PHASE II:

Expanding the Vision: Long-Term Care Insurance in Florida

Office of Insurance Regulation
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Summary

Recognizing the growing demand for long-term care, and the resulting financing pressures created by this growing demand, in August 2005 the Florida Office of Insurance Regulation completed a comprehensive research project into one aspect of this market; private long-term care insurance. In the first phase of the research, the overall long-term care market and the developing issues are reviewed, both on a national level but also with a particular focus on issues specific to Florida (this report can be found at http://www.floir.com/pdf/LTC_Phase_I.pdf). As follow-up to the Phase I report, public hearings were scheduled to solicit input from the public, the industry, and other interested parties.

Initially two hearings were scheduled, one in Tampa for August 26th, and a second in Miami for August 31st. Both were canceled due to Hurricane Katrina, but the Tampa hearing was rescheduled and was held on October 10, 2005.

As the initial analysis has been publicly exposed since August and has been available for review by the private insurance sector, consumers, and the regulatory community without substantive comment, the data included in Phase I is contained in this final report --- also called Phase II.

In addition, this final report adds the following analysis to the Office of Insurance Regulation's (OIR) vision of the future.

- **Federal Legislative Changes.** These changes are likely to dramatically affect the Florida landscape for the sale of long-term care insurance.

- **OIR's regulatory efforts to control rate spirals.** Rate spirals, otherwise known in the industry as death spirals can be created when the initial rates on long-term care insurance are too low, the book of business is later closed, and the subsequent poor experience justifies future rate increases. The OIR has been aggressive in identifying future death spirals by using its regulatory authority to enforce annual rate reviews.

- **Feedback from the public hearings.** Some of the feedback involved issues listed above, especially controlling death spirals and Florida's involvement in the State Long-Term Care Partnership Program. There were a multitude of other suggestions to encourage long-term care insurance sales and products.

The remainder of the report is predominately the data analysis included in the Phase I report with minor modifications based on the feedback received. Since the release of Phase I in August 2005 to date there has been some more activity regarding long-term care insurance rates. These are:

Date	Company Name	Rate Request	Rate Approved	Policy Types
Nov. 2005	American Heritage Life	35%	11.5%	372 long-term care policies
Nov. 2005	American Heritage Life	35%	14.5%	809 home health care policies
Jan. 2006	AF&L Insurance	20%	16%	2,422 long-term care policies
Jan. 2006	AF&L Insurance	50%	10%	2,524 home health care policies
Jan. 2006	AF&L Insurance	15%	5%	321 nursing home policies
Mar. 2006	Transamerica Occidental Ins.	35%	25%	5,365 long-term care policies

National States Insurance Company made a request for a 53% increase on LTC policies. This request was disapproved by the OIR. The company requested a hearing, which has been held, and the OIR awaits the Department of Administrative Hearings (DOAH) decision.

All of the rate increases above pertained to policies issued prior to March, 2003 on closed blocks.

Federal Legislative Changes

President Bush signed the Deficit Reduction Act of 2005 into law on February 8, 2006. The legislation tightened Medicaid eligibility by changing the look-back period for qualification from three years to five years, changed the treatment of financial assets such as annuities, and altered the treatment of individuals with substantial home equity in order to further restrict Medicaid eligibility. The legislation also clarified Medicaid transfer rules.

As striking as these changes will be for an aging population, it is the Long-Term Care Insurance-Medicaid Partnership Program provision of the law that will most likely impact Florida's long-term care insurance market. This partnership program, that began as a pilot project in 1987, allowed states to develop a public-private partnership with Medicaid and the private insurance market to create products that allowed individuals to purchase long-term care insurance in exchange for shielding assets in the determination of Medicaid eligibility.

Other states showed interest in this program, but the Omnibus Budget Reconciliation Act of 1993 restricted these programs to the initial four states. This restriction was removed by the most recent legislation.

California, Connecticut, Indiana and New York were the original four states granted authorization to develop these programs. California and Connecticut adopted a dollar-for-dollar program, which allows a person purchasing $100,000 in long-term care insurance to protect $100,000 in assets from determining Medicaid eligibility. The state of New York opted for a "total asset protection" model that protected all assets when an individual purchased a state-defined minimum package. Indiana offered a hybrid model.

According to a Government Accountability Office (GAO) report in 2005, this partnership program has been successful in encouraging people to purchase long-term care insurance in these

four states, eliminated the need for the majority of the consumers to apply for Medicaid, and as a result ultimately reduced Medicaid costs.[1]

The OIR expects Florida to achieve many of the same benefits as these pilot states. According to the American Council of Life Insurers, there are currently 16 states (including Florida) that have already passed enabling legislation to use this partnership program.[2] Florida is one of the first states in the process of passing additional legislation to make the program operational.

In preparation for consideration of this legislation, Chairman Grassley of the Senate Committee on Finance asked the GAO to conduct an analysis of the four states' partnership programs currently in use. The GAO found that currently there are 172,000 individuals with active partnership policies, the number of policies purchased each year has increased since the inception of this program, and most purchased policies were comprehensive policies covering both nursing home care and home and community-based care. Like other long-term care insurance, these policies are underwritten on an individual basis. The acceptance rate for these policies was 84% in those four states, the median age at the time of purchase ranged from 58-63 depending on the state, over 70% of those purchasing policies were married, and nearly 95% of those were purchasing long-term care insurance for the first time.

As the federal legislation has just recently passed, the OIR has not had time to evaluate feedback from the long-term care industry in Florida as this was subsequent to the public hearing held on October 10, 2005. Although the issue was raised in this venue, the general feeling was that Florida was in a unique position to take advantage of this expansion given Florida's elderly population. Several trade associations such as the American Council of Life Insurers have praised the recent federal legislation and predicted strong growth in the long-term care insurance market moving forward.

[1] GAO-05-1021R Long-Term Care Partnership Program, A letter to Charles E. Grassley Chairman of the U.S. Senate Committee on Finance.
[2] "Long-Term Care Insurance or Medicaid: Who Will Pay for Baby Boomers' Long-Term Care," American Council of Life Insurers Research Findings 2005, Andrew Melnyk, Phd.

OIR's Regulatory Efforts to Control Rate Spirals

The OIR has been particularly sensitive to the issue of rate increases and closed blocks of business that could potentially create a "death spiral" of continually increasing rates for holders of long-term care insurance policies. Florida was one of the states that adopted the NAIC's national rate stability model on March 1, 2003 that was created to address this specific issue.

These new standards had an immediate impact on Florida's insureds. The new standards require more disclosure at the point of sale including the disclosure of a ten-year history of the company's rate increases, as well as requiring an assurance that rates are reasonably expected to be sustained over the life of the coverage. Stricter suitability requirements and actuarial standards also should contribute to more appropriate sales of these products.

The new standards also restrict future rate increases, and mandate that 85% of future increases are used to enhance consumer benefits. Thus, the intent is for any rate increases to go almost entirely to cover claims – not for company profits. The result has been quite positive. In fact, to date there have been no rate increases for policies sold to Floridians after March 1, 2003.

Policies Sold Prior to March 1, 2003

OIR's current long-term care insurance regulatory focus is to help those consumers that purchased products prior to the implementation of the new standards. After a cursory review of the data, there is cause for concern. From 2002 to 2004, the amount of long-term care premium has nearly doubled in Florida from $587 million to $1.1 billion. Some of this increase is due to more covered lives, and the average age of the insured becoming older, and even the selection of richer (more expensive) plans. All of these reasons are legitimate reasons to see a spike in statewide long-term care insurance premiums. However, all of the premium increases have been for closed blocks of business sold prior to March 1, 2003.

The Problem of Rate Increases

If a long-term care insurance product has been appropriately priced, it is quite conceivable that no rate increase will ever be needed --- inflation and experience have already been considered in the original pricing of the product. If the policy has been underpriced, a future rate increase will be justified based on "poor" claims experience. The problem is that later rate increases often make the product unaffordable to consumers; frequently at a time when they are least able to pay.

In one example, a company ("Alpha Company") required a 130% increase for its LTC products from 2001 to 2005. These rates were justified and were approved. As the average premium soared from $1,264 to $2,914, the number of insureds dropped from 13,882 to 4,361. The conclusion is obvious: Some individuals could no longer afford to keep their policy in force.

While this situation should not occur under the new standards, the majority of Floridians with LTC insurance purchased their policies prior to March 1, 2003. Currently there are roughly 150 companies that have long-term care insurance policies in force, yet only 46 of these companies are selling new policies. The sale of new policies is important for rate stability in that it keeps an influx of new (healthy) individuals entering the risk pool, which helps stabilize losses, and ultimately stabilize rates. Of these 150 companies only 31 have required rate increases since inception. Even though this represents a mere fifth of the companies, the companies with rate increases have disproportionately been the larger companies, thus, 35% of Floridians with long-term care insurance policies have experienced a rate increase. Some of these rate increases have been relatively small (one company had a cumulative rate increase of 9.5%) while others have been astronomical (as much as 448%).

Annual Rate Certifications

In theory, long-term care policies that are underpriced can be adjusted annually. In actuality, companies often ignore the problem, continue with the underpriced products for several years, sell a multitude of policies as their underpriced products have a competitive edge versus rival products, and only apply for rate increases when it is too late. The company's only recourse is to close the block of business, and ask for significant rate increases. This is only a stopgap measure

and begins a vicious cycle, as a closed block of business no longer invites new healthier individuals, and spiraling cost increases will encourage the few healthy individuals to leave. This could necessitate even more rate increases.

One of the laws designed to prevent this occurring is the "annual rate certification" requirement that forces companies to justify their rates annually, and is part of the filing requirements in Section 627.410(6)&(7), Florida Statutes. These filings tend to be "routine" in that the majority of companies should not have to make any adjustments (assuming the product was priced appropriately) and their annual filing should merely reaffirm the adequacy of their current rate structure. The OIR has concern with the compliance record of the industry.

Beginning in 2005, the Office of Insurance Regulation initiated an aggressive review of the long-term care market by pursuing statutory compliance for annual rate certifications, and issuing significant fines to companies in non-compliance. Currently eight companies have settled cases with the OIR totaling fines of $112,500, while 33 additional cases are being pursued with fine recommendations totaling an additional $470,000. The average fine per company is $14,000 and depends on the number of long-term care policies, number of individuals with those policies, and the number of years the company was deemed to be in violation of the statute. It is OIR's belief that there may be many more companies with underpriced products, which will require additional rate increases. This aggressive regulatory stature is intended to ensure that unit sales are at adequate rates in the future.

Long-Term Care Insurance Public Hearing

The Office of Insurance Regulation conducted a public hearing on long-term care insurance issues from 10 am to 3 pm at the Marriott Tampa Westshore Hotel on October 10, 2005.

Florida Commissioner Kevin McCarty chaired the hearing, which included panelists from government agencies (Florida Department of Elder Affairs, Florida Department of Financial Services), trade organizations (The American Council of Life Insurers), academics (Elizabeth Goldsmith, PhD, Florida State University), legislators (The Honorable Kim Berfield and the Honorable Dennis Ross, The Florida House of Representatives, and the Honorable Mike Fasano, The Florida Senate), and other interested parties from the private sector, and consumer groups.

The key issues discussed included:

- The viability of long-term care insurance products as a financial tool to fund long-term care needs and how to integrate these products with other financial vehicles.

- The impact of Medicaid as a disincentive for Florida consumers to purchase long-term care insurance. This included a discussion of Medicaid spend-down rules, and the enabling legislation passed by Florida in anticipation of a change in the federal guidelines on Medicaid eligibility.

- The affordability of long-term care insurance products including rate increases, closed blocks of business, and the creation of "death spirals" of increasing costs.

- The unavailability of long-term care products in later years when it is needed. This included the concept of encouraging sales of long-term care insurance to younger individuals allowing years for policy benefit build-up at lower rates. Also the introduction of an incontestability clause that would prohibit policies over a certain age from being rescinded, even for misrepresentation.

One issue repeatedly addressed during the hearings was the National Association of Insurance Commissioners' (NAIC) rate stability amendments passed in March, 2003. Although there was general consensus that this was a positive step for making long-term care insurance more affordable to the elderly, there was concern that these protections were not extended to those

who purchased their products prior to these changes. Some of the issues address in this NAIC initiative included contingency benefits in the event of a policy lapse, and protections against closed blocks of business being used to justify rate increases resembling death spirals.

Although there was no voting mechanism or official report by the panelists represented at the public hearing, there was a general consensus for the following recommendations:

1. Increased protections for policyholders who have made the decision to purchase long-term care insurance prior to the adoption of the NAIC rate stability amendments in March, 2003.

2. The standardization of products, by requiring all insurers to offer a base standardized plan. This would allow consumers to comparison shop between companies and products. Carriers should be allowed flexibility to offer additional benefits beyond the baseline to allow for differentiation of products. These additional products would be priced separately.

3. An incontestability requirement for all policies that have been in force for two years. The purpose of this recommendation is to prevent the rescission of a policy due to allegations of fraud on the application at a time when the elderly insured would be unable to find other coverage if the policy were rescinded.

4. An expansion of Florida's pooling laws, which require pooling of all experience for forms with similar benefits, to be expanded to include affiliated companies. This will broaden the protections against closed blocks by prohibiting companies from closing blocks and selling nearly identical policies through affiliates as a way to circumvent the law.

5. The creation of an ombudsman position to represent consumer interests.

6. An increase in corporate tax incentives to encourage companies to offer long-term care insurance products in much the same way that they offer other health insurance, life insurance, and disability insurance products as part of the employment compensation package.

7. Implementation of an organized public awareness campaign for the types of long-term care insurance products, what can be purchased, for what coverage, and how these products can be coordinated with Medicare, Medicaid, and other financial instruments.

Many of these recommendations would require additional legislative and administrative changes to implement.

Introduction to the Long-Term Care Market

Sometimes people need help with the basic physical processes of daily living; this is especially true for the elderly. A serious physical injury or disease can result in the need for this basic help for an extended period of time, or even permanently. Historically, the family or the community primarily provided this help, with only the most severe cases receiving institutional assistance. Over time, however, a segment of the health care industry has grown to meet this need.

The long-term care industry evolved to provide a variety of services to those who need it. Whether through home or community based care or through institutionalized care, the industry provides a mechanism for skilled practitioners to assist those who need it. As this market has grown, an important societal question has arisen: Who should pay for it and how?

This question becomes increasingly important when the future demand for long-term care (LTC) is considered. A recent Congressional Budget Office (CBO) report estimates that approximately 19% of the over-65 segment of the population needs some level of LTC assistance, while 55% of those over-85 will also need assistance.[3] Looking ahead, the over-65 segment of the population is expected to double between 2000 and 2030, and within this group the over- 85 segment will grow the fastest.[4] This is just simple demographics; the baby boomers in the U.S. are growing older and living longer.

Moreover, while LTC is most commonly associated with the older segments of the population (over 65), the CBO report also asserts that nationally about a third of those receiving long-term care are younger, the need usually arising as a result of health problems such as diabetes, arthritis, or mental retardation.[5] Future demographic trends point away from the continued viability of the informal family support for long-term care as families are becoming smaller, there are fewer traditional "nuclear" families, and there is a continuing increase in inter-generational geographic dispersion within families.

[1] Congressional Budget Office, April 2004, "Financing Long-Term Care for the Elderly," Summary Page IX.
[4] Congressional Budget Office, April 2004, "Financing Long-Term Care for the Elderly," Page 13.
[5] Congressional Budget Office, April 2004, "Financing Long-Term Care for the Elderly," Page 16.

While the CBO report estimates that about a third of all LTC services are provided by family, it also means that the majority of LTC services are provided through other mechanisms, primarily through the LTC industry, which ultimately costs money. Currently, states' Medicaid programs pay the bulk of these expenses.[6]

According to a study by the U.S. Department of Health and Human Services, Medicaid expenditures for long-term care and home health services amounted to over half (55.6%) of total Medicaid spending.[7] During a time when states are struggling to manage their Medicaid budgets and expenditures, long-term care expenditures are adding additional pressure. The overall result is that twenty-three states reported Medicaid shortfalls in fiscal year 2003, with Medicaid averaging 22.4% of the total state spending.[8] For 2005, state budgets are, on average, predicting a 12.1% increase in expenditures to fund Medicaid, a rate that easily surpasses the overall growth rate of state revenues.[9]

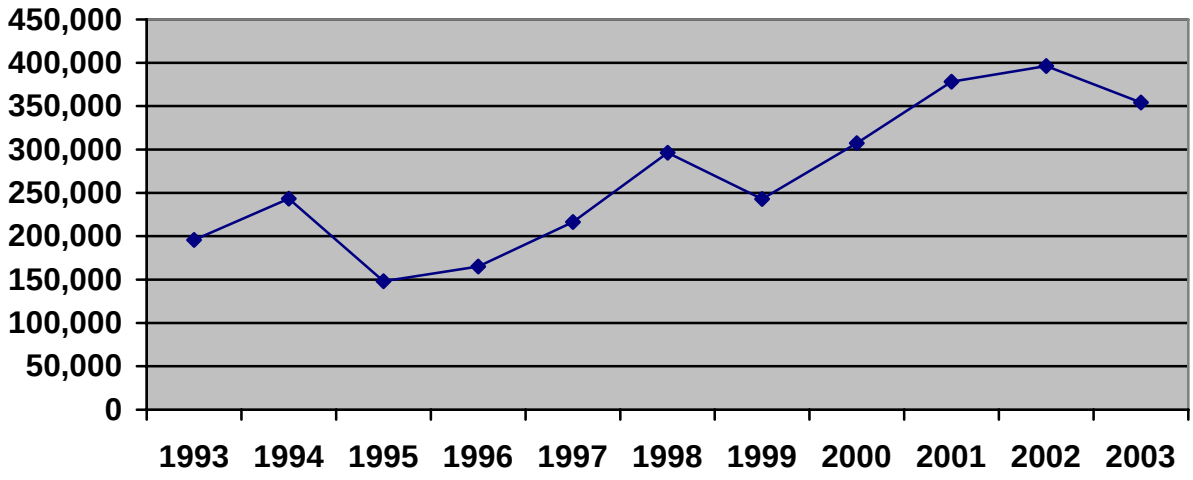
Other payment sources exist. In addition to personal savings (including annuities and reverse mortgages), and life insurance with LTC riders or accelerated benefit provisions, as individuals factor in and evaluate the expense and uncertainty related to providing for their own long-term care needs the insurance industry has responded with the creation and development of long-term care insurance. As a vehicle for individuals to manage their economic and health needs as well as a way for states to encourage a transfer of their Medicaid costs to the private sector, long-term care insurance would seem to be an important piece of the long-term care landscape. To date, however, this has not been the case.

[6] U.S. Department of Health & Human Services, "A Profile of Medicaid," Figure 2.15, 2000 Edition. Break out included 44.1% for Institutional Long-Term Care, 28.9% Inpatient & Outpatient Hospital, 27.5% Health Insurance, 11.7% Prescription Drugs, 11.5% Home Health & Other Community-Based Services, 6.6% Physicians, and 6.4% Other Acute Care.
[7] Ibid.
[8] 2002-2003 State Health Expenditure Report (co-published by the National Association of State Budget Officers, Milbank Memorial Fund, and the Reforming State Group).
[9] Ibid.

The CBO report referenced earlier estimates that long-term care insurance pays for only 3% of all long-term care expenditures.[10] In Florida in particular, only 5% of the over-45 population (the presumed target population) have long-term care insurance.[11] Figure 1 below shows that while enrollment in Florida has grown over the last decade, it certainly has not kept pace with increases in the target populations or increases in long-term care expenditures.

Figure 1

LTC Enrollment in Florida 1993-2003[12]



*The 1999 data was altered. National Financial reported 117,000 policies. Based on premium levels of $1.9 million, we believe this was a data error, and the correct number was 117, which is consistent with prior years.

This research is intended primarily to address why this is the case. In particular, why, with a demonstrated and growing demand for long-term care and the availability of a private market financing mechanism, has the long-term care insurance market not been more widely successful? With a thorough exploration of this issue through the first phase of the research and through a

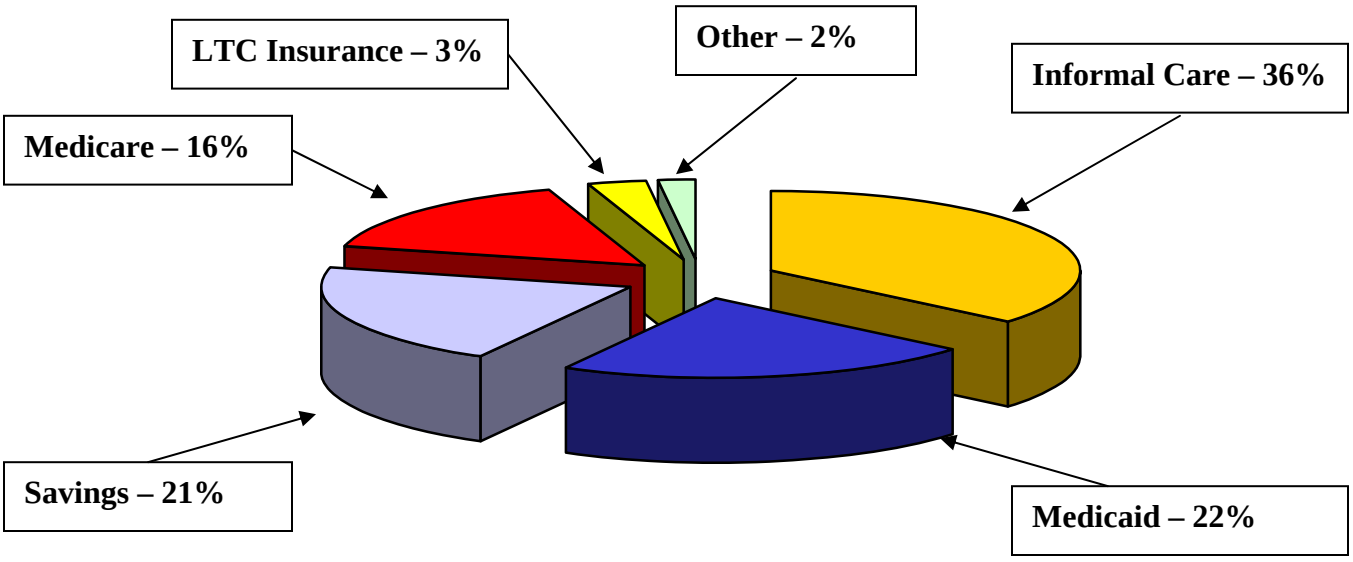
[8] Congressional Budget Office, April 2004, "Financing Long-Term Care for the Elderly," Summary, Page X.
[11] This percentage is an estimate and likely overestimates the true penetration rate. The "over 45" population is taken from the U.S. Census Bureau based on 2003 data, and the number of long-term care policyholders is taken from the NAIC's Long-Term Care Experience Report – Form C. This would not take into account that some of those included in the NAIC's aggregate number of LTC policyholders are under the age of 45.
[12] "Long-Term Care Experience Reports – Form C", NAIC, 1993-2003.

series of public hearings, the intended result of this project is to provide possible solutions so that Floridians can be assured of access to the long-term care they need.

Funding Long-Term Care: The National Perspective

The 2004 Congressional Budget Office Report estimates that the majority of long-term care services are paid by Medicaid/Medicare, or offered through informal care by friends, spouses, and relatives, as shown in Figure 2. Private insurers pay only 3% of all long-term care expenses:

Figure 2



Other studies like one from the National Governor's Association (NGA) have estimated that long-term care insurance is paying as much as 8% of the long-term care costs. However, these studies typically do not include the very real cost of "informal" care provided by friends and family members.[13]

With so much of the current long-term care expenditures being borne by public programs, particularly Medicaid, it is not surprising that a number of states have experimented with cost mitigation efforts. Some of these cost-saving projects pertain to changes in Medicaid programs,

[13] NGA Center for Best Practices – Fact Sheet. National Governor's Association copyright 2003. Diane Braunstein, Health Policy Studies Division.

often through public-private partnerships, to control and manage costs. Another option is to restrict eligibility. Finally some projects have sought to save costs by paying providers on a capitation basis, not a fee-for-service basis.

Shifting Costs to the Private Sector

From the public budget perspective, an appealing mechanism to manage and control costs for long-term care is to shift the costs to the private sector by encouraging individuals to purchase long-term care insurance. Many states are trying to encourage sales of LTC insurance. According to the NGA Center for Best Practices, 28 states provide tax incentives for purchasing LTC insurance. A few states have also provided tax credits for employers. *(To date, Florida is not one of the states that have utilized this option.)*

How much money can be saved? Karen Ignagni, president of America's Health Insurance Plans, testified in the U.S. House Energy and Commerce Subcommittee on Health that private LTC insurance can ultimately save $5,000 in expenditures per policyholder on Medicaid, and $1,600 per policyholder for those on Medicare, ultimately amounting to $30 billion nationwide.[14]

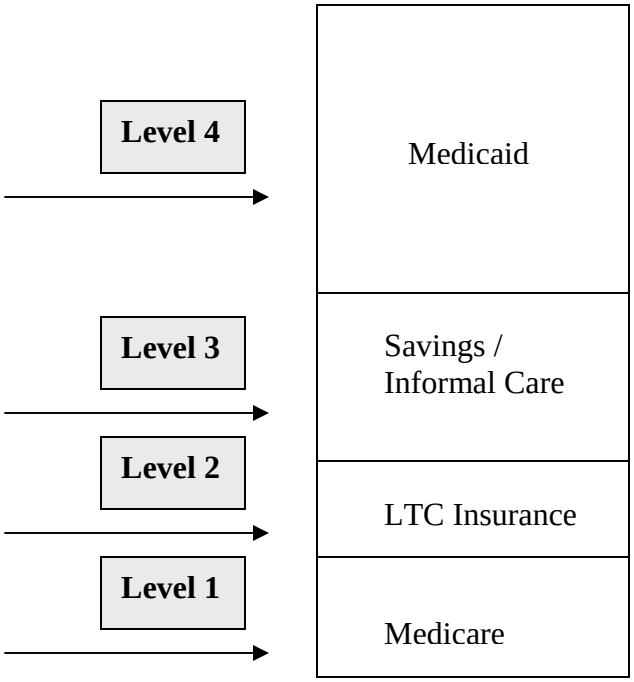
Coordinating the Funding of Long-Term Care

One of the challenges in the long-term care market is that the funding sources identified above are so varied; the federal government (Medicare and some Medicaid), state governments (Medicaid and other programs), the hard-to-quantify informal care (family and friends), an individual's personal savings and private insurance. Not only are these funding sources not well coordinated, they frequently are in conflict with each other. Accumulating personal savings and/or purchasing private insurance may, for example, make an individual ineligible for Medicaid, thus acting as a disincentive for consumers to buy private insurance or save money.

Although not by design, the current funding system can be viewed as a "layered" system, where a consumer moves to the next layer after exhausting the resources of the previous layer:

[14] "AHIP: Private LTC Can Save Public Health Programs," by Arthur D. Postal; National Underwriter, 4/28/2005.

Figure 3



Generally, after reaching age 65, a person may use up to 100 days of LTC benefits from Medicare, then turn to their long-term care insurance, then spend personal savings, and, when the personal savings are exhausted, finally apply for Medicaid. In actuality, the system is not this simple. Often people must use personal savings to cover costs not covered by insurance, and some people may even use Medicaid reimbursements to help pay their Medicare premiums.

As an example, in Florida one study showed that people entering nursing homes often entered with the knowledge that they would quickly exhaust their personal assets, and would utilize Medicaid to pay their bills. Of those entering nursing homes in Florida in FY 1999-2000, 83% began with Medicaid coverage, or applied for Medicaid coverage within three months of entering.[15] The result is that in FY 1999-2000, the state of Florida paid $1.55 billion for nursing home care, with the average Medicaid per diem rate being $44,665 per person, per year.[16]

[15] Report on the Medicaid Conversion Experience in Florida Nursing Homes, 2001. State of Florida Agency for Health Care Administration.
[16] Ibid.

The National Long-Term Care Private Insurance Market

Any analysis of the private long-term are insurance market must include a discussion of the factors that influence an individual's decision to purchase (or not to purchase) an LTC policy. As in any economic analysis, understanding the LTC marketplace can be couched in terms of supply and demand

Demand Characteristics – The decision to purchase LTC Insurance

Nationally, an estimated 4 % of people in the U.S. over the age of 45 have purchased long-term care insurance.[17] A lot of reasons for this low penetration rate have been offered in the general media. These reasons include the perceived need for the insurance, the difficulty in comparing insurance products, and the perceived affordability of long-term care insurance. As well, the delivery channels for long-term care may be important. To one degree or another, these explanations are related.

Unlike most other health related insurance products, the bulk of long-term care insurance is sold on an individual, rather than group, basis. The result is that rather than being another option in an employer's group health benefits often, an individual has to individually perceive the need for long-term care insurance, and then do the research and comparison shopping necessary to acquire the coverage they want. In economic terms, the transactions costs of long-term care insurance are very high relative to a group distribution channel.

The individual policy distribution mechanism likely leads to the often-cited "adverse selection" problem in long-term care insurance. Very briefly, the conventional wisdom suggests that most individuals do not think about buying long-term care insurance until such time as they perceive the need for it. For insurance providers, then, the opportunity to pool risks is very limited; consumers wanting to buy long-term care represent higher risks than the general population and

[17] This percentage is an estimate and likely overestimates the true penetration rate. The "over 45" population is taken from the U.S. Census Bureau based on 2003 data, and the number of long-term care policyholders is taken from the NAIC's Long-Term Care Experience Report – Form C. This would not take into account that some of those included in the NAIC's aggregate number of LTC policyholders are under the age of 45.

the general population is not buying the product. The net result is that those most actively interested in acquiring long-term care may find that it is unavailable or, because of the idiosyncratic risk they represent, extremely, if not prohibitively, expensive.

Costs associated with long-term care are also generally associated with overall health care costs. To maintain coverage, premiums often rise significantly as health care costs continue to rise at rates well above the general price level. At some point, these costs can become prohibitive to the policyholder, usually at a time when the need for the care increase in likelihood.

Who is Buying Long-Term Care Insurance?

Nationwide only 4.4 percent of people over 45 have purchased long-term care insurance.[18] Perhaps not surprisingly, Figure 4 shows that the Florida market is one of the largest markets for long-term care insurance as measured by aggregate earned premium

Figure 4
Total LTC Earned Premium 2003[19]

Rank	State	Total Premium
# 1	California	$4,354,046,048
# 2	**Florida**	**$4,202,765,436**
# 3	New York	$3,574,481,614
# 4	Illinois	$2,444,742,253
# 5	Pennsylvania	$2,328,228,708
# 6	Ohio	$1,883,867,817
# 7	Texas	$1,845,828,796
# 8	Washington	$1,223,459,099
# 9	Michigan	$1,171,715,545
# 10	Virginia	$1,155,738,145

[18] Ibid.
[19] Source: 2003 NAIC Data; LTC Insurance Experience Report C.

Within these totals, the majority of long-term care insurance (75%) is sold on an individual basis.[20] Although Florida is one of the leading states in long-term care insurance sales --- the amount of long-term care premium attributable to group policies is significantly below the national average, as seen in Figure 5. This is most likely the natural result of the unique demographics of Florida's population and workforce economy.

Figure 5
Percent of LTC Earned Premium that is Group Insurance

Rank	State	Percent Group
# 1	New York	24.7%
# 2	Illinois	22.8%
# 3	Ohio	21.7%
# 4	Maine	21.4%
# 5	Missouri	16.5%
# 6	California	16.3%
# 7	Connecticut	16.0%
# 8	Virginia	15.1%
# 9	New Jersey	14.6%
# 10	Michigan	14.1%
# 33	**Florida**	**4.9%**

According to a study by the Minnesota Department of Commerce, most LTC insurance is purchased by middle-income to upper-income individuals.[21] The premiums are usually unaffordable for lower-income people, while some upper-income people select to use their liquid assets rather than purchase insurance.[22]

[20] Congressional Budget Office, April 2004, "Financing Long-Term Care for the Elderly," Page 20.
[21] "Long-Term Care Insurance in Minnesota," January 20, 2005 by the Minnesota Department of Commerce, pg 3.
[22] Ibid.

More on Demand – Factors that Contribute to the Purchase of Insurance

Within the state aggregates are many other factors that likely contribute to the purchase of long-term care insurance and the purchase of group insurance in particular. State policymakers may not have control of many of these factors, but it is important to understand their interaction to determine why some states have more long-term care insurance sales than others. The initial focus in phase 1 of this project is to identify and measure potential factors. Although we have performed some preliminary correlations on state penetration rates *[Appendix A]*, and percentage of group LTC insurance *[Appendix B]*, the public hearings, and meetings with elderly individuals will be instructive and help us complete a quantitative study to develop a long-term care insurance model. Based on research previously mentioned, factors identified in the initial qualitative review can be broadly viewed in six (6) different categories:

- Income / Wealth
- General Demographic
- Provider Capacity
- Ethnic / Race
- Employment
- State Government Policy

While policy decisions may not be able to completely address these factors, it is useful to understand them. This is especially true if the decision is made to intervene in the marketplace via legislative initiatives.

Wealth / Income Factors

Variables in this category may include state Gross Domestic Product, per capita Gross Domestic Product, and percentage of the population that own their own home. While it may be that states with wealthier individuals are more likely to have more long-term care insurance sales, and individuals are more likely to pay the premiums to keep these in-force, it may also be that wealthier individuals plan to pay for long-term care out of their own personal savings. It may actually be the middle-class that is more likely to perceive the financial need for this type of insurance.

General Demographic Factors

Variables in this category may include total state population, population density, average family size, and the median age of the population. Based on the general data presented above, it appears that larger states with larger populations seem to be more likely to have long-term care insurance. This could be due to economies of scale and the capacity of the provider industry. Family characteristics like family size, and median age, may also be a factor as older individuals tend to perceive a greater need for this type of insurance, and those with smaller families may have less access to the informal care that involves nearly 1/3 of long-term care.

Provider Capacity

Some variables in this category could include the availability of insurance carriers, as well as availability of caregivers. The number of nursing homes, nursing home beds, occupancy rates, and nursing home residents may all be variables that need to be examined. For someone to purchase insurance they not only need to perceive the need for the product, but also need to have an outlet to use this product.

Ethnic / Race

Demographic differences in race and ethnicity may play a role in who purchases long-term care insurance. This could be due to cultural differences, or wealth differences among different population groups, but it may also be due to the sales force, and marketing efforts of the providers.

Employment

Although long-term care insurance does not have the same long history as traditional health insurance, it is still true that many people purchase insurance through employer-based initiatives, or through union negotiations. Large businesses usually have greater resources, and a greater pool of workers, to negotiate insurance products at reasonable prices. Some variables that may be important include unemployment rates, union membership, and numbers of small versus large businesses in the state.

State Government Policy

Although state policymakers cannot directly address many of the factors above, there is some room to provide incentives to employers or individuals to purchase long-term care insurance. Some variables to be included here include whether or not the state offers tax credits, the state premium tax rate, and other types of partnership programs states for Medicaid, and Medicaid expenditures.

Although there appears to be consensus among the states that long-term care is an item that will be on the agenda in future years, there does not seem to be a consensus as to how to handle the budding crisis. The increasing cost of long-term care, and budget shortfalls associated with Medicaid costs have spurned innovative pilot projects in different states to encourage the purchase of LTC insurance, or to mitigate costs of long-term care.

The Federal and state government initiatives for long-term care have been closely linked due to federal tax law, and the role that the federal government plays in determining the uses for Medicaid funding. The initiatives can be divided into these broad categories:

- Removing Disincentives to Purchase Long-Term Care Insurance
- Expanding Community-Based Alternatives for Medicaid Enrollees
- Providing Tax Incentives for Individuals and Employers to Purchase Long-Term Care Insurance
- Creating Alternative Funding Mechanisms for Long-Term Care Expenses
- Reorganizing State Agencies to Raise the Profile of Long-Term Care
- Expanding Liability Insurance for Long-Term Care Providers
- Encouraging the State Workforce to Purchase Long-Term Care Insurance
- Public Awareness Campaigns for Long-Term Care

Removing Disincentives to Purchase Long-Term Care Insurance

To qualify for Medicaid, individuals have to "spend down" their assets, and must exhaust any long-term care insurance. This provides a disincentive to purchase long-term care insurance, and creates an incentive to hide or transfer assets to become eligible for Medicaid. Evidence of this

trend can be found in the growth of Medicaid estate planning specialists within the legal and financial communities.

In 1988, four states began a pilot project to coordinate private long-term care insurance with special Medicaid eligibility standards. Their goal was to remove the disincentive to "spend down" assets to become eligible for Medicaid. The four states participating in this project are: California, Connecticut, Indiana, and New York. The four states' models work a little differently but generally, a person purchasing a $100,000 long-term care insurance policy would have $100,000 exempted from their determination for Medicaid eligibility. This is called the "dollar-for-dollar" model.

Although popular in these four states *(all four have long-term insurance penetration rates higher than the national average)*, the expansion of this program to other states has been limited. The Omnibus Budget Reconciliation Act of 1993 required that any state implementing partnership programs after May 14, 1993, must recover assets from the estates of all persons receiving services under Medicaid. Therefore, for new state programs, the asset-protection component of the partnership is only in effect while the person is alive. New states must recover Medicaid costs from the person's estate, after the Medicaid recipient dies. Now 16 states, including Florida, have passed this type of enabling legislation.

Expanding Community-Based Alternatives for Medicaid Enrollees

One of the key cost drivers for Medicaid is the cost of nursing homes for Medicaid recipients. Several states are exploring alternatives to encourage Medicaid recipients to receive care in their home, or in their community rather than living in a nursing home. The benefits are two-fold: 1) The cost savings of room and board for home-based services; and 2) Medicaid recipients prefer to receive services in their home as opposed to moving to a nursing home that may not be close to friends and family.

Some of the more notable innovations have come from Minnesota, Iowa, and Maryland. Minnesota passed legislation resulting in $183 million of appropriations for long-term care reform, which included an investment of $75 million in expanding home and community based

service options. The appropriation was to be partially funded by a $44 million from the downsizing of nursing home expenses. Iowa established a $25 million long-term care trust fund, which among other goals, is attempting to convert nursing home beds into assisted living facilities. Maryland's General Assembly passed a law that would allow certain Medicaid recipients to receive care in their home, or a supported living environment, and be permitted to hire their own personal assistant.

Providing Tax Incentives for Individuals and Employers

There are 28 states that currently provide some sort of tax incentives to purchase or offer long-term care insurance. Generally, these tax incentives are either to: A.) Encourage an individual to purchase long-term for himself or herself, or for a relative; or B.) Encourage employers to offer their employees long-term care insurance through a group product. To date, most states have focused on the former.

Alabama, California, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Missouri, Montana, Ohio, Utah, Virginia, West Virginia, and Wisconsin offer tax deductions for the purchase of long-term care insurance usually as an offset against the state's income tax. Not all states offer a full deduction. Some states offer a partial deduction, or enforce a cap for the maximum deduction.

Colorado, Maryland, Minnesota, New York, North Carolina, North Dakota and Oregon go further by allowing a tax credit, rather than a tax deduction. Maryland, Montana, North Dakota, Oregon, and West Virginia even allow a tax credit/deduction for family members. Other states like Indiana offer multiple tax savings approaches.

There are not as many states that offer employer-based tax incentives. Two notable states include Maine that allows a deduction for LTC employer-paid insurance premiums if the insurance is federally qualified, and Maryland that allows employers a state corporate income tax deduction of up to 5% of the total cost for employees' long-term care insurance costs.

Creating Alternative Funding Mechanisms for Long-Term Care Expenses

Health Savings Accounts (HSAs) and reverse mortgages are two innovative approaches spreading among the states. These are not "insurance" products *per se*, but can be used by the elderly to pay for long-term care expenses. The Medicare Reform Act of 2003 created Health Savings Accounts (HSAs). Coupled with a required high-deductible health insurance product, these entities are tax-free savings accounts that can be used to pay for qualified LTC insurance or LTC health expenses.

Reverse mortgages are financial instruments that use the equity in one's home to provide a stream of revenue that can pay for long-term care. The person can continue to live in their home indefinitely, however, when the person dies, the equity remaining in the home may be considerably diminished or even reach zero.

Life insurance policies offering accelerated payment of death benefits for the funding of long-term care expenses are a recent innovation that seems to be growing in appeal.

Reorganizing State Agencies to Raise the Profile of Long-Term Care

Another emerging trend is that states have been reorganizing their state agencies to more effectively focus staff and resources on long-term care issues. Florida is one of the leading states in this regard. In 2002, the state legislature created a new Office of Long-Term Care Policy in the Department of Elder Affairs to evaluate and improve the state's long-term care delivery systems. In Alaska, senior services that were handled by the Department of Administration were transferred to a new Senior and Disability Services Division that handles long-term care issues. Wisconsin recently consolidated two government agencies by creating a new Division of Disability and Elder Services to handle long-term care.

Expanding Liability Insurance for Long-Term Care Providers

In Florida, like many states, the growth rate for the number of new nursing homes has slowed. Some states have even seen a decline. While some of this is due to initiatives to encourage home-based care and assisted living communities, another problem is that nursing homes are

having difficulty obtaining affordable liability insurance. Consequently, underinsurance may also be a problem for some nursing homes.

Florida has been one of the states to address this problem. In 2001, Florida lawmakers added mandatory liability coverage requirements for nursing homes, and implemented tort reforms to cap punitive damages and attorney's fees to make liability insurance more affordable for providers. In 2003, the Texas legislature passed a law that requires nursing homes to maintain a minimum professional liability insurance coverage of at least $1 million per occurrence with a total of $3 million for all occurrences.

The Arkansas legislature recently authorized its state insurance commissioner to establish a voluntary liability insurance pool for long-term care insurance providers to make liability more accessible in that state.

Encouraging the State Workforce to Purchase Long-Term Care Insurance

Although the workforce represented by state government is usually small relative to the overall state population, one innovative approach is to use the state government and state employees as a starting point to encourage long-term care insurance.

Currently, over half of the states offer LTC insurance as a voluntary group benefit or on an individual basis for its government employees. The employee typically pays for these LTC policies through payroll deductions. However, even these programs are no more successful than private sector initiatives, as the participation rate is around 2%.[23] According to the National Governor's Association, although Florida does not currently offer this to their state employees, it is one of three states that are currently developing a state employee LTC insurance program.[24]

[23] NGA Center for Best Practices Aging Initiative – Issue Brief, June 18, 2004, Page 8

[24] Ibid. The BDMR did some follow-up on this statement. According to an analyst at the Florida Department of Management Services, DMS released an RFP for a Long-Term Care benefit as a state employee supplemental benefit in 1999 at the direction of Governor Bush. The results of the RFP were not implemented at that time. The analyst indicated that DMS is still pursuing this as a possible benefit for state employees in the future.

Public Awareness Campaigns for Long-Term Care

Several states have tried to encourage demand for long-term care products by raising awareness among consumers about long-term care insurance, and long-term care expenses. Some unique initiatives include that of Michigan, which conducted a $2.5 million multimedia campaign in 2001 to increase awareness of LTC costs. Minnesota's public awareness campaign focuses on employers, and encourages employers to offer long-term care group insurance products to their employees. Several states such as California, Connecticut, Hawaii, Kansas, Minnesota, Nebraska, Nevada, New York, North Carolina and Oregon have all conducted statewide campaigns to educate the public about long-term care.

Supply Characteristics

Even assuming the consumer demand is adequate, it is essential that we look at the supply side of the equation. This is especially important for long-term care insurance since the majority of insurance is sold on an individual basis. Unlike traditional health insurance where people are presented options through their employer, long-term care insurance is often sold individually. The number of companies and agents actively marketing these products may have a direct impact on the number of products sold, and ultimately, the penetration rate.

There are two distinct aspects of the supply issue: 1) The insurance companies selling long-term care insurance; and 2) Health care providers, like nursing homes, that actually provide long-term care. For long-term care insurance to be a vibrant market both components need to be functioning together --- a consumer needs to be able to purchase long-term care insurance at a reasonable rate, and once a person wants to use the benefits, the consumer needs to be able to find health care providers where the insurance can be redeemed.

Compared to other areas of the insurance industry, the long-term care insurance market does not nearly have the same number of underwriters. While there are over 1,500 companies nationally selling traditional health insurance, only 180 companies[25] (about 10%) have long-term care insurance policies in force.

[25] "Long-Term Care Insurance Coverage Trends," by Cheryl Coffman, Spring 2003 Edition of the NAIC Research Quarterly, Pg. 17.

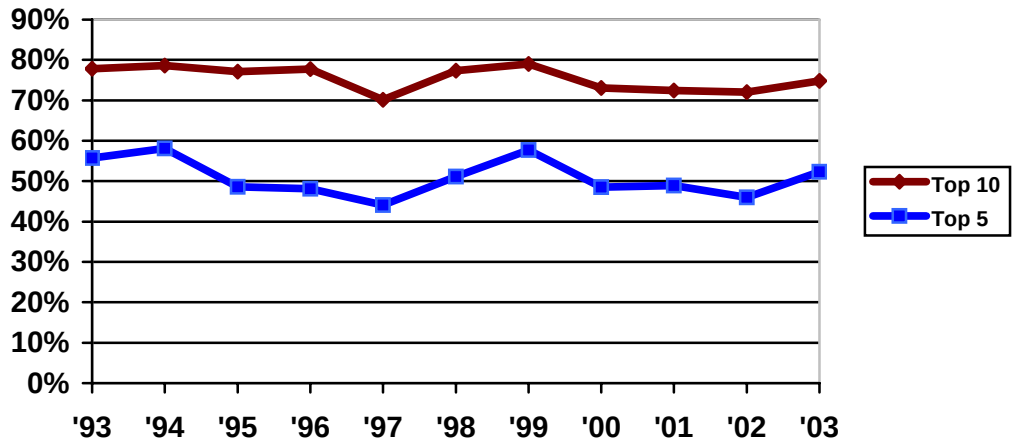
A.M. Best analysts have concluded that there is a large amount of volatility in this market with "significant changes" among the top writers, and lots of individual LTC blocks of business up for sale.[26] Their outlook is a growth in mergers and acquisitions signaling more consolidation in the industry in years to come. The roadblock to this consolidation is that the older blocks of business, often not subject to modern rating laws, have tended to be under-priced.

Florida Experience

While 180 companies may sell long-term care insurance nationwide, only 77 operate in the state of Florida. Florida's long-term care insurance market landscape does appear to be dominated by a few main players as seen in Figure 6:

Figure 6

Florida LTC Market Share by Leading Companies



Of the Top 10 companies in market share, seven have increased enrollment from 2000 to 2004, while three have decreased. This would seem to imply some market consolidation:

[26] "Shakeout Continues in the Individual Long-Term Care Market," Bestwire, 03/29/05.

Figure 7

Top 10 Florida LTC Insurance Writers by Market Share --- 2004

Rank	Company	2004 Enrollment	2000 Enrollment		Change
# 1	General Electric	52,442	29,371	⇧	79 %
# 2	John Hancock Life	42,704	17,137	⇧	149 %
# 3	Bankers Life & Casualty	34,875	14,111	⇧	147 %
# 4	UNUM Life Insurance Co.	33,470	15,605	⇧	114 %
# 5	Conseco Senior Health*	31,276	33,058	⇩	5 %
# 6	Penn Treaty Network	27,458	34,636	⇩	21 %
# 7	Continental Casualty	27,080	20,649	⇧	31%
# 8	Kanawha Insurance	11,119	5,893	⇧	89 %
# 9	Fortis Insurance*	10,979	13,102	⇩	16 %
# 10	National States Ins.	7,562	15,811	⇩	52 %

*These companies have discontinued writing LTC policies in Florida.

The companies in the Top 10, with the most experience and most at risk, are generally expanding (although not at the same pace as market demand, or the aging population). There may be concern in that there no new major competitors have entered the market within the last five years.

Provider Capacity

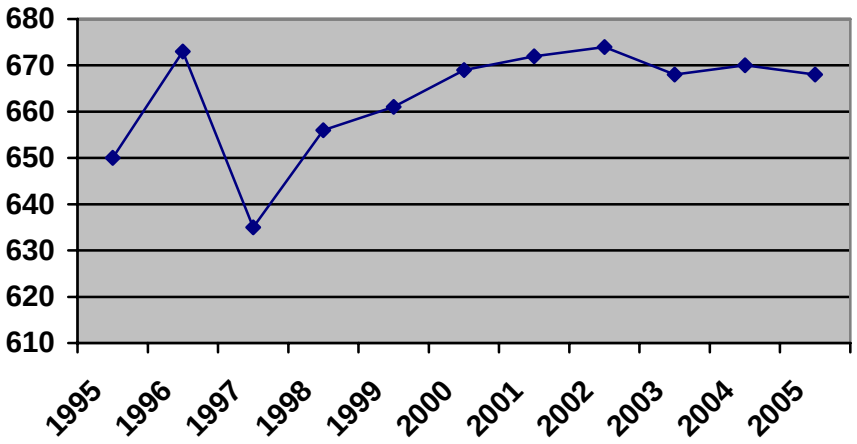
Another issue apart from insurance capacity is provider capacity. The aging population will put a burden on home health care service providers and nursing homes in the near future. The numbers of workers and facilities do not seem to be increasing at the same pace as demand,

which can ultimately create a provider "crunch." Even now, the turnover rates for workers in the home health care industry are much higher than other professions, and many have suggested that salaries are too low.

For a more precise analysis, capacity must be divided into several different areas including nursing homes, assisted living facilities, continuing care retirement communities, home health care providers, and even nursing staff. Not all of these entities are regulated in the same way, and not all types of providers qualify for use under the different long-term care insurance policies.

In Phase I, our focus is on the nursing home industry in Florida, partially because it is the most expensive, most regulated, and most visible of the forms of long-term care. Because it has one of the oldest populations by state, one may expect Florida to be rapidly increasing its number nursing homes. In fact, in recent years the number of nursing homes in Florida has become stagnant:

Figure 8
Nursing Homes in Florida – 1995-2005[27]



During the same period --- the occupancy rate for Florida's nursing homes has increased from 82.6% in 1999 to 85.6% in 2002; and the "resident rate" (number of those in nursing homes per 1,000 of the state population over age 85) has steadily dropped to 19.6% in 2002.[28] In contrast, the heavily populated states noted earlier all have a higher percentage in nursing homes.

These results are consistent in that Florida is being aggressive about controlling costs by keeping the elderly out of nursing homes, and elderly are being served through home health care and other community based programs. At the same time the low numbers of elderly in nursing homes implicitly suggests that there might be less access to institutional-based care in Florida than is needed. Given the rising occupancy rate in nursing homes, the number of nursing homes remaining flat, and the declining resident rate --- there could be more difficulties in the near future beyond just the long-term care insurance market.

[27] "Nursing Home Count 1995-2005 Tracking Sheet," Florida Agency for Health Care Administration via private correspondence to OIR, June 27, 2005.

[28] Florida's resident rate is the fourth lowest in the country. Only Oregon (14.3%), Arizona (16.9%), and Hawaii (18.6%) have less of the over 85 population in nursing homes.

Problems / Complaints about LTC Insurance: The Florida experience

Separate and apart from the supply and demand problems that could be affecting the long-term care insurance industry in Florida is the question of how well can long-term care insurance meet consumer needs. If people are not happy with the products, they may be reluctant to purchase or to keep their policies in force.

An important component of this research will include the scheduled public hearings, and other discussions with Florida consumers. Based on a qualitative review of the literature, and the Florida Department of Financial Services complaint database, it does appear that Florida consumers do perceive some systemic problems with LTC insurance products. Generally these can be broken down into three categories:

- **Premium Increases for LTC products**
- **The LTC insurance products are too confusing**
- **The LTC insurance products are difficult to compare**
- **The product does not meet the needs of the consumers**
- **Another Issue? Rescission**

Premium Increases for LTC Products

Many of the LTC Products use advertising that state that insurance companies cannot increase premiums due to age, or medical conditions. In fact, Florida law currently enforces both of these instances.[29] The advertising and policies typically inform the policyholder that their rates cannot be raised, unless they are raised for an entire class. Customers often buy the policies with the understanding that premiums will either not rise or rise modestly. This is an extremely important component in the overall effectiveness of the product --- if a consumer cannot afford to keep the policy in force, it has no value.

[29] For Mental or Physical Health: Section 627.9407(7), Florida Statutes; For Age: Section 627.9407(3)(a).

During the 1990s, many of the LTC products were significantly under-priced, and required multiple premium increases based on unexpectedly high loss ratios. This problem was not limited to Florida. It became so pronounced that the NAIC formed a task force to address the issue, which ultimately produced the NAIC Long-Term Care Model Regulation # 641, specifically, section 20 titled, "Premium Rate Schedule Increases." Florida adopted this rule, which is now codified in Rule 69O-157.113 Premium Rate Schedule Increases. Some of the main components of this rule include that for every rate increase request:

- An actuary must certify that the rates are sustainable in the event of moderately adverse conditions
- The company must submit an analysis of why their initial assumptions were wrong
- The new business premium must not be less than the renewal premium
- Except in exceptional circumstances, 85% of the increase must be used to pay claims
- The company must submit subsequent reports about lapse rates from which the Office may determine whether or not a rate spiral exists
- If there is excess premium based on subsequent loss ratio reports, the Commissioner may order rate adjustments or benefits adjustments.
- If rates are increased above a specified percentage, for each issue age the policyholder can convert to a paid-up policy equal to the amount of premiums already paid.

Since the implementation of this regulation in 2002, several states have reported "rate stabilization" among Long-Term Care products. Anecdotal evidence suggests, since implementation of these rules, some carriers have left the market. However, Phase II of this research will provide a deeper analysis of the data to learn how many closed blocks exist, examine the lapse rates to determine if any rate spirals exist, and how new, higher priced products are faring in the marketplace. As the complaint analysis shows --- premium increases remain the leading cause of complaints from purchasers of LTC products in Florida.

Standardization of Products – Are LTC Insurance Products too Confusing?

Several LTC studies have cited a problem with the lack of standardization of LTC insurance products. The CBO report states that standardization of "the variety of LTC insurance policies

now being sold would make it easier for consumers to compare premiums, might lead to more competition among insurers, and could make policies generally more understandable."[30] This may be a bit disingenuous.

The NAIC reports that 45 states have adopted laws based on the NAIC Model Act. Moreover, there does seem to be general standardization in the six activities of daily living (ADLs), and that a policyholder has to be deficient in three before the policy pays benefits.[31] The definition of long-term care is for either 12 months or 24 months in 47 states; most states have laws prohibiting the insurer from limiting the policy to skilled care; most have preexisting condition provisions; require outlines of coverage; and allow underwriting due to previous hospitalization.[32]

There does appear to be some disparity in the legal requirements for non-forfeiture requirements, and the requirements of LTC products sold as riders to a life insurance policy, as well as incontestability provisions and accelerated death benefits requirements. A review of forms filed in the 2000-2005 timeframe in Florida with an analysis of complaints during the same timeframe indicates that the "standardization" problem, if one exists, pertains more to the differing benefit levels.

Standardization of Products – Are LTC Insurance Products Difficult to Evaluate?

The short answer is likely yes. Even within the same policy, the consumer is usually allowed to select different benefit levels. For example, in one policy the nursing home benefit can be selected to be anywhere from $50 a day to $300 a day.[33] Some policies establish a maximum payout limit, and base other care on a percentage of that limit. For example, one policy allows Assisted Living Facilities or Home Health Care to be a percentage of the overall maximum daily benefit. The selection amounts vary from 50% to 100% depending on the premium paid by the consumer.[34]

[30] Congressional Budget Office, April 2004, "Financing Long-Term Care for the Elderly," Page 27.
[31] 2005 NAIC's Compendium of State Laws on Insurance Topics.
[32] 2005 NAIC's Compendium of State Laws on Insurance Topics.
[33] Senior American Life Insurance --- 3-LT0015FL-CO.
[34] Senior American Life Insurance --- 3-LT0019FL-CO.

Another common feature in long-term care insurance policies is an elimination period. This is the period when the consumer must pay out-of-pocket before the insurance policy begins making payments. Several filed policies allow the policyholder to select an elimination period from 0 days to 180 days.[35] This can potentially cause problems, as the elimination period acts as a type of deductible. If a person selects a 180-day elimination period, he or she may later find that they do not have enough personal savings to cover the first 180 days of long-term care expenses. Zero-day elimination periods make more sense for policyholders with low levels of personal savings, however, as expected; these policies cost significantly more than policies with longer elimination periods.

Even the maximum benefit level can vary significantly. One policy offers a monthly maximum benefit level from anywhere from $1,000 a month to $10,000 a month depending on what the consumer selects.[36] The duration of the policy --- how long benefits will be paid can also vary significantly. One policy allows the policyholder to select maximum payout periods to be 3 years, 4 years, 5 years, or lifetime.[37] The premium payment mode can be different, and typically consumers can select monthly payment, quarterly, semi-annual or annual.[38] Even who is eligible can vary. One company allows anyone from age 18-85 to purchase the policy while another company only allows someone from 40-84 to purchase the main benefits of the policy.[39]

Even if the main benefits are assured to be standardized, and the benefit levels are comparable, the policyholder still has the option of customizing the policy based on numerous riders. Some examples of riders found in recent Florida long-term care insurance policies include:

- Guarantee Purchase Option Rider
- Automatic Increase Rider
- Dual Waiver of Premium Rider (for married couples)
- Caregiver Rider

[35] Blue Cross / Blue Shield IDV-Policy Ed 04/03.
[36] Allianz Life Insurance Co. --- 5-P-Q-FL-1.
[37] Physicians Mutual – P104FL.
[38] Cincinnati Life Insurance --- LTC 200 FL (2/03).
[39] The 18-85 age example is from Blue Cross / Blue Shield W62117-1202; the 40-84 for the main provision of the policy is from Physicians Mutual – P104FL.

- Restoration of Benefits Rider
- Benefit Transfer Rider
- Survivorship Rider
- Return of Premium on Death Rider
- Inflation Guard Rider

A consumer sometimes must elect various benefit levels within each rider, for example, the inflation guard riders can be selected from 3% to 5% calculated with simple interest, or compounded.[40] This can make a significant difference in the ultimate amount of benefits paid *[See Appendix C]*. Some would argue that the degree of customization afforded a policyholder is beneficial because it allows the policyholder to target specific needs and create a personally tailored policy. On the other hand, this degree of customization makes it difficult to compare the costs of policies any different companies, or even between two different policies offered by the same company.

The Product Does not Meet the Needs of the Consumers

Another problem endemic to this type of insurance is that many people will not realize that they have a good or bad product, or even a product that meets their needs until it is time to utilize their insurance. At that point, it is too late to switch policies, as they would no longer meet new underwriting requirements. Florida has passed the NAIC Long-Term Care Model Regulation for the issue of suitability. It is in the Florida Administrative Code under Rule 69O-157.116 Suitability. Companies are required to develop suitability standards, train agents, and ascertain the consumer's ability to pay for a particular product, and in cases of replacement, validate that the new product is beneficial. The company is ultimately responsible for keeping statistics regarding suitability determinations, and sends these to the Office on an annual basis. Phase II of this research will study these data and determine if the rule has been effective.

A Developing Issue? Rescission

At time of sale, a long-term care insurance applicant is traditionally not required to undergo a physical examination, and the insurance company relies on the truthfulness of the information on

[40] Bankers Life & Casualty – 15442-FL.

the application for its underwriting. The underwriting review pertains more to the pricing of the product, than the accuracy of the information.

In cases where the applicant is not truthful, or withholds information, the company may rescind the policy based on the rescission language in the policy. The NAIC adopted a model law to guide the insurance company's actions during three specific timeframes[41]:

With the first 6 months	The policy can be rescinded during this timeframe if the insurance company makes a showing of misrepresentation that is material to the acceptance of coverage.
Six months to two years	The policy can be rescinded if there is a showing of misrepresentation AND the misrepresentation is material to the acceptance of coverage AND pertains to the condition for which benefits are sought.
Over two years	The policy is not contestable based on misrepresentation alone. There must be a showing of the insured knowingly and intentionally misrepresenting relevant facts relating to the insured's health. This is also commonly referred to as "fraud."

According to a review of the state insurance laws as of February 2005, only 23 states have adopted the NAIC Model Law incontestability provision stated above.[42] While Florida does not have separate statutory requirements for long-term care on this issue, the health insurance statute that also applies to long-term care includes the following language for long-term care:

> ***627.607 Time limit on certain defenses.--***
>
> ***(1) The contract shall include the following provision:***
>
> ***"Time Limit on Certain Defenses: After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period."***
>
> ***(2) A policy may, in place of the provision set forth in subsection (1), include the following provision:***

[41] "Long-Term Care Insurance Model Act," Section 7 Incontestability Period, Model # 640, NAIC.
[42] "NAIC's Compendium of State Laws on Insurance Topics," NAIC, February 2005.

"Incontestable:

(a) Misstatements in the Application: After this policy has been in force for 2 years during the insured's lifetime (excluding any period during which the insured is disabled), the insurer cannot contest the statements in the application.

(b) Preexisting Conditions: No claim for loss incurred or disability starting after 2 years from the issue date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage."

A review of recently filed long-term care policy forms in Florida shows that most companies do include the Model Act language regarding incontestability.

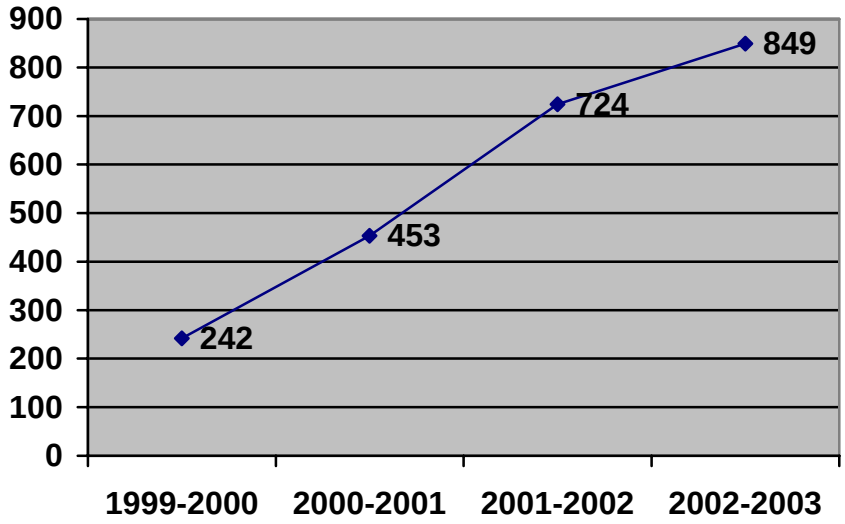
At the March 13, 2005 NAIC Senior Issues Task Force meeting, attorney Paul Roller stated that in his experience a few companies used the fraud exception (the only exception available after a two year period) as a tool to convince claimants that their policy could be rescinded, and therefore, encouraged them to accept a lesser settlement. The Commissioners present were concerned by this allegation, and there was general discussion about the possibility of having a two-year limit on incontestability --- with no exceptions, not even for fraud. Representatives of the industry did not seem immediately receptive to this idea.

Reviewing the Consumer Complaints in Florida Regarding Long-Term Care Insurance

An analysis of complaints filed with the Florida Department of Insurance from fiscal years 1999 to 2003[43] shows a growth rate in complaints that exceeds the growth in the sale of long-term care insurance:

[43] The Division of Consumer Services changed its collection methodology in June of 2002, therefore the subsequent data is not comparable. Currently the Division records "Requests for Service," which are more specific than complaints. Requests for service require an analyst to perform research and reach a resolution. Complaints that can be answered over the phone are not recorded. FYI-2003 to 2004 had 775 requests for service regarding LTC. FY 2004-2005 had 620 requests for services as of May 9, 2005.

Figure 8
Complaints Filed with the Florida DOI
FY 1999 – 2003



More important than the rise of the complaints are the types of complaints. Below is a brief summary of the top 10 complaint reasons for complaints received by the Florida Department of Financial Services from FY 1999 to 2003. A full table is in *Appendix D*:

1. Premium Issue

These complaints predominately pertain to rate increases. Typical complaints allege rate increases from 20% to 30%. These complaints are not limited to the amount of increase, but often cite the number of increases received over the years the individual has been a policyholder.

2. Premium Refund

This category usually pertained to policies recently issued where people wanted their money returned. In several instances, it appears that this was due to an agent problem.

3. Claim Handling Delay

These complaints allege that the company has never started paying benefits. Very few allege that the company paid benefits, and then stopped, or slowed down payments. Unlike major medical health insurance, many home health care/LTC policies do not have approved networks, or pre-certification requirements. It is possible that some of these "delays" are due to the fact that the claim will not be paid because the company determined it is not a covered benefit.

4. Claim Denial

Nearly all of the complaints in this category pertain to a submitted claim being denied by the company. Some typical reasons include situations, for example, where the doctor prescribed skilled assistance, and the policy does not covered skilled nursing.

5. Coverage Questions

Complaints and inquiries are received from policyholders who were not well informed about specific benefits and services provided by the LTC purchased by that policyholder.

6. Information Requested

The inquires/contacts with the department coded into the "information requested" category are diverse. One recurring theme, however, was a request for information about policy "non-forfeiture" options and its application to assisted living facilities versus nursing homes.

7. Agent Handling

Complaints are made about agent LTC policy marketing practices. A consistent theme among these complaints appeared to be instances of "twisting" -- encouraging a person to cancel an existing LTC product, and purchasing another LTC product.

8. Other

This reason code features an eclectic group of complaints, some of which could have been placed in other categories like complicated claim denials, more information about products and complaints about rate increases. One complaint was even received regarding an Internet quoting service.

9. Misrepresentation

Virtually all of the complaints alleged misconduct by the agent. Many of these types of complaints are also seen under the "Agent Handling" reason code.

10. Company Delays

Some of these complaints pertained to delays in claim payment, and could easily have been categorized with the "Claim Handling," or "Claim Denial" category. Some of these complaints referred to specific questions asked of the company, and the company had been slow in responding to a claimant's inquiry.

Concluding Remarks

This research in the first phase conducted by the Florida Office of Insurance Regulation attempted to analyze and understand the most important funding mechanism; private long-term care insurance. While this insurance product has been available on the market for some time, to date it does not appear to be broadly used, or widely accepted, as a vehicle through which consumers can and their long-term care needs. Instead, states have had to relying predominately on Medicaid.

There have been positive developments over the last year, most notably, the passage of federal legislation allowing states like Florida to develop private partnerships with Medicaid to provide an incentive for Floridians to purchase long-term care insurance without risking the loss of their private assets.

The passage of the NAIC rate stability model, combined with OIR's vigorous implementation of the annual rate reviews, should also help limit the number of future rate increases, and the "death spirals" which can plague underpriced long-term care insurance products.

Yet the feedback from the public hearings suggest that we have even more work to do to truly make the private market a major player in the payment of long-term care delivery. Improved

corporate tax incentives to encourage employers to offer long-term care insurance alongside health insurance, life insurance, and other traditional products in employee cafeteria plans. Stricter rules on rescissions by changing the incontestability laws. Even consumer education, and teaching seniors how to integrate long-term care insurance with other financial products must still be accomplished before the situation will improve. Ultimately there is no panacea to pay for long-term care for the elderly, but Florida is on the right road by encouraging more private sector involvement, and less reliance on Medicaid.

⁃ APPENDIX A --
LTC market penetration

For a cursory analysis, we used Pearson's Correlations statistics. This correlation merely shows correlation between these factors, and the outcome we desire – high market penetration of LTC insurance. It is important to remember that these correlations do not show causality, and many of this factors may be inter-correlated, and do not measure an independent effect.

Category	Correlation
LTC Percentage	+ 0.47
Percent in Labor Force	+ 0.32
Percent White	+ 0.31
Per Capita Expenditures	+ 0.30
Resident Rate	+ 0.29
Rural	+ 0.24
Tax Credits	+ 0.22
LTC Medicaid Per Capita	+ 0.21
Nursing Homes	+ 0.18
Median Age	+ 0.16
Vote for Bush 2000	+ 0.15
Nursing Home Beds	+ 0.13
Nursing Home Residents	+ 0.13
Vote for Bush 2004	+ 0.12
Personal Income	+ 0.10
Occupancy Rate	+ 0.08
State GDP	+ 0.06
Establishments < 20	+ 0.07
People in Cos < than 20	+ 0.06
Total Population	+ 0.06
Percent Homeownership	+ 0.05
Tax Revenue per capita	+ 0.04
LTC Medicaid Per Capita	+ 0.03
Per Capita GDP	- 0.01
Square Miles	- 0.03
Education per capita	- 0.05
Hispanic Percent	- 0.06
Union Membership - 2004	- 0.07
Percent Foreign Born	- 0.09
People in Cos > than 100	- 0.11
Medicaid Per Capita	- 0.13
Establishments > 100	- 0.14
Population Density	- 0.16
Govt. Spending per capita	- 0.16
Health Spending per capita	- 0.22
Family Size	- 0.23
Medicaid Per Capita over 65	- 0.27
Unemployment Rate - 2005	- 0.30
Percent Uninsured	- 0.32
Premium Tax Rate	- 0.34

➽ APPENDIX B --
LTC Group policies

For a cursory analysis, we used Pearson's Correlations statistics. This correlation merely shows correlation between these factors, and the outcome we desire – high percentage of group LTC insurance. It is important to remember that these correlations do not show causality, and many of this factors may be inter-correlated, and do not measure an independent effect.

Category	Correlation
Nursing Home Beds	+ 0.55
Nursing Home Residents	+ 0.54
State GDP	+ 0.49
Number of Nursing Homes	+ 0.48
Tax Revenue Per Capita	+ 0.47
Total Population	+ 0.46
Per Capita Expenditures 98	+ 0.37
Union Membership - 2004	+ 0.35
Percent Foreign Born	+ 0.34
Personal Income	+ 0.31
Medicaid per capita	+ 0.28
LTC Medicaid per capita	+ 0.28
State Tax Credits	+ 0.24
Percent Hispanic	+ 0.24
LTC Med per capita over 65	+ 0.24
Ed Spending per capita	+ 0.23
Per Capita GDP	+ 0.22
Population Density	+ 0.21
Family Size	+ 0.20
Medicaid per capita over 65	+ 0.19
Total Spending per cap	+ 0.19
Unemployment Rate - 2005	+ 0.18
People in Cos > 100	+ 0.14
Residents Rate	+ 0.06
Establishments < 20	+ 0.06
LTC Percentage	+ 0.04
Health Spending per cap.	+ 0.02
Square Miles	+ 0.01
Median Age	0.00
Occupancy Rate	- 0.03
Establishments > 100	- 0.06
Labor Force Perc.	- 0.08
Percent White	- 0.09
Percent Uninsured	- 0.12
Premium Tax Rate	- 0.17
People in Cos < 20	- 0.17
Percent Homeownership	- 0.22
Rural	- 0.22
Vote for Bush 2000	- 0.28
Vote for Bush 2004	- 0.29

-- APPENDIX C --

LTC Policy with $1,000 Monthly Benefit[44]

	5 Years	10 Years	20 Years
No Inflation Guard	$1,000	$1,000	$1,000
3 % Simple Interest	$1,150	$1,300	$1,600
5 % Compound Interest	$1,276	$1,629	$2,653

As this table shows, the inflation guard can make a significant difference, a difference that an unsavvy consumer may not appreciate at the time of purchase.

[44] Even how often the benefit is compounded can make a difference. For this table, the benefit was compounded yearly. For compounding monthly, the results would be $1,283 after 5 years, $1,647 after 10 years, and $2,673 after 20 years.

⁃ APPENDIX D ⁃

Complaint Issues FY 1999-2003			
Rank	**Categorization**	**Complaints**	**Percentage**
# 1	Premium Issue	672	29.6%
# 2	Premium Refund	263	11.6%
# 3	Claim Handling	234	10.3%
# 4	Claim Denial	230	10.1%
# 5	Coverage Question	145	6.4%
# 6	Information Requested	117	5.2%
# 7	Agent Handling	115	5.1%
# 8	Other	77	3.4%
# 9	Misrepresentation	71	3.1%
# 10	Co Delays / No Response	54	2.4%