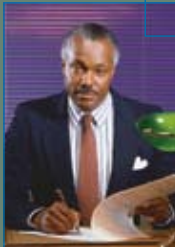




Guide to Long-Term Care Insurance

Providing health
benefits to over
200 million
Americans



John Hancock



**America's Health
Insurance Plans**

Providing health
benefits to over
200 million Americans.

America's Health Insurance Plans

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Contents

What is long-term care?	2
Are you likely to need long-term care?	2
What does long-term care cost?.....	3
Who pays the bills?	4
Where can I get long-term care coverage?	5
What are the types of long-term care policies?	5
What do policies cost?.....	6
Will my premiums increase as I get older?	8
What do long-term care insurance policies cover? ..	8
What is not covered?	9
What else should I know before I buy?	10
What about switching policies?	12
What should I look for in a policy?.....	12
Before you buy.....	13
Long-term care policy checklist.....	14
HIPAA's impact on long-term care insurance.....	16
Tax treatment.....	16
Consumer protection standards.....	17
If you need help	19

What is long-term care?

Insurance is an important tool for protecting yourself against risk. For instance, health insurance pays your doctor and hospital bills if you get sick or injured. But how can you help protect yourself against the significant financial risk posed by the potential need for long-term care services, either in a nursing home or in your own home?

Long-term care goes beyond medical care and nursing care to include all the assistance you could need if you ever have a chronic illness or disability that leaves you unable to care for yourself for an extended period of time. You can receive long-term care in a nursing home, assisted-living facility, or in your own home. Though older people use the most long-term care services, a young or middle-aged person who has been in an accident or suffered a debilitating illness might also need long-term care.

Beyond nursing homes, there is a range of services available in the community to help meet long-term care needs. Visiting nurses, home health aides, friendly visitor programs, home-delivered meals, chore services, adult daycare centers, and respite services for care-givers who need a break from daily responsibilities can supplement care given by family members.

These services are becoming more widely available. Some or all of them may be found in your community. Your local Area Agency on Aging or Office on Aging can help you locate the services you need. Call the Eldercare Locator at 800-677-1116 to identify your local office.

Are you likely to need long-term care?

You may never need long-term care. But about 19 percent of Americans aged 65 and older experience some degree of chronic physical impairment. Among those aged 85 or older, the proportion of people who are impaired and require long-term care is about 55 percent. In the year 2020, some 12 million older Americans are expected to need long-term care. Most will be cared for at home. Family members and

friends are the sole caregivers for 70 percent of elderly people. A study by the U.S. Department of Health and Human Services indicates that people age 65 face at least a 40 percent lifetime risk of entering a nursing home sometime during their lifetime. About 10 percent will stay there five years or longer.

The American population is growing older, and the group over age 85 is now the fastest-growing segment of the population. The odds of entering a nursing home, and staying for longer periods, increase with age. In fact, statistics show that at any given time, 22 percent of those age 85 and older are in a nursing home. Because women generally outlive men by several years, they face a 50 percent greater likelihood than men of entering a nursing home after age 65.

While certainly older people are more likely to need long-term care, your need for long-term care can come at any age. In fact, the U.S. Government Accountability Office estimates that 40 percent of the 13 million people receiving long-term care services are between the ages of 18 and 64.

What does long-term care cost?

Long-term care can be very expensive and the real amount you will spend depends on the level of services you need and the length of time you need care. One year in a nursing home can average more than \$50,000. In some regions, it can easily cost twice that amount.

Home care is less expensive but it still adds up. Bringing an aide into your home just three times a week (two to three hours per visit) to help with dressing, bathing, preparing meals, and similar household chores can easily cost \$1,000 a month or \$12,000 a year. Add in the cost of skilled help, such as physical therapists, and these costs can be much greater.

The average monthly fee assisted living facilities charge is around \$2,000. This includes rent and most additional fees. Some residents in the facility may pay significantly more if their care needs are higher.

Who pays the bills?

For the most part, the people who need the care pay the bills. Individuals and their families pay about one-fourth of all nursing home costs out-of-pocket. Generally, long-term care isn't covered by the health insurance you may have either on your own or through your employer.

What about the government? Generally, neither Medicare nor Medicaid cover long-term care. People over 65 and some younger people with disabilities have health coverage through the federal Medicare program. Medicare pays only about 12 percent for short-term skilled nursing home care following hospitalization. Medicare also pays for some skilled at-home care, but only for short-term unstable medical conditions and not for the ongoing assistance that many elderly, ill, or injured people need.

Medicare supplement insurance (often called Medigap or MedSupp) is private insurance that helps cover some of the gaps in Medicare coverage. While these policies help pay the deductible for hospitals and doctors, coinsurance payments, or what Medicare considers excess physician charges, they do not cover long-term care.

Medicaid – the federal program that provides health care coverage to lower-income Americans – pays almost half of all nursing home costs. Medicaid pays benefits either immediately, for people meeting federal poverty guidelines, or after nursing home residents exhaust their savings and become eligible. Turning to Medicaid once meant impoverishing the spouse who remained at home as well as the spouse confined to a nursing home. However, the law permits the at-home spouse to retain specified levels of assets and income.

It's impossible to predict what kind of care you might need in the future, or know exactly what the costs will be. But like other insurance, long-term care insurance allows people to pay a known, affordable premium for a policy to protect against the risk of much larger out-of-pocket expenses.

Since it's likely you will need long-term care, you should learn about the insurance coverage available to help that's most appropriate for you.

Where can I get long-term care coverage?

Although long-term care insurance is relatively new, more than 100 companies now offer coverage.

Long-term care insurance is generally available through groups and to individuals. Group insurance is typically offered through employers, and this type of coverage is becoming a more common benefit. By the end of 2002, more than 5,600 employers were offering a long-term care insurance plan to their employees, retirees, or both.

Individual long-term care insurance coverage is a good option if you are not employed, work for a small company that doesn't offer a plan, or are self-employed. Choosing a policy requires careful shopping because coverage and costs vary from company to company and depend on the benefit levels you choose.

What are the types of long-term care policies?

Several types of policies are available. Most are known as "indemnity" or "expense incurred" policies.

An indemnity or "per diem" policy pays up to a fixed benefit amount regardless of what you spend. With an expense-incurred policy, you choose the benefit amount when you buy the policy and you are reimbursed for actual expenses for services received up to a fixed dollar amount per day, week, or month.

Today, many companies also offer "integrated policies" or policies with "pooled benefits." This type of policy provides a total dollar amount that may be used for different types of long-term care services. There is usually a daily, weekly, or monthly dollar limit for your covered long-term care expenses.

For example, say you purchase a policy with a maximum benefit amount of \$150,000 of pooled benefits. Under this policy you would have a daily benefit of \$150 that would last for 1,000 days if you spend the maximum daily amount on care. If, however, your care costs less, you would receive benefits for more than 1,000 days.

There are no policies that guarantee to cover all expenses fully.

You usually have a choice of daily benefit amounts ranging from \$50 to more than \$300 per day for nursing home coverage. The daily benefit for at-home care may be less than the benefit for nursing home care. It's important to keep in mind that you are responsible for your actual nursing home or home care costs that exceed the daily benefit amount you purchased.

Because the per-day benefit you buy today may not be enough to cover higher costs years from now, most policies offer inflation adjustments. In many policies, for example, the initial benefit amount will increase automatically each year at a specified rate (such as 5 percent) compounded over the life of the policy.

Some life insurance policies offer long-term care benefits. With these accelerated or living benefits provisions, under certain circumstances a portion of the life insurance benefit is paid to the policyholder for long-term care services instead of to the beneficiary at the policyholder's death. Some companies make these benefits available to all policyholders; others offer them only to people buying new policies.

What do policies cost?

The cost of long-term care insurance varies widely, depending on the options you choose. For example, inflation adjustments can add between 40 and more than 100 percent to your premium. However, this option can keep benefits in line with the current cost of care.

The actual premium you will pay depends on many factors, including your age, the level of benefits, and the length of time you are willing to wait until benefits begin. A licensed long-term care insurance agent or a financial advisor can help in balancing policy features and premium cost.

AGE

In 2002, a policy offering a \$150 per day long-term care benefit for four years, with a 90-day deductible, cost a 50-year-old a national average of \$564 per year. For someone who was 65 years old, the national average cost was \$1,337, and for a 79-year-old, the national average cost was \$5,330. The same policy with an inflation protection feature cost, on average nationally, \$1,134 at age 50, \$2,346 at age 65, and \$7,572 at age 79. Please note that these are only national averages. The cost of long-term care varies significantly by state. For the cost of care and coverage in your area, check with a representative of a long-term care insurer, an insurance agent, or financial adviser.

Premiums generally remain the same each year (unless they are increased for an entire class of policyholders at once). That means that the younger you are when you first buy a policy, the lower your annual premium will be.

BENEFITS

The amount of your premium also depends on the amount of the daily benefit and how long you wish that benefit to be paid. For example, a policy that pays \$100 a day for up to five years of long-term care costs more than a policy that pays \$50 a day for three years.

ELIMINATION OR DEDUCTIBLE PERIODS

Elimination or deductible periods are the number of days you must be in residence at a nursing home or the number of home care visits you must receive before policy benefits begin. For instance, with a 20-day elimination period your policy will begin paying benefits on the twenty-first day. Most policies offer a choice of deductible ranging from zero to 180 days. The longer the elimination or deductible period, the lower the premium.

However, longer elimination periods also mean higher out-of-pocket costs. For instance, if you have a policy with a 100-day waiting period and you go to a nursing home for a year, you must pay for 100 days of care. If your stay costs \$150 a day, your total cost would be \$15,000. With a 30-day elimination period, your cost would be only \$4,500.

When you're considering a long-term care policy, you should determine not just how much you can pay for premiums, but also how long you could pay for your own care. Bear in mind that while 45 percent of nursing home stays last three months or less, more than one-third last one year or longer. The more costly longer stay may be the devastating financial blow that you may want to insure against.

Will my premiums increase as I get older?

In general, premiums will stay the same each year. If they do increase, it will be for the whole class of policyholders, not because you as an individual have aged or your health has deteriorated.

What do long-term care insurance policies cover?

Long-term care services are provided when a person cannot perform certain "activities of daily living" (ADLs), or is cognitively impaired because of senile dementia or Alzheimer's disease. Most commonly the ADLs used to determine the need for services include bathing, dressing, transferring (getting from a bed to a chair), toileting, eating, and continence.

Today's policies cover skilled, intermediate, and custodial care in state-licensed nursing homes. Long-term care policies usually also cover home care services such as skilled or nonskilled nursing care, physical therapy, homemakers, and home health aides provided by state-licensed and/or Medicare-certified home health agencies.

Many policies also cover assisted living, adult daycare and other care in the community, alternate care, and respite care for the caregiver.

"Alternate care" is nonconventional care and services developed by a licensed health care practitioner that serve as an alternative to more costly nursing home care. Benefits for alternate care may be available for special medical care and treatments, different sites of care, or medically necessary modifications to the

insured's home, like building ramps for wheelchairs or modifications to a kitchen or bathroom. A health care professional develops the alternate plan of care, the insured or insurer may initiate the plan, and the insurer approves it.

You should know that the benefit amount paid for alternate care would reduce the maximum or lifetime benefit available for later confinement in a long-term care facility. Policies may limit the expenses covered under this benefit (for instance, 60 percent of the lifetime maximum limit).

Alzheimer's disease and other organic cognitive disabilities are leading causes for nursing home admissions and worry for many older Americans. These conditions are generally covered under long-term care policies.

What is not covered?

All policies contain limits and exclusions to keep premiums reasonable and affordable. These are likely to differ from policy to policy. Before you buy, be sure you understand exactly what is and is not covered under a particular policy.

PREEXISTING CONDITIONS

Preexisting conditions are health problems you had when you became insured. Insurance companies may require that a period of time pass before the policy pays for care related to these conditions. For example, a company may exclude coverage of preexisting conditions for six months. This means that if you need long-term care within six months of the policy's issue date for that condition, you may be denied benefits. Companies do not generally exclude coverage for preexisting conditions for more than six months.

SPECIFIC EXCLUSIONS

Some mental and nervous disorders are not covered. Alcoholism and drug abuse are usually not covered, along with care needed after an intentionally self-inflicted injury.

What else should I know before I buy?

Virtually all policies now cover Alzheimer's disease and no longer require a hospital stay before paying nursing home benefits. Different options are available under different policies. These are:

ELIGIBILITY

If you are in reasonably good health and can take care of yourself and if you are between the ages of 18 and 84, you can probably buy long-term care insurance. Some companies do not sell individual policies to people under age 18 or over age 84. Age limitations apply only to your age at the time of purchase, not at the time you use the benefits.

DURATION OR DOLLAR LIMITATIONS OF BENEFITS

Long-term care policies generally limit benefits to a maximum dollar amount or a maximum number of days and may have separate benefit limits for nursing home, assisted living facility, and home health care within the same policy. For example, a policy may offer \$100 per day up to five years of nursing home coverage (many policies now offer lifetime nursing home coverage) and only up to \$80 per day up to five years of assisted living and home health care coverage.

Generally, there are two ways a company defines a policy's maximum benefit period. Under one definition, a policy may offer a one-time maximum benefit period. A policy with five years of nursing home coverage, issued by a company using this definition, would pay only for a total of five years in a policyholder's lifetime.

Other policies offer a maximum benefit period for each "period of disability." A policy with a five-year maximum benefit period would cover more than one nursing home stay lasting up to five years each if the periods of disability were separated by six months or more.

RENEWABILITY

Virtually all long-term care policies sold to individuals are guaranteed renewable; they cannot be canceled as long as you pay your premiums on time and as long as you have told the truth about your health on the application. Premiums can be increased, however, if they are increased for an entire group of policyholders.

The renewability provision, normally found on the first page of the policy, specifies under what conditions the policy can be canceled and when premiums may increase.

NONFORFEITURE BENEFITS

This benefit returns to policyholders some of their benefits if they drop their coverage. Most companies now offer this option. The most common types of nonforfeiture benefits offered today are “return of premium” or a “shortened benefit period.”

With a “return of premium” benefit, the policyholder receives cash, usually a percent of the total premiums paid to date after lapse or death. With a “shortened benefit period,” the long-term care coverage continues but the benefit period or duration amount is reduced as specified in the policy. A nonforfeiture benefit can add from 20 to 100 percent to a policy’s cost.

Some policies may offer “contingent nonforfeiture benefits upon lapse,” a feature that gives policyholders additional options in the face of a significant increase in policy premiums. If you do not purchase the optional nonforfeiture benefit, then a contingent nonforfeiture benefit is triggered if policy premiums rise by a specified percentage. For example, if, at age 70, your premium rises to 40 percent above the original premium, you have the option of either decreasing the amount your policy pays per day of care or of converting to a policy with a shorter duration of benefits.

WAIVER OF PREMIUM

This provision allows you to stop paying premiums during the time you are receiving benefits. Read the policy carefully to see if there are any restrictions on this provision, such as a requirement to be in a nursing home for any length of time (90 days is a typical requirement) or receiving home health care before premiums are waived.

DISCLOSURE

Your medical history is very important because the insurance company uses the information you provide on your application to assess your eligibility for coverage. The application must be accurate and complete. If it is not, the insurance company may be within its rights to deny coverage when you file a claim. In fact, many companies now waive the preexisting condition requirement if you fully disclose your medical history and are issued a policy.

What about switching policies?

New long-term care insurance policies may have more favorable provisions than older policies. Newer policies, for instance, generally do not require prior hospital stays or certain levels of care before benefits begin. But, if you do switch, preexisting condition exclusions for specified periods of time will have to begin again. In addition, your new premiums may be higher because they will be based on your current age.

You should never switch policies before making sure the new policy is better than the one you already have. And you should never drop an old policy before making sure the new one is in force.

What should I look for in a policy?

The National Association of Insurance Commissioners has developed standards that protect consumers. You should look for a policy that includes

- At least one year of nursing home or home health care coverage, including intermediate and custodial care. Nursing home or home health care benefits should not be limited primarily to skilled care.
- Coverage for Alzheimer's disease, if the policyholder develops it after purchasing the policy.
- An inflation protection option. The policy should offer a choice among:
 - automatically increasing the initial benefit level on an annual basis,

- or a guaranteed right to increase benefit levels periodically without providing evidence of insurability.
- An “outline of coverage” that describes in detail the policy’s benefits, limitations, and exclusions, and also allows you to compare it with others. A long-term care insurance shopper’s guide that helps you decide whether long-term care insurance is appropriate for you. Your company or agent should provide both of these.
- A guarantee that the policy cannot be canceled, nonrenewed, or otherwise terminated because you get older or suffer deterioration in physical or mental health.
- The right to return the policy for any reason within 30 days after you have purchased the policy and to receive a premium refund.
- No requirement that policyholders:
 - first be hospitalized in order to receive nursing home benefits or home health care benefits,
 - first receive skilled nursing home care before receiving intermediate or custodial nursing home care,
 - first receive nursing home care before receiving benefits for home health care.

Before you buy

Insurance policies are legal contracts. Read and compare the policies you are considering before you buy, and make sure you understand all of the provisions. Marketing or sales literature is no substitute for the actual policy. Read the policy itself before you buy.

Discuss the policies you are considering with people whose opinions you respect—perhaps your doctor, financial advisor, your children, or an informed friend or relative.

Ask for the insurance company's financial rating and for a summary of each policy's benefits or an outline of coverage. (Ratings result from analyses of a company's financial records.) Good agents and good insurance companies want you to know what you are buying.

And bear in mind: Even after you buy a policy, if you find that it does not meet your needs you generally have 30 days to return the policy and get your money back. This is called the "free look" period.

Don't give in to high-pressure sales tactics. Don't be afraid to ask your insurance agent to explain anything that is unclear. If you are not satisfied with an agent's answers, ask for someone to contact in the company itself. Call your state insurance department if you are not satisfied with the answers you get from the agent or from company representatives.

Long-term care policy checklist

Before you begin shopping, you should find out how much nursing home or home health care costs in your area today. If you needed care right away could you find it locally or would you have to go to another, potentially more expensive area? Once you've done some research, you can use the following checklist to help you compare policies you may be considering.

1. What services are covered?
 - Nursing home care
 - Home health care
 - Assisted living facility
 - Adult daycare
 - Alternate care
 - Respite care
 - Other
2. How much does the policy pay per day for nursing home care? For home health care? For an assisted living facility? For adult daycare? For alternate care? For respite care? Other?
3. How long will benefits last in a nursing home? At home? In an assisted living facility? Other?
4. Does the policy have a maximum lifetime benefit? If so, what is it for nursing home care? For home health care? For an assisted living facility? Other?

5. Does the policy have a maximum length of coverage for each period of confinement? If so, what is it for nursing home care? For home health care? For an assisted living facility?
6. How long must I wait before preexisting conditions are covered?
7. How many days must I wait before benefits begin for nursing home care? For home health care? For an assisted living facility? Other?
8. Are Alzheimer's disease and other organic mental and nervous disorders covered?
9. Does this policy require: An assessment of activities of daily living? An assessment of cognitive impairment? Physician certification of need? A prior hospital stay for nursing home care? Home health care? A prior nursing home stay for home health care coverage? Other?
10. Is the policy guaranteed renewable?
11. What is the age range for enrollment?
12. Is there a waiver-of-premium provision for nursing home care? For home health care?
13. How long must I be confined before premiums are waived?
14. Does the policy have a nonforfeiture benefit?
15. Does the policy offer an inflation adjustment feature? If so, what is the rate of increase? How often is it applied? For how long? Is there an additional cost?
16. What does the policy cost?
 - Per year?
 - With inflation feature
 - Without inflation feature
 - With nonforfeiture feature
 - Without nonforfeiture feature
 - Per month?
 - With inflation feature
 - Without inflation feature
 - With nonforfeiture feature
 - Without nonforfeiture feature
17. Is there a 30-day free look?

HIPAA's impact on long-term care insurance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affects how premiums and benefits are taxed and offers consumer protection standards for long-term care insurance. The following are answers to commonly asked questions about HIPAA.

Tax treatment

Q. What is tax clarification for private long-term care insurance and why is it necessary?

A. The clarifications assure that, like major medical coverage, benefits from qualified long-term care insurance plans generally are not taxed. Without HIPAA clarifications, these benefits might be considered taxable income.

Q. Will consumers be able to take a tax deduction for the premiums they pay on a tax-qualified long-term care insurance policy? Can consumers deduct from their taxes costs associated with receiving long-term care?

A. The answer to both questions is “yes.” HIPAA says that qualified long-term care insurance will now receive the same tax treatment as accident and health insurance. That means that premiums for long-term care insurance, as well as consumers’ out-of-pocket expenses for long-term care, can be applied toward meeting the federal tax codes’ 7.5 percent floor for medical expense deductions. However, there are limits, based on a policyholder’s age, for the total amount of long-term care premiums that can be applied toward the 7.5 percent minimum. (Check with your financial planner or tax adviser to see if you are eligible to take this deduction.)

Q. Will employers be able to deduct anything for the cost of providing or paying for qualified long-term care insurance for their employees?

A. Generally, employers will be able to deduct, as a business expense, both the cost of setting up a long-term care insurance plan for their employees

and the contributions that they may make toward paying for the cost of premiums.

Q. Will employer contributions be excluded from the taxable income of employees?

A. Yes.

Q. Can Individual Retirement Accounts (IRAs) and 401k funds be used to purchase private long-term care insurance?

A. No. However, under a demonstration project, tax-free funds deposited in Medical Savings Accounts can be used to pay long-term care insurance premiums.

Consumer protection standards

Q: What is the connection between consumer protection standards and tax treatment of long-term care plans?

A. To qualify for favorable tax treatment, a long-term care policy sold after 1996 must contain the consumer protection standards spelled out in HIPAA. Also, insurance companies must follow certain administrative and marketing practices or face significant fines. Generally speaking, policies sold prior to January 1, 1997, automatically will be eligible for favorable tax treatment. Lastly, nothing in the new law prevents states from imposing more stringent consumer protection standards.

Q: What kinds of consumer protections must insurance companies employ to meet HIPAA standards?

A: There are several. Consumers must receive a “Shopper’s Guide” and a description of the policy’s benefits and limitations (i.e., Outline of Coverage) early in the sales process. The Outline of Coverage allows consumers to compare policies from different companies. Companies must report annually the number of claims denied and information on policy replacements and terminations. Sales practices such as “twisting”—knowingly making misleading or incomplete comparisons of policies—are prohibited, as are high-pressure sales tactics.

Q. Do the HIPAA standards address limits on benefits and exclusions from coverage?

A: Yes. According to HIPAA, no policy can be sold as a long-term care insurance policy if it limits or excludes coverage by type of treatment, medical condition, or accident. However, there are several exceptions to this rule. For example, policies may limit or exclude coverage for preexisting conditions or diseases, mental or nervous disorders (but not Alzheimer's), or alcoholism or drug addiction. A policy cannot, however, exclude coverage for preexisting conditions for more than six months after the effective date of coverage.

Q: What will prevent a company from canceling my policy when I need it?

A: The law prohibits a company from not renewing a policy except for nonpayment of premiums. Policies cannot be canceled because of age or deterioration of mental or physical health. In fact, if a policyholder is late paying a premium, the policy can be reinstated up to five months later if the reason for nonpayment is shown to be cognitive impairment.

Q. Will these standards help people who, for whatever reason, lose their group coverage?

A: They will. People covered by a group policy will be allowed to continue their coverage when they leave their employer, so long as they pay their premiums in a timely fashion. Further, an individual who has been covered under a group plan for at least six months may convert to an individual policy if and when the group plan is discontinued. The individual may do so without providing evidence of insurability.

If you need help

Every state has a Department of Insurance that regulates insurers and assists consumers. If you need more information or if you want to register a complaint, check the government listings in your local phone book for your State's Department of Insurance.

Additional information about long-term care is available from the Area Agency on Aging. For your local office, call 1-800-677-1116. Other sources include:

American Health Care Association

1201 L Street, NW
Washington, D.C. 20005
(202) 842-4444
www.ahca.org

National Association of Insurance Commissioners

2301 McGee Street, Suite 800
Kansas City, MO 64108
(816) 842-3600
www.naic.org

National Council on the Aging

300 D Street, SW, Suite 801
Washington, DC 20024
(202) 479-1200
www.ncoa.org

University of Minnesota Extension Service

www.financinglongtermcare.umn.edu

For more information

- You can find AHIP online at www.ahip.org. This site offers additional consumer information about long-term care insurance and other insurance coverage.
- To find a long-term care insurance agent or financial adviser near you who has earned the Long-Term Care Professional (LTCP) designation, call AHIP's Insurance Education Program at 202-778-8471.

Although frequently revised, this booklet contains information that is subject to changing federal and state law. AHIP provides this booklet for guidance only; it is not a substitute for the advice of licensed insurance professionals and legal counsel.

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America's Health Insurance Plans, Washington, D.C.

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About AHIP

America's Health Insurance Plans is a national association representing nearly 1,300 members providing health benefits to more than 200 million Americans. AHIP and its predecessor organizations have advocated on behalf of health insurance plans for more than six decades.

As the voice of America's health insurers, our goal is to advance a vibrant, private-public health care system, one characterized by consumer choice, product flexibility and innovation. We support empowering consumers with the information they need to make health care decisions, promoting health care quality in partnership with health care providers, and expanding access to affordable health care coverage to all Americans.

AHIP's mission is to effectively advocate for a workable legislative and regulatory environment at the federal and state levels, one in which our members can advance their vision of a health care system that meets the needs of consumers, employers and public purchasers.

www.ahip.org