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The Historical Development of Benefit Eligibility Triggers Underlying the CLASS Plan

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The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief provides background on the historical development of benefit eligibility triggers in the private long-term care insurance market. Such a review is important because understanding how these triggers came into being, and the intent and forces that shaped their development, can provide important information to those charged with implementing the CLASS Plan.

Introduction and Overview of Historical Development of Long-Term Care Benefit

LifePlans reviewed the legislative history of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Regulation as well as the relevant IRS code and HIPAA legislation to construct the timeline for the development of benefit eligibility triggers. As well, we reviewed polices as far back as the early 1980s and surveyed key individuals involved in insurers' claims management units to obtain their insights.

Long-term care (LTC) insurance has been selling in the marketplace for the better part of 30 years, although early versions of the insurance covered only nursing home care and was called "Nursing Home Insurance." Through the 1970's and up to the late 1980's, the coverage was theoretically linked to the structure of Medicare coverage. Like many supplemental private health insurance policies, Nursing Home Insurance focused on what Medicare "did not cover." Medicare paid for skilled nursing home care for up to 100 days after a 3-day prior hospitalization and private insurance picked up coverage where Medicare ceased.

If care was initially considered to be "medically necessary" by Medicare, private insurance carriers offered continued coverage for custodial care even after a skilled need was no longer present. In essence, this extended available coverage from a limited amount of skilled nursing care (paid by Medicare) to a much more generous amount of skilled and custodial nursing home care (paid by private insurance and also by Medicaid for selected populations).

The insured-for-event in early policies, that is, the benefit trigger, was defined in terms of an individual's need for "medically necessary" care in a nursing home. Insurers varied in how they

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defined "medically necessary" and a typical insurance policy contract might have read that *"...Medically Necessary means care that is appropriate to the diagnosis, widely accepted by the practicing peer group based upon scientific criteria, and not experimental, investigative or randomized."*[1] Or it could be defined to mean *"...that admission to a nursing home is required due to injury or sickness and there exists a level of functional incapacity which makes a continued nursing home stay appropriate and reasonable."*[2] Either way, in most cases, benefits were payable when a doctor certified that there was an underlying need for the care. Diagnoses and prognoses were viewed as particularly important pieces of information justifying the medical necessity determination.

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The concept of medically necessary care as an LTC insurance benefit trigger did cause challenges for companies. In particular, as actuaries designed and priced policies, there was little basis on which to develop an estimate for future morbidity. It was very difficult to predict the circumstances under which a physician would certify that an individual required medically necessary care in a nursing home especially as the nature of that service modality changed. A combination of factors including the dearth of insured data on which to base LTC pricing, a rapidly changing service delivery environment, and uncertainty about knowing when a physician would deem an insured's care as medically necessary led companies to a search for more predictable benefit trigger criteria.

Another factor was also at work. While definitely growing, relatively sluggish sales of LTC insurance policies in the 1980s suggested that the then current product design was not going to reach a broader part of the public. Selling insurance to cover something that no one wanted to access – nursing home care – did not seem to be an attractive value proposition for fueling growth in the market. It was clear that for the coverage to sell, it needed to pay for custodial services where people desired them most – in their own homes. The need for a change in policy design, coupled with the expansion in public coverage for more home and community-based care led the industry to begin looking for benefit eligibility triggers that would allow them to cover such care. To work, the triggers had to:

- be clearly related to the need for the underlying services being insured;
- have widespread acceptance among the medical/professional community providing services to aging populations;
- be clearly defined in a manner that would allow them to be put into an insurance contract and easily understood by consumers; and,
- be easy to measure and administer using standard tools and methodologies.

In the late 1980's and early 1990s, insurers began to understand that the factors related to utilization of LTC services were based on functional and/or cognitive deficits. As carriers began to provide limited coverage for home care, they also added an additional pathway for benefits: deficits in Activities of Daily Living (ADLs) and/or cognition. Thus, throughout the beginning of the

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decade, policies tended to fall into one of two categories with respect to benefit triggers: (1) Triple Trigger policies that had three pathways to benefits − ADL limitations **or** Cognitive impairment **or** Medical necessity and (2) Double Trigger policies − ADL limitations **or** Cognitive impairment.

The ADLs were based on the standard Katz scale and included bathing, dressing, toileting, transferring, continence, and feeding.[3] These original ADLs were then slightly adapted and included in insurance contracts as a basis for determining eligibility for benefits. Their use implied a move away from a focus on underlying injury or sickness as the primary pathway to benefit eligibility toward a focus on the insured's functioning. In fact, in early insurance contracts, the language even stipulated that care would be considered necessary when there was a need for continual one-to-one assistance in performing a certain number of ADLs (e.g., 3 or more) or when continual supervision was necessary because of a cognitive impairment, ***even*** if there was no underlying injury or sickness.[4] An early definition for cognitive impairment read as follows: You are considered cognitively impaired if there is a *"...deterioration or loss in intellectual capacity which requires continual supervision to protect yourself or others as measured by clinical evidence and standardized tests that reliably measure your impairment in the areas of: short or long term memory; orientation to person (such as who you are), place (such as your location), and time (such as day, date and year); and your deductive or abstract reasoning."*[5]

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The most common test used to measure the presence of cognitive impairment was the Short Portable Mental Status Questionnaire (SPMSQ) and the more comprehensive Folstein. An important component of the early policy language was that it included a requirement for *"clinical evidence and standardized tests."*[6]

It is worth noting that through the early 1990s carriers made slight variations on ADL definitions and some defined functional dependence (i.e., the benefit trigger) in terms of the numbers of ADL deficiencies (e.g., 2 or 3 limitations), others included mobility as an ADL, and still others, used Instrumental Activities of Daily Living (IADLs). Unfortunately, during this period insurers in part competed for business on the basis of benefit trigger definitions. This led to confusion in the marketplace and a backlash among consumer advocates.

The Regulatory and Legal Framework

The first reported interest in developing a regulatory framework for private long-term care insurance was in 1985 when a series of conferences between legislators, regulators and industry representatives were held; there was also growing interest in Congress in the area of nursing home insurance.[7] As a result of a sustained effort, the NAIC adopted the first Model Act for LTC insurance in December 1986, followed by the first model regulation in 1987. Many states adopted these model regulations. In fact, by 1989, more than two-thirds of states had adopted the NAIC

model act and/or regulation.[8] The model regulations became the reference point for companies developing or modifying policies they were selling − or intended to sell − in the marketplace.

Soon thereafter, in December 1988, the first attempt aimed at modifying benefit eligibility triggers occurred. The regulation included prohibitions against prior hospitalization requirements as a condition for receipt of institutional benefits and in 1989, the same requirement was eliminated for home care benefits. It was not until 1995, however, that a new section – Section 27 – was added to the Act that provided for standards on benefit triggers. Regulators, consumer representatives, and the industry expressed widespread support for greater standardization in part because of a general sense that the medical necessity standard was problematic. Actuaries could not accurately predict morbidity under this standard, consumers did not have a good sense of when they would qualify for benefits, and regulators could not determine if benefits were being paid appropriately.

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Given the growing use by carriers of ADLs as components of the benefit eligibility triggers, an NAIC working group, which was established in 1994, decided to focus on ADLs and more specifically, on three key elements: (1) the definition of ADLs to be included in the Act; (2) the actual number that should be used to trigger eligibility for benefits; and (3) the level of impairment that would be used to determine a person's ability or inability to perform. By this time, an industry standard had already been developing based on the six Katz ADLs. The working group built on this standard. The group recommended – and the model was drafted on this basis – that if a policyholder was unable to perform three out of six ADLs they would qualify for benefits; companies were also given the right to establish a somewhat lower threshold of two of six ADL limitations. In both cases, the group decided that the standard for assistance needed to be hands-on (i.e., physical assistance from another person) and not stand-by (i.e., verbal queuing or the presence of another person nearby to prevent possible injury) in determining eligibility. Moreover, cognitive impairment was added as a benefit trigger.

Throughout the 1990s, policymakers were looking for ways to encourage individuals to purchase private LTC insurance. To that end, and as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), under certain circumstances both the premiums and benefits of LTC policies received preferential tax treatment. HIPAA provided the most explicit definitions for tax qualified benefit eligibility triggers and these are in effect to this day. Namely, an individual had to be certified as "chronically ill" and had to incur "qualified long-term care expenses." These terms were explicitly defined in Interim Guidance Notice 97-31.

With respect to the first term "a chronically ill individual" defined under Section 7702B (c)(2)(A) had to be certified by a licensed health care practitioner as unable to perform without substantial assistance from another

individual at least two of six ADLs for a period of at least 90 days due to a loss of functional capacity. This was referred to as the "**ADL Trigger.**" The "**Cognitive Trigger**" was defined to mean the individual required substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. Finally, the "**Similar Level Trigger**" gave authority to the Secretary's of the Treasury and DHHS to define another trigger for individuals having a level of disability similar to the level of disability described in the ADL Trigger.

The Federal government provided interim guidance regarding the precise definitions of some of these terms and this guidance has remained in effect ever since.[9] Noteworthy is the fact that to this day, the "Similar Level Trigger" has not been defined. While a variant of this trigger is included in the CLASS Plan it will likely not result in an additional definition, since the two other triggers (ADL and Cognitive) appear to be sufficient in identifying those individuals who present with a need for LTC services and are widely accepted by regulators, insurers, and consumer groups. The CLASS Plan also includes a fourth trigger "presumptive disability" for those who are in the process of being discharged (or were recently discharged) from a facility if they were there for LTC.

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In 1998, the Senior Issues Task Force (which was part of the NAIC) was charged with the task of reviewing the LTC Insurance Model Act and Regulation for compliance with the HIPAA triggers, and in 2000, they completed an update to the Model Regulation which added a new section – Section 28. The purpose of this section was to assure that the benefit eligibility standards for qualified LTC insurance policies were consistent with HIPAA. Because both the federal requirement − detailed in Section 213, 7702B and 4980C of the Internal Revenue Code – and the NAIC Model Act relied on the same six ADLs as well as definitions for cognitive impairment, there was no need to change the standard model act in any significant manner. The major change in HIPAA, which then was incorporated in the Model Regulation, had to do with an additional requirement that a licensed health care practitioner needed to certify that with respect to ADLs, the individual had to be unable to perform them for a period of no less than ninety days.

For a timeline of the key milestones in the development of benefit eligibility triggers, see the appendix titled "Key Milestones in the Development of Benefit Eligibility Triggers."

Considerations for CLASS Plan Design and Implementation

The development of benefit eligibility triggers in private LTC insurance demonstrates how the risk management and product development needs of insurers and the "benefit clarity" needs of consumers led to a generally well accepted and agreed-upon pathway to insurance benefits. As insurers were challenged with trying to price policies in a rapidly changing service delivery

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environment, and consumers were demanding coverage for home care, the focus on functional and cognitive triggers developed naturally. Such triggers were clearly related to the need for the underlying services being insured for, had widespread acceptance among the medical/professional community, could be defined in an understandable way in insurance contracts, and could be measured and administered using standard tools and methodologies. The role of the NAIC was to ratify and clarify what was already becoming an industry standard and assure consistency with HIPAA which strengthened the status of these triggers by conferring tax qualification status on policies that met them. Understanding how these triggers came into being will further support their proper use and implementation in the CLASS Plan.

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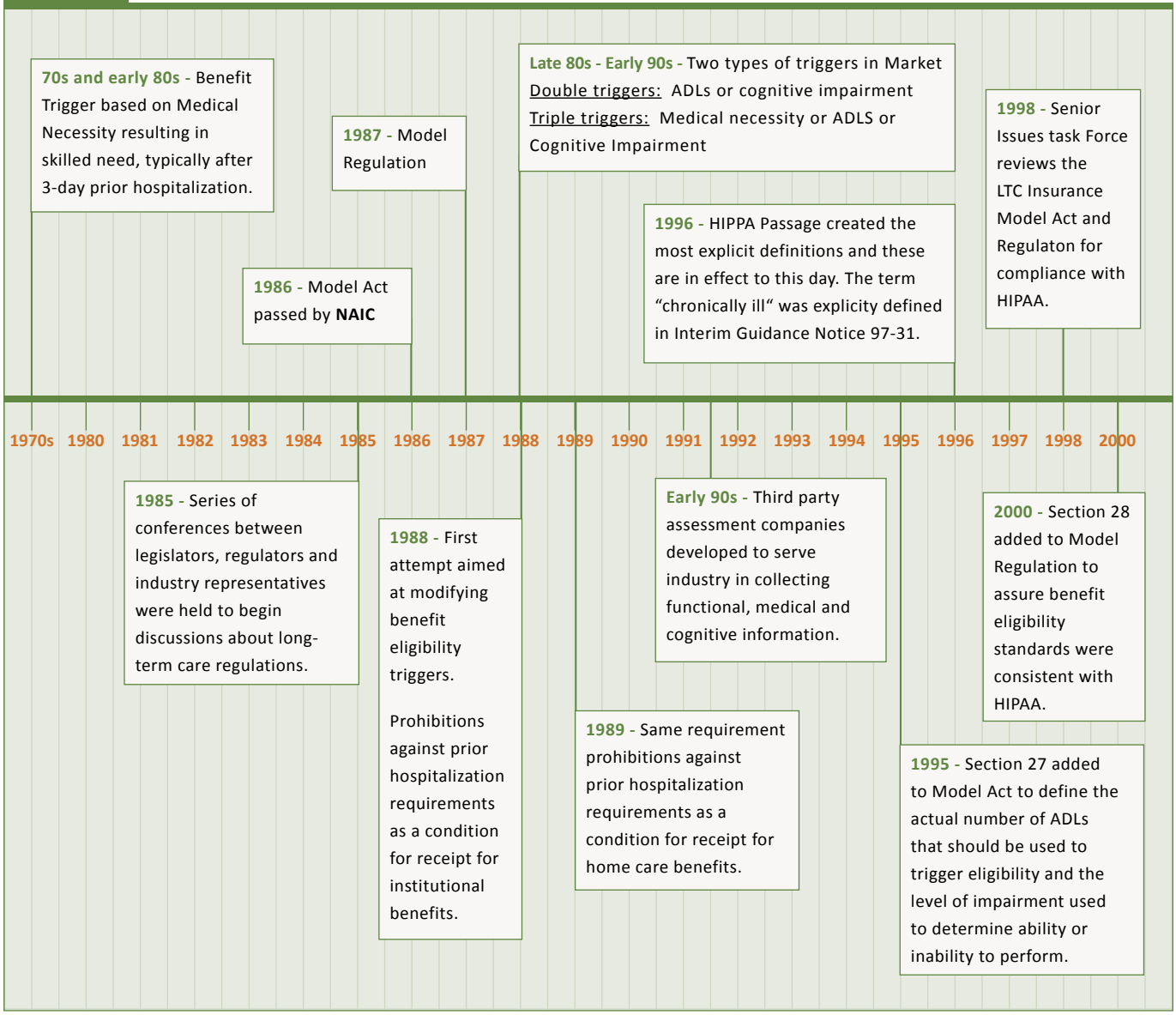
APPENDIX Key Milestones in the Development of Benefit Eligibility Triggers



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