CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

Testimony of

Bonnie Burns, Policy Specialist
California Health Advocates
bburns@cahealthadvocates.org

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Members of the Commission, thank you for inviting me to speak here today. I have been involved with long-term care insurance for more than 30 years; counseling people who have it, training others to understand it, working with state regulators to revise state law, consulting on state and national legislation, and acting as an expert witness in lawsuits. I have personally counseled hundreds of consumers on long-term care insurance and served as a funded consumer representative to the National Association of Insurance Commissioners (NAIC) since the inception of that program in 1992. I have watched this product evolve from restrictive nursing home policies in the 1970's and 80's, to policies with comprehensive benefits in the 2000's, to financial products marketed today that include a trigger for long-term care benefits.

Over the last 30 years long-term care insurance has evolved, faltered, and now withered as insurer experience with pricing assumptions crashed, huge premium increases have been imposed, and insurers have exited the market for more profitable territory. For almost as long, the middle class has been accused of deliberately diverting their assets to become eligible for Medicaid, an experience most never want to have. And during those decades, some remain convinced that the purchase of private long-term care insurance, despite its flaws, is the savior of state Medicaid budgets.

As Mark Meiners pointed out in 1983, *"Financing long-term care for the elderly is one of the most challenging health care problems facing us today. The dramatic increase in health expenditures for long-term care is straining public budgets and the specter of a rapidly aging population suggests that the problem will become worse."*[1]

His statement is just as accurate today as it was 30 years ago, except that now it comes with increased urgency. In 2013 that rapidly aging population has arrived, and for the next 17 years 10,000 people every day will be turning 65 and aging into the need for long-term care, placing even more strain on public budgets and individual resources.

Americans need a comprehensive integrated system of care for impaired people young and old, a system we do not have and are unlikely to get without a major shift in thinking and planning, which I hope this Commission can initiate.

Long-Term Care

Thirty years ago most long-term care occurred in nursing homes; the catastrophic, dreaded event in the last stages or years of life. Now as then, few people will voluntarily choose to live in a nursing home. Most nursing home stays occur when there are no other options. But today most long-term care begins at home or in an assisted living facility, something Baby Boomers are starting to understand as their parents and grand-parents get older and need care.

Virtually every person who needs long-term care must depend on someone else to find it, arrange it, supervise it, and find a way to pay for it. An individual who needs long-term care is seldom able to do these things for themselves. Family members are the first line of defense in long-term care. The average caregiver is a working woman in her 40's, usually an adult daughter or daughter-in-law, with children still at home. This "sandwich generation" caregiver is likely to spend almost as many years caring for a family member as she does raising a child.

> *Rachel is a 55 year old daughter-in-law who during a 10 year period found, arranged, and supervised care first for her husband's father, then his mother, and later an uncle while raising her 2 sons. As a result she was unable to continue her highly paid, highly skilled job in the computer industry. Two of these family members had Alzheimer's Disease, and for a time were able to be cared for at home with close supervision and daily care. As their conditions deteriorated each of them were placed in nursing homes where they later died. Her father-in-law, following a massive stroke could only be cared for in a nursing home, and survived there for 7 years. At the end of 10 years of caring for these family members Rachel was no longer qualified to work in her previous industry. It's unlikely that she will have the income or resources to pay for her own care when that time comes.*[2]

Rachel, in the example above, found that there is no single 800 number for people to call for comprehensive assistance with an impaired elder. Most people faced with finding or providing long-term care for a family member do so based on what they already know, who they know, and the services that are available in their community. Bad information abounds, along with an incredibly fragmented and dysfunctional system that pushes people into institutional care for lack of good alternatives, or sometimes just having the right information about home and community-based care. Younger people with disabilities face an even higher threshold, since many services that are available in a community are linked to aging service providers, making them harder for people with disabilities to find.

Caregivers struggle to find appropriate care for their family members and figure out how to pay for it. The familial relationship between caregiver and an impaired person is suddenly reversed, with all the complex issues of dependency that have to be dealt with, including personal, legal and financial resources. Family caregivers have little if any professional help or resources they can rely on until their family member is eligible for Medicaid. The ability to keep an impaired person at home once they are ADL or cognitively impaired depends on accurate information, available services, and having financial resources to pay for care.

Long-Term Care Insurance

Most consumers know very little about long-term care, except for their experiences with a family member or friend. And they know even less about long-term care insurance policies. These products and the benefits they provide are difficult to understand, and comparison is virtually impossible. Long-term care insurance, like all insurance, is regulated by each state. Policies and benefits differ from one state to another, even within a single company, with the exception of those elements required by federal law. However, there are many elements of long-term care policies unaffected by either state or federal rules, such as waiting periods, premium waivers, alternate plans of care, among others.

Consumers tend to base their purchase decision on a price comparison, as they do with many other products and purchases. That strategy may result in a long-term care insurance policy that is more likely to need rate increases later. Under-pricing for market share is still an issue because not all states have the regulatory authority to review rates, or they lack actuaries to closely examine and question a company's pricing. Buying a long-term care policy based on lower premium costs can also result in benefits that don't meet the needs of the insured later, or benefits that don't keep up with inflation.

When the need for long-term care occurs, often someone other than the purchaser –someone who is completely unfamiliar with the policy– will be faced with filing a claim and obtaining benefits many years after it was purchased. In that interval between purchase and use, the original company may have sold their block of long-term care insurance to another company, or transferred the responsibility for claims to a third party administrator. Finding out how and where to file a claim is often the beginning of a frustrating experience.

> *Marie's care initially began at home but it quickly became apparent that her dementia would require 24 hour care. She had a long-term care insurance policy that only paid for nursing home care. Her policy, purchased 20 years earlier had no inflation protection. Her share of the nursing home bill was more than a third of the actual cost, with the long-term care policy picking up the balance only after a long battle with the insurer. The claim was delayed by continual requests for information. The insurer insisted that forms completed and sent were incomplete, insufficient, not received, lost, or needed further review by company officials. Marie's daughter-in-law spoke to a different customer service person each time she called. Once payments began the benefits lasted for 2 years. Marie was a private pay patient until her death the following year, using assets intended to pay college tuition for her grandchildren*.[3]

Regulating Long-Term Care Insurance

Regulation of insurance products is a reactionary process. It occurs in response to a problem. It does not occur to limit the private market or stifle creativity, nor is it the purpose to impose costly and unnecessary requirements on insurance companies. Regulation reins in or prohibits bad practices, usually without correcting previous problems but establishing the rules to control future practices.

That regulatory process occurs in 2 ways. One is at the state level when regulators or politicians become aware of a problem in sufficient numbers that a response is needed. In that case a legislative or regulatory response occurs in that state. Another is through the National Association of Insurance Commissioners (NAIC), when an issue rises to the attention of several states with a desire to address it in a national document –an NAIC Model or Regulation– that gives guidance to states on changing or enacting a law or regulation.[i] And yet another is through the federal government when standards are set for a federal purpose such as a tax benefit, or asset protection granted as part of the federal Medicaid program.

The NAIC Senior Issues Task Force, charged with the responsibility for monitoring long-term care insurance, convened a hearing in June 2013 to explore current issues related to pricing and increasing premiums. An actuarial subgroup recently developed a bulletin to provide a framework to assist states in reviewing rate increases, and to give them additional tools to evaluate and approve rate increase requests. Other work continues in an attempt to better understand the forces driving pricing and rate increases, and devise solutions to make premiums more stable over the long term.

However, despite changes to the law, bad practices can continue and new issues arise. Here are two examples.

[i] The Interstate Insurance Product Regulation Commission (IIPRC) created by the NAIC, increasingly has a role in long-term care insurance form filing and rate review for its member states.

Rate Increases: Three times since the 1990's the NAIC has enacted requirements that were intended to eliminate large future rate increases in long-term care insurance policies, and 3 times those requirements have failed to accomplish that purpose. Recent rate increase announcements of as much as 85% cause serious financial problems for elderly policyholders, and in some cases cast doubt on the future solvency of a company.

> *"In general, prices have and will continue to increase," says Jesse Slome, [American Association of Long Term Care Insurance] AALTCI's executive director."*[4]

The NAIC is currently struggling with yet another attempt to control these rates in response to widespread complaints to state insurance commissioners from consumers and their families. For premiums to be stable, insurers must charge a high enough initial rate to prevent increases and maintain solvency decades into the future. The result is a high initial price that places coverage out of the reach of the middle class. The reverse strategy of charging lower initial rates and counting on future premium increases has a perverse effect. It is likely to increase the lapse rates –people who drop their policies when they can no longer afford coverage when premiums rise– and the reserves held to pay the claims of those policies are then released back to the insurer because there will be no claims paid to those lapsed policyholders.

The worst of all possible outcomes for purchasers of long-term care insurance is when an insured person spends thousands of dollars in premiums over many years, is unable to absorb a large rate increase and subsequently drops their policy losing all the benefits and premium dollars spent to protect themselves and their families. If long-term care insurance is expected to pay benefits in old age, decades after retirement, then premiums must remain stable and affordable.

Retirees today pay an ever increasing share of the cost of their medical care, with policymakers proposing they pay even more as part of various Medicare redesigns. Many retiree budgets are not sufficiently elastic to absorb large rate increases, particularly at the older ages when the need for care becomes more likely. Retirees in future years, with defined contribution retirement income, are even less likely to have the capacity to absorb premium increases than retirees today who benefit from defined benefits retirement income.

Inflation Protection: Despite state and federal requirements to offer inflation protection, one decision facing a prospective purchaser is whether to delay exercising the option. A future purchase option (FPO) allows a consumer to choose to buy and pay for inflation protection at periodic intervals, instead of building the cost into the policy at the front end. When that option is exercised later, the cost will be more expensive because it will be based on the policyholder's current age, affecting the decision about whether to pay for the option, and how much increased benefit they want to buy, if the policyholder has that option.

> *A policy with a future purchase option may be less expensive initially than a policy with compound inflation protection. However, over time the policy with a future purchase option may become more expensive than a policy with compound inflation.*[5] *(GAO Report)*

Over time, consumers are frequently priced out of the option to increase their benefit, as the cost at each decision point is ever greater. If they keep the policy for several decades without inflation protection, their static daily benefit will increase their risk of spending down to Medicaid eligibility as the cost of care rises. When consumers are shown the value of having inflation protection built into their policy cost from the beginning, they understand the value of that approach, and the danger of delaying that decision and that cost. Every long-term care insurance policy should have some minimum amount of inflation protection embedded in the policy at the time of purchase.

Long-Term Care Insurance Cannot Save State Budgets

Private long-term care insurance has often been promoted as the solution to financing this kind of care. Those of us who work directly with consumers know that insurance is not the solution for saving state Medicaid budgets. The market for long-term care insurance is those who are healthy enough to pass the underwriting screens, have the money to buy coverage, and enough money to continue to pay for it as premiums rise over time.

> *Private LTCI is currently being purchased primarily by middle aged and older Americans with higher than average incomes, who are healthy enough to pass underwriting, and who plan ahead.* [6] *(ASPE Brief)*

Recent insurance industry data show that buyers are younger than previous purchasers, have higher net worth, are better educated, and are more likely to live in a household in which someone works.[7] They are also unlikely to need or qualify in the future for state Medicaid benefits due to their higher net worth.

Studies by the Government Accounting Office (GAO) show buyers of Partnership policies also tend to be high net worth purchasers. The GAO found little impact on state Medicaid budgets by Partnership long-term care insurance products that are specifically designed to test the effect on Medicaid.

> *Because of the amount of insurance Partnership policyholders generally purchase and their typical income and assets, few Partnership policyholders are likely to ever become eligible for Medicaid, which suggests that the Partnership programs are likely to have a small impact on Medicaid spending.* [8]

Long-term care insurance is a niche product that works for higher net worth individuals, not for most of the middle class.

> *"I don't think the number of buyers will rise much in this economy," says Jesse Slome, executive director of the American Association of Long-Term Care Insurance (AALTCI). "It's not a universal solution – it's a niche solution."* [9]

Combination products, life insurance and annuities that trigger those benefits for long-term care expenses, are also likely to be attractive to the same high net worth population who can afford the premiums for stand-alone long-term care insurance. These combination products generally require a sizable lump sum premium, and accelerate the underlying benefit that can then be used to pay long-term care expenses. Benefits in these products have methods of calculating and inflating benefits different from stand-alone long-term care insurance policies and can leave an insured with unexpected out-of-pocket costs.

Women are disproportionately affected by long-term care as caregivers and receivers of care. The insurance industry has recently changed its pricing to reflect the greater risk of women using benefits, and will charge them higher premiums. Gender pricing will further worsen women's ability to afford long-term care insurance.

Asset Transfer May Be an Urban Legend

A long standing charge is that large numbers of the middle class deliberately make themselves artificially poor so they can take advantage of state Medicaid programs to pay for their care, a process known as "Medicaid or estate planning." Those of us who work directly with consumers know this to be mostly untrue, with the exception of vulnerable elders who are duped by trust mills, predatory insurance agents and others who exploit loopholes in the law and actively advertise and promote this process for a very large fee.

"Evidence on the extent to which individuals transfer assets for less than [Fair Market Value] FMV to become financially eligible for Medicaid coverage for long-term care is generally limited and often based on anecdote." [10] *(GAO Report)*

While spend-down is easier to see and account for in nursing homes due to the high cost of that care, many more people are likely to spend-down in the community for a variety of reasons. In some cases those who spend-down in the community have high medical expenses. Others have modest amounts of income and assets that make them ineligible for Medicaid.

Any major expense such as the death of a spouse is likely to rapidly deplete those resources and thrust them into eligibility for Medicaid. In addition, not all of those who spend-down also use long-term care services. Several studies, point to the lack of an intersection between the spend-down population and those who can afford long-term care insurance. [11]

"The Medicaid spend-down population and the population who can afford unsubsidized private long-term care insurance have little overlap." [12] *(Joshua Weiner, 2013)*

The studies reviewed in this paper do not support the claim that asset transfers are widespread or costly to Medicaid, or that restricting Medicaid eligibility would substantially increase savings or purchases of private long-term care insurance.[13] *(Ellen O'Brien, 2005)*

Broken Long-Term Care System

Elders and people with disabilities who have impairments in Instrumental Activities of Daily Living (IADL) or Activities of Daily Living (ADL) require help with everyday tasks of daily life, while those with dementia require supervision to protect themselves or others. But finding that help, getting services started and making sure needs are being met often requires the services of a trained person. It requires someone who knows the services these people need, where those services are, how to access and manage them, and whether these people meet the eligibility requirements or have to pay privately. For many impaired people, a few hours of help each day can make the difference between staying in their own homes for as long as possible or living in a nursing home.

Transportation to and from medical appointments, to the market and the pharmacy is also a critical service, as well as home-delivered or congregate meals. Nutrition is not only an important aspect of long-term care, but the socialization that occurs at nutrition sites often helps with depression that can occur when people are homebound, have lost a spouse, or have a serious illness.

Baby Boomers have had fewer children than their parents, ensuring there will be fewer caregivers available when they need care. Many more of them are single or divorced, and as a result may have lower incomes and may need to work past the typical retirement age. Being single or divorced also means less chance of a live-in caregiver, and less chance of getting care at home.

Today long-term care services are fragmented, dysfunctional, housed in specialized silos that don't communicate with each other, and are unavailable or inaccessible to those who need them. Public benefits have differing eligibility requirements and are subject to the vagaries of state budgets and political whim. Those on the margins of eligibility cost the most when their health conditions deteriorate pushing them into eligibility and much more expensive needs.

My sister is probably the best example of a broken system. She is disabled, on Medicaid and lives 500 miles from me. She lives at home for the moment, deficient in at least 2 activities of daily living.

She became dually eligible for Medicare and Medicaid on her 65th birthday and is eligible for benefits she sometimes gets and sometimes doesn't. Her Medicaid eligibility is sometimes canceled, for reasons no one is able to explain, but is eventually reinstated. Her medical coverage is separate from her social coverage, and neither communicates with the other. Any errors that occur to her state or federal eligibility and/or income cause an immediate suspension of her medical and social services. She is left on her own to resolve those errors, including overcharges to her bank account when any of her income is reduced or adjusted as a result of a change in state or federal benefits.

Recommendations

My hope for this Commission is that you will recognize that the system is broken at every level. There isn't a single way to fix this; it has to be an integrated approach. Just as all politics are local, so is the information people need, and the structure for care in the community. Public benefits can't be the only answer, but neither can private approaches and neither can insurance. Other countries have systems and strategies in place that can provide useful examples, if we choose to consider them.

For instance, in France people have the option to purchase insurance to supplement their national income adjusted, personal autonomy allowance (APA) they will receive if they become a dependent individual at age 60 or later. Privately purchased insurance is less expensive when it covers part of the risk and not all of risk. Japan created a national long-term care program funded by taxes and income based premiums, and here too people can and do buy insurance to cover part of the cost associated with dependency or serious illness. [14]

Long-term care insurance can be improved, but that does not mean it can be or should be turned into the primary financing for long-term care. But neither should the goal be to make these policies less expensive by taking out things like inflation protection or other elements that protect the purchaser, or increasing the vulnerability of later premium increases. There are many ways these products could be improved so that consumers would have the ability to choose appropriate coverage and have certainty about their benefits when they need to use them.

Consumers should be able to determine on their own how much of the daily cost they can pay, and how much they need an insurance policy to pay based on their own economic circumstance. There should be some scale, some rational relationship between the amount and duration of daily benefit that they can afford to buy based on their income and assets. Consumers need to know how to match up their needs with the cost of care and how much, if any, insurance protection they can afford.

To make these products work better for consumers, each element of a long-term care insurance policy should be standardized so that each expense or benefit is the same in every policy. I am not proposing that benefit packages be standardized as Medigap policies are, but I am suggesting that consumers shouldn't have to decipher how one policy benefit is different from another company's benefit for the same expense.

For instance, there should be no doubt when someone moves to another state that the expense they bought their policy to cover will be paid where they live. While definitions of care providers may vary from one state to another, the need for care and the services they need don't. The waiting period before benefits are paid should be imposed and administered the same way in every policy. Today companies accumulate and account for those days differently, so that a 90 day waiting period can actually be six months or longer. Few consumers understand that difference when they buy a long-term care policy. When rate increases occur, policyholders should have a range of options that can be exercised to mitigate the effect of those increases.

Policies should not be sold without a minimum amount of inflation protection. Even an 80 year old may live another 10 years or longer. A younger person has an even greater need for benefits that won't remain static over decades.

Personal care should be a mandatory benefit under a state Medicaid plan. Care at every level should be reorganized, coordinated, and delivered more efficiently at the local level. Geriatric care management needs to be incorporated into care assessment and into the delivery system for care. Housing and transportation are also important components of a coordinated system for long-term care. Family caregivers need to be supported, and funding streams need to be coordinated and integrated to ensure the best care at the most efficient cost.

The United States needs to build a system that will accommodate and care for millions of frail elderly and people with disabilities so they can exit this life with some dignity left intact. This means looking at everything, even what might have been some good ideas in the recently deceased CLASS Act, a proposal for a national insurance program. The federal long-term care insurance program could even be opened every 10 years to citizens who are not connected to federal employment.

For any of this to happen, people will have to lay aside their prejudices and work toward a common goal. There are hundreds of good ideas, it's your job to gather them, distill them, and present a comprehensive plan for the decades ahead, and the millions of people who need long-term care now and in the future.

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End Notes

[1] http://content.healthaffairs.org/content/2/2/55.citation

[2] Attachment 1, One Family's Experience With Long-term care

[3] Attachment 1, One Family's Experience With Long-Term Care

[4] Accessed at: http://articles.chicagotribune.com/2013-02-14/news/sns-rt-us-column-miller-ltcinsurancebre91d19n-20130214_1_long-term-care-insurance-jesse-slome-ltci

[5] GAO, (2007) *Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings* www.gao.gov/cgi-bin/getrpt?GAO-07-231

[6] ASPE (2012) Research Brief: Long-Term Care Insurance, http://aspe.hhs.gov/daltcp/reports/2012/ltcinsRB.pdf

http://aspe.hhs.gov/daltcp/reports/2012/ltcinsRB.pdf

[7] AHIP, *Who Buys Long-Term Care Insurance in 2010 – 2011*? A Twenty-Year Study of Buyers and Non-Buyers (in the Individual Market)

[8] GAO, (2007) *Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings* www.gao.gov/cgi-bin/getrpt?GAO-07-231

[9] Accessed at: http://wealthmanagement.com/insurance/playing-health-insurance-roulette

[10] GAO- (March 2007) *Medicaid Long-Term Care : Few Transferred Assets before Applying for Nursing Home Coverage; Impact of Deficit Reduction Act on Eligibility Is Uncertain* GAO-07-280

[11] Liu, K., Doty, P., Manton, K., *Medicaid Spenddown in Nursing Homes and the Community*. (March 1989)

[12] Weiner, J., Anderson, A., Khatutsky, G., Kaganova, Y., & O'Keeffe, J., (March 2013) *Medicaid Spend Down: New Estimates and Implications for Long-Term Services and Supports Financing Reform*. Final Report, SCAN Foundation. RTI Project Number 0213025.000.001

[13] O'Brien, Ellen. (2005) *Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net?* Washington, DC: Georgetown University.

[14] ASPE, Overview of Long-Term Care in Five Nations. (1995)

Attachment 1

One Family's Experience With Long-Term Care

Benefits from Germany paid for care in the U.S.:

One of my daughters spent an entire decade caring for 3 of her husband's family members. His father had a massive stroke and spent 7 years in a nursing home, his mother, and his unmarried uncle each had dementia. The demands of caregiving made it impossible for my daughter to continue her work in the computer industry and she gave up her employment to meet the demands of caregiving while continuing to raise her two sons. Her mother-in-law, and later her husband's uncle were cared for at home until their condition deteriorated and nursing home care was the only alternative. Ten years later, after all of these family members had died, she was unable to return to the high paying complex technical work she had done previously. She will have less Social Security income and little if any retirement to depend on in her old age as a result. All of these relatives received some income as retired German citizens, and later benefits that helped pay for some of their nursing home care.

A long term care insurance policy paid for some care:

Another of my daughters spent 4 years caring for and supervising the care of her mother-in-law with dementia. Although care initially began at home it quickly became apparent that she would need 24 hour care. Since she had a long-term care insurance policy that only paid for nursing home care the decision was made for them. Her policy had been purchased 20 years earlier and had no inflation protection. Her share of the cost was more than a third of the nursing home charges, with the long term care policy picking up the balance after a long battle with the company to pay the required benefit. The policy lasted for two years, and the remainder of her stay was paid for with funds drawn from her assets. Those assets had been intended to pay college tuition for her grandchildren.

Medicaid may pay for future care:

A son-in-law is supervising and providing some care to his mother who currently resides in a nearby assisted living facility. As her dementia worsens, and if she lives long enough, he will have to arrange for her to move into a nursing home. She has few assets and will most certainly be on Medicaid at that time.

Medicaid is paying for care:

My mother is 91 years old and living in an assisted living facility. She in on Medicaid, and has always been low income. Her only asset was her house and she negotiated a reverse mortgage on the small amount of equity she owned which quickly disappeared when she was convinced to leverage it in bogus investments that were "guaranteed" to increase her income. Because she is on Medicaid I have to supervise her care from 500 miles away, including staying in touch with the facility to monitor her condition and care, and convincing her by phone to go by ambulance to the hospital when she falls, an event that is happening more and more frequently. She, and our family, hopes she will pass away before a nursing home becomes her only option.

Medicaid is paying for care:

My sister is disabled and on Medicaid and also lives 500 miles away. She lives at home for the moment, deficient in at least 2 ADLs. I have had to frequently intervene in her care needs. She became dually eligible for Medicare and Medicaid on her 65th birthday and is eligible for benefits she sometimes gets and sometimes doesn't. Her Medicaid eligibility is frequently canceled, for reasons no one is able to explain, but is eventually reinstated. Her income changes with some frequency based on state or federal changes to SSI or Social Security, resulting in the need for us to pay her rent and other bills until her income is adjusted. Her health care providers frequently don't have current information about her chronic health conditions or medications resulting in

medical events that occur in an urgent care center or the local emergency room. Neither facility is in the same network or capable of exchanging medical records. When she is overcharged at the pharmacy or at the dentist that also requires personal intervention to ensure refunds are made. After months of negotiation, she now has a home care worker for a few hours each week. When the home care worker doesn't show up calls have to be made to resolve the problem. Her medical coverage is separate from her social coverage, and neither communicates with the other. Any errors that occur to her state or federal eligibility cause an immediate suspension of her medical and social services. She is left on her own to resolve those errors, including overcharges to her bank account when money is withheld or withdrawn. Her situation is probably the best example of a broken system.

Attachment 2

A Few Examples of Denied Claims LTCI

During my career I have counseled many hundreds of people with nursing home and long-term care insurance policies through our state Health Insurance Counseling and Advocacy Program, part of the federal Medicare program's State Health Insurance Assistance Program (SHIP). These are a few examples of cases I have worked on directly with the family member of an insured person in the last two years.

The insured is in the wrong place for benefits

In this case the insured person purchased her policy in another state many years ago. In that state the definition in the contract was slightly different than the license for a facility that provides assisted living care in California. The company denied benefits for assisted living care based on that difference. The claim was appealed to the state insurance department in the state of issue and the company paid the claim.

The insured does not meet the benefit trigger

In this case the company argued that the insured who was cognitively impaired had met the trigger for cognitive impairment but had not also met the ADL trigger. California law clearly requires that one or the other trigger be used to qualify for benefits but not both. A lawsuit was filed and the company settled for an undisclosed amount.

The caregiver is not licensed

In this case the company argued that the home care provider did not work for a licensed Home Health Agency and was not herself licensed as a home care provider. California law prohibits both those requirements in policies issued after 1993. After personal communication with the company the claim was paid.

The insured had Alzheimer's at the time of purchase

The individual was diagnosed with Alzheimer's Disease 7 years after purchase when a claim for benefits was filed. Two years before purchase at age 67 he had mentioned in passing to his doctor that he was more forgetful. The company rescinded coverage based on that information. A lawsuit was filed and the company settled for an undisclosed amount.

The Alternate Plan of Care does not apply

In this case the policy described a benefit that was otherwise not available in the policy. That benefit had been previously utilized to pay home care benefits for the spouse, now deceased. The surviving spouse with an identical policy later tried to claim the same benefit for home care under her policy and was denied with the explanation that the company "didn't do that anymore." A lawsuit was filed and the company settled the claim for an undisclosed amount.

The policy covers an alternate care facility but will not pay for assisted living

In this case the policy purchased in another state describes both a skilled nursing home and an alternate long-term care facility. The specific requirements for alternate long-term care facility can be met by an assisted living facility that provides dementia care in California. The daughter has moved her mother into a facility near her after reading the policy and thinking she had met those requirements. The company refused to pay benefits regardless of multiple submissions of evidence that state licensing and the services provided met the policy requirements. The claim was appealed to the insurance department in the state in which it was issued and the company agreed to pay the claim.