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Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives

May 1987

LONG-TERM CARE INSURANCE

Coverage Varies Widely in a Developing Market

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GAO

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Human Resources Division

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The Honorable Claude Pepper
Chairman, Subcommittee on Health and
Long-Term Care
Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

In response to your request, this report on private long-term care insurance policies provides information in three key areas: (1) policy benefits and premiums, (2) policy limitations and restrictions, and (3) the potential for abuse in the market.

As you requested, we did not obtain official comments from the Department of Health and Human Services. Unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time, we will provide copies to the Secretary of Health and Human Services, the Director of the Office of Management and Budget, and other interested parties.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

Of all demographic groups in society, the elderly group is at greatest risk of incurring high health care expenses. In 1988, estimated nursing home expenditures will exceed $46 billion, of which the elderly and their families will pay about half. Private long-term care insurance is a method of financing these potentially catastrophic expenses.

The Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, requested that GAO provide information on the private long-term care insurance market. In particular, GAO was asked to focus on benefits and premiums, policy limitations and restrictions, and the potential for abuse in the market.

Background

The Medicare program and private Medicare supplemental insurance (also known as "Medigap" policies) provide limited nursing home coverage for skilled care services. State Medicaid programs cover extended nursing home stays associated with chronic, debilitating disease but only for those who meet strict eligibility standards based on income and resources.

Unlike the Medigap market, no federal legislation defines guidelines for the long-term care insurance market, which differs from Medigap insurance in nature and scope. In 1980, the Congress amended the Social Security Act (the Baucus Amendment) to provide standards for policies marketed as Medigap insurance. But implementing regulations do not apply to long-term care policies.

In 1985, at congressional request, the Department of Health and Human Services (HHS) established a Task Force on Long-Term Health Care Policies. In consultation with the National Association of Insurance Commissioners, the task force is developing recommendations, due by October 1987, to improve consumer protection and promote the long-term care insurance market.

Results in Brief

Long-term care insurance policies offer consumers a wide range of coverages and premiums. In general, however, policy restrictions and limitations tend to reduce the benefits available to policyholders. For instance, almost all policies make benefits contingent on a prior hospital stay—a measure of medical necessity. But many policyholders with chronic, debilitating conditions may require assistance with eating, bathing, housekeeping, and other less medically oriented types of care. Furthermore, lack of uniform standards and marketing requirements

means consumers have little protection against substandard policies and sales abuse.

The potential for abuse related to both unclear policy language, especially with regard to coverage limitations, and abusive marketing practices exists in the long-term care insurance market just as it does in the Medigap market. A 1986 legislative proposal by the National Association of Insurance Commissioners attempts to strike a balance between protecting consumers and promoting product innovation. As of March 1987, at least nine states had taken action to improve consumer protection.

GAO's Analysis

GAO analyzed the premiums, benefits, and limitations of 33 policies offered by 25 insurers in 1986. These companies account for a sizable portion of the private long-term care insurance policies sold nationwide. Also, GAO assessed the potential for abuse in this market by surveying state insurance commissioners in 26 states, interviewing officials with consumer advocacy groups, and reviewing consumer guides in the long-term care insurance literature.

Review of Policies

The 33 policies offered a broad range of indemnity payments—fixed dollar amounts paid per eligible day of coverage. There was considerable variation in the indemnity benefit amounts available—from less than $10 to $120 per day—and, consequently, in the premiums charged—from $20 to over $7,000 per year for varying levels of coverage at different ages. Unlike health insurance policy payments that vary according to benefits received, these payments remain constant over the period of coverage and are not designed to keep pace with inflation. Duration of benefits also varied widely from 6 months to 6 years for nursing home care and 10 days to 6 years for home health services.

Many of the 33 policies offered a broad range of long-term care benefits. For instance, 48 percent provided benefits for four levels of long-term care (skilled, intermediate, custodial, and home care), and 63 percent give consumers a choice of waiting period (the length of time a policyholder must wait before benefits are payable). Moreover, over half the policies covered mental disorders of demonstrable organic origin (such as Alzheimer's disease). Because definitive diagnosis of Alzheimer's disease is difficult, however, insurers may be able to deny claims for such disorders.

Other policy clauses limited the use of benefits. For example, 88 percent made benefits contingent on prior hospitalization and all but two of these required nursing home admission within 14 to 30 days of hospital discharge. In addition, 32 percent of the nursing home policies paid benefits for shorter time periods as the level of care was reduced from skilled or intermediate to custodial care.

Generally, premium costs varied depending on age, daily indemnity benefit amounts, duration of benefits, and length of waiting periods. Insurers maintained that the lack of company-specific actuarial data made pricing long-term care policies difficult. They also contended that high premiums compensated them for taking risks associated with new product development in an uncertain and potentially expensive market and that, over time, competition would drive prices down.

Finally, about 70 percent of the 33 policies were guaranteed renewable. Although insurers reserve the right to change premiums for a class of insurers in a state, according to the National Association of Insurance Commissioners these policies cannot be canceled. For the remaining 30 percent of the policies, insurers could deny renewal at their sole discretion or by class, geographic area, or for stated reasons other than deterioration of health.

Abuse in the Market

State insurance officials, consumer advocates, and long-term care policy analysts told GAO the potential exists for the same types of abuse found in the sale and marketing of Medigap policies to occur in the long-term care insurance market. Many states have established programs to educate elderly persons shopping for long-term care insurance to guard against abusive marketing practices. Moreover, at least three states have taken formal action to address the problem of misleading policy language. Six other states set minimum standards for provisions included in long-term care insurance policies intended to reduce the potential for product content abuse.

The National Association of Insurance Commissioners developed model legislation to reduce the potential for abuse in the long-term care insurance market. The model act contains voluntary guidelines for policies, including (1) certain minimum standards for policy coverage; (2) an outline of coverage designed to give consumers clear information on benefits, exclusions, restrictions, limitations, and renewal provisions; and (3) a 10- or 30-day "free-look" provision that would allow a policyholder to return the policy after examination of its contents.

Matter for Congressional Consideration

Private long-term care insurance is a nascent line of insurance. Although the current market is small, it will probably expand as people become more aware of the limits of Medicare coverage and the potentially catastrophic out-of-pocket expenditures they may incur. There is some indication that misleading sales and marketing practices are being used in this market.

In response, some states have already taken action to better protect consumers. While some insurers and other industry experts believe that standards would stifle innovation in the market, other long-term care experts contend that minimum standards are needed to protect consumers. Striking a balance between experimentation and appropriate consumer protection is the dilemma facing legislators today in this developing market. The National Association of Insurance Commissioners has developed model legislation designed to strike this balance. Therefore, the Subcommittee may want to consider the desirability of enacting federal legislation to reduce potential abuse at this stage of market development.

Recommendations

Because of the matter for congressional consideration, GAO is making no recommendations to executive branch agencies.

Agency Comments

GAO did not request official agency comments on a draft of this report. The views of directly responsible federal and state officials were sought during the course of the work, however, and were incorporated in the report wherever appropriate.

Contents

Figures

Abbreviations

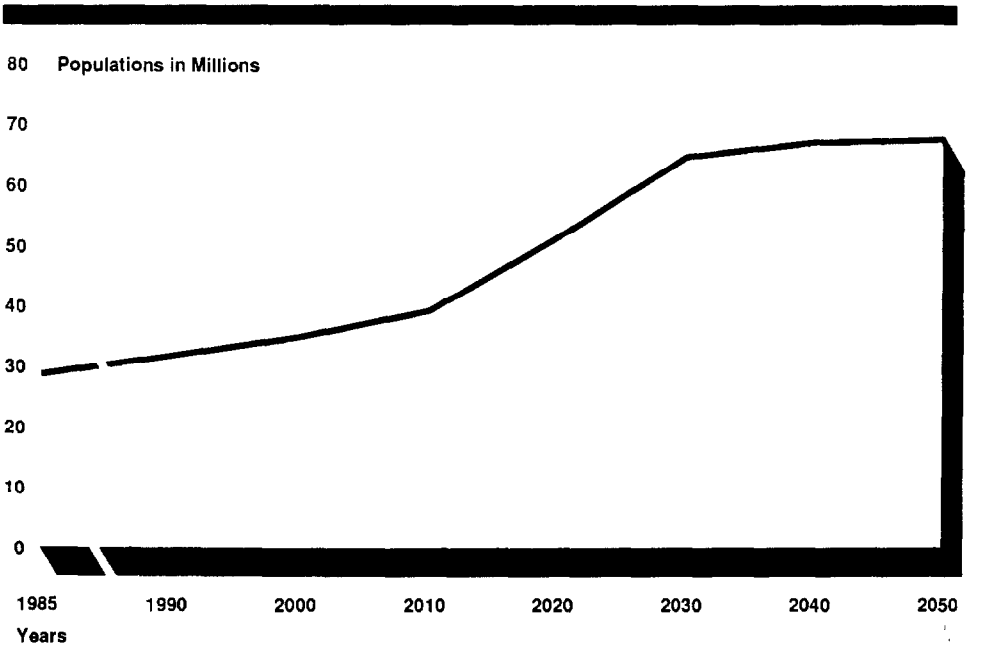
AARP	American Association of Retired Persons
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HIAA	Health Insurance Association of America
HHS	Department of Health and Human Services
NAIC	National Association of Insurance Commissioners
PPS	prospective payment system
SNF	skilled nursing facility

Introduction

One of every four elderly will enter a nursing home during his or her lifetime. Need for assistance with activities of daily living[1] —a potential predictor of long-term care utilization—increases dramatically with age. The 1982 National Long-Term Care Survey indicates that 12.6 percent of elderly aged 65 to 74 need such assistance, compared with 45.8 percent of those 85 years old and over. Moreover, 10.4 percent of those over 85 have severe limitations (require assistance with at least five activities of daily living) compared with 2.1 percent of those aged 65 through 74. In 1985, an estimated 2 percent of the elderly aged 65 to 74 were institutionalized in nursing homes compared with 16 percent of those over 85.

The elderly population—those 65 years of age and over—is growing rapidly. In 1985, the number of persons aged 65 and over was estimated at 28.6 million or 12.4 percent of the U.S. population. By 2030, the elderly population is expected to more than double to nearly 65 million or 21 percent of the population. This projected growth is illustrated in figure 1.1.

Figure 1.1: Projected Elderly Population (1985-2050)



Growth in the older subgroups within the elderly population will be the most dramatic, as table 1.1 indicates. For instance, those age 85 and

[1]Activities of daily living are bathing, dressing, eating, toileting, and getting out of bed and around indoors.

over comprised 9.4 percent of the elderly in 1985, but, by 2010, they will make up almost 17 percent of the elderly population.

Table 1.1: Projected Percent Distribution of the Elderly Population by Age (1985-2050)

	Percent of elderly population			
Age group	**1985**	**2010**	**2035**	**2050**
65 to 69	32.2	29.9	24.0	24.6
70 to 74	26.6	21.8	24.3	20.0
75 to 79	19.6	17.4	21.0	17.1
80 to 84	12.2	14.0	14.8	14.5
85 and over	9.4	16.9	16.0	23.7
Total	**100.0**	**100.0**	**100.0[a]**	**100.0[a]**

[a]Total may not add to 100 due to rounding.

Source: Computed from Bureau of Census, Publication Series P-25, No. 952, 1984.

Elderly Face Potentially High Long-Term Care Expenses

Of all demographic groups in society, the elderly group is at greatest risk of incurring high health care expenses. As table 1.2 shows, the Medicare program, enacted in 1965, was designed to finance medical expenses associated with acute and post-acute restorative care. Supplemental private "Medigap" policies fill some of the Medicare gaps (e.g., deductibles and copayments) but do not finance extended long-term care services. As a result, many elderly Americans face the risk that catastrophic out-of-pocket expenses associated with chronic debilitating illness will result in their impoverishment. In particular, Medicare does not cover skilled nursing home stays beyond 100 days, stays of any length requiring intermediate or custodial care, and home health care for those not confined to the home or requiring skilled nursing care.

Medicaid, a federal/state program of medical assistance, covers long-term care for certain categories of poor people. Medicaid eligibility, however, requires that individuals impoverish themselves before benefits begin. Through a process called "spend down," the elderly deplete their assets[2] to state eligibility levels. Available data indicate that as many as two-thirds of Medicaid nursing home patients entered the facilities as private payers. A Massachusetts study[3] showed that 63 percent of these persons spent down to Medicaid eligibility levels within 13 weeks of admission.

[2]An unknown number of the elderly also transfer their assets before applying for Medicaid to avoid impoverishment.

[3]U.S. Congressional Research Service, Financing and Delivery of Long-Term Care Services for the Elderly, U.S. Library of Congress, 85-1033 EPW (Washington, D.C., Oct. 17, 1985), p. 22.

Table 1.2: Schedule of Benefits Provided by Medicare and Medigap Insurance

Service	Benefit	Medicare pays	Beneficiary is responsible for	Percent of Medigap policies covering expenses[a]
Hospitalization—semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	First 60 days	All but the deductible	$520	56%
	61st to 90th day	All but daily coinsurance	$130 a day	100%
	91st to 150th day	All but daily coinsurance	$260 a day	100%
	Beyond 150 days	Nothing of covered charges up to 365 days.	All charges	100% cover 90%
Post hospital skilled facility care—in a facility approved by Medicare if the beneficiary has been in a hospital for at least 3 days and enters the facility within 30 days after hospital discharge	First 20 days	Full cost	Nothing	N/A
	Additional 80 days	All but $65 a day	$65 a day	47%
	Beyond 100 days	Nothing	All charges	-0-
Home health care	Unlimited medically necessary visits	Full cost	Nothing	N/A
—by a Medicare-certified home health agency for patients who are confined to home, under physician care, and need intermittent skilled nursing care or physical or speech therapy	Nothing	All charges	-0-	
—for chronic conditions if the listed requirements are not met				

[a]From on a sample of 142 policies, including Blue Cross and Blue Shield plans, the top five high-volume commercial insurers, and a random sample of lower volume commercial insurers in Arizona, California, Colorado, Florida, Maryland, Massachusetts, Missouri, New Jersey, Pennsylvania, Rhode Island, Washington, and the District of Columbia.

Source: Based on Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 1986), p. 20, and Medicare and Medicaid Guide, Commerce Clearing House, Inc., No. 505 (Nov. 4, 1986), p. 113.

The average cost of a year of nursing home care is about $22,000, according to the Department of Health and Human Services (HHS), which is responsible for Medicare and Medicaid. In the aggregate, nursing home costs in 1984 were $32.0 billion, of which Medicare paid only about 2.1 percent. Over 50 percent of nursing home costs were paid out-of-pocket by the elderly and their families, and Medicaid paid nearly 42 percent. In contrast, only 1.1 percent of nursing home costs were financed by private long-term care insurance. Nursing home expenditures are estimated to exceed $46 billion in 1988.

Potential for Private Long-Term Care Insurance Studied

Demographic trends, state efforts to reduce Medicaid spending, and projected improvement in the elderly's financial status led many insurers, providers, and policy analysts to conclude that the market for long-term care insurance has the potential for growth. In addition, widespread purchase of Medigap policies by approximately two-thirds of the elderly suggests that demand can be stimulated for a product that fills gaps in long-term care coverage. One study[4] estimates that by 2005, about 93 percent of all married couples and almost 60 percent of all single persons age 65 and over would be able to buy long-term care insurance with less than 5 percent of their cash income.[5] Another study by an investment banking firm[6] predicts that the market for such insurance may develop rapidly and finance 5 to 10 percent of total nursing home expenditures by the early 1990s.

Others are less optimistic about market growth and doubt that private insurance can contribute significantly to the financing of long-term care. These analysts believe that most individual policies currently on the market are affordable by only a small segment of the elderly population, may not offer comprehensive coverage for long-term care services, and provide indemnity payments not indexed to inflation.

In 1985, HHS established, at the request of the Congress and in consultation with the National Association of Insurance Commissioners (NAIC), a task force on long-term care insurance. The task force is reviewing issues relating to long-term care and making recommendations for promoting the development of the private long-term care insurance market. In addition, the task force is sponsoring efforts to assist companies in sharing actuarial data so that they can develop policies more quickly.

The NAIC established an advisory committee on long-term care in March 1985. Committee members represent the health insurance industry and the Health Care Financing Administration, the HHS agency that administers Medicare and Medicaid. The advisory committee recently issued a

[4]ICF, Inc., Private Financing of Long-Term Care: Current Methods and Resources. Prepared for the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (Washington, D.C., Jan. 1985).

[5]Certain groups of the elderly—notably women, blacks, and persons over 85 years of age—are expected to be disproportionately represented among the elderly with income below the poverty level.

[6]Robertson, Colman & Stephens, Long-Term Care Insurance: An Emerging Growth Opportunity for the Nursing Home Industry (San Francisco, July 29, 1986).

report[7] on long-term care insurance. It also developed a legislative proposal in the form of a model act (adopted by the NAIC in December 1986) designed to facilitate the development of long-term care insurance products while protecting the public from potential abuses in this new market. Other groups, including an advocacy group representing the elderly, the American Association of Retired Persons (AARP), trade associations representing insurers (the Health Insurance Association of America (HIAA) and the Blue Cross and Blue Shield Association), and trade associations representing providers (the American Health Care Association, the American Association of Homes for the Aging, and the National Association for Home Care) have also formed or participated in long-term care insurance task forces.

Objectives, Scope, and Methodology

The Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked us to determine

- which companies currently market long-term care insurance policies,
- the range of benefits and costs of policies currently being sold and the availability of coverage for different age groups,
- whether policies contain clauses that restrict eligibility for benefits,
- what loss experience data (the expected percent of benefits paid compared to premiums earned) are available for companies that have sold policies,
- whether marketing abuses have been identified and the potential for marketing abuse in this market, and
- what federal laws provide protection to individuals who purchase long-term care insurance policies.

To accomplish the first three objectives, we reviewed the literature on long-term care insurance (see bibliography on p. 49). We also examined consumer guides to the market and comparative studies of long-term care insurance policies. The Brookings Institution and HIAA provided the most recent and comprehensive analyses of policies marketed during 1986.

We obtained long-term care policies and policy brochures from the Brookings Institution to avoid duplicating their 1986 data-gathering effort. Also, we contacted insurance companies to (1) obtain copies of

[7]Long Term Care Insurance: An Industry Perspective on Market Development and Consumer Protection, Report submitted to NAIC Medicare Supplement, Long Term and Other Limited Benefit Plans Task Force (Jan. 1987).

policies where we had received only brochures for some plans that were included in the Brookings Institution analysis, (2) determine whether the policies had been revised during 1986, and (3) verify, where the Brookings Institution's documentation was not available, that the policies were being offered in 1986. Through our review of literature on long-term care insurance, we identified four policies not included in the Brookings study. In total, our analysis included 33 policies offered by 25 different companies (we included more than one policy for some companies). Available data indicate that as of July 1986, four of these companies accounted for about 75 percent of the estimated 200,000 policyholders nationwide. The companies are listed in appendix I and the policies are compared in appendix II.

Our survey of state insurance departments (in 26 states we contacted) indicated that at least 47 other companies had approved long-term care insurance policies in one or more of the states surveyed (see apps. III and IV). But state officials did not know whether these policies were similar to the 33 we reviewed. They also did not always know if these policies were currently being marketed or sold. Time constraints precluded expanding our scope to include these other policies.

All 33 policies we examined were marketed as long-term care policies, regardless of the comprehensiveness of coverage. For example, two companies offered only home health care benefits and another offered separate policies for different levels of care (e.g., skilled nursing or home care). We counted each policy as a long-term care insurance policy regardless of its limitations, except when our analysis necessitated differentiation by type of policy. For example, the two policies offering only home care are not included in the discussion of duration of nursing home benefits. In addition, because all policies or brochures did not contain information for each policy feature we analyzed, the total number of policies varies for some features, as noted in the text.

For each policy, we analyzed key features, including benefits, coverage, premium levels, and policy limitations, and compared these with the NAIC model act guidelines. Also, we evaluated the cumulative effect that certain policy restrictions might have on benefits. We did not, however, quantify the actual impacts of policy restrictions and limitations. Until more experience data become available on how insurers interpret restrictions and limitations during claims handling, such analyses cannot be done.

To obtain loss experience data, we contacted actuaries and insurance officials active in the long-term care insurance market. We inquired about their efforts to develop the data needed to project losses for these policies.

To determine the potential for sales and marketing abuse, we (1) contacted 26 states (see app. III), including 16 that either regulated long-term care insurers or were represented on the NAIC Long-Term Care Insurance Task Force and 10 others chosen randomly, (2) administered a telephone survey to officials in the 26 state insurance commissioners' offices to obtain their views on the potential for abuse and to document specific cases of marketing abuse, (3) reviewed state regulations and minimum standards pertaining to the marketing and selling of long-term care insurance, and (4) reviewed the NAIC task force study results.

Additionally, we contacted individuals knowledgeable about long-term care insurance products and abusive marketing tactics because of either their insurance industry experience (e.g., state insurance commissioners and members of HIAA) or their research on these issues (e.g., experts at the National Center for Health Services Research and SRI International). We also contacted representatives of advocacy groups for the elderly (e.g., AARP and the United Seniors Consumer Cooperative) to obtain their views on the incidence of and potential for abuse in this insurance market.

Finally, to ascertain whether any federal laws protect buyers of long-term care policies, we searched the United States Code and legislative history of section 9601 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272). The act established a task force on long-term care insurance, discussed on page 11, to advise the Secretary of HHS. We also determined whether regulations pertaining to Medicare supplemental health insurance (also called "Medigap" insurance) applied to long-term care insurance policies.

Our work was performed from November 1986 through January 1987, in accordance with generally accepted government auditing standards. At the Subcommittee's request, we did not obtain written comments on this report. The views of responsible federal, state, and private officials were sought, however, and incorporated in this report where appropriate.

Chapter 2

Benefits and Limitations of Private Long-Term Care Insurance

Long-term care insurers in 1986 offered a wide range of benefits and premiums, primarily to individuals. The current long-term care insurance market is relatively small. Both the individual and employer-based group markets may expand over the next few years, however, due to recent insurer activity.

Comparison of the policies is difficult because (1) definitions of care and other key policy features are not uniform and (2) effects of various policy restrictions and limitations on benefits are not known.

The Long-Term Care Insurance Market

As of mid-1986, an estimated 200,000 people held private long-term care policies. Presuming that most are over 65, this would represent less than 1 percent of the elderly. But there is considerable public and private sector interest in expanding the private insurance market to finance future long-term care expenses. By protecting individuals from catastrophic costs of care, insurance could reduce the number of persons applying for Medicaid, thereby reducing government expenditures for long-term care.

Surveying 60 of its members in 1986 to assess activity in the long-term care insurance market, HIAA found evidence of both expansion and contraction of the market. For example, 28 companies were either selling or developing long-term care policies. Since completion of the survey in June, four insurers that had not been selling began to market policies. On the other hand, a company with significant market share reduced its sales efforts, and another company stopped issuing new long-term care policies.

In our opinion, recent developments indicate that, in the next several years, significant market activity may occur. For example,

- Blue Cross and Blue Shield plans were increasing their activity in the market: 8 plans had policies scheduled for introduction in 1987, and 13 plans were developing new policies.
- At least three companies had individual policies that were approved for sale by state insurance departments in more than 40 states; most other insurers operated in only one or a few states.
- In Arizona, 63 companies recently filed for approval of long-term care insurance policies.

As of December 1986, we contacted 26 states (see app. III) and identified a total of 47 other companies (see app. IV) offering at least one approved policy in addition to the 33 policies we analyzed.

In the employer-based group long-term care market, there were two developments in early 1987:

- Two major commercial insurers announced the availability of group policies.
- The U.S. Office of Personnel Management issued a proposal to allow federal employees to convert a portion of their life insurance benefits to long-term care coverage.

Benefits Offered Vary Widely

We reviewed 33 long-term care insurance policies offered by 25 companies to determine the availability of benefits for four levels of long-term care services—skilled nursing care, intermediate care, custodial care, and home care. (A summary comparison of the salient features of these policies appears as app. II.) We found that definitions of care often were not uniform between policies, making comparisons difficult. Also, there was wide variation—from 1 to 6 years—in the length of time benefits would be paid and in daily indemnity amounts—under $10 to $120—for all levels of long-term care services. On the other hand, relatively short waiting periods were common but tended to duplicate Medicare skilled nursing home coverage.

In addition, almost all policies contained restrictive clauses that attempt to establish medical necessity. Insurers use these restrictions to establish conditions of appropriate use. These clauses, however, tend to reduce the likelihood that the policies will pay benefits, especially for custodial care, which is often based more on the need for assistance in performing activities of daily living than on the need for medical care. For example, almost all policies made benefit payments contingent on prior hospitalization, which serves as a proxy measure of medical need, and all but two of these policies required nursing home admission within either 14 or 30 days of hospital discharge.

The application of medical necessity clauses to intermediate, custodial, and home care can be particularly restrictive. Strictly speaking, these less intensive levels of care may not be medically necessary; that is, acute medical illness may not be the immediate cause of the need for services. Rather, assistance with eating, bathing, shopping, housekeeping, and so on may be needed as a result of chronic, debilitating

conditions. For the less medically intensive levels of care, measures of appropriate utilization other than medical necessity might better assure that policyholders would receive benefits for needed services.

Levels of Care Covered

The NAIC Advisory Committee, noting that definitions in long-term care policies vary, described four levels of services, as follows:

- skilled nursing home care—nursing and rehabilitative services given by skilled medical personnel on a daily basis under the orders of a physician;
- intermediate nursing home care—skilled nursing care provided on an occasional basis;
- custodial nursing home care—assistance in requirements of daily living such as eating and bathing, which can be provided by persons without medical skills (also referred to as personal care); and
- home care—a variety of services provided in the home, including skilled nursing care; speech, physical, and occupational therapy; social work, personal care, and homemaker and choreworker services.

Of the 33 policies reviewed, 16 (48 percent) included all four levels of care, and 28 (85 percent) included at least skilled, intermediate and custodial nursing home care. For other than skilled nursing home care, insurers used different terms—intermediate care, personal care, and custodial care—to describe their nursing home benefits. Definitions of these terms varied from policy to policy.

All policies stipulated that care be received in a licensed facility. State definitions of levels of care used in licensing facilities, however, varied considerably. One insurer was developing 50 different policies tailored to state differences. Insurers also incorporated other facility-specific requirements into their definitions. Specifically, certain insurers would not pay benefits to policyholders receiving care in facilities with less than a minimum number of beds, and others stipulated staffing patterns for different levels of care.

The NAIC Advisory Committee recognized that the lack of uniformity poses problems for insurers and consumers alike in the long-term care market. For insurers, utilization data from different states may not be comparable; as a result, companies may not be able to share actuarial data. This lack of actuarial data is likely to impede market development because insurers may view long-term care insurance as too risky. For

consumers, multiple definitions of levels of care make meaningful comparisons of competing policies very difficult.

Restrictive Clauses

The policies we reviewed contained restrictions that tend to reduce the probability that policyholders will receive benefits. Table 2.1 shows the number of policies that contained at least one of four restrictions we identified.

Table 2.1: Restrictions on the Payment of Benefits (1986)

Restriction	Policies containing restrictions
Care must be received in a skilled nursing facility	5[a]
Prior hospitalization required to receive long-term care benefits	29[b]
Care must be received within a specified time frame after hospital discharge:	
— 14 days	12[c]
— 30 days	13[c]
— 90 days	2[c]
— immediate	1[c]
Intermediate and custodial nursing home care must be preceded by more medically intensive care	14[d]

[a]Based on 28 policies offering skilled, intermediate, and custodial nursing home care.

[b]Based on 33 policies (the total number of policies reviewed).

[c]Based on 28 policies stipulating a time frame.

[d]Based on 31 policies offering nursing home benefits.

Policies requiring that services be provided in a skilled nursing facility (SNF) might encourage inappropriate placement of individuals at higher and more expensive levels of care than necessary. In states with preadmission screening programs, such placements might not be allowed, and insureds would be unable to collect benefits. Similarly, policyholders might be unable to receive benefits where SNF beds were in relatively short supply. In 1982, the number of SNFs varied from 4 (with 378 beds) in New Mexico to 1,085 (with 100,235 beds) in California.[1]

Another common restrictive clause required prior hospitalization to help assure that claims were paid only for medically necessary nursing home care. Policies with this requirement generally stipulated a hospital stay

[1]Current data on the number of beds in SNFs per 1,000 elderly were not available; however, in 1984, the national average was 53.7 beds in certified facilities per 1,000 Medicare recipients, ranging from 10.2 in Arizona to 96.6 in Minnesota.

of at least 3 consecutive days. Specifically, 88 percent (29 of 33) of policies had a restriction requiring prior hospitalization. At least one provided the option of paying a higher premium for nursing home coverage without a prior hospitalization requirement. Four policies had no such requirement.

In three policies (of which two were for home care only), the prior hospital stay requirement also pertained to home care benefits. According to 1982 data, about 14 percent of Medicare home health users did not have a hospital admission during the year they received home health benefits. Medicare does not have a prior hospitalization requirement for its home health benefit.

The NAIC Advisory Committee found prior hospitalization clauses to be appropriate, although less than perfect, proxies for medical necessity. According to a 1985 study,[2] however, at least 25 percent of intermediate level nursing home admissions are not preceded by a hospital stay. The advisory committee noted that some insurers were developing innovative long-term care insurance policies that included alternative mechanisms to assess the appropriateness of nursing home utilization. These mechanisms may allow insurers to develop measures of legitimate need rather than strict medical necessity in future long-term care policies.

Prior hospitalization clauses also stipulate the maximum number of days that may elapse between hospital discharge and long-term care services. Medicare regulations require that patients be admitted to a nursing home within 30 days of hospital discharge.[3] Similarly, in section 6(D) of the model act, NAIC recommends that long-term care insurance policies allow at least 30 days between hospital discharge and nursing home admission. Of the 29 nursing home and home care policies with a prior hospitalization restriction, 28 stipulated a time frame between hospital discharge and nursing home admission or home care, including one policy requiring that in-home private duty nursing begin immediately after hospitalization. Of the 28 policies, 12 (43 percent) required an elapsed time of no more than 14 days from hospital discharge; 13 (46 percent) specified 30 days; and 2 policies allowed 90 days to elapse between hospital discharge and nursing home admission.

[2]M. Smallegan, "There Was Nothing Else to Do: Needs for Care Before Nursing Home Admission," The Gerontologist, Vol. 25 (1985), pp. 364-69.

[3]HHS lengthened the allowable elapsed time from 14 to 30 days in December 1980.

Long-term care researchers note that it often takes time for physicians, patients, and family to decide whether alternatives to institutionalization can be arranged. Policyholders who face forfeiture of their nursing home benefits if they are not admitted quickly may feel pressured to seek nursing home admission without giving adequate consideration to other alternatives.[4] For this reason, allowing more time to enter a nursing home after hospitalization should benefit the insureds.

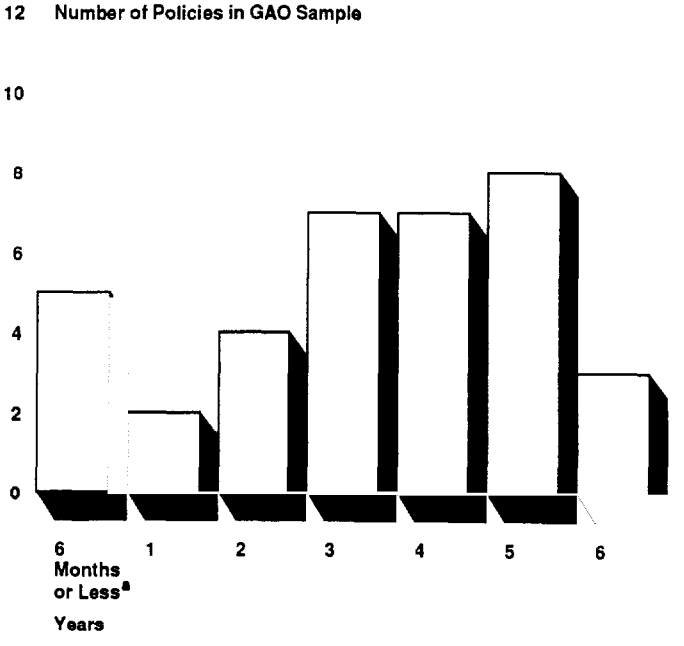
Another restrictive clause requires that less medically intensive nursing home stays be preceded by stays at successively higher levels of care. In 14 (45 percent) of the 31 policies offering nursing home benefits, receiving benefits at a lower level of care (e.g., intermediate or custodial) was contingent upon a stay of a specified length at a more medically-intensive level of care (e.g., skilled nursing). In our opinion, these clauses would preclude payment of benefits for many nursing home stays, such as those for individuals admitted directly to an intermediate care facility.

Duration of Benefits

All policies we reviewed stipulated the length of time benefits would be paid (duration of benefits) to policyholders. Nursing home benefits ranged from 3 months to 6 years and home health benefits ranged from 10 days to 6 years. Figures 2.1 and 2.2 show the duration of benefits offered in the policies we reviewed. In section 4(A) of the model act, NAIC recommends that long-term care insurance policies offer not less than 12 consecutive months of benefits but does not specify a particular level of care.

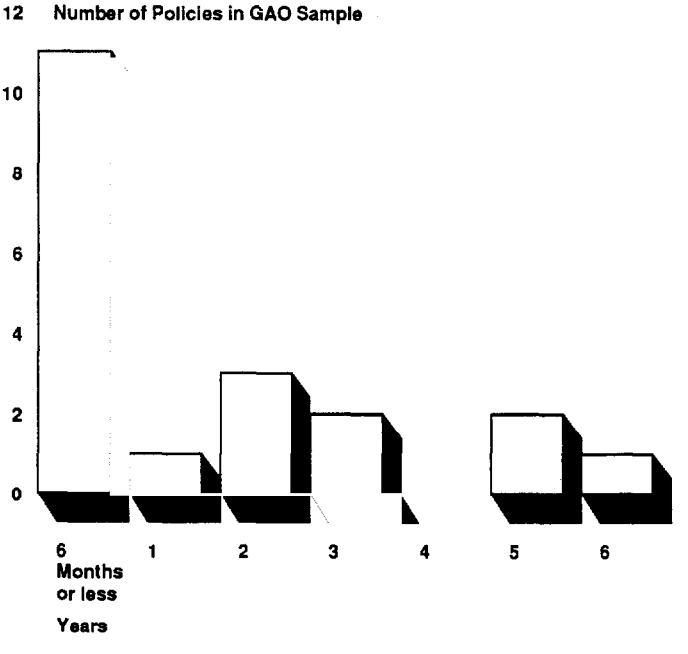
[4]M. Meiners, The State of the Art in Long-Term Care Insurance, U.S. Department of Health and Human Services, National Center for Health Services Research (Apr. 9, 1984), p. 15.

Figure 2.1: Maximum Duration of Nursing Home Benefits (1986)



[a]Custodial nursing home care only.

Figure 2.2: Maximum Duration of Home Care Benefits (1986)



One study[5] estimates that the average length of stay for "long-stay" nursing home patients is 2.5 years. Long-stayers are usually elderly persons who are no longer able to live in the community and may be expected to spend the rest of their lives institutionalized. Moreover, these long-stayers account for over 91 percent of nursing home residents. This suggests that 1 year of benefits may be insufficient to cover the expected expenses for many persons in nursing homes.

About 32 percent (10 of 31) of the nursing home policies we examined offer shorter durations of benefits for lower levels of nursing home care. Data for 1983, however, showed that Medicare nursing home patients admitted for post-acute rehabilitative care had a mean length of stay of 34.9 days compared with 419.7 days for non-Medicare patients admitted for chronic, maintenance therapy.[6] Because these custodial stays are typically much longer than stays at higher levels of care, benefits offered by the 10 policies did not correspond with probable need. More insurers, however, were offering custodial benefits in 1986 than in the past.

Indemnity Amounts and Lifetime Maximums

The long-term care policies offered a broad range of indemnity payments—fixed dollar amounts paid per eligible day of coverage—at all levels of long-term care.[7] We determined that there was a wide range of daily benefit amounts for each level of long-term care (see table 2.2). Futhermore, more than half the policies that covered one or more levels of nursing home care paid a daily benefit comparable to HCFA's 1985 estimated average SNF payment of $58 per day. Also, more than half offering home health benefits provided coverage comparable to HCFA's reported average charges by Medicare home health agencies, estimated at $49 per visit in 1985.

[5]E. Keeler, et al., "Short- and Long-Term Residents of Nursing Homes," Medical Care, Vol. XIX (1981), pp. 363-69.

[6]U.S. Department of Health and Human Services, Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare (Washington, D.C., Jan. 1985), p. 122.

[7]In general, indemnity policies limit insurers' liability. We identified nine indemnity policies that paid amounts charged or a fixed indemnity amount, whichever was less, and one service policy that covered per diem charges at participating nursing homes up to $72 per day.

Table 2.2: Range of Long-Term Care Benefit Amounts (1986)

Long-term care benefit	Lowest daily amount	Highest daily amount	Policies that cover at least $50 per day of nursing home services	Policies tha cover a least $4(per day/visi for home care services
Skilled care	$16	$120	27[a]	N/A
Intermediate care	$5	$120	22[b]	N/A
Custodial care	$2	$120	19[c]	N/A
Home care	$1	$120	N/A	1[d]

[a]Based on 31 policies offering skilled care.

[b]Based on 28 policies offering intermediate care.

[c]Based on 29 policies offering custodial care.

[d]Based on 21 policies offering home health care.

In addition to daily indemnity amounts, 16 (48 percent) of the 33 policies cited a lifetime maximum dollar payout. The range was from $13,000 to over $255,000. Four policies explicitly offered unlimited lifetime maximums and 13 (39 percent) policies were silent about lifetime maximums or did not state the dollar limit.

Many policies would pay the same benefit amount for different levels of care. Specifically,

- of 28 policies offering skilled, intermediate, and custodial care, 17 would pay the same amount for all three levels, and
- of 16 policies offering all three levels of nursing home care and home health care, 2 would pay the same amount for all four levels.

In contrast, more than 10 of 28 policies offering three levels of nursing home care would decrease the indemnity payment for care at either the intermediate and/or custodial level.

Indemnity policies have a major deficiency, discussed in the literature[8] —their benefits are not adjusted for inflation.[9] A payment level that is adequate today may not be adequate in the future. For example,

[8]M. Meiners, The State of the Art in Long-Term Care Insurance, U.S. Department of Health and Human Services, National Center for Health Services Research (Apr. 9, 1984) and J. Weiner, et al., Private Long-Term Care Insurance: Cost, Coverage, and Restrictions, The Brookings Institution (Washington, D.C., Dec. 1986) (draft).

[9]In 1987, one commercial insurer is offering the option of an automatic 5-percent annual increase in benefit payments for 10 years not to exceed 150 percent of the initial daily indemnity benefit.

assuming historic nursing home inflation rates continue, a policyholder with a $50 daily benefit purchased at age 65 would need about $160 per day to have comparable purchasing power at age 85. At an annual inflation rate of 6 percent, an indemnity level providing nearly full coverage initially would cover 75 percent of costs 5 years later; 56 percent 10 years later; 42 percent 15 years later; and 31 percent 20 years later. Consumers who buy at younger ages would pay lower premiums but face sharply eroded future benefits after adjusting for inflation.

Waiting Periods

Long-term care insurance policies vary in terms of the numbers of days insureds must wait before they are eligible to collect benefits. These waiting periods are analogous to deductibles—benefits are not payable until the insured has met a certain amount of expenses. In the case of long-term care, the deductible is a specified number of nursing home or home care days paid for by the policyholder.

Table 2.3 shows that 20 policies offered consumers two or three choices of when benefit payments will begin and 12 offered no choice. "First-dollar coverage" beginning on the first day of confinement (no waiting period) was offered as a choice in 13 policies and stipulated in 6 policies.

Table 2.3: Waiting Periods Before Benefits Are Paid (1986)

When benefits begin	Policies with different waiting periods[a]
Choices of waiting periods offered in policies:	
0 or 20 days	1
0, 20, or 100 days	10
20 or 100 days	4
0 or 100 days	2
20, 100, or 180 days	1
15, 30, or 90 days	1
20, 60, or 100 days	1
Total	**20**
Waiting periods stipulated (no choice) in policies:	
0 days	6
20 days	5
90 days	1
Total	**12**

[a]Based on 32 policies providing information on waiting periods.

Medicare and supplemental Medigap policies cover relatively short SNF stays of less than 100 days. Long-term care insurance policies with short waiting periods, therefore, often duplicate Medicare and Medigap coverage (except for stays that do not qualify for Medicare benefits). According to HHS, nearly 40 percent of nursing home admissions are for stays of less than 30 days, and another 10 percent are for stays between 30 and 90 days. Consumers with Medicare but not Medigap coverage, therefore, might find 21-day waiting periods preferable, whereas those with both Medicare and a Medigap policy providing nursing home coverage might prefer longer waiting periods.

Estimates indicate that increasing waiting periods in long-term care policies from 90 to 180 days could decrease annual premiums by about 14 percent. Year-long waiting periods could decrease premiums by about 31 percent,[10] but these longer waiting periods could result in substantial out-of-pocket costs to policy-holders or their families.

Other Benefits Offered

Consumer guides we reviewed suggest that consumers also weigh the benefits and costs of other policy features, such as

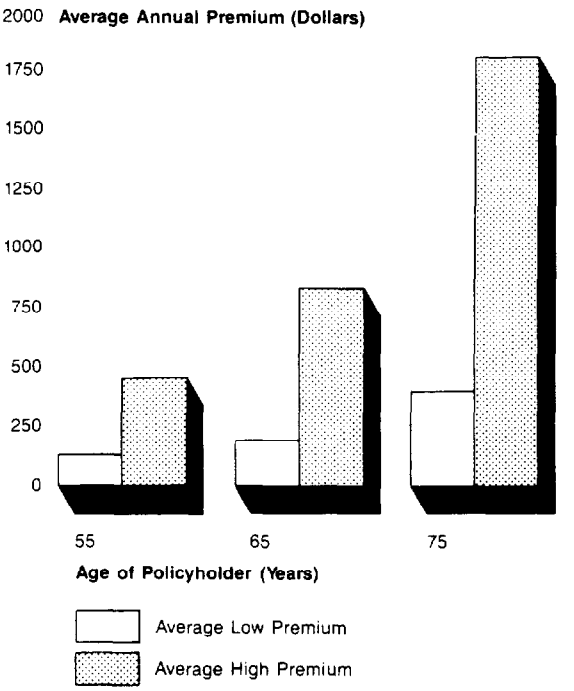
- waiver of premium—after an established number of days of confinement or benefit payments, premium payments are waived (16 policies);
- benefits for mandatory monthly physician recertification of medical necessity (2 policies);
- life insurance benefit for accidental death (2 policies); and
- hospital benefits (2 policies).

Premiums

Annual premiums ranged from $20 to $7,030 for varying levels of coverage at different ages. Generally, premium costs depend on age, daily indemnity benefit amounts, duration of benefits, and length of waiting periods. Given these components of policies, we calculated the average "low" premium (reflecting lowest daily indemnity benefit amounts, shortest duration of benefits, and longest waiting period) and the average "high" premium (reflecting highest daily indemnity benefit amounts, longest duration of benefits, and shortest waiting period), that individuals might expect to pay for long-term care policies. Figure 2.3 shows the average low and high premiums by age.

[10]M. Meiners and G. Trapnell, "Long-Term Care Insurance: Premium Estimates and Prototype Policies," Medical Care, Vol. 22 (Oct. 1984), pp. 901-11.

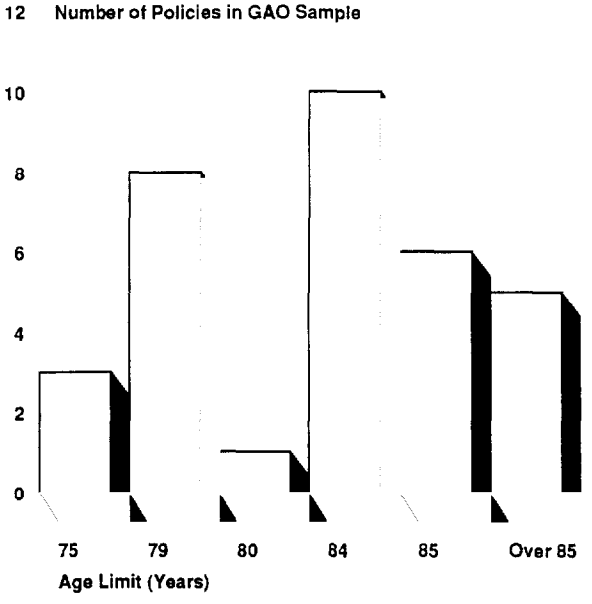
Figure 2.3: Range of Average Premium Costs by Age (1986)



Most policyholders pay premiums based on their age at the time the policy was initially issued. These are called level issue age premiums because they remain constant over the life of the policy, unless premiums are raised for all persons in a class. (See pp. 29-30 for a discussion of the relationship between level issue age premiums and renewability clauses.)

Long-term care insurance policies appeared to be available at many ages. All policies were available at age 65 and eighteen (53 percent) were available to individuals age 55 and below. Figure 2.4 shows the availability of policies for those 75 and over.

Figure 2.4: Availability of Long-Term Care Coverage for the Elderly (1986), **Age 75 and Over**



We examined neither the extent to which insurers were actively marketing policies to those under age 55 or over 79 nor the effect of health screening or other underwriting practices on the actual availability of long-term care insurance. These practices are particularly important in determining the availability of insurance for older individuals who are more likely to have chronic illnesses.

Insurers maintain that the lack of company-specific actuarial data makes pricing long-term care policies extremely difficult. They also contend that high premiums compensate them for taking risks associated with new product development in an uncertain and potentially very expensive market and that, over time, competition will drive prices down.

Loss Experience

Many companies have not been in the market long enough to experience sufficient claims to build an actuarial base. Moreover, early experience would not be statistically credible given the relatively small number of policies in force and the steep increase in claims expected as the insureds age. The experience of two companies with the longest-selling policies, however, appear to be significantly different. One company, experiencing unexpected adverse claims, stopped selling its original

policy and reduced duration of coverage from 4 to 2 years in its redesigned policy. The company, however, recently sold its long-term care insurance line of business. The other company, finding its experience relatively stable, extended the duration of benefits from 4 to 6 years.

Policy Limitations

Insurers use three policy features to try to minimize losses: (1) renewability limits, (2) exclusions, and (3) restrictions associated with preexisting conditions. In contrast to most of the restrictions we examined (see p. 19), these three types of limits are independent of medical necessity. They are not unique to long-term care insurance but are standard features of many health insurance products.

Most insurers reserve the right in their renewability clauses to raise premiums for a class of insureds. Almost all insurers also exclude coverage for preexisting conditions if treatment is initiated within the waiting period, which may pose potentially significant risks to policyholders. Moreover, language that could be construed to exclude Alzheimer's disease (an organic brain disease) in more than one-third of policies is an important limitation, given the prevalence of the disease among the elderly and its association with institutionalization.

Renewability Limits

Renewability refers to the right of the insurer to cancel an individual contract for reasons other than nonpayment of premiums, according to the NAIC Advisory Committee. The advisory committee report describes four types of renewability provisions, in order of increasing protection for consumers and risk for insurers, as follows:

- Optionally renewable—renewal is at the sole option of the insurer.
- Conditionally renewable—renewal can be declined at the option of the insurer by class, by geographic area, or for stated reasons other than deterioration of health.
- Guaranteed renewable—renewal cannot be declined by the insurer for any reason, but the insurer can revise premiums on a class basis.
- Noncancellable—renewal cannot be declined nor can premiums be increased by the insurer.

The literature and consumer guides highlight the importance of renewability of long-term care policies. It affects the likelihood that benefits will be paid out when needed; also, the insurer's financial position and reputation can affect the value of the policyholder's investment, according to consumer guides.

The model act states that long-term care insurance policies should not "be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured . . ." (sec. 6 (B) (1)). The NAIC Advisory Committee recommended that (1) optionally renewable policies should not be allowed, (2) conditionally renewable policies should not be cancellable for reasons of advancing age or deterioration of health, and (3) guaranteed renewable and noncancellable policies should be allowed.

All but one of the policies we reviewed conformed with NAIC recommendations. Specifically, of 33 policies,

- 23 were "guaranteed for life";
- 5 were conditionally renewable;
- 1 was optionally renewable; and
- 4 were renewable group policies.

Until recently, many long-term care insurers, believing that guaranteeing renewability was too risky, offered less favorable renewability terms. Some companies sold optionally renewable coverage because they regarded their policies as experimental and inherently risky. But others opposed offering coverage in this market that was not guaranteed renewable, arguing that it would be socially wrong to cancel coverage for elderly people who became uninsurable because of deterioration of health. Still others noted that even guaranteed renewability offered little benefit to some policyholders, especially those on fixed incomes, who might be priced out of the market if premiums were raised for a class of insureds.

Both consumers and responsible insurers argue against cancellation of prefunded policies financed through level premiums, the NAIC Advisory Committee reported. Consumers who have faithfully paid into a level premium policy have a right to expect continued coverage as risk increases with age. For such policies, initial claims cost is expected to be less than the premium, which allows reserves to build to meet future claims. It was the majority opinion of the NAIC Advisory Committee that "cancellation by the insurer of a level issue age premium individual policy should result in individual nonforfeiture benefits [a portion of the reserves] which are consistent with NAIC guidelines." The advisory committee report did not address the appropriateness of similar benefits for level premium guaranteed renewable policies that might be terminated because of nonpayment of premiums. None of the cancellable policies we reviewed contained a nonforfeiture benefits provision.

Exclusions

Long-term care policies contain explicit exclusion sections delineating certain conditions that will not be covered by the policy, regardless of the need for services. Claims made for such losses will be denied. The policies almost universally contain certain exclusions, also commonly found in health, life, and casualty insurance, that include losses resulting from war and civil commotion, intentionally self-inflicted injury or suicide, and services for which no charge is made to the policyholder. Other less common exclusions were dental treatment (except for injuries), eyeglasses, hearing aids, plastic surgery, and treatment for epilepsy, venereal disease, multiple sclerosis, and muscular dystrophy.

In addition to these exclusions, table 2.4 shows medical conditions most frequently excluded in the policies we reviewed.

Table 2.4: Medical Conditions Most Frequently Excluded From Long-Term Care Insurance Policies (1986)

Excluded condition	Policies containing conditions[a]
Nervous and mental disorders without demonstrable organic cause	18
Treatment delivered outside the U.S.	13
Alcohol-related disease	16
Narcotic-related disease	16
All nervous and mental disorders (including Alzheimer's disease)	12

[a]Numbers do not add to 33 because many policies had more than one exclusion.

The common exclusion for mental and nervous disorders has important implications for the value of long-term care insurance policies. In 1985, an estimated 2.5 million elderly persons were afflicted with Alzheimer's disease. Moreover, more than 50 percent of nursing home residents may have Alzheimer's disease.[11] The 12 policies that exclude all mental disorders would not meet this population's need for services. We identified 18 insurers who cover mental disorders of demonstrable organic origin; however, definitive diagnosis can only be made by either brain biopsy or autopsy. These diagnostic difficulties might preclude policyholders from receiving benefits if insurers chose to require proof of Alzheimer's disease before paying claims.

In addition to these explicit exclusions, insurers individually underwrite almost all long-term care policies—that is, they use medical and other information in considering whether to accept an applicant for coverage.

[11]Thomas Jazwiecki, Alternative Mechanisms for Financing the Care of Dementia, Prepared for the California Alzheimer's Disease Task Force (Sacramento, Feb. 20, 1986).

Companies reserved the right to deny coverage or charge extra premiums to those whose medical history or current disabilities indicated a high risk of using services. Because we did not review the underwriting guidelines, we do not know how this might restrict the availability of benefits for certain subgroups of the long-term care market.

Preexisting Conditions

Of the 33 policies we analyzed, 32 (97 percent) establish terms governing the payment of claims for health conditions existing before the effective date of the policy. These preexisting condition clauses are common to individual health insurance policies and essentially create a waiting period before the policy takes effect. Preexisting condition clauses protect insurers from individuals who might purchase coverage after losses are suffered. Such clauses are uniformly two-pronged; they (1) pertain to the length of time prior to the policy's effective date used to establish a condition as preexisting and (2) govern when benefits for such conditions are payable after the policy takes effect. Appendix II illustrates the dual nature of preexisting condition clauses.

In the model act, the NAIC defines as preexisting (1) conditions for which medical advice or treatment was recommended by or received from a physician or (2) conditions for which a prudent person experiencing symptoms would have sought diagnosis, care, or treatment (sec. 6(C)(1)). Policies generally incorporate both these concepts in their definitions of preexisting conditions, although we do not know how they administer claims in practice.

The NAIC model act recommends that insurers classify conditions as preexisting if they occur 6 months before the effective date of the policy for individuals 65 years of age and older and 24 months before for those under age 65 (secs. 6(C)(1) (a) and (b)). Some insurers, however, go farther back into an individual's medical history to classify a condition as preexisting. Most insurers classify conditions present 6 months prior to the policy effective date as preexisting. The longest period we identified was 5 years.

The NAIC model act includes a preexisting condition clause allowing no more than a 6-month wait for coverage for persons 65 years of age or older, and no more than 24 months for individuals under age 65 (secs. 6(C)(2)(a) and (b)). Of the 32 policies, 22 (69 percent) begin paying benefits for preexisting conditions 6 months after the effective date of the policy. One policy covered preexisting conditions within 30 days. The

remaining nine policies had waiting periods ranging from 3 months to 2 years.

In the same section, the model act also states that coverage for preexisting conditions might be excluded if confinement occurred within 6 months of the policy's effective date for those 65 or older and 24 months for those under 65. We did not analyze how underwriters used data from health screens and applications to deal with preexisting conditions. In most policies, however, benefits were permanently excluded if confinement was initiated during the waiting period.

Conclusions

There was considerable variation in both benefits and premiums available to individuals in the 33 private long-term care insurance policies we reviewed. In general, however, premiums increased with age, and insurers offered indemnity benefits that were not indexed to keep pace with inflation. Moreover, most of the policies reviewed contained restrictive clauses (such as requirements that policyholders be admitted to nursing homes within 30 days of hospital discharge) and limitations (such as exclusions for certain diseases) that might prevent some policyholders from collecting benefits.

On the other hand, more insurers now offer custodial care benefits, and nearly half of the policies reviewed provide benefits for all levels of nursing home care and home care benefits. Over 50 percent of the policies reviewed state that they cover organically caused mental disorders (e.g., Alzheimer's disease), although diagnostic difficulties may complicate claims handling. Most of the policies also let consumers choose the length of the waiting period and daily indemnity amounts from among several options.

Finally, most of the policies reviewed now guarantee renewability. Since insurers guaranteeing renewability reserve the right to raise premiums for a class of insureds, however, elderly policyholders on fixed incomes will be vulnerable to being priced out of the market.

Abuses in the Sale and Marketing of Long-Term Care Insurance

Nationally, with enactment of the Baucus Amendment on June 9, 1980 (creating section 1882 of the Social Security Act), the Congress adopted minimum policy content standards and anticipated loss ratios for Medigap policies; in addition, the Congress established federal criminal penalties for agents engaging in abusive sales and marketing practices. This legislation followed revelations that (1) Medigap policies varied greatly in terms of coverage and economic value as measured by loss ratios, (2) state regulation was inconsistent, and (3) sales and marketing abuses were increasing. We recently reported[1] that the Baucus Amendment is helping to protect the elderly against sales and marketing abuses. But long-term care insurance policies are not Medigap policies and therefore do not fall under section 1882.

Abuse in both product content and marketing in the long-term care insurance market have been reported:

- Unclear or complex policy language may mislead consumers about the content of long-term care insurance they are purchasing, especially with regard to coverage limitations. The NAIC Advisory Committee report noted, for instance, that policies that "provide only skilled care under restrictive circumstances may not be appropriate for approval, lest consumers think they have broader protection than they do." In at least three states, insurance commissioners have taken formal action in response to misleading policy language. These states and six others set minimum standards for long-term care insurance policies to reduce potential product content abuse. Similar action is pending in four other states.
- State insurance officials, consumer advocates, and long-term care policy analysts told us that the potential for abusive marketing techniques used to sell Medigap policies exists in the long-term care insurance market as well. The federal government and some states have established programs to educate elderly persons to protect themselves against abusive Medigap marketing techniques.

Potential for Abuse

In November 1986, the HHS Long-Term Health Care Policies Task Force requested general comments from the public on concerns about private long-term care insurance.[2] The task force and NAIC were particularly concerned about the trade-off between protecting consumers and

[1] Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986).

[2] Federal Register, Vol. 51, No. 214 (Nov. 5, 1986), p. 40265.

allowing insurers sufficient flexibility to develop innovative long-term care products.

The NAIC model act attempts to strike a balance between these two aspects by requiring disclosure of benefits. Section 6(G) recommends that insurers give applicants for long-term care insurance policies an outline of coverage that includes, at a minimum, clear descriptions of

- principal benefits and coverage provided;
- principal exclusions, restrictions, and limitations in the policy; and
- renewal provisions, including any reservation of a right to raise premiums.

A "right to return-free look" provision, the same as is included in Medigap policies, is recommended by NAIC in section 6(F) of the model act. This would allow policyholders who were unsatisfied for any reason to return the policy and receive a premium refund within 10 days. Persons who did not initiate the purchase of a policy but were instead solicited would have a 30-day free-look period. Of the policies we reviewed, 10 provided a 30-day free-look period and 23 provided a 10-day free-look period.

Abusive Medigap marketing techniques, such as posing as a federal agent to sell policies, knowingly selling policies that duplicate the policyholders' existing coverage, and selling supplemental policies by mail in states that have not approved their sale are prohibited by the Baucus Amendment. Some experts in long-term care agree that such abuses are likely to occur in that market as well. In addition, AARP officials report that it is not unusual for insurance sales agents to falsely claim that AARP endorses their products.

State Actions to Control Abuse

Even with the Baucus Amendment, some marketing abuse persists in the Medigap market as we stated in our October 1986 report. Unlike product content regulation, which is enforced at the federal level, regulation of sales abuse is a state responsibility.[3] States have initiated enforcement actions primarily in response to complaints from the elderly and their representatives. For instance, states have issued cease and desist orders to stop the use of misleading mailings, levied fines on and revoked licenses of agents misrepresenting themselves, and educated consumers

[3]In the McCarran-Ferguson Act (Public Law 79-15), the Congress delegated primary responsibility for regulating the insurance industry to the states.

on how to guard against fraud when buying Medigap insurance. We expect that at least some states will make similar efforts to control abusive marketing techniques in the long-term care market. The aggressiveness of insurance commissioners and resultant protection afforded consumers will, however, vary from state to state.

In three states, insurance commissioners have taken formal action to control abuse stemming from misleading policy language:

- Wisconsin, in 1981, enacted stringent minimum standards for nursing home policies to reduce abuse and confusion associated with the sale of such policies. The commissioner found that "significant misunderstanding exists with respect to nursing home insurance," which he characterized as "misleading, deceptive, obscure, and encouraging of misrepresentation." The commissioner also described sales presentations by some agents as misleading, confusing, incomplete, and deceptive.

  In 1986, the Wisconsin commissioner proposed to modify the 1981 standards to encourage more insurers to enter the long-term care market. Also, the commissioner intends to prevent the recurrence of marketing abuse by establishing disclosure requirements that will help consumers compare policies and clarify what different policies cover. Under the Wisconsin regulation, advertising and marketing of policies not meeting minimum standards and disclosure requirements would constitute an unfair trade practice.

- Minnesota is currently investigating a case in which 4,000 policyholders allegedly were led to believe they had purchased custodial care coverage when in fact their policies covered only skilled and intermediate care. State officials were not at liberty to discuss the details of the pending case.
- Washington state adopted regulations to prohibit unfair or deceptive practices in the advertising, sale, or marketing of long-term care policies setting an effective date of January 1, 1988. Some agents may take advantage of complex policy language to misrepresent the custodial care benefits offered by policies, Washington officials told us. For instance, agents may not always explain that custodial care benefits in certain policies are contingent on meeting a series of prerequisites, including prior stays in skilled and intermediate care facilities for specified lengths of time. AARP contends that the number of similar cases of abuse may increase as this new market expands.

In 1986, six other states—Arkansas, Colorado, Connecticut, Kentucky, Maine, and North Dakota—enacted laws establishing minimum policy features and benefits for long-term care insurance. Similar action is pending in four more states. In many cases, these actions reflect efforts to prevent potential misrepresentation to consumers that occurs in the sale of both nursing home and Medigap policies.

A number of states also have launched public information campaigns to educate elderly consumers so they can protect themselves against abusive marketing techniques and make better informed insurance decisions.

Conclusions

Private long-term care insurance is a nascent line of insurance. Although the current market is small, it will probably expand as people become more aware of the limits of Medicare coverage and the potentially catastrophic out-of-pocket expenditures they may incur. There is some indication that misleading sales and marketing practices are being used.

Matter for Congressional Consideration

NAIC has developed model legislation designed to strike a balance between protecting the consumer and allowing the insurance industry to experiment with different approaches to providing insurance in this new area. Striking this balance is the dilemma facing legislators today.

Therefore, the Subcommittee may want to consider the desirability of enacting federal legislation to reduce potential abuse at this stage of market development.

Insurance Companies Represented in GAO Review

Acceleration Life Insurance Company
Aetna Life Insurance and Annuity Company
AIG Life Insurance Company
American Bankers Insurance Company
American Integrity Insurance Company
American Republic Insurance Company*
AMEX Life Assurance Company (formerly Fireman's Fund)
Banker's Life and Casualty Company
Blue Cross of Washington and Alaska
California Benefit Life Insurance Company
Colonial Penn Life Insurance Company
Columbia Life Insurance Company
Continental Casualty Company (CNA)*
Equitable Life and Casualty Insurance Company*
Great Republic Life Insurance Company
Mutual Protective Insurance/Medico Life Insurance Company
National Foundation Life Insurance Company*
Penn Treaty Life Insurance Company
Providers Fidelity Life Insurance Company
Prudential Insurance Company of America, The
Sterling Life Insurance Company
Transport Life Insurance Company*
Underwriters Life Insurance Company*
United Equitable Corporation, The
World Life and Health Insurance Company of Penn.*

*These companies offer more than one policy.

Comparison of 33 Private Long-Term Care Insurance Policies Offered in 1986

Insurance company policy	Ages covered at purchase	Type of care covered and daily benefit amount	Duration of benefit
Acceleration Life's Long-Term Nursing Care	55–85	Skilled: $30 to $60 Intermd: $30 to $60 Cust: $30 to $60 Home: $30 to $60	Up to 5 yrs " " "
Aetna Life and Annuity's SNF Indemnity	55–84	Skilled: $40 to $100 Intermd: $40 to $100 Cust: $40 to $100 Home: 50% of above	Up to 4 yrs " " Up to 2 yrs
American Bankers' Comprehensive Nursing Home Care	62–84	Skilled: $10 to $60 Intermd: $ 7 to $40 Cust: $ 2 to $10 Home: Up to $10	Up to 4 yrs Up to 6 mos Up to 6 mos Up to 1 mo
American Integrity's Skilled Nursing Care	45 and over	Skilled: $30 or $40 Home: $30 or $40	Up to 1 yr[a] Up to 10 days
AIG Life's Care Span	0–79	Skilled: $20 to $120 Intermd: $20 to $120 Cust: $20 to $120 Home: $20 to $120 1st 30 days then 50%	Up to 5 yrs " " Up to 3 mos
American Republic's Preferred Nursing Home Indemnity	55–75	Skilled: $20 and up Intermd: $20 and up Cust: $20 and up Home: $10 and up	Up to 4.1 yrs " " Up to 6 mos
American Republic's Nursing Home Indemnity	55–75	Skilled: $20 and up Intermd: $20 and up Cust: $20 and up Home: $10 and up	Up to 4.1 yrs " " Up to 6 mos
AMEX Life's Guaranteed Renewable Nursing Home	0–80	Skilled: $10 to $80 Intermd: $10 to $80 Cust: $10 to $80 Home: 70 to 50% of above	Up to 6 yrs " " "
Bankers Life's Nursing Home	60–79	Skilled: $20 to $100 Intermd: $20 to $100 Cust: $20 to $100 Home: 50% of above	Up to 5 yrs[b] " " Up to 6 mos
Blue Cross of Washington and Alaska's Lasting Care	50–84	Skilled: Up to $72 Intermd: Up to $72 Cust: Up to $72 Home: Up to $1500 total 1st yr.	Up to 5.4 yrs " " "
California Benefit's Comprehensive Nursing Home Plan	50–85	Skilled: $30 to $100 Intermd: $30 to $100 Cust: $30 to $100	Up to 6 yrs " "
Colonial Penn Life's Colonial Care	60–79	Skilled: $30 to $80 Intermd: $30 to $80 Cust: $15 to $40 Home: $15 to $40	Up to 3 yrs[b] " " Up to 6 mos

Waiting period for benefits	Waiver of premium	Renewability	Preexisting conditions period: Before policy effective date	Preexisting conditions period: After policy effective date	3-day prior hospitalization	Time allowed to enter nursing home[g]
0 or 100 days	Yes	Conditional	12 months	6 months	Yes	30days[c]
20 or 100 days	Yes	Guaranteed for life	6 months	6 months[d]	Yes	30 days
0	No	Guaranteed for life	Not specified	2 years; 6 mos over 65	Yes	14 days[c]
0	No	Conditional	6 months	6 months	Yes	30 days[c]
0, 20, or 100 days	Yes	Guaranteed for life	12 months	12 months	Yes	30 days
90 days	Yes	Guaranteed for life	6 months	6 months	No	N/A
20 days; home, 0 days after nursing home stay	Yes	Guaranteed for life	6 months	6 months	No	[c]
20 or 100 days	Yes	Guaranteed for life	6 months	3 months	Yes	90 days
0, 20, or 100 days	Yes	Conditional	6 months	6 months	Yes	30 days
20 days or 180 days of total disability	Yes	Conditional	Not specified	None if total disability began after policy effective date.	Yes	Not specified
20, 100, or 180 days	No	Guaranteed for life	6 months	4 months	Yes	30 days[c]
0, 20, or 100 days	Yes	Guaranteed for life	12 months	12 months	Yes	30 days[c]

Insurance company policy	Ages covered at purchase	Type of care covered and daily benefit amount	Duration of benefit
Columbia Life's SNF/ Intermediate or Custodial Care	0–75	Skilled: $10 to $50 Intermd: $10 to $50 Cust: $10 to $50	Up to 4 yrs Up to 2 yrs "
Continental Casualty (CNA) Convalescent Nursing Care	60–84	Skilled: Up to $80 Intermd: Up to $80 Cust: Up to $80	Up 2.7 yrs[b] " "
Equitable Life and Casualty's Recovery Plan	50–85	Skilled: $10 to $60 Intermd: $ 5 to $30 Cust: $2.50 to $15 Home: $1.25 to $7.50	Up to 2 yrs Up to 1 yr Up to 6 mos Up to 30 days
Equitable Life and Casualty's Convalescent Companion	50–85	Skilled: $20, $40, $60 Intermd: $20, $40, $60 Cust: $10, $20, $30	Up to 1 yr[b] (combined) Up to 30 days
Equitable Life and Casualty's Home Care	50–85	Home: Up to $40 (1 visit)	Up to 1 yr (60 visits)
Great Republic Life's Skilled Nursing Care	All ages	Skilled: Up to $40 Home: Up to $30	Up to 3 yrs[b] "
Mutual Protective and Medico Life's Rehabilitative and Convalescent Nursing Care	18–79	Skilled: $ 6 to $80 Intermd: $10, $20, $40 Cust: $ 5, $10, $15 Home: $ 5, $10, $15	Up to 4 yrs Up to 6 mos " Up to 30 days
National Foundation Life's Health Care	18–85	Skilled: $20 to $50 Intermd: $20 to $50 Costs $10	Up to 3 yrs[b] " Up to 89 days
National Foundation Life's National Care II	0–79	Skilled: $50 and up Intermd: $50 and up Cust: 50% of above Home: 25% of above	Up to 5 yrs " Up to 2 yrs Up to 3 mos
Penn Treaty Life's Skilled Nursing Home and Custodial Care	18 & up	Not specified	Up to 5 yrs
Providers Fidelity Life's Nursing Home Income Plan	60–84	Skilled: $20 to $60 Intermd: 50% of above Cust: 50% of above	Up to 3 yrs[b] Up to 4 mos
Prudential's American Association of Retired Person (AARP) Nursing Home and Home Care	50–79	Skilled: $40 Intermd: $30 Cust: $30 Home: $20 or $25	Up to 2 yrs " " "
Sterling Life's Skilled Nursing Home Protection	35–84	Skilled: $30, $40, $50 Intermd: $30, $40, $50 Cust: $30, $40, $50	Up to 4 yrs "
Transport Life's LTC Plan	0–84	Skilled: $20 to $80 Intermd: $20 to $80 Cust: $20 to $80 Home: $10 to $40	Up to 4 yrs " Up to 2 mos

Waiting period for benefits	Waiver of premium	Renewability	Preexisting conditions period: Before policy effective date	Preexisting conditions period: After policy effective date	3-day prior hospitalization	Time allowed to enter nursing home[g]
20, 60, or 100 days	Yes	Guaranteed for life	5 years	6 months	No	Not required
0, 15, 30, or 90 days	No	Guaranteed for life	6 months	6 months[e]	Yes	30 days
0, 20, or 100 days	No	Guaranteed for life	5 years	6 months	Yes	14 days[c]
20 days	No	Guaranteed for life	6 months	6 months	Yes	30 days
0 days	No	Guaranteed for life	Not specified	3 months	Based on DRG Schedule[f]	30 days (home care only)
0 or 100 days	No	Guaranteed for life	6 months	6 months	Yes (for private-duty nurse at home)	Immediately after hosp. stay (home care only)
0, 20, or 100	No	Conditional	5 years	6 months	Yes	14 days[c]
0 days 30 days	Yes	Guaranteed for life	5 years; 6 mos. if older than 64	2 years; 6 mos. if older than 64	Yes	14 days
0 days	Yes	Guaranteed for life	6 months	6 months	Yes	14 days[c]
0 days	No	Guaranteed for life	5 years or within 30 days after	6 months	Yes	14 days[c]
0, 20, or 100 days	No	Renewable group policy	6 months	6 months	Yes	30 days[c]
20 days	No	Renewable group policy	6 months	6 months	Yes	30 days
20 days	Yes	Optional	Not defined	1 month	Yes	90 days
0, 20, or 100 days	Yes	Renewable group policy	12 months	6 months	Yes	14 days

Insurance company policy	Ages covered at purchase	Type of care covered and daily benefit amount	Duration of benefit
Transport Life's Convalescent Care	0–84	Skilled: $20 to $80 Intermd: $20 to $80 Cust: $15 to $60 Home: $10 to $40	Up to 5 yrs " Up to 1 yr Up to 2 mos
Underwriters Life's Convalescent Care Indemnity	55–79	Skilled: $40 to $100 Intermd: $40 to $100 Cust: $40 to $100	Up to 3 yrs " "
Underwriters Life's Convalescent Care Indemnity (TX only)	55–79	Skilled: $40 to $100 Intermd: $40 to $100 Cust: $40 to $100	Up to 3 yrs " "
United Equitable's Nursing Care Indemnity and Convalescent	60–84	Skilled: $20 to $60 Cust: $10 to $30 Home: $10 to $30	Up to 2 yrs[b] Up to 1 yr Not specified
World Life's Nursing Home Care	55–84	Skilled: Up to $67 Intermd: Up to $67 Cust: Up to $67	Up to 5 yrs " "
World Life's Senior Care II Skilled Nursing Facility	60 and over	Skilled: Up to $53 Intermd: Up to $53 Cust: Up to $53	Up to 2 yrs " "
World Life's Home Help Care Indemnity	55 and over	Home: Up to $60	Up to 2 yrs

Waiting period for benefits	Waiver of premium	Renewability	Preexisting conditions period: Before policy effective date	Preexisting conditions period: After policy effective date	3-day prior hospitalization	Time allowed to enter nursing home[g]
0, 20, or 100 days	Yes	Renewable group policy	12 months	12 months	Yes	14 days
20 or 100 days	No	Guaranteed for life	5 years	2 yrs; 3 mos. if 65 or older at purchase	Yes	14 days
20 or 100 days	No	Guaranteed for life	5 years	2 yrs; 3 mos. if 65 or older at purchase	Yes	14 days
0, 20, or 100 days	Yes	Guaranteed for life	6 months	6 months	No	[c]
0, 20, or 100 days	No	Guaranteed for life	5 years	6 months	Yes	30 days
0, or 20 days	No	Guaranteed for life	5 years	3 months declared, 2 yrs non-dec. conditions	Yes	14 days
Not specified	No	Guaranteed for life	5 years	6 months	Yes	14 days (home care only)

Notes:
— Cust. means custodial care.
— Intermd. means intermediate care.
— N/A means not applicable.
— LTC means long-term care.

This chart presents a simplified comparison of some important features of the long-term care insurance policies we reviewed. For ease of presentation, we have not presented many qualifiers stipulated in the policy language. We have also converted time limits expressed in days to either months (for waiting periods) or years (for benefits) to facilitate comparison of policies. We have not attempted to include all important policy features (e.g., other optional benefits offered, riders, premiums) but instead illustrate the diversity of policies offered to consumers in 1986. Because policy language is typically very complex, we advise consumers to scrutinize policies carefully prior to purchase.

[a]During a benefit period.

[b]Benefit per confinement period. (Some plans are subject to a lifetime maximum of benefits.)

[c]Policy stipulates timeframes between different levels of long-term care.

[d]Not applicable if fully disclosed on the application.

[e]Covered immediately unless confinement is due to a medical condition named in the schedule; confinement due to medical conditions named in the schedule are covered if confinement begins at least 90 days after policy effective date.

[f]Policy stipulates required days of hospital confinement and benefit maximums based on 466 diagnosis-related groups established under the Medicare program.

[g]Maximum time a policyholder has to enter a nursing home after a hospital discharge.

States Contacted About Abuse in the Sale and Marketing of Long-Term Care Insurance

1. Alabama	14. Maryland
2. Arizona	15. Massachusetts
3. Arkansas	16. Michigan
4. California	17. Minnesota
5. Colorado	18. New Jersey
6. Connecticut	19. New York
7. District of Columbia	20. North Dakota
8. Florida	21. Pennsylvania
9. Idaho	22. Tennessee
10. Illinois	23. Virginia
11. Kansas	24. Washington
12. Kentucky	25. West Virginia
13. Maine	26. Wisconsin

Insurance Companies That Have State-Approved Long-Term Care Insurance Policies but Not Represented in GAO Review

1. American Family Mutual of Iowa
2. American Independent Insurance Company
3. American Motorist
4. American Sun Life Insurance Company
5. American Travelers Life
6. Atlantic American Life Insurance
7. Atlantic and Pacific Life
8. Bankers Life Company
9. Bankers Multiple Line Insurance Company
10. Certified Life Insurance
11. Central Security Life of Texas
12. Central States Health and Life of Omaha
13. Colonial Life of America
14. Constitution Life
15. Continental General Insurance Company
16. Continental Life Insurance
17. Far West American Assurance Insurance
18. Federal Home Life
19. First Far West Insurance
20. Gerber Life
21. Great Fidelity Life Insurance
22. Guarantee Trust
23. Harvest Life
24. Integrity National Life
25. Intercontinental Life
26. Life Insurance of Connecticut
27. Life & Health Insurance of America
28. Life General Security
29. Lumbermen Mutual
30. Massachusetts Indemnity and Life
31. Mutual of Omaha
32. National States Insurance
33. National Health Insurance
34. Old American
35. Orange State Life/Health
36. Physicians Mutual
37. Pilgrim Life
38. Pioneer Life of Illinois
39. Pyramid Life Insurance
40. Reserve Life
41. Union Bankers Insurance

42. Union Benefit Life
43. Union Fidelity
44. United General Life
45. United Security Assurance
46. United of Omaha
47. World Insurance Company

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