnson and Karen Thurman for working with our member companies and AARP in drafting the Long-Term Care and Retirement Security Act of 2000.

Your leadership, Mr. Chairman, has been instrumental on this Act, as well as the Long-Term Care Security Act, which will help millions of Federal employees and retirees meet their long-term care needs. These measures will make a difference.

A major study by researchers at Brandeis University shows that an above-the-line Federal income tax deduction, like that included in your bill, would increase long-term care coverage by as much as 24 percent. It also shows that the resulting savings in Medicare

long-term care spending would more than pay for the foregone tax revenues.

To assure the quality and affordability of private coverage, consumer protections should go hand in hand with tax deductibility. HIAA has long supported policies aimed at protecting the consumers who purchase long-term care insurance. HIAA has worked for years at the State and Federal level to ensure that strong long-term care insurance consumer protections are in place.

We supported the long-term care consumer protections in the bipartisan Health Insurance Portability and Accountability Act of 1996. HIAA has taken a leading role in working with the NAIC, other industry trade groups, and consumer representatives to craft the revisions to the NAIC long-term care model legislation. And HIAA will work for State adoption of the revised model.

Along with the adoption of a deduction for long-term care premiums, HIAA supports including appropriate elements of the 2000 NAIC long-term care model act into the HIPAA long-term care consumer protections. However, as members of the committee and others in Congress consider the link between the 2000 NAIC model and Federal law, HIAA urges you to preserve the appropriate and distinct role of the States in the regulation of insurance.

As the insurance commissioner from Kansas earlier pointed out, particularly in the area of premium rate regulation, the States have the expertise and are at the right level of the market to make those kinds of determinations and do that regulation.

In conclusion long-term care insurance coverage continues to grow and will protect even more Americans if the Congress makes premiums tax deductible. HIAA is committed to working for reforms that will enable long-term care insurance to reach its full potential in meeting the Nation's long-term care needs.

Mr. Chairman, I am happy to answer any questions you may have.

[The prepared statement of Mr. Kahn follows:]

Statement

of the

Heath Insurance Association of America

SUPPORTING STATE AND FEDERAL LONG-TERM CARE INSURANCE CONSUMER PROTECTIONS

Presented by

Charles N. Kahn III
President
Health Insurance Association of America

Before the

Special Committee on Aging

of the

UNITED STATES SENATE

September 13, 2000

Introduction

Chairman Grassley, Members of the Committee, I am Charles N. Kahn III, President of the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. It is the nation's premier provider of self-study courses on health insurance and managed care.

I appreciate this opportunity to speak to you today about HIAA's longstanding efforts to help Americans protect themselves against the financial risk of long-term care needs – and to improve their long-term care choices – through private insurance. The long-term care insurance market has grown an average of 21 percent each year between 1987 and 1997. To date more than 100 companies have provided long-term care coverage to more than 6 million Americans. Quality private insurance coverage is offered through a variety of mechanisms, including individual coverage, employer-sponsored arrangements, and riders to life insurance plans.

Before I go any further, I want to thank you emphatically, Mr. Chairman, for your leadership on long-term care insurance issues – and particularly for your sponsorship of the "Long-Term Care and Retirement Security Act of 2000." I also want to express my sincere gratitude to the other Members of this Committee – Senators Jeffords, Hagel, and Bayh – for their cosponsorship of this measure.

Let me begin by summarizing the most important points of my testimony:

- Long-term care is the largest unfunded liability facing Americans today, and despite the tremendous need for long-term care protection, most Americans remain unprepared to meet their future long-term care needs.

- There is a growing and critical role for private insurance to provide a better means of financing long-term care for the vast majority of Americans who can afford to protect themselves. Continued growth of the market will protect millions of Americans against the financial risk of long-term care need, enhance their long-term care choices, and help reduce reliance on scarce public dollars.

- The long-term care insurance market is growing and the products that are available today are affordable for many middle class Americans and of high quality.

- Both the federal and state governments have a key role to play – through tax policy, consumer protection, and public education – in improving access to quality long-term care insurance coverage.

- HIAA has joined with AARP in calling on this Congress to enact legislation to provide a tax credit to individuals and families with current long-term care need

and to encourage private long-term care coverage against future need through an above-the-line deduction. HIAA supports Senator Grassley's legislation to enact these proposals, which would also strengthen federal long-term care insurance consumer protections.

- HIAA has an extensive history of supporting public policies aimed at maximizing the benefits that long-term care insurance can bring to consumers, caregivers, and government treasuries – including the development and implementation of long-term care insurance consumer protections.

- HIAA supports all the mandatory provisions of the 2000 National Association of Insurance Commissioners (NAIC) Long-Term Care Model Act and Regulation. HIAA also supports the adoption of the 2000 Model by the states. We believe the 2000 Model will go a long way toward addressing the long-term care insurance rate stability concerns of our industry, regulators, consumers, and this Committee.

- In conjunction with the establishment of an above-the-line federal income tax deduction for long-term care insurance premiums, HIAA supports updating the long-term care insurance consumer protection provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 by reference to the appropriate components of the 2000 NAIC Model.

- It is imperative, however, that the incorporation of components of the 2000 NAIC Model preserve the appropriate and distinct role of the states in the regulation of insurance.

Background

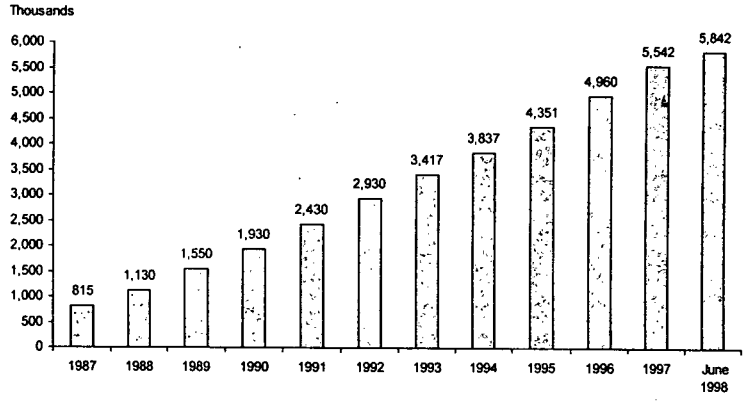
Long-term care is the largest unfunded liability facing Americans today, and despite the tremendous need for long-term care protection, there is a clear lack of adequate planning for it. Unless Congress begins now to take steps to address the looming long-term care crisis, an aging "boomer" generation will overwhelm our nation's patchwork long-term care system and leave millions of Americans unprepared for the heavy financial and emotional burden of long-term care. In 2020, one of six Americans will be age 65 or older – 20 million more seniors than today. By 2040, individuals 85 and older (the group most likely to require long-term care) will more than triple to over 12 million.

Today, fully 30 percent of long-term care costs in this country are paid for by the individuals who need long-term care or their families. But without substantial assistance, the full cost of long-term care is out of reach of most families. The average cost of a one-year nursing home stay is over $46,000 – and growing. Helping people pay for these services directly and helping them purchase quality insurance products should be part of our nation's answer to this long-term care need.

The Private Long-Term Care Insurance Market Today

The long-term care insurance market is growing, and the policies that are available today are affordable for many Americans, including middle income Americans. And the benefits offered are of very high quality. There is a critical role for private insurance to provide a better means of financing long-term care for the vast majority of Americans who can afford to protect themselves. Continued growth of the market will protect millions of Americans against the financial risk of long-term care need, improve their long-term care choices, and help reduce reliance on scarce public dollars. HIAA estimates reveal that, to date, more than 100 companies have sold over 6 million long-term care insurance policies, and the market has experienced an average annual growth of about 20 percent. These insurance policies include individual, group association, employer-sponsored, and riders to life insurance policies that accelerate the death benefit for long-term care.

Market Growth: A Half Million More Policies Each Year



SOURCE: HIAA LTC Survey, 1999.

A recent survey of long-term care insurance purchasers reveals positive trends in the long-term care coverage being purchased today:

- Middle income Americans continue to find long-term care insurance coverage affordable. More than a third of purchasers had annual incomes under $35,000.

- Coverage being purchased today is much more comprehensive than it was just a few years ago. The proportion of dual-coverage policies (i.e., those that cover both institutional care and home care) grew from 37 percent in 1990 to 77 percent in 2000.

- Over the past five years, the average daily nursing home benefit has increased by 28 percent, which is higher than the rate of inflation.

- The difference between the daily benefit paid in institutional settings and that paid in home care settings has narrowed significantly. The average daily benefit for home care has grown by 36 percent over the five-year period.

- There is also a growing trend toward the purchase of compound inflation protection. This trend probably reflects the increase in younger buyers, who are more likely to need inflation protection.

The Employer-Sponsored Long-Term Care Insurance Market

The growth in employer-sponsored plans during recent years is particularly promising. Employer plans offer the opportunity to reach a large number of people efficiently during their working years when premiums are more affordable. Enrollment experience shows that the average age of employees electing this coverage is 43. This is strong evidence that with education and availability, younger people can and will purchase long-term care protection. Most of these plans offer coverage to the elderly as well by including retired employees and their spouses and parents of the employee or employee's spouse.

By the middle of 1998, more than 2,100 employers were offering a long-term care insurance plan to their employees and retirees. There were more than 600 employer-sponsored plans introduced in 1997 and the first half of 1998. Since June 1990, many small employers (between one and 500 employees) have started offering long-term care insurance. This number has increased dramatically, rising from 58 in 1990 to more than 1,200 by mid-1998. This group represents over 60 percent of all employers offering long-term care coverage to their employees and/or retirees. There also have been substantial increases in the number of medium- and large-sized employers that offer long-term care coverage.

The employer-sponsored long-term care insurance market got a very significant boost this year with the recent congressional passage of "The Long-Term Care Security Act" (H.R. 4040). HIAA applauds Congress for passing this important measure. The Long-Term Care Security Act will help millions of federal employees, military personnel, retirees, and dependents meet their long-term care needs through quality private insurance coverage. The measure will also make the federal government – the nation's largest employer – a model for private sector employers by encouraging them to offer long-term care coverage to their employees and dependents.

Long-Term Care Insurance Rate Stability and Lapse Rates

The vast majority of companies currently offering long-term care insurance have not increased premiums on policies that they have developed and priced. There have been cases of long-term care insurance rate instability. However, these have generally

occurred in instances where an insurer has continued coverage of products acquired from other companies that have left the long-term care insurance market. Although long-term care insurance rates have generally been stable, limited cases of rate instability have raised the concerns of consumers, regulators, and lawmakers. Therefore, HIAA has taken a leadership role in working with the NAIC, other industry trade groups, and consumer representatives to craft improvements to NAIC Long-Term Care Models to address these issues.

For more than ten years, HIAA has worked to improve long-term care insurance products and protect long-term care insurance consumers. HIAA has carried out research to provide crucial information for long-term care insurers as they develop new policies or revise their assumptions about the future. HIAA has completed three major consumer surveys to determine the factors and reasons behind consumer decisions to buy - or not to buy – long-term care insurance coverage. These surveys have been instrumental in the development of NAIC suitability provisions that provide standards for appropriate long-term care insurance purchases. HIAA fully supports the NAIC suitability provisions. Moreover, it is critically important that each company develop and follow some criteria so that policies are not sold in cases where there is no need, insufficient ability to maintain premium payment, or some other reason why a purchase may not be suitable.

HIAA has also published actuarial data regarding long-term care insurance lapse experience in both the individual and employer-sponsored markets. This information has been an important source for tracking and understanding the improvements in long-term care insurance lapse rates. HIAA estimates that actual lapse rates for individual long-term care insurance policies are below five percent annually. For employer-sponsored coverage we estimate lapse rates below three percent annually. These figures exclude the roughly one to two percent of policy lapses due to the death of the policyholder.

Current pricing of long-term care insurance, as we understand it, generally reflects assumptions that 70 percent or more of policies issued will still be in force after eight years. A substantial portion of the 30 percent of "terminated policies" will have lapsed because of the death of the policyholder. It is important to note that the average lapse rates of individual long-term care insurance policies are comparable to, if not lower than, those for most individually sold life and health insurance products.

Helping Americans Through Long-Term Care Tax Relief

The enactment of the long-term care insurance tax clarifications in The Health Insurance Portability and Accountability Act (HIPAA) of 1996 were very helpful, but they are not enough. HIPAA's long-term care insurance tax benefits for premiums apply primarily to employer-sponsored long-term care coverage. But 80 percent of long-term care insurance is individual coverage. Under current tax law, an individual purchasing a long-term care policy, who is not self-employed, gets to deduct premiums only if he or she itemizes deductions and only to the extent medical expenses exceed 7.5 percent of adjusted gross income. Only about 4.5 percent of all tax returns report medical expenses as itemized deductions.

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

Long-Term Care Product	Percent of Insurers* (n=119)	Percent of Policies Sold (n=5.5 million)	Average Age of Buyer in 1997
Individual and group association	83%	80%	66
Employer-sponsored	17%	14%	43
LTC as part of a life insurance policy	13%	6%	45

*Totals more than 100 percent because some companies sell their products in more than one type of market.
SOURCE: HIAA LTC Survey, 1999.

Under current law, tax benefits can range from a full exclusion from income if one's employer pays the premiums to no tax benefit if an individual pays and does not have sizeable medical expenses. These disparities lead to inequitable results. For many, the current law's tax deduction is illusory.

Strengthening federal tax incentives for private long-term care insurance would help expand private long-term care insurance coverage and reduce the burden on public programs. Last year, HIAA commissioned researchers Marc A. Cohen, Ph.D. of LifePlans, Inc. and Maurice Weinrobe, Ph.D. professor of economics at Clark University, to examine the impact that a 100 percent "above-the line" federal income tax deduction for long-term care insurance premiums would have on the net cost of long-term care coverage to taxpayers, the expansion of coverage, and Medicaid spending for long-term care. Cohen and Weinrobe concluded that the above-the-line federal tax deduction would significantly increase long-term care insurance coverage and that the resulting savings in Medicaid spending would more than pay for the foregone tax revenues. Specifically, they estimate that the above-the-line deduction would:

- reduce long-term care insurance premium costs, on average, by 19 percent;

- spur the purchase of additional long-term care coverage by 14 – 24 percent above current growth; and

- generate more than enough future Medicaid savings from the expansion of private long-term care coverage to offset the cost of the tax deduction for these policies.

Thus, as individuals are encouraged to assume greater personal responsibility for meeting their future long-term care needs by purchasing private insurance, the fiscal pressures on the federal government and state governments will decline. This will help assure that the private sector piece of the long-term care financing puzzle will play an ever-growing and critical role in helping to address this important social policy issue.

What Difference Does Private Long-Term Care Coverage Make?

In addition to the peace of mind of knowing that there will be sufficient resources to pay for long-term care if needed, private long-term care coverage can bring significant improvements in quality of life. Recent studies of policyholders, claimants, and informal caregivers show that the presence of long-term care insurance can:

- delay or prevent institutionalization;

- afford a greater choice of long-term care services and providers;

- enable easier access home care and/or assisted living;

- ease the financial, physical, and emotional burdens on families providing care in the home; and

- preserve assets for heirs.

Earlier this year, the U.S. Department of Health and Human Services (HHS), Office of Disability, Aging, and Long-Term Care Policy (DALTCP) made public "A Descriptive Analysis of Patterns of Informal and Formal Caregiving among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community." This analysis is based on interviews with nearly 700 long-term care insurance claimants and informal caregivers. It presents the first systematic study of the practical benefits of private long-term care insurance coverage to policyholders and their families. Among the findings:

- The vast majority of claimants (86 percent) is satisfied with their policy and most (75 percent) had no difficulty understanding what their policy covered.

- About 90 percent of all individuals filing claims had no disagreements with their insurance companies or had a disagreement that was resolved satisfactorily.

- About 60 percent of claimants indicated that without their policy they would not be able to afford their current level of services and would have to consume fewer hours of paid care.

- Many also indicated that without their policy benefits, they would have to rely more on informal supports.

- About half of all claimants and informal caregivers indicated that without private insurance, they would have to seek institutional alternatives – nursing home care or assisted living facilities.

- About two in three informal caregivers indicate that the presence of private insurance benefits has reduced their level of stress.

HIAA/AARP Cooperation to Strengthen Access to Long-Term Care and Long-Term Care Insurance Consumer Protections

In March, HIAA joined AARP in calling for federal legislation to enact both an above-the-line deduction for long-term care insurance premiums and a tax credit of up to $3,000 for those with long-term care needs (or their caregivers). Working with HIAA and AARP, Senators Charles Grassley (R-IA) and Bob Graham (D-FL), along with Representatives Nancy Johnson (R-CT) and Karen Thurman (D-FL) in the House of Representatives, introduced the Long-Term Care and Retirement Security Act of 2000 (S. 2225/H.R. 3872). This legislation would:

- phase-in a 100 percent above-the-line tax deduction for long-term care insurance premiums;

- phase-in a $3,000 tax credit for those with current long-term care needs (or their caregivers);

- allow long-term care insurance to be offered under cafeteria plans and flexible spending arrangements (FSAs); and

- strengthen federal long-term care insurance consumer protections.

HIAA strongly supports the Long-Term Care and Retirement Security Act of 2000 and we continue to work for its enactment this year.

NAIC Long-Term Care Insurance Model Regulation

HIAA has a long history of working closely with the NAIC on models for long-term care insurance regulation. We supported all of the mandatory provisions of the Long-Term

Care Insurance Model as it stood before the recent changes were adopted. HIAA also supported, back in 1996, the incorporation of the relevant components of a previous version of the model into the long-term care insurance consumer protection provisions of HIPAA.

Since the enactment of HIPAA, we have continued to support NAIC efforts in three areas:

- protecting the equity of policyholders in the event of a premium rate increase;
- reducing the potential for premium rate increases; and
- improving consumer disclosure regarding the history of premium rate increases for a particular company and more clearly alerting applicants about the potential for future rate increases.

Based on work begun in the early 90's, in 1998 the NAIC added to the Long-Term Care Model a requirement to protect the equity of policyholders in the event of a significant premium rate increase. The requirement, known as "contingent benefit upon lapse," afforded those applicants who declined the nonforfeiture benefit (and the premium cost that the nonforfeiture benefit adds) some recourse in the event of a substantial increase or series of increases (e.g. decreasing the amount the policy pays per day of care or converting to a policy with a shorter duration of benefits) in the face of a significant increase in their policy premiums. HIAA was involved throughout the development of the contingent benefit upon lapse Model requirement and supported its addition to the Model.

On August 17, the NAIC adopted an updated Long-Term Care Insurance Model Regulation. The updated model offers states a new regulatory mechanism intended to guarantee stable long-term care insurance premiums. In brief, with respect to a state's regulation of premium rates, the recently updated NAIC Long-Term Care Insurance Model Regulation:

- Eliminates the use of loss ratio requirements on initial rate filings in order to increase margins to economically appropriate levels, thereby reducing the potential for future rate increases.

- Substantially increases the portion of any additions to the initial premium that must be paid out as LTC benefits by the insurer.

- Requires reimbursement to policyholders of premiums paid for unnecessary rate increases.

- Authorizes review and approval by the state insurance commissioner of a company's administration and claim practices.

- Provides that companies can be required to provide policyholders with the option to escape rate spirals by replacing or converting existing coverage, without

underwriting, to a comparable product currently being sold.

- Authorizes a state's insurance commissioner to ban a company from the marketplace for up to five years if the company persistently files inadequate initial premium rates.

- Requires a company to provide actuarial certification that no rate increases are anticipated.

In addition, the revised model adds the following provisions for disclosure to consumers regarding the potential for premium rate increases:

- Requires disclosure of rate increase histories for the past 10 years.

- Specifies information that companies must provide to applicants for long-term care coverage.

- Requires signed acknowledgement by applicants of potential rate increases.

- Strengthens requirements for agent training and licensure.

HIAA worked alongside the NAIC throughout the development and adoption of these amendments to the Long-Term Care Insurance Model Regulation. Just in the past three months, HIAA has consulted with the working group that has developed a guidance manual to assist states in their review of the required disclosure information. The manual includes standards for language and examples of acceptable and unacceptable disclosures.

HIAA supports the mandatory provisions of the 2000 NAIC Model and its adoption by the States. We expect formal endorsement when our Board of Directors meets later this year. HIAA also supports the use of the appropriate components of the 2000 NAIC Model to strengthen the consumer protection provisions of HIPAA. However, as members of this Committee – and others in Congress – consider linking the 2000 NAIC Model to federal law, HIAA urges that you take care to preserve the appropriate and distinct role of the states in the regulation of insurance.

NAIC Long-Term Care Insurance Model Provisions As Federal Tax Requirements

HIAA believes that legislation to strengthen tax incentives for long-term care insurance is a key step the federal government should take to help Americans plan for and protect against future long-term care needs. In conjunction with strengthening federal tax incentives for long-term care coverage, HIAA is willing to support the incorporation into HIPAA's long-term care insurance consumer protections of the appropriate components of the 2000 NAIC Long-Term Care Insurance Model.

When HIPAA established a federal tax definition of a "qualified long-term care insurance contract" (QLTCI), this legislation specified consumer protection requirements that had to be satisfied in order for a policy to be qualified, and also imposed a penalty tax on persons failing to meet certain consumer protection standards. These consumer protection requirements were largely imposed through cross-references in the Internal Revenue Code to provisions of the Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation , as promulgated by the NAIC.

- *Model Rules Incorporated by HIPAA.* Most of HIPAA's consumer protection rules for QLTCI contracts establish ground rules relating to fairness. These rules specify certain minimum requirements for policies and on company actions in their relationship with the consumer. For example:

  -- requiring policies to be at least guaranteed renewable;

  -- specifying the circumstances when coverage could be canceled or rescinded, such as when the applicant lied to obtain coverage;

  -- limiting the circumstances where benefits need not be provided, such as in the case of alcoholism or drug addiction;

  -- requiring free-look periods immediately after issue and grace periods for premium payments;

  -- requiring numerous disclosures, including an outline of coverage, and building in notice and other safeguards to prevent unintended lapses of policies;

  -- establishing minimum standards for home health benefits; and

  -- requiring offers of inflation protection and non-forfeiture benefits.

- *Model Rules Not Incorporated by HIPAA.* In addition to addressing the relationship between insurers and consumers, the Long-Term Care Insurance Models also include rules providing for the regulation of insurance companies by state insurance departments. The Models, for example, authorize state insurance departments to impose limitations with respect to the pricing of policies (*e.g.*, loss ratio requirements), and also authorize state insurance commissioners to impose sanctions or require remedial action in certain instances. These Model provisions were not incorporated by HIPAA as federal tax requirements since they relate more to the state's regulation of the insurance company than to the fairness standards that should be met with respect to a QLTCI contract.

Recommendation for Update of the Consumer Protection Standards. HIAA will support the 2000 NAIC Model provisions, and hopes for their speedy adoption by the states.

In addition, HIAA believes it is appropriate that federal legislation enhancing the tax treatment of QLTCI contracts include components of the 2000 NAIC Model the extent they establish ground rules relating to fairness or otherwise define minimum standards in the relationship between an insurer and consumer. As an example, HIAA recommends that the new Model provisions relating to contingent nonforfeiture benefits provided on lapse be included as new requirements relating to the definition of a QLTCI contract. In addition, HIAA recommends that the required disclosure to consumers relating to rate stability be added as a requirement. We would also note that HIAA supports the addition of the changes to the prescribed "Outline of Coverage" that is to be given to applicants, thereby providing an explanation of the value of these provisions to the consumer.

Similar to the framework of HIPAA, it would not be appropriate to include as federal tax requirements those provisions of the revised NAIC Models that relate more to the manner in which a state regulates an insurance company. The McCarren-Ferguson Act and the more recently enacted Gramm-Leach-Bliley (GLB) Act of 1999 affirm that the proper regulation of insurance companies resides with the states rather than with the federal government.

HIAA strongly supports the continued separation of these roles, as maintained by HIPAA and by GLB. While disclosures to consumers, such as of an insurer's history of price increases, may be appropriate as uniform federal tax requirements, the federal government should not take on the role of state insurance departments with respect to the regulation of the amount charged for policies. To do so would create very substantial coordination problems, since the methods for regulating prices in the Models will in many instances be inconsistent with the regulatory methods actually applied by states. As a result, states often would either need to defer to the federal regulatory scheme and forego their preferred method of regulation, or they would effectively have to prohibit the offering of QLTCI contracts in their State.

In addition, HIAA believes that the federal government should not authorize actions by state insurance departments that have not been authorized by the state in question, as this would similarly represent an intrusion on the state's proper role in the regulation of insurers. HIAA also believes that it would be inappropriate to take these regulatory powers away from the states.

Summary and Conclusions

Long-term care insurance coverage continues to grow and market competition and innovation continue to bring quality and value to consumers. Federal and state public policies will have a crucial role in determining how fully private long-term care insurance

realizes its potential to protect Americans against the financial risk of long-term care need, to improve their long-term care choices, and to relieve the burden on public programs. The combination of enhanced federal consumer protections, combined with state adoption of the 2000 NAIC Models, will improve long-term care insurance rate stability and ultimately make long-term care insurance a better product. This, combined with appropriate tax treatment of long-term care insurance, will substantially enhance the appeal of such insurance as a way for Americans to address the possible long-term care needs they could face with advancing age.

Thank you Mr. Chairman and Members of the Committee. We look forward to working with you for the enactment of legislation to help Americans meet their long-term care needs with quality long-term care insurance coverage.

The CHAIRMAN. Thank you.
Now, David.

STATEMENT OF DAVID S. MARTIN, GENERAL DIRECTOR, LONG-TERM CARE, CONTRACTS AND LEGISLATIVE SERVICES, JOHN HANCOCK LIFE INSURANCE COMPANY, BOSTON, MA, ON BEHALF OF THE AMERICAN COUNCIL OF LIFE INSURERS

Mr. MARTIN. Good afternoon, Mr. Chairman and members of the committee. On behalf of the ACLI, I want to thank you for the opportunity to talk about long-term care insurance and the rate stabilization regulation recently adopted by the NAIC.

ACLI member companies have 87 percent of the long-term care insurance in force in the United States.

I want to express our gratitude for the leadership role this committee has taken in highlighting the significant role that private long-term care insurance plays in retirement security. You and members of this committee have supported the need to encourage the private long-term care insurance market in order to meet the Nation's long-term care needs without crippling taxpayers and already strained Government programs. You, Mr. Chairman, were instrumental in including the above-the-line deduction in recent legislation.

Providing this important tax incentive means that Americans who take advantage of long-term care protection will not be a burden on the Medicaid system and will not have to spend down their retirement assets to pay for long-term care before becoming eligible for Medicaid.

Like our regulators, we are committed to maintaining and justifying consumer confidence in this increasingly important protection product. We believe that working together, the industry and its regulators have come up with a model regulation that affords maximum protection to purchasers both in terms of consumer protection and rate stability.

Consumer protections are important to buyers. Today, long-term care insurance is a product that is fully regulated, with an effective NAIC model that is used as a guidepost for States to follow and adopt. All States, including the District of Columbia, have adopted some version of the model. Further, the NAIC models have been revised, updated, and strengthened many times since the initial models were adopted in 1986.

The passage of HIPAA set certain requirements for long-term care policies in order for them to be eligible for favorable tax treatment. HIPAA provided the initial spring board needed to encourage purchase of this product. The Federal Government's message in HIPAA was that individuals have to begin to take responsibility for their own retirement future, and that message is now being heard throughout the public and private sectors.

We believe the passage of currently proposed Federal legislation for an above-the-line deduction and allowing cafeteria plans and flexible spending accounts, to include long-term care insurance, will build on that important message.

The ACLI and its member companies are also very proud and supportive of the major strides that have been made with respect

to the strong consumer protections now in place. Over the past 15 years, the NAIC, working with consumer groups and the insurance industry, has made certain that much needed consumer protections are included in the NAIC models. ACLI supports the current NAIC long-term care insurance models in total, and their adoption in the States.

The NAIC has recently completed its work on rate stability and has adopted a new and important consumer protection provision to address concerns over premium rate increases. The goal of this new provision is to ensure that the premium rates will be adequate over the life of the policy, that rate increases will be less likely, that only justifiable increases will occur, and that necessary increases will be smaller and less frequent.

ACLI supports the NAIC's overall effort and believes that consumers should be protected from unreasonable and unexpected rate increases. ACLI acknowledges that there have been situations where rate increases have occurred, and that some States did not have the proper tools to regulate and evaluate the rates.

It is important to stress, though, that the majority of the market has not experienced rate increases on this product line. The industry has stepped up to the plate on this issue and has joined with State regulators and consumer groups over the past 2 to 3 years to adequately address this matter and trying to accomplish all of this without harming future market innovation and growth.

It is important to note, too, that in recent years the average termination or lapse rate for long-term care insurance by policyholders has declined. ACLI's analysis shows that in the individual market, 2 percent of policyholders voluntarily lapsed or replaced their policies in 1997, versus 6 percent in 1992. Group terminations fell to 7 percent in 1997, from 8.5 percent in 1995.

Though concerns about premium rate increases are centered on a limited segment of the market, the insurance industry believes it had to address the issues head-on and believes we have accomplished that goal with the NAIC. The next step is for the States to move forward and adopt the new provisions.

In many cases, States will have to repeal their current requirements and replace them with the new NAIC rate stability provisions. Some States will have to have new authority to monitor, implement and enforce these unique new provisions, and this will take enabling legislation by the State to allow the State insurance departments to move forward on them. ACLI is committed to working with the States to accomplish that goal.

In conclusion, we believe that protection and coverage for long-term care is critical to the economic security and peace of mind of all American families. Private long-term care insurance is an important part of the solution for tomorrow's uncertain future.

Thank you, Mr. Chairman, and again I look forward to working with you. I would be happy to answer any questions.

[The prepared statement of Mr. Martin follows:]

Statement
of the
American Council of Life Insurers

Presented by

David S. Martin
Chair, ACLI Long-Term Care Insurance Committee

General Director, Long-Term Care, Contracts & Legislative Services
John Hancock Life Insurance Company

Before the

Senate Special Committee on Aging

of the

United States Congress

September 13, 2000

Good morning, Mr. Chairman and members of the Committee. I am David Martin, General Director, Long-Term Care, Contracts and Legislative Services at John Hancock Life Insurance Company in Boston. I also serve as the chair of the Long-Term Care Insurance Committee for the American Council of Life Insurers (ACLI). The ACLI is a Washington D. C.-based national trade association representing more than 400 member companies that offer life insurance, annuities, pensions, long-term care insurance, disability income insurance and other retirement and financial protection products. ACLI member companies have 87 percent of the long-term care insurance in force in the United States.

On behalf of the ACLI, I want to thank you for the opportunity to talk about long-term care insurance and the rate stabilization regulation recently adopted by the National Association of Insurance Commissioners (NAIC).

Before, discussing the new rate stability provisions of the NAIC Long-Term Care Insurance Model Regulation, I want to express our gratitude for the leadership role this Committee has taken in highlighting, through a series of hearings and in legislation, the significant role that private long-term care insurance protection plays in retirement security.

One of the greatest risks to asset loss in retirement is unanticipated long-term care expenses. Currently, it costs almost $16,000 annually for daily visits by a home health care aide and over $44,000 per year for nursing home care. Within the next 30 years, these expenses are projected to reach $68,000 per year for a home health care aide to $190,000 for a year of care in a nursing home. These costs can quickly erode a hard-earned retirement nest egg. Moreover, we know you are acutely aware that Medicaid will never be able to foot the bill for the millions of baby boomers who will need long-term care services in the not-so-distant future.

You and members of this Committee have supported the need to encourage the purchase of private long-term care insurance in order to meet the nation's long-term care needs without crippling taxpayers and already strained government programs.

You, Mr. Chairman, were instrumental in including the above-the-line deduction for qualified long-term care insurance in the minimum wage amendment to the Bankruptcy Reform bill, S.625, and in the Patients' Bill of Rights, S.1344. Moreover this provision has been included in two additional pieces of legislation. The Long-Term Care and Retirement Security Act of 2000, S.2225, was introduced by you and cosponsored by other members of this Committee. Most recently, you and other members of this Committee have cosponsored S. 2935, the Omnibus Long-Term Care Act of 2000.

Providing this important tax incentive means that Americans who take advantage of long-term care protection will not be a burden on the Medicaid system and will not have to spend-down their retirement assets to pay for long-term care before becoming eligible for Medicaid. Instead, they will have the choice of a variety of services if they are unable to perform a specific number of activities of daily living or are cognitively impaired. Today's long-term care insurance policies cover a wide range of services to help people live at home, participate in community life, as well as receive skilled care in a nursing home. Policies may also include respite care, medical equipment coverage, care coordination services, payment for family care givers, or coverage for home modification. These options can enable people who are chronically ill to live in the community and to retain their independence.

Like our regulators, we are committed to maintaining and justifying consumer confidence in this increasingly important protection product. We believe that, working together, the industry and its regulators have come up with a model regulation that affords maximum protection to long-term care insurance

purchasers both in terms of consumer protection and rate stability.

Consumer Protections

It can now be said that private long-term care insurance is clearly an idea whose time has come. The product is considered a valuable and meaningful tool for planning a financially secure retirement. It is also a product that is fully regulated with a substantial NAIC Model Act and Regulation which is used as an effective guidepost for states to follow and adopt. All states, including the District of Columbia, have some version of the Model enacted into their state laws and regulations. Further, the NAIC Long-Term Care Insurance Models have been revised, updated and strengthened many times since the initial Models were adopted in 1986.

The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which set certain requirements for long-term care insurance policies in order for them to be eligible for favorable tax treatment as federally qualified long-term care insurance policies, provided the initial spring board needed to encourage purchase of this product. It is important to recognize that HIPPA allows only a portion of the premiums to apply toward the 7.5 percent base for medical expense deductions currently allowed in the federal tax code.

The federal government's message through passage of this law was that individuals have to begin to take responsibility for their own retirement future and that message is now being heard throughout both the public and private sector. We firmly believe the passage of currently proposed federal legislation for an above-the-line deduction, and allowing cafeteria plans and flexible spending accounts to include long-term care insurance will help to continue to expand and build on that important message. The ACLI and its member companies are also

very proud and supportive of the major strides that have been made with long-term care insurance with respect to the strong consumer protections now in place. Over the past 15 years, the NAIC, working with consumer groups and the insurance industry, has made certain that much needed consumer protections are included in the NAIC Long-Term Care Insurance Model Act and Regulation. All long-term care policies must meet the consumer protections standards set by the state in which they are sold, and any policy purchased today that qualifies for the HIPAA federal tax incentives must meet numerous NAIC consumer protections and other standards required by this federal law.

ACLI supports the current NAIC Long-Term Care Insurance Models in total and their adoption in the states. A few examples of the consumer protections that currently exist in the model are:

(1) The offer of a nonforfeiture benefit — a policy provision that provides a paid-up benefit equal to the premiums if the policy is canceled or lapses;

(2) A contingent benefit upon lapse — a provision that requires if premiums increase to a certain level (based on a table of increases) the insured is offered (a) a reduction in the benefits provided by the contract so that premium costs remain the same, (b) a conversion of the policy to a paid-up status with a shorter benefit period, or (c) to keep the policy and pay the increase;

(3) the delivery of Long-Term Care Insurance Shopper's Guide — must be given to consumers by agents and insurers to help consumers understand long-term care insurance and decide which, if any, policy to purchase.

This guide is designed to educate consumers on how to purchase, how the policy works, and the cost and other shopping tips;

(4) An offer of inflation protection — a policy benefit provision that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services;

(5) A prohibition on limiting or excluding coverage for Alzheimer's or certain other illnesses;

(6) A prohibition on cancellation of the policy due to advancing age or deteriorating health;

(7) A prohibition on increasing premiums due to advancing age;

(8) A continuation or conversion required for individuals covered under group policies;

(9) A designated individual, other than the insured, to receive notice of policy termination due to nonpayment of a premium, and the reinstatement of the policy if there is proof of cognitive impairment or loss of functional capacity;

(10) A prohibition against post-claims underwriting;

(11) A prohibition on requiring a prior hospital stay in order to qualify for benefits;

(12) Minimum standards for home health and community care benefits; and,

(13) A 30 day free-look period.

Rate Stability

The NAIC has recently completed its work and has adopted a new and important consumer protection provision to address concerns over premium rate increases for long-term care insurance. The goal of this new provision is to increase the likelihood that premium rates offered by long-term care insurance companies will be adequate over the life of the policy, that rate increases will be less likely, that only justified increases will occur, and that necessary increases will be smaller and less frequent.

The following is a list of key provisions of new NAIC provisions on rate stability:

1. **Initial loss ratio requirements eliminated**.

   The current 60 percent loss ratio requirement on initial rate filings is eliminated. This enables companies to set more conservative initial premiums.

2. **Limits are established on expense allowances on increases**.

   All rate increases are subject to an 85 percent (70 percent for exceptional increases) loss ratio on the increase and 58 percent on the initial premium. The 58 percent allows for a more conservative initial premium and the 85 percent severely limits amounts available for commissions and profit. It provides a powerful incentive for companies to charge an adequate initial premium.

3. Unnecessary rate increases reimbursed to the policyholder.

For each rate increase, the insurer must file its subsequent experience with the commissioner and if the increase appears excessive, the commissioner may require the company to increase benefits at no further cost to the policyholder or to reduce the premiums. This makes certain that premium increases that turn out to be unnecessary are returned to policyholders.

4. Review of administration and claim practices authorized.

If the majority of policyholders subject to the increase are eligible for contingent benefit upon lapse, the company must file a plan, subject to commissioner approval, for improved administration or claims processing or demonstrate that appropriate processing is in effect. This is intended to eliminate lax administration and claims handling practices as a cause of continued rate increases. This will force companies to review claims more closely and to prevent them from paying inappropriate claims, which contribute to the need to increase premiums.

5. Option to escape rate spirals by converting to currently sold insurance provided.

Any time after the first rate increase, for other than an exceptional rate increase, if the majority of policyholders subject to the increase are eligible for contingent benefit upon lapse, and if the commissioner determines that a rising rate spiral exists, as demonstrated by a significant number of policyholders dropping their insurance, the commissioner may require the company to offer to replace existing coverage with a comparable product currently being sold without underwriting. This is a type of pooling. It

provides policyholders trapped in a rising rate spiral the opportunity to switch from the troubled policy to a more stable, current policy without the insured being subject to any underwriting.

6. **State Insurance Commissioner authorized to ban companies from the market place**.

If the Commissioner determines that a company has persistently filed inadequate initial premium rates, the State Insurance Commissioner may ban the company from marketing long-term care insurance in that for up to five years. This penalty will essentially put the company out of this business in the state. It is intended as a last resort for the Insurance Commissioner when all else fails.

7. **Actuarial certifications required**.

For all rate filings, the company is required to provide an actuarial certification that no rate increases are anticipated. Actuaries signing such certifications are subject to existing standards of professional actuarial practice. This puts the burden on the company, rather than the state, to secure actuarial certification.

8. **Disclosure of rate increase histories required**.

Companies must provide consumers with a rate increase history. This is intended to inform consumers of past company practices and to deter companies from increasing premiums.

This new measure, once adopted by states, will provide consumers the necessary peace of mind that the premium rate increase that they would pay in

the event of a rate increase, will be smaller, less frequent and more manageable. ACLI supports the NAIC's overall effort and believes consumers should be protected from unreasonable and unexpected rate increases.

ACLI acknowledges that there have been situations where rate increases have occurred and that some states did not have the proper tools to regulate and evaluate the rates. It is important to stress though that the majority of the market has not experienced rate increases on this product line. The industry has stepped up to the plate on this issue and has joined with state regulators, and consumer groups, working countless hours over the past three years to adequately and appropriately address this matter --- and trying to accomplish all of this without harming future market innovation and growth.

We recognize that the fear of rate increases has been a concern for some. It is important to remember that long-term care insurance is a guaranteed renewable product which means insurers are permitted under the contract to revise the premiums, but only if the rates are changed for the entire class of policyholders. Again, the majority of long-term care insurers have not raised the premium rates, but where rates have been increased, many of those increases have not been to an extent that should cause alarm to all consumers or regulators.

It is important to note, too, that in recent years the average termination or lapse rate for long-term care insurance by policyholders has declined. A long-term care policy lapses if the policyholder does not pay the premium by the end of a specified time, or if the policyholder replaces it with a newer product. ACLI's analysis shows that in the individual market, two percent of policyholders voluntarily lapsed or replaced their policies in 1997 versus six percent in 1992. Group terminations fell to seven percent in 1997 from eight and one-half percent in 1995. To minimize lapse rates, companies typically offer new

policyholders time to examine the policy, and the full premium is returned if the buyer decides within a specified period not to keep the policy. Since many buyers are older, many long-term care policies allow the policyholder to designate a third party for the insurer to notify when premiums are not paid. Insurers frequently reinstate coverage if the policy lapses because the policyholder has a cognitive impairment.

Though the issue of concern on premium rate increases is centered around a limited segment of the market, the insurance industry believes it had to address the concerns head on and believes we have accomplished that goal working with the NAIC. The next step is for the states to move forward and adopt the new provisions. In many cases states will have to repeal their current legislative or regulatory requirements and replace them with the new NAIC rate stability provisions. Some states will have to have new statutory authority to monitor, implement and enforce these unique new provisions and this will take enabling legislation by the state to allow the state insurance departments to move forward on them. ACLI is committed to working with the states to accomplish that goal.

A Smart and Knowledgeable Consumer

Another important part of purchasing long-term care insurance is to be a smart and knowledgeable consumer. Consumers must think through their purchase and understand what it is they are buying.

ACLI encourages consumers, when considering a major purchase of long-term care insurance, to:

(1) look for insurance companies that are reputable, consumer oriented, financially sound and licensed in their particular state,

(2) obtain the name, address and telephone number of the agent and insurance company,

(3) take time when making a purchase, ask for and read the outline of coverage of several policies,

(4) understand what the policy covers and ask questions to be clear about what the policy is not intended to cover,

(5) understand when the policy becomes effective, what triggers benefits and if it is tax deductible at the state and/or federal level,

(6) answer questions on medical history and health truthfully on the application, and,

(7) contact the State Insurance Department or the State Health Insurance Assistance Program with questions on long-term care insurance and the insurance company with specific questions about the policy.

In conclusion, we believe that protection and coverage for long-term care is critical to the economic security and peace of mind of all American families. Private long-term care insurance is an important part of the solution for tomorrow's uncertain future. As Americans enter the 21st century, living longer than ever before, their lives can be made more secure knowing that long-term care insurance can provide choices, help assure quality care, and protect their hard-earned savings and assets when they need assistance in the future. We also believe that the costs to Medicaid — and therefore to tomorrow's taxpayers — will be extraordinary as the baby boom generation ages into retirement, unless middle-income workers are encouraged to purchase private insurance

now to provide for their own eventual long-term care needs. ACLI believes it is essential that Americans be given an above-the line deduction for this product that is so vital for their retirement security.

While the financial benefits to individual policyholders are obvious, the benefits to government - and future taxpayers - of wider purchase of private long-term care insurance are substantial as illustrated by a new ACLI study *Can Aging Baby Boomers avoid the Nursing Home?* Medicaid's annual nursing home expenditures are projected to skyrocket from today's $29 billion to $134 billion by 2030 - an increase of 360 percent. ACLI's research indicates that by paying policyholders' nursing home costs - and by keeping policyholders out of nursing homes by paying for home- and community-based services, private long-term care insurance could reduce Medicaid's institutional care expenditures by $40 billion a year, or about 30 percent.

In addition, the ACLI study found that wider purchase of long-term care insurance could increase general tax revenues by $8 billion per year, because of the number of family caregivers who would remain at work. Today, 31 percent of caregivers quit work to care for an older person; nearly two-thirds have to cut back their work schedules; more than a quarter take leaves of absence, and 10 percent turn down promotions because of their caregiving responsibilities. It costs the typical working caregiver about $109 per day in lost wages and health benefits to provide full-time care at home - which is almost as much as the cost of nursing home care. I have brought copies of the study and have placed them on the table with my testimony.

Thank you Mr Chairman, and again, we look forward to working with you. I will be happy to answer any question that the Committee may have at this time.

The CHAIRMAN. Thank you very much.

I am going to start with Mr. Kanner. What understanding did your clients have about the potential for rate increases at the time they started shopping for their policies? Did they ask questions about rate increases that you might know about, or that you might know that they didn't ask about? Did they communicate about how much they could afford to pay in premiums?

Mr. KANNER. Excellent questions. For the most part, the brochures that were being used at that point in time did not talk about rate increases. They talked about guaranteed renewability. Most of my clients did not have express discussions with agents about affordability. Most of these people are from small towns. They have known their agents their whole lives. They write all their policies. There aren't a lot of secrets.

I think the assumption that client after client has said to me is, I assume this is going to work pretty much like other insurance. And a lot of these brochures say we can't raise the rate because you get older, we can't raise the rates because you get sicker, we can't raise the rates because you make claims. These are the kinds of things in most people's minds that lead to rate increases.

So I have heard lots of different stories from different people, but I think that there is a certain trust that the insurance industry brings to the table. People feel that if it is an insurance product that there is a shifting of risk that is occurring, that I am giving you money because you are an expert to manage my risk for me and you can make a profit on that.

I think there is that trust element, and I think a lot of people go into these purchases without asking many questions. That is why I think that some of the consumer protection solutions about let's try to educate people a little bit more—I think the little bit of a problem with that is maybe you should make the company ask the question, how much can you afford.

The CHAIRMAN. Getting back to your term that you used about guaranteed renewable for life, it is my understanding from your testimony that this feature did not protect the Hanson plaintiffs from experiencing such extreme premium increases that their policies became unaffordable and impossible to maintain.

Can you elaborate on the relationship between premiums and the term "guaranteed renewable" feature? Did your clients understand the limitations of the consumer protection that we refer to as guaranteed renewable?

Mr. KANNER. No, they really didn't. What is sort of interesting to me is in the course of discovery—you know, you get a chance to ask questions of the other side, and I asked, have you done any studies on how the average person reads these policies or these brochures? And except for very minimal readability standards, they have no data on how the consumer understands this, and I think that is a problem area.

The average client that I have understood guaranteed renewable as being something they could have for the rest of their life. I think they just assumed—and maybe they were wrong to assume it—I think they just assumed it would remain affordable and that the premiums wouldn't go up that much.

The CHAIRMAN. How about these policyholders who paid more than they would have ever gotten out of the policy? How was it that these policyholders didn't have the information upon the purchase of a policy that these things could happen?

Mr. KANNER. I don't know if you have ever bought one of these policies, Senator. You basically get a brochure that outlines some of the coverage points, and when you buy the policy in the brochure there is a statement that says you won't get more than $75,000, say, total, out of the policy. Then you start paying, and 5, 6, 7, 8 years later you are in it $70,000, you are in it $75,000, you are in it $80,000. What are you supposed to do? You have got to keep paying or you are going to lose it all.

I think that because it is a new product, there is very little consumer understanding. And I think that people tend to trust insurance companies, tend to trust their agents. And we have had these lawsuits all over the United States and we have had increases of 900 percent, 700 percent, in premiums. People are entitled to be protected in their reasonable expectations, but that may not help you in your job of trying to get more people interested in these products.

I mean, one of the things I really regret is that these horror stories of the Harold Hansons may discourage people from buying long-term care, and I think it is important that people do provide for their long-term needs. And I think it is important to be able to get some system where people feel that there is an ironclad protection that they are going to get their money that they responsibly invest for their long-term care needs. We just don't have that now.

I wish people asked better questions, but it is a new product and there is that trust thing with insurance companies. I think insurance companies want you to trust them, want you to believe that they can manage your risk. Unfortunately, there really isn't the data or the underwriting in some of these situations to guarantee that the policy will stay stable. I think you can do stable policies. I think a number of companies have done stable policies by careful underwriting and careful use of their data.

The CHAIRMAN. That was my next question. Is there anything more you can give us about how those companies were able to have a stable policy?

Mr. KANNER. Yes. I think that when a lot of this started in the early 1980's, a couple of companies—I think a lot of the credit goes to American Express, General Electric Company. I am not endorsing anybody and I don't know all of their different subsidiaries, but a lot of those companies decided, because there was limited data, they would grow the product slowly. And rather than making a kind of a land rush to run out there and sell as many policies as possible, they sold them in a controlled fashion.

They never said to anybody, we are not going to raise premiums. That was a decision they made internally. And I know there are some policies with General Electric that go back to the late 1970's that have never had a rate increase because the company says, OK, if we make mistakes, we will absorb it, we can kick more money in or we can put some of our capital in and keep paying claims because we are getting something of tremendous value.

You know, they have got the data now that they can write better policies. Their experience data is very valuable to them. It is proprietary. Like a drug company, they spent a little bit extra in research and development, they took some losses, and they have something of value. Not all companies did that. Unfortunately, not all companies share that data.

What is a little surprising is that there is no generally accepted pool of actuarial data that everybody is sharing right now. From talking to actuaries, my understanding is that is one of the problem areas. But I do commend the companies who have been selling these good policies, and I think that they are well positioned with this tax deduction to do a great job. Unfortunately, some of the loopholes for the other companies aren't really being closed, and that concerns me.

The CHAIRMAN. Mr. Kahn and Mr. Martin, what is your trade association's role in the policymaking process conducted by the NAIC, and does your organization support all or part of the recently approved National Association of Insurance Commissioners model regulations for rate stability and disclosure?

Mr. KAHN. We have been active participants in the development of the model, and I believe that the model responds to a number of the issues that Mr. Kanner raised. And we would like to see the model passed in every State. Some aspects of the model could be included in Federal legislation, if the Congress so chooses.

The CHAIRMAN. Did you want to comment on that?

Mr. MARTIN. Thank you, Mr. Chairman. Certainly, from ACLI's perspective, I would agree with Mr. Kahn that our objective has been to raise the bar that insurers must adhere to. And I think you will find in the new NAIC regulation that there is a bit of pain that is imposed on the companies, and I think rightly so.

We were in a meeting this past weekend in Dallas that Commissioner Sebelius talked about that was a primer on this whole new provision. And there is an escalating punishment that applies to companies that repeatedly do not do their tasks appropriately. And I think this is one of those occasions when certainly as a representative of both John Hancock and the ACLI—and I know the other companies that worked on this, too, with the consumer groups and the NAIC—it was a very good feeling, that this is a well-crafted, effective piece of legislation.

The CHAIRMAN. Then the natural follow-up would be you have this involvement; the organization has issued model regulations. Would your associations at the State level be active in helping to get States to adopt these?

Mr. KAHN. Yes. As I said, we feel very strongly that the States ought to adopt them.

The CHAIRMAN. But I mean would you lobby the—not you personally or maybe at the national level, but is it just natural for your organization to follow through and do what you can to see that the States actually adopt them as opposed to the fact that you are urging them to adopt them?

Mr. KAHN. The HIAA represents its companies in every State in the Union, so we are very active in every State house across the country. So this is going to be one of our priorities over the next year or so to get these standards put in place because we want the

industry to meet the kind of standard that was described by Mr. Martin.

The CHAIRMAN. OK, and maybe your answer is the same.

Mr. MARTIN. Yes, I would concur. We would certainly testify in favor of its adoption.

The CHAIRMAN. Then for Mr. Kahn or Mr. Martin, would you comment on Mr. Kanner's assertion that adequate actuarial data does not exist within the long-term care industry, and therefore such rating practices based on actuarial data are experimental to some degree?

Mr. KAHN. I think that may have been the case in the deep history, but today I think today actuarial data exists that has been produced by studies that our association has done over the years. The actuarial groups and others have produced a wealth of data that can be used by actuaries to make reasonable assumptions about the costs. So I think we are at a point today where you are going to get good rates set because the companies are going to know what they are likely to face.

Mr. MARTIN. I would add that the fact that the vast majority of companies and insureds have not had rate increases or been exposed to them would be evidence that there is much better experience on this, and that the objective of stable rates over time is clearly what the good companies writing this business want.

The CHAIRMAN. When it comes to these very extreme rate increases, does it happen because of poor underwriting or dishonest practices, or neither, or for some other reason?

Mr. MARTIN. I think a number of reasons that were touched on when you were talking to Commissioner Sebelius, but certainly the practice of low-balling where initial rates were not adequate. So experience, no matter how favorable, could not bail out those particular policies.

And I think if you look at claims administration, if there is a laxness, if underwriting is not properly done, too many people getting in—I think HIPAA has done a really fine job of setting a standard so that you don't have policies that are too liberal. Too many people go into claims and then the pools will be unstable. So there are a number of factors that cause it to happen.

The CHAIRMAN. In regard to the proposals from the insurance commissioner organization, is there any one of the proposals that is more important, in your view, than others?

Mr. KAHN. I think it is a package, so you have got to deal with the benefit structure, the future, the disclosure, and rates which are dealt with in the package. Really, Mr. Kanner presented a set of issues, and I think that package responds to all the issues.

The CHAIRMAN. Then from the standpoint of just the consumer benefit and the consumer protection, assuming that the States adopt these proposals for rate stability and disclosure, what would be the effect of this on the people who buy policies that reflect the proposed practices, in other words in those States that would adopt them?

Mr. KAHN. Well, I think, first, the issue of consumer knowledge both in terms of measuring their own ability to pay the premium, whether this is a benefit they really want to have, I think that will be clearer to them. And, second, I think they can be confident that

they are going to have either a stable rate or a rate that if they need help over time adjusting to, they will have some contingencies.

The CHAIRMAN. From your perspective, a question I asked the first panel, the track record of States adopting model State regulations for insurance.

Mr. KAHN. Well, I think it has been excellent from my experience in long-term care. I know as far as HIPAA is concerned, in the individual market, there are only four States that haven't done it. And in those States, I am not confident HCFA has done a great job of regulating. So I am not sure you can take much solace in a Federal fall-back. So my answer is whether it is the Medicare Supplemental area, long-term care or individual market under HIPAA, the States have responded to their responsibilities quite well.

The CHAIRMAN. Either one of you, would you expect this to be done in a relatively timely manner? I am not sure what that means, but from my standpoint what it might take in previous attempts by the National Association of Insurance Commissioners to get regulations adopted.

Mr. MARTIN. I am not sure what the exact time period would be, but I can tell you as this issue has moved over the last year at the NAIC, there has been full determination to bring this to resolution, to have it be effective. And certainly just from this past meeting in Dallas, the quarterly meeting of the NAIC, and the way this was presented to the regulators as well as the industry and consumer groups, I think this is much higher on the radar screen than other issues that we have dealt with.

When I look back to HIPAA, there were a number of us who worked with the NAIC and consumer groups to go out to those States, to work with those States to get them to bring their statutes or regulations in line with HIPAA so that tax-qualified policies could be issued. So I think you are going to see that there will be an even more accelerated determination of that here. So I would think it would be a shorter period of time, not a longer one.

Mr. KAHN. I think the bigger issue will be the cycle of legislative sessions which sometimes come every 2 years. You don't have consistency across the country in terms of legislative sessions that can take this up within the next few months of next year.

The CHAIRMAN. If all three of you or any one of you would like to comment on what Commissioner Sebelius said about the term "level premiums" and that this has caused confusion, would there be a comment you could make on that, whether or not you have agreement with that or disagreement?

Mr. MARTIN. I would agree with her comments. You know, we have a definition of guaranteed renewable that is in State codes, and I think it has been a source of some confusion, and I think as we have seen by some of the comments that Mr. Kanner mentioned, some misrepresentation.

We support the idea of not using the term "level premium," that there would be clear disclosure that the policy someone is buying can have the rates increased. But at the same time, if I were a consumer, I would rather buy under this new regulation where I know there are limits and that there are penalties imposed on the company.

Mr. KAHN. I think that is why the new regulation is important, is because the regulation deals with this important issue, one that must be addressed for the consumer's protection.

Mr. KANNER. I think the bigger problem has not been the misrepresentation of "level premium," though that has occurred in some cases. I think it is more what I call the omissions, the other information that people aren't getting when they are making this very important decision.

The CHAIRMAN. I thank you all very much.

In the way of summarizing here, some people might be interested in what our next steps are. We obviously would like to have an opportunity to get the legislation that Mr. Kahn talked about passed yet this year. It does have White House support. It has bipartisan interest in the Senate and House, and so obviously I think with all that there is some chance it could be on the agenda before the end of the year.

I would also want to follow up, as I suggested with the first panel, on exactly the extent to which we would legislate or not legislate at the Federal level. As I indicated, the NAIC would like to work with us. Any of you other interested stakeholders who would like to work with us on that issue, I would be glad to have that done. In fact, I want to encourage that sort of comment.

The bottom line of it is that we want to move forward with a public-private partnership here between Medicaid-Medicare, and private insurance, and the two being separate obviously, but to encourage the sort of product that will give quality of care here in people's retirement, and particularly in very late years of retirement when people need more help. That is our goal, that is where we are headed, and I think each of you have contributed well to that, as our first panel did, understanding where we are and where we need to go.

I should give a compliment to those who have acted very responsibly in the private sector through the insurance companies and salespeople for helping us develop product—or I shouldn't say helping us. They have developed products on their own. We have given some incentive at the Federal level, not enough incentive. We want to give more incentive because this is very important that we have alternatives to Federal programs that sometimes have too many people falling through the cracks or do not provide the quality of care that people would anticipate.

So thank you all very much.

[Whereupon, at 12:41 p.m. the committee was adjourned.]

APPENDIX

Statement for the Record

on

"Long Term Care Insurance: Protecting Consumers from Hidden Rate Hikes"

Submitted to the
Senate Special Committee on Aging

by

William Abrams

Chief Operating Officer

of the American Health Care Association

September 13, 2000

I want to commend Senator Grassley and each member of the Senate Special Committee on Aging for the opportunity to submit testimony for the record at the hearing on "Long Term Care Insurance: Protecting Consumers from Hidden Rate Hikes."

My name is William Abrams. I am the Chief Operating Officer of the American Health Care Association (AHCA), which is a federation of affiliated associations representing more than 12,000 non-profit and for-profit assisted living, nursing facility and subacute care providers, nationwide.

Senator Grassley, I want to thank you and your Committee for the interest and attention you have devoted to the issue of long term care financing and the role that private long term care insurance has and will continue to play in the provision of care. We are delighted you have chosen to hold this hearing because its outcome will serve to renew consumer, state regulator and lawmaker confidence in these important products.

Let me also say that we support the insurance industry position that the proper regulation of insurance companies resides with the states rather then with the federal government.

The professional caregivers, who make up AHCA's membership, strongly support state and Congressional actions that create a strong individual and employer-based long term care insurance market – actions that:

- raise public awareness on the shortcomings of our nation's current "welfare-based" long term care financing system and the need for individuals and families to actively take responsibility for their own long term care planning;
- enhance individual access to quality and affordable long term care insurance that covers the widest possible range of long term care services; and,
- provide the economic incentives to encourage and enable Americans, at all income levels, to purchase and maintain long term care insurance policies.

Such actions are key ingredients of a more comprehensive financing reform strategy that is needed if this nation is to meet the growing long term care needs of its citizens in the new century.

This Committee is well aware of the challenge our nation faces in providing and paying for its growing long term care needs. Over the next fifty years, demographic forces alone will seriously threaten the viability of the current long term care financing system.

The aging of the baby boom generation and longer life-spans will contribute to an increase in the size of the elderly population, both in absolute and relative terms. In absolute terms, growth of the elderly will generate explosive demand for long term care services. Growth of the elderly population relative to the working population makes financing these additional long term care services a serious problem. Simply stated, the need for long term care in the future, will exceed government's ability to pay for it. As a

result, expansion of private long term care insurance offers the most promising way to improve our nation's long term care financing system.

The current system for financing long term care consists of an unstable patchwork of federal and state programs with minimal private insurance-based participation. Today estimates vary, but it can be said that long term care insurance pays approximately five percent of our nation's long term care bill.

Many in Congress have grown to understand that the solution to this long term care financing crisis lies in a public/private partnership solution with a balance between the two roles yet to be formally defined.

AHCA believes that Congressional action leading to an expansion of the long term care insurance market will allow for more targeted spending by the government for those with greatest need.

An important question to be asked is why, given the enactment of the tax incentives and consumer protections offered with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), hasn't the public part of this equation been stronger. It is our belief that the incentives contained in HIPPA, didn't go far enough to attract real public attention and motivate action. Today, just as before HIPPA was enacted, most Americans fail to understand the financial risk they face in someday needing long term care. They do not understand how long term care is paid for. Few are aware of the options available to them to finance long term care . They are unaware of the value that long term care insurance offers in terms of paying the bills and in protecting hard earned savings and assets that have been accumulated during a lifetime. As a result, a majority of Americans are not motivated to action and are not preparing for the potential of needing long term care.

The proper role of the federal government should be to provide the education and the incentives to motivate action on the part of the public.

There may be another answer to this question that could be a stimulus to further steps being taken by both Congress and the insurance industry.

While many in Congress recognize the key role long term care insurance will play in helping the nation meet the long term care financing challenge of the future, additional incentives have been slow in coming.

However, Senator Grassley, you deserve high praise for the leadership you have provided in advancing legislation designed to meet that challenge. Your bill to provide an "above-the-line" tax deduction for long term care insurance premiums has found growing bipartisan interest and support. In these few final days of this session, it is our hope that there will be sufficient time for Congress to pass your bill.

AHCA strongly supports an "above-the-line" tax deduction because it would go a long way toward making long term care insurance more affordable. Insurance industry research has found that a 100 percent "above-the-line" federal income tax deduction for insurance premiums would provide savings to both consumers and government as well as expand the market penetration of long term care insurance. This industry research found that the savings to the Medicaid program would far exceed the loss of revenue to the U.S. Treasury.

Today, almost 80 percent of the long term care policies are sold in the individual market. The average buyer is approximately age 67. These policies are purchased directly from the insurance company and not through an employer. These policies can be expensive because of higher administrative costs resulting from marketing, enrollment, and agent commissions. There is also the disadvantage of adverse risk selection.

An impact of the "above-the-line" deduction would increase market penetration and expand risk pools. We believe this impact will serve to stabilize and reduce individual premium costs and make affordable long term care insurance available to more Americans. A "refundable tax credit", which AHCA prefers, would have the same positive impacts plus one more critically important one. A "refundable tax credit" would benefit consumers at all income levels and, if properly targeted, it would provide the greatest help to those most in need of assistance.

We further believe that the costs of individual insurance could be reduced through the offering of creative new insurance products that would appeal to a broad number of younger investment-oriented consumers. Such products would be "annuity- or equity-based", meaning that they would retain value and provide a return should an individual buyer not require long term care services. Like other long term care insurance products, these policies would offer asset protection and allow consumers to select from a full range of appropriate long term care services including home and community-based care programs, assisted living, and nursing home care, etc.

Logic dictates that such an "annuity- or equity-based" product would find strong acceptance in the growing employer-based group market where the average buyer is age 47. Group market premium costs are lower today because, in part, buyers are younger and the pool widens to include lower-risk individuals. Administrative costs tend to be less, and groups have better leverage when negotiating premium costs. While initial "annuity- or equity-based" product offerings have been only modestly received, we believe that with increased public education and increased tax incentives they will become more viable products.

Congress is to be congratulated for its successful efforts to expand the group market this year by passing legislation that will give the Federal family an opportunity to purchase long term care insurance through the Federal Employee Health Benefit Program at an estimated savings of 15 to 20 percent below market. When enacted by the President, this federal offering will serve as a strong model that private employers can follow.

AHCA and the long term care professionals it represents strongly support an enhanced long term care insurance market because:

– Expansion is necessary to ensure the future provision of quality long term care when the current financing system fails to meet the growing needs of the aging baby boom population.
– Expansion is needed to eliminate the perverse "spend down" requirements, the hardship and stigma individuals face when qualifying for Medicaid long term care services.
– Expansion of long term care insurance will provide for a more equitable allocation of public and private resources for long term care in the future.

Chairman Grassley, I want to thank you and members of your committee for allowing me to submit our comments for the record. We are anxious to work with you to advance legislation that will ensure that this nation can continue to provide the quality long term care services our nations elderly and disabled so rightly deserve.

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