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Long-Term Care Insurance

Statement of
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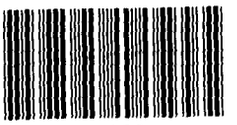
Long-Term Care and
Subcommittee on Housing and
Consumer Interests
Select Committee on Aging
House of Representatives



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SUMMARY

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 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.

GAO analyzed the premiums, benefits, and limitations of 33 policies offered by 25 insurers in 1986. These companies accounted for about 75 percent of the private long-term care insurance policies in 1986. 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 the long-term care insurance literature.

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 of the 33 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, the 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.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our recent report[1] on long-term care insurance policies.

Private long-term care insurance is a rapidly developing market. In mid 1986 there were an estimated 200,000 policyholders, but by April 1987, that number had grown to more than 420,000, according to a survey by the Department of Health and Human Services' Task Force on Long-Term Health Care Policies.

My testimony today highlights the results of our analysis of 33 long-term care policies offered by 25 companies in 1986, and information we gathered through discussions with state insurance officials and other knowledgeable individuals, on the potential for abuse in the marketing and selling of this type of insurance.

Of the 33 policies reviewed, 28 covered all three levels of nursing home care (skilled, intermediate, and custodial) and 21 covered home health care. About half covered all four levels of long term care. Annual premiums ranged from $20 to $7,030 for varying levels of coverage at different ages. Generally policy restrictions and limitations tended to reduce the benefits available. Also, the potential for abuse related to unclear policy language and abusive marketing practices exists in this market just as it does in the Medigap market.

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[1]Long-Term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-80, May 29, 1987).

Payments Not Adjusted for Inflation

All but one policy we reviewed were indemnity policies paying a fixed dollar amount per eligible day of care ranging from $10 to $120 a day. More than half of the policies that covered one or more levels of nursing home care paid a daily benefit comparable to the $58 average skilled nursing facility payment under Medicare in 1985, and more than half of the policies offering home health benefits provided coverage comparable to the 1985 average Medicare home health visit charge of $49.

One major deficiency of indemnity policies is that their benefits are generally not adjusted for inflation. A payment level that is adequate today may not be adequate in the future. For example, a 65-year-old individual who purchased a policy with a $50 daily indemnity benefit would have nearly full nursing home coverage initially, but, assuming that the current 6-percent annual nursing home inflation rate continues, that policy would cover only 31 percent of costs at age 85.

Shorter Duration of Benefits for Lower Levels of Care

All policies we reviewed stipulated the length of time benefits would be paid to policyholders--referred to as duration of benefits. The duration of nursing home benefits ranged from 3 months to 6 years, and the duration of home health benefits ranged from 10 days to 6 years.

About one-third of the nursing home policies we examined offer shorter durations of benefits for lower levels of nursing

home care, such as custodial care. Data for 1983, however, showed that Medicare nursing home patients admitted for postacute rehabilitative care had a mean length of stay of about 35 days compared with about 420 days for non-Medicare patients admitted for chronic, maintenance therapy. Because these custodial stays are typically much longer than stays at higher levels of care, the duration of benefits offered by the 10 policies did not correspond with probable need.

Restrictive Clauses

Almost all the policies we reviewed contained restrictive clauses that attempt to establish medical necessity (such as requiring a 3-day prior hospital stay before becoming eligible for benefits) as a basis for receiving benefits. 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:

-- About 45 percent of the policies required that less medically intensive nursing home care (such as intermediate or custodial care) be preceded by a more medically intensive level of care (such as hospital or skilled nursing care). In our opinion, these clauses would preclude payment of benefits for many nursing home

stays, such as those for individuals initially admitted for intermediate or custodial care.

-- About 18 percent of the policies that provided all three levels of nursing home care required that nursing home services be provided in a skilled nursing facility. This restriction might encourage inappropriate placement of individuals at a higher and more expensive level of care than necessary. Furthermore, policyholders might be unable to receive benefits where skilled nursing facility beds are in relatively short supply.

Policy Limitations

All of the policies contained features that limit coverage. In contrast to the restrictions I just mentioned, these limitations (for example, renewability limits and exclusions) are basically independent of medical necessity.

Renewability refers to the right of the insurer to cancel an individual's policy for reasons other than nonpayment of premiums. Like many other policy limitations and restrictions, renewability of long-term care policies affects the likelihood that benefits will be paid when needed. Only guaranteed renewable or noncancelable policies offer consumers assurance that renewal of their policy cannot be declined for any reason. Insurers can, however, raise premium rates on a class basis for guaranteed renewable policies. Although we did not find any noncancelable policies in the 33 we examined, 23 of the policies

were guaranteed renewable for life. Until recently, many long-term care insurers believed that guaranteeing renewability was too risky, so they only offered renewability terms that were less favorable to consumers.

With policies that are not guaranteed renewable, consumers who pay premiums for years could have their long-term care policies canceled and not receive any compensation for the premiums they have paid. For example, an insurer could cancel a policy for all policyholders or not renew an individual policy. If this happens, consumers would lose the premiums paid and be without coverage. None of the policies we reviewed contained a provision to compensate policyholders for the premiums paid in the event the policy is canceled.

Insurers also exclude coverage for certain services or conditions, such as care provided for nervous and mental disorders. Excluding all nervous and mental disorders has important implications for the value of long-term care insurance because people with Alzheimer's disease will not be covered for services related to this disease. An estimated 2.5 million elderly had Alzheimer's in 1985. Of the 33 policies we evaluated, 12 excluded services for this disease. Although 18 of the policies would appear to cover Alzheimer's, policyholders might be precluded from receiving benefits if insurers choose to require proof of the disease. Currently, definitive diagnosis of Alzheimer's can be made only by either brain biopsy or autopsy.

We did not determine the criteria insurers use to decide when claims for Alzheimer's disease-related services are payable.

Potential for Abuse

The final issue I would like to discuss is the potential for abuse in the marketing of long-term care insurance policies. 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. For example, ambiguous or complex policy language could mislead consumers about the coverage they are purchasing, or sales agents could knowingly sell consumers policies that duplicate their existing coverage under Medicare or a supplemental insurance policy. Some cases of abuse in the long-term care market have already been reported.

Although there are no federal laws that specifically govern the long-term care insurance industry, some states are initiating action to reduce the potential for and deal with alleged cases of abuse. Several states, including Colorado, Connecticut, Kentucky, and Wisconsin, have enacted minimum standards for policies to reduce abuse and eliminate confusion in the sale of long-term care insurance. Also, at least one state has initiated enforcement action in response to complaints of questionable marketing and selling practices. Efforts to deal with abuse vary from state to state but one commonly used approach is a public information campaign to educate elderly consumers so that they can better protect themselves.

The National Association of Insurance Commissioners 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. In this regard, we believe the Congress should consider the desirability of enacting federal legislation to reduce potential abuse at this stage of market development.

This concludes my statement. I will be happy to answer any questions you may have.