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

April 1989

LONG-TERM CARE INSURANCE

State Regulatory Requirements Provide Inconsistent Consumer Protection

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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 state regulation of private long-term care insurance provides information on the states' efforts to regulate the content of such policies and the insurers and their agents who market and sell them.

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.

The major contributors to this report are listed in appendix IV.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Expenditures for long-term care services in the United States are expected to exceed $46 billion in 1988, principally for nursing home care. Publicly funded health care programs—Medicare for the aged and Medicaid for the poor—pay less than half. The balance is paid by consumers, mainly elderly. With average yearly nursing home costs exceeding $25,000, extended care is beyond the means of many. Private long-term care insurance offers potential to help defray these costs.

The long-term care insurance market is similar in its stage of development to the market for Medicare supplemental—"Medigap"—insurance in the 1970s. Early experiences in the Medigap market were that policies varied greatly in terms of coverage and value, state regulation was inconsistent, and there were reported sales and marketing abuses. For these reasons, the Congress in 1980 enacted legislation to define minimum standards for Medigap policies, even though states retained principal responsibility for enforcing the standards.

In light of these past problems with Medigap, the Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked GAO for information on long-term care insurance. Specifically, he wanted to know (1) the extent to which states have established minimum standards through the adoption of long-term care insurance legislation and regulations and (2) the mechanisms by which states enforce their standards.

Background

Because general health insurance coverage, including Medicare, is primarily directed at acute care, long-term care benefits are limited. Medicaid provides such benefits, but to become eligible individuals must be impoverished. Private long-term care insurance is intended to address these gaps and limitations in other insurance. Typically, such policies pay a set amount over a specified period for each day a policyholder uses a covered service. But there is considerable variation among policies in terms of coverage, the amounts payable per day, and other conditions affecting policy value and cost.

The market for long-term care insurance is growing. In 1986, some 125,000 policies were in force; in 1988, more than 1,000,000. Along with this growth have come concerns about the adequacy of policies, as recent studies have shown that some can be quite restrictive in the extent and duration of coverage. Unlike the Medigap market, no federal legislation regulates the long-term care insurance market.

In 1986 and 1987, the National Association of Insurance Commissioners (NAIC) adopted a model long-term care insurance act and regulation. NAIC, an organization of state regulatory agency heads, suggested that states use these as guides in developing their own standards. In December 1988, NAIC made key improvements to its models. To obtain information on state regulation of long-term care insurance, GAO surveyed the states' insurance regulatory agencies and reviewed state laws and regulations concerning such insurance.

Results in Brief

State approaches to regulating long-term care insurance vary widely. Half the states have adopted specific legislation, although they vary in the degree to which they meet NAIC's recommended minimum standards. Many states allow insurers to use policy provisions that offer consumers less protection than recommended. While such provisions can result in lower policy premiums, they can adversely affect policyholders by (1) decreasing the likelihood that needed services will be covered and (2) increasing the risk of policy terminations for reasons other than nonpayment of premiums. The variances we noted between NAIC-recommended standards and those used by some of the states may be due to the time lag that states can encounter when enacting new legislation and promulgating regulations. (See pp. 15-26.)

Few states compile statistics on long-term care insurance complaints or instances involving misleading or abusive practices. Such information can be useful in monitoring insurers. About 30 percent of the states, however, told us they had received complaints or identified cases of abuse, and 20 percent said they had taken enforcement action against insurers or their agents. In addition, few states collect the data necessary to routinely monitor insurers' loss ratios. Such ratios measure the value of the policies to the consumer by relating premium costs to the benefits policyholders receive or are expected to receive. (See pp. 27-33.)

Principal Findings

Limitations May Deny Benefits to Many

Forty-three states allow insurers to require that nursing home stays be preceded by stays at successively higher levels of care. For example, hospitalization may be required before the insured becomes eligible for nursing home coverage. Such requirements can reduce by more than

half the likelihood that policyholders will receive benefits, regardless of need. This is so because many elderly persons with chronic or debilitating conditions do not require hospitalization, but may require assistance with activities of daily living. In December 1988, the NAIC recommended that states either no longer permit insurers to use these provisions or, alternatively, require insurers using them to offer policies without the provisions. (See p. 18.)

Twenty-seven states told GAO that they permit insurers to exclude coverage for persons having Alzheimer's disease. The Alzheimer's exclusion is particularly restrictive because more than 50 percent of nursing home residents may have the disease. Because of its restrictiveness, the NAIC has recommended that states do not permit the exclusion. (See p. 19.)

Thirty-one states said they would approve long-term care policies that limit coverage to skilled nursing care only. The NAIC has suggested that states not permit this ". . .lest consumers think they have broader coverage than they do." Currently, Medicare provides for skilled nursing care but no coverage for lower levels of nursing home care. Thus, not providing coverage for intermediate and custodial level care leaves a significant gap in coverage for many elderly persons who may remain at great risk for catastrophic nursing home expenses. (See p. 20.)

Policy Renewal Often Not Assured

Continued insurance coverage is a basic consumer protection and a reasonable expectation due to the nature of long-term care insurance. That is, it covers a potentially catastrophic event that may occur sometime in the future. The NAIC model regulation specifies that states should require insurers to offer guaranteed renewable policies. Insurers generally cannot cancel such policies unilaterally except for nonpayment of premiums, although they can increase premiums for classes of policyholders. Thirty-six states told GAO they allow insurers to use renewability provisions less favorable to the consumer than those suggested by the NAIC. (See p. 21.)

Some Market Abuse Identified

About a third of the states responding to GAO's survey either identified incidents of unacceptable practices or received complaints alleging abuse by sales agents or insurers of long-term care insurance. The most frequent of these involved (1) misrepresentation of policy coverage by sales agents, (2) insurers' reported failure to pay claims, and (3) false or deceptive advertising or sales practices. As a result of investigating such incidents, 10 states took enforcement action against either insurers or

their agents during 1986 or 1987. The information states provided on both the volume of identified problems and enforcement actions taken often was based on estimates. Generally, states did not maintain separate files of such information for long-term care insurance. (See p. 29.)

Loss Ratio Data Often Not Compiled

Many states have adopted loss ratio standards as a means of measuring the value to consumers of long-term care policies sold in their states. Such ratios are compiled by dividing the amount of incurred claims by the amount of earned premiums for a reporting period. Thirty-three states have adopted minimum loss ratio standards for individual policies, and most use the NAIC-suggested standard of 60 percent. But most states cannot monitor actual long-term care insurance loss ratios because they do not require insurers to routinely report benefit and premium data separately for long-term care policies. The NAIC is designing a data collection form that requires separate reporting of such data for long-term care policies. (See p. 32.)

Matters for Congressional Consideration

While states have taken some actions to adopt minimum long-term care regulatory standards, many do not conform to the standards suggested by NAIC's models, and future state action is unclear. In the meantime, the long-term care insurance industry is growing rapidly. To help assure that new policies provide at least a minimum level of consumer protection, the Congress may want to consider the desirability of enacting federal legislation—as was done with the Medigap insurance market—directed at establishing minimum standards for long-term care insurance. (See p. 35.)

Agency Comments

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

Contents

Abbreviations

GAO	General Accounting Office
HIAA	Health Insurance Association of America
HHS	Department of Health and Human Services
NAIC	National Association of Insurance Commissioners

Introduction

Because of demographic changes and increased life expectancy, the need for long-term care services by older persons is substantial and growing rapidly. Today, persons age 65 or older represent 12 percent of the population; by 2030, when the baby boom generation will have reached at least age 65, they will represent 21 percent of the population.[1] In addition, persons age 85 and older, who are at the greatest risk of needing long-term care services, are one of the fastest growing age groups in the country.

Given this anticipated increase in demand for services and the limitations of existing publicly funded long-term care coverage, the financing and delivery of long-term care for the elderly has been and will remain an important public policy issue. In the 100th Congress, bills were introduced (although not enacted) proposing large-scale revision of the way long-term care is financed. There has been interest in private sector approaches to financing long-term care because of concern over the cost of expanding publicly financed long-term care benefits. Consequently, considerable attention has focused on private insurance for long-term care.

A relatively new but growing market, long-term care insurance is similar in its stage of development to the market that existed for Medicare supplemental, or "Medigap" insurance, in the 1970s. Early Medigap policies varied greatly in terms of coverage and value, state regulation of them was inconsistent, and reported sales and marketing abuses were a recurring problem. In light of these past problems with Medigap, the Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked us for information on long-term care insurance. Specifically, the Subcommittee wanted to know (1) the extent to which states have established minimum standards through the adoption of legislation and regulations on long-term care insurance and (2) the mechanisms states have to enforce their standards.

Financing Long-Term Care

Long-term care refers to a wide range of medical and support services provided to persons who have lost some or all capacity to function on their own due to a chronic illness or condition and are expected to require such services over a prolonged period of time. General health insurance covers primarily acute care, but coverage of nursing home

[1]U.S. Congressional Research Service, Long-Term Care for the Elderly, U.S. Library of Congress IB88098 (Washington, D.C.: Dec. 6, 1988).

services[2] and home health benefits is limited. This places people who need long-term assistance in performing activities of daily living at risk for the catastrophic expenses that can be incurred.

One example of the catastrophic impact long-term care can have is the cost of nursing home care. On average, a year of care in a nursing home costs about $25,000. The Department of Health and Human Services (HHS) has estimated that nursing home costs in 1987 were $40.6 billion. Of this amount, Medicare paid less than 2 percent, Medicaid paid about 42 percent, and private insurance paid less than 1 percent. More than 50 percent of nursing home costs were paid out-of-pocket by the elderly and their families. Nursing home expenditures for 1988 are expected to exceed $46 billion.

Limitations of Public Financing

The Medicare program was designed to finance medical expenses associated with acute and post-acute restorative care for the aged and disabled. It does not cover skilled nursing home stays beyond 150 days annually, stays of any length requiring intermediate or custodial care, and home health care for those not confined to the home or not requiring skilled nursing care. Medigap policies fill some of the Medicare gaps (e.g., deductibles and copayments) but do not finance extended long-term 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 be impoverished before benefits begin. Through a process called "spend down," the elderly deplete their income and assets to state eligibility levels.

Private Insurance: A Developing Market

Private long-term care insurance policies typically offer nursing care indemnity benefits. That is, they pay a set amount each day for a specified period of time that a policyholder stays in a covered facility. A policy may or may not cover all types of long-term care, and different policies may define long-term care services or facilities differently. In addition to nursing home services, many long-term care policies also

[2]There are primarily three types of long-term care nursing home services and facilities: skilled, intermediate, and custodial. In general, the nursing care services are defined 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; and 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).

cover home care services. These can include skilled nursing care; speech, physical, and occupational therapy; and social work, personal care, and homemaker and choreworker services. There is considerable variation, however, among private long-term care policies in terms of coverage, the amounts payable per day of service, duration of coverage, and other conditions affecting the value of policies.

Given the current limitations in federally financed long-term care coverage, the potential exists for expansion of the private insurance market. Although private long-term care insurance is not a new idea, this insurance market is still in its early stages of development. At least two insurance companies, AMEX Life Assurance Company (formerly Fireman's Fund American Life), and United Equitable Life Insurance Company, have marketed nursing home policies for more than 10 years. But in general, only a few companies offered long-term care coverage before 1986, when approximately 125,000 policies were in force.

Recently, however, both the number of companies entering the market and the number of policies sold have significantly increased. According to the Health Insurance Association of America (HIAA), in 1988 there were more than 100 companies marketing long-term care insurance and more than 1,000,000 policyholders.

Thus far, most long-term care policies (about 97 percent) have been sold to individuals, primarily to people over age 65. Only about 18,000 policies in force are through group plans. But activity in the group market may increase in coming years, as six insurers have entered it in the past year and several large employers now offer a long-term care insurance option to their employees. While more group policies are being sold, the decision to buy the coverage is still made on an individual basis. Generally, persons electing group coverage are responsible for paying the full premiums. Also, with both individual and group policies, insurers determine premium levels by the age of the insured at the time the policy is issued.

States Have Key Responsibility for Regulation

Traditionally, states have had the primary responsibility for regulating the insurance industry. In 1945, this practice was reaffirmed by the Congress through enactment of the McCarran-Ferguson Act (P.L. 79-15). Consequently, regulating the long-term care insurance industry currently is a state function. Although specific laws, resources, and regulatory philosophies vary among the states, state insurance regulatory

agencies generally perform the same functions. These include (1) implementing requirements for regulating insurance premium rates and the content of insurance policies, (2) licensing insurance companies and agents to conduct business in the state, (3) enforcing consumer protection standards and unfair trade practices laws, and (4) examining the financial condition of insurance companies.

States' insurance regulatory agencies are linked through the National Association of Insurance Commissioners (NAIC). The NAIC comprises the heads of regulatory agencies in each state, the District of Columbia, and the U.S. territories. It provides a forum for state insurance officials to discuss common problems, standardize the annual reporting of financial information by insurance companies, and develop model legislative acts for adoption by the states.

The HHS and NAIC Roles

While states have the principal responsibility for regulating the private insurance market, in at least two instances the federal government has played a role in helping guide state regulatory practices:

1. Defining regulatory standards for the Medigap market. In 1980, the Congress enacted Public Law 96-265, which added section 1882 to the Social Security Act. Commonly referred to as the Baucus amendment, this provision was a response to marketing and advertising abuses in the sale of Medigap insurance to the elderly.[3] The Baucus amendment defines minimum standards for policies that must be met before companies can market them as Medigap policies. NAIC had developed the standards for inclusion in a model regulation it adopted in June 1979; the next year the Congress incorporated them into section 1882 by reference to the model regulation.

The Baucus amendment relies primarily on the states to adopt and enforce the Medigap standards. Federal responsibilities involve determining whether state laws and regulations are equivalent to the Baucus amendment standards and certifying policies on a voluntary basis in states that do not have equivalent standards. Forty-six states, the District of Columbia, and Puerto Rico are certified as meeting or exceeding

[3]Many abuses were detailed in 1978 hearings and summarized in the hearings record and a committee staff study. House of Representatives, Select Committee on Aging, Abuses in the Sale of Health Insurance to the Elderly, Hearings, Committee Publication No.95-165, Nov.28, 1978; and House of Representative, Select Committee on Aging, Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal, Staff Study, Committee Publication No. 95-[illegible], Nov. 28, 1978.

the Baucus amendment standards.[4] The Baucus amendment also contains federal sanctions, consisting of fines and/or imprisonment for insurers or their agents who are involved in abusive practices specified in the act.[5]

2. Providing guidance to the NAIC in its development of model long-term care insurance regulatory standards. In 1986, as required by law, HHS established a task force on long-term care policies. It reviewed issues relating to long-term care, including NAIC positions, and made recommendations for promoting the development of the private long-term care insurance market.[6]

In March 1985, the NAIC established an advisory committee on long-term care. The next year, the committee developed a legislative proposal in the form of a model act.[7] Acting on the proposal in December 1986, the NAIC adopted a long-term care insurance model act. A year after that, NAIC adopted a model regulation for implementing the model act. The NAIC amended its models in 1987 and 1988 to improve policyholder coverage and strengthen consumer protection.[8] NAIC's model law and regulation suggest that states should adopt minimum standards with regard to certain policy restrictions and exclusions that tend to reduce the probability that policyholders will receive benefits.

Balance Required in Regulation of Long-Term Care Insurance

The NAIC long-term care insurance models are intended to give states minimum standards to use in formulating their long-term care insurance laws and regulations. The standards represent NAIC's approach to addressing concerns over consumer protection while giving insurers flexibility in designing long-term care policies. The models, which provide suggestions for regulating long-term care policies, have the support

[4]Because of changes in Medicare benefits under the Catastrophic Coverage Act of 1988 (P.L. 100-360, July 1, 1988), state regulatory programs must be recertified based on the revised standards.

[5]Sanctionable practices include (1) knowingly or willfully furnishing false information with respect to compliance with the NAIC model standards to obtain federal certification or (2) knowingly selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale.

[6]Task Force on Long-Term Health Care Policies, HHS, Report To Congress And The Secretary, Sept. 1987.

[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.

[8]A chronology of NAIC's adoption of key long-term care insurance provisions appears in app. I.

of the HIAA, a health insurance trade association. But the states have ultimate responsibility for setting the standards that govern insurers operating in their jurisdictions. In doing so, the states must decide on the appropriate balance between consumer protection and the insurance industry's need for flexibility to experiment with different approaches to providing insurance in this new area.

An appropriate regulatory balance is, however, difficult to achieve. For example, restrictions and limitations in long-term care policies tend to reduce the benefits available to policyholders.[9] According to one recent study, requiring hospitalization before nursing home care is covered and skilled nursing care before lower levels of care are covered reduce a policyholder's chances of collecting benefits by about half.[10] In combination with other restrictions, the policies analyzed for this study would not pay any benefits, on average, 61 percent of the time.

To the extent that restrictions are removed and coverage is increased, however, policy prices can increase to the point where they may not be affordable to the majority of older persons seeking such coverage. But as affordability is increased by restricting or limiting services, the likelihood of policyholders obtaining benefits decreases.

Objectives, Scope, and Methodology

The Chairman of the Subcommittee on Health and Long-Term Care, House Select Committee on Aging asked us to determine the extent to which states have (1) adopted legislation establishing standards specifically for long-term care insurance policies and (2) implemented procedures for enforcing the standards.

In accomplishing these objectives, we reviewed literature on state insurance departments' operations, regulation of health insurance in general, and regulation of long-term care insurance. In addition to interviewing several state insurance regulatory officials, we obtained comments from representatives of the NAIC, HIAA, and the Intergovernmental Health Policy Project—three organizations that are knowledgeable about state insurance regulatory activities.

[9]Long-term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-[illegible] May 1987).

[10]United Seniors Health Cooperative, in collaboration with W. Weissert and C. Wilson, Private Long Term Care Insurance: How Well Is It Meeting Consumer Needs and Public Policy Concerns? [illegible] 1988.

Our primary data sources were (1) a questionnaire we developed and sent to the insurance agency heads in 50 states and the District of Columbia in May 1988 and (2) legislative materials obtained from states that had adopted specific long-term care insurance legislation. Although we did not independently verify the information we received, we did contact several state insurance agency officials by telephone to complete and clarify state responses to our questionnaire. One state, Idaho, did not return the questionnaire with sufficient data in time to be included in this report.[11]

To further analyze state long-term care insurance requirements, we reviewed copies of laws and regulations in effect as of October 1, 1988, for the 25 states that adopted legislation specifically for regulating long-term care insurance.[12] For our analysis we (1) noted key terms that were defined, (2) identified the disclosure and performance standards insurers were required to meet, and (3) compared the states' requirements to those suggested by NAIC's model act and regulation, especially those that provided protection for consumers.

We did not evaluate the merits of the NAIC model act and regulation to determine their appropriateness or completeness. The provisions of the models gave us a basis for comparing the states' requirements because they represent a consensus approach among the heads of state regulatory agencies to providing a minimum level of consumer protection while allowing insurers flexibility in developing long-term care insurance.

Our work was performed from August 1987 through December 1988, in accordance with generally accepted government auditing standards. At the Subcommittee's request, we did not obtain written comments on this report. However, the views of responsible state and NAIC officials were sought and are incorporated in the report where appropriate.

[11]In total, 49 states and the District of Columbia responded to our survey. Throughout the remainder of this report, we refer to the District of Columbia as a state when discussing the survey results.

[12]The requirements found in the 25 states' laws and regulations we reviewed may differ from the requirements these states reported on our questionnaire because some states completed our data collection instrument before their laws became effective.

State Regulation of Long-Term Care Policy Coverage Varies

By establishing minimum standards in its model act and regulation, NAIC seeks to limit insurers' use of certain restrictions and exceptions that can reduce the likelihood of policyholders receiving benefits, despite their need. For example, under NAIC's standards, insurers could not (1) exclude coverage for persons with Alzheimer's, as this disease often requires nursing home services, or (2) issue policies that are not renewable at the discretion of the policyholder.

But state approaches to regulating long-term care insurance are still evolving and vary widely in the degree to which they conform with NAIC standards. Some states regulate long-term care insurers and policy coverage under their general health insurance authorities, while others regulate through specific long-term care insurance laws and regulations. About half the states have enacted specific legislation governing long-term care insurance, but many of these laws conflict with the provisions of the NAIC models.

Overall, the majority of states allow insurers to sell policies with provisions that are contrary to NAIC's recommended practices and minimum standards. Such provisions, though helping reduce insurers' costs and policy premiums, can adversely affect policyholders by (1) decreasing the likelihood that needed benefits will be covered and (2) increasing risks of policy terminations for reasons other than nonpayment of premiums.

Because NAIC's models were adopted only recently and have been amended several times, the variances we noted between NAIC's currently recommended standards and those used by the states may be due to the time lag states can encounter when enacting new legislation and promulgating regulations. Sufficient time has not yet passed to assess the degree to which states will ultimately adopt the NAIC's standards. NAIC officials expect that, within the next 2 years, more than 90 percent of the states will adopt standards that are at least equal to its minimum model standards.

States' Conformity With Model Standards Varies

Although states have specific laws for regulating insurers, they vary substantially in the means and extent to which they regulate long-term care insurance. Half the states have enacted specific long-term care insurance laws,[1] and half rely on their general health insurance laws and regulations and/or on laws and regulations covering other forms of insurance such as Medigap or disability policies.

Of the 25 states that had enacted specific long-term care insurance laws (effective on or before October 1, 1988),[2] 21 characterized their requirements as the same, or similar to, the NAIC model.[3] As discussed in the following sections, however, the extent of the similarity between the NAIC model act and individual states' laws varies among states.

States use their policy approval processes to ensure compliance with their standards for policy content. Of the 50 states, all but one, Oregon, require insurers to obtain the insurance agency's approval before they market new individual long-term care policies within the state. Most (43) of these states indicated that they must decide whether the policy is acceptable within a designated period, usually 30 days, or it automatically becomes approved.[4]

Certain Coverage Limitations Regulated by States

While long-term care policies vary, many insurers use similar provisions to help control utilization of and access to covered services and to define and control their financial risks. NAIC suggests that states disallow or limit insurers' use of certain of these provisions that can adversely affect consumers by reducing their likelihood of obtaining benefits, regardless of the actual need for the services. The selected provisions of

[1]One state, Wisconsin, is included in the number of states with long-term care insurance laws because the state has adopted specific long-term care insurance standards through regulations. The potential effect of these regulations, as structured, is similar to that of the long-term care insurance laws in the remaining states.

[2]The 25 states with long-term care insurance laws, including key provisions therein, are listed in app. II. The long-term care insurance requirements as practiced in 50 states are listed in app. III.

[3]Two of the remaining four states indicated that they had not adopted the NAIC model or similar legislation because they enacted long-term care insurance laws prior to development of the NAIC model. Another state said it did not agree with most of the NAIC model provisions because they were too general. The fourth state indicated that legislation similar to the NAIC model was introduced in its legislature but was not adopted because a consensus could not be reached.

[4]The period allowed for state review ranged from 15 to 90 days, with 29 states allowing up to 45 days and 13 states allowing either 60 or 90 days. One state, Utah, did not place a time limit for approval.

the NAIC model act and regulation[5] that provide some protection for consumers

- prohibit insurers from requiring that policyholders receive a higher level of care before becoming eligible for lower levels of nursing home care, unless policies are offered without such provisions (adopted December 1988);
- require coverage for Alzheimer's disease (adopted December 1987);
- prohibit insurers from offering coverage for only skilled care or substantially more coverage for skilled care than for lower levels of care (adopted June 1987); and
- require that individual policies be guaranteed renewable or noncancellable (adopted December 1987).

Of the 25 states with long-term care insurance laws, at least 3 (Kansas, Maine, and Washington) have adopted provisions that are consistent with most of those specified in the NAIC models. But many states are not in conformance with NAIC's guidance. Of the 50 states responding to our questionnaire,

- at least 43 allow insurers to require that nursing home care be preceded by a hospitalization,
- 27 allow insurers to exclude Alzheimer's disease and other mental or nervous disorders of demonstrable organic origin from coverage,
- 31 allow insurers to limit coverage to skilled nursing care only, and
- 36 allow insurers to sell individual long-term care policies with renewability provisions that are less favorable to consumers than guaranteed renewable.

Selected policy provisions adopted by the 25 states that have enacted long-term care insurance legislation are listed in appendix II and discussed below.

Some Nursing Home Coverage Based on Receipt of Higher Levels of Care

Most states allow insurers to limit nursing home coverage by stipulating that policyholders qualify for and obtain higher levels of care, such as prior hospitalization or skilled nursing, before becoming eligible for coverage under lower levels of care. This serves to preclude coverage for many policyholders who otherwise would qualify for intermediate, custodial, or home health care. While the NAIC long-term care insurance

[5]A list of key consumer protection provisions of the NAIC long-term care insurance model act and regulation is presented in app. I.

models have allowed these prior care provisions in the past, as discussed below, recent amendments to the model act suggest that states either preclude their use in the future or require insurers using the provision to also offer policies without it.

Prior Hospitalization Clauses Allowed by 43 States

A restrictive clause commonly found in long-term care insurance policies requires that policyholders be hospitalized for at least 3 days before they can become eligible for benefits. Insurers use this provision to help control claims costs by linking eligibility for long-term care insurance coverage to an acute episode of an illness. Oftentimes, however, the need for long-term care is not preceded by such an event.

Prior to December 1988, the NAIC model act specifically permitted use of the prior hospitalization provision. In December 1988, however, the NAIC amended its model act regarding insurers' use of the provision. Under the amended NAIC model, states can either disallow the use of the prior hospitalization provision or require insurers that use it to also offer policies without the provision. Also, the NAIC model suggests that the states adopting the new amendments not make them effective until 1 year after adoption ". . .to establish a transition period to allow insurers to redesign their products, encouraging the development of alternative screening mechanisms."

At the time of our survey, most states (43) allowed insurers to include a prior hospitalization provision in their long-term care policies. Of the 25 states that had enacted long-term care insurance laws, 23 allowed insurers to include such a provision in policies sold in-state. Four of the 23 states did not allow insurers to apply the provision without meeting specified conditions. For example, Kentucky disallowed the use of a prior hospitalization provision for admission to an intermediate care facility, but allowed it for admission to other types of facilities. In only five states does legislation conform with NAIC's current standard regarding the prior hospitalization provision. Kansas and Maine unconditionally disallowed insurers to use it, and Florida, Washington, and Wisconsin required that insurers using the provision offer policies without it.

Policies containing the 3-day prior hospitalization provision also require that the policyholder enter a nursing home within a certain period after discharge. Most states that specifically allowed prior hospitalization requirements (16 of 23), also had established minimum standards for the time period insurers must allow policyholders before they are

required to enter a nursing facility following an inpatient hospital discharge. Of the 16 states with standards, all but 2 had the same standard as NAIC's minimum requirement of no less than 30 days. The two remaining states used 14- and 60-day standards, respectively.

According to the HHS task force report, long-term care policies setting a short time limit present problems. Deciding whether alternatives to institutionalization can be arranged often takes some time. In addition, there may be a limited number of nursing home beds available and waiting lists for those beds. Policyholders who are not admitted within the time limit because of the unavailability of nursing home beds could lose their nursing home benefits.

Stepdown Provisions Often Allowed

Another restrictive clause, which we refer to as the stepdown provision, requires that less medically intensive nursing home stays be preceded by stays at successively higher levels of care. Insurers commonly use this provision for the same reason as the prior hospitalization clause. It provides insurers a way of controlling costs by restricting the use of covered services to a certain population—generally, policyholders who enter a nursing home for care related to an acute episode of an illness.

As with the prior hospitalization provision, before the December 1988 model act amendment the NAIC did not preclude use of stepdown provisions. In December 1988, however, the model act was amended to prohibit insurers from requiring that a lower level of nursing home care be preceded by a higher level of nursing home care.

In most of the 25 states with long-term care insurance statutes, use of the stepdown provision was permissible. In four states, it was not:

- Kansas did not permit insurers to require prior confinement in facilities providing higher levels of care as a condition for covering lower levels of care.
- Kentucky, Maine, and Wisconsin did not permit insurers to condition intermediate level care coverage on the prior receipt of skilled nursing care benefits.

Exclusion of Alzheimer's Coverage Permitted in 27 States

NAIC's model regulation stipulates that insurers be required to include coverage for Alzheimer's disease in their long-term care policies. Excluding coverage for persons diagnosed with Alzheimer's disease is particularly restrictive because more than 50 percent of nursing home residents

may have Alzheimer's,[6] and about 2.5 million elderly persons were estimated to have the disease in 1985.

In responding to our questionnaire, 27 states indicated that they would permit insurers to exclude coverage for Alzheimer's disease. More than half of these states (18) were among those that enacted long-term care insurance laws. Of the seven states with long-term care insurance laws that prohibit insurers from excluding Alzheimer's disease coverage, five allowed the insurers to use the prior hospitalization provision.[7] Because hospitalization is neither required nor likely for persons as a direct result of Alzheimer's, this could negate the states' coverage requirement for the illness.

Of the 25 states that have not enacted long-term care legislation, 10 indicated that it is their practice not to approve policies that exclude coverage for Alzheimer's disease. Eight of these states, however, will approve policies that include a prior hospitalization provision.

Coverage of Only Skilled Care Allowed in 31 States

According to the NAIC, it is inappropriate for state insurance regulatory agencies to approve policies for sale as long-term care policies if they restrict coverage to only skilled nursing care ". . .lest consumers think they have broader protection than they do." Consequently, NAIC's model act specifies that states not approve policies that (1) cover only skilled nursing care or (2) structure their coverage to provide substantially more coverage for skilled than for lower levels of care. Medicare does not provide for any coverage of intermediate or custodial care. Consequently, these are the long-term care services for which there remains a significant gap in coverage for elderly persons, and for which they are at risk for catastrophic expenses.

Thirty-one states permitted insurers to market long-term care policies that cover only skilled nursing care. Of these states, 13 had long-term care legislation. Also, all 13 states allowed insurers to use the 3-day prior hospitalization provision. Consequently, in these states, eligibility

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

[7]Wisconsin was the only state allowing prior hospitalization clauses to have modified the provision to mitigate its restrictiveness on persons suffering from irreversible dementia (including Alzheimer's disease). It did not permit insurers to use prior hospitalization clauses to deny coverage for such persons who require nursing home care but would otherwise, because of the provision, be ineligible.

for skilled nursing coverage was more restrictive than Medicare's,[8] though the private coverage would extend beyond the Medicare limit of 150 days.

Additionally, most states with long-term care insurance laws (17 of 25) had not adopted NAIC's recommended provision stipulating that insurers not provide substantially more coverage for skilled nursing care than for lower levels of care. Structuring policies in this manner can have a similar effect as those policies covering only skilled care. Of the eight states adopting provisions directed at helping to assure balanced coverage among the levels of care offered by insurers, four (Florida, Illinois, South Carolina, and Wyoming) adopted language similar to that contained in the NAIC model act.

The remaining four states included the following provisions in their long-term care insurance laws or regulations:

- Georgia: Coverage for other than skilled nursing care may not be "unreasonably lower" than that provided for skilled care.
- Maine: Benefits may differ for different levels of care but the lowest level of daily benefits cannot be less than the lesser of (1) 50 percent of the highest level of benefits or (2) the usual and customary charge. Additionally, if a policy provides separate benefit periods for skilled nursing facilities and intermediate care facilities, the benefit period for intermediate care must be at least equal to the benefit period for skilled nursing care.
- Ohio: Similar to NAIC, except an applicant may obtain coverage providing only or mostly skilled nursing care only when there is written acknowledgment that the applicant requests or knowingly accepts and understands such coverage.
- Wisconsin: Benefits may differ for different levels of care but benefits for lowest level of care must be worth at least 50 percent of benefits for highest level of care.

[8]Under the Catastrophic Coverage Act of 1988, Medicare no longer requires prior hospitalization as a condition for receiving skilled nursing care.

Renewability Provisions Often Provide Little Consumer Protection

Assurance of continued coverage is a basic consumer protection, according to the HHS Task Force on Long-term Care Policies, and a reasonable expectation. This is due to the nature of long-term care insurance—protection against a potentially catastrophic event that may occur sometime in the future. Further, as policyholders age, the prospects of obtaining alternative coverage decrease while the costs increase. The NAIC model regulation therefore prohibits cancellation or nonrenewal of long-term care insurance policies for individuals except under certain prescribed conditions. The model act provides a minimum renewability standard that state insurance commissioners can adopt. This standard specifies that no long-term care insurance may ". . be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder."

Of the 50 states answering our questionnaire, 36 permitted insurers to use policy renewal provisions less favorable to the consumer than those suggested by NAIC in its model act and regulation. Also, few states required insurers to include in long-term care policies provisions for the distribution to policyholders of reserves if the insurer terminates coverage. As a portion of the premium of most long-term care policies currently being marketed represents a reserve for future claims, according to the NAIC Advisory Committee's report, policyholders have a right to receive the reserve portion of premiums when coverage is involuntarily terminated.

Many States Not in Conformance With Renewability Standard

According to the NAIC Advisory Committee, renewability refers to the right of the insurer to cancel individual policies for reasons other than nonpayment of premiums. The committee described the following four types of renewability provisions, in order of increasing protection for consumers and risk for insurers:

- 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—the insurer cannot decline renewal for any reason, but can revise premiums on a class basis.
- Noncancellable—renewal cannot be declined nor premiums be increased by the insurer.

In its model regulation, the NAIC states that no renewability provision less than guaranteed renewable, should be allowed.

Of the 25 states with long-term care insurance legislation, all but 3 (Kentucky, New York, and Texas) had adopted the NAIC standard that coverage not be cancelled for reasons related to the health or age of the policyholder. Kentucky, New York, and Texas' long-term care insurance laws were silent on this matter. Also, 6 of these 25 states (Iowa, Kansas, Maine, Minnesota, North Dakota, and Washington) specified in either their long-term care insurance laws or regulations that policies must be guaranteed renewable or noncancellable. Three states specified that policies can be conditionally renewable, and the remaining 16 did not specify the types of renewability allowed.

Considering both states that have long-term care laws and those without, 36 states indicated that they would allow renewability provisions that are less favorable to the consumer than guaranteed renewable. Of the 50 states that answered our questions on renewability:

- 22 would approve policies that are optionally renewable. Since renewal of these policies is at the sole discretion of the insurer, these states had not incorporated NAIC's standard that policies cannot be cancelled because of a policyholder's age or declining health.
- 36 would approve conditionally renewable policies.

While 48 states permitted insurers to guarantee renewability at their discretion, only 14 required insurers to guarantee renewability. The definition of "guaranteed renewable" and the conditions under which insurers can terminate such policies, however, varied among states. Under NAIC's model regulation, insurers can use the term "guaranteed renewable" only when the policyholder

> "...has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis."

However, the regulation provides that the state insurance commissioner may authorize nonrenewal on a statewide basis if the insurer can demonstrate that (1) renewal will jeopardize the insurer's solvency or (2) losses on the policy are such that even with reasonable rate adjustments substantial losses will continue to occur.

In responding to our questionnaire, 35 states indicated that a guaranteed renewable policy could not be cancelled, nonrenewed, or terminated in any way except for nonpayment of premiums. Yet seven of these states (Hawaii, Illinois, Louisiana, Michigan, Nevada, New Mexico, and Oregon) made exceptions to this requirement. Including these 7 states, a total of 21 states specified conditions under which a guaranteed renewable policy could be cancelled or nonrenewed (see table 2.1).

Table 2.1: Conditions Under Which States Allow Individual Guaranteed Renewable Policies to Be Nonrenewed or Terminated (1988)

Conditions under which states allow terminations	No. of states
If terminated by group or class of policyholders	12
If terminated on a statewide basis	12
If continuation would jeopardize the insurer's solvency	7
If policyholders are given advance notice	5
If approved by the state insurance regulatory agency head	9

Few States Protect Policyholders Rights to Reserves

The prevalent form of long-term care insurance currently marketed is the level-premium policy.[9] For such policies, an insurer's initial claims cost is expected to be less than its premiums, which allows reserves to build up to meet future claims.[10] For this reason, according to the NAIC Advisory Committee, both consumers and responsible insurers argue against cancellation of policies financed through level premiums. However, as noted in the prior section, most states allow insurers to terminate long-term care policies for a variety of reasons other than nonpayment of premiums. When such terminations occur for level-premium policies, according to the advisory committee, policyholders have a right to receive reserves resulting from their level premiums.

The NAIC Advisory Committee's position on the distribution of reserves is that "cancellation by the insurer of a level issue age premium individual policy should result in individual nonforfeiture benefits [that is,

[9]That is, the premium has two components: (1) an amount reflecting the probability of a policyholder using covered services during the year for which the premium is paid and (2) an amount to be retained as reserves against future use of services should the policyholder continue to renew the policy. Such policies are referred to as level-premium policies because the premium is based on the age and other underwriting characteristics of the policyholder at the time the policy is first purchased, and policyholders can continue to renew the policies at that rate. The concept is similar to that of whole life insurance policies.

[10]The expectation is that eventually claims costs would escalate to the point where they would exceed current premiums and reserves would be drawn down to meet expenses.

return of a portion of the reserves] which are consistent with NAIC guidelines." NAIC's long-term care insurance model act and regulation, however, do not contain a provision that suggests states must require insurers to incorporate nonforfeiture value benefits in their long-term care policies. Even though the majority of the states allow insurers to terminate policyholders' coverage for reasons other than nonpayment of premiums, only eight states indicated that they require insurers to incorporate a nonforfeiture value benefits provision in their long-term care policies.

Terms Often Not Defined in Laws and Regulations

For consumers, a key issue in states' regulation of long-term care insurance is whether the definitions of services covered under specific policies are clear and uniform. The absence of clear and uniform definitions for levels of care and facilities makes it difficult to understand precisely what services are covered and in what types of facilities, and to make meaningful comparisons between competing policies.

In our 1987 report, for example, we found that while each of the 33 long-term care policies we reviewed stipulated that care be received in a licensed facility, certain insurers would not pay benefits to policyholders receiving care in facilities with fewer than a minimum number of beds, and others stipulated staffing patterns for different levels of care. Furthermore, a few policies provided coverage for skilled, intermediate, and custodial levels of care but required that all services be provided in a skilled nursing facility. These definitions can reduce the likelihood of policyholders obtaining benefits to the extent that the facilities as defined are in short supply and may not be available to policyholders when needed.

By adopting specific definitions for services and facilities and requiring insurers to adhere to them, states can provide consumers protection similar to that provided by minimum standards. Essentially, the definitions themselves establish standards that must be met.

Of the 25 states that have enacted long-term care insurance legislation, most (24) have established definitions for certain terms used in policies marketed in-state, but many long-term care terms were not defined.[11] What constitutes the long-term care services depends on the facilities

[11]Regardless of whether a state has enacted long-term care insurance legislation, each state usually defines facility types for purposes of licensure. Our review excluded states lacking long-term care insurance laws because we had no state legislation that specifically related the states' definitions to long-term care insurance.

and services defined in the policies. Coverage in long-term care policies can range from only one level of care to all four—home, custodial, intermediate, and skilled care. However, most states have not established definitions for facility types and the various levels of care in either their long-term care insurance statutes or regulations, as table 2.2 shows.

Table 2.2: States Defining Long-Term Care Terms

Terms	No. of states with definition
Skilled-level care	6
Intermediate care	6
Custodial care	6
Home care	3
Skilled nursing care facility	7
Intermediate nursing care facility	7
Custodial/personal care facility	0

Of the 10 states that define nursing home services, five (Connecticut, Iowa, Kansas, Maine, and Washington) require that the services insurers provide be as inclusive as the states' definition of the services. The remaining states were silent on this matter.

The extent to which and how states ultimately will define long-term care terms is still unclear; many states (15 of the 25 with laws) had not promulgated regulations at the time we completed our review of the states' legislation (October 1988). As more states define terms through regulations, some may adopt definitions for facility types and the various levels of long-term care.

State Efforts to Regulate Marketing and Sales of Long-Term Care Insurance

In addition to regulating coverage and other policy provisions, states use a variety of mechanisms to monitor insurer practices in marketing and selling long-term care insurance. These mechanisms include complaint-handling systems and review of marketing materials and selected aspects of insurers' operations. About a third of the 50 states responding to our questionnaire indicated receiving complaints alleging abuse or otherwise identifying incidents of unacceptable practices involving sales agents or insurers of long-term care. The most frequent complaints or incidents involved

1. misrepresentation of policy coverage by sales agents,
2. insurers' reported failure to pay claims, or
3. false or deceptive advertising or sales practices.

On the basis of their investigations of such incidents, 10 states undertook some enforcement action against either insurers or their agents during 1986 or 1987. Actions taken most often involved assessing fines, revoking agents' or brokers' licenses, and conducting investigatory hearings.

Most information states gave us on both the volume of identified problems and their enforcement actions was based on their estimates of complaint/incident activity, as they generally did not maintain separate files of such information for long-term care insurance.

Many states also have adopted loss ratio standards to measure the value to consumers of long-term care policies sold in their states. The loss ratio for a policy represents the percentage of premiums collected that are expected to be paid out in benefits. Thirty-three states have established minimum loss ratio standards for individual policies; most use the NAIC-suggested standard of 60 percent. Most states, however, cannot monitor insurers' actual long-term care policy loss ratios because they do not require insurers to report benefit and premium data separately for long-term care policies. The NAIC is designing a data collection form that requires separate reporting of such data for long-term care policies.

States Use General Standards to Control Marketing Abuse

In developing its long-term care insurance models, the NAIC did not include requirements to deal specifically with consumer protection against unfair marketing or sales practices. The NAIC concluded that its models for other insurance lines of business gave regulators sufficient leverage to deal with such practices.

Forty-six states said that they use standards established by state general health insurance or trade practice laws for regulating long-term care insurers' marketing and sales practices. Such standards are directed at helping protect consumers against fraud, abuse, and deception in the marketing and selling of private insurance. Twelve states indicated that they also use standards established by laws or regulations specifically relating to long-term care insurance.

In most states, the insurance regulatory agency has primary authority to enforce the marketing and sales standards. And, in all but two states, the state regulatory agencies use the same examination and investigative staff for monitoring sales and marketing practices involving long-term care insurance as for other types of insurance. Alaska and Texas indicated that they have staff assigned specifically to long-term care insurance market activities.

States Monitor Compliance Through Complaints, Industry Reviews

State insurance regulatory agencies employ three primary methods to monitor compliance with standards for protecting consumers against marketing and sales abuse. In most states, consumer complaints form the basis for monitoring insurers. In addition, many states also routinely review insurers' marketing materials and/or perform market conduct examinations—that is, review selected aspects of insurer operations.

Policyholder complaints are the key source of information that most insurance regulatory agencies use to identify problems with policy provisions or companies. Forty-nine states said they use a formal insurance complaint-handling system to monitor advertising and sales practices in the long-term care insurance market. Of these states, 12 rely totally on this source of information to alert their investigators of potentially abusive marketing and sales practices.

In addition, 17 states also review and approve insurance companies' marketing or advertising materials, and 32 perform market conduct examinations. A market conduct examination is an evaluation of insurers' compliance with state requirements and their dealings with policyholders and claimants in the state, such as in claims handling, advertising, underwriting, and other trade practices. The primary purpose of such examinations is to identify insurers engaging in unfair trade or business practices and to develop the basic information needed for regulatory action.

Eighteen States Report Incidents or Complaints of Abuse or Deception

To determine the extent of marketing abuse identified over a 2-year period, we asked state insurance regulatory agencies for the number of incidents identified or complaints received involving long-term care insurance in 1986 and 1987. Of the 50 states that responded to our questionnaire, 19 either lacked records of abuse cases in the marketing and sale of long-term care insurance or could not readily recover the records. Some of these states indicated that the information was not readily available because they had manual record-keeping systems. Others stated that cases involving long-term care insurance were not filed so that they could be easily distinguished from other health insurance cases. Thirteen of the 50 states said, however, that they had neither received any complaints from the public nor identified any abusive practices on their own.

Eighteen states had received complaints and/or identified incidents of marketing abuse involving long-term care insurance. They provided information from existing records or estimates on the number of cases and types documented in 1986 and 1987. The number of incidents reported ranged from a single case in one state to about 900 cases in another state. The type of abusive practice most frequently reported was misrepresentation of policy coverage by an agent, as shown in table 3.1.

Table 3.1: Complaints and Incidents of Marketing and Sales Abuse Reported by 18 States (1986-1987)

Type of complaint or incident	No. of states	No. of cases
Misrepresentation of policy coverage by an agent	14	1 638
Failure to pay claims	13	703
Other unfair or deceptive sales practices	10	252
False or deceptive advertising	7	250
Failure to refund money after consumer returned policy during free-look period	10	205
Misleading policy language	7	181
Use of scare tactics to induce sales	10	151
Drastic increases in policyholders' premiums	9	113
Cancellation of policyholders' coverage for reasons other than nonpayment of premiums	7	75

Fines and Suspension or Revocation of License Among Enforcement Actions

Some states have initiated enforcement action as a result of their investigations of fraud, abuse, or deception in the marketing and sale of long-term care insurance. Enforcement actions at the disposal of most states include cease-and-desist orders, license suspensions or revocations, and fines. While most states did not maintain separate records of enforcement actions, 10 states reported taking such actions and estimated the number of incidents of each action taken during 1986 and 1987 (see table 3.2).

Table 3.2: Enforcement Actions Reported by 10 States Resulting From Investigations During 1986 and 1987

Type of enforcement action	No. of states	No. of actions
Fines	9	131
Suspension/revocation of agent's/broker's license	8	102
Hearings	6	47
Cease-and-desist orders	8	32
Suspension/revocation of insurer's license	2	9
Imprisonment	2	6

Many States Require Policy Disclosure

Consumers of all ages should understand what they are buying, the NAIC Advisory Committee asserted, and the benefits and limitations of long-term care insurance products should be fully and fairly presented. Also, the committee believes that state statutes and regulations should require insurance companies to provide full disclosure of relevant policy information.

The NAIC model act 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.

Of the 25 states that have enacted specific long-term care insurance legislation, 23 require insurers to give consumers an outline of coverage, at either application or policy delivery.[1] Generally, the states' outlines of coverage provisions were similar to NAIC's.

[1]Texas' and New York's legislation did not include this requirement. However, neither state had promulgated regulations at the time we completed our review.

In December 1988, the NAIC adopted a model act provision that directs the state insurance commissioner to prescribe a standard format for the content of an outline of coverage. A description of the outline of coverage format was added to the NAIC model regulation. One state, Washington, has a similar requirement. The state requires each insurer to use a standardized disclosure form so that consumers may easily compare policy provisions and costs. The form requires the insurer to indicate when it does not provide coverage of certain specific benefits as well as when it does. The insurer must prepare the form as though each question or issue raised has been asked by a senior citizen.

The NAIC model act also includes a "right to return free-look" provision. This provision, similar to the one NAIC suggested for Medigap policies, allows policyholders who are unsatisfied for any reason to return the policy within 10 days and receive a premium refund. Persons who did not initiate the purchase of a policy but were solicited (so-called "direct response") receive a 30-day free-look period. Of the 25 states with long-term care insurance legislation, 19 have adopted the same or similar free-look requirements as NAIC and 6 have not.

Many States Established Consumer Education Programs

In addition to adopting standards to protect long-term care insurance consumers from marketing and sales abuse, many states have initiated consumer education programs. State efforts to educate consumers include

- publicizing the availability of assistance from the insurance regulatory agency (38 states),
- sponsoring consumer awareness seminars (27 states),
- sponsoring periodic information campaigns through various forms of media (21 states), and
- publishing a consumer's guide (25 states).

The HHS Task Force suggested that states, as a method of educating consumers, develop consumer guides that include a list of commonly asked questions and provide a basis for comparing long-term care policies. Incorporating consumer guides with disclosure statements on an insurance policy may increase consumer awareness. The NAIC Advisory Committee also suggested that consumer guides specifically addressing long-term care insurance be made widely available.

Two states gave us examples of consumer guides they published. The Minnesota Department of Commerce disseminates a pamphlet to consumers called "A Discussion of Long-Term Care Insurance," which contains questions and answers about long-term care services, insurance, and state requirements. It also includes a list of dos and don'ts to remember when considering the purchase of long-term care insurance. A guide published by the Kansas Insurance Department (1) discusses key provisions of the state's long-term care insurance act, (2) presents questions and answers about long-term care, (3) defines policy terms, and (4) gives tips on health insurance. Especially significant is the inclusion in the Kansas shopper's guide of a comparison of several policies that are designed to comply with its new law and are available for sale in the state.

Loss Ratios Set but Data Collection Often Lacking

For many lines of insurance, state regulators traditionally have used loss ratios to measure the relative value of the policies sold in their states. Such ratios are computed by dividing the amount of incurred claims[2] by the amount of earned premiums for a reporting period. They provide a common denominator for consumers and regulators to compare and evaluate insurance policies, as the ratio measures the aggregate amount of premiums returned to policyholders in the form of benefits paid. For long-term care insurance, as for any relatively new line of policy coverage for an insurer, loss ratios are at best an indication or estimate of the value of a policy. It can take some time for new policies to "mature," given among other things the lag-time between when the policies are written and when benefits are expected to be paid. For states choosing to use loss ratios, the NAIC established a benchmark of 60 percent for individual long-term care policies. That is, insurers should be expected to price policies with the expectation that in the aggregate at least, 60 percent of premiums collected will be paid out as benefits.

Thirty-three states have designated loss ratio percentages for long-term care policies, of which 18 specified the same percentage as the NAIC's suggested minimum standard for individual policies. Two states chose 65 percent and the remaining 13 states chose either a 55 or 50 percent minimum standard. Twelve of the 33 states have established minimum loss ratio standards specifically for individual long-term care policies through legislation. The remaining states use loss ratio standards that

[2]Incurred claims include not only paid claims but also reserves for claims for services policyholders received during the period that have not yet been settled by or reported to the insurer

they established for other types of insurance such as Medigap. Of the 33 states, 21 indicated that they periodically monitor insurers' actual loss ratios against the states' standards. Most states (36), however, cannot do this routinely because they do not require insurers to report premiums, payout, and reserves experience data separately for long-term care policies. Instead, the data are often aggregated with other lines of business—such as general health insurance.

The NAIC is designing a form for collecting long-term care policies' experience data. The use of a standard form to collect separate data could enhance the ability to better evaluate the value of long-term care insurance to consumers and insurers alike.

Conclusions

Given the increases in the nation's elderly population and the concurrent growth in the demand for long-term care, the financing and delivery of such care constitute an important public policy issue. But budget constraints on the Medicare and Medicaid programs make it likely that private insurance will be considered in conjunction with any federally sponsored long-term care initiative. In regulating the insurance industry and structuring and administering Medicaid, the states will continue to play a key role in the long-term care insurance debate.

Long-term care insurance is a relatively new industry, however, and insurers are still gaining the experience needed to enter and remain in the market. Caution is required in setting regulatory standards. If standards are too rigorous, insurers may become unwilling to enter or remain in the market and/or policy prices may become so high as to significantly limit product marketability. On the other hand, if standards are too lenient consumers may face the same problems that occurred in the 1970s with Medigap policies. Then, policies varied significantly in terms of coverage and value, state regulation was inconsistent, and instances of marketing and sales abuse escalated.

In 1979, the NAIC adopted minimum standards for Medigap policies. In 1980, those standards were incorporated into federal law under the Baucus amendment. The amendment encouraged states to adopt uniform minimum standards for addressing the problems and concerns with the Medigap market. By providing for combined federal/state oversight and enforcement, the legislation helped ensure consistent application of the standards nationwide and provided a means to reduce instances of marketing and sales abuse.

Despite NAIC Model Standards, Consumer Protection Is Inconsistent Across States

For long-term care insurance, the NAIC has developed a model act and regulation designed to establish minimum standards for protecting the consumer and allowing the insurance industry to experiment with different approaches to providing such insurance. There is no federal legislation, however, that addresses regulation of the long-term care insurance market.

It is too early to determine the degree to which states ultimately will adopt the NAIC model minimum standards. Because the NAIC only first adopted its model act in 1986 and has added or amended standards annually since then, the variances between NAIC's recommended standards and those most states were using in 1988 may reflect the time lag

states can encounter in enacting new legislation and promulgating regulations. While states are at different levels in developing their regulatory programs, responses to our questionnaire nevertheless point up some significant differences between state practices and NAIC's recommendations. For example, some states indicated they were not disapproving policies that contained (1) exclusions for coverage of Alzheimer's disease (27 states), (2) renewability provisions less favorable to the consumer than guaranteed renewable (36 states), and (3) coverage for only skilled nursing care (31 states).

We did not evaluate the merits of the NAIC model standards and therefore, cannot comment on the adequacy of consumer protection they provide. However, they represent a consensus among state regulators on the minimum standards insurers should meet to provide a reasonable level of consumer protection at this stage of market development. The divergence between state regulatory practices and the NAIC minimum standards raises questions about the adequacy of consumer protection, particularly in light of studies that show the restrictiveness of many policy provisions allowed and used by insurers in some states. Without additional state actions to bring state standards to at least NAIC-recommended levels, the intended consumer protection will not be incorporated consistently across states.

Matter for Congressional Consideration

While states have taken some actions to adopt minimum long-term care insurance regulatory standards, many do not conform to the standards suggested by NAIC's models and future state action is unclear. In the meantime, the long-term care insurance industry is growing rapidly. To help assure that new policies will provide at least a minimum level of consumer protection, the Congress may want to consider the desirability of enacting federal legislation—as was done with the Medigap insurance market—directed at establishing minimum standards for long-term care insurance.

Consumer Protection Provisions of NAIC's Model Act and Regulation

1986 and 1987 Model Act Provisions

- Prohibit an insurer from cancelling a policy because of the policy holder's age or deteriorating health.
- Limit the length of time an insurer may exclude coverage for preexisting conditions to 6 months, with no distinction based on age.
- Furnish policyholders with an outline of coverage detailing policy benefits, exclusions, and renewal provisions.
- Offer the consumer a 10- to 30-day "free-look" period within which to return the policy for any reason and receive a complete premium refund.
- Prohibit any long-term care insurance policy from offering coverage for only skilled care.

1987 Model Regulation Provisions

- Require coverage for Alzheimer's disease.
- Require individual policies to be guaranteed renewable or noncancellable.
- Require individual policies to have an expected loss ratio of at least 60 percent.
- Provide group policyholders with a basis for individual continuation or conversion of coverage.
- Require that benefits continue after termination of the policy if institutionalization begins while the long-term care insurance is in force and continues without interruption after termination.

Key December 1988 Changes to Long-Term Care Insurance Model Act and Regulations

- Prohibit insurers from requiring that policyholders be hospitalized as a condition of eligibility for benefits (as an alternative to total prohibition, the amendment suggests requiring those insurers who retain the restriction to also offer coverage without the restriction).
- Prohibit insurers from requiring that policyholders receive benefit at a higher level of nursing home care as a condition of eligibility for benefits at a lower level of care.
- Prescribe a standard format for the content of an outline of coverage.
- Provide group policyholders with a basis for individual conversion or continuation of coverage. (The 1987 provision was expanded.)

Key Requirements of the 25 States With Long-Term Care Insurance Laws

State	Services/facilities defined	Skilled care only coverage	Stepdown provision
Arizona (L)	None	Allowed (N/P)	Allowed (N/P)
Colorado (L/R)	SNF, ICF	Allowed (N/P)	Allowed (N/P)
Connecticut (L/R)	CC,SNF	Allowed (N/P)	Allowed (N/P)
Florida (L)	None	Disallowed	Allowed (N/P)
Georgia (L)	None	Disallowed	Allowed (N/P)
Hawaii (L)	None	Allowed (N/P)	Allowed (N/P)
Illinois (L)	None	Disallowed	Allowed (N/P)
Indiana (L/R)	None	Allowed (N/P)	Allowed (N/P)
Iowa (L/R)	SC, IC, CC, SNF, ICF	Allowed (N/P)	Allowed (N/P)
Kansas (L/R)	SC, IC, (CC by reference)	Disallowed	Disallowed
Kentucky (L/R)	SC, IC, SNF, ICF by reference	Disallowed	Disallowed for ICF
Maine (L/R)	SC, IC, CC, SNF, ICF, HC (described in consumer's guide)	Disallowed	Disallowed for ICF
Minnesota (L)	HC	Disallowed	Allowed (N/P)
Nebraska (L)	None	Allowed (N/P)	Allowed (N/P)
New York	None	Allowed (N/P)	Allowed (N/P)
N. Carolina (L)	SNF, ICF, HC by reference	Allowed (N/P)	Allowed (N/P)
N. Dakota (L/R)	None	Allowed (N/P)	Allowed (N/P)
Ohio (L)	None	Disallowed unless requested	Allowed (N/P)
Oklahoma (L)	None	Allowed (N/P)	Allowed (N/P)
S. Carolina (L)	None	Disallowed	Allowed (N/P)
Texas (L)	None	Allowed (N/P)	Allowed (N/P)
Virginia (L)	None	Allowed (N/P)	Allowed (N/P)
Washington (L/R)	SC,IC,CC	Disallowed	Allowed (must offer option)
Wisconsin (R)	SC, IC, CC, SNF, ICF	Disallowed	Disallowed
Wyoming (L)	None	Disallowed	Allowed (N/P)
NAIC model (L/R)	**Definitional requirements**	**Disallowed**	**Disallowed**

Exclude Alzheimer's disease coverage	Prior hospital	Minimum time allowed to enter nursing home	Lowest renewability level allowed	Minimum loss ratio for individual policies	Right to return/ free-look period
Allowed (N/P)	Allowed	30 days	No provision	None	10 days (30 for direct response)
Disallowed	Allowed (N/P)	N/A	Conditionally	None	No provision
Allowed (N/P)	Allowed	14 days	Conditionally	55%	10-30 days (30 for direct response)
Allowed (N/P)	Allowed (must offer option)	30 days	Non-specific	None	30 days
Allowed (N/P)	Allowed	30 days	No provision	None	30 days
Allowed (N/P)	Allowed	30 days	No provision	None	30 days
Allowed (N/P)	Allowed	30 days	No provision	None	10 days (30 for direct response)
Allowed (N/P)	Allowed (N/P)	N/A	No provision	None	10 days
Disallowed	Allowed	30 days	Guaranteed	60%	10 days (30 for direct response)
Disallowed	Disallowed	N/A	Guaranteed	55%	30 days
Allowed (N/P)	Disallowed for ICF	N/A	No provision	50%	No provision
Disallowed	Disallowed	N/A	Guaranteed	60%	No provision
Allowed (N/P)	Allowed	No provision	Guaranteed	60%	30 days
Allowed (N/P)	Allowed	30 days	No provision	None	10 days (30 for direct response)
Allowed (N/P)	Allowed (N/P)	No provision	No provision	None	No provision
Allowed (N/P)	Allowed	30 days	No provision	None	10 days (30 for direct response)
Disallowed	Allowed	30 days	Guaranteed	60%	10 days (30 for direct response)
Allowed (N/P)	Allowed	30 days	No provision	None	30 days for direct response
Allowed (N/P)	Allowed	30 days	No provision	None	10 days (30 for direct response)
Allowed (N/P)	Allowed	30 days	No provision	None	10 days (30 for direct response)
Allowed (N/P)	Allowed (N/P)	No provision	No provision	None	No provision
Allowed (N/P)	Allowed	60 days	No provision	None	10 days (30 for direct response)
Disallowed	Allowed (must offer option)	30 days	Guaranteed	60%	30 days (60 for direct response)
Disallowed	Allowed (does not apply to irreversible dementia; must offer option)	No provision	Conditionally	55%	No provision
Allowed (N/P)	Allowed	30 days	No provision	None	30 days
Disallowed	**Allowed (must offer option)**	**30 days**	**Guaranteed**	**60%**	**10 days (30 for direct response)**

Legend:
CC means custodial care
HC means home care
IC means intermediate care
ICF means intermediate care facility
L means law; R means regulation
N/A means not applicable or not available
N/P means no provision in law or regulation
SC means skilled care
SCF means skilled care facility

Note: This chart presents a simplified description of several important long-term care insurance requirements that the 25 states had adopted at the time of our survey; 15 of these states had not promulgated regulations at that time. Also, the chart compares state requirements with NAIC model standards. We have not attempted to include all the important requirements but instead have selected several that are key to consumer protection.

States' Requirements as Practiced in Regulating Long-Term Care Insurance

States	Skilled care only coverage	Exclude Alzheimer's disease coverage	Prior hospitalization	Lowest renewability level allowed	Mimimum loss ratio for individual policies	Monitors actual loss ratio
Alabama	Allowed	Allowed	Allowed	Conditionally	None	No
Alaska	Allowed	Allowed	Allowed	Conditionally	60%	Yes
Arizona	Allowed	Allowed	Allowed	Optionally	50%	No
Arkansas	Allowed	Allowed	Allowed	Optionally	None	No
California	Disallowed	Disallowed	Allowed	Optionally	50%	Yes
Colorado	Disallowed	Disallowed	Allowed	Conditionally	None	No
Connecticut	Allowed	Disallowed	Allowed	Guaranteed	55%	Yes
Delaware	Allowed	Allowed	Allowed	Conditionally	None	No
District of Columbia	Allowed	Disallowed	Allowed	Optionally	55%	Yes
Florida	Allowed	Allowed	Allowed	Optionally	None	No
Georgia	Disallowed	Allowed	Allowed	Guaranteed	None	No
Hawaii	Allowed	Allowed	Allowed	Guaranteed	None	No
Illinois	Disallowed	Disallowed	Allowed	Guaranteed	None	Yes
Indiana	Allowed	Allowed	Allowed	Conditionally	60%	Yes
Iowa	Disallowed	Disallowed	Allowed	Guaranteed	60%	No
Kansas	Disallowed	Disallowed	Disallowed	Guaranteed	55%	Yes
Kentucky	Disallowed	Allowed	Disallowed	Optionally	50%	No
Louisiana	Allowed	Allowed	Allowed	Optionally	None	No
Maine	Disallowed	Disallowed	Allowed	Guaranteed	60%	Yes
Maryland	Allowed	Allowed	Allowed	Optionally	None	No
Massachusetts	Allowed	Allowed	Allowed	Guaranteed	65%	Yes
Michigan	Allowed	Allowed	Allowed	Optionally	65%	No
Minnesota	Disallowed	Disallowed	Allowed	Guaranteed	60%	Yes
Mississippi	Allowed	Allowed	Allowed	Optionally	None	No
Missouri	Disallowed	Disallowed	Allowed	Conditionally	None	No
Montana	Allowed	Allowed	Allowed	Optionally	None	No
Nebraska	Allowed	Disallowed	Allowed	Conditionally	60%	Yes
Nevada	Allowed	Allowed	Allowed	Optionally	60%	Yes
New Hampshire	Allowed	Allowed	Allowed	Optionally	50%	No
New Jersey	Allowed	Disallowed	Allowed	Conditionally	50%	Yes
New Mexico	Allowed	Allowed	Allowed	Optionally	None	No
New York	Disallowed	Disallowed	Allowed	Guaranteed	55%	Yes
North Carolina	Allowed	Disallowed	Allowed	Optionally	60%	No
North Dakota	Disallowed	Disallowed	Allowed	Guaranteed	60%	No
Ohio	Allowed	Allowed	Allowed	Conditionally	None	No
Oklahoma	Allowed	Allowed	Allowed	Conditionally	None	No
Oregon	Allowed	Allowed	Disallowed	Conditionally	60%	No

(continued)

States	Skilled care only coverage	Exclude Alzheimer's disease coverage	Prior hospitalization	Lowest renewability level allowed	Mimimum loss ratio for individual policies	Monitors actual loss ratio
Pennsylvania	Disallowed	Disallowed	Allowed	Optionally	60%	No
Rhode Island	Allowed	Allowed	Allowed	Optionally	55%	No
South Carolina	Disallowed	Allowed	Allowed	Guaranteed	55%	Yes
South Dakota	Allowed	Disallowed	Allowed	Optionally	60%	Yes
Tennessee	Allowed	Disallowed	Allowed	Conditionally	60%	Yes
Texas	Allowed	Allowed	Allowed	Optionally	60%	No
Utah	Disallowed	Disallowed	Allowed	Optionally	60%	No
Vermont	Disallowed	Disallowed	Disallowed	Conditionally	60%	Yes
Virginia	Allowed	Allowed	Allowed	Conditionally	60%	Yes
Washington	Disallowed	Disallowed	Disallowed	Guaranteed	55%	No
West Virginia	Allowed	Disallowed	Disallowed	Optionally	60%	Yes
Wisconsin	Disallowed	Disallowed	Disallowed	Guaranteed	55%	Yes
Wyoming	Disallowed	Allowed	Allowed	Optionally	None	No

Note: This chart presents a simplified description of key long-term care insurance requirements that the 50 states reported they enforce as their practice in regulating long-term care insurance. (The 50 includes the District of Columbia, but excludes Idaho, which did not return our questionnaire with sufficient data in time to be included in this report.) The states reported these requirements based on their practices at the time they completed the questionnaire (from May to October 1988). We did not attempt to gather information about all requirements but instead inquired about many of those that are key to consumer protection.

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