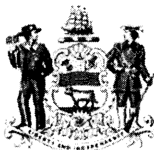

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MEMORANDUM

DATE: August 23, 2010

TO: Mr. Mitch Crane, Esquire
Delaware Department of Insurance

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 14 DE Reg. 92 [Department of Insurance Proposed Rescission of Long-term Care Insurance Policy Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Insurance's (DOIs) proposal to amend its regulation regarding long-term care insurance published as 14 DE Reg. 92 in the August 1, 2010 issue of the Register of Regulations. SCPD has the following observations.

First, the regulation allows insurers to condition eligibility for benefits on the presence of a deficiency in performance of at least 3 activities of daily living ("ADLs"). See §26.1. The regulation lists the following 6 activities of daily living (ADLs): bathing, continence, dressing, eating, toileting, and transferring (§26.2.1). This threshold will have a systemic effect on State public benefits programs. For example, if the threshold were 2 ADLs, more insureds would qualify for private insurance-funded supports, lessening reliance on public benefits. The Division of Services for Aging & Adults with Physical Disabilities (DSAAPD) also includes "mobility" and "hygiene" on its list of ADLs and requires that an individual have only one (1) ADL deficit to be eligible for long-term care programs (e.g. intermediate or skilled nursing care, waivers).

SCPD recommends that the Department also utilize "instrumental activities of daily living" [(IADLs - attached) as a condition of eligibility. According to the U.S. Department of Health and Human Services' *Measuring the Activities of Daily Living: Comparisons Across National Surveys*, ADLs, as useful as they are, do not measure the full range of activities necessary for independent living in the community. To partly fill this gap in disability classification, the IADLs were developed (Lawson and Brody, 1969). The IADLs capture a range of activities that are more complex than those needed for the ADLs, including handling personal finances, meal preparation, shopping,

traveling, doing housework, using the telephone, and taking medications (Fillenbaum et al., 1978). Recent research suggests that there is a hierarchical relationship between some IADL items and ADL items, with IADL disabilities representing less severe dysfunction (Spector, Katz, and Fullton, 1987).

Another domain, related to ADLs and IADLs, is cognitive ability. Persons with Alzheimer's disease and related dementias are prime examples of individuals with cognitive impairment. Cognitive impairment and ADL status are correlated but are separate dimensions of functioning (Fillenbaum et al., 1978). Not all persons with substantial cognitive impairment have ADL dysfunctions. DSAAPD assesses individuals for cognitive and mental health issues. These findings are documented and a risk category for mental health is assigned. Individuals presenting with a need for ADL assistance resulting from a primary or secondary diagnosis of mental illness, mental retardation or a related developmental disability are screened and referred for services in accordance with that process determination.

<u>Because ADLs do not cover all domains of disability, estimates of the need for long-term care services that rely solely on ADL measures will miss a substantial proportion of the disabled population.</u>

SCPD also encourages the Department to consider use of the International Classification of Functioning, Disability and Health (ICF), which is a classification of health and health-related domains (see attached information). These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. Since an individual's functioning and disability occurs in a context, the ICF also includes a list of environmental factors. The ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity. The ICF thus 'mainstreams' the experience of disability and recognizes it as a universal human experience. By shifting the focus from cause to impact, it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability. Furthermore, ICF takes into account the social aspects of disability and does not see disability only as a 'medical' or 'biological' dysfunction.

Second, §12.2 provides a disincentive for home-based care. It recites, in pertinent part, as follows:

> 12.2. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate.

It would be preferable to prompt insurers to offer the same dollar coverage for home-based services. Otherwise, the regulation effectively encourages nursing home placement since home care would be supported by only half the amount of payments that could be made to a nursing home.

Third, §30.1 authorizes compensation to an agent selling long-term care policies of 35% of the total of premiums paid from all the selling agent's policies each policy year. Reasonable persons might view this as "gouging" the elderly and near-elderly. Such excessive compensation likewise artificially raises premiums well beyond the insurer's risk of pay-outs.

Fourth, in §4.0, definition of "Benefit Trigger", second sentence, "purposed" should be "purposes".

Fifth, in §5.0, the definition of "bathing" is as follows:

> "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

This definition is difficult to understand. For example, if an insured can dab his/her body with a damp sponge outside of a tub or shower, does the insured have the ability to "bathe"? The use of the term "or" is disjunctive and suggests that there is no bathing deficit if someone can rub his/her body with a sponge outside of a tub or shower. This is a perversion of the normal view of bathing.

Sixth, in §5.0, the definition of "continence" is as follows:

> "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function.

The definition is "odd". The first part appears to define "continence". The second part appears to define "incontinence", i.e., lack of bowel and bladder control.

Seventh, in §5.0, definition of "home health care services", there is a lack of "people-first" language, and, indeed, use of pejorative language - "ill, disabled, or infirm persons". For example, the term "infirm" is outdated and pejorative. It is considered an insulting term which should be avoided in contemporary regulations. The Guidelines for Reporting and Writing About People with Disabilities, 5th edition, recites as follows:

> PUT PEOPLE FIRST, not their disability...Crippled, deformed, suffers from, victim of, the retarded, <u>infirm</u>, the deaf and dumb, etc. are never acceptable under any circumstances.

Eighth, in §5.0, the definition of "mental or nervous disorder" is as follows:

> "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder.

According to Wikipedia, the term "neurosis" "is no longer part of mainstream psychiatric terminology". Indeed, it does even appear in the index to the DSM-IV. However, the more important aspect of this definition is the authorization for insurers to discriminate against applicants with "mental or nervous disorders". While §6.2 bars policy limits and exclusions based on type of illness, treatment, or medical condition, §6.2.2 incredibly has an exception for "mental or nervous disorders". Thus, insurers are authorized to discriminate in policy limits and coverage based on an extremely broad definition of "mental or nervous disorder". Likewise, §6.2.3 authorizes discrimination based on alcoholism and drug addiction. Sections 6.2.2 and 6.2.3 should be stricken in their entirety. Both State and federal public policy promote parity in health insurance and discourage discrimination based on mental illness and substance abuse dependency. See, e.g. Title 18 Del.C. §3343, which recites as follows: (N)o carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan." For a similar federal perspective, see attached article, SAMHSA News, "Parity: Landmark Legislation Takes Effect. What are the Implications for Millions of Americans?" (January/February, 2010).

Ninth, in §6.1.1, second sentence, delete the colon and do not capitalize "(t)hat".

Tenth, §6.1.6.2 contains a mandatory disclosure to be provided to insureds in bold print. However, the following "disclosure" would not be understood by the ordinary policyholder:

> Insurers will be allowed a carry forward of the initially disclosed maximum premium increase, but said carry forward is lost within twenty-four (24) months if not utilized.

This mandatory disclosure will be unintelligible to consumers. In addition, as a general proposition, SCPD encourages the Department to simplify disclosures provided to applicants. Other states (e.g. New York) require insurance documentation to be written at a "lay person" level.

Eleventh, §6.2.6 is unclear. It is common for persons in need of care to be relocated close to other relatives who may live some distance from the home/domicile of the insured, perhaps in another state. This section is unclear on whether the insurer could deny services based on such relocation, especially if the insured's home/domicile is not immediately sold. Consider how the following text should be interpreted:

> No territorial limits are permissible, except that nothing herein shall preclude limiting benefits...to specific providers within a particular geographic area. Moreover, nothing herein shall prohibit the limitation of services to a particular geographical area when the insured elects to receive services within that specific geographical area. For purposes of this clause, the location of receipt of services must be within 50 miles of the domicile of the insured at the time of entry therein or that area, including the nearest three nursing

homes, whichever distance is greater.

It would be preferable to simply disallow territorial limitations, at least within the United States.

Twelfth, there is a "typo" in §8.2.5.1, i.e., "proemium" should be "premium".

Thirteenth, §22.0 contains a model outline of coverage to be shared with applicants. Par. 15 directs applicants to an undefined "State Senior Health Insurance Assistance Program". SCPD suspects this may be the ElderInfo program referenced in §24.1.6. It would be preferable to include more specific information in the Par.15 notice. For the same reason, more specificity should be included in Appendix C, "Things You Should Know Before You Buy Long-Term Care Insurance", which refers generically to the "state's insurance counseling program" and the "department of aging". Delaware does not have a department of aging.

Fourteenth, SCPD recommends that there be an acknowledgement in writing of receipt by the consumer regarding disclosures which the Department of Insurance mandates be shared with the applicant.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: The Honorable Jack Markell
The Honorable Matthew Denn
The Honorable Rita Landgraf
Ms. Rosanne Mahaney, DMMA
Mr. William Love, DSAAPD
Ms. Kevin Huckshorn, DSAMH
Mental Health Association
National Alliance on Mental Illness – DE
AARP
Senate Insurance Committee
House Economic Development/ Banking/ Insurance/ Commerce Committee.
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

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