2. Revisions to the Long-Term Care Section of the Training Manual

Ms. Marvin indicated that the working group has distributed copies of suggested changes to the long-term care section of the training manual (Attachment One-B). She stated the working group should consider the addition of a paragraph that describes the NAIC, its process and how it relates to long-term care products and their regulation. She suggested the language from the NAIC *Shopper's Guide to Long-Term Care Insurance* be used as a boilerplate for this purpose. Ms. Marvin indicated that the working group would like interested parties to submit comments on changes proposed to this training manual by Oct. 1, 1995, for inclusion and discussions in its future conference call.

3. Discuss Changes to the NAIC *Shopper's Guide to Long-Term Care Insurance*

Ms. Marvin indicated the working group had been charged to revise the NAIC *Shopper's Guide to Long-Term Care Insurance* and incorporate changes made to the NAIC long-term care models. She stated the working group asked interested parties to provide comments after the Summer National Meeting in St. Louis and had received comments from Metropolitan Life. She reminded the working group and interested parties that the working group plans to conclude the revisions by the Winter National Meeting in San Antonio. Ms. Marvin indicated that the working group had determined need to expand the provision dealing with employer group insurance and life insurance policies with accelerated benefits for long-term care services.

Ms. Marvin indicated that the working group also discussed changes to the format and layout of the guide in an effort to facilitate the ability of consumers to review this guide. She indicated that the working group is considering a requirement that the guide be distributed on 8½ x 11 size paper. Ben St. John (HCFA) stated that HCFA has decided to make its publications in this size because it has found that senior citizens often have diminished motor skills and the large size paper assists them in reviewing the material. Bob Glowacki (Aegon) stated that Aegon utilizes the 8½ x 11 size with its shopper's guide for the same reasons described by Mr. St. John. Wally Noble (Prudential) stated the current size of the guide often creates problems with mailing because of postal standards. Ms. Jones indicated the materials previously distributed showing sales materials used by companies included examples of companies using the larger size. She stated it has made it much easier to identify this guide and thinks that the larger size should assist consumers in identifying it and using it.

Ms. Marvin requested interested parties submit comments on these issues as well as suggested changes to the guide by Oct. 1, 1995. She indicated the working group would have a conference call shortly thereafter and provide interested parties with the changes for review and comment prior to the Winter National Meeting in San Antonio.

Having no further business, Senior Counseling Activities Working Group adjourned at 11:15 a.m.

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ATTACHMENT ONE-A

Health Insurance Counseling Training Manual
Chapter 2 - Options to Supplement Medicare
Draft Amendments: September 10, 1995

Page 17 - Required Coverages - #8

8). ~~Since 1992, u~~Under federal ~~regulations~~ law, it is not ~~longer~~ legal for a person to be sold a policy that duplicates the coverage of ~~a policy they already own~~ Medicare or Medicaid. ~~Basically, this provision prevents insurance agents from selling a Medigap policy to a Medicare beneficiary which will duplicate existing coverage, including Medicaid, that the person may have.~~ However, certain exemptions were added to the federal law in 1994. It is now permissible to sell duplicate coverage (not multiple Medicare supplement policies) if the company discloses the extent of duplication and pays without regard to other coverage.

Page 29 - Open Enrollment for Medicare Supplement Insurance

Within six month of first time enrollment in Medicare Part B (Medical) at age 65 or older, any Medicare supplement can be purchased without regard to health condition or evidence or insurability. In 1994, the Federal law was amended to allow persons covered by Medicare prior to age 65 a six month open enrollment period when they turn age 65.

Page 31 - Open Enrollment for Medicare Supplement Insurance - #5

5. What if I am under 65 and disabled? Am I eligible for open enrollment?

If you are under 65, disabled and already receiving Medicare parts A and B, in most states you are not entitled to the open enrollment guarantees. *(check with the State Insurance Commissioner's office to make sure).* If you are under 65, disabled and ~~not~~ receiving Medicare Part B, you will be eligible for open enrollment at age ~~as long as you wait until you are 65 before enrolling in Medicare Part B~~ in all states, even in those that require open enrollment at earlier ages.

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ATTACHMENT ONE-B

Health Insurance Counseling Training Manual
Chapter 5 - Long-Term Care
Draft: September 8, 1995

Page 16 - Case Management

Case Managed: This has to do with who will decide if a person will be paid benefits. The need for nursing home care is usually decided by a physician. With a case managed policy, it could be determined by a case manager who would review medical reports against a check-list of requirements.

The basis for finding if a person is entitled to be paid benefits is generally based on a person's ability to perform ~~injury or sickness, cognitive impairment, or their ability to perform~~ certain activities of daily living (ADLs) and includes a provision for cognitive impairment. These activities of daily living (ADLs) that are most commonly used are ~~can include such things as~~

- ✓ Bathing;
- ✓ Dressing;
- ✓ Toileting ~~Using the toilet~~;
- ✓ Continence (control of bowel and bladder functions)
- ✓ Transferring (moving into and out of a chair of bed; and
- ✓ Eating (~~F~~feeding oneself).

Measuring a person's ability to perform these ADLs for the purposes of determining benefits generally requires the hands-on assistance of another person to perform the prescribed activities of daily living. Some policies may be less stringent and determine benefits on the basis of stand-by assistance of another person. Many policies require a deficiency in 2 ADLs before benefits are paid but a deficiency in 3 ADLs is also common.

Cognitive impairment is commonly described ~~as deterioration of loss of intellectual capacity as shown by measurable deficits in the areas of memory, orientation, and reasoning,~~ as a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness such as those caused by Alzheimer's disease or similar forms of senility or dementia. Companies generally determine a person's cognitive impairment on the basis that supervision or verbal cueing by another person is needed in order to protect the insured or others.

Definitions vary on what constitutes disability from policy to policy and stipulate the degree of impairment and number of ADLs an individual cannot do for benefits to be paid. Some policies will also include a medical necessity test in addition to the ADLs and cognitive impairment.

Page 38 - Block 12

Is premium level at age of entry?: The use of level premiums at age of entry is a pricing structure taken from life insurance.

Consumers are encouraged to buy a long-term care policy at an early age to save premium dollars in future years. There is a financial incentive for individuals to buy a policy in their late 50s or 60s to maintain lower premium rates for the duration of their lives.

Premiums may increase as costs go up, but not because of advancing age. The majority of LTC policies use level premiums. Consumers who buy a long-term care policy at an early age may save premium dollars in future years. If the premium is not level at the age of purchase, it may be based on what is called "attained age." Some states prohibit "attained age" rating once the policyholder reaches a certain age—generally, at age 65.

A company may request the right to change premiums by filing the revised rates with the insurance commissioner. A rate change will be granted if the company is able to prove the current rates are too low and that the minimum loss ratio requirements will be met with the new rates.

Increases would be for all policyholders and calculated at the age the policy was issued. The Commissioner must allow such increases as a consumer protection measure to insure that there are sufficient funds to pay future claims.

Rate Guarantees - Some states may have adopted provisions that require companies to guarantee their rates for a certain period of time. Generally, these requirements are that the initial rate may not be changed for the first four years a policy is in force, no increases during a five year period greater than 25% for insureds under age 65, no increase during any five year period greater than 15% for insureds age 65 to 80, and no more than a 10% increase in any five year period for persons ages 80 and above.

Page 60 - Nonforfeiture

In mid-1993, the National Association of Insurance Commissioners (NAIC) made a recommendation that all long-term care insurance policies should have a nonforfeiture feature.