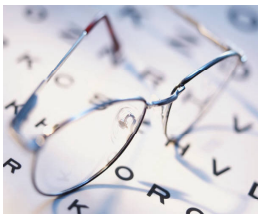

Reading the Fine Print

Focus on Long Term Care Insurance

Will it meet the needs of Canadian families and communities?

BY: Wendy Armstrong
Raisa Deber

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Reading the Fine Print is an overview of the private health insurance sector in Canada with a focus on new Long Term Care (and Critical Illness) policies being marketed in Canada and their potential for meeting the needs of Canadian families. This examination of the relative merits of long-term care insurance included a comparison of three different policies.

Consumer Proverb

"An education is what you get from reading the fine print; a learning experience is what you get when you don't."

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Summary of Key Findings

Over the past decade, a number of Canadian provinces have limited hospital inpatient care and removed or restricted coverage for health-related products and services outside hospital walls, particularly in extended care situations. In order to protect family income, assets and access to care options in this new environment, Canadians are being encouraged to purchase new private health insurance products. The following are key findings from a review of the private health insurance landscape in Canada and an in-depth analysis of one such product – long term care insurance, including a comparison of three different long term care policies. A lot can be learned from reading the fine print in private insurance policies.

- The health and life insurance industry in Canada has undergone significant restructuring since the early 1990s. New trade agreements have led to a far more integrated North American (global) industry. Accompanying de-regulation of the financial services sector has resulted in increased concentration, overlapping lines of business and new products and sales venues. Compared to other countries, there is little government intervention in the practices of the health insurance industry in Canada and limited protection for consumers. A similar gap in consumer information and analysis is attributed by some observers to the lack of government involvement in regulation of the industry. Consumers may also be put at risk due to required authorizations for widespread collection and sharing of personal information.

- Surprisingly, Canadians already rely more on private health insurance (primarily obtained through the workplace) to pay for medical expenses than do citizens in many other industrialized nations. In 2000, private health insurance policies paid for 11.4% of total health care expenditures in Canada. This compares with 1.6% in Denmark, 0.9% in Italy, 0.3 % in Japan, 6.3% in New Zealand and 3.3% (1996) in the U.K. private out-of-pocket spending is also higher in Canada than many other countries – almost 16% of total health care expenditures. (OECD 2004)

- Long-term care insurance is a complex, expensive and high-risk product. The products reviewed offer limited protection from the high and sometimes catastrophic costs associated with long term institutional or community care, and that only in limited circumstances and settings. A confusing array of options influences monthly premiums and value at time of claim. Pre-purchased limits, limitation and exclusion clauses and company interpretations often restrict care choices - including opportunities for highly desired home care and assisted living alternatives. The marketing materials reviewed are often misleading. As one example (among many others) the odds of making a claim on a policy are much lower than implied by brochures, and the proportion/scope of costs covered by common policies overestimated. Individuals with a greater risk of making a claim are usually unable to purchase policies due to strict underwriting guidelines. Retirees may be forced to let a policy lapse due to rising premiums before being disabled enough to make a claim, and many policyholders will never make a claim. The costs of recommended policies over time are beyond the reach of most Canadians.

- Critical illness insurance policies are often sold as a companion or substitute for long-term care insurance. These policies are less complex, but appear to share some common features with long term care insurance related to limitations and exclusions, misleading marketing and rising premiums over time. While originally created to cover income losses and non-direct costs associated with a major medical event, a widely promoted feature of critical illness policies is access to the services of a referral company called Best Doctors Inc. This company provides a “free” second opinion based on a medical chart review and will arrange expedited diagnostic and treatment services, a practice that may be fueling a parallel private medical market in Canada. Decisions by provinces to limit portability appear to have been instrumental in the growth of medical tourism inside and outside the country.

- Increased reliance on private long-term care (and critical illness) insurance does not appear to be a viable alternative to protect Canadian families and communities from the high costs of unpredictable care needs or effectively influence the price and quality of suppliers. In order for private health insurance premiums to be affordable enough to attract a sufficient number of purchasers in a voluntary market (i.e. enough contributors to pay out claims and return benefits to investors), companies must be

able to refuse higher-risk applicants and cap claims. Significant public subsidies appear to be required for companies to be in business. Limiting or restricting access to public alternatives for those who choose not to insure as well as the “uninsurable” may also be necessary in order to create sufficient demand. This has significant and far-reaching consequences for a society.

Context for the Study

Over the past decade there has been a significant shift in who is responsible for the payment of a range of products, services and environments required to manage an episode of illness or injury in many Canadian provinces. Due to budgetary cuts in the early 1990s and new technologies that have reduced the need for lengthy inpatient treatment, the roles of hospitals have changed. The number of hospital beds has shrunk, people are less likely to be admitted and the length of stay has shortened. For example, the number of reported hospital beds in Alberta dropped from around 13,300 in 1989 to 9,400 in 1995 and 6,300 in 1999 while the population rose from about 2.4 to 2.9 million.[1] Similarly, people with long-term care needs are less likely to be placed in institutions; auxiliary hospital and nursing home beds in Alberta have been limited and the bar for entry raised.[2] All these changes have led to longer periods of recovery and management of both minor and complex medical conditions in home and other settings where families absorb most of the direct and indirect costs of care. [3] Similar shifts in the site and costs of care are occurring in other provinces.

Changes in the site of care often translate into changes in who pays for what. This is because the *Canada Health Act* 1984 only requires full coverage of all "medically necessary" hospital and physician services.[4] Provinces can, but are not obligated to fund programs and services beyond these limits (e.g. nursing home programs, drug plans, ambulance services, home nursing, chiropractic visits) in order to receive health care funding from the federal government.[5] As a number of research studies, as well as federal and provincial reports and

[1] Hospital Care in Alberta Statistical Supplement, 1989; pages v and vi, Canada Health Act Annual Reports, Health Canada, 1994-1995: page 53, 1998-1999: page 60

[2] See The Alberta Centre for Health Services Utilization Research Report, "Trends in Uses of Health Care Services by Elderly in Alberta", 1999. The number of long term care facility beds (i.e. approved auxiliary hospitals and nursing homes) in 2004 was 14,065. This compares to about 13,650 in 1993.

[3] Dr. Roger Palmer, former Alberta Deputy Minister of Health and Wellness, interview, summer 2005

[4] An exception to full coverage of "hospital services" (defined as including "accommodation and meals") is that Section 19.2 of the *CHA* allows "user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution" without penalty to a province. Mental institutions are also excluded.

[5] Note that in 1995, the federal government clarified that it interpreted the *Canada Health Act* as requiring provincial governments to cover "facility fees" being charged to patients in private surgical clinics for otherwise insured hospital procedures (e.g. cataract surgery, abortions) because these clinics were considered to be replacement sites for insured surgical procedures performed by physicians in hospitals.

commissions have noted, the shift from hospitals can thus imply a shift from public payment to individuals and their families.

To the extent such shifts occur, a growing number of Canadian families may find themselves facing unexpected financial hardship, medical debt or the loss of assets along with new care burdens for informal family caregivers. To date, the most affected populations have been retirees and the estimated 50% of workers without employer-based benefit plans, particularly Canadians with ongoing medical needs due to longer treatment regimes or a chronic disabling or deteriorating medical condition.

One frequently proposed solution to alleviate these hardships is to place greater reliance on private health insurance, particularly new “long term care” and “critical illness” insurance policies purchased in the private sector. This report exams one such category of policies – long term care insurance, and to a lesser extent critical illness insurance.

Advocates of such policies argue that these alternatives will effectively fill the growing gaps in public coverage outside hospital walls, ensure timely access to a wide array of required and desired medical goods and services and provide good value for money. Other common assumptions are that such policies are readily obtained and affordable and can be counted on to provide reliable protection with minimal risk.

In order to test these assumptions a small research project was undertaken to explore the availability, affordability, scope, value and risks associated with long term care insurance in Canada. This was done through an environmental scan of the private health insurance landscape in Canada; a review of available literature; interviews with key informants; and, a comparative analysis of the long term care insurance policies of three different companies. Information from previous research on changing long term care environments in Alberta and B.C. and a companion project (*A Case Study of the Conversion of an Alberta Nursing Home to a Designated Assisted Living Program*) helped to inform the analysis.

Findings from this project suggest that the majority of common assumptions related to long term care insurance are erroneous. Significant deficits in the consumer information and consumer protection landscape in Canada were identified as well as widespread “market failure”. In addition, this study found that critical illness insurance (often marketed as a

companion or substitute for long term care insurance) is being promoted as a vehicle for the private purchase of expedited medical treatments.

1. Overview of Private Health Insurance in Canada

Most Canadians have little knowledge of the complexities of private health insurance as it exists today - for good reason. Individuals purchase it infrequently (compared to other goods and services) through a variety of intermediaries, the language and contract terms are confusing and most Canadians have little experience making claims for major medical expenses on private insurance policies.[6] In addition, there have been considerable changes in the nature of the private health insurance industry in Canada and the regulatory and public policy landscape in which it operates.[7]

In Canada, legislative prohibitions, regulations, public expectations and generally accepted industry practices have all limited private insurance coverage of "medically necessary" hospital and physician services as well as certain services covered by provincial extended health care programs.[8] Outside these controlled arenas, however, private insurance to cover medical related expenses has played a growing role in Canadians' lives. Examples of insurance products covering direct and indirect costs arising from illness or injury include disability (income) insurance, accident insurance, prepackaged travel or credit insurance, auto insurance, supplemental medical and dental, and relatively new critical illness and long term care insurance.[9] However, the four most important types of insurance products often classified as "health insurance" are:

a) Supplemental medical coverage
b) Disability (income) insurance

[6] For example, in Canada's historic public hospital insurance system, tax dollars have funded a network of "approved" public hospitals (owned and run by charities) with services provided free at point of service.

[7] See M. Velia and R. Faubert, "Adapting to Change, Adapting to change: The life and health insurance industry amidst a changing financial services landscape", Statistics Canada, June 2002

[8] These restrictions were recommended by the "Hall Commission" in the 1960s to protect the opportunities for price, access and quality controls inherent in a dominant publicly controlled payer system and incorporated into the legislative framework for Canadian health insurance, at both the federal and provincial levels.

[9] Supplemental plans typically cover some of the costs of products and services outside provincial plans such as drugs, semi-private/private hospital room fees, ambulance services, and practitioners such as chiropractors and physiotherapists. Public coverage for these services varies widely across provinces.

c) Critical Illness insurance, and
d) Long Term Care insurance [10]

Most Canadians' experience is with supplemental medical insurance (i.e. health and dental) and disability insurance (sick time) obtained through a place of employment. The trade association for health and life insurers in Canada, the Canadian Life and Health Insurance Association (CLHIA) estimate that about 21 million Canadians (out of 32.5 million) have some kind of coverage with a supplemental health and dental plan. Of these, less than 750,000 are covered through individually purchased plans.

With employer sponsored health benefit plans, eligibility and enrollment are usually automatic by virtue of employment and continue as long as the relationship lasts.[11] Both workers and employers usually contribute to monthly premiums. Premiums are kept down by virtue of the fact that older persons and individuals with significant disabilities (who are more likely to make claims) are unlikely to be part of the work force. Insurers' administration costs are also lower due to economies of scale. In addition, contributions by employers to supplemental health and dental plans are considered a non-taxable benefit for workers, a de facto public subsidy that further reduces the burden (and visibility) of costs.[12]

Most of these workplace plans operate on a "community" or group-rated model where all participants pay the same premiums and are eligible for the same benefits.[13] Unlike shopping for a health plan as an individual consumer in the open marketplace or being part of a small employer plan, members of large employer plans are rarely individually assessed, refused coverage or discriminated against based on age, sex or other characteristics. Nor are they usually required to pay higher premiums or excluded from coverage for claims arising from "pre-existing" conditions such as asthma, diabetes or a family history of cancer. Workers leaving employer plans (voluntarily or involuntarily) and going out to purchase policies on

[10] See textbook by Harrington et al, *Risk Management and Insurance; Second Canadian Edition*, McGraw Hill Ryerson, 2004: page 300.

[11] Some plans are "true" risk-rated insurance products provided by commercial insurance companies; other employers self-insure (i.e. pay the costs themselves) and insurance companies simply administer the plan.

[12] UBC health economist Robert Evans recently estimated these subsidies to be about 5 billion per year.

[13] This is changing with the introduction of flexible benefit plans. It should be noted that a number of provincial and federal laws also affect what is allowed within employer sponsored benefit plans.

their own are often surprised to discover that insurance companies can (and do) refuse to insure them if it appears that a company may be at risk for too many claims. Companies also share information about their risk status (gathered during the application process) with other companies, thus limiting access to other marketplace options. “Sticker shock” is also common once monthly premiums are no longer cushioned by an employer’s contributions.

Another reason for widespread lack of awareness about the discriminatory practices of health and life insurance companies may be the abundance of pre-packed credit, accident and travel health insurance policies sold by travel agents, banks or credit card companies *in conjunction with* other products (i.e. airline flights, mortgages or lines of credit).[14] Purchasers of these “networked” insurance products also do not undergo an in-depth risk assessment by the insurance company underwriting the policy at time of application, however, built-in exclusions found in the fine print of policy contracts and company interpretations often restrict opportunities to make a claim should a misfortune arise. Most people purchase such policies in a hurry from poorly informed secondary sales agents and are often unaware they may be automatically excluded from making a claim if they have not met certain eligibility criteria - e.g. a complete exam by a doctor within the last 18 months - even if they have paid all the premiums. Full-time professional insurance agents like to point out how insurance companies tend to do the “underwriting” (i.e. determining eligibility for coverage) "at time of claim" rather than "at time of purchase" with these types of policies, often leading to unhappy would-be claimants. Premiums are usually higher as well, but the ease and convenience is attractive to consumers. Banks often sell the products of a subsidiary or affiliate and the Canadian Bankers Association is lobbying for banks to be allowed more sales opportunities.

The process of insurance companies assessing individual or group risk and determining appropriate premiums based on degree of insurability is referred to “underwriting”. Actuaries are the behind-the-scenes statisticians who study and compute insurance risks and develop strategies to minimize such risks and guide the underwriting process. The reason insurance companies are allowed to discriminate against higher risk would-be purchasers is because these companies operate in a voluntary market where not everyone chooses to purchase insurance or can afford to purchase insurance. This limits the pool of dollars that can be collected over time from policyholders to pay out future claims and keep a company in

[14] Another factor may be that auto insurance is mandatory in all provinces except Newfoundland and companies cannot refuse to insure someone who has a valid driver’s license – albeit a higher premiums.

business. Restricting high-risk applicants (and capping benefits) enables companies to provide policies at an affordable price to a smaller segment of the market while still earning the profits necessary to attract companies to get into the business. In voluntary markets, the price of premiums is the primary selling feature.[15]

In some countries, private insurers operate under different rules. For example, private insurers may be required to "take all comers" and/or provide community-rated policies.[16] The existence of such rules often depends on the role private insurers play in a country's health care system - categorized in a 2004 international Organization for Economic Co-operation and Development publication as either a primary, complementary, supplementary or duplicate insurer role.[17] Premium increases also often have to be reviewed by regulators along with claims management practices.

Factors affecting monthly premiums for private health insurance include the frequency and cost of claims experienced by the company, the costs of administration and marketing and how well a company's investments (in mortgages and real estate, mutual funds, other companies and government bonds) are doing. The attraction for investor-owned companies to get into the insurance business is that premiums collected from policyholders provide a significant pool of capital to invest and return dividends to investors.

Surprisingly, Canadians rely more on private health insurance to pay medical expenses than do citizens in many other industrialized nations. In 2000, private health insurance policies paid 11.4% of the total (public and private) health care expenditures in Canada. This

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[15] For an excellent overview of these issues see Raisa Deber et al, Why not private health insurance? 1. Insurance made easy, *Canadian Medical Association Journal*, Sep 1999; 161:539 – 542, Why not private health insurance? 2. Actuarial principles meet provider dreams, *Canadian Medical Journal*, Sep 1999; 161: 545 – 547

[16] For example, duplicate private insurance in Australia (covering part of the costs of private hospital care and choice of surgeons) is not tied to the workplace and insurance companies are required to "take all comers". The near collapse of the Australian health insurance industry a few years ago due to high numbers of healthy families dropping optional coverage because of rising premiums (related to more high risk individuals in the pool) led to major government subsidies to encourage individuals to re-purchase policies.

[17] Private health insurance is considered to fill a "primary" role when it is the primary source of coverage for a population group without access to public health cover. It fills a "duplicate" role in countries where privately funded providers operate parallel to the public delivery system and optional private insurance duplicates universal public coverage. It fills a "complementary" role when it is used to cover any required cost sharing related to public coverage (i.e. co-payments) and a "supplementary" role in those situations when it finances goods and services excluded from public coverage (such as dental care in Canada). See reference below.

compares with 1.6% in Denmark, 0.9% in Italy, 0.3 % in Japan, 6.3% in New Zealand and 3.3% (1996) in the U.K.[18] Private out-of-pocket spending is also higher in Canada than many other countries – almost 16% of total expenditures. This higher private spending is often attributed to Canada's lack of a universal public drug program and the growing scope of services outside the sweep of *Canada Health Act* as care has shifted outside hospitals.

Over the past decade employer sponsored private benefit plans have absorbed the costs of a number of services and products decanted from public hospitals and public health plans (e.g. physiotherapy, eye exams, intravenous therapy, drugs, diabetic equipment and supplies, certain physician services). This has resulted in more frequent claims and increased premiums for employers and workers. Prices for products and services paid by private benefit plans are also usually more expensive than if the same service is paid by a provincial health plan at a set price.

Employers have argued that this shift is now threatening the sustainability and continued existence of such plans.[19] In order to avoid rising private health premiums and labour costs (which include the cost of benefits) a number of employers in Canada, including public employers, are turning to part-time and casual workers and limiting the number of full-time jobs with benefits or retiree benefits – echoing the experiences of workers and retirees in the United States.[20] Ironically, one of the frequently cited cost-savings of contracting out public hospital services to private clinics is the opportunity to avoid the rising costs of *public* workers' *private* health plans. (In B.C. and Alberta many employer benefit plans also pay all or part of the monthly public health insurance premiums levied on residents.)
Workplace health benefit plans in Canada are also being restructured similar to worker benefit plans in the United States. Strategies for reducing costs include deleting items, introducing caps on categories of services, reducing total yearly maximums and/or moving to "defined contribution" health plans. Similar to defined contribution pension plans, these plans enable employers to limit their liabilities and costs by providing workers with a fixed or

[18] See comprehensive details in OECD Health Project (ed.) 2004, Private Health Insurance in OECD Countries, OECD Publications, Paris, September 2004.

[19] As discussed in Employer Committee on Health Care (Ontario) and (Alberta)'s "A Presentation to Commissioner Romanow and the Commission on the Future of Health Care", personal files, undated.

[20] Note: Evidence of dropping coverage in Canada can be found in comparisons of 1996 and 2001 Worker and Employee Statistics Canada surveys. (Personal correspondence, Colleen Fuller, 2006)

reduced amount of dollars in return for more plan member control in the use of these funds. Workers may be given a "defined" amount of money to shop and purchase a plan of their own choosing (often with a high deductible) and/or a specified yearly amount in a health spending account (HSA) or medical savings account (MSA) for incidental spending. While such plans are appealing on the surface, there are many hidden risks and costs.[21]

It should also be noted that during the past fifteen years many employer sponsored disability plans (originally used for income replacement and job retraining) began directly purchasing expedited assessments and treatments from doctors and private clinics in an attempt to reduce the costs of income replacement – similar to strategies pursued by a number of provincial workers' compensation boards. Auto insurance schemes in some provinces are also paying for more health care. This drives up the premiums for these products as well. [22]

The Canadian Regulatory Environment for Private Health Insurance

In Canada, responsibilities for the market conduct of insurance companies and sales intermediaries (brokers, agents, financial advisors, banks, travel agents, etc.) rest with provincial governments. Each province has Superintendent of Insurance, however, most responsibilities are delegated to arm's length organizations, trade associations and industry-funded programs. Such responsibilities include licensing, policing, complaint handling, dispute resolution, consumer information, consumer education and a compensation fund to deal with insolvencies within the industry. The names, mandates and cultures of delegated organizations differ among provinces. In Alberta, the Alberta Insurance Council (established in 1989) licenses sellers and takes complaints about the business practices of companies, agents and brokers. The Financial Services Commission of Ontario (established in1998) fills a similar role in Ontario. Typically, professional agents and brokers are required to pass certain knowledge tests and be sponsored by a specific company in order to be licensed. Individuals selling policies secondary to another product usually do not have to be licensed as individuals. In some cases, the institution or company (i.e. bank, travel agent) for which they work may be licensed. There are a number of differences across the provinces.

[21] For a better understanding of these hidden risks and costs see Forget et al, "Medical Savings Accounts: Will They Reduce Costs?" *Canadian Medical Association Journal* 167(2): 143-147, 2002. Also see MSA and HSA information on Families USA web site at http://www.familiesusa.org/index.html.

[22] Note: Spending on health care by disability insurers (and auto insurers) is not currently captured in the private spending data reported by CIHI. (Personal communication from Geoff Ballinger, CIHI, 2005)

CompCorp (formed in1990) is an industry-run fund that provides prescribed compensation for policyholders of insolvent member companies under certain circumstances. The industry-sponsored Canadian Life and Health Insurance Ombudsmen Service (CLHIO) formed in 2002, offers a dispute resolution service for certain types of complaints. When it comes to pre-purchase information, all requests appear to be directed to the Canadian Life and Health Insurance Association's Consumer Assistance Centre, including referrals from the new Financial Consumers' Agency (FCA). The Canadian Life and Health Insurance Association (CLHIA) is a trade association for the health and life insurance industry in Canada. The FCA, created in 2001 and funded by levies on financial institutions, is responsible for industry oversight and enhancing consumer protection and education in the financial services sector. Despite all these organizations, pertinent and relevant information about the private health insurance sector in Canada is difficult to obtain. For example, access to information and statistics related to the practices, issues and performance of the industry on the CLHIA site is blocked to non-members and a formal request for access was denied.

The Canadian Council of Insurance Regulators acts as a forum for all the provincial Superintendents of Insurance. Provincial Superintendents monitor the solvency of provincially incorporated companies while the federal government monitors the solvency of federally incorporated companies. Most are federally incorporated. This monitoring is done to ensure that a company has enough capital (or re-insurance from another company) to cover all potential claims associated with sold in-force policies. The federal government also plays the lead role in determining the overall structure and activities of the financial services sector, including who can underwrite and sell insurance. De-regulation of traditional players, products and practices within the sector (e.g. banks, brokerages, insurers, trust companies, credit unions, mutual funds) has been ongoing since the late 1980s. This has led to overlaps of former distinct lines of business, increased concentration and widespread vertical and horizontal integration.[23] Many life insurance companies once owned by policyholders have also been converted to investor-owned companies, a process called "demutualization".

Voluntary guidelines appear to dominate. In general, Superintendents of Insurance seem to take the position that regulation of marketplace practices, similar to that found in the U.S. or

[23] See "Wikopedia" for definitions, http://en.wikipedia.org/wiki/Vertical_integration.

other countries, is unnecessary in Canada because "the industry manages things well, and some of the onus has to be on consumers." [24] However, this perception may be influenced by a lack of regulator visibility of complaints and concerns or contact with consumers. Two provincial regulators contacted in a search for expertise related to evaluating long term care insurance products had "never heard" of long term care insurance, despite it being in the Canadian market since around 1994. Media stories, presentations by consumer advocates to federal and provincial government committees over the past decade and a recent study on the problems encountered by Ontario cancer patients with disability insurance policies suggest there may be more below the water line.[25]

In most circumstances, consumers are left to turn to lawyers and the courts for redress and remedies, an often expensive, lengthy and cumbersome approach. Insurance policies are considered contracts in which one entity (an insurance company) assumes a risk in return for regular contributions by another entity (a policyholder) and a duty of care. Regulatory and dispute resolution bodies deal only with "process" complaints (not contract disputes) and a number of them emphasized that insurance policies are unique contractual arrangements between two parties; therefore "whatever the consumer buys is what has been sold."

Regulation, monitoring and consumer protection related to the collection and sharing of personal medical and financial information within the industry also appears limited. The Federal and Alberta Privacy Commissioner Offices, responsible for the federal Personal Information Protection and Electronic Documents Act (PIPEDA) and the Alberta Personal Information and Protection Act (PIPA) and Health Information Act (HIA), advise it is up to individual consumers to question or complain to an insurance agent or company prior to filing a formal complaint with them. However, it is difficult to determine just what kind of complaint would be investigated and to what purpose. Given the power of insurance companies to refuse someone services and the limited options and actions afforded consumers or regulators, it is difficult to determine the practical value of existing laws in this area.

Most health insurance policies fall under the class of "accident and sickness" insurance for the purpose of regulation, although whether a particular policy falls under the "accident and

[24] Telephone interview, member of the Canadian Council of Insurance Regulators, 2005

[25] For example, see Ellen Roseman, "Sisters hope to warn about long term care insurance", Toronto Star, April 17th, 2004

sickness" or "life" classification will depend on how policies are structured. Tax treatment of premiums and benefits is complex and convoluted with differing rules related to how policies are designed, who pays the premiums (workers, employers, individuals, self-employed) and how these are paid. Current tax policies support subsidies in the form of tax concessions in order to increase access and improve sales.[26]

Consumer Resources and Information in Canada

There is a noticeable absence of independent consumer-focused information, analysis and advice related to private health insurance in Canada in comparison to other countries. A number of factors appear to have contributed to this situation. These include the role that private health insurance has played in Canada in recent decades, the reduced capacity (and/or existence) of independent consumer interest voices in Canada during the1990s and a lack of government involvement in monitoring and regulating the industry. According to Dr. Norma Neilson, a risk management expert at the University of Calgary, "The industry has stepped up to the plate to avoid regulation and so keeps regulation to minimum, but it means that regulators haven't gotten into consumer education."[27]

Other factors may limit critical analysis by consumer-type organizations. Similar to the way in which pharmaceutical companies often seek out relationships with patient advocacy groups, insurance companies often cultivate relationships with seniors, retiree groups and caregiver organizations. Such relationships provide important opportunities for building good will as well as for the distribution of a company's insurance products through affinity programs in exchange for income to support an organization's advocacy goals. For example, the Canadian Association of Retired Persons (CARP) has a "recommended" CARP Long Term Care Insurance Plan underwritten by Combined Insurance Company of America as well as other insurance products offered through a preferred insurance broker.

The CLHIA Consumer Assistance Centre provides very basic product descriptions and directs consumers to individual brokers, agents and financial advisors for other advice and information. While brokers and financial advisors like to claim independence, according to

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[26] Based on telephone interviews and correspondence with CCRA and Finance Canada officials, 2005

[27]. Norma Neilson, personal interview and correspondence, summer 2005.

one former regulator who agreed to speak off-the-record, "The word broker is a little bit of misnomer because they are essentially insurance agents. Insurance brokers usually represent three or four companies and are remunerated by commission from these companies just like agents – and most financial advisors." Many factors can influence the advice of agents, brokers and financial advisors, including their level of comfort and/or familiarity with products and companies and which products carry the highest commissions. "The dilemma" he points out, "is that while there are a lot of bright, educated and honest people selling products, there are also a lot of bright, educated and dishonest people." Without an independent source of information, it is difficult for consumers, who make such purchases rarely, to tell the difference. It is also difficult to ask the right questions – or understand the answers, given the complexity of financial contracts and language.[28]

Just recently, the Canadian Council of Insurance Regulators decided that Canadian consumers do not need to know what their agent or broker makes on sales of specific insurance policies.[29] This issue of disclosure had originally arisen out of regulator and public concerns in Canada over allegations and settlements in the U.S. related to bid rigging and secret commissions paid to brokers to steer business to particular insurance companies.[30] One company involved in these allegations, Aon, became the focus of public attention in Alberta in the fall of 2005 when its Canadian consulting subsidiary won a 1.5 million dollar Alberta government contract to examine the feasibility of private insurance models replacing current public health care funding models and come up with concrete proposals in four key areas: non-emergent services, drugs, health care products and continuing care services. [31]

2. Overview of Long Term Care Insurance in Canada

Both long term care and critical illness insurance were first introduced into Canada in the early to mid 1990s in tandem with cuts to federal and provincial health spending, new trade agreements and de-regulation of the financial services sector. These trade agreements

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[28] See discussion in Industry Canada, "The Consumer Trends Report", 2005: page 126

[29] See James Daw, "Insurance regulators propose new guides", Toronto Star, Feb. 15th, 2006

[30] Both Qui Tam (whistle-blower) laws http://www.quitam.com/ and the role and structure of state Attorney-General offices in the U.S. appear to play a significant role in such activities coming to light.

removed previous ceilings on foreign investment, opening the door to American investors acquiring Canadian companies and Canadian-based companies increasing their presence in the more lucrative American and global markets.[32] This created a far more integrated North American industry and market. Both this integration and the relaxation of rules appear to have played an important role in these new products coming into the Canadian marketplace.

Nonetheless, long term care insurance had a rocky beginning in Canada. For example, a "comprehensive home health and long term facility care" policy, marketed by a Canadian subsidiary of American Family Life Insurance Assurance Company (AFLAC) based in Toronto, first appeared in Alberta around 1995. A year later, Great-West Life (part of the Power Corp group of companies) signed a deal to market these AFLAC policies across Canada. Two years later AFLAC Canada was sold to Ingle Health and Life Insurance, but Ingle was ultimately forced to give up its insurance charter due to reported undercapitalization. Great West Life no longer advertises long term care insurance.

Since 1999, the number of companies selling this type of insurance in Canada has grown significantly. Company banners have included Combined Insurance Company of America (Aon), Clarica, Manulife, Penncorp, RBC Life (another early entrant), Sun Life and UnumProvident. This has occurred against a background of shrinkage of the overall number of health and life insurance companies in Canada due to mergers and acquisitions, resulting in a handful of major players and fewer choices for brokers and consumers.[33] For example, Sun Life has now taken over Clarica and RBC has purchased the Canadian operations of Provident Life and Accident Insurance. In 2004 Manulife acquired U.S. based giant John Hancock – which had previously acquired Maritime Life. Theses changes are not always visible to the public because companies may continue to sell or service contracts under already established names. "It is such a large industry – but such a small industry" one broker commented, going on the explain the challenges he faced trying to do a good job for his clients when the culture and policy interpretations can change so much when mergers occur and there are so few alternatives.

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[31] See details in RFP Number 05-190, Health Benefit Design Options, Alberta Health and Wellness, 30/09/05.

[32] In 2004, Canadian-based life and health insurers generated 54% of their premiums from foreign clients. (See "Industry Information", CLHIA web site, http://www.clhia.ca/e4.htm.)

[33] The number of health and life insurance companies operating in Canada dropped from 163 in 1990 to 105 in 2004 with 5 companies accounting for about 59% of domestic general assets. (Finance Canada and CLHIA)

While the decreasing number of companies raises concerns about a lack of competitive pressure and related higher prices and lower service quality (particularly when companies become "too big to fail"), companies argue that such mergers provide economies of scale and help avoid insolvencies.[34]

By 2003, 34,000 Canadians owned long term care insurance policies, a 22% growth over 2002, but a lower growth rate than the previous two years. Just two companies were responsible for 80% of the new premiums in 2003 and the top three carriers accounted for 80% of all the in-force premiums. In general, long term care insurance sales in Canada have been slow while critical illness sales have soared, while the opposite is true in the U.S.[35]

The Nature and Scope of Long Term Care Insurance

Designed originally to defray some of the high costs of nursing home care (and later home health care and assisted living), long term care insurance policies have been marketed in the United States for almost two decades. Benefits are usually described as a certain amount of money or cash benefit (i.e. $20 to $300 per day) to be paid out on a daily or weekly basis depending on the amount purchased at time of sale. Payments begin after a pre-selected waiting (elimination) period of 0 – 30 – 60 - 90 or 180 days following company approval of a claim based on a professional assessment of someone's functional deficits. These payments continue for a chosen duration of 1 – 2 – 3 – 4 – 5 years or for the lifetime of the insured. The two main components of long term care policies are often described as payment towards:

- "Home Care – i.e. care is provided to you in your home, assisting you with activities of daily living (i.e. bathing, feeding, toileting, grooming, dressing), and

- Facility Care – care is provided in a certified facility in your province, by trained and licensed staff." [36]

[34] Similar arguments have been made on both sides related to bank mergers; see Robert Kerton, "Consumers Assess Mergers Among Big Banks", Consumers' Association of Canada, Dec. 31, 2003.

[35] Interview with Executive Director of LIMRA International, 2005

[36] Drawn from Harrington et al textbook: page 304.

Policies are packaged and sold in different ways and a complex array of options influence both monthly premiums and the value of a policy at time of claim. Where and how this money is spent (and claims are paid) is governed by specifics in a policy contract.

Underwriting Requirements and Information Sharing

Strict underwriting guidelines limit access to these policies for older individuals and those with pre-existing conditions, particularly functional limitations. The degree of scrutiny and assessment of one's medical and social history and capabilities at time of application typically depends on the age at which one tries to purchase such a policy. At the lower-end of the scale is completion of a short underwriting questionnaire and a telephone interview. At the higher-end, there are face-to-face interviews and extensive questionnaires. There may also be additional requirements related to medical records or medical tests.

For example, the *Manulife Underwriting Guide* has an extensive list of conditions and drugs to be reviewed by the agent or broker with an applicant. These are identified as "acceptable", "automatic decline" or "postpone". Listed automatic declines include a positive HIV status, a history of alcohol abuse, having received home care in the last two years, severe or uncontrolled anxiety, any cancer with evidence of metastasis or recurrence, history of TIA or stroke, chronic renal failure, multiple sclerosis and Parkinson's disease (diagnosed or suggested). A six-page list of medications and indications signaling uninsurability is attached to the Guide. Ditropan, Taxol, Zyprexa, Urocholine, Talwin, L-Dopa, Prednisone and Baclefen are some of the listed drugs. Applicants are to be advised by the agent that if an impairment arises within two years of the date of issue, the company will do a full review to ensure the medical history was fully disclosed, including writing to an individual's provincial health plan for a list of all doctors seen and services rendered in the past ten years. If a medical history has not been fully disclosed (deliberately or inadvertently) the company can refuse to pay benefits.

On the other hand, factors considered to play a role in maintaining independence and avoiding claims identified in the *RBC Underwriting Guide* include working full or part-time, a spouse in good health, family or friends living in the household, volunteering, participating in hobbies and activities outside the home, the ability to drive and the ability to travel without

accompaniment or assistance. These factors would work in an applicant's favor in applying for long term care insurance.

All companies require applicants to sign a relatively standard "medical authorization" form allowing access and sharing of personal, medical and financial information for range of related purposes. Failure to sign such a form leads to automatic denial by the company. The following are excerpts from one such form:

> *"I/We authorize any health care professional, as well as any health or social service establishment, any insurance company, the Medical Information Bureau, financial institution, personal information agents or security agencies, my/our employer or any former employer and any public body holding personal information concerning me/us, particularly medical information, to supply this information to XXX Life Insurance Company and its reinsurers for the risk assessment or the investigation necessary for the study of any claim...*
>
> *I/We authorize XXX Life Insurance Company, or it's Reinsurer, to exchange the personal information contained in this application with other insurers, market intermediaries, financial institutions, or persons whom I/we have indicated as references and to inquire of them for the appraisal of the risk or in the event of a claim."* [37]

Another factor affecting approval of an applicant is an insurance company's use of the services of the Medical Information Bureau (MIB). Based in Westwood, Massachusetts, the MIB is an association of over 500 U.S. and Canadian health and life insurance companies. It maintains a database of personal and medical information drawn from health and life insurance applications and claims in order to prevent application fraud or omission. The use of MIB services is also considered important to limit adverse risk selection against insurance companies by agents selling policies to inappropriate candidates related to commission incentives. Once access to one's information is authorized, information collected can be used to deny or limit coverage and claims. Information collected by a company on each applicant is sent to the MIB and past records of the Bureau are checked. Information is in the form of a

[37] From RBC Medical Authorization Form. Note: A Reinsurer is a company that accepts part of another insurer's risk in return for a share of premium income. Often these are affiliated companies.

code, which serves as a red flag for insurers to look closer. Files are kept for seven years and include existing medical conditions, height and weight, blood pressure, ECG readings, lab results that could be significant (including predictive genetic testing if in a medical chart) and non-medical information such as an adverse driving record or participation in a hazardous sport**.** There are over 230 codes with more planned.

There are many exceptions in Canadian privacy and human rights laws for insurance companies and their affiliates (which often include banks, credit-reporting companies, reinsurers, underwriting support organizations, contracted hardware and software companies and internal fraud investigation units). Stories of cross-border trafficking of personal medical and financial information by insurance companies (related to U.S. Homeland Security laws), identity theft and the issue of insurer or employer discrimination based on predictive genetic testing have all received some attention in Canada in recent years. However, there has been little public discussion of how the current development of personal electronic health records and linkages by governments in Canada will expand low-cost access to such information by insurers and their affiliates – putting insurance applicants and claimants at risk of even more networking of information. A proposed amendment to the Alberta *Health Information Act* would allow disclosure of unspecified personal health information held by public "custodians" to any third party payer for payment purposes without the knowledge or consent of the person in question. [38]

Information about the rate of refusal of long term care insurance applicants is closely guarded by companies, however, a recent North American Long Term Care Insurance Forum (LTCIF) E - poll with nine reporting insurers identified most rejection rates fell between 15% and 30%. There are also indications from the industry literature that approval requirements will become increasingly strict, thus further limiting access to policies (and claims) for many individuals. "Consumer fraud" is a big issue within the industry. Obtaining an insurance contract for a certain price without fully disclosing one's known risk status (thus leaving an insurer vulnerable to increased claims) is considered a deliberate attempt to defraud them. Industry efforts to avoid both deliberate and inadvertent consumer fraud can lead to delays in processing both applications and claims.

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[38] Circulated via E-mail to selected stakeholders in the summer of 2005.

The Promise and the Realities of Long Term Care Insurance

A 2003 *Consumer Reports* investigation in the U.S. uncovered many problems with typical long term care policies, including difficulties with claims, misleading marketing and poor value for money. Their conclusion: "For most people, long-term care insurance is too risky and too expensive." [39] Similar problems were identified here in Canada.

On web-sites, in hard copy promotional materials and in the "pitches" given by many sales agents, descriptions of eroding public benefits and the high odds of requiring a lengthy episode of nursing home care are typically followed by take-home messages that policies will cover most of these expenses in a variety of circumstances such as:

> *"If you require care because of an illness, accident or deteriorating mental abilities. . . "*

The opportunity to avoid admission to a nursing home through care in one's own home and being able to go to a facility of one's choice are featured prominently:

> *"With long term care insurance you can choose to stay at home and hire the help you may need."*

The words "choice and "independence" dominate, along with the opportunity to avoid "government" facilities - a rather strange denigration given the fact that there are almost no such facilities; the long term care sector in Canada has been heavily privatized since its inception (Extendicare, Central Park Lodge), although such facilities are admittedly regulated and heavily subsidized by governments.

The reality, however, is often quite different. In fact, the circumstances in which a paid up policyholder would qualify to make a claim are limited by both the degree of one's functional disability and the cause. The following is an abbreviated excerpt from one policy dealing with exclusions and limitations:

[39] For more details see Consumer Reports on-line, "Do you need long-term-care insurance*?"*, November, 2003

> *"Benefits are not payable for any loss that results in directly or indirectly from . . .an attempted suicide or self-inflicted injury while mentally competent or incompetent, use or intake of any drug except as prescribed by physician (does not include cigars, cigarettes or incidental use of alcohol), nervous or mental disorders without demonstrable organic cause, operating a motor vehicle while impaired . . ."*

Most policies also restrict where and how funds can be used. Each is different. For example, one standard long term care insurance contract reviewed includes:

> *"Long term care facility does not mean a hospital or institution that is operated mainly for the treatment and care of mental conditions without organic cause, tuberculosis, alcoholism, drug addiction, training, schooling or occupational therapy. Covered care must be provided by a licensed agency and be outlined in Plan of Care. Benefits are not payable if care is provided by family member."*

The major way that insurers limit their risks, however, is by capping benefits. The amount of money available once someone has qualified for benefits is limited to whatever daily cash benefits one chooses to purchase. This could be a little as $10 to $20 per day. Benefits are also limited by the maximum length of time chosen.

Few people are experts in interpreting population health statistics or the management of diseases or conditions. If they were, they might recognize that the diagnosis of a disease or condition does not necessarily mean that symptoms will be severe; many cases result in relatively mild and manageable symptoms requiring limited interventions. Accordingly, the odds of developing a diagnosed condition which are often cited in promotional literature (i.e. X persons over the age of 65 will suffer from arthritis, cancer, dementia or a stroke) as a reason for purchasing long term care insurance are far higher than the odds of making a claim on such a policy related to the same disease or condition.

While it is true that a number of older Canadians may well require an intermittent or extended period of treatment, recovery or rehabilitation outside hospital walls related to a diagnosed condition, relatively few in comparison would qualify for long term care insurance benefits. Why? Again, most people requiring such interventions will not experience the degree of

disability and dependence – or threshold - required to trigger payment of benefits in a long term care policy.

In order to qualify for benefits, a policyholder typically has to be assessed as being unable to perform 2 out of 5 to 7 company defined “activities of daily living”(ADLs) or have significant cognitive impairment affecting his or her safety and/or ability to perform certain “instrumental activities of daily living”(IADLs). ADLs include such things as such as bathing, dressing, transferring, toileting, managing continence and feeding. IADLs include the ability to do laundry, take medication, shop for necessities, do housekeeping, arrange for transportation, use the telephone, manage personal finances and do cooking or meal preparation.

Although there are many situations (e.g. recovery from a stroke, or awaiting surgery) in which one can imagine requiring assistance with such tasks due to medical-related functional deficits, the definitions and interpretations of phrases in insurance contracts such as “substantial assistance” or “an inability to perform” often enable companies to escape paying claims. For example, requiring “substantial” assistance with eating could be interpreted as requiring someone to cut up food on a plate and provide stand-by assistance in case of choking or it could be restricted to requiring spoon-feeding – all the time. Not being able to buy groceries or make meals is not considered an *inability* to eat or feed oneself. Thus, simply moving into an assisted living complex, attending a day program or requiring help with medications or bathing does not automatically (or necessarily) lead to benefits being paid. Indeed, depending on interpretations, marginal gains in self-care capabilities of claimants may even lead to the loss of benefits. (Similar problems often arise with individuals receiving disability insurance benefits depending on contract wording and interpretation.)

As outlined earlier, there are also restrictions related to the cause of one’s disabilities and the location of care, details of which can only be found in the actual insurance contract. Some policies are far more flexible than others related to the care setting for which benefits can be used and one company has no restrictions on use of daily cash benefits. However, many policies require that a facility, program, agency and/or person providing services are government licensed or accredited. This is not always the case with private-pay options in Canada. For example, some policies will only pay for care in facilities providing 24-hour skilled nursing care by RNs, but such care is disappearing in Alberta and B.C. with the substitution of Assisted and Supportive Living programs for traditional nursing home and

complex care clients. (RN availability on-site will depend on the model of staffing chosen by the operator and/or health authority.) Unfortunately, many well-intentioned insurance agents appear to be unaware of the changes in the Canadian continuing care landscape, many which may limit the value of long-term care policies even more than in the United States.

The most discouraging aspect of these policies, particularly for those hoping these policies might fill the gaps in public coverage is that the biggest selling feature - "care in one's own home" in lieu of admission to a long-term care facility - is often an illusion.[40] By the time someone is disabled enough to qualify for benefits, he or she usually requires full-time twenty-four hour around-the-clock care and oversight. This necessitates financial and human resources far in excess of what most families and social networks can sustain except for a very short period of time.

Most people purchase policies with lower daily cash benefits (or longer elimination periods) due to the high premium prices. Such policies may only provide $20 to $100 or $200 per day, but hourly fees for personal care aides (PCA) from private home health agencies in Canada currently run around $18 to $22 dollars. RN care ranges from $43 to $48 per hour and LPN care between $25 and $30. (Workers typically take home about half of these amounts and usually do not have workplace health benefits.) If someone has complex care needs, families often feel more comfortable with a more qualified care provider. A $100 daily benefit would buy about four hours of LPN care at today's prices. Who pays or provides care for the other twenty hours? Unless someone has a large family and social network at time of need (which few people do) home care options are extremely limited. At best, such policies provide a limited amount of respite for a family caregiver.

Inflation in the costs of care is an even bigger problem according to numerous U.S. consumer analysts. Ten, twenty or thirty years from today, a $100 daily cash benefit might be a drop in the bucket – barely enough to purchase an hour's worth of care, unless adequate "inflation protection" is purchased at extra cost. Few Canadians seem to be making such additional purchases. Indeed, according to LIMRA International, the average yearly premium for policies purchased in Canada in 2003 was $1,356 per year, indicating correspondingly low levels of coverage. The basic cost of a private-pay nursing home bed in one Edmonton facility (The Devonshire) is already $5750.00 per month or about $190 per day.

[40] See Consumer Reports Magazine "How to Judge a Policy", October 1997: page 44

Having a private long term care insurance policy could also restrict one's access to public benefits as provinces increasingly turn to public policies that make government a "payer of last resort" - i.e. only providing public funding for services if no private insurer (or family) is available to pick up the costs. In such situations, a low-value long term care policy may not add benefits, but instead replace benefits or limit benefits.

Remarkably, it appears as though long-term care insurance policies often provide *less choice* and *less coverage* than existing public programs in most (but not all) Canadian provinces.

How Affordable is Long Term Care Insurance?

Each company structures its policies somewhat differently, making head to head comparisons difficult. Premiums for the three policies evaluated as part of this project (Manulife, Sun Life/Clarica and RBC) start at around $100 to $130 per month for quite limited benefits. More flexible or recommended policies have monthly premiums of about $250 to $350 if purchased between the ages of 55 and 65. For a couple, this would translate into $260 to $700 per month out of their family budget. Every five years, premiums can rise unless one chooses a shorter fixed-term payment period with level and higher premiums. Only one company, RBC, offers a cap on the amount that premiums will increase, but there are trade-offs that are discussed later in this paper. Policies with more generous daily benefits or purchased later in life can run to more than $1,000 per month.

Our analysis suggests that low premium policies provide false security. High premium policies erode discretionary income and retirees' ability to maintain good health with proper diet, recreational opportunities and good management of minor health conditions. The challenge is often for someone to continue paying premiums until such as time as he or she may need to make a claim. In the U.S., dramatic premium increases over time by some companies, as well as company failures, have forced many seniors to let their policies lapse, sometimes months away from admission to a nursing home. Similar problems have been reported in Britain.[41] Most respected U.S. sources suggest purchasing flexible policies with

[41] See Guardian, "Watchdog to probe sales methods of long-term care plans FSA set to act following our exposure of 100% premium increases", May 11th, 2005.

short elimination periods (30 days) and good inflation protection; however, these policies are often beyond the financial reach of families.

Some Canadian retirees may find themselves in a situation of double jeopardy. Many provincial extended health plans and social security programs for seniors are decreasing their scope of coverage or moving to family income testing. Therefore, retirees with incomes above rather low "low-income" cut-offs may need to purchase additional private insurance to cover more common risks and expenses required in either the long or short term – i.e. prescription drugs, dental care, physiotherapy, vision care, ambulance services, assistive devices and short-term home health aide or home nursing care. One such private plan with three levels of coverage was reviewed for this project. Premiums for the lowest level range from $62.10 monthly for someone aged 65 to 69 in B.C. ($96.80 for someone 90 plus) to $68 in Alberta, $71.70 in Ontario and $70.70 in the Atlantic provinces. Deluxe plan premiums run from $118.40 per month for someone aged 65 to 69 in B.C. ($171.90 for someone 90 plus) to $207.90 in the Maritimes. The yearly amount available for short-term home health or home nursing in the basic plan is $1,000 (plus $1,000 each for prosthetic appliances and durable medical equipment). In the deluxe plan, funding for each category rises to $3,500 per year.

According to Industry Canada's 2005 *Consumer Trends Report*, the median after-tax income of elderly Canadian families was $31,103 in 2001 (almost unchanged from 1993) and the median after-tax income of unattached seniors was $16,734 for women ($1395 per month) and $18,232 ($1520 per month) for men. Increasingly, seniors are also expected to access savings and/or assets tied up in their homes to cover medical bills and related expenses through instruments such as reverse mortgages and lines of credit. But assets can quickly disappear. Gary Keillor, an Edmonton-based financial planner explained the predicament facing many retirees in the new millennium:[42]

> *"Most of my clientele are retired people. Many of them coming to me wanting give up the hassle of home ownership - repairs and shoveling snow. They want to sell their house and move into a condominium or one of the new rental accommodations for seniors. When markets were treating us wonderfully this was economically viable to do so. But these days with the volatility of the market, the most you can get for a $165,000 tax paid capital investment from*

[42] Interview with Gary Keillor conducted by author for *Eldercare on the Auction Block* report, 2002.

> *the sale of your home with a fully guaranteed investment is about 4.5% paid monthly. That's only about $619 dollars per month. After taxes they may be lucky to have $500 per month. Add to that the Old Age Security of about $500 per month, and any CPP earnings and it's still not a lot, so it leads to people going through their assets very quickly. With a longer life expectation and little earning power, assets can disappear pretty quickly. I don't recommend people sell their houses now. I encourage them to try and stay in their homes."*

The Vanier Institute of the Family suggests there may even more financial challenges facing baby-boomers and the next generation given growing debt loads. With the rising costs-of-living and increasing out-of-pocket medical costs, it is also difficult to see how most retirees would be able to maintain paying premiums. Recognizing the limited resources of many retirees, some sales agents are encouraging high income working adult children to purchase policies on a parent's behalf and pay the premiums as a way of protecting themselves from having to leave a job in order to provide care should something unpredictable occur.

What are the Odds of Needing Nursing Home Care and Making a Claim?

Promotional materials often cite high odds of requiring a long episode of nursing home or nursing home-type care, however agents themselves may be victims of bad information and interpretations. For example, in a 2003 article, the founder of the Canadian Academy of Senior Advisors is reported saying that "60% of all seniors will need long-term [residential] care or home care, but less than one percent of those 65 and older have a policy."[43] This statement appears to imply that either most seniors would require nursing home care and/or that long term care policies cover the costs of both short and long-term home care in all situations. Another example can be found in an "Advisor's Guide" designed to motivate agents and brokers to sell policies. It states: "Those who are 65 years old can expect, on average to live in an institution for one year (men) and 2.3 years (women) during the remainder of the lives."[44] This appears to imply that pretty well everyone over the age of 65 will require long term institutional care before they die – for a fairly long time.

[43] See Mark Beaudry, "Products for Seniors: Long-term care is perfect, but poorly understood", The Insurance Journal on-line, October 3rd, 2003.

[44] See Manulife Financial, *Living for Today. Caring for Tomorrow*, Advisor's Guide to LivngCare: page 5.

Not so. Canada's population may be "aging", but disability is not a given. In fact, Canadian seniors are overall healthier than ever and have less disability prior to death.[45] Many people die suddenly and not everyone living past the age of 65 will need extended institutional care before they die. If "high needs" nursing home, extended hospital or palliative care is required (i.e. the type of care situation and settings covered in typical long term care insurance policies), for the vast majority it will be in the last few months or year of life.

In the United States, a recent 2002 InterCompany study of long term care insurance claims by the U.S. Society of Actuaries found 75% of all claims (open and closed) had claims duration of one year or less. Only 1.2% lasted more than five years. This is why policies with longer elimination periods of 3 to 6 months (during which time the individual has to pay all the costs of care) have lower premiums. Insurance companies do not disclose how many policy holders die without making a claim, but many sell an optional benefit for return-of-premium-paid should the policy not be used. Reliable and accurate Canadian data on claims or use of licensed long term care facilities is difficult to find, however, available spot data from Alberta and British Columbia reveals fewer licensed long term care beds per population, rising acuity at time of admission and deceasing average lengths of stays.[46] There are currently about 14,000 licensed long-term care facility beds in Alberta used for a variety of purposes (including some short-term care) in comparison to an estimated 330,000 seniors.[47]

In contrast to the claims made by sales agents at the beginning of this section, Russell Todd, an independent Calgary-based financial planner, suggests quite different odds. "While sales of many of these policies play on the fear factor that we will all need a theoretical fortune to pay for an episode of long term care, in fact, we think only about 10% of the population may actually require such care." [48] While recognizing the need to protect such individuals and families from the high costs of care, he is reluctant to encourage people to commit future income they may need to live on in their retirement years to high premium insurance policies,

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[45] See Michael Rachlis et al in "Revitalizing Medicare: Shared Problems, Public Solutions", Tommy Douglas Research Institute, January 2001.

[46] For example, British Columbia (2002 Jeremy Tate and Andrew Butler paper entitled "What a Difference a Year Makes") and Alberta sources (unofficial data from Capital and Chinook Health Authorities) suggest the average length-of -stay has dropped more than half in recent years (down to 13 – 18 months in some cases).

[47] See May 2005 Alberta Auditor-General's report on "Seniors Care and Programs".

[48] Russell Todd, Personal telephone interview, summer 2005

given the limited benefits. Instead, he suggests both putting aside some earmarked liquid funds for more likely scenarios and making sure one's voice is heard in shaping the future of the public sector given that most people will have little choice but to rely on the public sector.

3. Sampling the Fare: The Trade Offs Among Three Policies

In order to see just how useful these long term care insurance policies would be in the current Alberta context for continuing or long term care situations, three were put to the test:

- Manulife LivingCare
- RBC Long Term Care Insurance, and
- Clarica (now Sun Life) Long Term Care Insurance

Available information was obtained, reviewed and analyzed based on completed research and interviews with informants. A summary of the features, trade offs and sample price quotes from these different policies can be found in detailed chart in Appendix A at the end of this paper. This chart demonstrates the complexities of these policies.

One of the big trade-offs among policies is that the more flexible a policy is related to the use of cash benefits, the higher the price and greater potential for future premium increases. For example, the RBC basic policy only covers "facility care", described as a licensed facility with skilled care. While the company also offers a home care rider which can be bought at time of purchase, this rider has a minimum two month elimination period, no optional inflation protection and it only reimburses actual receipts for authorized services rather than full daily benefits. Only these more limited home care benefits can be used in any "assisted living" setting which most insurers (including RBC) consider someone's "home" rather than a long term care facility even when the person is "placed" in such a setting by a public health plan authorities as a substitute for nursing home care. Instead, home care benefits (to the maximum amount purchased) can primary be used to pay for limited personal care and clinical services currently provided or contracted by public health plans (i.e. regional health authorities) in many settings. Depending on company and provincial/regional health authority policies (related to who is the payer of first or last resort) funds may be used to "top up" or add-on approved services.

However, RBC is the only policy reviewed which limits future premium increases to 50% more than the original premium. There are no limits on premium increases with the seemingly more flexible Manulife and Sun Life Policies. Given the performance of long term care insurers in other countries (U.S. and England), there is a high probability that premiums could rise substantially, forcing individuals to let their policies lapse before making a claim, particularly if a company's investments do not do well.[49]

Another important factor is the responsiveness of an insurance company related to processing and paying claims. While RBC appears to have the most restrictive policy of the three compared, the company was also the most responsive to inquiries for information and policy interpretations. Manulife was the least responsive and did not return repeated calls.

4. Critical Illness Insurance Substitutes – and Best Doctors Inc.

Critical illness policies are often sold as a substitute or companion to long-term care insurance and many companies have leapt into the market since these policies were first introduced into Canada. This type of insurance had its beginnings in South Africa with the brother of pioneer heart transplant surgeon, Dr. Christian Barnard, who identified the need for some protection from the non-medical costs associated with long periods of disability that medical advances were creating. Similar to life insurance policies, critical illness policies pay out the full face value of a policy (commonly $100,000) upon a confirmed diagnosis of one of the defined illnesses or conditions listed in the policy - subject to a specified "survival period" after the event. Survival periods are usually 30 days, but may be up to 6 months for a diagnosis of paralysis or multiple sclerosis. The money can be used for any purpose, however, if the policyholder dies before the survival period ends, no benefits are paid.

The most commonly covered diseases and conditions are cancer, heart disease and stroke and 85% of claims in Canada reportedly arise from these conditions. Lists of covered illnesses and conditions differ among companies, as do the definitions of conditions and exclusions. Most policies are ten-year renewable policies. Premiums for $100,000 policies range from about $300 to $900 per year for a 35-year-old non-smoking male or female, but

[49] Commenting on a request by one company for approval of 35-50% increases in long term care premiums in Pennsylvania (where approvals are required), an industry executive pointed out that "a 20% premium rate increase is required for every one percent drop in interest rates." (Pittsburgh Business Times, 26.09.05)

are subject to increases. A recent case profiled by *CBC Marketplace* detailed the unsuccessful battles of a small town farm couple in Saskatchewan taking on Combined Insurance over continual increases in their critical illness insurance premiums after taking the word of a salesman that premiums would not increase. Premiums began at $48 dollars a month for each of them (for a $25,000 payout) but jumped to $58 dollars, then $75, in less than three years. Despite letters, lobbies, the involvement of CBC Marketplace and a meeting with the company's Vice President, nothing changed.[50]

Similar to long term care insurance policies; applicants with pre-existing conditions and/or a family history of medical problems may have difficulties obtaining policies or policies to cover certain illnesses. In a recent case profiled in the *Edmonton Journal*, a woman in her late 30s in good health, whose father died of cancer and whose mother (still alive) was treated for breast cancer 20 years ago, was sold a $100,000 face value critical illness policy for an initial premium of $975 year. However, because of her family history, her policy excludes any claims related to cancer, the very reason she first considered buying a policy.[51]

Although the stated purpose of these policies is to protect families from the high costs of *non-medical* expenses at times of serious illness, policyholders are nonetheless encouraged to use their lump sum payment or personal savings and credit to purchase expedited medical assessments and treatment. This is done through a listed benefit provided in most critical illness (and disability) policies for the services of a broker and case management company called Best Doctors Inc. Using the enticement of a "free" second opinion based on a medical chart review, the company will facilitate access to a roster of "best" Canadian and out-of-country providers. It will also obtain quotes and arrange bookings. Services are described as Interconsultation (medical review), FindBestDoc (physician locator) and FindBest Care (care management). No information is readily available about the company's ownership, its practices and financial relationships with the doctors or treatment centres in its referral network. One agent bubbled over with enthusiasm describing this benefit:

> *"You can send them your chart and have Harvard trained doctors provide a second opinion - or, and this is what most people would do, have them take*

[50] See CBC Marketplace, "Small town farmers take on big-city insurance company", January 8th, 2006.

[51] Personal interview with policyholder J'Val Shuster, 2005

> *your file and farm it out to six different hospitals and send you the top three quotes. You will have all the information you need about having a procedure or operation, including the doctor's bio, where to stay and what it costs. We know we have limitations in Canada. This allows us to jump the queue. It's not so much about jumping the queue in Canada as forming your own queue by going to the U.S."*

Other professionals are less enthusiastic. Although a fan of critical insurance for its originally intended purpose, Thais McKee, who has been in the business for almost two decades, points out the downsides of this feature. "Prices of even the simplest procedures in the States are far higher than the average purchased $100,000 benefit and claimants often end up pulling additional money out of their RRSPs – perhaps up to $160,000 - and then are left with nothing live on."[52]

Canadians seem to agree. Even a survey by Best Doctors found that most Canadians do not want to be treated away from home.[53] Currently, these critical illness insurance dollars can also be spent a number of user-pay diagnostic and treatment clinics in Canada – usually outside a patient's home province. This is due to a loophole in the Canadian Medicare system. This loophole arose in response to aggressive cross-border marketing by a few American and Canadian clinics in the early 1990s. These marketing practices led to some provinces restricting inter-provincial and out-of-country portability by requiring residents to obtain prior approval for elective treatments outside their home province.[54].[55] By limiting coverage outside provincial boundaries, the field was left open for private clinics and treatment centres outside Canada or in neighbouring provinces (depending on provincial rules) to market private sales of otherwise publicly insured procedures to non-residents – leading to the growth of a new "medical tourism" industry.[56]

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[52] Personal interview with Thais McKee, 2005

[53] Daniela Cambone reports on this in "Critical Illness insurance; Canadians speak out: We don't want to be treated in the U.S.", The Insurance Journal on-line, February 2, 2004

[54] Some provinces such as Alberta and Ontario also reduced benefits for out-of-country non-elective treatments.

[55] For example, marketing by the Calgary-based Gimbel Eye Centre in Saskatchewan led to the Saskatchewan government withdrawing former automatic benefits for out-of-province cataract surgeries in 1996.

[56] See "Surgical Tourism and The Canada Health Act 1984", Surgical Tourism Inc., 2005.

The attraction for private clinics and doctors in Canada is the opportunities such a situation presents for sales of procedures free from Medicare restrictions on extra-billing and public oversight. Similar to the common business practice of a company requiring an employee or contracted party to sign a "condition of employment" agreement that he or she will not market the same services to the company's clients outside this relationship, some provinces have legislation or regulations that restrict physicians moonlighting outside Medicare. Others do not. More access to these critical illness insurance dollars may be a factor behind the current push by private clinic owners, particularly outspoken members of CIMCA, an organization of independent medical treatment centres in Canada, to allow private sales of Medicare-insured procedures (by opted-in Medicare physicians) to residents of their home provinces.[57]

Critical illness insurance policies are particularly attractive to workers and small business owners without sick time benefits, in that these policies provide a lump sum of money which can be used to help keep a family or small business going during a time of illness, albeit related to limited number of ailments. With two-income families now the norm in order to maintain the same purchasing power families had in 1989, there is little flex in family budgets to cope with the loss of one of these incomes through illness. Farmers, the self-employed, small business and seasonal workers are particularly vulnerable.[58]

However, incentives inherent in these plans could have some undesirable consequences. A 2005 financial writer's column noted that these policies can create incentives to maintain often futile treatment in order to keep an individual alive long enough to trigger an insurance payout. The example given was a catastrophic stroke, where keeping that person alive through the survival period of a critical illness policy would obtain a payout to help support a surviving spouse. [59]

[57] The failure of governments to enforce legislative restrictions on sales to other third party payers has also probably played a role. For example, at one time disability insurers primarily paid for income replacement, but now many pay for expedited medical assessments and treatments. While these activities were kept relatively quiet during the 1990s, the November 2005 Benefits Canada magazine openly promotes the role that private case management companies plays in obtaining "front of line care" paid by disability plans.

[58] The high number of these workers in Alberta may have influenced a recent 17-point proposal by the Calgary Chamber of Commerce (Feb. 3rd, 2006). It calls for increasing public subsidies for individuals and small companies to be able purchase higher cost expedited medical care from local suppliers outside Medicare.

[59] See James Daw, "But will you live to collect it?" July 21, 2005.

The other risk with these policies is that the Best Doctors promotional material could encourage frightened families to be rushed into spending their savings or the lump sum benefit purchasing overpriced medical procedures or unnecessary and unproven tests and treatments which do not deliver promised benefits. The need for immediate action following a diagnosis is often not as "urgent" (or wise) as people assume.[60] In such "critical" situations, patients and families can be easily misled and held hostage for high prices and quick decisions. In today's health care environment where commercial interests and objectives have gained increasing influence, the need for caution is even more imperative.

The dramatic asymmetry of information between buyers and sellers and the potential "your money or your life – or suffering" nature of such transactions are some of the reasons why a high degree of societal intervention is considered essential in the area of sales of medical products and services. These are also some of the underlying reasons why "normal market forces" (which can positively influence access, fair pricing, responsiveness and quality) simply do not exist when it comes to private medical markets. In the economics literature, this phenomenon is described as "market failure" in meeting the needs of a population.[61]

5. Market Failure in the Private Health Insurance Arena

Faced with complex decisions in a world buffeted by a dizzying pace of technological and social change, politicians (who also often suffer from asymmetry of information and pressure from the vested financial services sector) have both deliberately and inadvertently shifted significant new medical expenses to Canadian families, workers and employers. The assumption has been that these costs will be picked up and paid through readily available and affordable - and far less restrictive - private insurance dollars. However, this small study of private long term care insurance policies in Canada provides compelling evidence of widespread market failure in the private health insurance arena, similar to the phenomenon found in private medical markets – for many of the same reasons.

For example, economic evidence has repeatedly demonstrated that in order for private markets to be effective and efficient in meeting the needs of a population, purchasers need

[60] See Dr. Susan Love's "Breast Book", multiple editions. Information at http://www.susanlovemd.com/

[61] See J. Hurley, "An overview of the normative economics of the health sector", Chapter 2, Anthony J. Culver and Joseph P. Newhouse (editors) *Handbook of Economics*, Volume 1, Part 1, Pages 55-118, Elsevier, 2000

to be able to make a reasonably informed choice among a number of competitively (similarly) priced suppliers. These choices need to be based on accurate and understandable information about the risks and benefits of a purchase without undue coercion or threat. Effective remedies and redress mechanisms must exist to limit unscrupulous suppliers, prevent harm from unsafe products and avoid wasted dollars. Shared rules and values, and mechanisms to monitor and enforce these rules and values, are essential. There also needs to be enough people who want (and can afford) to purchase the product or service at a price that provides marginal benefits above the cost of production for suppliers in order to encourage new market entrants and real competition.

Yet this analysis of long term care insurance – similar to many other evaluations of private health insurance - identified a dramatic asymmetry of information, power and resources between sellers and buyers. It also identified often misleading marketing (with implied threats of misfortune for failing to purchase), high stakes, high prices and a lack of effective or timely remedies for harm done – and limited value. Many people, particularly those most likely to need protection (the product), are shut out of the market. It also appears as though this method of financing can fuel a "seller's market" for care needs in which individual consumers (patients) and families may be more subject to exploitative practices, high prices and increased risks. Such situations require far more regulation and oversight than currently exists to limit harm.

The underlying problem appears to be that in a voluntary insurance market, where many people choose not to insure, few companies are interested, *or able*, to provide coverage to higher-risk individuals at an affordable price. In fact, in order to keep policies affordable enough to generate a sufficient number of purchasers to contribute to a shared pool of money and earn enough profits for companies, significant public subsidies appear to be required. These subsidies are paid in part to those who are "uninsurable" due to circumstances beyond their control. Restricting widespread consumer access to alternatives (such as public long term care benefits) may also be necessary to drive sufficient demand.

Universally accessible tax-funded "insurance" programs avoid this free rider problem of people choosing not to insure (and then requiring services) as well as meeting the needs of the uninsurable and those with changing employment circumstances by making participation in financing care obligatory. Everyone contributes a little to a pool of money through taxes

(as they are able) over a long period of time in order to support the unfortunate few who require significant services, recognizing that others contributing to the pool share an obligation to support them should they become one of the unfortunate few.

UBC health economist Robert Evans reinforces these findings in a recent paper. In his paper, he points out that in countries outside North America where commercial health insurance plays a small but significant role, there are substantial regulatory regimes and costs associated with managing these naturally dysfunctional markets. He also points out that the reason universal public health systems dominate in industrialized countries, and the reason why Canadians first introduced universal public programs for hospital and physician care, is precisely because of the failure of private insurance regimes to effectively or efficiently meet the needs of Canadian society.[62] During the 1960s, 1970s and 1980s many provinces voluntarily expanded universal programs to include coverage of a significant portion of the costs of products and services (e.g. drugs, diabetic supplies, home care) required outside public hospital walls - for the same reasons. Now both benefits for hospital and physician services as well as these extended benefit programs are being eroded.

6. Conclusions

The findings of this brief study suggest that Canadians and public policy makers face a conundrum. Clearly, there are no simple answers when it comes to meeting important moral, social and economic imperatives related to helping families and communities weather the storms of ill health, particularly in extended care situations. Increased reliance on private long term care insurance does not appear to be an effective solution. There is no evidence these products will effectively fill the growing gaps in benefits outside hospital walls, ensure timely access to a wide array of required and desired medical goods and services or provide good value for money. Furthermore, significant segments of the population cannot access these products due to either price or pre-existing conditions.

However, continuing to shift increasing burdens and costs to only those individuals who need care, and their families, also appears to be a flawed solution. This is supported by extensive

[62] See Robert Evans, "Preserving Privilege, Promoting Profit: the Payoffs from Private Insurance" in *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada*, Edited by Colleen Flood, Lorne Sossin and Kent Roach, University of Toronto Press, 2005.

research over the past decade by Janet Fast and Norah Keating et al at the University of Alberta. Their research has demonstrated that shifting too many responsibilities for long term care situations to families has significant hidden costs for family caregivers, the children, spouses and employers of family caregivers, for society at large and even for recipients of care. [63] Some of these costs include strained family ties due to forfeited income (and forgone pensions) of family caregivers, deterioration of marital and family relationships and deterioration of the health of informal family caregivers. Employers bear additional costs when family caregivers come in late, leave early, drop back to part-time or give up work entirely. Society bears extra costs through lost tax revenues, higher poverty rates, family bankruptcies and new demands on the health system.

Shared public responsibility for the unpredictable and potentially crippling costs of a chronic condition or long episodes of treatment, rehabilitation and palliative care (including lost income) has always been the poor cousin within Canadian health care system – ameliorated only by sufficient capacity within the public institutional sector for families to fall back on. Now, this capacity has disappeared at the same time as family finances and capacity are under stress due to rising costs for basic needs (e.g. utilities, transportation) and smaller families. Instead of resolving problems, current strategies such as decreasing the comprehensives of public care supports and shifting costs to affected families appear to be creating a more costly and less responsive environment for all.

While there are serious challenges to ensuring Canadian society is able to effectively manage the costs associated with illness or injury as well as avoiding harm from poorly evaluated products and services or exploitative situations, this study suggests that sober second thought needs to be given to the merits of encouraging families (or workers and employers) to spend their dollars on expanding private health insurance alternatives.

A lot can be learned from reading the fine print in long term care insurance policies.

[63] See Janet Fast et al, "Conceptualizing and Operationalizing the Hidden Costs of Informal Eldercare", *Final Technical Report to the NHRDP Development Program*, March 17th, 1997.

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Appendix A

	RBC FINANCIAL GROUP	MANULIFE FINANCIAL	SUN LIFE FINANCIAL/CLARICA
ISSUE AGES	30-80 years old (facility care) 30-75 years old (home care)	40-80 years old	31-80 years old
BENEFITS TRIGGER	Inability to perform at least 2 of 6 company defined Activities of Daily Living or ADLs (e.g. bathing, dressing, eating, continence, toileting, transferring) or cognitive impairment, and care is "medically necessary" for treatment. *You must satisfy these requirements before benefits will be paid. Named ADLs and interpretation of terms such as "inability" vary by company. If you are unhappy with a decision, your only choice is to take a company to court.*	Inability to perform 2 or more of 6 company defined Activities of Daily Living or cognitive impairment based on clinical data and tests. A person will be considered unable to perform ADLs if he/she requires the physical assistance of another person. *The hands-on care to make up for these deficits is called "personal care" as opposed to "nursing care" and commonly provided by care aides with minimal training.*	When person needs substantial human assistance to perform at least 2 of 6 company-defined Activities of Daily living or continual supervision to protect themselves from threats to health and safety due to deteriorated mental abilities. *You will not qualify for benefits if you need less assistance than bar set by a company.*
DAILY BENEFIT	Minimum $10/day ($70 wk) Maximum $300/day ($2100 wk) *Your choice. Higher daily benefits = higher premiums*	Minimum $20 day Maximum $300 day *$20 would pay for one hour of non-professional care from a private agency at today's prices. (LPN, RN 2-3X higher)*	Minimum $150 week Maximum $2,000 week *24-hour home care is largely an illusion (except for a very short period of time) because of the expense.*
BENEFIT PERIOD	1-2-5 years or unlimited for lifetime of insured. *Your choice. Longer benefit periods = higher premiums*	750 times daily benefit (2 years) 2000 times daily benefit (5.5 years) or Unlimited for lifetime of insured	100 - 150 - 250 - 500 weeks or Unlimited for lifetime of insured. *The maximum time your policy will pay benefits.*
ELIMINATION PEROD	0 – 30 – 60 - 90 days Elimination period options differ for Facility and Home Care Shortest elimination period for Home Care Benefits is 60 days. *Your choice. Shorter periods = higher premiums*	0 - 30 - 50 or 90 days *The "elimination period" is the waiting period after your claim approval before your benefits kick in, during which time you must pay all your own expenses.*	30 - 90 or180 days *Longer elimination periods make your policy far less valuable. (See "What are the Odds")*
INFLATION PROTECTION*	Optional Cost of Living (COLA) clause is available for Facility Benefit to help maintain the value of the daily cash benefit over time. Not available for optional Home Care Benefit. *Your choice. Increases monthly premiums.*	Optional inflation protection clause increases the daily benefit amount by 2% per year for 20 years; Benefit increases by 40% after 20 years. *Inflation protection is considered essential or your policy will buy little care in 20-30 years when you need it.*	Every 3 years the company offers increased coverage without new evidence of insurability but if not taken up after two offers, no further offers are made. *Methods of calculation of inflation protection differ among policies and affect value.*

* *Italics denotes general information and comment (based on research) not specific to individual companies*

* *This chart is based on best available information from multiple sources and should be checked against standard policies. There are other features to some of these policies that are not included in this chart due to space considerations.*

Appendix A ***Comparison of Selected Features of Three Long Term Care Insurance Policies in Canada (2005)***

	RBC FINANCIAL GROUP	**MANULIFE FINANCIAL**	**SUN LIFE FINANCIAL/CLARICA**
COVERED BENEFITS Note different methods of benefit payment.	Provides full daily cash benefit only if admitted to strictly defined "Long Term Care Facility" once elimination period complete. May purchase Optional Home Care Rider that reimburses actual paid receipts up to the full daily cash benefit amount for approved "medically necessary" expenses on case-by-case basis. Home Care Benefit may include approved adult day care, respite care, in-home personal and professional care, and some equipment rental. It does not include home making (i.e. the cost of someone to do chores or make meals, run errands, etc.). Only these more restricted "home care" benefits are paid in assisted living and other supportive living settings, even when "placed" in these settings by health authorities. i.e. cannot be reimbursed for the cost of rent or meals or cleaning in assisted living settings.	Full cash benefit for each day the insured receives any approved services even if cost of service is less than the daily cash benefit. (Indemnity) Services *may* include Long Term Care Facility Care (extended care, intermediate care or personal care), Home Health Care, Adult Day Care, Hospice Care, Respite Care. Durable Medical Equipment (rental up to $5,000), Emergency Response System (install and rental) *Service providers and settings must usually be government licensed or accredited facilities and have certain skilled staffing in place. Many privately paid alternatives in Alberta do not meet such criteria.*	Provides weekly income in the amount of the purchased cash benefit with no restrictions on use of money (e.g. may be used to pay family member or other household bills) once elimination period complete. *Income policies are usually the most expensive policies. In general, the more flexible the policy related to use of funds (a desired feature), the higher the premiums. Some companies offer a "return of premium" option if no claim has been made at time of death, however, this option can increase premiums up to 50% and the method of calculation can limit the pay-out to an estate.*
LIMITATIONS and EXCLUSIONS	"Benefits are not payable for any loss that results in directly or indirectly from . . . attempted suicide or self-inflicted injury while mentally competent or incompetent, use or intake of any drug except as prescribed by physician (does not include cigars, cigarettes or incidental use of alcohol), committing criminal offence, nervous or mental disorders without demonstrable organic cause, operating a motor vehicle while impaired, etc." *Excerpt from sample policy. Benefits will not be paid in these circumstances. All policies have similar limitations and exclusions.*	"Long term care facility does not mean a hospital or institution that is operated mainly for the treatment and care of mental conditions without organic cause, tuberculosis, alcoholism, drug addiction, training, schooling or occupational therapy. Covered care must be provided by a licensed agency and be outlined in Plan of Care. Benefits are not payable if care is provided by family member." *There are often many hoops to jump through. The setting or program you want may not be eligible for coverage. Policies do not cover expenses such as medications and supplies except when included in the price of facility care.*	No restrictions on use of weekly cash benefits, but similar limitations and exclusions as in other policies related to causes of disability. *It is suggested that you never sign a policy you are counting onto protect you without first obtaining and reviewing a copy of a standard policy over a number of days or weeks, preferably with the help of a lawyer. These are very complicated policies. Make sure you understand the implications. Responsible agents and brokers should willingly provide copies to prospective clients.*
ELIGIBILITY	Underwriting questionnaire and interview required to determine eligibility to purchase policy. Depth depends on age. Must sign medical authorization form allowing access to all personal and health records – from public bodies, employers, financial institutions, physicians, etc.	Company has a list of conditions and drugs identified as acceptable, automatic decline or postpone. If impairment within 2 years of date of issue, company does full review to ensure medical history was fully disclosed including writing to provincial plan for list of all doctors seen and services rendered in the past 10 years. *If medical history not fully disclosed, the company can refuse to pay benefits citing fraud by the applicant.*	Similar underwriting process and requirement for signed release of medical and related lifestyle information. *Reported 15% to 30% applicant rejection rate among nine North American companies selling long term care insurance. (Long Term Care Insurance Forum poll) Companies may also require certain exams or tests.*

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* *This chart is based on best available information from multiple sources and should be checked against standard policies. There are other features to some of these policies that are not included in this chart due to space considerations.*

Appendix A ***Comparison of Selected Features of Three Long Term Care Insurance Policies in Canada (2005)***

	RBC FINANCIAL GROUP	**MANULIFE FINANCIAL**	**SUN LIFE FINANCIAL/CLARICA**
Sample quoted premiums (non-comparable)	If Marjorie or John, aged 65, purchased a **$100 daily cash benefit** for facility care with a maximum **benefit period of 1 year** and **0 day elimination period** plus a Home Care Rider **with up to $100 reimbursement of actual cash receipt**s and **60 day** elimination period, she/he would pay monthly premiums of $127.00 for the first 5 years. If she/he added an **inflation protection** clause for the Facility Benefit (not available for Home Care Rider) monthly premiums would rise to $144.62. If the benefit period increased to 5 years, premiums would rise to $339.27 for the first 5 years. **NOTE: RBC provides a 5-year premium guarantee from date of issue <u>with lifetime cap on increases to 50% of original premium.</u>** The trade-off is less flexibility in use of funds.	If Richard, aged 60, purchased a $**300 daily benefit** with **unlimited lifetime coverage, no inflation protection**, and a **90 elimination period**, his premiums would be $ 423.50monthly for the first 5 years. However, if he purchased lower $100 daily cash benefit, his premiums would be $137.42 monthly. If his 70 year old brother Ed purchased the same policy, he would pay $344.25 monthly for the lower $100 daily Benefit and $1033.75 for the $300 daily benefit. **Manulife can increase the premiums every 5 years for as long as the policy is in force. No cap.** *Major increases in premiums by some companies in the U.S. over the past 10-20 years have forced many people to let their policies to lapse.*	If Janet, aged 55, purchased a policy that would pay her a $1400 **weekly income benefit ($200 per day)** for a **maximum 5 year benefit period** with a **30 day elimination period** her monthly premiums would be $252.55 per month for the first 5 years - or $300.74 monthly for a 20 year fixed term quick pay option. (No inflation protection available – but may purchase additional coverage at additional expense when offered by the company.) If increased to a lifetime benefit period monthly premiums rise to $330.59. **Premiums subject to unlimited increases every five years based on review of costs by province. No cap.** *Some companies charge different premiums based on gender or smoking habits, others do not.*

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