



FSA Consultation on The Regulation of Long-term Care Insurance, CP 200

Response by CCC

January 2004

Introduction

CCC was established in 1992 as the Continuing Care Conference and our members work together for better care for older people. CCC is a coalition of the many stakeholders concerned with the provision and funding of care in old age and can therefore objectively act and speak on the benefit of the consumer and patient. Our membership includes care providers and commissioners, financial services providers, trade and professional bodies, and providers of information, advisory and advocacy services.

One of our long-standing core objectives has been to secure the regulation of long-term care financial products. Accordingly, CCC welcomes the FSA's consultation process and is pleased to have the opportunity to respond. We fully endorse the spirit of the CP in terms of placing the welfare, independence and choices of the consumer at the heart of LTCI provision. We would call for all providers and funders of care, public, private and not-for-profit, similarly to endorse these fundamental principles, and to go on to adopt them as the basis for future policy and practice.

Rather than respond in a 'corporate' sense CCC has instead encouraged its members to respond to the FSA's consultation paper on their own account. CCC's members also had the opportunity to attend a briefing session conducted by FSA, ABI and CCC specialists which was held on 8 December 2003. We are very grateful to the FSA for the role they played in setting up and conducting the consultation event.

This response therefore draws on points made by speakers and participants at that seminar, but, rather than repeat the full range of their views here, CCC's response concentrates on some of those issues arising from the wider context of care provision – namely, those issues which have a bearing on the external risks associated with the purchase of long-term care insurance products and their consequent regulation.

Answers to Specific Questions

Question 1: Do you agree with our analysis of consumer risks arising from different LTCI products? Are there any that we have overlooked?

The consultation paper has quite properly identified various elements of political risk associated with LTCI. We do not disagree with the analysis but draw particular attention to risks relating to eligibility for State-funded care and the assessment of care needs.

Eligibility for Care / Assessment Issues

Consumers buying immediate care plans need to be aware that their policies may no longer be necessary even with no change in State provision. Some examples are given below.

If a policy is paying for long-term care and the health of the patient deteriorates to the extent that he or she would qualify for fully-funded NHS continuing care, then the payments from that policy would no longer be required to fund care. Instead, payments could be paid back to the individual rather than to the care provider. It should be noted that there are tax implications because current Inland Revenue rules only allow payments to be tax free if they are paid direct to the care provider.

This example highlights the need to recognise that many conditions initially assessed as requiring long-term care are progressive medical conditions and that the system of assessment needs to incorporate re-assessment as well as the initial assessment.

Another current 'risk factor' concerns the consistency of assessment and eligibility for care. The report of the NHS Ombudsman in February 2003, *NHS Funding for Long Term Care*, contained the results of four investigations into complaints into the way health authorities set and applied their eligibility for NHS funding for the continuing care of older and disabled people. The complaints were upheld. Consequently, all Strategic Health Authorities have reviewed their eligibility criteria. According to a Parliamentary answer dated 19 January 2004, Directions that will introduce a legal framework for assessment for NHS fully-funded continuing care are still 'forthcoming'.

An illustration of the resulting uncertainty is the rise in the number of complaints that the Ombudsman has subsequently received – in 2002-03, Health Service Ombudsman's office received 3,994 complaints, compared with 2,660 the year before. According to the Ombudsman, the rise was 'almost entirely' due to the number of complaints about NHS continuing care funding.

CCC members have noted the similarity between one of the cases contained in the Health Service Ombudsman's report and the condition of people being assessed for the top band of free nursing care. It should be noted that, in this context and in the context of free nursing care, various CCC members have also noted the lack of consistency in the level of free nursing care (RNCC) payments from region to region or even between adjoining Primary Care Trusts (PCTs).

CCC has been a long-standing advocate of transparency and consistency of care assessment and standardisation of assessment tools which can be used across all sectors and care settings. We also recognise their importance in relation to immediate care needs planning and, where appropriate, financial provision.

It is widely recognised that, in order to give adequate financial advice, an adviser on LTCI must have an understanding of the complexities of care legislation and the interface with welfare benefits. The examples above point to the risk that mistakes in advice may arise not from the incompetence or misunderstanding of a financial adviser but as a result of the NHS or local authorities failing to fulfil their legal duties.

Vulnerability of Consumers

We agree that pre-funded and immediate needs policies are completely different, have different characteristics and that the intended client groups (and their actual or perceived vulnerability) are separate and distinct. The point was made repeatedly at the consultation seminar on 8 December. That said, we should draw to your attention the view of the Nursing Home Fees Agency (NHFA), which states, "...in 99.9% of cases of Immediate Need purchases the purchaser is acting as attorney for the beneficiary and is not likely to be vulnerable through age". Other CCC members have commented that in the overwhelming majority of such cases the individual is acting through his or her attorney.

In many cases the policy applicant him or herself will be beyond 'vulnerability', being severely debilitated or disabled. Accordingly they will usually have insufficient capacity to conduct their own

affairs and so it will be a close family member, spouse, child or sibling, who will be arranging care fee funding on their behalf. It is not unreasonable therefore to propose that any financial advice process for this frail elderly client group should have an element dedicated to the familial situation and outcomes. For instance, there is a need to ensure that the family is not left to pay top up bills later on down the line.

Question 8:

(i) Do you agree with our proposals to bring LTCI intermediaries into the scope of the FSCS?

Yes.

and

(ii) do you agree with our proposal to treat compensation claims relating to the mediation of LTCI products as 'investment' claims, which means that the maximum claim will be £48,000?

On grounds of consistency, yes. However, immediate needs policies can cost far in excess of £48,00, therefore claims in respect of these policies should not be capped at that level.

LTCI policies pay out a periodic benefit, not a lump sum, which is paid out under a life or critical illness policy. If, as a result, there is any uncertainty about the interpretation of the cap on claims, clarification would be welcome.

Question 10 i) – iv):

CCC would make some 'headline' observations, based on the fact that the advice processes for selling pre-funded products and immediate needs products are very different.

The level and extent of knowledge of the state benefits system and relevant legal matters required for pre-funded products is much less demanding than that required for immediate needs products. Several significant variables, such as the requirement for care and the configuration and level of State care provision, are by definition unknown at the time of purchase of pre-funded products.

On these grounds, we believe that only those advisers who wish to advise on immediate needs products should pass examinations and maintain CPD to demonstrate that they are keeping up-to-date with changing legislation. The syllabus is appropriate for those advising on immediate needs products but it is too detailed for those advising on pre-funded products.

On grandfathering, CCC has mixed views, which reflect the dilemma already acknowledged by the FSA: the need for consumer protection and the need not to close off the supply of advisers. We support 'grandfathering'; however, it should not be an automatic waiver. Perhaps, as suggested by one of our members, firms of financial advisers should demonstrate a degree of competency through application to the FSA, which would admit or exclude the firm at its discretion.

Question 12: Do you agree with our decision not to standardise ADLs?

Yes. CCC believes that to do so could inhibit the development of innovative products.

Concluding Remarks

CCC hopes that its focused response to the FSA's consultation will be helpful and, building on the close co-operation that already exists with the FSA, CCC stands ready to assist in the policy development processes that will now follow. CCC is a powerful conduit for the free flow of information between policy makers, opinion-formers and care and funding providers and is thus well

placed to assist the FSA in the dissemination of whatever outcomes emerge from the consultation process. If the FSA has any points on which it would like to gauge the reaction of CCC's broad-based membership, we would be happy to act as a sounding board.

We look forward to the publication of the final rules in April 2004.

**CCC,
January 2004**