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LONG-TERM CARE INSURANCE

Better Controls Needed to Protect Consumers

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SUMMARY

GAO and others have identified significant problems with long-term care insurance policies and the standards that govern them. GAO has also identified problems with insurance companies selling long-term care insurance to low-income people. The National Association of Insurance Commissioners (NAIC) has developed model standards for this insurance. Despite the standards, consumers are still vulnerable to considerable risks for several reasons.

First, many states and insurance companies have not adopted all NAIC standards. Insurance companies have adopted NAIC standards more quickly than states have, but most policies we reviewed did not meet more recent NAIC standards, particularly those regarding disclosure and inflation protection.

Second, NAIC standards do not sufficiently address several features of long-term care insurance that have important consequences for consumers. For example, policy terminology, definitions, and eligibility criteria are expressed in language that is sometimes vague and inconsistent among policies. As a result, consumers are unable to compare policies or to foresee conditions under which they might be denied benefits. In addition, consumers face considerable financial risks. For example, they are vulnerable to price hikes for premiums that could make it difficult for them to retain their policies.

Finally, people with low incomes have purchased policies, although the insurance is expensive and they may be covered by a government program such as Medicaid. Companies that GAO reviewed do little to prevent the sale of long-term care insurance to people with low incomes.

GAO believes that standards in addition to the current NAIC standards are necessary. The new standards should promote uniform terminology and definitions for eligibility criteria, long-term care services, and long-term care facilities. The standards should also establish guidelines that address the relevance of eligibility criteria for different types of impairments, and establish formal grievance procedures. In addition, they should establish requirements that protect consumers against forfeiting all of their investments in premiums if their policies lapse, options for upgrading, and a structure for agents' sales commissions. If states do not adopt the NAIC standards, the Congress may wish to consider enacting legislation that sets minimum federal standards for long-term care insurance. Such legislation could include the current NAIC standards and the additional standards we have suggested.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our recent studies of long-term care insurance. One study reviewed long-term care insurance policies and the standards that govern them.[1] We presented testimony on this study in October 1991 before the Subcommittee on Commerce, Consumer Protection, and Competitiveness of the Committee on Energy and Commerce.[2] The other study reviewed company practices regarding the sales of long-term care insurance to people with limited financial resources.[3] As a result of these studies, we identified significant problems with long-term care insurance policies, the model standards developed for them by the National Association of Insurance Commissioners (NAIC), and company efforts to prevent the sales of such policies to low-income people.

RESULTS IN BRIEF

What we found, in brief, is that while NAIC standards have expanded, consumers are still vulnerable to considerable risks in purchasing long-term care insurance. Consumers are at risk for two major reasons.

First, many states have not adopted key NAIC standards, including some developed between 1986 and 1988. The NAIC standards, although not mandatory, suggest the minimum regulatory standards states should adopt. Insurance companies have adopted NAIC standards more quickly than states have, but most policies we reviewed did not meet more recent NAIC standards, particularly those regarding disclosure and inflation protection.

Second, the NAIC standards themselves do not sufficiently address several features of long-term care insurance that have important consequences for consumers. For example, policy terminology, definitions, and eligibility criteria are often expressed in language that is vague and inconsistent across policies. These problems make it difficult to compare policies and to judge which provisions can reduce the likelihood that a policyholder will receive benefits.

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

[2]Long-Term Care Insurance: Consumers Lack Protection In A Developing Market (GAO/T-HRD-92-05, October 24, 1991).

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

Consumers also face considerable financial risks. For example, insurance companies' setting of policy prices in a new market that lacks experience data requires periodic adjustments. As a result, consumers are vulnerable to price hikes that could make it difficult for them to retain their policies. Policyholders who allow their policies to lapse, however, almost always lose the investment component of their premiums.[4] Finally, in the absence of certain standards, consumers are limited in their options to upgrade policies and are vulnerable to abuses in the sale of long-term care insurance.

In addition to problems with insurance policies and standards, our work at eight insurance companies found that, except for Medicaid recipients, the companies do little to prevent the sale of long-term care insurance to consumers who cannot afford it. Because of its cost, one study showed that people with limited financial resources should not purchase long-term care insurance.[5] Nevertheless, many people with household incomes below $15,000 have purchased it.

SCOPE AND METHODOLOGY

In our study of long-term care insurance policies and standards, we compared each state's long-term care insurance laws and regulations with NAIC standards. We also reviewed 44 policies for sale in late 1990 by 27 insurers in eight states (Alabama, Arizona, California, Florida, Missouri, New Jersey, Pennsylvania, and Washington). The policies were randomly selected from insurers whose policies had been approved for sale by the eight states' insurance regulatory agencies. In addition, we consulted officials at NAIC, the Department of Health and Human Services, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association. We also consulted major consumer groups and private and government actuaries.

In our study of companies' sales practices, we obtained information from eight companies that sell long-term care

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[4]Policyholders who allow their policies to lapse will not get back a portion of the money they have paid in premiums. As with whole-life policies, most long-term care insurance policies have fixed annual premiums. Insurance companies price such policies so that they accrue substantial investment reserves in the early years to cover the increased risks for the companies in the later years. However, unlike whole-life policies, long-term care policies generally do not return any of the investment reserves to policyholders who allow their policies to lapse.

[5]Stephen C. Goss, Who Should Buy Long-Term Care Insurance? What Type of Policy Makes Sense? Presented at the Sixth Annual Conference of Private Long-Term Care Insurance, March 1990.

insurance policies nationally. The long-term care business of these companies collectively represented about one-half of the policies sold in this country.

STATES AND INSURERS LAG IN MEETING NAIC STANDARDS

In 1986 NAIC established model standards that have evolved rapidly. Although these standards are not mandatory for the states, they suggest the minimum standards states should adopt for regulating long-term care insurance. Many states, however, do not meet key NAIC standards developed between 1986 and 1988. We found, for example, that 23 states have not adopted standards requiring insurers to guarantee policy renewal and 19 states have not adopted standards disallowing Alzheimer's disease exclusions. These particular standards are basic to ensuring that policyholders are able to maintain coverage and that policyholders with Alzheimer's disease who need long-term care are not summarily excluded from receiving benefits.

States lag even further in adopting NAIC standards established after 1988. For example, 40 states have not adopted standards for inflation protection, home health care benefits, or disclosure of post-claims underwriting.[6]

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

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

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

NAIC STANDARDS SILENT ON KEY POLICY FEATURES

Now I would like to discuss the risks to consumers I enumerated earlier on which the NAIC standards are silent.

Services and Facilities

Consumers confront an array of policies made bewildering by the absence of uniform terminology and definitions. The absence of uniformity makes it difficult to compare policies and to judge which provisions could reduce the likelihood a policyholder would receive benefits. For example, in our sample of policies, common terms for services (such as "custodial care") and facilities (such as "nursing home") were often modified by provisions that could in effect preclude covering the intended services or eliminate the policyholder's area nursing homes from the pool of eligible facilities. These consequences likely would not be foreseen except by those especially knowledgeable about provider requirements and the delivery of long-term care services in a given state.

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

Regarding eligible facilities, consider one complaint to state commissioners we visited. A policyholder complained that her insurance company would not provide benefits unless she received care in a nursing home with 24-hour nursing services; the policy also required that these services be provided by a registered nurse. None of the several nursing homes in her area met these requirements. Of the 44 policies we reviewed, 12 policies required that the facilities provide 24-hour nursing services for custodial care.

Eligibility Criteria

Eligibility criteria in our sample policies were often vague, were not sufficient to assess the eligibility of many individuals with physical or mental impairments, or had implications for restricting benefits in ways that were not obvious. Two types of criteria illustrate these problems.

Many insurance companies use eligibility criteria that require that care be "medically necessary." But some policies do not define the term. Of the 30 policies that required care to be medically necessary, 6 left the term undefined. For the other policies, the definition varied. Apart from problems with the definition of medically necessary, medical necessity is not a relevant criterion for policyholders who do not need medical services. Some policyholders may need only custodial or home health care due to physical or cognitive impairments.

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

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

Grievance Process

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

NAIC STANDARDS DO NOT PROTECT CONSUMERS FROM PRICING OR MARKETING RISKS

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

Differences in Premiums for Similar Policies

We found substantial differences in premiums for policies that offered similar benefits and little consensus among actuaries on the definition of a reasonable price. For instance, annual premiums for four policies in our sample that offered only nursing home care ranged from about $1,200 to $1,600 (a difference of 33 percent).[4] Premiums for six policies offering nursing home care and home health care ranged from about $1,200 to $3,000 (a difference of 150 percent). Premiums for six policies that offered nursing home care, home health care, and adult day care ranged from about $1,400 to $2,700 (a difference of 93 percent). To the consumer, policies in each of these groups would have appeared similar because they offered the same basic benefits and dollar coverage. Moreover, the differences in the premiums across these three groups indicate that consumers could purchase policies that provided a full range of benefits at the same price as policies that provided only nursing home care.

Premium Increases

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

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[4]Premiums are based on coverage for a 75-year-old who obtains a policy that provides 3 years of nursing home care, begins paying $80 per day after the first 90 or 100 days of nursing home confinement, and provides no inflation protection.

Lack of Nonforfeiture Benefits

Consumer vulnerability to financial loss is compounded by the fact that policyholders who do not retain their policies almost always forfeit the investment component of their premiums. On average, insurance companies we reviewed expected that 60 percent or more of their original policyholders would allow their policies to lapse within 10 years; one company expected an 89-percent lapse rate after 10 years.[5] In all but two policies we reviewed, policyholders who allow their policies to lapse would lose the entire investment component of their premiums.

In our sample of policies, a consumer who purchased a policy at age 75 and allowed it to lapse at age 85 would, on average, lose about $20,000 in premiums. For either of the two policies in our sample that offered nonforfeiture benefits, the policyholder would receive back about $12,000 to $14,000 of the $20,000. The other 42 policies would offer the policyholder nothing back. NAIC standards do not require insurance companies to provide nonforfeiture benefits.

Limitations on Policy Upgrading

Consumers buying long-term care policies also face risks that are inherent in new, rapidly evolving insurance markets. For example, upgrading policies can be particularly troublesome for consumers who purchased earlier-generation policies. Many of the earlier policies contain overly restrictive provisions prohibited by NAIC, such as a prior hospitalization requirement. Today, many policyholders who bought such polices and who want to upgrade them to current standards may do so only with significantly higher premiums, if at all. These policyholders must meet the same requirements and the same terms as new purchasers. That is, they must meet the insurance company's criteria for medical underwriting and preexisting conditions, as well as pay the premium for their age group. The premium generally more than doubles for the 10-year difference between age 65 and 75. None of the policies we reviewed offered the option of upgrading the policy under more favorable conditions.

Incentives for Marketing Abuses

The high first-year sales commissions that agents can earn by selling long-term care policies create an incentive to make the consumer's specific long-term care requirements less of a consideration than the sale itself. The size of commissions are of concern to NAIC because high sales commissions have created incentives for abuses in the sale of other insurance to older

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

people. For example, large commissions associated with the initial sale of Medigap policies created undesirable incentives for agents to "churn" (that is, to sell) new policies to their customers.[6] As a result, a commission structure was established by NAIC that reduced incentives to churn Medigap policies. NAIC adopted Medigap standards for long-term care insurance, but they were presented as an option that states and insurers should consider adopting if they identified marketing abuses. The standards stipulate that insurance companies spread commissions over several years by limiting first-year commissions to no more than 200 percent of the commissions paid in the second year. In renewal years, the commissions should be the same as the second year and continue at that level for a reasonable number of years.

Agent commissions can be substantial. Of 16 policies we reviewed that had agent commission rates, only 1 paid first-year commissions that would meet NAIC's optional standards. The other 15 policies paid much higher commissions. On average, commissions were about 60 percent of the total value of the first year's premium. For half of the policies, this was at least twice NAIC's recommended rate. With one policy, for example, the sales agent could earn an initial commission of $2,000 (based on a 70-percent commission rate) for selling the policy to a 75-year-old consumer. These types of commissions provide considerable incentives for agents to sell policies to consumers who do not need them.

BETTER CONTROLS NEEDED IN SALES TO PEOPLE WITH LIMITED FINANCIAL RESOURCES

In addition to problems with policies and standards, we identified problems with insurance companies selling long-term care insurance to low-income people. We have just described the problems with high first-year sales commissions. Such commissions could also encourage agents to inappropriately sell long-term care insurance to low-income people.

Companies Lack Criteria and Data to Assess Who Should Buy

Because long-term care insurance is expensive, it is generally not appropriate for people with limited financial resources. People covered by Medicaid generally do not need it because Medicaid will pay for their care. Long-term care insurance may be inappropriate for other low-income people who

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[6]Medigap refers to private insurance policies designed to fill some of the gaps in Medicare coverage, such as deductibles and copayments.

would become eligible for Medicaid soon after they incur nursing home expenses.

Officials from the eight companies we reviewed said that they do not want to sell long-term care insurance to people for whom it is inappropriate. Despite their stated intentions, the companies do not have clearly established financial criteria about who should buy. Only one company has established such financial criteria. It recommends that this insurance should be purchased by people with nonhousing assets of $20,000 or more. In addition, companies do not know whether they are selling to low-income people because they do not systematically obtain financial information from applicants. A recent study showed that almost 20 percent of purchasers had household incomes of $15,000 or less a year.[7]

NAIC recognizes that this insurance may not be an appropriate purchase for Medicaid recipients. NAIC standards require applications for long-term care insurance to contain questions about whether the applicant has Medicaid coverage. However, applications from two of the eight companies we reviewed did not contain such questions.

Training Material Says Little About Avoiding Sales to Low-Income People

All but one of the insurance companies we reviewed sell long-term care insurance through agents. We reviewed material that companies use to train these agents. We also inquired about training requirements for agents. Not all companies require their agents to attend training courses.

Officials from most of the companies told us that their agents are instructed not to sell to low-income people. Officials from two companies told us that their agents are instructed to ask applicants about their incomes and assets, and to consider this information when making a sale. However, the companies provide agents with limited training or material on assessing the financial condition of potential buyers or on avoiding sales to low-income people.

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[7]LifePlans, Inc., Who Buys Long-Term Care Insurance?, Health Insurance Association of America (1992).

Companies Do Not Specifically Monitor Sales to Low-Income People

Seven companies that sell insurance through agents do not monitor whether agents sell to low-income people. However, company officials told us that agents will be disciplined if it is discovered that they do not meet company standards for selling to low-income people. Officials of these companies could not tell us if, or how frequently, they discipline agents for such sales. The companies do not maintain records to indicate whether agents have been reprimanded or terminated for this problem.

Several officials said that because low-income people cannot afford long-term care insurance, they generally do not buy it. Therefore, they said that there is little need to discipline agents for such sales. This belief seems to be inconsistent with the recent survey indicating that low-income people represent a substantial proportion of the people who purchase long-term care insurance.[8]

Companies Provide Limited or No Guidance to Consumers

Only four of the eight companies provide consumers with marketing material that alerts them to potential problems of affordability. For example, two companies inform consumers that it is important to buy only what they can afford. Another company's marketing brochure recommends this product only to people with nonhousing assets of $20,000 or more. It also advises people who might qualify for Medicaid that, since they do not need this coverage, they should not apply for it. The brochures and informational letters from the other four companies do not address the issue.

CONCLUSIONS AND MATTER FOR CONSIDERATION

We believe standards in addition to current NAIC standards are needed. These standards should

- promote uniformity of terminology and definitions for eligibility criteria, long-term care services, and long-term care facilities;
- establish guidelines that address the relevance of eligibility criteria for different types of impairments;
- establish formal grievance procedures;
- establish requirements for nonforfeiture benefits;

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[8]LifePlans, Inc., 1992.

- establish options for upgrading coverage; and
- establish a sales-commission structure for long-term care insurance, as was done for Medigap insurance, that reduces incentives for marketing abuses.

New standards alone would not ensure adequate consumer protection. Despite substantial progress in recent years, many states have not adopted key NAIC standards, and when they will do so is uncertain. Therefore, if states do not adopt the NAIC standards, the Congress may wish to consider enacting legislation that sets minimum federal standards for long-term care insurance. Such legislation could include the current NAIC standards and the additional standards we have suggested.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

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