U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE FEDERAL ROLE IN CONSUMER PROTECTION AND REGULATION OF LONG-TERM CARE INSURANCE

June 1991

Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under contract between HHS's Office of Family, Community and Long-Term Care Policy (now DALTCP) and Lewin/ICF. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

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PREFACE

In November 1990, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) assembled a panel of experts of varying backgrounds to discuss the potential goals and roles of the federal government in the long term care insurance market. The panel included representatives from the insurance industry, consumer groups, the National Association of Insurance Commissioners (NAIC), the Health Insurance of America (HIAA), and government, as well as persons with expert knowledge of long term care insurance, The participants included the following:

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This paper was prepared by Lisa Alecxih and Dave Kennell of Lewin/ICF. The paper which follows was originally the background piece to stimulate discussion among the participants and has since been revised to reflect input from members of the panel and the conclusions of the group, as well as more recent available data.

This report was developed in conjunction with a study of long term care financing reform conducted by the Office of the Assistant Secretary for Planning and Evaluation. Other reports also developed during the course of the study include:

- access to nursing home care
- Medicaid spenddown
- the combined burden of acute and long term care expenses

Copies of the reports may be obtained by writing to:

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EXECUTIVE SUMMARY

Background

The risks of needing long term care are significant: nearly one- third of all persons who turned age 65 in 1990 will spend at least three months in a nursing home before they die, and over 20 percent will spend one year or longer in a nursing home.[1] At an annual cost of $30,000, a year in a nursing home can be a catastrophic expense.

Long term care insurance provides the elderly with an opportunity to reduce the risk of the potentially catastrophic costs of long term care. It reduces the risk by spreading the costs of long term care among all purchasers of insurance. Spreading the costs of long term care across all insurance purchasers reduces the financial risk of long term care to any single individual. As a result, the well being of both purchasers who incur the risk and those who do not incur the risk is increased. Purchasers who incur long term care costs pay less than they would have because they have insurance. The well being of purchasers who do not incur the risk is also increased because they know that if the risk does occur they will be protected by insurance.

There is a sharp contrast between the elderly's lack of insurance for long term care and their protection against the risks of acute care. As of the end of 1990, over 1.9 million long term care insurance policies had been purchased.[2] Although analysts estimate that between 10 and 40 percent of the elderly could afford to purchase long term care insurance, less than five percent have done so. In contrast, almost all elderly persons are protected from high acute care costs by Medicare insurance and most elderly have private Medigap insurance.

Barriers to Insurance Coverage

Both supply and demand barriers help explain the disparity between the number of persons who could afford long term care insurance and the number who have actually purchased it. Key factors limiting consumer demand for long term care insurance include (see Figure 1):

- **Lack of Information** -- Many elderly underestimate the likelihood of requiring long term care services and the potential cost of those services.

- **Misperception of Public and Private Programs** -- Many people believe that the Medicare program covers long term care services, when in fact Medicare

[1] Lewin/ICF estimate from the Brookings/ICF Long Term Care Financing Model 1990 and Peter Kemper and Christopher Murtaugh, "Lifetime Use of Nursing Home Care," The New England Journal of Medicine, Vol. 324, No. 9, 1991.
[2] Health Insurance Association of America (HIAA). News Release, May 30, 1991.

accounts for less than two percent of nursing home expenditures. There is also a misperception that retiree health plans or Medicare supplemental insurance covers long term care services.

- **Delayed Preparation for/Denial of Long Term Care Needs** -- Many persons do not think about preparing for long term care needs until they are too old or disabled to purchase insurance.

- **Complexity of Product and Lack of Standard Terminology** -- Long term care insurance is a complex product that is rapidly changing as it matures. Due to this evolution of the product and the absence of standard terms it is often unclear how a particular product compares to other products.

- **Uncertainty Concerning the Value of Products** -- Some consumers are reluctant to purchase long term care insurance because they are not sure if the products will cover the types of care they may need in the future. In addition, a general misunderstanding and mistrust toward all insurance products inhibits demand.

- **Lack of Clarity of Benefit Triggers/Premium Increase Provisions** - - Many policies contain vague language that make the circumstances under which benefits will be paid unclear, as well as when and how much premiums may increase over time.

- **Consumer Confusion/Dissatisfaction** -- Consumer confusion and dissatisfaction caused by misperceptions, the complexity of the product, rapidly changing product lines, unclear benefit triggers, and uncertainty concerning the value of the product, increases indecision among those considering long term care insurance and also increases the likelihood that purchase decisions will be delayed in order to wait for future products to be developed.

- **Long Lag Time Between Purchase and Benefit Payment** -- The substantial amount of time between the purchase of long term care insurance and when benefits are likely to be paid means that consumers may want to spend their current dollars on items with a more rapid benefit, such as Medigap policies.

- **Misleading Marketing Practices** -- Consumers have reported problems with the marketing, sale, and payment of benefits of long term care insurance. Misleading and fraudulent marketing practices, denial of claims, premium increases, and policy cancellations by a few insurance companies have resulted in some long term care insurance purchasers failing to receive benefits.

- **Affordability** -- Many of today's elderly have low incomes and therefore cannot afford long term care insurance premiums that average almost $100 per month at age 65. However, most elderly do spend comparable amounts on Medigap insurance.

- **Perception of Need** -- Some consumers with adequate information and without confusion decide they do not need long term care insurance because they have too few assets to protect or have family and friends available to provide care.

FIGURE 1. Barriers to the Growth of Long Term Care Insurance Purchase	
Consumer Demand Barriers	**Supply Barriers**
• Lack of information • Misperceptions of public/private programs • Delayed preparation for/denial of long term care needs • Product complexity and lack of standard terminology • Uncertain value of products • Lack of clarity of benefit triggers/premium increase provisions • Consumer confusion/dissatisfaction • Long lag time between purchase and benefit payment • Misleading marketing practices • Affordability • Perception of Need	• Lack of data for pricing the risk • Uncertainty of tax status • Lack of interest from large group markets • Inconsistent/inappropriate and rapidly changing regulatory standards

On the supply side, the following factors constrict the number of long term care insurance policies available on the market:

- **Lack of Interest from Large Group Markets** - Unlike most major health/life products sold, long term care insurance has yet to capture the interest of many large group markets. These large markets would allow insurers to spread risks and reduce advertising and overhead costs.

- **Lack of Data** -- Most insurers do not have the claims experience necessary to confidently price long term care insurance, which leads to coverage limitations and conservative pricing.

- **Uncertainty of Tax Status** -- The uncertain tax status of benefit payments and premiums has inhibited the marketing of long term care insurance products.

- **Inconsistent/Inappropriate and Rapidly Changing Regulatory Standards** -- Regulatory standards vary across states, and insurers must tailor their products to the regulatory provisions of each state. With the many changes in regulatory standards in the past five years, insurers' cost of developing products has increased. Also, some regulation modeled after Medicare supplemental policies regulation may be inappropriate for long term care insurance.

Current Regulation

In order to address the barriers to demand, some states have undertaken consumer education efforts to address the lack of information on the risk of using long term care and the misperception of public programs. Some have also instituted counseling programs to reduce consumer confusion.

Most states have concentrated their efforts on regulation of long term care insurance products. Virtually all states have regulations against fraudulent and misleading marketing practices, guidelines for standardized language to reduce confusion, and reporting requirements for determining the equitability of premiums. In addition to these standards, every state has an insurance department that enforces these regulations.

Some argue that current regulation and consumer education efforts related to long term care insurance do not adequately protect consumers. Others contend that once the market matures and a large proportion of states institute the National Association of Insurance Commissioners (NAIC) model standards (which are discussed in this report) that many of the current problems will be addressed.

Potential Government Role

Given the state role, what role, if any, should the federal government play in consumer protection and the regulation of long term care insurance? How should the federal government address the supply and demand barriers to the purchase of long term care insurance? By reducing or eliminating barriers to the long term care insurance market, the federal government could contribute to increasing the economic security of those who purchase long term care insurance and, to some extent, reduce public expenditures for long term care in the long run.

There are at least four major goals the federal government might pursue if the current regulatory and incentive structures are judged inadequate. These four goals, and possible courses of action, for the federal government in the long term care insurance market are described below (see Figure 2).

Increase Consumer Awareness -- By increasing consumer awareness regarding the risk of long term care use, the lack of third party coverage for the costs of such care and the availability of mechanisms, such as long term care insurance, to cover the cost of such care, the government could assist individuals to reach more informed decisions about how to plan for their future long term care needs. Increased consumer awareness would address the lack of information, misperception of public and private programs, delayed preparation for and denial of long term care needs, and some of the confusion experienced by consumers when considering long term care insurance purchase. The federal government could increase consumer awareness through:

- Information provided through current consumer education programs (e.g., by funding state counseling programs and/or disseminating information through Area Agencies on Aging);

- Expanded beneficiary assistance programs and new information campaigns; and/or

- Nominal tax subsidies for the purchase of long term care insurance that would help educate consumers as well as reduce the after-tax cost of insurance.

Increase Insurance Coverage -- Similar to the consensus developing concerning health insurance, the government may determine that Americans should have protection against the cost of long term care services and that the best mechanism for ensuring that protection is long term care insurance. Establishing a goal of increased long term care insurance purchase implies efforts to eliminate most of the barriers to the growth of the market discussed above. If the government determines that the purchase of long term care insurance by Americans is desirable, the federal government could increase the number of individuals who purchase long term care insurance by:

- Increasing consumer confidence in the market through mandated and/or encouraged requirements for policies;

- Assisting states in enforcement of regulations, data collection, monitoring, and consumer education efforts;

- Assisting insurers by providing a reinsurance pool (a mechanism to protect any one insurer from unusually high claims) or data;

- Launching a consumer education campaign; and/or

- Clarifying the federal tax code that applies to long term care insurance and/or offering tax subsidies for the purchase of long term care insurance.

FIGURE 2. Potential Government Goals and Roles for the Long Term Care Insurance Market						
Goals	**Roles**					
	No Federal Intervention	**Mandated/ Encouraged Requirements**	**Assistance to States**	**Assistance to Insurers**	**Consumer Education**	**Tax Clarification/ Changes**
Increase Consumer Coverage	X		X		X	X
Increase Insurance Coverage		X	X	X	X	X
Protect Consumers						
• Financially Strong Insurers		X	X	X		
• Payment of Benefits		X	X			
• Consistent Enforcement		X	X			
• "High Quality" Products		X				
• Informed Consumerss					X	
Consistent Regulations		X				

Protect Consumers -- By protecting consumers who purchase long term care insurance, the government could reduce many consumer demand barriers and increase the confidence level of prospective purchasers. The government could protect consumers by ensuring:

- **The Financial Strength of Insurers** -- Many experts recommend that one of the foremost factors to consider when purchasing long term care insurance is the financial status of the insurer. Financially strong insurers are more likely to be able to pay future product benefits. The federal government could ensure that insurers are financially strong through: 1) additional and uniform mandated and/or encouraged solvency requirements for insurers; 2) assistance to states in enforcement of regulations and technical expertise; and/or 3) assistance for, insurers by providing a reinsurance pool to reduce the risk of offering products and product features where there is little known about the risk.

- **Benefit Payments** -- One concern of consumers is that insurers may not provide promised benefits. The federal government could ensure the payment of benefits through: 1) efforts to maintain the solvency of insurers through reporting requirements or other regulations, 2) mandated and/or encouraged requirements, such as loss ratios; and/or 3) assistance to states in preventing fraud, particularly in the enforcement of regulations.

- **Consistent Enforcement** -- Consistent enforcement of regulations in all states would guarantee all purchasers of long term care insurance a minimum level of protection, possibly increasing consumer confidence and minimizing abuses. The government could ensure consistent enforcement of regulations for long term

care insurance through: 1) federally mandated and/or encouraged requirements to which states must adhere; and/or 2) assistance to states through funding or technical expertise.

- **The Sale of Only "High Quality" Products** -- By guaranteeing that only "high quality" long term care insurance products are marketed by insurers the federal government could protect consumers. This could be accomplished by requiring that long term care insurance products meet rigorous minimum standards or by providing a government seal of approval for those products that meet certain standards.

- **Informed Consumers** -- Informed consumers are more likely to be able to make decisions concerning long term care insurance products that are in their best interest, as well as recognize misleading or inappropriate marketing practices.

Establish Consistent Regulations - Consistent regulatory requirements in all states would assist insurers in the marketing and development of long term care insurance products, as well as serve to increase insurance coverage and protect consumers. The government could establish consistent regulation for long term care insurance through federally mandated requirements or by encouraging states to adopt minimum standards similar to the approach used for Medicare supplemental insurance.

These goals and their corresponding roles are not necessarily mutually exclusive. However, some goals are conflicting. For example, if the goal of protecting consumers by ensuring that only "high quality" products are sold were adopted, increasing insurance purchase may be difficult because the products are likely to become more expensive as a result of these regulatory requirements. Also, some of the roles may bring about unwanted consequences. For example, establishing minimum regulatory requirements to boost consumer confidence and in turn increase insurance purchase could also have the effect of stifling product innovation and make premiums unaffordable for many. Any contemplated federal role must have goals and intentions weighed against likely outcomes and adverse consequences.

INTRODUCTION

Long term care insurance provides the elderly with the opportunity to spread the potentially high costs of using long term care services among all purchasers of the product. Long term care insurance is a relatively new product and is therefore subject to a number of barriers to its growth. This discussion paper explores current regulatory mechanisms to protect consumers, addresses barriers to the growth of the market, and provides a more detailed discussion of the potential goals and roles the federal government may wish to pursue in the long term care insurance market.

I. CURRENT REGULATION

Prior to discussing the potential roles the federal government may wish to pursue in the long term care insurance market, it is important to understand the current system of government regulation in order to make a determination as to whether the current system should change. Current long term care insurance regulation includes state regulatory efforts and model standards adopted by the National Association of Insurance Commissioners (NAIC).[3]

A. Regulation of Private Long Term Care Insurance

Like other insurance products, states are responsible for the regulation and monitoring of long term care insurance. There are three primary areas of state regulation:

- Prior approval of policies generally based on a review of policy readability, standardization of policy terms, and minimum benefit requirements;
- Monitoring marketing and business practices to protect consumers from unfair or deceptive acts under unfair trade practice regulations; and
- Premium rate review/control and efforts to ensure solvency of companies selling policies.

State legislatures have great leeway in instituting minimum standards for benefits, financial reserves, solvency, loss ratios, and cancellation of policies, and in instituting other forms of regulation of long term care insurance products. Because it is a relatively new form of insurance, there is little uniformity in the regulation of long term care insurance across states. Insurers, therefore, must tailor their individual products to the regulatory provisions of each state.

Most states have based their regulation of long term care insurance on model standards developed by the NAIC. In 1986, the initial model act, developed by the NAIC in conjunction with the Department of Health and Human Services (DHHS) and consumer and insurance representatives, was endorsed by the NAIC. A model regulation followed a year later. The model act generally outlines recommended minimum requirements for long term care insurance in legislative language. The model regulation provides more specificity to implement the model act. For example, the model act requires that an outline of coverage in a standard format with basic descriptions and

[3] Long term care insurance is defined by the NAIC as any insurance policy or rider which provides coverage for not less than twelve consecutive months 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.

exclusions be delivered to all prospective applicants. The model regulation actually prescribes a standard format and content of the outline of coverage, including specific wording and presentation instructions.

The NAIC has attempted to balance the need for strong consumer protection with the need for innovation and flexibility in the development of a new product.[4] The Model Act's stated purpose is:

> .. to promote the public interest, to promote the availability of long term care insurance policies, to protect applicants for long term care insurance...from unfair or deceptive 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.[5]

The NAIC has reviewed the model act and regulation every six months (although it is not required to), and several versions have subsequently been issued. States do not necessarily amend their regulations as often as the NAIC updates the model act because state adherence to NAIC model legislation is voluntary. Also, some states only partially adopt the NAIC guidelines. Therefore, even in states that have adopted "the NAIC model act," the standards in place may differ from the most recent NAIC model act (December 1990).

B. NAIC Model Standards

Figure 3 summarizes the major provisions of the NAIC model act and regulation and when each provision was instituted. The NAIC Standards currently contain the following protections as of December 1990:

Prior Approval of Policies

- Preexisting condition exclusion periods of longer than six months are prohibited. Also, in issuing replacement policies for similar benefits preexisting conditions are prohibited.

- Policies may not exclude or limit benefits for persons with Alzheimer's Disease (model regulation only).

- Policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

[4] Earl Pomeroy (President of the National Association of Insurance Commissioners). Testimony before the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives, May 2, 1990.
[5] Long Term Care Insurance Model Act, Model Laws, Regulations and Guidelines, Vol. I, No. 132.

- Policies may not make nursing home or home care benefits contingent on a prior hospital stay.

- Conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care ("step-down") is prohibited.

- Minimum standards for home health care benefits are prescribed if a policy provides home health care services (home health care services are distinct from post-confinement home health benefits), including prohibitions against tying benefits for home care to the need for skilled nursing, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers (model regulation only).

- Individual policies must be guaranteed renewable -- which means that policies may not be individually canceled due to the age or diminishing health status of the insured. Group products must provide for continuation or conversion of coverage.

FIGURE 3. Key Provisions of the National Association of Insurance Commissioners	
Key Provisions	**Year Instituted**
Model Act	
Definition of Long Term Care Insurance Including Cognitive Impairment	1986 1990
Extraterritorial Jurisdiction	1986
Guaranteed Renewability	1986
Free Look Period 10/30 Days Uniform Free Look of 30 Days	 1986 1989
6 Month Preexisting Condition Limit	1987
Outline of Coverage	1988
Prior Hospitalization/Institutionalization Requirements Prohibited	1988
Penalties	1990
Model Regulation	
Policy Definitions	1987
Cannot Prohibit Coverage for Alzheimer's Disease	1987
Loss Ratio Requirements	1987
Guaranteed Renewability	1987
Replacement Requirements	1987
Filing Requirements	1987
Continuation/Conversion	1988
Outline of Coverage	1988
Post Claims Underwriting Restrictions	1989
Minimum Standards for Home Health Care	1989
Must Offer Inflation Protection Minimum of 5 Percent Compounded Annually	1989 1990
Delivery of Shopper's Guide	1990
Reporting Requirements Related to Sales Practices, Advertisement and Claims/Premium Experience	1990
Agent Licensing	1990
Standards for Marketing	1990
Prohibited Marketing Practices	1990
SOURCE: Health Insurance Association of America (HIAA) and Lewin/ICF.	

Monitoring Marketing and Business Practice

- Purchasers have a 30 day "free-look" period during which they may return the policy for a full refund.

- Purchasers must be *offered* the opportunity to purchase a product with inflation protection either in the form of annual increases, the right to periodically increase benefit levels without requiring evidence of health status, or a percentage of actual charges. Annual increases, as well a periodic upgrades, should be compounded annually at a rate not less than five percent (model regulation only).

- Post-claims underwriting (checking a policy holder's medical history only after a claim is filed, instead of when the application is taken) is limited by denying payment based on technicalities or omission of information that was not requested on the application. Insurers must clearly inform applicants that the policy can be invalidated it the information provided is not correct and complete. For applicants age 80 and over, the insurer is also required to obtain some form of documented medical assessment (report of a physical, an assessment of functional capacity, physician's statement, or medical records). Insurers must also keep records of policy rescissions and report them to insurance commissioners (model regulation only).

- A detailed and uniform outline of coverage must be delivered to all prospective applicants for long term care insurance at the time of initial in-person solicitation. Solicitations through direct response mailings must provide an outline of coverage at least by the time the policy is delivered. This outline should include a description of principal benefits and coverage; a statement of principal exclusions, reductions and limitations; a statement of terms under which the policy may be continued in force or discontinued, including any provisions in the policy of a right to change premiums; a description of terms under which the policy may be returned and premium refunded; and a brief description of the relationship of benefits that do increase to benefits that do not increase, including a graph over at least 20 years.

- A "Shopper's Guide" approved by NAIC must be delivered to applicants (model regulation only).[6]

- Insurers must maintain information concerning lapsed and replacement policies in relation to total annual sales for each agent and report these figures annually for the 10 percent of agents with the greatest percentages of lapses and replacements and for each company overall (model regulation only).

- Insurers must provide a copy of long term care insurance advertisement to the State Insurance Commissioner for review or approval at the Commissioner's discretion (model regulation only).

- Agents must demonstrate knowledge of long term care insurance by passing a test and maintaining a license (model regulation only).

- Insurers are required to adhere to the following marketing standards: fair and accurate comparisons to other products; assure excessive insurance is not sold; inform consumers that the policy may not cover all of the costs of long term care, and provide written notice to prospective policyholders of the availability of senior insurance counseling programs.

[6] In an effort to increase consumer awareness, the NAIC provided 15,000 copies of the “Shopper’s Guide” to states and consumers during 1990.

- Agents and insurers are prohibited against: 1) twisting (knowingly misrepresenting or fraudulently comparing insurance policies or insurers to convert. an existing policy or initiate a new policy); 2) high pressure sales tactics; and 3) deceptive cold lead advertising (marketing which is not represented as a solicitation) (model regulation only).

- Fines are permitted to be levied by State Insurance Commissioners (the greater of three times any commission for a policy involved in a violation or up to $10,000 per violation per agent and per insurer).

- Included as an optional provision are regulations to limit agent compensation in order to address marketing abuses that result from the large difference between first year and renewal commissions. This provision is listed as optional due to the lack of consensus on the extent of abuses and the emerging nature of the long term care insurance market because many replacements may be appropriate (model regulation only).

Premium Rate Control and Solvency Requirements

- Companies are required to have reserves and to meet an expected premium-to-loss ratio of at least 60 percent for individual policies. The expected loss ratio does not require that the target loss ratio be demonstrated. Traditionally, premium-to- loss ratios have been used with health and accident policies as a benchmark of a reasonable relationships between premiums and benefits paid. The recommended interpretation of the loss ratio for long term care insurance policies is based on factors designed to provide latitude to the company. This is because long term care insurance policies are not purchased primarily for immediate protection like accident and health benefits, but rather for a need that normally occurs toward the end of the life span, similar to life insurance. Also, long term care insurance policies have a relatively small claims rate and are subject to variable lengths of nursing home stays. Permitting additional factors not normally allowed in interpreting loss ratios is intended to foster development of products and permit leeway for the lack of claims experience. Regulators are permitted to take into account such factors because of the need for adequate reserving of the long term care insurance risk. Factors include: statistical credibility of incurred claims experience and earned premiums; the period for which rates are computed to provide coverage; experienced and projected trends; concentration of experience within early policy duration; expected claim fluctuation; experience refunds, adjustments or dividends; renewability features; all appropriate expense factors; interest; experimental nature of the coverage; policy reserves; mix of business by risk classification; and product features such as long elimination periods, high deductibles, and high maximum limits.

- The NAIC will require companies to report loss ratios for long term care insurance on both a calendar year basis and a cumulative basis by calendar year duration for the policies in the state and nationwide beginning with the claims

experience for 1991 (1990 reporting is voluntary). This will assist insurance regulators in tracking expected to actual results.

Information concerning the number of policies currently in force that meet the current NAIC standards is not available. In general, the top-selling policies currently offered meet the most recent NAIC standards. Most of the major companies in the long term care insurance market, those insurance companies selling the top 15 individual products that make up 75 percent of the market, market on a national basis. In general, these companies design a product that adheres to NAIC standards and then may alter the product on a state specific basis to conform to particular state provisions, which may be more or less stringent than NAIC standards. Although the majority of policies offered conform to recent NAIC standards, many of the policies in force were purchased prior to many of the 1988 improvements in the NAIC standards (i.e., three day prior hospitalization prohibition).

C. The Capacity of State Insurance Regulators

States differ in the level of regulation and the enforcement of those regulations. Before the development of the NAIC model, only a few states regulated long term care insurance specifically. By May 1991, all fifty states had statutes and/or regulations governing the benefits to be provided in a long term care insurance policy.[7] (See Attachment 1 and Attachment 2).

Forty-two states have instituted some form of the model act or regulation approved by the NAIC. More states have conformed to the model act, which has more general provisions, than the model regulation. Twenty-three states have based their regulation on the NAIC model regulation. Most states do not have legislation or regulation in place that conforms to the most recently updated provisions of the NAIC model act and regulations (December 1990). For example, as of May 1991, only thirteen states prohibited post claims underwriting in accordance with the December 1989 requirements of the model.[8] Some lag between approval of model standards by the NAIC and state adoption of the standards is to be expected. The thirteen states prohibiting post-claims underwriting is up from five as of September 1990. In 1989, the then President of the NAIC indicated in Congressional testimony that he expected that more than 90 percent of the states would adopt standards at least equal to minimum model standards by 1991.

State insurance regulators generally review initial applications to sell a product, marketing materials, and periodic rate filings. Few states currently require actual loss ratios and other reporting requirements specifically for long term care insurance products on an annual basis to ensure enforcement of standards. Such reporting, on a

[7] The District of Columbia had not adopted legislation or regulations specific to long term care insurance. It should be noted, that just because a state has not adopted regulations specific to long term care insurance it does not mean that there are no regulatory provisions that apply to long term care.

[8] Although past claims underwriting has always been prohibited under the Unfair Trade Practices Act.

state and national basis, has been made part of the NAIC annual statement beginning with reporting year 1991. State insurance departments rely heavily upon consumer complaints to identify problematic insurance companies and agents. According to the GAO, in 1989 most states used the insurance regulatory agency as the primary authority to enforce the marketing and sales standards. In all but two states (Alaska and Texas), regulatory agencies used the same examination and investigation staff for monitoring sales and marketing practices involving long term care insurance as for other types of insurance.[9]

Most states do not report consumer complaints against long term care insurance separately from other health-related products. According to a survey by the Intergovernmental Health Policy Project of George Washington University conducted during 1988 and 1989, consumer complaints were reportedly resolved in favor of the consumer most of the time.[10] The IHPP survey also found that:

- Five states regularly published information for the public concerning complaints against particular insurance companies and/or agents.

- Two states actively disseminated information about insurance company loss ratios.

- Twenty-two states regulated advertising by insurance companies by requiring prior submission of advertisements and twelve states had taken special action to regulate celebrity endorsements of private insurance policies.

- Twenty-eight state insurance departments distributed literature on long term care insurance and five more were developing guides on the topic at the time of the Intergovernmental Health Policy Project survey.

- Twenty-three states operated toll-free telephone lines to assist consumers with insurance-related questions.

- Seven states operated counseling programs to advise consumers shopping for health or long term care insurance.

Significantly, the majority of the state insurance officials surveyed believed that their departments were hampered in conducting consumer education and protection activities by funding constraints (36 states) and/or staffing shortages (40 states).

[9] General Accounting Office, "Long Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection", Report to the Chairman, Subcommittee on Health and Long Term Care, Select Committee on Aging, House of Representatives, HRD-89-67, April, 1989.

[10] Susan Laudicina, State Insurance Departments' Consumer Education and Protection Activities: Findings of a National Survey. Report prepared for the American Association of Retired Persons. Intergovernmental Health Policy Project/George Washington University: Washington, D.C., 1989.

The Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce contacted all 50 state insurance departments to learn about the departments' efforts in regulating long term care insurance. The Subcommittee's assessment was that "the majority appear to know little about what is going on in their states... and although they rely heavily on complaints to monitor companies selling long term care insurance, few have organized complaint gathering systems. Regulators lack clear actuarial standards and centralized data on companies and agents." The Subcommittee felt state insurance departments are "understaffed and under-informed, and their ability to resolve problems and willingness to reach out-of-state offenders is distinctly limited."[11]

Families USA, a consumer-oriented organization which focuses on the needs of elderly persons and their families, investigated the information available from state insurance commissioners in 20 states during 1989. Eight states were able to provide information specifically about nursing home insurance complaints. In some states, complaint information is not made available to the public. Of those states that could provide complaint information, Families USA reported that the quality of the data varied greatly. Pennsylvania, for example, could not provide any information about the nature of the complaints. Only a few states provided information on the outcome of complaints. None of the twenty states contacted had information on actual loss ratios of long term care insurance policies, or on the commissions agents earned on different policies.[12]

The Office of the Inspector General, DHHS, based on a recent review of enforcement efforts related to long term care insurance in a sample of states, concluded that:[13]

- Long term care complaint data are incomplete and inconclusive;
- States report little enforcement action against long term care insurance companies and agents; and
- Strong laws and regulations will have limited effectiveness if they are not adequately monitored and enforced.

Because the long term care insurance market is new and so dynamic, some of these findings are not surprising. A key question is how well the regulations will work in a mature market.

Some recent actions of the NAIC designed to address some of the enforcement deficiencies discussed above include:

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[11] Representative John D. Dingell, Chairman of the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives. Introduction to hearing on long term care insurance, May 2, 1990.

[12] Ron Pollack, (Executive Director of Families USA). Testimony before the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives, May 2, 1990.

[13] Office of the Inspector General, DHHS, “State Regulation of Long-Term Care Insurance,” OEI-09-91-00700, May 1991.

- The NAIC will require the reporting of loss experience on an annual basis beginning with experience for 1991 in March/June of 1992 (see Attachment 3).

- The NAIC collects regulatory actions taken by insurance departments against agents for conduct which is in violation of state law or regulation.

- The NAIC has also recently been operating a special activities data base which permits states to share information and raise inquiries about individuals and entities of insurance regulatory concern.

- Finally, the NAIC has begun a national complaint data base that states may participate in at their option.

II. BARRIERS TO GROWTH OF THE LONG TERM CARE INSURANCE MARKET

In order to define the appropriate role of the federal government in the long term care insurance market, one needs to understand current problems in the market, particularly barriers to the growth of long term care insurance coverage. These barriers can be divided into barriers affecting consumer demand for long term care insurance and barriers restricting the supply of the product.

A. Barriers Affecting Consumer Demand

The decision to protect oneself against the risk of needing long term care services is a personal one. Some persons are highly risk averse and will spend large amounts of money to try to protect themselves. They may buy products of little value out of fear. At the other extreme, some persons do not want to think about the possibility that they will become disabled enough to need long term care, particularly in a nursing home. Other consumers do not perceive a need for long term care insurance because they believe family or friends will be available and able to provide care. These individuals will probably not consider buying insurance even if they could get a good product at a reasonable price. The vast majority of the elderly, however, lie between these two extremes. For them, the basic decision is whether the future benefit is worth the sacrifice of using current income or assets to pay the premium or other fees. Complicating this decision is the uncertainty of whether the future benefit will actually be there when they need it.

There are a number of fundamental issues related to the decision to purchase long term care insurance that pose problems for consumers, including lack of information for decision making, the complexity of the product, rapidly changing product lines, the uncertain value of products, and other barriers.

1. Lack of Information/Misperceptions of Public Programs

Many elderly persons do not realize that, after age 65, one out of three individuals will be in a nursing home for three months or more and that about one in five will be in a nursing home for a year or more. Thus, they underestimate the risk of needing long term care. Many elderly also mistakenly believe that they do not need to protect themselves against the risks of long term care because they think that Medicare or Medigap policies will cover the cost of a nursing home stay.[14] In fact, Medicare only covers short-term post acute care stays and Medigap policies do not cover long term care. Finally, some of the elderly do not understand the limits of Medicaid. They do not

[14] R.L. Associates, American Public Views Long Term Care, for the American Association of Retired Persons (AARP) and Villers Foundation, 1987, p. 7.

understand that they must spend nearly all their income and assets on care before they qualify for Medicaid assistance, and that even when Medicaid begins paying they still must contribute nearly all their income toward the cost of their care. At a cost of $30,000 per year, the potential cost of a nursing home stay is a significant financial expense to most elderly.

2. Delaying Purchase of Long Term Care Insurance/Denial of Long Term Care Needs

Another problem facing consumers is that many persons do not think about purchasing long term care insurance until they are too old to purchase it at a reasonable price or too disabled to purchase it at all. Most companies do not sell initial insurance policies to persons over age 84. The decision to purchase long term care insurance involves admitting that there may be a time when one will not be able to care for oneself. This is often a difficult realization and one that is less likely to occur during one's working life, when long term care insurance premiums are lower. Older persons are also likely to have this realization thrust upon them by an illness or disabling condition when underwriting practices of insurance companies will most likely exclude them from being able to purchase long term care insurance.

It should be noted that even though purchasing long term care insurance products at younger ages reduces premium costs, it also carries a larger risk for purchasers because of the very long period between initial purchase and potential use. Purchasers in the employer market face increased risks in relation to: 1) benefit adequacy being eroded by inflation; 2) potential changes in the delivery system that make policy benefits obsolete; and 3) reductions in income that may cause a purchaser to lapse his or her policy.

3. Complexity of the Product and Lack of Standard Terminology

Long term care insurance is a complex product that can take a number of forms. Policies offered can pay a per diem, which may or may not be indexed; a fixed percentage of charges; or a percentage of one's whole life insurance as a life-insurance rider. Determining whether or not a policy will adequately meet a person's long term care needs in terms of the amount of benefits paid and under what conditions the insurance benefit will be paid are dependent on a clear understanding of the terminology used in the policy, as well as an understanding on the part of the purchaser of when benefits are likely to be needed and how benefits and service costs (and the relationship between the two) will be affected by inflation over time. The different forms of the insurance and a lack of common terminology make it difficult for consumers to understand what they are buying and whether it will provide benefits when they need them. Long term care insurance can be more difficult for the elderly to understand than Medicare supplemental policies, which most purchase, because the product does not "wrap-around" the familiar Medicare program to reduce out-of-pocket health care costs in a concrete and immediate manner. Such a variety of policies and terms is likely to limit the ability of persons to do thorough comparison shopping.

4. Rapidly Changing Product Lines

Contributing to the complexity of the decision to purchase long term care insurance are the rapid changes in the product lines companies have introduced in response to consumer demand and changes in NAIC regulations. The policies offered today differ considerably from those offered before 1987. Faced with uncertainties and lacking actual experience with an insured population, insurers initially tried to protect themselves against financial loss by imposing restrictions and limitations on what policies covered. Insurers typically tried to protect themselves against moral hazard by imposing high deductibles, focusing on skilled nursing care, requiring prior hospitalization before nursing home care, and only covering home care that followed a nursing home stay. To protect against adverse selection, insurers usually screened for health problems, did not sell policies to persons over age 80, and did not provide coverage for preexisting conditions and most mental illnesses. To protect against the general uncertainty of the future, insurers typically offered only fixed indemnity benefits that did not increase with inflation, and often reserved the right to unilaterally cancel policies.[15]

The changes in products have been in response to consumer input and evolving regulatory requirements. These changes are product innovations that have improved consumer protection and benefits for purchasers. These changes have also contributed to the confusion of some consumers.

Many of the 1.9 million policies sold to date contain these older types of policy restrictions. Because long term care insurance is designed to be a lifetime, rather than an annual benefit, improvements in regulation and policy standards generally do not benefit persons who purchased insurance prior to when the improvements were instituted. Therefore, policies in force usually remain in force with the benefits purchased unless the purchaser upgrades to a more recent policy, in which case he or she is usually subject to underwriting provisions again and the current age-rated premium. Currently, someone replacing a policy also forfeits any equity built up in the previous policy. The NAIC is currently debating whether nonforfeiture standards should be enacted and has distributed an exposure draft on upgrades. An emerging policy issue is whether or not persons who hold these "older" policies should consider purchasing a more recent policy.

5. Uncertain Value of Products

Many elderly persons may be able to afford long term care insurance premiums, but fear that after paying premiums for a long time the products will not cover the care

[15] Joshua Wiener and Katherine Harris, “High Quality Private Long Term Care Insurance: Can We Get There From Here”, The Brookings Institution: Washington, D.C., May, 1989.

needs related to their disability.[16] In essence, these persons wonder whether the policies are financially worthwhile and whether a product in its infancy will pay the long term care benefits promised. Some consumers may be waiting to see how the market performs or for future products to be developed. Some elderly also worry about whether their insurance company will still be in business when they need insurance. Many elderly misunderstand and mistrust insurance products in general. In addition, few long term care insurance policies offer "forfeiture" benefits which would allow consumers some financial return if they stop paying premiums after a number of years.

6. Lack of Clarity of Benefit Triggers/Premium Increase Provisions

Some more recently marketed policies still have provisions which are unclear to some consumers. Some policies contain vague and one-sided language that makes it unclear under what conditions benefits will be paid and under what circumstances premiums may increase. For example, a few policies have "medical necessity clauses" with no explanation of what constitutes a medical necessity, aside from it being determined by the policyholder's physician; some policies with activities of daily living (ADL) triggers for benefits do not explain how it will be determined if a person has the necessary level of impairment (i.e., requiring someone to physically assist the disabled persons; requiring stand-by or supervisory assistance; or having a need for equipment to perform the ADL); and policies offering "level premiums" that are "guaranteed renewable" still may increase premiums as long as premiums are increased for all purchasers in a category.

Much of the policy language used today can give the purchaser the perception of being covered for services that may actually be denied payment when he or she files a claim. This is more of a problem for home care services than nursing home care. Based on a review of 44 long term care policies, the General Accounting Office observed that determining a policyholder's eligibility for benefits involves considerable judgment.[17] In light of this vagueness in policy language, it is unclear whether or not persons considering purchasing their first policy should wait a year or two in order to see what other improvements may be instituted. The risk of delaying purchase, though, is that they may develop a medical condition that could keep them from purchasing the policy of their choice at a later date.

7. Consumer Confusion/Dissatisfaction

Some consumers are confused or dissatisfied with long term care insurance as the result of misperceptions, complex products, rapidly changing product lines, unclear benefit triggers, and uncertainty concerning the value of the product. Confusion often

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[16] James Firman, “Consumer Concerns with the Evolving Market for Private Long Term Care Insurance,” Testimony before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce; May 3, 1990.

[17] Janet Shikles, “Long-Term Care Insurance: Risks to Consumers Should be Reduced,” GAO Testimony before the Subcommittee on Health, Ways and Means Committee, House of Representatives, GAO/T-HRD-91-14, April 11, 1991.

causes indecision among those considering long term care insurance and dissatisfaction with current policies prompts some potential purchasers to wait until the market has matured.

8. Long Lag Time Between Purchase and Benefit Payment

The long lag time between purchasing long term care insurance and when benefits are likely to be paid creates additional problems for purchasers. This lag time, on average a 15 to 20 year period before nursing home use for a 65 year old purchaser, provides an opportunity for inflation to erode benefits significantly, particularly if no inflation protection is purchased. The lag time is also problematic for purchasers who lapse their policy. Due to the delayed nature of the risk, long term care insurance policies build up a large amount of reserves, through premium payments and interest, in order to pay benefits. With current policies, when a purchaser lapses a policy, that built-up equity is forfeited. A survey conducted by the House Committee on Energy and Commerce found that for a sample of 24 companies that sold two-thirds of long term care insurance policies between 1986 through 1989, 37 percent of purchasers had lapsed their coverage.[18] An HIAA survey found a 16 percent lapse rate for policies representing one-third of the market. (It should be noted that some "lapses" are to purchase more up-to-date policies.)

9. Misleading Marketing Practices

Potential purchasers of long term care insurance must face the possibility that some dishonest and/or ignorant agents or insurance companies may use fraudulent and misleading marketing practices. Anecdotal evidence indicates that problems are more likely to be the result of agent ignorance than purposeful attempts to fraudulently market long term care insurance. Congressional hearings and investigations by consumer groups have revealed problems with the marketing, sale, and payment of benefits of long term care insurance. After, listening to fourteen sales presentations for long term care insurance, a reporter for Consumer Reports concluded that every sales agent misrepresented some aspect of the policy, the financial condition of the insurer, or the quality of the competitor's product. She also felt that not one sales' agent properly explained benefits, restrictions, and policy limitations.[19] Fraudulent marketing practices, denial of claims, premium increases, and policy cancellation have resulted in some long term care insurance purchasers failing to receive benefits they believed they had bought.

Specifically, some agents misrepresent their product as covering all long term care, when certain policy restrictions may mean that many services a disabled person may require are excluded. Convincing a client to replace a policy with a more expensive one without good reason, or "rolling", is a tactic used by some agents to increase

[18] Data collected by staff for the “Hearings on Long Term Care Insurance,” held before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, U.S. House of Representatives, May 2, 1990.
[19] Consumer Reports, “Gotcha! The Traps in Long Term Care Insurance,” June, 1991, p. 427.

commissions. However, it may be appropriate in some instances, for consumers to upgrade to new and better products. Another method used to increase commissions is selling duplicative or overlapping coverage, although with the indemnity nature of most long term care products "excess" insurance may not be a large problem, particularly if the policies purchased do not include adequate inflation protection. Also of concern is the falsification or failure to collect information on applications, which later causes a person's policy to be rescinded (clean- sheeting). High pressure or scare tactics have also been used by agents to sell long term care insurance. Finally, although prohibited under NAIC model guidelines, a couple of smaller companies check a policy holder's medical history only after a claim is filed, instead of when an application is taken. If the company discovers an undisclosed health condition within two years that would have led to the rejection of the application, the company may deny benefits, cancel the policy, or both. This practice is called post-claim underwriting.

HIAA contends that only a small number of insurance companies and agents engage in fraudulent and misleading marketing practices and would welcome a fair study to document any specific problems. Cases of such activity are the result of the lack of clarity in some product provision, regulations, inadequate education of agents, difficulties in enforcement, and possibly the structure of agent commissions that encourages new policies over renewals.

10. Affordability

Many of today's elderly have low incomes and therefore cannot afford long term care insurance premiums that average almost $100 per month at age 65. However, most elderly pay similar levels of premiums of Medigap insurance. As improvements to the product are instituted, prices for long term care insurance are likely to increase. In the future, though, the increased financial resources of the elderly and the ability to purchase insurance at an earlier age should expand the market for long term care insurance.

As a comparison, affordability can be viewed in light of Medicare supplemental insurance policy costs and purchase rates. Approximately 70 percent of the elderly have Medigap policies which cost an average premium of $70 per month. At age 65, the cost of long term care policy which covered four years of nursing home care at a constant rate of $80 per day, and home care at $40 per visit, with a 20-day deductible, averaged $1,135 per year in 1990, or about $95 per month; a difference of only $25 per month. Choosing a similar long term care insurance policy with benefits that increase over time costs an average of $116 per month at age 65 in 1990; a difference of over $45 per month. Much of the affordability issue involves a decision on how to balance the trade-off between depth of coverage for acute and long term care and price (i.e., is it necessary to have both long term care insurance and Medigap; if so, how much is affordable; if not, which is more important?)

11. Perception of Need

For some consumers the decision to purchase long term care insurance is not influenced by affordability, confusion or any of the other barriers discussed above, but rather a decision not to purchase long term care insurance. Some consumers do not perceive a need for risk pooling because they believe family or friends will be available and able to provide care. Others may decide that using accumulated assets to pay for care shortly before death is a preferable approach to financing long term care. Finally, still others may have sufficient income to afford premiums but too few assets to want protection through long term care insurance.

B. Barriers Affecting Supply

Offering a long term care insurance product can pose problems for insurers. There are a number of obstacles impeding insurers from entering the market, increasing their market penetration, and improving their products and marketing practices. Some problems specific to insurers include: lack of data for pricing the risk, an uncertain tax status, lack of a group market, and inconsistent regulatory standards.

1. The Lack of Data for Pricing Long Term Care Insurance

Given the newness of the products and the lag time for insured claims data, almost all insurers have limited claims experience for the use of long term care services necessary to confidently price the product. Of particular concern to insurers is estimating the increase in service use as a result of moral hazard. Another area for which insurers lack data is the degree to which those buying long term care insurance do so because they are more likely to require services (adverse selection), and the best underwriting methods to curtail this adverse selection. This lack of data to predict long term care service use makes it nearly impossible for insurers to know if they are adequately pricing their products.

The lack of good data is compounded by the fact that long term care insurance companies enter into long term agreements with their residents and purchasers. There are significant uncertainties associated with pricing products which may not be used for up to 30 years (particularly for persons who purchase during their working years). Over this time horizon, small differences in mortality, interest rates, disability rates, or availability of nursing home beds can make a large difference in the ultimate cost of a policy. This uncertainty has led some insurers to limit their risks by obscuring the events which trigger benefits and by aggressive underwriting. In some cases, this uncertainty has understandably prevented suppliers from improving their products.

2. Uncertainty of Tax Status

The uncertain tax status of long term care insurance benefits has inhibited the growth of the employer market. It is not clear whether benefits paid from long term care

insurance will receive the same preferential tax treatment that accident and health insurance benefits currently receive.[20] Insurers and employers are also reluctant to widely offer long term care insurance in a group market, largely because of the uncertainty of the tax laws concerning the deductibility of long term care insurance premiums. Insurers would like the Congress or, IRS to clarify the treatment of long term care insurance so that it is treated similar to other accident and health insurance products. It appears that the IRS has deferred to Congress on the tax clarification issue.

3. The Lack of Interest from Large Group Markets

Insurance companies have group markets for most major health/life products sold, including health insurance, disability insurance, and life insurance. Group markets, particularly employee-based groups, reduce advertising and overhead costs by providing a captured audience for the sale of an insurance product. Group markets also spread the risk over a larger population and reduce adverse selection. Having employers offer long term care insurance also "legitimizes" the product and would be expected to cause an upward shift in the demand curve for the product.

Long term care insurance currently does not have the advantage of having many group market participants or employer subsidies for premiums. In 1990, 105 employers offered long term care insurance to almost 700,000 employees, plus an unknown number of spouses, retirees, and parents of employees, where the purchaser was responsible for the full cost of the policy. As of the end of 1990, 135,000 policies were sold representing only seven percent of all policies sold.[21]

4. The Lack of Consistency in Regulations (and some inappropriate regulations)

As discussed earlier, insurance regulation is primarily a state responsibility and, as a result, the requirements that must be met by insurers offering long term care insurance vary from state to state. With a new product, such as long term care insurance, this variance may be desirable for producing innovative regulation to learn about problems and how to address them. But this situation can make it difficult for insurers to expand their market because often many different products must be designed to meet the requirements of each state. Stringent standards (i.e., high loss ratios, mandated benefits) imposed by some states to sell long term care insurance that may better protect consumers may also cause insurers to become unwilling to enter the market. Alternatively, in these highly regulated states, policy and entry prices may become so high as to significantly limit product marketability. A further effect of the rapid change in regulations over the past several years has been to increase the expense of developing products.

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[20] Employer payments toward accident and health insurance premiums are deductible expenses for tax purposes. Premiums paid and benefits received by employees from accident and health insurance are not included in taxable income. Also accident and health insurance is explicitly excluded from the definition of deferred compensation when used in conjunction with an employer's cafeteria plan (Section 125 plan or flexible spending account).

[21] Health Insurance Association of America, News Release, May 30, 1991.

Also of concern to suppliers of long term care insurance products is the appropriateness of regulatory standards modeled after Medicare supplemental insurance regulation. Some standards used heavily in evaluating the fairness of Medigap premiums, such as loss ratios, may not be directly applicable to long term care products. In addition, current emphasis on strictly standardizing products and limiting the types of product offered could be considered inappropriate for a maturing market.

III. POTENTIAL FEDERAL ROLES IN THE LONG TERM CARE INSURANCE MARKET

A. Goals of the Federal Government

The following are at least four potential goals of the federal government that could be pursued for the long term care insurance market if the current regulatory and incentive structures are judged inadequate:

- **Increase Consumer Awareness** -- By increasing consumer awareness regarding the risk of long term care use, the lack of third party coverage for and the costs of such care and the availability of mechanisms, such as long term care insurance, to cover the cost of such care, the government could assist individuals to reach well-informed decisions as to an appropriate course of action to prepare for potential long term care needs. Increased consumer awareness would address the lack of information, misperception of public programs, delayed preparation for/denial of long term care needs, and some of the confusion experienced by consumers when considering long term care insurance.

- **Increase Insurance Coverage** -- Similar to the consensus developing concerning health insurance, the government may determine that Americans should have protection against the cost of long term care services and the best mechanism for ensuring that protection is long term care insurance. Establishing a goal of increased long term care insurance purchase implies efforts to eliminate most of the barriers to the growth of the market discussed above.

- **Protect Consumers** -- By protecting consumers who purchase long term care insurance, the government could reduce consumer demand barriers related to product complexity, benefit triggers, premium increases, the long lag time between purchase and benefit payment, and marketing practices. The government could protect consumers by ensuring:
  - The Financial Strength of Insurers -- Experts recommend that one of the foremost factors to consider when purchasing long term care insurance is the financial status of the insurer because financially strong insurers are more likely to be able to pay the future benefits of the product.
  - Benefit Payments -- One concern of consumers is that insurers may not provide promised benefits.
  - Consistent Enforcement -- A consistent level of enforcement of regulations in all states would guarantee all purchasers of long term care insurance a minimum level of protection, possibly increasing consumer confidence and minimizing abuses.
  - The Sale of Only "High Quality" Products -- By guaranteeing that only "high quality" long term care insurance products are marketed by insurers the federal government could protect consumers.

- Informed Consumers -- Informed consumers are more likely to be able to make decisions concerning long term care insurance products that are in their best interest, as well as recognize misleading or inappropriate marketing practices.

- **Establish Consistent Regulations** -- Consistent regulatory requirements in all states would assist insurers in the marketing and development of long term care insurance products, as well as serve to increase insurance coverage and protect consumers.

There are six primary roles the federal government could establish in order to meet these goals (see Figure 4): (1) maintain its current status of non-intervention; (2) mandating/encouraging minimum regulations and reporting requirements; (3) providing assistance to the states; (4) assisting insurers; (5) educating consumers, insurers and agents; and (6) clarifying the tax treatment of long term care insurance. Some roles could be accomplished in conjunction with other roles, depending on the level of federal involvement deemed necessary.

FIGURE 4. Potential Roles of the Federal Government in the Long Term Care Insurance Market

Role	Goal	Expected Outcome
Federal Regulation/Encouragement -- establish (or encourage states to establish) minimum reporting requirements for insurers and/or minimum standards to sell long-term care insurance.	Private adequate and consistent consumer protection standards and regulations as well as reduced consumer confusion, and increased insurance purchase.	Consistent regulatory standards and a method for monitoring the long term care insurance market; does not guarantee consistent enforcement; may reduce affordability and innovation.
Federal Assistance to States -- provide federal assistance for enforcement to states through funding and/or technical assistance.	Increase consumer awareness, protection and insurance purchase.	Improved enforcement of regulatory standards and reduced consumer confusion.
Assistance for Insurers -- establish a reinsurance pool, provide open access to claims experience data, and/or promote group purchase of long term care insurance.	Increase long term care insurance purchase.	Greater consumer awareness and confidence in long term care insurance and increased participation of insurers in the market, with little to no effect on regulation of the market.
Consumer Education -- institute federal efforts or assistance to states to educate consumers about long term care and long term care insurance.	Increase consumer awareness of the need for long term care insurance and factors which should influence the decision to purchase.	Reduced consumer confusion and misperceptions concerning long term care needs, coverage by Medicare and Medicaid, and long term care insurance products.
Tax Code Clarification -- make explicit IRS tax regulations regarding long term care insurance reserves, benefits, and premiums.	Increase long term care insurance purchase.	Increased participation of insurers in the market and an expanded group market, including employee groups.
No Federal Intervention -- maintain state responsibility for regulatory and consumer education efforts.	Permit state flexibility and avoid instituting rigorous standards that may drive insurers from the market and/or make the product unaffordable.	State flexibility and a possibly thriving market, but also the potential for inconsistent regulatory standards and enforcement across states.

B. No Federal Intervention

By not intervening in the long term care insurance market at the current time, the federal government would be accepting the NAIC standards and the state process of adopting those standards. It is expected that many of the problems facing consumers and insurers described in the previous section will eventually be taken up as issues for

the model standards by the NAIC. As discussed earlier, all 50 states have statutes and/or regulations governing the benefits provided by long term care insurance policies. Forty-two of these states have regulations based on NAIC model guidelines, although not necessarily those most recently adopted by the organization. Proponents of the current regulatory mechanisms argue that innovation, local presence, regulatory experience, and technical knowledge along with accountability to residents of a state are necessary prerequisites for effective regulation best provided through the current regulatory system.

The NAIC has taken a leadership role in establishing and encouraging regulatory standards and reporting requirements for long term care insurance. The NAIC model is still evolving. In December 1990, the NAIC considered specific consumer protection issues, including:

- Discontinuance and replacement -- More explicit requirements to determine whether a purchaser is replacing current accident and sickness or long term care insurance policies, as well as further disclosure and consent restrictions in such cases, were adopted.

- Cancellation and nonrenewal -- Insurance commissioner authority to allow nonrenewal of policies in solvency situations was eliminated.

- Marketing Issues -- Prohibitions against twisting (knowingly misrepresenting or fraudulently comparing insurance policies or insurers to convert an existing policy or initiate a new policy), high pressure tactics, and cold lead advertising (marketing which is not represented as a solicitation) were instituted. Penalties were also established.

- Lapse Rates -- Requirements for maintaining and reporting data on lapses, by company and agent were approved.

- Agent commission issues -- An optional provision restricting the level of commissions for initial sales versus renewals was recommended.

Issues expected to be adopted or at least proposed during the December 1991 NAIC meetings are:

- Adoption of enhanced inflation protection provisions including more stringent requirements that policies including inflation protection be offered to consumers, requiring level premiums for policies with inflation protection, and the ability to make policies non-cancelable;

- A draft of non-forfeiture provisions; and

- Consideration of proposals on rate stabilization in the form of an annual or lifetime cap on percent increases permitted for premiums.

The NAIC has also published a "Shopper's Guide" which the model regulations require insurers to deliver at solicitation of the policy and is made available by state insurance departments. The "Shopper's Guide," along with the outline of coverage, and the newly enacted marketing standards are all recent improvements by the NAIC designed to enhance consumer protection and reduce some of the barriers to purchase long term care insurance discussed in the previous section.

Because it is difficult to anticipate every potential regulatory problem, advocates of no federal intervention believe that this option would allow adequate state flexibility to promote long term care insurance permit laboratories for innovations which may enhance the overall quality of long term care insurance and prevent the establishment of standards that would drive insurers from the market and/or make the product unaffordable. In addition, those in favor of maintaining state preeminence in the regulation of long term care insurance cite the lack of federal experience with the market as a barrier to fashioning workable solutions to regulatory issues. Also, organizations other than the NAIC may assist in the development of the long term care insurance market if there is no federal intervention. For example, the Society of Actuaries has made arrangements in the past to pool company data without identifying information to obtain better experience information for pricing purposes.

If states do not adopt the NAIC standards in a timely manner, the federal government may want to reconsider intervening in the long term care insurance market. In fact, in 1989 then President of the NAIC, Earl Pomeroy, stated in congressional testimony that he would not oppose federal intervention referencing the NAIC model if the states did not meet a two year timeline for instituting regulatory standards at least as stringent as the 1989 NAIC model for long term care insurance.

C. Federal Regulation/Encouragement

The NAIC's responsiveness to the evolving long term care insurance market does not guarantee that states are as responsive. As discussed earlier, most states have instituted minimum standards for long term care insurance which conform to earlier versions of the NAIC model which is to be expected while the model is still evolving. This has caused a lack of uniformity in requirements across states and unequal protection for consumers. Federal regulation/encouragement of certain requirements could serve to meet the potential government goals of:

- Increased insurance coverage by boosting consumer confidence;
- Consumer protection; and
- Consistent regulations.

In April 1991, Senators Mitchell and Pryor (S.846) and Representative Wyden (H.R. 1916) introduced legislation to establish federal standards for long term care insurance policies. Previously, the federal government has become involved in state regulation of certain other markets when a need for standardization and uniformity in enforcement criteria due to abuses has presented itself. Two markets that are somewhat similar to long term care insurance are Medicare supplemental insurance policies and pensions.

Medicare supplemental insurance policies, often referred to as Medigap insurance, are designed primarily to pay deductible and/or coinsurance amounts for hospital, medical, and surgical expenses covered by Medicare. In 1980, section 1882 was added to the Social Security Act. This provision, commonly referred to as the Baucus amendment, was a response to marketing and advertising abuses in the sale of Medigap insurance to the elderly. The most common problems identified were: (1) marketing abuses; (2) inadequate information to permit an informed choice; and (3) inadequate policy benefits, especially with respect to premiums paid.[22]

The Baucus amendment defines minimum standards for policies that must be met before they can be marketed as certified Medicare Supplemental policies, The standards are contained in a model regulation approved by the NAIC in 1979 and incorporated in section 1882 by reference, States could voluntarily adopt the standards and policies issued in those states would be deemed "certified." Insurers had the option, but were not required, to solicit certification from the Secretary of DHHS for policies issued in states that did not adopt the 1979 NAIC standards. These standards include:

- Requiring Medigap policies to cover Medicare's coinsurance amounts within certain limits;

- Requiring that purchasers of a policy have a “free look" period, during which they may return an unwanted policy for cancellation and receive a full refund of any premium paid;

- Standardizing many of the terms used in policies;

- Limiting the period for which coverage may be denied for preexisting conditions; and

- Requiring cancellation and termination clauses to be prominently displayed.

In addition, the Baucus amendment established loss ratio targets for Medigap policies that set a goal for the percentage of insurance premiums to be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group

[22] General Accounting Office, “Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies”, Report to the Subcommittee on Health, Committee on Ways and Means, United States House of Representatives, October, 1986.

policies. Finally, the Baucus amendment contains federal sanctions, consisting of fines and/or imprisonment for posing as a federal agent to sell Medigap policies, knowingly selling policies that duplicate coverage the individual already has, and selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale. Recent changes to the Baucus amendments increased the federal role, including requiring additional standards for policies and requiring that policies be issued in an approved state or be certified.

Long term care insurance is similar to Medigap policies prior to the Baucus amendments in that: the product offers a health- related insurance benefit; consumers often lack adequate information for decision-making; policies are subject to similar types of marketing abuses; it is unclear if premiums are fair given the benefits offered; and the regulation and enforcement of the market is a state responsibility. Key differences are:

- The maturity of the market -- When mandatory federal requirements were instituted, the Medigap market had been in existence a decade longer than the current long term care insurance market; and

- Long term care insurance purchases a prefunded benefit, as opposed to an annual benefit -- This means that a large amount of equity is built up over the life of the long term care insurance policy, because benefits that are used toward the end of the life of the policy are prefunded. It also means that some of the loss ratio and solvency issues are different (this is discussed in more detail in the following section). Finally, it means that unless otherwise specified any improvements in regulatory requirements do not affect policies purchased prior to the passage of the requirement.

- Wrap-around to social insurance program -- Medigap policies are tied to a social insurance program in that they cover copays and deductibles for Medicare. Long term care insurance is a freestanding policy not related to a federal social insurance program and there is not general agreement on the "best" set of benefits. Also long term care insurance is not just sold to the population age 65 and over.

One lesson learned from the Baucus amendment is that a federal mandate does not guarantee the expected results. Another lesson is that enforcement of regulatory standards is as important as the standards themselves. Most states have adopted Medigap insurance regulatory programs at least as stringent as the NAIC model referenced in the Baucus amendment, but certain aspects of the model have not been effective. For example, minimum loss standards for Medigap policies specified by the Baucus amendment are not as effective as they could be because they require plans to meet "anticipated" rather than actual loss ratios and also provide no enforcement mechanism. In 1987, the NAIC revised its model state legislation by requiring companies to file more comprehensive loss ratio information -- including monitoring of actual loss ratios. According to a General Accounting Office (GAO) report, about one-

third of Medigap insurers representing 12 percent of premium volume, pay out less than 60 cents in benefits per premium dollar.[23]

The Congress became involved again in Medigap regulation in October 1990 with the passage of the fiscal year 1991 budget resolution. The legislation is intended to protect the elderly from paying for unnecessary, duplicative health insurance. Under the legislation, Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), either the federal government or the NAIC shall specify the provisions of up to ten standard private health insurance policies containing "a core group of basic benefits." The NAIC has revised standards that reflect the new federal provisions and most states have until July 30th to adopt these provisions.

The legislation changes the voluntary nature of certification for Medicare Supplemental policies by mandating certification to sell a product and including periodic reviews of state regulatory programs by the Secretary and state reporting requirements. It also establishes fines up to $25,000 and up to five years in prison for violations of the federal standards. The legislation calls for "uniform language and definitions" for benefits and a "uniform format" to be used in policies. An open enrollment period of six months (i.e., no medical underwriting) for newly eligible Medicare beneficiaries was established. The reconciliation bill would also require insurers to pay Medigap benefits equal to at least 65 cents of every dollar received in premiums for individual policies and provide refunds if loss ratio requirements are not met. Nearly a decade after first requiring minimum standards for Medigap policies, the Congress felt that some of the standards were not effective and instituted stricter standards.

There are also certain similarities between the regulation of pension benefits and long term care insurance policies. The greatest similarities are that both types of benefits are funded over a long period of time and that the terms under which benefits can be paid can be complicated and confusing. To address these problems, the Employee Retirement Income Security Act of 1974 (ERISA) established certain minimum standards that pension plans had to meet. ERISA also established a mechanism to guarantee the security of worker benefits if a company terminated its pension plan. Since 1974, ERISA has been modified significantly and both its minimum standards and its benefit guarantee provisions have been tightened.

Due to this legislation and the minimum standards regulation the cost of adopting pension plans has increased. In addition, the ongoing regulatory costs have increased significantly. As a result, pension plan coverage rates have stagnated since ERISA's passage. ERISA's rules have also had the effect of shifting plan coverage from defined benefit plans, which are more heavily regulated, to defined contribution plans. In sum, ERISA's minimum standards legislation has addressed many of the plan abuses which were common before ERISA. However, ERISA's regulatory costs have been a major factor in the lack of increase in pension coverage over the last 15 years.

[23] General Accounting Office, Medigap Insurance Testimony, T-HRD-90-16, March 13, 1990, Appendix III.

There are two areas in which the federal government could establish mandatory requirements or encourage voluntary state compliance (similar to the Baucus mechanism): 1) minimum reporting requirements; and 2) minimum standards to sell insurance.

1. Minimum Reporting Requirements

Minimum reporting requirements for long term care insurance may provide a method of ensuring that consumers are treated fairly by insurers and/or a method of monitoring trends and developments in the long term care insurance market. The minimum reporting requirements discussed below have been suggested.

Loss Ratios -- Expected loss ratios are generally requested by insurers when rate increases for a product are filed in order to assess whether premiums versus benefits under the increase will be fair to the consumer. Expected loss ratios included as a part of a rate filing do not necessarily reflect actual loss ratios of a product. There are number of alternative methods for calculating loss ratios. Simple annual loss ratios (claims incurred in a year as a percent of premiums paid in a year) are an inappropriate measure for determining the total value of long term care insurance unless it is reported for all years of a policy life because generally the same premium is paid over a number of years for a risk that grows over time. Therefore, the loss ratios using simple annual loss ratios would be very small in the initial years and very high in the later years of the policy life. Simple annual loss ratios, though, can provide a method of tracking actual to expected results in the short run.

A better measure of the overall adequacy of a premium rate are cumulative loss ratios which require that all liabilities for all years in which the policy will be in force be related to the premiums collected, taking into account accumulated investment income. Cumulative loss ratios are subject to the assumptions used in their calculation because the true cumulative loss ratio cannot be determined until a cohort of issues have all terminated. Reserves are sometimes used in calculations of loss ratios as an approximation of expected claims. The NAIC has adopted reporting forms on both a calendar year basis and a cumulative basis by calendar year duration for the policies (see Attachment 3). Policy reserves are also to be reported but changes in reserves are not to be used in calculating the loss ratios.

Requiring insurers to meet actual loss ratios is a mechanism used with other health and accident insurance to ensure that purchasers are receiving a fair return for their premium dollar. Issues for potential federal regulation include: the most appropriate method for assessing loss ratios; assumptions to be used in the calculation of loss ratios; and requirements for reporting experience over time. Some argue that loss ratios should not be the primary regulatory measure for long term care insurance because of uncertainties related to claims experience, costs, and future liabilities (don't know results for 20 years), and that other measures to ensure fairness in premiums charged to the

consumer should be instituted.[24] Federal involvement in requiring a minimum loss ratio would be usurping a traditional state role (as has been done in the Medigap market) but it may provide consumers with sufficient confidence to spur demand to increase insurance coverage.

Policy Lapses and Rescissions -- As an indication of the relationship between policy lapses and rate increases and insurers' good faith efforts, some support requiring companies to report the number of policy lapses (purchasers voluntarily ceasing premium payments), changes in coverage for existing policy holders, and rescissions (insurance company will no longer cover purchaser). This information would provide indications of the effect of rate increases on policy holders, on whether companies were inappropriately marketing policies (rolling), and possible post-claims underwriting. Such information would assist policy makers and regulators in monitoring consumer protection efforts. The NAIC model requires much of this data to be collected.

Market Trends -- By requiring insurers to report demographic and economic characteristics of long term care insurance applicants and purchasers, as well as information on claims experience (including denials), the federal government would be able to better monitor trends in the long term care insurance market. A better understanding of these trends would permit more informed policy-making related to long term care. Insurers are likely to object to such reporting on proprietary grounds.

2. Minimum Standards to Sell Insurance

Imposing minimum standards which must be adhered to before a company can be licensed to sell long term care products or before specific products can be sold has been suggested as a method for standardizing products and facilitating comparison shopping. Minimum standards to sell insurance would provide a method of establishing the potential federal goal of consistent regulations. Establishing consistent minimum regulatory requirements would also guarantee that all policies sold in a state (including group policies) met a minimum requirement level.[25] The best method of establishing minimum standards would be one in which continual revisions are possible.

Many of the standards that could be instituted are contained in the current NAIC model. These standards include: no prior hospitalization requirement to receive benefits, not limiting coverage to or providing significantly more coverage for skilled care, limiting exclusion periods for preexisting conditions, prohibiting post-claims

[24] Gordon Trapnell, "Industry Practices and Regulation", Actuarial Research Corporation. Alternatives suggested include: mandatory paid up non-forfeiture values; restrictions on ultimate rate increases; restrictions on circumstances that rate increases are allowed; and measures to assure full and accurate disclosure of all terms and conditions concerning how much the policy will pay. Also James Firman (Director United Seniors Health Cooperative). Testimony before the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives, May 2, 1990.

[25] Currently, under the NAIC model long term care insurance products marketed through employers or qualified group associations must meet the standards and regulations of the state where the employer or association originates the product. This means that more stringent regulations in other states where the policy may be marketed do not apply to these products unless the state has extra-territorial provisions.

underwriting, prohibiting denial or limiting of benefits to persons with Alzheimer's Disease, prohibiting conditioning eligibility for benefits on having received a higher level of care, minimum standards for home health benefits, guaranteed renewability of policies, providing a "free-look" period, offering/requiring inflation protection, and providing an outline of coverage and a shopper's guide. Other standards that have been proposed include:

- Mandating Non-Forfeiture Benefits (outright or as an option) -- One of the primary purposes of long term care insurance is to prefund for the cost of services needed at the end of the life span. Often insurers set a level premium that is higher than needed in the early years so that this amount can be invested. This can lead to the accumulation of substantial assets. By not requiring that the assets that are built up over the life of the policy be returned to the purchaser, all equity is lost by failing to pay a premium. Some analysts recommend that a "reduced paid up benefit", which continues a lapsed purchaser's coverage but with reduced benefits, be required.[26] A problem with non-forfeiture benefits is that such provisions are likely to further increase the cost of long term care insurance. The NAIC is conducting a study of the effect of non-forfeiture benefits on premiums and adopted an exposure draft at its December 1990 meeting requiring non-forfeiture benefits be offered.

- Disallowing Rate Increases for Policies With Fixed Benefits -- A "guaranteed renewable" clause may not be much of a guarantee if premiums are allowed to increase such that purchasers lapse a long term care insurance policy because they can no longer afford it. Accident and health insurance premiums increase on a regular basis because they generally cover medical and hospital services for which costs increase steadily. Most long term care insurance policies have a fixed, or specified fixed indexed, indemnity benefit. The amount paid to policy holders is not dependent upon the cost of services. Some argue that allowing rate increases for fixed benefits is a transfer of risk from the insurer to the policyholder.[27] On the other hand, given the uncertainty regarding the effect of insurance coverage on long term care use and the uncertainty surrounding the expected use of home care services, allowing insurers to increase premiums based on information from additional claims experience may not be unreasonable.

- Clear Specification of Benefit Triggers -- The minimum requirements for receiving benefits based on contract language are often not clear. Activity of daily living (ADL) benefit triggers do not always specify how ADL impairment will be determined and what level of impairment (e.g., active human assistance, unable to perform) is required. Also, provisions to cover policy holders with Alzheimer's Disease do not necessarily mean that being diagnosed with the disease will trigger benefits. Most policies still require Alzheimer's patients to meet the

[26] Gordon Trapnell (Actuary for Actuarial Research Corporation). Testimony before the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives, May 2, 1990.
[27] Ibid.

requisite ADL level, many of whom do not have serious ADL limitations.[28] Requiring standard definitions and language for benefit triggers has been proposed. The evolving nature of ADL definitions and understanding may argue for a gradual, flexible standardization of language in some cases.

- Inflation Protection -- Most long term care policies provide fixed indemnity benefits, rather than benefits linked to costs or charges. Because of the potentially long period between initial purchase of a policy and its eventual use, the value of an indemnity benefit to the consumer can deteriorate considerably. Most policies that offer an inflation adjustment, offer either: 1) the option to periodically increase benefit levels at higher premiums based on the attained age; or 2) a fixed increase each year, generally based on some percentage of the original indemnity benefit amount that is capped after a certain period of time (i.e., a policy that initially pays $100 per day in a nursing home would increase by $5 per year). The first option means higher premiums in order to have benefits adjusted for inflation and the second means potentially inadequate benefit levels if nursing home costs increase at a rate faster than the fixed increase allowed under the policy. The NAIC Model regulations specify that companies should offer the option of benefits with at least five percent annually compounded benefits. Requiring insurers to include "true" inflation protection, defined as benefits indexed based on the compounded increases in long term care prices, with all policies has been proposed. Such requirements increase an insurer's uncertainty/risk and will likely increase premiums. At a minimum, including some information concerning the effect of inflation on benefits versus the cost of services over time in shopper's guides and policy solicitation material has been suggested. A task force of the NAIC is currently examining this issue.

- Home Care Benefits -- Insurers are designing and pricing home health care benefits based on even less information than is available on nursing home prices and utilization. As a result, home health benefit provisions are often limited. It is often unclear whether the consumer is purchasing adequate home care benefits that will provide reimbursement when services are required. Some have suggested that the federal government establish minimum home care benefit standards and terminology to guarantee legitimate home care benefits are provided in long term care insurance policies.

- Standard Language/Terminology -- Many of the terms and the language used in long term care insurance policies are unfamiliar to consumers. In addition, policies do not necessarily use the same terms in the same manner. It has been suggested that the federal government establish standard terminology for long term care insurance policies (i.e., ADLs, standard assessment tools) to reduce confusion and facilitate comparison shopping by consumers. Again, such standardization may be premature for some areas because of the lack of consensus in the industry on standard practices.

[28] Joshua Wiener, op. cit. Estimates that 40 percent of the elderly with moderate to severe cognitive impairment receive no active human assistance in any of five ADLs.

The likely outcome of instituting minimum reporting requirements or standards to sell long term care insurance would be an increased measure of consumer protection through the monitoring of insurance practices and comparability of products which may in turn reduce consumer confusion, elevate consumer confidence and increase insurance purchase. On the other hand, requiring more reporting and minimum provisions of insurers would also likely increase long term care insurance premiums to some degree (to a greater degree if several minimum provisions are combined) which may have the effect of decreasing insurance purchase. Also, some argue that there isn't sufficient agreement on minimum policy provisions and standard terminology and that requiring such features may have the effect of stifling product innovation in an immature product market.[29]

D. Providing Federal Assistance to States

Providing federal assistance to states might facilitate meeting the goals of increased consumer awareness, protection, and insurance purchase. These goals could be served by assisting states in the enforcement of regulatory standards for long term care insurance. The federal government could provide funding for enforcement efforts and/or provide technical assistance. Such efforts could assist states in identifying and cracking down on companies that offer substandard products and are on shaky financial ground.

One form of technical assistance could be the establishment of a national data base of complaints against insurance companies and agents offering long term care insurance in which states would be required to participate. Such a centralized data base would permit the government and consumers to better track bad insurers and agents, particularly across states. Information could be provided to consumers on a request basis or in a regularly published document. The government could even establish fines or other deterrents of illegal business practices that could be enforced based on submitted and investigated complaints. It is probably advisable to allow the NAIC complaint system to become established prior to a federal role of this sort. Care must be taken in the construction and use of a complaint data base to avoid duplication of complaints and potential abuses.

Another possible federal role of assistance to states could be aiding states in instituting a system of public press releases on agent and company fines. An SRI study on Medigap regulations showed that such actions were effective in decreasing agent abuses.

The expected outcome of providing federal assistance to states would be increased consumer awareness and protection which may increase long term care insurance purchase. Such federal assistance would be less intrusive than

[29] One strategy that could encourage minimum standards and may also allow innovation would be through waivers to companies granted by the Secretary.

mandated/encouraged minimum requirements. An important consideration in providing such assistance would be allocating scarce resources in an efficient manner.

E. Federal Assistance For Insurers

The federal government could institute a number of incentives for insurers to offer quality long term care insurance products. This would serve to accomplish the potential federal goals of increasing insurance purchase and protecting consumers. Some suggested incentives include:

- Seal of Approval -- A federal seal of approval for products which meet some agreed upon standards (i.e., financial strength of company, quality of product, claims payment record) could be established. Such a voluntary certification strategy could embody current NAIC standards or provide for more stringent standards dependent on whether the government wished to attempt to increase the quality of coverage offered. Such an approach may have problems of misrepresentation and confusion concerning the role of the federal government in sponsoring or backing a policy. The evolving nature of the product also presents a problem.

- Reinsurance Pool -- Insurers offering long term care insurance are facing an unknown risk because they will not have a full cohort of claims experience for another fifteen to twenty years. A federally sponsored reinsurance pool to protect insurers from excessive risk might encourage insurers to offer long term care insurance and reduce premiums as a result of the reduced risk. Participation in a reinsurance pool could be conditioned upon using federally approved criteria for policies, such as minimum benefits or underwriting criteria. A federal reinsurance pool offers a mechanism for instituting federal standards without preempting state regulation. This would have the effect of expanding the potential population covered by long term care insurance.

- Promoting Group Purchase -- Promoting group purchases of long term care insurance could be an effective tool for screening products and educating consumers. Group purchase could be encouraged through clarifications of the tax code related to long term care insurance. (These clarifications are discussed more fully in a later section.) The federal government could also offer incentives for group purchase by allowing tax incentives similar to those for health insurance. Bills introduced by Senator Cohen (S.314) and Representative Rhodes include provisions to clarify the tax treatment of long term care insurance and accelerated death benefits. The bill defines long term care insurance similarly to the NAIC and also includes tax incentives for the use of individual retirement accounts to pay long term care insurance premiums.

Many experts argue that federal assistance for insurers through a seal of approval process or a reinsurance pool is unnecessary. Efforts to promote group

purchase, though, are considered an efficient method of increasing long term care insurance coverage.

F. Federal Support for Consumer Education

Some speculate that much of the lack of consumer interest in long term care insurance is the result of a failure to understand the risk of use of long term care services, the potential cost of the services, and current public long term care benefits. Increasing consumer education efforts would increase consumer understanding and "comfort levels" and may also increase the affordability of purchasing long term care insurance by lowering the initial age of purchase. Contributing to a lack of consumer interest is general confusion over what is being offered by long term care insurance and what constitutes a good buy. It may be useful for consumers to have an independent source of information concerning long term care insurance products. Finally, some elderly may be encouraged to purchase long term care insurance if they knew what the federal government was planning to do in terms of long term care benefits (i.e., whether or not a major social insurance program will be established).

The federal government could support the education of consumers by: providing funds to state counseling programs; sponsoring consumer awareness seminars; publishing a consumer's guide; running public service announcements; launching a nationwide information campaign (e.g., detailing what "long term care" services Medicare and Medigap do and do not cover); consolidating and standardizing information on long term care policies offered; developing some rule of thumb criteria for determining the need and appropriate benefit level for long term care insurance based on a consumer's financial resources and social support; and/or publicizing government intentions with regard to long term care policy. As discussed earlier, OBRA 90 included funding to states for counseling services to the elderly.

Federal support for consumer education is considered by many experts as the most appropriate and efficient initial role for the federal government in the long term care insurance market. Consumer education is expected to increase information and reduce misperceptions of public programs which would allow individuals to make better informed decisions.

G. Federal Tax Clarification

The insurance industry and financial planners recommend that the federal government clarify the treatment of long term care insurance in the tax code. Such clarification may increase insurance coverage by allowing insurers the increased marketing potential of tax advantages. Many purchasers operate under the assumption that long term care insurance benefits paid to a claimant are not taxable and premiums paid may be used in calculating the medical deductions for individual income tax purposes, but the IRS has not issued an explicit ruling on the matter.

Another area of tax uncertainty that could be clarified is whether or not long term care insurance may be treated similar to other accident and health insurance policies so that it could be included as an option in cafeteria plans (flexible benefits and flexible spending accounts) and employer contributions would be tax deductible. Being able to include long term care insurance under a cafeteria plan would mean that premiums could be paid with employee pre-tax income even if the employee paid the entire premium. Interpretation of an IRS private letter ruling implies that such arrangements would be permissible as long as a purchaser cannot receive cash payments from the policy, in which case cash nonforfeiture values (as opposed to reduced paid-up benefits) may be problematic.

An area for potential change to the tax code is two year full preliminary term reserving methods for long term care. Federal corporate income tax laws disallow expense deduction for reserves in the first two years of premium payments for long term care insurance policies. This tax policy reduces the incentive for companies to make reserve payments in the first two years of a policy, possibly resulting in higher premiums. This reserving method is stipulated because there is no uniformity among state requirements, although most states use this method. An undesirable effect may be to discourage products that are intended to be true level premium plans, with modest commissions and expenses, and sold in a manner expected to produce relatively low lapse rates. Further investigation into the effect of alternative reserving methods and their tax incentives should be encouraged.

With clarifications in these areas, insurers and agents could more confidently market potential tax advantages and also more aggressively become involved in the employer group market. In addition, some argue that offering some form of tax incentive for long term care insurance purchase would encourage the purchase of the product as well as serve as an effective means of education about the need for protection against the costs of long term care.

IV. CONCLUSIONS OF THE DEPARTMENTAL WORK GROUP ON CONSUMER PROTECTION AND REGULATION OF LONG TERM CARE INSURANCE

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) assembled a panel of experts of varying backgrounds to discuss the potential roles of the federal government in the long term care insurance market. The panel included representatives from the insurance industry, consumer groups, the National Association of Insurance Commissioners, and government, as well as persons with expert knowledge of long term care, particularly long term care insurance. (For a complete list of participants see Attachment 4.)

Several potential steps for improving the long term care insurance market were agreed upon by the panel. Most members of the panel expressed concern about the "appropriateness" of long term care insurance purchase for some persons (e.g., not having persons who would qualify for Medicaid purchase insurance) and that quality insurers offer quality products.

The panel also agreed upon the following:

- The federal government needs to clarify the tax status of long term care insurance products (although the panel did not agree upon the treatment of two year reserves as an expense deduction).

- The federal government should provide additional beneficiary assistance and counseling, particularly in terms of explaining the government's role in long term care (Medicare and Medicaid program benefits) and the lack of long term care benefits in Medigap policies.

- There is a need for an independent source of information concerning the risk of long term care use and comparisons of long term care insurance policies.

- Capabilities in state insurance departments should be increased.

- Mandatory federal regulation of long term care insurance products would likely stifle innovation. Although, widespread agreement has been reached on some standards, such as prohibiting prior hospitalization requirements, consensus has not been reached on other issues. For example, standard definitions for benefit triggers for home care are currently being tested and developed in the market by insurance companies but an accepted standard has not emerged. As the market matures, the federal government should monitor the progress of states in adopting NAIC model regulations for long term care insurance and the adequacy of regulations in providing consumer protection before acting.

Areas in which the panel did not reach consensus related mostly to standards that should be included in federally mandated regulations for long term care insurance should NAIC specifications and state enforcement be judged inadequate. These areas without consensus included:

- Mandating non-forfeiture or reduced paid-up benefits to be included in policies for purchasers who lapse.
- Requiring inflation protection in all policies, not just as an option.
- Forbidding or limiting increases in premiums for indemnity policies.
- Specifying uniform benefit triggers (e.g., definitions for ADLs).
- Standardizing language and terminology used in policies.

Most of these issues are currently under review by the NAIC Long Term Care Insurance Task Force.

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Wilson, Catherine E., and Weissert William G., "Private Long-Term Care Insurance: After Coverage Restrictions Is There Anything Left?" Inquiry, Winter 1989.

ATTACHMENT 1: STATE ADOPTION OF LONG TERM CARE ACT PROVISIONS

State Adoptions of Long-Term Care Insurance Act Provisions				
	Alabama	**Alaska**	**Arizona**	**Arkansas**
Cite	Regulation 91 (1990)	SB 315 (1990)	§§ 20-1691 to 20-1691.6 (1987/1989)	§§ 27-97-201 to 27-97-213 (1989)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Current model language, cover at least 12 mo.	Current model language; cover at least 12 mo.	Must cover for at least 24 mo.; does not contain last part of model definition	Current model language; cover at least 12 mo.
Specific Provision for Life Insurance Riders?	Yes	Yes	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes
Preexisting Condition Provision	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6/24 mo. as in original model; does not include waiver language	6 mo.; may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	Prohibited after after July 1, 1990	Prohibited after March 17, 1990
Uniform 30 Day "Free Look"	Yes	Yes	10/30 (10 days for agent-sold policies, 30 days for direct response) as in original model	Yes
Requires Outline of Coverage	Yes	Current model language	Same as original model	Current model language
Policy Summary for Life Products	Yes	Yes	No provision	No provision
Report of Accelerated Death Benefits Required?	Yes	Yes	No	No
Miscellaneous			HB 2364 pending to adopt recent amendments	

State Adoptions of Long-Term Care Insurance Act Provisions				
	California	**Colorado**	**Connecticut**	**Delaware**
Cite	§§ 10230 to 10235.22 (1989/1990)	§§ 10-19-101 to 10-19-115 (1990)	Admin. Code tit. 38 §§ 174x-1 to 174x-7 (1986); § 38-174x (1986/1990)	tit. 18 §§ 7101 to 7106 (1990)
Based on Model?	Yes	Yes	No	Yes
Definition of Long-Term Care Insurance	Current model language; cover at least 12 mo.	Cover at least 12 mo.; model language	Cover at least 1 yr.	Current model language; cover at least 12 mo.
Specific Provision for Life Insurance Riders?	Yes, in life insurance laws	Yes	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	No provision	Yes
Preexisting Condition Provision	6 mo.; may not use exclusion or waiver unless approved by Commissioner	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited after January 1, 1990	Prohibited after 7-1-91	May if offer policy without prior hospitalization requirement	Prohibited
Uniform 30 Day "Free Look"	Yes	Yes	10 to 30 days for individual policies, 30 days for direct response	No provision
Requires Outline of Coverage	Original model with additions	Current model language	No provision	No provision
Policy Summary for Life Products	No provision	No provision	No provision	No provision
Report of Accelerated Death Benefits Required?	No	No	No	No
Miscellaneous	Amendments pending in SB 114			

State Adoptions of Long-Term Care Insurance Act Provisions				
	District of Columbia	**Florida**	**Georgia**	**Hawaii**
Cite	No action to date	§§ 627.9401 to 627.9408 (1988/1989)	§§ 33-42-1- to 33-42-7 (1988/1989)	§§ 431:10A-521 to 431:10A-531 (1989/1990)
Based on Model?		Yes	Yes	Yes
Definition of Long-Term Care Insurance		Not less than 24 mo. of coverage; part of model definition	Not less than 24 mo. of coverage; similar to model but varies in some respects	At least 12 mo., current model language
Specific Provision for Life Insurance Riders?		No	Yes	Yes
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?		Yes	Yes; may not provide coverage for lower levels which is not "unreasonably lower" than that for skilled care	No provision
Preexisting Condition Provision		6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6 mo. as in original model, does not include waiver language
Can Condition Coverage on Prior Hospitalization?		Allowed, regulation requires offer of policy without prior hospitalization	Allowed if also offer policy without prior hospitalization requirement	Allowed
Uniform 30 Day "Free Look"		Yes	Yes	Yes
Requires Outline of Coverage		Original model language	Original model language	Original model language
Policy Summary for Life Products		No provision	No provision	No provision
Report of Accelerated Death Benefits Required?		No	No	No
Miscellaneous				SB 1204 pending requires policy summary

State Adoptions of Long-Term Care Insurance Act Provisions				
	Idaho	**Illinois**	**Indiana**	**Iowa**
Cite	§§ 41-4601 to 41-4606 (1988/1990)	Ch.I.C. §§ 351A-1 to 351A-11 (1989)	§§ 27-8-12-1 to 27-8-12-16 (1987)	§§ 514G.1 to 514G.8 (1987/1990)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo. most of current definition	Not less than 12 mo. most of current definition	At least 12 mo., first and last sentence of definition	Not less than 12 mo. most of model language
Specific Provision for Life Insurance Riders?	Yes, in regulation	Yes	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	No provision	Yes
Preexisting Condition Provision	6 mo.; may not use exclusion or waiver	6 mo.; may not use exclusion or waiver	6/24 as in original model, does not include waiver language	6/24 as in original model
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	No provisions	Prohibited
Uniform 30 Day "Free Look"	Yes	Yes	10/30 as in original model	10/30 as in original model
Requires Outline of Coverage	Current model language	Model language	Original model language	As in original model
Policy Summary for Life Products	Summary required	Model language	No provision	No provision
Report of Accelerated Death Benefits Required?	Yes	Model language	No	No
Miscellaneous	Additional consumer protection provisions		Some of consumer protection amendments pending in HB 1563	SB 516 pending adopts consumer protection amendments

State Adoptions of Long-Term Care Insurance Act Provisions				
	Kansas	**Kentucky**	**Louisiana**	**Maine**
Cite	§§ 40-2225 to 40-2228 (1988/1989)	§ 304.17-314 (1987/1990)	§§ 22:1731 to 22:1737 (1989)	tit. 24-A §§ 5051 to 5055 (1986/1989)
Based on Model?	Yes	No	Yes	No
Definition of Long-Term Care Insurance	Not less than 12 mo. most of model language	No minimum benefit period specified, just state that it is a policy covering care in a long-term health care facility	Not less than 12 mo., most of model language	Not less than 12 mo., definition excludes policies issued by associations, unions, etc. until 10-1-90
Specific Provision for Life Insurance Riders?	In life insurance statutes	No	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Must also provide coverage for intermediate care by regulation	Must provide coverage for skilled, intermediate and custodial care	Yes	Cannot limit to skilled care only, custodial care benefits must be at least 50% of skilled care benefits
Preexisting Condition Provision	6/24 as in original model; may not use exclusion or waiver	Regulation provides for 6/24 as in original model	6 mo., may not use exclusion or waiver	Regulation provides 6 mo. before, 6/24 after covered depending on age, no waivers or exclusions
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited, except regulation says may for custodial care	Prohibited after Sept. 1, 1990	Prohibited
Uniform 30 Day "Free Look"	Yes, in regulation	No provision	10/30 as in original model	No provision
Requires Outline of Coverage	As in original model	Regulation requires outline, like original model	As in original model	No provision
Policy Summary for Life Products	No provision	No provision	No provision	No provision
Report of Accelerated Death Benefits Required?	No	No	No	No
Miscellaneous		Must advertise availability of long-term care insurance, consumer's guide		Tax incentives; innovative policy designs encouraged

State Adoptions of Long-Term Care Insurance Act Provisions				
	Maryland	**Massachusetts**	**Michigan**	**Minnesota**
Cite	art. 48A §§ 642 to 649 (1989)	211 Code of Mass. Regs. 65:01 to 65:16 (1989)	§§ 500.2280 to 500.2290 (1990)	§§ 62A.46 to 62A.56 (1986/1990)
Based on Model?	Yes	Partially	Yes	No
Definition of Long-Term Care Insurance	Not less than 24 mo., last sentence of model definition included	Most of model language, no time specified	Not less than 12 mo., most of model language	No specified length of policy, none of model language
Specific Provision for Life Insurance Riders?	No	No	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	No provision	Yes	No provision
Preexisting Condition Provision	9 mo. instead of 6, may not contain exclusion or waiver	6 mo.	6 mo., may not contain exclusion or waiver	90 days
Can Condition Coverage on Prior Hospitalization?	Prohibited after 7-1-90	Prohibited	Prohibited	Prohibited
Uniform 30 Day "Free Look"	Yes	No provision	Yes	Yes
Requires Outline of Coverage	Same as original model	No provision	Yes, not model	Requires an outline, no contents specified
Policy Summary for Life Products	No provision	No provision	No provision	No provision
Report of Accelerated Death Benefits Required?	No	No	No	No
Miscellaneous				Requires offering of two policies with different levels of coverage; must specify another person who will get notice of cancellation for nonpayment of premiums

State Adoptions of Long-Term Care Insurance Act Provisions				
	Mississippi	**Missouri**	**Montana**	**Nebraska**
Cite	Reg. 90-102 (1990)	SB 765 (1990)	§§ 33-22-1101 to 33-22-1121 (1989/1991)	§§ 44-4501 to 44-4517 (1987/1989)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo.; model language	Not less than 12 mo.; model language	Not less than 12 mo.; model language	Not less than 12 mo. most of model language
Specific Provision for Life Insurance Riders?	Yes	Yes	Yes	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes
Preexisting Condition Provision	6 mo.; may not contain exclusion or waiver	6 mo.; may not contain exclusion or waiver	6 mo.; may not contain exclusion or waiver	6 mo.; may not contain exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	Prohibited	Prohibited after 8-25-90
Uniform 30 Day "Free Look"	Yes	Yes	10/30 as in original model	Yes
Requires Outline of Coverage	Current model language	Current model language	Current model language	Same as original model
Policy Summary for Life Products	Yes	Yes	Yes	No provision
Report of Accelerated Death Benefits Required?	Yes	Yes	Yes	No
Miscellaneous				

State Adoptions of Long-Term Care Insurance Act Provisions				
	Nevada	**New Hampshire**	**New Jersey**	**New Mexico**
Cite	**Regulation** §§ 6878.010 to 6878.135 (1988/1991)	§§ 415-D:1 to 415-D:11 (1990)	**Admin. Code** §§ 11.4-34.1 to 11.4-34.13 (1989)	§§ 59A-23A-1 to 59A-23A-8 (1989)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 24 mo., most of model language	Not less than 24 mo., most of model language	Not less than 24 mo., most of model language	At least 6 mo. coverage, most of model language
Specific Provision for Life Insurance Riders?	No	No	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes
Preexisting Condition Provision	6 mo., may not contain exclusion or waiver	6 mo., may not use exclusion or waiver	6 mo., may not use exclusion or waiver	6 mo., may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited after 1-11-91	Prohibited	Prohibited	Permitted if also offer a policy without such requirement
Uniform 30 Day "Free Look"	10/30 as in original model	Yes	Yes	Yes
Requires Outline of Coverage	Same as original model	Requires outline, more brief than current model	No provision	Outline of coverage as in original model
Policy Summary for Life Products	No provision	No provision	No provision	No provision
Report of Accelerated Death Benefits Required?	No	No	No	No
Miscellaneous				

State Adoptions of Long-Term Care Insurance Act Provisions				
	New York	**North Carolina**	**North Dakota**	**Ohio**
Cite	§ 1117 (1986)	§§ 58-55-1 to 58-55-35 (1987/1990)	§§ 26.1-45-01 to 26.1-45-12 (1987/1991) (Amendments eff. 7-1-91)	§§ 3923.41 to 3923.48 (1988)
Based on Model?	No	Yes	Yes	Yes
Definition of Long-Term Care Insurance	None specified; duration at discretion of Commissioner	Not less than 12 mo., most of model language	Not less than 1 yr., model language	Not less than 1 yr., most of model language
Specific Provision for Life Insurance Riders?	No	No	Yes	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	No provision	Yes	Yes	May provide for skilled care only or mostly skilled care with written acceptance
Preexisting Condition Provision	None	6 mo. no provision regarding exclusions or waivers	6 mo. with specific exception; no waivers or exclusions	6 mo. if 65 or over; 24 mo. if under 65; contains provisions saying may not use exclusions or waivers
Can Condition Coverage on Prior Hospitalization?	No provision	Prohibited	Prohibited after 7-12-90	Allowed
Uniform 30 Day "Free Look"	No provision	Yes	Yes	10/30
Requires Outline of Coverage	No provision	Outline of coverage, as in original model	Current model language	Outline of coverage similar to original model
Policy Summary for Life Products	No provision	No provision	Yes	No provision
Report of Accelerated Death Benefits Required?	No	No	Yes	No
Miscellaneous	Contains criteria commissioner may use for policy approval			HB 216 pending contains many recent amendments to model

State Adoptions of Long-Term Care Insurance Act Provisions				
	Oklahoma	**Oregon**	**Pennsylvania**	**Rhode Island**
Cite	tit. 36 §§ 4421 to 4427 (1987/1989)	§§ 743.650 743.656 (1989)	HB 506 pending	§§ 27-34.2-1 to 27-34.2-12 (1988/1990)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo., model language	Not less than 24 mo., most of model language		Not less than 12 mo., most of model language
Specific Provision for Life Insurance Riders?	Yes	No		Yes
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	No provision	Yes, evaluation based on aggregate days of care covered for lower levels of care, when compared to days of care covered for skilled care		Yes, evaluation based on aggregate days of care covered for lower levels of care when compared to days of care covered for skilled care
Preexisting Condition Provision	12 mo. if 65 or older, 24 mo. if under 65; no language regarding exclusions or waivers	6 mo., may not use exclusions or waivers		6 mo., may not use exclusions or waivers
Can Condition Coverage on Prior Hospitalization?	Allowed	Prohibited		Prohibited
Uniform 30 Day "Free Look"	10/30 as in original model	Yes		10/30 as in original model
Requires Outline of Coverage	Outline of coverage similar to original model	Current model language		Current model language
Policy Summary for Life Products	Model summary in regulation	No provision		Yes
Report of Accelerated Death Benefits Required?	No	No		Yes
Miscellaneous				Amendments pending in HB 5902

State Adoptions of Long-Term Care Insurance Act Provisions				
	South Carolina	**South Dakota**	**Tennessee**	**Texas**
Cite	§§ 38-72-10 to 38-72-100 (1988/1990)	§§ 58-17B-1 to 58-17B-15 (1989/1991)	§§ 56-42-101 to 56-42-106 (1988) (Amendments eff. 7-1-91 are included)	art. 3.70-1(F)(5) (1987); Regulation 3.3801 to 3.3838 (1990)
Based on Model?	Yes	Yes	Yes	Yes
Definition of Long-Term Care Insurance	Not less than 12 mo., model language	Not less than 24 mo., most of model language	Not less than 12 mo., most of model language	Most of model definition in regulation, 12 mo.
Specific Provision for Life Insurance Riders?	Yes	Yes, in regulation	No	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes, evaluation based on aggregate days of care covered for lower levels of care when compared to days of care covered for skilled care	Yes, in regulation
Preexisting Condition Provision	6 mo., no language on exclusions or waivers	6 mo., may not use exclusions or waivers	6 mo., may not use waivers or riders to limit or reduce benefits	Provisions in reg., 6 mo., age 65 or over, 12 mo., under age 65; may not use exclusion or waiver
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited after 7-1-91	Prohibited after 7-1-91	Prohibited in regulation
Uniform 30 Day "Free Look"	Yes	Yes	Yes	10 days in regulation
Requires Outline of Coverage	Current model language	Outline of coverage as in original model	Current model language	Outline of coverage in regulation
Policy Summary for Life Products	Yes	No provision	No provision	No provision
Report of Accelerated Death Benefits Required?	Yes	No	No	No
Miscellaneous				Statute only authorizes Commissioner to adopt regulations

State Adoptions of Long-Term Care Insurance Act Provisions				
	Utah	**Vermont**	**Virginia**	**Washington**
Cite	§§ 31A-22-1401 to 31A-22-1410 (1991)	tit. 8 §§ 8051 to 8063 (1989)	§§ 38.2-5200 to 38.2-5208 (1987/1990)	§§ 48.84-010 to 48.84910 (1988)
Based on Model?	Yes	Yes	Yes	No
Definition of Long-Term Care Insurance	Not less than 12 mo., model language	Not less than 12 mo., most of model language	Not less than 12 mo., model language	Definition does not contain minimum period of coverage; disability rule says "prolonged period of time"
Specific Provision for Life Insurance Riders?	Yes	No	Yes	No
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	Yes	Yes	Yes, can't differentiate benefits on basis of level of care
Preexisting Condition Provision	6 mo., may not use waiver or riders to limit or reduce benefits	6 mo., may not use waiver or riders to limit or reduce benefits	6 mo., no waiver or exclusion allowed	Sought treatment 1 year before or 6 mo. after effective date, definition similar to model
Can Condition Coverage on Prior Hospitalization?	Prohibited	Prohibited	Prohibited	Reg. says if require prior hospitalization or skilled care, must also offer policy without requirement
Uniform 30 Day "Free Look"	Yes	Yes	Yes	30 days for individual policies, 60 for direct response
Requires Outline of Coverage	Current model language	Outline of coverage as in original model plus buyer's guide	Current model language	No provision
Policy Summary for Life Products	Yes	No provision	Requires consumer's guide and policy summary	
Report of Accelerated Death Benefits Required?	Yes	No	Provision for accel. benefits	No
Miscellaneous				Agent may not complete medical history portion of application

State Adoptions of Long-Term Care Insurance Act Provisions				
	West Virginia	**Wisconsin**	**Wyoming**	**TOTALS**
Cite	§§ 33-15A-1 to 33-15A-7 (1989)	§§ 632.71 to 632.84, 600.03, 625.16 (1989/1990); Reg. INS. 3.46 (1991)	§§ 26-38-101 to 26-38-106 (1988/1991)	
Based on Model?	Yes	No	Yes	42 - based on model 7 - not based on model 1 - partially
Definition of Long-Term Care Insurance	Not less than 24 mo., most of model language	Does not contain minimum period of coverage	Not less than 12 mo., model language	32 - 12 mo. 10 - 24 mo. 7 - Other
Specific Provision for Life Insurance Riders?	No	No	Yes	20 - with specific provisions
Provision that Can't Limit to Skilled Care or Give Significantly More Coverage?	Yes	In regulation	Yes	41 - can't limit
Preexisting Condition Provision	6 mo., may not contain waiver or exclusion	6 mo., no waiver or exclusion language	6 months, no waiver or exclusion language	35 - 6 mo. provision 7 - 6/24 mo. provision 6 - Other
Can Condition Coverage on Prior Hospitalization?	Prohibited after 7-1-90	Regulation prohibits after 6-1-91	Prohibited after 7-1-91	39 - Prohibit 2 - Allow 6 - Other
Uniform 30 Day "Free Look"	10/30 as in original model	Yes	Yes	30 - 30 day free look 11 - 10/30 2 - Other
Requires Outline of Coverage	Current model language on outline	In regulation, not model	As in original model	43 - Require Outline of Coverage
Policy Summary for Life Products	No provision	No provision	No provision	13 - Require Summary
Report of Accelerated Death Benefits Required?	No	No	No	11 - Require Report
Miscellaneous				

Every effort has been made to make this information as correct and complete as possible. For questions about specific state laws, you should consult the statutes.

ATTACHMENT 2: STATE ADOPTION OF LONG TERM CARE REGULATION PROVISIONS

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Alabama	**Alaska**	**Arizona**	**Arkansas**
Cite	Reg. 91 (1990)	No action to date	Model pending	Rule 13 (1990)
Based on Model?	Yes		Yes	Yes
Adopted Model Law?	Most of Act combined with regulation	No	Yes	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"	Model language			Yes
Provision for Continuation and Conversion	Model language			Yes
Prohibits Post-Claims Underwriting	Model language			No provision
Replacement Notices	Model language before 1990 amendments			Model language before 1990 amendments
Standards for Home Health Care	Model language			No provision
Inflation Protection?	Model language			No provision
Reserve Standards for Accelerated Life Products	Model language			Model language on reserves
Loss Ratios	At least 60% loss ratio, use Model criteria for evaluation			Loss ratio of at least 60% required
Standard Format for Outline of Coverage	Model language			Model format
Filing Requirement?	No			Yes
Miscellaneous	Requirement to deliver NAIC Shopper's Guide; consumer protection amendments pending			

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	California	**Colorado**	**Connecticut**	**Delaware**
Cite	Ins. Code §§ 10230 to 10237.3 (1989/1990)	Reg. 90-15 (1991)	tit. 38 §§ 174x-1 to 174x-7 (1986)	Reg. 63 (1990)
Based on Model?	Yes	Yes	No	Yes
Adopted Model Law?	Yes	Yes	No	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"	Yes	Yes	No provision	Yes
Provision for Continuation and Conversion	Yes	Yes	Includes provision consistent with model	Model language
Prohibits Post-Claims Underwriting	No provision	Yes	Yes	
Replacement Notices	Model language before 1990 amendments	Model language before 1990 amendments	Model language before 1990 amendments	Model language before 1990 amendments
Standards for Home Health Care	No provision	Model language	Statute requires coverage; no specific standards	Model language
Inflation Protection?	Model language	Model language	No provision	Model language
Reserve Standards for Accelerated Life Products	No provision	No provision	No provision	Model language
Loss Ratios	Loss ratio of 60%, authority to adopt standards of NAIC	Loss ratio of 60% use model criteria for evaluation	Loss ratio of 55% for individual policies and 60% for group required	Loss ratio of 60%, use model criteria for evaluation
Standard Format for Outline of Coverage	Model format	Model format	No provision	Model format
Filing Requirement?	Yes	Yes	No	No
Miscellaneous	Enhanced definition of senile dementia, which must be covered	Requires delivery of a shopper's guide		File information on lapses with annual statement; cost disclosure provision

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	District of Columbia	**Florida**	**Georgia**	**Hawaii**
Cite	No action to date	§§ 4-81.001 to 4-81.022 (1989)	Ch. 120-2-16 (1989)	No action to date
Based on Model?		Yes	Yes	
Adopted Model Law?	No	Yes	Yes	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"		May not contain provision less favorable than guaranteed renewable	Yes, model language	
Provision for Continuation and Conversion		Model language	Model language	
Prohibits Post-Claims Underwriting		No provision	No provision	
Replacement Notices		Model language before 1990 amendments	Model language before 1990 amendments	
Standards for Home Health Care		Must provide some benefits for home health care, adult day care, etc.	No provision	
Inflation Protection?		No provision	Yes	
Reserve Standards for Accelerated Life Products		No provision	No provision	
Loss Ratios		Loss ratio of at least 60%; use model criteria for evaluation	Loss ratio of at least 60%; use model criteria for evaluation	
Standard Format for Outline of Coverage		No provision	Model format	
Filing Requirement?		Yes	Yes	
Miscellaneous		Nonduplication provision	Contains Buyer's Guide	

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Idaho	**Illinois**	**Indiana**	**Iowa**
Cite	Regulation 60 (1990)	tit. 50 §§ 2012.10 to 2012.110 (1990)	tit. 760 R-1-43-1 to 1-43-11 (1989)	§§ 191-39.1 to 191-39.10 (1988/1990)
Based on Model?	Yes	Yes	Yes	Yes
Adopted Model Law?	Yes	Yes	Yes	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"	Model language	Yes, most of model language	Model language	Model language
Provision for Continuation and Conversion	Model language	Model language	Must provide, but no standards specified	No
Prohibits Post-Claims Underwriting	Model language	No provision	No provision	No provision
Replacement Notices	Model language before 1990 amendments	Model language before 1990 amendments	Model language before 1990 amendments	Model language before 1990 amendments
Standards for Home Health Care	Model language	Model language	No provision	No provision
Inflation Protection?	Model language	Model language	No provision	No provision
Reserve Standards for Accelerated Life Products	Model language	Model language	Model	No provision
Loss Ratios	At least 60%; loss ratio, use model criteria for evaluation	At least 60%; loss ratio, use some model criteria for evaluation	At least 60% loss ratio	At least 60% loss ratio, use model criteria for evaluation
Standard Format for Outline of Coverage	Model format	Model format	No provision	Brief portion of model format
Filing Requirement?	No	No	Yes	No
Miscellaneous				Return of premium provision; pending revisions include most of current model including agent commission limitations

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Kansas	**Kentucky**	**Louisiana**	**Maine**
Cite	§ 40-4-37 (1988)	Reg. 17:080 (1987)	No action to date	Ch. 420 §§ 1 to 12 (1988/1989)
Based on Model?	Partially	No		Partially
Adopted Model Law?	Yes	No	Yes	No
Standardization of "Guaranteed Renewable" and "Noncancellable"	Earlier version of model language, more brief	No		All policies must be guaranteed renewable
Provision for Continuation and Conversion	No	Use health insurance provision in statute		Must provide, no specifics
Prohibits Post-Claims Underwriting	No provision	No provision		No provision
Replacement Notices	Similar to model language	Use rules for health insurance replacement in 12:060		Model language before 1990 amendments
Standards for Home Health Care	No provision	No provision		Yes
Inflation Protection?	No provision	No provision		No provision
Reserve Standards for Accelerated Life Products	No provision	No provision		No provision
Loss Ratios	Loss ratio of at least 55% for individual policies, 60% for groups	Anticipated loss ratios of at least 50%		At least 60% loss ratios, use model criteria for evaluation
Standard Format for Outline of Coverage	No provision	Not based on NAIC model		Format not based on NAIC model
Filing Requirement?	No	No		Prior approval required by statute
Miscellaneous		Must advertise availability of coverage yearly		Contains consumer's guide; amendments pending

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Maryland	**Massachusetts**	**Michigan**	**Minnesota**
Cite	No action to date	211 Code of Mass Regs. 65:01 to 65:16 (1989)	No action to date	No action to date
Based on Model?		Partially		
Adopted Model Law?	Yes	Parts of model act included in regulation	Yes	No
Standardization of "Guaranteed Renewable" and "Noncancellable"		May not contain provision less than guaranteed renewable		
Provision for Continuation and Conversion		Contains continuation provision		
Prohibits Post-Claims Underwriting		No provision		
Replacement Notices		Model language before 1990 amendments		
Standards for Home Health Care		Must provide home health care benefits		In statute
Inflation Protection?		Yes		
Reserve Standards for Accelerated Life Products		No provision		
Loss Ratios		Loss ratios of 60% for individual policies, 80% for group		60% individual, 65% group loss ratio in statute
Standard Format for Outline of Coverage		Requires "disclosure statement" not based on model format		
Filing Requirement?		Yes, extensive form and rate filing requirements		
Miscellaneous		May not exclude mental and nervous conditions		

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Mississippi	**Missouri**	**Montana**	**Nebraska**
Cite	Regulation 90-102 (1990)	Model pending	Reg. 6.6.3101 to 6.6.3116 (1991)	tit. 210 ch. 46 (1989)
Based on Model?	Yes	Yes	Yes	Yes
Adopted Model Law?	Most of model act combined with regulation	Yes	Yes	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"	Model language		Model language	Model language
Provision for Continuation and Conversion	Model language		Model language	Must provide, no specifics
Prohibits Post-Claims Underwriting	Model language		Model language	No provision
Replacement Notices	Model language		Model language before 1990 amendments	Model language before 1990 amendments
Standards for Home Health Care	Model language		Model language	No provision
Inflation Protection?	Model language		Model language	No provision
Reserve Standards for Accelerated Life Products	Model language		Model language	No provision
Loss Ratios	At least 60% loss ratio, use model criteria for evaluation		At least 60% loss ratio, use model criteria for evaluation	At least 60% loss ratio, use model criteria for evaluation
Standard Format for Outline of Coverage	Model language		Model language	No provision
Filing Requirement?	No		No	Yes
Miscellaneous	Require delivery of NAIC Shopper's Guide	Pending regulation contains consumer protection amendments	Require delivery of NAIC Shopper's	Amendments pending to adopt recent changes to model

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Nevada	**New Hampshire**	**New Jersey**	**New Mexico**
Cite	§§ 6878.005 to 6878.415 (1988/1991)	No action to date	§§ 11.4-34.1 to 11.4-34.13 (1989)	No action to date
Based on Model?	Yes		Yes	
Adopted Model Law?	Model law provisions incorporated into regulation	Yes	Yes	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"	Model language		Yes	
Provision for Continuation and Conversion	Must provide, no specifics		Model language	
Prohibits Post-Claims Underwriting	No provision		No provision	
Replacement Notices	Model language before 1990 amendments		Model language before 1990 amendments	
Standards for Home Health Care	No provision		No provision	
Inflation Protection?	No provision		No provision	
Reserve Standards for Accelerated Life Products	No provision		Yes	
Loss Ratios	At least 60% loss ratio, use model criteria for evaluation		Loss ratios adopted by reference	
Standard Format for Outline of Coverage	No provision		Model format	
Filing Requirement?	No		Yes	Yes, in statute
Miscellaneous	Requires delivery of NAIC Shopper's Guide or one developed by commissioner			

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	New York	**North Carolina**	**North Dakota**	**Ohio**
Cite	Model pending	Ch. 12 §§ 1001 to 1016 (1990/1991)	§§ 45-06-05-01 to 45-06-05-09 (1988/1990)	No action to date
Based on Model?		Yes	Yes	
Adopted Model Law?	No	Yes	Yes	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"		Model language	Model language	
Provision for Continuation and Conversion		Model language	Model language	
Prohibits Post-Claims Underwriting		Model language	Model language	
Replacement Notices		Model language before 1990 amendments	Model language before 1990 amendments	
Standards for Home Health Care		Model language	Model language	
Inflation Protection?		Model language	Model language	
Reserve Standards for Accelerated Life Products		Model language	No provision	
Loss Ratios		At least 60% loss ratios, use model criteria for evaluation	At least 60% loss ratios, use model criteria for evaluation	
Standard Format for Outline of Coverage		Model language	Model format	
Filing Requirement?		Yes, prior approval requirement in statute	Yes	Yes, in statute
Miscellaneous		Limit agent compensation		

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Oklahoma	**Oregon**	**Pennsylvania**	**Rhode Island**
Cite	Part VI Rule 36-44A-1 (1989/1990)	Reg. 836-52-500 to 836-52-645 (1991)	No action to date	Reg. XLIV (1989/1990)
Based on Model?	Yes	Partially		Yes
Adopted Model Law?	Yes	Yes	No	Yes
Standardization of "Guaranteed Renewable" and "Noncancellable"	Model language	No provision		Model language
Provision for Continuation and Conversion	No provision	No provision		No provision
Prohibits Post-Claims Underwriting	Model language	Model language		Model language
Replacement Notices	Model language before 1990 amendments	Model language before 1990 amendments		Model language before 1990 amendments
Standards for Home Health Care	No provision	After 1-1-92 no policy may be offered without such benefits; model language for standards		Model language
Inflation Protection?	Yes	No provision		Yes
Reserve Standards for Accelerated Life Products	Model language on reserve standards	Reserves for LTC policies and riders; model standards		Model language on reserve standards
Loss Ratios	At least 60% loss ratio, use model criteria for evaluation	At least 60% loss ratio, use model criteria for evaluation		At least 60% loss ratio, use model criteria for evaluation
Standard Format for Outline of Coverage	Model format	Model format allowed; Oregon designed own format		Model format
Filing Requirement?	No	Yes, prior approval		No
Miscellaneous		Standards for ADL; may not exclude Alzheimer's; requires delivery of NAIC Shopper's Guide or other form designed by Director; some consumer protection amendments in place		

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	South Carolina	**South Dakota**	**Tennessee**	**Texas**
Cite	Reg. 69-44 (1989)	§§ 20:06:21:01 to 20:06:21:09 (1990)	Model pending	§§ 3.3801 to 3.3838 (1990)
Based on Model?	Yes	No		Yes
Adopted Model Law?	Yes	Yes	Yes	Some of model act included in regulation
Standardization of "Guaranteed Renewable" and "Noncancellable"	Yes	Statute requires all policies to be guaranteed renewable		Yes
Provision for Continuation and Conversion	Model language	No		Model language
Prohibits Post-Claims Underwriting		No provision		No provision
Replacement Notices	References regulation controlling health insurance	No provision		Model language before 1990 amendments
Standards for Home Health Care	Provides for home care (but see below)	No provision		No provision
Inflation Protection?	Yes, optional benefit	Yes		Yes
Reserve Standards for Accelerated Life Products	No provision	No provision		Reserves required according to method acceptance to Board
Loss Ratios	At least 60% loss ratio, use model criteria for evaluation	Individual policy 60%, group 75% loss ratio		At least 60% loss ratio, use model criteria for evaluation
Standard Format for Outline of Coverage	Model format	No provision		Model format
Filing Requirement?	Yes	No		Yes
Miscellaneous	HB 5084 suspends enforcement of home health care section until June 30, 1991			Contains readability standards, amendments pending

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	Utah	**Vermont**	**Virginia**	**Washington**
Cite	No action to date	Regulation 90-1 pending	Regulation pending	§§ 284-54-010 to 284-54-900 (1989)
Based on Model?		Yes	Yes	No
Adopted Model Law?	No	Yes	Yes	No
Standardization of "Guaranteed Renewable" and "Noncancellable"				All policies are guaranteed renewable
Provision for Continuation and Conversion				No provision
Prohibits Post-Claims Underwriting				No provision
Replacement Notices				Use notice for accident and sickness insurance
Standards for Home Health Care				No provision
Inflation Protection?		Required by statute		No provision
Reserve Standards for Accelerated Life Products				No provision
Loss Ratios			Required to meet standards for accident and sickness insurance	Loss ratios; reference chapter of regulations, at least 60% for individual policies, group ratio varies by size
Standard Format for Outline of Coverage				Disclosure form, not based on NAIC format
Filing Requirement?				Prior approval requirement in general disability statutes
Miscellaneous			Circular letter requires delivery of NAIC Shopper's Guide	List of unfair or deceptive acts; no exclusions for mental or nervous condition permitted

State Adoptions of Long-Term Care Insurance Regulation Provisions				
	West Virginia	**Wisconsin**	**Wyoming**	**Totals**
Cite	No action to date	§ INS. 3.46 (1991) (Eff. 6-1-91)	Ch. XXXVII (1990)	
Based on Model?		No	Yes	23 - Based on model 9 - Other
Adopted Model Law?	Yes	No	Yes	
Standardization of "Guaranteed Renewable" and "Noncancellable"		Yes	Model language	29 - Guaranteed Renewable Defined
Provision for Continuation and Conversion		Yes, not model language	No provision	24 - Continuation and Conversion Provision
Prohibits Post-Claims Underwriting		Similar to model language	Model language	13 - Prohibits
Replacement Notices		Required, but no format specified	Model language before 1990 amendments	30 - Replacement Notices Included
Standards for Home Health Care		Yes	Model language	18 - Home Health Care Standards
Inflation Protection?		Similar to model language	Model language	20 - Requires Inflation Protection
Reserve Standards for Accelerated Life Products		Model language	No provision	14 - Reserve Standards
Loss Ratios		At least 65% for individual policies and group mail order, 75% for other group	At least 60% loss ratio, use model criteria for evaluation	24 - 60% Loss Ratio 10 - Other Specified Ratio
Standard Format for Outline of Coverage		Prescribe format not based on NAIC model	Model format	20 - Model Format for Outline of Coverage 4 - Other Format Specified
Filing Requirement?		No	No	18 - Filing Requirement
Miscellaneous		Requires delivery of guide to Long-Term Care, first year commissions limited to 400% second yr.	NAIC Shopper's Guide required	7 - NAIC Shopper's Guide 2 - Limit agents' commissions

Every effort has been made to make this information as correct and complete as possible. For questions about specific state laws, you should consult the regulations.

ATTACHMENT 3: NAIC LONG TERM CARE EXPERIENCE REPORTING FORMS

Explanatory Notes for the Long Term Care Experience Reporting Forms

The purpose of the Long Term Care Insurance Experience Reporting Forms is to monitor compliance with a lifetime loss ratio standard. In general, policy duration loss ratios computed without the impact of the change in policy (active life) reserves are considerably below the lifetime standard in the early durations and considerably above the lifetime standard in the later durations.

The method chosen to measure compliance with the lifetime loss ratio standard is to compare the actual loss ratio being developed by calendar year durations to those anticipated in the latest policy form filing. Additional analysis is performed on a cumulative basis. A ratio of actual to expected loss ratios of 1.00 would be a rough indication that the experience is on track to produce the lifetime anticipated loss ratio.

Factors to be considered when interpreting the actual to expected ratio are: Actual persistency relative to assumed persistency, the distribution of business by issue age, elimination period and statistical credibility of experience.

The analysis of calendar year duration and cumulative loss ratio experience excludes the change in policy (active life) reserves. However, policy (active life) reserves are shown in order to indicate the change in the level of assets being allocated to fund possible future claims. The ratio of the sum of the incurred claims and the change in policy (active life) reserves to earned premiums should not be expected to reproduce the lifetime anticipated loss ratio however. Nor are they expected to be level by duration nor should they be used to measure the value of benefits to policyholders. This is because statutory policy (active life) reserves are based on assumptions different than the pricing assumptions and may utilize a "preliminary term" methodology which depresses the change in policy reserves during the preliminary term period and accelerates the change in policy reserves after the preliminary term period.

Because of the relatively small claim rates and variable nursing home stays, the statistical credibility of long term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health. This fact has an impact on the interpretation of statewide loss ratio data. It also has an impact on the decision to make upward or downward premium adjustments.

LONG TERM CARE EXPERIENCE REPORTING FORM - A Claim Experience by Calendar Duration								
Policy Form	**First Year Issued**	**Calendar Duration**	**Earned Premiums By Duration**	**Incurred and Paid**	**Reserve for Incurred but Unpaid**	**Change in Policy (Active Life) Reserves over the Experience Period**	**Anticipated Calendar Duration Loss Ratio**	**Number of Insured Lives**
		0						
		1						
		2						
		3						
		4						
		5-9						
		10+						
		Total						
Policy Form Calendar Year Actual to Expected Ratio								

Form A Instructions

1. Experience on all long term care insurance policies and contracts except for accelerated death benefit-type products should be reported separately by policy form using nationwide experience.

2. Policy forms should be grouped by individual, group direct response and other group with experience reported separately for each form. Experience under forms which provide substantially similar coverage and provisions, which are issued to substantially similar risk classes and which are issued under similar underwriting standards, may be combined.

3. The anticipated calendar duration loss ratio must be calculated as a weighted average of the policy duration loss ratios that were filed in conjunction with the latest rate filing for the respective policy forms. The weights should be based on the relative proportion of earned premiums by policy duration within each calendar duration.

4. A total anticipated calendar year loss ratio should be calculated for each policy form. The total anticipated calendar year loss ratio should be calculated by weighting the anticipated calendar year loss ratio by the actual earned premium by duration.

5. The change in policy (active life) reserves should neither be deducted from the earned premiums nor added to incurred claims but should be reported separately in the appropriate column.

6. Claims incurred during the experience period and paid during the development period and the reserve for claims, both reported and unreported, incurred during

the experience period but unpaid at the end of the development period should be allocated to the appropriate calendar duration cell.

7. The experience period is the calendar year prior to the statement year. The experience is developed to the development date. The development date is December 31 of the statement year. The statement year is the calendar year reported upon by the Annual Statement which this form supplements.

8. The number of insured lives as of the end of experience period should be reported for each of the calendar year duration cells.

9. Calendar duration is defined to be the reporting year (RY) minus the year of issue (IY) of the policy or certificate, i.e., RY-IY.

10. The policy form calendar year actual to expected ratio is to be calculated by dividing the ratio of total incurred claims to the total earned premiums by the total anticipated calendar year loss ratio.

LONG TERM CARE EXPERIENCE REPORTING FORM - B								
Policy Form	**First Year Issued**	**Calendar Duration**	**Actual Earned Premiums**	**Actual Incurred Claims**	**Anticipated Earned Premium**	**Anticipated Incurred Claim**	**Policy Reserves**	**Number of Insured Lives**
		0						
		1						
		2						
		3						
		4						
		5-9						
		10+						
		Total						
Policy Form Cumulative Actual to Expected Ratio (National Experience)								

Form B Instructions

1. Experience on all long term care insurance policies and contracts except for accelerated death benefit-type products should be reported separately by policy form using nationwide experience.

2. Policy forms should be grouped by individual, group direct response and other group with experience reported separately for each form. Experience under forms which provide substantially similar coverage and provisions, which are issued to substantially similar risk classes and which are issued under similar underwriting standards, may be combined.

3. The change in policy reserves should not be deducted from either the earned premiums nor added to incurred claims.

4. Policy (active life) reserves as of the end of the observation period should be reported separately.

5. For each calendar year of issue starting with the first year of issue, anticipated earned premiums and anticipated incurred claims by calendar duration should be calculated given the actual earned premiums for duration 0 in conjunction with persistency and loss ratio assumptions as given in the latest policy form filing. Calendar duration experience should be combined for all years of issue.

6. Cumulative anticipated experience over all calendar durations should be calculated by accumulating, at the appropriate interest rate, the calendar duration anticipated earned premiums and incurred claims until the end of the experience period.

7. Actual earned premiums and incurred claims should be determined for each calendar duration for each calendar year of issue starting with the first year of issue. Total calendar duration experience should be obtained by adding together

the appropriate calendar duration results for each calendar year starting with the first year of issue. Incurred claims for each calendar duration for each calendar year should be obtained by discounting all appropriate claim payments and any ending claim reserve to the mid-point of the calendar year of incurral.

8. Cumulative actual experience over all calendar durations should be calculated by accumulating, at the appropriate interest rate, the actual calendar duration experience until the end of the experience period.

9. The appropriate interest rate, as used in this reporting form, is the valuation interest rate for contract reserves for health insurance contracts as defined in the NAIC Model Minimum Reserve Standards for Individual and Group Health Insurance Contracts.

10. The experience period is from the inception of the policy form to the end of the statement year. The experience is developed to the development date. The development date is December 31 of the statement year. The statement year is the calendar year reported upon by the Annual Statement which this form supplements.

11. The number of insured lives as of the end of the experience period should be reported for each of the calendar year duration cells.

12. The policy form cumulative actual to expected ratio is to be calculated b dividing the ratio of cumulative incurred claims to the cumulative actual earned premiums by the ratio of cumulative anticipated incurred claims to cumulative anticipated earned premiums.

LONG TERM CARE EXPERIENCE REPORTING FORM - C								
Policy Form	**First Year Issued**	**Calendar Duration**	**Actual Earned Premiums**	**Actual Incurred Claims**	**Anticipated Earned Premium**	**Anticipated Incurred Claim**	**Policy Reserves**	**Number of Insured Lives**
		0						
		1						
		2						
		3						
		4						
		5-9						
		10+						
		Total						
Policy Form Cumulative Actual to Expected Ratio (State of Filing Experience)								

Form C Instructions

1. Experience on all long term care insurance policies and contracts except for accelerated death benefit-type products should be reported separately by policy form using experience for the state in which the filing is being made.

2. Policy forms should be grouped by individual, group direct response and other group with experience reported separately for each form. Experience under forms which provide substantially similar coverage and provisions, which are issued to substantially similar risk classes and which are issued under similar underwriting standards, may be combined.

3. The change in policy reserves should not be deducted from either the earned premiums nor added to incurred claims.

4. Policy (active life) reserves as of the end of the observation period should be reported separately.

5. For each calendar year of issue starting with the first year of issue, anticipated earned premiums and anticipated incurred claims by calendar duration should be calculated given the actual earned premiums for duration 0 in conjunction with persistency and loss ratio assumptions as given in the latest policy form filing. Calendar duration experience should be combined for all years of issue.

6. Cumulative anticipated experience over all calendar durations should be calculated by accumulating, at the appropriate interest rate, the calendar duration anticipated earned premiums and incurred claims until the end of the experience period.

7. Actual earned premiums and incurred claims should be determined for each calendar duration for each calendar year of issue starting with the first year of issue. Total calendar duration experience should be obtained by adding together

the appropriate calendar duration results for each calendar year starting with the first year of issue. Incurred claims for each calendar duration for each calendar duration for each calendar year should be obtained by discounting all appropriate claim payments and any ending claim reserve to the mid-point of the calendar year of incurral.

8. Cumulative actual experience over all calendar durations should be calculated by accumulating, at the appropriate interest rate, the actual calendar duration experience until the end of the experience period.

9. The appropriate interest rate, as used in this reporting form, is the valuation interest rate for contract reserves for health insurance contracts as defined in the NAIC Model Minimum Reserve Standards for Individual and Group Home Insurance Contracts.

10. The experience period is from the inception of the policy form to the end of the statement year. The experience is developed to the development date. The development date is December 31 of the statement year. The statement year is the calendar year reported upon by the Annual Statement which this form supplements.

11. The number of insured lives as of the end of the experience period should be reported for each of the calendar year duration cells.

12. The policy form cumulative actual to expected ratio is to be calculated by dividing the ratio of cumulative incurred claims to the cumulative actual earned premiums by the ratio of cumulative anticipated incurred claims to cumulative anticipated earned premiums.

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