

# Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance

*Prepared by*

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THE KAISER COMMISSION ON  
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## Overview

American families today are struggling to pay for long-term care, caught in the crosshairs of an economic meltdown dramatically reducing the personal resources that have fueled over 25 percent of the nation's long-term care spending until now.<sup>1</sup> These sources of out-of-pocket financing, which include home equity, personal savings, and income from adult children, have provided critical private funding for a long-term care system in which insurance has played a very small role, covering only about 10 percent of all seniors.<sup>2</sup>

The decline in personal financial resources comes at a time when states are facing negative growth in revenue collections and unprecedented budgetary shortfalls, forcing them to reduce spending growth in Medicaid, the nation's long-term care safety net and major financing engine.<sup>3</sup> Medicaid pays for approximately 70 percent of nursing home patients, 12 percent of assisted living residents, and nearly all people with developmental disabilities.<sup>4</sup> However, many states are cutting back on Medicaid and long-term care services to help balance their budgets. According to the Center on Budget and Policy Priorities, at least 21 states and the District of Columbia have cut or are considering cuts to medical, long-term care, or other services for the elderly and disabled.<sup>5</sup> These reductions combined with a diminishing pool of private resources will serve to further worsen the long-standing funding gap between long-term care need and available financing.<sup>6</sup>

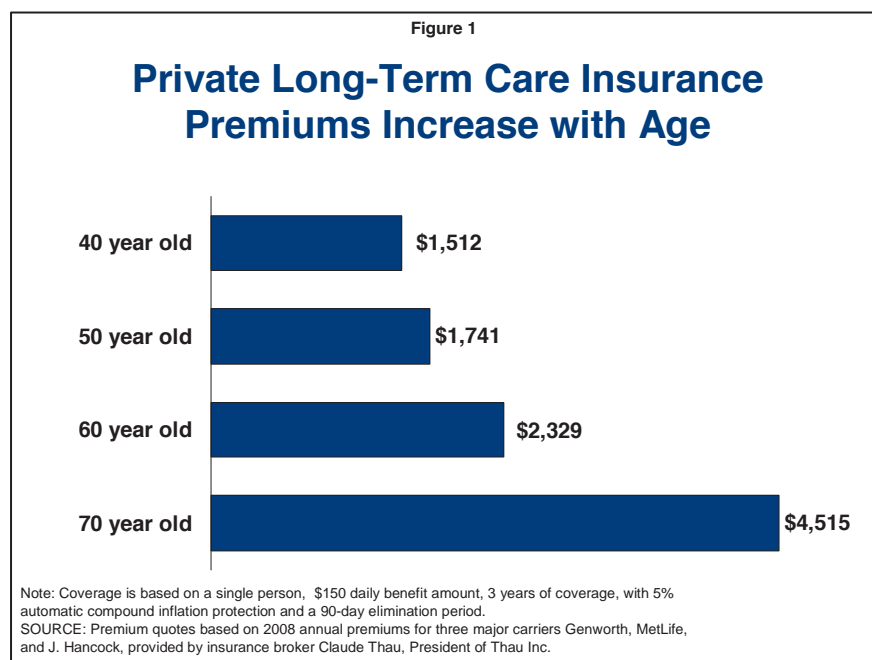
At the same time, federal policymakers are grappling with two policy imperatives that could diminish their ability to seek publicly funded solutions to the growing financing gap for long-term care. These imperatives include the desire to control growth in national spending on entitlement programs for the elderly and the need to finance healthcare coverage for the uninsured. Some policymakers may consider these policy goals to conflict with adding federal funds to the long-term care system through new programs or other public solutions.

In grappling with multiple priorities and scarce public dollars, policymakers may be interested in exploring whether private long-term care insurance could play a larger role in financing America's long-term care needs. In doing so, they must carefully examine the private long-term care insurance market and consider whether this financial product could fill the long-term care financing gap and what policy changes would be necessary to achieve such a goal.

This policy brief examines, in depth, the fundamentals of long-term care insurance, a product designed, purchased, and used much differently from health insurance. It describes the results of a study exploring how consumers buy policies, what they are buying, how much the insurance costs, how policies cover services, and how regulations work to protect consumers. This study relies on expert interviews, collection of 2008 premium data from three major carriers, and a literature review. The brief explores some of the key challenges policymakers face in enlarging the role of private long-term care insurance in financing long-term care.

## Key Findings:

- **Cost remains a key barrier to expanding the role of private insurance.** People who shop for, but do not buy, long-term care insurance cite cost as the most important reason for their decision.<sup>7</sup> Premium amounts vary by age of purchase. For individuals age 60 with no partner, the annual premiums for a typical policy averaged \$2,329 across three products offered by three major carriers (Figure 1). For a couple the same age, premiums for the same policy design averaged \$3,096 combined for the two people.<sup>8</sup> If purchased at age 70, premiums would cost, on average across these products, \$4,515 per year for an individual and \$6,010 for a married couple. Policymakers seeking to increase the purchase of long-term care insurance will have to address its cost and the ability of consumers to pay premiums.



- **Health risk can deny consumers coverage.** Before purchasing insurance, many consumers must undergo a detailed health screening and evaluation to determine their insurability and risk rating. Industry experts estimate that 15 to 20 percent of those who apply do not get coverage.<sup>9</sup> Policymakers interested in promoting the role of private long-term care insurance will need to seek ways to reduce coverage denial rates or provide private financing alternatives for individuals denied coverage.
- **Buyers face complex product design issues.** The complexity of today's long-term care insurance products reflects a market in which consumers traditionally have worked with individual agents to tailor products along multiple dimensions such as how much they will receive in daily benefits, how long the coverage will last, and how their benefits will be protected from inflation. Even policies with the same design elements can differ from one insurance carrier to another in even more subtle ways such as the definition of certain services. Any policy effort to expand the marketing and appeal of long-term care insurance to a broader group will require product simplification and consumer education.

- **Time lag between purchase and use of benefits creates problems in service use.** One of the major challenges of long-term care insurance is the time lag element, since it can be 20 to 30 years before the purchased insurance is used. Changing service definitions and the evolution of new forms of residential care as well as the advent of assistive technologies test the flexibility of long-term care insurance products.<sup>10</sup> Policymakers must consider how to ensure the product flexibility that will provide today's purchaser with tomorrow's services and technology.
- **Employer-based market offers promise but adequacy of coverage is a concern.** At the same time that private long-term care insurance policies sold individually by agents have been declining, insurers have been selling a growing number of long-term care insurance policies through employers or other groups. Product options sold in this manner are often simpler than the individual market and underwriting is more limited. However, buyers in the group market tend to earn less than buyers in the individual market and therefore opt for less expensive policies in which benefits do not automatically grow with inflation.<sup>11</sup> Policymakers interested in boosting the employer-based market must carefully consider how to balance growth among younger consumers with the need to ensure that inflation does not erode their coverage over time.
- **Medicaid Partnership Program will shape products and the market.** At least 30 states have approved state plan amendments to participate in a long-term care insurance partnership program with Medicaid that allows long-term care insurance policyholders to qualify for a Medicaid asset disregard. This disregard allows policyholders to retain a certain portion of their assets and qualify for Medicaid coverage.<sup>12</sup> A policyholder who receives \$150,000 in benefits from his or her long-term care insurance policy, for example, and meets all other program requirements can qualify for Medicaid using an asset test that is \$150,000 higher than the ordinary Medicaid asset test (which is typically \$2,000).<sup>13</sup> One potential outcome of this program is that, going forward, nearly every policy sold in the 30 or more partnership states will likely qualify for the program and therefore include a Medicaid asset disregard. This makes Medicaid an integral component of many private long-term care insurance policies. Any policy effort to expand the role of private insurance should consider explicitly how the Medicaid partnership program can complement and work in tandem with other efforts to attract long-term care insurance purchasers.

Long-term care insurance can serve as an important source of financing for policyholders in need of long-term care. Policyholders typically use their insurance benefits to pay for care at home or in an assisted living facility and report that they would likely use less paid care in the absence of their policies.<sup>14</sup> At the same time, product cost, complexity, and changes in technology are among the many challenges policymakers face in creating a larger role for private insurance in financing America's long-term care system.

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## I. Introduction

Insurance carriers have sold about 10 million long-term care insurance policies since 1987.<sup>15</sup> Of the 6 to 7 million of these that remain current, the industry sold about 4 million through individual agents and slightly more than 2 million through employers or groups.<sup>16</sup> These policies specifically cover the costs of long-term care services that can include nursing home care (average cost of \$70,000 per year), assisted living facilities (\$35,000 per year), and home healthcare (\$35 per hour for a certified aide).<sup>17</sup> In 2007, long-term care insurance policies paid \$4 billion in claims on behalf of disabled policyholders, a small fraction of the over \$200 billion in national long-term care spending.<sup>18</sup>

Long-term care insurance is a product that contains elements similar to both medical and life insurance. As with certain types of life insurance, the long-term care insurance purchaser selects the amount of insurance coverage at the time of purchase and usually pays premiums until they need benefits, if ever. Like medical insurance, the payment of long-term care insurance benefits is on a fee-for-service basis (up to coverage limits) only for the services and types of providers covered under the terms of the policy. However, unlike the way many health insurance policies work today, long-term care insurance companies do not negotiate rates with providers or maintain provider networks. Long-term care insurers pay beneficiaries directly or pay providers the charges up to the daily maximum benefit level the insured has selected.

In general, the majority of long-term care insurance purchasers buy their policies directly through individual insurance sales agents. These purchasers are usually married, in their late 50s, and more financially secure than the overall population.<sup>19</sup> About 50 percent of people buying long-term care insurance earn above \$75,000 annually compared to 31 percent of the general population age 50 and older.<sup>20</sup> Three-quarters of purchasers have liquid assets (i.e., assets not including the home) over \$100,000 compared to 30 percent of the general population.<sup>21</sup> About 16 percent of long-term care insurance buyers earn less than \$35,000 annually.<sup>22</sup>

Recently, insurers have been selling a growing number of long-term care insurance policies through employers or other groups. Buyers in this market tend to earn less and be younger than individual purchasers – age 41 on average.<sup>23</sup> Unlike employer-sponsored health insurance, individuals who purchase long-term care insurance through an employer usually pay 100 percent of the premium and, as long as they continue paying premiums, remain covered under the policy regardless of whether they continue working for that employer. In addition, group long-term care insurance policies do not cover families the way that group health insurance often does, but employers permit employees to purchase separate long-term care insurance policies for certain family members, such as spouses or parents.

**Study Methodology.** This policy brief presents the results of a study on today's long-term care insurance market, specifically how consumers purchase policies, how much they pay, and what the policies cover. It also examines important policy issues related to the expanded use of this financial tool to fund long-term care.

For this study, we relied on three main sources of information: 1) expert interviews, 2) data collection, and 3) an examination of the literature, including industry reports. Using a standard interview protocol, we conducted eight interviews in May and June 2008. These interviews included the following experts: Claude Thau, Thau Inc.; John Cutler, U.S. Office of Personnel Management; Bonnie Burns, California Health Advocates; Marc Cohen, Lifeplans, Inc.; David

Martin and Marie Roche at John Hancock Long-Term Care Insurance; Eileen Tell, Long-Term Care Group; Jennifer Cook and Brian Webb, National Association of Insurance Commissioners.

We collected data on 2008 premiums for long-term care insurance products sold by three major national carriers: John Hancock, MetLife, and Genworth. This premium data does not reflect an industry average but rather a snapshot of the premium levels a consumer would typically encounter in the private long-term care insurance marketplace. Claude Thau provided the premiums in March and September 2008. He is an insurance broker and President of Thau, Inc., an independent long-term care consulting firm, and co-author of annual survey reports for *Broker World Magazine* on group and individual private long-term care insurance premiums and other market trends.<sup>24</sup> The premium quotes displayed in this paper are representative of those provided by any sales agent working with the same set of assumptions about policy features, geography, and underwriting categories.

We reviewed and synthesized the results of a wide range of studies cited in the endnotes of the brief. These include the work of government agencies such as the U.S. Government Accountability Office (GAO) and the U.S. Department of Health and Human Services (HHS) as well as industry-produced reports and independent studies.

## II. How Do Consumers Buy Long-Term Care Insurance?

There are three main steps to purchasing a long-term care insurance policy. First, a potential purchaser usually meets with an insurance agent (individually or as part of a group) to hear about long-term care insurance and to consider whether the insurance makes sense for them. If so, they decide on key parameters about their coverage such as how much their policy will pay in benefits per day and the total amount of coverage they can receive. Second, a buyer selects among a variety of insurance carriers and products. Third, he or she applies for coverage to the insurer and undergoes an underwriting (health assessment) process before being approved to purchase the product. Below we describe these three steps in more detail.

In most states with Medicaid partnership programs recently approved under the Deficit Reduction Act (DRA), any long-term care insurance policy can qualify for the Medicaid asset disregard benefit as long as it meets certain federal and state guidelines. Federal and state partnership requirements do not dictate coverage and product choices except to set minimum guidelines for inflation protection (described further below). In other words, future purchasers in the 30 or more partnership states can make coverage decisions much in the same way that they do now and, as long as they select a minimum level of inflation protection, their policy will qualify for a Medicaid asset disregard.

**1. Coverage Decisions.** The process of making coverage decisions usually begins when an agent presents coverage decisions to a consumer or group of consumers. In the individual market, an agent will meet with a potential buyer in person, describe a variety of policy design options, and work with the consumer to tailor the product to his or her needs and personal budget. In the group market, agents usually present coverage options to a group of employees and provide a written description of coverage decisions.

The following are the most fundamental policy design features consumers in the individual market must consider when purchasing a policy. Many consumers in the group market face all or some of these decisions as well. In either case, potential buyers must consider how



coverage decisions affect the premium and whether they will be able to afford, currently and in the future, the coverage they select.

- **Daily Maximum Benefit Amount.** When an individual applies for long-term care insurance coverage, he or she will choose a maximum daily benefit amount. This amount, which most often ranges from \$100 to \$200 per day, is the maximum the insurance will pay for covered services received on any day.<sup>25</sup> The consumer may be able to choose different amounts by service setting (e.g., \$100/day for nursing home care and \$80/day for home care). All other features being equal, the higher the selected daily benefit amount, the higher the premium.

**On average, purchasers select daily benefit amounts of about \$128 in the group market and about \$145 in the individual market.<sup>26</sup> Individual purchasers with annual incomes below \$25,000 tend to select slightly lower average daily benefit amounts (\$116/day for nursing home care and \$105/day for home care).<sup>27</sup>**

- **Benefit Period/Lifetime Maximum Benefit.** Individuals applying for insurance coverage must also decide the length of time over which benefits will be paid or the total pool of money available for benefits. When the daily benefit amount exceeds covered expenses, the difference can extend the length of the policy.<sup>28</sup> For example, a daily benefit amount of \$100 paid out over 3 years translates roughly into a maximum of about \$109,500 available for benefits. If an individual uses services that cost less than \$100 per day, the pool of money will last longer than 3 years. In general, the total dollars paid by the policy determines the amount of assets that qualify for a Medicaid disregard under the Medicaid Partnership program. The longer the benefit period or larger the total pool of funds, the higher the annual premium.

**The majority of individual and group market purchasers choose a benefit period between three and five years.<sup>29</sup> Individual purchasers with annual incomes below \$25,000 often choose shorter benefit periods.<sup>30</sup>**

- **Covered Services.** Generally, most policies sold today cover a comprehensive set of benefits that include nursing home services, assisted living facilities, home care services, and adult day care.<sup>31</sup> They often cover a limited amount of informal caregiver services delivered by a neighbor or friend.<sup>32</sup> Nearly all policies also include some type of care coordination, bed reservation benefits (holds a bed while the insured is visiting family or away), homemaker services, and transportation.<sup>33</sup> In addition, many policies now offer a feature insurers call an “alternative plan of care.” This mutually agreed on plan by the insured and the insurer may allow payment for services that are not otherwise covered but may delay or prevent institutionalization such as a home renovation or new forms of care not currently in existence.<sup>34</sup>

**Regardless of income, more than 90 percent of individual purchasers choose policies that offer a comprehensive set of benefits.<sup>35</sup>**

- **Elimination Period (EP).** Most long-term care insurance policies require that a specified amount of time elapse after an insured individual qualifies for long-term care (according to the terms of the policy) before the policy pays benefits. The insured selects this so-called elimination period at the time of purchase. The longer the EP, the lower the premium but the higher the out-of-pocket costs at the time the insured needs care.<sup>36</sup>

**Regardless of income, the majority of policies sold in both individual and group settings include EPs of 90 days or more.<sup>37</sup>**

- **Inflation Protection.** Because long-term care insurance policies pay benefits many years after the purchase of a policy, inflation can erode the daily benefit amount. Consumers have the option of purchasing features that increase benefits over time in an attempt to keep up with the cost of care.

Consumers have a wide variety of inflation protection options. Table 1 illustrates how daily benefit amounts increase under some different inflation protection options.

- **Compound.** Under automatic compound inflation protection, the benefit increases by a percentage of the previous year's amount, but the premium is intended to remain level over time. Many individually sold policies increase by 5 percent compounded annually. Some policies grow by the Consumer Price Index for All Urban Consumers (CPI-U) compounded annually.<sup>38</sup> Others increase by 3 percent per year.<sup>39</sup> Federal law requires that Medicaid partnership-qualified policies include automatic compound inflation protection of some level.<sup>40</sup>
- **Simple.** Under simple inflation protection, the benefit increases by a percentage of the original daily benefit amount, typically 5 percent, while the premium is intended to remain level over time.
- **Future Purchase Option.** Under a feature sold most often in the group market, a policyholder has the option, at pre-defined, regular intervals, to raise the daily benefit amount and pay for that increase based on his or her current age. If the policyholder chooses to raise the daily benefit amount, it will increase by an amount determined by the insurer that may be equal to 5 percent compounded annually or some other level.<sup>41</sup> If the insured chooses not to boost the daily benefit amount at a given interval, the daily coverage amount will effectively contain no inflation protection. In general, the premium increase attributable to accepting a benefit increase varies depending on the insured's age at the time that the increase is purchased.<sup>42</sup> With this approach, premiums start low but get higher over time if the insured wants to retain purchasing power.

**Table 1. 30-year Benefit Values Under Different Options for Inflation Protection**

Type of Inflation Protection	Purchase Year 2005	Year 1 2006	Year 10 2015	Year 20 2025	Year 30 2035
Automatic Compound: 5%	\$100	\$105	\$163	\$265	\$432
Automatic Compound: CPI-U*	\$100	\$104	\$151	\$227	\$342
Simple: 5%	\$100	\$105	\$150	\$200	\$250
No Increase	\$100	\$100	\$100	\$100	\$100

\* Calculated using the average annual growth rate of the CPI-U from 1997-2007.

**About half of individual policies sold in 2006 include 5 percent compound inflation protection. The future purchase option (45.4 percent) was the most common design in the group market.<sup>43</sup>**

**In the individual market, inflation protection appears to be the feature that varies the most with income level. Eighty-six percent of buyers with annual income over \$75,000 have some type of inflation protection compared to 71 percent of buyers with annual income between \$50,000 and \$74,999; 67 percent of buyers with income between \$25,000 and \$49,999; and 44 percent of buyers with annual income below \$25,000.<sup>44</sup>**

**Summary.** Long-term care insurance purchasers tend to select policies that pay for a comprehensive array of services with coverage amounts of up to \$150 per day for 3 to 5 years, an elimination period of around 90 days and, in the individual market, automatic compound inflation protection of 5 percent. Since all of the new DRA partnership states require minimum inflation protection at levels *below* 5 percent, it is likely that many if not all policies sold individually in the 30 or more partnership states will qualify for the program.

It is not clear how partnership minimum inflation protection requirements will affect purchaser choices in the future. As annual income drops, individual purchasers tend to select less robust inflation protection (e.g., simple, future purchase option). While the Medicaid partnership requirement that qualified policies include automatic compound inflation protection may increase the overall number of policies sold with this feature, a growing percentage of purchasers may select levels of compound inflation protection below 5 percent, particularly if the program attracts more lower income purchasers.

**2. Product/Carrier Decision.** In addition to coverage decisions, purchasers in the individual long-term care insurance market must also select among different products offered by different insurance carriers. Purchasers in the group market generally skip this step as most employers have pre-selected one product from a single carrier for their employees.

Consumers can choose among 40 to 45 long-term care insurance carriers, although three carriers, Genworth, John Hancock, and MetLife dominate the market, accounting for more than 50 percent of individual long-term care insurance sales in 2006.<sup>45</sup> This dominance is due, in part, to a lack of profits in the industry that led some carriers to leave the market and others to consolidate.<sup>46</sup>

Many carriers, including the ones mentioned above offer at least two products. Products vary in subtle but important ways that allow carriers to differentiate standard and deluxe policies as well as distinguish themselves from one another. For example, some policies count only service days toward the elimination period while others count calendar days.<sup>47</sup> Also, carriers and products vary in their definition of assisted living facility and of the assisted living facility benefits they will pay.<sup>48</sup>

**3. Underwriting.** In addition to making coverage decisions and selecting a product, individual market purchasers also submit an application for insurance coverage to an insurer and then undergo a detailed health screening and evaluation to determine their insurability and risk rating. Underwriting techniques assess the applicant's likelihood of developing a cognitive impairment or chronic degenerative condition that carries a high risk of needing long-term care.<sup>49</sup>

About 15 to 20 percent of all applicants experience rejection when seeking coverage because of their risk for needing long-term care.<sup>50</sup> Once an insurer accepts an applicant, the insurer will place him or her into one of three health risk categories: preferred, standard, or substandard. A substandard rating would result in the highest premium, all other things being equal.<sup>51</sup>

In contrast to the individual market, employers often require that long-term care insurance carriers offer coverage to all active employees regardless of health status (referred to as “guaranteed issue”).<sup>52</sup> Only active employees can receive guaranteed issue and only during the initial enrollment period. Any employee who does not buy at his or her first opportunity or any spouse/dependent must undergo a full underwriting assessment similar to that performed in the individual market.

### III. How Much Does Long-Term Care Insurance Cost?

A long-term care insurance policy purchased in 2008 that is priced to reflect the most typical coverage decisions (\$150/day, 3-year benefit period, 5 percent compound inflation protection, comprehensive benefits, and 90-day EP) can typically cost between \$2,140 and \$2,460 per year for a single 60-year-old. This depends on the product and carrier (see Table 2), with lower prices provided for couples where both individuals purchase insurance. The tables and figures below present 2008 annual premiums for products offered by three of the largest carriers for the standard risk category.<sup>53 54</sup>

<b>Table 2. 2008 Annual Premiums, \$150 per Day, 3 Years Comprehensive Coverage, 5 Percent Automatic Compound Inflation Protection, 90-Day Elimination Period</b>						
Age of Insured	Single			Married Couple		
	Genworth	MetLife	J. Hancock	Genworth	MetLife	J. Hancock
40	\$1,701	\$1,349	\$1,485	\$2,041	\$1,888	\$2,079
50	\$1,874	\$1,590	\$1,760	\$2,249	\$2,226	\$2,464
60	\$2,460	\$2,140	\$2,386	\$2,952	\$2,997	\$3,340
70	\$4,680	\$4,359	\$4,507	\$5,616	\$6,103	\$6,310

Source: Premium quotes provided by insurance broker Claude Thau, President of Thau Inc.

The same policy with a five instead of three-year benefit period costs more. As Table 3 shows, a policy with this longer benefit period costs a single 60-year-old between \$2,997 and \$3,183, depending on the carrier. A 60-year-old couple with the same policies will pay between \$3,819 and \$4,406.

<b>Table 3. 2008 Annual Premiums, \$150 per Day, 5 Years Comprehensive Coverage, 5 Percent Automatic Compound Inflation Protection, 90-Day Elimination Period</b>						
Age of Insured	Single			Married Couple		
	Genworth	MetLife	J. Hancock	Genworth	MetLife	J. Hancock
40	\$2,189	\$1,849	\$2,113	\$2,627	\$2,588	\$2,958
50	\$2,363	\$2,191	\$2,365	\$2,835	\$3,068	\$3,310
60	\$3,183	\$2,997	\$3,147	\$3,819	\$4,196	\$4,406
70	\$6,172	\$5,982	\$5,869	\$7,406	\$8,375	\$8,217

Source: Premium quotes provided by insurance broker Claude Thau, President of Thau Inc.

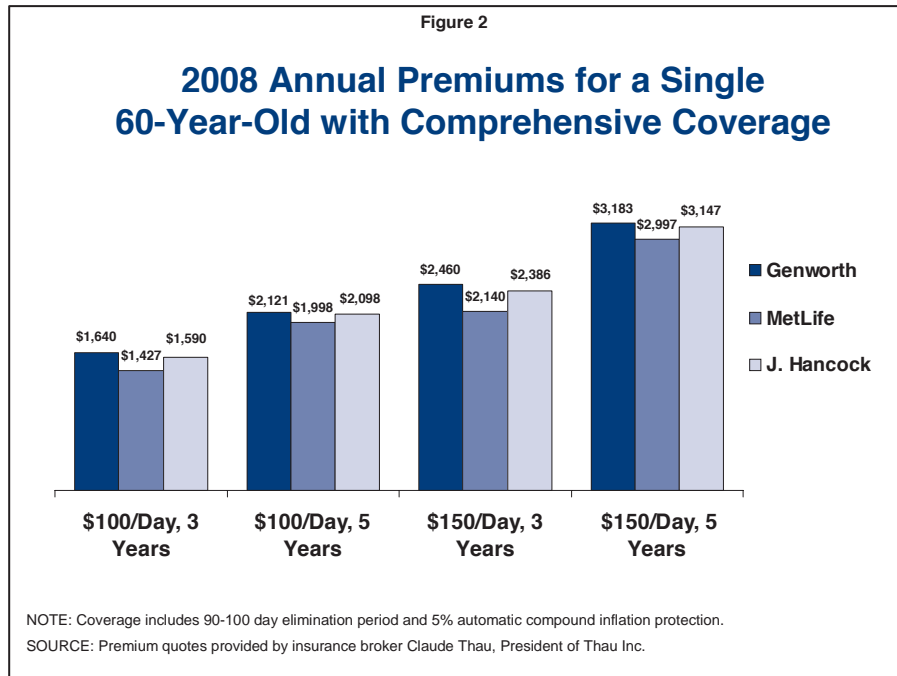
Table 4 illustrates how premiums vary by jurisdiction. This premium variance occurs primarily because of regulatory differences and because companies may not have their most recent product approved in each state. The premiums do not vary consistently across carriers. In the three geographically diverse states we examined, the same Genworth \$150/day, 5-year product costs the least (\$2,841 annually) in New York and the most (\$3,501 annually) in Oregon. However, the MetLife product costs the least in New York (\$2,847 annually) but the most in Florida (\$3,351 annually).

<b>Table 4. 2008 Annual Premiums, \$150 per Day Policy, 5-Year Comprehensive Policy, 5 Percent Automatic Compound Inflation Projection, 90-Day Elimination Period</b>			
<b>60-Year-Old Single Individual</b>			
	<b>Genworth</b>	<b>MetLife</b>	<b>J. Hancock</b>
Florida	\$3,105	\$3,351	\$2,665
Oregon	\$3,501	\$2,997	\$3,299
New York	\$2,841	\$2,847	\$2,893

*Source: Premium quotes provided by insurance broker Claude Thau, President of Thau Inc.*

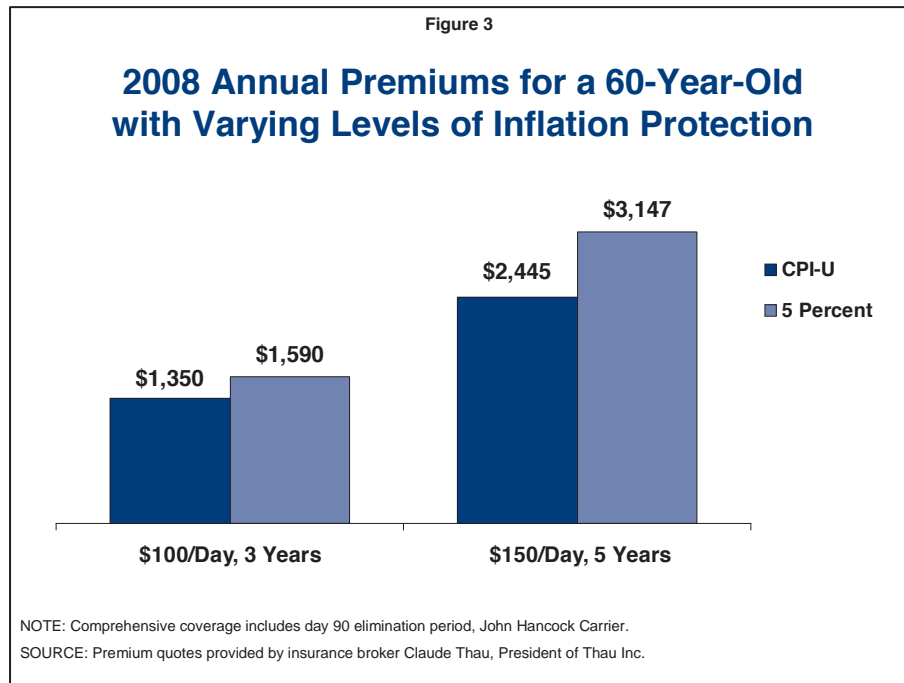
**Trade-offs Between Premiums and Coverage Features.** Consumers can exchange certain coverage features for lower annual premium costs. Lower daily benefit amounts and shorter benefit periods reduce the premium. Figure 2 shows the following trade-offs.

- **\$100/Day Daily Benefit Amount and 3-Year Benefit Period.** A 60-year-old single individual consumer can buy a \$100 per day, 3-year policy with 5 percent automatic compound inflation protection for between \$1,427 and \$1,640, depending on the carrier.
- **\$100/Day Daily Benefit Amount and 5-Year Benefit Period.** Increasing the length of coverage to 5 years but keeping a \$100 per day benefit level increases the premium to between \$1,998 and \$2,121 per year.
- **\$150/Day Daily Benefit Amount and 3-Year Benefit Period.** However, keeping a 3-year benefit period but increasing the daily benefit amount to \$150 increases the premium to between \$2,140 and \$2,460 per year.
- **\$150/Day Daily Benefit Amount and 5-Year Benefit Period.** When both the daily benefit amount and benefit rise to \$150 per day over 5 years, the premium rises to between \$2,997 and \$3,183 per year.



The trade-off that may be closely linked to income level is whether to buy inflation protection, which type (i.e., simple, compound, future purchase option) to select and at what level (e.g., 3 percent, CPI, 5 percent). In order to qualify as a Medicaid partnership product, the DRA requires that the policy contain automatic compound inflation protection for purchasers under age 61 but leaves the minimum level of this protection (e.g., 3 percent, CPI, 5 percent) to the discretion of states. Few states require 5 percent inflation protection (which is most often sold in the individual market).<sup>55</sup> Instead, many states permit inflation protection at levels below 5 percent such as not less than 3 percent (e.g., Missouri, Ohio, South Dakota) or 1 percent (e.g., Nebraska). Some states permit the increase to be any amount (e.g., Oregon, Minnesota, Georgia) and, so far, most of the new programs permit an increase amount equal to the CPI.<sup>56</sup>

To illustrate how a lower automatic compound inflation level affects price, Figure 3 shows premiums for a CPI-U rise compared to a 5 percent rise. Expanding the inflation protection level from CPI-U to 5 percent increases the annual premium by \$240 or 18 percent for the \$100 per day, 3-year policy, and by \$702 or 29 percent for the \$150 per day, 5-year policy.<sup>57</sup>



**Premium Increases.** An important feature of long-term care insurance is that the policyholder's premium is intended to remain unchanged for the life of the policy. Insurers cannot increase an individual policyholder's premium amount because of age or health status. However, an insurer can increase rates for a group of policyholders if the insurer demonstrates to state regulators that the experience under the policies is significantly worse than had been anticipated.<sup>58</sup>

Rate hikes occur when insurers set initial premium prices too low to generate, with investment income, the revenue necessary to cover claims payments and expenses. In the early part of this decade and before, insurers were projecting that certain factors such as high interest rates on invested reserves would enable them to charge a relatively low premium and still have adequate funds for claims payment. However, when interest rates and other factors turned out to be lower than assumed, many insurers requested a rate increase from state regulators.<sup>59</sup> Results from a recent GAO study indicate that the frequency and degree of rate increases vary significantly across companies and states. Among four companies studied, two implemented increases ranging from 30 to 70 percent on multiple products. Another long-standing company implemented only one small hike and another none.

The National Association of Insurance Commissioners (NAIC) responded to such increases by developing rate setting standards in 2000 that would require insurers to set premiums using more conservative assumptions. The NAIC designed these standards to achieve more rate stability and reduce the need for higher premiums. More than half of the states have adopted these standards as well as many of the larger national insurers.<sup>60</sup> Although the new standards will likely improve rate stability for policies going forward, some consumers will continue to experience rate increases on older policies.<sup>61</sup>



## IV. When and How Are Benefits Paid?

Before paying benefits under a long-term care insurance policy, an insurer must determine that the policyholder has a significant disability that necessitates long-term care. When Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996, it specified how disabled an insured person must be and how to measure that disability in order for the policyholder to receive benefits under a tax-favored long-term care insurance policy.<sup>62</sup> Nearly all policies sold today define and measure need for long-term care according to HIPAA. These disability requirements are referred to as “benefit triggers” and they can either be physical or cognitive.

- **Physical Benefit Trigger.** Under this criteria, an insured may qualify for benefits under a long-term care insurance policy when he or she is unable to perform at least two of five or two of six (depending on the policy) standard activities of daily living (bathing, dressing, toileting, transferring, continence, and eating) without substantial assistance (either directly hands-on or standing by) from another person.<sup>63</sup> This condition must be certified by a physician or nurse to be expected to last at least 90 days.
- **Cognitive Benefit Trigger.** Alternatively, a policyholder can qualify for benefits under his or her policy because of a severe cognitive impairment.<sup>64</sup> This usually comes under the definition of a loss of or deterioration in intellectual capacity such as Alzheimer’s disease or other types of dementia.<sup>65</sup>

In general, the insurer verifies qualification for benefits through a combination of activities that can include, depending on the insurer, an in-person assessment of the insured, a review of medical records, and a written certification from a licensed healthcare practitioner.<sup>66</sup> Insurers initiate the process of determining whether the beneficiary meets the benefit trigger at the time of the claim’s filing. In the case where the insured’s condition is very clear, as in the case of a paralyzing stroke, an insurer may verify qualification for benefits through a phone call with the primary physician or care provider.<sup>67</sup>

**Receiving Covered Services.** Once a policyholder meets the benefit trigger and satisfies the elimination period, the policy will begin paying claims for covered services. Most insurance carriers waive premium payments once benefit payments begin. Insurers pay claims only for the specific types of services covered under the policy and delivered by covered providers. For example, if assisted living is not a covered service under the policy or if the assisted living provider does not meet the policy’s provider criteria, the insurer will not pay for these services. Insurers reimburse for qualified services only up to the daily benefit amount selected at the time of purchase.

If a new type of long-term care service develops between the time a person purchases long-term care insurance and begins to need care, some policies have the flexibility to cover these new services even if they are not explicitly covered under the policy. This flexibility may be available, on approval of the insurer, if the insured’s policy contains an alternate care feature.

The reliability of this feature to adapt older policies for new services is unproven. Industry experts note instances in which an insured individual has received a home modification under the alternate care feature in order to forestall institutionalization. However, consumer advocates point to examples of policyholders who expected but were unable to receive newly developed services under this benefit feature.<sup>68</sup>



**Claims Payment Issues.** As with any insurance product, there have been disputes between long-term care insurance claimants and insurers about eligibility for benefits and other contract terms. Recent press reports and congressional oversight activity have raised concerns that denials of benefit claims are excessive and leaving consumers without insurance coverage as they begin needing long-term care.<sup>69</sup> In a review of insurance complaint data from five states, GAO found that although the *total* number of long-term care insurance complaints to state regulators dropped from 846 to 721 between 2001 and 2007, complaints related to claims settlement issues rose from 215 to 315 during the same period.<sup>70</sup>

Evidence of systemic wrongdoing by long-term care insurance carriers is inconclusive. In a study by HHS of long-term care insurance claimants, researchers found that nearly 96 percent of those filing claims received immediate approval for their claims and about half of those denied (2 percent) later gained approval. Claimants that did not yet meet the benefit triggers made up the remaining 2 percent of denials.

In an effort to assess charges of high claims denial rates, the NAIC requested data from the top 25 long-term care insurance carriers in the individual market. The NAIC found that variations in data reporting among insurers might contribute to confusion about claims denial rates and make examination of claims issues difficult. For example, when a policy pays \$100 a day and the nursing home charge is \$150 per day, some companies report the uncovered \$50 as a partial denial while others do not.<sup>71</sup> Some companies report claims denials on a per person basis and others on a per bill basis. Therefore, while the NAIC has found an increase in the percentage of claims denied, it also acknowledges significant limitations in existing data and has indicated it is working with insurers to resolve these inconsistencies.<sup>72</sup>

## **V. How is Long-Term Care Insurance Regulated to Protect Consumers?**

States regulate long-term care insurance. State legislatures and regulatory bodies set long-term care insurance standards designed to protect consumers against bad business practices by insurers and state insurance commissioners monitor and enforce these standards. Working with states and insurers, the NAIC has developed model laws and regulations to provide states with the regulatory best practices for long-term care insurance. However, states vary in their adoption of all or part of the most updated NAIC-recommended standards.<sup>73</sup>

In two major respects, the federal government has overlaid state regulations with additional requirements for long-term care insurers. First, as described earlier, HIPAA established federal standards that specify the conditions such as benefit trigger criteria and certain quality standards under which long-term care insurance can qualify for favorable tax treatment.

Second, through the DRA, Congress established federal requirements for long-term care insurance policies to qualify as Medicaid partnership policies. Generally, the DRA requires that policies contain some level of compound inflation protection for individuals under age 61 and some level of inflation protection (can be simple) to individuals between ages 61 and 76.<sup>74</sup> It requires that partnership policies be HIPAA-qualified and meet certain NAIC model regulations adopted in 2000, and that state Medicaid agencies work with state insurance departments to ensure proper training of insurance sales agents.<sup>75</sup> It also requires the Secretary of HHS to develop standards under which states can choose to honor asset disregards resulting from partnership policies sold under other states' partnership programs. States have discretion in

how they implement partnership programs under statutory requirements and federal implementing guidelines, such as the amount of inflation protection and number of hours required for agent training.

## VI. Issues/Trends to Watch

The following are issues and trends in the private long-term care insurance market that address whether the long-term care insurance market can expand and fill a larger role in our current system. The section also examines how well these insurance products serve the needs of policyholders.

**Rising Premium Costs.** Even before the recent financial crisis, premiums have been rising in response to low interest rates and higher expected claims.<sup>76</sup> This increase is responsible, in part, for stunted growth in the sale of individual policies for the past several years. While sales growth is positive in the employer market and may improve in the individual market, the cost of long-term care insurance remains an obstacle to furthering the penetration of long-term care insurance. As noted above, cost is the most important reason potential purchasers provide for why they do not buy insurance. Policymakers interested in directly reducing purchaser costs could consider policy options such as supplementing coverage (e.g., by providing catastrophic coverage), additional tax deductions for premiums or tax credits toward the purchase of long-term care insurance, or direct premium subsidies. They should also monitor the effect of the financial crisis on premium levels and insurance company reserves.

**Coverage Denial and Product Complexity.** Two issues inherent in the individual market reduce the ability of long-term care insurance to fill the long-term care financing gap for many potential purchasers. First, not all potential buyers get a policy. As noted above, industry experts estimate that 15 to 20 percent of those who apply for coverage are denied.<sup>77</sup> Policymakers interested in promoting the role of private long-term care insurance will need to seek ways to reduce coverage denial rates or provide private financing alternatives for rejected individuals. Second, the complexity of insurance products requires the individual-level attention and guidance of a sales agent or other consumer advisor. A long-term care insurance expansion on a scale large enough to shift financing will require some simplification and standardization of products as well as a communications and education strategy.

### Inflation Protection.

**Group Market.** A relatively high percentage of employer-based policies are being sold without automatic compound inflation protection and to young purchasers.<sup>78</sup> If policyholders decline optional adjustments to their daily coverage and premiums, inflation will significantly erode their purchasing power. The growth of the employer-based market raises concern about whether many of the future long-term care insurance claimants will have sufficient coverage relative to service costs. Policymakers concerned about this issue could monitor and study whether group market purchasers tend to accept or decline benefit and premium increases, and the impact of their choices on their benefit levels over time.

**Individual Market.** It appears that buyers at middle and lower income levels may be more willing to trade off inflation protection for a lower premium than to reduce daily benefit amounts. The Medicaid partnership program requirements for a minimum level of

inflation protection may reduce the number of policies sold without any inflation protection, particularly to lower or middle income purchasers. However, policymakers and industry leaders should continue to consider ways to guide lower and middle income purchasers in making the coverage/premium trade-offs that yield the most value and insure the highest level of protection in the future.

**Premium Increases and Claims Denials.** According to a recent GAO report, some policyholders may continue to experience rate increases because they bought their policies under lower initial premiums when insurers were anticipating less costly experience.<sup>79</sup> Because state regulators vary in how they review and approve carriers' applications for rate increases, policyholders may experience higher rates inconsistently across the country. Policymakers, the NAIC, and others can continue to observe the impact of rate increases on policyholders and whether the new rate setting standards are effective in stabilizing rates on newer policies.

As the NAIC and the industry work to improve consistency of claims data across insurance carriers, state and federal policymakers will have the opportunity to further examine and monitor the pervasiveness of claims disputes and inappropriate denials, and to implement independent review for contested cases. Premium increases and claims denials affect the experience of current policyholders as well as the perception of the public overall about the reliability of private long-term care insurance products.

**Flexibility for Assisted Living, Residential Care, and Other Service Innovations.** Changing service definitions and the evolution of new forms of residential care test the flexibility of long-term care insurance products. Unlike well-understood and defined services such as nursing home and home care, assisted living and other forms of residential care do not always meet the service definitions contained in long-term care insurance policies.<sup>80</sup> In addition, assistive technologies are rapidly advancing. Future users of long-term care may receive assistance at home from a range of technologies that include motion sensors and other remote monitoring devices.<sup>81</sup> While the alternate plan of care feature may provide some coverage of assistive technology, today's contracts do not explicitly cover technology nor are they designed for the type of large one-time purchases that home technology installations may require. A challenge for long-term care insurance carriers and policymakers will be to ensure the flexibility that today's purchaser may expect 20 or 30 years from now if they need and desire assistive technology that enables them to stay at home.

**Medicaid Partnership Products.** A majority of states either have received or are seeking approval to implement a Medicaid partnership program. When these programs are fully implemented, any individual or group product sold in these states and meeting minimum requirements for the program will entitle the purchaser to a Medicaid asset disregard. One potential outcome of this program is that, going forward, nearly every policy sold in the 30 or more partnership states will likely qualify for the program and therefore include a Medicaid asset disregard. If so, policymakers should monitor how the partnership program requirements affect the average levels of automatic compound inflation protection, the implications of these decisions for future service use, and future Medicaid obligations.

## VII. Conclusion

Evidence exists that long-term care insurance provides a valuable benefit to the vast majority of claimants. In a longitudinal study of 1,400 policyholders receiving paid services and filing claims, most of the respondents were using their insurance benefits to pay for care at home or in an assisted living facility.<sup>82</sup> These respondents reported high levels of satisfaction with their service providers and nearly all reported having no disagreements with their insurance company or having the disagreements satisfactorily resolved. A majority of respondents stated that they would have to decrease the amount of paid care they received if they did not have their policies.<sup>83</sup>

Middle-income individuals are among those who could most benefit from many of the advantages that a well-designed and high-quality long-term care insurance policy has to offer. These are the individuals and families most at risk of financial calamity and having to rely on Medicaid in the face of a significant long-term care need such as Alzheimer's disease. Such an event can devastate family members who, after exhausting their assets, may have very little choice of care setting other than a Medicaid nursing home.<sup>84</sup>

However, current purchasers of long-term care insurance are not primarily middle-income but instead earn more and have more assets than average. They buy a substantial amount of comprehensive coverage and protect it aggressively against inflation. These policies, if purchased at age 60 from one of the three largest insurers, can cost between roughly \$2,000 and \$3,000 annually depending on the carrier and length of the policy. The benefits from these policies are available when policyholders develop a fairly significant level of impairment and use the services as they are defined in their policy.

Even in the absence of policies to further promote the purchase of long-term care insurance, the market will continue to evolve and change. The group market will likely grow and bring changes to the type of coverage that is sold and the age and income of policyholders. The new partnership programs may attract more middle-income purchasers and increase the percentage of policies sold with compound inflation protection but at levels that fall below the 5 percent now typical in the individual market. The percentage of elderly who own long-term care insurance policies will grow steadily over time. However, it appears unlikely that the long-term care insurance market will experience the kind of dramatic growth necessary to shift a substantial portion of the long-term care financing burden from Medicaid and individuals to private insurance.

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<sup>1</sup> *Long-Term Care – an Essential Element of Healthcare Reform*, a chartbook authored by Anne Tumlinson and Christine Aguiar, of Avalere Health for the SCAN Foundation, December 2008.

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<sup>10</sup> Burns, Bonnie, Testimony for the July 28, 2008, hearing before the U.S. House Energy and Commerce Committee, Subcommittee of Oversight and Investigations.

<sup>11</sup> *Group Long-Term Care Survey*, Broker World, February 2008. Broker World is a national insurance magazine that provides information about life and health insurance products to the independent life and health insurance agents who select and sell products from a variety of companies. The magazine is produced monthly. Its 2008 topics include updates on the annuities market, disability insurance, employee benefits, and health insurance. Some issues include results from a survey of products in a particular area such as private long-term care insurance and annuities. The magazine publishes an annual update on the individual and group private long-term care insurance markets using data it collects each year from a sample of insurance carriers who represent nearly 90 percent of the market. The individual market data is collected and analyzed by Claude Thau, Thau Inc., and Steve Pummer, Towers Perrin, who also analyze the group market data along with Dan Cathcart, also of Towers Perrin. Issues of the magazine and reprints of its studies can be accessed and purchased at [www.brokerworldmag.com](http://www.brokerworldmag.com).

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<sup>19</sup> *Who Buys Long-Term Care Insurance?*, April 2007.

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<sup>28</sup> Interview with Eileen Tell, May 28, 2008.

<sup>29</sup> *Who Buys Long-Term Care Insurance?* April 2007 and *Group Long-Term Care Survey*, Broker World, February 2008.

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<sup>31</sup> *Ninth Annual LTCI Survey*, Broker World, July 2007.

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<sup>37</sup> GAO, March 2006 and *Group Long-Term Care Insurance Survey*, Broker World, February 2008.



<sup>38</sup> <http://www.dehpg.net/LTCTPartnership/map.aspx>

<sup>39</sup> <http://www.dehpg.net/LTCTPartnership/map.aspx>

<sup>40</sup> Public Law 109-171.

<sup>41</sup> Email exchange, Eileen Tell, September 23, 2008.

<sup>42</sup> Email exchange, Eileen Tell, September 23, 2008.

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<sup>53</sup> The Genworth product is Classic Select. The MetLife product is Value 2 and the John Hancock product, unless otherwise noted is Custom Care II. We did not have sales data on each of these products that would enable us to calculate a weighted average of annual premiums. Therefore, we present the premiums for each of the three products. The premiums assume a standard underwriting risk category.

<sup>54</sup> The Genworth product is Classic Select. The MetLife product is Value 2 and the John Hancock product, unless otherwise noted is Custom Care II. We did not have sales data on each of these products that would enable us to calculate a weighted average of annual premiums. Therefore, we present the premiums for each of the three products. The premiums assume a standard underwriting risk category.

<sup>55</sup> <http://www.dehpg.net/LTCTPartnership/map.aspx>

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<sup>57</sup> John Hancock does not offer a CPI automatic compound inflation protection feature in its Custom Care II product. Therefore we compare premiums between Custom Care II and the Leading Edge product which has a 100-day elimination period.

<sup>58</sup> *Long-Term Care Insurance, Oversight of Rate Setting and Claims Settlement Practices*, U.S. Government Accountability Office (GAO), June 30, 2008. GAO-08-712.

<sup>59</sup> GAO, June 2008.

<sup>60</sup> GAO, June 2008.

<sup>61</sup> GAO, June 2008.

<sup>62</sup> Under federal law, benefits paid long-term care insurance policies that meet certain criteria are usually not considered tax deductible. In addition, premiums paid for these tax-qualified policies may be included as a deductible medical expense for taxpayers whose deductible medical expenses add up to more than 7.5 percent of the taxpayer's adjusted gross income.

<sup>63</sup> *Long-Term Care, Understanding Needs and Options*, 2005.

<sup>64</sup> *Long-Term Care, Understanding Needs and Options*, 2005.

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