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Long-Term Care Insurance:

Consumers Lack Protection In A Developing Market

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Subcommittee on Commerce, Consumer Protection,
and Competitiveness
Committee on Energy and Commerce
House of Representatives

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SUMMARY

GAO and others have identified significant problems with long-term care insurance policies and with the standards that govern them. Model standards, intended for adoption by the states, have been developed for this insurance by the National Association of Insurance Commissioners (NAIC). Although the NAIC standards offer greater consumer protection than existed before 1986, consumers of long-term care insurance are still vulnerable to considerable coverage and financial risks for two major reasons.

First, many states do not meet NAIC standards, including standards developed between 1986 and 1988. For example, 23 states have not developed standards requiring insurers to guarantee policy renewal, and 19 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 did not meet more recent NAIC standards, particularly those regarding disclosure and inflation protection.

Second, NAIC standards themselves do not sufficiently address several features of long-term care insurance that have important consequences for the consumer. For example, policy terminology, provisions, and eligibility criteria are expressed in language that is sometimes vague and not consistent across policies. Consumers are therefore unable to make comparisons among policies and may not foresee conditions under which they might, as policyholders, be denied benefits. In addition, consumers face financial risks related to the newness of the long-term care insurance market. For example, they are vulnerable to price hikes for premiums that could make it difficult for them to retain their policies. Allowing their policies to lapse, however, nearly always results in losing their investments in premiums. Finally, in the absence of marketing standards, consumers are limited in their options to upgrade policies and are vulnerable to abuses in the sale of long-term care insurance.

To address these issues, GAO believes NAIC should consider extending its model standards to require greater uniformity of language among policies, improve methods for determining eligibility, and provide greater protection against loss of a policyholder's coverage and financial investment. If states fail to incorporate these and existing NAIC standards into their laws and regulations, the Congress may want to consider legislation that sets federal minimum standards for long-term care insurance.

Madam Chairwoman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our review of long-term care insurance policies and the standards that govern them. We presented our preliminary results last April before the Subcommittee on Health of the House Ways and Means Committee.[1] At that hearing, we and others identified significant problems with long-term care insurance policies and with the model standards developed for this insurance by the National Association of Insurance Commissioners (NAIC).

RESULTS IN BRIEF

What we found, in brief, is that today's NAIC model standards for long-term care insurance provide greater consumer protection than existed before 1986, but two key problems remain. First, state standards have improved, but many states have not adopted key NAIC standards, including standards developed between 1986 and 1988. Insurers have adopted NAIC standards more quickly than states have, but have not incorporated more recent NAIC standards, such as those for inflation protection, into their policies.

Second, the model standards do not sufficiently address several significant areas, including:

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[1]Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/T-HRD-91-14, April 11, 1991).

-- Terms and definitions. Terms and definitions are not uniform across policies for long-term care services, facilities, and eligibility criteria. This absence of uniformity makes it difficult or impossible to compare policies and to judge which policy provisions could reduce the likelihood that a policyholder would receive benefits.

-- Pricing. Price is not a good indicator of value--premiums for policies that offer similar benefits may vary as much as 150 percent. In addition, setting premium prices in a new market without experience data requires periodic adjustments. But multiple price hikes could make long-term care policies unnaffordable for some people. Policyholders who allow their policies to lapse, however, almost always lose their entire investment in premiums.

-- Marketing. Many agents earn high first-year sales commissions. Consumers are vulnerable to those agents who would try to sell them unnecessary policies for the sake of earning the commission.

SCOPE AND METHODOLOGY

In conducting our review, we compared each state's long-term care laws and regulations with NAIC standards. We also reviewed

44 policies for sale by 27 insurers in eight states (Alabama, Arizona, California, Florida, Missouri, New Jersey, Pennsylvania, and Washington). The policies were randomly selected from insurers whose policies had been approved for sale.

We consulted officials at NAIC, the Department of Health and Human Services, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association. We also consulted major consumer groups and private and government actuaries. We considered all these views in our assessment of the adequacy of NAIC model standards in addressing consumer protection issues.

STATES AND INSURERS LAG IN MEETING NAIC STANDARDS

In 1986 NAIC established model standards that have evolved rapidly. Although these standards are not mandatory for the states, they suggest the minimum standards states should adopt for regulating long-term care insurance. Today, the NAIC standards provide increased consumer protection while offering insurance companies some flexibility in a competitive, emerging market. Many states, however, do not meet key NAIC standards developed between 1986 and 1988. We found, for example, that 23 states have not developed standards requiring insurers to guarantee policy renewal and 19 states have not adopted standards disallowing Alzheimer's disease exclusions. These standards are basic to ensuring that

policyholders are able to maintain coverage and that policyholders with Alzheimer's disease who need long-term care are not summarily excluded from receiving benefits.

States lag even further in adopting NAIC standards established after 1988. Forty states have not adopted standards for inflation protection, home health care benefits, or disclosure of post-claims underwriting.[2]

Insurers have adopted NAIC standards more quickly than states have, but most policies we reviewed did not meet more recent NAIC standards, particularly those regarding disclosure and inflation. Disclosure standards help clarify or simplify policies, as well as help protect consumers from unfair or deceptive marketing practices. For instance, NAIC standards require that insurers provide consumers with outlines of coverage, using a specific format and content, that summarize policy provisions. Despite this specificity, 41 of 44 outlines of coverage we reviewed did not meet NAIC standards.

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[2]Post-claims underwriting occurs when an insurer checks a policyholder's medical history only after a claim is filed. This may result in a denied claim if the insurer determines that the policyholder provided invalid medical-related information on an application.

Inflation standards provide for protection against the rising cost of long-term care. NAIC standards require that the daily benefit amount, such as $80 a day for nursing home care, be compounded at 5 percent or more a year. At a lower rate, policyholders are likely to find their benefits eroded over time and inadequate to cover costs. However, of the 34 policies in our sample that offered inflation protection, only 1 met the NAIC standard.

NAIC STANDARDS SILENT ON INCONSISTENT TERMS, ELIGIBILITY CRITERIA, AND GRIEVANCE PROCEDURES

Now I'd like to discuss the risks to consumers I enumerated earlier about which the NAIC standards are silent.

Inconsistent Terms

Consumers confront an array of policies made bewildering by the absence of uniform terms and definitions. The absence of uniformity results in policies that are not clear in how they define covered services and eligible facilities and how they determine a consumer's eligibility for benefits. For example, in our sample of policies, common terms for services (such as "custodial care") and facilities (such as "nursing home") were

often modified by provisions that could in effect preclude covering the intended services or could eliminate the nursing homes in the policyholder's area from the pool of eligible facilities. These consequences likely would not be grasped except by those especially knowledgeable about provider requirements and the delivery of long-term care services in a given state.

In short, the limitations of certain policy provisions may not be obvious to the typical consumer. Of the 44 policies we reviewed, 23 contained restrictions on what was meant by skilled, intermediate, and custodial care and 37 contained restrictions regarding eligible facilities. These restrictions were not obvious. For example, one policy excluded physical therapy from its coverage of skilled services, despite the generally accepted definition of skilled care as including physical therapy. In our sample of policies reviewed, 10 policies limited benefits covered through restrictions on skilled or intermediate care.

Regarding eligible facilities, consider two complaints to state commissioners we visited. The policies of two individuals had provisions that, for all practical purposes, denied covering them for nursing home care. One 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. The policyholder discovered that his state did not

require such records and that few, if any, nursing homes in his area maintained such daily records.

Another 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 these services be provided by a registered nurse. None of the several nursing homes in her area met these requirements. Of the 44 policies we reviewed, 22 policies required that facilities keep daily medical records for each nursing home resident and 12 policies required that facilities provide 24-hour nursing service for custodial care.

Eligibility Criteria

Our sample policies also contained "gatekeeper" criteria, used to determine a policyholder's eligibility to receive covered services, that were problematic. Eligibility criteria were often not specified, were not sufficient to assess the eligibility of many individuals with physical or mental impairments, or had implications for restricting benefits in ways that were not obvious. Two types of criteria illustrate these problems.

Many insurers use eligibility criteria that require that care be "medically necessary." But some policies do not define the term. Of the 30 policies that required care to be medically

necessary, 6 left the term undefined. For the other policies, the definition varied. Apart from problems with the definition of medical necessity, medical necessity is not a relevant criterion for policyholders who do not need medical services. Some policyholders may need only custodial or home health care due to physical or cognitive impairments.

Insurers are beginning to use criteria other than medical necessity, such as activities of daily living (ADLs), to determine eligibility for long-term care benefits. These activities can include bathing, transferring from a bed or chair, dressing, toileting, and eating. In using these criteria, insurers determine impairment by evaluating a policyholder's physical ability to perform ADLs. Although ADLs are promising criteria for determining eligibility, some of the policies we reviewed present significant problems. Of the 27 policies that used ADLs, 17 did not describe the ADLs that the insurer would use to determine whether benefits would be provided. For example, one policy required that policyholders have a physical limitation that rendered them incapable of performing the activities of daily living, but did not specify or define any ADLs. Without this information, the circumstances under which the insurer would have provided benefits was unclear.

The dilemma consumers face when assessing a policy's eligibility criteria and judging the likelihood that they will receive benefits can be well understood from the perspective of people with Alzheimer's disease. Many sufferers of Alzheimer's disease do not need medical services nor do they have serious ADL limitations. These people, who need supervision because they suffer from cognitive impairment, require different criteria. However, absent any measure of cognitive impairment, policyholders with Alzheimer's disease must meet other requirements. Therefore, these people could be denied coverage if their policies use only medical necessity or ADLs as eligibility criteria.

Grievance Process

Despite the prevalence of ambiguous provisions and eligibility requirements, most of the policies in our sample did not have a formal grievance process. The grievance process allows policyholders to formally contest insurers' decisions about their eligibility. At a minimum, such a process could help resolve different interpretations of contractual obligations between policyholders and insurers. Each of the 10 policies in our sample that offered a grievance process indicated that the insurer would reconsider claims and would review materials submitted by policyholders to support their claims.

NAIC STANDARDS DO NOT PROTECT CONSUMERS FROM PRICING OR MARKETING RISKS

Consumers face considerable pricing and marketing risks in purchasing long-term care insurance. NAIC standards need to be strengthened to sufficiently address these risks.

Great Differences in Premiums for Similar Policies

We found substantial differences in premiums for policies that offered similar benefits and little consensus among actuaries on the definition of a reasonable price. For instance, annual premiums for four policies in our sample that offered nursing home care ranged from about $1,200 to $1,600 (a difference of 33 percent).[3] Premiums for six policies offering nursing home care and home health care ranged from about $1,200 to $3,000 (a difference of 150 percent). Premiums for six policies that offered nursing home care, home health care, and adult day care ranged from about $1,400 to $2,700 (a difference of 93 percent). To the consumer, policies in each of these groups would have appeared

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[3]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.

similar because they offered the same basic benefits and dollar coverage. Moreover, the differences in the premiums across these three groups indicate that consumers could purchase policies that provided a full range of benefits at the same price as policies that provided only nursing home care.

Premium Increases

Policyholders who obtain long-term care insurance at low prices cannot be guaranteed that their policies will remain a bargain. Policyholders run the risk of unpredictable premium increases that may make it difficult for them to retain their policies. Some insurers may initially underprice policies because of the extremely competitive market. Low initial prices work to consumers' advantage, however, only if insurers do not raise them significantly in the future. However, pricing policies in a new market without actual experience data on the use of long-term care services will require insurers to make periodic adjustments.

Because the long-term care insurance market is still developing, the extent to which policy prices will increase remains uncertain. However, we are not encouraged by some recent increases in premiums. In the three states from which we were able to obtain data, we identified 13 requests for premium increases, resulting in 12 increases. Arizona had 11 of the 13 requests for price increases, ranging from 15 to 54 percent.

These requests were quite recent. Between 1988 and 1990, the state allowed increases for all 11 policies. In one instance, Arizona allowed a 30-percent increase on three policies issued by one insurance company. The state had previously granted a rate increase for one or more of the three policies.

Lack of Nonforfeiture Benefits

Consumer vulnerability to financial loss is compounded by the fact that policyholders who do not retain their policies almost always forfeit their investment in premiums. On average, insurers we reviewed expected that 60 percent or more of their original policyholders would allow their policies to lapse within 10 years; one insurer expected an 89-percent lapse rate after 10 years.[4] In all but two policies we reviewed, policyholders who allow their policies to lapse would lose their entire investment in premiums.

In our sample of policies, a consumer who purchased a policy at age 75 and allowed it to lapse at age 85 would, on average, lose an entire investment of about $20,000. For either of the two policies in our sample that offered nonforfeiture benefits, the policyholder would receive back about $12,000 to $14,000 of the $20,000. The other 42 policies would offer the policyholder

[4]This analysis included 20 policies for which we had lapse rate data and which excluded mortality as a basis for lapsing.

nothing back. NAIC standards do not require insurers to provide nonforfeiture benefits.

Limitations on Policy Upgrading

Consumers buying long-term care policies also face risks that are inherent in new, rapidly evolving insurance markets. For example, upgrading policies can be particularly troublesome for consumers who purchased earlier-generation policies. Many of the earlier policies contain provisions that do not meet NAIC standards or lack certain consumer safeguards, such as inflation protection. Typically, however, policyholders who want to upgrade their policies must meet the same requirements and the same terms as new purchasers. This includes meeting the insurer's criteria for medical underwriting and preexisting conditions and paying the premium for their particular age group. The premium generally more than doubles for the 10-year difference from age 65 to 75. None of the policies we reviewed provided upgrading options under terms more generous than those just discussed.

Incentives for Marketing Abuses

The high first-year sales commissions that agents can earn by selling long-term care policies create an incentive to make the consumer's specific long-term care requirements less of a consideration than the sale itself. NAIC established standards to

address the issue, but they were presented as an option that states and insurers should consider adopting if they identified marketing abuses. The standards stipulate that insurers spread commissions over several years by limiting first-year commissions to no more than 200 percent of the commissions paid in the second year. In renewal years, the commissions should be the same as the second year and continue at that level for a reasonable number of years.

Agent commissions can be substantial. Of 16 policies we reviewed that had agent commission rates, only 1 paid first-year commissions that would meet NAIC's optional standards. The other 15 policies paid much higher commissions. On average, commissions were about 60 percent of the total value of the first year's premium. For half of the policies, this was at least twice NAIC's recommended rate. With 1 policy, for example, the 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 consumer. These types of commissions provide considerable incentives for agents to sell policies to consumers who do not need them.

CONCLUSIONS AND MATTER FOR CONGRESSIONAL CONSIDERATION

NAIC's long-term care insurance standards, which provide a national model for the states, have improved significantly in the past 5 years. Although state standards have also improved, many states have not adopted key standards, and insurers have not incorporated some recent standards into their policies.

In addition, NAIC standards do not sufficiently address several significant issues. For example, the absence of uniform terms, definitions, and eligibility criteria makes it difficult or impossible to compare policies. It is particularly difficult to understand under what circumstances benefits will be provided and how certain provisions can limit eligibility. Consumers also face considerable pricing risks, such as unpredictable premium increases, that may force policyholders to lapse policies and lose their investments in premiums. Finally, in the absence of standards, consumers are limited in their options to upgrade policies and are vulnerable to marketing abuses because of the financial incentives created by high first-year commissions.

To address these issues, we believe NAIC should consider extending its model standards to require more uniform language among policies, improve methods for determining eligibility, and provide greater protection against policyholders' loss of coverage

and financial investment. Improving NAIC standards alone, however, does not ensure adequate consumer protection. Despite substantial progress in recent years, many states have yet to adopt NAIC's model standards, and when they will do so is not certain. If states do not adopt the NAIC standards, the Congress may want to consider legislation that sets federal minimum standards for long-term care insurance.

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Madam Chairwoman, this concludes my statement. I would be happy to answer any questions.

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