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Long-Term Health Care Insurance Challenges: Meeting The Needs of an Aging Population

Angela S. Curran*

I. INTRODUCTION

America is graying. Approximately 21% of the American population—51.4 million people—is 55 years of age or older.¹ By the turn of the century, there will be 10 million more elderly than in 1980,² and they will live longer. Women at age sixty-five will have a remaining life expectancy of twenty years; men the same age can expect to live another sixteen years.³ The “old-old,” individuals over eighty years of age, is the fastest growing segment of the elderly population. They currently comprise about 1.3% of the general population (3.3 million people).⁴ By the beginning of the twenty-first century, almost 5 million people will be at least eighty-five years of age.⁵

Our aging population has many health needs that have not yet been fully addressed by the public and private sectors. In fact, nearly 90% of the disabled elderly who are not in nursing homes receive unpaid assistance from relatives and friends.⁶ The now-repealed Medicare Catastrophic Coverage Act of 1988⁷ was an at-

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1. SENATE SPECIAL COMMITTEE ON AGING, DEVELOPMENTS IN AGING: 1987 VOL. 3, S. REP. NO. 100-291, 100th Cong., 2d Sess., at 5 (1988) [hereinafter DEVELOPMENTS IN AGING]. The “elderly”—those 65 years of age or older—constitute 12% of the total population (29.2 million people). As the “baby-boomers” age between 1985 and 2020, the elderly population is expected to double. *Id.*

2. Burke, *Long-Term Care: The Public Role and Private Initiatives*, in 1 HEALTH CARE FIN. REV. 1 (Supp. 1988).

3. *Id.* (citing SOCIAL SECURITY ADMINISTRATION: THE 1988 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL OLD-AGE AND SURVIVORS INSURANCE AND THE FEDERAL DISABILITY INSURANCE TRUST FUNDS, H.R. Doc. No. 192, 100th Cong. 2d Sess. (1988)).

4. SPECIAL COMMITTEE ON LONG-TERM HEALTH CARE INSURANCE, WISCONSIN LEGISLATIVE COUNCIL STAFF, OVERVIEW OF LONG-TERM CARE INSURANCE, at 4-5 (1986).

5. *Id.* at 5.

6. A. RIVLIN & J. WEINER, CARING FOR THE DISABLED ELDERLY: WHO WILL PAY? 5 (1988).

7. Pub. L. No. 100-360, 102 Stat. 683 (1988), (codified as amended in scattered sections of Titles 18 and 19 of the Social Security Act, 42 U.S.C. §§ 1395 & 1396 (1988); repealed by Pub. L. No. 101-234, 103 Stat. 1979 (1989)).

tempt to expand the Medicare Program⁸ to shield Medicare beneficiaries from the catastrophic costs associated with a short-term, acute illness by, among other things, increasing coverage for short-term stays in a certified skilled nursing facility,⁹ expanding benefits for hospice care,¹⁰ increasing benefits for home health services,¹¹ and providing new, but limited coverage for respite care.¹² The Catastrophic Coverage Act, however, did not address growing problem of financial costs associated with long-term chronic conditions.¹³ The major health problems of the elderly are no longer associated with acute conditions. According to the Senate Special Committee On Aging, arthritis, hypertension, Alzheimer's disease, and other chronic conditions are now occurring with greater frequency.¹⁴ Approximately 80% of the elderly have at least one dis-

8. 42 U.S.C.A. § 1395a-1395xx, (West 1983 and Supp. 1989).

9. A certified skilled nursing facility ("SNF") is defined as an institution primarily engaged in providing to residents skilled nursing care and related rehabilitation services. 42 U.S.C.A. § 1395i-3(a) (West Supp. 1990). Effective January 1, 1989, the Catastrophic Coverage Act would have extended Medicare Part A coverage for qualified stays in a SNF from 100 days to 150 days per year, eliminated the requirement that a beneficiary have a three-day hospital stay before becoming eligible for SNF benefits, and required the beneficiary to pay coinsurance for only the first eight days of SNF care in an amount equal to 20% of the nationwide average daily cost for SNF care. Pub. L. No 100-360, § 102, 102 Stat. 684-87 (1988) (codified at 42 U.S.C.A. § 1395d) (West 1989)). That amount was estimated to be \$20.50 per day in 1989. *Catastrophic-Costs Bill Is Sent to White House*, 46 CONG. Q. 1606 (1988).

10. The Act would have eliminated the 210-day limit for hospice care under Part A. Pub. L. No. 100-360, § 101, 102 Stat. 684-85 (codified at 42 U.S.C.A. § 1395d).

11. Effective January 1, 1990, the Act would have paid Medicare Part B benefits for qualified home health care services seven days per week for up to 38 days if a physician certified the need for such care on a daily basis. Pub. L. No. 100-360, § 206, 102 Stat. 731-32 (codified at 42 U.S.C.A. § 1395x(m)).

12. Also effective January 1, 1990, benefits would have been paid under Medicare Part B for up to eighty hours per year of paid care to give a respite to an unpaid family member or friend who lives with, and cares for, a "chronically dependent" beneficiary. Pub. L. No. 100-360, § 205, 102 Stat. 729-31 (codified at 42 U.S.C.A. § 1395k(a)). A "chronically dependent" beneficiary is one who lives with a voluntary care-giver whom a physician certifies is dependent upon the care-giver for assistance with at least two activities of daily living (i.e. eating, bathing, dressing, toileting, moving in and out of bed). Benefits include services for homemaking, personal care, and professional nursing care. To be eligible for respite care benefits, however, the beneficiary must have surpassed the Part B out-of-pocket limit (\$1,370 in 1990) or the prescription drug deductible starting in 1991. *Id.*

13. The Act did not change the law excluding Medicare coverage for "custodial care," that is, care that consists primarily of nonmedical assistance with activities of daily living. 42 U.S.C.A. § 1395y(a)(9). Approximately 90% of all nursing home residents require custodial rather than skilled care. HOUSE SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HEALTH AND LONG TERM CARE, 100TH CONG., 1ST SESS., NURSING HOME INSURANCE: EXPLOITING FEAR FOR PROFIT? app. V at 100-634 (Comm. Print. 1987) [hereinafter NURSING HOME INSURANCE].

14. DEVELOPMENTS IN AGING, *supra* note 1, at 8-9.

ability arising from a chronic health condition.¹⁵

Although there is no generally accepted definition of "long-term care," it is recognized as the type of care associated with chronic illness. The term is used to describe a wide array of services, both medical and nonmedical, in both institutional and noninstitutional settings. The Health Care Financing Administration defines "long-term care" as "the professional or personal services required on a recurring or continuous basis by an individual because of chronic or permanent physical or mental impairment. These services may be provided in a variety of settings, including the client's own home."¹⁶ Unlike acute care, the need for long-term care should be determined by measuring disabilities that prevent the individual from carrying out normal day-to-day activities.¹⁷ Such activities are divided into two categories: personal and "environmental" or "support." In the first category, bathing, dressing, getting in and out of bed, toileting, and eating commonly are defined as "activities of daily living" ("ADLs"). In the second category, tasks such as cooking, cleaning and shopping are defined as "instrumental activities of daily living" ("IADLs").¹⁸

The financing of the long-term care needs of the elderly currently is the focus of debate at national and state levels,¹⁹ in both the public and private sectors.²⁰ One alternative that has received

15. *Id.* at 8.

16. NATIONAL RESEARCH COUNCIL, THE AGING POPULATION IN THE TWENTY-FIRST CENTURY: STATISTICS FOR HEALTH POLICY 137 (D. Gilford ed. 1988) [hereinafter THE AGING POPULATION].

17. See, e.g., Doty, Liu & Weiner, *An Overview of Long-Term Care*, 6 HEALTH CARE FIN. REV. 69 (1985).

18. Scanlon, *A Perspective On Long-Term Care for the Elderly*, HEALTH CARE FIN. REV. 7 (1988 Ann. Supp.). See also THE AGING POPULATION, *supra* note 16, at 138-39.

19. Historically, Medicare has not provided benefits for long-term care needs. The Catastrophic Coverage Act propelled the debate over long-term care into the political limelight, thus mobilizing the 101st Congress. The Act authorized \$1.5 million to establish a bipartisan commission on comprehensive health care to make specific recommendations to Congress concerning long-term care for Medicare beneficiaries as well as comprehensive health care for all citizens. The Act also authorized for the period covering 1989-93 \$5 million annually for research on the delivery and financing of long-term care services. Pub. L. No. 100-360, 102 Stat. 765-68 (1988). The 15-member commission was called the U.S. BiPartisan Commission On Comprehensive Health Care, but popularly was referred to as the "Pepper Commission" in honor of the late Claude Pepper (Dem. Fla.) who was elected Chairman in February 1989. The Commission was added to the legislation in an attempt to mollify Rep. Pepper, who had threatened to attach an amendment establishing a federal program for home care services for the elderly. This legislation is discussed *infra* at notes 236-78 and accompanying text. See generally *New 'Pepper Commission' Has Rocky Beginning*, 47 CONG. Q. 524-25 (1989); "Pepper Bill" *Pits Politics Against Process*, 46 CONG. Q. 1491-93 (1988).

20. The elderly population is the largest potential voting block in the United States.

much attention by those examining the issue of long-term care is private, long-term care insurance. Such insurance was virtually nonexistent prior to 1980, but the insurance industry now has accepted the need for long-term care as an insurable risk.²¹ As of 1986, approximately 200,000 policies insuring long-term care were in force.²² In a 1988 survey, the Health Insurance Association of America reported 105 of its member companies selling long-term care insurance in 1988. It further estimated that there are currently 1.1 million individual and group policies in effect.²³ Approximate annual premiums for a person at age 65 range from \$300 to \$700; premiums for those at age 79 range from \$725 to \$1,500.²⁴

Two recent market trends have the potential to reduce premiums and further increase consumption. Employer-sponsored plans are being offered with increasing frequency, even though the tax consequences for employers and employees are not clear.²⁵ Alaska

See Backers of Long-Term Care Bill See End to Long Wait, Chicago Tribune, Mar. 13, 1989, § 1, at 4, col. 4. The pressure at both the federal and state levels to provide some measure of insurance for long-term care costs often is attributed to the vocal lobbying efforts of groups representing senior citizens, for example, the Gray Panthers, the American Association of Retired Persons ("AARP"), and the Villers Foundation. *See, e.g., Long-Term Care '88: Campaign for an Issue*, 46 CONG. Q. 939 (1988).

21. Fireman's Fund American Life Insurance Company (now AMEX Life Assurance Company) and United Equitable Life Insurance Company started underwriting policies covering nursing home costs in the late 1970s. *See* NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, LONG-TERM CARE INSURANCE: AN INDUSTRY PERSPECTIVE ON MARKET DEVELOPMENT AND CONSUMER PROTECTION 7-8 (1986) [hereinafter NAIC REPORT]; Meiners, *The State of the Art in Long-Term Care Insurance*, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH (April 9, 1984).

22. U.S. GENERAL ACCOUNTING OFFICE, LONG-TERM CARE INSURANCE: COVERAGE VARIES WIDELY IN A DEVELOPING MARKET, REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, HOUSE SELECT COMMITTEE ON AGING 16 (May 1987) [hereinafter GAO REPORT].

23. HEALTH INSURANCE ASSOCIATION OF AMERICA, RESEARCH BULLETIN, LONG-TERM CARE INSURANCE: MARKET TRENDS 5 (March 1989) [hereinafter HIAA RESEARCH BULLETIN].

24. A. RIVLIN & J. WEINER, *supra* note 6, at 60.

25. HIAA RESEARCH BULLETIN, *supra* note 23, at 17-21. The 101st Congress introduced proposals to amend the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* (1985 & Supp. 1990), to permit employer contributions for long-term care health plans with favorable tax consequences for employer and employee. H.R. 1865, 101st Cong., 1st Sess. (1989); S. 138, 101st Cong., 1st Sess. (1989). It is beyond the scope of this Article to evaluate these proposed changes. It should be noted, however, that such changes have been recommended to facilitate the increased use of private, long-term care insurance and concomitant decrease in premiums. *See, e.g.,* TASK FORCE ON LONG-TERM HEALTH CARE POLICIES, HEALTH CARE FINANCING ADMINISTRATION, FACT SHEET ON LONG-TERM CARE (1987), *reprinted in* TASK FORCE ON LONG-TERM HEALTH CARE POLICIES, REPORT TO CONGRESS AND THE SECRETARY 41-53 and app.

has sponsored a plan for state employees since 1987,²⁶ and Congress has considered several bills providing a long-term care plan for federal civil employees.²⁷ Employer-sponsored group plans are attractive because premiums are lower and more affordable at younger ages. Moreover, although individual insurers often rely upon medical underwriting criteria to determine eligibility for benefits, group long-term care policies determine the need for care by assessing inability to perform ADLs.²⁸ This method of evaluation more closely follows the definition of "long-term care."

Several insurance companies also are offering optional long-term care riders to universal life insurance policies.²⁹ Under these plans, death benefits are prepaid (usually at the rate of 2% per month) if the insured becomes eligible for coverage under the long-term care rider.³⁰ These products are considered to be one of the most promising innovations of the private, long-term care insurance market. The premium for the rider typically is lower than a free-standing long-term care insurance product, and the policy generally provides a greater return on investment.³¹

The following discussion is limited to freestanding indemnity policies that insure long-term care. There are, however, other models of long-term care insurance. Long-term care benefits can be offered through a health maintenance organization or similarly managed-care environment.³² Social Health Maintenance Organizations ("S/HMOs") integrate a broad array of chronic care benefits with acute care benefits in a managed-care environment, but S/HMOs are available only in four cities.³³ Continuing care retirement communities ("CCRCs") provide sheltered housing and a

at 135-46 [hereinafter LONG-TERM HEALTH CARE TASK FORCE REPORT]; NAIC REPORT, *supra* note 21, at 38-40.

26. HIAA RESEARCH BULLETIN, *supra* note 23, at 17-21.

27. H.R. 212, 101st Cong., 1st Sess. (1989); S. 38, 101st Cong., 1st Sess. (1989).

28. HIAA RESEARCH BULLETIN, *supra* note 23, at 17-21.

29. *Id.* at 22. First Penn Pacific Life Insurance Company and ITT Life Insurance Company currently offer such policies in Illinois. Telephone interview with Mark Fulginza, Evaluation Unit, Illinois Department of Insurance (Apr. 26, 1989).

30. HIAA RESEARCH BULLETIN, *supra* note 23, at 22.

31. *Id.*

32. As of April 1989, only one HMO, Group Health of Puget Sound in Washington, has offered such benefits to its enrollees. *Id.* at 23.

33. *See generally*, A. RIVLIN & J. WEINER, *supra* note 6, ch. 6; LEUTZ, CHANGING HEALTH CARE FOR AN AGING SOCIETY: PLANNING FOR THE SOCIAL HEALTH MAINTENANCE ORGANIZATION (1985). Congress mandated a S/HMO demonstration project as part of the Deficit Reduction Act of 1984. There currently are only four demonstration plans in Brooklyn, New York; Portland, Oregon; Minneapolis, Minnesota; and Long Beach, California. A. RIVLIN & J. WEINER, *supra* note 6, at 97-98.

continuum of care services.³⁴ Depending upon an elderly client's financial resources and personal preferences, CCRCs or managed-care programs provide an alternative to indemnity long-term care insurance.

II. SOURCES OF PUBLIC FINANCING OF LONG-TERM CARE

Advice about long-term care insurance should not be offered in a vacuum. Rather, the consumer must evaluate relative costs and benefits of private insurance in light of the current public financing available for long-term care. The following section provides a brief overview of federal financing programs.

A. Background Information

The poverty rate among the elderly has declined from 28.5% in 1966 to 12.8% in 1986.³⁵ Their average median income in 1986, however, was only \$19,992.³⁶ Elderly persons, in particular those over 85 years of age, are more likely to be just above the poverty line than their younger counterparts.³⁷ Poverty rates also remain high for elderly women, and the elderly who live alone.³⁸

Given these statistics, it is not surprising that the health care expenditures for the elderly far outpace their incomes. In 1984 (the last year for which separate figures for the elderly are available), projected total health care expenditures for the elderly were \$119.9 billion (or \$4,202 per elderly person).³⁹ Twenty-one percent of these health care expenditures (approximately \$25 billion) were for nursing home care.⁴⁰ In 1987, nursing home expenditures for all ages totalled \$41.6 billion.⁴¹ By the year 2000, nursing home

34. See generally, A. RIVLIN & J. WEINER, *supra* note 6, ch. 5; Cohen, *Life Care: New Options for Financing and Delivering Long-Term Care*, 9 HEALTH CARE FIN. REV. 139 (1988 Ann. Supp.). Aetna Life & Casualty and Metropolitan Life Insurance Company currently provides coverage to CCRC members.

35. DEVELOPMENTS IN AGING, *supra* note 1, at 28. However, there is such a wide diversity among the elderly's income that these figures are misleading. *Id.* at 28-29.

36. *Id.* at 28.

37. *Id.* at 28-29.

38. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 66. One-third (9 million) of the elderly population live alone. CHAIRMAN OF HOUSE SELECT COMMITTEE ON AGING, AGING NOTES: AN INFORMATION BRIEF, H.R. REP. NO. 100-668, 100th Cong., 2d Sess. at 7 (1988) [hereinafter cited as AGING NOTES].

39. Waldo & Lazenby, *Demographic Characteristics and Health Care Use and Expenditures By the Aged in the United States: 1977-1984*, 6 HEALTH CARE FIN. REV. 1, 8, 10 (Fall 1984); THE AGING POPULATION, *supra* note 16, at 156.

40. Waldo & Lazenby, *supra* note 39, at 8; THE AGING POPULATION, *supra* note 16, at 157.

41. DEVELOPMENTS IN AGING, *supra* note 1, at 30. People under age 65 represent

expenditures are expected to triple to \$129 billion.⁴² Long-term care is expensive. In 1988, the average national nursing home cost per person per year was estimated to be \$25,000.⁴³ As can be expected, costs are much higher in urban areas such as Washington D.C., where annual nursing home costs ranged from \$36,000 to \$48,000 in 1988.⁴⁴ Medicare reimbursement rates for home health care averaged \$63.11 per day in 1988.⁴⁵

Not only is cost a major problem for the elderly, but they face a significant risk of incurring these extraordinary expenses for long-term care as well. Approximately 1.3 million elderly—5% of the elderly population—were admitted to nursing homes in 1985.⁴⁶ The U.S. Administration On Aging⁴⁷ expects the elderly nursing home population to reach 2 million by the turn of the century and 4.6 million by 2040.⁴⁸ Those over 85 constitute almost half of the elderly nursing home population,⁴⁹ with women comprising 75% of nursing home residents.⁵⁰ Elderly persons between the ages of 65 and 69 face a 5% risk of entering a nursing home within five years, and a 43% risk of entering a nursing home during their remaining lifetimes.⁵¹ Most (75%) nursing home residents stay in the home for less than one year, and less than one-half of residents stay in the home fewer than three months.⁵² The average length of stay in a nursing home, however, is 456 days⁵³ because “long-stayers,” patients who spend more than one year in a nursing home, account for over 91% of all nursing home admissions.⁵⁴

11. 3% of all nursing home admissions (approximately 146,000 admissions per year). LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 84-91.

42. DEVELOPMENTS IN AGING, *supra* note 1, at 31.

43. *Id.* at 27.

44. G. SHEARER, LONG-TERM CARE: ANALYSIS OF PUBLIC POLICY OPTIONS 12 (1988).

45. *Id.*

46. DEVELOPMENTS IN AGING, *supra* note 1, at 12.

47. The Commission is the principal agency for carrying out legislative programs created for the elderly. See 42 U.S.C.A. § 3011 *et seq.* (1988).

48. DEVELOPMENTS IN AGING, *supra* note 1, at 12. Nursing home occupancy rates averaged 92% in 1985. A. RIVLIN & J. WEINER, *supra* note 6, at 8.

49. DEVELOPMENTS IN AGING, *supra* note 1, at 12, 14. The median age of nursing home residents is 81 years. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 67.

50. DEVELOPMENTS IN AGING, *supra* note 1, at 14.

51. CHAIRMAN OF THE HOUSE SELECT COMMITTEE ON AGING, LONG-TERM CARE AND PERSONAL IMPOVERISHMENT: SEVEN IN TEN ELDERLY LIVING ALONE ARE AT RISK, H.R. Doc. No. 110-631, 100th Cong., 1st Sess. 5 (1987) [hereinafter LONG-TERM CARE AND PERSONAL IMPOVERISHMENT].

52. DEVELOPMENTS IN AGING, *supra* note 1, at 12.

53. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 67.

54. GAO REPORT, *supra* note 22, at 27.

B. Government Programs that Finance Long-Term Care

1. Nursing Home Expenditures

The 1984 health care expenditures of the elderly (\$119 billion) were financed as follows:

- 25.0% Out-of-pocket
- 7.2% Private insurance
- 48.8% Medicare
- 12.8% Medicaid
- 5.6% Other government programs⁵⁵

The nursing home expenditures of the elderly for the same year (\$25 billion), however, were financed largely by out-of-pocket payments and Medicaid:

- 50.1% Out-of-pocket
- 1.1% Private insurance
- 2.1% Medicare
- 41.5% Medicaid
- 4.4% Other government programs⁵⁶

Medicaid⁵⁷ is the principal source of public funding for long-term care. It has become the primary source of government funding for long-term care because the needy elderly can turn to it when they have drained their own assets. Under the federal-state matching program, approximately 32 states provide medical assistance to medically needy elderly who meet state-prescribed income levels.⁵⁸ If the elderly person's income is above the prescribed income level, he or she can become eligible for Medicaid benefits by "spending-down" to the poverty level.⁵⁹

Forty-eight percent of all nursing home residents are Medicaid recipients,⁶⁰ but many were not Medicaid-eligible when they entered the nursing home. Rather, almost one-half of the persons entering nursing homes as private payors became eligible to receive Medicaid benefits after entering the nursing home.⁶¹ A recent

55. THE AGING POPULATION, *supra* note 16, at 156-57.

56. DEVELOPMENTS IN AGING, *supra* note 1, at 30.

57. 42 U.S.C.A. § 1396 *et seq.* (West 1983 & Supp. 1989).

58. *Id.* at 35-36. In states that do not have medically needy programs, there is an option that extends coverage of nursing home benefits to persons with incomes up to 300% of the basic federal Supplemental Social Security Income level. For a more extensive discussion of Medicaid spend-down requirements, *see generally* DEVELOPMENTS IN AGING, *supra* note 1, at 35-36, 38-40.

59. 42 U.S.C.A. § 1396a.

60. DEVELOPMENTS IN AGING, *supra* note 1, at 35.

61. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 19.

study by the House Select Committee On Aging estimates that after only thirteen weeks in a nursing home, seven of ten elderly persons living alone reduce their income to the federal poverty level.⁶² The Committee's finding for married couples also is staggering: within six months after one spouse enters a nursing home, approximately 50% of elderly couples will spend down their income to poverty level.⁶³

Medicaid was not intended to be a long-term care insurance program even though, in 1987, it paid \$13.3 billion for nursing home care for its beneficiaries.⁶⁴ The Medicare program cannot be considered a source of funds for nursing home expenditures because it was not designed to reimburse beneficiaries for these costs. Indeed, Medicare pays only 2% of the national expenditures for elderly nursing home care (\$607 million in 1986).⁶⁵ The average Medicare reimbursement for care in an SNF in 1986 was for twenty-seven days, although the statute provided coverage for up to one hundred days.⁶⁶ The elderly, therefore, must be aware of other options.

2. Home Care

Home-based, long-term care services allow individuals to avoid unneeded institutionalization and to maintain their independence in the community.⁶⁷ Services range from medical and therapeutic services to assistance with activities of daily living.⁶⁸ Home health

62. LONG-TERM CARE AND PERSONAL IMPOVERISHMENT, *supra* note 51, at 6. Within one year of entering a nursing home, two-thirds of elderly living alone deplete their income and assets. *Id.*

63. *Id.* at 8. Similarly, one-half of elderly couples will deplete income and assets after one spouse is in a nursing home for one year. *Id.* The Medicare Catastrophic Coverage Act included amendments to curb the incidence of spousal impoverishment after one spouse enters a nursing home. See Pub. L. No. 100-360, § 303, 102 Stat. 754-64 (1988), 42 U.S.C.A. § 1396r-5 (West Supp. 1989). The amendments contained the following provisions. In any period of continuous institutionalization of a person, the couple's total assets are to be counted and divided equally, with half considered to be available for each spouse. The home, household goods, and personal effects are excluded. If the at-home spouse is left with less than \$12,000 after the division of assets, the institutionalized spouse may transfer an amount sufficient to raise the at-home spouse's assets to \$12,000. Also, effective September 30, 1989, states must permit the at-home spouse to keep a maintenance allowance from the institutionalized spouses's income in an amount sufficient to bring the at-home spouse's total monthly income to 122% of the federal poverty level for a two-person household (\$786 in 1988), but not to exceed \$1,500 per month. The permitted level of assets and monthly maintenance allowance will be indexed for inflation.

64. DEVELOPMENTS IN AGING, *supra* note 1, at 30.

65. See *id.* at 28.

66. *Id.* at 34. Medicare denied approximately 31.8% of all SNF claims in 1986. *Id.* at 35.

67. *Id.* at 41.

68. *Id.*

benefits that may be reimbursed under Medicaid include part-time nursing, home health aides, and medical equipment and supplies.⁶⁹ Under the "2176 Waiver" program (named after the section of the Act creating the program), Medicaid requirements can be waived to permit states to provide a broader range of home-based and community-based services to recipients who would otherwise resort to Medicaid-financed care in a skilled nursing facility or intermediate care facility, provided the alternative services cost no more than the institutional care.⁷⁰ The services allowed under the waiver include long-term nursing or therapy for chronic conditions, case management, personal care, homemaker and chore services, adult day health care, and respite care.⁷¹ As of 1987, forty-six states had 180 approved waiver programs in operation.⁷²

Like nursing home care, home care services can deplete an elderly person's assets in a short period of time. Using an estimated daily cost of \$43 per home care visit, the House Select Committee On Aging determined that almost 80% of the elderly living alone and 33% of elderly couples would fall to the poverty level after one year of home care services provided five days per week.⁷³ Medicare does provide some reimbursement for home health services, but the emphasis is on acute care, not chronic care. To receive home health benefits, a beneficiary must be under the care of a physician, confined to the home, and in need of skilled nursing care, physical therapy, speech therapy, medical social services, a home health aide, medical supplies or durable medical equipment.⁷⁴ Home health benefits are one of the fastest growing portions of the Medicare budget, but still they comprise only 3.8% of total program outlays.⁷⁵

3. Community-based Services

Both the Social Services Block Grants⁷⁶ and the Older Ameri-

69. 42 U.S.C.A. §§ 1396a, 1396n (West 1983 and Supp. 1989).

70. *Id.* § 1396n(b).

71. *Id.* For a more extensive discussion of home and community services under Medicaid, see generally R. PIERCE, *LONG-TERM CARE FOR THE ELDERLY: A LEGISLATOR'S GUIDE* ch. 4 (1987).

72. *DEVELOPMENTS IN AGING*, *supra* note 1, at 45. Five states, including Florida, California, Illinois, New York, and Oregon, account for 56% of all aged and disabled waiver recipients. *Id.*

73. *LONG-TERM CARE AND PERSONAL IMPOVERISHMENT*, *supra* note 51, at 8.

74. 42 U.S.C.A. § 1395x(m) (West 1983 and Supp. 1989).

75. *DEVELOPMENTS IN AGING*, *supra* note 1, at 43. For 1987, Medicare outlays for home health care were \$2.5 billion. *Id.*

76. 42 U.S.C. § 1397 *et seq.* (1988).

cans Act⁷⁷ are designed to prevent inappropriate institutionalization by providing community-based services such as transportation, nutrition, and personal and legal services. Funding is provided by grants to the States.

III. LONG-TERM CARE INSURANCE

Advising the elderly that current federal programs provide only limited financing of their long-term care needs is the first step in developing a financing plan for their long-term care. A 1985 survey conducted by the American Association of Retired Persons ("AARP") revealed that 79% of its members believed that Medicare would pay for all or part of their extended nursing home care.⁷⁸ In addition, many elderly have Medicare supplemental insurance policies, commonly known as "Medigap" policies, which are designed primarily to pay coinsurance and deductibles required under Medicare.⁷⁹ In the 1985 AARP survey, 35% of the members with Medigap coverage believed that their policies included coverage for extended nursing home care, although most of these policies do not.⁸⁰ Publications by the federal government, such as the "Guide to Health Insurance For People With Medicare," should be used to educate clients about the limited coverage for custodial care and other long-term care under Medicare and Medigap policies.⁸¹ Elderly clients should be informed that, unlike Medigap policies, long-term care insurance is not designed to fill

77. 42 U.S.C.A. § 3001 *et seq.* (West 1983 and Supp. 1989). For a more detailed discussion of these programs, see generally DEVELOPMENTS IN AGING, *supra* note 1, at 46-47; R. PIERCE, *supra* note 71, ch. 4.

78. American Association of Retired Persons, Preferences of AARP Members for Specific Long-Term Care Insurance Product Features (unpublished survey conducted by Towers, Perrin, Forster and Crosby, Washington D.C., 1985) [hereinafter AARP Survey].

79. Approximately 65% of the noninstitutionalized elderly have purchased private Medigap policies. THE AGING POPULATION, *supra* note 16, at 156.

80. AARP Survey, *supra* note 78. Unlike long-term care insurance, Medigap policies are regulated by federal law. 42 U.S.C.A. § 1395ss (West 1983 and Supp. 1989). The regulations were a direct response to the actual and perceived abuses in the sales and marketing of such policies. DEPARTMENT OF HEALTH AND HUMAN SERVICES, REPORT TO CONGRESS: STUDY OF HEALTH INSURANCE DESIGNED TO SUPPLEMENT MEDICARE AND OTHER LIMITED BENEFIT HEALTH INSURANCE SOLD TO MEDICARE BENEFICIARIES (Washington, D.C. 1987) [hereinafter HHS REPORT TO CONGRESS]. Among other things, the "Baucus Amendment," as the law is commonly known, prohibits the intentional sale of policies that duplicate Medicare covered services. 42 U.S.C.A. § 1395ss(d)(3) (West 1983).

81. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE (Government Printing Office 1986).

the gaps in Medicare coverage. Rather, it is designed to provide coverage for the long-term care costs described in the beginning of this Article.

A. *Evolution of the Product*

Insurers developed long-term care insurance to avoid two common underwriting problems: "adverse selection" and "induced demand" (or "moral hazard").⁸² Adverse selection describes the risk that only those persons who have a greater chance of needing long-term care will purchase insurance, thereby increasing the average use of insurance and raising premiums.⁸³ Policy features such as exclusions for certain conditions, delayed coverage for preexisting conditions, limitations on renewal, reliance on medical underwriting, and age limits are used by long-term care insurers to reduce the risk of adverse selection.⁸⁴ Induced demand refers to the insurer's risk that the presence of insurance will encourage use of covered services when the insured may not have used such services in the absence of insurance.⁸⁵ To avoid induced demand, long-term care insurers initially designed policies with long waiting periods, required prior hospitalization for eligibility for benefits, and provided fewer benefits for noninstitutional or lower level care when it was perceived that induced demand would be greatest.⁸⁶

Periodically since 1984, there have been several surveys of long-term care insurance policies that have evaluated specific insurance products and demonstrated their weaknesses.⁸⁷ There are at least 105 companies currently offering long-term care policies. Many of these companies offer the consumer options that, alone and in com-

82. See generally LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 59-61, app. at 167. A. RIVLIN & J. WEINER, *supra* note 6, at 65-68.

83. A. RIVLIN & J. WEINER, *supra* note 6, at 66.

84. See LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 59-61, app. at 167; A. RIVLIN & J. WEINER, *supra* note 6, at 65-68.

85. *Id.* On the one hand, the risk of induced demand appears to be great with long-term care insurance. Statistics show that informal caregiving by family and friends accounts for over 70% of all assistance received by disabled and chronically ill elderly. On the other hand, however, there is no evidence that families are less willing to provide caregiving services because of private insurance. Moreover, people generally prefer not to enter nursing homes for as long as possible. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 59; see also A. RIVLIN & J. WEINER, *supra* note 6, at 5.

86. See LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 59-61, app. at 167. A. RIVLIN & J. WEINER, *supra* note 6, at 65-68.

87. See J. FIRMAN, W. WEISSERT & P. WILSON, PRIVATE LONG-TERM CARE INSURANCE: HOW WELL IS IT MEETING CONSUMER NEEDS AND PUBLIC POLICY CONCERNS? (United Seniors Health Bulletin, Sept. 1988); GAO REPORT, *supra* note 22, ch. 2; *Who Can Afford A Nursing Home?*, CONSUMER REP., 300 (May 1988); Bingham, *Planning for the Elderly: Long-Term Care Insurance*, PROB. AND PROP. 12 (1989).

bination, may affect the level of coverage, the chance of receiving benefits, and premium rates. Moreover, despite recent findings indicating that the market has become more consumer-oriented as a result of state regulation,⁸⁸ many policies have not been upgraded to reflect state-of-the-art features nor the minimum legislative standards. Specific policy features will be evaluated in the corresponding discussion of applicable regulatory standards.

B. *Evolution of Uniform Standards*

Prior to 1986, there were no uniform standards for long-term care insurance. In 1986, however, the National Association of Insurance Commissioners ("NAIC") published the Long-Term Care Insurance Model Act (the "Model Act") and Long-Term Care Insurance Model Regulations (the "Model Regulations"). The NAIC Model Act and NAIC Model Regulations, most recently amended in January 1990, define a new class of insurance, set forth its purpose, and specify disclosure, format, and minimum performance standards that apply predominantly to group and individual long-term care insurance policies.⁸⁹ The NAIC Model Act and Model Regulations also recognize the need for different requirements for group policies under certain circumstances, such as exclusions for preexisting conditions and conversion of policies for former employees. As of January 1990, 28 states adopted the NAIC Model Act with some variation.⁹⁰ Several states have enacted legislation concerning long-term care insurance that is more

88. See HIAA RESEARCH BULLETIN, *supra* note 23, Summary.

89. Unless otherwise noted, all references are to the Model Act and Model Regulations, NAIC MODEL INSURANCE LAWS, REGULATIONS, AND GUIDELINES, vol. III (1984), amended as of January 1990 [hereinafter NAIC MODEL ACT].

90. ARIZ. REV. STAT. ANN. § 20-1691 *et seq.* (1988); DEL. CODE ANN. tit. 18, § 7101 *et seq.* (1989); HAWAII REV. STAT. § 431:10-521 *et seq.* (Supp. 1989); IDAHO CODE § 41-4601 *et seq.* (1988); ILL. REV. STAT. ch. 73, para. 963A-1 *et seq.* (Supp. 1989) (the Illinois Department of Insurance has not yet adopted the Model Regulations); IND. CODE ANN. § 12-125-1 *et seq.* (West Supp. 1988); IOWA CODE ANN. § 514G.1 *et seq.* (West 1987); KAN. STAT. ANN. § 40-2225 *et seq.* (1988); MD. CODE ANN. art. 48A, § 642 *et seq.* (1989); NEB. REV. STAT. § 44-4501 *et seq.* (1987); NEV. ADMIN. CODE § 33-15A-1 *et seq.* (1988); N.H. REV. STAT. ANN. § 415-D:1 *et seq.* (1990); N.M. STAT. ANN. § 59A-23A-1 *et seq.* (1989); N.C. Gen. Stat. § 58-540 *et seq.* (1987); N.D. CENT. CODE § 26.1-45-01 (1987); OHIO REV. CODE ANN. § 3923.41 *et seq.* (Baldwin 1988); OKLA. STAT. ANN. tit. 36, § 4421 *et seq.* (1987); R.I. GEN. LAWS § 27-34.2-1 *et seq.* (1988); S.C. CODE ANN. § 38-72-60 (Law Co-op. 1988); S.D. CODIFIED LAWS ANN. §§ 58-17B-1 to 58-17B15 (Supp. 1989); TENN. CODE ANN. §§ 56-42-101 to 56-42-106 (Supp. 1988); VT. STAT. ANN. tit. 8, § 8051 *et seq.* (1989); VA. CODE ANN. § 38.2-5200 *et seq.* (1987); W. VA. CODE § 33-15A-1 *et seq.* (1989); WYO. STAT. 26-38-101 *et seq.* (Supp. 1988).

stringent than the NAIC Model Act in some respect⁹¹ or takes a different regulatory approach.⁹² Other states have made efforts to increase the consumption of private, long-term care insurance.

Recent state and federal legislative activity concerning long-term care insurance is attributable to two objectives: providing incentive for insurers to enter a market in which they had little or no experience in underwriting the risk, and providing sufficient consumer protection to prevent the same type of abuses in sales and marketing of long-term care insurance that occurred with Medigap policies in the late 1970s and early 1980s.⁹³ Indeed, the "purposes" provision of the NAIC Model Act includes these two objectives.⁹⁴ These objectives, however, often conflict, resulting in unfortunate lack of clarity in the legislation.

Two competing strategies exist for regulating the mechanics of long-term care insurance policies. The less restrictive approach adopted by the NAIC is to set minimum standards of coverage and to permit insurers broad discretion in establishing levels and limits of coverage, as long as the coverage adequately is defined in the policy.⁹⁵ Insurers, however, may do only what is minimally required to comply with such performance standards, unless the market simply will not tolerate such minimal performance. The more restrictive approach is "standardization," in which the regulation mandates the level and limits of coverage.⁹⁶ Several states have chosen the latter approach, although insurers allege that it discourages them from entering the market.⁹⁷

C. Compliance with Legislative Performance Standards

Evaluating long-term care insurance policies to determine compliance with legislative performance standards is not a simple task.

91. CAL. INS. CODE § 10230 *et seq.* (West Supp. 1988); CONN. GEN. STAT. ANN. § 38-174x (West 1987); FLA. STAT. ANN. § 627.9401 *et seq.* (West Supp. 1989); GA. CODE ANN. § 33-42-1 *et seq.* (1988); ME. REV. STAT. ANN. tit. 24A, § 5051 *et seq.* (Supp. 1988); MINN. STAT. ANN. § 62A.46 *et seq.* (West 1986 and Supp. 1988); WASH. REV. CODE ANN. § 48.84.010 *et seq.* (Supp. 1988); WIS. ADMIN. CODE § Ins. 3.46 (1986).

92. COLO. REV. STAT. § 10-19 to 101 *et seq.* (1987 and Supp. 1988); KY. REV. STAT. ANN. § 304.17-314 (Michie/Bobbs-Merrill Supp. 1986); N.Y. INS. LAW § 1117 (McKinney 1986); TEX. INS. CODE ANN. § 370-1(f)(5) (Vernon 1987).

93. The sales and marketing abuses that occurred with Medigap policies have received more publicity than similar abuses in sales and marketing of long-term care insurance. See *infra* notes 251-53 and accompanying text.

94. NAIC MODEL ACT § 1.

95. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 34.

96. *Id.* See also, G. SHEARER, *supra* note 44, at 32.

97. NAIC REPORT, *supra* note 21, at 28-29.

Many of these standards specifically are designed to permit insurers freedom to experiment. The NAIC Model Act, for example, expressly states that one of its purposes is to "facilitate flexibility and innovation in the development of long-term care insurance coverage."⁹⁸ The standards set forth in the NAIC Model Act often are vague, particularly in their combined effect. In addition, many companies offer a menu of options that are confusing even for the educated consumer, and an ill-advised combination of options often can have adverse consequences on the overall policy coverage. Accordingly, evaluating these policies involves application of basic legal principles governing the construction and interpretation of insurance policies. First, as recognized in the NAIC Model Act, a long-term care insurance policy must meet the purchaser's reasonable expectations of coverage.⁹⁹ Risk-shifting from insured to insurer is an essential element of any contract of insurance.¹⁰⁰

In Illinois, as in other jurisdictions, the primary objective of interpreting an insurance contract is giving effect to the intent of the parties.¹⁰¹ When a provision in an insurance policy is subject to more than one reasonable interpretation, it is ambiguous and must be construed against the insurer and in favor of the insured.¹⁰² Ambiguous provisions in which an insurer limits its liability are construed most strongly against the insurer.¹⁰³ Thus, exclusionary provisions operate to limit or deny coverage only when they are clear, definite, and explicit.¹⁰⁴ Illinois, moreover, extends the principle of an implied contractual duty of good faith and fair dealing to the interpretation of insurance policies.¹⁰⁵

D. *The NAIC Model Approach*

The NAIC Model Act contains two types of regulation. The first is "performance standards," which control the mechanics of the insurance instrument, including standards of coverage, rules regarding renewability, and limitations or exclusions of coverage.

98. NAIC MODEL ACT § 1.

99. NAIC MODEL ACT Draft Note to § 4.

100. See generally 12 J. APPLEMAN, INSURANCE LAW & PRACTICE, §§ 7001, 7004 (1981).

101. *Playboy Enters., Inc. v. St. Paul Fire & Marine Ins. Co.*, 769 F.2d 425, 427-8 (7th Cir. 1985) (applying Illinois law); *Economy Fire & Casualty Co. v. Kubik*, 142 Ill. App. 3d 906, 909, 492 N.E.2d 504, 506 (1st Dist. 1986).

102. 12 J. APPLEMAN, *supra* note 100, §§ 7001, 7004.

103. *Id.*

104. *Id.*

105. *Eckenrode v. Life of Am. Ins. Co.*, 470 F.2d 1, 5 (7th Cir. 1972) (applying Illinois law).

The second type of regulation contains standards controlling the structure, presentation, and distribution of the policy, such as disclosure statements, "free-look" provisions, and the size of the print. Performance requirements strongly affect the insurer's underwriting and the premium rates; structural regulations do not.¹⁰⁶ Therefore, structural requirements do not increase the costs for the insurer to as great a degree as stringent mechanical requirements. Both types of regulation will be discussed below.

1. Performance Standards

a. Definitions

Policies that are marketed or offered as "long-term care insurance" or "nursing home insurance" must meet the requirements of the Model Act.¹⁰⁷ The Illinois law contains essentially the same provision.¹⁰⁸ The NAIC Model Act defines "long-term care insurance" as follows:

any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans; [a]nd health maintenance organizations or any similar organization¹⁰⁹

The Model Act specifically excludes any insurance policy that is offered primarily to provide basic Medicare supplement coverage, or specified disease coverage, among others.¹¹⁰ Laws and regulations concerning Medicare supplement insurance are made expressly inapplicable to long-term care insurance.¹¹¹

106. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 34.

107. NAIC MODEL ACT § 2. The Model Act, however, does not provide a definition of a "nursing home policy" nor are such policies mentioned in any other provision of the Act. The Maine statute defines a "nursing home care policy" as a policy in which 50% or more of the benefits payable are related to nursing home confinement. ME. REV. STAT. ANN. tit. 24-A, § 5051(3) (Supp. 1988). Such a distinction between a long-term care policy and a nursing home policy has the effect of alerting the consumer that the policy provides only limited benefits.

108. ILL. REV. STAT. ch. 73 para. 963A-1 (Supp. 1989). Unless otherwise noted, the Illinois legislation incorporates all provisions of the NAIC MODEL ACT.

109. NAIC MODEL ACT § 4.

110. *Id.*

111. *Id.* § 2. The Model Act applies to life-care riders to life insurance policies. The

Even this definition sets a minimum standard of twelve months for the duration of benefits. By permitting long-term care insurance to provide benefits for only twelve consecutive months, the Model Act promotes policies that offer the consumer very little actual benefit in light of the risk of institutionalization. In 1983, non-Medicare patients admitted to nursing homes for chronic care had a mean length of stay of 419.7 days.¹¹² One private study estimates that the “long-stayers”— residents who stay in a nursing home for more than one year— account for 91% of nursing home admissions.¹¹³ If an insurer can offer a product that does not meet reasonable expectations for long-term coverage, in this case in excess of one year, then this regulation does not provide adequate consumer protection. However, according to a survey of twenty-nine long-term care policies offered by its members, the median maximum benefit period for nursing home care was four years, and the median maximum coverage period for home health care was two years.¹¹⁴

Moreover, the Model Act’s definition of long-term care insurance is vague because it does not specify whether the policy must offer the minimum period of coverage for all levels of care. The Model Act prohibits long-term care insurance policies from providing coverage for skilled nursing care only or providing “significantly more coverage for skilled care in a facility than coverage for lower levels of care.”¹¹⁵ But it remains unclear from these two provisions whether all levels of care must be covered for the minimum period of twelve consecutive months. If the intention of the law is to require equal minimum benefits for all levels of care, then the definitional section should be amended expressly to require minimum coverage of twelve consecutive months regardless of the level of care or type of facility.¹¹⁶

Another weakness in the definition of long-term care insurance policies is the exclusion of insurance policies that are marketed primarily as, for example, Medigap, disability or health policies, but offer long-term care benefits. It would not be necessary for such

NAIC Comment to Section 1 of the Model Act recognizes that this product raises regulatory concerns that are not yet addressed in the Model Act, but such regulations are forthcoming. NAIC MODEL ACT Comment to § 1.

112. HHS REPORT TO CONGRESS, *supra* note 80, at 122.

113. Keeler, *Short and Long-Term Residents of Nursing Homes*, 19 MED. CARE 363-69 (1981).

114. HIAA RESEARCH BULLETIN, *supra* note 23, at 10-11.

115. NAIC MODEL ACT § 6(B)(3).

116. A federal proposal included this clause. See *infra* notes 242-43 and accompanying text.

policies to meet the minimum standards of the Model Act. A proposed amendment to the Model Act would have corrected this gap specifically by including all such insurance policies that contain a long-term care benefit of at least six months in the definition of long-term care insurance.¹¹⁷

The NAIC Model Act applies as well to "group long-term care insurance."¹¹⁸ Among other things, the Act provides that such insurance can be offered only by a legitimate association (e.g., professional, trade, or occupation association) and only if it is maintained in good faith for purposes other than obtaining insurance.¹¹⁹ The State Commissioner of Insurance is authorized to permit a "group" not meeting the requirements of the Model Act to offer long-term care insurance if issuance of a group policy comports with public policy.¹²⁰ However, a group policy issued in another state by such a group may not be offered in the home state unless the sister state has a similar regulatory program and has made a determination that the group policy is in the public interest.¹²¹

b. Cancellation/renewal

The NAIC describes four types of renewability provisions, all of which have been used in long-term care policies. "Optionally renewable" provisions leave renewal at the sole option of the insurer. "Conditionally renewable" provisions permit the insurer to refuse renewal by class or geographic area. The insurer may also decline

117. NAIC Memorandum of Carol Olson, Senior Attorney, Long-Term Care Insurance Model Act and Regulations Proposed Amendments (available from the NAIC) (March 22, 1989).

118. NAIC MODEL ACT § 4(E).

119. *Id.* § 4(E)(2)(3). Although not specifically expressed in the DRAFT NOTES OF THE NAIC MODEL ACT, this regulation apparently is intended to prevent exemptions of group policies offered by sham senior citizen groups, such as one that operated in Minnesota in 1984-86. In that case, MediCo Life Insurance Company agents sold over 4,000 policies to senior citizens in the state, first soliciting them to purchase the policy and then informing them that they were required to join a senior citizen federation to purchase the insurance. The policies sold paid custodial benefits of less than \$2 per day. The federation was exempt from the minimum benefits provision then in effect in Minnesota, and from disclosure requirements; most insureds believed that they had received better benefits. The Minnesota Department of Insurance investigated from 1984 to 1986 and was prepared to file a formal action for unfair and deceptive insurance practices. The insurance company, however, entered into a consent order under which all policyholders were given the option of a refund or policy conversion. *Nursing Home Insurance: Exploiting Fear for Profit?, Joint Hearing Before the Subcommittee on Health and Long-Term Care and the Subcommittee on Housing and Consumer Interests*, 100th Congress, 1st Sess. 58-78 (statement and exhibits submitted by Michael Hatch, Commissioner of Minnesota Department of Commerce) [hereinafter *Joint Hearing*].

120. NAIC MODEL ACT § 4(E)(4).

121. *Id.* § 5.

renewal for stated reasons other than deterioration of health. "Guaranteed renewable" provisions prohibit the insurer's declination of renewal for any reason, but permit premiums to be revised on a class basis. "Noncancellable" provisions both ensure renewal and prohibit the insurer's raising the premium.¹²²

The NAIC Model Act adopts the recommendation of the NAIC, allowing insurers to renew long-term care insurance conditionally, and to decline renewal for reasons other than the age or deterioration of the mental or physical health of the insured.¹²³ The Model Regulations provide, however, that if a policy is represented as "guaranteed renewable" or "noncancellable," the terms must be explained in the outline of coverage that insurers must provide at the time of initial solicitation.¹²⁴ Insurers may request the state's insurance commissioner to authorize nonrenewal on a statewide basis if renewal would jeopardize the insurer's solvency, or if the loss experience of the insurer warrants nonrenewal.¹²⁵

The Congressional Task Force On Long-Term Health Care Policies concluded that the NAIC Model Act provision concerning renewal is inadequate because it may lead to nonrenewal when policyholders are no longer able to buy another policy.¹²⁶ According to the HIAA, all the policies introduced in 1988 that it examined were guaranteed renewable;¹²⁷ many policies introduced prior to 1988, however, still are conditionally renewable or optionally renewable.¹²⁸ Clients should be advised of the insurer's rights to cancel or raise premiums under such renewal provisions.

Some long-term care policies currently are being offered as group insurance, either through employers or associations. The Model Regulations provide that such group insurance must provide a covered individual with a basis for continuation or conversion of coverage when employment is terminated or if the group insurance is canceled.¹²⁹

122. NAIC REPORT, *supra* note 21, at 23.

123. NAIC MODEL ACT § 6(B)(1). The Illinois legislation contains an identical provision. ILL. REV. STAT. ch. 73 para. 963A-4(1) (Supp. 1989).

124. NAIC MODEL REGS. § 6(A); NAIC MODEL ACT § 6(G).

125. NAIC MODEL REGS. § 6(A)(1)(a), (b).

126. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 35-36. Most companies do not offer insurance to persons over the age of 79. HIAA RESEARCH BULLETIN, *supra* note 23, at 13. A few companies, including Aetna Life & Casualty, American Republic Insurance Company, and Medico Life will write coverage to age 84. Bingham, *supra* note 88, at 13.

127. HIAA RESEARCH BULLETIN, *supra* note 23, Summary.

128. *Id.* at 12; see also *Who Can Afford A Nursing Home?*, *supra* note 87, at 302.

129. NAIC MODEL REGS. § 6(D).

*c. Policy exclusions**i. Preexisting Conditions*

Under the NAIC Model Act, if an insurer limits coverage for a preexisting condition, it cannot define "preexisting condition more restrictively than as: . . . a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured person."¹³⁰ Moreover, an insurer may not use a waiver or rider to limit or reduce benefits for a specific preexisting condition beyond the six-month waiting period.¹³¹

The Model Act previously contained a definition of preexisting condition that included an "ordinarily prudent person" standard as well as the subjective standard of actual diagnosis and treatment.¹³² Many of the states that have adopted some form of the Model Act, including Illinois, still include this standard to describe a preexisting condition.¹³³ This definition of preexisting condition is more restrictive than the current NAIC Model Act definition. It therefore provides more discretion to an insurer to deny benefits for undiagnosed illnesses and may require more judicial intervention to define the parameters of the "ordinarily prudent person" test. Other states provide the same restrictive definition as Illinois and also extend the waiting period before paying benefits for a preexisting condition.¹³⁴ These longer waiting periods were sanctioned by the 1986 draft of the Model Act.¹³⁵ However, the current six-month waiting period contained in the NAIC Model

130. NAIC MODEL ACT § 6(C)(1). This provision does not apply to group policies. *Id.*

131. NAIC MODEL ACT § 6(C)(4). According to the Task Force on Long-Term Health Care Policies, this provision may present problems for Continuing Care Retirement Communities to the extent they fall within the scope of the Act, because CCRCs typically restrict coverage for pre-existing conditions or require an additional fee. *See* LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 61.

132. *See* NAIC MODEL INSURANCE LAWS, REGULATIONS, AND GUIDELINES (Oct. 1986); NAIC REPORT, *supra* note 21, at app. M.

133. For example, Illinois defines "preexisting condition" as:

the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage for an insured person.

ILL. REV. STAT. ch. 73, para. 963A-5(a) (1989). *See also* R.I. GEN. LAWS § 27-34.2-6(c) (1989).

134. The waiting period is extended to 12 months for people above 65 years of age and 24 months for persons younger than 65. *See e.g.*, IND. CODE ANN. § 27-8-12-10(a) (West Supp. 1990).

135. *See supra* note 130.

Act treats all insureds equally and also provides increased coverage.

ii. Mental or nervous disorders

Like health and life policies, long-term care policies may contain explicit provisions excluding certain conditions from coverage.¹³⁶ The most controversial exclusionary provision in long-term care policies is the exclusion for nervous and mental disorders, particularly care for Alzheimer's disease, an organic brain disorder¹³⁷ afflicting an estimated 2.5 million elderly persons in 1985.¹³⁸ Perhaps as many as 50% of nursing home residents may have the disease.¹³⁹ A definitive diagnosis of Alzheimer's, however, can be made only by brain biopsy or autopsy.¹⁴⁰

The policy exclusion for mental and nervous disorders must be read very carefully, because vague policy language creates an ambiguity about coverage for Alzheimer's disease. Some policies expressly exclude all "mental and nervous disorders," leaving no doubt that Alzheimer's is not covered.¹⁴¹ Others explicitly cover mental and nervous disorders with a demonstrable organic cause,¹⁴² while other policies expressly cover Alzheimer's disease.¹⁴³ The NAIC Model Regulations currently prohibit an exclusion or limitation of benefits for Alzheimer's disease.¹⁴⁴ This regulation alleviates many of the ambiguities created by the policy provisions. Nevertheless, because the Model Act does not specify which criteria are necessary, it is prudent to determine which information is required by the individual insurer to demonstrate that an insured has Alzheimer's disease.

d. *Benefit eligibility and limitations*

i. Definitions of levels of care and providers of services

The benefit and access structure of a long-term care insurance

136. Typical exclusions include losses resulting from war, intentionally self-inflicted injury or attempted suicide, services for which the insured was not charged, alcohol- or drug-related diseases, and treatment delivered outside the United States. See GAO REPORT, *supra* note 22, at 31.

137. THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 1337 (15th Ed. 1987).

138. GAO REPORT, *supra* note 22, at 31.

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

143. See J. FIRMAN, W. WEISSERT & P. WILSON, *supra* note 87, at 27-28.

144. NAIC MODEL REGS. § 6(B)(2). Minnesota has a similar prohibition in its statute. MINN. STAT. ANN. § 62A.48 (Supp. 1990).

policy should be reasonably clear in defining the level of care that is covered by the policy.¹⁴⁵ Levels of care and service definitions for long-term care policies, however, frequently fail the "reasonable clear" test. The variations in the types of care covered by long-term care policies and the manner in which these levels of care are defined make it almost impossible to comparison shop and evaluate the protection afforded by the policy.

Long-term care policies basically cover skilled and intermediate nursing care,¹⁴⁶ custodial care and home care, although not with any degree of uniformity. The NAIC defines four basic levels of care offered by long-term care insurers:

1. "Skilled nursing home care": nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician.
2. "Intermediate nursing home care": skilled nursing care provided on an occasional basis.
3. "Custodial nursing home care" or "personal care": assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills.
4. "Home care": a variety of services provided in the home, including skilled nursing care; speech, physical or occupational therapy; and social work, personal care, homemaker and choreworker services.¹⁴⁷

The NAIC Model Regulations, however, do not define these levels of care. Rather, they simply provide that skilled nursing care, intermediate care, personal care, home care, and other services "shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered."¹⁴⁸

Similarly, providers of services, such as skilled nursing facilities and home care agencies, also must be defined "in relation to the services and facilities required to be available and the licensure or degree of status of those providing or supervising the services."¹⁴⁹ Insurers may require that the provider be licensed or certified.¹⁵⁰ The HIAA survey found that all policies covered nursing home care that took place in facilities meeting state licensure require-

145. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 147-49.

146. The new quality of care survey laws for Medicaid have phased out the distinction between skilled nursing facilities and intermediate care facilities. Pub. L. No. 100-360, § 411(1), 102 Stat. 800-804 (1988). All will be referred to as "nursing facilities."

147. NAIC REPORT, *supra* note 21, at app. F.

148. NAIC MODEL REGS. § 5(E).

149. *Id.* § 5(F).

150. *Id.*

ments for skilled and intermediate care facilities.¹⁵¹

Most state regulations defining skilled nursing facilities and intermediate care facilities are inextricably tied to the Medicaid reimbursement requirements. However, unlike Medicaid, most private, long-term care policies pay a daily indemnity benefit for a stated period of time, regardless of the services provided to the insured. Accordingly, level of care distinctions based on the type of covered services and the time of coverage make sense in a long-term care policy only if they are used to determine eligibility for benefits and not the amount of payment.¹⁵²

Some state laws, however, are not as dependent upon Medicaid definitions, such as licensing and certification laws addressed primarily to quality assurance. To avoid consumer confusion, state legislators should consider prohibiting insurers from using a particular designation to describe a facility or provider, unless the definition contained in the policy conforms to the applicable state law. Then, insurers that define covered facilities and services more restrictively than state law could be required to disclose that fact or use a different designation to describe the facility or service.

For example, the Illinois Nursing Home Care Reform Act defines a "long-term care facility" as a private home, institution, building, residence, or any other place that provides personal care, sheltered care or nursing for three or more persons not related to the provider.¹⁵³ The Act also defines "personal care," and "sheltered care."¹⁵⁴ Under this proposal, an Illinois insurer could use these terms to define covered services only if the covered services matched the state law definitions.¹⁵⁵

ii. Levels of care offered: conditioning eligibility on prior hospitalization or prior stay in skilled nursing facilities

The variation in benefits packages offered by insurers is the primary source of confusion among consumers and regulators of the industry, and it is beyond the scope of this Article to evaluate the

151. HIAA RESEARCH BULLETIN, *supra* note 23, at 9.

152. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 147-49.

153. ILL. REV. STAT. ch. 111 1/2, paras. 4151-101 *et seq.* (Supp. 1989).

154. *Id.* paras. 4151-120, 4151-124.

155. "Home health services" are defined under the Illinois Home Health Agency Licensing Act as "services provided to a person at his residence according to a plan of treatment for illness or infirmity prescribed by a physician" and including intermittent nursing services and services such as physical therapy, occupational therapy, speech therapy, medical social services, or services provided by a home health aide. ILL. REV. STAT. ch. 111 1/2, para. 2802.5 (1988).

many different options.¹⁵⁶ However, several insurance policy provisions restrict access to care and may have the adverse effect of reducing the insured's chances of collecting benefits.¹⁵⁷

Most policies still require at least three days of hospitalization for eligibility for benefits and also require a skilled nursing home stay before paying benefits for lower levels of institutional or noninstitutional care.¹⁵⁸ The NAIC Model Act currently recommends prohibition of prior hospitalization or prior institutionalization requirements. The Act provides, alternatively, that policies that condition eligibility for benefits upon prior hospitalization for the same or related conditions must allow a period of at least thirty days from discharge for entry into a covered facility.¹⁵⁹ This recommended change in the Model Act reflects the finding that at least 54% of all nursing home admissions do not occur after a prior hospitalization.¹⁶⁰ Similarly, the Model Act suggests another provision that would prohibit sale of an insurance policy that conditions eligibility for home health benefits on any prior institutionalization requirement.¹⁶¹ The Illinois legislation does not include these prohibitions, but other states have amended their legislation to incorporate the change recommended in the Model Act.¹⁶²

156. Such evaluations are found in the surveys referred to *supra* at note 87.

157. See generally, J. FIRMAN, W. WEISSERT & P. WILSON, *supra* note 87. The authors evaluated 77 plans offered by 29 companies as of July 1988 to determine the probability of collecting benefits, the total benefits paid for an extended nursing home stay, and the comprehensiveness of home care coverage. The authors then examined the restrictions found in most of the policies, including prior hospitalization requirements; requirements that insured receive skilled level care prior to receiving benefits for lower level care; waiting periods; and requirements for home health benefits. The authors devised probability estimates based upon the combined effect of the above restrictions, and found that the average probability of collecting benefits was 6% if the insured was admitted to a nursing home and not collecting benefits from any of the long-term care policies surveyed. Because most of the plans that cover Alzheimer's disease also had prior hospitalization requirements or required skilled nursing care prior to coverage for lower levels of care, most of the period of illness for Alzheimer's would not be covered. The authors also estimated that a \$50 per day indemnity plan is grossly inadequate to meet long-term care costs because two-thirds of the policies did not offer benefits that adjusted for inflation. Finally, the authors found that because there were severe restrictions on home health benefits, for example, prior hospitalization or confinement in a nursing home, or certification by a physician that the insured otherwise would need nursing home care, there was only a small likelihood of receiving home health benefits.

158. See HIAA RESEARCH BULLETIN, *supra* note 23, at 10.

159. NAIC MODEL ACT § 6(D)(3). The Catastrophic Coverage Act would have eliminated the three-day prior hospitalization requirement for SNF benefits. See Pub. L. No 100-360, § 102, 102 Stat. 684-87 (1988) (codified at 42 U.S.C.A. § 1395(d) (West 1989)), *supra* note 9.

160. See J. FIRMAN, W. WEISSERT & P. WILSON, *supra* note 87, at 42.

161. NAIC MODEL ACT § 6(D)(1).

162. Illinois law provides only that policies that condition eligibility for benefits upon

Policies that do not require prior hospitalization or institutionalization may instead require a physician's certification of need.¹⁶³ Some innovative policies, however, are moving away from medical underwriting criteria to determine eligibility for benefits.¹⁶⁴ Instead, insurers are using criteria based on ADLs to measure disability.¹⁶⁵ Although using such criteria rather than a prior hospitalization requirement may provide the insured with benefits for more services, the policy should be evaluated carefully to assure that the criteria are clear and definite and do not permit arbitrary decisionmaking by the insurer.

For example, in a policy that currently is being offered by one insurer, the insured would have to pass an "Activities of Daily Living Test" to become eligible for benefits.¹⁶⁶ An insured is eligible for adult day care services if unable to perform one or more ADLs (defined in the policy as transferring, walking, eating, dressing, toileting and bathing) without the assistance of another person.¹⁶⁷ Benefits for all other covered services (i.e. nursing home, hospice care, home health, or home hospice care) are available only if the insured is unable to perform two or more ADLs without assistance from another person.¹⁶⁸ The policy specifically requires that all services be prescribed by a physician, but it is not clear if the physician must be an agent of the insurer or even whether the physician, as opposed to another health care technician, certifies that the insured meets the ADL tests. If the professional who performs the test is an agent of the insurer, he or she may tend to decide close cases in favor of the insurer.¹⁶⁹ Further, it is unclear precisely how it is determined that the insured is "unable to perform" an ADL. For example, although the ADL test may appear to be independent of medical criteria of need such as a prior hospitalization requirement, such medical criteria nevertheless may be incorporated

prior hospitalization must allow a period of at least 30 days from discharge for entry into a covered facility. ILL. REV. STAT. ch. 73, para. 963A-6 (1987). See, e.g., KAN. STAT. ANN. § 40-2228(f) (Supp. 1989).

163. HIAA RESEARCH BULLETIN, *supra* note 23, at 10.

164. Wallack, *Recent Trends in Financing Long Term Care*, HEALTH CARE FIN. REV., 97, 99-100 (Supp. 1988); HIAA RESEARCH BULLETIN, *supra* note 23, at 10. However, medical underwriting still is used to evaluate applications for long-term care insurance.

165. *Id.*

166. Mutual of Omaha, "Long-Term Care Plus" Specimen Policy dated January 1989. This policy currently is offered for sale in Illinois.

167. *Id.*

168. *Id.*

169. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 151.

into the determination that the insured is unable to perform an ADL.

iii. Home care benefits

The NAIC has enacted amendments to the Model Regulations that provide minimum standards for long-term care policies that contain home care benefits.¹⁷⁰ "Home care benefits" are not health care services. Rather, they are defined as personal care services, respite care, and other nonmedical services to assist the insured in the activities of daily living.¹⁷¹ The Model Regulations currently do not regulate eligibility criteria for home care benefits. An earlier proposed amendment, however, would have permitted an insurer to determine eligibility for home care benefits by requiring a home care treatment plan. The plan could be prescribed by a physician or developed by assessing the insured's ability to perform ADLs as part of a case management program, but "only if the insurer has reasonable review standards which it applies consistently."¹⁷² Those standards may not require the insured to be unable to perform more than two ADLs to qualify for home care benefits.¹⁷³ The proposed amendment also would prohibit limitations of home care benefits such as requirement of prior hospitalization or confinement in a skilled nursing home, payment only for services that are medically necessary or provided only by licensed health care professionals, or limitation of benefits to home care services only when the insured would otherwise need skilled care in a skilled nursing facility.¹⁷⁴ These restrictions are common in the long-term care policies currently being offered for sale.¹⁷⁵

iv. Comparison of benefits for all levels of care

Once a policy's covered services are determined, it is still necessary to compare the amount of benefits paid for each level of care. The NAIC Model Act mandates that a long-term care policy cannot provide coverage only for skilled nursing care nor can it provide "significantly more coverage for skilled care in a facility than coverage for lower level care."¹⁷⁶ The Act, however, does not define the phrase "significantly more coverage," and the surveys of

170. See NAIC MODEL REGULATIONS (Jan. 1990).

171. *Id.* § 5(B).

172. NAIC Memorandum of Carol Olson, *supra* note 117.

173. *Id.*

174. *Id.*

175. See surveys referenced *supra* note 87.

176. NAIC MODEL ACT § 6(B)(3).

long-term care policies reveal wide variations in benefits for lower levels of care.¹⁷⁷ For example, the policy may indemnify home health care services at a rate equal to less than 50% of the indemnity rate for nursing home care; it may include lower indemnity rates for intermediate or custodial care; it may limit the number of days for lower levels of care; or it may provide lower maximum benefits for lower level care.¹⁷⁸

Accordingly, the regulation should be more specific. One state, Tennessee, specifies that determining whether a policy is providing "significantly more coverage" for skilled care shall be based on the aggregate days of care for lower levels compared to days covered for skilled care.¹⁷⁹ Even this method, however, does not provide any specific guidelines as to what constitutes "significantly more coverage." For example, if a policy provides 365 days of skilled nursing home benefits, but only 150 days of benefits for other levels of care, does the policy meet the legislative standard? In the absence of explicit regulations, the state department of insurance may provide detailed information as to how they evaluate policies for compliance with this performance standard.

v. Waiting periods

The purpose of the NAIC Model Act is to provide minimum performance standards, not to standardize long-term care insurance. Accordingly, it does little to regulate the deductible period, which is usually defined in long-term care policies in terms of time and commonly is called a "waiting period." In fact, the Model Act prohibits insurers only from establishing a new waiting period if existing coverage is converted to or replaced by other insurance with the company.¹⁸⁰

As with other provisions in long-term care policies, those concerning waiting periods vary greatly.¹⁸¹ As a general rule, however, the longer the waiting period, the lower the premium.¹⁸² Many policies permit the consumer to select a waiting period of 0-100 days; some policies offer waiting periods of six months or one year; and others offer "first-dollar" coverage with no waiting period.¹⁸³ Although it is a matter of personal preference whether first

177. See *supra* note 87.

178. See *supra* note 158.

179. TENN. CODE ANN. § 56-42-105(b)(3) (Supp. 1988).

180. NAIC MODEL ACT § 6(B)(2).

181. See surveys cited *supra* note 87.

182. See, e.g., A. RIVLIN & J. WEINER, *supra* note 6, ch. 4.

183. HIAA RESEARCH BULLETIN, *supra* note 23, at 11-12.

dollar coverage is desirable, the waiting period requirement should be compared to the maximum benefit provisions of the policy. For example, a policy with no waiting period may pay benefits for only the minimum period prescribed by law (twelve consecutive months under the Model Act);¹⁸⁴ a policy with a longer waiting period may provide more benefits over time.

e. Loss ratios

In measuring the relative value of health insurance, regulators typically have used a "loss ratio" to assure that benefits are reasonable in relation to premiums charged.¹⁸⁵ The loss ratio essentially compares total claims and expenses with premiums collected.¹⁸⁶

Long-term care insurance loss ratios, however, are difficult to estimate because there is little actuarial data available and there is a long period of time between purchase of the policy and anticipated collection of benefits.¹⁸⁷ Nevertheless, the NAIC Model Act authorizes the Commissioner of Insurance to establish loss ratio standards for long-term care insurance.¹⁸⁸ The Model Regulations consider benefits under individual long-term care insurance policies reasonable in relation to premiums if the expected loss ratio is at least 60%.¹⁸⁹ However, in calculating loss ratios, long-term care insurers are permitted to include a number of factors traditionally not allowed in calculating such rates to provide insurers with "sufficient latitude to achieve the sixty percent loss ratio."¹⁹⁰

Federal law currently requires a loss ratio of 60% for Medigap policies.¹⁹¹ However, a federal government study found that 64% of Medigap policies marketed in 1984 had loss ratios lower than the 60% target rate.¹⁹² In light of the latitude given to insurers under the Model Act in estimating insurance loss ratios, and the findings concerning Medigap loss ratios, a potential consumer of

184. NAIC MODEL ACT § 4(A).

185. LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, at 36-37 and app. at 249-50.

186. *Id.* Loss ratios are calculated by dividing the sum of incurred claims, reserves for future claims, and expenses by the amount of earned premiums.

187. *Id.* See also NAIC REPORT, *supra* note 21, at 26-27; G. SHEARER, *supra* note 44, at 27-28.

188. NAIC MODEL ACT § 6(E).

189. NAIC MODEL REGS. § 14.

190. *Id.* § 14 and Drafting Note to § 14.

191. 42 U.S.C.A. § 1395ss(c) (Supp. 1989).

192. *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies* at 30, U.S. GEN'L ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN OF THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE INSURANCE, HOUSE SELECT COMMITTEE ON AGING, (October 1987).

long-term care insurance should ask the insurer for specific information about its estimated loss ratios.

2. Standards for the Form and Content of Long-term Care Insurance Policies

The NAIC Model Act not only provides minimum standards of coverage, it also regulates the form and content of long-term care policies. Individual purchasers of such insurance must be given a "free look" and have the right to return the policy within ten days of its delivery if not satisfied for any reason (thirty days if the policy was issued pursuant to a direct response solicitation).¹⁹³ The first page of the policy must include a prominent notice informing the purchaser of this right.¹⁹⁴

In addition, a purchaser must receive an "outline of coverage" at the time of initial solicitation on a form prescribed by the insurance commissioner. The outline must include a description of the principal benefits and coverage; principal exclusions, reductions, or limitations; terms of renewal and cancellation, premium revision and premium refunds; and a brief description of the relationship of cost of care to benefits.¹⁹⁵ The Model Regulations include the standard form prescribed by the NAIC.¹⁹⁶

These standards are more consumer-oriented than the performance standards discussed in the previous section. The outline of coverage can be a useful tool for comparing policies. However, the elderly client should be advised not to rely solely upon the outline. Rather, the client should request a specimen policy from the insurance agent or company. Although the NAIC Model Act does not require the insurer or its agent to provide a specimen policy, refusal to provide a specimen could indicate that the outline of coverage does not disclose all the salient features of the policy.

193. NAIC MODEL ACT § 6(F).

194. *Id.*

195. *Id.* § 6(G).

196. There are several options currently offered in long-term care policies that are not discussed in this Article, but which may provide the client with added protection, most notably, provisions adjusting benefits for inflation and waiving payment of premiums after the policyholder starts collecting benefits. For more information about these provisions, see HIAA RESEARCH BULLETIN, *supra* note 23. In addition, there are several pamphlets containing basic information about long-term care insurance that will provide the elderly client with a good starting point to evaluate policy options. See, e.g., HIAA, THE CONSUMER'S GUIDE TO LONG TERM CARE INSURANCE, and UNITED SENIORS HEALTH COOPERATIVE, LONG-TERM CARE: A DOLLAR AND SENSE GUIDE (1988).

E. Other Legislative Approaches

Other state legislative approaches to long-term care insurance generally fall within two categories: (1) regulation of performance standards that differ from the NAIC Model Act; and (2) incentives to promote the sale of long-term care insurance.

1. Regulatory Efforts

The most notable departures from the minimum standards approach of the NAIC Model Act are the state programs that require at least partial "standardization" of the long-term care insurance market by uniform definitions for key policy terms and restricting variations in policy provisions.¹⁹⁷ Such legislation has been criticized by the NAIC as "misguided" and "restrictive."¹⁹⁸

Minnesota has standardized the long-term care insurance that can be offered for sale in the state.¹⁹⁹ It establishes two types of policies, designated "A" and "AA," that differ in level of benefits and other key provisions.²⁰⁰ Both "A" and "AA" policies must include the following provisions:

1. Preexisting conditions must be covered during the first six months of coverage if the condition insured was not diagnosed or treated during the ninety days immediately preceding the effective date of coverage;
2. The maximum allowable waiting period is ninety days;
3. The policy cannot exclude coverage for mental or nervous disorders with a demonstrable organic cause, such as Alzheimer's disease;
4. The policy must be guaranteed renewable;
5. The policyholder can elect to have premiums paid in full at age 65 by payment of higher premiums up to age sixty-five;
6. Premiums must be waived while benefits are being paid for nursing home confinement;
7. The policy must include a thirty-day free look period;
8. If home care services must begin within a specified period after discharge from a hospital or nursing facility, that period may be no less than thirty days; and²⁰¹
9. Home care benefits must cover at least seven paid visits per week.²⁰²

197. See G. SHEARER, *supra* note 44, at 32-39 (arguing for standardization of the market as a way to improve the market).

198. NAIC REPORT, *supra* note 21, at 28 and app. H at 145, 147.

199. MINN. STAT. ANN. § 62A.46 (West 1986 and Supp. 1989).

200. *Id.* § 62A.48.

201. *Id.* § 62A.48(1).

202. *Id.* § 62A.48(2).

Type "AA" policies must provide a maximum lifetime benefit of \$100,000.²⁰³ Nursing home and home care coverage cannot be subject to separate lifetime maximums and only a one-day prior hospitalization requirement can be imposed for long-term care in a nursing facility.²⁰⁴ If benefits are paid on a per diem basis, the minimum daily benefit for care in a nursing facility must be \$60 or actual charges and the minimum daily benefit for home care must be \$25 or actual charges.²⁰⁵

Type "A" policies must provide a lifetime maximum benefit of \$50,000, and a requirement of prior hospitalization for up to three days may be imposed for nursing facility or home care benefits.²⁰⁶ The minimum daily benefit for nursing facility care is \$40 or actual charges and the minimum daily benefit for home care is \$25 or actual charges.²⁰⁷ As of 1987, four private companies and Blue Cross and Blue Shield of Minnesota filed policies with the Minnesota Department of Insurance that meet the type A requirements. Interestingly, the premium schedules for those policies were lower than the policies previously being offered in Minnesota by the same four private companies.²⁰⁸

Kentucky takes a different approach. The Kentucky law mandates that all insurers issuing individual health insurance policies in the state on an expense-incurred basis develop a health policy to provide benefits for services in a licensed long-term health facility.²⁰⁹ These policies must satisfy the following standards:

1. Benefits must be payable upon certification by an attending physician that long-term care is required;
2. The policy must contain the same coinsurance and deductible provisions as other services covered by these insurers;
3. The policy must include a deductible clause (waiting period) of sixty days from the date of admission to the facility;
4. The policy must provide complete coverage on an expense-incurred basis and pay at least 75% of the total cost of covered long-term care;
5. Insurers must offer nonduplicative coverage for Medicare beneficiaries;
6. The policy cannot condition admission to an intermediate care

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

208. *See Joint Hearing, supra* note 119, at 60-61 (statement of Michael Hatch, Commissioner of Minnesota Department of Commerce).

209. KY. REV. STAT. ANN. § 304.17-314 (Michie/Bobbs-Merrill 1988).

facility upon prior hospitalization or prior confinement in a skilled nursing facility; and

7. The policy must provide coverage for skilled, intermediate, and custodial care.²¹⁰

A law mandating all individual health insurers to provide a long-term care policy seems misguided because it forces companies that otherwise would not enter the market to sell such policies, and therefore increases the chance that premiums will be higher to offset the unwanted risk. New York has similar laws requiring health insurers to offer optional home health coverage, hospice services, and nursing home care.²¹¹

Standardization of long-term care policies does deserve closer scrutiny, however. The principal advantage of standardization is that consumers will be better able to understand the choices in the marketplace.²¹² Massachusetts instituted a standardization program for Medigap policies in 1980 that established three levels of coverage.²¹³ The program apparently achieved its goals of reducing consumer confusion and ensuring comprehensive Medigap coverage. The Commissioner of Insurance received fewer than one hundred complaints about Medigap policies in 1985, and the Massachusetts Medigap policies have been rated as the best in the country.²¹⁴ Massachusetts recently announced a quasi-standardization approach for the long-term care insurance market similar to its Medigap program.²¹⁵

2. Incentives to Buy and Sell Long-Term Care Insurance

a. Tax incentives

Colorado was the first state to allow a state tax deduction for amounts up to \$2,000 per year, deposited in an "individual medical account," which can be withdrawn without penalty only to pay medical, dental, and long-term care expenses of the account-holder.²¹⁶ Some states are considering legislation that would provide similar deductions,²¹⁷ or deductions or tax credits for the purchase of long-term care insurance premiums.²¹⁸ Other states,

210. *Id.*

211. N.Y. INS. LAW § 1117 (McKinney 1990).

212. See G. SHEARER, *supra* note 44, at 12.

213. *Id.*

214. *Id.*

215. MASS. REGS. CODE tit. 211, § 65.00 (1988).

216. COLO. REV. STAT. § 39-22-504.6 (Supp. 1988).

217. Ohio, H.B. 558 (1987).

218. California, S.B. 658, A.B. 159, A.B. 1227 (1988); New York, A.B. 6306 (1988).

however, have defeated similar legislative proposals.²¹⁹ Some states have provided incentives to purchase long-term care coverage by linking the coverage with public financing programs.

b. Public/private financing "partnerships"

South Carolina law allows any premiums paid for long-term care insurance to be excluded in determining the amount an individual must contribute to the cost of Medicaid services.²²⁰ Indiana has established a long-term care program under which a Medicare beneficiary can become eligible to receive Medicaid benefits for long-term costs not covered by Medicare or private insurance without spending down her assets. To qualify, the recipient must purchase a Medicare supplement policy or enroll in a prepaid health plan, and purchase a qualified long-term care policy or enroll in a prepaid plan for long-term care services.²²¹

Several states are participating in the "Program to Promote Long-Term Care Insurance for the Elderly" sponsored by the Robert Wood Johnson Foundation.²²² The program is intended to evaluate the potential of private market products in states that are willing to expand the private role in public financing of long-term care.²²³ Massachusetts is using its grant from the Foundation to subsidize the purchase of private insurance by low-income persons.²²⁴ Furthermore, if a Massachusetts consumer purchases a policy providing at least three years of coverage, the consumer will not be required to spend down assets to qualify for Medicaid when the insurance coverage ends.²²⁵ Wisconsin, another Foundation grant recipient, is considering a similar program that permits a waiver of the Medicaid "spend-down" provision to a person who purchases a qualified policy that meets or exceeds standards more stringent than the NAIC Model laws.²²⁶

219. Arizona (bill permitting tax deduction for purchase of premiums); Hawaii (bill providing tax credit for premiums); Idaho (bill providing tax deduction for premiums).

220. S.C. CODE REGS. 38-72-100 (1989).

221. IND. CODE ANN. § 12-1-25-7 (West Supp. 1989).

222. The participating states are California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin. See G. SHEARER, *supra* note 44, at 89-92; Meiners, *Reforming Long Term Care Financing Through Insurance*, 6 HEALTH CARE FIN. REV. 109, 111-12 (Supp. 1988).

223. G. SHEARER, *supra* note 44, at 89-92; Meiners, *supra* note 221, at 111-12.

224. G. SHEARER, *supra* note 44, at 89-90.

225. *Id.*

226. *Id.*

c. Alternative financing mechanisms

Approximately 75% of all elderly own their homes, with an average home equity value of \$54,000.²²⁷ Home equity conversions allow elderly homeowners to borrow funds based upon the equity value of their homes.²²⁸ The most popular type of conversion is the reverse annuity mortgage, in which loan proceeds are paid by lenders on a monthly or other periodic basis to the mortgagor and repayment is deferred for the term of the loan.²²⁹ Proceeds of the mortgage can be used to pay long-term care expenses, including the purchase of long-term care insurance.²³⁰ Various federal and state agencies have implemented quasi-public home equity conversion programs for the elderly.²³¹ This option should be closely explored as a means to finance the purchase of long-term care insurance.

IV. FEDERAL PROPOSALS TO REGULATE LONG-TERM CARE INSURANCE

The Medicare Catastrophic Coverage Act did not provide benefits for long-term care, but its enactment spawned an increased awareness of the need for a federal response to the growing long-term care crisis.²³² The members of the 100th and 101st Congresses introduced over twenty bills concerning long-term care.²³³ There is, however, no clear, bipartisan consensus on how to resolve the problem of financing long-term care. Generally, the proposed legislation concerning long-term care insurance falls into three categories: federal consumer protection legislation, federal tax incentives, and universal social insurance programs to meet the long-term care needs of the elderly and disabled. Although in his presidential campaign, George Bush stated that he was committed to "putting a long-term care law on the books quickly,"²³⁴ he also has stated that the need for long-term care primarily is a family is-

227. See generally A. RIVLIN & J. WEINER, *supra* note 6, ch. 8; Weinrobe, *Home Equity Conversion and the Financing of Long Term Care*, 6 HEALTH CARE FIN. REV. 113 (Supp. 1988); Jacobs & Weissart, *Using Home Equity to Finance Long-Term Care*, 12 J. HEALTH POL., POL'Y & L., 77 (Spring 1987).

228. *Id.*

229. *Id.*

230. A. RIVLIN & J. WEINER, *supra* note 6, at 123.

231. See Weinrobe, *supra* note 227, for a discussion of these programs.

232. See, e.g., *Lawmakers Taking Hard Look at Problem of Long-Term Care*, 46 CONG. Q. 938, 940 (1988).

233. This Article will address only the proposals pending in the 101st Congress, some of which have been reintroduced from the 100th Congress.

234. See *The Candidates Speak Out*, MODERN MATURITY, Oct.-Nov. 1988 at 38.

sue.²³⁵ As president, Bush has backed away from his “read my lips—no new taxes” position, but has asserted repeatedly that he will not impose new taxes to pay for social programs. Accordingly, because a universal social insurance program for long-term care cannot be financed by increasing tax revenues, it is reasonable to assume that, at least initially, President Bush will support only legislation encouraging personal responsibility for financing long-term care.

*A. Proposals for a Federal Long-Term Care Insurance
Consumer Protection Act*

As of April 1989, three bills were introduced in Congress²³⁶ to provide for the application of minimum standards to long-term care insurance. Two bills were introduced in the House of Representatives,²³⁷ and one bill has been introduced in the Senate.²³⁸ Both Democrats and Republicans supported these proposals. Both bills propose to create a program of voluntary certification of long-term care insurance policies that meet minimum standards and specified requirements. Under each proposal, a “Long-Term Care Insurance Panel” would review policies submitted for certification to assure compliance with the standards established in the legislation.²³⁹ The Secretary of Health and Human Services (or the Secretary’s designee) would certify qualified policies, which then could be held out to the general public as having been authorized by the Secretary.²⁴⁰ The bills carry a criminal penalty for misrepresenting that a policy is certified or advertising, soliciting, or offering for sale via the mail any long-term care policy that has not been ap-

235. *Id.*

236. 42 U.S.C.A. § 1396 (West 1983 and Supp. 1988).

237. H.R. 1288, 100th Cong., 1st Sess. (1989); H.R. 1325, 100th Cong., 1st Sess. (1989). H.R. 1288 would amend the Public Health Service Act. The bill has been referred to the House Committee on Energy and Commerce. H.R. 1325, sponsored by Rep. Pete Stark (D-Cal.), would amend Title XVIII of the Social Security Act (Medicare). The bill has been referred to the House Ways and Means Committee and the House Energy and Commerce Committee.

238. S. 142, 100th Cong., 1st Sess. (1989). S. 142, The Long-Term Care Protection Act of 1989, would amend Title XVIII of the Social Security Act (Medicare). The bill was cosponsored by Senators Cohen (R-Me.), Kassebaum (R-Kan.), McCain (R-Ariz.), and Bradley (D-N.J.).

239. H.R. 1288 § 2615(b)(2); H.R. 1325 § 1882A(b)(2); S. 142 § 1882A(2)(A). Under each proposed program, the Panel would consist of the Secretary of Health and Human Services (or his designee), state insurance commissioners (or superintendents, where applicable), individual Medicare beneficiaries, and representatives of employers and labor. Only the Senate bill’s Panel would also include a representative of the insurance industry. S. 142 § 1882A(2)(A).

240. H.R. 1288 § 2615(c); H.R. 1325 § 1882a(c); S. 142 § 1882(c).

proved by the state into which it is mailed.²⁴¹

Each bill contains a definition of qualified "long-term care insurance" policy. The House bills incorporate the NAIC Model Act definition,²⁴² but the policy must offer coverage for at least twenty-four months regardless of the type of facility or level of care.²⁴³ One of the bills—H.R. 1325—applies to "extended care insurance policies," defined as policies that would otherwise qualify as long-term care policies but only provide coverage for six to twenty-four months.²⁴⁴ The bill, however, does not require insurers to label or otherwise differentiate between such policies.

Under the provisions of each bill, the Secretary may certify policies only if they meet certain minimum standards, but the standards vary among the different proposals. All the proposals, however, incorporate certain provisions of the NAIC Model Act and Regulations, include a thirty-day "free look," and require policies to contain a statement (to be developed by the Secretary) describing the benefits and limitations under the legislation.²⁴⁵ Each bill also contains a provision under which policies are deemed to meet the federal standards if they are issued in a state with a regulatory program that is at least as stringent as the NAIC Model Act, meets the other legislative requirements, and applies the standards equally to all long-term care policies.²⁴⁶

The origin of these bills is not hard to trace. They are all patterned after the "Baucus Amendment" to the Medicare laws, which establishes a voluntary certification program for Medicare supplement insurance policies.²⁴⁷ Under the Baucus Amendment, however, it is a felony to knowingly sell a health insurance policy that duplicates Medicare benefits.²⁴⁸ The bills proposing a federal

241. Violation would be punishable by a maximum sentence of five years imprisonment, a fine of \$25,000, or both. H.R. 1288, § 2615(d); H.R. 1325 § 1882A(d); S. 142 § 1882A(d).

242. NAIC MODEL ACT § 4(A).

243. H.R. 1288 § 2615(e)(1); H.R. 1325 § 1882A(f)(1). The Senate proposal contains a definition of long-term care insurance that requires only twelve months of consecutive coverage like the NAIC Model Act.

244. H.R. 1325 § 1882A(f)(2).

245. H.R. 1288 § 2615(c); H.R. 1325 § 1882A(c); S. 142 § 1882A(c). H.R. 1288 and H.R. 1325 also prohibit prior hospitalization requirements and provisions that condition eligibility for benefits for lower levels of care on a prior nursing home stay; and they provide that an insurer must offer at least one policy providing benefits for home- and community-based services. *Id.* S. 142 requires policies to be guaranteed renewable at the same premium rate. *Id.*

246. H.R. 1288, § 2615(b)(1); H.R. 1325, § 1882A(b)(1); S. 142 § 1882A(b)(1).

247. 42 U.S.C.A. § 1395ss (West 1983 and Supp. 1989).

248. *Id.* § 1395ss(d)(3).

consumer protection program do not similarly prohibit duplicative coverage. Senator David Durenberger (R-Minn.) proposed an amendment to the pending bill to clarify that it applies to duplication of benefits furnished by a skilled nursing facility or home health agency,²⁴⁹ but the proposed amendment did not specify whether a long-term care policy is a "health insurance policy" as the term is used in the Baucus Amendment.²⁵⁰ Applying the prohibition against duplication of benefits to long-term care policies would not only equalize the treatment of Medigap and long-term care policies under federal laws, but it also would prohibit long-term care insurers from purporting to cover treatment of an acute illness already covered by Medicare. Furthermore, it would have the beneficial effect of focusing the attention of long-term care insurers on the long-term care needs of the chronically ill.

The Baucus Amendment was precipitated by the actual and perceived sales and marketing abuses concerning Medigap policies.²⁵¹ Although not as publicized, there have been similar abuses reported about the sale and marketing of long-term care insurance.²⁵² Most of the complaints result from agents' poor understanding of the products they are offering, or "switching" or "twisting" practices in which the agent convinces the elderly client to drop his present insurance and buy a new policy. There have been serious abuses reported.²⁵³

The proposed legislation to create a federal certification program would not completely deter such sales and marketing abuses in the long-term care insurance market. The national certification pro-

249. S. 142 § 3.

250. 42 U.S.C.A. § 1395ss (West 1983 and Supp. 1989).

251. NURSING HOME INSURANCE, *supra* note 13.

252. *Id.* at 8-17; *see also*, JOINT HEARING, *supra* note 119, at 37-48 (statement of John Gilmore, independent insurance agent); *id.* at 56-78 (Michael Hatch, Commissioner of the Minnesota Department of Commerce).

253. The MediCo Life Investigation in Minnesota offered over 4,000 policies (which met the minimum requirements of state law) to the elderly in Minnesota and then informed them that they had to join a federation to purchase the policies. The federation was exempt from complying with the applicable Minnesota standards for long-term care insurance. The agents misrepresented the benefits of the policy, and 95% of the purchasers believed that they had purchased a comprehensive policy when in reality their custodial benefits were limited to \$2 per day. *See* JOINT HEARING, *supra* note 119, at 56-78 (statement and exhibits of Michael Hatch, Commissioner of Minnesota Department of Insurance). In another "overselling" case one agent sold an elderly couple in California 21 long-term care policies representing \$19,000 in premiums. Not one policy covered custodial care. *See id.* at 79 (statement of Bonnie Burns). [Note: The Illinois Department of Insurance has not taken any formal action against long-term care insurers. Telephone interview with Mark Fulzinga, Evaluation Unit, Illinois Department of Insurance (April 26, 1989)].

gram for Medigap policies, however, has curbed sales and marketing abuses without stifling the supply side of the market.²⁵⁴ There is no reason to believe such a program would not have the same positive effect on the long-term care market and help eliminate substandard products.²⁵⁵ As of 1986, no Medigap policies had been federally certified.²⁵⁶ A long-term care insurance certification program likewise could become a "paper tiger" if the industry perceives the federal law as too restrictive.

Proposals for a federal certification program have been criticized because they would increase "twisting" practices, because agents could convince the elderly that their existing policies should be replaced by certified policies. The insured may then be subject to new waiting periods, preexisting condition restrictions and, perhaps, higher premiums.²⁵⁷

B. Tax Incentives

It is beyond the subject matter of this Article to examine the proposals for federal tax incentives in taking personal responsibility for one's long-term care and for universal social insurance programs. Both types of proposals, however, will affect the regulation of private, long-term care insurance. The proposals for federal tax incentives vary.²⁵⁸ All of them, however, essentially are intended

254. GAO REPORT, *supra* note 22.

255. Ohio law specifically provides that a violation of its Long-Term Care Insurance Act (patterned after the NAIC MODEL ACT) is an unfair and deceptive insurance practice, subjecting the violator to a fine of \$1,000. OHIO REV. CODE ANN. § 3923.48-.99 (Anderson 1989). Rhode Island law permits the Director of Insurance to levy administrative penalties of \$500 to \$50,000 for violations of its long-term care insurance provision. R.I. GEN. LAWS § 27-34.2-10(C) (1989).

256. GAO REPORT, *supra* note 22, at 10.

257. G. SHEARER, *supra* note 44, at 86-87.

258. Congressman Matthew Rinaldo (Rep.-N.J.) introduced legislation during the 1st Session of the 100th Congress proposing amendments to the Internal Revenue Code, U.S.C. title 26, to exclude from gross income benefits received under long-term care policies that are certified by the Secretary; employer contributions for such insurance; amounts withdrawn from individual retirement accounts to purchase certified policies; and amounts received on cancellation or surrender of life insurance contracts and used to purchase certified long-term care policies. H.R. 3501, 100th Cong., 1st Sess. (1987). Other proposals include S. 139, 101st Cong., 1st Sess. (1989) (exclusion from gross income for withdrawals from individual retirement accounts to pay long-term care insurance premiums); S. 140, 101st Cong., 1st Sess. (1989) (tax credit); S. 141, 101st Cong., 1st Sess. (1989) (tax credit for premiums); H.R. 338, 101st Cong., 1st Sess. (1989) (deduction for contribution to long-term care savings accounts); H.R. 421, 101st Cong., 1st Sess. (1989) (tax benefit for insurers offering long-term care policies); and H.R. 688, §§ 101, 102, 103, 101st Cong., 1st Sess. (1989) (exclusion of long-term care benefits from gross income; exclusion from gross income for withdrawals from individual retirement accounts to pay long-term care insurance premiums). For further discussion of this issue,

to promote consumption of private, long-term care insurance and to encourage personal responsibility for long-term care planning by private risk-pooling via long-term care insurance.²⁵⁹ In addition, by providing incentives only for "qualified" long-term care insurance policies, the legislative proposals dictate consumer protection policy concerning acceptable products.

There have been no published projections about the cost in tax dollars arising from such proposals. These proposals, however, should not be evaluated without reference to a broader public policy issue: whether long-term care financing should be privately or publicly supported. The subtle objective of the proposals for individual tax incentives is to delay or prevent the enactment of legislation creating a social insurance program for long-term care. The value of these tax incentives for low- and middle-income taxpayers is questionable, however. Even with the tax incentives, private, long-term care insurance may be too expensive for such taxpayers.²⁶⁰

C. *Proposals for a Universal Social Insurance Program for Long-Term Care*

Although the use of private, long-term care insurance has increased substantially since 1980,²⁶¹ it is not likely to become the primary mechanism for financing long-term care. A recent study estimated that, even assuming the most favorable conditions (e.g., low premiums and purchase of policies at age sixty-five), a third of the elderly population in the years 2016-2020 will not be able to afford private, long-term care insurance.²⁶² If more realistic premium levels are considered, the number of elderly unable to afford such insurance rises to almost 50%.²⁶³

Recent surveys suggest that a majority of voting-age adults favor

see NAIC REPORT, *supra* note 21, app. K. Rep. Rinaldo's proposals as well as other proposals introduced in the 100th Congress to provide federal tax incentives for long-term care planning are discussed in Moran & Weingart, *Long-Term Care Financing Through Federal Tax Incentives*, 6 HEALTH CARE FIN. REV. 117 (Supp. 1988).

259. Moran & Weingart, *supra* note 258, at 117-18.

260. See LONG-TERM HEALTH CARE TASK FORCE REPORT, *supra* note 25, app. at 178-87.

261. See *supra* notes 21-23 and accompanying text.

262. A. RIVLIN & J. WEINER, *supra* note 6, ch. 4. J. FIRMAN, W. WEISSERT & P. WILSON, *supra* note 87, at 43, estimate that a policy with no prior hospitalization or prior skilled care requirements that paid a daily benefit of \$80 per day (adjusted for inflation), with a waiting period of 90 days and a 4-year maximum benefit period, would have an annual premium of \$2,000 to \$2,500 for persons age 65, and premiums of \$7,000 to \$8,500 for persons age 80.

263. A. RIVLIN & J. WEINER, *supra* note 6, ch. 4.

some form of government insurance for long-term care.²⁶⁴ Approximately 75% favor government assistance for long-term care insurance.²⁶⁵ Thirty-five percent of the voters surveyed favored a universal government assistance program, while 60% preferred a program focusing only on the most needy.²⁶⁶ Despite these statistics, at least one-third of the people surveyed who favor an expansive federal program do not want to pay more taxes to finance such programs.²⁶⁷ All in all, however, nearly 50% of those surveyed rate long-term care for the elderly and disabled as an important public concern.²⁶⁸

Armed with this public "mandate," the dismal statistics on the spiraling costs of long-term care, and the elderly's concomitant inability to pay those costs, several Democratic legislators in the health care political arena have proposed social insurance programs, which are estimated to cost from \$8 billion to \$55 billion.²⁶⁹ All proposed programs would be financed through tax increases of one form or another, including payroll taxes, gift and estate taxes, alcohol and gasoline taxes, income taxes, premium increases for Medicare, or a combination of the above.²⁷⁰ Some of the proposals expand the Medicare program to include long-term care, while others propose the creation of a freestanding program.²⁷¹

It is not the purpose of this Article to analyze thoroughly the public policy implications of these legislative proposals.²⁷² The crucial inquiry is whether the market for private, long-term care insurance will be eliminated or altered by them. If after their enactment there is still a need for private insurance, the issue becomes whether it should be federally regulated. Under most of the proposals, there still will be a market for private insurance, although not for the same type of product that has been discussed

264. See, e.g., HIAA RESEARCH BULLETIN, *Public Attitudes on Long-Term Care* (March 1989).

265. *Id.* at 17.

266. *Id.* at 18.

267. *Id.* at 20.

268. *Id.* at 4-5.

269. G. SHEARER, *supra* note 44, at app. B (outlining the key provisions of the various legislative proposals).

270. *Id.* at 40-43, Table VII-1 and app. B.

271. The key proposals from the 100th and 101st Congress include S. 2305, 100th Cong., 2d Sess. (1988); S. 2681, 100th Cong., 2d Sess. (1988); H.R. 200, 101st Cong., 2d Sess. (1989); H.R. 1325, 100th Cong., 2d Sess. (1988); H.R. 3436, 100th Cong., 2d Sess. (1988).

272. For a discussion of these programs, see G. SHEARER, *supra* note 44, ch. 9; A. RIVLIN & J. WEINER, *supra* note 6, chs. 10-17.

in this Article. For example, H.R. 3436²⁷³ covers only home health care and will reimburse providers only for charges up to 75% of the Medicare SNF benefit rate. Because Medicare catastrophic coverage pays benefits for only 150 days of SNF care, the Medicare-eligible elderly still would be uninsured for extended stays in a skilled nursing facility and for all stays in other types of facilities. Accordingly, a private market could develop for "nursing home insurance," rather than long-term care insurance, as that term has been used here.²⁷⁴

The private, long-term care insurance market also would be affected by the proposals that contain waiting periods before covered persons become eligible for federal benefits, or require copayments. For example, H.R. 1325 requires a three-month waiting period before receipt of benefits for nursing home care. S. 2305 requires an even longer waiting period, two years, before receipt of benefits for nursing home care.²⁷⁵ With the exception of H.R. 3436, these proposals require a copayment, although the amount varies from 5% to 50% depending upon the type of service. These provisions most likely will create a market for "gap" long-term care insurance similar to the Medigap policies. Indeed, for the proposals that expand the Medicare program rather than create an independent program, the private, long-term care insurance market could be displaced by an expanded Medigap insurance market. The legislation therefore should contain provisions to ensure that private insurance does not duplicate federal benefits, similar to the current law concerning Medigap insurance.²⁷⁶

The federal proposals for a long-term care social insurance program also might have the affect of altering how the private market assesses the need for long-term care. The proposals contain eligibility criteria based upon the ability to perform activities of daily living. The more innovative policies on the market are using this type of evaluation, but many state laws still permit prior hospitalization requirements.²⁷⁷ Federal legislation using ADL criteria to determine eligibility, however, may provide a standard against

273. See *supra* note 271.

274. See *supra* note 107 and accompanying text for further reference to "nursing home insurance."

275. Sen. Mitchell stated that he intended for the private market to develop affordable insurance to fill the gap. See *Mitchell Offers Long Term Bill*, 46 CONG. Q. 1084 (1988).

276. See 42 U.S.C.A. § 1395ss(d)(3)(A) (West 1983 and Supp. 1989).

277. See *supra* note 158 and accompanying text (discussing prior hospitalization requirement).

which the private market can be measured. It may also encourage state legislators to require policies sold in their respective states to use similar eligibility criteria.

None of the proposals contain provisions to regulate the private, long-term care industry. Accordingly, legislation such as the proposals mentioned above still would be necessary to set minimum standards or to establish a federal certification process for private, long-term care insurance. An alternative would be to enact legislation and regulations that establish standards for private, long-term care gap policies and permit companies to bid competitively for the right to market such insurance.²⁷⁸

V. CONCLUSION

Planning for the financing of long-term care through private, long-term care insurance may be affected by any of the current legislative proposals for long-term care. Federal legislators are poised to address these proposals, but it is unclear whether any of the current proposals will be enacted. For the moment, then, private, long-term care insurance is the most viable option for personal planning for long-term care.

The insurance industry faces a formidable challenge, however, in designing long-term care insurance policies that are comprehensive, that meet the minimum performance standards required by state law, and that remain affordable. The products currently being offered often fail to meet these goals. Accordingly, policies must be thoroughly evaluated to assure compliance with applicable law and comprehensiveness of coverage.

278. See G. SHEARER, *supra* note 44, at 48.