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HEALTH CARE REFORM

Supplemental and Long-Term Care Insurance

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SUMMARY

In general, the Health Security Act addresses issues that GAO has identified with long-term care insurance concerning the need for

- disclosure standards that protect consumers from unfair or deceptive marketing practices,
- inflation protection that protects against the increasing costs of long-term care,
- nonforfeiture benefits that provide a return on the investment in premiums when a policy lapses,
- uniform definitions of services and facilities that enable comparison of policies,
- clear and relevant eligibility criteria,
- the ability to upgrade older policies,
- grievance procedures that enable policyholders to contest insurance company decisions, and
- sales commission standards that discourage questionable sales practices.

However, the Health Security Act is not as comprehensive in addressing issues concerning insurance that supplements insurance people already have. Specifically, the Act's section on supplemental insurance does not include some features that protect consumers from the sale of duplicate policies or high-pressure sales techniques. It also does not appear to include other types of supplemental insurance that cover specific diseases or conditions requiring hospitalization. Such types of insurance may be unnecessary for many consumers because they provide limited, narrow coverage.

Mr. Chairman, Madam Chairwoman, and Members of the Subcommittees:

I am pleased to be here today to testify in response to your request that we discuss the extent to which provisions of the Administration's Health Security Act dealing with private long-term care insurance and supplemental health insurance address problems we have identified previously. The Administration proposal has detailed sections that would govern the content and marketing of long-term care and supplemental insurance policies. Both of these types of insurance have been subject to numerous abuses by some agents and insurance companies as GAO has reported over the last few years.[1] In general, we believe that the section of the Administration's proposal on long-term care insurance contains the kinds of consumer protection measures that we have advocated. With regard to the section on supplemental insurance, however, some problems are not addressed. Without attempting to review or assess all the sections on long term care insurance in their entirety, I will discuss the provisions that pertain to our earlier work.

BACKGROUND

Long-term care often presents a significant financial burden for many people. As a result, many consumers purchase long-term care insurance to defray the costs of care. Supplemental insurance

[1]A complete listing of our past work on this subject may be found in Appendix I.

is another type of health insurance that provides limited coverage for specific diseases or services.

Health insurance is generally regulated by state governments. To help states monitor variations in policies and sales practices, the National Association of Insurance Commissioners (NAIC), a nonprofit organization of state insurance commissioners, has developed model standards. Although the NAIC standards are not mandatory, they suggest the current minimum standards that states should adopt. To varying degrees, states have adopted the NAIC standards. Insurance companies must comply with the standards in states where they have been adopted. However, we found that policies often did not meet NAIC standards.

PROPOSALS FOR LONG-TERM CARE INSURANCE POLICIES

While long-term care insurance can provide important benefits for consumers, some policies have not provided adequate consumer protection. The Administration proposal has a number of provisions that address problems with the content of policies that have been identified previously.

Disclosure Standards

The Health Security Act contains disclosure standards that require a standard outline of coverage for each long-term care insurance policy. Disclosure standards help to clarify or simplify policies, as well as help to protect consumers from unfair or deceptive marketing practices. Thus, the Act requires that there be made available to consumers an outline containing a description of the principle benefits covered, limitations on coverage, and premiums. NAIC standards also require an outline with the same features. However, most policies we reviewed in 1991 did not meet NAIC standards.[2]

Inflation Protection

The Health Security Act addresses the increasing cost of long-term care in part by providing that inflation protection be offered to consumers. The Act requires that the amount of the benefit be compounded annually at not less than 5 percent a year (or other rate as determined by the Secretary of Health and Human Services). This protection can only be waived in writing by the consumer. Without adequate inflation protection, inflation can erode the benefits of long-term care insurance policies and make them inadequate to cover costs.

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[2]Long-Term Care Insurance: Risks To Consumers Should Be Reduced (GAO/HRD-92-14, December 26, 1991).

Nonforfeiture Benefits

The Health Security Act also addresses the problems associated with policyholders who allow their policies to lapse. The Act requires the Secretary to develop regulations that establish an "appropriate" return on an investment in premiums when a policy lapses (called nonforfeiture benefits). Insurance companies we reviewed expect about 20 percent of long-term care policies to lapse during the first year of ownership and about half of all policies to lapse within 5 years. This can entail a major financial loss for consumers. For example, based on our review of policies, a consumer who purchased a policy at age 75 and allowed it to lapse at age 85 would lose, on average, about $20,000 in premiums. Until recently, few policies offered policyholders nonforfeiture benefits. Since our study of policies, NAIC approved standards in June 1993 that require nonforfeiture benefits for all policies.[3] Currently, NAIC is drafting a model regulation that will specify the types of nonforfeiture benefits that should be provided.

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[3]Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (GAO/HRD-93-129, August 25, 1993).

Services and Facilities

The Health Security Act requires that long-term care policies include uniform terms, definitions, and formats, as established by the Secretary. The absence of uniformity has made it difficult or impossible to compare policies and to know which provisions could reduce the likelihood a policyholder would receive benefits.

Some policies we reviewed used terms relative to services (such as "custodial care" and "plan of care") that were not used in other policies. Further, common terms for services (such as "custodial care") and facilities (such as "nursing home") were often defined differently and could, in effect, preclude covering the intended services or eliminate the policyholder's local nursing homes from the pool of eligible facilities. In short, the limitations of certain policy provisions may be difficult to identify. Most policies we reviewed contained restrictions on what was meant by skilled, intermediate, and custodial care, as well as restrictions regarding eligible facilities. A complaint to a state commissioner illustrates the problem. A policyholder complained that her insurance company 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. Yet none of the nursing homes in her area met these requirements. Although NAIC has disclosure standards, they do not require uniform terms and definitions.

Although the Health Security Act requires that policies providing benefits for any nursing home must provide benefits for all types of nursing homes licensed by the State, the Act falls somewhat short in its specification of services and facilities. It allows the option of providing benefits in other types of unlicensed residential facilities, but consumers may not realize the benefits available in the facility they choose unless they receive information on the specific types and number of local facilities that are covered. The importance of alternative residential facilities, such as assisted living or board and care, is increasing. Construction of new certified facilities, or the addition of beds to existing facilities, has been restricted in some states and attempts have been made to use existing facilities for people with more extensive needs. Alternative residential facilities have been developing and their importance as a source of "institutional" long-term care may increase.

Eligibility

The Health Security Act addresses the problem of vague or confusing eligibility criteria by requiring policies to specify the levels of functional or cognitive impairments necessary to receive benefits.

In policies we reviewed, eligibility criteria were often

vague, were not sufficient to assess the eligibility of people 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 insurance companies use eligibility criteria that require care to be "medically necessary." But, some policies we reviewed did not define the term. For the other policies, the definition varied. Apart from problems with the definition of medically necessary, 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 because of physical or cognitive impairments.

- Some insurance companies use eligibility criteria such as "activities of daily living" (ADLs). The activities include bathing, transferring from bed or chair, dressing, toileting, and eating. In using such criteria, companies determine impairment by evaluating a consumer's ability to perform ADLs. Although ADLs are promising criteria for determining eligibility, most of the policies we reviewed that used ADLs did not describe them. As a result, the circumstances under which the company would provide benefits was unclear. Further, some people, such as those with Alzheimer's disease, require criteria other than

medical necessity or ADLs. Such people generally do not need medical services and they may not have serious ADL limitations.

NAIC standards are silent on guidelines that address the relevance of eligibility criteria for different types of impairments.

Policy Upgrading

The Health Security Act addresses the problems faced by consumers when they try to upgrade coverage of older policies. The Act provides authority for the Secretary to set the terms and conditions that insurance companies can place on policyholders' eligibility to obtain improved coverage. The terms and conditions include any restrictions on premium increases and medical underwriting.

This is an important protection because many older policies contain overly restrictive provisions that are now prohibited by NAIC, such as a prior hospitalization requirement. More than one million consumers have purchased those earlier generation policies. Today, many policyholders who bought such policies and who want to upgrade them to current standards may do so only with significantly higher premiums. In addition, the policyholders must meet the same requirements as new purchasers, such as medical criteria and

preexisting conditions (which may not have existed at the time the original policy was purchased). NAIC standards are silent on some important issues of upgrading individual policies.

Grievance Procedures

The Health Security Act facilitates a grievance process that allows policyholders to formally contest insurance companies' decisions about their eligibility. The Act provides grants to states to, among other things, establish administrative procedure for the resolution of disputes about long-term care insurance.

At a minimum, a grievance process could help to resolve different interpretations of contractual obligations between policyholders and companies. Despite the prevalence of ambiguous provisions and eligibility requirements, most policies in our 1991 study did not have a formal grievance process. The policies that offered a grievance process indicated that the company would reconsider claims and would review materials submitted by policyholders to support their claims. NAIC standards are silent on the issue of a grievance process.

BETTER SAFEGUARDS NEEDED FOR INSURANCE MARKETING

In addition to standards covering the content of policies, the Health Security Act contains standards that address the marketing of policies. While the Act prohibits certain sales practices, it establishes no standards related specifically to the sale of policies to low-income persons. The Act merely provides authority for the Secretary to establish such standards.

Because long-term care insurance is expensive, it may not be appropriate for people with limited financial resources.[4] But, companies that we reviewed did little to prevent the sale of long-term care insurance to people with low incomes. We also found that, in their marketing materials, the companies provided limited or no guidance to consumers on the affordability of long-term care insurance. Recognizing that long-term care insurance is generally not be an appropriate purchase for Medicaid recipients, NAIC model regulations include a requirement that long-term care insurance applications include a question to determine whether the applicant is covered by Medicaid.

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[4]Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, March 27, 1992).

Incentives for Marketing Abuses

The Health Security Act requires the Secretary to develop regulations that establish limits on commissions. The high first-year sales commissions that agents can earn create an incentive for abuses in the sale of long-term care insurance. For example, until the practice was prohibited, large commissions associated with the initial sales of Medigap policies created undesirable incentives for agents to "churn" (that is, to sell) new policies to customers who already had insurance. Currently, NAIC has standards, like Medigap commission standards, that were presented as an option that states and insurers should consider adopting when they identify marketing abuses.

SUPPLEMENTAL INSURANCE

The Health Security Act defines supplemental insurance as a policy that provides coverage for services or items not included in the comprehensive benefit package or coverage for services or items that are included, but limited in amount or scope. It specifically excludes from the definition, Medicare supplement insurance (i.e., Medigap), long-term care insurance, hospital indemnity insurance, specific disease insurance, accident insurance. It also excludes cost sharing policies for which there are provisions in another section of the Act. So defined, it is unclear how large a market will remain for supplemental insurance, particularly if Congress

enacts legislation with universal health insurance coverage. Nonetheless, we have previously found abuses with this kind of insurance. Most of the work we have done on supplemental insurance concerns Medigap insurance, a type of supplemental insurance for which Congress has already enacted notable reforms. While the Health Security Act defines supplemental so as to exclude Medigap, it is nonetheless worthwhile to review briefly some of the problems that plagued Medigap because they are analogous to problems in supplemental insurance generally.

Prohibition of Duplicative Coverage

The Health Security Act prohibits the sale of any supplemental policy that duplicates any coverage provided in the Act's comprehensive benefit package or in Medicare Part B. This is similar to the current prohibition of the sale of duplicative policies in the Medigap market. The purchase by some consumers of multiple policies that duplicated coverage in other policies or even in Medicare was a persistent problem in the sale of Medigap insurance as consumers were confused about what they already had and what they needed.

Marketing Abuses Not Addressed
by the Administration Plan

The Administration plan does not deal with two types of abuses we have previously identified in supplemental insurance: churning and misleading sales practices.

As discussed above, some agents have persuaded consumers of Medigap policies to replace their policies unnecessarily, which resulted in new waiting periods during which policyholders are not covered for preexisting conditions. The NAIC Medigap consumer protection standards of 1989 required that replacement Medigap policies waive the waiting periods applicable to preexisting conditions (or other similar restrictions) to the extent such time was spent under the original policy. The Congress added this protection to federal law in OBRA 1990. To reduce the incentive to churn policies, NAIC's consumer protection standards limited agent's first year commissions to no more than 200 percent of the commissions for the second year. Although the Health Security Act section on long-term care insurance requires the Secretary to develop regulations that establish limits on commissions, there is no such restriction with regard to supplemental insurance.

Finally, there have been problems with sales tactics used to make initial contact with older consumers. Some companies use "cold-lead" cards that solicit information from consumers without

disclosing that the purpose of follow-up calls is to sell insurance. Some agents have used high pressure sales techniques, which are also now prohibited for Medigap insurance.[5] The Health Security Act section on supplemental insurance does not appear to address this issue, although it is covered for long-term care.

Specific Disease and Hospital Indemnity Policies Not Covered

While the section on supplemental insurance in the Health Security Act provides important protection for consumers, it does not include specific disease and hospital indemnity insurance. Benefits from these types of policies typically are payable directly to the policyholder and may be used for any purpose. Hospital indemnity policies generally pay a fixed amount, such as $50, for each day the insured is in the hospital up to some maximum. Specific disease policies (sometimes called "dread disease" policies) cover only particular diseases, typically cancer, and pay a fixed amount for each day of hospitalization or outpatient treatment.

Dread disease and hospital indemnity policies provide narrow protection. They provide limited, fixed benefits without provisions for inflation, and benefits are paid only when the

[5]Medigap Insurance: Better Consumer Protection Should Result From Changes to Baucus Amendment (GAO/HRD-91-49) March 5, 1991

consumer is confined to a hospital or contracts the covered disease. Moreover, they offer a poor return to policyholders. Our review of policies found they had an average loss ratio of 53 percent.[6] Assuming limited funds for health insurance, a consumer's best course of action would be to purchase coverage for the broadest set of possible contingencies.

CONCLUSION

We have testified before your subcommittees on previous occasions and reported on problems in the market for long-term care insurance. We have advocated that consumers be afforded the protection of disclosure standards, an inflation protection option, clear and uniform definitions of services, facilities and eligibility criteria, grievance procedures, nonforfeiture benefits, options for upgrading coverage, and a sales commission structure that reduces incentives for marketing abuses. We believe that the section of the Health Security Act dealing with long-term care insurance generally incorporates these protections.

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[6]A loss ratio is the ratio of benefits paid to total premiums paid. Thus, a ratio of 53 percent means that, on average, 53 cents of each premium dollar was returned to a policyholder in benefit payments or used to increase reserves against future claims. The portion of earned premiums that is not returned to policyholders is available for marketing, administration, and profit. Health Insurance: Hospital Indemnity and Specified Disease Policies Are Of Limited Value (GAO/HRD-88-93, July 12, 1988).

Finally, while the Health Security Act addresses supplemental insurance, it is less comprehensive and offers less protection to consumers than is the case with long-term care insurance.

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This concludes my statement. I would be happy to answer any questions.

GAO REPORTS ON
LONG-TERM CARE INSURANCE AND SUPPLEMENTAL INSURANCE
1988 - 1993

Health Insurance: Hospital Indemnity and Specified Disease Policies Are Of Limited Value (GAO/HRD-88-93, July 12, 1988).

Long-Term Care Insurance: Proposals To Link Private Insurance and Medicaid Need Close Scrutiny (GAO/HRD-90-154, Sept. 10, 1990).

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

Long-Term Care Insurance: Consumers Lack Protection in a Developing Market (GAO/T-HRD-92-5, Oct. 24, 1991).

Long-Term Care Insurance: Risks To Consumers Should Be Reduced (GAO/HRD-92-14, Dec. 26, 1991).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (GAO/HRD-92-54, Feb. 28, 1992).

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, Mar. 27, 1992).

Long-Term Care Insurance: Better Controls Needed to Protect Consumers (GAO/T-HRD-92-31, May 20, 1992).

Long-Term Care Insurance: Actions Needed to Reduce Risks to Consumers (GAO/T-HRD-92-44, June 23, 1992).

Long-Term Care Insurance Partnerships (GAO/HRD-92-44R, Sept. 25, 1992).

Long-Term Care Insurance: Tax Preferences Reduce Costs More For Those in Higher Tax Brackets (GAO/GGD-93-110, June 22, 1993).

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (GAO/HRD-93-129, Aug. 25, 1993).

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