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LONG-TERM CARE INSURANCE: Risks to Consumers Should Be Reduced

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Subcommittee on Health
Committee on Ways and Means
House of Representatives

SUMMARY

By June 1990, approximately 1.6 million Americans had purchased long-term care insurance as protection from the devastating costs of nursing home care. This type of insurance is relatively new, and the market is expected to grow. While the policies have improved significantly, consumers still face considerable risks.

Beginning in 1986, the National Association of Insurance Commissioners (NAIC) established standards that have evolved rapidly. Today, the standards provide increased consumer protection while offering insurance companies some flexibility in a competitive, emerging market. However, many states still do not meet NAIC standards developed between 1986 and 1988. For example, 24 states still have not developed standards requiring insurers to guarantee policy renewal, and 18 states have not adopted standards disallowing Alzheimer's disease exclusions. Insurers have adopted NAIC standards more quickly than states have, but most policies we reviewed still do not meet all NAIC standards.

Although NAIC standards provide the foundation for consumer protection, problems remain. Consumers confront a bewildering array of policies made more confusing by the absence of uniform terms and definitions. For example, most policies contain definitions that potentially limit access to benefits. Of the 44 policies we reviewed, 23 contain restrictive definitions for levels of care, and 37 contain restrictive definitions of facilities. Such definitions can have the effect of eliminating coverage for services typically offered to nursing home residents or reducing the number of nursing homes available to policyholders who would otherwise qualify for benefits.

Consumers also risk unpredictable premium increases that make it difficult for them to retain their policies. Yet, if they allow their policies to lapse, they will lose the money they invested in premiums. On average, insurers we reviewed expect that 60 percent or more of their original policyholders will allow their policies to lapse within 10 years; one insurer expects an 89 percent lapse rate. Policyholders who allow their policies to lapse lose their entire investment in premiums. NAIC standards do not address this issue.

We believe NAIC should consider expanding and strengthening its standards to obtain more uniformity among policies, improve methods for determining eligibility, and provide greater protection against loss of a policyholder's coverage and financial investment. States have made substantial progress in recent years in adopting long-term care insurance standards. However, many states still do not meet NAIC's minimum standards and it is uncertain when they will. As a result, the Congress may want to consider legislation, as was done with the Medigap insurance market, to establish minimum standards for long-term care insurance.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the preliminary results of our review of long-term care insurance policies and the standards that govern them. Hearings before your Subcommittee in 1989 identified significant problems involving the adequacy of both the policies and standards for them. Although expensive, many policies were found to be restrictive. States were slow to adopt model regulatory standards, and the model standards offered little consumer protection in key areas such as inflation protection. In light of these problems, you asked us for a status report on the policies and the current standards. You also asked us to report on whether there is a need for minimum federal standards.

BACKGROUND

Long-term care refers to a range of medical and support services provided to people who have lost their capacity to function independently because of a chronic illness or condition. Recent estimates predict that 43 percent of Americans who turned 65-years-old last year will enter a nursing home at some point in their lives, and 24 percent will stay 1 year or more.[1] For most people, long-term care presents an unbearable financial strain. For example, nursing home care can cost $30,000 or more a year. In response to consumers' desire to be protected from these

costs, the private long-term care insurance market has expanded greatly. Before 1986, few companies offered long-term care insurance. By June 1990, 1.6 million policies had been sold by 130 or more companies.[2]

Private long-term care insurance policies typically offer indemnity benefits for nursing care.[3] That is, these policies pay a set amount each day for a specific period of time a policyholder receives care. A policy may or may not cover all types of long-term care, and different policies may define covered long-term care services or facilities differently. In addition, many policies also cover home care services.[4]

Traditionally, states have had the primary responsibility for regulating the insurance industry. State insurance regulatory agencies are linked through the National Association of Insurance Commissioners (NAIC), which comprises the heads of the state agencies. As with other types of insurance, NAIC establishes standards for regulating long-term care insurance, but these standards are not mandatory. State regulatory agencies have the ultimate responsibility for setting the state standards.

The market for long-term care insurance resembles the market for Medicare supplemental or "Medigap" insurance in the 1970s. Early Medigap policies varied greatly in value and coverage. State regulation was inconsistent, with sales and marketing abuses a

recurring problem. Similar problems were identified with long-term care insurance in hearings before this Subcommittee in 1989. In light of these problems, the Subcommittee asked that we assess (1) the extent to which state standards and long-term care insurance policies meet NAIC standards; (2) the adequacy with which the standards and policies address consumer protection issues such as the definition of benefits, determination of eligibility, and inflation protection; and (3) whether there is a need for minimum federal standards.

SCOPE AND METHODOLOGY

We compared each state's long-term care laws and regulations with NAIC standards to identify the strengths and weaknesses of state regulatory standards. The NAIC provided us with the states' current laws and regulations.[5] To determine whether insurance policies meet NAIC standards, we reviewed 44 policies for sale by 27 insurers in eight states (Alabama, Arizona, California, Florida, Missouri, New Jersey, Pennsylvania, and Washington). To obtain policies for review, we randomly selected insurers in each state from the universe of insurers with policies approved for sale. Then, we assessed whether the policies these insurers were currently selling meet key NAIC and state standards.

We also consulted officials of insurance organizations such as the NAIC, as well as major consumer groups and private and

government actuaries. We considered their views in our assessment of the adequacy of standards in addressing consumer protection issues.

STATE STANDARDS AND INSURANCE POLICY PROVISIONS OFTEN DO NOT MEET NAIC STANDARDS

Over the past 5 years NAIC standards have improved significantly. The standards are not mandatory, however, and the states have continued to lag behind in adopting them. Insurers have been more responsive to NAIC standards than the states, but policies still do not meet several key standards.

NAIC Standards Strengthened

Since 1986, NAIC has amended its standards annually. Early standards aimed at eliminating many restrictive policy provisions, such as excluding coverage for people with Alzheimer's disease or denying policyholders the right to renew their policies.[6] NAIC amendments sought to clarify policies by establishing standards requiring an outline of coverage that describes policy benefits, exclusions, and renewal provisions.

More recent amendments recommend that states prohibit insurers from requiring that policyholders be hospitalized before they can enter nursing homes; these amendments also protect policyholders

against post-claims underwriting. This practice involves denying claims based on technical details, such as omission of information not explicitly requested or provided on the policy application form. NAIC has also sought to improve policies by strengthening inflation protection standards and establishing minimum standards for home health care benefits.

States Lag in Adopting NAIC Standards

Although states have progressed since we last reported on the issue, most states still lag in adopting key NAIC standards.[7] The differences between NAIC and state standards may result, in part, from the time required to develop new legislation or regulations. However, many states still do not meet NAIC standards developed between 1986 and 1988. For example, 24 states still have not developed standards requiring insurers to guarantee policy renewal. In addition, 19 states have not developed standards, or met those developed, prohibiting the prior hospitalization requirement. And 18 states have not adopted standards prohibiting exclusions for Alzheimer's disease. Even fewer states meet the standards NAIC established after 1988. For example, 40 states have not adopted NAIC standards for home health care benefits, inflation protection, or disclosure requirements for post-claims underwriting.

Policies Improved but Do Not Meet Recent NAIC Standards

Insurers have adopted NAIC standards more quickly than states. For example, most of the 44 policies we reviewed meet the key NAIC standards developed in 1988 or earlier. The policies often do not meet more recent NAIC standards, however, especially the disclosure standards.

Disclosure standards help protect consumers from unfair or deceptive marketing practices. For instance, to determine whether insurance agents are selling unnecessary insurance or unfairly targeting individuals, NAIC standards require specific information on policy applications. But none of the applications we reviewed meet all NAIC standards. For example, 20 do not ask whether the applicants are already covered by Medicaid, and 42 do not ask whether the applicants had other long-term care insurance in the past 12 months and who sold it to them.

Insurers should adopt these standards because the standards include important information insurers need to determine whether an applicant should purchase long-term care insurance. Some insurers have had problems with aggressive sales agents selling policies to consumers who do not need them. We found several cases of these problems. In one case, the state of California brought suit against an insurance agency whose agents sold

unnecessary policies to 100 or more older consumers. The agents sold an older man 16 different health policies over 3-1/2 years; about half of the policies provided nursing home coverage. These problems might have been avoided if the insurer had met NAIC disclosure requirements and used the information to monitor its agents.

Some policies we reviewed also do not meet NAIC standards for determining eligibility for home health care. These standards were designed to eliminate overly restrictive provisions. However, of the 37 policies that offer home health care, 10 policies contain such restrictive provisions. That is, 5 still require policyholders to receive nursing home care before home health care benefits are provided, and 5 require a physician to certify that without home health care, the policyholder would need to be in a hospital or nursing home. Neither of these provisions is permissible under NAIC standards because each is considered too restrictive.

Lastly, 10 policies offer no inflation protection. We found only 1 policy containing an inflation protection provision that meets current NAIC standards. This policy meets the standard that requires benefits to be increased at the rate of 5 percent or more, compounded annually.

In contrast, most other policies that offer inflation protection use a simple rate of inflation that increases benefits by 5 percent or less annually. Many of these policies also limit the inflation increases either to a certain period of time (generally 10 to 20 years), a percentage of the daily benefit (generally benefits can be increased by 50 to 75 percent), or until the time a policyholder reaches a certain age. The age limits are most restrictive for elderly policyholders. For example, two policies stop making inflation adjustments when a policyholder reaches the age of 70. As the average policyholder is near this age when he or she purchases long-term care insurance, these policies eliminate inflation protection for many policyholders.

NAIC STANDARDS DO NOT ADDRESS DEFINITIONS, ELIGIBILITY CRITERIA, AND GRIEVANCES

Consumers face many difficulties in assessing long-term care policies, even when policies meet current NAIC standards. Some of these difficulties arise because policies vary so widely in how they (1) define covered benefits and (2) determine eligibility for benefits. In addition, determining a policyholder's eligibility for benefits involves considerable judgement, and a policyholder and insurer can disagree about whether benefits should be provided. A grievance process could help resolve such disputes.

Definitions for Levels of Care and Facilities Often Restrictive

Neither states nor NAIC has developed uniform definitions of long-term care benefits. As a result, definitions for levels of care and facilities differ widely in the policies we reviewed. These differences make it difficult for consumers to compare policies.

In addition, most policies contain definitions that potentially limit access to benefits. Of the 44 policies we reviewed, 23 define levels of care restrictively, and 37 define facilities restrictively. Such definitions can have the effect of eliminating coverage for benefits typically offered to nursing home residents or reducing the number of nursing homes available to policyholders who would otherwise qualify for benefits. For instance,

-- 10 policies limit benefits through their definition of skilled or intermediate care (for example, 1 policy excludes physical therapy from the definition of skilled care, though the service is typically included in skilled care);

-- 22 require that facilities keep daily medical records, which is not required by Medicare or the states we visited;

-- 12 require that facilities provide 24-hour nursing service for custodial care (several states we visited do not have this requirement); and

-- 12 require that custodial care be provided in a skilled or intermediate care facility.

Two complaints to state commissioners illustrate the problems that policyholders face with definitions of facilities. First, a man who was a policyholder learned that the insurer would not provide benefits unless he received care in a nursing home that maintained a daily medical record for each resident; he discovered that his state did not require such records and that he would have difficulty locating a nursing home in his area that did. Second, a woman who had been a policyholder complained that her insurer would not provide benefits unless she received care in a nursing home with 24-hour nursing services; the policy also required that the nursing services be provided by a registered nurse. She spoke with several nursing homes in her area and found that none met these requirements.

No Criteria for Determining Eligibility

Policyholders face additional problems about how their eligibility for benefits is determined. To avoid confusion, policies should clearly explain eligibility criteria. These

"gatekeeper" criteria may be the most important provisions in a long-term care insurance policy because these criteria determine how and when a policyholder will receive benefits.

NAIC recommends that states prohibit insurers from using certain restrictive eligibility criteria such as prior hospitalization. NAIC standards discourage insurers from using these criteria, but NAIC has not provided alternative eligibility criteria. In our sample of 44 policies, we found many that used criteria that were either not defined or were defined in ways that could potentially be restrictive. Thus, the insurer's contractual obligations to provide benefits were not always clear.

Many insurers replaced prior hospitalization criteria with criteria that requires "medically necessary" care. But some policies do not define the term. Of the 30 policies that use medical necessity as a criterion for determining eligibility, 6 leave the term undefined. Apart from problems with the definition, use of medical necessity for determining eligibility can be quite restrictive. For example, some policyholders who require custodial or home health care may not need medical services. However, they may need services because they are physically or cognitively impaired. For these less intensive levels of care, other criteria for determining impairment might better assure that policyholders receive necessary benefits.

Our review of policies indicates that many insurers are beginning to use other measures of impairment. For example, 27 policies use limits in activities of daily living (ADLs) to determine when benefits would be provided. These activities include bathing, transferring from a bed or a chair, dressing, toileting, and eating. Although ADLs are promising criteria for determining eligibility for benefits, some policies that we reviewed have significant problems with ADLs. Of the 27 policies that use ADLs, 17 do not specify or describe the ADLs that the insurer would use to determine whether benefits would be paid. Such descriptions are critical because they determine the number of policyholders who will receive benefits.

Another issue involves how insurers determine whether policyholders are impaired in their ADLs and thus eligible for benefits. Some policies consider policyholders to be impaired if they can only perform the ADLs with active human assistance; others require that policyholders need "supervision or stand-by" help or mechanical assistance. Requiring that policyholders need active human assistance can reduce the number of elderly qualifying for benefits by 40 percent.[8] Of the 27 policies that use ADLs, only 1 requires supervision or stand-by assistance. The remaining 26 policies make it difficult to determine how the insurer evaluates impairment--17 require human assistance, but do not specify whether it has to be active assistance; and 9 do not describe the type of assistance required.

ADLs alone are often inadequate criteria for determining benefit eligibility. For example, nearly all policies specifically claim to cover policyholders with Alzheimer's disease. A substantial proportion of people with Alzheimer's disease, however, do not have serious ADL limitations. These people--who suffer from cognitive impairment and need supervision--often require different eligibility criteria. Of 27 policies that use ADLs, only 8 include cognitive impairment as an eligibility criterion. Absent any measure of cognitive impairment, policyholders with Alzheimer's disease must meet ADL requirements.

Finally, some policies present special problems when they combine medical necessity with ADLs or measures of cognitive impairment. For example, of the 27 policies, 5 require that a policyholder meet both medical necessity and ADL criteria to obtain benefits. In this situation, a policyholder could need assistance with an ADL but not receive benefits because he or she could not meet the insurer's requirements for the medical necessity criteria. Other policies do not have this problem because they allow medical necessity or other criteria such as ADLs or cognitive impairment.

Standards Do Not Address Consumer Grievance Process

Determining the need for long-term care services is a matter of considerable judgement. Whatever standards insurers use to make determinations--medical necessity or ADL criteria--different people can reach different conclusions about a policyholder's eligibility. Given this situation, a grievance process could help to resolve differences of opinion over whether benefits should be provided. Ten policies we reviewed offer some type of grievance process although they vary in detail and formality. Of these, most simply indicate that the insurer will reconsider the policyholder's claim and review any material the policyholder submitted in support of it.

NAIC STANDARDS DO NOT PROTECT CONSUMERS FROM INAPPROPRIATE PRICES

NAIC standards give insurers considerable discretion in establishing premiums for new policies and in changing premiums for policies that are already on the market. As a result, consumers face another risk in purchasing long-term care insurance: paying an inappropriate price.

Premiums Can Vary Widely for Similar Policies

We found substantial differences in premiums for similar polices and little consensus among actuaries on the definition of a reasonable price. As a result, price is not always a good measure of value. For example, annual premiums for six policies that offer nursing and home care range from about $1,200 to $3,000 (a difference of 150 percent).[9] Premiums for six other policies that offer nursing, as well as home and adult day care, range from about $1,400 to $2,700 (a difference of 93 percent). From the consumer's perspective, these policies would appear similar because they offer the same basic benefits and dollar coverage.

Policyholders who obtain long-term care insurance at the lowest market price cannot be sure that the policy will remain a bargain. Under NAIC standards, insurers can increase premiums on existing policies. Insurers can thus transfer from themselves to aging policyholders a substantial portion of the risk associated with long-term care insurance; that is, insurers who incur more claims than expected can simply increase premiums.

Future Premium Increases May Become a Problem

Premium increases can place policyholders at risk of being priced out of the market at the time when they are at greatest risk for needing long-term care services. The risk of future premium increases may be significant, given that some insurers may initially underprice policies because of the extremely competitive market.[10] In fact, there appears to be considerable competitive pressure to keep prices down. For example, most insurers who recently asked for premium changes, in three states that provided us data, requested price decreases. (This included 16 of 28 price change requests.[11]) A common reason for these requests was to allow insurers to become more competitive. For 13 policies, state regulators allowed insurers to reduce prices from 10 percent to 43 percent.

But even a policyholder who bought insurance at a low initial price could face substantial price increases in the future. Low initial prices work to consumers' advantage only if insurers do not increase these prices significantly in the future. We do not know how often this will occur, but we are not encouraged by recent premium increases. We identified 12 requests for price increases in the three states where we were able to obtain such information. Arizona had 11 of the 12 requests for price increases, ranging from 15 percent to 54 percent. These requests

were quite recent. Between 1988 and 1990, the state allowed increases for all 11 policies. In one example, Arizona allowed a 30 percent increase on 3 policies issued by one insurance company. The state had already granted a rate increase for 1 or more of these 3 policies.

Requiring Nonforfeiture Benefits Can Reduce Pricing Risks and Enhance Policy Value

Insurers expect that many policyholders will allow their policies to lapse. On average, insurers we reviewed expect that 60 percent or more of their original policyholders will allow their policies to lapse within 10 years; one insurer expects an 89 percent lapse rate after 10 years. In all but two policies we reviewed, policyholders forfeit, that is, lose their entire investment in premiums if they allow their policies to lapse. NAIC standards do not require insurers to provide nonforfeiture benefits (that is, the return of a portion of the reserves resulting from their premium payments).

Nonforfeiture benefits would significantly enhance the value of policies. For example, on the basis of our review of 44 policies, a consumer who purchases a policy at the age of 75 and allows it to lapse at the age of 85 will, on average, lose nearly $20,000 in premiums. For either of the two policies in our sample that offer nonforfeiture benefits, the policyholder would

receive back about $12,000 to $14,000 of the $20,000.[12] The policyholder would receive nothing back on any of the other 42 policies.

Most policies sold today offer level premiums. Essentially, level premiums result in overpayment in the early years of a policy and underpayment in later years. In this way, insurers accumulate substantial reserves for payment when claims are filed. This pricing feature results in insurers accumulating substantial reserves over relatively few years. Consequently, insurers can benefit when policyholders allow their policies to lapse, unless the policies include nonforfeiture benefits.

SIGNIFICANT MARKETING ISSUES STILL TO BE RESOLVED

Consumers who purchase long-term care insurance also face risks that are inherent in new, rapidly evolving markets. Policyholders who purchased insurance policies only 2 years ago may find their coverage limited, compared with current policies. But updating their policies may not be possible. In addition, most insurers for which we had data pay high first-year sales commissions for their long-term care policies. Such commissions encouraged marketing abuses in the sale of Medigap policies and pose a similar potential problem for long-term care insurance.

State and NAIC Standards Do Not Address Policy Upgrading

Neither NAIC nor the states we visited address the issue of upgrading policies. Today, many policyholders who want to upgrade their policies may do so only with significantly higher premiums, if at all. These policyholders must meet the same requirements and terms as new purchasers. That is, they must meet the insurer's criteria for medical underwriting and preexisting conditions, as well as pay the premium for their particular age group. The premium generally more than doubles for the 10-year difference from the age of 65 to 75. None of the policies we reviewed offer the option of upgrading the policy under more favorable conditions.

NAIC Standards for Agent Commissions Optional

We also found that some insurers pay high first-year commissions for the sale of their long-term care policies. The size of commissions and the methods of payment are of concern to NAIC because high sales commissions have created incentives for abuses in the sale of other insurance policies to older people. For example, large commissions associated with the initial sale of Medigap policies created undesirable incentives for agents to "churn" (that is, to sell) new policies to their customers.

Essentially, agents received large commissions on the initial sale of such policies and small commissions on renewals. Medigap standards have been revised to reduce incentives to churn policies by limiting the size of the first-year commissions and other compensation that may be paid to a sales agent. In addition, the standards require companies to spread the total compensation over several years.

NAIC has adopted the same Medigap standards for long-term care insurance. But NAIC established the standards as an option that states and insurers should consider adopting if they identify marketing abuses. These standards stipulate that insurers should limit first-year commissions to no more than 200 percent of the commissions paid in the second year. In renewal years, the commissions are to be the same as the second year and continue at that level for a reasonable number of years.

Long-term care policies are often more expensive than Medigap policies. As a result, agent commissions can be substantial. Of 16 policies we reviewed, only 1 paid first-year commissions that would meet NAIC's optional standards. (We were unable to determine the agent commission rates for the other 28 policies in our sample.) The remaining 15 policies paid substantially higher commissions. On average, commissions were 60 percent of the total value of the first year's premium. For half of the policies, this was at least twice what is recommended under the

optional standards. With one such policy, a sales agent could earn an initial commission of $2,000 (based on a 70 percent commission rate) for selling the policy to a 75-year-old.

CONCLUSION

NAIC standards have improved significantly in the last 5 years. Although state standards have also improved, many states have not adopted key NAIC standards, and insurers have not incorporated recent NAIC standards into their policies. Further, although standards and insurance policies have improved, consumers still face considerable risks in purchasing policies.

Consumers confront a bewildering array of policies made more confusing by the absence of uniform terms and definitions. As a result, it is difficult or impossible for a consumer to understand when benefits will be paid or to compare the benefits and value of policies. Consumers also risk unpredictable premium increases that can make it difficult for them to retain their policies. Yet, if consumers allow their policies to lapse, they will lose the money they invested in premiums.

While states have progressed in recent years in adopting long-term care insurance regulatory standards, many do not conform to the standards suggested by NAIC and future state action is unclear. Therefore, the Congress may want to consider enacting

federal legislation--as was done with the Medigap insurance market--to establish minimum standards for long-term care insurance.

Consideration should also be given to expanding and strengthening existing standards. Specifically, consideration should be given to

-- developing more uniform definitions for long-term care services and for eligibility criteria (the absence of uniform definitions and eligibility criteria currently makes it difficult for consumers to compare policies or to assess coverage);

-- requiring nonforfeiture benefits (long-term care insurance premiums allow insurers to build substantial reserves to meet future expenses; allowing policyholders to recover such reserves if they allow their policies to lapse would lessen their financial losses);

-- establishing minimum standards that allow consumers to upgrade coverage (because standards and policies are evolving rapidly, consumers could benefit from a method for upgrading policies that they purchased but later found to be deficient);

-- establishing minimum standards for policyholder grievance procedures (because determining eligibility for services is judgmental, policyholders could benefit from a defined grievance process to help resolve coverage disputes); and

-- requiring the same standards for agent commissions in long-term care insurance as in Medigap insurance (the agent commission structure used by some insurers provides incentives to agents that can lead to consumer abuse).

Adopting these standards will likely increase premiums. We believe, however, that they warrant consideration because they would significantly improve consumer protection in a rapidly evolving, complex market.

This concludes my testimony. I will be happy to answer any questions you might have at this time.

ENDNOTES

1. P. Kemper and C. Murtaugh, "Lifetime Use of Nursing Home Care," The New England Journal of Medicine, Vol. 324, No. 9 (Feb. 28, 1991).

2. S. Van Gelder and D. Johnson, "Long-Term Care Insurance: A Market Update." Health Insurance Association of America Research Bulletin (Washington, D.C., Jan. 1991), p. 2.

3. In general, nursing home services are defined as skilled nursing home care--nursing and rehabilitative services provided by trained health professionals on a daily basis under the orders of a physician; intermediate nursing home care--skilled nursing care provided on an occasional basis; and custodial nursing home care (also referred to as personal care)--assistance in requirements of daily living such as eating and bathing, which can be provided by people without medical skills.

4. Home care services can provide skilled nursing care by medical professionals, as well as assistance with activities of daily living such as eating and bathing, which can be provided by people without medical skills (also referred to as personal care).

5. We reviewed state laws and regulations as provided by NAIC, February 1991.

6. Excluding coverage for people with Alzheimer's disease is particularly restrictive because more than 50 percent of nursing home residents may have Alzheimer's and about 2.5 million elderly were estimated to have the disease in 1985. See Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection (GAO/HRD-89-67, Apr. 24, 1989), pp. 19, 20, and 22.

7. Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection.

8. J. Wiener and K. Harris. "High Quality Private Long-Term Care Insurance: Can We Get There From Here?" (Washington, D.C.: The Brookings Institution, May 1990), p. 11.

9. Premiums are based on coverage for a 75-year-old who obtains a policy that provides 3 years of nursing home care, begins paying $80 per day after the first 90 or 100 days of nursing home confinement, and provides no inflation protection.

10. M. Peavy, "The Price Is Right," Best's Review (Nov. 1989).

11. Of the remaining five states we visited, two did not review insurer price changes; two had requests for price changes, but did not provide us with data, and one had no requests.

12. Although this type of nonforfeiture benefit has a cash value, insurers could provide other types of nonforfeiture benefits. For example, a policy that provides reduced paid up benefits includes a reduced daily benefit, payable for the maximum length of the policy. Although the dollar amount covered daily is reduced, the types of benefits provided remain the same.