

APPENDIX Jd:

**MANAGING A CASH BENEFIT DESIGN IN
LONG-TERM CARE INSURANCE**

Managing a Cash Benefit Design in Long Term Care Insurance

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INTRODUCTION

The use of cash benefits in long term care insurance has a long and varied history. Contrary to popular belief, cash benefits were more prevalent in the early days of the product's history – in the late 1980's and early 1990's – than they are today. With the emphasis of the CLASS Act on a pure cash benefit payment model, it is important to review the history of the use of cash benefits and address key issues in best practices when managing such a policy.

We begin with some basic terminology used to describe the basis on which long term care insurance pays benefits since the terminology is not always used consistently. We provide some level-setting definitions:

Cash (Disability) Benefit – the insurer pays a pre-defined cash benefit for each day the insured satisfies the “Chronically Ill” definition of needing help with 2 or more activities of daily living (ADLs) or having a severe cognitive impairment. The cash payment is made without regard to whether the claimant receives either paid services or informal care.

Reimbursement Benefit – the insurer reimburses (or pays directly with assignment to a provider) expenses incurred for covered services, up to the daily or monthly maximum amount selected by the insured for that service. Payments are made for each day the claimant is Chronically Ill and receives a covered service.

Indemnity Benefit – same as the above however, instead of paying expenses up to a set dollar amount, the insurer pays the set dollar amount without regard to the actual cost of services incurred. They may pay in excess of the cost of the care received. But it is required that the insured both be Chronically Ill and incur covered expenses.

HISTORY OF CASH BENEFITS

Cash benefits first emerged largely because of the flexibility they provided for both insurers and the insured and for the enhanced market appeal of a broadly flexible benefit. It is important to keep in mind that, at the time cash benefits emerged, most long term care policies did not include benefits beyond the basic home health care

(sometimes even limited to skilled home care) and nursing home care. In contrast, today's coverage includes a vast array of alternative care settings and providers (discussed in greater detail below).

The use of a pure cash benefit began in the late 1980's to early 1990's primarily with two insurers. Aetna – exclusively in the group market – initiated a pure disability benefit model which, at that time, paid for loss in 2 of 5 Activities of Daily Living, with bathing being the ADL not counted. The net impact of that, given the highly predictable order of ADL loss, with bathing and dressing most typically the first two losses, is that an insured would in effect need to have a deficit in 3 ADLs (bathing, dressing and toileting) in order to satisfy the benefit trigger and receive benefits. At the time that Aetna offered this product, it was not entirely uncommon for insurers to have a variety of benefit triggers with some using the same approach of excluding bathing as a countable ADL. Fortunately, this is no longer the case and all six of the basic ADLs are almost exclusively used today as the basis on which loss is determined.

At about the same time, UNUM began development of a retirement community-based insurance product with a cash benefit payment. One reason for this model for this specific market was that Continuing Care Retirement Communities (CCRCs) usually do not employ agency staff or have care facilities that would have satisfied prevailing policy definitions. Since CCRC services and facilities are often exclusively used by residents, they may not be traditionally licensed. The cash benefit was relatively small because it was meant to “gap fill” the differential in costs when residents in a CCRC move out of independent living to a higher (more costly) level of care; they would continue to pay their independent living fee but would use the insurance to pay the additional costs of assisted living or nursing home care. UNUM then expanded the cash benefit model to the individual and group markets. Nursing home care, with both Aetna and UNUM, was paid for on either an indemnity or a reimbursement basis.

Both companies subsequently moved to a hybrid approach. In about late 1990's, Aetna developed a service-based (reimbursement) policy in part for competitive reasons and also because they were not satisfied with the experience on their disability-based model. Interestingly, Aetna continued to use the 2/5 ADL loss requirement for its cash benefit but used the more generous and more prevailing 2/6 ADL loss requirement for the service reimbursement model. The choice of which benefit model to offer was typically made at the employer level. Similarly, UNUM began with just a disability model and shortly thereafter added what they call the professional services option (reimbursement payment).

Today, cash as a component of coverage is prevalent. There is also a great deal of diversity with respect to the number of carriers offering a cash benefit component as well as with the ways in which the benefit is fashioned.

CATEGORIES OF CASH BENEFITS

Today there are four approaches to offering cash benefits. Of these, what we call “All Cash” is the most akin to CLASS. The others offer various modifications with a cash benefit that is not as comprehensive as the “All Cash” approach. With these variations, it seems the industry is looking for ways to offer some of the additional flexibility of cash while also offering a more cost-competitive product. (Tables 1 and 2 show the prevalence of the various cash benefit types across both the individual and group markets.) The specific design variations offered within the family of “cash benefits” are summarized below.

All Cash

This type of product generally pays exclusively a cash benefit in specified amounts once eligibility triggers have been met. The cash benefit can be paid only when the insured is not confined in a care facility (with the facility-based benefit paid on a reimbursement or indemnity basis), or the policy can pay a cash benefit for any level of care need. At present, none of the “All Cash” products vary the benefit amount by degree of disability as CLASS is contemplating. Management of the “all cash” benefit varies (as discussed below), but generally insurers offering these types of products do not require proof of the receipt of either paid or unpaid long term care services. Sometimes, insurers that provide the “All Cash” model do not include other “ancillary” benefits like respite care, hospice care, informal caregiver training, equipment or home modification as the “cash” can be used for those types of services, and more.

Four companies have been associated with this type of benefit; Aetna, MedAmerica, Metropolitan Life and UNUM. Of these, only MedAmerica and UNUM are actively selling this product today. Aetna offered this product in the group market, as noted above, but no longer sells long term care insurance and has transferred some of its group cases to other carriers (most notably Prudential). MetLife recently stopped selling its “all cash” policy although they continue to administer the policies of this type which are in-force.

MedAmerica offers “All Cash” products that feature cash benefits paid on a monthly basis. Insureds who meet the benefit triggers must submit a form each month certifying that they continue to have the condition (or reside in the same care facility) as when they were initially assessed as benefit eligible. MedAmerica seems to be using this

monthly form as the plan of care required of tax-qualified long term care insurance products under HIPAA.

Unum offers both a cash product (called Total Home Care) and a service reimbursement product (Professional Home Care). In the group market, the choice of which to offer is generally made at the sponsoring employer level. Although they are no longer selling in the individual market, previously the insured could select at time of purchase the approach they preferred. Unum's target market includes numerous small businesses many of which include some amount of employer contribution. This serves in effect as a way of lowering the price of the "All Cash" product to the insured.

Cash Benefit as a Rider.

Some companies offer a cash benefit as a rider to a traditional expense reimbursement policy. The rider, obtained for an additional premium cost, allows insureds to receive the full amount of their home care benefit in cash assuming they meet all of the benefit triggers. The rider must have been selected at time of purchase. This option is offered as a part of a service reimbursement policy but changes how the home care benefits are paid. The prevailing approach is one where insureds decide on a month-to-month basis whether to elect benefits in the form of cash or as an expense reimbursement. Insureds using this benefit are more frequently assessed for benefit eligibility than those with the service reimbursement benefit. Some insurers have stopped offering this rider on policies with a lifetime duration and/or with high daily benefit amounts. And others have stopped using this approach entirely and instead use a "Built-in Cash Component" described below.

Built-in Cash Component.

Some carriers build in to the policy a provision for a cash benefit offered at less than the full home care benefit amount as an option at the time of claim. If the insured so chooses, they can elect to receive cash (typically on a month to month basis) in lieu of home health care benefits. The cash benefit may be paid at anywhere from 10% to 50% of the home care reimbursement amount. (Most carriers offer a home care benefit equal to the facility care benefit, and some even allow the home care benefit to be set at 150% of the facility care benefit amount.)

The idea behind this approach is to design the product to include a cash feature which is "premium neutral" thus mitigating some of the risk management issues associated with the "all cash" model. This model is also easier to sell since it offers the flexibility of cash without the "sticker shock" of the higher premium of the rider approach or "all cash" approach. In some cases, insurers put lifetime limits on the use of the cash benefit option and in other cases they do not.

Remainder or Ancillary Cash.

Two companies at present have a different approach. For both, the cash benefit is integral to the policy and not offered as an additional-cost rider. One company allows the insured to access cash if there are benefits remaining in their monthly home care reimbursement benefit at the end of the month. It is essentially an expense reimbursement policy with an added cash feature. Insureds who meet the benefit trigger and are receiving home care receive a traditional expense reimbursement benefit, however, if at the end of the month there are any funds remaining in their monthly home care benefit allowance (an amount chosen by them at time of purchase), they can elect to receive reimbursement for a wide array of long term care related expenses not covered in the policy, including family care, at up to 50% of that unused portion in the form of cash. The “cost” for family care is based on the number of hours of care that will be provided and prevailing rates for that type of care when provided by a home health aide or similar provider type in the area. They can also elect to leave the unused balance in their “pool of benefits” thereby conserving their lifetime maximum for future use.

Another insurer offers cash as a separate benefit that can be accessed by insureds who have met specific conditions. To be eligible for this benefit, the insured must: 1) meet the eligibility triggers; 2) satisfy the elimination period; 3) receive care at home; and 4) receive at least one day of home care during the month. Further, the insured must not have resided in a nursing home or assisted living facility during the calendar month. The cash benefit does not reduce the insured’s lifetime maximum benefit and can be continued as long the insured continues to meet these conditions. The cash amount is equal to 15% of the monthly service benefit to be used as the insured’s discretion; no proof of services or other verification of how the funds were used is required. The benefit is paid as a supplement to the regular service reimbursement benefit.

THE EXTENT OF CASH BENEFITS IN TODAY’S MARKETPLACE

There are no data on the percent of policies in-force with a cash benefit. Given the variability in the types of cash benefits offered, an overall percentage would not have much meaning; some carriers offer a pure cash model, while others have cash as a more modest component of the coverage. Since almost all the insurers offering a cash benefit also offer a reimbursement policy option, we can’t even derive a meaningful estimate of how much “cash” benefit is in-force based on carrier market share. For example, data from Broker World, 2009 indicate that in 2008, 38% of insureds had coverage with a company that offers a cash benefit option (either at point of sale or at time of claim) while about two-thirds of insureds have coverage with insurers not offering any cash component. Sales of cash benefits range from 1-3% of a company’s business to about

40%, based on anecdotal estimates provided by companies that sell both types of policies. So while we can say that less than one-third of today's insureds have a policy with a cash component, we cannot provide more specific market penetration estimates.

Data are available based on annual sales figures in the individual market only. As a percent of new lives in 2008, 3% of 2008 buyers in the individual market purchased a policy with a cash benefit as a base feature in the policy. Similarly, an additional 3% of new buyers bought a policy with a rider providing some type of cash benefit. These numbers, however, mask a significant amount of variation by company. Observe the following variation based on 2008 new lives in the individual market:

- Not surprisingly, MedAmerica and UNUM, both of which offer a cash benefit as an integral component of the policy, had the largest share of buyers with a cash benefit – over 80% of their new sales.
- Other companies that offer a cash benefit as a policy component had a smaller percent of their 2008 sales selecting a cash-based benefit plan (ranging from 2% for one insurers and as much as 39% for another, with sales levels in between those amounts for the other insurers).

CLOSER LOOK AT CASH BENEFITS

Table 3 shows the variation in the types of cash benefits offered. Of 13 policies with a cash component, nine have a cash benefit as a built-in feature of the product. Four offer a cash benefit only through a rider to the base policy. And three offer both a built-in cash benefit and an optional rider for an enhanced cash benefit. As noted previously, insurers tend to base the cash benefit on a percentage of either the monthly home care benefit or the monthly maximum for all levels of care if the policy has the same amount for all. Options range from 10% to 50%, but the most common percentage is 40%. Riders, however, tend to give insureds options for higher percentages, such as 50% and even 100%.

With built-in optional cash benefits, insureds inform the insurer at claim whether they wish to receive cash. Most policies let the insured change between cash and reimbursement from month to month. Cash benefit riders typically must be purchased at time of application and cannot be added later even with underwriting. The insured is typically not permitted to receive other home care or facility benefits while receiving a cash benefit.

Many policies with cash benefits, whether built-in or offered through riders, do not place restrictions on how insureds spend the cash, nor do they require that the insured prove receipt of care or services. Most policies with cash benefits reduce the overall pool of benefits “dollar for dollar,” though one insurer offers a cash benefit rider of 15% of the

home care benefit over and above the other benefits and does not apply the cash payouts towards the overall pool. Most policies pay either cash or expense reimbursement, but one or two provide an additional small cash pool on top of the expense reimbursement (although the total amount paid is limited to the monthly maximum).

ADVANTAGES OF THE CASH BENEFIT MODEL

The Cash Benefit model presents advantages for both the insurer and for the insured.

Advantages for the Insured

- **Flexibility.** The most obvious advantage for the insured is the flexibility in how funds can be used. This allows the insured to use the cash payment for non-traditional providers of care, informal caregivers, non-licensed providers, home modifications, help with instrumental activities of daily living (IADLs) like meal preparation, housekeeping, transportation and other services that are either not covered or are covered on a more limited basis under a traditional reimbursement product. Another advantage for the insured is the flexibility to “save up” the daily cash benefit payments and use them only on days when paid care is needed. For many people, paid care needs are “lumpy” in the sense that one might need full-time care during the weekday but no care at night or on weekends when family care is available. A fixed daily benefit reimbursement amount does not accommodate that type of expenditure pattern but a cash benefit which can be “banked” until needed can better match the uneven pattern of care needs. A cash benefit also can provide value to family members who may incur costs associated with caregiving. For example, a daughter who needs to hire child care or quit her job in order to provide personal care for her mother can use the cash benefit to offset those costs.
- **Product “Shelf Life.”** Another advantage to insureds is that cash benefits have more flexibility to remain useful and contemporary as new types of services and providers evolve. For someone buying a policy today which they likely won’t use for 20 to 30 years, this flexibility can be important. If the policy benefits and covered services are defined based on what is known about today’s service environment, without flexibility to upgrade, the policy can more quickly become obsolete.

Advantages for the Insurer.

- **Compliance.** A cash-based product is easier for the insurer to develop, file and maintain policy language since there is no need for provider or service definitions. Additionally, this means fewer state variations which also expedites

the state regulatory approval process. A cash benefit also has a longer “shelf life” which benefits the insurer as they do not need to design and file product updates as often in order to keep pace with a changing service system.

- Administration. A cash benefit policy can be easier to administer in the sense that the insurer does not need to verify provider or service eligibility – only that a qualifying disability and the need for long term care exists and that other policy provisions are met. One carrier mentioned that benefit payments are facilitated with a cash policy because they are typically transmitted via electronic funds transfer.
- Competitive Advantage. There is also a competitive advantage when a policy pays a cash benefit – all else being equal – because of the flexibility and appeal of cash. (While this is offset by the fact that a cash policy is more expensive, it is possible to design the cash benefit so that it is premium neutral with a competitor’s product.)

DISADVANTAGES OF THE CASH BENEFIT MODEL

Cost.

One of the primary disadvantages, both for consumers and insurers, is that this benefit approach is more expensive, with estimates ranging from about 20% to 35% to as much as 60% to 100% higher cost for a cash benefit. The range depends on the pricing assumptions and the type of cash benefit and other features of the policy and the age of the insured at time of purchase. (Table 4 shows premium differentials across insurers with and without a cash features for some sample policy designs.)

The greater level of expense is due in part simply to the fact that benefits are paid more often than they would be with a reimbursement policy; specifically they are paid whether or not the insured receives paid care and the benefit is available to be paid every day the insured is disabled, compared with a more intermittent payment schedule (e.g., 4-5 times a week) for someone with a reimbursement policy since that reflects the more typical pattern of paid service use. There are additional factors playing in to the higher costs of the cash model including greater administrative costs relative to functions around benefit determination, re-certification and fraud management. These are discussed in a later section.

Another concern with cash benefits is a higher claims denial rate which in turn generates greater administrative costs; this will become even more of an issue as a growing number of states require independent third party review of claim denials.

Another cost disadvantage for the insured is the fact that a cash benefit typically has little or no “salvage” value. Salvage refers to the pricing concept whereby the insurer assumes that neither the full benefit amount per day nor the lifetime maximum will be

fully utilized; this is especially true with high daily benefit amounts. With a cash benefit, the experience is that there is little or no “salvage.” Thus, insureds are not able to “conserve” their lifetime benefit maximum if they have coverage of less than “lifetime” duration because they will receive a cash payment on every day they are disabled even if they are not incurring expenses; these payments would “draw down” on their lifetime maximum. Of course, the individual can choose not to make a claim for benefits under the cash model as a way of conserving benefits but that is more difficult to do (logistically and practically) with a cash benefit. The appeal of receiving cash (perhaps to be used later if needed) is a strong incentive to make the claim rather than “holding off” just in case more care is needed later.

One carrier cited the “hassle factor” as a reason that a reimbursement benefit costs less than a cash benefit – meaning that the more documentation that is required to make a benefit claim (e.g., providing documentation of covered expense), the less likely the individual is to make the claim. The lack of a “hassle factor” with a cash benefit therefore can be another factor making it more expensive.

Managing the Benefits.

Another disadvantage for the insured is that they have to manage their cash benefit dollars and take sole responsibility for finding, arranging and verifying the appropriateness and “quality” of the care providers they elect to use. I don’t find this argument very compelling at all. In the Lifeplans LTCI admission cohort survey, it was clear that claimants very rarely relied on insurance company case managers to identify specific providers or “arrange” services for them. They picked their own providers (NF, ALF, home care) based on their own criteria. For NF, ALF it was reputation in the community, physician or other medical provider recommendations, and proximity. For home care, it is less clear what criteria claimants used to pick specific providers were chosen, but two thirds of claimants used agencies and one third hired individual providers. Let’s just imagine that an insurance company provides a “recommended” plan of care. The operative word here is “recommended.” Is a home care agency going to follow that plan to the letter? I doubt it because the schedule of service (e.g. how many days a week, hours, morning vs. evening) and tasks to be performed (baths on which days) will be worked out between the claimant and the agency (or individually hired aides). If the insured has given power of attorney to a caregiver or family member, there is no guarantee that the cash payments will be used as they should be to provide and pay for care. Some carriers provide a detailed plan of care that makes recommendations with regard to the nature and type of care insureds need to best meet their situation. Following this plan of care can help insureds make the most of their cash benefits.

Insureds may also use up total benefit dollars faster since benefits can be paid out even if they are not incurring expenses (e.g., if family or friend are providing care at no charge). Unless the insured “saves” those cash benefit payments for later use when

paid/formal care is the only alternative (e.g., nursing home care perhaps), the benefits available at that time might be greatly reduced.

Tax Implications.

While likely, there may be negative tax consequences for the insured with a high pay out cash policy. HIPAA imposes a limit on the amount of cash benefit relative to the amount of long term care expenses that can be received tax-free with a tax-qualified policy. In contrast, there is no limit on the amount of reimbursement for expenses that can be received tax-free. Some cash benefit options today can have a rather high daily benefit amount so it is not entirely unlikely that someone could receive, say, a \$500/day cash benefit and incur no long term care costs – in which case they could face a tax liability based on the amount in excess of the IRS cap (today set at \$290). This would mean that \$210/day (or over \$76,000/year) could be considered taxable income for the insured. This concern is less critical for CLASS given the significantly lower benefit amounts being considered.

Higher Administrative Costs.

One of the most important disadvantages for the insurer is the fact that a cash benefit is more costly for the insurer to administer (which translates into higher premium costs) because of the need for more in-person assessments and more frequent reassessments. Without the service records or provider input the insurer would receive under a reimbursement model, the insurer cannot assess continued benefit eligibility without doing costly in-person assessments more frequently than they would otherwise do. There is also considerable potential for fraud and abuse given the incentive for someone to “stay on claim” even when they are no longer chronically ill – an incentive that is much greater when they are receiving a cash payment, without a requirement to receive services. Surprisingly, there is a fairly significant “recovery” rate in long term care – one estimate cited by a large third party administrator finds that 30 to 40% of those who meet the benefit triggers and receive benefits eventually recover. So the ability to continually re-assess eligibility status is critical to the accurate payment of benefits. Additionally, without service records or provider input, the insurer cannot assess continued benefit eligibility without doing costly in-person assessments more frequently than they would otherwise do so.

CONSUMER RESPONSE TO CASH

Most carriers offering a cash benefit indicated that insureds articulate a preference for a cash benefit because of the flexibility of the offer. However, whether they elect such an option or not depends upon how competitively it is priced. In one insurer’s experience, initial “take up” of their cash rider (month-to-month option to elect 100% cash) was high – about 40%. But when the product was re-rated at about 28% higher premium,

take up dropped significantly to about 3%. That was the motivation for this insurer to move to a “built-in” premium neutral approach to cash.

Aside from this anecdotal information, data on the extent to which insureds elect a cash benefit – either as an optional rider – or to use on a month-by-month basis is not known. Similarly, information is not available on how insureds typically use cash. Aside from a few company-specific studies over the year, most insurers do not track how the cash benefit is used.

ALTERNATIVES TO A CASH BENEFIT: FLEXIBILITY OF TODAY’S LONG TERM CARE INSURANCE PRODUCTS WITH A REIMBURSEMENT MODEL.

The biggest advantage of the cash disability model, when first introduced, was the flexibility for the insured to use non-traditional providers or less costly providers for non-institutional care and to cover services not typically covered at that time (e.g., assisted living facility care, caregiver training, devices, respite or hospice care). However, reimbursement type policies have significantly diversified to accommodate a vast array of new types of providers, services and benefits. One of the most important – coverage for care in an assisted living facility – while virtually unknown as a benefit in the 1990s is universally covered in today’s policies, usually at the same benefit level as nursing home care.

Other benefit provisions which offer much of the same flexibility of a cash benefit are discussed below. The prevalence of these features in policies being sold today (based on data from 2008 sales) is strong. These data, exclusively for the individual market, are summarized in Figure 1 and discussed below.

Caregiver training typically provides a total benefit amount (sometimes expressed as a multiple of the nursing home DBA – e.g., 5 x DBA) to teach an informal caregiver how to safely provide personal care and supervision. The vast majority of plans offer this as a base feature in the policy, but one company does offer it as a rider. As a result, 99% of buyers in 2008 had this feature as part of their coverage.

Informal Caregiver Benefits allow payment to an informal (non-licensed) caregiver. Definitions of who qualifies as an informal caregiver may vary; some policies include family under any circumstances and some may limit the use of the benefit to family not living with the claimant on a regular basis. Nine of the 23 companies surveyed in 2008 include an informal caregiver benefit – most as a feature in the base policy. Overall, just under over 70% of all buyers had a policy with this feature.

Monthly Home Care: Since most people do not receive the same amount of care on a daily basis, having a monthly home care maximum instead of a daily limit gives the flexibility to “stack services” on days when people need more care and to preserve

benefits on days when they do not need paid care. While once fairly unique, most policies today do offer a monthly home care. Only four companies selling in 2008 do not have a monthly home care benefit. As a result, over 50% of all buyers in 2008 obtained a policy and/or rider that provides the flexibility of a monthly home care benefit.

An Indemnity Benefit pays a flat dollar amount when covered expenses are incurred, even if the benefit payment exceeds the amount of expenses. The insured can then use the difference essentially as a cash benefit to pay for some items not otherwise covered under the policy (e.g., private duty nurse in a nursing home stay). About half the companies selling in the individual market offer an indemnity benefit payment either as integral to the policy or through the offer of a rider. Of 2008 buyers, 7% obtained this provision as a base feature of the policy while 4% purchased it as a rider.

Respite care provides time off for informal caregivers, generally by providing benefits (home care, ALF or other services) without requiring that the elimination period be satisfied. This provision is included as an integral policy feature in nearly all policies; only one company selling in 2008 did not include respite care (although that carrier may have other policy features that serve a similar purpose – e.g, a 0 day elimination period for home care);

An Alternative Plan of Care provides flexibility for the insured to request the insurer to approve coverage for providers, treatments, services and care settings not otherwise covered under the policy. While most carriers do not authorize a cash payment under this provision, it is used to provide flexibility to pay for home modification, equipment, transportation, informal caregivers, family care and many other things. Overall, 80% of 2008 buyers obtained a policy with an APC as a base feature of their coverage.

Home Modification and Equipment benefits are designed to enhance independence when someone has ADL impairments and typically include things like wheelchair ramps, tub rails, and other adaptive devices. Access to this benefit is also widespread. Over 84% of buyers in 2008 had a policy with this feature either as an integral component of the coverage, or (2%) as a rider.

International Care. Many policies now pay for care abroad, either as a routine policy feature or on a limited/defined basis. Over 80% of buyers in 2008 had a policy with this feature as an integral component of their coverage.

[INSERT FIGURE 1 HERE]

Data on the extent of these flexible benefits in the group market is less readily available. However, Broker World 2009 indicates that six carriers in the group market include coverage for informal care and/or family care. Sometimes the option is made at the

employer level when they select the package of benefit features to offer and sometimes it may be an integral policy component. The Federal Long Term Care Insurance Plan also includes a benefit for informal and family caregivers and CalPERS has a provision for coverage for independent providers who are not licensed or agency-affiliated.

BEST PRACTICES IN MANAGING A CASH BENEFIT

As discussed above, the major disadvantage of a cash benefit is the added cost due to a variety of factors. The most “manageable” of these pertain to the following: managing utilization, accurate and timely benefit determination and re-assessments and monitoring and addressing potential fraud and abuse. This section summarizes the “best practices” insurers use to maintain as competitive and cost-effective cash benefit as possible, as well as to ensure that benefits are provided equitably and appropriately.

Underwriting.

While the CLASS Act will be offered without underwriting, most of the insurers offering a cash product underwrite to varying degrees. All insurers in the individual market employ underwriting. If an insured is requesting a high daily/monthly benefit amount and/or a large lifetime maximum where a cash benefit component is included, the insurer will generally take in to account the risk posed by that applicant relative to the coverage they are seeking. Some insurers make a “counter offer” of reduced coverage than what was applied for rather than declining an applicant or issuing them coverage on a sub-standard (higher premium) basis.

On the group side, one carrier offering an all cash option does not offer guaranteed issue. However, they use both case-level and individual underwriting although a short-form may be used in this market. Another insurer with an “all cash” benefit offers coverage on a guaranteed issue basis but does case level underwriting, limits the benefit amounts and durations, and sets either minimum participation levels and/or requires an employer contribution which significantly enhances participation. In earlier policy forms with its cash benefit, this insurer offered coverage on a guaranteed issue basis but had a policy provision which indicated that benefits would be triggered by a loss of 2 additional ADLs to whatever the applicant had at time of enrollment; the result of this is that if someone was already impaired in 2 ADLs at the time of enrollment, benefits would not begin until they reached a 4 ADL level of loss. While we would not, for many reasons, consider this a “best practice,” it was being used at one point in time to manage the risk of not using underwriting with an “all cash” product.

Another carrier offers a cash benefit rider in the group market without underwriting however, as is typically the case with guaranteed issue, it is limited to a defined

enrollment period and a meaningful “actively at work” definition. Also, the maximum daily benefit offered on a guaranteed issue basis is under \$350/day. Anything over that (coverage goes up to \$500/day in this case) must be underwritten. While it is rare, one carrier that does offer a lifetime benefit in the group market with a cash rider would only do so with full underwriting.

Benefit Design.

While some insurers offer lifetime coverage, most do not allow a policy to be issued with both lifetime coverage and a cash benefit option. This is more true for those offering a cash benefit rider or an all cash benefit than for those carriers which have “ancillary cash” or a built-in cash provision. Those two approaches are another alternative strategy for using benefit design to manage the risk of the cash benefit. Insurers also impose limits on the amount of daily or monthly benefit available with a cash benefit. Some do so within a cash rider by allowing a benefit amount less than the full amount that can be sold on an indemnity or reimbursement basis (e.g., a \$350/day maximum on the cash rider but a \$500 maximum on the reimbursement benefit).

With respect to the “built-in” cash benefit, several insurers indicated that the “built-in” cash benefit was designed to be “premium neutral,” which is why it pays at a lower rate (10% to 50%) than when benefits are elected on an expense reimbursement basis.

Additionally, most insurers offering a monthly benefit – whether cash or reimbursement – do so on a pro-rated basis. The amount of monthly benefit available to the claimant is equal to the percentage of days of the month on which they satisfied the benefit eligibility criteria. For example, someone who becomes disabled on June 1st and remains disabled the entire month would receive their entire monthly benefit amount (whether cash or reimbursement) but someone becoming disabled on June 15th would receive only half of their monthly benefit allowance.

A few insurers impose an “inner limit” on the amount of benefits that can be paid with cash. So someone with a lifetime policy maximum of \$150,000 might only be allowed to receive 10 x the monthly maximum or \$60,000 in the case of a \$6,000/month benefit amount. When a smaller lifetime limit is imposed, it might be offered as an “ancillary” benefit and may or may not draw down on the lifetime maximum although it is unusual to have any benefit payment fall “outside” the lifetime policy maximum – whether it is a cash benefit or not.

Benefit Determination & Recertification.

Appropriate and timely benefit assessments and re-assessments were cited universally by those administering cash benefits as one of the most important risk management tools. The additional challenge of administering a cash benefit policy is that it is more

difficult to determine benefit eligibility (i.e., the nature and degree of functional or cognitive loss) without records of expenses incurred, services provided or other medical or care notes. Therefore, an in-person assessment is typically required either more frequently or all the time (it differs by carrier practice) in the case of a cash benefit where it is used less frequently in a reimbursement benefit when other information is available and adequate to substantiate the loss.

Similarly, given the not insignificant (30 to 40%) recovery rate in long term care, it is very important to do timely re-assessments. One study found that 70% of claimants had at least one “transition” in terms of nature and degree of disability over the course of their disability. At a minimum, some carriers mentioned conducting re-assessments every 90 days. Receipt of a cash benefit is a powerful incentive for an insured or their family to maintain the receipt of benefits when the insured may no longer be benefit eligible; this is especially true if the cash benefit is being used for basic living expenses and not for the provision of paid care which of course would no longer be needed upon recovery. One carrier said that the need to do more frequent on-site assessments with a cash policy likely results in assessments costs which are two or four times as much as they would be under a reimbursement policy.

Some of the tools carriers use to assist in gathering needed information for benefit reassessment include structures questionnaires to physicians about the claimant’s need for supervision and support, ADL questionnaires for providers and informal caregivers, medical management tools, and the like. Telephone-based assessments can be helpful but only when there is other corroborating information like care notes or provider records.

Plan of Care.

A tax-qualified LTC policy must provide benefits in accordance with an approved Plan of Care developed by a Licensed Health Care Practitioner. While all TQ policies do this, the interpretation of what constitutes a Plan of Care and how it can be used varies widely. Some insurers see the Plan of Care merely as an articulation and description of the nature and degree of loss such that the insured is benefit eligible and do not go further to specify recommended or prescribed service types or frequencies. Other Plans of Care do go into further detail about care options and service settings, including both those covered under the plan as well as other community or free resources that might be available to the insured to help support their care needs. Some insurers monitor that benefits are provided in accordance with the Plan of Care by reviewing expenses submitted under a reimbursement policy. In a cash policy, the insurer interested in maintaining care consistent with the Plan of Care must rely upon care notes provided by either formal or informal caregivers. Some companies provide a format and guidelines by which families can document care notes while others do not. One unique approach

by a company that offers an “ancillary cash” benefit is to use the Plan of Care to define the type, amount and allowable expenses associated with the amount of the unused monthly benefit maximum which can be spent on long term care that isn’t covered in the policy – be it family care, equipment and devices or other items. They consider this a “cash and counseling” type model. It is also important to note that the Plan of Care is never a “hard and fast” document – it changes as insureds’ care needs and their options for receiving care change. If family care is initially available, a Plan of Care may reflect that in its recommendations; if that situation changes (e.g., a family helper becomes ill or moves), then the Plan of Care is modified to identify an alternative appropriate option for care.

In creating the Plan of Care, some insurers take care to assess the adequacy and competency of informal supports and unlicensed caregivers to provide care. This is an important factor whether those individuals provide care as a supplement to a reimbursement policy or as the primary source of care within a cash benefit plan. One carrier identified instances where the insured’s desired plan of care was to rely upon a spouse who was disabled to the point of being unable to provide the care needed.

Based on the claimant study mentioned above, for about one-third of all claimants, there is a recommendation for some type of change to the plan of care as indicated by the insured’s needs and personal situation. This figure remains fairly constant over time underscoring the need for on-going monitoring of care needs to help insureds get the most value of their coverage. And over 90% of claimants at all points in their disability cited that care management was helpful to them.

Fraud Investigation.

A focused and active fraud investigative unit is universally cited as an integral component critical to a cash benefit plan. While fraud investigation is also important for any policy, there is a significantly heightened potential/incentive for fraud with a cash benefit. Most insurers have a dedicated fraud unit, they might use a vendor for the service and it typically involves hiring private investigators. Insurers tend to focus on situations where an insured has an especially high daily benefit amount and where the initial assessment and subsequent reassessments suggest a high likelihood of recovery. One carrier indicated that they are successful in documenting fraud in about 50% of the suspected cases. One carrier mentioned that fraud investigations typically costs about \$2,000 to \$4,000 per case, sometimes higher.

Carriers indicated that fraud is also a more significant concern with a younger claimant population, which has obvious implications for CLASS. One insurer suggested that the fraud rates found in LTD might be a good proxy for estimating anticipated fraud in a cash-based benefit, in part because both are focusing on a younger, at work population. With older populations, the concern focuses more on fraud against the claimant and not

by the claimant. Some carriers said that in general there is more evidence of fraud perpetrated by the family of the claimant than by the claimant themselves.

Experience Monitoring.

As with all LTCL, experience monitoring against pricing assumptions is critical. Insurers say it is very important to know the actuarial assumptions with regard to utilization and recovery and to evaluate actual practice against that.

PREMIUM IMPACT

Table ___ compares premiums under varying types of cash benefit provisions. Some companies offer more than one option so the data provided represent multiple offerings of multiple insurers. Samples ages of 45, 55, 65, and 75 are used. The “base plan” chosen for analysis is one with a \$6,000/month benefit (\$200/day), a 90-100 day elimination period, built-in 5% compound inflation protection and a lifetime maximum roughly equal to 5 years. In most cases, these policies pay the same amount for home care as facility care. Obviously, there will be other minor benefit differences (e.g., one policy may have a more generous bed reservation benefit than another), but for the most part the important coverage elements are the same. We used only standard, non-discounted rates.

Obviously, for policies with a cash rider, the additional premium cost of that rider depends on whether it pays 20% of the home care reimbursement amount or 100%. For the smaller benefits (20% - 25%), the additional cost is roughly 13 to 30%. At the other extreme, the 100% cash benefit can add as much as 70% to the premium, although insurers vary considerable in how they price this rider.

The additional premium cost for the ancillary cash design is more modest – roughly 7% to 17% depending on company, cash amount and issue age.

For companies with a “built-in” cash benefit, we show actual annual premium amounts since those companies do not have a “no cash” option against which to compare the premium cost. There are few consistent patterns; for the most part the higher the built-in cash amount, the higher the premium, but in some cases, a more limited policy design has a higher premium cost. Other plan design and price assumption differs are likely to be a factor.

Finally, we compare two “all cash” policies with 4 “no cash” policies. The premiums and the premium differentials are both shown. Again, there are differences by carrier. The additional cost for an “all cash” vs “no cash” policy ranges from 20% at the oldest ages to 100% nearly across all ages for one company.

IMPLICATIONS FOR CLASS ACT

One of the primary concerns for CLASS is the premium cost impact of a cash benefit design and whether CLASS can be competitive with other private insurance offerings and thus attract a significant and healthy risk pool based on the premiums associated with the plan design. A cash benefit – all else equal – adds 20% to 100% to the premium cost of a “no-cash benefit” plan. Yet many of the competing plans in the private market without a cash benefit have significant benefit flexibility as shown in the summary of “ancillary” benefits included in today’s coverage.

While a cash benefit has strong consumer appeal because of its flexibility, the experience shows that, given a choice, most people prefer the more affordable non-cash or limited cash benefit plan. A concern for CLASS is whether the cash benefit will be more attractive to the population most at risk of being heavy users of benefit – those with current disabilities – and might not be price-competitive to attract a broad and healthy risk pool as well.

Unfortunately, the prevailing risk management techniques which are critical with a cash benefit design in order to maintain appropriate and cost-competitive coverage at the same time add to administrative costs. So it will be a challenge for CLASS to maintain the 3% of premium allowance for administrative costs while also having as robust and appropriate risk management infrastructure as will be needed. There are already concerns with the 3% premium allowance and the additional considerations needed to appropriately manage a cash benefit within that margin only make that more challenging.

It will be important for CLASS to anticipate the need for in-person assessments and appropriately scheduled re-assessments based on presenting condition of the claimant as part of its administrative cost structure. Establishing a strong benefit determination, review and appeal process and robust protocols for timely reassessments is the single most important challenge for CLASS in order to maintain the cost competitiveness and rate stability of the all-cash model. The infrastructure, risk management tools, training and staffing are all necessary to provide the required structure and process to support the cash benefit. There will be an additional administrative burden if the level of the cash benefit is varied with degree of disability; this will strengthen the incentives for insureds to maintain benefit eligibility and may encourage what is called “ADL-creep” where higher degrees of loss than are actually found are claimed. All this means additional risk management measures will be needed even beyond those that are already being brought to bear on LTCI in general and a cash benefit in particular; today, there are no products that pay a higher benefit level based on degree of loss alone.

Similarly, utilizing the plan of care to help guide claimants to appropriate services and providers and to help them manage care costs is also important. The language of CLASS seems to provide for an ability to monitor expenses and determine benefit payouts accordingly. One of the most promising best practices we observed would be the model where the plan of care takes in to account actual expenses and imputed expenses for unpaid/informal care and bases the approved cash allowance on those expenses.

There are few plan design strategies that CLASS can utilize to manage the costs of the all cash approach. The coverage is already defined as unlimited/lifetime. To some extent, the lower daily benefit amounts will help mitigate the costs of the cash approach. It is not clear whether there is any flexibility to include variations on “all cash” – e.g., a full benefit payout for expense reimbursement and then a portion of the balance up to the pro-rated monthly maximum paid in cash, rather than all of the balance paid in cash.

The industry has other “best practices” applicable to CLASS. Specifically, CLASS should consider some of the tools carriers use to assist in gathering needed information for benefit reassessment include structures questionnaires to physicians about the claimant’s need for supervision and support, ADL questionnaires for providers and informal caregivers, medical management tools, and the like. Telephone-based assessments can be helpful but only when there is other corroborating information like care notes or provider records.

Finally, with respect to marketing and education, if CLASS is more costly relative to the private market competition, it will need to focus specifically on the advantages of the cash benefit and how a smaller cash benefit provides more flexibility than a larger benefit amount paid on a reimbursement benefit. Helping consumers see the product advantages associated with a higher premium may help but this is still a challenge in such a highly price sensitive market. The concern, of course is that this message may work for those who have current or anticipated care needs but be less persuasive with a broader and healthier risk pool.

**Table 1: Types of Cash Benefits in Long Term Care Insurance – Individual Market and Multi-life Market
(companies are listed in order of market share in terms of in-force policies)**

Company	No Cash Component	All Cash	Cash Rider	Built-in Cash Component	Ancillary/ Remainder Cash
Genworth Financial	X				
John Hancock			X		
Bankers Life					
Transamerica	X			X	
MetLife		X			X
UNUM		X			
River Source (IDS)					
Thrivent					
Penn Treaty					
Allianz		X	X	X	
State Farm	X				
Fortis					
New York Life	X				
Northwestern LTC	X			X	
Mutual of Omaha				X	
MedAmerica		X		X	
Prudential			X	X	
Mass Mutual	X				
Ability Resources					
Physician's Mutual	X		X		
Equitable Life & Casualty	X				
Knights of Columbus					
CUNA Mutual	X				
Guarantee Trust	X				
Country Life	X				
State Life	X				
AIG Life				X	
Berkshire Life	X				
Standard Life & Accident					
Minnesota Life	X				
Assurity Life	X				

Other companies with cash benefits: LifeSecure (Ancillary); United of Omaha (Built-in). Does not include companies no longer selling in the individual market.

Table 2: Types of Cash Benefits in Long Term Care Insurance – Group and Association Market

(listed in order of market share in terms of in-force policies)

Company	No Cash Component	All Cash	Cash Rider	Built-in Cash Component	Ancillary/ Remainder Cash
UNUM		X			
Met Life	X				
John Hancock					
C.N.A.		X			
Federal LTC Insurance Program	X				
CalPERS	X				
Prudential				X	
Genworth Financial					
WEA	X				
(Aetna) – not selling		X			

Table 3. Summary of LTC Insurance Policies with Cash Benefit

Product	Policy Type	Classification	How Benefit is Implemented	Level of Cash Benefit Options	Is there a "Lifetime Limit" specific for the Cash Benefit	Limits on Receipt of Other Benefits	Limits on Use How Cash Can be Benefit
Allianz Generation Protector II	Individual	Cash Rider	Not clear if have to select % at purchase or at time of claim	Can elect 10%, 25% or 50% through monthly rider or 100% daily benefit in cash through full rider (up to \$250 per day). Assume the amount is based on the home and community benefit which is set at a pre-selected % of NH.	No	Only for 100% cash benefit	None
American General	Individual	Ancillary Cash		40% of pre-selected monthly maximum (and can switch between cash and reimbursement)	No	Yes, in lieu of HCC and Facility Care benefits	None
C.N.A.	Group						
John Hancock Custom Care II Enhanced	Individual	Rider	Automatic at time of claim	15% of HCC monthly benefit	No info	Assume can't use with NF or AL benefits	None

Product	Policy Type	Classification	How Benefit is Implemented	Level of Cash Benefit Options	Is there a "Lifetime Limit" specific for the Cash Benefit	Limits on Receipt of Other Benefits	Limits on Use How Cash Can be Benefited
LifeSecure	Individual	Ancillary	Automatic at time of claim	Up to 50% of unused portion of monthly benefit	No	No	Yes subject to plan of care specifics and documented expenses but family care allowed
MEDAmerica Simplicity	Individual	All Cash	Consumer must submit benefit request form each month	Selected by consumer at purchase	N/A (this is a cash-only policy)	No	None
MetLifePremier	Individual	Built into policy All Cash	No info	Selected by consumer at purchase	N/A (this is a cash-only policy)	No	None
MetLife LTC LifeStage Advantage	Individual	As rider (not available for \$1m total benefit)	At initial application	Full monthly benefit	No	No	None
Mutual of Omaha Mutual Care My Way	Individual	Built into policy	At time of claim (can stop and restart cash benefit)	35% of HC monthly included, but option to increase to 40% or 50% (not sure if requires rider)	No	Yes, no other benefits payable	None

Product	Policy Type	Classification	How Benefit is Implemented	Level of Cash Benefit Options	Is there a "Lifetime Limit" specific for the Cash Benefit	Limits on Receipt of Other Benefits	Limits on Use How Cash Can be Benefit
Mutual of Omaha Mutual Care 3 & 5	Individual	Built into policy	At time of claim (can stop and restart cash benefit)	35% of HC monthly	No	Yes, no other benefits payable	None
Physicians Mutual	Individual	As rider at time of purchase only	At initial application (must receive HHC at least 1 day during the month)	20% of home and community care benefit	No	Yes, does not apply to people living in NF or ALF or hospice	None
Prudential GLTC 3.5	Group			50% Cash Alternative			
Prudential LTC3 (Prudential Evolution offers a "starter" cash benefit of \$1,500 per month for a year)	Individual	Built into policy and available in two riders: one for 50% of benefit and one for 100% cash.	At time of claim and requested monthly	40% of HC Daily Benefit (see note in previous column on riders).	No	Yes, must receive HC benefit only	None
Prudential LTC3	Group	Built into policy and available as rider	No info	No info	No info	No info	No info
Transamerica Transcare	Individual	Built into policy	No info	10 times the daily benefit (30%)	No info	No info	No info

Product	Policy Type	Classification	How Benefit is Implemented	Level of Cash Benefit Options	Is there a "Lifetime Limit" specific for the Cash Benefit	Limits on Receipt of Other Benefits	Limits on Use How Cash Can be Benefit
United of Omaha – Assured Solutions & Assured Solutions Plus	Individual	Built into policy and option for larger cash benefit (50% of home care)	Option at time of claim	40% of the Basic Home Care Services ¹ Monthly Benefit Amount selected	No	Yes – in lieu of other services	None

¹ Basic Home Care Services include home health aide and homemaker services.

Table 4: Premium Impact of Cash Benefit Under Alternative Approaches*

CASH BENEFIT RIDERS – Cash Rider

Additional Premium Cost by Cash Amount and By Company

AGE	20% Cash	25% Cash	50% Cash	50% Cash	75% Cash	75% Cash	75% Cash	100% Cash	100% Cash	100% Cash
45	13%	30%	13%	41%	28%	50%	59%	39%	70%	70%
55	13%	30%	11%	41%	25%	50%	59%	36%	70%	70%
65	13%	30%	8%	50%	20%	49%	59%	33%	66%	70%
75	13%	30%	7%	50%	19%	49%	59%	30%	66%	70%

Notes: \$200/day, 5 year lifetime maximum, 5% compound inflation protection for life, 90-100 day elimination period. These riders all provide cash benefit in lieu of home care reimbursement and cash paid reduces the lifetime maximum. For 20% rider, insured must receive at least one day of paid home care in the month in order to receive the cash benefit and the cash benefit does not reduce the lifetime maximum.

CASH BENEFIT RIDERS – Ancillary/Additional Cash Model

Additional Premium Cost by Cash Amount and By Company

Age	15% Cash	25% Cash
45	10%	7%
55	10%	13%
65	10%	11%
75	8%	17%

Notes: Same coverage amounts as above however the 15% cash benefit is an “additional” amount to expense reimbursement and does not count against the lifetime maximum. For the 25% cash plan, cash benefit only paid if covered expenses also received and only if the maximum benefits paid (reimbursement plus cash) do not exceed the policy’s maximum monthly/daily benefit for home care.

Premium Comparisons under Alternative Built-in Cash

Benefit Payment Scenarios

AGE	10x DBA per month	10 x DBA per month	35% Built in	40% Built in	40% Built in	40% Built in	50% Built in
45	\$4,330	\$2,766	\$3,313	\$3,379	\$2,918	\$3,328	\$3,750
55	\$5,927	\$3,409	\$3,770	\$3,845	\$3,702	\$3,938	\$4,267
65	\$8,157	\$5,710	\$6,338	\$6,465	\$5,885	\$6,314	\$7,175
75	\$15,913	\$12,544	\$13,975	\$14,254	\$14,244	\$15,017	\$15,820

Note: Similar benefit design as above. Benefits paid reduce lifetime maximum.

Premium Comparison: All Cash vs. No Cash Component

Age	ALL CASH*	ALL CASH	NO CASH	NO CASH	NO CASH	NO CASH
45	\$4,273	\$3,888	\$3,180	\$5,688	\$2,052	\$2,160
55	\$5,745	\$5,440	\$3,840	\$6,972	\$3,024	\$3,300
65	\$8,599	\$10,152	\$5,880	\$9,696	\$4,692	\$5,640
75	\$16,031	\$19,008	\$13,380	\$16,932	\$7,800	\$10,560

Premium Comparison: All Cash vs. No Cash Component – by percentage difference in premium ALL CASH/NO CASH

Age	ALL CASH*	NO CASH	NO CASH	NO CASH	NO CASH
45	\$4,273/\$3,888	1.3/1.2	0.75/0.68	2.1/1.9	1.9/1.8
55	\$5,745/\$5,440	1.5/1.4	0.82/0.78	1.9/1.8	1.7/1.8
65	\$8,599/\$10,152	1.5/1.7	0.89/1.05	1.8/2.2	1.5/1.8
75	\$16,031/\$19,008	1.2/1.4	0.95/1.12	2.1/2.4	1.5/1.8

Note: Same as table above but percents rather than pure premiums.

*NOTE: All plans were run, when possible, with monthly benefit maximums of \$6000, 100% home care, 5 year benefit length, 5% automatic compound inflation, standard health rating, no discounts. Possible exceptions follow:

- One insurer offers a lifetime maximum of 5.5 years equivalent as closest option to the “standard plan” used.
- Another insurer offers only a daily, not a monthly maximum.
- The “ALL CASH” plan column one is for a lesser lifetime maximum - \$300,000 which equates to roughly 4.17 years; this was the closest approximation to a 5 year plan.
- The other “ALL CASH” plan is for a 5 year lifetime maximum.

A REPORT ON THE ACTUARIAL, MARKETING, AND LEGAL ANALYSES OF THE CLASS PROGRAM

For additional information, you may visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

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[HTML versions of Appendices will be added as they are formatted]

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Jb: CLASS Program Benefit Triggers and Cognitive Impairment	http://aspe.hhs.gov/daltcp/reports/2011/class/appJb.pdf
Jc: Strategic Analysis of HHS Entry into the Long-Term Care Insurance Market	http://aspe.hhs.gov/daltcp/reports/2011/class/appJc.pdf
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Nc: Presentation Entitled "The Long-Term Care Policy Simulator Model"	http://aspe.hhs.gov/daltcp/reports/2011/class/appNc.pdf
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APPENDIX O: Actuarial Report on the Development of CLASS Benefit Plans	[47 PDF pages]
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APPENDIX P: June 22, 2011 Technical Experts Meeting
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<http://aspe.hhs.gov/daltcp/reports/2011/class/appP.htm>

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Pa: Agenda and Discussion Issues and
Questions

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPa.pdf>

Pb: Presentation Entitled "Core Assumptions and
Model Outputs"

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPb.pdf>

Pc: Presentation Entitled "Actuarial Research
Corporation's Long Term Care Insurance
Model"

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPc.pdf>

Pd: Presentation Entitled "The Avalere Long-
Term Care Policy Simulator Model"

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPd.pdf>

Pe: Presentation Entitled "Alternative Approaches
to CLASS Benefit Design: The CLASS
Partnership"

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APPENDIX Q: Table 2: Actuarial and Demographic Assumptions

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APPENDIX R: Figure 1: Daily Benefit Amount for Increased Benefit

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